

Haryana

Medico Legal Manual

2012

Prepared by Health Department Haryana in consultation with Office of the Director General of Police, Haryana; Department of Forensic Medicine PGIMER, Chandigarh and PGIMS, Rohtak.

Haryana Medico Legal Manual 2012

(Prepared By Committee of Experts as per the order of State Government vide Endst. No 4PM-09/3314-20
dated 17.04.2009)

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|--|-----------------|
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**First Edition
Year-2012**

PREAMBLE

Medico legal evidence is critical to the success of investigation of crimes against person. This is particularly true of homicides and cases of sexual offences. It is therefore imperative to develop state of the art standard protocols and guidelines for medico legal examination and update them from time to time. With this objective, the Government constituted a Committee of Experts under the chairmanship of Director General, Health Services, Haryana and comprising representatives of important stakeholders, namely, Forensic Medicine experts from PGIMER Chandigarh, PGIMS Rohtak, Directorate of Health Services and the Police.

After series of meetings at various levels, the Committee has prepared General Guidelines, a Protocol for Postmortem Examination, Protocol for Medico legal Examination of Victims of Sexual abuse, Modern Mortuary Design, etc for providing effective and efficient Medico Legal Services to the public in the State of Haryana. On the basis of recommendation of the said Committee and keeping in view the requirements of the Code of Criminal Procedure 1973, the Government of Haryana in the Health Department hereby promulgates the **Haryana Medico Legal Manual 2012**. The provisions of this Manual shall be binding on all doctors, as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 (102 of 1956), practicing in the State of Haryana. All medico legal examinations in the state of Haryana shall be governed by this Manual.

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CHAPTER I

GENERAL GUIDELINES

CHAPTER I

General Guidelines

Important guidelines and Instructions for medical/Para-medical and other staff on duty in the OPD, wards and in emergency for dealing with medico-legal cases in various health institutions in the State of Haryana are as under,-

1. **Most important duty**- The first and foremost duty of the treating doctor is to save the life of a patient and give necessary urgent treatment. Police should be informed as early as possible but the patient should not be allowed to suffer. For this he must not wait for the arrival of police.
2. **Medical Officers** should prepare the MLR in all cases brought in the emergency by the police, those coming of their own for medico legal examination or any other case in which foul play is suspected. Further, the Medical Officer on duty shall himself/herself write the medico-legal report (MLR). The following category of cases admitted in the hospital are to be treated amongst others as medico legal cases-
 - 2.1. Cases of grievous injuries (See definition under 320 IPC), drowning, hanging, sexual offences, attempted suicide etc.
 - 2.2. Cases of poisoning even if accidental.
 - 2.3. Cases of injuries due to traffic accidents even when an accident had occurred due to patient's mistake and no body else is to be blamed.
 - 2.4. Burns even, if accidental.
 - 2.5. Cases of grievous injuries (See definition under Section 320 IPC) even if accidental including fall from a height, burial under earth mound etc.
 - 2.6. Cases of grievous injuries caused by electric shock or lightening, natural disaster etc.
 - 2.7. Cases of attempted abortion by unauthorized person.
 - 2.8. Cases of bites/injuries caused by animals.
 - 2.9. All unconscious patients with injury of any nature.
 - 2.10. All patients brought to the hospital in suspicious circumstances.
 - 2.11. Person under police custody or judicial custody.

3. **Whenever a suspected medico legal case** is brought in the emergency, it shall be the duty of the Medical Officer on duty to send information to the police station/post of the area, in **Form I** in triplicate. Information shall be sent to the police by the quickest possible means. Acknowledgement from the police officer receiving the information will be kept in the file of the patient and in other OPD cases it shall be pasted in the OPD register or with the Medical Officer for further reference.

4. **The Medical Officer** will make a note in the file of the patient as to the time and date of informing the police. He will then make a complete record of all injuries and also note the date and time of admission of the case therein. Name and addresses of the attendants who brought the patient should also be recorded in the file and admission O.P.D. register if possible.

The Medical Officer will also mark with red pen on the top of first page of the file of the patient the letters "M.L.C." or put the stamp "**Medicolegal case**". The stamp should be kept with the staff nurse on duty in the emergency. The Medical Officer will also see that the card of the patient is marked/stamped "Medicolegal case" by the duty staff nurse on duty.

5. **Protocol for filing the medicolegal report is as under:-**

- 5.1. **Consent** - Always take the consent of the injured person on the MLR Form. If the patient is less than 12 years, take the consent of the guardian/accompanying person and get his signature/thumb impression; consent is not required in case of accused person u/s 53 and 53A of Cr. P.C. and even reasonable force can be used for his examination on the request of the police official not below the rank of a Sub Inspector.
- 5.2. If an unconscious/ semiconscious patient is brought in emergency along with family/guardian, the consent shall be taken from them. In case of refusal by the family/guardian the medical officer shall mention on the MLR that the consent could not be recorded. (Write brief reasons).
- 5.3. The preliminary entries like name of the hospital/institute, MLR No., with date, name of the doctor with full designation and place of posting,

exact date and time of examination, name of the injured with complete address age/sex, caste/occupation, name of the accompanied person and relation with the injured, name and number of the constable/HC with police post/police station and district must be entered before the examination of the injured is started. If admitted, write the C.R. No. with date and name of the ward.

- 5.4. **Identification marks** - Two identification marks preferably on the exposed parts of the body be recorded for comparing the same for identification in the court while giving the evidence.
- 5.5. Brief history of the incident be recorded as stated by the injured/ accompanying person regarding time, manner (accidental/ intentional) with weapon/ means caused and place of event of injury/poisoning, and the time sequence of symptoms/ incapacitation developed etc.
- 5.6. General condition of the person like pulse, BP, respiration, temperature, pupils, level of consciousness, posture, gait, speech, bleeding through natural orifices like ear, nose, mouth, rectum, vagina, etc., paralysis, urinary/faecal retention/incontinence, smell etc. be recorded. The condition of the clothes be recorded regarding their disorder, buttons(intact, undone, or torn), rents, tears, cuts whether coinciding with a particular injury, presence of stains like blood, mud/sand, weeds, faecal, seminal etc., foreign matter, stippling, burns etc.
- 5.7. **Particulars of injuries** - The person should be examined in a systematic way from front as well as back aspect from head to toe. Always depict the site of the injury and presence of stains and foreign material on the diagram. All the injuries should be recorded in a way as if you are giving a statement in the court. The following particulars of each and every injury must be recorded.
 - 5.7.1. **Type of injury** like abrasion, bruise, wounds (lacerated, incised, punctured, etc.), fracture dislocation or burns etc.
 - 5.7.2. **Size** - Exact dimensions (in centimeters) of each injury should be noted down in respect of its length, breadth and depth where ever possible.
 - 5.7.3. **Shape** that is circular, oval, spindle, triangular, elliptical, crescentric, satellite, etc., margins/edges of wounds should be examined (by hands/lenses where ever necessary), regular or irregular having

bruise on its vicinity, floor must be examined by just retracting the edges for seeing the tissue in it. Foreign matter like grease, dirt, gravel, straw, coal, paint, glass, weed, metal, palettes, bullets, wads, clothes, hair etc. should be reported and must be preserved for further analysis.

5.7.4. **Location** of injuries.

5.7.5. **Age of injuries** - Colour changes and healing process.

5.7.6. **Direction** of the injuries

5.7.7. **Nature of injuries** like simple/grievous/dangerous. Doctors shall specify the sub-section of the Section 320 IPC as given in the note below for declaring the injury to be grievous.

5.7.8. **Duration of injuries** - Time lapsed between infliction of injuries and examination.

5.7.9. **Note:** As per section 320 of the Indian Penal Code, only the following kinds of hurt are designated as "grievous",-

5.7.9.1. Emasculation.

5.7.9.2. Permanent privation of the sight of either eye.

5.7.9.3. Permanent privation of the hearing of either ear.

5.7.9.4. Privation of any member or joint.

5.7.9.5. Destruction or permanent impairing of the powers of any member or joint.

5.7.9.6. Permanent disfiguration of the head or face.

5.7.9.7. Fracture or dislocation of a bone or tooth, and

5.7.9.8. Any hurt which endangers life or which causes the sufferer to be during the space of twenty days in severe bodily pain, or unable to follow his ordinary pursuits.

6. **The medico-legal report (MLR):**

6.1. The medico-legal report (MLR) shall be prepared in **Form II** using a copying pencil or ball-point pen and carbonless paper. Each MLR Form shall be numbered and have security features, namely, a watermark and a hologram, to prevent counterfeiting. The name and designation of the examining doctor will be stated, in capital letters, at the bottom of the report. The report will be prepared in quadruplicate - the original shall be given to the police; the first copy shall be preserved in the hospital

registry; the second copy will be placed on the indoor file in case of admitted patients and the third copy will be retained by the examining doctor. Patient will also be given a copy of the MLR (second copy if the patient is not admitted and photocopy attested by the examining doctor, if admitted) on request, or if the same is required for the purpose of further treatment at any other Health Institution, without fulfilling the conditions described at para 25 (Page15) no other person will be given a copy of the MLR except in case he fulfill the condition mention at Para 25. All private cases (not brought by the police) shall be charged fee as prescribed by the State Government. In case of failure to pay such fee, the MLR so prepared shall be sent to the police.

All juveniles, prisoners and victims of alleged custodial violence shall be exempted from payment of fee mentioned above as well as treatment and investigation charges.

Medical Officer who first examines the case, shall prepare the medico legal report. However, in difficult cases, the Medical Officer should take the help of another Medical Officer or Sr. Medical Officer for conducting the medico legal examination or for preparing the MLR.

Note: As and when the MLR Form is computerized, there will be no need for the carbon copying process. The required number of copies of the MLR will be printed and signed individually.

6.2. The medico legal report should be handed over to the police immediately after the examination. If there is any injury kept under observation, the same may be recorded as such and result thereof communicated to the police at the earliest. The medical officer issuing the medicolegal report will be held responsible if any complication arises for not handing over the report to the police immediately after the examination has been conducted.

6.3. In some cases, the police ask for medicolegal report after the case has been discharged/expired. It is irregular to issue a medicolegal report on medicolegal form in such cases. The police, however, can ask for any specific information (including details of injuries) which may be supplied to them from the record of the case and the medical officer supplying

the information should write on top of such report that the same has been noted from the file of the case. Such report should never be back dated.

6.4. Medicolegal report (MLR) should not be written in the presence of a police officer, patient's relatives or any other interested party. If a medicolegal report has already been issued elsewhere, it is not permissible to issue a second MLR unless specifically requested by the police in writing or by the order of the Court (See point No. 46 Page No. 20).

7. Examining female patients in the presence of the attendant/relative/guardian.

A female patient, even if she is not a medicolegal case, should not be examined without the presence of a relative of the patient or a woman hospital attendant. The Medical Officer in his own interest should refrain from acting otherwise.

8. Statement and dying declaration.

If a patient is likely to expire as a result of injuries (including burns) or alleged criminal act, immediate arrangement should be made to get the his/her dying declaration recorded. The Medical Officer will immediately ask the police officer on duty in writing to call a magistrate or if there is no time to call a magistrate, the Medical Officer will himself record the dying declaration keeping in view the legal provisions in this regard. The dying declaration should be recorded in the presence of another doctor or staff member who will witness the statement and will append his signatures at the bottom of the declaration. The Medical Officer recording the statement (either in question/answer form or narrative) should also certify that the patient was conscious and in sound state of mind when the statement was recorded and remained so till the statement was completed. If possible the signature or thumb impression of the patient be obtained on the dying declaration after the same has been read over to him/her. Police officers or relatives of the patient should not be present at the time of recording of the dying declaration.

9. In case of a patient who is not fit to make a statement, the reason should be noted and duly explained in the file. A careful watch is kept and police be informed as soon as the patient becomes fit to make the statement.

10. Discharging a medico legal case.

No medico legal case shall be discharged or leave against medical advice (LAMA) without informing the police in Form-I in triplicate.

