उत्तर प्रदेश आयुर्विज्ञान विश्वविद्यालय

सैफई, इटावा (उ0प्र0) – 206 130

संo: 105/यूपीयूएमएस/सीoएमoएसo(26)/2026–27 दिनांक: 12 मई, 2026

सेवा में,

समस्त विभागाध्यक्ष, क्लीनिकल,
उ0प्र0 आयुर्विज्ञान विश्वविद्यालय,
सैफई, इटावा।

महोदय,

अवगत कराना है कि कार्यालय आदेश संख्या–114/यूपीयूएमएस/सीएमएस/2025–26 दिनांक 07 मार्च, 2026 के द्वारा चिकित्सालय में आकस्मिक दुर्घटनाओं एवं मेडिको–लीगल प्रकरणों से सम्बन्धित मरीजों के समुचित प्रबंधन, अभिलेखीकरण एवं अभिलेखों के रख–रखाव हेतु गठित समिति द्वारा एस0ओ0पी0 तैयार कर पत्र संख्या–26/इमरजेंसी/यूपीयूएमएस/2026–27 दिनांक 27.04.2026 के माध्यम से उपलब्ध कराई गयी है।

उक्त तैयार एस0ओ0पी0 को मा0 कुलपति महोदय के अनुमोदनोंपरान्त तत्काल प्रभाव से चिकित्सालय में लागू किया जाता है।

संलग्नक–एस0ओ0पी0।

(प्रो0 (डा0) एस0पी0 सिंह)
मुख्य चिकित्सा अधीक्षक

प्रतिलिपि: निम्नलिखित को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित–

1. कुलसचिव।
2. चिकित्सा अधीक्षक।
3. उप चिकित्सा अधीक्षक–01 एवं 02, ट्रामा एवं इमरजेंसी।
4. प्रभारी–वेबसाइट को इस आशय से कि पत्र के साथ संलग्नक को विश्वविद्यालय की वेबसाइट पर अपलोड करने का कष्ट करें।
5. मुख्य चिकित्सा अभिलेख अधिकारी।
6. प्रमुख निजी सचिव को, मा0 कुलपति महोदय के अवलोकनार्थ।
7. कार्यालय प्रति।

(प्रो0 (डा0) एस0पी0 सिंह)
मुख्य चिकित्सा अधीक्षक

उत्तर प्रदेश आयुर्विज्ञान विश्वविद्यालय, सैफई, इटावा (उ0प्र0)

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पत्रांक: 26 / इमरजेन्सी / उ0प्र0आयुर्0वि0 / 2026-27 दिनॉक:- 27 / 04 / 2026

सेवा में,

मुख्य चिकित्सा अधीक्षक
उ0प्र0 आयुर्विज्ञान विश्वविद्यालय,
सैफई, इटावा (उ0प्र0)

विषयः– कार्यालय आदेश संख्या–114 / यूपी0यू0एम0एस0 / सी0एम0एस0 / 2025–26 दिनांक 07.03.2026 के अनुपालन में मेडिको–लीगल केस प्रबंधन हेतु मानक संचालन प्रक्रिया (SOP) प्रस्तुत करने के संबंध में।

महोदय,

उपर्युक्त विषयक कार्यालय आदेश के अनुपालन में सादर अवगत कराना है कि चिकित्सालय में आकस्मिक दुर्घटनाओं एवं मेडिको–लीगल प्रकरणों से संबंधित मरीजों के समुचित प्रबंधन, अभिलेखीकरण एवं अभिलेखों के रख–रखाव हेतु गठित समिति द्वारा "Standard Operating Procedures (SOP) for Medico-Legal Work at UPUMS, Saifai" तैयार कर ली गई है। तथा विस्तृत विचार–विमर्श उपरांत सर्वसम्मति से उक्त SOP को अंतिम रूप प्रदान किया गया है। समस्त 07 सदस्यों के हस्ताक्षरयुक्त SOP की मूल प्रति इस पत्र के साथ संलग्न कर सादर आपकी सेवा में प्रस्तुत है।

अतः उक्त SOP का अवलोकन कर अनुमोदित करने का कष्ट करें।

संलग्नकः– मेडिको–लीगल कार्य हेतु SOP की मूल प्रति – 01 अदद।

समिति सदस्य

(कैलाश श्रीवास्वत)
मुख्य चिकित्सा अभिलेख अधिकारी

(श्रीमती लवली जेम्स)
चीफ नर्सिंग ऑफिसर

(डॉ0 विश्वदीपक)
चीफ मेडिकल ऑफिसर

(डॉ0 राजेश वर्मा)
प्रो0(जू0ग्रेड), जनरल सर्जरी

27/04/2026
(डॉ0 वेदान्त कुलश्रेष्ठ)
एसो0 प्रो0, फोरेन्सिक मेडिसिन

(डॉ0 प्रदीप गुप्ता)
एसो0प्रो0 ऑर्थोपेडिक्स

(डॉ0 प्रशांत कुमार मिश्रा)
प्रो0एण्ड इंचार्ज, ट्रॉमा एण्ड इमरजेन्सी

Uttar Pradesh University of Medical Sciences
Saifai, Etawah, Uttar Pradesh

Standard Operating Procedures (SOP)

for

Medico-Legal Work

at UPUMS, Saifai

Standard Operating Procedures (SOP) for Medico-Legal Work at UPUMS, Saifai

Prepared by:

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5. Dr. Vishwadeepak- Chief Medical Officer (NFSG).
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CONTENTS

MEDICO-LEGAL CASE (MLC)

a. Definition of Medico-legal Case

Cases wherever attending doctor after taking history and clinical examination of the patient thinks that some investigation by law enforcing agencies are essential so as to fix the responsibility regarding the case in accordance with the law of land.

b. Duty of Registered Medical Practitioner (RMP) in MLC

- To save the life of a patient and to give primary treatment is the foremost responsibility. Make sure that process of MLC registration and documentation should be appropriate and is going on simultaneously.
- Registered medical practitioner (RMP) i.e. Emergency Medical Officer (EMO)/Assistant Emergency Medical Officer (Asst .EMO) at Emergency should decide whether the case is to be registered as MLC or not.
- **Consent** of family members **NOT** required for registration of a case as MLC.

c. Categorization of Various Medico-Legal Cases: The cases that should be considered medico-legal cases are as follows:

1. Cases of trauma including road traffic accidents, self-fall which include fall from height, trauma caused by and to someone which is suggestive of the commission of an offense (assault), mass disasters like industrial accidents or stampedes and domestic violence.

2. Cases of burns including industrial or domestic fire accidents, self inflicted or by others.

3. Cases of electrocution caused either accidentally or by self, lightning deaths.

4. Cases of asphyxia like hanging, manual or ligature strangulation, smothering, choking by a foreign body, drowning, suffocation (carbon monoxide poisoning).

5. Cases of sexual assault (rape), including consensual sexual contact between minors of both genders.

6. Cases requiring age estimation related to any offenses/ as required by the legal authorities except for age categorization for participating in sporting activities.

7. Cases of suspected or confirmed criminal abortion indicating involvement of quacks.

8. Cases of poisoning like consumption of organophosphates, rat-killer, vegetable poisons, corrosive acid, drug overdose, or unknown poisons.

9. Cases of animal attacks like dog bites, bull attacks, etc.

10. Cases of snake bites either venomous or nonvenomous, scorpion, wasps or bee stings.

11. Cases (Accused) brought by police for medicolegal examination and evidence collection involved in crimes like assault or sexual offenses.

12. Cases [Under Trial Person (UTP)/convicted person] sent through the court order from prison to hospital for treatment of existing disease or medicolegal examination.

13. Cases of torture in police custody perpetrated by police or by others.

14. Cases of brought dead with history not clear and suspecting foul play or underlying cause of death is unknown.

15. Death of a female due to unnatural cause, married for less than 7 years duration (underlying reason with a dowry-related issue in history or others).

