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Medicolegal Case Management Manual

Mohd Sarwar Mir[1]*, Nissar Ahmad Wani[2] and Shaista Ganai[3]

[1]*Assistant Professor & I/C Head, Department of Hospital Administration, GMC Handwara, India*

[2]*Medical Superintendent, Associated Hospital, GMC Handwara, India*

[3]*Medical Officer (Admin), Health and Medical Education Department, J&K, India*

***Corresponding author:** Mohd Sarwar Mir, Assistant Professor & I/C Head, Department of Hospital Administration, GMC Handwara, India

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Chapter 1: General Guidelines

Most Important Duty

The first and foremost duty of the treating doctor is to save the life of a patient and give necessary urgent treatment. Police should be informed as early as possible but the patient should not be allowed to suffer. For this he must not wait for the arrival of police.

Definition

Medicolegal case is a case of injury ailment where an attending doctor after taking history and clinical examination of the patient, thinks that some investigations by law enforcing agencies are essential so as to fix the responsibility regarding the case in accordance with the law.

Following category of cases be labeled as medico-legal.

1. Road-side accidents, factory accidents or any other unnatural mishap.
2. Suspected or evident homicides or suicides, including attempted
3. Suspected or evident poisoning
4. Burn injuries due to any cause
5. Injury cases where there is likelihood of death in near future
6. Suspected or evident sexual offences
7. Suspected or evident Criminal abortions
8. Unconscious cases, where cause of unconsciousness is not clear.
9. Cases brought dead with improper history
10. Cases referred by court or otherwise which require age certificate.
11. Cases pertaining to dowry Act, Domestic violence and violence against child
12. Cases of human rights violation
13. Cases pertaining to Elderly abuse

Registration of Medicolegal Case in a Hospital

1. It is purely the responsibility of treating doctor in causality or outpatient of a hospital to decide when to label a case as medico-legal.
2. Request of the patient or the accompanying relative or friends etc. for not registering the case as medico legal shall not be entertained. The Medical Officer/Resident doctor has to base his decision on the nature of circumstances.
3. The cases whether brought by police or by somebody else must be registered as medicolegal in the emergency department if not registered elsewhere.
4. Any case mentioned in the above list even if several days after the incident by police shall be registered as medicolegal. At this period opinion regarding the case is to be given according to the present condition of the patient.

5. In case Medical Officer/Resident doctor has not labeled a case as medicolegal in emergency, but indoor doctor thinks so, he should inform the same to the concerned hospital authorities, Duty Officer on duty must go ahead in fulfilling the formalities including making of an injury report as per his examination findings.
6. In any case registered as medicolegal in one hospital and referred to another hospital, a fresh injury report need not be prepared, although case is labeled as medico-legal for other formalities. The referral slip be attached on the medicolegal report form.

Medicolegal Cases Brought by Police

The Medical Officer/Resident doctor on duty for medicolegal work should ensure that requisition form is received from Investigating Officer or Station House Officer, giving brief facts of the case [1]. This is important for the ends of justice and will help the Medical Officer in conducting examination.

Intimation of Medicolegal Cases to Police

Whenever a suspected medicolegal case is brought in the emergency/OPD, it shall be the duty of the Medical Officer/Resident doctor on duty to send information to the police station/post of the area. Information shall be sent to the police by the quickest possible means. Acknowledgement from the police officer receiving the information will be kept in the file of the patient and in other OPD cases it shall be pasted in the OPD register or with the Medical Officer for further reference [2]. The Medical Officer/Resident doctor will make a note in the file of the patient as to the time and date of informing the police. Medical Officer/Resident doctor will then make a complete record of all injuries and also note the date and time of admission of the case therein. Name and addresses of the attendants who brought the patient should also be recorded in the file and admission O.P.D. register if possible. The Medical Officer will also mark with red pen on the top of first page of the file of the patient the letters "M.L.C." or put the stamp "Medicolegal case". The stamp should be kept with the staff nurse on duty in the emergency [3]. The Medical Officer will also see that the card of the patient is marked/stamped "Medicolegal case" by the duty staff nurse on duty.

