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GOVERNMENT OF ARUNACHAL PRADESH
DEPARTMENT OF HEALTH AND FAMILY WELFARE
3RD FLOOR, BLOCK NO. 2
CIVIL SECRETARIAT
ITANAGAR

———

NOTIFICATION

The 5th April, 2025

No.DMETR-12/2/2024. —In pursuance of the approval of the competent authority vide No. DMETR-12/1/2024 dated 4th April, 2025, in the interest of public service, the Governor of Arunachal Pradesh is pleased to notify the COMPREHENSIVE MEDICO-LEGAL MANUAL for Department of Health and Family Welfare, Government of Arunachal Pradesh.

CHAPTER - I

MEDICO - LEGAL CASE (MLC)

1.1. What/which is a medico-legal case (MLC)?

Any case wherever after taking history and clinical examination of the patient, attending doctor/medical officer thinks that some investigation by law enforcing agencies is essential to ascertains circumstances and fix the responsibility regarding the occurrence of the cause in accordance with the law of land.

1.2. Who is Registered Medical Practitioner (RMP)?

"Registered Medical Practitioner" means a medical practitioner who possesses any medical qualification recognised under the National Medical Commission Act, 2019 and whose name has been entered in the National Medical Register or a State Medical Register under that act [Bharatiya Nagarik Suraksha Sanhita (BNSS) 2023 Section 51 (3)(b)]. Ex. Emergency Medical Officer (EMO), Treating Doctor, General Practitioner (GP), Medical Officer (MO), Duty Medical Officer (DMO), Doctor on Duty etc.

1.3. What is expected from an RMP?

1.3.1. Take position of responsibility

1.3.2. Independent functioning

1.3.3. Know the relevant provisions under various laws

1.3.4 Attend as expert witness in the court of law

1.4. What are the duties of Registered Medical Practitioner (RMP) in MLC cases?

1.4.1. To save the life or give primary treatment to patient is the foremost responsibility

1.4.2. To decide whether registered the case as MLC or non-MLC

1.4.3. To send the police intimation about the case

1.4.4. Proper documentation

1.4.5. Collection and Preservation of medico-legally important evidences

1.5. List of MLCs

1.5.1. Injuries (Accidents /Assault/animal bite or attack)

1.5.2. Suspected or evident cases of suicides or homicides(suspected/attempted/confirmed)

1.5.3. Poisoning (confirmed or suspected)

1.5.4. Burns

1.5.5. Sexual Offences

1.5.6. Criminal Abortion(suspected/confirmed)

1.5.7. All patients brought to the hospital in suspicious circumstances/ improper history (ex: found dead on road)

1.5.8. Unconscious patients (cause not clear)

1.5.9. Child Abuse

1.5.10. Domestic Violence

1.5.11. Death under Police/Judicial Custody

1.5.12. Sudden death on operation table/after parenteral administration of a drug/ medication/ whose cause of death unknown

1.5.13. Case of Drunkenness

1.5.14. Age estimation

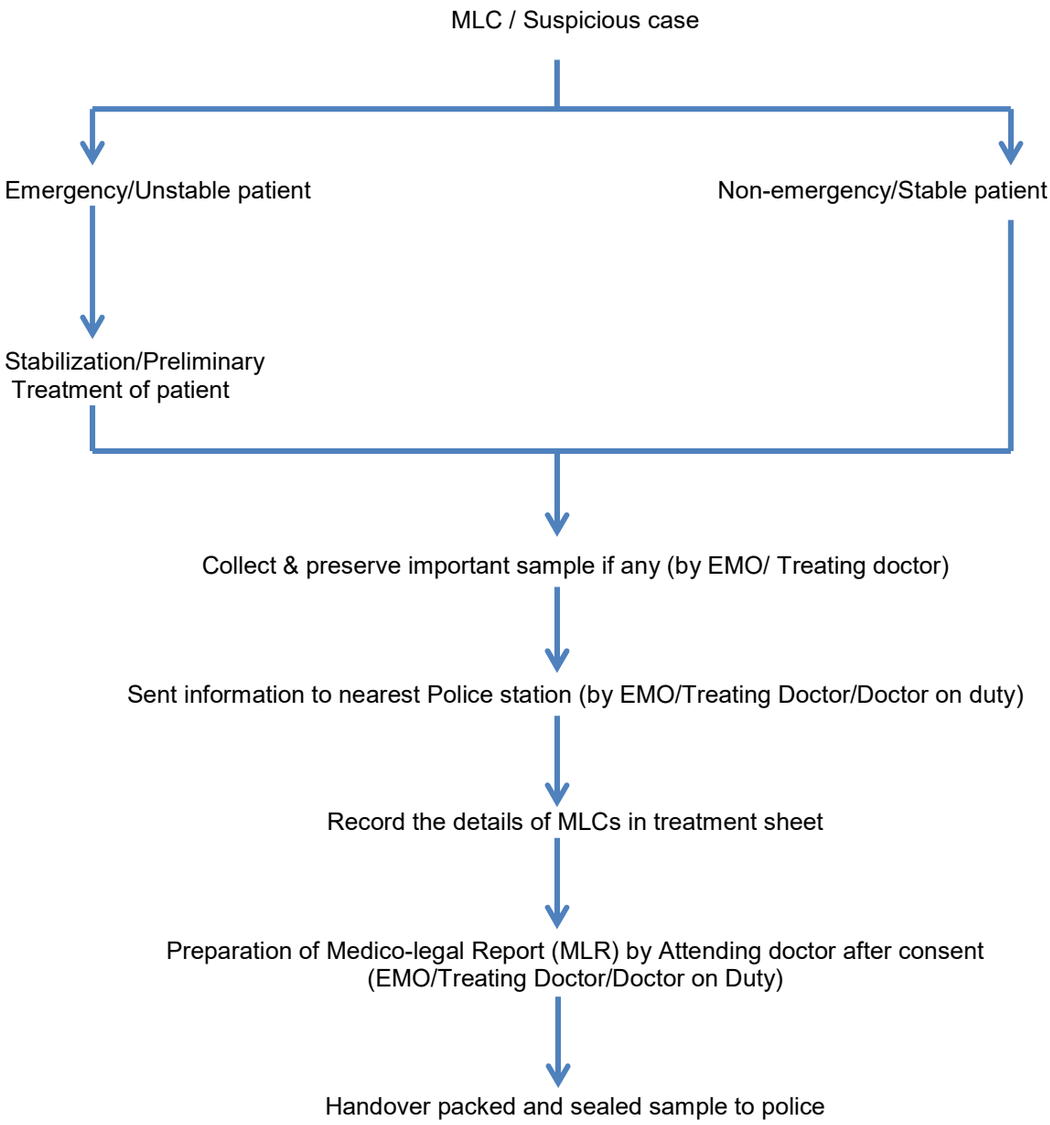
1.5.15. Brought Dead

1.5.16. Natural Disaster

1.6. Work Flow for Medico-legal Cases (MLC) brought to Emergency

1.6.1 All patients/cases confirmed or suspected MLCs, are allotted an MLC number.

1.6.2 Out-patient department (OPD)/ in-patient department (IPD) MLC information must reach emergency to allot MLC Number.



1.7. Protocol for filling the Medicolegal Report (MLR)

1.7.1. Preliminary:

1.7.1.1. Explain the medico-legal aspects to the patient and obtain consent for the examination on the MLR sheet. If the patient is under 12 years old, unconscious, or of unsound mind, obtain consent from the guardian/accompanying person or the police.

1.7.1.2. Fill in the MLR number, UHID (Unique Hospital Identification) number, time and date of arrival, time and date of police intimation, name and number of the accompanying police officer. Document the police request/reference number, police station and date where applicable.

1.7.1.3. Thoroughly document the particulars of the patient/person concerned.

1.7.1.4. Document the details of the accompanying person (e.g., name, address, relationship with the patient concerned, contact number, etc.).

1.7.1.5. Clearly document the time and date of examination and mention the place of examination if necessary.

1.7.1.6. Note two identification marks, preferably on exposed areas of the body.

1.7.1.7. Take a proper history in the person/patient/guardian's own words based on the case and document it correctly.

1.7.2. Examination:

1.7.2.1. Provide detailed documentation of injuries (type, size, shape, color, location, vascular or neurological deficit, restriction of movement) and use diagrams where necessary.

1.7.2.2. Document injuries, mentioning length, breadth and depth as deemed appropriate.

1.7.2.3. Use a two-point reference for the location (one vertical and one horizontal).

1.7.2.4. Record the general condition of the patient/person (e.g., GCS, pulse rate, blood pressure, respiratory rate, temperature, Spo2 saturation, intubation, neck collar, bandage, etc.).

1.7.2.5. In cases of poisoning or other specific conditions, provide a detailed general examination and note other relevant signs.

1.7.2.6. Document the condition of clothing/any smell/foreign body, etc.

1.7.2.7. Record the details of the investigation and any treatment provided.

1.7.3. Opinion:

1.7.3.1. Provide a clear and concise opinion on the duration of the injury, the weapon used, and the nature of the injury.

1.7.3.2. Mention any trace evidence/samples collected, preserved, and handed over.

CHAPTER - II

GENERAL GUIDELINES FOR HANDLING MLC

2.1. Assign an MLC number to all patients/cases confirmed or suspected medico-legal cases (MLC) including self-examination come to Emergency or out-patient department (OPD).

2.2. Each MLC number should be assigned in a coded format, such as 001/2025.

2.3. Cases involving sexual assault, age estimation, drunkenness tests, potency tests, sex verification or confirmation tests etc. should be referred to the on-duty doctor responsible of such examination; or to the medical superintendent, whenever medical board is required for examination and report after generating an OPD ticket.

2.4. EMO/Treating Doctors can write and sign MLC information to the police. Reporting MLCs to the police/magistrate is mandatory under Bharatiya Nagarik Suraksha Sanhita (BNSS)2023 Section 33, 397 and the POCSO Act, 2012.

2.5. If a case recorded as an MLC at another hospital is referred, do not issue a new MLC number. Continue treatment under the existing MLC number and inform the police.

2.6. If a case is brought several days after the incident, assign a new MLC number and send a report to the police.

2.7. If the EMO in the Emergency department does not register a case as MLC initially, but the IPD (in-patient department) treating doctor believes it necessary, record it as MLC even if initially missed.

2.8. Injury reports should be made only once (usual practice). Do not prepare new reports for referred documented MLCs unless requested by a competent authority (police/magistrate).

2.9. Prepare reports (except post-mortem reports) only after obtaining consent from the patient / guardian / accompanying person after explaining the medico-legal aspects. Document informed refusal on the consent form or treatment sheet if consent is refused.

2.10. Document detailed findings in all MLCs (both fresh and referred) in treatment sheet.

2.11. Maintain a separate file for MLCs containing Discharge/referral/Death summary or LAMA (leave against medical advice) [physical/digital]. This file should include information on admission, case history, examination findings, investigations and reports, treatments and the corresponding dates and times.

2.12. Medico-Legal Reports should be prepared and signed by the examining doctor on every page. When applicable, the report can be signed by two or more doctors together.

2.13. Always prepare report in triplets: one for hospital records, one for the patient/department records, and the original for the police.

2.14. Label all treatment papers, investigation reports, etc., as MLC, and maintain records for future medico-legal use (these may be required by the court for the case).

2.15. Hand over the patient's belongings or samples preserved for medico-legal purposes to the police officer after being packed and sealed and obtain a proper receipt in every case.

2.16. Notify the police and security staff whenever a patient absconds, is forcibly taken away by attendants, or a dead body is removed and leaves the hospital against medical advice (LAMA) in MLCs. Ensure this is documented in the patient's file.

2.17. In the event of impending death in an MLC, the Medical Officer should immediately request the police officer to call a magistrate in writing. If there is no time to call a magistrate, the dying declaration should be recorded by the doctor himself in the presence of another doctor or staff member. The doctor must ensure and document that the patient is in a compos mentis (alert mental state) during the declaration.

2.18. Information to police (Mandatory)

2.18.1. New MLCs (fresh & referred)

2.18.2. Death in MLCs

2.18.3. Brought dead/Death on arrival cases

2.18.4. LAMA/Absconded in MLCs

2.18.5. Death on operation table cases- For safety and transparency purpose

2.18.6. Pregnancy death - For safety and transparency purpose

CHAPTER - 3

SPECIFIC CASES

(Important Points to be remembered)

3.1. Rape/Sexual Assault Cases (Suspect and Survivor):

3.1.1. Be polite towards the survivor or accused.

3.1.2. Prioritize First Aid or treatment when required. All private or public hospitals shall treat free of cost to the victims of sexual assault and acid attack [Bharatiya Nagarik Suraksha Sanhita (BNSS) 2023 Section 397]; and contravention of it punishable under [Bharatiya Nyaya Sanhita (BNS) 2023 Section 200].

3.1.3. Do not delay the examination. Denying examination of the rape survivor is unlawful**.**

3.1.4. Ensure that a female attendant is present during the examination of the survivor. If the survivor prefers, she may have a female acquaintance or relative accompany her.

3.1.5. Female survivors under Protection of Children from Sexual Offences Act, 2012 (POCSO) mandatorily be examined by only a female RMP. Male survivors or accused under this Act, and individuals over 18 years, whether survivors or accused, can be examined by any RMP with their consent.

3.1.6. When examining genitalia in children with painful conditions, sedatives or analgesics may be needed.

3.1.7. Consent must before examination of survivor, if person is< 12 years or person of unsound mind obtain consent of parent/ guardian/entrusted person.

3.1.8. Doctor must give following information during consent-

3.1.8.1. Regarding the nature and purpose of examination.

3.1.8.2. Examination will help in the prosecution of those who committed the crime

3.1.8.3. The procedure may involve an examination of the mouth, breasts, vagina, anus and rectum.

3.1.8.4. Examination may include removing and isolating clothing, or some samples such as scalp hair, genital swab, nail clippings, blood samples etc.

3.1.8.5. That the Survivor or in case of child <12y, Parents/Guardian or any other person in whom child reposes trust has the legal right to refuse full or part of the examination.

3.1.8.5.1. In case of refusal, inform that it would not affect treatment aspects but may hinder conviction of the accused.

3.1.8.5.2. Informed refusal must be recorded with the signature of survivor and two witnesses.

3.1.9. **For suspects or accused,** medical examination can be conducted with reasonable force if they decline consent under BNSS 2023 Section 52 (1) and record that, the examination is being done under mentioned section applied by police or magistrate.

3.1.10. Any doctor examining the survivor of sexual assault (BNSS 2023 Section 184), must inform the police about incident irrespective of consent for examination (BNSS 2023 Section 397, POCSO act 2012).

3.1.11. Ensure that the survivor and suspect do not encounter each other at the place of examination.

3.1.12. Do not attempt to undress the survivor/suspect for examination. Convince them to undress themselves.

3.1.13. Examine properly and fill the prescribed forms for accused and survivors.

3.1.14. Record the injuries with details- type, size, shape colour, location etc. and depict the injuries on appropriate body diagrams.

3.1.15. The exact time of commencement and completion of the examination shall be noted in the report.

3.1.16. The report shall state precisely the reasons for each conclusion arrived at.

3.1.17. If clothes are to be preserved and sealed, always provide proper clothing or inform the relatives to bring a set of clothes.

3.1.18. Examination report shall be made in triplicate (original for investigating officer, 2nd copy for survivor and 3rd for hospital record). Each page must be signed by examining doctor.

3.1.19. Examination report must have following particulars

(a) The name and address of the survivor or accused and of the person by whom she or he was brought;

(b) The age of the survivor or accused;

(c) The description of material taken from the person of the survivor or accused for DNA profiling;

(d) Marks of injury, if any, on the person of the survivor or accused;

(e) General mental condition (for survivor only);

(f) Other material particulars in reasonable detail.

3.1.20. After collection, the evidence materials should be packed and sealed, and then forwarded to the forensic laboratory for analysis, following receipt of the checklist from the police.

3.1.21. The medical sample should be sent to the hospital laboratory.

3.1.22. Examination and evidence collection for sexual assault survivors or accused individuals will be conducted using an Evidence collection or **Sexual Assault Forensic Examination (SAFE) Kit** provided by the government. This kit includes instructions, proforma, and necessary materials.

3.1.23. The registered medical practitioner shall, within a period of seven days (for survivor BNSS 2023 Section 184)/without delay [for accused BNSS 2023 Section 52(5)] forward the report to the investigating officer.

3.1.24. Never conduct or comment on “Two-Finger Test”.

3.1.25. Avoid making any judgmental remarks or comments that might appear unsympathetic or apathetic.(Like comments on shape, size, and/or elasticity of the anal/vaginal opening or about previous sexual experience or habituation to anal/vaginal intercourse)

3.1.26. Remember, Rape is a legal decision not a medical diagnosis.

3.1.27. Always provide information regarding psychiatric counselling to the survivor.

3.1.28. If age estimation is required, should be done by the age estimation board formed in the referred institution.

3.1.29. Doctor shall ask about the merits of such examination to police when request for potency examination of accused**.**

Note**:**

1. Spermatozoa may be recovered from cervix and posterior fornix beyond 96 hours after the assault. Hence, it is advisable to collect swabs up to at least 3 weeks after the assault, considering the individual circumstances of the case and age of the survivor.
2. Study result conducted at NICFS on the Persistence of Spermatozoa in vagina /Cervix are also in consonance with the below reported recovery time.

