MEDICO LEGAL MANUAL

CONTENTS

4. Performa for examination and report of a case of injury
5. Examination of weapon
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7. Sexual offence- examination of accused/ examination of potency
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9. Sexual assault — examination of survivor (link)

7. Important contacts

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 theforemost responsibility.
- 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,

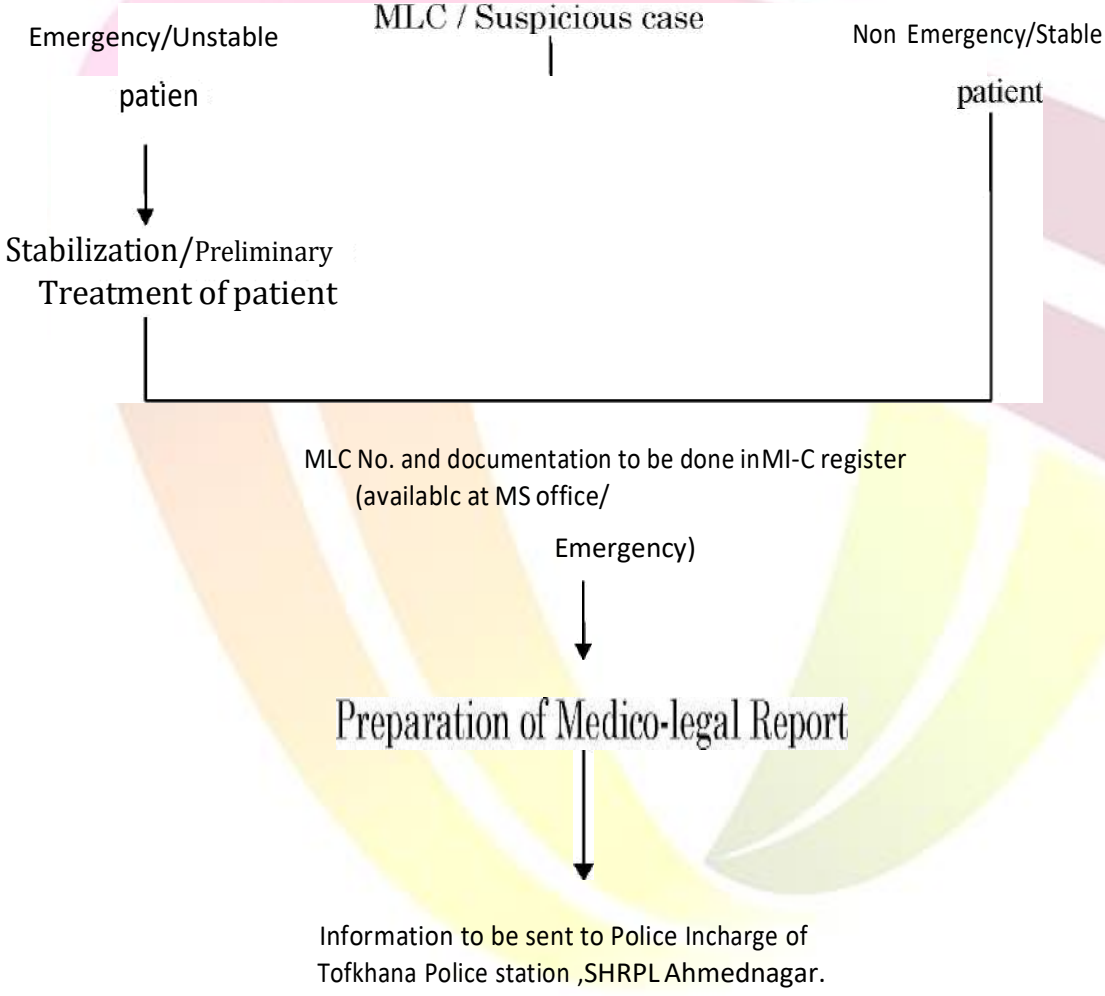
C) List of MLC

- Injuries due to Accidents and Assault.
- Suspected or evident cases of suicides or homicides (even attempted cases).
- Confirmed or suspected cases of Poisoning.
- Burns.
- Cases of injuries with likelihood of death.
- Sexual Offences.
- Suspected or evident Criminal Abortion.
- All patients brought to the hospital in suspicious circumstances/improper history (ex: found dead on road).
- Unconscious patients where cause of unconsciouancsfi is not clear.

- Child Abuse.
- Domestic Violence.
- Person under Police Custody or Judicial Custody.
- Patients dying suddenly on operation table or after parentaladministration of a drug or medication.
- Case of Drunkenness.
- Brought Dead.
- Natural Disaster.

D) Work Flow for Medico-legal Cases brought to Emergency in SHRPLAhmednagar.

- All patient's/cases are given hospital Registration No. in Emergency
- OPD/IPD if a case is medico-legal. information must reach Emergency andIPD/MLC number is collect.



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, color, age of injury, direction, nature, duration). Use diagramwherever 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.

GENERAL GUIDELINES

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

1, **If a MLC, recorded elsewhere (in other hospital) is referred,** it should be treated as MLC but NO NEW MLC number should be issued. Treatment should continue in old MLC number. Neither a new MLR should be prepared nor is it needed to inform the police.

2. If a case is brought several days after the incident, it should bereported and findings to be noted regarding the present condition ofthe patient.

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

4. 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).

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

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

7. If a Medico-legal case is not admitted, entry shall be made in the MLCRegister.

8. Consent for emergency surgery, when no attendant is available canbe given by the Medical Superintendent of the hospital.

9. If (EMO)/(Asst .EMO) in Emergency does not register a case as MLCbut 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.

10. 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.

11. X rays, blood reports, microbiological, pathological investigations etc in Medico- legal case should be labeled as MLC & kept along with other documents of the case.