11. Death of medico legal case.

Whenever a medicolegal case dies, the police officer I/C of the police post/police station of the area should be informed immediately in Form-I and a note to the effect be recorded on the file of the deceased. When the body of a medicolegal case is sent to the mortuary, clear instructions should be given to the mortuary attendant, not to hand over the body to the relatives without post mortem. Complete chain of custody of the dead body shall be maintained at all times until the time the body is finely handed over to the relatives of the deceased. The body shall be transported to the mortuary. Name of the ward attendant or any other employee/ police staff transporting the dead body shall be recorded in the file or in the OPD register. Once the information is received by the police and the police official has arrived at the hospital, he shall be responsible along with the hospital staff for the safety of the dead body. It shall be ensured that samples remain intact, shall not be tempered at all times. Death certificate should not be issued in Medico-legal cases by the doctor conducting the Post-Mortem examination. Only the Hospital registry should do so.

12. Cases of poisoning.

Stomach wash, urine, blood etc. in poisoning cases must be collected and preserved in bottles which should be properly sealed, labeled and made into a parcel. The sealed parcel along with a letter and a copy of medicolegal report is sent through the police official concerned to the chemical examiner to Govt. of Haryana Karnal/FSL Madhuban for detection of suspected poison. The letter should give particulars of the

case, details of the bottles, sample impression of the seal put on the bottle and the poison suspected.

13. Rape/sexual assault cases.

Detailed guidelines for examination of Rape/sexual assault cases are contained in **Form III** of the Manual, and the same must be followed in letter and spirit, provided that in case of examination of an accused person, consent is not required as per section 53 A of the code of Criminal Procedure, 1973. Medico legal examination in Rape/sexual assault cases of female victims is not be conducted by the male Doctor (Criminal Misc. No. 13 MA/2002-State of Haryana Vs Rajesh and subsequently circulated to all Districts vide memo no. 3PM-2002/4581-4604 dated 28/31-5-2005. Further age estimation shall be done in the **Form IV**.

14. Examination of the accused at the request of the police officer.

When ever request is received from a police officer, not below the rank of a Sub-Inspector, for medical examination of an arrested accused in accordance with section 53 or 53A of the Code of Criminal Procedure 1973, it shall be lawful for the registered medical practitioner to make such an examination of the arrested person and to use such force as is reasonably necessary for that purpose. The consent of the arrested accused person is NOT required in such cases.

15. Collection of parcel by the police.

The police officer, who collected the M.L.R, should be informed to collect the parcel containing the samples (for transmission to the Chemical examiner/FSL, Department of Pathology PGIMS, Rohtak) immediately and if collection of sample is delayed, the sample may deteriorate and render the analysis difficult.

16. Suspecting foul play in cases admitted as ordinary non-medicolegal patients.

Cases which are admitted as an ordinary non medico-legal case but in which the Medical Officer suspects foul play should be immediately

brought to the notice of the police in writing so that they may take necessary action in the matter. In the event of death of such a case, a written report should be sent to the police so that a medicolegal post mortem could be arranged. The body of such a case should be sent to the mortuary and not be handed over to the relatives. For details, please see para 11.

17. No dues.

The staff nurse in emergency ward should see that all charges have been paid by the relatives of the patient/deceased. In case of difficulty, she should inform medical officer on duty.

18. Hospital record.

Original hospital record/file of the medicolegal case should not be handed over to the police authorities. If the police requests M.S/RMO/SMO/MO I/c for the original record of a case, they should be given a photo copy instead. The Civil Surgeon shall designate a official of each institution in writing for maintaining & keeping the record for for future reference.

At times, the Courts ask for the original record. In such cases, duplicate/photo copy shall be retained for record. The original file/X-Ray plates are then submitted to the Court under a sealed cover.

19. Clothes in medico legal cases

Details of clothing including color, condition, size etc. should be written in the MLR. Torn/damaged/stained etc portions should be encircled with signature. Clothes in medico legal cases involved in rape (See separate guidelines for examination of rape victims), stab injuries, fire arm injuries, burns, unidentified dead body etc. should be made into a parcel, sealed and handed over to the police. Clothes of accident victims are not to be preserved unless asked for by the police.

20. Fire arm injuries, lead shots etc. recovered from the wounds/clothes.

Bullets, lead shots etc recovered from the wounds or body in fire arm injury cases should be put in a bottle(s), sealed and handed over to the police at the earliest under proper acknowledgement to be sent to the

Forensic expert for opinion. Details of all such recovered material should be mentioned in the MLR. If the parcel is not collected by the police within a reasonable time frame, the Medical Superintendent/CMO and also the district SP/DSP are informed about the delay.

21. Criminal abortion

Cases of attempted abortions performed by un-authorized persons (for detail see M.T.P. act of 1971 and relevant rules framed under the said act) such as dais and RMPs are to be considered as medico legal cases and reported to the police.

22. Medicolegal cases brought dead to the Institution

In the first instance, vigorous attempts must be made to resuscitate the patient. After all attempts have failed to revive the patient and he/she is declared dead, his/her name, age, address is to be noted. If possible, the names of the persons who brought the deceased may also be noted. The body is then sent to the mortuary and postmortem examination is conducted on the request of the police.

23. Consent/Permission from relatives for autopsy

Consent or permission of the relatives is not required for conducting a medico legal postmortem examination.

24. Authority to conduct a medicolegal post mortem

A medicolegal post mortem can be conducted only after a written request has been made by the police or by the order of the Court. A medicolegal post mortem examination can be conducted only by a medical officer who has been authorized to do so. It may however, be noted that no medicolegal Postmortem examination is permitted to be conducted after sunset, unless there is serious threat to the law & order machinery and a request to that effect is received from the District Superintendent of Police, or Dy. Commissioner of Police in a Police Commissionerate, as the case may be.

25. Supplying copy of medico legal report/PMR to individuals other than the patient and the police officer investigating the case.

25.1. A medico legal report or post mortem report given by an expert is confidential and not a public document as held in State V/s Gian

Singh (1981CRL. L.J. 538) of Delhi High Court. Copy of the PMR/MLR may, however, be given subject to fulfillment of the following three conditions:-

25.1.1. Applicant shall submit a written application addressed to the concerned Medical Officer clearly stating his/her relationship with the patient/deceased person;

25.1.2. Applicant shall pay the fee prescribed by the State Govt. with the Health department and enclose the receipt for the same along with the application, and

25.1.3. The Applicant shall furnish NOC from concerned Police Station (investigating the matter) clearly stating that the issuance of copies of MLR/PMR will not hinder the investigation.

25.2. Alternatively.

The applicant shall produce order of the Court directing the Medical Officer concerned to provide him/her copy of the PMR/MLR.

25.3. Note:- Requests for copy of PMR/MLR under the RTI Act are not maintainable (for details, please see para No. 47).

26. Belongings of the medico legal cases.

26.1. The belongings of medico legal cases if alive shall be handed over to the relatives of the patient accompanying him in the presence of the doctors treating the case and this fact shall be recorded in the file. In case no relative is accompanying the patient, a list of important articles of the person shall be prepared by the Staff Nurse, whosoever is on duty, in duplicate, and articles handed over to the police officer for custody. In all such cases, proper receipt must be obtained.

26.2. In case of medicolegal cases brought dead, belonging of the deceased shall be handed over to the relatives attending on the patient, if available (after verifying the nature of relationship) or to the police officer dealing with the case. A proper receipt must be obtained in each case.

26.3. In case of unknown person brought to the emergency, either in a dying or dead condition, the list of important items like jewellery, cash, wrist watch or any important document shall be prepared by Medical officer or Staff Nurse on duty and articles shall be handed over either

the police or to the Medical Supdt. of the Hospital. Proper receipt shall be obtained in either case.

27. Medicolegal cases not admitted

If a medicolegal case is not admitted, entry shall be made in the OPD register. MLR will be prepared by the Medical Officer on duty in Emergency. A copy of MLR should be given to the patient only on request or if the same is required for the purpose of further treatment at any other Health Institution (see para 6)., without fulfilling the requirements contained in para 25 above.

28. X-Ray of the medicolegal cases should remain attached to the file and preserved.

29. Referral cases

If patient is serious and proper arrangements are not available, then it should be referred to higher centre for treatment with full details clearly stating that MLR could not be prepared due to seriousness of the patient.

30. The file including the x-ray shall be kept in record. However, if there is a holiday, the file shall be kept with Staff Nurse in charge till it is sent to the record keeper. Under no circumstances, the Medical Officer shall take the file to his/her home.

31. In case of **unconscious patient not accompanied by any attendant and treated as unknown patient**, two identification marks must be noted on the file.

32. Emergency surgery

When emergency surgery is required and no attendant is available to give the consent, the surgeon and emergency medical officer will decide and may conduct an emergency surgery on the patient. Please note that the surgeon treating the case will be held responsible if such a patient dies for want of operative treatment because of the non-availability of attendant to give consent for surgery.

33. Taking away a patient or body of a medicolegal case forcibly by the attendant.

The Medical Officer can not act as a security staff or police officer. He can not forcibly detain a medicolegal case or his body. In case the attendants want to take away a medicolegal case/body, the implication of their action should be explained to them politely. If they still insist, the Medical Officer should get it in writing from the attendants that they are taking away the patient/body against medical advice. If they refuse to write anything and take away the patient/body, the Medical Officer should record the same on the file of the patient. In such cases, the doctor in charge of the case, Medical Superintendent /SMO/MO Incharge/RMO, Police Station/post of the area and security staff be informed immediately.

34. Treating the patient v/s Information to the police

The first and foremost duty of the Medical Officer is to treat and save the life of the patient. Everything else is secondary. Information to be police be sent as soon as possible but under no circumstance, the treatment should be delayed because of non arrival of the police.

35. Summons

Summons from the courts should always be accepted. In case particulars of the case i.e. name the patient, date of admission etc. are not mentioned on the summons and the Medical Officer is not able to trace the case file etc., the summons may be returned to be court requesting the court to supply the relevant particulars. A very polite language be used if the summons are not accepted e.g. "The particulars of the case i.e name of the patient/ deceased and date of admission/death, C.R./MLR/PMR No. have not been given. No useful purpose will be served by attending the Court on_____ Kindly provide the necessary particulars so that the relevant papers are brought at the time of the next hearing."

Utmost care should be taken if the summons is received from the Session Court or High Court. In case the doctor is busy in some urgent work or an operation/consultation is already fixed and the notice is too short, information to this effect may be supplied to the Court and request be made for adjournment.

To avoid unpleasantness, the doctors must attend the court when summoned. In case, one cannot attend the court because of unavoidable circumstances, an official communication should be sent to the Court well in time.

The Medical Officers are likely to receive bail able warrants in case they do not attend the court. This requires furnishing security for the amount ordered by the court. In case a Medical Officer does not still attend the court, the security amount will be forfeited and a non bail able warrant will be issued by the court which will be very embarrassing to the medical officer concerned and to Health Department.

In case a medical officer does not attend the Court and also fails to inform the Court, the Court may prosecute him/her u/s 174 IPC.

36. T.A/D.A on Govt. Cases

TA/DA will be paid as per Govt. Rules.

37. Signature of the medical officer.

Name of the medical officer should be written in capital letters below the signature on all MLRs/PMRs.

38. Death Certificate

Death certificate should not be issued in Medico-legal cases by the doctor conducting the Post-Mortem examination. Only the Hospital registry should do so.

39. Dealing with police

The medical officer is advised to render all possible help to the police investigating a case. The first duty of the medical officer is to save and treat the patient. Everything else is secondary. The medical officer is advised to be polite to the police. Any rudeness on the part of the police should be brought to the notice of the CMO/PMO/M.S.

40. Medical Secrecy

According to Declaration of Geneva as adopted by the World Medical Association (1948), every member of the Medical Profession has solemnly pledged that he will maintain the secrets of the patient confided in him even after the patient has died.

41. Record of the medicolegal cases

Record of the medicolegal case should not be divulged to any unauthorized person. Cases have occurred when the culprits have posed themselves as relatives and have taken away the record of the case and produced the same in the court after making changes therein which suited them.

42. Secrecy of the patient's illness in non-medicolegal case.

Even in non-medicolegal cases, secrecy of the patient's illness has to be maintained except in such case where "public interest" is involved.