Table**:** maximum reported recovery times for Spermatozoa from living sexual assault survivor

Sperm	Vagina	Cervix	Mouth	Rectum	Anus
Motile	6-18 hours	3-7.5 days	-	-	-
Non-motile	14hrs – 10 days	7.5 – 19 days	2-31 hours	4-113 hours	2-24 hours

3.2. Firearm Injuries:

3.2.1. Bullets, lead shots, pellets, etc., recovered from wounds or the body should be air-dried, placed in a bottle padded with cotton, documented, sealed and handed over to the police.

3.2.2. Mention the entry and exit wounds.

3.2.3. Take an X-ray of the track or whole body before recovery from the body.

3.2.4. Always pick the bullet using fingers or rubber-tipped forceps, not metal/toothed forceps.

3.2.5. Never wash the bullet.

3.2.6. Preserve clothes, hand rub, blood, hair surrounding the wound and gauze rub over blackening/tattooing areas where applicable.

3.3. Criminal Abortion:

3.3.1. Provide proper treatment.

3.3.2. Take a detailed history and document it.

3.3.3. If the patient refuses to make a statement, the doctor should not pursue the matter and must consult a senior professional colleague.

3.3.4. Examine and preserve the clothes.

3.3.5. Collect and preserve blood samples and remains of the product of conception **(POC)** for chemical and DNA analysis if required.

3.3.6. Counsel the patient about health consequences and contraception.

3.3.7. If the patient expires, send the body to the mortuary for further police action.

3.4. Burns:

3.4.1. Take a detailed history and document it.

3.4.2. Provide primary treatment.

3.4.3. Note burns in terms of the extent of the involved area in percentage and degree.

3.4.4. Make a proper sketch showing the areas involved.

3.4.5. Note and preserve any inflammable agents present on the body/clothing.

3.5. Hanging/Strangulation:

3.5.1. Describe the ligature mark's position, width, length, direction and extent, whether complete or incomplete.

3.5.2. Cut the ligature material in situ away from the knot to avoid disturbing it. Secure the cut ends and knot separately with threads.

3.5.3. Preserve the ligature material.

3.5.4. Examine the ligature material for its nature, position, type of knot, circumference of the loop, length of short and long free ends, foreign bodies and stains.

3.6. Poisoning:

3.6.1. Provide primary treatment.

3.6.2. Take a detailed history of the substance consumed, amount, time, place and number of people involved.

3.6.3. Properly document the history, treatment and sealed articles.

3.6.4. Collect and preserve clothes, samples of vomitus/stomach wash and blood samples where possible and make a record.

3.6.5. Never allow unauthorized persons near the victim in cases of homicidal poisoning.

3.7. Injury Cases:

3.7.1. Provide primary treatment.

3.7.2. Examine and record all injuries in the proper format.

3.7.3. The opinion should include the type of weapon (sharp/blunt/pointed), nature of injury (simple/grievous), and duration of injury.

3.7.4. Preserve sample evidence, when necessary.

3.8. Child Abuse:

3.8.1. Approach all children with extreme sensitivity and recognize their vulnerability.

3.8.2. Provide proper treatment.

3.8.3. Medical examination should usually be done within 24 hours or as soon as possible.

3.8.4. Obtain written consent from parents/guardians/entrusted person.

3.8.5. Obtain verbal, expressed, or written consent from the child.

3.8.6. Record the child's weight, height and sexual development.

3.8.7. Take a detailed history and document it correctly.

3.8.8. Prepare the child by explaining the examination and showing the equipment; this helps reduce fears and anxiety. Encourage the child to ask questions about the examination.

3.8.9. If possible, interview the child alone (separately from the attendants) in a separate room.

3.8.10. Psychiatric counselling is advised.

3.8.11. Never put undue pressure on a child for a medical examination if they refuse, even after convincing. However, in conditions requiring medical attention, such as bleeding or a suspected foreign body, consider sedation or general anaesthesia.

3.8.12. Avoid unnecessary painful and invasive procedures.

3.9. Drunkenness:

3.9.1. Take a detailed history and document it correctly in the provided form.

3.9.2. Consent should be obtained before examination, but under Section 51(1) BNSS 2023, examination of an arrested accused can be carried out by a doctor with reasonable force when refuse. Record that, the examination is being done under above mentioned section applied by police or magistrate.

3.9.3. Examine properly and document it.

3.9.4. Collect urine/blood samples whenever necessary. Note the collection time and date.

3.9.5. Never use rubber stoppers for sample collection. Use screw-capped bottles / vacutainer.

3.9.6. Mention the starting and ending time and date of the examination.

3.9.7. Do not use spirit for cleaning the skin, and ensure the syringe is free from any trace of alcohol. Chlorhexidine can be used instead.

3.10. Age Estimation

3.10.1. Age estimation should be conducted by a medical board rather than an individual doctor.

3.10.2. A medical examination to determine age should only be conducted when mandated by the police, court, or other authorities, particularly when primary documents are unavailable, altered, or suspected of tampering.

3.10.3. These examinations should be considered a last resort.

3.10.4. Primary documents accepted for age verification (Juvenile Justice rules, 2007) include—

(a) Matriculation or equivalent certificates, if available; and in absence thereof;

(b) The date of birth certificates from first school attended (not play school) and in absence thereof;

(c) The birth certificate issued by a corporation or municipal authority or a panchayat ;

3.10.5. The Ministry of Youth Affairs and sports, has the National Code Against Age Fraud in Sports (NCAAFS) to ensure fair play in sports.

3.10.6. The medical board should include physician (a lady doctor in case of female subject), dental surgeon, radiologist and civil surgeon (forensic doctor). Forensic doctor being chairman, should include any other medical expert in the medical board as deemed necessary.

IMPORTANT NOTE :

1. Omission to produce document or electronic record to public servant by person, legally bound to produce it punishable under Bharatiya Nyaya Sanhita (BNS) 2023 Section 210, Causing Omission to give notice or information to public servant by person legally bound to give it punishable under BNS 2023 Section 211, Intentional omission to give information of offence by person bound to inform punishable under BNS 2023 Section 239.

2. Disappearance of evidence (failure to collect, destruction or loss), or giving false information to screen offender – punishable under BNS 2023 Section 238.

CHAPTER - 4

SUMMONS or SUBPOENA

4.1. A document compelling a witness to attend a court of law on a specific day, time and place for the purpose of giving evidence, under penalty.

4.2. Issued by the court and served to the witness by the police, an officer of the court, a public servant, or by post.

4.3. When served, keep one copy and acknowledge receipt by signing another copy.

4.4. Must be obeyed, or it can result in punishment. If there are valid and urgent reasons, communicate it to the court.

4.5. Doctors give evidence as expert witnesses.

4.6. For all medico-legal purposes in medicine, courts in India consider an MBBS degree as sufficient educational qualification to give evidence as an expert witness.

4.7. **Attend the specified court on the scheduled date and time to give evidence, preferably through *Virtual Conference (VC) or in person.***

4.8. Submit the summon attendance receipt copy to the respective department/institute office (usual practice) or in court, along with a cash memo for travel allowance, diet allowance, etc., when attending court in person.

4.9. **Dos and Don’ts inside court proceedings**

(a) Take an oath or affirmation when asked.

(b) Dress appropriately, and do not discuss the case with anyone except the lawyer who called you.

(c) Use simple language, remain calm, and do not refuse to answer questions.

(d) If a question is unfair, you can raise it with the lawyer or judge.

(e) Avoid using phrases like "In my opinion," "I think," or "I imagine."

(f) Only provide information that is asked for, and do not volunteer extra details.

(g) Do not try to memorize your testimony as the law allows you to refresh your memory from copies of reports.

(h) After giving evidence, review the transcript for any errors. Request corrections if necessary, and sign at the bottom of the transcript in every page.

(i) Take receipt of attendance for evidence from court.

CHAPTER – 5

GUIDELINES FOR MORTUARY ASSISTANTS AND ATTENDANTS FOR RECEIVING AND HANDING OVER MEDICO-LEGAL CASE (MLC)/NON-MLC BODIES

5.1. Mortuary attendants will receive the Death Slip from the hospital along with the dead body.

5.2. The mortuary attendant will verify the details on the death slip and ensure they match the tag on the dead body. They will then record these details in the entry register.

5.3. If the dead body is brought from outside (MLC/Non-MLC) or from the institution (non-MLC), the applicant must complete a dead body preservation request form, stating the reason.

5.4. The deceased's relatives/legal heirs/applicant must sign and provide their name, time, and date in the entry register.

5.5. The keys will be kept exclusively with the mortuary attendant.

5.6. After processing the documents, the mortuary attendant will open the cold cabinet and place the body inside the chamber.

5.7. When the relatives/legal heirs wish to take the non-MLC dead body, they must first sign with the date and time in the receiving column of the dead body entry register, providing their address details or a photocopy of their ID card and contact number.

5.8. The mortuary attendant will then open the cold cabinet and remove the body from the chamber.

5.9. The mortuary attendant will match the tag on the dead body with the details on the death slip.

5.10. At least two relatives must identify the dead body and the mortuary attendant must verify this.

5.11. The body will be transferred to the vehicle only after the matching procedure is complete.

5.12. If the MLC case has been waived off from a post-mortem examination, the mortuary attendant must check the waiver application submitted to the Investigating Officer (I.O.), the I.O.'s permission and the request letter to the mortuary in-charge, along with the death slip and dead body preservation request form. If everything is in order, the attendant will proceed.

5.13. After the post-mortem examination, if there is a delay in taking away the dead body, the police will fill out the dead body preservation form, taking responsibility for the body's custody.

5.14. Vigilance is advised, especially during nighttime hours, ensuring the body is identified in well-lit areas.

5.15. Mortuary attendants must take special precautions when handling two bodies with identical features (name, age, sex, appearances, etc.).

CHAPTER – 6

CODE OF CONDUCT IN POST-MORTEM EXAMINATION

All members of the forensic community are requested to adhere to the following instructions:

6.1. Inquest papers for all cases should initially be reviewed by a resident/tutor/doctor on duty/medical officer before the post-mortem examination. Any inadequacies in the inquest papers should be reported to the senior staff as necessary.

6.2. Residents/tutors/duty doctors must ensure that the body is identified by the family members of the deceased or the person in legal possession of the body, in the presence of the **police/Investigating Officer (I.O.)** for unknown bodies. This should be followed by obtaining a signature on the back of the forwarding letter/inquest paper before the post-mortem examination.

6.3. Post-mortem examinations will be conducted individually or as a team, depending on the sensitivity or extraordinary nature of the case.

6.4. Only individuals directly involved in the post-mortem examination are to be present in the examination room. When necessary, the I.O. should be present, and a videographer or photographer should be involved if videography or photography is required.

6.5. Any items or possessions recovered from the body during the post-mortem examination should be handed over strictly to the family members in presence of police by the doctors only.

6.6. The post-mortem report should be prepared and submitted within 3 to 7 days timeframe, and delayed beyond depends on the nature of the case.

6.7. "The department's office staff must promptly inform the Investigating Officer (I.O.) of the case once the post-mortem report is ready, utilizing the fastest available communication method, such as Wireless transfer, voice or video calls, Whats App, email, or SMS".

6.8. In cases where it is rational or indicated, the duty doctor should preserve viscera/ histopathology samples and consult seniors whenever necessary.

6.9. All medical officers, mortuary attendants, and staff are strictly prohibited from discussing any information about post-mortem findings with the I.O./police personnel, the deceased's party, or any other person to avoid conflict of interest and maintain confidentiality. This applies both before and after the finalization of the post-mortem report and its approval for dispatch, or afterward. This policy is in place to prevent any miscarriage of justice.

6.10. Medical officers should bear in mind that post-mortem reports are issued for the delivery of justice, it is essential to maintain the highest standards of credibility and practice, as these works are subject to national and international scrutiny.

CHAPTER - 7

PROCEDURAL GUIDELINES FOR POST-MORTEM/ AUTOPSY EXAMINATION

7.1. Jurisdiction:

7.1.1. Every Government hospital should conduct post-mortem examinations only on bodies received from the police station within their jurisdiction.

7.1.2. Medico-legal autopsy requests outside the jurisdiction require special permission from the **Judicial Magistrate**, to be produced by the **Investigating Officer (IO).**

7.1.3. Post-mortem examinations after normal duty hours require an authorized letter from a magistrate stating the reason, except for organ donation cases. **Night or after-duty hours post-mortems for organ donation can be conducted where the post-mortem room has adequate infrastructure and is deemed suitable for such procedures on a regular basis.**

7.1.4. A **pathological autopsy** should be conducted by the hospital pathologist whenever necessary to determine the actual disease or cause of death. This procedure must be carried out after obtaining proper consent from the family members, next of kin, or an authorized person on their behalf.

7.2. Pre-requisites for Post-Mortem Examination

7.2.1. Required papers:

7.2.1.1. Request/forwarding letter from police/magistrate

7.2.1.2. Inquest/Detailed fact sheets of the case

7.2.1.3. Dead body challan

7.2.1.4. Optional

7.2.1.4.1. MLC police intimation

7.2.1.4.2. Death report, death summary and other hospital records where applicable

7.2.1.4.3. Other relevant statements/documents that may be helpful

7.2.2. The presence of the investigating officer of the case is mandatory before/during the post-mortem examination to handle any discrepancies and understand the case details.

7.2.3. In the case of a magistrate inquest, the magistrate is advised to be present and discuss the case with the autopsy surgeon. If not, a police officer familiar with the case should conduct the post-mortem proceedings in writing.

7.2.4. To form a Medical Board for a post-mortem examination, the Investigating Officer must submit a request to the Head of Department (HOD) or Medical Superintendent using the appropriate format available in the mortuary, or as directed by the state authority.

7.2.5. Videography/Photography must follow the procedures and guidelines of the National Human Rights Commission (NHRC) and Ministry of Health and Family Welfare(MHFW). The Investigating Officer must arrange for the videographer/photographer and obtain permission from the mortuary in-charge/autopsy surgeon using the proper format available in the mortuary if no request is included in the forwarding letter.

7.2.6. The IO will report to the doctor (autopsy surgeon/medical officer) on duty with inquest papers for the post-mortem examination.

7.2.7. The doctor on duty will review the case papers for facts, discrepancies, or missing information. Any discrepancies in the papers must be corrected by IO/Police officer prior to the autopsy and sign after correction as appropriate.

7.2.8. The dead body must be identified by the relatives and police before the post-mortem examination. Signatures of at least two relatives and the police identifying the body are required.

7.2.9. In the case of unknown bodies, the Investigating Officer is responsible for correct identification.

7.2.10. Unauthorized persons are not allowed in the mortuary hall during the post-mortem examination. Only the Investigating Officer and the videographer (if videography is required) are permitted.

7.2.11. Universal precautions must be followed for highly infectious diseases per protocol by the authority.

7.3. After Post-Mortem Examination

7.3.1. After completing the post-mortem, the body will be stitched, cleaned, packed, and handed over to the investigating officer for further transfer to the next of kin/legal custodian of the deceased.

7.3.2. Articles and clothes present on the body are collected and handed over to the investigating officer/police for the next of kin/legal custodian.

7.3.3. Viscera or any specimens preserved during the examination are packed with relevant details on the sample container/box, signed by the doctor (autopsy surgeon), and sealed with the department seal used for medico-legal purposes.

7.3.4. Once the sample is received by the Investigating Officer, the chain of custody is considered complete.

7.3.5. The sample seal should be sent along with the chemical examination form to issue the chain of custody.

7.3.6. The autopsy surgeon should issue the post-mortem certificate in the proper format for the transportation of the body.

7.3.7. If embalming is done, a certificate should be issued in the proper format. For domestic cases, three copies are issued and for international cases, five copies are issued, mentioning the days fit for air transport.

7.3.8. If the body is to be preserved in cold storage after the post-mortem, the request form available in the mortuary should be filled out and submitted.

7.4. Waive-off

7.4.1. The autopsy surgeon has no authority to waive off the post-mortem examination in medico-legal death cases.

7.4.2. "The magistrate, as the principal investigating agency having discretionary power and rightful custodian of the body, has the authority to waive the post-mortem examination in accordance with S*ection 194 of Bharatiya Nagarik Suraksha Sanhita (BNSS) 2023".*

CHAPTER - 8

GUIDELINES FOR VIDEO-FILMING AND PHOTOGRAPHY OF POST-MORTEM EXAMINATION

8.1. Guidelines for video-filming and photography of post-mortem examinations in cases of custodial deaths, encounter deaths, and deaths in police action have been formulated by National Human Rights Commission (NHRC), Delhi, as per circular D.O. No 1/743/2014/FC dated 18th November, 2014.

8.2. Ministry of Health and Family welfare (MoHFW) on 15 November 2021 notifies a new protocol for Post-Mortem after sunset in hospitals.

8.2.1. The Investigating Officer is responsible for arranging videography and photography.

8.2.2. The Investigating Officer maintains chain of custody, privacy and confidentiality and must communicate this to the legal heirs of the deceased.

8.2.3. The Investigating Officer will fill out the videography/photography request form for permission available in the mortuary and submit it to the autopsy surgeon if no request is in the forwarding letter.

8.2.4. One copy of the form will be attached to the inquest papers and another copy will be kept for office records.

8.2.5. All the post-mortem conducted in night hours videography shall be done for future legal purpose.

8.2.6. In cases of custodial deaths, encounter deaths and deaths in police action, photographs of the deceased should be taken and the post-mortem examination should be video-filmed. The video film and photographs should be sent to the Commission.