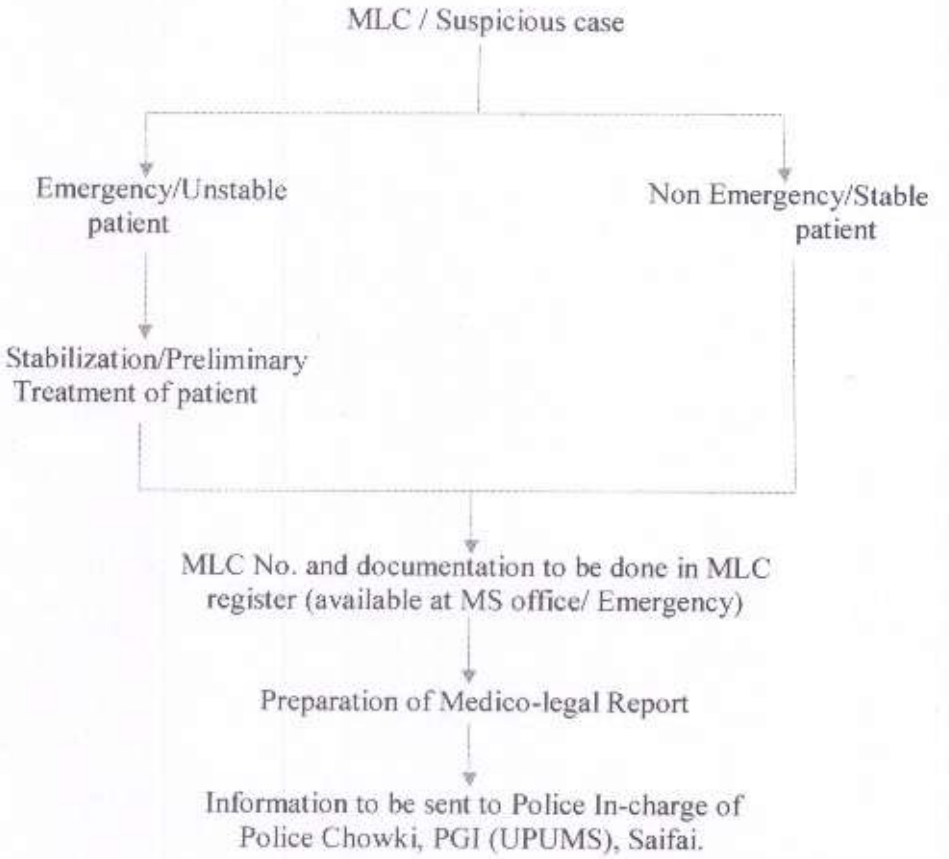
16. Cases of unknown patients presenting in an unconscious state where the underlying cause could not be elicited.

17. Any other cases falling under the MLC cases like medical negligence or related to legal implications.

Note: The cases falling under the above categories should be labelled or marked as Medico-legal Cases by the medical officer on duty who is dealing with the case in Casualty and he/she is required to intimate nearest jurisdictional Police station (PS) or police outpost of the hospital without any delay.

d. Work Flow for Medico-legal Cases brought to Emergency in UPUMS, Saifai

- All patients/cases are given hospital Registration No. in Emergency.
- From OPD/IPD if a case is Medico—legal, information must reach Emergency and MLC number is allotted.



e. Protocol for filling the Medico-legal Report (MLR) is as under.

I. Preliminary

a) Information to the police should be sent in proper form.

b) Take Consent for examination of the patient on the MLR Form. If less than 12 years or brought unconscious take the consent of the guardian/accompanying person /Police Constable.

c) The Preliminary entries should be complete.

d) Two Identification Marks have to be noted preferably on accessible parts.

e) Time and date of examination should be indicated clearly. If the patient is under observation to decide the severity of injury/condition, same should be indicated in Medico-legal Report.

f) Take proper history in patient/guardian's own words and document correctly.

g) In cases of poisoning and other cases, General Examination and other signs should be mentioned in detail. Use standard formats wherever possible.

h) Details of police constable who brought the case should be noted.

II. Examination:

Mention the examination of injuries in detail (type, site, size, shape, colour, age of injury, direction, nature, duration). Use diagram wherever necessary.

III. Opinion

a) Opinion should be crisp and to the point. Articles preserved should be enumerated.

b) Prepare three copies of the document, one copy is kept at Emergency room, other as hospital record and the Original is given to the police.

c) Full name of the doctor should be written in block letters below his signature. Stamp of Faculty/SR/JR/MO or of the department should also be affixed.

d) Corrections, if any, should be initialized and abbreviations are to be avoided.

e) Words should be distinct and legible and the report should be serially numbered.

GENERAL GUIDELINES

Important guidelines and Instructions for dealing with Medico-Legal Cases (MLC) are as following-

1. When any MLC patient is referred from another hospital with proper MLC documents, there is no need of making new MLC registration. (Police intimation should be given to the nearest PS or police outpost for tracing purposes)

2. When any MLC patient is referred from another hospital without proper MLC documents, a fresh MLC should be made.

3. If a case is brought several days after the incident, it should be reported and findings to be noted regarding the present condition of the patient.

4. MLC can be written and signed by (EMO)/Asst.EMO /Faculty. Wherever possible, Faculty member should sign along with SR/JR if the report is prepared by them. This will facilitate court procedure when SR/ JR are not available at UPUMS, Saifai and cannot be contacted. In such cases the faculty may be required to give evidence in the court.

5. All treatment papers, investigation reports etc. to be labeled as MLC & record should be maintained for future Medico-legal use (same may be required by court for the case).

6. When Medico-legal case is to be discharged from hospital, police should be informed and information should also be sent to the Emergency to make an entry in Medico-legal register.

7. Belongings of the Medico-legal cases should be handed over to the police officer and proper receipt must be obtained in every case.

8. If a Medico-legal case is not admitted, entry shall be made in the MLC Register.

9. Consent for emergency surgery, when no attendant is available can be given by the Medical Superintendent of the hospital.

10. If (EMO)/(Asst .EMO) in Emergency does not register a case as MLC but the treating doctor thinks that the case is a MLC then it should be recorded as MLC and can be considered as MLC at any point of time, even if missed initially.

11. Any non MLC case can be converted to MLC at any stage depending upon specific allegations. **Note:** Backdating of MLC should not be done if the patient comes for MLC registration and MLC was not done before due to any reason. The MLC number should be generated on that date and time.

12. In case of taking away a patient or body of a Medico-legal case forcibly by the attendant, the Medical Officer should record the same on the file of the patient and Police Station/Post of the area and security staff should be informed immediately.

13. X rays, blood reports, microbiological, pathological investigations etc in Medicolegal case should be labelled as MLC & kept along with other documents of the case.

Brought Dead (DOA) Cases – Registration & Legal Procedure

1. General Provisions – Applicable to All Brought Dead Cases:

1.1 All Brought Dead cases shall be mandatorily registered as a Medico-Legal Case (MLC).

1.2 OPD/Emergency Registration shall be done in every case and a separate MLC number shall be generated.

1.3 In every case, details of the Next of Kin (NOK) – full name, father's/husband's name, relationship with the deceased, permanent address, and active mobile number – shall be mandatorily recorded.

1.4 A self-attested photocopy of the NOK's valid photo ID proof (Aadhaar/Voter ID/Driving License/Passport) shall be attached with the registration slip and retained in records. The NOK's signature/thumb impression shall be obtained on the registration slip.

1.5 The Duty Medical Officer shall mandatorily prepare and attach the Death Declaration and CPR Note in the case file.

2. Additional Provisions for Unknown Brought Dead Cases:

2.1 If NOK is not available, the name, designation, badge number, police station, district, and mobile number of the police official/personnel bringing the deceased shall be recorded and their signature obtained.

2.2 Photography and fingerprints of the deceased shall be preserved as per rules for identification purposes.

3. Additional Provisions for Known Brought Dead Cases:

3.1 An OPD slip with complete details shall be prepared based on the available identification of the deceased.

3.2 First-degree blood relative shall be given priority for recording as the NOK.

4. Mandatory Legal Procedure:

4.1 MLC intimation for every Brought Dead case shall be sent immediately to the concerned police station in the prescribed format and the acknowledgement receipt shall be kept in records.

4.2 The complete case file including Death Declaration, CPR Note, and MLC shall be mandatorily uploaded on the CRS Portal within 24 hours for death registration.

4.3 Postmortem examination shall be mandatory in all Brought Dead cases. The body shall not be handed over to relatives under any circumstances without legal permission from Police/Magistrate.

4.4 An unidentified body shall be preserved in the mortuary for 72 hours as per rules. If unidentified thereafter, disposal shall be done as per procedure.

4.5 All original records shall be permanently preserved by the MRD and shall be made available to the competent court/investigating agency on demand.

