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Contents

Original Articles

- Women's Plight in India: A Comprehensive Study** 07
Arun Kumar, Ritu Singh Meena
- Death on the Operation Table and Death in Legal / Police Custody** 13
Roohi Kohli, Vivekanshu Verma, Promod Kohli
- Demographics of Driver and Pillion Rider in Fatal Cases of Motorised Two Wheeler Accidents** 37
Prabeesh Y, Fairouz Khan, Padmini Hannah Noone, Sudhamshu Raj Sharma
- Use of Artificial Intelligence in the field of Forensic Medicine & Crime Scene Investigation: A Way Forward** 41
Fakhar Alam, Faiz Ahmad, Mohd Asrarul Haque, Anil Yadav
- Hospital Death Audit in Practice** 47
Vivekanshu Verma, Shri Gopal Kabra

Review Article

- To Be Or Not To Be Sued under Consumer Protection Act: Medicolegal dilemma for the Health Care Providers** 57
Shri Gopal Kabra, Vivekanshu Verma

Case Reports

- Munchausen Syndrome by Proxy: Factitious Disorder Imposed** 71
Shri Gopal Kabra, Vivekanshu Verma
- An Orphan Disease Begets an Orphan Judgment** 79
Vivekanshu Verma, Shri Gopal Kabra
- A Suicidal Case of Fresh Water Drowning: A Case Report** 87
Richa Choudhary, Pradeep Kumar Yadav, Rishabh Yadav, Madhulika Pandey, Vivek Pathak
- Guidelines for Authors** 93

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Women's Plight in India: A Comprehensive Study

Arun Kumar¹, Ritu Singh Meena²

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Abstract

Women have historically battled for their standing and rights in society. They have been fighting for equality for a long time in order to lead lifestyles that are exactly like those of men. Even after independence, they are still at odds. In the current context, a lot of women continue to struggle with these problems. In Indian culture, women are regarded as goddesses. But the challenges they face only serve to illustrate the opposite of this notion. People treat them cruelly and hold less respect for women, yet on the one hand, they revere them as goddesses. It is common for women to experience marginalization and exclusion due to sociocultural, socioeconomic, and political factors. Social structures and patriarchal norms ultimately control the process of empowerment and resource access. Deprivation of the fundamental legal right to engage in socioeconomic activities; prohibitions on working outside the home; lack of education and skills; incorrect interpretations and realizations of personal restrictions; shame related to women's sexual orientation; and household chores. From ancient times to the present, women's roles have had various ups and downs. Many factors, including economic dependence, caste restrictions, religious prohibitions, lack of leadership abilities, male-dominated society, dowry practices, trafficking in girls, prostitution, domestic violence, and sexual harassment, continue to contribute to women's dissatisfaction with their participation in society today. The paper will explore the plight of women in the society and within the household. Various policies and Government schemes will also be discussed in this paper.

Keywords: Oppression; Restricted Rights; Constitution guarantees; Violence; Ancient India.

INTRODUCTION

We, the Indians have rich cultural heritage and we are preserving well all these heritages. Are we securing our women, like we are securing our cultural heritage? Women in India even after ages are not safe, secure, independent and empowered.

India, a nation with a rich cultural history, has long been known for its gender inequality and the mistreatment of women. The goal of this study is to present a thorough awareness of the difficulties that Indian women confront, their socioeconomic situation, and the initiatives being taken to better their lot in life. Women have played a significant role in Indian culture and society since ancient times. However, there has long been discussion and worry about the situation of women in India. Even with the recent advancements, women in India still face numerous obstacles today. India's initiatives to empower women have made significant progress in recent years. In an effort to increase women's access to economic opportunities, education, and health, the government has put in place a number of initiatives. The proportion of women in the workforce has significantly increased, and

Author Affiliation: ^{1,2}Assistant Professor, Maharishi Law School, Maharishi University of Information Technology, Noida 201304, Uttar Pradesh, India.

Corresponding Author: Ritu Singh Meena, Assistant Professor, Maharishi Law School, Maharishi University of Information Technology, Noida 201304, Uttar Pradesh, India.

E-mail: ritusmeena@gmail.com

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they are now holding prominent positions in a variety of industries, including politics, business, and entertainment. We can observe from our evolutionary history the biological and cultural contributions that women make to society. From ancient times, women have been acknowledged in our Vedas and other literature and have been given significant roles. The texts of the Ramayana and Mahabharat have been greatly impacted by the contributions of women, and because of this, it's possible that they have become the most sacred of all.

Gradual change in women status

In ancient Indian society, women's status underwent constant change throughout various phases of history. Women had an honorable standing in society and access to education throughout the Vedic Period (300 BC). Women enjoyed rights, were treated with respect, and were important members of society in many spheres. Women had access to education and were permitted to study Vedic texts, mantras, and rites. They were regarded as knowledgeable and frequently participated in religious rites and celebrations. Arranged marriages were common, although the partner's preference was also taken into account. While polygamy was common, certain areas also tolerated polyandry, or having many husbands. Divorce was legal and, in some cases, could be started by women. An ancient Indian text called the Manava Dharma Shastra, or Manusmriti, describes legal and ritual requirements along with social and moral rules. Rishi Manu offers advice on a variety of topics in this work, including women's roles and responsibilities. It is important to keep in mind that these opinions may not accurately reflect current viewpoints on gender roles and equality because they were molded by the cultural context of the period. According to Rishi Manu, woman's role in life was to serve and care for her husband, to be faithful and submissive to him. Women totally lost their independence when these laws were put into place in society.

The 19th century saw disparities in women's standing among various social strata and geographical areas. All things considered, though, it can be claimed that women's rights and opportunities were generally less than those of men. Throughout the 19th century, women did not enjoy the same political and legal privileges as males. In some areas, they needed the approval of a male relative to vote, occupy public office, or sign contracts. For many women, access to school was

restricted. Even though some middle-class or rich women were able to pursue higher education, it was frequently concentrated on social graces and household skills rather than academic subjects. Girls were not always included in public education systems, and when they were, their curricula were sometimes inferior to those of boys. There were few job options for women, and they were frequently required to engage in low-wage domestic jobs. During the industrial revolution, some women worked in factories as well, but their pay was usually lower than that of men, and their working conditions were frequently subpar.

In general, women's position in the 19th century was defined by their restricted rights, opportunities, and social expectations. However, in certain nations, the foundation for notable advancements in women's rights and opportunities was established by the rise of social movements and slow societal transformations.

During the 20th century women and men were granted equal rights. Women would inevitably be granted the same rights as males due to developments in economics and technology. Indian women saw tremendous social, political, and economic change in the 20th century, which raised their standing and expanded their prospects. Women's education was made possible by the Indian Women's University Act of 1920 and the Indian Education Act of 1891. There has been a notable surge in the enrolment of girls in schools and institutions. In 1927, the Indian National Congress issued a resolution permitting women to take part in the freedom struggle. Women were given the ability to vote in provincial and local elections in 1932. Following India's independence in 1947, women were granted the ability to vote at the federal level. Indira Gandhi became India's first female prime minister in 1967. The Hindu Marriage Act of 1955, the Hindu Succession Act of 1956, the Dowry Prohibition Act of 1961, and the Protection of Women from Domestic Violence Act of 2005 are just a few of the laws that have been passed to defend women's rights.

Indian women have achieved great progress in the 21st century in a number of societal domains. They have made remarkable advancements in social awareness, politics, careers, and education. Indian women's literacy rates have risen dramatically and they now have access to high-quality education. Higher education and professional degrees are being sought after by women in a variety of professions, including STEM (Science, Technology, Engineering, and Mathematics). Top roles in a

variety of fields, including technology, business, and healthcare, are currently held by Indian women. Over time, the number of women in Indian politics has increased. There are now more women in the Indian Parliament and state legislatures, and some of them have even occupied prominent roles like governors and chief ministers.

The plight of women in society and household

In our scriptures, women are considered to be symbols of spirituality. However, in prehistoric India, women were not granted equality or privileges. In comparison to men, they have received worse treatment. In the past, there was a great deal of social evil, including female infanticide, child marriage, the sati system, and dowries. Throughout history, women's struggle in society has been a complex and varied subject. Because of their gender, women have experienced a variety of forms of oppression, injustice, and unfairness.

Lot of progress has been done in recent years but there is still more to be done to protect women's rights and gender equality.

India's initiatives to empower women have made significant progress in recent years. In an effort to increase women's access to economic opportunities, education, and health, the government has put in place a number of initiatives. The proportion of women in the workforce has significantly increased, and they are now holding prominent positions in a variety of industries, including politics, business, and entertainment. Women's health and reproductive rights are also very important issues. Worldwide, a large number of women lack access to safe abortion procedures, comprehensive sexuality education, and family planning options. Maternal mortality, unsafe abortion practices, and unwanted pregnancies may result from this. Millions of women worldwide are impacted by the widespread problem of violence against women. This covers violence of all kinds, including sexual, physical, and psychological, in the community, at work, and at home.

Lack of access to economic and educational opportunities is one of the most important problems facing women worldwide. Girls are often denied the opportunity to go to school, which hinders their ability to grow as individuals and feeds the cycle of inequality and poverty. Obstacles for women in the workforce include harassment at work, the gender pay gap, and a lack of leadership possibilities.

The silent suffering of women can be seen in their household. Women take on a disproportionate amount of domestic work within the walls of the home. Without enough assistance or acknowledgment, women frequently find themselves juggling many jobs, from childcare and eldercare to cooking and cleaning. Despite progress made in the area of gender equality, cultural expectations and conventions uphold the idea that household chores are exclusively the domain of women, keeping them confined to the home. Women's dependence inside the household is further entrenched by their frequent exclusion from decision-making processes, economic possibilities, and education. Their dependence on this source not only restricts their independence but also leaves them vulnerable to many kinds of abuse and exploitation.

Legal reforms for women in India

Legislation has made it possible for all Indian women to enjoy the same rights and protection from discrimination that the Indian Constitution guarantees. Equal rights legislation has a critical role in changing the nation's ideals, mechanisms, and views as well as women's access to justice, healthcare, and education. Women make up half of the population. Women's involvement in public life has increased in the modern age. An increasing number of Indian women are entering the workforce, pursuing careers in banking, trade, international forums, advertising, fashion, and other multinational fields. They have also demonstrated their competence in roles such as legislators, bureaucrats, judges, lawyers, doctors, engineers, accountants, and so on. To be able to participate actively in the development of their country, women want laws and policies that are robust.

Legal framework related to women

India claims to be a modern nation with great pride, but it does not treat all of its residents fairly. India is home to the patriarchal social structure, in which men are viewed as holding the majority of power. The government has made an effort to protect women by enacting laws and rules that are focused on their well-being. Some legal provisions are follows as under:

Dowry Prohibition Act, 1961

Kanyadan is connected to the traditional Vedic marriage customs. According to Dharamshastara, until the bridegroom receives a dakshina,

Kanyadan's meritorious deed is not complete. Thus, varadakshina, or giving something in kind or cash to the bridegroom upon her surrender, is required. There was nothing forceful about the consensual nature of the activity. Over time, the dowry's voluntary component has vanished and its coercive component has gradually increased. It has been deeply ingrained in both pre-marital and post-marital relationships. What was formerly meant to be the bridegroom's taken dakshina has now grown out of proportion and taken on the name "dowry." This tradition has evolved into a means of extorting the bride's family for as much money as possible; failing to do so would result in the married woman being harassed by her in-laws. Deaths from demands of dowry are not unusual in Indian households and villages. One of the main reasons domestic violence occurs in marriages is the inability to pay dowry. Therefore, on May 1, 1961, the Dowry Prohibition Act was passed in order to outlaw the practice of offering or accepting dowries and to prevent actions that would follow from this malpractice. Since the Act's passage, certain changes have been made, and the Domestic Violence Act of 2005 was put into place to provide further legal protection for women who experience violence in their homes the majority of which is caused by the dowry custom.

Maternity Benefit Amendment Act, 2017: Women have always been subject to various constraints and compulsions in civilizations where men have held a dominant position. The issue of her repression transcends all geographical boundaries, religious affiliations, and sociocultural connections. The modern workplace culture demands that employees always be at the top of their job, maintain their competitiveness, and carefully observe all deadlines. A woman may find it difficult to strike a balance between her personal and professional lives as a result of the strain of raising a newborn and the additional pressure to perform well at work. The Maternity Benefit Amendment Act of 2017 was enacted with the intention of protecting recently given mothers and preventing any negative reaction that they might have as a result of becoming moms. It has also been demonstrated that a mother's physical and emotional health improves when she spends time bonding with her child. The 2017 update to this Act was a progressive one that eliminated long-standing patriarchal ideas and helped to create a more fair and safe workplace for women.

Sexual Harassment at Workplace (Prevention, Prohibition and Redressal) - POSH Act, 2013:

For many years, women's rights activists and organizations have worked to have the Indian Constitution amended to include legislation safeguarding women's rights. Section 75 of Bharatiya Nyaya Sanhita (BNS), 2023: defines Sexual harassment. A man committing any of the following acts: (i) physical contact and advances involving unwelcome and explicit sexual overtures; or (ii) a demand or request for sexual favours; or (iii) showing pornography against the will of a woman; or (iv) making sexually coloured remarks, shall be guilty of the offence of sexual harassment. When sexual harassment occurs at work, it becomes problematic since it not only compromises the terms and conditions of employment by not fostering a safe environment, Women's rights require extra protection in a patriarchal society like India, which is why numerous laws have been created to do just that. One such piece of law is **Sexual Harassment at Workplace (Prevention, Prohibition and Redressal) - POSH Act, 2013**. The Hon'ble Supreme Court noted the necessity for such legislation for the first time in *Vishaka v. State of Rajasthan* (1997). Since there was no legislation establishing procedures to prevent workplace sexual harassment, the Court in this decision imposed rules that had to be adhered to by all workplaces. This lawsuit set a precedent for safeguarding women against sexual harassment in the workplace. The Honorable Supreme Court ruled that a woman's fundamental rights under Articles 14, 15, 19, and 21 of the Constitution are violated when she is subjected to sexual harassment at work.

Section 78 of Bharatiya Nyaya Sanhita (BNS) 2023, defines the criminal act of Stalking a female person by any male person, corresponding to older section 354-D of Indian Penal Code (IPC), 1860

Government initiatives to overcome the challenges faced by women:-

Government of India has indeed taken various initiatives to empower women and improve their socio-economic conditions in recent years. However, there is still a long way to go to ensure that all women in India are provided equal opportunities and rights.

1. **Beti Bachao Beti Padhao** Launched in 2015, this campaign aims to improve the Child Sex Ratio and ensure the education and well-being of the girl child.
2. **Maternity Benefit (Amendment) Act, 2017:** This act increased the duration of paid

maternity leave for women from 12 weeks to 26 weeks, providing better support for working mothers.

3. **Pradhan Mantri Matritva Vandana Yojana (PMMVY):** Introduced in 2017, this scheme provides a cash incentive to pregnant women and lactating mothers to improve maternal and child health.
4. **Women's Reservation Bill:** The Constitution (One Hundred and Sixth Amendment) Act, popularly known as the Women's Reservation Bill, 2023 (ISO 15919: Nārī Śakti Vandan Adhiniyam), was introduced in Lok Sabha on 19 September, 2023 during the special session of Parliament. This legislation seeks to allocate 33 percent of the seats in the directly elected Lok Sabha.
5. **Ujjawala Scheme:** Launched in 2016, this initiative aims to provide free LPG connections to women from below poverty line families, promoting their safety and health.

Despite these initiatives, challenges persist. Women in India still face issues like gender-based violence, lack of education and employment opportunities, unequal pay, and limited access to healthcare services. Addressing these challenges requires continuous efforts from the government, civil society, and individuals to create a more inclusive and equitable society for women.

CONCLUSION

However, there is still space for progress in India with regard to women's safety and gender equality. To further empower Indian women in the twenty-first century, concerns including sexual harassment, domestic abuse, and gender inequality must be addressed. Women still confront obstacles in the modern society, notwithstanding a minor improvement in their status. They have to strike a balance between their personal and work commitments. They could collaborate without the support of their husbands. It is even more uncomfortable for women when family members torture them instead of helping them. In the workplace and at home, sexual harassment by co-workers, supervisors, neighbours, friends, and other family members is more common. It is important to remember that women did not have the same status as males throughout the various Era. Women's duties remained mainly restricted to the home, and they still relied heavily on men for

social and financial assistance. Women's standing decreased and they were subjected to additional limitations and injustices as Indian culture developed. While it is true that women today have more independence than they did in the past, discrimination still occurs in many areas of society, making this statement untrue in many ways. Even though modern Indian women enjoy a high status, the entire image of women's status in India is not adequate. Finally, but just as importantly, we need to keep in mind that a country cannot advance without the active involvement of its mothers, wives, sisters, and daughters.

Eliminating crimes against women is still a difficult task, though. Women's rights in India have come a long way, but there is still much more to be done to protect and empower them. Examples of these forms of abuse include rape and sex discrimination. By upholding women's autonomy and enhancing their involvement and decision-making authority in the home and in public life, we can avert evils. Every person is entitled to a particular set of fundamental rights. Sadly, not everyone has equal access to and ability to exercise these rights; women and girls are one such group. Women face abuse and humiliation everywhere in the world, which makes them fight a battle that never needed to be fought in the first place. The condition of women in India is appalling, whether it is a girl child being killed the moment she is born or the horrifying stories of sexual abuse we hear about on a daily basis.

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Death on the Operation Table and Death in Legal / Police Custody

Roohi Kohli¹, Vivekanshu Verma², Promod Kohli³

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Abstract

Death during surgery on the operation table as well as the Death in Legal custody, is a profoundly serious event with extensive ramifications. Both are seen with suspicion of negligence at some level and require audit & introspection and in some cases police investigation. Comprehensive guidelines to reduce such instances and proper handling of the situation when it occurs have been prepared. Such preventive strategies and their proper compliance will be useful in mitigating avoidable suffering and miscarriage of justice.

Keywords: Death; Custody; Operation; Negligence; Torture; Police; Postmortem.

Key Message: Custodial Death, Police Custody, Operation Theatre, Perioperative Deaths, Criminal Negligence, Death Audit, Prison, Torture, Police, Postmortem, Bharatiya Nagarik Suraksha Sanhita (BNSS) 2023, formerly known as CrPC (Criminal Procedure Code), Bharatiya Nyaya Sanhita (BNS) 2023, formerly known as IPC (Indian penal Code), Bharatiya Sakshya Adhinyam (BSA) 2023, formerly known as IEA (Indian Evidence Act), Human Rights, Indian Police Act

INTRODUCTION

The word “custody” means caring and protective care.¹ Thus, the custodian has the legal duty to take care of somebody under their custody. So, the Custodians, whether a police officer or medical officer on duty, are legally bound to provide protective care. And during hospitalization whether for surgery or medical management, the healthcare providers (HCPs) have the legal duty to provide care in the best interest of their patients. Death on the Operation Table (DOT) is rare but a serious

condition, not only for the grieving family but also for the surgeon & anesthetist concerned. It has adverse medico-socio-legal consequences. There is a need to prepare guidelines for prevention & anticipation of DOT as also for the overall handling of the situation, as & when it happens.

MATERIAL & METHODS

The authors have deliberated on the issue and developed the guidelines, on the basis of their professional experience & observations, besides a literature search. The authors have also done a ‘compare & contrast’ with the Death in Legal Custody (DLC) so that the focus on the guidelines w.r.t. DLC already in place is also re-kindled.

DISCUSSION

Sudden Death, whether the death of patient on the operating table, or the death of arrested accused in legal custody, is a matter to

Author Affiliation: ¹Advocate (Lawyer), ²Associate Consultant, ³Medico-legal Consultant, Department of Emergency and Trauma Care, Medanta - The Medicity, Gurugram 122001, Haryana, India.

Corresponding Author: Vivekanshu Verma, Associate Consultant, Department of Emergency and Trauma Care, Medanta - The Medicity, Gurugram 122001, Haryana, India.

E-mail: vivekanshuv@gmail.com

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introspect, as it is profoundly serious event with extensive ramifications. The implementation of comprehensive guidelines, combined with sincere adherence to these protocols, can significantly reduce the occurrence of such tragic incidents. Moreover, these measures can mitigate the impact when such events do occur. By focusing on preventive strategies and thorough procedural compliance, the healthcare system can enhance patient safety and trust, ultimately leading to better outcomes and a reduction in the frequency and severity of these critical incidents. Similarly, the Police department, focusing on preventing the 3rd degree physical torture during interrogation and strictly watched by the higher Police authorities 24 hrs., round the clock, by Closed-Circuit Tele-Vision (CCTV) cameras in the Prisons and Police Station cell, to be mandatorily installed by all the states and union territories of India, as per the Apex Court orders,² may enhance the sense of security & faith in the legal system. But such CCTV cannot be installed in the Operation Theatre, compromising the patient's privacy, who would be undressed for the surgery, required to cure the suffering. Audiovisual Recording of a female patient, who is undressed for surgery is Unethical act as per Medical Ethics: NMC Rules and Regulations (2023),³ unless an informed consent in writing is given by the patient, only for academic purposes.

The deaths that occur in the operating theatre can cause significant distress to the patient's relatives and lead to questions about the medical team's performance. Surgical procedures involve a team effort, comprising surgeons, anesthesiologists, specialists, and nursing staff. While anaesthetizing a patient and maintaining their vital signs carry inherent uncertainties, the surgical team is best positioned to explain the events that occurred during the procedure. The medical team has superior knowledge of what transpires in the operating theatre when the patient is under anesthesia, which can lead to a burden of explanation for the team in cases of litigation or when addressing relatives' concerns. This highlights the importance of transparent communication and accountability in medical practice

Death on the Operation Table

Operative death is **defined** as death occurring within 30 days,⁴ of surgery / Anesthesia. The cause of death is generally considered to be directly or indirectly related to surgery. However, if death occurs on the operation table or within 24 hrs. of completion of surgery, it is considered

to be directly related to surgery / anesthesia (unless proved otherwise) and is seen with greater seriousness.

Incidence

According to global estimates, approximately 4.2 million individuals succumb to death within 30 days after undergoing surgery every year.⁵ In the United Kingdom (excepting Scotland), approximately 20,000 deaths per annum occur within 30 days of surgery, 2000 of which occur within 24 hrs. of surgery. About 100 (5%) of these deaths occur intra-operatively, a figure that has remained consistent throughout the last decade.⁴ According to Lunn and Mushin's scientific estimates, the mortality rate directly attributable to anesthesia is approximately 1 death in 166 cases, which represents a 0.6% anesthesia-related mortality rate.⁵

A study conducted by Harrison over a 10-year period (1967-1976) revealed that anesthesia played a contributing role in mortality in 2.2 cases per 10,000 anesthetics administered. This accounted for 2.2% of the total surgical mortality rate, which was found to be 10.15 deaths per 1,000 surgeries.⁶ The data in Indian hospitals is not clear. It is likely to be more than this and a significant number of cases also go un-reported. Practically all surgery & anesthesia consultants must have encountered one or more DOT during their professional career. Although all cases of hospital death are sad, but DOT, especially when unexpected, has special significance. When death occurs intra-operatively or within 24 hrs., it has medical, legal & socio-legal consequences.

Mishaps in OT

A mishap during anesthesia administration can lead to patient death. Respiratory failure and related respiratory complications are the leading cause of death directly attributable to anesthesia administration, making them the most common anaesthesia-related fatal outcome.⁷ Surgical mishaps include accidental cutting of a major blood vessel or aneurysm, which is directly attributable to the surgeon. Other potential causes of death include asphyxia,⁸ sudden shock induced by the surgical procedure itself, pre-existing myocardial or coronary disease, aspiration of gastric contents, fat or air embolism, hypothermia, incompatible blood transfusion, and massive blood loss resulting in hypovolemia, and hemorrhagic shock.

Deaths in Robotic Surgery

Malfunction of the Robotic arm, utilizing **Artificial intelligence (AI)** during a Robotic Surgery or anesthesia-related equipment malfunction may result in a fatal error. These malfunctions range from minor disruptions to severe complications, including patient injuries and deaths. One major study found that between 2000 and 2013, there were over 8,000 reports of robotic-surgery malfunctions, resulted in at least **144 deaths** over a 14-year period in the USA.⁹ These included incidents where burnt or broken pieces of instruments fell into patients, unintended instrument operations, and system errors. Such malfunctions often led to delays as surgeons had to either restart the system or switch to manual techniques, sometimes resulting in the rescheduling of procedures. The integration of AI in robotic surgery raises critical liability questions. If a robotic system marketed with specific safety features fails, determining responsibility can be complex. Legal experts argue for clear standards to ensure patient rights and foster medical innovation. In cases where AI substitutes for human expertise, strict liability may be more appropriate to incentivize improvements in technology and avoid premature automation.

These surgical complications can have devastating consequences and highlight the importance of precise and vigilant care in the operating room. In cases where a patient dies in the pre-operative period, an autopsy may reveal a significant underlying condition, such as coronary artery arteriosclerosis, that contributed to their death. This condition may have been clinically silent and undetectable, even with thorough routine examination and investigations. The failure to diagnose such a condition preoperatively does not necessarily indicate negligence on the part of the anesthesiologist, as some diseases may not be apparent despite diligent evaluation.¹⁰

Preventable Anesthesia Mishaps

A 1978 study by Cooper *et al.*,¹¹ found that 82% of preventable anesthesia mishaps were the result of human error. The surgeons & anesthesiologists are indeed trained to prevent deaths or attempt, with dedication, the resuscitation process, but are not trained to handle the situation that develops after such an event has occurred. Their distress, particularly when it was an unexpected event, is immense. They are themselves sad because of death of their patient and at times, when they had put in extra-ordinary amount of effort, may even require some emotional support for themselves,

to overcome the depression & stress. They are not adequately trained in grief counseling and in communication skills, especially when they are exposed to a large number of family members & friends of the deceased, with accusing expressions, and aggressive body language. Moreover, the emotional stress on their minds might result in errors when they handle the next case. A questionnaire survey in the British Medical Journal (2001), highlighted attitudes of surgeons to intra-operative death.¹² A feeling of sadness, helplessness & guilt tends to affect the surgeons / anesthesiologists, who indeed are human beings with their limitations. Most surgeons & anesthesiologists recommend that the concerned surgeon / anesthesiologist should avoid conducting another procedure for the next 24 hrs. after an intra-operative death. It may not be advisable to generalize this for all DOTs, but it does reflect the need for the performer to attain the optimum level of emotional stability before doing the next case. The circumstances in all cases of DOT are not similar. There are high risk situations where DOT was a significant possibility / probability, beforehand and the family members were mentally prepared for it. A sympathetic grief counseling is all that is required in such a case and there may be no reason to defer the next surgery for 24 hrs.

There can be several factors for a DOT. These factors may be related to Anesthesia, surgical procedure, patient related factors, disease related factors or instrument failure and so on. It may be due to negligence (civil or criminal) or an error of judgment or a medical accident or it may just be the disease process from which the patient succumbed despite the best efforts of the treating doctors. Hospitals & doctors, by themselves, do a mortality audit to look into the gaps and see what went wrong and where they could improve. However, when the family members jump to the conclusion & suggest criminal negligence, at the first instance, this may trigger an unpleasant & violent situation, to the utter disadvantage of the doctors & the hospital.