43. Examination of the record (file) in non medicolegal case.

Relatives wanting to see the file of a non –medico-legal case, be sent to the concerned treating doctor or Medical Superintendent for getting necessary permission. The patient's file is a secret document and as such should not be divulged to any un- authorized person.

44. Examination of the record (file) by L.I.C. or other investigation agencies.

All records (file) related to Medicolegal cases/Post-mortem cases are not open to any person including the L.I.C. or other investigation agencies. In case of Non-Medicolegal cases, such agencies be asked to make application to the Medical Superintendent /SMO/MO Incharge/RMO who may permit inspection of the record when considered necessary, keeping in view the secrecy of the illness of the patient.

45. Inspection of record by lawyers

Under no circumstances, the record of the case will be allowed to be inspected by a lawyer. In case a lawyer gets a court order in this regard, the matter will be referred to the Medical Superintendent/ SMO/MO incharge/RMO for guidance as the court orders cannot be defied.

46. Re-examination in case of Medicolegal/Post-mortem cases

Re-examination in case of Medicolegal/Post-mortem cases shall not be conducted except on written request of the investigation officer or by the orders of the Judicial Magistrate. Re-examination should be done by the Board constituted by the Civil Surgeon or the Medical College concerned.

47. Information under the Right to Information Act.

Right to Information Act 2005 has been enacted by the Parliament to bring about transparency in the functioning of government/public authorities. Under this Act, a citizen of India has the right to seek information from designated Public Information Officers (PIOs) on payment of the prescribed fee. Large number of requests is received by health authorities under the RTI Act to provide information like copies of post mortem reports, medico legal reports etc. However, it has been noticed that different PIOs respond differently to such requests. In this context, it is very important that PIOs are aware of important legal provisions of the RTI Act, especially section 8 (1), relevant portion of which is reproduced below:

“Notwithstanding anything contained in this Act, there shall be no obligation to give any citizen,—

- a. *information, disclosure of which would prejudicially affect the sovereignty and integrity of India, the security, strategic, scientific or economic interests of the State, relation with foreign State or lead to incitement of an offence;*
- b. *information which has been expressly forbidden to be published by any court of law or tribunal or the disclosure of which may constitute contempt of court;*
- c. *information, the disclosure of which would cause a breach of privilege of Parliament or the State Legislature;*
- d. *information including commercial confidence, trade secrets or intellectual property, the disclosure of which would harm the competitive position of a third party, unless the competent authority is satisfied that larger public interest warrants the disclosure of such information;*
- e. ***information available to a person in his fiduciary relationship, unless the competent authority is satisfied that the larger public interest warrants the disclosure of such information;***
- f. *information received in confidence from foreign Government;*
- g. *information, the disclosure of which would endanger the life or physical safety of any person or identify the source of information or assistance given in confidence for law enforcement or security purposes;*
- h. ***information which would impede the process of investigation or apprehension or prosecution of offenders;”***

It may be seen that clause (e) of this section provides for exemption of information which is available to a person in his **“fiduciary relationship”**. Doctor- patient relationship falls under this category. Therefore, the PIO

can claim exemption u/s 8(1) (e) of the RTI Act if information pertaining to a victim/patient is sought by a 3rd person.

Secondly, if an FIR has been registered in a case and investigation is in progress, the PIO can claim exemption under clause (h) on the ground that providing copy of PMR or MLR would impede the investigation and/or apprehension or prosecution of offenders. Similarly, in cases where the disclosure of information may endanger the life and safety of any person (potential witnesses, victim etc), exemption can be claimed under Section 8(1) (g).

In case of doubt whether an FIR has been registered in a case, the PIO may officially write to the Police and ascertain the status. Time limit of 30 days for providing information under the RTI Act is sufficient for this purpose.

48. Age Estimation

A Board of three members namely Dental Surgeon, Radiologist and Third member shall be among the Forensic Expert/Orthopedic Surgeon/Physician. General Duty Medical Officer may be the third member in case of there is no Forensic Expert/Orthopedic Surgeon/Physician available in the District. In case of examination of Female is required then the Fourth Member shall be Lady Medical Officer.

CHAPTER II

Protocol for Medico legal Postmortem Examination (PME)

CHAPTER II

Protocol for Medico legal Postmortem Examination (PME)

49. Objectives of PME are as under:-

- 49.1.** To know the Cause of death.
- 49.2.** Time since death.
- 49.3.** Time of injury.
- 49.4.** To establish the identity of the deceased.

50. Important Guidelines for conducting the PME are as under:-

- 50.1.** Written request/ requisition in **Form V** along with copy of the inquest report from competent authority like police or Court orders is a must.
- 50.2.** Post-mortem examination is permitted from Sunrise to Sunset on all days of the week, however once the P.M is commenced, it shall be completed in a single sitting.
- 50.3.** A receipt should be issued to the police official indicating the date and exact time of bringing the body in the mortuary. Prior to receipt of the police papers, it should be ensured that a tag indicating the name of police post with FIR/DD number has been put on the dead body by the police for purposes of identification and a completely filled request form (refer **Form V**) has been submitted along with the inquest papers by the police officials;
- 50.4.** PME should be carried out as early as possible but only when adequate day light (sunlight) is available. Always avoid delay in performing PME. The PME report shall be prepared in **Form VI**.
- 50.5.** The identity of the dead body must be confirmed by the relatives/police before the start of the PME; always take signature of at least two relatives/police before the PM report in case of known bodies, and police official in case the body is unknown along with two identification marks to be noted.
- 50.6.** Medical officer should always try to study all available facts of the case prior to PME from inquest report, hospital record, if any, condition of the deceased before death for taking universal precautions in all cases & special precaution for self as well as staff of the mortuary in case of high risk infectious diseases like AIDS, rabies etc; in hospital

death, the bed head ticket/summary of the death must be perused to know his clinical condition, treatment and terminal events etc;

- 50.7.** Don't allow any unauthorized person in the mortuary while PME is going on;
- 50.8.** Medical Officer should not borrow the version of the relatives or the police while giving opinion which must be based honestly on the scientific evidence;
- 50.9.** Prepare the PM report simultaneously and at the earliest and hand over a copy to the police immediately.
- 50.10.** Hand over the PM report and other articles only to an authorized police official i.e. to the investigating officer of the case or any other official duly authorized by him.
- 50.11.** Do not supply copy of the medico legal report/PMR to individuals other than the police officer investigating the case.
- 50.12. Referral of body for post-mortem.** In case the Medical Officer concerned is of the opinion that the post-mortem examination can be better conducted at PGIMS Rohtak or any other specialized facility, he/she shall carry out external examination of the body and record his findings on plain paper and enclose the same with the referral slip explaining the reasons and grounds for referral. All such references shall be made only with the approval of Civil Surgeon/or any other officer authorized in this regard.
- 50.13. Exemption for Post-mortem:-**This decision to exempt post-mortem is not to be taken by Health Department. Postmortem can be exempted only by the Court or by the Police.
- 50.14. Board of Doctors for Post-mortem:-**Board of Doctors for Post-mortem may be constituted by the Medical College/Civil Surgeon/PMO/In charge of institution_on the receipt of written request from the Police or after satisfying himself/herself of the necessity thereof.
- 50.15. Re-examination in case of Medicolegal/Post-mortem cases:-**Re-examination in case of Medicolegal/Post-mortem cases shall not be conducted except on the written request of the investigation officer or on the order of the Court. It should be done by the Board

constituted by the Medical College/Civil Surgeon of the concerned District.

50.16. Video recording of Post-mortem Cases: - Videography of Post Mortem Examination may be done by the Police Department where ever they require. Equipment and manpower required for Videography shall be arranged by the Police Department. The Video recording, hard as well as soft copy would be retained with the police department.

50.17. Supplying copy of medicolegal report/PMR to individuals other than police officer investigating the case:

50.17.1. A medicolegal report or post mortem report given by an expert is confidential in nature and not a public document as held in State V/s Gian Singh (1981CRL. L.J. 538) by the Delhi High Court, copy of the PMR/MLR may, however, be given to the next of kin of deceased subject to fulfillment of the following three conditions :-

50.17.1.1. Applicant shall submit a written application addressed to the concerned Medical Officer clearly stating his/her relationship with the patient/deceased person;

50.17.1.2. Applicant shall pay the fee prescribed by the State Govt. with the Health department and enclose the receipt for the same along with the application, **and**

50.17.1.3. The Applicant shall furnish NOC from concerned Police Station (investigating the matter) clearly stating that the issuance of copies of MLR/PMR will not hinder the investigation.

50.17.2. Alternatively.

The applicant shall produce order of the Court specifically directing the Medical Officer to provide him/her copy of the PMR/MLR.

50.17.3. Note:- Requests for copy of PMR/MLR under the RTI Act are not maintainable (for details please see para No. 46 of the medico legal guidelines).

51. PROCEDURE FOR PME

51.1. External examination:- It includes the followings:

51.1.1. Belongings – Always compare with the inquest papers. The clothes should be examined for any evidence of injuries, struggle marks and stains;

51.1.2. Stains-blood, semen, mud, sand, faecal, foreign bodies, injuries and other abnormalities;

51.1.3. Measure Height, weight of the body and condition of the pupils.

51.1.4. State of natural orifices – for discharge, stains, foreign bodies, injuries and other abnormalities;

51.1.5. Post-mortem changes-

51.1.5.1. Hypostasis – its extent, position and state of fixation.

51.1.5.2. Rigor mortis – its state and distribution,

51.1.5.3. Colour change over the body parts.

51.1.5.4. State of decomposition like;

- a. Greenish discoloration of right iliac fossa/entire abdomen and chest and other body parts;
- b. Distension of abdomen
- c. Marbling of skin – area
- d. Protrusion of tongue and eyeballs
- e. Blood tinged froth at mouth and nostrils
- f. Blister and peeling of cuticle
- g. Bloating of face, neck, breast, penis/scrotum/vulva
- h. Regurgitation of stomach contents
- i. Prolapsed of rectum and faecal matter
- j. Prolapsed of uterus and expulsion of foetus 'if any'
- k. Degloving, Loosening of hair/nails
- l. Maggots
- m. Colliquative putrefaction
- n. Skeletonisation etc.

51.2. External injuries – Examine from head to toe, first front and then back aspect of the body, in a systemic way so as to see all the parts of the body. Details of the injuries in respect of type, size, situation, direction, edges, ends, colour changes/ healing process, surrounding area, foreign bodies, etc. be described/noted down in the PME. Also depict the seat of the injuries on the diagrams. The

photographs of all the injuries/parts with should be taken with scale/measuring tape kept alongside.

- 51.3. Evidence of sexual assault in a female dead bodies**– (a) vulva and vagina be examined for presence of injury, semen, foreign bodies; (b) hymen to be examined for recent old tears; (c) vaginal swab be collected for chemical analysis(see separate guidelines issued for examination of sexual assault victims).
- 51.4.** Examination of the dead body should be thorough and complete. All the three body cavities and the organs contained in them should be carefully examined even though the apparent cause of death has been found in one of them, just to avoid unnecessary and unpleasant cross examination in the court.

52. Internal Examination

- 52.1.** Head and neck :- The scalp should be reflected by marking incision from mastoid to mastoid on the top of the head and look for any extravasations of blood in it.
- 52.2.** Skull be examined for fractures. After removal of vault by electric saw, the Dura matter be examined for tears, the extra Dural haematoma, if present be measured and described in details.
- 52.3.** After removing the Dura matter, subdural and subarachnoid spaces be examined for the presence of blood/pus/granulations etc.
- 52.4.** Brain be then removed and its signs of increased intracranial tension like flattening of gyri. Obliteration of sulci, herniation of tonsillar parts and tentorial grooving, the substance of brain be examined for softening, injury hematoma or any pathological condition like cyst and infection etc.
- 52.5.** Lips are everted and examined for injuries; Mouth and pharynx are examined for injuries and presence of foreign bodies.
- 52.6.** The body should be opened usually by one straight “I” shaped incision from chin to public symphysis along the midline sparing umbilicus on either side. While reflecting the skin and muscles of chest wall and abdomen look for any deep bruise or other injury. The abdominal cavity should be opened first before the chest cavity. Look for any

adhesion, congestion, inflammation of peritoneum or any exudation of fluid pus or fluid in the abdomen pelvic cavities or any perforation or damage of any organ. Normally the peritoneal cavity does not contain any fluid.