Discharge of Medicolegal case

1. In each and every medicolegal case who is going to be discharged, an information regarding the day of discharge be given to police at least 24 hours before the discharge period.
2. Immediate information be sent to police, if a medico-legal case (patient) leaves or absconds hospital against medical advice (L.A.M.A)

Emergency Surgery

When emergency surgery is required and no attendant is available to give the consent, the surgeon and emergency medical officer will decide and may conduct an emergency surgery on the patient. Please note that the surgeon treating the case will be held responsible if such a patient dies for want of operative treatment because of the non availability of attendant to give consent for surgery [4].

Taking away a Patient or Body of a Medicolegal Case Forcibly by the Attendant

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

Clothes in Medicolegal Cases

Details of clothing including color, condition, size etc. should be written in the MLR. Torn/damaged/stained etc portions should be encircled with signature. Clothes in medico legal cases involved in rape , stab injuries, fire arm injuries, burns, unidentified dead body etc. should be made into a parcel, sealed and handed over to the police. Clothes of accident victims are not to be preserved unless asked for by the police [5].

Hospital Record

Original hospital record/file of the medicolegal case should not be handed over to the police authorities. If the police requests M.S/RMO/SMO/MO I/c for the original record of a case, they should be given a photocopy instead. At times, the Courts ask for the original record. In such cases, duplicate/photo copy shall be retained for record. The original file/X-Ray plates are then submitted to the Court under a sealed cover

Chapter 2: Preparation of Medicolegal Report

A medico-legal report comprises of three parts:

a) Preamble: which contains the date, time place of examination, name of the person, the person who brought the case and the person who identified.

b) Findings/Observations: this includes description of injuries and description of other examination/observation made on the patient.

c) Opinion: In this part based on the findings and observations, the medical officer/resident doctor will opine regarding the nature of injuries, that is simple or grievous, the nature of weapon and any other information that may help the investigations.

Preparing the Report

1) Consent - Always take the consent of the injured person on the medicolegal report. If the patient is less than 12 years, take the consent of the guardian/accompanying person and get his signature/thumb impression; consent is not required in case of accused person u/s 53 and 53A of Cr. P.C. and even reasonable force can be used for his examination on the request of the police official not below the rank of a Sub Inspector. If an unconscious/ semiconscious patient is brought in emergency along with family/ guardian, the consent shall be taken from them. In case of refusal by the family/guardian the medical officer/Resident doctor shall mention on the medicolegal report that the consent could not be recorded [6].

2) The medicolegal report must be prepared by Medical Officer/resident doctor for all cases whether requiring admission for treatment in the emergency department or not. The injury report should be written in a neat and legible handwriting by the examining Doctor himself. Medical Officer/Resident Doctor who first examines the case, shall prepare the medicolegal report. However, in difficult cases, the Medical Officer/Resident doctor should take the help of another Medical Officer or Sr. Medical Officer or consultant for conducting the medicolegal examination or for preparing the medicolegal report.

3) Report should be completed as early as possible after examining the person and taking life-saving measures where required.

4) The preliminary information like name, age, sex and address etc. should be properly filled.

5) Name, relation and address of the accompanying person must also be recorded before letting them go.

6) If accompanied by police officer, his name, rank, number and police station should be recorded.

7) Time of examination along with date of examination must be indicated clearly.

8) Two copies of medico-legal injury report should be prepared. The original copy should be handed over to the police while the office copy should be retained in the register for record.

9) In all such reports, full name of the Medical Officer/resident doctor should be written in block letters below his signatures. Stamp of attending doctor should also be affixed.

10) In case where the nature of injury cannot be ascertained, patient must be kept under observation and admitted in appropriate ward and the same may be mentioned in the medico-legal report.

11) In case where the condition of the patient is so serious that he does not warrant preparation of detailed injury report in the emergency, such detailed report should be prepared in wards by the treating doctor. The Casualty Medical Officers/resident doctor in such cases should mention on their injury report forms the general condition of the patient and indicate that detailed examination and report is to be prepared in the ward.

12) Before examining the person a short history regarding the incidence should be mentioned. If patient is not a fit condition then name and the address of the informant should be mentioned and his version of the incident be taken.

13) General physical examination should always be undertaken and findings like mental status, pulse, Blood Pressure, Respiratory Rate, Pupils etc. be recorded in the injury report.

14) Two identification marks like scars, moles or tattoo marks preferably on the exposed parts of the body should always be recorded.

15) While describing an injury, its type (i.e. abrasion, contusion or laceration etc.), dimension i.e. length, breadth and depth (depth should be mentioned where possible, in case of stab injuries measuring for depth is not available) and location (along with position from a bony point) must be mentioned.