Whether deaths were 'expected' or 'unexpected', may not be important or relevant in all cases. A death in the hospital itself is unwelcome and if it is directly related to a surgical procedure, the sadness increases many folds. 'Humane' doctors are psychologically conditioned to be sensitive to mortality and they even run a potential risk of getting into depression & anxiety in some cases.¹³ The other viewpoint is that the professionalism in doctors helps them to cope with such situations objectively and without affecting their emotional stability or their professional competence & skills, they can move forwards with their subsequent professional tasks.

Adverse reactions to anesthetic drugs are relatively common, but rarely fatal. However, life-threatening anaphylactic reactions can occur, particularly with drugs like xylocaine, and prompt access to full resuscitative facilities and expertise in the operating theater is crucial.

It's important to note that there is no reliable screening test to predict drug allergies, and anaphylaxis can occur unexpectedly in any patient. Interestingly, women are three times more likely to experience anaphylaxis than men, and reactions typically occur within minutes of exposure, even with small doses. This highlights the limitations of administering a small "test dose" before the main dose, as it may not detect potential allergies.¹⁴

This situation needs to be addressed under preventive aspects of DOT as well as handling the situation when DOT has actually happened. All good hospitals must have guidelines on how to deal with DOT as part of their risk management strategy.

Currently, there are no published professional guidelines concerning the management of DOT.

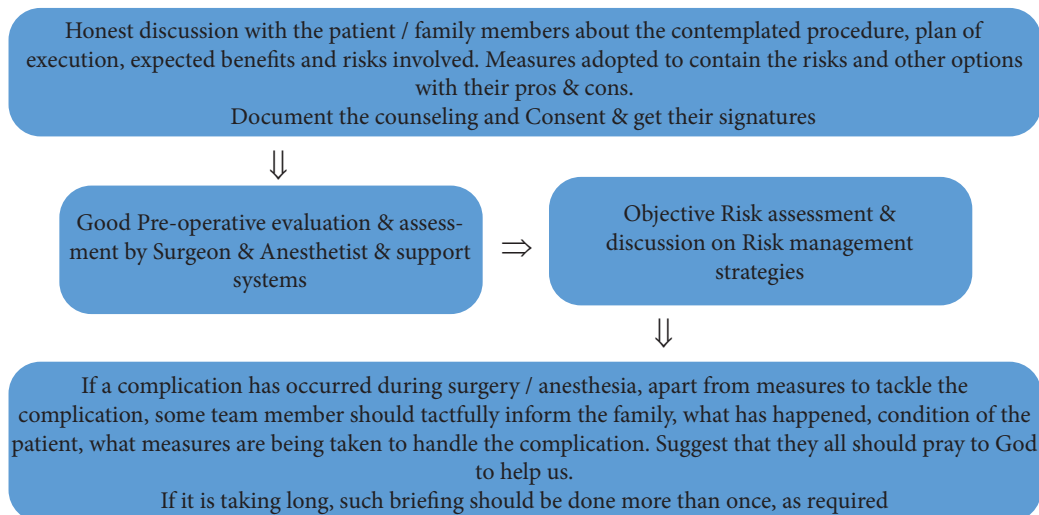
No doubt, these events are rare and heterogenous. There is also some resistance to implementing quasi-judicial directives. In the absence of research and hard evidence, guidelines based on personal clinical & medico-legal experience may be an acceptable approach.

The risk management strategy should include a detailed joint assessment & preparation meeting (including the surgical & anesthesia team, OT nurse & technician allotted for the case, biomedical engineer, blood bank representative, hospital manager and any other expert relevant for the case) in the pre-operative period, as a routine protocol, prudent & objective counseling of the patient / family members, recounting the safety precautions during surgery and the resuscitation protocol and grief counseling protocol.

These guidelines, if properly prepared and honestly implemented will be useful for all the parties involved. Such guidelines should actually be included in the UG & PG curriculum.

Suggested Operating Procedure (SOPs) for preventing DOT:

Step by step Guidelines suggested are as under



Debriefing of the Incident

If DOT has occurred, the operating & circulating team members must collect & be debriefed by the

team leader, reminding everybody that it was the will of God the Almighty and we need to bow before Him. The steps to be followed should be as under:

A quick debriefing session to ensure

1. Unanimity & Consistency on facts
2. Unanimity & Consistency on possible cause of death
3. Delegate one person to ensure that the OT is not cleaned up till further orders. The broken ampoules & used vials, catheters & tubes etc should remain as such
4. Delegate one person to complete medical records
5. Surgeon & anesthetist to tactfully break bad news to the family with all sensitivity & compassion
6. Rest of the OT list to be suspended till further orders

**Discussion with the family**

1. Call 2-3 members of the family in the side room of the OT, make them sit in a room
2. While breaking the bad news, be sure to dwell on the operative findings, any difficulties encountered in surgery / anesthesia and efforts made to tackle them, any additional help sought and the resuscitation details
3. Maintain proper sensitivity, compassion & empathy throughout. Listen to whatever they have to say. Don't mind their outbursts
4. Inform them of the possible cause of death, which can be confirmed only after PME
5. Seek permission for PME and talk about the legal obligation to inform the police.
6. If they agree, send the police intimation
7. If they don't agree for PME, take the refusal consent. Also inform them that the power to waive off the PME in a case of DOT lies with the Police & not with the doctor and so Police intimation will still need to be done

**Precautions if you sense aggression / violence**

1. Lock up all the team members from external access
2. Call the security incharge & the Hospital administrator for help. One of them will inform the Police for necessary action
3. Collect doctors from within the hospital as well as from outside, as many as possible
4. Depute one person as the spokesperson (not from the treating team)
5. After the medical records are completed, secure them under lock & key
6. When the Police asks for the medical records (after you have completed them the same day or request for a period of 1-2 days) the self attested photocopy of the original set whose pages are numbered & initialed, are handed over with a proper receiving obtained
7. The Body is handed over to the police

**Some clarifications**

1. If the patient had an illness at a stage which can explain the cause of death, the patient's family was adequately counseled about his vulnerability & high risk for surgery, including possibility of DOT, and the same properly documented, and the family is satisfied with the efforts made, there may be no need for PME or Police intimation
2. In such a situation, a detailed note must be made in the file explaining these details
3. In such a situation, refusal consent for PME must be documented
4. In such a situation the body should be handed over to the family
5. Proper Death summary be made & delivered with proper receiving
6. Show sensitivity on billing

Debriefing & Time Out

Communicate a temporary halt to the remaining operating list to the OT nurse so that he / she can do the needful to the wards & to the concerned patients.

Do not clean up the area but respectfully cover the body with a clean sheet.

The surgeon & the anesthetist (preferably together) should communicate the bad news to the family of the deceased. This counseling should observe the following precautions:

- a) Do not talk to the large group of family members together and do not talk to them in the waiting area or in the corridor. Select 2 or 3 responsible members, make them sit in

- a room and talk to them with all sensitivity & empathy.
- b) Your tone & tenor, facial expression, body language and the content of communication must reflect sensitivity, sympathy, compassion and empathy. It should certainly NOT give a reflection of guilt, frustration or failure. The communication should follow the dictum, "Doctor can make prudent efforts, but the result is in the God's hand".
 - c) The content of your communication should be honest but tactful. If a realistic prognosis and outcome possibilities had been communicated in the pre-operative consent counseling, this communication would become a bit easier. An example of such a communication could be something like, "I have the unpleasant task to give the bad news. The procedure started well but by the time we had removed the extensive tumor, the patient started bleeding. The bleeding was significant and from multiple places. We packed the area and gave blood transfusion. By the time we removed the packs, we realized that the patient had started bleeding from more areas though the ferociousness of bleeding had got reduced. Taking this to be DIC (Disseminated Intravascular coagulation), we sent for the relevant investigations and gave fresh blood & FFPs (Fresh Frozen Plasma) to control the situation. We brought in a cardiologist & the clinical hematologist on board and made all the possible efforts but unfortunately, we could not save him. We feel sad for this loss. We would like a postmortem examination, with your consent, to know exactly the cause of death". Allow them to ask questions and provide the answers with tactful honesty. Be a good listener. Don't mind their outbursts, in view of the sensitivity of the situation.
 - d) If they agree for the PME (Postmortem Examination), inform the police and let them take on from there. In most cases of anesthesia-related deaths, autopsy findings are unremarkable, as there are no specific diagnostic changes pathognomonic of anesthetic-related mortality. Absent underlying conditions like myocardial infarction, deaths from anoxia or acute cardiovascular collapse typically lack distinct pathological features, making diagnosis challenging.¹⁵
 - e) During Autopsy, the Forensic expert must preserve the viscera for histopathology and toxicology. Histological examination of the brain is crucial, particularly to detect the effects of hypoxia in specific regions like Sommer's area of the hippocampal gyrus and the cerebellum, where changes are likely to occur even with brief hypoxic episodes. In victims who suffered short-term hypoxia but survived for an extended period under anesthesia, brain morphology typically reveals diffuse and severe leuco-encephalopathy in the cerebral hemispheres, with notable sparing of the immediate sub-cortical connecting fibers.¹⁶ In cases of autopsy for suspected Anesthetics deaths, it is essential to send the injection site, blood, and liver samples for toxicological analysis to identify the local anesthetic and its metabolites. When interpreting the toxicology report, it's important to consider that certain drugs can interact with anesthetic agents, either potentiating or altering their effects. Additionally, during autopsy, the distinctive odor of the anesthetic agent used for general anesthesia (e.g., Ether has sweet smelling but pungent odour) may be detectable, providing a crucial clue for medicolegal investigation.¹⁶
 - f) If they don't agree to the Autopsy, take their refusal consent. Informing or not informing the police will depend on the level of satisfaction of the family members of the deceased. If they are satisfied with the explanations given and are willing to document it, the police may not be called, and the body may be handed over to the family by following due protocols. However, if they are not satisfied or confused / ambiguous about it, intimation to the police becomes necessary. It is important to convey to them that it is obligatory for them to intimate the police and that the body of the deceased has to be handed over to the police, in cases of DOT. And they may decide about it by the time the police arrive and discuss with them whether PME is desired or not. The police have the power to waive off a PME and can take a call on the matter.
 - g) In the meantime, complete your medical records, particularly the operation notes, anesthesia notes, mortality note and death summary.

- h) If the police had been called, they need to be shown the operation room & the other details related to the surgery & the mortality. The police might take photographs, seize used ampules / vials, tubes, catheters, samples etc., following the seizure protocol. They will prepare a panchnama & undertake some other formalities. Depending on the circumstances, the police may allow you to clean up the area or may decide to seal the area.
- i) In case the family members of the deceased have collected a mob, it might be important to not only call the members of the fraternity & other socially important persons but also file a complaint of intimidation & ruckus against them. Under these circumstances, avoid direct interaction of the surgeon & anesthetist with the mob and may interact through the hospital manager or a deputed spokesperson.
- j) The surgeon & anesthetist and their team members should be insulated from the mob and taken away to a comfortable place.

Relevant Case Laws on alleged DOT

It's not surprising to reveal, that the First malpractice lawsuit against treating doctors (Orthopedician) was legally reported in Independent India was in 1953, which involved fatal iatrogenic toxicity, was file by doctor (who was patient's father). Similarly, the highest compensation (Rs. Eleven Crores) paid for medical negligence till now (infamously called the Jackpot judgement), was also filed by doctor (patient's husband) against treating dermatologist, for causing death due to medical negligence in advising overdose of steroids & lack of hygiene, resulting in superadded infection in immunosuppressed state due to iatrogenic steroids for treating Steven Johnson Syndrome. But it doesn't mean "Doctors are Doctor's enemy", instead it can be interpreted that, those doctors have better awareness of medical know how, and thus recognise the fatal errors in diagnosis/ treatment earlier than laypersons, since in both the above-described cases, the patient died during treatment inside Hospital premises.

- a) **Iatrogenic Death on Table (DOT):** Pharmacological toxicity resulting in First Indian Lawsuit for alleged Medical Malpractice. In 1953, a 20yrs old male victim of Roadside trauma with femur fracture, was prescribed opioid analgesic in fatal overdose, causing sedation with comatose

state & failed to recognise the toxicity, died of due to negligence of the treating doctor, resuscitation initiated after 4 hrs, only when patient's father (who was also a doctor) raised the alarm. Hon'ble Supreme Court held the Hospital & doctor liable.¹⁷

Facts: 20yrs old youth suffered femur fracture due to trauma, received first aid & shifted to Poona Hospital in taxi with wooden rods support tied on broken limb to Poona 200 miles away, in a taxi after a journey of about eleven hours, by his father, who was also doctor. Orthopedician admitted patient & advised urgent shifting to OT for treatment of fracture, gave Morphine as analgesic without anaesthetic doctor, attempted manual reduction & traction of Femur Fracture for one hour. Patient brought out of OT, remained unconscious and had breathing difficulty 2hrs later, went into respiratory failure and eventually died 4hrs later during resuscitation.¹⁸

Plaintiff: You made multiple attempts for about an hour to reduce my fracture, used excessive manual force in OT, and gave me opioid overdose during orthopaedic procedure, failed to monitor me during narcosis, ignored my abnormal shallow breathing during unconscious state and didn't secured my airway timely, resulting in compromised airway, lack of oxygen supply, causing hypoxic damage to vital centres of my brain, resuscitation initiated only after my father (who was also a doctor) raised the alarm.

Défense: I have not done any reduction of your fracture but had merely provided immobilisation with light traction and given morphine on advise of my senior Ortho consultant, for relieving your pain during traction in Operation theatre. Although my consultant advised to give two injections of morphine to you in OT, but I have given only one to you, thus it's not an overdose. And as per my observation, I have documented cause of death (without post-mortem) as Cerebral Fat Embolism due to long bone fracture, as it may have occurred due to circulation of fat globules released from bone marrow of broken femur, thus blocking the supply of oxygen to vital area of brain.

Result: Patient's father filed lawsuit of alleged medical negligence against Hospital & doctor - Court held them negligent - Liable to pay damages under Fatal Accidents act, 1855,¹⁹ - Monetary Compensation of Rs 3000/- to the patient's father.²⁰

Toxicokinetics: Opiates are a group of naturally occurring compounds derived from the juice of the poppy Papaver somniferum. Morphine is the classic

opiate derivative used widely in medicine. The term opioids refers to these and other derivatives of naturally occurring opium (e.g., morphine, heroin, codeine, and hydrocodone) as well as new, totally synthetic opiate analogues (eg, fentanyl, butorphanol, meperidine, and methadone). Opioids share the ability to stimulate a number of specific opiate receptors in the CNS, causing sedation and respiratory depression. Death results from respiratory failure, usually as a result of apnoea or pulmonary aspiration of gastric contents. In addition, acute noncardiogenic pulmonary oedema may occur by unknown mechanisms.

The toxic dose varies widely, depending on the specific compound, the route and rate of administration, and tolerance to the effects of the drug. Usually, peak effects occur within 2–3 hours, but absorption may be slowed by the pharmacologic effects of opioids. Some patients have been found to be rapid metabolizers of codeine (to morphine through the hepatic enzyme CYP2D6), which may increase the risk for acute intoxication. Diagnosis is simple when typical manifestations of opiate intoxication are present (pinpoint pupils and respiratory and CNS depression) and is confirmed when the patient quickly awakens after administration of naloxone. Maintain an open airway and assist ventilation if necessary. Administer supplemental oxygen & Naloxone.²¹

Case Discussion: The court held them guilty of negligence & wrongful acts on the following grounds:

- The Clinical notes did not justify the reasons doctor has stated for delaying his treatment of unconsciousness or surgical reduction of fracture.
- Nowhere in the case history had doctor mentioned that that he had given only one injection of morphine, instead of two. When asked during cross exam about two injections, doctor told that he has given only one injection, and he forgot to give second injection of morphine.
- Doctor's plea that fat embolism must have set in right from time of the accident or on account of inadequate immobilisation & hazards of long journey in taxi, was not justified as there was no mention of this in the clinical notes, nor any symptoms nor signs were mentioned which occur many hours prior to setting of pulmonary symptoms, nor did he warn patient's father of this risk of embolism.

- The letter exchanged between doctor & patient's father later, clearly stated that he had done fracture reduction.

Court Observed: A person who holds himself out ready to give medical advice and treatment impliedly holds forth that he is possessed of skill and knowledge for the Purpose. Such a person when consulted by a patient, owes certain duties, namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give, and a duty of care in the administration of that treatment. A breach of any of these duties gives a right of action of negligence against him. The medical practitioner has a discretion in choosing the treatment which he proposes to give to the patient and such discretion is wider in cases of emergency, but, he must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care according to the circumstances of each case.

b) Court Acquittal for the alleged anesthetic Negligence:

In *Rajkumari v R Singh*: The pregnant patient experienced numbness and foot drop after a caesarean section, persisting for over six months, post-delivery. The National Commission investigated alleged medical negligence due to excessive anesthesia. However, the dose of Xylocaine (1.5 ml for a 95 kg patient) was deemed appropriate. Medical evidence showed that neurological injuries during labor are common and often unrelated to spinal anesthesia. The foot drop could have resulted from various mechanisms, including compression or pre-existing neuropathy. The case against the anesthetist was dismissed due to lack of evidence of medical negligence.²²

c) Court held the anesthetic negligent:²³

In the case of *Goyal Hospital and Research Centre Pvt Ltd v Kishan Gopal Shukla*,²⁴ the pregnant patient with preexisting disease: mitral stenosis and regurgitation was carried to full term without early termination advice. A caesarean section under general anesthesia led to coma and death. The National Commission deemed the anaesthetic procedure negligent, highlighting the importance of informed choices. Epidural analgesia could have avoided fatal complications.²⁵ Similarly, in *MC Katare v Bombay Hospital and Medical Research Centre*,²⁶ the choice of general anesthesia over spinal anesthesia for a patient undergoing surgery was deemed an error of

judgment by the anesthetist, highlighting the importance of informed anaesthetic choices in patient care.²⁶ In *Kapildeo Singh v Sagina Khatoon*:²⁷ An orthopedician's negligent administration of excessive anesthesia led to a patient's death during knee surgery. The patient, with pre-existing low blood pressure, never regained consciousness. The National Commission applied the principle of *res ipsa loquitur*, holding the surgeon liable for damages due to his obvious mistake.²⁸

Medicolegal Analogy in the Institutional Deaths:

Deaths in institutional settings include those that occur in various facilities, such as police stations, lock-ups, police vehicles, hospitals, and during transportation to or from these institutions, as well as after transfer from one institution to another.²⁹ Custodial death or Death in Legal Custody (DLC) has some similarities & some differences from Death on Operation Table (DOT).³⁰ DLC may occur in Police custody or in judicial custody and in both situations, there is a possibility of exploitation of official 'power'.

Similarities between DOT & DLC

- 1) In both, the access is not available to the person's family.
 - 2) In both, the doctor / police or jail official is the dominant party and the person on the table / person in custody is the vulnerable party.
 - 3) In both, the person is dependent on the discretion & actions of the dominant party.
 - 4) In both, exploitation & human right violations are well known.³¹
 - 5) In both, the burden of proof shifts on to the dominant party which is exclusive control of the vulnerable party.
 - 6) In both, after the event the victim gets a lot of public sympathy in general and media attraction in particular. The impact & consequences of both in terms of human rights and penal action are similar.
 - 7) In both, the investigation requires to assess whether the cause of death was illness / natural cause or negligence. In DLC, additional elements of suicide & abetment to suicide are also relevant. In DLC, complicity with a 3rd person with an intent to kill, is also investigated where relevant.³²
 - 8) The operating surgeon & Anesthetist are vicariously liable for the actions & omissions of their team members, in civil courts.³³ The SHO is vicariously liable for the acts & omissions of his team members, in civil courts. In criminal courts the vicarious liability will not apply.
 - 9) Shifting the patient from OT to ICU to escape liability³⁴ does not help if death is declared within 24 hrs. of shifting & if the cause is directly related to the surgery.³⁵ Similarly, shifting the prisoner from the lock-up to the hospital to escape the liability does not help if the death is directly related to events against him, in police custody.
 - 10) In both, doctrine of **egg - shell skull rule** may be considered in deciding compensation in civil litigation.³⁶ This takes into consideration the pre-existing hidden / latent medical conditions which may get triggered or aggravated by the events in the Operation Theater or in the police custody. In the U.S. the **most common cause of custody death was natural illness and disease progression** such as heart disease and cancer.³⁷ Similarly, in the (DOT) Death on Operation Table, the most common cause considered is sudden cardiac death,³⁸ acute exacerbation of the co-existing natural illness (Cancer, Coronary Artery Disease with acute massive myocardial infarction, Acute Exacerbation of Asthma, Allergic anaphylaxis to anesthetic agent, Pulmonary Embolism, Massive Bleeding, Brain Stroke or Ruptured Aneurysm of major vessel), for which patient is admitted and undergoing the surgery.
-

Differences between DOT & DLC

- a) In DOT, the patient had approached the doctor voluntarily for help and consented for the procedure. In DLC, the police had approached the person and took him along against his wishes, without his consent.
 - b) In DOT, the intention for the process was for the benefit of the person concerned. In DLC, the intention for the process was for judicial action against this person.
 - c) In DOT, the report of the medical negligence board, besides the PME is very important. In DLC, the PME & opinion of Forensic experts is very important.
 - d) In DOT, surgery for life threatening conditions with proper DOT consent absolves the doctor, if he dies despite best efforts. In DLC, if the arrested person is ill, he needs to be hospitalized & he can be kept in custody at the hospital.
 - e) In DOT, there is no gender difference in the incidence, and DOT is more commonly seen at the extremes of age: infants and elderly, due to their fragile status. But in DPC, Death rates in custody exhibit variations by age and gender across different countries and continents, with some similarities observed globally. A common trend is the disproportionately high representation of males in custody, attributed to the fact that men are significantly more likely to be taken into police custody than women worldwide.³⁹ And the age of DPC are mostly seen in youths from 15 to 40 yrs., as they are commonly prone for involved in criminal activity, and gets arrested for different crimes, all around the world.
-

Custodial death:

Deaths in Prison Custody encompass those that occur within prison walls, juvenile detention facilities and during transportation to or from these institutions. This category also includes fatalities that happen in medical facilities after transfer from adult and juvenile detention centers, ensuring a comprehensive accounting of deaths within the criminal justice system. Custodial death is a death that occurs while a person is in the custody of law enforcement agency. Death in police custody refers to the sudden deaths of individuals who have been arrested, detained, or otherwise kept in police custody.⁴⁰

Definition of Custodial Death

The Minnesota Protocol,⁴¹ defines custodial death as death that has occurred in custody, where the state is involved, where the person was in the custody of the State or where the State may have failed to meet the obligation to protect life. State agents include the police, military, or paramilitary personnel/ or groups, prison authorities or those acting under the direction of the State.⁴²

This definition encompasses deaths that occur during the arrest process, transportation, or while in police custody, regardless of the location, including police stations, private properties, medical facilities, public spaces, or police vehicles.⁴³

Such incidents often draw significant public attention and may be surrounded by controversy and questions regarding the circumstances and causes of death.

Manner of Death in DPC

The manner of death in custodial deaths is closely tied to the cause of death, and the findings often overlap. The manner of death can be classified into six categories: self-inflicted, natural causes, justifiable homicide, unlawful homicide, accidental, or other. Self-inflicted deaths include suicides, such as hangings and self-inflicted gunshot wounds. Justifiable homicide refers to lawful killings, like a prison officer acting in self-defense. Right of private defence of body can be stretched to the extent of voluntarily causing death. Killing without evil or criminal intent: To claim such a right, the accused duty officer must be able to demonstrate the circumstances were such that there existed a reasonable ground to apprehend he would suffer grievous hurt that would even cause death.⁴³ But wrongfully confining a person by police officer is not justifiable, so if during illegal arrest, death

occurs, then it's not acceptable as a legal defence, as per Section 37 of BNS, 2023: Acts against which there is no right to private defence.⁴⁴

In Section 38 of BNS, 2023: When right of private defence of body extends to causing death: Clause(f) an assault with the intention of wrongfully confining a person, under circumstances which may reasonably cause him to apprehend that he will be unable to have recourse to the public authorities for his release.⁴⁵

Accidental deaths encompass various scenarios, including drug and alcohol toxicity, head injuries, burns, drowning, fatal car accidents, and accidental hangings, as determined by the coroner. In the United States, the leading causes of death in police custody are natural illnesses and disease progression, such as heart disease and cancer, as the research studies had the exclusion criteria for deaths due to suicide, which is quite common cause of custodial death.⁴⁶ In contrast, European countries experience a higher proportion of non-natural deaths, primarily attributed to substance abuse (alcohol, drugs, and medications), suicide, injury, and trauma.⁴⁷

Thorough investigations are essential to determine the cause and culpability of custody deaths, as some may be preventable, while others may not. A total of 669 cases of custodial deaths have been reported in India by National Human Rights Commission (NHRC) during 5 years, from 1.4.2017 to 31.3.2022.⁴⁸ According to the National Crime Records Bureau (NCRB) data, over the past decade (2010 to 2019), out of 1,004 deaths in police custody, 69% were attributed to natural causes, with 40% due to illness and 29% classified as suspected suicides.⁴⁹ Deaths in police custody are reported initially as suicide, in the news by the concerned police authority, but on postmortem examination by medical board during Magistrate inquest, reveals physical assault and police torture, due to multiple injuries with different delicate sites on victim's body with different duration of injury (Battered Person due to Custodial Violence) as per the colour changes in the Abrasions, Bruise & hematoma in vital areas with passage of time, highly unlikely to be due to self-harm.

Role of NHRC in Reporting DPC & Autopsy Mandatory

The NHRC has historically worked to establish mechanisms for reporting custodial deaths. In 1993, the NHRC issued a directive to the chief secretaries of all states, mandating that all cases of custodial death and rape be reported within 24 hours, warning

that failure to do so would result in an “adverse inference.”⁵⁰ This was reinforced by a 1995 directive urging the implementation of the previous order and requiring that all post-mortem examinations of custodial deaths be filmed.⁵¹ The NHRC also addressed the chief ministers of all states and union territories in 1997, expressing concerns over the accuracy of post-mortem reports, which were suspected of being influenced by police pressure.⁵² Recognizing the critical role of post-mortem reports in determining the cause of death, the NHRC (1997) directed that all such records be sent to the Commission.⁵³ In 1997, the NHRC introduced guidelines and a model autopsy form for use in all custodial death cases across the states. However, more than two decades later, significant gaps in the documentation of autopsies persist.⁵⁴ Despite efforts to standardize protocols with the NHRC form, it still has several shortcomings.⁵⁵ Clear guidelines and instructions are needed to assist doctors in following this uniform protocol.