- 52.7.** Neck structures including hyoid bone, thyroid cartilage and tracheal rings are dissected and look for evidence of extravasations of blood and fractures. The type of fractures of hyoid bone i.e. inward/outward compression fracture is noted down.
- 52.8.** Thorax:- while exposing the chest wall look for any injury under the skin in tissues and fractures of ribs/sternum etc. any fluid/blood present in the cavity be measured and described its condition;
- 52.9.** Air passages – examine for the presence of soot, sand, mud, weed, froth and foreign bodies etc.;
- 52.10.** Lungs- weigh, note consistency, congestion, oedema, injuries, natural disease;
- 52.11.** Heart- pericardium and its contents are examined', note the condition of the walls, chambers and valves, coronaries-see patency/occlusion of lumen preferably its % should be described. The entire heart be preserved after dissecting it in formalin when cardiac pathology is suspected and see the condition of the aorta and its branches;
- 52.12.** Oesophagus is opened and examined for presence of varices, corrosion and other abnormalities.
- 52.13.** Abdomen – peritoneal cavity and its contents like blood, fluid be measured and noted down. Liver, spleen, kidneys, pancreas, adrenals and intestines may be dissected out and examined for evidence of natural disease, violence or poisoning.
- 52.14.** Stomach- remove it after tying both ends and dissect in a clean tray. The contents be examined and described as to the nature, degree of digestion, smell, foreign particles, and colour and quantity and condition of stomach wall. Similarly the small intestine and large intestines be examined.

- 52.15. Urinary bladder be opened and urine if present, be measured as to its quantity. Colour, smell etc. be also noted down.
- 52.16. In females, evidence of pregnancy/recent delivery if any be looked for and described in details,
- 52.17. Testicles be dissected and exposed to look for injuries and disease;
- 52.18. All the bones/skeletal system be examined for the presence of any fracture or evidence of violence and note down the stages of its repair;
- 52.19. Spinal cord be dissected and examined for evidence of injury and disease in suspected cases only;
- 52.20. Viscera/blood/urine be preserved in case of suspected poisoning and if the body was decomposed particularly when the cause of death is not certain.

53. General Guidelines:

- 53.1. The Post-mortem findings shall be recorded in the prescribed Performa/report preferably then and there. If any rough notes have been prepared, the same may be destroyed immediately;
- 53.2. Viscera be sent for chemical analysis in suspected cases of poisoning or when the cause of death is suspected/ uncertain.
- 53.3. Sample of blood, bones and deep red skeletal muscle should be collected in case of unidentified, decomposed/purified dead bodies, unidentified Foetus and Foetal remains. (detailed guidelines given in the see Annexure 'I').
- 53.4. When natural death is suspected to be the cause of death; different organs are to be preserved in formalin for histopathological examination.
- 53.5. **Opinion** – whenever viscera are preserved for chemical analysis or histopathological examination, the cause of death may be reserved and the final opinion regarding cause of death should be furnished on receipt of the chemical analysis report and HPR (Histo-pathological report).

- 53.6.** Opinion must be based on scientific facts. The Medical Officer shall explain about the injuries whether ante-mortem or postmortem, Cause of injuries and weapon used.
- 53.7.** PM report must be dispatched as early as possible to avoid suspicion.
- 53.8.** A meticulous external as well as internal examination must be carried out in each and every case; No organ should be left unexamined;
- 53.9.** Medical Officer must be trained and taught autopsy procedure preferably in the department of forensic medicine in a medical college. They should also refer to standard text books to understand the procedures of conducting PME.
- 53.10. In case of unknown dead bodies-** Attributes like age, sex, height, weight, complexion, nutrition, status, hair, scars, mole, tattoo marks, deformities, dental details, personal belongings etc. be recorded in detail in the PM reports.

Important cases where the precautions are to be taken regarding special findings:-

54. Mechanical injuries

- 54.1.** Measurements and position and location of each and every type of injury be recorded and described in details;
- 54.2.** Presence of foreign bodies on the dead body be noted down and preserved for analysis;
- 54.3.** Colour changes(stage of healing process) in and around the injuries be recorded;
- 54.4.** Belongings and viscera should be preserved whenever required.

55. Firearm injury

- 55.1.** Prior to the examination of the body, it should be x-rayed for ascertaining the exact location of the bullet/pellets; clothes should be examined for the presence of holes corresponding to the entry and exit firearm wounds; Always try to locate the entry and exit wounds; the presence of singeing, blackening, tattooing, abraded collar incase of bullet and spreading of the pellets should be recorded; when the bones (e.g. Skull) having entry and exit wounds by rifled ammunition (bullet) then look for punched in and punched out margins which will suggest entry and exit wounds respectively;

- 55.2. Always note down the dimensions of entry/exit wounds.
- 55.3. Always preserve the clothes for forensic ballistics analysis.

56. Burn cases.

- 56.1. Find out the nature of burns whether Ante Mortem /Post Mortem by seeing the vital changes and presence of scab/separation of scabs and infection etc. This will also indicate its time/age of burns.
- 56.2. Extent and degree of the burns are to be described with percentage.
- 56.3. Condition of hair (like singeing, blackening), body parts and clothes be noted down.
- 56.4. Presence of soot particles in the trachea/air passages would suggest that burns are ante-mortem.
- 56.5. Smell of kerosene-oil or other inflammable agents on the body/cloth be recorded.

57. Hanging.

- 57.1. Ligating material if present be examined in respect of its nature, position, type of knot, circumference of loop, length of short and long free ends, foreign bodies and stains. Material should be preserved without disturbing the knot;
- 57.2. Ligature mark- Describe its position, nature, direction and extent whether complete or incomplete. The situation of mark is measured in relation to chin, ears and external occipital protuberance Usually it is situated obliquely in the upper part of the neck;
- 57.3. Presence of salivary stains along the mouth;
- 57.4. Distribution of the post-mortem staining;
- 57.5. Injuries other than ligature mark are to be described in details.

58. Strangulation by ligature

- 58.1. Ligature mark- Describe its position, nature, direction and extent, whether complete or incomplete. The situation of mark is measured in relation to chin, ears and external occipital protuberance. The ligature mark is situated horizontally in the lower part of neck usually below the thyroid cartilage;
- 58.2. Injuries other than the ligature mark should be recorded in details;

58.3. The fractures of various cartilages, if present, are to be noted.

59. Manual strangulation

59.1. Marks of fingers are present over the front and sides of the neck in the form of superficial abrasions or contusions. These may be multiple or single on one side; internally the presence of fracture of hyoid bone along with other cartilages be examined; effusion of blood is to be appreciated;

59.2. Presence of injuries on other body parts beside the neck be noted down;

59.3. Viscera should be preserved in doubtful cases of incapacitation;

59.4. Belongings be sealed and handed over to the police.

60. Bodies recovered from water

60.1. Always look for evidence of fine, copious leathery froth around the nostrils and mouth; if it is a decomposed body then look for evidence of water in the G.I. Tract and preserve the long bone/sternum etc. for the presence of diatoms in the body and advise the Investigating Officer to collect water from the site of recovery of the body for comparing the diatoms.

60.2. Any ante-mortem injury over the body should be recorded.

For Police:

The Doctor can ask the Investigating Officer to make necessary arrangements for the visit to the scene of crime/to furnish photographs and relevant documents and other details if required for the post mortem examination. The investigation Officer shall collect about 1 litre of fluid from the place of death/recovery of body and to submit the same along with this jar containing bones for detection of diatoms & comparison thereof, if any (to be sent to FSL, Madhuban (Karnal).

61. PMR Report:

Each page of the PMR report should be duly signed by the Medical Officer/Board of Doctors. The original copy shall be given to the Police; first copy shall be retained with Medical officer/ Board of Doctors. Second copy is to be given for Director FSL, Madhuban for Chemical Analysis and third copy is for the Hospital Registry. In case of Histopathology analysis is required, a photocopy of the PMR

Report to be sent to the HOD, Pathology Department, PGIMS Rohtak.

62. Finger Prints/Finger Tips:

Finger Prints are to be taken by the Police Department. Finger Tips will be taken by the Medical Officer on request of the Police.

- 63.** Handed over to the police and samples sent to FSL, Madhuban, Karnal, Chemical Examiner to Govt of Haryana Karnal and HOD, Department of Pathology, or to any other department PGIMS, Rohtak:

To the Police (Please tick)

- 63.1. Duly stitched body after completing autopsy.
- 63.2. A copy of post-mortem report No. PME/ ____dated____
- 63.3. Police inquest papers -----in number duly initialled by me.
- 63.4. A sealed parcel bearing 5 seals containing clothing and belonging of the deceased.
- 63.5. A sealed parcel bearing 3 seals containing Photographs if taken.
- 63.6. A sealed packet bearing 5 seals containing Video Cassettes If recorded (Video cassettes in case of custody deaths, Murder, Dowry death and abetment of suicide).
- 63.7. Sample of the seal.

To the Director, FSL, Madhuban, Karnal/Chemical Examiner to the Government of Haryana for chemical analysis.

- 63.8. A sealed Packet Bearing 5 seals containing Viscera -Stomach with contents, pieces of small and large intestine with contents, pieces of liver, Spleen and both kidneys.
- 63.9. A sealed Packet Bearing 2 seals containing 2.5 ml Blood in 2 EDTA vials.
- 63.10. A sealed Packet Bearing 2 seals containing 100 to 200 grms of deep red muscles Tissue preferably in the DSMO (Dimethyl Sulphoxide) or normal saline in case of unidentified bodies/foetus
- 63.11. A sealed Packet Bearing 5 seals containing intact long bones like femur, tibia and atleast two molar teeth in case of adult and femur in case of mature featus.
- 63.12. A sealed packet bearing 3 seals containing debris collected from the body surface.

- 63.13. A sealed packet bearing 3 seals containing Foreign body (like bullet, ligature, Maggots, Hairs, Debris, Nail Scrapings etc. Make Packets for each category.)
- 63.14. A sealed jar bearing 5 seals containing sample of preservative used.
- 63.15. A sealed packet bearing 2 seals containing vaginal swab semen or any other material.
- 63.16. An envelope containing 3 seals Finger prints/ finger tips (all ten) in case of unidentified cases on a plain paper, folded and put in an envelop.
- 63.17. Any other.
- 63.18. An envelope bearing 5 seals addressed to the Director, FSL, Madhuban Karnal containing (i) a forwarding memo & (ii) a copy of the Post-Mortem Report of this case.
- 63.19. Sample of the seal.
- To HOD, Department of Pathology, PGIMS for Histopathology or any other Department.**
- 63.20. A sealed Packet Bearing 5 seals containing Piece/Part of liver, kidney (one half of each), spleen for histopathology.
- 63.21. An envelope bearing 5 seals addressed to HOD Department of Pathology, PGIMS, contain a forwarding letter and a copy of PMR of the case.
- 63.22. Sample of the seal.
- 64.** In suspected murder cases due to rape the Medical Officer/s shall fill the Form for examining protocol for victims of sexual abuse in addition to post-mortem report.
- 65.** Each page of the Post mortem report should bear PMR No./Date/Initials of the Medical Officer.

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FORM I

(Haryana Medicolegal Manual 2012)

General Hospital/CHC/PHC _____ District _____

Medicolegal Case (M.L.C.) information

Time _____ am/pm

Date _____

To

The Officer in charge

Police Post/Station,

District _____ I am to inform you that a patient with the following particulars has been brought to the General Hospital/CHC/PHC _____ of the district _____ and is being treated/discharged/LAMA has expired in the emergency OPD/ _____ ward of the General Hospital/CHC/PHC Name _____ S/o, D/o _____ Age _____ Sex _____ Hospital Central Registration No. _____ Date and time of admission _____ Diagnosis _____ grievous hurt/head injury/burns _____.

MLR attached: Yes/No

Signature
(Name of the Medical Officer)
(in block letter)

Time and of the receiving the information at the police post.