8.2.7. The objectives of video-filming and photography of the post-mortem examination are:

8.2.7.1. To record detailed findings, especially marks of injury and violence that may suggest custodial torture.

8.2.7.2. To supplement the post-mortem report findings with videographic evidence, ruling out undue influence or suppression of material information.

8.2.7.3. To facilitate an independent review of the post-mortem examination report if required later.

8.2.8. Precautions before conducting the post-mortem examination:

8.2.8.1. Both hands of the deceased should be wrapped in white paper bags before transportation. The body should be covered in special body bags with zip pouches for proper transportation.

8.2.8.2. Clothing on the deceased's body should not be removed by the police or any other person. It should be collected, examined, preserved, and sealed by the doctor conducting the autopsy and sent for further examination to the concerned forensic science laboratory. A detailed note on the clothing examination should be included in the post-mortem report by the doctor.

8.2.8.3. In cases of alleged firearm deaths, the body should undergo radiological examination (X-rays/CT scan) before autopsy.

8.2.9. Video-filming and photography of the post-mortem examination should be done as follows:

8.2.9.1. The voice of the doctor conducting the post-mortem should be recorded, narrating prima-facie observations.

8.2.9.2. A total of 20-25 coloured photographs covering the whole body should be taken, including some without removing clothes. Photographs should include:

8.2.9.3. Profile photo-face (front, right lateral, and left lateral views), back of the head.

8.2.9.4. Front of the body (up to torso-chest and abdomen) and back.

8.2.9.5. Upper extremity - front and back.

8.2.9.6. Lower extremity - front and back.

8.2.9.7. Focused images on each injury/lesion, zoomed in after properly numbering the injuries*.

8.2.9.8. Internal examination findings (2 photos of soles and palms each, after making an incision to show absence/evidence of any old/deep-seated injury).

8.2.10. In firearm injuries, describe each injury with reference to the heel and midline to assist in event reconstruction.

8.2.10.1. Photographs should include the post-mortem number, date of examination, and a scale for dimensions in the frame.

8.2.10.2. The camera should be held at right angles to the object being photographed.

8.2.10.3. Video-filming and photography should be conducted by a person trained in forensic photography and videography. A high-quality digital camera with 10X optical zoom and a minimum of 10 megapixels should be used.

CHAPTER – 9

DEPARTMENT EMBALMING PROTOCOL

9.1. What is embalming?

Embalming is the art of temporarily preserving the remains of deceased through a process of chemical treatment in order to slow the process of decomposition and prepare the body for academic, transportation purpose etc.

Embalming only for Medico-Legal Case (MLC) or Post-mortem (PM) case.

9.2. Pre-embalming procedure

9.2.1. Verification of following documents is required

(a) Requisition from for embalming with consent

(b) Postmortem conduction certificate/Postmortem report

(c) No Objection certificate

(d) Identification of dead body (Photo identity)

(e) Communicable disease (Documents)

(f) Embassy-High commission requisition form/Information to embassy. If foreign national

9.2.2. Examination of dead body for features of

(a) Features of decomposition

(b) Injury/Postmortem incision

(c) Removal of organs/ tissues

9.2.3. Must be enquired about the purpose of embalming

9.3. Requirements

9.3.1. The Following instruments must be ready

(a) Scalpels

(b) Forceps-Fine and toothed.

(c) Scissors-Curved and Straight

(d) Artery forceps

(e) Sponge holding forceps

(f) Syringes (10ml and 50ml) and needles

(g) Embalming injection machine, if required

(h) Weighing machine

9.3.2. For safety of personnel following kits must be ready

(a) Surgical gloves
(b) Disposable aprons

(c) Face mask

(d) Goggles

(e) Head Cap

(f) Shoe cover

9.3.3. Following accessories also ready before embalming

(a) Cotton

(b) Liquid soap

(c) Thread

(d) Disposal bag (red yellow)

9.4. A Standardized Embalming Technique

9.4.1. Postmortem examination irrevocably disrupts the circulatory system due to the dissection of organs and viscera. Therefore, a cavity embalming technique will be used in all cases.

Chemicals Used for Embalming Fluid:

(a) Formalin - 60% (concentration may be reduced to 1/4th to prevent formalin toxicity to staff)

(b) Methanol - 25%

(c) Glycerine - 20%

(d) Mercuric Chloride - 1%

Approximately half to one litre of embalming fluid will be used per body.

9.4.2. Procedure:

9.4.2.1. During the process, the technician will bend, flex, and massage the arms and legs to relieve rigor mortis. Multiple-point injections of embalming fluids into the blood vessels (carotid/femoral) are performed using a centrifugal pump. Massaging the body helps break up circulatory clots, ensuring proper distribution of the embalming fluid.

9.4.2.2. For **cavity embalming**, all fluids will be completely removed from the body cavities, which will be dried using dryers. The embalming fluid will then be filled into the cavities using a trochar. Cotton soaked in embalming fluid can be packed inside the thoracic and abdominal cavities. Multi-layer dry cotton and gauze pieces will be used to pack the cavity to prevent fluid leakage. The incision will be sutured with fewer margins than usual, or a double suture may be used.

9.4.2.3. Hypodermic injection of embalming fluid into tissue with a needle and syringe is used as needed where arterial fluid has not been successfully distributed during the main arterial injection.

9.4.2.4. Surface embalming restores areas directly on the skin's surface and other superficial areas, as well as areas damaged by accidents, decomposition, etc.

9.4.2.5. Closure involves tightly inserting embalming fluid-soaked cotton balls into all natural orifices.

9.4.3. Post-Embalming Care: After embalming, the body will be washed again. Scented powders will be applied to mask bad odors and the face will be powdered to prevent oiliness and achieve a matte and fresh effect.

9.4.4. Special Cases (Badly Decomposed / Severely Mutilated Body, or Transportation to Foreign Country): These cases require special treatment beyond that of a 'normal case,' including surgical restoration.

9.4.5 Embalming Certificate: The duty doctor, after finishing the process may issue the embalming certificate in the proper format (03 copies for national / 05 copies for foreign nationals). Embalming certificate numbers will be issued serially and a copy will be kept.

9.4.6. Handing Over the Dead Body and Embalming Certificate: After embalming, the body is handed over to the claimants. Three copies of the certificate for domestic travel and five copies for international travel will be provided to the claimant with proper receipt.

9.4.7. Maintenance of Records/Log Book: All documents pertaining to procedure will be properly kept.

CHAPTER – 10

CONSENT

10.1. "**Consent**" (Latin *consentirez*: to feel or sense with) is a voluntary agreement, permission or approval to a particular purpose. According to Section 13 of Indian Contract Act (ICA) 1872 "two or more persons are said to consent when they agree upon the same thing in the same sense". It is playing the pivotal role in present days medical practice.

10.2. Why Consent?

10.2.1. Gives the fundamental rights

10.2.2. To avoid professional negligence/misconduct

10.2.3. Refrain from allegation of assault

10.2.4. To maintain good Doctor-patient relationship

10.2.5. Reduce unwanted miscommunication

10.2.6. A legal document

10.3. What are the types of Consent?

10.3.1. Implied Consent: it is the demeanour and conduct of the person shows itself and point towards willingness. Example- submitting for clinical examination, forwarding hand to measure BP.

10.3.2. Expressed or informed consent: is the one which is stated in distinct and explicit language by the doctor to patient.

10.3.3. Types :

10.3.3.1. Oral/ verbal- patient understood the same and agree. Example- vaginal examination, suturing wound etc.

10.3.3.2. Written- patient read the same in written form, understood, agree and sign. Example- taken for surgeries, anaesthesia etc.

10.3.4. Proxy or substituted consent: informed permission given by the parents/ next to kin/ legal guardians as an authority to safeguard the welfare and best interest of their issue. Example- for children, coma patient etc.

10.3.5. Informed assent: an agreement to medical procedures in circumstances where person (child) is not legally authorized to give consent even though understanding the matters. It respects a child's developing cognitive capacity and recognizes their opinion or wishes. Example- 12 to 17 years child.

10.3.6. Blanket consent: practiced in every hospital that cover almost everything a doctor might do during course of treatment and patient consent for it or consent for abiding hospital rule during admission. Legally it is invalid.

10.3.7. Informed Refusal: patients' refusal after full disclosure and understanding all aspects of the particular act. Example- Leave against medical advice.

10.4. Dilemma of which consent or when?

10.4.1. Dilemma still exists

10.4.2. Law requires consent, not written as mandatory.

10.4.3. Hence, no clear prescription when written consent required; Generally determined by Medical Practitioner itself.

10.4.4. Before performing an operation, the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed. **7.16 IMC (Professional conduct, Etiquette and Ethics) Regulations, 2002*

10.5. What are the components of consent?

10.5.1. Disclosure (transmission of information): A medical practitioner shall provide to the patient all the relevant information while obtaining the needed consent relating to procedure/ diagnosis/ treatment. Regarding the nature and extent of information is always been the issue of debate. There is a presumption that some standard information is required to be disclosed to every patient, and the extent of such disclosure is neither left to the discretion of the doctor nor he can rely upon the defense of disclosure like a reasonable medical practice or practitioner.

10.5.1.1. What to be disclosed?

10.5.1.1.1. Nature of the disease condition

10.5.1.1.2. Explain objective of examination

10.5.1.1.3. Standard proposed treatment procedure

10.5.1.1.4. Expectations of the standard recommended treatment and likelihood of success.

10.5.1.1.5. Alternative treatment that are available, its success and failure

10.5.1.1.6. Availability of facilities in the setup

10.5.1.1.7. Risks and benefits involved in both proposed and alternative treatment

10.5.1.1.8. Complications and follow up of the treatment

10.5.1.1.9. Further procedure to be executed if failure occur

10.5.1.1.10. Next step if procedure is in step wise

10.5.1.1.11. Potential risks of not receiving the treatment

10.5.1.1.12. Anaesthetics procedure to be used

10.5.1.1.13. To be informed if treatment is new

10.5.1.1.14. Particular known inherent risks that are materials to the informed decision, so he or she may accept or reject

10.5.1.1.15. If asked or situation arises expenditure also be disclosed.

10.5.2. **Comprehension** (language in explanation): Should be patient's own (native) language or most understandable language, avoiding complex medical terminology (use lay language, common everyday analogue, numerical application, drawing, pictorial representation of procedures etc.). Their understanding can be checked by asking them back about it.

10.5.3. **Competence:** It can be affected by age and infirmity but it does not justify any impairment to human dignity or personal integrity. Consent is taken from following persons in relation to medical examination and treatment in accordance to law.

10.5.3.1. **Competency for consent?**

10.5.3.1.1. Conscious, mentally sound adults not disqualified by any law to which they are subject≥ 18 years of age.

10.5.3.1.2. Children ≥12 years for general-physical examination only

10.5.3.1.3. Parents or guardian when child <12 years of age, unconscious, unsoundness of mind, intoxicated.

10.5.3.1.4. Loco-parentis (head master or warden of residential school) may be obtained in emergency situation

10.5.3.1.5. Both spouse**-** contraceptive sterilization, artificial insemination, donation of sperm or ovum, surrogacy, any operation that hampers sexual right of the spouse

10.5.4. **Voluntariness:** Consent should be free (ICA 1872 Section 14), voluntary, clear; must not be controlled by the outside factors that affects the outcome.

10.5.5. **Agreement:** after understanding the provided information, patient agree or sign for the intended act.

10.6. Consent shall not be given under :

10.6.1. Coercion (ICA 1872 Section 15),

10.6.2. Undue influences (ICA 1872 Section 16)

10.6.3. Fraud (ICA 1872 Section 17),

10.6.4. Mis-presentation (ICA 1872 Section 18)

10.6.5. Mistake (ICA 1872 Section 20,21,22)

10.6.6. Committing crime or illegal act

10.6.7. Fear or misconception (unsoundness of mind or intoxication) [Section 28 Bharatiya Nyaya Sanhita (BNS) 2023]

10.7. How consent shall be?

10.7.1. Consent shall be free (ICA 1872 Section 14), voluntary, clear, intelligent, informed, direct, personal and valid.

10.7.2. According to ICA 1872 Section 10 agreements are contracts- All agreements are contracts if they are made by the free consent of parties competent to contract, for a lawful consideration and with a lawful object and are not hereby expressly declared to be void. [**valid consent**]

10.7.3. **Essential is to have offer, acceptance of it and consideration**

10.8. Rules of consent :

10.8.1. Any procedure beyond routine physical examination, expressed consent depending on extent of it.

10.8.2. Consent is not defence in professional negligence**.**

10.8.3. Should be taken in the presence of disinterested third party. Example- Nurse.

10.8.4. Nature of illness should not be disclosed to third party without consent of patient.

10.8.5. Patient should be informed that he or she has rights to refuse.

10.8.6. It is unlawful to detain an adult person without his or her will. If person want discharge against medical advice, then record, obtain signature and discharge.

10.8.7. A living adult can give consent for organ donation. If donor may have health risk after donation, doctor should avoid the procedure.

10.8.8. A person of competent mental faculty is entitled to execute an advance medical directive (living will).

10.8.9. In passive euthanasia guardian gives the consent.

10.8.10. Consent from community required when research is based on community.

10.8.11. Consent required in pathological autopsy.

10.9. Exceptions of Consent

10.9.1. **Emergencies:** when immediate need of intervention to save the life of patient, where patients guardian, next to kin, in charge etc. are not present.

10.9.2. **Therapeutic waiver:** waived off rights by patient to choose or refuse in writing.

10.9.3. Medico-Legal post-mortem examination.

10.9.4. **Crime accused/arrested:** can be examined forcibly when police request under Bharatiya Nagarik Suraksha Sanhita (BNSS) 2023 Section 51(1) & 52(1).

10.9.5. **Prisoner:** Prisoners can be treated forcibly without their consent in the interest of society

10.10. Limitations :

10.10.1. Simply presented as a form to sign

10.10.2. Patients feel just a formality

10.10.3. When such choices are absent in realities, it cannot create opportunities

10.10.4. Developed within a particular cultural context, which may not fit in certain societies.

10.11. **Punishment :**

10.11.1. Failure to take consent before any medical procedure or treatment surely makes doctors liable to punishment under law –

10.11.2. Bharatiya Nyaya Sanhita 2023

10.11.3. Consumers protection act 1986/2019

10.11.4. National medical Council 2019

10.12. Indian Law view on consent

10.12.1. **Patient's autonomy is given utmost importance** (Art. 21 of the Indian Constitution…right to life and personal liberty). … "it expresses widest amplitude and covers a wide variety of rights, including the right to live with human dignity and all that goes along with it and many more…

10.12.2. **Indian law also presumes that the medical practitioner is in a dominating position** vis-à-vis the patient – hence, it is his duty to obtain proper consent by providing all necessary information.

10.13. Development Of Consent

10.13.1. Consent is essential for treatment.

10.13.2. informed consent needed.

10.13.3. Prior informed consent.

CHAPTER - 11

MEDICAL CERTIFICATE OF CAUSE OF DEATH (MCCD)

11.1. Stop calling it as DEATH CERTIFICATE.

11.2. Doctor can issue MCCD under Registration of Birth and Death Act, 1969(RBD Act, 1969).

11.3. Form No. 4 for institutional death and Form No. 4A for non-institutional deaths shall be issued along with Form No. 2 (death report) for further submission in registrar office.

11.4. In NATURAL DEATH

11.4.1. MCCD issued as per provision of 10(3) RBD Act.

11.4.2. It OBLIGATES in the event of the death of any person any medical practitioner, who has attended the deceased during his/her last illness, after the death of that person, forthwith issue MCCD, without charging any fee, in a PRESCRIBED FORM stating to the best of his knowledge and belief the cause of death (ample and justifiable evidence).

11.5. In MLC (accident/suicide/homicide/suspicious) DEATH

11.5.1. Section 10(3) RBD Act, does not differentiate between MLC and Non-MLC death or prohibits issuing MCCD.

11.5.2. **When there is ample and justifiable evidence,** the DOCTOR shall issue MCCD in an appropriate form, inform the police about the case and hand over copy of MCCD to police.

11.6. In MLC DEATH or BROUGHT DEATH case, dead body must be sent to mortuary after filling the appropriate form like death report for further police action.

11.7. No law in India authorizes DOCTORS to order for Post-Mortem Examination, the police decides whether to do autopsy or not as per Bharatiya Nagarik Suraksha Sanhita (BNSS) 2023 Section 194(3)(iv) and (v). This section gives discretionary power to police relating to the post-mortem examination.

Death certificate	**Medical Cause of Death Certificate**
Issued by Registrar of Birth and Death in Form No. 6 as per Section 12 & 17 of RBD Act.	Issued by Registered Medical Practitioner in Form No. 4/4A as per Section 10(3) of RBD Act.

11.8. BNSS 2023 Section 194(3) when-

11.8.1. (iv) there is any DOUBT regarding the CAUSE OF DEATH; or

11.8.2. (v) the police officer for ANY OTHER REASON considers it expedient so to do, he shall, subject to such rules as the State Government may prescribe in this behalf, forward the body, with a view to its being examined, to the nearest Civil Surgeon, or other qualified medical person appointed in this behalf by the State Government, if the state of the weather and the distance admit of its being so forwarded without risk of such putrefaction on the road as would render such examination useless.