Autopsy in DPC

Properly conducted autopsies and post-mortem reports can serve as powerful evidence of police abuse in custody. **Postmortem** of Custodial Deaths is mandatory, to be done by a medical board of senior Medical Officers including one Forensic Medicine Expert, appointed by Medical superintendent of the District Hospital/ Principal of Government Medical College, and Complete Digital Videography by a professional photographer, recording the whole procedure of postmortem examination is recommended by NHRC, which should be submitted by the investigating Magistrate to the concerned Court, with his investigation report. A review of autopsy reports on young girls and women died in police custody, reveals forensic biases and stereotypes about rape during these examinations.⁵⁶ The 2014 guidelines by the Ministry of Health and Family Welfare for the medico-legal examination of survivors and victims of sexual violence need to be followed even in cases of death.⁵⁷ These guidelines should also include specific instructions for examining lesbian, gay, bisexual, transgender, queer, and intersex individuals. An analysis of post-mortem reports on custodial deaths highlights existing gaps in documentation, such as the absence of provisional medical opinions or explanations for possible causes of injuries, persistent comments on the status of the hymen and vaginal introitus, and a lack of understanding regarding the limitations of medical evidence.⁵⁸ Though when in judicial custody there is no direct control of the police, the

circumstances are similar. Death in Legal Custody (DLC) can occur due to various causes such as use of excessive force, neglect, or abuse by the authorities and includes cases pushed into suicide as also complicity with a 3rd person intending to kill. Some medicolegal cases do go un-reported also or get mired in the ambiguities of investigations and cover-ups. The state is accountable when it fails to protect, preserve, or respect the right to life and must investigate such unlawful deaths. Healthcare providers play a crucial role in this investigation process through their thorough documentation of autopsies in cases of custodial deaths.

In the British India (before independence), the early incidence of custody death was reported in Madras in the year 1678.⁵⁹ Thus it is popularly known as, the **first recorded instance of custodial death in India, reported in the Journal** and its certification by medical practitioners occurred in Madras in 1678. The JP Modi's Textbook of Medical Jurisprudence and Toxicology, 27th Ed. 2022,⁶⁰ describes the first reported case of custodial death in Indian History, as per the records: Thomas Savage, a British Soldier posted in Indian subcontinent, abused his superior officer in a drunken brawl and was tied to a cot, with his neck and heels bound, hands behind, and knees on shoulders. This physical restraint for conducting the third-degree torture led to his death, as per preliminary investigations. William Langhorne (Governor) ordered an inspection of Savage's body by expert surgeons. Surgeons who conducted the postmortem examination of the Tortured Dead in Legal Custody, included Dr. John Waldo and Dr. Bezalier Sherman, who both examined the body and issued **India's first death certificate**,⁶¹ describing the victim's cause of death: “We, the undersigned, being immediately to assist there about said Thomas Savage, found him dead with apparent marks of binding about his neck, which we judge to be the cause of his death.”

Guidelines for Postmortem in DPC

Healthcare professionals (HCPs) must adhere to the highest ethical standards in their practice. Key principles include:

- **Non-Maleficence:** HCPs are bound by the Hippocratic oath to “do no harm,” irrespective of the victim's background. This aligns with the principle of non-maleficence.
- **Justice:** HCPs must ensure fairness in their practice, adhering to the principle of justice.
- **Dignity:** HCPs must treat the family of the victim with dignity and handle the body of the deceased with respect.

Failing to document torture or existing findings implies complicity in the crime and constitutes a breach of medical ethics. Doctors must maintain objectivity, regardless of their employer – whether in the health department, home department, or a private body.

Duties and Obligations of Doctors

- **Establishing Identity:** Ensure the identity of the deceased is established.
- **Revealing Cause and Circumstances of Death:** Accurately determine and report the cause and circumstances of the death.
- **Exercising Care and Skill:** Apply care and skill in all aspects of their work.

Aims of Autopsy in Custodial Deaths

- **Record Identifying Characteristics:** Document the identifying characteristics of the deceased.
- **Record Injuries and Findings:** Note all injuries, lesions, infections, and bleeding.
- **Conclusions About Identity:** Determine the identity of the deceased.
- **Conclusions About Cause of Death:** Determine the cause of death and contributing factors.

The autopsy report is essential for understanding the circumstances leading to the death and for documenting possible torture and ill-treatment.

Who Can Carry Out the Post-Mortem Examination

- **Qualified Medical Experts:** Autopsies should be conducted by trained medical experts, preferably a team of two or more, including at least one forensic medicine expert.
- **Forensic Experts:** Ideally, forensic experts should perform the examination. If not available, reports and samples must be sent to a forensic expert for validation.
- **Private and Public Institutions:** Both can conduct autopsies to ensure independent investigations.
- **Illegal Practices:** Autopsies should not be conducted by unqualified attendants or mortuary cleaners. This illegal practice must stop.
- **Police Presence:** No police personnel should be present during the autopsy to avoid undue influence.

Information to Next of Kin About Autopsy Procedures

- **Intimation:** The police are responsible for informing the next of kin. The medical examiner must treat them with dignity.
- **Representation:** Next of kin should be informed of the autopsy time and allowed representation by a family doctor or lawyer.
- **Consent:** While consent is not required, the process should be explained to the next of kin.
- **Organ Retention:** If organs need to be retained for further examination, this should be communicated to the next of kin.
- **Body Handover:** The body must be handed over in a dignified manner to allow for customary funeral rites.
- **Cause of Death Certificate:** The doctor must provide this certificate, not the police.
- **Personal Belongings:** Belongings should be handed over to the Investigating Officer after documentation.
- **Psychological Support:** The doctor should offer initial psychological support and make counseling services available.
- **Communication:** The doctor must be sensitive and unbiased when communicating autopsy findings.
- **Report Copy:** A copy of the post-mortem report and videography should be provided to the next of kin free of charge, ensuring safety and privacy.

Key Principles in Carrying Out an Autopsy

- **Recording Details:** Record the date, start and finish times, and the place of the autopsy.
- **Personnel Documentation:** Document the names, roles, and affiliations of all persons present.
- **Photographic Documentation:** Use high-quality cameras for comprehensive and reviewable photographs. Include a reference scale and case identifier in each photo.
- **Serial Photographs:** Take serial photographs to document the course of the external examination.
- **Comprehensive Photographs:** Ensure all signs of injury or disease are documented.
- **Facial Features:** Photograph identifying facial features after cleaning the body.

- **Videography:** Mandatory videography of the autopsy procedure by a professional videographer.
- **Radiological Examination:** If available, use CT scanning or plain X-rays for comprehensive documentation, especially in firearm-related deaths.

*Guidelines for Video-Filming and Photography in Police Action Deaths:*⁶²

- **Recording Findings:** Record detailed findings, especially injury marks that may suggest torture.
- **Supplementing Reports:** Use videographic evidence to supplement the post-mortem report and prevent suppression of information.
- **Independent Review:** Facilitate independent review of the autopsy report.

Precautions Before Conducting a Post-Mortem Examination

- **Transportation:** Wrap the deceased's hands in white paper bags and transport the body in a special body bag.
- **Clothing Examination:** Clothing should not be removed by the police but should be examined and preserved by the doctor.

Post-Autopsy Procedures in Custodial Deaths

After completing the autopsy in cases of custodial deaths, the following steps should be meticulously followed:⁶³

- 1. Recording and Listing Specimens:**
 - o Record and list all saved specimens in the autopsy report.
 - o Label each specimen with the name of the deceased, autopsy identification number, date and time of collection, the name of the doctor (if applicable), and the contents.
- 2. Securing Evidence:**
 - o Carefully secure all evidence.
 - o Initiate the chain of custody record with the appropriate release forms.
 - o Ensure agreement with the investigating officer regarding the storage and transportation of samples to the laboratory.
- 3. Transporting Samples:**
 - o Transportation of samples is typically the responsibility of the police.
 - o Follow full chain of custody requirements to ensure the security of the samples.
- 4. Large Organ and Tissue Specimens:**
 - o Large organ and tissue specimens may be retained by the forensic doctor for:
 - o Better examination of an organ of particular importance (e.g., the brain).
 - o Further examination by an expert.
 - o Use as direct evidence.
 - o Document the authorization for retention.
 - o Inform the next of kin about the retention of organs, tissues, or fetuses.
- 5. Histology/Histopathology:**
 - o In cases of potentially unlawful death, retain small representative samples of all major organs, including both normal and abnormal tissue areas, in 10% formalin.
 - o Process histologically and stain with hematoxylin and eosin (and other stains as indicated).
 - o Preserve wet tissue, paraffin blocks, and slides indefinitely.
 - o Ensure arrangements are made for a suitable histopathologist, preferably with forensic training and experience, to report on the histology.
 - o Conduct the evaluation in consultation to ensure the histopathologist understands the autopsy history and findings, and the forensic doctor understands the histopathologist's conclusions and limitations.
- 6. Toxicology (including Biochemistry):**
 - o Maintain clear communication with the testing laboratory regarding the required fluids, volumes, and tissues.
 - o Record the site from which each specimen has been obtained.
 - o **Blood Collection:**
 - Collect at least 10 ml of blood, preferably from a peripheral site (e.g., the femoral vein) before commencing the autopsy.
 - Add 1% w/v sodium fluoride (NaF) to the collection tube to prevent

post-collection fermentation and putrefaction.

- If peripheral blood is not available, collect from a central site (e.g., the heart).
- As a last resort, blood from a body cavity can be collected, though it is likely to be contaminated by leakage from other structures (e.g., stomach or bowel contents, mucus, urine, pus, or serous fluids), which can severely compromise the interpretation of results.

Section: 41-51 (now BNSS Act, 2023 Section: 35-49),⁶⁶ IPC Section. 330, 331 (now BNS Act 2023, Section-120) Voluntary causing hurt or grievous hurt to the arrested person, by physically torturing to extort the confession,⁶⁷ Indian evidence Act Section: 25, 26 (now BSA Act, 2023 Section: 22, 23) for Accused's confession is irrelevant if taken under threat, coercion or intoxication caused by police officer,⁶⁸ and Indian Police Act 1861 (Section: 7, 29),⁶⁹ have touched upon the rights of the arrested persons and duties of the Police / Jail authorities, to prevent the exploitation of powers, to torture the accused person, arrested in alleged criminal act.

Legal Provisions & Procedures for Preventing the Custodial Deaths:

New Bharatiya Criminal laws, 2024

The constitutional provisions (Article 21 & 22)⁶⁴ of the Human Rights Act 1993,⁶⁵ CrPC, 1973

Criminal Laws for guiding Investigating Officers (IO) under BNSS 2023- PROVISIONS RELATED TO ARREST:⁷⁰

Section 35: Circumstances Allowing Police to Arrest Without a Warrant

- A police officer can arrest a person without a magistrate's order or a warrant if the person commits a cognizable offense.
- In situations where arrest under sub-section (1) is not necessary, the police officer shall issue a directive for the person to attend before him.
- If the punishment for the offense is less than 3 years and the accused is either suffering from a serious illness or is over 60 years old, an arrest can only be made with the permission of the Deputy Superintendent of Police (DSP).

Section 36: Procedure for Arrest and Duties of the Arresting Officer

- Every police officer making an arrest must wear identification clearly showing their name and rank.
- An arrest memorandum will be prepared, which must be signed by a witness and the person arrested.

Section 38: The arrested person has the right to meet an advocate of their choice during interrogation.

- The arrested person has the right to meet with a lawyer of their choice during police interrogation, though not for the entire duration.
- If the name and address of the arrested person cannot be determined within 24 hours, they will be brought before a Magistrate.

Section 43: How Arrests are Made

- The arrest of a woman shall be carried out by a female police officer. In extreme circumstances, a male police officer may be involved but should avoid physical contact.
- A police officer may use handcuffs during the arrest or while presenting the individual in court, considering the nature and severity of the offense, especially for habitual offenders, terrorists, those involved in drug-related offenses, acid attacks, counterfeiting currency, human trafficking, child sexual offenses, or offenses against the state.
- In critical or forceful situations, if a woman's arrest must be made at night, written permission must be obtained from a Magistrate of the First Class.

Section 44: Searching a Place Entered by a Person Sought for Arrest

- If a person acting under a warrant of arrest, or any police officer with the authority to arrest, believes that the individual sought has entered or is within a place, any resident or person in charge of that place must, upon the officer's request, allow free entry and provide all reasonable facilities for a search.

Section 47: Persons arrested must be informed of the grounds for their arrest and their right to bail by the arresting police officer.

- Every police officer who arrests a person must inform them of the reasons for their arrest and their right to seek bail.

Section 48: Duty of Person Making Arrest to Inform Relatives or Friends.

- The police officer or any other person making the arrest must promptly provide information about the arrest and the location where the arrested person is being held to any of their relatives or a person nominated by the arrested individual. If the offense is bailable, they must also inform the arrested person about their right to seek bail.

Section 52: Medical Examination of Accused arrested in Rape Cases

- When an individual is arrested on suspicion of committing rape or attempted rape, they shall undergo a medical examination conducted by a Registered Medical Practitioner at the request of a police officer.
 - The medical professional shall promptly prepare a report containing all relevant information, including DNA profiling of the accused, and forward it to the investigating officer.
-

Section 53: Medical Examination of Arrested Persons.

- Upon arrest, a medical officer shall conduct an examination of the individual and provide a copy of the report to the arrestee or their designated representative.
- In cases where the arrestee is female, the examination shall be performed by a female medical officer.

Section 55: Procedure for Arrest without Warrant by Subordinate Officer.

- When the officer in charge of a police station requires a subordinate officer to make an arrest without a warrant, the request shall be made in writing, and the subordinate officer shall be provided with a written order to that effect.

Section 56: Health and Safety of Arrested Persons.

- The officer responsible for detaining the accused has a duty to ensure the health and well-being of the individual in custody and shall take all necessary precautions to guarantee their safety and access to medical attention if needed.

Section 57: Presentation of Arrested Person before Magistrate or Officer in Charge.

- A police officer who makes an arrest without a warrant shall, without undue delay, present the arrested person before either the officer in charge of the police station or a Magistrate, as soon as practicable.

Section 58: Maximum Detention Period for Arrested Persons.

A person arrested without a warrant shall not be detained for more than 24 hours and shall be produced before a Magistrate within that timeframe, unless a longer detention period is authorized by law or a judicial order.

Section 61: Authority to Pursue and Re-Arrest Escaped Detainees.

- If a person in lawful custody escapes or is rescued, the authorities may immediately pursue and re-arrest them in any location within India, to restore the person to lawful custody.

Section 62: Arrests to be Made in Accordance with Established Procedures in the Sanhita.

- All arrests shall be carried out strictly in accordance with the provisions outlined in this code of Sanhita or any other applicable laws in force, which govern the procedures for arrest.

Section 196: Magistrate's Inquest.

- inquests in cases of deaths occurring:
 - in prison,
 - in police custody,
 - due to police firing,
 - exhumation, and
 - as dowry deaths.

Magistrate's Inquest:

According to Black's Law Dictionary,⁷¹ an inquest is an investigation by medical officers, sometimes with a jury's assistance, into the manner of death of a person who died under suspicious circumstances or in prison. Since Police Officers on duty are the

culprit accused of custodial deaths, thus another police officer if assigned for legal investigation, will be biased towards his/ her colleague police officer, happen to be working in the same state police department. So, the death in Police custody should ideally be conducted by an external agency, who can supersede the Police Officer.

Homonymous Analogy of Section 176 in the BNSS & CrPC for DPC:

Section 176 in the CrPC, 1973	Section 176 in the BNSS, 2023
: Magistrate inquest	: Procedure for investigation
Magistrate conducts an inquest in cases of deaths occurring (i) in prison, (ii) in police custody (iii) due to police firing, (iv) exhumation, and (v) as dowry deaths.	Whenever a person dies in the custody of the police, Section 176 requires the Magistrate to hold an enquiry into the cause of death. ⁷²

Since the Magistrate is the appropriately higher legal authority, to whom all the police officers report, so the inquest has to be conducted by the Duty Magistrate of that district, hence it is labelled in the New Bharatiya Criminal Laws as Magistrate's Inquest: According to Section 196 of the Bharatiya Nagarik Suraksha Sanhita (BNSS) 2023,⁷³ corresponding to Section 176 of the CrPC,⁷⁴ district magistrates, sub-divisional magistrates, judicial magistrates, or revenue officials designated as executive magistrates (such as district collectors, deputy collectors, or tahsildars) conduct inquests in cases of deaths occurring (i) in prison, (ii) in police

custody, (iii) due to police firing, (iv) exhumation, and (v) as dowry deaths.

The Supreme Court mandates that the **inquest must be held at the location where the body is found.**⁷⁵ However, it has been observed that many investigating officers, improperly move the body to a mortuary before conducting the inquest, which is against proper practice.⁷⁶

Flowchart for Investigating Deaths in Police Custody:

Creating a flowchart for investigating deaths in police custody involves outlining the key steps

and decision points that guide the process from the initial incident to the final report. Here's a textual outline of such a flowchart:

1. Incident Occurs

- o Death in police custody reported.

2. Initial Response

- o Secure the scene.
- o Notify relevant authorities (internal affairs, external oversight bodies).
- o Preserve evidence.

3. Immediate Actions

- o Separate and interview involved officers.
- o Provide medical aid if applicable.
- o Notify the family of the deceased.

4. Preliminary Investigation

- o Conduct a preliminary review of the incident.
- o Gather initial statements from witnesses.
- o Collect physical evidence (CCTV footage, body cam footage, etc.).

5. Assign Investigation Team

- o Internal Affairs or external independent investigation unit takes charge.
- o Appoint lead investigator.

6. Detailed Investigation

- o Conduct thorough interviews (officers, witnesses, medical personnel).
- o Review all physical evidence (autopsy report, forensic analysis).
- o Analyze documentation (arrest records, detention logs).

7. Consult Experts

- o Engage forensic experts, medical examiners, legal advisors.
- o Obtain expert opinions on cause of death and procedural adherence.

8. Review Policies and Procedures

- o Examine compliance with existing policies.
- o Identify any breaches or gaps in procedures.

9. Compile Findings

- o Summarize evidence and findings.
- o Prepare a detailed investigation report.

10. Decision Point

- o Determine if the death was due to natural causes, accident, suicide, or foul play.
- o Identify any criminal or administrative liability.

11. Recommendations

- o Suggest disciplinary actions, policy changes, or further investigations.
- o Recommend training or procedural improvements.

12. Report to Authorities

- o Submit findings to relevant authorities (police department, oversight bodies, prosecutor's office).
- o Notify the family of the deceased and provide a summary of findings.

13. Public Disclosure

- o Release information to the public, ensuring transparency.
- o Conduct a press briefing if necessary.

14. Follow-Up

- o Monitor implementation of recommendations.
- o Review the effectiveness of changes and improvements.

All these steps are taken with a view to bring about greater accountability and transparency in the system.

Case Laws for Preventing Deaths in Police Custody:

Some detailed guidelines have also been given by the courts & other authorities. However, there should be some mechanism to ensure strict compliance with those guidelines.

The DK Basu case (1997),⁷⁷ is regarded as the most landmark case of criminal jurisprudence, and the findings are popularly known as **DK Basu guidelines** for preventing custodial torture and deaths. Step into any police station across India, and you'll notice a striking feature - a prominently displayed charter of rights for arrested individuals. This is a lasting impact of the landmark Supreme Court judgment in D.K. Basu v. State of West Bengal, a seminal case that challenged illegal detentions, arbitrary arrests, and custodial brutality, forever changing the landscape of arrest protocols and safeguarding individual rights.

Adv. Abhishek Singhvi, was appointed as amicus curiae (a legal term, meaning friend of the court), who fought the landmark case of DK Basu v. State of West Bengal, has described his observations in the Case no.2 questioning that the police cruelty on innocent/ suspects/ arrested in alleged crime, as "Who Watches the Watchmen", comparing the role of State Police with watchmen (whose duty is to safeguard the public from crime), in his book titled: From the trenches: India's Top Lawyer on his Most important Cases (2020).⁷⁸

Justice D.K. Basu, a retired judge of the Hon'ble Calcutta High Court, was driven by his conscience to act against custodial torture and deaths. He penned a letter to the Chief Justice of India, appending a series of news articles highlighting separate incidents of such violations. His poignant question - why were these blatant breaches of law being tolerated? - resonated deeply. The matter came up before Justice O. Chinnappa Reddy, Hon'ble Supreme Court, moved by his plea, converted the letter into a landmark public interest litigation. This pioneering move has since been termed '**epistolary jurisdiction**,' where the court takes Suo moto cognizance of a matter based on a letter, demonstrating the vast reach of its powers when justice demands it.

In the DK Basu case, state governments presented three primary arguments:

Firstly, they claimed that existing laws, such as the Code of Criminal Procedure (CrPC), already provided sufficient safeguards against custodial violence. While the CrPC code mandated inquiries into allegations of abuse and punishment for errant officers, the Law Reports revealed a stark reality: Police officer's dismissals were rare, suspensions were the norm, and actual legal prosecution was almost nonexistent. The crucial question remained: what tangible benefits did these remedies offer to the victims of custodial torture?

Secondly, they posited that introducing additional safeguards to the arrested person would hinder effective police investigations, leading to lawlessness. This '**scarecrow argument**' - intimidating in appearance but lacking substance - attempted to create a false dichotomy between protecting human rights and ensuring public safety. Implementing safeguards against illegal arrest and custodial violence does not hinder investigations. In fact, the law allows for thorough investigation, interrogation, and preventive detention when necessary. However, it explicitly prohibits torture and 'third-degree methods'. The response to terrorism cannot be state-sponsored terrorism.

Thirdly, the claim that these safeguards are already informally implemented, rendering formal orders unnecessary, is unconvincing.

The Apex Court observed that these above arguments should not deter the Hon'ble Court from establishing minimum mandatory standards, ensuring uniform application across the board. Moreover, victims of such violations should have the ability to cite their legal rights and seek redress when needed, rather than relying on informal practices.

The DK Basu case has gone down in history as one of the longest running cases of the Supreme Court during which the court has persistently monitored a particular matter, that of torture in custody. The recent incidents of custodial deaths in Tamil Nadu, Gujarat and the many unreported incidents of custodial torture, peaceful protesters being beaten up, sexually assaulted in custody, minors being detained in police stations, are all compelling enough for the judiciary to take forth the legacy of the DK Basu case. And rest is the History, when Hon'ble Apex Court laid down the following guidelines, which got incorporated in the Bharatiya Nagarik Suraksha Sanhita (BNSS), the Indian Criminal Procedure (CrPC), where the title of the act of BNSS, replaces the word Criminal with **Public Safety & Security (Nagarik Suraksha)** highlighting the human right of every person, whether the arrested suspect or accused in alleged crime, to be treated as innocent, until proven otherwise (during Court trial), and said that arrest and detention will be subject to the guidelines:

1. ****Identification of Police Officers****: Any police officer involved in the arrest and interrogation of an arrestee must wear accurate, visible, and clear identification and name tags indicating their designations. The details of all police personnel handling the interrogation must be recorded in a register.
2. ****Arrest Memo****: The officer making the arrest must prepare an arrest memo at the time of the arrest. This memo should be attested by at least one witness, who may be a family member of the arrestee or a respectable person from the locality where the arrest is made. The memo must be countersigned by the arrestee and must include the time and date of the arrest.
3. ****Notification of Arrest****: An arrestee is entitled to have one friend, relative, or other person interested in their welfare informed of their arrest and detention as soon as

possible. If the attesting witness of the arrest memo is a friend or relative, additional notification may not be necessary.

4. ****Notification for Distant Relatives****: If the next friend or relative of the arrestee lives outside the district or town, the police must notify the time, place of arrest, and venue of custody through the Legal Aid Organisation in the district and the local police station within 8 to 12 hours of the arrest.
5. ****Awareness of Rights****: The arrested person must be informed of their right to have someone notified of their arrest or detention immediately upon being arrested or detained.
6. ****Case Diary Entry****: An entry must be made in the case diary at the place of detention regarding the arrest. This entry should disclose the name of the arrestee's next friend who has been informed, as well as the names and details of the police officials in whose custody the arrestee is held.
7. ****Medical Examination at Arrest****: Upon request, the arrestee should be examined at the time of arrest. Any injuries, major or minor, present on their body must be recorded in an "Inspection Memo." This memo must be signed by both the arrestee and the police officer, and a copy should be given to the arrestee.
8. ****Regular Medical Examination****: During custody, the arrestee must undergo a medical examination by a trained doctor every 48 hours. This examination should be conducted by a doctor from a panel approved by the Director of Health Services of the concerned State or Union Territory. The Director should prepare such a panel for all Tehsils and Districts.
9. ****Documentation to Magistrate****: Copies of all documents, including the arrest memo, should be sent to the Magistrate for record-keeping.
10. ****Attorney Access****: The arrestee should be allowed to meet with their attorney during interrogation, though not necessarily throughout the entire process.
11. ****Police Control Room****: Each district and state headquarters must have a police control room where information regarding the arrest and place of custody is communicated by the officer in charge within 12 hours of the

arrest. This information should be displayed on a visible noticeboard at the control room.

The second set of safeguards were by the judgement of Justice TS Thakur, Hon'ble Supreme Court (2015)⁷⁹ to prevent the violations by the police using tolls like camera monitoring, and directed all the state governments, to set up State Human Rights Commissions (SHRC) and set up Human Right courts to address the complaints of police atrocities on arrested persons during custody. The Supreme Court also directed all the State governments for installation of CCTVs in all the prisons / Police Stations, across the country, to prevent torture and human rights violation of the arrested persons.

Roadmap for Implementing Human Rights Safeguards in Police Custody:

I. Establishment of State Human Rights Commissions (SHRCs)

- Direct states (Delhi, Himachal Pradesh, Mizoram, Arunachal Pradesh, Meghalaya, Tripura, and Nagaland) to set up SHRCs.
- Section 21 of the Protection of Human Rights Act, 1993 as amended in 2006,⁸⁰ stipulates constitution of State Human Rights Commissions (SHRCs) in all the States.
- The creation of a Human Rights Commission in all the States would definitely facilitate in 'better' protection and promotion of human rights.
- Fill all vacancies on SHRCs within three months

II. Human Rights Courts

- Direct state governments to establish/ specify human rights courts in different districts as per section 30 of the Protection of Human Rights Act.⁸¹ Section 30 of the Act provides that the State Government shall specify with the concurrence of the Chief Justice of the High Court, for each district a Court of Session to be a Human Rights Court so that the offences arising out of violation of human rights are tried and disposed of speedily.

III. CCTV Cameras in Prisons

- Install CCTV cameras in all prisons, phased if necessary, based on reported human rights violations. CCTV cameras will help go a long way in preventing violation of human rights of those incarcerating

in jails. It will also help the authorities in maintaining proper discipline among the inmates and taking corrective measures wherever abuses are noticed.

IV. Non-Official Visitors

- Appoint non-official visitors to prisons and police stations under relevant provisions and rules.

V. Prosecution for Human Rights Violations

- Launch prosecutions in cases where enquiries establish culpability for deaths or injuries in custody
- Ensure prosecutions are in accordance with law and based on enquiry reports and investigations.

Table 1: Medicolegal Riddle in Rhymes on DOT & DPC

In the sterile light, the scalpel gleams, An arena of hopes, and whispered dreams, Yet shadows linger, fraught with dread, For here, the dance of life meets death's thread.	Criminal negligence, a grave, stark phrase, Ignites the need for a critical gaze, Audits to follow, each detail to trace, For justice to find its rightful place. Guidelines crafted, to stem the tide, Of deaths in custody, and surgical demise, Preventive measures, meticulously drawn, To ensure each dawn is rightfully born.
On the operation table, silent and still, A heart may falter, despite the skill, In hands that heal, or so they strive, But not all emerge, not all survive.	
Each death in surgery, a shroud of doubt, Was it fate, or a route not thought out? Negligence whispers, shadows conceal, Calls for an audit, for the truth to reveal.	Bharatiya Nagarik Suraksha Sanhita guides, Ensuring justice, where negligence hides, With Nyaya Sanhita, the laws refined, In the Sakshya Adhiniyam, truth we find.
In the cold confines of a prison's keep, Where justice should guard those in its sleep, A life may ebb, unseen, unheard, Custodial shadows, by suspicion stirred.	Human rights, a beacon bright, The truth emerges, for justice years, To mitigate suffering, to halt the pain, So no life is lost, in vain again.
In legal custody, where hope grows thin, Neglect or malice, where to begin? The echoes of torture, the silent cries, Demand a scrutiny, through discerning eyes.	For each life matters, in surgery or cell, A story of dignity, in the tales we tell, Preventive strategies, compliance strong, Ensure justice prevails, where it belongs.