5. Legal Basis:

This procedure is in compliance with the relevant provisions of the Bharatiya Nagarik Suraksha Sanhita, 2023 [Sections 39, 196 & 199]; Clinical Establishments (Registration and Regulation) Act, 2010; U.P. Clinical Establishments Rules, 2016; and Registration of Births and Deaths Act, 1969.

6. Fixation of Responsibility:

The Duty Medical Officer (DMO), Emergency In-charge, Registration Counter Staff, Medical Records Department (MRD), and Security In-charge shall be individually and collectively responsible for strict compliance of this procedure.

7. Penal Provisions:

In case of violation/non-compliance of the above instructions, disciplinary and penal action shall be initiated against the concerned officer/staff under Sections 199 & 202 of BNSS, 2023 and relevant service rules.

RECORD KEEPING

1. Always prepare three copies of the Medico-legal report, one is kept as hospital record, other is kept in the office of Medical Superintendent and the original is given to police after getting proper receipt.

2. Hospital records or file of MLC should be kept as confidential in Record Section till judgment by the court of law pertaining to the case has been issued (Minimum 10 years, for practical purposes, no time limit).

3. If Medico-legal report has already been issued, then duplicate Medico-legal report should not be issued unless specifically requested by the police in writing or by the order of the court.

4. The responsibility of safe custody of the MLR/MLC register will rest upon the person to whom it has been issued (Nursing in-charge/OPD in-charge/any other, as the case may be).

5. Filled up MLR register must be handed over to the Medical Record Section for safe keeping.

6. No unauthorized person shall have access to the medico legal records (including medico legal register) of the hospital without the written permission of Medical Superintendent or any other authorized officer.

Supplying Medico-legal report in original or copy to individuals other than the investigating agency

a) Medico-legal report is a confidential and not a public document. It should be issued only to the police after proper requisition letter or on order of the court of law.

b) Original MLR or its copy or print shall not be given to any other interested or disinterested third party (even the patient or his/her relatives) or to any other department of the hospital for any reason (such as to keep as a record or to perform any investigation or any procedures), providing copy of MLR or original MLR has nothing to do with patient management protocol in the hospital, however MLR number and date of preparing MLR shall be notified in the patient case record to make aware treating doctors regarding their medico legal duties while managing such patients.

Belongings of the medico-legal cases

The belongings/valuables of medico-legal cases (Alive/Dead) shall be handled as following:

i. The belongings shall be handed over to the relatives of the deceased,

if available (after verifying the nature of the relationship) in the presence of police. Care should be taken not to handover any belongings which can be a potential piece of evidence. or

ii. The police officer dealing with the case.

iii. All belongings along with the body of deceased shall be sent to the mortuary, as it is, for autopsy after due noting of belongings in patient case sheet.

In all such cases, the proper receipt from relatives and police must be obtained.

Investigations in Medico legal cases

a) A separate request for investigation shall be made by the doctor who is preparing MLR mentioning all details of medico legal case including MLR number of the case.

b) MLC CT/X-rays/Investigation forms should be filled in triplicate by the on duty JR/SR/Faculty and are sent to the radiology department. This form must bear MLC seal, patient ID sticker and seal of concerned doctor/ department referring the patient.

c) Reporting of MLC x-rays is an important legal duty of the hospital and thus opinion in MLC X-ray request form should be finalized in time and should sent back to the doctor making a request.

d) The opinion in the x-ray report should be legible. It is desirable that the radiologist should give a clear opinion about the x-ray findings.

Preservation of other material/evidence

a) This is one of the most important medico-legal duties as the material/evidence is required in the investigation of a case.

b) If the sample(s) are collected during preparation of MLR in Emergency/IPD/OPD, it shall be the duty of doctor preparing MLR to preserve, pack, seal, label and hand it over to the concerned police official along with sample seal.

c) When the sample(s) are taken in IPD/ICU/OT at later stage during the course of treatment, it shall be the duty of treating doctor to collect sample(s), pack, seal, label and hand it over to the concerned police official along with sample seal.

d) All such preserved samples must be kept in safe custody under lock and key until they are handed over to the concerned police official.

e) Acknowledgement of receiving of preserved samples by police official should be taken and documented.

f) If preserved samples/ articles are not collected by the concerned police station in a timely manner, the SSP, Etawah should be informed about the backlog with a copy of letter to Medical Superintendent, UPUMS, Saifai.

Correction of Errors in Records

In medico-legal cases, correction of errors in records made during treatment shall be done on the basis of an application from a first blood relative and a duly notarized affidavit (when both patient and relative are available). **Legal Basis: Indian Evidence Act, 1872 (Sections 35, 114), Indian Penal Code, 1860 (Sections 177, 182)**

Change in Patient Identity/Name

Change in patient's name, age, address, or any other identity-related details shall be made only on the basis of a written order/recommendation of the concerned Sub-Divisional Magistrate/District Magistrate. **Legal Basis: Code of Criminal Procedure, 1973 (Sections 154, 174)**

Issuance of Reports/Documents

Injury Report, Supplementary Report, BHT, and other medico-legal documents shall be issued only to the Hon'ble Court, Police (Investigating Officer), or competent authority, through lawful means, on the basis of a summons/authorized letter. **Legal Basis: Code of Criminal Procedure, 1973 (Sections 91, 92), Indian Evidence Act, 1872 (Section 65)**

Information to Insurance Company and Confidentiality

For settlement of insurance claims, necessary documents shall be sent directly to the insurance company by registered post upon receipt of the insurance company's request letter and prescribed fee. Conversation/records between patient and doctor shall not be made public. **Legal Basis: Consumer Protection Act, 2019, Information Technology Act, 2000**

Completion and Submission of File to MRD

The concerned doctor shall compulsorily prepare the complete file (MLC/BHT) of each medico-legal patient and submit it to MRD with signature. **Legal Basis: National Medical Commission (formerly Medical Council of India) – Professional Conduct & Ethics Regulations, 2002**

***To ensure uniformity, transparency, and accountability in examination, injury report, police intimation, evidence preservation, record custody, and legal compliance for Medico-Legal Cases (MLC) received in Emergency-**

1. Injury Report & Police Intimation (PI)

1.1 The Injury Report of every MLC patient shall be prepared by the Duty Medical Officer/CMO preferably within a maximum of 2 hours of arrival.

1.2 The report shall mandatorily bear the signature, name, designation, and official seal. Any cutting/overwriting shall be attested by short initials of the Duty Medical Officer/CMO.

1.3 Police Intimation (PI) shall be sent preferably within a maximum of 1 hour in the prescribed format to the concerned Police Station, and an entry with date and time shall be made in the MLC Register.

1.4 The Injury Report shall be prepared in three copies—(i) Original for Investigating Officer, (ii) Copy for Case File, (iii) Copy for MRD record. Acknowledgement receipt from the Investigating Officer shall be obtained and attached to the Case File.

1.5 Photo-documentation of injuries shall be done by the Duty Medical Officer/CMO and digital photographs shall be preserved in a sealed envelope/CD along with the Case File. In cases of female/minor patients, examination and photography shall be done only after written consent and in the presence of female staff.

2. Evidence Preservation & Seizure

2.1 All physical evidence (clothes, weapons, bullets, biological samples, vomitus, gastric lavage, etc.) shall be packed with seal, label, and signature of the Duty Medical Officer/CMO and handed over to the Investigating Officer against acknowledgement.

2.2 In case of non-availability of police, the evidence shall be kept in sealed condition in the secure locker of Emergency and an entry with date and time shall be made in the MLC Duty Register.

3. Patient Transfer & Chain of Custody

3.1 Safe transfer of the MLC patient to the concerned ward shall be the responsibility of the Duty Medical Officer/CMO.

3.2 Transfer of Case File shall be done only through authorized staff/Ward Boy.

3.3 The Ward In-charge shall provide acknowledgement with date, time, name, designation, and signature, which shall be recorded by the CMO in the MLC Register, thereby establishing a proper Chain of Custody.

3.4 Transfer of female patients shall be done only in the presence of female staff.

4. Record Management at Ward Level

4.1 Completion of Case Sheet, Treatment Chart, Nursing Notes, and related records shall be ensured by the concerned Consultant.

4.2 Within 48 hours of Discharge/LAMA/Death, the MLC file shall be deposited in MRD by the Ward In-charge and the MRD receipt number shall be entered in the Ward's Admission-Discharge Register.

4.3 Information of Discharge/LAMA/Death (PI) shall be issued by the Consultant as per rules and attached to the Case File. In case of death, Death Summary and Death Certificate shall also be prepared and uploaded on the CRS Portal within 24 hours.