This section implies that a post-mortem examination is not required if the cause of death is clear and undisputed.

CHAPTER – 12

PRESERVATION OF SAMPLE/VISCERA

12.1. **"Forensic Toxicology"** involves applying the science and study of poisons to aid in investigations. It primarily focuses on the medico-legal aspects of the harmful effects of xenobiotics. This field also encompasses the analysis and identification of medicines, drugs as well as the enforcement of agricultural, industrial, and public legislation. Forensic toxicologists play a crucial role in establishing poisoning as the cause of death and determining the circumstances in post-mortem investigations.

The preservation of body fluids and viscera in suspected cases of poisoning during autopsies is based on the poison's route, movement, distribution and affinity to organs, breakdown within the body, and excretion. Standard viscera and body fluids preserved for toxicological analysis in such cases include the stomach and its contents, liver with gall bladder, kidneys, proximal 10-30 cm of small intestines and their contents, spleen, blood, or urine. Additional viscera also preserved for some specific poisons. Routine preservatives used in suspected poisoning cases are saturated solutions of common salt or rectified spirit, Sodium fluoride (NaF) + Potassium oxalate (K2C2O4) for blood and NaF/Thymol for urine. However, some poison samples require specific preservatives due to their unique properties.

Sample	Poisonous substances	Preservative
1. Viscera or Organ	Any suspected poison	Rectified spirit Saturated solution of common salt
	Corrosive acids, corrosive alkalis, corrosive sublimate, aconite	Rectified spirit
	Alcohol, kerosene, chloroform, ether, chloral hydrate, formic acid, formaldehyde, acetic acid, phenol, paraldehyde, phosphorus, anesthetic agents	Saturated solution of common salt
2. Blood	Any suspected substance	NaF+ K2C2O4
	Oxalic acid, ethylene glycol, fluoride, carbon monoxide	Na-Citrate
3. Urine	Any suspected poison	NaF / Few grains of thymol/ Phenyl mercuric nitrite
	Alcohol, cocaine, cyanide, carbon monoxide	Sodium Fluoride (only)

12.1.1. Some DO's and DON'Ts

(a) Collect the stomach and its contents, proximal small intestines and their contents, other routine viscera, blood, or urine in separate containers/jars/bottles/tubes.

(b) The brain must be preserved in cases of a decomposed body.

(c) The stomach and intestines should be opened before storage in jars/containers.

(d) Use a preservative in equal or greater quantity than the viscera.

(e) Only fill the container/jar/bottle to two-thirds capacity with viscera and preservative.

(f) Use glass or non-reactive hard plastic airtight containers/tubes for carbon monoxide and other gases/volatile substances.

(g) Avoid using rubber inserts under the caps of bottles/jars for substances like chloroform and phenol.

(h) Avoid using plastic bottles for cocaine samples.

(i) Apply a layer of liquid paraffin over the top layer of the preservative and ensure minimal headspace after filling.

(j) Submit or send samples to the laboratory promptly to prevent degradation and losses.

(k) Do not use a preservative if the sample is to be analyzed immediately.

(l) Do not use preservatives for bones, hairs, and nails.

(m) Never use formalin as a preservative for viscera intended for toxicological analysis.

(n) Preserve a sample of the preservative used in a separate bottle/jar/container.

(o) Label the bottle/container/jar with required details.

(p) Include a clear and visible warning on the label if the contents are infectious.

(q) Seal the bottle/container/jar with lac wax.

(r) Place the sealed bottles/containers/jars containing viscera and preservative samples into a box.

12.1.2. GUIDELINE FOR PRESERVATION OF VISCERA/OTHER MATERIALS FOR CHEMICAL ANALYSIS

Sample	Quantity	Methods of Collection, Preservation & Packaging	Preservative
1	2	3	4
1. Stomach with its contents	Whole stomach + 100 ml/gm contents or as available	Both ends are tied, cut both ends, and open via greater curvature and contents collected in the screw cap wide mouth jar containing preservative without contamination along with stomach in same jar.	**Saturated solution of common salt** **Rectified spirit-** corrosive acids/alkalis, corrosive sublimate, aconite **[not phenol]** **No preservative**- if to be examined immediately.
2. Intestines loops with its contents	About 10- 30 cm	Both ends are tied and put into screw cap wide mouth jar without contamination.	DO
3. Liver with gall bladder	About 100 gm	Expose the liver and cut away from the portal tract as required, collect in the screw cap wide mouth jar without contamination	DO
4. Spleen	About 100 gm or ½ of the spleen	Expose the spleen, free attachment and cut as required, collect in the screw cap wide mouth jar without contamination	DO
5. kidney	About 100 gm or ½ of the kidney	Expose the kidney, free attachment and cut as required, collect in the screw cap wide mouth jar without contamination	DO
6. Blood	5-10 ml	Aspirate or syringed out after puncture into or after opening heart/ major internal veins using disposable syringe. or	30 mg of Potassium Oxalate ($K_2C_2O_4$) + 100 mg of Sodium Fluoride (NaF) per 10 ml of blood

Sample	Quantity	Methods of Collection, Preservation & Packaging	Preservative
1	2	3	4
		Clean area with alcohol wipe and allow to dry, puncture cubital vein, collect in in preservative containing vacutainer tube (ante-mortem sample).	
7. Urine	50 ml of urine or as much available	Expose bladder and clean area, puncture with wide bore needle and aspirate / give a small cut and aspirate by syringe without needle, transfer it to urine collection container and add preservative. Collect from urine flow or catheter in the sterile urine container (ante-mortem sample).	100 mg of Sodium Fluoride (NaF) per 10 ml of urine/ few grains of thymol/ 50 mg of phenyl mercuric nitrite for 10 ml urine
8. Gastric aspirate	25-50 ml or as much available	Collect the lavage sample in preservative containing wide mouth screw cap container / jar / bottle.	**Saturated solution of common salt** **Rectified spirit-** corrosive acids/alkalis, corrosive sublimate, aconite **[not phenol]** **No preservative**- if to be examined immediately.

12.1.3. SPECIAL SAMPLE TO BE PRESERVED IN ADDITION TO ROUTINE VISCERA

Sample	Indication	Quantity	Methods of Collection, Preservation & Packaging	Preservative
1	2	3	4	5
1. Blood	Alcohol	05-10 ml	Aspirate or syringed out after puncture into or after opening heart/ major internal veins using disposable syringe. OR Clean area with alcohol wipe and allow to dry, puncture cubital vein; then collect in preservative containing vacutainer tube or bottle (ante-mortem sample).	100 mg sodium Flouride (NaF) per 10 ml of blood
	Oxalic acid, ethylene glycol, fluoride, carbon monoxide	05-10 ml	DO	30 mg Na-Citrate
	Volatile / inhalant / gaseous (CO, CN, Coal gas, ammonia, H2S etc.) poison	05-10 ml	DO	A layer of liquid paraffin added to the top of blood to avoid losses in air tight cap bottle / Vacutainer plain vial

Sample	Indication	Quantity	Methods of Collection, Preservation & Packaging	Preservative
1	2	3	4	5
2. CSF	Alcohol	As much possible	Take wide bore long needle attached with 10-20 ml syringe, Flex neck, palpate atlanto-occipital membrane in the middle, pierce the skin with needle pointing towards nasal bridge, go about 2 cm deep and feel resistance, aspirate CSF and transfer into preservative containing vacutainer tube. Or Open Skull, expose dura and pierce dura after making nick, aspirate CSF from sides and base, transfer into vacutainer tube.	10 mg NaF per 1ml of CSF
3. Vitreous humor	Alcohol / chloroform Cocaine, morphine, tricyclic anti-depressants	1.5-03 ml or as available	Take 5m syringe with needle 15/17 gauze, retract eyelid, puncture eye ball on lateral part at oblique angle (60*), aspirate vitreous (1.5 to 3ml), transfer to preservative containing bottle/ yellow top vacutainer tube. Take plain tape water equal amount and inject into eyeball to restore shape.	10 mg NaF per 1ml of vitreous
4. Vomitus	Food poisoning	100 mg or as much available	Collect in preservative containing wide mouth screw cap plastic jar or bottle	Saturated solution of common salt (NaCL)
	Alkaloids, organo-phosphorus, alcohol, anaesthetics, Carbon monoxide, cyanides. Barbiturates, opiates, strychnine, volatiles	100gm	Collect in preservative containing wide mouth jar / bottle after cut of brain tissue. For volatiles/ inhalants/ gaseous poisons- glass / non-reactive plastic wide mouth air tight cap jar or bottle immediately containing preservative, a thin layer of liquid is put over top of preservative and close the bottle or jar. Ensure there is very little head space after filling.	Saturated solution of common salt (NaCL)
5. Spinal cords	Anaesthetics, strychnine, galsemine, barbiturates, opium etc.	Entire length	Collect in the preservative containing wide mouth screw cap jar / container after opening the spines.	Saturated solution of common salt (NaCL)

Sample	Indication	Quantity	Methods of Collection, Preservation & Packaging	Preservative
1	2	3	4	5
6. Lungs	Volatile / inhalant / gaseous (Carbon monoxide, hydrocyanic acid, Coal gas, ammonia, H2S etc.) poison	One lung for volatiles; 100 gm	Expose chest cavity, ties off one lung in main bronchus, cut and transfer glass / non-reactive plastic wide mouth air tight cap jar or bottle immediately containing preservative, a thin layer of liquid is put over top of preservative and close the bottle or jar. Ensure there is very little head space after filling.	Saturated solution of common salt (NaCl); Under paraffin layer
7. Heart	Cardiac poisons (digitalis, yellow oleander, aconite etc.) strychnine	100 gm of heart	Expose the chest cavity, cut as required, collect in screw cap wide mouth plastic jar / bottle without contamination.	Saturated solution of common salt (NaCl); Or rectified spirit Rectified spirit-aconite
8. Spleen	septicemia	As required	Sear the surface with hot blade, make a hole with a sterile blade and plunge a sterile swab into the organ and put into culture bottle. Store at 4*C temperature	Desired culture media
9. Uterus, appen-dages, upper part of vagina	Criminal abortion (abortifacients)	Whole	Expose area and collect after separation from attachments, transfer into preservative containing screw cap wide mouth jar / bottle without contamination	Saturated solution of common salt (NaCl) / rectified spirits
10. Muscle (skeletal)	Anaesthetic agents, Insulin, Morphine, Heroin, Cocaine, other illicit drugs	50-100 gm of skeletal muscle (thigh / buttock)	Expose the area and cut the muscle as required, transfer into preservative containing screw cap wide mouth jar / bottle without contamination	Saturated solution of common salt (NaCl) / rectified spirits
11. Fats	Insecticides / pesticides, anesthetics	10 gm (abdominal wall / peri-nephric region)	Expose the area and cut the fats as required, transfer into preservative containing screw cap wide mouth jar / bottle without contamination	Saturated solution of common salt (NaCl) / rectified spirits
12. Bones (long bones)	Heavy metal poisoning	200 gm / 10-15 cm	Expose the area and cut the bone as required, wash and transfer into plastic container with preservatives. Or After wash allow to complete air dry and packed in paper bag.	Saturated solution of common salt (NaCl)

Sample	Indication	Quantity	Methods of Collection, Preservation & Packaging	Preservative
1	2	3	4	5
13. Skin and under lying tissues	Anaesthetic agents, Insulin, Morphine, Heroin, Cocaine, other illicit drugs **[injection death]**	5-10 cm diameter around site & underlying tissue till tract present + control from opposite side	Expose the area, take out desired skin with underlying tissue and store into preservative containing wide mouth screw cap jar/bottle without contamination (For cocaine glass jar preferable)	Saturated solution of common salt (NaCl)
	Corrosive	5-10 cm diameter around site & underlying tissue till tract present + control from opposite side	Expose area, take out desired skin with underlying tissue, store into preservative containing wide mouth screw cap jar/bottle without contamination	Rectified spirits Phenol- saturated common salt solution
	Snake bite/ sting bite/ animal bites	5-10 cm diameter around site & underlying tissue till tract present + control from opposite side	Expose the area, take out desired skin with underlying tissue and store into preservative containing wide mouth screw cap jar/bottle without contamination	Saturated solution of common salt (NaCl)
	Electrocution	5-10 cm diameter around site electrocution injury for metallic residue	Expose the area, take out desired skin with soft tissue and store into preservative containing wide mouth screw cap jar/bottle without contamination	Saturated solution of common salt (NaCl)
	Heavy metal	5-10 cm diameter of desired area (thigh / back)	Expose the area, take out desired skin and store into preservative containing wide mouth screw cap jar/bottle without contamination	Saturated solution of common salt (NaCl)
	Burn **(petroleum product)**	Swab as required	Take cotton or gauge swab and store into airtight plastic bag / container without contamination	No preservative
14. Hair	Heavy metals Barbiturate, Anesthetics, Opium	15-20 scalp hair bands (plucked)	Pluck the sample hair with help of clean tweezers / forceps in white paper / butter paper and pack in paper envelope. Air dry is required	No preservative
	Burn hair (Petroleum product)	Swab as required	Pluck the sample hair with help of clean tweezers / forceps in plastic container. Or take cotton or gauge swab from hair and store in plastic bag / container.	No preservative
15. Nails	Heavy metals Barbiturate, anesthetics, opium	As available	Scrapping / clippings from fingers & toes in white paper, pack in paper envelope.	No preservative

Sample	Indication	Quantity	Methods of Collection, Preservation & Packaging	Preservative
1	2	3	4	5
16. Abortus	Abortifacients in criminal abortion	whole	Collect and store into wide mouth screw cap jar/bottle without contamination	Saturated solution of common salt (NaCl) or rectified spirits
17. Amniotic fluid	Abortifacients in criminal abortion	As much possible	Collect and store into wide mouth screw cap jar/bottle without contamination	Saturated solution of common salt (NaCl) or rectified spirits
18. Meconium	Abortifacients in criminal abortion	As much possible	Collect and store into wide mouth screw cap jar/bottle without contamination	Saturated solution of common salt (NaCl) or rectified spirits
19. Milk	Opium, thallium	As much possible	Collect and store into wide mouth screw cap jar/bottle without contamination	Saturated solution of common salt (NaCl) or rectified spirits
20. Sweat	Drug abuse	As desired	Collect swab from skin surface and air dry and pack in paper envelope.	No preservative
21. Nasal	Cocaine, inhalant abuse	Swab as required	Collect swab from nostril and air dry and pack in the paper envelope.	No preservative
22. Insects or maggots	antidepressants, barbiturates, benzodiazepine, cocaine, opiates	As desired	Collect live maggot in jar or bottle	Drop in boiling absolute alcohol
23. Clothes	Acidic/ alkaline substance	As available/ required	Collect and preserve in dry and clean thick plastic/class container	No preservative

12.1.4 COLLECTION AND PRESERVATION IN FIREARM OR OTHER INFLAMMABLE SUBSTANCE CASES

Specimen	Quantity	Collection & preservation	Preservative
1. Pellets/fragments of Bullets, cartridges, cartridge cases, wads etc.	As available	Collect with fingers / rubber tip forceps, air dried, kept over cotton gauze in suitable container. Do not clean.	No preservative
2. Bullet	Whatever available	Collect with fingers/ rubber tipped forceps, air dried, kept over cotton gauze in suitable container. Do not clean	No preservative
3. Firearm /gun	As available	Collect and packed in a cardboard box, envelop or paper bag separately from ammunition and or magazine.	
4. Smoke or gun powder	As required	Moist cotton swab with distilled water, rub the both hands and finger web separately, dry in air & pack in paper bag separately	No preservative
5. Clothes	All clothes/ bearing holes (firearm case)	Collect, dried in air & pack in paper bag or envelope.	No preservative
6. Solid materials (clothes, debris etc.) contains inflammable substances	As available	Collect and kept in air tight non-reactive plastic packet/ bag / container immediately.	No preservative

12.2. DNA Profiling or Typing

"DNA profiling or typing" has proven to be an immensely powerful tool for identifying the source of biological specimens. This technology has dramatically enhanced the ability to solve crimes that were previously considered unsolvable. Worldwide, DNA evidence has withstood legal scrutiny and has revolutionized crime investigations. The term "DNA Fingerprinting" is often used to emphasize the uniqueness of this technology in differentiating individuals, even those who are related, akin to dermal fingerprints. The Transplantation of Human Organs and Tissues Act, (THOTA) 1994, BNSS 51, 52, 53 & 184 mandates the DNA profiling in India.

DNA profiling can be employed in various cases where the identity of individuals, suspects, or victims needs to be established from biological clues found on the bodies of suspects/victims, at crime scenes, on weapons, and more. Common scenarios where doctors apply DNA profiling include:

(a) Murder or physical assault
(b) Rape or sexual offenses
(c) Unidentified bodies, accidents, mass disasters
(d) Parentage disputes
(e) Organ transplantation
(f) Wildlife crime

12.2.1. What is DNA? (Definition)

DNA is the genetic material present in the nuclei of cells of living organisms. The average human body is composed of about 100 trillion cells. DNA is present in the nucleus of a cell as a double helix, super coiled to form chromosomes along with intercalated proteins. There are 23 pairs of chromosomes, transmitted through ova and sperm, with 23 chromosomes from the mother and 23 from the father. Only 0.1% of DNA (about 3 million bases) differs from one person to another. Forensic scientists analyse a few variable regions to generate a DNA profile of an individual, which can then be compared with biological clue materials or control samples.