These guidelines are critical in maintaining the integrity of the legal process, safeguarding the rights of individuals, and promoting transparency within the law enforcement system.

The violation of these guidelines would attract not only departmental action but also the contempt of court proceedings in a High Court having the jurisdiction over the matter. To ensure the protection of arrestees' rights and uphold transparency in police procedures, several essential guidelines have been established. Under Section 302/304 IPC (updated as Section 103/ 105 of BNS, 2023), in each case where the enquiry establishes culpability in custodial death

and framing of uniform definition of custodial death and mandatory deployment of at least two women constables in each district were also recommended by the Amicus. These measures aim to enhance accountability and provide safeguards during the arrest and interrogation process.

However, after DK Basu case, the instances of custodial death and violence have reduced but it didn't stop. To enumerate these few landmark judgements by Indian Courts, not only punishing the Police Officers, held responsible for the custodial deaths, but also providing monetary compensation to the deceased's family, are described below:

In the case of *Niyamavedi vs Director, CBI* (2000),⁸² the Apex Court directed the CBI to pay Rs 2.1 lakhs in compensation to the wife of Gopal Behara, who died two years earlier in CBI custody. Behara, a tea stall owner in Sukinda mines, Jajpur district, Orissa, and a key witness in a murder case, died during CBI interrogation. His wife claimed CBI officials murdered him. The Deputy SP of CBI was charged under Sections 341 of IPC (Punishment for wrongful restraint), 343 of IPC (wrongful confinement for 3 or more days) both of which are now clubbed together in clause (2) and (3) of section 127 of BNS (2023): wrongful confinement, and Section 108 of BNS (2023): Abetment of suicide corresponding to Section 306 of the IPC.⁸³

In the *J. Prabhavathiamma v/s The State of Kerala* (2007),⁸⁴ following a protracted trial spanning over a decade, a CBI court in Thiruvananthapuram sentenced two serving police officers to death, for the murder of a scrap metal shop worker, who the court determined was killed in custody. In his ruling, Judge J Nazar condemned the officers' actions as a "brutal and dastardly murder" that undermines the public's trust in law enforcement, stating, "If the faith of the people in the institution is lost, it will have far-reaching consequences for public order and law and order, leading to a dangerous situation."⁸⁵

In the landmark case of *Yashwant Vs State of Maharashtra* (2018),⁸⁶ the Supreme Court upheld the conviction of 9 Maharashtra police officers in a 1993 custodial death case, increasing their prison sentences from three to seven years each. On September 4, the bench comprising Justices NV Ramana and MM Shantanagoudar emphasized that police misconduct erodes public trust in the criminal justice system. The court held the officers guilty under Section 330 of the Indian Penal Code (Corresponding to Section 120 the BNS, 2023),⁸⁷ which pertains to causing harm voluntarily by the police officer on duty, resulting in hurt to the custodial victim, to extract confessions or restore property. The verdict underscored the importance of accountability, noting that "with great power comes greater responsibility".⁸⁸

CONCLUSION

Death on the Operating Table (as also Death in Legal Custody) is rare but a very serious event with far reaching consequences. A proper set of guidelines and sincere implementation of the same can go a long way in reducing not only the incidence of these events but also help in lowering their impact. To prevent the death/ torture in

police custody, regular medical examination of the arrested, to check his/ her wellbeing, by a Registered Medical Practitioner is mandatory. And vice versa, for investigating the alleged medical malpractice, criminal negligence, including patient's Death on the Operating Table, the patient's attendants may file a legal complaint to the Police Officer, in the Hospital's jurisdiction. Public Awareness to their human rights, including the right to live, of the admitted patients/ arrested persons, is the key for prevention of sudden institutional deaths related with medicolegal scenarios. Some of the guidelines,³⁰ unfortunately, have been limited to mere paper regulations. The authors hope that the guidelines will be taken seriously, at all levels and followed in letter & in spirit.

Conflict of Interest: Nil

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Cell: +91-9821671871

E-mail: sales@rfppl.co.in

Demographics of Driver and Pillion Rider in Fatal Cases of Motorised Two Wheeler Accidents

Prabeesh Y¹, Fairoz Khan², Padmini Hannah Noone³, Sudhamshu Raj Sharma⁴

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Abstract

Background: Motorised two wheeler accidents cause a great deal of morbidity and mortality. The demographics of the same including the factors involved helps to identify the risks involved. This can help in policy making in order to save lives.

Methods: A study was conducted during the period 2011 to 2013 after obtaining ethical clearance from the institutional ethics committee. The demographics of driver and pillion riders involved in fatal cases of motorised two wheelers were collected in a prospective autopsy based study in the Department of Forensic Medicine. The data collected included incidence rate of two wheeler accidents compared to total number of road traffic accidents, sex ratio, age pattern, day wise distribution, time of occurrence and vehicles collided.

Conclusion: Out of a total number of 84 autopsies on road traffic accident cases, 37 cases were that of two wheeler accidents. Male predominance pattern was seen in drivers and pillion riders. Drivers were more affected. Age wise the highest number was in the range of 21 to 30 years. Day wise drivers were more affected on Saturday and pillion rider on Monday. Time wise majority of cases were during 12pm to 8pm duration. Vehicles with gear had more incidence. Majority of fatalities occurred on the spot. Most of the vehicles collided with heavy vehicles.

Key words: Motorised two wheeler; Driver; Pillion rider; Autopsy; Demographics; Risks.

INTRODUCTION

Motorised two wheelers form a major part of the traffic since it is an easy and convenient mode of transport. However accidents involving them are common. All over the world accidents involving such two wheelers have increased morbidity and mortality.¹ Analysing the pattern involved can help

to know the trends involved and assessment of risk factors involved. Motorcycle injuries constitute a major but neglected emerging public health problem in developing countries and are one of the leading causes of injuries and deaths among victims of accidents.² Motor cycle is statistically found to be riskier than car with the risk of being involved in road traffic accident around eight times and the risk of mortality or morbidity over 24 times per kilometer journey as that of a car.³ In this study the various factors involved including the age, sex distribution, time, date and month of incidence, survival period and types of vehicles involved were analysed.

MATERIALS AND METHODS

The present study was conducted in the Department of Forensic Medicine and Toxicology,

Author Affiliation: ¹Assistant Professor, ²Associate Professor, ³Professor, ⁴Professor and HOD (Retired), Department of Forensic Medicine and Toxicology, Vydehi Institute of Medical Sciences and Research Centre, Bengaluru 560066, Karnataka, India.

Corresponding Author: Padmini Hannah Noone, Professor, Department of Forensic Medicine and Toxicology, Vydehi Institute of Medical Sciences and Research Centre, Bengaluru 560066, Karnataka, India.

E-mail: padmininoone@gmail.com

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Vydehi Institute of Medical sciences and Research Center, from November 2011 to June 2013 after obtaining ethical clearance from the institutional ethics committee. The study included all fatalities due to motorised two-wheeled vehicular accidents. Fatalities due to Road Traffic Accident where information on nature of vehicle was not available was excluded from the study. History was collected from the police requisition forms 146(1) and 146(11) and information was also collected from friends and relatives of the deceased were all collected.

RESULTS AND DISCUSSION

Two wheeler accidents showed 31% of the total no of Road traffic accidents in Whitefield area of Bangalore, India. (37 cases out of 84 autopsies)

Table 1: showing sex distribution

Sex	Driver	%	Pillion Rider	%
Male	32	86.49	3	8.11
Female	0	0	2	5.41

Table 2: showing age distribution

Age	Driver	%	Pillion rider
0 to 10	0	0	0
11 to 20	2	5.41	1
21 to 30	12	32.43	3
31 to 40	10	27.03	1
41 to 50	4	10.81	0
51 to 60	2	5.41	0
<60	2	5.41	0

Table 3: showing day wise distribution

Day of incidence	Driver	%	Pillion rider	%
Monday	6	16.22	2	5.41
Tuesday	4	10.81	1	2.70
Wednesday	6	16.22	0	0
Thursday	2	5.41	0	0
Friday	4	10.81	1	2.70
Saturday	7	18.92	0	0
Sunday	4	10.81	0	0

Table 4: showing the month of incidence

Month of incidence	Drivers	Pillion riders
January	7	1
February	1	0
March	4	0
April	2	0
May	2	0
June	1	0

July	0	0
August	1	2
September	1	0
October	6	0
November	3	0
December	5	2

Table 5: showing the time of incidence the occurrence

Time of incidence	Drivers	Pillion riders
8am – 12am	8	2
12pm – 8pm	17	1
8pm – 12pm	5	2
12am – 8am	2	0

Table 6: showing the incidence in vehicles with and without gear

Type of vehicle	Drivers	Pillion riders
Without gear	10	1
With gear	22	4

Table 7: showing time of death occurrence

Place of death	Drivers	%	Pillion Rider
On spot	15	40.54	3
On the way to hospital	2	5.41	0
In hospital	15	40.54	2

Table 8: showing survival period

Survival Period	Driver	%	Pillion rider
On spot	14	37.84	3
< 1 hour	3	8.11	1
1 to 6 hours	3	8.11	1
> 6 hours	12	32.43	0

Table 9: showing the collision pattern

V / S	Drivers	%	Pillion rider	%
Self / Skid	4	10.81	0	0.00
Pedestrian	1	2.70	0	0.00
Object/ Tree/Poles	3	8.11	0	0.00
Two wheelers	2	5.41	0	0.00
Car/Sumo/Jeep	3	8.11	0	0.00
Tractor/ mini loader	3	8.11	0	0.00
Lorry/Water tanker/ Bus	16	43.24	4	10.81
Tipper/Big Lorry/ Trailers	4	10.81	1	2.70

Results are presented in table 1 to table 9.

It was observed that Male predominance is seen in the pattern (table 1), the majority of the victims were between 20 and 30 years (table 2). Day wise distributions of the fatalities indicated maximum

on Saturday followed by Mondays in drivers (table 3). It was observed that the month of January had higher incidence (table 4), It was observed that the time of incidence the occurrence (table 5) was higher between 12pm to 8pm. It was observed that the incidence rate was higher in vehicles with gears. (table 6) in most cases death occurred on the spot (table 7) and survival time was minimal (table 8) Following Pattern emerged.

Two wheeler accidents are the second commonest among road traffic accidents which constitutes 31% of total cases that was autopsied at this center. Male predominance was commonly seen, Females are pillion riders, and Age of incidence being commonest was noticed in 21-30 years of age group followed 31-40 years. Fatalities are most commonly seen during Saturday and Mondays.

Most of the deaths occurred on the spot compared to deaths in the hospital and the survival period is more than 6 hours in most of the cases, in both rider and pillion rider in the current study. Among the motorized two wheeler crashes, head-on collision especially with the heavy vehicles that is water tankers/lorry/bus were most with 46%. The next was self-fall, occurring after skid or by losing balance. This is seen in 18%.

DISCUSSION

In a study done on motorcycle related injuries in Teheran for a period of 2 years, shows that crashes involved in another vehicle were commonest kind of accidents. Fatalities related to head injuries were the commonest cause of death. The peak age of victims ranges from 20-39 yrs. Most of the injuries occur during Fridays. This is compared to current study which also showed that crashing involving another vehicle were common with peak age of victims ranging from 20-39 yrs. Most common cause of death was related to fatality of head injuries and most common days of occurrence were on Fridays and Mondays⁴.

In a prospective study done in Port Harcourt on 186 cases of road traffic accidents, 47.3% of them are motorcycles. Females involved in 25 numbers of cases and pillion passengers were being injured, most of the injuries occurred in rainy season. Motor car collision were the commonest mechanism of injury this in contrast with the current study where male to female incidence show that female were involve only in 5% of cases. Riders were most commonly injured compared pillions. Accidents were most commonly seen in winter season, motorcyclists – water tanker/lorry/bus collision

were the commonest Mechanism of injury.⁵ In a study in India,⁶ Gender wise preponderance was of males. In majority of cases it was riders' who were involved in fatal injuries; amounting to 61.2%. Nonetheless, even pillion riders' involvement shows a significant 6.1% of the total.

In a study carried out in Karachi;⁷ of the total 2090 autopsies, 581 (27.8%) were victims of RTA. Of these RTA victims 324 (55.8%) were of those between the ages of 19 and 40 years. There were 510 (87.8%) males and 71 (12.2%) females with a ratio of male: female being 7:1. This ratio was 4.2:1 for those aged 0-18 years and 11:1 for those aged 19-40 years ($p=0.05$).

On the spot care and first aid measures are extremely important in saving lives. Similar results with respect to age, sex, time of occurrence, type of vehicle involved were obtained in a study conducted by Jain A *et al.*⁸ Male preponderance has been mentioned in other articles as well.⁹ Weekend has been mentioned as having higher incidence in other studies as well.¹⁰ According to a study on key factor analysis¹¹ the researchers have analysed the direct factors involved which determines the severity of the road traffic accidents. In case of two wheelers they have concluded that the gender of the automobile driver, visibility, and drunk driving or not are important factors. Perhaps visibility is the reason why January is seen as having higher incidence in the present study. Heavy motor vehicle collision with two wheeler was seen as having higher incidence in a previous study as well.¹² Hence the authors have recommended separating the two in the road to reduce such incidences.

Conclusion and Acknowledgement

In the present study it can be seen that male sex, young age, geared vehicle, weekends and collision with heavy vehicles, are seen to have a higher incidence of mortality. Knowledge of these risk factors can help to make policies for saving lives. On the spot care has to be given importance and initiatives for starting treatment at the earliest has to be encouraged.

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Use of Artificial Intelligence in the field of Forensic Medicine & Crime Scene Investigation: A way forward

Fakhar Alam¹, Faiz Ahmad², Mohd Asrarul Haque³, Anil Yadav⁴

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Abstract

Forensic Medicine deals with applying medical knowledge in the administration of justice, bridging medical science with the law. The professions of forensic medicine and criminal investigation are increasingly utilizing the cutting-edge technology known as artificial intelligence (AI). It is used by forensic pathologists to establish the identity of an unknown person, estimate the age of injuries, primarily bruises, detect and analyze trace evidence, etc. It is very convenient to store, analyze, and transmit massive data within a very short time. This new technology is also helpful in conducting non-invasive autopsy by using various technologies such as Sonography, CT scans, MRIs, 3D surface scanning, etc. Detection and analysis of many trace evidence can be carried out by using AI. It is also very convenient to reconstruct the crime scene by creating video animation. However, as of now, its use is minimal and at a nascent stage. Moreover, it is not legally acceptable in a court of law.

Keywords: Artificial intelligence; Forensic Medicine; Identification; Autopsy; Technology; Criminal investigation.

INTRODUCTION

In a broad sense, Artificial Intelligence (AI) may be defined as intelligent works done by man-made machines, particularly computer systems, as opposed to the natural intelligent work done by human beings. Alan Turing, the founding father of AI, first defined artificial intelligence as the science and engineering of making intelligent machines

and brilliant computer programs.¹ During the mid-1950s, John McCarthy, an American computer scientist, also defined it as “the science and engineering of making intelligent machines”.² So, AI is a technology that enables machines to work efficiently, simulating human intelligence in problem-solving. This technology is widely used in many fields, such as industry, research, and health sectors. Very high-profile applications use AI, such as advanced web search engines, autonomous vehicles, generative and creative tools, video games, robotic surgeries, etc.

Gradually, AI has also been applied in the field of forensic medicine for the last decade.³ AI technologies were used to estimate the biological age of migrants or human remains. It was used in the field of justice and criminal law.⁴ An outline of the regular uses of AI in the realm of forensic medicine was provided by Tournois and Lefèvre.⁵ Many complicated cases can be better analyzed and understood by using AI technologies.

Author Affiliation:

¹Professor, ²Associate Professor, ³Assistant Professor, ⁴Associate Professor, Department of Forensic Medicine, F.H. Medical College & Hospital, Agra 282006, U.P., Jawaharlal Nehru Medical College, A.M.U., Aligarh 202002, U.P., RUHS College of Medical Science, Jaipur 302033, Rajasthan, India.

Corresponding Author: Fakhar Alam, Professor, Department of Forensic Medicine, F.H. Medical College & Hospital, Agra 282006, Uttar Pradesh, India.

E-mail: drfakharalam@gmail.com

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Definitions of terms related to AI & Machine:

A. Machine Learning (ML):

It is a statistical technique for fitting models to data and learning by training models using data.⁶ It is a range of powerful computational algorithms capable of generating predictive models via intelligent autonomous analysis of relatively large and often unstructured data. This technology enables DNA analysis faster and more accurate.

B. Deep Learning (DL):

In order to perform tasks like computer vision and natural language processing (NPL), deep learning, a subcategory of machine learning, uses a deep neural network with a specific configuration in which neurons are organized in several successive layers. This network can also independently learn representations of the 5 data and gradually extract complex features. Deep learning is used in medicine to detect diseases from medical imaging.⁷

C. Natural Language Processing (NPL):

In order to achieve human-like language processing 1, a theoretically motivated range of computational techniques for analyzing and representing naturally occurring texts at one or more levels of linguistic analysis are employed for a variety of tasks or applications. In medicine, these techniques are used to organize information in healthcare systems and extract pertinent information from narrative texts to help with decision-making.⁸

D. Robotics:

The Robot Institute of America defined it as “a reprogrammable multifunctional manipulator designed to move material, parts, tools, or specialized devices through variable programmed motions for various tasks”. Virtobot, a Robot System for Optical 3D Scanning in Forensic Medicine, is a new technique for non-invasive autopsy.⁹

E. Artificial Neural Network (ANN):

This new term, “Artificial Neural Network,” is derived from biological neural networks that develop the structure of a human brain. Similar to the human brain, which has neurons interconnected to one another, artificial neural networks also have neurons that are interconnected to one another in various layers of the networks. It mimics the natural human neuron system. It is a new data processing pattern described as a mathematic simulation system of the structure and function of the human brain.¹⁰

F. Convolutional Neural Networks (CNNs):

It is a regularized type of feed-forward neural network that learns feature engineering by itself via filter optimization. Using regularized weights over fewer connections prevents vanishing gradients and exploding gradients seen during backpropagation in earlier neural networks. CNNs make the explicit assumption that inputs have specific structures like images. This allows for the encoding of this property into the architecture by sharing the weights for each location in the image and having neurons respond only locally.¹¹

Applications of AI:

Many AI applications have been developed in the field of thanatology, especially for post-mortem identification,¹²⁻¹⁴ the calculation of the post-mortem interval,^{15,16} and the establishment of the cause of death.¹⁷⁻²⁰ In some clinical forensic medicine practices, AI applications are also helpful, such as age estimation,²¹⁻²⁴ gender determination,²⁵⁻²⁷ and age estimation of bruises.²⁸ Bruises undergo color changes due to the breaking down of hemoglobin during the healing process. It is originally reddish, then violet-blue, then greenish on the third day because of biliverdin, brown on the fourth or fifth day because of bilirubin, and finally yellow because of the build-up of hemosiderin pigment, which vanishes in ten to fourteen days, it turns brown due to bilirubin and later turns yellow due to the accumulation of hemosiderin pigment, disappearing in 10–14 days. These color changes were initially studied by naked eye examination, which is inaccurate. Now, the machines can detect such color changes more accurately, which is less time-consuming. It was also used in the assessment and management of violent behaviors among prisoners.²⁹

Now, AI technologies are also applied in various fields of autopsies.³⁰ This is very important because autopsy examination plays a vital role in criminal investigation. Virtopsy, which is also known as Virtual Autopsy, is noteworthy to be cited here. This non-invasive technology uses various imaging techniques such as CT scans, MRI, and 3D surface scanning to examine the body.³¹ These technologies enable thorough study of internal injury or pathological conditions without invasive dissection of the body.³²

In cases of unknown or mutilated bodies, identification may be challenging. In the traditional methods for identification, we depend on different parameters like anthropology, facial descriptions,

tattoos, scars, body marks, etc. In the newer era, we use fingerprints, iris scans, DNA analysis, etc. However, in this modern era, different AI technologies are introduced. Super human-like computers can be utilized for identification. These machines can process and store data such as facial features, gait, voice, retinal patterns, fingerprint patterns, etc.^{35,36}

In crime scene investigations too, AI is also very useful. Conventional methods, such as naked eye examination, microscopy, infrared examination, and various chemical tests, will take longer and sometimes may give erroneous reports, which may be due to inadequate samples. However, machines can detect such trace evidence more accurately within a shorter duration. In cases of sexual offenses, it may be challenging to detect the presence of sperm, especially when there is a very small sample. In such cases, the use of Convolutional neural networks trained by the VGG19 network and a variation of VGG19 with 1942 can fulfill this task. They can reduce the scanning time by locating the sperm on the microscope images.³⁷ Detection and analysis of many trace evidence can be carried out by using AI. It is also very convenient to reconstruct the crime scene by creating video animation.

In forensic ballistics, AI technologies are also now applied. When a bullet leaves a barrel, it carries microscopic evidence, which can be analyzed to establish the type of weapon used. It guides experts to the place where they need to look for gunpowder and cartridge tubes and compare the traces with a database through image processing without actual human involvement. Some algorithms allow for the highlighting of the residues resulting from firing with firearms, allowing for the detection of the explosion inside the barrel changes due to shock waves, as well as the provision of data that allow for the establishment of the class and calibre.³³

AI has future prospects in identifying various poisonous drugs and substances in the field of Forensic Toxicology. Helma C. *et al.* revealed in a scientific paper that there can be human errors by using the spectrophotometer, neutron, and high-performance liquid chromatography (HPLC), and in this sense, AI can play an essential role by providing a data set as a sample which will increase the precision of the method, the efficiency, and even the reduction in the costs of investigations.³⁴

AI technologies are also applied to evaluate medical malpractice cases. This may be useful to a certain extent in the future investigation of medical negligence cases.

DISCUSSION

Since the last decade, there has been increased application of AI in the field of Forensic Medicine & Toxicology. The application of AI in this field may be considered from the following few perspectives:

1. To assist the forensic pathologist regarding the accuracy of both the anatomopathological diagnosis macroscopically, as well as all complementary examinations;
2. To reduce subjective judgment, all the factors that define human nature through its vulnerability;
3. To eliminate unnecessary investigation, saving both time & cost;
4. It is very convenient for storing & transporting files as it is created in digital form, very convenient in storing many huge files;
5. It gives a very fast and more solid opinion.

Previous studies showed that AI in the field of Forensic Medicine & Toxicology is mainly applied in Forensic Thanatology and clinical Forensic Medicine.^{27,28,32} In thanatology, AI models were designed for post-mortem identification, determining the causes of death, and estimating the post-mortem interval. So far, in Clinical Forensic Medicine, AI has been used to estimate the age of living individuals, the risk of violent reoffending among prisoners, and bruises dating.

The use of AI permeates almost all spheres of life, and it is becoming more sophisticated day by day, too. It also brings with it a host of legal implications and challenges that demand careful consideration and regulation. It is challenging to keep pace with the rapidly proliferating application of AI and the existing legal system. The policymakers worldwide are having a tough time formulating a comprehensive law governing the use of AI. It is currently not admissible in a court of law. There aren't any three statutory laws or regulations that specifically govern the application of AI in India either. Nonetheless, particular frameworks for different industries have been recognized for the creation and application of AI.³¹ In the financial industry, Stockbrokers, Depository Participants, Recognized Stock Exchanges, and Depositories received a circular from SEBI in January 2019 outlining reporting requirements for systems and applications that use and offer Artificial Intelligence (AI) and Machine Learning (ML). The National Digital Health Mission's (NDHM) plan

in the health sector notes the requirement for rules and guidelines to guarantee the dependability of AI systems in healthcare.

CONCLUSION

Though we have heard of the increasing application of AI in many fields, including the health sector, the application of AI in the field of Forensic Medicine & Toxicology is in a nascent stage. There is a paucity of literature that shows that AI applications are used by forensic pathologists in daily practice to date. However, there has been an increase in interest in the application of AI in the field of Forensic Medicine and various crime investigations. It would not be wrong to say that in the near future, AI may be applied in routine forensic work.

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Mayur Vihar Phase-I

Delhi - 110 091(India).

Mobile: 9821671871, Phone: 91-11-79695648

E-mail: author@rfppl.co.in

Hospital Death Audit in Practice

Vivekanshu Verma¹, Shri Gopal Kabra²

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Abstract

Mortality audit, also known as death review, is a systemic process that documents the causes of death and factors that contributed to it. Conducted by a medical audit committee and recommended by Quality Council of India, this review aligns with standards set by NABH and JCI. It scrutinizes deaths occurring in Operation Theatres, addressing issues on criminal negligence under the Consumer Protection Act. The audit investigates therapeutic misadventures, surgical errors, and deficiencies in surgery, involving Healthcare Providers (HCPs). It also examines anesthetic toxicity, overdoses, anaphylaxis, and other critical factors. Through verbal autopsies and postmortem analyses of the critical facts, the process aims to identify lapses and improve future medical practices, ensuring higher quality care and patient safety.

Keywords: Medical Audit; Committee; Quality Council; NABH; JCI; Death in Operation theatre; CP Act; Therapeutic misadventure; Surgical errors; Deficiencies in surgery; HCPs; Anesthetic toxicity; Overdose; Anaphylaxis; Autopsy; Postmortem.

INTRODUCTION

Medical Audit, i.e. expert scrutiny and review of all hospital deaths is a basic quality control method of hospital management. It is one of the standards of the National Accreditation Board for Hospitals and Health Care Providers (NABH), a constituent board of Quality Council of India. The best method for it is autopsy. However, since autopsy can be done only with relatives' consent, it is not possible because of their religious beliefs and social perceptions. The next best is **death audit** which is retrospective peer review of the death file.

Standard Operating Procedures (SOPs) for Death Audit in Hospitals

- Purpose
- Objectives
- Scope
- Definitions
- Responsibilities
- General Procedures
 - a. Notification and Identification
 - b. Immediate Care of the Deceased
 - c. Preliminary Documentation
- Detailed Audit Procedure
 - a. Medical Records Review
 - b. Clinical Review
 - c. Mortality Review Meetings
- Forensic Examination and Autopsy
 - a. Indications for Forensic Examination
 - b. Procedure for Requesting an Autopsy

Author Affiliation: ¹Associate Consultant, Medanta - The Medicity, Gurugram 122001, Haryana, ²Director Legal Affairs and Medical Audit, Santokba Durlabhji Memorial Hospital, Jaipur 302015, Rajasthan, India.

Corresponding Author: Shri Gopal Kabra, Director Legal Affairs and Medical Audit, Santokba Durlabhji Memorial Hospital, Jaipur 302015, Rajasthan, India.