5. Special Circumstances

5.1 In case of patient absconding (ABSCOND), the Ward In-charge shall immediately issue PI and inform the concerned Police Station and make entry in records. A copy of the PI shall be attached to the Case File.

5.2 If an MLC file is lost/damaged, a police report shall be lodged by the Ward In-charge within 24 hours at the concerned Police Station and intimation in writing shall be given to the Superintendent and MRD. Duplicate file shall be prepared only after written approval of the Superintendent.

6. Confidentiality & Issue of Documents

6.1 All information, records, and photographs related to MLC shall remain confidential.

6.2 Records shall be issued only to the Hon'ble Court/Investigating Officer/Competent Authority on lawful basis of summons or authorized letter. Every issue shall be entered in the MRD Issue Register.

7. Fixation of Responsibility

7.1 CMO/Duty Medical Officer: Responsible for timely Injury Report, PI, evidence preservation, safe transfer, and custody acknowledgement.

7.2 Ward In-charge: Responsible for receipt of Case File, its safety, depositing in MRD within 48 hours, and reporting of ABSCOND/missing file.

7.3 Consultant: Responsible for completeness of records, Discharge/LAMA/Death procedure, and issuing related PI.

7.4 MRD: Responsible for permanent physical and digital preservation of MLC records and timely production before competent authority.

8. Legal Basis

This procedure is in compliance with the relevant provisions of the following Acts and Rules:

1. Bharatiya Nagarik Suraksha Sanhita, 2023 – Sections 39, 176, 196, 199, 202

2. Indian Evidence Act, 1872 – Sections 35, 65, 114

3. Code of Criminal Procedure, 1973 – Sections 91, 92, 174

4. Clinical Establishments (Registration and Regulation) Act, 2010

5. U.P. Clinical Establishments Rules, 2016

6. Registration of Births and Deaths Act, 1969

7. Information Technology Act, 2000

8. National Medical Commission – Professional Conduct & Ethics Regulations, 2002

9. Compliance & Penal Provisions

9.1 Compliance with the above provisions by all concerned is mandatory.

9.2 In case of any violation, disciplinary and penal action shall be initiated against the concerned officer/staff under Sections 199 & 202 of BNSS, 2023 and relevant Service Conduct Rules. In case of willful or repeated violation, action up to suspension or termination from service may be taken.

DEATH IN MEDICO-LEGAL CASE

1. Whenever there is a death in a Medico-legal case, the police officer should be informed. Death certificate should not be issued in Medico-legal cases and body must be sent for Medico-legal autopsy after filling the appropriate format.

2. **All cases brought dead to the Institution**: In all the cases brought dead, MLC is registered, police is informed and body is sent to Mortuary of UPUMS, Saifai after filling the appropriate form.

3. Cause of death certification in cases other than MLC can only be issued by Emergency Medical Officer (EMO)/ Assistant EMO/ treating doctor who has attended the patient in his last illness and is sure about the cause of death.

MEDICO-LEGAL AUTOPSY IN MLC

1. Autopsy is done in the Autopsy Block (Post-mortem House) of UPUMS, Saifai by the Department of Forensic Medicine and Toxicology.

2. Autopsy is conducted on all days from 9 am to 5 pm.

3. Cold storage facility in the event of death in Medico-legal case is available in the mortuary. Any case for autopsy, if brought to mortuary beyond working hours can be kept in cold storage.

DYING DECLARATION

1. In case of impending death in MLC, the Medical Officer should immediately ask the police officer on duty in writing to call a magistrate. If there is no time to call a magistrate, the dying declaration should be recorded by the doctor himself in the presence of another doctor or staff member.

2. The primary duty of a doctor in dying declaration is to ascertain and document Compos Mentis (alert mental state) of the patient at the beginning and at the end of the statement.

SPECIFIC CASES

(Important Points to be remembered)

i. Rape/Sexual Assault Cases (suspect and survivor)

a) Be polite to the suspect and Victim.

b) Always take consent. In case of suspect, medical examination can be done even if he declines to give consent.

c) Take a detailed history and document it in person's own words.

d) Examine them properly and fill the prescribed form for suspect and survivor.

e) Always provide information regarding psychiatric counselling to the Victim.

f) All male and female Registered Medical Practitioners are eligible to examine the Victim.

g) Always examine the Victim in presence of female attendees. Victim can have a female acquaintance/relative with her if she wants.

h) In case of children, sedative or analgesic may be needed for examining genitalia in painful condition.

i) Do not delay the examination. Exact time of commencement and completion must be noted in the report.

j) Never attempt to undress the Victim for examination. Convince her to undress herself.

k) Never pass judgmental remark or comments that might appear unsympathetic.

l) Denying examination of the rape Victim is unlawful.

m) Following instructions to be followed depending on the circumstances:-

- Take history whether she has taken bath and changed the clothes.
- With cotton swab collect vaginal secretion from posterior fornix and prepare 4 slides.
- Place loose pubic hair in a labeled envelope.
- Obtain fingernail scrapings.
- Preserve garments for seminal and blood stain.
- Collect blood sample (15 ml).
- If age estimation required then refer to the Department of Forensic Medicine.
- If clothes are to be preserved and sealed, always provide proper clothing or inform the relatives to bring one set of clothes.
- Treatment of Victim should be given when needed.

ii. Fire Arm Injuries

a) Bullets, lead shots etc recovered from the wounds or body in fire arm injury should be air dried then put in a bottle(s), padded with cotton, documented sealed and handed over to the police.

b) Always try to mention about the entry and exit wound.

c) Always take X-Ray of the track or whole body.

d) Never pick the bullet using a metal/ toothed forceps, rather use fingers or rubber tipped forceps.

e) Never wash the bullet.

iii. Criminal Abortion

a) Give proper treatment.

b) Always perform examination of clothes and take blood sample.

c) Proper history and documentation.

d) If patient dies, send for Medico-legal autopsy.

e) Preserve the remains of product of conception (POC) for Chemical Analysis and DNA Analysis if required.

f) Clothes are recorded and preserved

g) If she refuses to make a statement, the doctor should not pursue the matter. He must consult a senior professional colleague.

iv. Burns:

a) Proper history and documentation.

b) Give primary treatment.

c) Extent and degree of the burns to be noted.

d) Make a proper sketch showing areas involved and state in percentage.

e) Inflammable agents on the body/cloth are recorded and preserved.

f) Dying declaration if required should be taken especially in young married females.

v. Hanging/Strangulation

a) Ligature mark- Describe its position, nature, width, direction and extent whether complete or incomplete.

b) Ligature material in-situ should be cut away from the knot so as not to disturb the knot. Then the cut ends and knot have to be secured with threads separately.

c) Ligature material should be preserved.

d) Examination of ligature material in respect of its nature, position, type of knot, circumference of loop, length of short and long free ends, foreign bodies and stains.

vi. Poisoning

a) Give primary treatment. Take proper history.

b) History of Substance consumed, amount consumed, when, where & number of people consumed.

c) Proper documentation of history, treatment and articles sealed.

d) Send properly sealed, labelled samples of vomitus /stomach wash and blood sample to the police and make record wherever possible.

e) Never allow the entry of unauthorized person near the Victim in a case of homicidal poisoning.

vii. Injury Cases

a) Give primary treatment.

b) Examine and record all injuries properly.

c) Proper documentation.

d) Opinion should include injury by type of weapon (sharp/blunt), manner (Self-inflicted, homicidal, accidental) and duration of injury.

viii. Drunkenness

a) Take proper history and document correctly in the form provided.

b) Consent should be taken but under Sec 53 (1) CrPC, examination of an accused can be carried out by a doctor at the request of the police, even without his consent.

c) Examine properly and collect urine, blood sample in a proper way.

d) Mention the starting and ending time of examination.

e) Never use rubber stopper in collection of sample. Use screw — capped bottle.

f) Spirit must not be used for cleaning the skin and the syringe must be free from any trace of alcohol. Chlorhexidine can be used instead.

ix. Child Abuse

a)All children should be approached with extreme sensitivity and their vulnerability recognized and understood.

b)Give proper treatment.

c)Usually medical examination should be done within 24 hrs or as soon as possible.

d)Consent from parents/guardians in written should be taken.

e)Consent from child in form of verbal, expressed or written is to be taken.

f) Record the child's weight, height and sexual development,

g)Take proper history and document it correctly.

h)Always prepare the child by explaining the examination and showing equipment; this has been shown to diminish fears and anxiety. Encourage the child to ask questions about the examination.