Signature of the Police Officer _____
Name (in capital letters) _____
Seal of the Police Post _____

FORM II
(Haryana Medicolegal Manual 2012)
Medico Legal Report

Form III

(Haryana Medicolegal Manual 2012)

**Medico legal
Examination
Report of
Victims/Accused of
Sexual Abuse**

FORM III

Medical Examination Report for Victims/Accused of Sexual Abuse

STEP -I. CONSENT (not required in case of accused)

Medico-legal report No.....dated.....

FIR No..... P.S.....Distt.....Dated.....

(The identity and purpose of examination should not be disclosed to unrelated person. The record should be kept in proper custody and supervision.)

1. Name
2. Son/daughter/wife of
3. Address.
Distt.
4. Date of birth.....
5. Age.....
6. SexMarital Status.....Occupation.....
7. HeightWeight.....
8. History of Allergies.....
9. Current medication (if any)
10. Accompanied byRelation with victim.....
11. Address.....
12. Brought by.....P.S.....Distt.....
13. Date and time of arrival.....Place of examination.....
14. Date and Time of Starting Examination
15. Date and Time of Completing Examination.....
16. Consent

Photograph
(Optional)

मैं पुत्र/पुत्रीअपनी सम्पूर्ण चिकित्सा-विधिक जाँच हेतु स्वतन्त्र रूप से तथा स्वेच्छापूर्वक अपनी सहमति प्रदान करता/करती हूँ। इस संदर्भ में मेरी ऐसी चिकित्सा-विधिक जाँच इससे पहले नहीं हुई है। मुझे इस जाँच के प्रयोजन, प्रक्रिया, परिणाम एवं लाभ बारे भली भाँति अवगत करा दिया गया है। यह जाँच मेरे पक्ष या विपक्ष में जा सकती है।

.....वाह/साथी व्यक्ति के हस्ताक्षर

हस्ताक्षर/निशान अंगूठा व्यक्ति जिसका परीक्षण किया गया है या संरक्षक (यदि पीड़ित नाबालिग/सम्बन्धी/विद्यार्थी/इनसेन और अन्य है)

STEP –II. HISTORY

17. Marks of Identification

- (1)
-
- (2)

18. History / Brief description of the incident (as narrated by the victim)

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19. General Physical Examination

(1) Physical development

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(2) General condition of the person:

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(3) Gait of the victim:

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(4) Behavioral Symptoms:

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(5) Condition of various clothes:

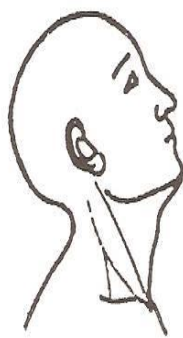
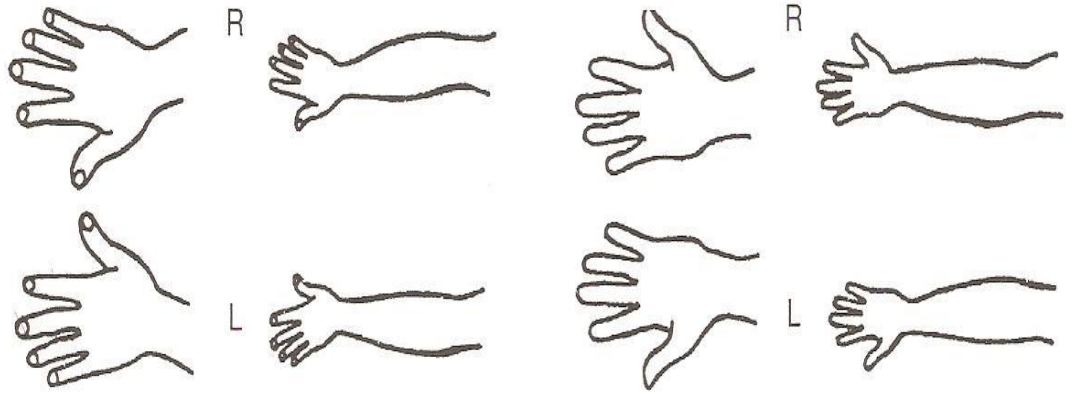
- a) Tears/Cuts/rents -
- b) Foreign matter –
- c) Stains –
 - i) Blood
 - ii) Seminal
 - iii) Faecal
 - iv) Mud
- d) Burns
- e) Buttons (intact/ undone/ broken/ torn)
- f) Since the assault, were the clothes changed? Yes / No
 If yes, are the clothes available? Yes / No
 Have the clothes been washed / repaired? Yes / No
- g) Since assault, has the person -
 - i) Eaten food Yes / No
 - ii) Ingested liquid Yes / No
 - iii) Smoked Yes / No
 - iv) Brushed Yes / No
 - v) Gargled Yes / No

20. Examination of injuries

(Sample collection for Forensic Science Laboratory from the body parts to be examined must be accomplished before the digital examination of that part of the body.)

| Location of injury | Type of injury (Bruises, abrasions, bite marks, cuts etc.) | Dimensions (length, breadth, depth, shape, margins & directions) | Stage of healing | Simple/grievous /dangerous to life | Cause of injury |
|---|--|--|------------------|------------------------------------|-----------------|
| Scalp | | | | | |
| Face | | | | | |
| Eyes (R) (L) | | | | | |
| Lips and buccal injury /Gums | | | | | |
| Ears | Right | | | | |
| | Left | | | | |
| Neck | | | | | |
| Shoulders | Rt | | | | |
| | Lt. | | | | |
| Thorax (including breast) | | | | | |
| Abdomen | | | | | |
| Upper arms Rt. Lt. | | | | | |
| Wrist, fore arms and hand Rt. Lt. | | | | | |
| Thighs, legs and feet Rt. Lt. | | | | | |
| Others (if any) | | | | | |

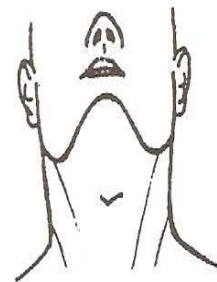
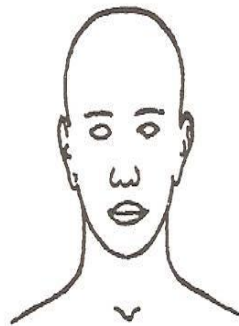
Physical Examination of Injuries may be documented on the enclosed diagrams.

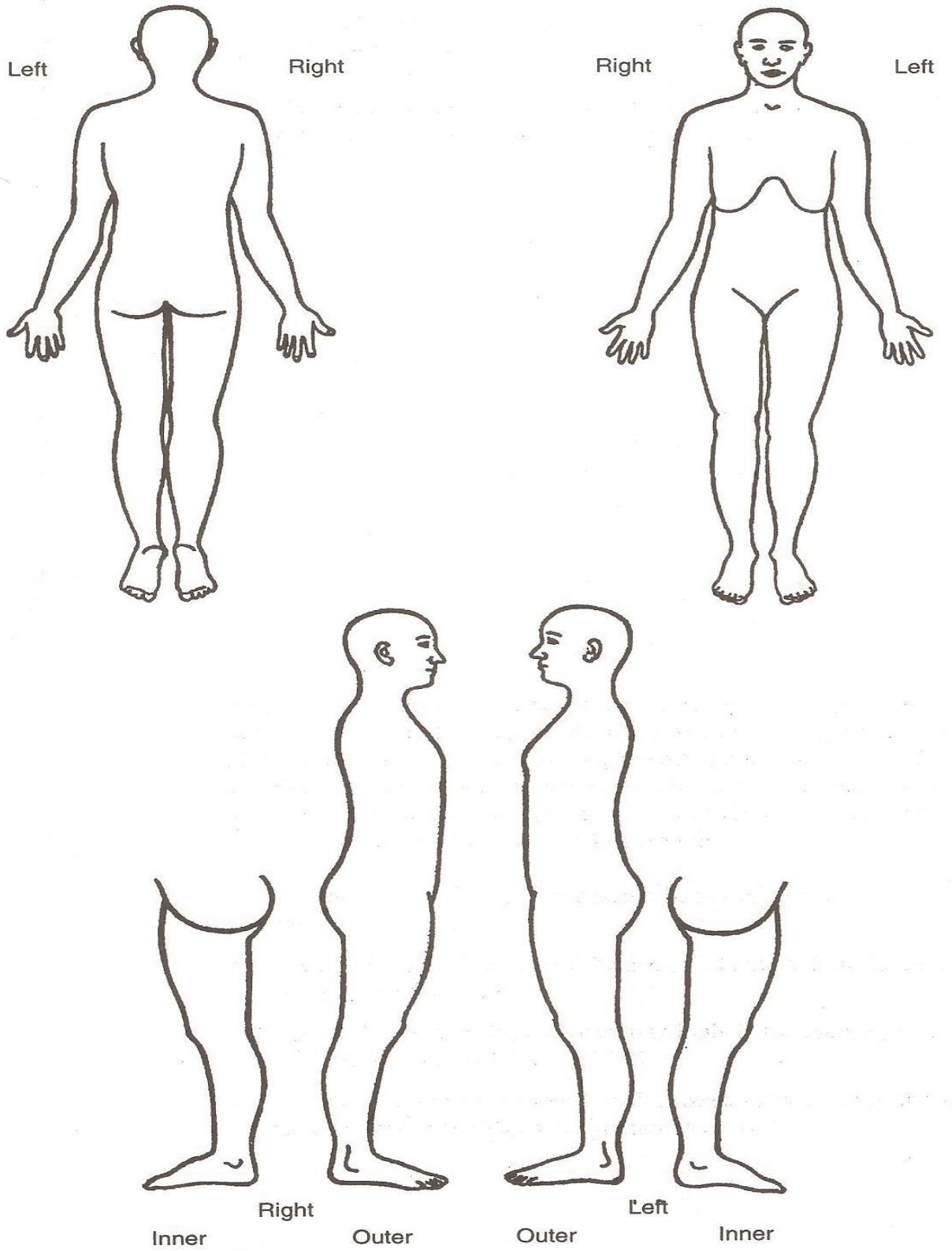


Right



Left





Note: In case of MALE victim/accused, please go to serial no. 23.

21. Details regarding penetration (as narrated by the female victim/accused):

a) Was penetration attempted by penis, fingers or other object? Write Yes (Y), No (N) or Don't Know (DK)

| Orifice | Attempted penetration | | | Completed penetration | | | Emission of semen | | |
|---------|-----------------------|-----------|-----------|-----------------------|-----------|-----------|-------------------|----|------------|
| | By Penis | By Finger | By Object | By Penis | By Finger | By Object | Yes | No | Don't Know |
| Vagina | | | | | | | | | |
| Anus | | | | | | | | | |
| Mouth | | | | | | | | | |

b) Was oral sex performed by assailant on the victim? Yes / No / Don't Know / Don't Remember

c) Masturbation of the victim by assailant? Yes / No / Don't Know / Don't Remember

d) Masturbation of assailant by the victim? Yes / No / Don't Know / Don't Remember

e) Whether condom was used by the assailant/alleged accused? Yes / No / Don't Know / Don't Remember

If yes, describe location:

f) Did ejaculation occur outside body orifice? Yes / No / Don't Know / Don't Remember

If yes, describe location:

g) Kissing, Licking or sucking of breast or other parts of patient's body? Yes / No / Don't Know / Don't Remember

If yes, describe location:

h) If penetration was attempted by object, describe the object:

i) Was there any H/O previous intercourse prior to the assault? (other than assault)

Yes / No / Don't Know / Don't Remember If yes, when

j) Was the victim menstruating at the time of the assault? Yes / No / Don't Know / Don't Remember

k) Since the assault, has there been any vaginal discharge/bleeding?

Yes / No / Don't Know / Don't Remember

l) Prior to the assault, has there been any vaginal discharge/bleeding?

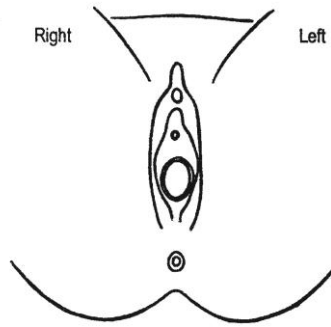
Yes / No / Don't Know / Don't Remember

m) Between the assault and the time of the examination did the patient:

| | Yes | No | Don't Know |
|----------------|-----|----|------------|
| Bathe | | | |
| Wash | | | |
| Urinate | | | |
| Defecate | | | |
| Use spermicide | | | |

22. Local Examination of Genitalia:

(A) For use in Adult Females only



State of the Tops of Thighs, Pubic Region and Perineum:

.....