A typical DNA case involves comparing evidence samples, such as semen from a forensic investigation or crime scene, with known or reference samples, such as blood from a suspect. The possible outcomes of this comparison can be a match, exclusion, or inconclusiveness.

Since a person's DNA is the same in all cells of their body, DNA in blood is identical to DNA in skin cells, semen, saliva, etc. The source of a biological clue material can only be identified by analysing an authenticated control sample from the individual. A control sample ensures the accuracy and reliability of the DNA testing process and the validity of the DNA profiles generated in a forensic investigation.

12.2.2. If an individual's direct sample is not available, items expected to carry their secretions or body cells, such as toothbrushes or razors, may be sent for analysis. Alternatively, control samples from close relatives may be desired. In cases of blood transfusion or organ transplantation, an oral swab may be collected as a control sample.

12.2.3. Common Scenarios for Control Samples:

12.2.3.1. Murder, Physical Assault, or Sexual Assault: Samples from all suspects and victims/ survivors.

12.2.3.2. Unidentified Bodies, Accidents, Mass Disasters:

(a) Exclusive items of the suspected deceased expected to carry their secretions or body cells.

(b) Control samples from the suspected deceased's parents.

(c) If one parent is unavailable, control samples from siblings and the surviving parent.

(d) Control samples from the spouse and children of the suspected deceased.

12.2.3.3. Parentage Disputes: Control samples from the child, putative mother, and father.

12.2.3.4. Wildlife Crime: Control blood or tissue specimens from the suspected animal.

Conclusive sample for determining DNA	
Living subjects	Blood, buccal epithelial cells, hair follicles
Well preserved dead body	Post-mortem blood, skeletal muscle, teeth
Charred dead body	Skeletal fragments from deep region, Semi-solid blood from cardiac cavity
Decomposed/ skeletonized body	Long bones, teeth

If DNA evidence is not properly documented, collected, packaged, and preserved, it may fail to meet the legal and scientific standards required for court admissibility. Given that even very small DNA samples can be a crucial evidence, meticulous care must be taken to avoid contamination.

12.3. Do's and Don'ts for Medico-Legal Experts in Handling Biological Evidence

12.3.1. Do's:

(a) Biological materials may contain infectious agents. Avoid direct contact by wearing gloves, masks, or other protective gear.

(b) Wear gloves throughout collection and avoid cross-contaminating different samples.

(c) Use disposable or sterilized devices (e.g., scissors, forceps, vaginal speculum) for sample collection to prevent cross-contamination.

(d) Change gloves after collecting each piece of evidence to prevent cross-contamination.

(e) Air dry evidence specimens like clothing, sanitary pads and tampons in the shade before packing at room temperature.

(f) Air dry swabs (e.g., vaginal, cervical, anal, oral, penile, body) and their smear slides before packing and store at room temperature.

(g) Pack each exhibit separately in paper envelopes, paper bags, or cardboard boxes and seal properly. Paper packaging can help prevent the deterioration of biological samples if not completely dry.

(h) Store liquid reference blood samples at 4°C and transport under refrigerated conditions.

(i) Air dry blood-stained FTA cards, filter paper, or gauze pieces before packing and store at room temperature.

(j) Transfer post-mortem blood as dried stains on sterile gauze or filter paper.

(k) If dry semen or saliva stains are found on a body, use a moistened cotton swab to swab the area thoroughly, applying light pressure.

(l) Collect samples from wet stains over body using cotton swab, air dry it and put it in a paper bag.

(m) Collect urine, vaginal, or oral wash in a leak-proof sterile plastic container and store at 4°C without preservatives.

(n) Swab the inner and outer surfaces of a condom separately, air dry and pack.

(o) Store dried samples in a cool, dry place.

(p) Collect hair with forceps, avoiding contact with the root region and mount on a glass slide for root preservation.

(q) Pack hair samples or nail clippings in a sheet of white butter paper and fold properly.

(r) Pack individual foreign hairs or clumps of hair separately.

(s) Collect soft tissue in a clean plastic container with or without a saturated salt solution, store at -20°C, and transport under refrigerated conditions.

(t) In mass disasters, accidents, or cases with burnt or mutilated bodies, collect 2-3 tissues like deep skeletal muscle, skin, or other least affected tissue (5-10g) during autopsy in clean, sterilized plastic containers.

(u) Separate fetal and maternal tissues during collection.

(v) Prefer teeth and long bones (femur or humerus) when only skeletal remnants are available.

(w) Transfer fresh blood and tissues to the laboratory under refrigerated conditions as soon as possible to minimize degradation.

(x) Inform whether biological clue material exhibits were laundered or diluted with other body fluids.

(y) Inform about the health of the victims & suspects, such as AIDS, hepatitis, etc.

(z) Mention details about the donor's blood transfusion or organ transplantation.

(aa) Maintain and document the chain of custody.

12.3.2. Don'ts

(a) Do not touch any exhibit with bare hands.

(b) Do not collect different exhibits while wearing the same gloves.

(c) Do not cough or sneeze during sampling or over areas expected to carry biological clue materials.

(d) Do not eat, drink, or smoke when recovering evidence samples.

(e) Avoid excessive handling of evidence after collection.

(f) Never pack biological materials in polythene bags/envelopes or airtight containers.

(g) Avoid using glass containers for tissue samples as they may break.

(h) Never use fixatives when preparing smear slides.

(i) Do not pack materials until they are completely dried.

(j) Never use printed paper as it may contaminate evidence materials/exhibits with ink.

(k) Do not expose evidence materials to heaters, direct sunlight, intense light sources, blowers, or hair dryers for faster drying.

(l) Do not reopen preserved items for interview purposes.

(m) Avoid contact of victim and suspect samples; never pack multiple items/objects together.

(n) Do not thaw and refreeze frozen tissue samples as it will cause DNA breakdown.

(o) Never preserve tissue in formalin.

(p) Never reuse packaging.

12.3.3. COLLECTION AND PRESERVATION OF DNA SAMPLE IN MEDICO-LEGAL EXAMINATION

Specimens or samples	Collection	Purpose
1	2	3
1. Clothing	(a) The victim should undress on a clean white sheet of paper in order to collect any foreign matter that may fall to floor from herself or her clothing. (b) Ensure whether the clothes are incidental or they have been changed. (c) Items such as hosiery or bra, underpants, blouse, shirt, salwar etc. should be collected and placed in paper bags. Wet or blood-stained clothing should be air dried before packing in paper bags. (d) Each piece of clothing must be folded inward, placing a piece of clean paper against any stain, so the stains are not in contact with the bag or other parts of clothing. (e) Ensure packaging is properly labeled and delivered to laboratories as soon as possible.	(a) Detection of blood, saliva, semen, vaginal secretions etc. on clothing. (b) Identification of victim or accused(s) by DNA Profiling
2. Sanitary pad/ Tampon	(a) Sanitary pad must not be removed if it is attached to the under pant. (b) If the sanitary pad was detached from the underpants at the time of medical examination, the sticky side of the sanitary pad must be covered by the waxed sheet to prevent the pad from Sticking to the paper collection bag.	(a) Presence of spermatozoa/ semen. (b) Identification of accused(s) by DNA profiling.
3. Condom	(a) The condom used during assault may be collected and swabbed separately from inner and outer surface.	(a) Presence of spermatozoa / Semen (inner surface) and vaginal epithelial cells (outer surface).

Specimens or samples	Collection	Purpose
1	2	3
4. Evidence on body/ skin (visible / invisible)	(a) The evidence site on the body surface may be determined by asking the patient, by examination and by use of the Ultraviolet light source, which will reveal stains that are invisible in normal light. (b) Moisten the swabs by using Phosphate Buffered Saline (PBS)/saline/molecular grade water for lifting suspected stains (saliva, semen et.) from the body surface. (c) Areas that may be swabbed include the breasts, face, neck and hands. (d) If bite marks are present, they should be photographed with and without the evidence documentation ruler after taking the necessary swabs. (e) Any foreign hair / vegetation sample present on the body surface should be collected using sterilized forceps and packed separately in a catch paper which should be properly folded and labeled.	(b) Detection of spermatozoa/ semen, saliva, blood etc. (c) Identification of victim or accused(s) by DNA profiling.
5. Head hair	(a) Hair sample should be collected using clean forceps. (b) Where there is evidence of semen or other matted material on head hair, it may be collected with the help of a moistened swab. Matted hairs may be collected using sterilized scissors and forceps and packed in another sheet of paper which should also be folded and labeled. (c) Control samples of body, scalp and auxiliary hairs should be taken, ideally by plucking (not by cutting the tips) to obtain hair root that contain adequate DNA for the analysis.	(a) Identification of victim or accused(s) by DNA profiling.
6. Pubic hair	(a) A sheet of catch paper should be placed under the buttocks. (b) Pubic hair should then be combed with the combusing downward strokes so that any loose hair or debris will fall onto the paper which should be carefully folded and labeled. (c) Combing the pubic hair with gloved fingers may also be assisted in obtaining samples of loose hair or debris. (d) Any matted pubic hair which indicates the presence of blood or semen should be collected using sterilized scissors and forceps and packed in another sheet of paper which should also be folded and labeled or matted material may be collected with the help of a moistened swab. (e) For reference purposes in order to obtain a comparative sample from the victim, pubic hair should be collected, ideally, by plucking and not by cutting the tips to obtain hair root.	(a) Detection of spermatozoa/ semen, blood, saliva etc. (b) Identification of victim or accused(s) by DNA profiling.

Specimens or samples	Collection	Purpose
1	2	3
7. Vulval swab	(a) Vulval swab should be taken prior to the collection of Vaginal or cervical swabs. (b) To collect vulval swab, labia majora should be separated carefully with the left hand. Swabbing should be done around the inner surface of the labia minor a and fossa navicularis.	(a) Detection of spermatozoa/ semen. (b) Identification of accused(s) by DNA profiling.
8. Vaginal swab	(a) Swabs of the vaginal fornices are essential to collect any saliva or semen that may be present in vaginal area. Swabs of anterior and posterior vaginal fornices should be taken using a vaginal Speculum.	(a) Detection of spermatozoa/ semen. (b) Identification of accused(s) by DNA profiling.
9. Cervical swab	(a) Swab should be taken from cervical orifice by collecting as much of the mucous plug as possible.	(a) Detection of spermatozoa/ semen. (b) Identification of accused(s) by DNA profiling.
10. Anal/ Rectal swab	(a) In case of possible ano-rectal assault, external anal and rectal swabs should be collected. The swab should be slightly moistened with sterile water and the anus carefully swabbed, slightly extending into the anal canal. (b) When conducting the rectal swab, gentle lateral traction (separation of the cheeks of the buttocks) should be applied for about three minutes to allow for dilation of the anal sphincter.	(a) Detection of spermatozoa/ semen/lubricant (b) Identification of victim or accused(s) by DNA profiling.
11. Oral swab/ washing	(a) Oral swabbing is essential to collect seminal fluid in the oral cavity in suspected oro-genital contact. The oral swab collection is shown in figure 5. (b) Swab multiple sites in mouth with one or more swabs (c) For oral washing sample, rinse mouth with 10 ml of sterile water and collect it in container	(a) Detection of spermatozoa/ semen. (b) Identification of victim or accused(s) by DNA profiling. (c) To corroborate oro-genital Contact.
12. Penile and Urethral swab	(a) Moisten the tip of swab with a drop of sterile water and roll it around the tip (glans) of the penis including the sulcus and urethral meatus. The inside of the foreskin (if present) should be swabbed.	(a) Detection of spermatozoa/ semen, saliva etc. (b) To corroborate Peno- vaginal contact between accused and victim.
13. Smear slides (Vaginal, cervical, anal, oral etc.)	(c) A smear on a glass slide can also be prepared by rolling a swab (Vaginal, cervical, anal, oral etc.) over a slide without rubbing it as the latter may cause the spermatozoa to break and thereby give a false negative result. (d) Moisten the swabs by using PBS/saline/molecular grade water for lifting suspected dry seminal stains from the body surface.	(a) Detection of spermatozoa/ semen.

Specimens or samples	Collection	Purpose
1	2	3
14. Nail clipping/ Nail scraping	(a) Fingernail clippings and fingernail scrapings from the left and the right hand should be separately collected and packed in a piece of white butter paper and put into a labeled and sealed envelope.	(a) Establish the physical contact during assault/violence. (b) Identification of victim or accused(s) by DNA profiling.
15. Urine sample	(a) Urine should be taken into leak proof Sterile plastic container.	(a) Pregnancy test. (b) Detection of spermatozoa/ semen. (c) Identification of accused(s) By DNA profiling.
16. Vaginal wash	(a) Vaginal wash should be taken into leak proof sterile plastic container.	
17. Aborted Fetus	(a) Fetal tissue samples should be collected in sterile plastic container and stored at -20ºC.	(a) To establish paternity by DNA profiling.
18. Blood	(a) Around 2-3 ml of blood should be collected as reference blood sample in a purple cap (Ethylenediaminetetraacetic acid (EDTA)) tube for DNA Profiling. Few drops of blood should be taken on Flinders Technology Associates (FTA) Card/ Gauze piece and air dried. (b) Approx. 3-5 ml of blood may be taken in grey top (Sodium Fluoride) tube for alcohol and drug tests.	(a) Blood grouping and DNA profile of the concerned individual (victim or accused). (b) Detection of alcohol and drugs.

12.3.4. COLLECTION AND PRESERVATION OF DNA SAMPLE DURING AUTOPSY

Sample	Indication	quantity	Collection, preservation, packaging	Transportation
1	2	3	4	5
1. Blood	DNA	2-5 ml/ 5-10 ml	Collect in the EDTA vacutainer tube using disposable syringe from heart or major internal vessels, refrigerate at 4*C (do nor freeze)	Blood samples must be kept in thermos flask or thermocol box stuffed with dry ice/coolant pack
	DNA	As required	Collect blood using disposable syringe from heart or major internal vessels, transfer on cotton gauze piece/ Filter paper / FTA card. Air dry it and keep in paper packet / envelope	Transport in room temperature
	DNA	As required	Blood stains on gauze piece after rubbing on them over organ / muscles/ fetal skin. Dry the gauze piece and preserve it in paper envelope.	Transport in room temperature

Sample	Indication	quantity	Collection, preservation, packaging	Transportation
1	2	3	4	5
2. Tissues / organs (ideally liver, heart, kidney, muscles or fresh soft tissue of any solid organ; muscle, heart & brain from decomposed body)	DNA	50-100 gm of tissue or organ	Pick up the organs using clean pairs of forceps after cut, and put in a sterile plastic tubes/ container/ packets and store frozen at -20*C immediately without any preservative/ additives.	While transporting the exhibits containers/packet must be kept in thermocol box with dry ice / coolant pack and vaccine carrier.
3. Teeth/ bones (Long bones/ teeth (molar)/ ribs/ vertebrae)	DNA	10-15 cm of femur bone 4 molar teeth	Cut bone/extract tooth using fresh or properly cleaned tooth extractor or blade, clean and wash, and store frozen at -20*C immediately without any preservative/ additives. or Allow it to dry completely in air. Roll / pack in brown paper, envelope and seal in cotton cloth / card board boxes etc.	Transport in room temperature
4. Abortus/ aborted fetus	DNA	50 gm or about 2 cm^2 portion	Take the abortus tissue from the selected area using fresh or properly clean blade and put in a sterile plastic tubes/ container/ packets and store frozen at -20*C immediately without any preservative/ additives.	While transporting the exhibits containers/packet must be kept in thermocol box with dry ice / coolant pack and vaccine carrier.
5. Hair with root	DNA	15-20 hair	Pluck the sample with help of clean tweezers / forceps in white paper / butter paper and pack in paper envelope. If wet, allow the hairs to dry in shade. Never wash the recovered hairs.	Transport in room temperature

12.4. FORENSIC HISTOPATOLOGY

12.4.1. Forensic histopathological examination is fundamental in forensic pathology and is essential for medico-legal investigations. It aids in determining the cause of death, confirming or challenging findings from gross autopsies, detecting the presence of toxins, poisons, or foreign substances in the body through specific tissue reactions or changes caused by toxic agents, understanding disease processes, differentiating between natural and traumatic deaths, and serving as critical scientific documentary evidence that can support or refute claims in court.

12.4.2. For sampling, 1-2 pieces (standard size: 20mm x 12mm x 5mm) of the desired organ or tissue, including both affected or diseased and normal areas, should be preserved in 10% buffered formalin or 95% alcohol as a preservative.

12.5. CHAIN OF CUSTODY

IMPORTANT POINTS TO BE REMEMBERED

12.5.1. **Label** the packed exhibit with MLC/PM/Case reference No., description of the Exhibit (sample), Name of Person/Deceased, Age & Sex, Date and Time of collection, Police Station, and the Medical Officer's Signature & Name.

12.5.2. Hand over the packed & sealed samples to the police, along with a duly filled authentication form containing the sample lac seal, for forensic analysis.

12.5.3. Keep a copy of the authentication form with the case file upon receipt.

Note: The quantity of samples required varies by laboratory. Please consult the lab where your sample will be analysed before sending it.