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

j) Psychiatric counselling is advised.

k)Never put undue pressure on a child for medical examination, if he/she denies even after convincing. But in conditions requiring medical attention, such as bleeding or a foreign body is suspected, consider sedation or a general anaesthesia.

l) Avoid unnecessary painful and invasive procedures.

PRESERVATION OF SAMPLES

1. All samples should be properly labelled (Hospital registration no, Pt's name, age, date, police station), sealed (seal available at MS office) and signed by doctor who prepared the MLC with his designation & full name.

2. All samples requiring toxicological, ballistic, DNA, blood grouping analysis to be sealed and handed over to the police to be sent to specialized labs like forensic science laboratory.

APPENDICES

Appendix 1

As per Section 116 of the Bhartiya Nyaya Sanhita, 2023 (Previously S. 320 IPC), following kinds of hurt are designated as "GRIEVOUS"-

1. Emasculation (applicable only for males).
2. Permanent privation of the sight of either eye.
3. Permanent privation of hearing of either ear.
4. Privation of any member or joint.
5. Destruction or permanent impairing of the powers of any member or joint.
6. Permanent disfiguration of the head or face.
7. Fracture or dislocation of a bone or tooth.
8. Any hurt which endangers life or which causes the victim to be in severe bodily pain or unable to follow his ordinary pursuits for a period of 15 days.

Appendix 2

PENAL PROVISIONS RELATED TO MEDICAL PRACTICE

- S.39 CrPC (S. 33 BNSS)- Every person aware of the commission of, or of the intention of any other person to commit any offence punishable under IPC shall forthwith give information to the nearest Magistrate or police officer of such commission or intention.
- S. 52 IPC [S. 2 (11) BNS]- Nothing is said to be done in good faith which is done without due care and attention.
- S. 174 IPC (S. 208 BNS)- Non Attendance, in obedience to summon from court. (6 months imprisonment).
- S.175 IPC (S. 210 BNS)- Omission to produce the documents to public servant by person legally bound to produce it. (6 months imprisonment).
- S. 176 IPC (S. 211 BNS)- Omission to give notice or information to public servant by person legally bound to produce it. (1 month imprisonment).
- S.177 IPC (S. 212 BNS)- Furnishing false information. (Upto 6 months Imprisonment)
- S.179 IPC (S. 202 BNS)- Refusing answering to public servant authorized to question. (Upto 6 months imprisonment).
- S. 191 IPC (S. 227 BNS)- Giving false evidence.
- S.192 IPC (S. 228 BNS)- Fabricating false evidence.
- S.193 IPC (S. 229 BNS)- Punishment for false evidence (upto 7 years imprisonment).
- S.194 IPC (S. 230 BNS)- Giving or fabricating false evidence with intent to produce conviction of capital offences. (upto 10 years imprisonment).
- S.197 IPC (S. 234 BNS)- Issuing or signing false certificate. (upto 7 years imprisonment).

- S.201 IPC (S. 238 BNS): Causing disappearance of evidence of offence or giving false information to screen offender. (upto 10 years imprisonment).
- S.202 IPC (S. 239 BNS): Intentional omission to give information of offence. (upto 6 months imprisonment).

Annexures (Forms)

INFORMED CONSENT

I ..... aged.....hereby give my consent and authorize Dr..... and his/her team to perform the treatment/procedure at .....Hospital, ... (place) on ..... (date).

My doctor has explained me the following in the language that I can understand:

1. The nature of treatment/procedure:

   _____

   _____

2. The benefits of having the above treatment procedure, and alternate ways of treating my condition. The alternatives to this procedure include:

   _____

   _____

3. The reasonably foreseeable risks of the treatment:

   _____

   _____

Further, I consent for the retaining any tissue/substance that is removed during the procedure for investigation purposes or disposing the same in accordance with customary clinical practice.

I have signed this consent voluntarily without any undue influence/pressure.

Signature of patient:

Place & Date:

Signature & Name of Doctor

Reg. No. & Designation

Date, Time, Place

Signature of witness:

Relationship to patient:

NOTE:

- The format may be modified as per individual requirements or experiences of Hospitals.
- The format should be in English as well as local language.
- The consent should refer to a specific procedure. Obtaining 'blanket' consent does not have legal validity.
- In case of minor or mentally ill patients, consent should be taken from the guardian. Accordingly, changes may be made in the initial part of format mentioning the guardian's name and relation with the patient.

MEDICAL CERTIFICATE OF CAUSE OF DEATH

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

Name of the Hospital:.....
I hereby certify that the person whose particulars are given below died in the hospital in ward No. ..... on .....at.... AM/PM

Name of the Deceased					For Statistical use
Sex	Age at Death				
	If 1 year or more, age in Years	If less than 1 year, age in Months	If less than one month, age in Days	If less than one day, age in Hours	
1. Male 2. Female					
CAUSE OF DEATH				Interval between onset & death approx.	
I					
Immediate Cause State the disease, injury or of)complication which caused death, not the mode of dying such as heart failure, asthenia, etc.	(a) ..... Due to (or as a consequence				
Antecedent Cause Morbid conditions, if any, giving rise of)to the above Cause, stating underlying conditions last	(b) ..... Due to (or as a consequence (c)				
II					
Other significant conditions contributing to the death but not related to the disease or conditions causing it	.....				
Manner of death: 1. Natural 2. Accident 3. Suicide 4. Homicide 5. Pending investigation	How did the injury occur?				
If the deceased was a female, was the death associated with pregnancy? 1. Yes 2. No If yes, was there a delivery? 1. Yes 2. No.					
Name and signature of the Medical Practitioner certifying the cause of death Date of Certification.....					

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

Certified that Shri/Smt/Kum.....S/W/D/of .....
resident of ..... was admitted to the hospital on ..... and expired on .....
at... .....A.M/P.M

Doctor.....
.....
Signature and address of Medical Practitioner/
Medical attendant with Registration No.

POLICE INTIMATION

Name of the Hospital/Clinic

To: The PSI,

..... Police Station

Sir,

Mr./Ms./Mrs. ..... s/d/w of .....
aged.....years is treated as in-patient / out-patient in this hospital with history of
....
on .....at.....(am/pm) at place ..... (given by patient/bystander).

This is for your information and necessary action.

Date & Time of intimation: Signature & Seal of MO

Place

WOUND CERTIFICATE/ INJURY REPORT

MLC No.: Name of Hospital:

Name: OP/IP No.:

Sex: Date of admission:

Age: Date of discharge:

Address:

Brought by:

Consent:

Identification marks: i)

ii)

History: [as stated by patient (if conscious) or accompanied person]

Details of injuries:

Above person was examined by me on ..... (date) at ..... AM/PM and found the following injuries:

Sl. No.	Type of injury/ Nature of Injury	Dimensions	Location	Time since injury (stage of healing)	Whether Simple/ grievous	Kind of weapon/object (blunt/sharp)	Weapon dangerous or not	Remarks (if further examination required)

Investigations done (X-ray and Laboratory findings):

Opinion:

i. The injury Nos. ..... are Grievous and the injury Nos..... are Simple in nature.
ii. The above injuries are fresh /..... days/ weeks/ months old.
iii. The above injuries are caused by Blunt/Sharp /.....object or weapon.

Place & Date:

Signature of doctor & Seal

FORMAT FOR WEAPON EXAMINATION

To:

The Investigating Officer,
..... Police Station.
Sub: Examination on the weapon – reg.
Ref: i) Your letter No. ..... dated .....
ii) ..... P.S., Cr. No. ..... u/s .....
iii) Wound / Postmortem report No. ..... of.....
Hospital/Institution.

With reference to above, received a sealed article on ..... (date) from Mr/Ms.....P.C. No. ..... of ..... P.S. The article was examined on ..... (date) at..... am/pm, the details of which were given below.

1. Name of weapon:
2. Type of weapon:
3. Weight:
4. Description of the weapon: *(Made of metal/wood/any other material. In sharp weapons, the blade, handle, hilt, edges/ margins etc. should be described.)*

5. Dimensions: *(Length x Breadth x Thickness. In case of round objects like rod, length & circumference should be measured.)*

6. Stains/ Foreign body present on the weapon, if any:

Opinion:
I am of the opinion that the external injury Nos. .....mentioned in the wound / postmortem report could / could not be caused by the above examined weapon.
After examination, the weapon was marked/signed, packed, sealed & handed over to PC No. ..... Mr/Ms..... of.....police station.