E-mail: kabrasg@hotmail.com

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- Legal Documentation
 - a. Death Certificate
 - b. Medicolegal Report
- Communication with Relatives
 - a. Informing the Family
 - b. Providing Support and Information
- Reporting and Record Keeping
 - a. Internal Reporting
 - b. External Reporting
 - c. Record Maintenance
- Confidentiality and Security
- Training and Competency
- Review and Audit
- Guidelines by Medical Councils & Hospital Administration

Purpose

The documentation and audit of hospital mortality, particularly in medicolegal cases, are crucial for maintaining transparency, accountability, and quality of care in a tertiary centre. This SOP outlines the comprehensive process for conducting a dead patient's medical audit, ensuring all legal and clinical requirements are met.

Objectives

- To ensure accurate and thorough documentation of hospital mortality.
- To identify and review factors contributing to patient deaths.
- To comply with legal and regulatory requirements in medicolegal cases.
- To improve patient care through systematic mortality audits.

Scope

This SOP applies to all healthcare professionals, administrative staff, and relevant stakeholders involved in managing and documenting hospital mortality in a tertiary centre.

Definitions

- **Medical Audit:** A systematic review of medical records and clinical practices to ensure quality and compliance.
- **Medicolegal Case:** Any case involving legal implications related to a patient's

death, including suspected foul play, negligence, or unexplained causes.

- **Tertiary Centre:** A hospital providing specialized medical care, typically involving advanced and complex treatments.

Responsibilities

- **Hospital Administration**
 - Ensure resources and support for conducting mortality audits.
 - Enforce policies and procedures related to documenting hospital mortality.
- **Medical Staff**
 - Conduct thorough and accurate documentation of patient care.
 - Participate in mortality review meetings and audits.
- **Mortality Review Committee**
 - Oversee the audit process.
 - Review and analyze findings from mortality audits.
 - Recommend improvements based on audit outcomes.
- **Legal and Forensic Team**
 - Ensure compliance with legal requirements.
 - Assist in the preparation of medicolegal reports.

General Procedures

- **Notification and Identification**
 - **Immediate Notification:** Upon a patient's death, notify the attending physician, nursing staff, and hospital administration immediately.
 - **Identification Verification:** Verify the deceased patient's identity using hospital records and identification tags.
- **Immediate Care of the Deceased**
 - **Body Handling:** Handle the body with respect and care, following standard infection control protocols.
 - **Securing Belongings:** Secure the deceased's personal belongings and document them accurately.

➤ Preliminary Documentation

- **Death Note:** The attending physician should write a preliminary death note, including the time, date, and suspected cause of death.
- **Initial Report:** The nursing staff should document the circumstances surrounding the death in the patient's medical records.

Detailed Audit Procedure

➤ Medical Records Review

- **Comprehensive Review:** Review the deceased patient's entire medical record, including admission notes, progress notes, medication charts, and diagnostic reports.
- **Identify Gaps:** Identify any gaps or inconsistencies in the medical records and address them promptly.

➤ Clinical Review

- **Clinical Pathway Analysis:** Analyze the clinical pathway and treatment decisions made during the patient's stay.
- **Contributing Factors:** Identify any factors that may have contributed to the patient's death, including clinical decisions, procedural issues, and system failures.

➤ Mortality Review Meetings

- **Interdisciplinary Meetings:** Conduct regular mortality review meetings involving an interdisciplinary team, including physicians, nurses, and administrative staff.
- **Case Presentation:** Present each case in detail, discussing the clinical course, contributing factors, and potential areas for improvement.
- **Actionable Insights:** Develop actionable insights and recommendations based on the review findings.

Forensic Examination and Autopsy

➤ Indications for Forensic Examination

- **Unnatural Deaths:** Suspected foul play, suicide, or accidents.

- **Unexplained Deaths:** Deaths with unclear or unknown causes.
- **Legal Requirements:** Deaths requiring a forensic examination by law.

➤ Procedure for Requesting an Autopsy

- **Authorization:** Obtain appropriate authorization from the legal authorities or the deceased's next of kin, as required.
- **Forensic Pathologist:** Coordinate with a forensic pathologist to conduct the autopsy.
- **Documentation:** Ensure all autopsy findings are thoroughly documented and included in the medical records.

Legal Documentation

➤ Death Certificate

- **Accurate Completion:** Complete the death certificate accurately, including all required information such as the cause of death, manner of death, and any contributing factors.
- **Timely Submission:** Submit the death certificate to the relevant authorities promptly, following local regulations.

➤ Medicolegal Report

- **Detailed Report:** Prepare a detailed medicolegal report, including a summary of the medical history, clinical course, and autopsy findings.
- **Legal Compliance:** Ensure the report complies with all legal requirements and standards.

Communication with Relatives

➤ Informing the Family

- **Timely Notification:** Inform the family of the patient's death as soon as possible, using a compassionate and empathetic approach.
- **Clear Information:** Provide clear and concise information about the circumstances of the death and any next steps.

➤ Providing Support and Information

- **Support Services:** Offer support services, including counseling and bereavement support.

- **Legal Guidance:** Provide information about legal processes, including the issuance of the death certificate and any required legal investigations.

Reporting and Record Keeping

➤ **Internal Reporting**

- **Incident Report:** Complete an internal incident report detailing the circumstances of the death and any immediate actions taken.
- **Audit Report:** Prepare a comprehensive audit report summarizing the findings of the mortality audit and any recommendations for improvement.

➤ **External Reporting**

- **Regulatory Authorities:** Report the death to relevant regulatory authorities as required by law.
- **Insurance Providers:** Notify insurance providers and complete any necessary documentation for claims processing.

➤ **Record Maintenance**

- **Secure Storage:** Store all records related to the deceased patient securely, ensuring they are accessible only to authorized personnel.
- **Retention Period:** Maintain records for the legally required duration, ensuring they are complete and accurately reflect all aspects of care and the audit process.

Confidentiality and Security

- **Patient Privacy:** Maintain the confidentiality of all patient information, including medical records and audit findings.
- **Data Security:** Ensure that all records and reports are stored securely, with access restricted to authorized personnel only.

Training and Competency

➤ **Staff Training**

- **Regular Training:** Provide regular training sessions for staff on the procedures for documenting hospital mortality and conducting medical

audits.

- **Scenario-based Learning:** Utilize scenario-based learning to enhance practical skills and preparedness.

➤ **Competency Assessment**

- **Periodic Assessments:** Conduct periodic competency assessments to ensure staff are proficient in managing medicolegal cases and documenting hospital mortality.
- **Continuous Improvement:** Encourage continuous improvement through feedback, learning from past cases, and staying updated with legal and medical advancements.

Review and Audit

➤ **Regular Review**

- **Procedure Review:** Conduct regular reviews of the procedures for documenting hospital mortality and conducting medical audits.
- **Stakeholder Involvement:** Involve relevant stakeholders, including medical staff, administration, and legal advisors, in the review process.

➤ **Audits**

- **Internal Audits:** Perform regular internal audits of mortality documentation and medical audit processes to ensure compliance and identify areas for improvement.
- **External Audits:** Cooperate with external auditors and regulatory bodies during scheduled audits.

Guidelines

- Local and national regulations on death documentation and medicolegal reporting.
- Hospital policies and procedures on mortality audits.
- Guidelines from professional medical and forensic associations.

The systematic documentation and audit of hospital mortality, particularly in medicolegal cases, are essential for maintaining transparency, accountability, and high standards of patient care. By following these SOPs, the tertiary centre can ensure compliance with legal requirements, enhance the quality of care, and provide

support to bereaved families. Through regular training, comprehensive reviews, and effective communication, healthcare professionals can manage medicolegal cases with competence and compassion, upholding the integrity of the healthcare institution

Process and Procedures

The following is the method of Death Audit, just following the Audit Cycle (Fig. 1) that the first author had established himself in a multi-disciplinary private hospital in Jaipur while working as their Director Legal and Medical audit.



Fig. 1: The Audit Cycle (Citation: Prakash, Anjan. Medical audit. Jaypee Publishers. 2011. Audit Cycle, p20.)

DISCUSSION

Death summary: It was made compulsory that every death file must have a death summary. This was in place of discharge summary. Death summary is a concise summary of chronological events recorded in the case file. Medical Records Department (MRD) will not accept any death file that did not have death summary. The death summary is typed and transmitted on line to the Audit Cell. At the end of the month the Audit Cell would take printout of all the death summaries. They are sorted for each specialty and endorsed to the specialty heads for conducting a death review and send their written compliance. The MRD too is provided with a copy to make the respective death file available to the department.

Mortality Audit: It is compulsory for all the medical staff, including house surgeons and DNB candidates of the specialty, to attend the meeting.

The primary physician in-charge of the case presents the case details, usually as a power point presentation. The cause of death certificate showing the underlying cause, the intermediate cause and immediate cause of death is the last slide. The case is critiqued and discussed. All questions raised by the members have to be answered by the case in-charge. Any deficiency noted in investigations, interpretation or treatment is discussed. The case discussion is most educative for all, especially the DNB candidates. However, the discussion is not recorded for fear of litigation. On the death summary, an endorsement is made that the case was discussed, and lessons learnt were shared. The Head of the Department returns all the death summaries discussed along with the participants list to the Audit Cell.

Cause of death certificate: It's a vital legal document. Unfortunately the law enforcement authorities, being unaware, do not insist for it -

they just want a death certificate. A cause of death certificate in the WHO approved format, detailing in sequence, the underlying cause of death, the events that is intermediate cause of death and the final event that is immediate cause of death, executed on the basis of sequence of events in death summary, is virtually a death summary in few words. The underlying disease is the cause of death and not the final event that is reported. The ICD coded causes of death, provide a readily retrievable real time mortality statistics. Unless underlying cause of death extracted for the cause of death certificate is mandatorily reported to a central agency, no reliable mortality statistics will be available at the state or the national level. The death certificate is executed by the House Surgeon on duty at that time. They are, therefore, to be trained, else they would write Cardio Respiratory Arrest as cause of death. Gross Mortality, Net Mortality, Mortality Pattern (percentage occurrence) and Case Fatality Ratio, Maternal Mortality, Infant Mortality are the essential statistics for quality control. Annual mortality statistics were presented at a hospital meeting with the Medical Auditor during these periodic Hospital Mortality Meet.

Notes from Medical Auditors' Desk

In the halls where healing thrives,
A new task arrives, the audit jives.
Clipboards in hand, with keen eyes keen,
They review the charts, the pages unseen.

Through sterile halls, they silently tread,
Ensuring compliance, by the book they're led.
Policies and procedures, they scrutinize,
No detail too small, no corner hides.

Patients rest in beds so white,
While auditors work late into the night.
Metrics and measures, each box checked,
Standards upheld, no room for neglect.

The sterile beeps of monitors blend,
With the whispers of audit pens.
Safety, care, and protocols grand,
All under the auditor's watchful hand.

They sift through data, thick and dense,
Making sense of every pretense.
Ensuring every rule's adhered,
So the hospital's mission is clear.

With the dawn, their task concludes,
A report compiled, with insights imbued.
Improvements noted, praise where it's due,
The audit's done, the hospital anew.

Healing continues, as it should,
With each audit, ensuring the good.
In the quiet halls where hope resides,
The audit measures, and care abides.

ICD coded data base: Universally followed and WHO mandated International Classification of

Disease Code (ICD 10) is followed for maintaining the disease coded patient data base. One of the parameters recorded is Outcome. Under it, Discharge, Expired and LAMA is entered for each patient. Shuffling for 'Expired' collects all the mortality cases together. It is then possible to correlate with and collect disease specific, sex specific, and age specific mortality data.

Operative and anesthetic deaths: Death of a patient within 24 to 48 hours after anesthesia and operation is considered anesthetic death and, death of a person in the hospital within 30 days of operation, an operative death. In these cases the death summary received is immediately endorsed to the Heads (Anesthesia and Surgery) for an immediate joint review. Since on a per-operative set back, after immediate resuscitative measures the patient is shifted to ICU where final death is declared, 'on table death' is not technically appropriate label for these deaths. Audit of these deaths is a crucial procedure for identifying anesthetic or surgical mishaps.

Verbal Autopsy: This is a retrospective review of a death record by a Forensic expert in collaboration with the subject experts. This is usually done in criminal complaints (FIR). As has been mandated in Jacob Mathew judgment, the police officer is required to approach the principal of a medical college to constitute a Board for conducting the review. The physician complaint against provides the entire case record (preferably transcribed) to the police to be provided to the Board. The Board issues summons to the Primary Physician to appear before the Board and present his case and be subjected to cross examination. The Board then issues a detailed report, that includes examination of the primary physician. This has the same legal value as a postmortem report.

Mini Autopsy: In selected cases relatives of the deceased are persuaded to give written permission to take biopsies of the diseased organ without in any way mutilating the body. Histopathology report of the tissue could be used to substantiate the clinical diagnosis.

Virtual Autopsy: Autopsy done by Radiological imaging by CT scan with contrast of the whole body, to ascertain the cause of death in the patients, who died as inpatient during hospital stay. It may identify the hidden focus of infection, a forgotten gauze piece after surgical closure, acting as direct evidence as a res ipsa loquitur, the thing speaks for itself, for the proving the surgical negligence by the OT Doctor / Nurse. This is undergoing as a clinical trial to establish standard

practice of care in the premier institutes e.g., PGI Chandigarh.

Hospital Mortality Meet: Annual mortality statistics are presented and discussed. Selected cases of hospital deaths are scheduled for the meet. The entire medical faculty attends. This is to detect system failures and to develop protocols for prevention of the same.

Peer Review: In cases of FIR or criminal complaint under IPC 304 A, a peer review is undertaken. All the treating doctors, the respective department head, chief pathologist, chief radiologist, Medical Superintendent (MS) and legal cell chief are required to attend. The case is discussed in detail. The case file is examined in detail to ensure its completeness. It is duly indexed. The concerned doctors are briefed about what statement they are to make in Hindi before the police. The entire case file is photocopied and attested for handing over to the police. Concerned doctors are asked to be ready for appearance before the Medical Board of the Medical College.

Hospital Death Audit: Riddle in Rhymes

In the halls of healing, lives entwined,
Where hope and healthcare are reassigned,
A somber task, the medical audit starts,
To analyze why the patient's life departs.

A committee forms, with solemn grace,
From the NABH, their watchful place,
With JCI Commission, the standards set,
To trace critical steps where fate was met.

Within Operation theater, stark and bright,
Where death and life in that silence fight,
The Country's Quality Council takes its stand,
To understand what their ill fate had planned.

Therapeutic adventures, brave and bold,
In Operation theaters, success tales are told.
But surgical errors shadow, dark and grim,
Sterile Gauzes, if left inside, brings foe at brim
If not brought in light, chance of survival, slim.

Deficiencies in Patient's surgery, laid bare,
A health care provider's cross to bear.
Anesthetic toxicity, the hidden foe,
An Overdose and pain's overflow.

Intoxication, or the anaphylaxis's grip,
In moments where the heart may slip.
The audit seeks to find the truth,
In every lapse, in every proof.

The autopsy and postmortem speak,
Of silent battles, harsh and bleak.
In the Hospital MRD Records, stories lie,
Of when, where how and sometimes why?

To prevent the echoes of despair,
The Medical auditor's role is to repair.
To learn, to change, to better strive,
So more may heal, and more survive.

CONCLUSION

In a dynamic and highly complex discipline like practice of medicine, deficiency, mistakes, mishaps, accidents are a routine occurrence. Mortality Audit is to timely detect these deficiencies to initiate measure to prevent its recurrence. Mortality audit is never to penalize a physician. The fear of litigation, especially after CP Act, has totally ruined the hospital functioning. Development of clinical acumen and surgical skill is a lifelong learning experience from one's own mistakes and the mistakes committed by colleagues, labelled medicolegally as therapeutic misadventure. Statutory protection under Exemption Clauses, that exempt a physician from any civil or criminal liability, if strictly implemented, will go a long way to take care of the situation. Good Faith doctrine has be accorded due credence. Medical negligence decisions should also be subjected to Medical Audit by professional bodies, Medical Councils and ICMR.

Conflict of Interest: Nil

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Mobile: 9821671871, Phone: 91-11-79695648
E-mail: author@rfppl.co.in

To Be or Not to Be Sued under Consumer Protection Act: Medicolegal dilemma for the Health Care Providers

Shri Gopal Kabra¹, Vivekanshu Verma²

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Abstract

A landmark judgment by the Hon'ble Apex Court in *Bar of Indian Lawyers vs. D.K. Gandhi* (2024) has illuminated the medicolegal dilemmas faced by health care providers under the Consumer Protection Act (CPA). This paper critically examines the judiciary's interpretation that professions, including medical and legal, are excluded from the scope of the CPA 2019. The legal analysis with critical eyes and juristic approach, reveals that the Act, intended to safeguard consumers from unfair trade practices, does not encompass the services rendered by professionals whose work is grounded in specialized knowledge and skill. The judgment underscores the necessity for judicial interpretation in clarifying legislative intent, emphasizing that professionals should not be categorized alongside traders and businessmen. This exclusion reflects a deliberate legislative choice, aiming to distinguish the unique nature of professional services from commercial transactions. The paper further explores the implications of this ruling for health care providers, advocating for a procedural strategy to raise preliminary objections against complaints filed under the CPA 2019. Ultimately, this judgment serves as a definitive guide, reinforcing the specialized regulatory frameworks governing professional conduct and ensuring that medical professionals are rightly excluded from the consumer protection ambit.

Keywords: Health Care Provider (HCP); Doctor; Lawyer; Court; Laws; Consumer Protection Act (CPA).

INTRODUCTION

Statutory interpretation of the Consumer Protection Act 2019 clarifies that professions, including legal and medical, are not and cannot be encompassed by the Act. When ambiguity arises in any statutory provision, it is the judiciary's role to

decipher the legal citations used. By employing the method of 'literal construction' within the broader 'context of the schematic approach, its scope, and the considering the professed purpose of the Legal Act and applying various rules of construction, the judiciary decodes the likely intention of the lawmakers, who framed the CPA Act in 1987. The primary goal of judicial construction is to ascertain the "Intent of Law makers." Statutes are presumed to include specific components, as lawmakers are assumed to have intended their inclusion. This assumption guides the judiciary in interpreting the language and purpose of the law. By examining these components and applying various rules of construction, the judiciary seeks to clarify the likely intent of the lawmakers. This process ensures that the broader context, scheme, and objectives of the statute are considered, providing a clear understanding of the law's intended scope and application.

Author Affiliation: ¹Medico-legal Consultant, Santokba Durlabhji Memorial Hospital, Jaipur 302015, Rajasthan, ²Associate Consultant, Department of Emergency and Trauma Care, Medanta - The Medicity, Gurugram 122001, Haryana, India.

Corresponding Author: Shri Gopal Kabra, Medicolegal Consultant, Santokba Durlabhji Memorial Hospital, Jaipur 302015, Rajasthan, India.

E-mail: kabrasg@hotmail.com

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DISCUSSION

'To Be Or Not To Be' is the famous proverb, on the dilemma faced by protagonist, in the world famous play titled, Hamlet, written by William Shakespeare,¹ for the audience. In deliberating on the aforementioned basis to the medicolegal dilemma for Health Care Providers (HCPs), 'To Be Or Not To Be' Sued under Consumer Protection Act, the Hon'ble Apex Court in the Case of: Bar of Indian Lawyers vs D.K. Gandhi,² on May 14, 2024, decreed that neither the statement of the objects and reasons of the Consumer Protection Act, 1986, nor that of the CP Act, 2019, suggest that professions such as legal and medical services fall within the scope of the Act. The judiciary interprets statutes to include certain components that lawmakers are assumed to have intended. By examining the language, context, and purpose of the Act, the judiciary elucidates the likely intent of the lawmakers. This process ensures that the Act is applied as intended, protecting consumers while recognizing the unique nature of professional services, such as doctors and lawyers.

It is a well-established principle that professionals cannot be categorized as businessmen or traders, and their clients or patients cannot be classified as consumers. The Consumer Protection Act, 2019,³ was enacted by the Parliament "to provide for protection of the interests of consumers and for the said purpose, to establish authorities for timely and effectively administration and settlement of the consumer's dispute and for matters connected therewith or incidental there to".

The new legislation prominently features the theme of consumer protection, aiming to enhance it through various procedural measures. Key among these interventions are the bolstering of class action lawsuits and the introduction of mediation as an alternative dispute resolution forum. By strengthening class actions, the legislation enables consumers to collectively pursue legal action, thereby increasing their leverage and ability to seek justice against corporations or entities that have wronged them. This collective approach not only facilitates access to justice for individual consumers who might otherwise lack the resources to pursue litigation independently but also acts as a significant deterrent against corporate misconduct.

In addition to reinforcing class actions, the legislation introduces mediation as an alternative forum for resolving disputes. Mediation offers a less adversarial and often more expedient way to handle conflicts, focusing on mutually agreeable solutions rather than protracted legal battles. This approach

can reduce the burden on courts and provide a more efficient path to resolution for consumers, ultimately leading to quicker, more satisfactory outcomes.

By integrating these procedural enhancements, the new legislation aims to create a more robust framework for consumer rights. The dual emphasis on class actions and mediation reflects a comprehensive strategy to protect consumers, ensuring they have multiple avenues to seek redress and resolve disputes. This multifaceted approach not only empowers consumers but also promotes a fairer, more accountable marketplace. As a result, the legislation represents a significant step forward in safeguarding consumer interests and fostering a more just economic environment. A consumer⁴ is an individual who purchases goods or services for personal use or ownership, rather than for resale or use in production and manufacturing. A person, to be a consumer of goods, should satisfy, that the goods are bought for consideration. A person who uses goods with the buyer's approval is considered a consumer. However, anyone who obtains goods for resale or commercial purposes does not qualify as a consumer.

The pertinent sections of this judgment are provided below: Though the query posed before the Hon'ble Supreme Court is whether a legal complaint alleging the 'deficiency in the service' against an advocate, practicing the law, would be maintainable under the CPA Act, further questions arise from this, which deserve consideration: The question of whether the Lawmakers intended to include the professional services delivered by the Law professionals within the scope of the Consumer Protection Act (CP Act) 1986, as re-enacted in 2019, merits careful consideration. Given the nature of professional work, which demands a highest level of teaching, professional training with internship, and expertise in proficiency, which involves specialized mental work, where success depends on numerous factors beyond one's control, it is clear that a professional's role cannot be compared to that of a businessman, trader, or service provider of goods as outlined in the Consumer Protection Act.

Professionals operate in specialized fields where their success is influenced by various uncontrollable elements, making it inappropriate to treat them on par with those engaged in business or trade. The consumer services delivered by a businessman or trader to consumers concerning goods or products are fundamentally different from those provided by professionals to their clients. Lawmakers are presumed to have a thorough understanding of the legal aspects, but there seems no strong reason or compelling logic to believe that the Lawmakers proposed to encompass

professions, professionals, or their services within the Act's ambit.

Definitions

Black's Law Dictionary defines Profession:
As a public declaration respecting something.⁵
Also a calling, vocation, known employment;
divinity, medicine, and law are called the "**learned**

professions." As we have heard during legal arguments between the defence and prosecution in medicolegal cases, when the lawyers addresses their opposite attorney as "**my learned colleague**" or "**my learned friend**" maintaining the due respect and etiquettes of legal profession, while proving their point of allegations or defence.

Table 1: Practical Definitions of Profession & Professional

Practical Definitions of Profession & Professional
Profession: <ul style="list-style-type: none">- A business or trade that requires specialized training, skills, and expertise.- An occupation or career that involves providing expert services or guidance to clients or customers.- A field or industry that requires a high level of education, training, and proficiency.
Professional: <ul style="list-style-type: none">- A person who provides expert services or guidance in a particular field or industry.- A service provider who has specialized training, skills, and expertise in a specific area.- An individual who is qualified and certified to practice in a particular business or trade.
Learned profession: <p>A learned profession is an occupation that requires advanced education, training, and expertise in a specific field of study, typically in a discipline that involves intellectual and theoretical foundations. Learned professions often involve:</p> <ol style="list-style-type: none">1) Advanced degrees: Typically requiring a bachelor's degree or higher, such as a master's or doctoral degree.2) Specialized knowledge: Involving a deep understanding of theoretical and practical concepts, principles, and methods.3) Expertise: Demonstrating a high level of skill, proficiency, and judgment in applying knowledge to real-world situations.4) Critical thinking: Requiring analysis, evaluation, and problem-solving skills to address complex issues.5) Ethics and standards: Adhering to professional codes of conduct, ethics, and standards that guide practice. <p>Examples of learned professions include:</p> <ul style="list-style-type: none">➤ Law➤ Medicine➤ Engineering➤ Architecture➤ Dentistry➤ Veterinary medicine➤ Pharmacy➤ Psychology➤ Social work➤ Academia (Professorship) <p>These professions often require continuous learning, professional development, and staying current with advancements in their field to maintain expertise and provide high-quality services.</p> <p>Learned professional: A learned professional is an individual who has acquired advanced knowledge, skills, and expertise in a specific field of study, typically through formal education and training. They possess a deep understanding of theoretical and practical concepts, principles, and methods, and demonstrate a high level of proficiency and judgment in applying their knowledge to real-world situations.</p> <p>Characteristics of a learned professional include:</p> <ol style="list-style-type: none">a. Advanced education: Typically holding a bachelor's degree or higher, such as a master's or doctoral degree.b. Specialized knowledge: Having a deep understanding of their field, including its theories, principles, and methods.c. Expertise: Demonstrating a high level of skill, proficiency, and judgment in their field.d. Critical thinking: Possessing strong analytical, evaluative, and problem-solving skills.e. Continuous learning: Committing to ongoing professional development to stay current with advancements in their field.f. Ethical practice: Adhering to professional codes of conduct, ethics, and standards that guide their practice. <p>Examples of learned professionals include:</p> <ul style="list-style-type: none">➤ Doctors and medical specialists➤ Lawyers and judges➤ Engineers and architects➤ Professors and researchers➤ Dentists and veterinarians➤ Pharmacists and psychologists➤ Social workers and counselors <p>Learned professionals are recognized for their expertise and are often sought out for their advice, guidance and services.</p>

The word “profession” has its roots in Proto-Indo-European root⁶ meaning “to speak, tell, say” and has evolved over time to encompass various meanings. Here’s a breakdown of its etymological journey:

- Mid-14th century: “Any solemn declaration”
- 15th century: “Occupation one professes to be skilled in, a calling” (derived from “professen,” meaning “to take a vow” in a religious order)
- Medieval Latin: “Professare” (to declare publicly) from “professus” (avowed)
- Latin: “Profiteri” (to declare openly, testify voluntarily, acknowledge, make public statement of)
- “Pro-” (forth) from PIE root “*per-” (1) (forward)
- “Fateri” (acknowledge, confess) from PIE root “*bha-” (2) (to speak, tell, say)

Related words and roots:

- “Professed” and “professing”
- Proto-Indo-European root “*bhā-” (to speak, tell, say)
- Greek: “pheme” (speech, voice, utterance), “phōnē” (voice, sound), “phanai” (to speak)
- Sanskrit: “bhanati” (speaks)
- Latin: “fari” (to say), “fabula” (narrative, account), “fama” (talk, rumor, report)
- Armenian: “ban, bay” (word, term)
- Old Slavonic: “bajati” (to talk, tell)
- Old English: “boian” (to boast), “ben” (prayer, request)
- Old Irish: “bann” (law)

This etymological exploration reveals the word “profession” has its roots in the idea of publicly declaring or acknowledging something, whether it’s a vow, an occupation, or a statement.