.....

.....

.....

State of the sphincters :.....

.....

.....

.....

.....

State of perineal musculature:.....

.....

.....

.....

.....

Labia Majora :.....

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Labia Minora :

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.....

.....

Fourchette and introitus:.....

.....

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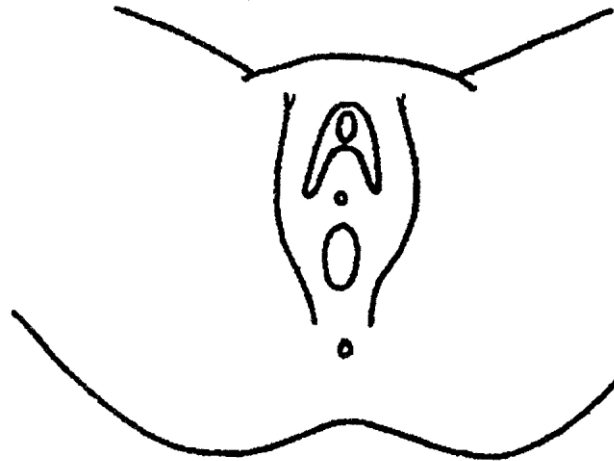
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Fornices :
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.....
.....
.....

Uterus :
.....
.....
.....
.....

Hymen (only if relevant) :
.....
.....
.....
.....

(B) In the case of Pre-Pubertal Female



State of the Tops of Thighs, Pubic Region and Perineum:
.....
.....
.....
.....

State of the sphincters :
.....
.....
.....
.....

State of perineal musculature:

.....

.....

.....

Labia Majora :

.....

.....

.....

Labia Minora :

.....

.....

.....

Fourchette and introitus:.....

.....

.....

.....

Anus and Rectum :

.....

.....

.....

P/Vaginal digital examination only if relevant.....

P/Vaginal speculum examination only if relevant.....

23. Details regarding penetration (as narrated by the male victim/accused):

a) Was penetration attempted by penis, fingers or other object? Write Yes (Y), No (N) or Don't Know (DK)

| Orifice | Attempted penetration | | | Completed penetration | | | Emission of semen | | |
|---------|-----------------------|-----------|-----------|-----------------------|-----------|-----------|-------------------|----|------------|
| | By Penis | By Finger | By Object | By Penis | By Finger | By Object | Yes | No | Don't Know |
| Anus | | | | | | | | | |
| Mouth | | | | | | | | | |

b) Was oral sex performed by assailant on the victim? Yes / No / Don't Know / Don't Remember

c) Masturbation of the victim by assailant? Yes / No / Don't Know / Don't Remember

d) Masturbation of assailant by the victim? Yes / No / Don't Know / Don't Remember

e) Did ejaculation occur outside body orifice? Yes / No / Don't Know / Don't Remember

If yes, describe location:

f) Kissing, Licking or sucking of any parts of the patient's body?

Yes / No / Don't Know / Don't Remember If yes, describe location:.....

g) If penetration was attempted by object, describe the object:

h) Between the assault and the time of the examination did the patient:

| | Yes | No | Don't Know |
|----------------|-----|----|------------|
| Bathe | | | |
| Wash | | | |
| Urinate | | | |
| Defecate | | | |
| Use spermicide | | | |

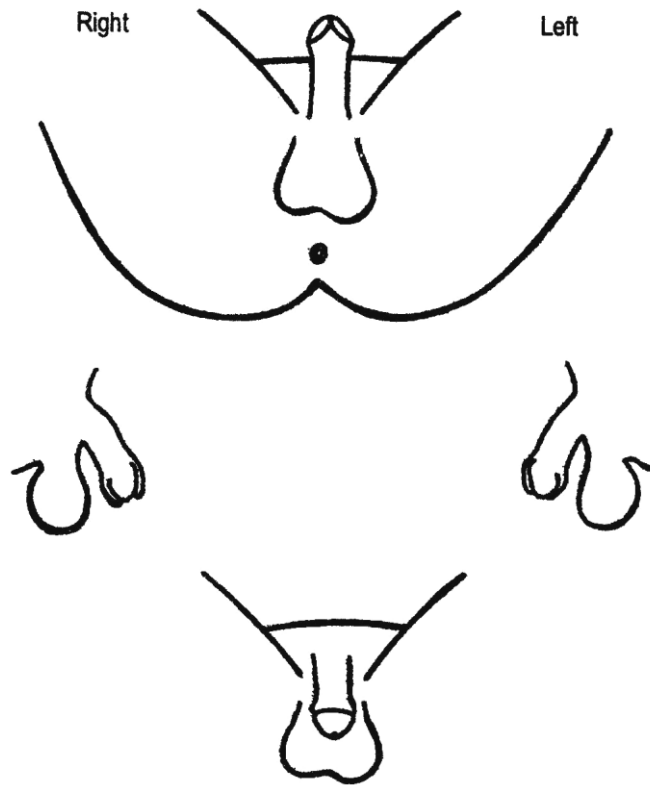
i) Since the assault, has there been any anal discharge/bleeding? Yes/No/Don't Know/Don't Remember

23.1 In case of Penetration by Penis (Rape)

a) Emergency contraception given. Yes/no

b) IQ Assessment of the patient (by the Psychiatrist)

24. Local Examination of Genitalia: (For use in Male Survivors only)



State of the Penis and testicles :

.....

.....

.....

.....

| S. No. | STEP No. (as per the Protocol) | Item | Instructions (if any) | Sample taken or not. If not, reason thereof. |
|--------|-----------------------------------|-------------------|---|---|
| 1. | 3 A | Clothing outer | Air dry each item in shade and pack it separately. Use more envelopes if needed and label them 3A/2, 3A/3 and so on. Also encircle the suspected area on the clothing to facilitate lab examination. | |
| 2. | 3B | Clothing inner | -do - | |
| 3. | 4 | Debris collection | Entire body surface should be examined from head to toe for fibres, leaf matter, soil and so on. Debris found on each site of the body should be collected in a white sheet of paper, folded and packed in a separate envelope and marked accordingly.. | |
| 4. | 4 | Nail Scrapings | Collection stick is provided in the kit. Nail Scraping should be done very gently so as to remove loose debris only. | |
| 5. | 4 | Body Fluids | Any suspicious stain on the body should be lifted by dropping a drop of distilled water on the stain and rolling the collection swab over it. The swabs so collected should be air dried under shade before being placed in the container. Use extra envelopes provided in the kit if needed. | |

| | | | | |
|-----|----|--|---|--|
| 6. | 4. | In-Between Fingers | Collection stick is provided in the kit. In between fingers should be done very gently so as to remove loose debris only. | |
| 7. | 5 | Breast swab | As above. Remember the envelopes are self sealing. Don't lick them. | |
| 8. | 6 | Combing pubic hair | Place the collection paper under the butts and gently comb the pubic hair. Remember to pack the comb also along with the specimen in the envelope. | |
| 9. | 7 | Pubic hair | Few pubic hair may be plucked so as to enable DNA extraction from the roots, if needed. | |
| 10. | 8 | Matted pubic hair | Use scissors to cut the matted hair. | |
| 11. | 9 | Vulval swabs | Make two slides for each swab, fix them and pack them with stained portion facing each other. The swabs should be air dried under shade before being placed in the container. | |
| 12. | 9 | Vaginal swabs i) Anterior, ii) Posterior and iii) Lateral (2 numbers) | -do- | |
| 13. | 9 | Cervical swabs | -do- | |
| 14. | 10 | Culture | | |
| 15. | 11 | Vaginal wash | Inject the fluid in the upper vagina and agitate slightly with the speculum. Draw the fluid back with the syringe | |

| | | | | |
|-----|----|--------------------|---|--|
| | | | and store it in a tube for examination for spermatozoa and DNA. | |
| 16. | 12 | Rectal examination | Make two slides for each swab, fix them and pack them with stained portion facing each other. The swabs should be air dried under shade before being placed in the container. | |
| 17. | 13 | Oral swab | -do- | |
| 18. | 14 | Blood collection | Collect blood for grouping in citrate vial (2 ml), and for alcohol and drugs in oxalate solution (5 ml). | |
| 19. | 15 | Urine collection | Collect urine sample (5 ml) in oxalate solution. | |

26. Referral/Advice

.....

.....

.....

.....

27. Opinion

1. Age of survivor :

.....

.....

.....

2. Evidence of injury if any :

.....

.....

.....

3. Evidence of intercourse :
.....
.....

4. Evidence of child sexual abuse :
.....
.....

5 Investigation (Lab and Radiologist :
.....
.....

6.Opinion after receiving laboratory test reports :
.....
.....
.....

Examining Doctor.....**Designation**.....

PHC/CHC/Hospital/Department.....

Dated.....

Signature of examining Doctor

Name:

Designation:

Summary of Steps of Examination

- Step 1 - Consent
- Step 2 - History
- Step 3 - a. Clothing outer
b. Clothing inner
- Step 4 - Debris collection (5 Envelopes)
- Step 5 - Breast Swab
- Step 6 - Combing pubic hair
- Step 7 - Clipping of pubic hair
- Step 8 - Matted pubic hair
- Step 9 - a. Cervical mucous collection
b. Vaginal secretion collection
- Step 10 - Culture
- Step 11 - Washing from vagina
- Step 12 - Rectal examination
- Step 13 - Oral Swab
- Step 14 - Blood collection
EDTA, Plain
- Step15 - Urine Collection

FORM IV
(Haryana Medico legal Manual 2012)
Medical Examination for Age Estimation

Medico-legal report No.....dated.....

FIR No..... P.S.....Distt.....Dated.....

(The identity and purpose of examination should not be disclosed to unrelated person. The record should be kept in proper custody and supervision.)

1. Name
2. D/o/W/o.....
3. Address.
Distt.....
4. Date of birth.....
5. Age.....
6. SexMarital Status.....Occupation.....
7. HeightWeight.....
8. History of Allergies.....
9. Current medication (if any)
10. Accompanied byRelation with victim.....
11. Name of the female hospital attendant in whose presence examination was conducted (in case of female).....
12. Address.....
13. Brought by.....P.S.....Distt.....
14. Date and time of arrival.....Place of examination.....
15. Date and Time of Starting Examination
16. Date and Time of Completing Examination.....
17. Consent (not required in case of accused)

Photograph
(Optional)

मैं पुत्र/पुत्री
 अपनी सम्पूर्ण चिकित्सा-विधिक जाँच हेतू स्वतन्त्र रूप से तथा स्वेच्छापूर्वक अपनी सहमति प्रदान करता/करती हूँ। इस संदर्भ में मेरी ऐसी चिकित्सा-विधिक जाँच इससे पहले नहीं हुई है। मुझे इस जाँच के प्रयोजन, प्रक्रिया, परिणाम एवं लाभ बारे भली भाँति अवगत करा दिया गया है। यह जाँच मेरे पक्ष या विपक्ष में जा सकती है।

वाह/साथी व्यक्ति के हस्ताक्षर

.....
 हस्ताक्षर/निशान अंगूठा व्यक्ति जिसका परीक्षण किया गया है या संरक्षक (यदि पीड़ित नाबालिग/सम्बन्धी/विद्यार्थी/इनसेन और अन्य है)

18. Marks of Identification

(1)

(2)

19. General Physical Examination

(1) Height (cms)

(2) Weight (kgs)

(3) Chest Expansion (cms)

(4) Abdominal Circumference (cms)

(5) Pulse

(6) BP

20. Secondary Sexual Characters' Stage (Tanner stages)**Girls :-** (encircle the stage of development)

(1) Menarche Age (Started or not started, how many years before)

(2) Pubic hair

(3) Breast development

(4) Axillary hair

(5) Acne

(6) Any other important finding

Boys :- (encircle the stage of development)

(1) Public hair

(2) Penis development infantile/adult-like

(3) Axillary hair brown/ light grey/black/ dark black

(4) Acne

(5) Adam's apple prominent/non prominent

(6) Hoarseness of voice present/absent

(7) Scrotum development smooth surface/ rough surface and rugocities

(8) Testis size pearl-beads size/marble-ball size/pigeon's

-egg size/hen's-egg size

(9) Moustache

(10) Beard

21. Dentition

Oral examination of teeth (this is done by clinical examination by noting tooth eruption, the sequence of eruption)

- Temporary teeth

- Permanent teeth
- Space for third molar
- Radiological examination of dentition (by AP, oblique tangential view of jaw with open mouth Or an Orthopantogram if facilities are available)
- Stage of crown and root development stage of molars (2nd and 3rd Molar teeth)

22. Ossification of Bones:

| X-Ray advised | Findings Observed | Inference about age |
|---------------|-------------------|---------------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

Inference of Ossification findings in bones

23. Opinion

After performing general physical, dental, and radiological examination, I am of considered opinion that age of this person is betweenand years.