Place: Signature & Name of doctor
Date & Time: Official seal

Receipt of weapon & report:

 # The format for weapon examination varies from weapon to weapon, hence needs to be modified accordingly.

AGE ESTIMATION CERTIFICATE

Received requisition from (Police /Magistrate) ..... for the age estimation of the person (name)..... through letter No....., bearing the Crime No. ..... u/s ..... of .....police station.

Name of the person:

Age as alleged by the person:

Sex:

Address:

Date, time and place of examination:

Name of female attendant present (while examining female person):

Consent:

Identification marks:

1.

2.

History of the alleged incident:

General Physical Examination (Built and appearance):

Height : ..... cm

Weight .....kg

Facial hair:

Axillary hair:

Pubic Hair:

Voice:

Menarche:

Development of breast:

External genitalia development:

Onset of puberty (Date of menarche & Regularity of menses):

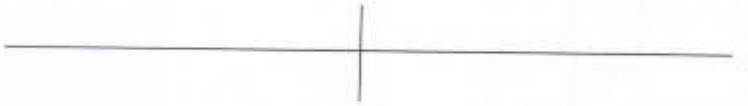
Opinion on age from GPE:

Dental examination:

i) Total number of teeth present:

- Temporary teeth:
- Permanent teeth:

ii) Dental chart of the individual:



Opinion on age from Dental examination:

Radiological examination:

X-ray of Joint	X-ray No. & date	Observations

Opinion on age from Radiological examination:

Final Opinion on Age:

On perusal of General physical examination, Dental and Radiological examinations, I am of the opinion that the above examined person is above ..... years and below..... years of age.

Place:

Signature of Doctor

Date:

Name, Designation, Reg. No.

REPORT ON MEDICO-LEGAL EXAMINATION OF SURVIVOR (VICTIM) OF SEXUAL VIOLENCE

1. Name of the Hospital ..... OPD No. ..... IP No. .....

2. Name ..... D/o or S/o (where known).....

3. Address.....

4. Age (as reported) ..... Date of Birth (if known).....

5. Sex (M/F/Others) .....

6. Date and Time of arrival in the hospital .....

7. Date and Time of commencement of examination.....

8. Brought by ..... (Name & signature)

9. MLC No. .....Police Station.....

10. Whether conscious, oriented to time, place and person.....

11. Any physical/intellectual/psychosocial disability .....(Interpreters or special educators will be needed where the survivor has special needs such as hearing/speech disability, language barriers, intellectual or psychosocial disability.)

12. Informed Consent/refusal:

I..... D/o or S/o.....hereby give my consent for:

a) Medical examination for treatment Yes / No

b) This medico legal examination Yes / No

c) Sample collection for clinical & forensic examination Yes / No

I also understand that as per law the hospital is required to inform police and this has been explained to me. I want the information to be revealed to the police: Yes / No.

I have understood the purpose and the procedure of the examination including the risk and benefit, explained to me by the examining doctor. My right to refuse the examination at any stage and the consequence of such refusal, including that my medical treatment will not be affected by my refusal, has also been explained and may be recorded. Contents of the above have been explained to me in .....language with the help of a special educator/interpreter/support person (circle as appropriate). If special educator/interpreter/support person has helped, then his/her name and signature.....

Name & signature of survivor or parent/Guardian/person in whom the child reposes trust in case of child (<12 years) ..... with date, time and place.

Name & Signature/ thumb impression of witness ..... with date, time and place.

13. Marks of identification

(i) .....

(ii) .....

Left thumb Impression

14. Relevant Medical/Surgical history

a. Onset of menarche (in case of girls): Yes / No Age of onset.....

b. Menstrual history: Cycle length and duration .....LMP .....

c. Menstruation at the time of incident: Yes / No

d. Menstruation at the time of examination: Yes/ No

e. Was the survivor pregnant at time of incident: Yes/No.

If yes, duration of pregnancy .....wks

f. Contraception use: Yes/No. If yes, method used: .....

g. Vaccination status – Tetanus / Hepatitis B (vaccinated/not vaccinated)

15. History related to sexual violence:

A. About sexual violence:

- Date, time, & location of incident:
- Number of Assailants (name, sex, approximate age, any relationship with the survivor):
- Description of incident in the words of the narrator: survivor/informant (specify name and relation to survivor):

B. Type of physical violence used, if any:

C. Emotional abuse or violence (insulting, cursing, belittling, terrorizing), use of restraints, used or threatened the use of weapons or objects, verbal threats, luring (sweets, chocolates, money, job):

D. Drug/alcohol intoxication. If yes, whether sleeping or unconscious at the time of the incident:

E. If survivor has left any marks of injury on assailant:

F. Details regarding sexual violence: (Write Yes/No/Don't know against each item)

- Penetration by penis/fingers/object/any other body parts into vagina, urethra, anus or mouth:
- Ejaculation (into body orifices or any other part):
- Oral sex by assailant on survivor:
- Forced masturbation by self/of assailant:
- Touching, fondling, kissing, licking or sucking any part of survivor's body (if yes, describe):
- Condom/Lubricant/Object used (if yes, describe):
- Post-incidence, has the survivor changed clothes/undergarments, cleaned clothes/ undergarments, bathed, douched, passed urine/stools, rinsing of mouth/brushing/vomiting:
- Time since incident:
- Any vaginal/anal/oral bleeding/discharge prior to or after the incident of sexual violence:
- Any painful urination/ painful defecation/ fissures/ abdominal pain/ pain in genitals or any other part since the incident of sexual violence:

16. General Physical Examination.

a) Pulse..... BP..... Temp.....

b) Resp. Rate..... Pupils.....

c) Any observation in terms of general physical wellbeing of the survivor.....

17. Examination for injuries on the body, if any:

[Note the pattern of injuries sustained during an incident of sexual violence, which may show considerable variation.

This may range from complete absence of injuries (more frequently) to grievous injuries (very rare)] (Note the Injury type, dimensions, site, shape, colour, swelling, signs of healing, simple/grievous)

18. Local examination of genital parts/other orifices

A. External Genitalia: Record findings and state 'NA' where not applicable.

- Urethral meatus & vestibule:
- Labia majora & Labia minora:
- Fourchette& Introitus:
- Hymen: • Perineum:
- Any other: If victim is male/other gender: Examine the Penis, Scrotum, Testes, Clitoropenis, Labioscrotum.

B. Per Vaginum / Per Speculum examination:

(Should not be done unless required for detection of injuries or for medical treatment)

C. Anus and Rectum:

(Bleeding/ tear/ discharge/ oedema/ tenderness)

D. Oral Cavity:

(Bleeding/ tear /discharge/ oedema/ tenderness)

19. Systemic examination:

20. Sample collection/ investigations for hospital laboratory/ Clinical laboratory:

- Blood for HIV, VDRL, HbsAg
- Urine test for Pregnancy
- Ultrasound for pregnancy/internal injury
- X-ray for Injury

21. Samples Collection for Forensic Science Laboratory:

a) Debris collection paper:

b) Clothing evidence where available:

(To be packed in separate paper bags after air drying)

c) Body evidence samples as appropriate:

(Swabs from stains on the body, Scalp hair (10-15 strands), Head hair combings, Nail scrapings & clippings (both hands separately), Oral swab, Blood for grouping & drug/alcohol intoxication (plain vial/vacutainer), Blood for alcohol level (Sodium fluoride vial/vacutainer), Blood for DNA analysis (EDTA vial/vacutainer), Urine for drug testing, Any other (tampon/sanitary napkin / condom / object)

d) Genital and Anal evidence:

Matted pubic hair, Pubic hair combings (mention if shaved), Cutting of pubic hair (mention if shaved), Two swabs each from vulva, vagina & anus (for semen examination & DNA testing), Vaginal smear (air dried) for semen examination, Vaginal washing, Urethral swab, Swab from glans of penis / clitoropenis. [Swab sticks for collecting samples should be moistened with distilled water]

22. Provisional medical opinion:

I have examined (name of survivor) ..... M/F/Other.....aged..... reporting (type

of sexual violence and circumstances)..... days/hours after the incidence. My findings are as follows:

- Samples collected (for FSL):
- Samples collected (for hospital laboratory):
- Clinical findings:
- Additional observations (if any): The Opinion is kept pending awaiting the above laboratory reports.