16) Where possible opinion regarding the nature of injury (simple or grievous) should be mentioned but in case it is not possible, reasons should be given e.g. opinion reserved pending CT report, of the patient under observations. In such cases the opinion may be given at a later date [7].

17) As per section 320 of the Indian Penal Code, only the following kinds of hurt are designated as «grievous»,- i. Emasculation. ii. Permanent privation of the sight of either eye. iii. Permanent privation of the hearing of either ear. iv. Privation of any member or joint. v. Destruction or permanent impairing of the powers of any member or joint. vi. Permanent disfiguration of the head or face. vii. Fracture or dislocation of a bone or tooth, and viii. Any hurt which endangers life or which causes the sufferer to be during the space of twenty days in severe bodily pain, or unable to follow his ordinary pursuits [8].

18) While interpreting the weapon of offence the opinion should be given in the form of hard blunt weapon, soft blunt weapon, cutting weapon, stabbing weapon or fire-arm etc.

19) While mentioning the age of injuries, findings like fresh hemorrhage, clot formation, color of scab, color changes in bruise healing, findings of pus formation etc. should be taken into account.

20) Investigation when required (like X-ray examination in suspected fracture cases) must be undertaken and to be recorded in medicolegal report. If referred for investigations, the

concerned department should submit the reports regarding the investigation as early as possible to the referring medical Officer/ Resident doctor to expedite the completion of medicolegal report by the concerned doctor who prepared the medicolegal report. Failure to do so may prove negligence. In case is referred for opinion, the opinion is to be written on the medicolegal report form [9].

21) Any material (like bullets) gastric lavage fluid, weapons found on the body etc. should be mentioned in the report and handed over to the Investigating Officer under sealed cover. Where clothes are blood stain, these should be taken possession of by the medical officer/resident doctor and sent to Police station in sealed cover with a mention of it in the report.

22) Death summary to be prepared in duplicate, one copy to be issued to the Police.

23) All medico-legal reports, register shall be kept in proper safe custody under the Medical officer/Resident doctor till completed and then sent to record section [10]. There should not be access to any unauthorized person to these documents and should be kept with an official deputed by the hospital so that it is not tampered with. It shall be given to authorized public officer by that official only.

24) In case where an opinion was kept pending subsequent opinion on the report is given at an appropriate time, after going through the earlier report. This opinion be also sent to the record section from where it will be issue to the police.

25) Examining female patients in the presence of the attendant/ relative/guardian. A female patient, even if she is not a medicolegal case, should not be examined without the presence of a relative of the patient or a woman hospital attendant.

Poisoning Cases

1) In suspected poisoning cases, (where required and indicated) gastric lavage should be done.

2) Give details of symptoms and probable nature of poison used.

3) Stomach wash, urine, blood etc. in poisoning cases must be collected and preserved in bottles which should be properly sealed, labeled and made into a parcel.

4) The sealed parcel along with a letter and a copy of medicolegal report is sent through the police official concerned to the forensic sciences laboratory through police for detection of suspected poison.

5) The letter should give particulars of the case, details of the bottles, sample impression of the seal put on the bottle and the poison suspected.

Firearm Injuries

1) In case of fire arm injuries, blackening, tattooing or singeing if present should be mentioned

2) Wound of entry, wound of exit if present is also required to be mentioned.

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

4) Details of all such recovered material should be mentioned in the medicolegal report.

5) If the parcel is not collected by the police within reasonable time frame, the Medical Superintendent/CMO and also the district SP are informed about the delay.

Rape/Sexual Assault Cases

Sample Collection for Forensic Science Laboratory

1) Samples are to be collected as per the protocol and packed in the envelopes provided in the SAFE kit.

2) Envelopes are numbered. The number matches with the corresponding step number in the protocol.

3) In some cases, you may not need all the envelopes in the kit. For example, if no debris are found on the body surface, envelopes titled 'Debri Collection' will not be required. 'No Specimen' will be written across the label on such envelopes.

4) In other situations, you may need extra supplies. Envelopes and supplies have been provided in the kit to cater to the basic minimum requirements. Use more envelopes, slides, oral swabs, vials etc. from the hospital supplies depending on the requirement.

5) All the envelopes in the kit are self sealing.