CHAPTER - 13

MEDICAL RECORDS, MAINTENANCE AND DISBURSEMENT

13.1. **All medico-legal reports should be prepared in a printed format (preferably)** or **in legible handwriting.**

13.2. Always prepare the medico-legal report in triplets. One copy is kept as a departmental record, another is stored in the medical records section and the original is given to the police/requester (authority) with a proper receipt**.** In MLCs, where the patient applies for an examination, such as an injury report, sexual assault examination report etc. in Emergency/Out Patient Department, one of the true copies of the report is for the patient.

13.3. The original hospital record of the medico-legal case should not be handed over to the police. However, if the investigating officer requests, a photocopy of the record may be supplied and a receipt of the same must be obtained.

13.4. If a medico-legal report has already been issued, a duplicate/true copy report should not be issued unless specifically requested by the police/magistrate in writing with the reason specified or by court order.

13.5. **Timelines for Medical Records preservation varies under different acts/ rules/ regulatory bodies in India.**

13.6. If a request is made for medical records by the patient / authorized attendants, or legal authorities, it must be duly acknowledged, and the documents should be issued within 72 hours (per NMC)/ within 30 days after communication of request for electronic health records (per EHRS 2016) / within 30 days from the date of receipt of request or within 48 hours if information concerning the life and liberty of the applicant from the date of receipt of request (RTI act 2005).

13.7. Post-mortem reports in cases of custodial deaths, as well as cases requiring viscera reports in custodial deaths, must be submitted to the magistrate within two months. The viscera report should be sent immediately upon receipt.

13.8. Requests for a copy of post-mortem report to hospital from any relative or authorized person on behalf of the deceased shall not be entertained. Instead, they must follow the due process to obtain a copy from the police or magistrate, being the custodians of the report.

13.9. Issuing or signing a false certificate is punishable under BNS 2023 Section 229.

13.10. Maintain a separate register/record for MLCs, report/certificate disbursement, and discharge/ referral/death summary files where such registers/files are maintained in the hospital.

13.11. The medico-legal and post-mortem reports should be uploaded whenever report dissemination involves medical authorities, provided the MedLeaPR (Medico-legal and Post-Mortem report) facility is available".

13.12. MLC register/record book should be maintained assigning new serial number each year.

13.13. Obtain a signature, name date, phone number etc. and a copy of the identity card after verification while disbursing reports, certificates, or medical records.

13.14. **Record Maintenance/Retention**

13.14.1. **National Medical Commission (NMC):** 3 years

13.14.2. **Ministry of Health & Family Welfare (MOHFW):**

13.14.2.1. **Electronic health Records (EHR standards 2016)** for lifetime of the person and made inactive 3 years after death of person but not to destroy permanently.

13. 14.2.2. Medico-legal case record until final disposal of the case

13.14.2.3. Hard copy in-patient and out-patient records for 3 years

13.15. **MTP Act:** 5 years

13.16 **PCPNDT Act**: 2 years from date of counselling, procedure or test

13.17 **Consumer protection Act, 2019**: 3 years or more (minimum for filling complaints 2 years or may extend if sufficient reason).

13.18 **Clinical establishment Act, 2010:** at least 3 or 5 years or in accordance with any other relevant Act in force.

13.19 **Limitation Act,1963:** in case of minors, up to 03 years after attainment majority.

ANNEXURE- I

MEDICO- LEGAL CASE (MLC) – POLICE INFORMATION
GOVERNMENT OF ARUNACHAL PRADESH
(PREPARE IN DUPLICATE AND OBTAIN SIGNATURE OF THE RECEIVING OFFICER)

To ,

Time…… AM/PM
Date :……..

The Station House Officer/OC
…… Police Station.

Sir Madam,

A patient with the following details had arrived at the Emergency/OPD and is currently being treated, discharged, or had expired. This is for your information and necessary action.

Name :…… S/D/W of …… Age : …….. Sex :…….. UHID No……

MLC No…… Address :……

Pin Code :……

Reason for sending police intimation :……..

Marks of identification :

(1)

(2)

Brought by : Name :…….. Relation : …… Address :……..

Received by Name : Name of the Police Person

Designation :

Date :

Signature of the Treating Doctor

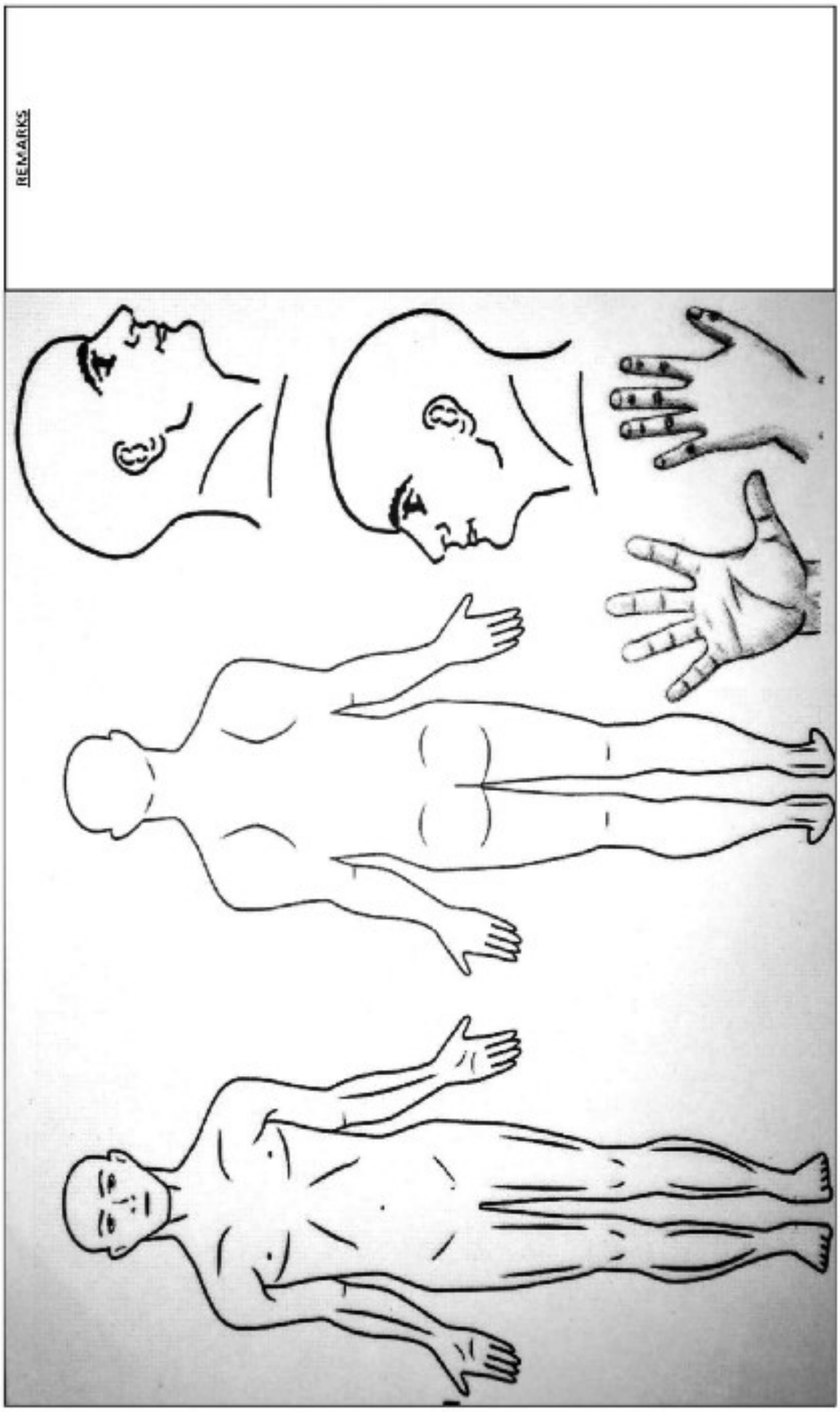
Name :

Stamp :

MEDICO LEGAL CASE REPORT
GOVERNMENT OF ARUNACHAL PRADESH

MLC No :…….. UHID No :……	Name : ……S/D/W of …….. Age …… Sex …… Residence …… Marks of identification : 1…… 2……
Date and Hour of arrival: …… Name and No. of Police Constable Accompanying :…… Patient fit/unfit for statement Date and time of report sent to police Admitted/ Not Admitted	**PARTICULARS OF INJURES** Alleged H/O …….. on ……at ……AM/PM, brought by …… Relationship with patient …….. phone No……..
Consent 1. I consent to the on-duty doctor examining me. 2. I have not previously been examined for my injuries by and other doctor. 3. It has been explained to me in my native or most understandable language (Hindi/English) that the examination results may or may not be in my favour. 4. All injuries listed in the report have been read to me in my native or most understandable language (Hindi/English),and I understand the same. **Sign/ Thumb impression of patent of guardian**	**Investigation :**
Duration of injures :…….. Kind of weapon used or Poison suspected in suspected poisoning :…… Nature of inury : 1. Simple 2. Grievous Sample preserved …… Sample sealed and handed to …… (Tick the appropriate nature of injury)	…….. Sign, Name of Medical officer with designation and Reg No.

ANNEXURE- III



Annexure- IV

PROFORMA FOR EXAMINATION OF AGE

Photo to by attested by doctor

MLC No.…… Dated ……..……..

Hospital OPD/IPD No. ……Dated ……

Vide Reference No. ……....

……..U/S…… Dated……..

Place of Examination: ……

Date & Time of Examination……..

Brought and identified by: ……

…… Signature: …….

(I) Particulars Information:

1. Name of the Person: ……

   Sex. ……..

   Age. …….. (Stated by police)

   ……. (stated by individual)

   Caste. …… Religion. ……..……..

   Occupation. ……..…… Marital Status. ……..……

   Father/Guardian's name. ……..

   Address. ….……

   ……

(II) INFORMED CONSENT:

I…….....

Daughter/Son/Guardian of …….…… hereby give my full informed valid consent for the complete medical examination for the purpose of age estimation and agree to the following- a) Examination of genitals area and other secondary sexual characters of body b) Dental examination c) Radiography/Photography/Videography for the purpose of investigation or legal evidence. The purpose and procedure, consequences of examination, use of such findings, and the findings may go against my favor, have been explained to me. All this has been explained to me in my own native or most understandable language and I understood the same. (With the help of a special educator/interpreter/support person; circle as appropriate)

I also understand that as per law the hospital is required to inform who applied for the same and this has been explained to me.

Name and Signature educator/interpreter/support person if any: ……

Signature/ Thumb impression	Signature/ Thumb impression
Name:	Name:
Contact No :	Contact No:
(Witness/ accompanying person)	(Person self / Guardian in case of minor)

(III) Signature, name & designation of male/female attendant (In presence of whom examination conducted):

Thumb Impression

(IV) Identification marks:

(a) Thumb Impression (Right if Female; Left if Male)

(b) Any scar/ mole/deformity etc. ……..

……..…….

……..…….

(V) History (as narrated by police / authority):……..…….

……...……

……..……

……...……

(VI) General physical examination:

(a) Emotional/ mental status: ……..……...…

(b) Height…….…… Weight ……..…….

body built……..…… Hoarseness of voice (Present/Absent) ……..... Adam's Apple (prominent/non-prominent). ……B.P……..……Pulse……

(c) Chest girth at the level of nipple. ……..……

(d) Abdominal girth at the level of umbilicus. ……..……

(VII) Secondary sexual Characters:

(a) Date of Menarche…… Last menstrual period……..……

(b)	*Pubic hair*	*:*	*P1*	*P2*	*P3*	*P4*	*P5*
(c)	*Testis size*	*:*	*P1*	*P2*	*P3*	*P4*	*P5*
(d)	*Scrotum development & rugosities*	*:*	*smooth surface/ rough surface*				
(e)	*Penis development*	*:*	*Infantile/ adult like*				
(f)	*Breast development*	*:*	*B1*	*B2*	*B3*	*B4*	*B5*
(g)	*Axillary hair*	*:*	*Dark brown/ Grey/ Mixed*				
(h)	*Moustache*	*:*					
(i)	*Beard*	*:*					
(j)	*Acne*	*:*	*Present / Absent*				
(k)	*Any other important finding*	*:*					

(VIII) Dentition: (Tick if erupted, Cross if unerupted and encircle if the teeth erupted, but missing)

Total No…….. Temporary……. Permanent……

Artificial if any…… Spacing behind 2nd permanent molar: YES / NO

(IX) Any other significant finding/ examination / referral: ……
……...

(X) Radiological Examination report with date:

Orthopantomogram:…….

Shoulder Joint:……..

Elbow joint:…….

Wrist joint:……..

Pelvis with upper end of femur:……

Knee joint:……

Ankle joint:……

(XI) The examination concluded at ……AM/PM on……

XII) Opinion : After performing of above general physical, dental and radiological examination on the person ……bearing above mentioned identification marks on date……., we are of the considered opinion that- He /She is ……..…….. years of age at the time of medical board examination.

(Report contains……pages each signed by doctor)

Signature:

Name:

Dept. / Designation (seal):

Signature:

Name:

Dept. / Designation (seal):

Signature:
Name:
Dept./ Designation (seal):

RECEIPT (by police/authority):
Signature:
Name:
Designation:
Police Station/Address:

Note: Medical board required for age estimation (Dental, Radiology and Forensic Doctor). Board is formed only if primary document presented is doubtful or no other document available for age proof.

Annexure- V

Age Estimation Format (Sports)

Space for colour photograph Attested by Gazetted officer

A. Informed consent

B. I ……..……S/D/O or Gurdian of……..…..

……..……

voluntarily give my consent for complete medical examination for the purpose of age estimation. I understand that this examination may involve physical examination including genital examination, dental examination and radiography. The purpose, procedure and use of such examination have been explained tome in the language which I understand.

Signature of the candidate / guardian:

Signature of the accompanying person/witness:

(Note: Consent by guardian is essential in respect of athletes below 12 years)

C. Preamble

1. Age category.....
2. Sports Discipline.....
3. Events to be participated .....
4. Case Serial No.....
5. Name.....
6. Age as stated(Any documentary evidence like birth certificate).....
7. Sex.....
8. Permanent Address.....

   .....

   .....
9. Corresponding address.....

   .....

   .....
10. Name of school/college/Institute.....
11. Tel. No.& e-mail.....
12. Father’s name.....
13. Mother`s name.....
14. Name of the person accompanying.....
15. Date and Time of examination.....
16. Place of examination.....

17. Marks of identification (Scar/mole/deformity etc.):

    1. .....

    2. .....

18. Thumb impression (right in female and left in male)

    Signature

Thumb impression

D. General Physical Examination

1. Height(cm):……...
2. Weight(kg):……
3. Chest girth at the level of nipples:……
4. Abdominal girth at the level of naval:……
5. For calculating Body development index (BDI):……
   - I. Biacromial breath (cm):……....
   - II. Biliospinale breath(cm):……
   - III. Forearm circumference (cm) in males:……..
   - IV. Mid-thigh circumference (cm) in females:……
6. Voice (Hoarseness of voice):……

E. Dental Examination

(i) Dental Data:

	(S) 8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8 (S)
(Rt.).	..... …….	(Lt.)
	(S) 8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8 (S)

   (a) Temporary……..

   (b) Permanent……

   (c) Space for third molar (S)……

   (d) Partially erupted/completely erupted……

(ii) **Dental X-ray:** Oral pantogram (OPG)……

(iii) **Dental X-ray findings**:……

F. Radiological Examination/MRI/CT scan (as applicable)

Note : A single film of hand and wrist is sufficient for age below 13 years. Wherever radiological examination is not indicated MRI/CT scan may be done.

1. X-ray advised (as per requirements):
   (i) Shoulder joint: A.P view
   (ii) Elbow joint : A.P and lateral view
   (iii) Hand with wrist : A.P view
   (iv) Pelvis with hip joint : A.P view
2. Date of Radiological examination :

3. Name of the Radiographer :

Radiological findings :

Sl. No.	X-ray advised	Findings	Age inference

G. Age Certificate

After performing general physical, dental and radiological examination, we are of the considered opinion that the biological age of the person is about..... years which is consistent /not consistent with birth certificate/ age document.