23. Treatment prescribed:

(STI prevention treatment, Emergency contraception, Wound treatment, Tetanus prophylaxis, Hepatitis B vaccination, Post exposure prophylaxis for HIV, Counseling, Other)

24. Date and time of completion of examination ..... This report contains ..... number of sheets and.....number of envelopes.

Signature & Name of Examining Doctor

Place: Seal of Examining Doctor

25. Final Opinion (After receiving Lab reports)

Findings in support of the above opinion, taking into account the history, clinical examination findings and Laboratory reports of ..... bearing identification marks described above, ... hours/ days after the incident of sexual violence, I am of the opinion that:

a) There are signs suggestive of vaginal/anal/oral intercourse with/without force. (Presence/absence of genital &/or physical injuries; Lab report positive for semen)

b) There are signs suggestive of vaginal/anal/oral intercourse under the influence of drugs/alcohol. (Absence of genital & physical injuries; Lab report positive for semen, drugs/alcohol)

c) There are no signs suggestive of vaginal/anal/oral intercourse, but there is evidence of physical &/or genital assault. (Presence of physical &/or genital injuries; Lab report negative for semen/ drugs/lubricant)

d) There are no signs suggestive of vaginal/anal/oral penetration. (Absence of physical &/or genital injuries; Lab report negative for semen/ drugs/ alcohol/ lubricant)

e) There is a possibility of vaginal/anal/oral penetration by a lubricated object. (Absence of physical &/or genital injuries; Lab report positive for lubricant only)

f) Any other comments:

Date: Signature & Name of Examining Doctor

Place: Seal of Examining Doctor

[Copy of the entire medical report must be given to the survivor/ Victim free of cost immediately]

REPORT ON MEDICO-LEGAL EXAMINATION OF ACCUSED OF SEXUAL VIOLENCE

1. Name of the Hospital ..... OPD No. ..... IP No. .....

2. Name ..... S/o or D/o (where known).....

3. Address.....

4. Age (as reported) ..... Date of Birth (if known).....

5. Sex (M/F/Others) .....

6. Date and Time of arrival to the hospital, brought by Police/ Court order/ Self..... ..... 7. Date and Time of commencement of examination.....

8. Brought by .....(Name & signatures)

9. MLC No. .....Police Station.....

10. Whether conscious, oriented to time, place and person.....

11. Any physical/intellectual/psychosocial disability .....

(Interpreters or special educators will be needed where the accused has special needs such as hearing/speech disability, language barriers, intellectual or psychosocial disability.)

12. Informed Consent/refusal:

I .....S/o or D/o.....hereby give my consent for my / my ward's

a) Medical examination for treatment Yes / No

b) Medico legal examination Yes / No

c) Sample collection for clinical & forensic examination Yes / No

I also understand that as per law the hospital is required to inform police and this has been explained to me. I have been explained that if I refuse to consent for this medico-legal examination it may be treated by the court as evidence against me. I have also been explained that as per law [*sec 53 CrPC (51 BNSS), 53A CrPC (52 BNSS) and 54 CrPC (53 BNSS)*] reasonable force can be used to compel me for undergoing this examination.

d) I want the information to be revealed to the police Yes / No

(in case of voluntary reporting)

I have understood the purpose and the procedure of the examination including the risk and benefit, explained to me by the examining doctor. My right to refuse the examination at any stage and the consequence of such refusal, including that my medical treatment will not be affected by my refusal, has also been explained and may be recorded. Contents of the above have been explained to me in ..... language with the help of a special educator/interpreter/support person (circle as appropriate). If special educator/interpreter/support person has helped, then his/her name and Signature .....

Name & signature/thumb impression of accused with date, time & place.

.....

Name & signature/thumb impression of Parent/Guardian with Date, time and place (in case accused is less than 12 years of age).

13. Marks of identification

(1) .....

(2) .....

14. Relevant Medical/Surgical history:

a. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment, consumption of drugs/medicines that may affect the interpretation of current physical findings:

b. Contraception use: Yes/No. If yes, method used: .....

c. Vaccination status – Tetanus / Hepatitis B: Vaccinated/not vaccinated

d. If accused is a female:

• Menstrual history: Cycle length & duration ..... LMP.....

• Menstruation at the time of incident: Yes / No

• Menstruation at the time of examination: Yes / No

15. History related to sexual violence:

A. About sexual violence:

• Date, time, & location of incident:

• Estimated duration between the sexual violence & accused/ perpetrator reaching the hospital:

• Number of episode/s:

• Whether known to the survivor: Yes / No; If yes, relationship with the survivor ..... • Description of incident in the words of the narrator: accused/informant (specify name and relation to accused):

B. Type of physical/emotional violence used by the accused, if any (describe):

C. Any H/O drug/alcohol intoxication:

D. If survivor has left any marks of injury on accused, enter details:

E. Details regarding sexual violence: (Write Yes/No/Don't know against each item)

• Penetration by penis/fingers/object/any other body parts into victim's vagina, urethra, anus or mouth: • Ejaculation (into victim's body orifices or any other part):

• Oral sex by assailant on survivor:

• Masturbation of assailant by survivor or forced manipulation of assailant's genitals by survivor:

• Post-incidence, has the accused changed clothes/undergarments, cleaned/washed clothes/ undergarments, bathed, cleaned genitals, passed urine/stools:

• Touching, fondling, kissing, licking or sucking any part of survivor's body (if yes, describe):

- Kissing, licking or sucking any part of assailant's body by survivor (if yes, describe):
- Condom/Lubricant/ Object used (if yes, describe):
- Exhibitionism/any other forms of sexual violence:

16. General Physical Examination.

- Pulse.....BP.....Temp.....
- Resp. Rate..... Pupils.....
- Any observation in terms of general physical appearance .....

17. Examination for injuries on the body, if any:

(Note the Injury type, dimensions, site, shape, colour, swelling, signs of healing, simple/grievous)

18. Local examination of genital parts/other orifices

E. External Genitalia: Record findings and state NA where it is not applicable.

- Inner thighs:
- Mons pubis:
- Foreskin, Glans & shaft of penis:
- Scrotum, Testes:
- Urethral meatus & vestibule:
- Any other (bleeding/discharge/oedema)
- If accused is female: (Examine Labia majora & Labia minora, Fourchette & Introitus, Hymen, Perineum)
- If accused is third gender: (Examine Clitoropenis & Labioscrotum)

F. Anus and Rectum:

(Bleeding/ tear/ discharge/ oedema/ tenderness)

G. Oral Cavity:

(Bleeding/ tear /discharge/ oedema/ tenderness)

19. Systemic examination:

20. Psychological assessment:

21. Sample collection/ investigations for hospital laboratory/ Clinical laboratory:

- Blood for HIV, VDRL, HbsAg, Sugar, HbA1c
- Urine for sugar, drugs
- ECG, Colour Doppler for genitals
- X-ray for Injury

22. Samples Collection for Forensic Science Laboratory:

a) Debris collection paper:

b) Clothing evidence where available:

Describe the appearance of clothes worn by accused at the time of incident of sexual violence (To be packed in separate paper bags after air drying).

c) Body evidence samples as appropriate:

Swabs from stains on the body, Scalp hair (10-15 strands), Head hair combings, Nail scrapings & clippings (both hands separately), Oral swab, Blood for grouping & drug intoxication (plain vial/vacutainer), Blood for alcohol level (Sodium fluoride vial/vacutainer), Blood for DNA analysis (EDTA vial/vacutainer), Urine for drug testing, Any other (condom / object)

d) Genital and Anal evidence:

Matted pubic hair, Pubic hair combings (mention if shaved), Cutting of pubic hair (mention if shaved), Swabs from glans penis, clitoropenis, shaft of penis & anus (for semen examination & DNA testing), Blotting paper wiped on shaft of penis (for Lugol's iodine test), Any other. [Swab sticks for collecting samples should be moistened with distilled water]

23. Provisional medical opinion:

I have examined (name of accused/perpetrator) ..... M/F/Other..... aged..... reporting ..... days/hours after the alleged incident, after having (bathed etc) .....

My findings are as follows:

- Samples collected (for FSL):
- Samples collected (for hospital laboratory):
- Clinical findings:
- Additional observations (if any):

The Opinion is kept pending awaiting the above laboratory reports.