Dental Surgeon
 Name and Designation

Radiologist
 Name and Designation

Forensic Expert/
 Orthopedician/
 Physician/MO
 Name and Designation

Lady Medical Officer
 Name and Designation
 (in case of female only)

FORM V

(Haryana Medico legal Manual 2012)

(Please fill in Block letters)

To,

Sir,

You are requested to perform autopsy on the body of;

Name of the deceased:

Age _____ Sex _____ Marrital Status _____

Address _____

Name and number of police officials accompanying the body;

- | | | |
|----|------------|------|
| 1. | Rank & No. | P.S. |
| 2. | Rank & No. | P.S. |

Name and of relative identifying body and relationship with the deceased

- 1.
- 2.

Date and time of incident:

Date and time of death:

Please preserve the following:

- 1.Viscera
- 2.Clothes
- 3.Any other(specify)
- 4.Short history of the case:

Signature of the IO.

Name

Rank

Police Station

FORM VI
(Haryana Medico legal Manual 2012)

Post Mortem Examination Report

POST-MORTEM EXAMINATION REPORT

NAME OF THE INSTITUTION _____

Post Mortem Report No. _____ Date _____

Name of the Doctor/Board of doctors _____

Date & Time of Inquest (as per the Inquest Report) _____

Date & Time of receipt of the body
and Inquest papers for Autopsy _____

Date & Time of commencement of Autopsy _____

Whence brought/referral _____

A. CASE PARTICULARS

1. (a) Name of deceased _____

(b) S/O, D/O, W/O _____

(c) Address: _____

2. Age (Approx) : _____ Yrs; Sex : Male/Female

Marrital Status _____

3. Body brought by (Name and rank of Police Officials)
- (1) _____
- (2) _____
- of Police Station _____

4. Identified by (Names & addresses of relatives/acquaintances)
- (1) _____
- _____
- (2) _____
- _____

5 In case of Unidentified Dead Bodies,

a) Marks of Identification:-

- (1) _____
- (2) _____

6. In case of hospital death – (particulars as per hospital records)

Date & Time of Admission in Hospital _____

Date & Time of Death in Hospital _____

Central Registration No. of Hospital _____

7. Symptoms observed before death if any _____

8. In case of Female

- Unmarried/married/ -----
- divorcee/widow since -----
- Primigravida/Multipara -----
- No. of children -----
- Youngest -----
- Eldest -----

B. General Description/Examination.**9. GENERAL**

(1) Length: _____ cms.

(2) Physique: Well built/average built/poor built/emaciated

(3) Description of clothes/jewellery and other items worn on the body

(Note: Important areas be encircled on the clothing wherever possible and handed over to the police.)

10. Post-mortem Changes:

i. As seen at Autopsy:

- Whether rigor mortis present _____
- Post mortem staining _____

11. (a) External general appearance:

(b) **State of eyes:**

Pupils-

Rt. _____

Lt. _____

Cornea-

Rt. _____

Lt. _____

(c) **Natural orifices.** (Please note presence of blood, froth etc. in mouth, nose, ears (specify Rt. & Lt.), anus, vagina and urethra).

12. EXAMINATION OF **EXTERNAL INJURIES:**

13. INTERNAL EXAMINATION

| S. No. | Component | Remarks |
|--------|---|---------|
| 1. | Cranium & Spinal Cord (Brain must be exposed in every case. Spinal cord need not to be examined except in case of injury to vertebral column/ Spinal Cord) | |
| | a. Scalp | |
| | b. Skull & Vertebra | |
| | c. Meninges and Vessels | |
| | d. Brain. | |
| | e. Spinal Cord | |
| 2. | Mouth, Pharynx & Oesophagus. | |
| 3. | Neck | |
| | a. Ligature mark, If any. | |
| | b. Hyoid bone | |
| | c. Condition of neck tissues Thyroid | |

| | | |
|-----------|---|--|
| | d. Larynx & Trachea | |
| 4. | Thorax | |
| | a. Ribs / Sternum and Chest wall, Cartilage | |
| | b. – Pleura / pleural Cavity. | |
| | c. Lungs Rt. Lt. | |
| | d. Pericardium | |
| | e. Heart Coronary Arteries Rt. Lt. Atherosclerosis | |
| | f. Large blood vessels In Aorta etc. Atherosclerosis | |
| 5. | Abdomen | |
| | a. Peritoneum, Retroperitonem, | |

| | | |
|--|--|--|
| | b. Stomach and its contents | |
| | c. Small intestine and its contents | |
| | d. Large intestine and its contents | |
| | e. Liver and gall bladder | |
| | f. Spleen | |
| | g. Pancreas | |
| | h. Kidneys Rt. Lt. | |
| | i. Urinary Bladder | |
| | j. Organs Of Generation. --In case of Male: --- Testis --In case of Female: --Uterus (empty or not) | |

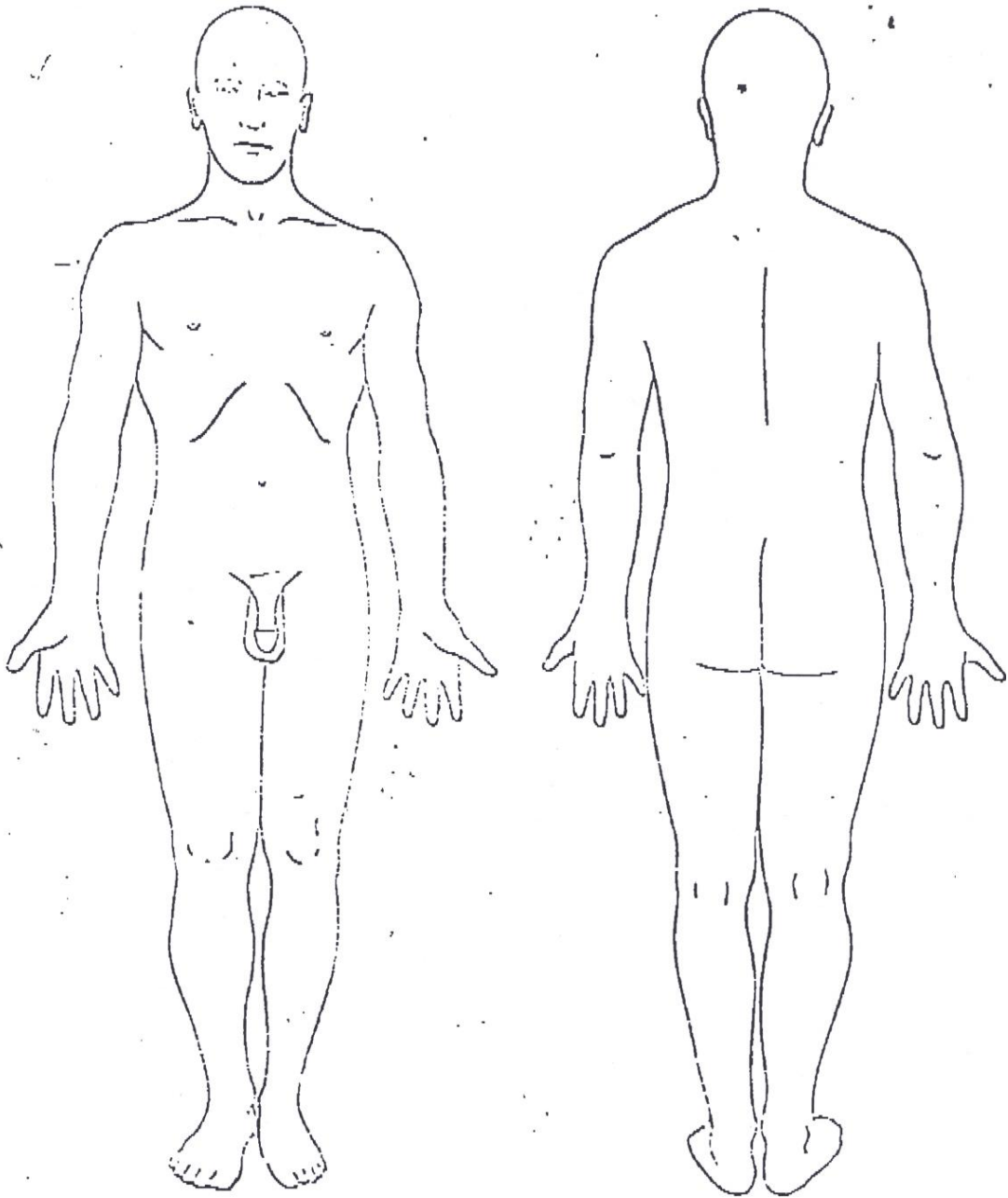
| | | |
|--|--|--|
| | --Size --Products of conception --Ovary Rt. Lt. | |
|--|--|--|

5. Muscles , bones and joints

| Injury | Disease or Deformity | Fracture | Dis-loction |
|--------|----------------------|----------|-------------|
| | | | |

Note: In important cases, the Medical Officer may mention weight/length of important organs.

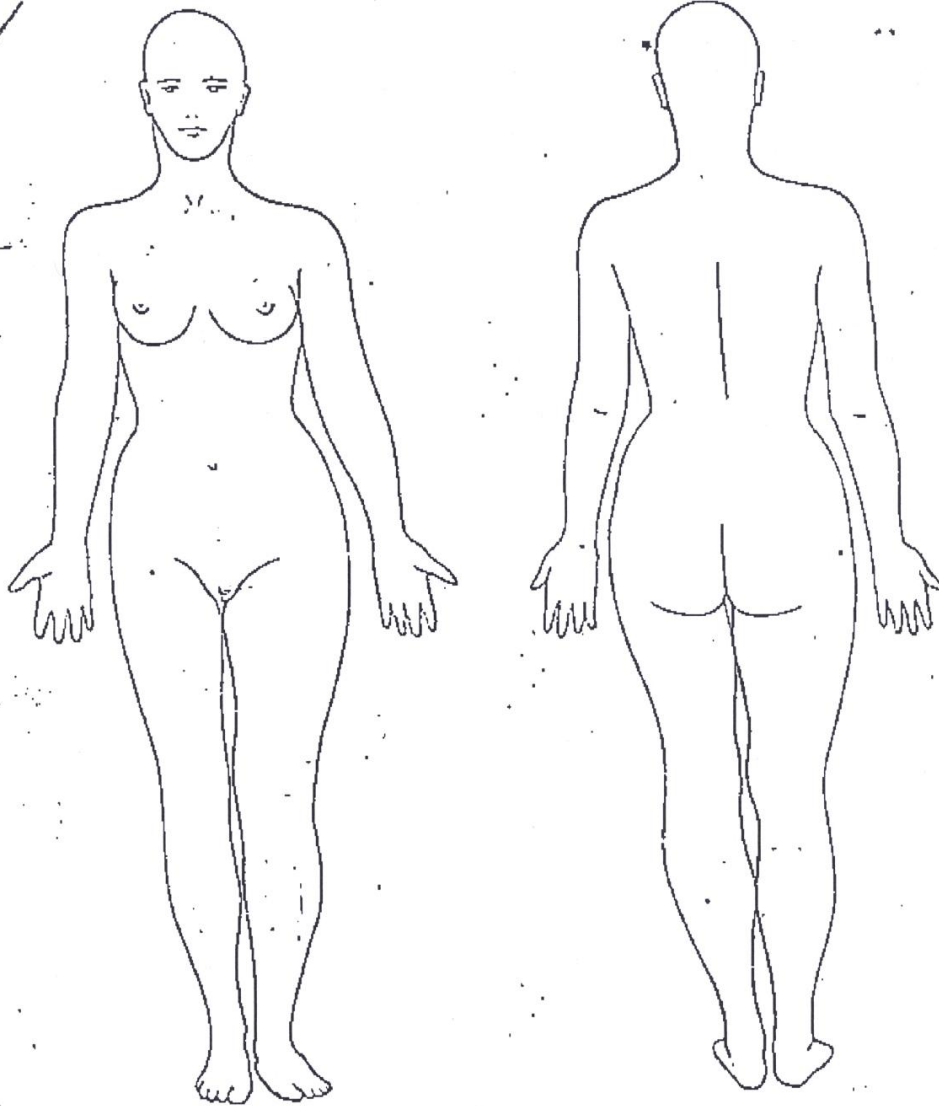
Full Body: Male-Anterior and Posterior Views (Ventral and Dorsal)