Steps in Examination of Victim

Consent: A written informed informed be taken from the victim. The identity and purpose of examination should not be disclosed to unrelated person. The record should be kept in proper custody and supervision. The following details to be noted name, parentage, Address, Age, Martial Status, occupation. height, Weight ,Current medication (if any),date and time of arrival, place of examination,

date and time of Starting Examination , date and time of completing examination.

History

a) Marks of Identification

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

General Physical Examination

1) Physical development

2) General condition of the person

3) Gait of the victim

4) Behavioral Symptoms

5) Condition of various clothes

a) Tears/Cuts/rents

b) Foreign matter

c) Stains

i) Blood

ii) Seminal

iii) Faecal

iv) Mud

d) Burns

e) Buttons (intact/ undone/ broken/ torn)

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

1) Location of injury

2) Type of injury (Bruises, abrasions, bite marks, cuts etc.)

3) Dimensions (length, breadth, depth, shape, margins & directions)

4) Stage of healing

5) Simple/grievous /dangerous to life

6) Cause of injury

7) Details regarding penetration

Local Examination of Genitalia:

(A) For use in Adult Females only

1) State of the Tops of Thighs, Pubic Region and Perineum

2) State of the sphincters

3) State of perineal musculature, Labia Majora, Labia Minora, Fourchette and introitus, Anus and Rectum

4) Per Vaginum Examination

5) Per Speculum examination …

6) State of Hymen (only if relevant)

(B) In the case of Pre-Pubertal Female

1) State of the Tops of Thighs, Pubic Region and Perineum

2) State of the sphincters.

3) State of perineal musculature, Labia Major, Labia Minora , Fourchette and introitus ,anus and rectum

4) P/Vaginal digital examination only if relevant

5) P/Vaginal speculum examination only if relevant

Local Examination of Genitalia: (For use in male victims only): The following points need to

1) State of the Penis and testicles

2) State of anal area including sphincters

3) State of perineum and perineal musculature and other injuries

4) Proctoscopy Findings

Summary of Examination of Victim:

1) Step 1 - Consent

2) Step 2 – History

3) Step 3 - a. Clothing outer b. Clothing inner

4) Step 4 - Debris collection (5 Envelopes)

5) Step 5 - Breast Swab

6) Step 6 - Combing pubic hair

7) Step 7 - Clipping of pubic hair

8) Step 8 - Matted pubic hair

9) Step 9 - a. Cervical mucous collection b. Vaginal secretion collection

10) Step 10 - Culture

11) Step 11 - Washing from vagina

12) Step 12 - Rectal examination

13) Step 13 - Oral Swab

14) Step 14 - Blood collection EDTA, Plain

15) Step15 - Urine Sample Collection

Opinion: The components of opinion include

1) Age of survivor

2) Evidence of injury if any

3) Evidence of intercourse

4) Evidence of child sexual abuse

5) Investigation (Lab and Radiologist)

6) Opinion after receiving laboratory test reports

Chapter 3: Dealing with the Dead

Whenever a medicolegal case dies, the police officer I/C of the police post/police station of the area should be informed immediately and a note to the effect be recorded on the file of the deceased.

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

Disposal of Patients Who on Examination are Found Already Dead on Arrival in the Casualty (Brought in Dead)

1. All cases brought dead must be registered as medicolegal in the casualty, along with all possible details about the deceased obtained from the persons accompanying. Addresses of persons bringing such a dead individual must always be noted.

2. In all such cases registered as medicolegal information to police be sent.

3. While preparing casualty card, it must be mentioned that the deceased was 'brought dead'. Also, mention the date and time when the deceased was brought to casualty.

4. All such bodies should not be handed over to the relatives, but sent to mortuary. They should only be handed over to appropriate police authorities.

Disposal of bodies in Medicolegal Cases Dying in Casualty/ Wards

1) All dead bodies of medico-legal cases that expire in a casualty/ward should be sent to the mortuary of the hospital for onward handing over to police.

2) All dead bodies of medicolegal cases be handed over to a police officer not less than the rank of A.S.I for inquest

3) In no case such bodies be handed over to relatives directly. However, relatives must be informed accordingly.

4) In case relatives are not present, police officer should be informed and intimation be sent to the relatives through them.

5) A "death summary' in duplicate should be prepared by the Medical Officer attending such cases and one copy should be handed over to the police officer who receives the dead body of the deceased and second copy attached to the case records.