24. Treatment prescribed:

(STI prevention treatment, Wound treatment, Tetanus prophylaxis, Hepatitis B vaccination, Post exposure prophylaxis for HIV, Counseling, Other). Copy of the treatment protocol / prescription has to be given to Accused.

25. Date and time of completion of examination .....

This report contains ..... number of sheets and.....number of envelopes.

Signature & Name of Examining Doctor

Date & Place: Seal of Examining Doctor

26. Final Opinion: (After receiving Lab reports)

Findings in support of the above opinion, taking into account the history, clinical examination findings and laboratory reports of ..... bearing identification marks described above, ... hours/ days after the incident of sexual violence, I am of the opinion that:

a. There are signs / no signs suggestive of recent sexual intercourse into vagina/anus/oral cavity (sexual intercourse into vagina if vaginal epithelial cells and vaginal fluid positive; into anus if anal epithelial cells and fecal matter positive; into oral cavity if saliva is positive on swabs taken from shaft/glans penis)

b. There are signs / no signs suggestive of being under the influence of drug/alcohol (if signs of effect of drug or alcohol positive)

c. There are no signs suggestive of sexual intercourse (in cases of fingering/ use of object / other non-penetrative sexual acts)

d. Any other comments (like use of force in physical &/or genital injuries; in cases of fingering/ use of object / non-penetrative sexual acts)

Signature & Name of Examining Doctor

Date & Place: Seal of Examining Doctor

[Note: As per the Protection of Children from Sexual Offences (POCSO) Act, 2012, a male/female/other can be an accused person. Hence, mention 'Not applicable' wherever it is not related to the particular gender.]

POTENCY CERTIFICATE

OPD/IPD No.:

MLC No.:

1. Name:
2. Sex:
3. Age:
4. Marital status:
5. Address:
6. Brought by:
7. Consent:

8. Identification marks:
   i)
   ii)
9. Date & time of examination:

History (As stated by the patient)

1. History related to the case:

2. Personal history:
   a. Past illness:
   b. Local/General disease:
   c. Morning erection of penis, Night emissions:
   d. Sexual history:
   e. Previous trauma /surgery (spine, genitalia):
   f. Drug intake/Addiction:

GENERAL PHYSICAL EXAMINATION

1. Height: Weight:
2. Pulse: BP: Temp:
3. Secondary sexual characters

GENITAL EXAMINATION

1. Penis:
   - Length: (in flaccid/erect state)
   - Circumference: (in flaccid/erect state)

- Disease / deformity:
- Sensation over glans:
- Prepuce retraction:
- Stains / discharge:
- Injuries:

2. Scrotum:
   - Testes (infantile/adult/enlarged/atrophied/absent): Rt. Lt.
   - Disease:
   - Epididymis, Spermatic cord:
   - Cremastric reflex

SYSTEMIC EXAMINATION

CVS: RS: CNS: P/A:

COLLECTION OF SAMPLES FOR LABORATORY EXAMINATION

1. Blood Sugar:
2. Urine for drug assay:
3. Hormonal assay (Testosterone, Oestrogen, TSH):
4. X-ray Lumbar spine:
5. Any other:

OPINION

From above examination, I am of the opinion that:

i) The person is incapable of performing sexual intercourse. [If injury/disease known to cause impotence is present]

ii) There is nothing to suggest that the person is incapable of performing sexual intercourse. [If findings are normal, but psychological causes cannot be ruled out]

Place: Signature of Doctor

Date: Name & Designation

DRUNKENNESS CERTIFICATE

OPD/IPD No.: MLC No.:

1. Name:
2. Age:
3. Sex:
4. Address:
5. Brought by:
6. Consent:

7. Identification marks:

i)

ii)

8. Brief history:

9. General examination:

   a. Built: Nourishment:

   b. Height: Weight:

   c. Pulse: BP: Temperature:

   d. Orientation:

   e. Smell of alcohol from mouth:

   f. Smell of alcohol from breath:

   g. State of clothing:

   h. Speech:

   i. Eyes:

10. Examination for muscular Co-ordination:

   a. Finger nose test:

   b. Picking a pencil from the floor:

   c. Gait:

   d. Reaction time:

11. Injuries:

12. Systemic examination:

CVS: RS:

CNS: P/A:

13. Collection of materials for analysis:

FINAL OPINION:

i) The person has consumed / not consumed alcohol.

ii) The person is under / not under the influence of alcohol.

Signature:

Name of Medical Officer:

Official Seal:

FORMAT FOR SENDING BLOOD AND URINE FOR ALCOHOL ESTIMATION

In suspected case of drunkenness, the blood and urine samples have to be sent to FSL/RFSL for qualitative and quantitative analysis in the following format.

To,

The Deputy Director,

The Regional Forensic Science Laboratory, ...

Sir/Madam,

The following samples were preserved during the examination of below mentioned person with history of alcohol consumption for qualitative and quantitative estimation of alcohol.

Name:

Sex : Age:

MLC No. : Date:

Crime No.: Police Station:

Samples preserved:

1. Blood:

   10 ml venous blood preserved with 100 mg Sodium Fluoride + 30 mg Potassium Oxalate."

   Date and time of collection ..... at ..... am/pm.

2. Urine:

   1st sample: 30 ml urine collected on .....(date) at.....am/pm.

   2nd sample: 30 ml urine collected on .....(date) at.....am/pm.

   Preservative: For 10 ml urine: Few crystals of Thymol / 1 ml Conc. HCl.

   (First sample should be collected as soon as the patient was brought for examination and another collected after 30 min of initial examination)

   Place: Signature of the Doctor

   Date: Name, designation, Reg. No.

 # The gray capped Vacutainer tube contains Sodium Fluoride + Potassium Oxalate.

FORMAT FOR PRESERVING EVIDENTIARY MATERIALS FOR DNA ANALYSIS

To:

The Director,

Forensic Science Laboratory, ...

Place PM / MLC No.:

Name of the deceased:

Sex:

Age:

Crime/ UDR No.:

Police Station:

Sir/Madam,

I am herewith sending the following evidentiary materials collected from the above mentioned case for the purpose of DNA analysis.

1.

2.

3.

4.

5.

Type of analysis requested

Sample Seal

Yours sincerely,

Place:

Date:

Signature of the Doctor

Name, designation, Reg. No.

DYING DECLARATION

Name and designation of the person recording dying declaration:

.....

Date and time of recording dying declaration (starting and ending time):

.....

Place of recording declaration: .....

Name of the declarant:

Sex:

Age:

Address:

Statement on compos mentis (at the beginning of declaration):

Statement recorded (as told by the declarant):

Statement on compos mentis (at the end of declaration):

Signature/Thumb print of the Declarant

Signature of the Recorder & Designation Name

& Signature of Witnesses:

[Usually, dying declaration shall be recorded by Judicial Magistrate of nearby Court. In critical condition of the patient, doctor needs to inform the nearby Police Station to bring the Magistrate for recording dying declaration. Before and after recording the declaration, the treating doctor has to certify the compos mentis of the patient. However, in a situation where there is no time for arranging the Magistrate for recording statement, the doctor can record the statement.]

FORMAT FOR RECORDING COMPOS MENTIS

To:

.....

.....

Name of the person:

Sex:

Age:

Address:

Identification marks:

i)

ii)

Place of examination:

Statement on compos mentis:

I have examined the above mentioned person on ..... at.....am/pm (before giving statement) for his/her level of consciousness, orientation to place, time and person, and other mental faculties. I hereby certify that he/she is in possession of sound mind to give the statement. Further, I have examined the above mentioned person on ..... at..... am/pm (after completing statement) and certify that he/she is in possession of sound mind.

Place:

Date:

Signature of the Doctor

Name, designation, Reg. No.

FORMAT FOR SENDING INTIMATION TO RECORD DYING DECLARATION

To:

Sub-Inspector of Police,

..... Police Station

I have examined Mr/Ms/Mrs.....aged ..... years is under treatment in ..... ward, ... Hospital and he/she is in critical health condition and want to give a statement. Hence, I request you to make an arrangement for bringing the Magistrate for recording his/her statement for legal purpose.

Date & time of intimation:

Signature of the Doctor

Name & Designation

[Police intimation can be sent through phone in case of very critical condition where doctor feels that there is a limited time for survivability of the patient. This needs to be documented in the written intimation by mentioning the date and time of telephonic intimation.]

IMPORTANT CONTACTS

1. SHO, Saifai Police Station (CUG Number): 9454403280
2. Trauma Centre UPUMS, Saifai: 9151035788