Interpreting the Prologue or the Preamble of the CP Act, 2019 to construe ‘the definition of profession’ as ‘business’ or ‘trade,’ or ‘professional’ as ‘service provider,’ would unduly extend the Act’s scope beyond its intended purpose, potentially undermining its effectiveness.

Therefore, it is our considered opinion that the Consumer Protection Act 1986, got amended in 2019 and re-enacted, was specifically designed to protect consumers from unfair trade practices and unethical business conduct.⁷ There is no

evidence to suggest that the Lawmaker intended to include professions, or the services provided by professionals within the purview of the Act. The primary objective of the CP Act is to safeguard consumer rights within the realm of business and trade, not to regulate professional services.⁸

It is notable that the legislative analysis of the CP Act 2019 undoubtedly indicates the lawmakers’ intent to exclude the medical profession from its scope. The drafted Consumer Protection Bill 2018, which was presented and debated in both houses of Parliament, initially included the term ‘healthcare’ and Healthcare providers in the inclusionary part of Section 2(42). However, the legislative members objected to this inclusion. The Lawmakers piloting the CPA Bill clarified that the inclusion was in deference to the Supreme Court’s judgment in IMA vs. VP Shantha 1995.⁹ Despite this explanation, the legislative members didn’t agree, leading to an amendment of the Bill. In the Consumer Protection Bill 2019, the ‘healthcare’ was deliberately removed, and this revised version was ultimately approved. The deliberate deletion of the term ‘healthcare’ from the preamble of updated Consumer Protection Act 2019 was a considered decision by Parliament following thorough deliberation. After thorough discussion and critical analysis, the Hon’ble Bench has unequivocally concluded that the professions of law and medical professionals aren’t, and can’t be, included under the provisions of the CP Act, re-enacted in 2019. This interpretation hinges on a careful examination of the Act’s language, legislative history, and the broader context of its provisions.

Article 141 of the Indian Constitution,¹⁰ mandates that the law declared by the Supreme Court in a judgment is binding on all courts within the territory of India. The principles evolved, along with the reason and rationale underlying the decision, forms the Latin maxim: ratio decidendi, which became the binding segment of the court’s decision. Considering this constitutional mandate, the Hon’ble Supreme Court’s legal interpretation of the CP Act 2019, serves as a definitive guide for all subordinate courts.

Physicians, when faced with complaints filed against them under the Consumer Protection Act, should now interpose an objection *in limine* (this is a Latin phrase often used in legal contexts which means: Submit an objection prior to the commencement of proceedings), citing the Supreme Court’s judgment that explicitly excludes the Learned professions (including legal & medical) from the Act. This procedural strategy should

allow the matter to be Set aside in compliance with the Supreme Court's interpretation. A similar approach should be taken by legal professionals. This course of action was exemplified in the DK Gandhi judgement involving an advocate.

In the case at hand, a complaint was filed against a lawyer under the CP Act. The lawyer interposed an objection *in limine*, asserting that the legal profession is not included within the ambit of the Consumer Protection Act. The Consumer Forum ruled in favor of the advocate, supporting the exclusion of legal services from the Consumer Protection Act. However, upon appeal to the NCDRC, the NCDRC relied on the landmark judgment of the Apex Court in IMA vs VP Shantha, to rule that legal services were indeed covered under the Act. This decision was subsequently challenged in the Hon'ble Supreme Court.

The Hon'ble Supreme Court, upon reviewing the appeal, overruled the National Commission's decision. The Apex Court analysed that the earlier judgment in IMA vs VP Shantha, which had included medical services within the purview of the CP Act, was not applicable in the current context of the CPA (2019) Act. The Hon'ble Supreme Court's judgment emphasized that neither the legal nor the medical professions were intended to be covered by the Consumer Protection Act, amended in 2019. This interpretation was drawn from the legislative intent and the specific language of the Act, which did not encompass these professions.

Regulation by professional councils, such as the Bar Councils or Medical Councils, does not grant professionals immunity from civil or criminal liability for misconduct or negligence. However, in our view, the Consumer Protection Act was never intended to apply to professions or professionals, and thus they should not be subject to its provisions of the CP Act, of either 1986 or 2019. In light of this consideration, the court summarized its conclusions as follows: The Consumer Protection Act (CP Act) of 1986, as revised in 2019, was enacted with the primary goal of safeguarding consumers against deceptive trade practices and unethical business conduct. The legislative intent was never to bring professions or professional services within the scope of the Act, but rather to focus on regulating commercial activities that impact consumer welfare. The Hon'ble Apex Court's decision underscores the importance of legislative clarity and judicial interpretation in delineating the scope of statutory provisions. It also highlights the necessity for professionals to be aware of the legal framework governing their practice and to assert their rights appropriately within that framework.

The Hon'ble Supreme Court Bench's decision, comprising two judges, in the case of Bar of Indian Lawyers vs. D.K. Gandhi on May 14, 2024, overrides and overrules, completely overturns and nullifies the decision of the Hon'ble Bombay High Court in the case of MLAG (Medicos Legal Action Group) vs. Union of India dated October 25, 2021.¹¹

The Hon'ble Bombay High Court had been approached to interpret the CPA 2019, and issue orders to Consumer Forums to refrain from registering cases of medical negligence. The court dismissed the petition on several grounds:

- i. The petition was deemed thoroughly misconceived.
- ii. The language of Section 2(42) in CPA 2019 is almost identical to that of Section 2(1)(o) of the 1986 Act, leading to the conclusion that the legal meaning of the section should remain the same.
- iii. Healthcare was not specifically included in the Integrative part of the section of CPA to avoid overburdening it.
- iv. The Lawmakers' statement in Parliament, regarding the 2019 Bill, could not be construed as a reflection of Parliament's will.
- v. The court inferred that Lawmakers did not intend to exclude healthcare from CPA 2019.

The Hon'ble Bombay High Court essentially based its decision on the belief that the intent of Parliament was not to exclude healthcare from the Bill. However, this interpretation has been overruled by the Hon'ble Supreme Court's decision. In the D.K. Gandhi case,¹² the Hon'ble Apex Court thoroughly analyzed the CPA 2019, and concluded that the professions of Law and Medicine aren't, and can't be, considered included under the CPA Act. This decision was reached after considering the legislative intent, the specific interpretation of the amended CP Act 2019, and the broader context of its provisions. The Supreme Court emphasized that neither the legal nor the medical professions were intended to be covered by CPA (2019), contrary to the Hon'ble Bombay High Court's interpretation.

The Hon'ble Supreme Court's Decision has binding effect on all over the India and its jurisdiction including all the lower courts of India, Under the Indian Constitution's Article 141 mandate, which states that the case-law, decided by the Hon'ble Supreme Court, has binding effect on all over the India, and its jurisdiction including all the lower courts of India.¹³ This judgment provides a definitive interpretation that excludes legal and

medical professionals from the scope of CPA 2019, effectively nullifying the Bombay High Court's ruling. The doctors should note this Hon'ble Apex Court judgment into account and adopt a unified stance. Physicians, when faced with complaints under CPA 2019, should submit an objection prior to the commencement of proceedings, citing this Hon'ble Supreme Court's judgment, which explicitly excludes the Healthcare providers from the Consumer Protection Act. This approach will ensure that the matter is handled in accordance with the Hon'ble Apex Court's interpretation and that medical professionals are rightly excluded from the purview of the Act.¹⁴

Table 2. Medicolegal Puzzle in Rhymes

Medicolegal Puzzle in Rhymes
<p>Within the realms of law and care, A puzzle lies, both bright and fair. "To be or not to be," we see, The question of liability.</p> <p>A doctor's touch, a lawyer's plea, Under Consumer's scrutiny. But here's the twist, as courts unfold, Professions' bounds, in acts, we hold.</p> <p>The Hon'ble Court, in wisdom's gaze, Did look upon the legal maze. In DK Gandhi's case, they did decree, That doctors, lawyers, should be free.</p> <p>From acts designed for trade and sale, Not for those whose tasks entail, A higher call, a learned skill, Where stakes are more than simple till.</p> <p>To read the laws, to understand, Is justice's fine and noble hand. In statutes, words can twist and bend, So courts must bring the clearer end.</p> <p>Intent of law, the heart, the key, Not caught in mere formality. So when in doubt, judiciary, Must guide us through this quandary.</p> <p>Though patient sues and client cries, In fields where great expertise lies, The Court asserts with logic strong, They don't to consumer laws belong.</p> <p>For health and law, so intertwined, Are guided by a different mind. Their counsels judge, their peers review, Their codes are made for what they do.</p> <p>So here's the riddle, wrapped in rhyme, Of how the law sees such a time. "To be or not to be," we muse, But now we know, they can't accuse.</p> <p>For in the end, the Court has shown, The bounds of acts are clearly known. With wisdom, law, and judgment fine, Professionals, thus, are well-defined.</p>

In summary, the Hon'ble Apex Court's decision in, *Bar Of Indian Lawyers vs D.K. Gandhi*,¹⁵ clarifies that the lawyers and doctors are excluded from CPA 2019. This binding ruling overrules the Hon'ble Bombay High Court's judgment,¹⁶ and both legal and medical professionals should invoke this precedent to protect their interests under the Act.

Decriminalizing Medical Negligence Or Criminalizing Medical Practice:

It was professed before the Parliament to decriminalize medical negligence but what in reality happened to specifically criminalize practice of medicine by registered medical practitioners: Medical negligence deaths to be decriminalized, as Lok Sabha passed new criminal law bills on BNS, 2023. At that moment, cases of criminal negligence are handled under IPC 304 A, which pertains to causing death due to negligence. The announcement was immediately hailed by the medicos and the various medical associations, especially the Indian Medical Association (IMA), which had urged the government to decriminalize medical negligence death.

The BNS (2023) Section 106 (1) describes that: Any person who causes the death of another through a rash or negligent act, but without intent to harm, shall face imprisonment of up to five years and/or a fine. However, if the act is committed by a RMP during a medical procedure, the punishment shall be imprisonment of up to two years and/or a fine.

Interpretation: In the context of this sub-section of 106 of BNS (2023), the term RMP shall be construed to mean a medical practitioner who:

- Possesses a medical qualification that is duly recognized under the National Medical Commission Act, 2019; and
- Has been enrolled in the National Medical Register or a State Medical Register in accordance with the provisions of that Act.

The BNS (2023) Section 106 (2) describes that: Any person who causes the death of another person due to reckless and negligent driving, but does not intend to cause harm, and fails to report the incident to a police officer on duty or the duty Magistrate promptly, shall be liable to a prison sentence of up to ten years and/or a fine.¹⁸

Note: In Indian Penal Code (IPC), 1860, prior to repeal, "causing the death of another person due to reckless and negligent driving, followed by escaping without reporting it" was not recognised as an offence.¹⁹

Lawmakers proposed amendment to **decriminalise** (exempt from criminal liability) medical procedures as promised during proceedings. However, the amendment made was the exact opposite of what was promised to the doctors by the Lawmakers. The amendment in fact criminalizes all acts “done by a registered medical practitioner while performing a medical procedure.”

Following amendments were made in BNS 2023, Section 106:

1. In BNS 106 (1) the punishment was increased to imprisonment of “five years” in place of “Two years” in IPC 304 A.
2. And to it was: “If such an act is committed by a RMP during the performance of a medical procedure, the RMP shall be subject to imprisonment for a term of up to two years and shall also be liable to a fine.”

Interpretation: In the context of this sub-section of 106 of BNS (2023), the term RMP shall be construed to mean a medical practitioner who:

- Possesses a medical qualification that is duly recognized under the National Medical Commission Act, 2019; and
- Has been enrolled in the National Medical Register or a State Medical Register in accordance with the provisions of that Act.²⁰

Objections in the BNS 2023, Section 106:

1. The provisions of BNS 106(1) are in contravention of the provisions in Chapter III of BNS which under the good faith doctrine provide exemption from criminal liability to a duly qualified, registered and licensed physician. All acts done in good faith for the benefit of the patient with his/her consent are exempted from criminal liability.
2. Identifying specifically acts of registered medical professionals for harsh criminal liability is arbitrary, discriminatory and violative of equality.
3. It is not evident that the amendment made by official amendment in the BNS draft bill was subjected to the debate needed for approval before the Parliament.²¹ What was the justification given by the lawmakers for the amendment in contravention of their statement that they would bring an official amendment to decriminalize medical negligence?

4. Was it not an act of parliamentary impropriety if not an act of misleading Parliament?

Suggested Amendment in BNS, 2023:

Kindly Delete from BNS 106(1) “and if such act is done by a registered medical practitioner while performing medical procedure, he shall be punished with imprisonment of either description for a term which may extend to two years, and shall also be liable to fine.” And

Substitute it with BNS 106(1) “ An act of a registered medical practitioner (RMP) while performing a medical procedure, shall be exempted from any criminal liability, under the provisions of Bhartiya Nyaya Sanhita, 2023.”

Utilizing Artificial intelligence for interpreting Laws relevant in Legal Medicine:

All these issues were the point of discussion and debate with the help of Artificial Intelligence – Copilot.²² It highlights the stand that the medical profession can take to get the amendment amended or declared ultra vires.

The discussion and the debate in the form of queries and response.

Q.1. Which Section of BNS, 2023 corresponds to IPC 304- A of IPC?

Response

The section of the Bharatiya Nyaya Sanhita (BNS) corresponding to Section 304A of the Indian Penal Code (IPC), which deals with causing death by negligence, is Section 106. This section imposes a punishment of up to five years of either simple or rigorous imprisonment, along with a fine.

Q.2. Is there a specific aspect of this section you are interested in exploring further?

The original Sec 304 A of IPC was:

Any person who causes the death of another by performing a rash or negligent act, which does not constitute culpable homicide, shall be subject to imprisonment for a term up to two years, a fine, or both.²²(emphasis added)

Interpretation: It may be seen that the liability and punishment for negligence for a medical practitioner remains same in BNS 106(1) and IPC 304 A. The worse aspect is that under amended 106(1) the medical professional's acts are specifically added for criminal liability.

Q.3. Yes, what is added to it for registered medical practitioner?

Response

For registered medical practitioners, the Bharatiya Nyaya Sanhita (BNS) includes specific provisions under Section 106 to address their unique position. These provisions recognize the complexity and risks involved in medical practice. Here are some key points:

1. **Good Faith Exemption:** If a registered medical practitioner causes death by negligence while acting in good faith and in the course of their professional duties, they may be exempt from criminal liability. This is to ensure that doctors are not unduly penalized for unintended outcomes while performing their duties with reasonable care and skill.
2. **Informed Consent:** The importance of obtaining informed consent from patients is emphasized. If a medical practitioner has obtained informed consent and has acted within the scope of that consent, it can serve as a defense against allegations of negligence.
3. **Standard of Care:** The standard of care expected from medical practitioners is higher than that of an ordinary person. The law takes into account the specialized knowledge and skills of medical professionals when determining negligence.
4. **Expert Testimony:** In cases involving medical negligence, expert testimony from other medical professionals is often required to establish whether the standard of care was breached.

These provisions aim to balance the need for accountability with the recognition of the inherent risks in medical practice.

Is there a specific case or scenario you would like to discuss in relation to these provisions?

Q.4. These are not part of BNS, 106, but are part of Exemption sections of BNS that protects a doctor from criminal liability!

Response

Thank you for pointing that out. You're correct that the specific protections for registered medical practitioners are part of the exemption sections in the Bharatiya Nyaya Sanhita (BNS), rather than Section 106, itself. These exemptions are designed to protect doctors from liability under certain

conditions. Here are some key points from those sections:

1. **Good Faith Exemption:** This exemption protects doctors who act in good faith and within the scope of their professional duties. If a medical practitioner causes harm or death while performing their duties with reasonable care and skill, they may be exempt from criminal liability.
2. **Informed Consent:** Emphasizing the importance of informed consent, this exemption protects doctors who have obtained proper consent from patients before proceeding with treatment. If the treatment is within the scope of the consent given, it can serve as a defense against negligence claims.
3. **Standard of Care:** The law recognizes that medical practitioners are held to a higher standard of care due to their specialized knowledge and skills. This exemption takes into account the complexities of medical practice when determining negligence.
4. **Expert Testimony:** In cases of alleged medical negligence, expert testimony from other medical professionals is often required to establish whether the standard of care was breached. This helps ensure that judgments are based on informed medical opinions.

These exemptions aim to balance the need for accountability with the recognition of the inherent risks and complexities in medical practice.²²

Q. 5. Is there a specific exemption or case you would like to explore further? In contradiction to these provisions, lawmakers added Sec 106(1) to specifically criminalize medical procedures!

Response

It sounds like you're referring to a recent legislative change that might impact medical practitioners. Section 106(1) of the Bharatiya Nyaya Sanhita (BNS) appears to specifically address the criminalization of certain medical procedures, which could indeed be seen as contradictory to the protective provisions for doctors.

This addition could potentially create a challenging environment for medical practitioners, as it might increase the risk of criminal liability even when acting in good faith and within the scope of their professional duties. It's important to understand the exact wording and implications of Section 106(1) to fully grasp its impact.

Q. 6. Would you like to delve deeper into the specifics of Section 106(1) and its implications for medical practitioners? Or perhaps discuss how this change might affect the legal landscape for medical professionals in India?

Response

Section 106(1) of the Bharatiya Nyaya Sanhita (BNS) appears to introduce specific criminal liability for certain medical procedures, which could indeed be seen as contradictory to the protective provisions for doctors. Here are some key points to consider:

- 1. Criminalization of Medical Procedures:** This section might criminalize specific medical procedures if they result in harm or death, regardless of the intent or good faith of the medical practitioner. This could include procedures that are inherently risky but necessary for patient care.
- 2. Impact on Medical Practice:** The introduction of such a provision could create a chilling effect on medical practice. Doctors might become more hesitant to perform certain procedures, even when they are medically necessary, due to fear of criminal liability.
- 3. Balancing Accountability and Protection:** While the intent might be to ensure accountability, it's crucial to balance this with protections for medical practitioners who act in good faith. Over-criminalization could undermine the ability of doctors to provide effective care.
- 4. Legal and Ethical Implications:** This change raises important legal and ethical questions. It could lead to increased litigation and a need for clearer guidelines on what constitutes criminal negligence in medical practice.
- 5. Role of Expert Testimony:** In cases where Section 106(1) of BNS is invoked, expert testimony will be crucial to determine whether the medical practitioner acted within the accepted standard of care.²³

Understanding the exact wording and legislative intent behind Section 106(1) is essential to fully grasp its implications. It might also be helpful to look at any legal commentaries or case laws that have emerged since their introduction.

Q. 7. Would you like to explore any specific aspect of this section further, such as its legislative history or potential case studies? Will the lawmaker ever be able to decriminalize medical negligence. Would you like to explore any specific aspect of this issue

further, such as potential legal challenges or the impact on medical practice?

Response

Let's Hope for the best and prepare for the worst!

Q. 8. A medical practitioner can be prosecuted for gross negligent acts under BNS- 106, like any other person.²⁴ Why then is this discriminatory provision that too in contravention of the exemption clauses?

Response

Your concern as a RMP, is quite valid. The introduction of a provision that specifically criminalizes certain medical procedures under Section 106(1) of the Bharatiya Nyaya Sanhita (BNS) seems contradictory, especially given the existing exemption clauses designed to protect medical practitioners. Here are some points to consider:

- 1. Consistency in Legislation:** Laws should be consistent and coherent. Introducing a provision that criminalizes medical procedures while having exemption clauses to protect doctors creates a legal contradiction. This inconsistency can lead to confusion and uncertainty in the medical community.
- 2. Discriminatory Impact:** If medical practitioners are subject to additional criminal liabilities that are not applied to other professionals, it can be seen as discriminatory. This could discourage doctors from performing necessary but high-risk procedures, ultimately affecting patient care.
- 3. Legislative Intent and Trust:** The Lawmakers' statement about decriminalizing medical negligence followed by the introduction of a criminalizing provision can undermine trust in the legislative process. It raises questions about the true intent behind the legislation and the transparency of the process.
- 4. Legal Challenges:** Such contradictory provisions could be challenged in court. Legal professionals and medical associations might argue that the provision is unfair and inconsistent with the broader legislative intent of protecting medical practitioners acting in good faith.
- 5. Impact on Medical Practice:**²⁵ The fear of criminal liability might lead to defensive medicine,²⁶ where doctors avoid certain procedures or over-prescribe tests²⁷ and treatments to protect themselves from

potential legal action.²⁸ This can increase healthcare costs and negatively impact patient care.²⁹

Addressing these concerns requires a clear and consistent legal framework that balances accountability with the need to protect medical practitioners who act in good faith. It might be beneficial for medical associations to engage with lawmakers to clarify these provisions and ensure that the laws support both patient safety and the professional integrity of doctors.

Q. 9. Would you like to explore potential legal challenges or discuss how medical associations might address these issues with lawmakers?

Response

To address the concerns regarding the contradictory provisions in the Bharatiya Nyaya Sanhita (BNS) and their impact on medical practitioners, here are some potential steps and strategies that medical associations and legal professionals might consider:

Table 3. Interpreting Best Practice Guidelines

Key Principles of Best Practice Guidelines:

- **Guidelines augment, but don't replace, clinical judgment:** They offer suggestions, not rules, and acknowledge individual patient variations due to biological differences, comorbidities, resource availability, and personal preferences.
- **Intended use:** Guidelines primarily support clinicians in providing better patient care but may also be used by non-clinicians (e.g., insurers, administrators, lawyers) for quality measurement, payment determination, and legal cases. Primarily intended for clinicians to enhance patient care, guidelines may also be used by non-clinicians (insurers, administrators, lawyers) for:
 - Quality measurement
 - Payment determination
 - Malpractice cases
- **Effective implementation: Well-crafted guidelines are essential but insufficient for quality improvement. They require a comprehensive program engaging patients and clinicians in decision-making, supported by:**
 - A patient and clinician engagement program
 - Implementation strategies, including:
 - Systems enhancements
 - Clinical reminders
 - Quality improvement tools
 - Decision support tools
 - Outcomes measurement and feedback

Guidelines and Clinical Judgment:

Guidelines are designed to support, not supplant, clinical judgment.³⁵ They offer suggestions, not rigid rules, acknowledging individual patient variations due to:

- Biological differences (drug metabolism, immune response, genetic endowment)
- Comorbid conditions
- Local resource availability (social and economic environment)
- Patient preferences

While guidelines apply to most patients, some require tailored management.³⁶

1. Engage in Dialogue with Lawmakers

- **Consultation and Advocacy:** Medical associations can engage in direct dialogue with lawmakers to express their concerns about the contradictory provisions. They can advocate for a clear and consistent legal framework that balances accountability with protection for medical practitioners.
- **Public Statements:** Issuing public statements and position papers can help raise awareness about the potential negative impacts of the current provisions on medical practice and patient care.

2. Legal Challenges

- **Judicial Review:** Legal professionals can file petitions for judicial review to

challenge the contradictory provisions.³⁰ They can argue that these provisions are inconsistent with the broader legislative intent and the principles of fairness and non-discrimination.

- **Case Law:** Leveraging existing case law and precedents where courts have ruled in favor of protecting medical practitioners acting in good faith,³¹ can strengthen the argument against the new provisions.³²

3. Clarification and Amendments

- **Propose Amendments:** Medical associations can propose specific amendments to the BNS to remove or modify the contradictory provisions. This can include clarifying the scope of Section

106(1), and ensuring it aligns with the exemption clauses.

- **Legislative Committees:** Participating in legislative committee hearings and providing expert testimony can help influence the drafting and amendment process.

4. Education and Training

- **Legal Education:** Providing legal education and training to medical practitioners about their rights and responsibilities under the current legal framework can help them navigate the complexities of the law.³³
- **Risk Management:** Implementing risk management strategies and best practices³⁴ can help medical practitioners minimize the risk of legal liability.

Best Practice Guidelines (BPG) are primarily designed for clinicians to enhance patient care, but they may also be utilized by non-clinical stakeholders, such as:

- Insurers
- Healthcare administrators
- Lawyers

These stakeholders may repurpose guidelines for various objectives, including:

- Quality assessment and measurement
- Payment determination and reimbursement decisions
- Malpractice litigation and defense

This secondary use of Best Practice guidelines can have significant implications for healthcare delivery and patient outcomes.³⁷ Although Best Practice guidelines are mainly intended for clinicians to inform patient care, they can also be leveraged by non-clinical professionals in diverse ways. For instance, insurers and administrators may apply guidelines to evaluate quality performance and determine payment structures. Additionally, guidelines may be invoked in malpractice proceedings, thus Best Practice guidelines: '**To be or not to be**' used by Lawyers, in suing the RMP for alleged medical malpractice.³⁸ This broader application of guidelines underscores their significance in shaping healthcare practices and policies.

5. Public Awareness Campaigns

- **Informing the Public:** Educating the public about the importance of protecting medical practitioners who act in good faith can help build support for legislative changes.

- **Media Engagement:** Engaging with the media to highlight the issues and potential impacts on healthcare can help garner public and political support for necessary changes.

6. Collaboration with Legal Experts

- **Interdisciplinary Collaboration:** Collaborating with legal experts, ethicists, and other stakeholders can help develop comprehensive strategies to address the legal and ethical implications of the current provisions.
- **Research and Analysis:** Conducting research and analysis on the impact of the provisions on medical practice and patient care can provide evidence-based support for proposed changes.

By taking these steps, medical associations and legal professionals can work towards creating a legal environment that supports both accountability and the professional integrity of medical practitioners. Wouldn't we like to explore any of these strategies in more detail or discuss specific actions that can be taken, to safeguard our clinical practice!

CONCLUSION

To conclude, the Hon'ble Apex Court's ruling has set a clear precedent that the Learned professionals of law and medicine (Lawyers and Doctors) are excluded from the legal provisions of CP Act, 2019. This decision has a binding effect on all Indian courts, including the consumer courts of NCDRC, State Consumer court, District consumer court and should guide the handling of complaints against legal and medical professionals under the CP Act. Both lawyers and physicians should raise preliminary objections based on this ruling to ensure that their professions are rightly excluded from the provisions of the Consumer Protection Act.

Disclosure of AI Assistance

The authors acknowledge the use of AI-assisted technologies in the writing process to improve language clarity and readability. While AI tools were employed to enhance the content, the authors have thoroughly reviewed, edited, and validated the final publication, taking full responsibility for its accuracy and integrity.

Conflict of Interest: Nil

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Munchausen Syndrome by Proxy: Factitious Disorder Imposed

Shri Gopal Kabra¹, Vivekanshu Verma²

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Abstract

Factitious Disorder Imposed on Another (FDIA) involves caregivers fabricating or inducing illness in someone under their care. In some cases, caregivers misuse FDIA to manipulate legal outcomes by creating false medical histories, leading doctors to unnecessary interventions. When complications arise, they accuse the medical team of negligence. This deceit compromises accurate diagnoses and treatments, making healthcare providers appear negligent. Proving medical negligence requires showing that the provider breached their duty of care, but FDIA obscures the true source of harm. Addressing FDIA misuse involves thorough investigations, recognizing red flags, and ensuring collaboration between legal and medical professionals. A case scenario on FDIA involving patient suffering from Fibroids, who underwent surgery, is described for understanding the practical challenges faced by healthcare professionals, as observed by bird's eye view, to highlight the pertinent issue.