Dying Declaration

The dying declaration is defined as "A statement written or verbal, made by a person who has since dying, as to the cause of his condition or as to any circumstances of the transaction or event which resulted in his death", and is admissible as evidence in case in which the cause of that person's death is the subject of enquiry. In case a person who has sustained the serious injuries and is in danger of life or likely to succumb, the medical officer should inform the magistrate so that the dying declaration of the person is recorded. In case it is expected that this person will die before the arrival of Magistrate, the medical attendant can record the Dying Declaration himself. It is better to take the written statement of the person making declaration otherwise it should be recorded in the identical words of the person. No suggestion should be made to the person and no attempt should be made to seek information by asking leading questions. The contents of the declaration should be read over to the dying individual and if possible it should be signed by the declaration. Further, It should be attested by the write and signed by the witnesses present. After recording the declaration, it should be forwarded to the Police or to the Magistrate under who is conducting the inquiry of the case. Prior to the recording of Dying declaration, the attending doctor is required to issue a certificate of the "Fitness of mind" to give dying declaration. The Medical Officer should be careful while issuing such a certificate as he will be summoned to the court of law.

Role of Mortuary

In a hospital mortuary, dead bodies dying in the Hospital are kept and preserved properly, before being handed over to the relatives of the deceased. In Medico-legal case, it is to be ensured that the bodies are not to be handed over to the relatives but to concerned Police personnel for inquest and subsequent post-mortem, if required.

Unclaimed Cases

In all unclaimed cases and unknown death cases, it is mandatory to preserve the dead bodies for a period of atleast 72 hours before it is handed over to religious organizations/ municipal bodies for last rites after obtaining proper permission through police from dictrict magistrate.In case these bodies get identified, they are handed over to relatives concerned after noting the same fact on the death certificate.

Mortuary Register

Maintaining records in relation to storage of dead bodies and their disposal at mortuary is a very important function. A mortuary register indicating all the details of the case in various columns, so that proper identity could be traced when required, should be available.

1) The date and time of receipt of the body in mortuary and its disposal should be also be mentioned on the said register together with signature of the person whom the dead body has been handed over to.

2) A serial number should be allotted to each dead body and the same be affixed against the cabin where dead body has been kept.

3) In no case any dead body should be stored in the mortuary without entering in the register.

4) Outside hospital dead bodies can be preserved in cold storage after permission from hospital authority concerned for this purpose.

Preparation of Post Mortem Report

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

Special attention may be given to the following aspects:

1) To properly record the date and hour of receipt of inquest paper, date and hour of starting autopsy, name of the person who brought the body and the name of the person who identified the body and the probable time of death.

2) While describing injuries early indicate whether injuries are ant-mortem/post-mortem with the reasons thereof. Also, indicate whether the injuries are sufficient in the ordinary course of nature to cause death and the nature of the weapon used for causing each of the injury.

3) In case of death by burn injuries, state degree of burn extent and details of burns including cause of burn injuries.

4) In case of death caused by poison, must state whether the viscera is preserved and sealed.

5) While describing the contents in the stomach, special mention must be made of the food whether digested or semi-digested. If possible, indicate the food material present and smell, if any.

6) While describing the clothing's of the deceased one must indicate whether they were blood stained or any other noticeable mark like charring tattooing scorching or blackening and also indicate whether the clothes have been taken possession of and sent to the police and whether these were sealed.

7) Mention must be made of any other special peculiar of the case, if noticed.

8) Post-mortem report must be signed, seal be affixed and certified that it is correct.

Chapter 4: Court Proceedings

In the Indian Evidence Act 1872, Indian Evidence (amendment) Act 2003 and Code of Criminal Procedure 1973 deal with the issues of evidence.

Definition

Evidence is the statements that are made before the court by the witness regarding to the matters or fact under enquiry. These statements are called oral evidence while the documents produced for the inspection of the court are called documentary evidence (IEA Section 3). Thus, the evidence could be either an oral evidence or documentary evidence.

Classification

1) Direct Evidence-The direct evidence could be oral or documentary. It relates to the fact which is directly seen, heard or perceived by the witness and deposed in the court as oral evidence. Direct Documentary evidence is when facts relating a document are verified by the witness.