Dated:

Signature:

Name:

Designation:

(All the parameters should be considered for the age estimation)

H. Body development index method: Optional method (BDI method is valid upto18years)

$$\textbf{BDI} = \frac{\text{Middle breadth x 2 forearm circumference(corrected)}}{\text{Body height x 10}}$$

$$\textbf{Middle breadth} = \frac{\text{Biacromial breadth + Biliospinale breadth}}{2}$$

Forearm circumference (corrected) = Forearm circumference given–Rohrar index (RI) (Corrected)

$$\textbf{Rohrar index} = \frac{\text{Body weight (kg)}}{\text{Body height}^3 \text{ x } 10} = \frac{\text{Kg}}{\text{M}^3 \text{ x } 10}$$

Corrected Rohrar index = Corresponding corrected value to the calculated Rohrar index (Correlate with table 1: Rohrar index– corrected value)

Biological age= Corresponding age to the BDI index value

(Correlate with table 2 : Mean value of body development index children, Wutschrk,1973)

Table-1 : ROHRAR INDEX AND CORRECTED VALUE

RI	Correction	RI	Correction	RI	Correction
1	**2**	**3**	**4**	**5**	**6**
0.90	+3.7	1.13	0.0	1.36	-3.7
0.91	+3.5	1.14	0.2	1.37	-3.8
0.92	+3.4	1.15	0.3	1.38	-4.0
0.93	+3.2	1.16	0.5	1.39	-4.2
0.94	+3.1	1.17	0.6	1.40	-4.3
0.95	+2.9	1.18	0.8	1.41	-4.5
0.96	+2.7	1.19	1.0	1.42	-4.7
0.97	+2.6	1.20	1.1	1.43	-4.8
0.98	+2.4	1.21	1.3	1.44	-5.0
0.99	+2.3	1.22	1.5	1.45	-5.1

RI	Correction	RI	Correction	RI	Correction
1	**2**	**3**	**4**	**5**	**6**
1.00	+2.1	1.23	1.6	1.46	-5.3
1.01	+1.0	1.24	1.8	1.47	-5.5
1.02	+1.8	1.25	1.9	1.48	-5.6
1.03	+1.6	1.26	2.1	1.49	-5.8
1.04	+1.5	1.27	2.3	1.50	-5.9
1.05	+1.3	1.28	2.4		
1.06	+1.1	1.29	2.6		
1.07	+1.0	1.30	2.7		
1.08	+0.8	1.31	2.9		

Table-2 Mean Values of Body Development Index of GDR Children (WUTSCHRK, 1973)

Biological Age in Years	Boys	Girls
4	0.52	0.52
5	0.57	0.57
6	0. 57	0.61
7	0. 59	0.64
8	0. 62	0.67
9	0.65	0.70
10	0.67	0.73
11	0.69	0.75
12	0.70	0.75
13	0.72	0.79
14	0.80	0.84
15	0.83	0.87
16	0.84	0.88
17	0.86	0.91
18	0.90	0.97
Adult	**0.00 (?)**	0.97

Annexure - VI

PROFORMA FOR EXAMINATION OF DRUNKENNESS

MLC No.……..…… Dated ……..……

Hospital OPD/IPD No. …… Dated ……..……

Vide Reference No. ……U/S……..……

Dated……..

Place of Examination: ……..……...

Date & Time of Examination……..……..

Brought and identified by: …… Signature: ……..

(I) Particulars Information:

1. Name of the Person: ……. Sex. …….

   Age. …….. (Stated by police) ……. (stated by individual)

   Caste. …… Religion. …….. Occupation. ……..
   Marital Status. ……..

   Father/Guardian's name. ……

   Address. ……..……

   ……
   ……...

(II) INFORMED CONSENT: * I ……

Daughter/Son/Guardian of …… hereby give my full informed valid consent and agree to the following- a) Complete medical examination of the body b) Collection of samples/investigations for medical and forensic examination and treatment c) Photography/Videography for the purpose of investigation or legal evidence. The purpose and procedure, consequences of examination, use of such findings and the findings may go against my favor, have been explained to me. All this has been explained to me in my own native or most understandable language and I understood the same. (With the help of a special educator/interpreter/support person; circle as appropriate)

I also understand that as per law the hospital is required to inform who applied for the same and this has been explained to me.

Name and Signature educator/interpreter/support person if any: ……..

Signature/ Thumb impression	Signature/ Thumb impression
Name:	Name:
Contact No:	Contact No:
(Witness/ accompanying person)	(Person self / Guardian in case of minor)

(III) Signature, name & designation of male/female attendant (In presence of whom examination conducted):

Thumb Impression

(IV) Identification marks:

(a) Thumb Impression (Right if Female; Left if Male)

(b) Any scar/ mole/deformity etc. ……

……

……

(V) Alleged History:

(a) As given by police:……..

……

……

……

(b) As given by alleged person (admits/ deny as per statement):……

……

……

……

(VI) Medical history: (Any history of Hearing/Vision/Balance/epilepsy/psychiatric illness/addiction/ trauma/ Chronic illness/any other illness etc.)

……..

……..

……..

(VII) General physical examination:

(a) **Emotional/ mental status:**

Memory: Clear/vague/Confused

Orientation: Time/Place- Good/Moderate/Bad/Indefinite

Reaction time: Normal/Delayed/Early

(b) **Height**……..……**Weight**…….……..**body built**……..
voice……..…… **B.P**……**Pulse**……
R.R……..**Temperature**……..

(c) **Injury/Any other**:……

……

(d) **General appearance:**

Clothing: Decent/Soiled/Torn/Disordered

Behaviour: Sober/Abusive/Talkative/Aggressive/Boastful/Calm

(e) **Face:** Normal/Flushed/Pale

(f) **Eyes: Conjunctiva-** Normal/Congested; Pupils- Normal/Dilated/Contracted; Reaction to light- Normal/Delayed/Sluggish/Non-reacting; Visual acuity- Normal/Abnormal; Nystagmus: Horizontal gaze- Coarse/Fine/Continuous/Absent, Vertical gaze-Yes/No; Convergence-Yes/No

(g) **Ear (discharge) :** Yes/No

(h) **Mouth (Smell of alcohol/Vomitus) :** Yes/No

(i) **Tongue :** Dry/Moist/Clean/Furred

(j) **Speech :** Normal/Incoherent/Stuttering/Over-precise/Thick-slurred

(k) **Gait :** Normal/Broad-gauge/Stumbling/Self-control

(l) **Reflexes :** Normal/Exaggerated/Depressed

(m) **Muscular co-ordination :**

- **Finger nose test:** Sway/ Correct use
- **Romberg test:** Stand still/ Sway
- **Walk and Turn test:** Stand still/start too soon/stops walking/Misses heel or toe/gait on turning/steps off line
- **One leg stand test:** Sway/Puts down/Hops

(VIII) Systemic Examination :……..……..

Chest:……..…

CVS:…….……

P/A:……..…….

CNS:……..

(IX) Sample preserved:

Blood (in NaF + K oxalate):

Urine (NaF/Phenyl mercuric nitrate):

(X) The examination concluded at …… **AM/PM on**……..

(XI) Report of chemical examination (Blood/urine) with date:……

(XII) Opinion: After performing of above general physical and chemical examination on the person …….. bearing above mentioned identification marks on date……., I / we am / are of the considered opinion that He /She has

1. Consumed alcohol and is under influence of it.
2. Consumed alcohol but is not under its influence.
3. Not consumed alcohol.

(Report contains…….. pages each signed by doctor)

Signature: Signature:

Name: Name:

Dept. / Designation: Dept. / Designation:

RECEIPT (by police/official):

Signature:

Name:

Designation:

Police Station/Address

Annexure- VII

FORM OF CERTIFICATE RECOMMENDED FOR LEAVE OR EXTENSION OR COMMUNICATION OF LEAVE AND FOR FITNESS

Signature of patient or thumb impression : ……..

To be filled in by the applicant in the presence of the Government Medical Attendant, or Medical Practitioner.

Identification marks: -

(a) ……

(b) ……

I, Dr. ……..…….. after careful examination of the case certify hereby that ……whose signature is given above is suffering from ……..……..and I consider that a period of absence from duty of …….. with effect from ……is absolutely necessary for the restoration of his health.

I, Dr. …….....after careful examination of the case certify hereby that …….. on restoration of health is now fit to join service.

Place: …….

Date:……

Signature of Medical attendant.

Registration No. ……

(Medical Council of India / State Medical Council of ……..…. State)

Note: The nature and probable duration of the illness should also be specified. This certificate must be accompanied by a brief resume of the case giving the nature of the illness, its symptoms, causes and duration.

Annexure - VIII

For Hospital Events

FORM NO. 4
(See Rule 7)
MEDICAL CERTIFICATE OF CAUSE OF DEATH
(Hospital In-patients. Not to be used for still births)
To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital ……..

I hereby certify that the person whose particulars are given below died in the hospital in Ward No.……
On ……At ……..……AM/PM

Name of Deceased					For use of Statistical Office
Sex	Age of Death				
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours	
1. Male 2. Female					
CAUSE OF DEATH (I) (a)…..…….…… due to (or as a consequences of) Immediate cause State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc. Antecedent cause (b) ……..….. Morbid conditions, if any, giving rise to the above cause,due to (or as a consequences of) stating underlying conditions last (II) Other significant conditions contributing to the death but (c)…… …….. not related to the disease or condition causing it …… ……..				Interval between onset and death approx.	

Manner of Death How did the injury occur?

1. Natural 2. Accident 3. Suicide 4. Homicide 5. Pending investigation

……

If deceased was a female, was pregnancy the death associated with? : 1. Yes 2. No

If yes, was there a delivery? : 1. Yes 2. No

……

Name and signature of the Medical Attendant certifying the cause of death

Date of verification …….

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum…… S/W/D of Shri ……

R/O ……. was admitted to this hospital on……..……
and expired on ……..

Doctor……..

(Medical Superintendent & Name of Hospital)

Annexure - IX

For Non-Hospital Events

FORM NO. 4A

(See Rule 7)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

(For non-institutional deaths. Not to be used for still births)
To be sent to Registrar along with Form No. 2 (Death Report)

I hereby certify that the deceased Shri/Smt/Km…… son/wife/daughter ……was under my treatment from …… to……..……..……and he/she died on …… at ……...A.M./P.M.

Name of Deceased					For use of Statistical Office
Sex	Age of Death				
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours	
1. Male 2. Female					
CAUSE OF DEATH (I) (a) …….. …….. due to (or as a consequences of) Immediate cause State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc. Antecedent cause (b) …… Morbid conditions, if any, giving rise to the above cause, due to (or as a consequences of) stating underlying conditions last (II) Other significant conditions contributing to the death but (c) ……..…. …… not related to the disease or condition causing it …… ……				Interval between onset and death approx.	

If deceased was a female, was pregnancy the death associated with? : 1. Yes 2. No

If yes, was there a delivery? : 1. Yes 2. No

……..

Name and signature of the Medical Attendant certifying the cause of death

Date of verification ……..

……..

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum…….. S/W/D of Shri .....……

R/O ……..... was under my treatment from……..…to …….and he/she expired on ……..at…….AM/PM

Doctor……..

(Medical Superintendent & Name of Hospital)

Annexure- X

DEADBODY PRESERVATION REQUEST FORM

To,

The Mortuary In-Charge

Date ……..

…….. **Hospital**

Arunachal Pradesh.

Sub: - Regarding Dead body preservation in Mortuary.

Sir/Madam,

I, ……S/D/W of……..

Address……applying for dead body preservation in Mortuary of the deceased-

Name: …… Age/Sex : ……..……..……..……

S/D/W of……..……..UHID……..……...……..……

Address: ……..……

……

who has been declared dead by the Doctor.

I have checked the deceased body that there is no jewellery or money or any kind of precious item on dead body. *** (if jewellery or money, mentioned and must be noted) kindly preserve the dead body in the mortuary.

Witness:

1. Name :

   ID number :

2. Names :

   ID number :

Claimant Name :

Mobile number :

ID number :

Attachment : 1. Applicant's ID card Photocopy

2. Death Document of Deceased

Annexure- XI

POST-MORTEM EXAMINATION REQUEST FORM

(For Office use only)
PM Number:
Date:

[To be filled in duplicate. ALL NAMES TO BE FILLED IN CAPITAL LETTERS]

To,

The In-Charge/ On-duty Doctor

…….Hospital

Arunachal Pradesh

Sir, it is requested that an autopsy may be performed on the dead body of Name: …….. S/D/W of ……Age: ……..Sex ……Address ……...

……

G.D. / FIR No……U/S …… Dated…… PS:……

Name of Police Officer who has sealed and labelled the body: ……

Name and address of relatives identifying the body:

1. Name:……S/D/W of……..……
   Address ……Relation with deceased…….
2. Name: ……..……S/D/W of……
   Address …….
   Relation with deceased: …….

Short History of the case:

Person last seen alive: ……..Date & Time of incidence: ……

Date & Time of death: ……

Details of Investigating Officer:

Name:……..…… PS: ……..……..

Mobile Number: …….

Note : (Very Important)

1. Identification of dead body & handing over of the dead body to relatives is the duty of the investigating officer.
2. To ensure proper identification & handing over of dead body I.O. must depute responsible officer in case he has to leave in between.
3. Photographs and fingerprints for identification have to be taken by the police, if necessary.

……...

Signature of Investigating Officer

After Post Mortem Examination, received the following:

☐ Dead Body

☐ Viscera

Samples for Histopathology/…….…….....

……(Signature)

Name ……...……

Annexure- XII

POST MORTEM EXAMINATION REPORT

Post-Mortem Examination report number: 000/0000 Of:……..

S/D/W/of ……, **in case FIR/GDE Number:** …….

Dated: ……. **PS:** ……. **Conducted by Dr**:……...

I. CASE PARTICULARS :

Name of deceased: ……..…….Resident of:……

Probable Age:……., Sex:……
Date and Time of body received in mortuary cold storage facility: ……

Date and Time of request from I.O. for post mortem examination: ……

Time and Date of post mortem examination: From…… to…….

II. INVESTIGATING OFFICER:

III. IDENTIFIED BY / IDENTIFICATRION MARKS: -

1. NAME/ADDRESS & RELATION SAME AS WRITTEN IN PM REQUEST FORM BY IO
2. NAME/ADDRESS & RELATION SAME AS WRITTEN IN PM REQUEST FORM BY IO

IV. BRIEF HISTORY AS PER I/O:

SAME AS WRITTEN IN PM REQUEST FORM BY IO. Include initial hospital visit and referral chain of hospital (if any) here.

V. INFORMATION AS PER HOSPITAL INVESTIGATION PAPERS:

If applicable: time of arrival & admission in last hospital where death occurred, duration of stay.

Date and time of death in last hospital. Include reference number of documents that is quoted here (MLC no, death summary number etc)

Cause of death as mentioned in submitted hospital record.

VI. EXTERNAL GENERAL APPEARANCE

Condition of body received, clothes, hospital sheets wrap etc. detailed description of clothes, ornaments. Bandages, tubes catheters etc. any gross visible deformity or anything that is not

(Dr. ……..)

covered in external injuries. Body weight, length, physique/built; eyes, mouth, ears, nose, nails etc.

VII. POST MORTEM CHANGES

Hypostasis: …….

Rigor Mortis: ……..

Decomposition Changes: ……

VIII. EXTERNAL EXAMINATION (Injuries etc):

Number wise description of injuries- type, size, shape, color, direction, location, angles etc. Paragraph description of burn injuries**.**

IX. INTERNAL EXAMINATION

(A) Head

Scalp: …….

Skull:……

Brain (general appearance) Weight. Description of meninges and other related structures if needed. Cut section findings.

(B) Neck

Subcutaneous Tissue: ……...……

Mouth/ tongue/Larynx/Pharynx/Trachea: ……..…….

Hyoid Bone and Thyroid Cartilage: ……..

Esophagus: …….

Vessels: ……..

(C) Chest

Collar Bone, Sternum, Ribs, chest wall: …….

Pleural Cavity: ……..

Lungs: Weight. Gross appearance and cut section findings.

Pericardium: Heart: Weight. Gross appearance and dissection findings

Vessels: ……..

(D) Abdomen

Peritoneal cavity:. ……..

Stomach: Contents : Walls and Mucosa:……..

Small and large intestines : Contents. Walls and Mucosa

Liver : Gross appearance and cut section findings.

(Dr. ……..)

Gall bladder:…….

Spleen: Gross appearance and cut section findings.

Kidneys: Gross appearance and cut section findings.

Abdominal vessels: Unremarkable.

(E) Pelvis

Pelvic cavity: description of pelvic organs in females.

Pelvic bones: …….

Bladder and uterus: ……

Vessels: ……

Genital organ- penis, scrotum, urethra, vagina etc.

(F) Spinal Column: (to be opened when indicated)

X. MATERIAL PRESERVED:

OPINION: COD, Probable time since death (keep all factors including observation in inquest), time since injury etc.

After the post-mortem examination:

A: The dead body was handed over to the I.O. after completion of post mortem examination.

P.M. Report in original in…….pages +……..(number) of Diagram Sheet along with ……...(Number) Inquest Paper, submitted by I.O. and duly signed by Dr. ……..

B: Following items were sealed and handed over to the I.O.

1. Histo-pathology samples description
2. Viscera
3. Other articles with purpose of preservation

Handed over to:……..

Signature: …… (here signature to be taken only on office copy of report)

Name and Belt No. ……

(Dr. ……..)

Annexure- XIII

REQUEST FOR VIDEOGRAPHY/PHOTOGRAPHY OF THE POST-MORTEM PRECEEDINGS

To Date: ……..
The Mortuary In-charge
…… Hospital
Arunachal Pradesh

Respected Sir,

With due regards, I am submitting this for your kind permission to allow the Videography/ Photography in case of Police Post-Mortem/ GDE/FIR No. ……..……..
Dated …….. PS……of deceased……..……
S/W/D of ……
Reason for Videography/ Photography:……..……
……..
……..
……..
……..

Thanking you

Signature of I.O

Note : The necessary arrangement for the videography/photography has to be done by the I.O. The responsibility of maintaining chain of custody, privacy and confidentiality will solely rest on the Investigating Officer and legal heirs of deceased are be communicated the same.

Annexure - XIV

REQUEST FOR CONSTITUTION OF MEDICAL BOARD

To,
Date: ……
The Superintendent
…….. Hospital
Arunachal Pradesh

Respected Sir/Madam,

With due regards, I am submitting this for your kind Constitution of the Medical Board in case of Police Post-Mortem/ GDE/FIR No. ……..……..
Dated …….. PS……of deceased……..……
S/W/D of ……
Reason for constitution of Medical Board: ……..……..……
……..
……..
……..
……..