Keywords: Factitious Disorder; Medical Negligence; Malpractice; Legal Medicine; Consumer Protection.

INTRODUCTION

The adjective "Factitious" means artificial, not natural. It originated in the mid-17th century,¹ meaning "made by human skill or effort." It derives from the Latin word "facticius," meaning "made by art," which in turn comes from "facere," meaning "to do" or "to make." Thus, Factitious disorder is a psychological illness of simulating/ manipulating the signs of critical illness of self or another near & dear one, modified deliberately, to create more confusion in actual diagnosis of disease.

This manipulation exploits the trust and responsibility inherent in the patient-doctor relationship. Doctors rely on the caregiver's account of symptoms and medical history to make informed decisions about treatment.

When this information is falsified, it compromises the accuracy of diagnoses and appropriateness of interventions, increasing the risk of iatrogenic harm. Consequently, the medical team may appear negligent when in reality, they were misled by the caregiver's deceit.

Legally, proving medical negligence requires demonstrating that the healthcare provider breached their duty of care, directly causing harm to the patient.

In the context of FDIA, the caregiver's actions can obscure the true source of harm, making it seem as though the medical team is at fault. This not only damages the reputation and careers of healthcare professionals but also undermines the integrity of the medical and legal systems.

Author Affiliation: ¹Director Legal Affairs and Medical Audit, Santokba Durlabhji Memorial Hospital, Jaipur 302015, Rajasthan, ²Associate Consultant, Medanta - The Medicity, Gurugram 122001, Haryana, India.

Corresponding Author: Vivekanshu Verma, Associate Consultant, Medanta - The Medicity, Gurugram 122001, Haryana, India.

E-mail: vivekanshuv@gmail.com

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Factitious disorders involve physical or psychological symptoms that are voluntarily self-induced, differentiating them from conversion disorder, where symptoms are produced unconsciously. In factitious disorders, individuals intentionally create or exacerbate symptoms, but

this behavior is neurotic, as they are unable to stop themselves. Their motivations are involuntarily adopted, unlike in malingering, where symptoms are exaggerated for a clear personal gain or to avoid unpleasant situations.

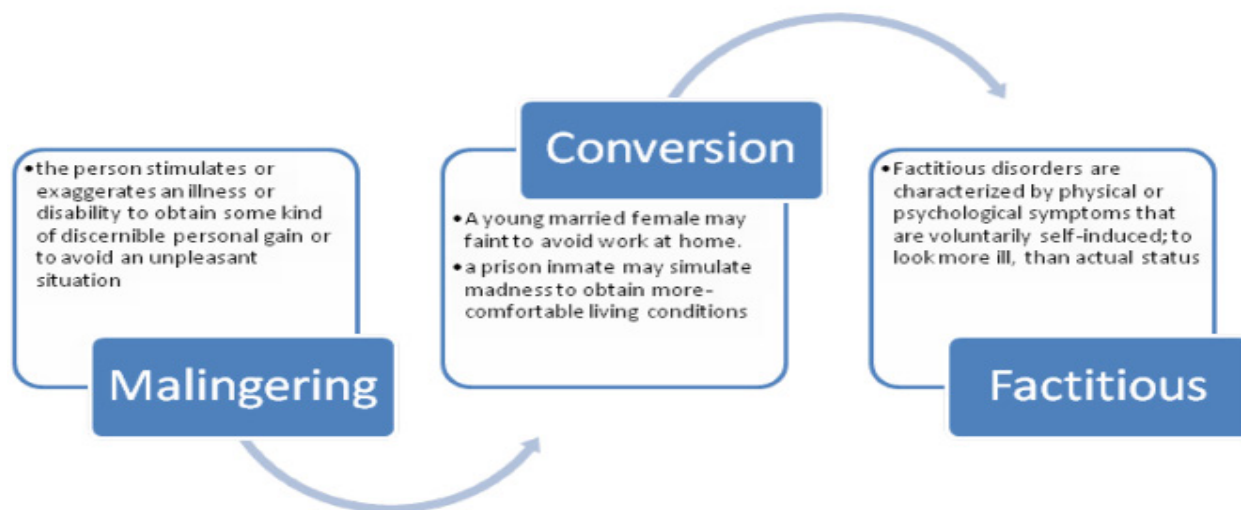


Fig. 1: Flowchart Differentiating Factitious disorder from Conversion disorder & Malingering

Munchausen's syndrome is named after Baron Munchausen, a German aristocrat renowned for his wild, unbelievable tales about his exploits and past.²

A variant of Munchausen's syndrome, known as Munchausen's syndrome by proxy, involves a caregiver fabricating or inducing illness in someone under their care.³ The term "proxy" originates from the Middle English word "procuracie," meaning

"procuracion." It refers to a person authorized to act on behalf of another or the function or authority of serving in someone else's place. In law, a proxy can be either general or special.⁴ A general proxy grants the holder broad discretion to act on behalf of someone in various matters. In contrast, a special proxy restricts the holder's authority to specific proposals or resolutions.

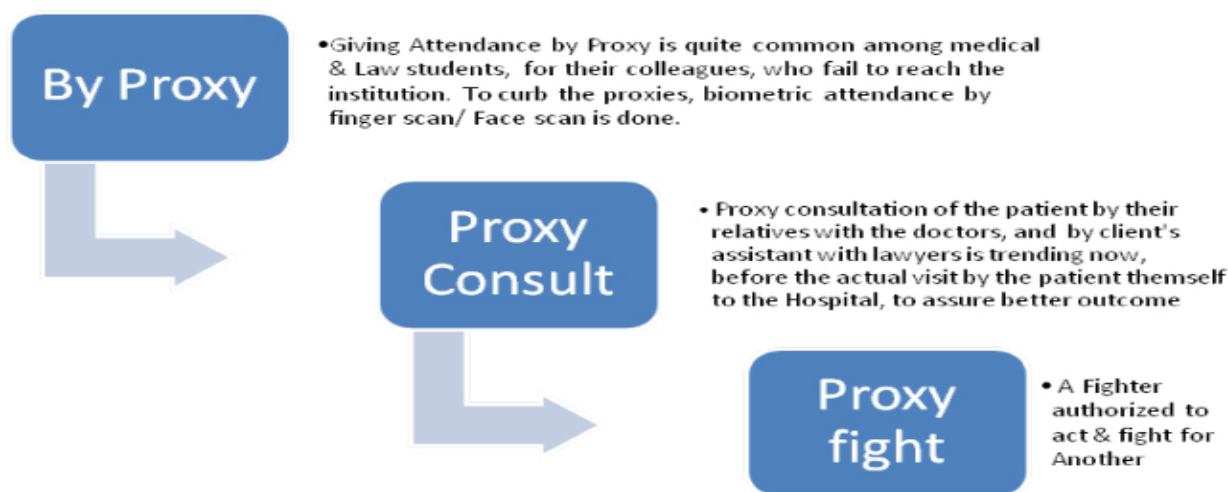
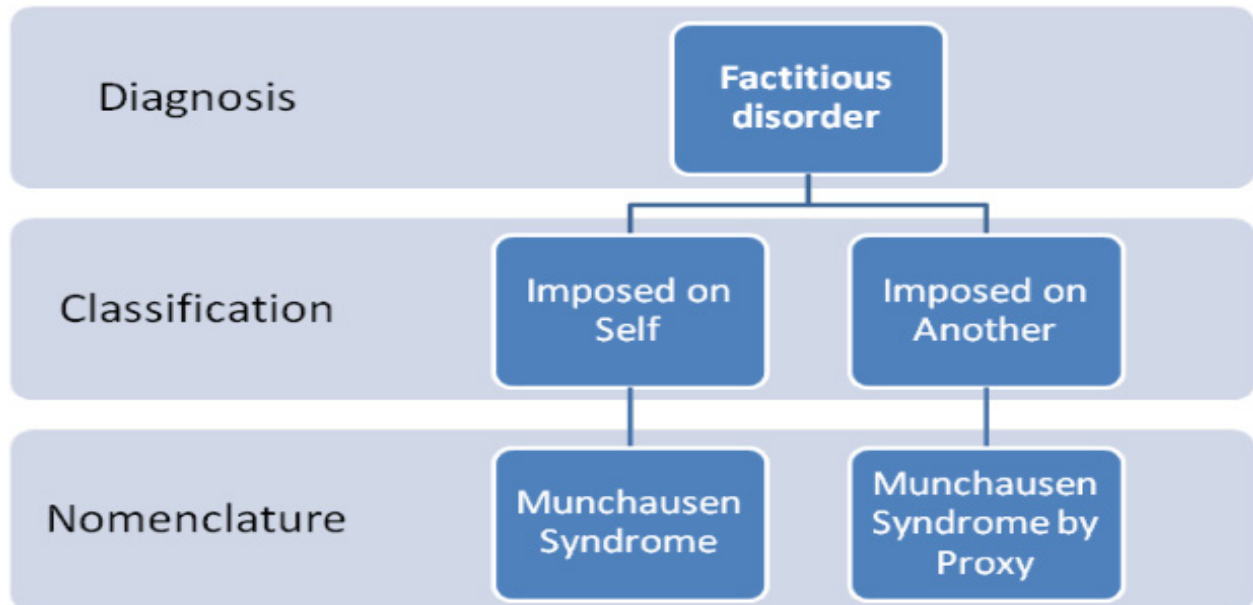


Fig. 2: Types of Proxies

Factitious Disorder Imposed on Another (FDIA), formerly known as Munchausen Syndrome by Proxy, involves a caregiver fabricating or inducing illness in someone under their care, often to

gain attention or sympathy. In certain instances, caregivers may misuse FDIA to manipulate legal outcomes, including proving medical negligence against healthcare professionals.



In such cases of Factitious Disorder Imposed on Another, the caregiver deliberately produces or exaggerates symptoms in the patient, creating a false medical history that leads doctors to unnecessary tests, treatments, and hospitalizations. When complications arise from these interventions, the caregiver might accuse the medical team of negligence. By fabricating or exacerbating the patient's condition, the caregiver can present a compelling case of medical malpractice, claiming the healthcare providers failed in their duty of care.

CASE STUDY

Real-Time Medico-Legal Case in Local Context

A man brought his 50-year-old wife to a gynaecologist, insisting on personally informing the doctor of her complaints. Despite her regular periods having stopped, he claimed she experienced heavy bleeding and severe pain every few months. He mentioned that she had been examined at a government hospital and diagnosed with a fibroid in her uterus, but the treatment she received was ineffective. He advised that she needed a hysterectomy. Continuing he said, although he could have had the surgery done for free at the government hospital, he chose to take her to a private hospital, seeking the best facilities and complication-free treatment. He emphasized that, despite his limited means, he wanted the best care for his wife.

Upon examination and investigation by the gynaecologist, it was found that she had adenomyosis and a fibroid in her uterus.

After obtaining informed consent for surgery and anaesthesia, a Laparoscopic Assisted Vaginal Hysterectomy with Bilateral Salpingo-Oophorectomy was performed, as desired and insisted. This procedure involved removing the entire uterus, along with both fallopian tubes and ovaries, through a combination of laparoscopic mobilization from above and vaginal removal. The patient's husband specifically chose this technically challenging operation due for its benefits: no large abdominal incision, minimal scarring, and quick postoperative recovery.

During the surgery, while separating the uterus from the urinary bladder, some bladder fibers were torn due to the uterus being adhered to the bladder because of adenomyosis. The surgeon repaired the tear with a stitch. The rest of the operation proceeded without incident. At the end of the surgery, the surgeon tested the bladder's integrity by filling it with a coloured dye, confirming there was no leakage. A catheter was left in the bladder to prevent distension during the postoperative period.

Complaints Start

The next day, when the surgeon visited the patient, the patient's husband confronted her,

saying, "You have injured her urinary passage. I have read your operation notes."

The surgeon explained that due to adenomyosis, the uterus was adhered to the urinary bladder, necessitating separation and resulting in some bladder muscle fibres being damaged. The damage was repaired without opening the bladder.

The husband questioned why a catheter was left in her bladder, implying it was to cover up the damage. When the surgeon began to explain, he interrupted, asking why a bottle of blood was requested.

He complained that his son had to donate blood, became weak, took leave from work, and they had to pay for it, yet the blood was not used. He accused the surgeon of a cover-up.

Despite the catheter draining properly, there was slight leakage, soiling the bed sheet. The husband created a commotion in the ward, insisting that the urinary passage was cut during surgery and demanding a urologist specialist to come.

He filed a written complaint with the medical superintendent.

Medical Progress and Recovery

As expected after a vaginal hysterectomy, the patient recovered well, resumed a normal diet, had regular bowel movements, and was able to walk. The catheter, which was to remain for two weeks, was still in place. She was advised to be discharged with the catheter, to be removed on the follow-up visit. Although the patient was willing to go home, her husband was reluctant due to the catheter. He lodged a written protest with the medical superintendent but eventually took her home after receiving assurance of proper follow-up care.

The patient was brought to the hospital on the scheduled date. The gynaecologist clamped the urinary catheter to allow the bladder to fill and tested for any leakage. After confirming there was no leakage, the catheter was removed. However, the next day, the patient was brought back to the hospital by her husband, who complained that she was leaking urine and wetting her undergarments. Upon questioning, the patient mentioned that she experienced urine leakage whenever she sneezed, coughed or strained.

Doctor's Diagnosis

The surgeon diagnosed her with stress incontinence and explained that prolonged catheter use can weaken the urethral sphincter.

With time and appropriate pelvic exercises, the sphincter's tone would return, and the incontinence would stop. She was advised to visit the hospital's physiotherapy department to learn these exercises.

The husband refused this suggestion, insisting that she be admitted and treated by a competent urologist to repair the supposed damage to her urinary bladder.

He caused a commotion in the outpatient department, demanding that the Medical Superintendent's assurance of proper care be honoured, and insisted on her admission and treatment.

Urologist's Opinion

She was admitted and referred to the hospital's urologist, who recommended descending pyelography to assess the urinary passage's function and integrity.

The test showed that both kidneys were functioning normally, with the radio-opaque dye making the urine visible in sequential radiographs as it passed through the urinary tracts.

The ureter from one kidney to the bladder was fully visualized with no leakage. The other ureter was partially visualized, showing slight dilation in the upper part and some obstruction in the lower part but no leakage.

The urinary bladder was well-filled with opaque urine and showed no signs of leakage. The urologist then performed a cystoscopy, finding one ureter opening normal and the other stretched due to a visible stitch on the bladder wall.

After filling the bladder with coloured dye and confirming no leakage into the vagina, the urologist concluded that the vaginal hysterectomy had not caused any breach in the urinary passage.

No surgical intervention was needed.

The urologist advised discharge with continued pelvic floor exercises and a follow-up review in a month or six weeks.

Legal Aspects⁵

The patient's husband interpreted the findings to suit his narrative. He extracted details from the reports and filed a written complaint, alleging negligent injury to her urinary passage. He claimed that the urologist was trying to cover up for the gynaecologist and demanded immediate surgical intervention to correct the supposed operative injury, threatening to file a criminal complaint and go to the media if his demands were not met.

The urologist explained that no surgical intervention was indicated or advisable at this stage, as the patient was still recovering from the operation. A reassessment would be done after six weeks, once the tissues had stabilized, to make an informed decision.

Cost of Care

The husband made a significant issue of her wetting her clothes. The patient had been prescribed diapers and physiotherapy. He demanded to know who would bear the cost. The medical superintendent ordered the hospital to supply the diapers and directed the physiotherapist to provide home care. The husband lodged a written protest before taking the patient home.

Before leaving, he made a scene in the ward, shouting, "See, they are providing diapers worth thousands for free. If they were not at fault, would they do so? I have forced them."

He brought the patient back after the stipulated weeks, alleging that the injury persisted, the leakage continued, and she was still wetting her clothes. He claimed that her condition had made both their lives miserable, as he had to take leave from work to care for her.

Readmission for Second Opinion

She was readmitted and, at the husband's written insistence, examined by another senior urologist. Descending pyelography was repeated, and this time, the previously un-visualized lower part of the ureter was fully visible from the kidney to the bladder, showing no breach in the urinary passage.

The surgeon also examined the bladder cystoscopically, filled it with coloured dye and tested for leakage, finding none.

However, the pyelography report noted a small collection of radio-opaque urine in the vaginal vault, despite no evidence of a breach in the urinary passage.

The patient's husband extracted this finding from the report and used it as evidence of injury and leakage, filing a written complaint with the superintendent.

He demanded that the urologist perform surgery to correct the leakage, threatening to lodge a police complaint, expose the situation in the media, and write to the Hon'ble Prime Minister and his State Chief minister, if his demands were not met.

He refused to take her home unless the urologist operated on her making his complaint now against the urologist.

Challenges faced

After obtaining informed consent, the senior urologist performed surgery. He detached the lower end of the ureter, which showed slight obstruction in the pyelography and was stretched in the cystoscopy and transplanted it to a different location in the bladder. This was a major and technically challenging operation. He also separated the bladder from the vagina, where they were in close contact, and repaired the intervening area to prevent any potential seepage from the bladder to the vagina.

The patient recovered uneventfully. Descending pyelography confirmed that the transplanted ureter was functioning well, draining urine into the bladder, which filled normally without leakage. The bladder was filled with coloured dye, and no leakage into the vagina was observed. The patient was then discharged.

Two days later, the husband returned with the patient, alleging continuous leakage and constant wetting of clothes. The patient, however, mentioned that she could not fully hold her urine, with occasional dribbling, especially when straining.

The surgeon verified this by asking her to hold her urine and then cough, which resulted in some leakage, confirming stress incontinence. The surgeon explained that unless she does regular and proper pelvic exercises to strengthen her ability to hold urine, there was nothing more he could do surgically.

Threats & Complaints

The husband demanded a written statement from the surgeon, claiming that the operation to repair the damage caused by the gynaecologist had failed. He caused a disturbance in the surgeon's chamber and the superintendent's office, parading his wife before taking her home.

He claimed, "She has urine leakage and wets her clothes. They injured her urinary passage during the operation and tried to hide it, postponing action until I forced them. By then, it was too late and didn't help. They've made her life hell, and I've lost my job. They don't realize whom they're dealing with. I'll make them pay dearly."

Complaint under CPA

He served a legal notice and, later, filed a complaint in the Consumer Forum, claiming over Rs. 90 lakhs in compensation (Smt. Chandravati

Rai and Ramkrishna Rai vs. Santokba Durlabhji Hospital and Dr. Preeti Sharma: Complaint No. 30/2010, State Consumer Disputes Redressal Commission, Rajasthan, Bench No.2, Jaipur).⁶ He created scenes in court, lamenting the poor condition of his 'incontinent' wife and himself. He obtained a report from a urologist suggesting an 'occult vesico-vaginal fistula' (VVF).

Though, on test with radiopaque dye, no fistulous tract had been identified, he diagnosed VVF on the basis of some opaque dye present in the vagina. He overlooked the fact that a trickle of urine from urethra in females would collect in the vagina. The urologist was not examined. He won a compensation of 20 lakhs.

CASE DISCUSSION

In the Indian context, this is a typical case where an over-dominant husband exploits the real and enforced medical conditions of his submissive wife, acting as a martyr for personal gain and monetary benefits—a case of Munchausen Syndrome by Proxy. This situation presents a significant medico-legal dilemma for honest senior specialists.⁷

Addressing this misuse of FDIA involves thorough investigations, recognizing red flags of fabricated illnesses, and ensuring multidisciplinary collaboration. Legal and medical professionals must work together to uncover the truth, protect patients, and hold manipulative caregivers accountable, thereby safeguarding both patient welfare and the fairness of the judicial process.

Munchausen syndrome by proxy, now known as Factitious Disorder Imposed by Another (FDIA), is a recognized mental health condition. Individuals with this disorder, often dominant and assertive, present themselves as saviours of a vulnerable, supposedly ill person.

They impose their perception of the illness on the patient, typically a relative or close associate, and publicly claim that even top medical professionals cannot diagnose or treat the condition properly.

These individuals often exaggerate the patients' symptoms and acquire extensive medical knowledge to support their claims.

To achieve his goals, he exaggerates the patient's symptoms, distorts facts, and even fabricates conditions to discredit the treating doctors.

He moves the patient from one doctor to another, none of whom finds any specific pathology to explain the alleged complaints.

He claims that the doctors are unable to diagnose the cause of the patient's suffering.

He demands sophisticated tests such as endoscopy, CT scans, MRI, and PET scans.

When these tests return negative results, he accuses the doctors of conducting unnecessary tests just to make money. He frequently disputes with the doctors, files complaints, and makes public statements to the press, emphasizing the supposed plight of the 'poor' patient.

Although he portrays himself as a selfless savior and martyr for a good cause, his actions are driven by personal gain, public image, and, where possible, financial benefits.

The Consumer Protection Act (CPA Act, 2019),⁸ in the country is often exploited for these purposes.

A Recent case highlighting these Medico-legal issues was the jackpot judgment for alleged medical negligence, providing medical compensation of 11 Crores, to the patient's husband.⁹

Law enforcement authorities, often unaware of this medical condition, tend to take such cases at face value. It is usually with great difficulty that a doctor can diagnose the condition in the caregiver, providing sufficient evidence to satisfy the authorities. Numerous cases have been reported in global literature where the individual has been prosecuted and penalized.

The characteristics of the Syndrome

In this condition, the caregiver deliberately causes or reports false symptoms in the dependent individual, often a child to seek attention, sympathy, or other emotional gratification. The caregiver may subject the person to unnecessary medical treatments, tests and hospitalizations, creating a complex and deceptive medical history. This manipulation not only endangers the victim's health but also misleads healthcare professionals, complicating diagnosis and treatment.

Munchausen's syndrome by proxy is a severe form of abuse and requires thorough investigation and intervention by medical, psychological, and legal professionals to protect the victim and address the caregiver's behavior.

Awareness and early recognition of the signs are crucial for safeguarding those affected and ensuring they receive appropriate care and support. The characteristics of the syndrome, as described by researchers,¹⁰ are as follows:

The study defines Munchausen syndrome by proxy (MSBP), more formally known as factitious

disorder imposed on another, as a form of abuse where a caregiver deliberately produces or feigns illness in a person under their care to ensure the proxy receives medical attention that gratifies the caregiver.

While well-documented in paediatric literature, few cases involving adult proxies (MSB-AP) have been reported. This study reviews existing literature on MSB-AP to provide a framework for clinicians to recognize this disorder.

Diagnostic criteria

According to Bursch B. (2020) in describing "Munchausen by Proxy: Five Core Principles" (Annals of Paediatrics and Child Health),¹¹ the following signs are important to identify in a caregiver:

- Refusal to leave the victim's side during assessments.
- Spotty, vague, or inconsistent medical history of the victim.
- Possession of medical knowledge and possibly working in a medical setting.
- Discrepancies between the caregiver's reports and those of medical personnel.
- A strong desire to be perceived as proficient in caring for the victim.
- Frequent seeking of approval and attention from medical staff.
- Unquestioning acceptance of recommendations for invasive diagnostic and surgical procedures.
- Switching doctors when confronted with doubts or resistance from medical staff.

Additionally, caregivers often seek multiple second opinions, further medical interventions to investigate rare possibilities, and additional medical procedures to achieve perfection. Thus they not only increasing the cost of care, and expect that it should be done by the Hospital complementary, but also exposes their patients to various Hospital acquired infections, by bringing them repeatedly in the OPD, when even proxy visit might be needed, to get the refill of prescriptions, but just to satisfy their ego, that their patient is still suffering, inspite of the best possible treatment administered.

Medico-legal Riddle in Rhymes on Factitious Disorder

Do you know a disorder Factitious
In which, an intention is Malicious
Instigates false allegation, Vicious
Most of Clinical History is Fictitious
That wastes Time/Money Precious
On mere assumptions, suspicious
That Treating Doctor not Judicious
Behave so Violently, like Seditious
Exceeding harmful and pernicious
Damages Relationships Propitious
As if on day & time so inauspicious
Refuses Most of Advice Capricious
Claim A Compensation, Ambitious
Inspite of no Harm, Cruel flagitious
Guess by how he acts surreptitious

CONCLUSION

Caregivers have legally misused Factitious Disorder Imposed on Another (FDIA) to prove medical negligence against doctors. FDIA, where a caregiver fabricates or induces illness in someone under their care, can be exploited to manipulate legal outcomes.

By deliberately producing or exaggerating symptoms, the caregiver creates a false medical history, leading doctors to unnecessary tests, treatments, and hospitalizations.

When complications arise, the caregiver accuses the medical team of negligence, claiming they failed in their duty of care. This deceit compromises accurate diagnoses and interventions, making healthcare providers appear negligent.

To summarize the issues: Addressing this misuse requires thorough investigations, recognizing fabricated illnesses, and ensuring multidisciplinary collaboration to protect patients and uphold the integrity of the medical and legal systems.

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Declaration of generative AI and AI-assisted technologies in the writing process: *Nil*

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An Orphan Disease Begets an Orphan Judgment

Vivekanshu Verma¹, Shri Gopal Kabra²

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Abstract

An orphan disease is characterized by its rarity, leading to a lack of interest from pharmaceutical industries and medical researchers due to limited financial viability. Consequently, the etiopathology and causative agents of such diseases remain unidentified, and specific drug therapies are unavailable. Treatment relies on the clinical experience and intuition of individual physicians, with no standardized protocol or sufficient patient data for validation. Toxic Epidermal Necrolysis (TEN) is one such orphan disease, with an incidence of 1 to 1.5 per million. It often results from severe hypersensitivity reactions to drugs or infections, causing the immune system to destroy the epidermal layer, leading to multiorgan failure and a high mortality rate. This case highlights the complexities and controversies in managing TEN. Despite numerous specialists' involvement, her treatment led to a legal battle, culminating in a significant compensation award due to alleged medical negligence.

Keywords: Negligence; Malpractice; Court; Hospital; Orphan disease; Adverse Drug Reaction; TEN; SJS; Medico-legal.

INTRODUCTION

*Success has many fathers and failure is an orphan.*¹ An orphan disease is one that is so rare that pharmaceutical industries and medical researchers take no interest in it, as they do not find it a financially viable proposition in it. As a result, the etiopathology of the disease remains unexplored, specific causative agents remain unidentified and no specific drug therapy is made available. That is why the disease is labelled an 'orphan'. The term "orphan" originates from the early 14th century, meaning "a child bereaved of one or both parents,

typically the latter." It derives from the Late Latin word "orphanus," meaning "parentless child," which also influenced Old French and Italian terms. The Latin term traces back to the Greek "orphanos," which means "orphaned, without parents, fatherless," and literally "deprived." This stems from the Proto-Indo-European (PIE) root *orbho-, meaning "bereft of father" or "deprived of free status." This PIE root also led to related terms in various languages, such as Hittite "harb-" (change allegiance), Latin "orbus" (bereft), Sanskrit "arbhah" (weak, child), Armenian "orb" (orphan), and Old Church Slavonic "rabu" (slave). Additionally, it connects to Old English "ierfa" (heir), Old High German "arabeit" (work), and Gothic "arbja" (heir), illustrating a broader historical context of hardship, change, and deprivation.²

Medically, because of non-availability of approved treatment protocol, the disease is treated by different physicians with available medicines as per their clinical experience, intuition and discretion. Besides, the disease being rare, no single physician/expert gets to see more than few patients in his entire career, to acquire sufficient experience.