Name _____ Case No. _____

Date _____

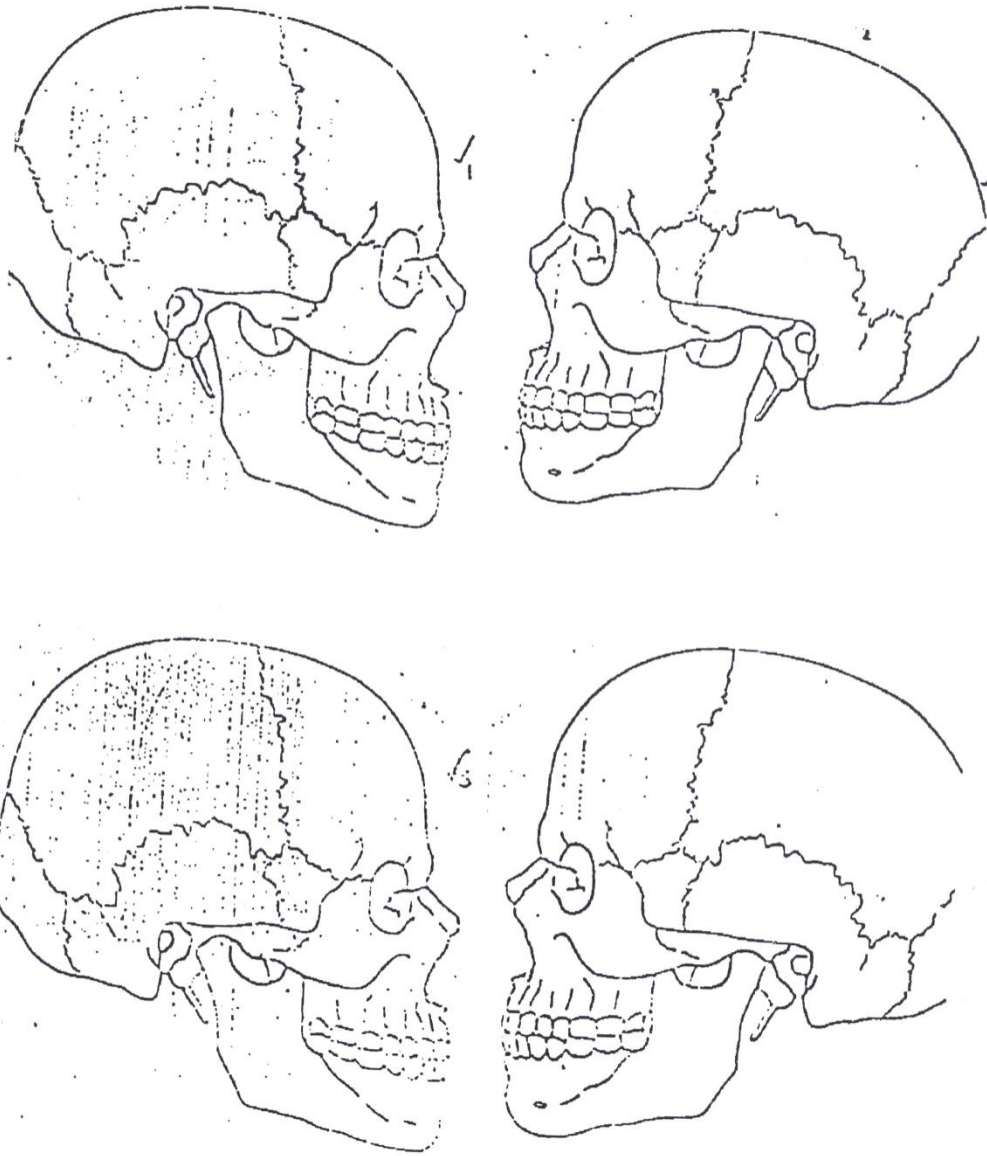
Full Body: Female-Anterior and Posterior Views

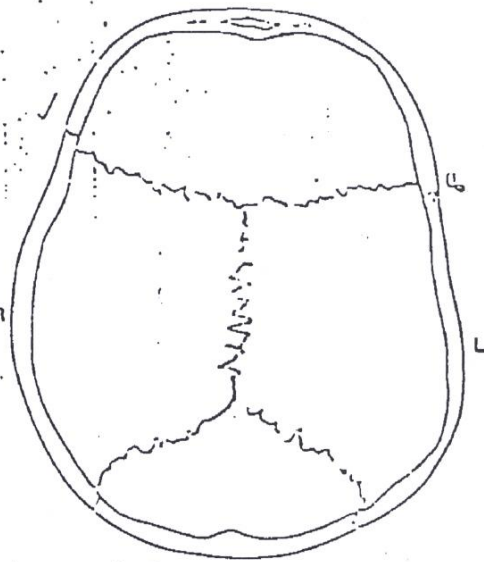
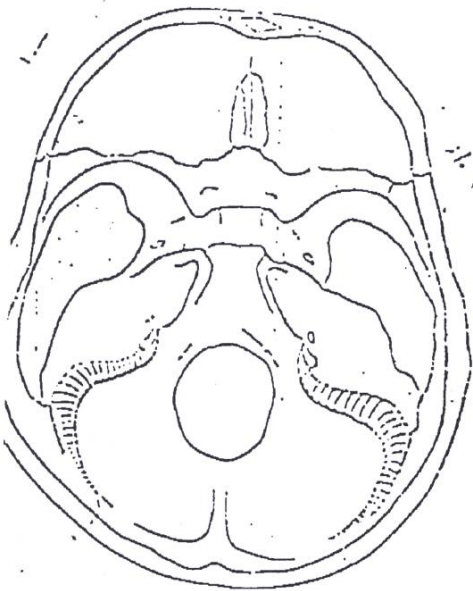
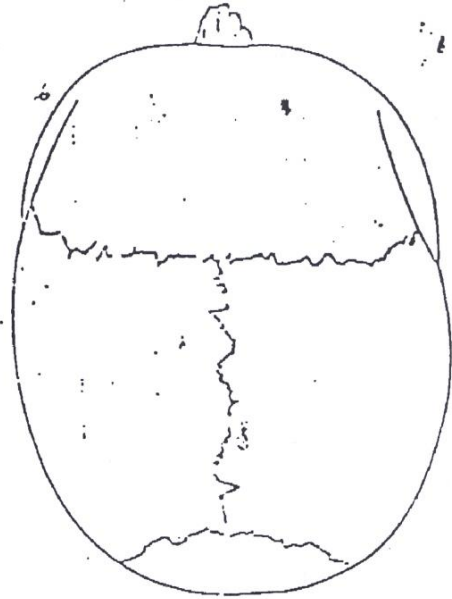
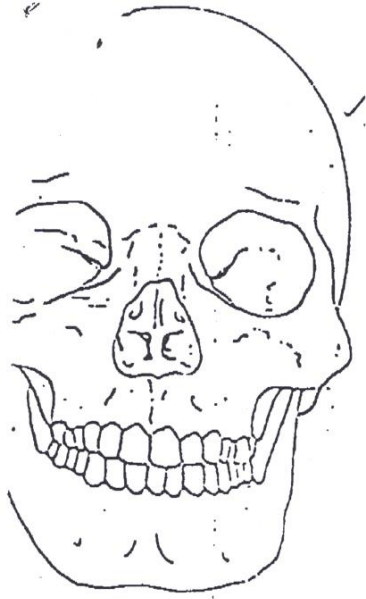


Name _____ Case No. _____

Date _____

Head - Surface and Skeletal Anatomy : Lateral view





Inner View of Skull

ANNEXURE I
(Haryana Medicolegal Manual 2012)

Guidelines for sample collection preservation and forwarding for unidentified dead bodies.

- 66.** From a dead body always collect two different types of samples in duplicate.
- 67.** If the dead body is fresh.
- 67.1. Blood may be taken through cardiac puncture using sterile, disposable syringe.
- 67.2. Two tubes of blood, 2-5 ml each, should be collected in EDTA vial/vacutainer that prevents coagulation of blood. If not available these vials may can be taken from FSL, Madhuban or Mobile Forensic Units posted in each district of Haryana.
- 67.2.1. After taking blood in EDTA vial mix it gently.
- 67.2.2. The blood should be sent immediately to the Laboratory within 12-24 hours,
- 67.2.3. While transportation the ESTA vacutainers/vials should be kept in thermos flask/thermocool box stuffed with Ice or coolant packs.
- 67.3. Also approximately 100 to 200 g. Of deep red skeletal muscle tissue may be taken by clean, sterilized scalpet blade or scissors and may be packed in a sterile container preferably having DMSO(dimethyl sulphoxide) or normal saline as preservative, freeze the sample collected.
- 67.3.1. While transportation the samples should be kept in thermos flask/thermocool box stuffed with Ice or coolant packs.
- Never use Formalin/formaldehyde as preservative of tissue samples.**
- 68.** If dead body decomposed/purification has set in
- 68.1. **Intact long bones** like femur/tibia and at least two molar teeth should be collected for DNA analysis.
(Never prefer to collect:*clavicle, sternum bone * Cut bones)
- 68.2. The bones should completely cleaned. Any adhering tissue material must be removed completely.

- 68.3. Washed with distilled water to remove sticking debris.
- 68.4. Dried completely and rolled in paper followed by packing and sealing in loose cotton cloth. (Do not use polythene bag/airtight container for keeping the bones.)

69. Skeletal remains or exhumed Bones

Each item of evidence should document properly. Each item can be picked up with a clean-gloved hand.

- 69.1. When entire Skelton is available: Prefer to collect long bones like femur and two-three molar teeth. The bone should be cleaned properly with distilled water, any adhering tissue material/ debris should be completely removed and dried completely.
- 69.2. Pack them in paper/loose cotton cloth packing and send to laboratory at room temperature at the earliest.(polythene/airtight container-medium/cotton wool should not be used to pack or wrap the samples).

70. Unidentified Foetus and Foetal remains.

70.1. In case of premature aborted foetus:

100-200 g of foetal tissue preserved preferably in DMSO (dimethyl sulphoxide) or in normal saline.

70.2. In case of mature foetus

100-200 g of foetal tissue preserved preferably in DMSO or in normal saline and at least one long bone (Femur)

71. Forwarding of samples.

- 71.1. Package and seal the samples in a parcel of clean cotton cloth.
- 71.2. Parcels should be sealed with legible seal of competent authority, duly signed specimen sample seal should be given along with forwarding letter.
- 71.3. The parcels should have following details legibly written in it: FIR number and police station/PMR number/MLR number date of collection, signature of the medical officer, collecting authority etc.
- 71.4. Detailed case history, places of recovery of exhibits and other relevant details should be attached with the forwarding letter.

- 71.5.** Relevant questions pertaining to the nature of examination required should be clearly mentioned.
- 71.6.** In cases involving medical examination of victim, suspect, dead body. A copy of the medico legal report (MLR), post mortem report (PMR) should also be forwarded to the laboratory.
- 71.7.** In case where reference blood sample is collected. Completely filled blood authentication /identification form should be attached with the form.
- 71.8.** Authority letter by the forwarding authority must be sent along with the forwarding letter.
-

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