Thanking you

Signature of I.O

Note : The decision for constitution of Medical Board is as per direction and guidelines of the state authority.

Annexure - XV

POST MORTEM COMPLETION REPORT

Post-Mortem No.…..…… Date…….. PS …… Case No. ……..

This is hereby certified that post mortem examination on the body of:

Name: .....S/D/W of ……..

Age: ……Sex. …….. Address ……..

…… Date and time of death ……..; is completed at …….. Hospital, Arunachal Pradesh on date …….. Time of completion ……and is handed over to Police ……..……..

No…….. PS……..

The body may be further handed over to the next of kin for the purpose of embalming/ transport/ proper cremation.

Signature and seal of the Doctor

Annexure - XVI

EMBALMING CERTIFICATE

Date: ……..

This is to certify that embalming has been done on the body of ……

…… S/W/D/o ……..……..

aged ……..years, Male/Female, R/o ……..……

……..

an Indian/Foreign national on ……..at ……..AM/PM.

(In case of Post-mortem examination done outside)

Post-mortem report dated on……..……..and no objection certificate from the concern police authority have been verified and found in order. Post-mortem examination done by ……at ……..……

Embalming is to ensure that the body is non-hazardous to public health and fit for transport in airtight coffin within the period of one days/ three days/ five days/ seven days.

After embalming, the body has been handed over to the applicant/claimant.

Cause of Death/ Nature of case ……..……

Signature of Doctor

Received 3 (Indian)/ 5 (foreigner) nos certificate of the embalming and embalmed body of …… ……..

Signature of applicant/claimant:

Date:

Name:

Address:

Annexure- XVII

REQUEST FOR PRESERVING DEAD-BODY AFTER CONDUCTION OF POST-MORTEM EXAMINATION

To,

Date: ……..

The Mortuary In-charge

……..Hospital

Arunachal Pradesh

Sub: application for dead body preservation after post-mortem examination

Respected Sir,

I, Mr/Ms……..……S/W/D of……

the legal guardian of the deceased/ IO of the case, request you to kindly allow the preservation of deceased…….……S/D/W of……..……..……..…… whose post-mortem examination has been conducted vide PM No.....……on dated……..…… at ……

The legal custody of the deceased is entirely upon me and will be fully responsible of it.

Reason of preservation:

……

……

……

……

……

……

……

This is for your kind perusal and necessary action.

Thanking you.

Signature of legal guardian/I.O **Relation with deceased:**

Phone No:

ID proof attached: (To be produced in original during handing over of dead body).

For the use of on duty Doctor

(The request received and processed after instructions by mortuary in charge)

Signature of on duty MO/Doctor

Annexure- XVIII

AUTOPSY SPECIMEN (S) AUTHENTICATION FORM

(To be completed by the Authorized Medical Officer who conducted the Postmortem)

1. Identity of person from whom samples are being collected:
   Name: ……..Religion/Caste ……..
   Date of Death……...PM No. ……
   Hospital UHID # (If any) ……

2. Cause of Death/Nature of Death …….....
   ……

3. Has the individual received a blood transfusion or bone marrow transplant in the last three months?
   YES / NO

4. Specimen Collection:……..
   Collection Centre Name: ……
   Collection Centre Address: ……...

5. Description of Samples Collected:

Sample	Storage conditions	Other remarks

6. Chain of Custody
   Sample Collected by: ……..
   Sample collection date & time: …….
   Specimen(s) sealed and released by ……..

(Name, signature and stamp of sampling authority)

Specimen(s) released to: ……

Mode of release: Hand delivery ……Mail……..

Date sent to CFSL……

Sample Seal

(Name, signature and stamp of sampling authority)

Annexure - XIX

BLOOD SAMPLE AUTHENTICATION FORM
Central Forensic Science Laboratory

A. Particular of donor

(i) Name (in block letter):……

(ii) Father/Guardian's name:……..

(iii) Sex: ……

(iv) Date of Birth:……

(v) Address:……
…
……

Attested Photograph by Medical officer

(vi) Medical history:

Normal Chronic Disease:……..

Genetic Disease:……..

(vii) Blood transfusion, if any in past three months:……..

(viii) Organ Transplantation, if any:……

B. Case details:

Case no: ……Date: ……
PS:…… U/S:……

C. Purpose for conducting test:……

D. Declaration by the blood donor:……

I ……hereby certify that the blood sample is being collected with my consent and acknowledge the above information to be true.

Signature of Donor

Name:

Date

Left Thumb Impression Right Thumb Impression

E. **Sample Collection:** preferably 2 ml of blood be collected in vacutainer or sterilized tube using EDTA as anticoagulant. The tubes should be preserved in the ice container for transport. Alternatively, blood sample can be dried on clean sterilized gauge/filter paper/FTA card and sealed in paper envelope.

(i) Blood sample : Liquid Blood/ Blood Stain

(ii) Date and Time of Collection: ……

(iii) Volume:……

Specimen Seat

Collected by:

Signature, Name & Designation of medical Officer with Stamp

F. Collection procedure witness by:

Witness:
Signature:
Designation:
Address:
Date:

Witness:
Signature:
Designation:
Address:
Date:

For Office Use
Case No.

DNA Typing Unit, CFSL Kolkata
Exhibit No.

ABORTUS (Aborted Fetus) IDENTIFICATION FORM
(DNA PATTERNITY TEST)

(To be completed by the Authorized Medical Officer who conducted the Medical /Postmortem Examination)

1. Identity of person from whom samples are being collected :

   Name of person : …… …Age ……

   Address ……..

   Whether the individual is juvenile or deceased ?
   ……..

   Medical history:

2. Specimen collection (See instruction)

   Hospital Name : ……..

   Hospital Telephone No. ……

   Address : ……

   Medical Examiner : ……

   Date & Time ……

3. Has the individual received a blood transfusion or bone marrow transplant in the last three months? YES / NO

4. Types of Specimen(s) collected (Please specify the portion of Abortus)

   (i) ……

   (ii) ……..

   (iii) ……

   Weeks of Gestation ……..

   Storage conditions used ……

6. Chain of Custody

   Specimen sealed and released by :……

   Specimen released to ……..

   Mode of release: Hand delivery ……

   Mail ……..

   Date sent to CFSL:

Signature Name, and stamp of authority Medical Office

Sample seal

ABORTUS SPECIMEN COLLECTION INSTRUMENTS

Abortus collection	**Wear gloves while collecting samples** **Tissue from an abortus shall be selected by the physician and approximately 2 cm^2 portion must be placed into a sterile plastic tube.** **Print the mother's name and the date of collection on the label.** **Physician should put his/her initials on the label.**
Storage	**Do not preserve the tissue in formalin. Freeze the tissue and transport it on ice.** **Blood sample should be collected in sterile EDTA tubes. Do not freeze the blood sample.**
Forms	**Complete the forms, documenting all the required information.** **Sign the form, where indicated to verify collecting the biological samples.**
Packing	**Package each sample (abortus & mother) separately and affix with a tamper proof seal.**

Annexure - XXI

HISTOPATHOLOGY SAMPLE AUTHENTICATION FORM

To,

Date : ……..

……..

The Pathologist

……Hospital,

Arunachal Pradesh

Madam/Sir,

I am sending herewith sealed bottles/ jars containing viscera of Post-Mortem Number .....

Dated……on the body of……..S/D/W of……

Address ……

For Histopathological Analysis through investigating officer. He/ She is suspected to be a case of the viscera/organ handed over to the investigating officer.

Details of the viscera/organ is as follows:

Sample	Preservative

Sample Seal

(Name, signature and stamp of sampling authority)

Annexure - XXII

Examination of Weapon

Office No : Date: ……..

To,

The Investigating Officer,

PS: ……

Subject- Regarding examination of given weapon/ article.

In reference to your letter number ……..……...…

Dated of PS ……and PM report number…….……...

received a seal packet bearing.....of seal of P.S. .....

for examination and subsequent opinion.

Along with sealed packet following document are submitted by police-

1. Case diary.....
2. P.M. report No. .....
3. MLC report No. .....
4. FSL report No. .....
5. Any another document.....

Examination of weapon/ articles-

Before opening the packet (describe seal, date, PM No., MLC. No, Police Station, DD, FIR No.):

On opening the packet: a …….....(Name of weapon and article) is recovered.

The detailed examination is as follow:

Name of the weapon: ..... type (heavy/ light) .....

Made up of material: ……

Part: .....

Weight: .....

Blunt or sharp: ……

Edges (single / double and/ or serrated/ non-serrated): .....

Pointed / non-pointed ..... hilt (present /absent) .....

In case of lathi, bamboo, rod etc.

Length: ..... width: .....

No. Of nodes: ..... distance between nodes: .....

Any other (stain, foreign material, rust, print, design etc.): ……

Dimensions (as per diagram): ……

OPINION: After examination of above mentioned weapon and submitted document, I am of the considered opinion that the injury ..... (Mention the injury no., if any) found on the body of deceased as mention in the PM / injury report could be / could not be possible with the weapon submitted by the police.

Weapon resealed and handed over to the police ..... for further investigation.

Date: Name and Signature of MO/Doctor on Duty

SEAL

Annexure - XXIII

ANAESTHESIA INFORMED CONSENT

PATIENT NAME ……..AGE……..SEX ……..

UHID Number…….

PLANNED FOR SURGERY ……

……..

ANAESTHESIA CONSIDERED IS- ☐ General Anaesthesia ☐ Spinal / Epidural

☐ Regional block with sedation ☐ Moderate / Deep sedation

** Depending on peri-operative circumstances, a specific modality of anaesthesia may need to be changed to another for the patient's well-being.

RISKS AND COMPLICATIONS OF ANAESTHESIA

While anaesthesia for surgery is generally safe, there are potential complications. These can include, but are not limited to, drug reactions (such as rash, itching, nausea, vomiting, shock, and cardiac/respiratory arrest), eye injuries, nerve injuries, loss of sensation, persistent numbness, weakness, pain, or the possibility of not fully reversing from anaesthesia, and the need for post-operative ventilatory support ranging from a few hours to several days. Risks are higher for patients with serious medical conditions. Although extremely rare, awareness during general anaesthesia has been reported. Specialized procedures may pose risks such as infection, lung collapse, and retained catheters. The insertion or removal of airways may cause damage to teeth, dental prostheses, lips, sore throat, or hoarseness. Considering your condition and the anaesthesia, additional risks may include-

……..

……..

……..

……..

……..

RISKS AND COMPLICATIONS OF MODERATE SEDATION

Specific risks and side effects include temporary memory loss (including the inability to recall the procedure), headache, a "hangover" feeling, stomach upset with possible vomiting, and unpleasant memories.

ACKNOWLEDGEMENT AND CONSENT FOR ANAESTHESIA

I give my full informed consent to undergo the proposed anaesthesia, fully understanding the associated material risks and any practical alternatives. I also understand that receiving anaesthesia on an outpatient basis, restrict driving and must be accompanied by a responsible adult when leaving the hospital. I have read and understood this consent form, or it has been read to me. I have had ample opportunity to ask questions about the anaesthesia plan and proposed procedures. I voluntarily consent to the anaesthesia team administering anaesthesia, managing post-operative pain, and performing procedures they deem reasonably necessary, appropriate, or desirable in their professional judgment, **including any unforeseen procedures not known at the time this consent is given.**

Reason for patients' inability to sign

……..

Signature & Name of Patient/Guadian **Signature & Name of Anaesthetist**

Relationship with Patient

Signature & Name of Witness

1. ……

2. ……

Annexure - XXIV

LEAVE AGAINST MEDICAL ADVICE (LAMA)
Government of Arunachal Pradesh

Date:……

I,……..……Son/Daughter/Wife of ……..……. choose to discharge my patient/myself from the hospital of my own free will. I have been informed about the condition/diagnosis of my patient/myself. The immediate life-threatening risks and potential future outcomes of leaving the hospital without treatment have been explained to me in my native/most understandable language, and I fully understand the same. If my/my patient's condition worsens or results in death, I accept the entire responsibility. I will not hold any doctor, nurse, hospital staff or administration responsible for any adverse incidents that occur in the future as a result of my decision.

Signature & Name of Patient Signature & Name of Guardian

UHID No: Relationship with Patient

Witness: Signature & Name of Doctor

1. ……

2. ……

Annexure - XXV

PATIENT REFERRAL FORM

……..**Hospital**

Patient Information:…….. Date & Time:……

(i) Name: …… Age/Sex ……..

(ii) Address: ……

(iii) Contact Number: ……MLC No. ……..…

Medical Information:

(i) Diagnosis: ……..……

(ii) Condition:□ Stable □ Critical □ Deteriorating

(iii) Presenting Symptoms: ……..……..……

Treatment Provided at Health Facility:

(i) ……..……

(ii) ……

(iii) ……

Reason for Referral:

(i) ……..……

(ii) ……..……

Referred To:

(i) Hospital Name: ……..…….

(ii) Department/Specialty: ……..…….

(iii) Contact Person/Number: …….

Transport Arrangements:

- ☐ Ambulance ☐ Private Vehicle ☐ Other:

  ……..……

Accompanying Medical Staff : ☐ Yes ☐ No

- Name(s): …….

Referring Doctor:

(i) Name: ……..

(ii) Designation: …….

(iii) Signature: …… Date: ……..

Additional Notes:……..

Annexure- XXVI

DYING DECLARATION FORM

I, Dr/Mr/Ms……., S/D/W of ……..……

Resident at, ……..……..……
And currently working as ……,

Am here to record the dying declaration of Mr/Ms/Miss ……..……

Aged ……years, S/D/W of ……..……

Residing at, ……..……..……,
who is Married / Un-married, and by Occupation / Profession is a ……

This declaration is being recorded on …… at ……..……
AM/PM at ……..……
Hospital, Arunachal Pradesh, word by word as narrated by declarant, in presence of the following mentioned witnesses:

Witness 1	**Witness 2**
Name ……..	Name ……
S/D/W of …….	S/D/W of ……
Resident of ……	Resident of ……

Questions that maybe asked:

1. What is your name?.....
2. What is the year/season/month/ day/ date?.....
3. Whether it is morning/evening/night?.....
4. Where do you live?.....
5. Where do you think you are?……
6. Are you married? What is the name of your nephew or niece / eldest or youngest sibling?
7. What is your education? What do you do? ……

CERTIFICATION OF COMPOS MENTIS

I have thoroughly examined declarant's level of consciousness, orientation, memory and other mental faculties. I hereby certify that the individual is in a sound state of mind to deliver his/her dying declaration.

I, Dr……., have come to record your dying declaration.

Will you be able to answer my questions? Yes/ No

DYING DECLARATION

I have examined the declarant before recording this dying declaration and found that his/her condition is critical, and despite the lifesaving treatment being administered, he/she may pass away at any moment. The words of the declarant, as stated by him/her (must be on facts), are as follows:

……
……
……..
……
……

To clarify the points mentioned above and for further continuation, I asked the following questions (avoid leading questions) and the answers recorded in sequence:

1. Why were you brought to the hospital? (describe the incident in detail since beginning)

   ……
   ……
   ……

2. At what time the incident took place?

   ……
   ……
   ……

3. How, by whom, under what circumstances and at which place, did you sustain injury?

   ……
   ……
   ……

4. What is the reason behind this incident?

……
……
……

5. Did you have any past enmity with the assailant(s)?

……
……
……

6. Who were present at the time of the incident?

……
……
……

7. Is there anything else that you want to mention about the incident?

……
……
……

8. Can you sign/put thumb impression? Yes/ No

The recorded dying declaration is accurate according to my dictation. I am signing this statement after reading it, and it bears my signature/thumb impression. (It should be translated into the declarant's mother tongue by a translator).

I, Dr ……, certify that I recorded the above declaration. I also certify that the declarant, Mr./Ms./Miss ……, maintained a sound state of mind throughout the dictation of his/her declaration. The recording ended on …… at …… AM/PM.

Signature/ Thumb impression of Declarant **Doctor’s Signature & Seal**

Translator’s Name, address & Signature:

……

Recorded and signed in our presence:

Signature of first Witness Signature of Second Witness

Annexure - XXVII

FINAL OR SUBSEQUENT OPINION OF POST MORTEM EXAMINATION

Post-Mortem Examination report number :000/000……Of : ……

S/D/W/of ……,

in case FIR/GDE Number : ……..Dated : ……

PS : ……Conducted by Dr: ……..

I. CASE PARTICULARS :

Name of deceased : ……

Resident of : ……..

Probable Age : …….. Sex : ……

Date & Time of post mortem examination : …… From ……..

to ……

II. INVESTIGATING OFFICER :

III. IDENTIFIED BY / IDENTIFICATRION MARKS: -

1. NAME/ADDRESS & RELATION SAME AS WRITTEN IN PM REQUEST FORM BY IO
2. NAME/ADDRESS & RELATION SAME AS WRITTEN IN PM REQUEST FORM BY IO

IV. BRIEF HISTORY of CASE:

SAME AS WRITTEN IN PM REQUEST FORM BY IO. Include initial hospital visit and referral chain of hospital (if any) here.

V. SUMMARY OF FINDINGS : ……...

……..

……..

V. **HISTOPATHOLOGY/TOXICOLOGY EXAMINATION FINDINGS :** ……..

……

……

VI. FINAL OPINION : ……

……

……

Pawan Kumar Sain, IAS
Commissioner (Health & FW),
Government of Arunachal Pradesh,
Itanagar.

———————

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