Author Affiliation: ¹Associate Consultant, Medanta - The Medicity, Gurugram 122001, Haryana, ²Director Legal Affairs and Medical Audit, Santokba Durlabhji Memorial Hospital, Jaipur 302015, Rajasthan, India.

Corresponding Author: Shri Gopal Kabra, Director Legal Affairs and Medical Audit, Santokba Durlabhji Memorial Hospital, Jaipur 302015, Rajasthan, India.

E-mail: kabrasg@hotmail.com

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Even at institutional level there is not statistically significant number of patients to scientifically validate the treatment schedule followed.³ Thus, there is plethora of treatment schedules with contradictory claims.⁴

Toxic Epidermal Necrolysis (TEN) is an orphan disease

Toxic Epidermal Necrolysis (TEN) is one such a rare disease with an incidence of 1 to 1.5 per million population, thus it may be considered as an orphan disease, internationally.^{5,6,7} But, although rare, it is still a very serious condition, that courses to fatal outcome in about 30-50% of cases, inspite of best of care.⁸ It is said to be a result of severe hypersensitive reaction to some drug or an infection or combination of the two.⁹ The triggered toxicity is an immune mediated response that selectively identifies the epidermal layer of the skin and mucous membrane to be non-self and destroys it by necrolysis.¹⁰ The necrolysed cells in turn release toxins that effect body systems and cause death by multiorgan failure. Add to it the resistant

hospital strains of microorganisms that colonise the epidermis-denuded body surface areas. The oozing serum provides nutrient rich medium for the microorganisms to thrive. Fortunately, the intact active dermis does not allow entry of the bacteria in the blood stream (unlike deep burns where entire skin is shed).¹¹ However, the toxins secreted by them may seep in to damage the vital organs. Any intrusive procedure such as IV canulation and fluid infusion or nasogastric intubation, is attended with great risk of introduction of the surface bacteria inside the body. It must be understood though that all the above are probabilities, their actual occurrence uncertain and widely variable.

A CASE REPORT

Consider in this light the TEN case, treated at a reputed Hospital in Kolkata and later at another Hospital, based in Mumbai. Being an orphan disease, the patient (a clinical psychologist with her husband, himself an allopathic doctor) consulted 19 specialists - physicians, dermatologists, plastic

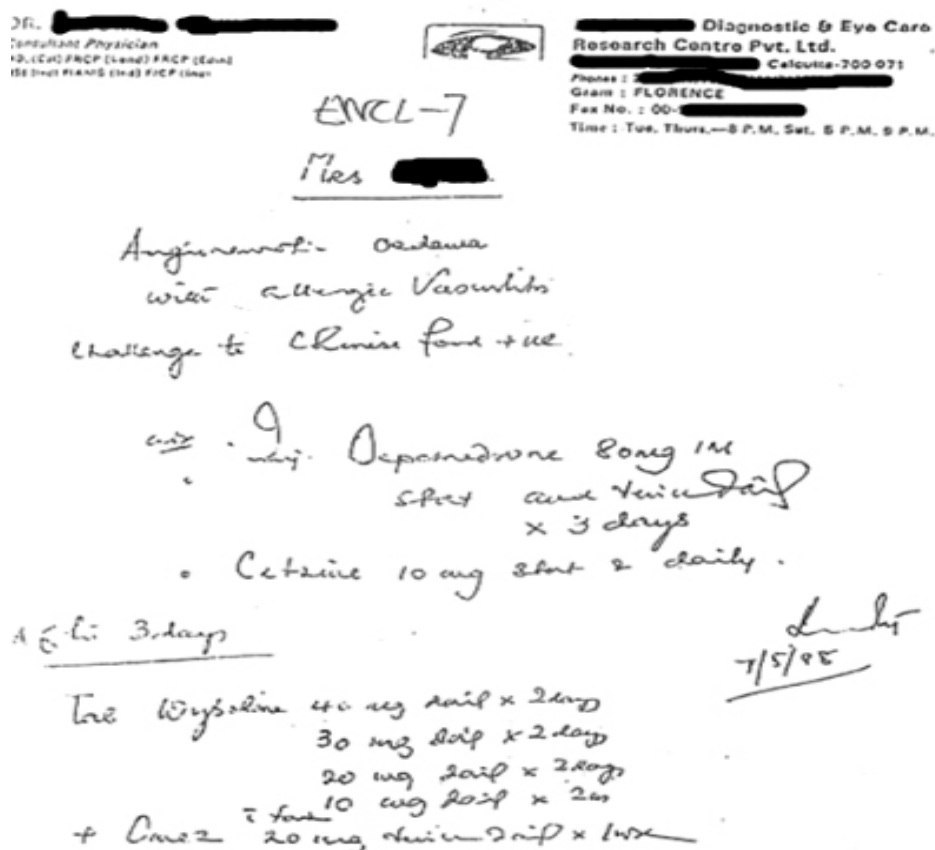


Fig. 1: Patient's Prescription for Angioneurotic oedema, for managing allergy to Chinese food

Unfortunately, there was a severe abnormal reaction to it that relentlessly progressed from some skin rashes, **to angioneurotic oedema**, to

When her condition deteriorated, Patient was admitted to Kolkata Hospital under a classmate of patient's husband. Patient's Husband was constantly present by the side of his wife, and being her primary physician supervised and maintained a tight control over her nursing and medical treatment.

[illegible]

Fig. 2: Patient's IPD Case Referral for Toxic Epidermal Necrolysis

It is he who invited 19 specialists to come and examine his wife and decided whose prescribed treatment was to be followed. He was responsible for their acts. However, when his wife died, he

betrayed good faith and alleged that all of them acted negligently and that his wife died due to 'cumulative' negligence of all the consultants.

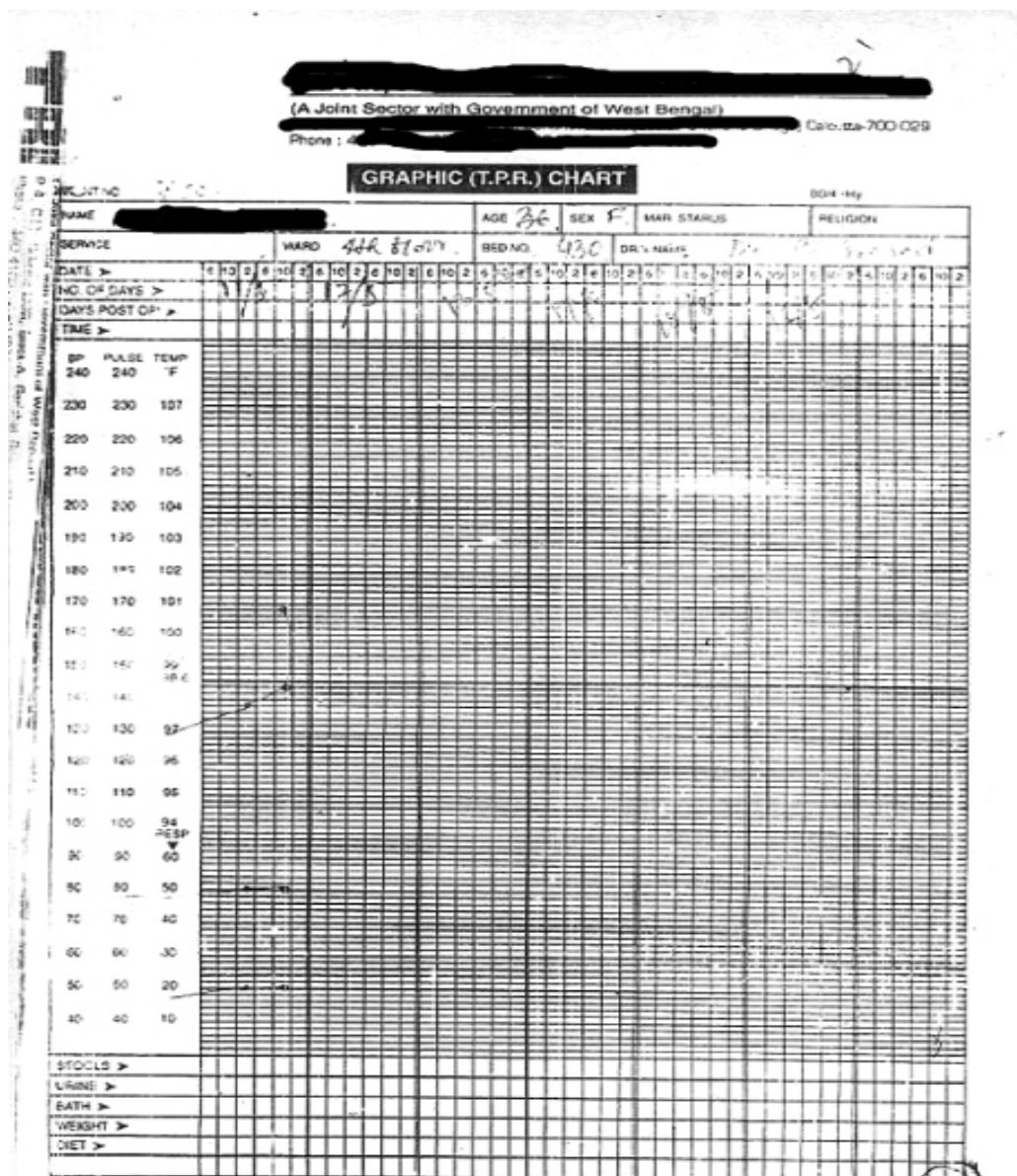


Fig. 3: Negligently filled Monitoring Chart of the TEN patient by the bedside nurses during inpatient care in IPD

When it was pointed out that he was involved and was responsible for all the treatment received by the patient, the Hon'ble Apex Court decreed it to be a 'contributory negligence' and allowed 10% rebate from the 11 crore compensation awarded.¹⁵

CASE DISCUSSION

Medical negligence is defined as the failure to provide reasonable care and skill, thereby

endangering the health or life of a patient.¹⁶ This can occur when healthcare providers do not meet the accepted standards of practice, leading to harm or worsening of the patient's condition. Negligence encompasses a wide range of errors, including misdiagnosis, incorrect treatment, surgical mistakes, or inadequate follow-up care.¹⁷ The key aspect of medical negligence is the deviation from the expected level of competence, which directly impacts patient safety.¹⁸ It underscores the critical

need for healthcare professionals to maintain high standards to prevent harm and ensure patient well-being.

Complaints

The **chief allegation** was use of steroids in high dose. And that steroid, according to some expert opinion, are not to be used for treatment of TEN (Toxic Epidermal Necrolysis). That steroid being immunosuppressant enhance the chances of infection in an already vulnerable patient.

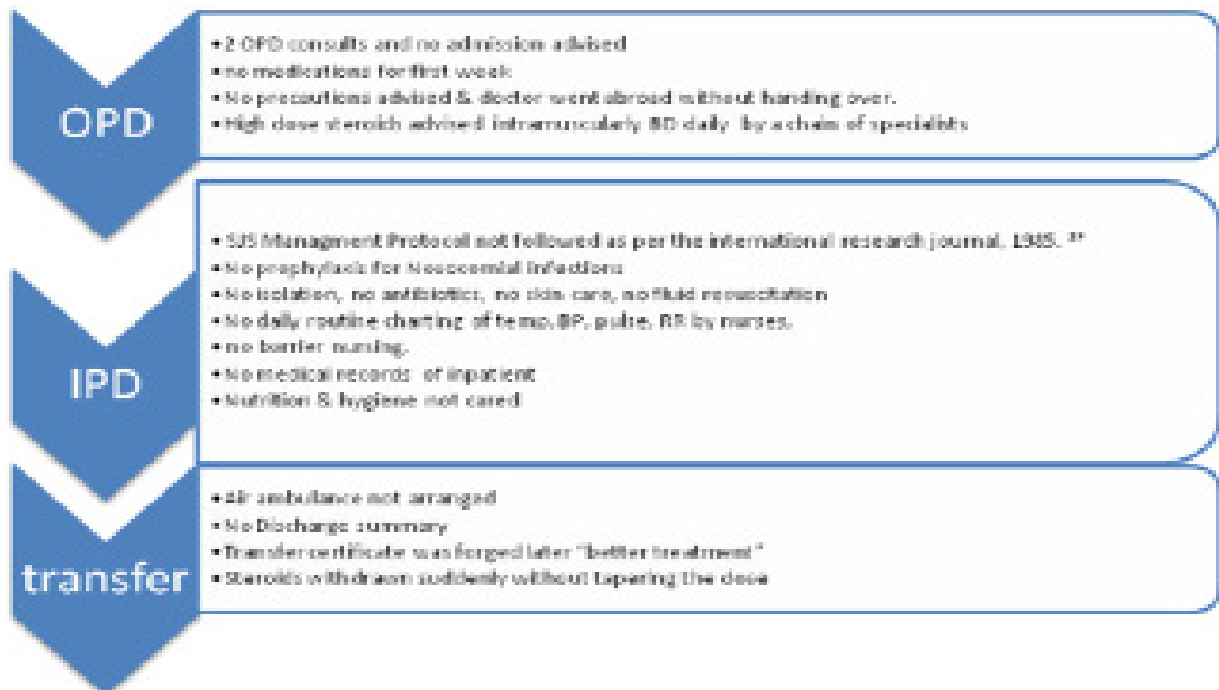
Patient's husband placed before the Apex Court expert opinions that he had procured to support his allegations. Though equal number of expert opinions were submitted by the respondent specialists to counter it, the Hon'ble Court disregarded the later as being retrospective justification to cover up their negligent acts.

Despite the controversy, corticosteroids remain a part of the therapeutic arsenal for Steven Johnson's Syndrome (SJS) and TEN, especially in severe cases. Their use is often tailored to the individual patient's condition and response to treatment. The steroids are prescribed not per se to treat SJS or TEN but to retard the deadly effect of toxins on cells.

Toxins cause death of cells by rupturing the membranes of intracellular lysosomes. Ruptured lysosomes liberate their acidic enzymes that digests the cell itself - necrolysis. (Lysosomes are called the suicidal bags of the cell). Steroids by stabilizing the lysosome membrane tend to protect the cell. This is universally true for all inflammations that cause cell death.

Steroids are frequently prescribed to provide immediate relief from inflammatory painful conditions. Imagine a patient with agonizingly painful blisters and raw skin all over her body and the relief she must have got from receiving steroids. There was very little choice giving her the usual painkillers. It was like a status asthmatics patient in suffocating agony responding to steroid therapy.

The Alleged Medical Negligence during patient care was enumerated by the patient's lawyer at different times not only in the OPD (Out Patient Department) consultation, but also in IPD (In Patient Department) care, as well as during the Patient transfer from one hospital to another, chronologically described by the prosecution, summarised in the flowchart below:



As stated earlier, TEN is a life-threatening orphan disease about which very little is known. A physician when called in to tackle the crisis in such a disease, has nothing to fall back upon except his clinical judgment. He honestly prescribes, in good faith, a treatment that he believes, in his clinical judgment, would help

tide over the crisis. His real time bed-side clinical judgment and decision cannot be substituted by a virtual decision in retrospect, by any expert, least so by a judicial officer. There is nothing to doubt good faith of, bed side, real time decision of the treating physician. He certainly cannot be faulted.

Cause of death

Besides, the legal principle of probability²⁰ and proximity²¹ to ascertain cause and effect, cannot be applied in the absence of medical evidence that the probability had manifestly actualized. In the instant case, the steroid treatment is alleged to have lowered the patient's immunity that caused infection. The steroids affect *cellular immunity* by causing disappearance of white blood cells (WBCs) from blood.²² This did not actualize in the present patient who had well documented leucocytosis till her end. Also, there was firm evidence that there was no dreaded infection of lungs, kidneys or other vital organs. There was also no wide spread infection of the skin. As documented by the Mumbai Hospital, a small patch of *Pseudomonas Pyocyanus* was healing, and the denuded epithelium was rejuvenating. The cause of death was endogenous toxins of TEN and toxins liberated from necrolysed epithelium that caused multiorgan failure.

Other allegations

There was an allegation of very poor nursing care evidenced by not noting of vital parameters in the patient record on certain dates. The Apex Court passed nasty strictures, little realising that on those days both arms, arm pits, mouth and perineum were full of blisters and raw areas of desquamating skin epithelium. How could one wrap the sphygmomanometer cuff around the arm or put a thermometer in blister filled arm pit or mouth, that also every four to six hours. Not surprisingly her physician husband, in constant attendance, prohibited it. However, he later manipulated this fact to malign the hospital.

The same was true for the intravenous infusion. Putting an indwelling intravenous cannula and giving infusions through it was hazardous because of the possibility of introducing dreaded infection in the blood stream from the body surface. The patient was taking enough fluids, liquid and semisolid feeds by mouth and was well hydrated and nutrition was well maintained, as documented by treating consultants. The riskier option of putting a nasogastric tube to feed the patient was unnecessary and inadvisable. Patient's husband was active partner to all these decisions. Being an Infection Specialist (HIV AIDS researcher at Ohio State University) he tightly controlled all such risky activities.

Apex Court Decision

Yet, Patient's husband managed to get a judgment from the Apex Court awarding him, a

foreign resident of Indian origin, a compensation of 11 crores for cumulative negligence of 26 top doctors of the country that caused death of his wife (the deceased patient) by the deadly orphan disease of Toxic Epidermal Necrolysis (TEN).

In this case, multiple specialists were consulted, but her condition deteriorated, leading to her death. Her Husband accused the specialists of negligence, leading to a landmark legal battle. The Supreme Court awarded patient's life partner, substantial compensation, citing cumulative negligence despite conflicting expert opinions on steroid use in TEN treatment. This judgment highlighted the complexities and controversies in managing orphan diseases and the challenges faced by the medical profession in treating such rare and life-threatening conditions. A decision that orphaned the medical profession of the country.

As written by William Gaddis in his Novel's Opening line, Novel titled: *A Frolic of his Own* (1994),²³ Opening Line: "Justice? You get justice in the next world; in this world you have the law." The title *A Frolic of his Own* is from a judicial decision about vicarious liability in *Joel v. Morison*.²⁴ If the driver was deviating from his master's implied commands while conducting his master's business, the master would be liable for his actions. However, if the driver was on a personal errand, unrelated to his master's business, the master would not be liable. The doctrine of respondent superior holds that a principal is liable for an agent's negligence only when the agent is acting within the "course of his employment" at the time of the accident. Although the agent was conducting the employer's business, he momentarily deviated from his master's implied command.

Recent Updates in Criminal Law on Death due to Medical Negligence

The Bharatiya Nyaya Sanhita (BNS) 2023,²⁵ prescribes a lesser punishment for doctors causing death by negligence compared to other offenders. However, under the BNS, imprisonment is mandatory if found guilty. Section 106 of the BNS, corresponding to Section 304A of the Indian Penal Code (IPC), deals with 'causing death by negligence' and imposes a punishment of up to five years of either simple or rigorous imprisonment along with a fine. Specifically, Section 106 of the BNS states that if a registered medical practitioner causes death by negligence while performing a medical procedure, the punishment shall be two years of imprisonment with a fine. The law clarifies that a "registered medical practitioner" refers

to an individual holding a medical qualification recognized under the National Medical Commission Act 2019,²⁶ with their name listed in the National Medical Register or a State Medical Register under that Act. This distinction in punishment reflects the unique position and responsibilities of medical professionals in the context of legal accountability.

CONCLUSION

An orphan disease, such as Toxic Epidermal Necrolysis (TEN), is rare and lacks interest from pharmaceutical companies and researchers due to limited financial incentives. This results in unexplored etiopathology, unidentified causative agents, and no specific drug therapies. Physicians rely on their clinical experience and discretion for treatment, leading to varied and unvalidated treatment protocols. TEN, is a severe condition resulting from hypersensitive reactions to drugs or infections, causing immune-mediated destruction of the epidermis and mucous membranes, often leading to multiorgan failure and a high mortality rate. This judgment highlighted the lack of standardized protocols and the complexities in treating rare diseases, ultimately questioning the liability in medical practice. The case reveals the systemic issues in managing orphan diseases and the need for clear guidelines to protect both patients and healthcare providers.

Conflict of Interest: *Nil*

Declaration of generative AI and AI-assisted technologies in the writing process:

During the preparation of this work the author utilized the 'Chat GPT' in order to improve the language and readability. After using this tool/service, the author reviewed and edited the content as needed and take full responsibility for the content of the publication.

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A Suicidal Case of Fresh Water Drowning: A Case Report

Richa Choudhary¹, Pradeep Kumar Yadav², Rishabh Yadav³,
Madhulika Shukla⁴, Vivek Pathak⁵

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Abstract

Introduction: Drowning is the process of experiencing respiratory impairment from submersion/immersion in liquid. Drowning is a violent form of asphyxial death and the manner of death may be accidental, suicidal & homicidal. In cases of suicidal drowning medico-legal examination may be very difficult, especially regarding differentiating between suicide, accident or homicide, and natural death. In the present case scenario, we discussed a case of suicidal fresh water drowning with many positive findings suggestive of a suicidal death.

Keywords: Drowning; Fresh Water Drowning; Salt Water Drowning; Asphyxia; Frothy discharge; Washerwoman hand.

INTRODUCTION

Drowning is the process of experiencing respiratory impairment from submersion/immersion in liquid. Outcomes are classified as death, morbidity and no morbidity. Drowning is a serious worldwide and preventable injury problem, especially in low and middle-income countries.¹ In 2019, an estimated 236000 people died from drowning, making drowning a major public health problem worldwide. In 2019, injuries accounted for almost 8% of total global mortality. Drowning is the third leading cause of unintentional injury death, accounting for 7% of all injury-related deaths. The Global report on

drowning (2014) shows that age is one of the major risk factors for drowning. This relationship is often associated with a lapse in supervision. Globally, the highest drowning rates are among children 1-4 years, followed by children 5-9 years.¹ World Health Organization (WHO) had adopted the new definition at the first world congress on drowning in 2002 as "Drowning is the process of experiencing respiratory impairment from submersion or immersion in liquid." World Health Organization (WHO) described drowning is one of the top five causes of death in children aged between 1 and 14 years and one of the ten leading causes of death in children and young people aged between 1 and 24 years.² Rate of drowning death is 82 cases per day in India (Accidental deaths and suicidal deaths in India 2013 statistics, National crime records bureau 2014). National Crime Records Bureau (NCRB) data 2014 stated that, out of 316,828 cases of unnatural deaths, 29,903 cases (9.4%) died due to drowning in which 23,166 cases (77.47%) were male, 6736 cases (22.52%) were females and 1 case (0.0033%) was transgender; this was the second most common cause of unnatural death after road traffic accidents (53.4%). Amongst the total number of drowning deaths, near about 11,884

Author Affiliation: ¹Professor, ²Assistant Professor, ³Senior Resident, ^{4,5}Junior Resident, Department of Forensic Medicine & Toxicology, Dr. Ram Manohar Lohia Institute of Medical Sciences, Lucknow 226010, Uttar Pradesh, India.

Corresponding Author: Richa Choudhary, Department of Forensic Medicine & Toxicology, Dr. Ram Manohar Lohia Institute of Medical Sciences, Lucknow 226010, Uttar Pradesh, India.

E-mail: drricha_c@hotmail.com

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cases (39.74%) died due to accidental fall in water, 7426 cases (5.6%) died due to suicidal drowning.²

CASE SUMMARY

An identified dead body of a male, Hindu, 34 years old was brought for a medico-legal autopsy at S.R.N. Hospital Mortuary, Moti Lal Nehru Medical College, Prayagraj. The body was recovered by Police from Ganga River. The deceased was wearing blue shirt and yellow pyjama. All clothes of the deceased were soaked in water and had mud stains. Deceased was thin built (Fig. 1). On

External examination, rigor mortis was developed in whole of the body and post-mortem lividity was more prominent over the back and was fixed. There was oozing of blood and frothy discharge from the mouth and nasal orifice (Fig. 2). Eyes were closed and pupils dilated. Cyanosis was marked in nails of both hands and feet. Washerwoman's hands appearance was marked on hands and feet (Fig. 3). Chest had marked marbling. Internally, all organs and mucosa were congested. Trachea was mud and froth filled. Lungs were congested and oozing of froth was present from cut section of lungs (Fig. 4). Right side of the heart was dilated. Stomach along with intestine was filled with water.



Fig. 1: Body after removing the body bag.



Fig. 2: Blood and frothy discharge from mouth and nasal orifice



Fig. 3: Washerwoman's feet



Fig. 4: Oozing of froth and blood from lungs on cut section

Opinion:

The findings of frothy discharge from the mouth and nose, congestion of the lungs with froth on sectioning, and water-filled stomach and intestines strongly suggest that the deceased died from drowning. The presence of washerwoman's hands indicates prolonged immersion in water. The dilation of the right side of the heart and the overall congestion of internal organs are consistent with asphyxia due to drowning. There is no evidence of external or internal injuries that could suggest an alternate cause of death.

Cause of Death:

The cause of death is asphyxia due to drowning. The findings are consistent with the deceased having been submerged in water, leading to the inhalation of water, respiratory failure, and subsequent death.

DISCUSSION

Deaths due to drowning are generally due to suicide or accidental in nature. Suicide by drowning is not uncommon in India. About 30,000 people drown in India annually and the number could be even bigger than this.³ Hypoxia is the starting point for all morbidity and mortality and it must remain the focus of treatment. Unexpected submersion triggers breath-holding and a struggle to surface. Reflex inspiratory efforts lead to hypoxemia by either laryngospasm or aspiration. The quantity of fluid aspirated, rather than the composition, determines subsequent pulmonary derangement. Aspiration of 1–3 ml/kg body weight of either salt or fresh water compromises the integrity of pulmonary surfactant leading to: alveolar collapse, atelectasis, noncardiogenic pulmonary oedema, intrapulmonary shunting and ventilation-perfusion mismatch (V/Q), resulting in acute respiratory distress syndrome (ARDS).⁴ In the present case, history was suggestive of suicide. In the post mortem examination, no external injury was found and body was not tied. All findings were suggestive of death due to drowning. There was marked cyanosis, froth and blood mixed discharge from mouth and nose, trachea filled with mud, stomach and intestine filled with water while internally all organs were congested and lungs showed oozing of blood and froth from cut section. Despite a number of drowning risk factors being common in India and numerous media sources reporting on drowning

cases, little empirical data are available on the burden or context of drowning-related morbidity or mortality within the country. A better understanding of the context and trends of fatal and non-fatal drowning is required to inform appropriate prevention strategies.⁵ Contrary to the general perception, swimming skills have no role in the prevention of drowning. Rather, public awareness about direct supervision of children in and near water bodies, and restricting their access to water bodies by fencing of ponds, lakes, and rivers, and availability of safety/rescue devices, etc., need to be emphasized.⁶

CONCLUSION

Most of the drowning cases are accidental in nature. Drowning induced acute respiratory failure is frequent condition that can be fatal. Covering wells, using doorway barriers and playpens, fencing swimming pools and otherwise controlling access to water hazards greatly reduces water hazard exposure and risk. Community-based, supervised childcare for pre-school children can reduce drowning risk and has other proven health benefits. Teaching school-age children basic swimming, water safety and safe rescue skills is another approach. But these efforts must be undertaken with an emphasis on safety, and an overall risk management that includes safety-tested curricula, a safe training area, screening and student selection, and student-instructor ratios established for safety.

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