2) Indirect or circumstantial Evidence-It means when the circumstances interferential prove the occurrence of a principal fact eg. X has shot Y in a room. Z saw the X with a fire arm weapon outside the room a minute before the fire in the room. The Z has not seen X firing but his observation circumstantially relates to the principal act of firing the Y.

3) Hearsay Evidence-It means the information, knowledge, experience gathered from others. The hearsay evidence is not of much value in the court of law.

4) Prima fasciae Evidence- It is evidence that is considered as a proof on its face value regarding the fact.

5) Material Evidence-It is evidence in connection with the principal fact having substantial and relevant bearing on the decision making by a material object. While recording of oral evidence if it refers to the existence of any material thing, the court may ask for its inspection eg. Clothing's, weapon of offence, part of poison or any other exhibits.

6) Original Evidence- It is an independent probative force of its own or is relevant proof by itself.

7) Derivative Evidence- It is a probative force from some other source or becomes relevant proof through its relation to certain other facts.

8) Relevant Evidence-It isi evidence that has a direct bearing upon the fact in issues in a case.

9) Conclusive Evidence-It is evidence that by itself proves the fact in issue in a case, excluding all other evidence.

Recording of Evidence in Court of Law

1) Oral Evidence: In a court of law, all facts, except the contents of documents or electronic records may be proved by oral evidence (I.E.A Sec.59). The Medical man is usually summoned to the court of law to give the oral evidence regarding the documents /opinion prepared by him. The oral evidence is of more significance as it gives an opportunity to defense counsel to cross examination to clarify the facts. The evidence is recorded in a definite manner as described earlier that is examination-in-chief, cross -examination and re-examination .During evidence any reference made to the material thing, court may instruct to produce the same eg. Weapon, clothing's or any other exhibits for identification and opinion. Therefore, any material/exhibit examined by an expert should be properly sealed and signed or some identification marks put on the exhibit where ever needed along with dimensions recorded so that the exhibit examined is easily identified in the court at the time of deposing the evidence. The special precautions should be taken to maintain the chain of custody, right from the preservation till it is finally produced before the court of law. This is very important and should be invariably followed. While deposing, the witness is permitted to refresh his memory. According to section 159 (I.E.A) "A witness may, while under examination, refresh his memory by referring to any writing made by himself ……." He can even refresh his memory by reference to any other document with the permission of court. The medical officer can cite the publications or the opinions of the experts expressed in any treatise or professional treatises. A medical officer though usually appears on behalf of the public prosecutor (State) but he is a witness of Science and therefore, he should express his opinion based on the scientific facts irrespective whether it is supporting the prosecution or defense.

A Mute or Deaf Person may Give Evidence by Signs, Writing or Through an Interpreter

In certain circumstances, the evidence may be admissible without the presence of witness, such as following;

a) Dying declaration (Section 32 and 157 IEA).

b) Expert opinion expressed in a book or treatise, when author is dead or cannot be found (Sec.60 IEA).

c) Evidence of Medical officer recorded in a lower court but Medical officer can be summoned by higher court if any deficiency is observed or needs further explanation (Section 291 Cr PC).

d) Evidence recorded in earlier judicial proceeding when the witness is dead or is not found or incapable of giving evidence or undue delay or unreasonable expenses to call such witness (Sec 33 IEA and Sec. 291 Cr.P.C).

e) Evidence of Mint officers or Indian Security press (Section 292 Cr.P.C).

f) Report of certain Govt. Scientific experts:

i) Chemical examiner or assistant chemical examiner

ii) Chief inspector of explosives

iii) Director Finger Print Bureau

iv) Director's Central Forensic Science Laboratories or State Forensic Science Laboratory,

v) Director of Haffkine Institute , Mumbai

vi) Serologist to the government (Sec. 293(1) Cr.P.C)

vii) Public records eg birth and death certificate etc. (Sec. 74, 76, 78 and 35 of IEA), (vi) Hospital records regarding routine entries.

However, in practice Forensic science experts of Central Forensic Science Laboratories and Forensic Science Laboratory are quite frequently summoned to the court of law which is within the rights of the court, prosecution and defense counsel.

Documentary Evidence

Various types of medico-legal documents are issued by a medical expert which are submitted to the courts of law. The medical officer is summoned to prove the contents of the documents either by primary or by secondary evidence

(A) Primary Documentary Evidence: Document is produced itself for the inspection by the court (IEA Sec.62)

(B) Secondary Documentary Evidence: When certified copies of an original document made in a mechanical process or copies made from or compared with the original or oral accounts of the contents of the documents by some person who has himself seen it (IEA Sec 63). The usual medical documents produced may be as under:

a) Medical certificates

b) Medical Legal records

c) Deposition of medical witness

d) Dying declaration

e) Expert opinion

f) Previously recorded evidence

(C) The evidence is recorded in a particular sequence (Section 138 of IEA) that is:

a) Examination-in-chief

b) Cross examination

c) Re-examination

d) Question by Judge

Examination-in-Chief

The examination-in-chief is conducted by the counsel who has

summoned the witness. Objective of this examination is to place all the relevant and significant facts of the case. In case of expert evidence, his emphasis is on the proper interpretation of facts and opinion given by the expert in the medico-legal report/document. In case of State versus accused cases, this examination is carried out by the public prosecutor. Leading questions are not allowed in this examination. The leading questions are those wherein answer is suggested in the question itself.

Cross Examination

The cross examination is conducted by the opposite counsel. Objective of this examination is to bring forward any fact or opinion that may go in favor of his client. He may attempt to weaken the witness by asking questions which may show contradictions inaccuracies and conflict of opinion. He may also cite literature to prove that the opinion is ill founded .The leading questions are allowed. The witness cannot refuse to answer the questions. In case, he finds it objectionable, he can address the Judge and wait for the directions. Questions asked by the defense counsel can be objected by the public prosecutor. In such situation, medical officer should stop and wait for the instructions from the court. If court says" objection over ruled" he should answer the question. If court says, "Objection sustained" he need not answer the question. There is no time limit. The Examination may last for days together.

Re-Examination

After cross examination if the counsel who has summoned feels that certain obscure points require clarification, he may re-examine the witness but he cannot raise any new issue during re-examination without the permission of Judge and opposite counsel. In case, new issue is raised, the opposite counsel has right to cross examine again on that issue.

Question by Judges

The judge may ask questions at any stage but ordinarily it is observed that they ask some questions after the examination-in-chief and cross-examination is over to clear certain doubts.

After the evidence is recorded, the recorded evidence either typed or computer print at times written in hand is provided to the witness. The Medical officer should go through the evidence and after making necessary corrections sign at the end. He should not leave without taking permission from the court.

Medical Certificates

a) Certificate of illness. It should mention duration of illness, name and address of the doctor, registration number of doctor, left thumb impression of the patient along with the signature.

b) Certificate of insanity- to be issued on a prescribed format by a competent authority.

c) Death certificate- is to be issued by a registered medical practitioner looking after the patient at the time of his last illness, not to be issued if the cause of death is not clear or suspects foul play or he has not seen the patient at least once in last fortnight before death.

d) Certificate of Age and Sex-to be issued after complete laid procedure and examination (Physical, Dental, Radiological examination, Impression of left thumb, signature of the patient to be recorded).

e) Disability certificate-to be issued after thorough and complete examination.

Summons

Summons from the courts should always be accepted. In case particulars of the case i.e. name the patient, date of admission etc. are not mentioned on the summons and the Medical Officer is not able to trace the case file etc., the summons may be returned to be court requesting the court to supply the relevant particulars. A very polite language be used if the summons are not accepted e.g. "The particulars of the case i.e name of the patient/ deceased and date of admission/death, C.R./MLR/PMR No. have not been given. No useful purpose will be served by attending the Court on_____ Kindly provide the necessary particulars so that the relevant papers are brought at the time of the next hearing." Utmost care should be taken if the summons is received from the Session Court or High Court. In case the doctor is busy in some urgent work or an operation/ consultation is already fixed and the notice is too short, information to this effect may be supplied to the Court and request be made for adjournment.To avoid unpleasantness, the doctors must attend the court when summoned. In case, one cannot attend the court because of unavoidable circumstances, an official communication should be sent to the Court well in time.

The Medical Officers are likely to receive bail able warrants in case they do not attend the court. This requires furnishing security for the amount ordered by the court. In case a Medical Officer does not still attend the court, the security amount will be forfeited and a non bail able warrant will be issued by the court which will be very embarrassing to the medical officer concerned and to Health Department. In case a medical officer does not attend the Court and also fails to inform the Court, the Court may prosecute him/her u/s 174 IPC.

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Mohd Sarwar Mir. Biomed J Sci & Tech Res

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