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 station after getting proper receipt.

2. Hospital records Or files of MLC Should be kept, as confidential in Record Section till judgment by the court, of law pertaining to the case has been issued (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..

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 ,Police is informed and body is sent to Mortuary C I V I L D I S T R I C T H O S P I T A L A h m e d n a g a r after filling the appropriate form.

3. **Cause of death certification in cases other than MLC** can only lie issued by Emergency Medical Officer (EMO)/ Assistant EMO/ treatingDoctor who has attended the case within 7 days and is sure about thecause of death.

MEDICO-LEGAL AUTOPSY IN MLC

1. Autopsy is done in the mortuary Complex of Civil District Hospital Ahmednagar by the Department, of Forensic Medicine And Toxicology.

2. Autopsy is conducted Monday to Friday from 10 am to 5 pm.
timing on Saturday, Sunday and on all holidays is mom 10 am to 2 m.

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 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)

- *Be* polite to the suspect anal victim.
- Always take consent. In case of suspect, medical examination can bedone even if he declines to give consent..
- Take a detailed history and document it in person's own words.
  Examine them properly and fill the precribed form for suspect and survivor
- **(Annexure 7 & Annexure 9,** respectively).\
- Always provide information regarding psychiatric counseling to the victim.
- All male and fema]e Registered Medical :Practitioners are eligible toexamine the victim.
- Always examine the victim in presence of female attendees. Victim canhave a female acquaintance/relative wit h her if she wants.
- In case of children, sedative or analgesic may be needed forexamining genitalia in painful condition.
- Do not delay the examination. Exact time of commencement and completion must be noted in the report.
- Never attempt to undress the victim for examination. Convince herto undress herself.
- Never paas judgmental remark or comments that might appearUnsympathetic:.
- Denying examination of the rape victim is unlawful.

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 posteriorfornix 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 theDepartment 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.
- **NOTE:** Staining of vaginal smear, examination of slide and opinion in sexual assault cases, is being given by Department Of Forensic Medicine And Toxicology. The slide can be prepared, dried and forwarded to Department Of ForensicMedicine for needful.
- 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 withcotton, 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 usefingers or rubber tipped forceps.

iii. Neve 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 ChemicalAnalysis and DNA Analysis if required.

f) Clothes are recorded and preserved

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

e) r wash the bullet.

iv) Burns:

a) Proper history and documentation
b) Give primary treatment.
e) 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,
I) Dying declaration if required should be taken especially in young marriedfemales.

V. Hanging/Strangulation

a) Ligature mark- Describe its position, nature, width, direction and extentwhether 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 circumference of loop, length of short and long free ends foreignbodies 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) <u>Proper documentation of history, treatment and articles sealed.</u>
d) Send properly sealed, labeled samples of vomitus /stomach wash andblood sample to the police and make record wherever possible.
e) Never allow the entry of unauthorized person near the victim in a ease ofhomicidal

vii. Injury Cases

a) Give primary treatment.
b) Examine and record all injuries properly.
c) Proper **documentation (Annexure 4).**
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 **(Annexure6).**

b) Consent should be taken but under Sec 53 (1) CrPC, examination of anaccused 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 8kin and the syringe must befree from any trace of alcohol. Chlorhexidine can be used instead.

ix. Child Abuse

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

b) Give proper treatment.

e) Usually medical examination should be done within 24 hrs or as soon aspossible.

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.

I) Record the child's weight , height and sexual developement,

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

j) Psychiatric counseling 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 anesthesia.

l) Avoid unnecessary painful arid invasive procedures.

PRESERVATION OF SAMPLES

1. All samples should be properly labeled (Hospital Registration no, Pt's name, age, date- police station), sealed (seal available at MS office) anal sign by doctor who prepared the WILC 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 lab.

Appendices

As per section 320 of the Indian Penal Code, following kindsof hurt are designated as "GRIEVOUS"

- Emasculation (applicable only for males).
- Permanent privation of the sight of either eye.
- Permanent privation of hearing of either *ear.*
- Privation of any *member* or joint.
- Destruction or permanent impairing of the powers of anymember or joint.
- Permanent, disfiguration of' the head or face,
- Fracture or dislocation of a bone or tooth.
- S. 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 20 days.

APPENDIX 2

PENAL PROVISIONS RELATED TO MEDICAL PRACTICE

S.39 CrPC- 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 Magistrateor police officer of such commission or intention.

- **S. 52 IPC**- Notching is said to be alone in faith which is done Without due care and attention.
- **S.74 IPC**- Non Attendance, in obedience to summon from court.(6 month imprisonment).
- **S.175 IPC**- Omission to produce the documents to public servant byperson legally bound to produce it. (6months imprisonment.).
- **S. 176 IPC**- Omission to give notice or information to publicservant by person legally bound to produce it. (1 month imprisonment).

- **S.177 IPC**- Furnishing false information. (Upto 6 months Imprisonment)
- **S.179 IPC**- Refusing answering to public servant authorized toquestion, (Upto 6 months imprisonment).
- **S. 191 IPC**- Giving false evidence.
- **S.182 IPC**- Fabricating false evidence.
- **S.193 IPC**- Punishment for fal8e evidence (upto 7 years imprisonment).
- **S. 194 IPC**- Giving or fabricating false evidence with intent to produceconviction of capital offences. (upto 10 years imprisonment).
- **S. 197 IPC**- Issuing or signing false certificate. (upto 7 yearsimprisonment).
- **S. 201 IPC**: Causing disappearance of evidence of offence or givingfalse information to screen offender.(upto 10 years imprisonment).
- **S.202 IPC**: Intentional omission to give information of offence. (upto 6months imprisonment)

SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

ANNEXURES (FORMS)

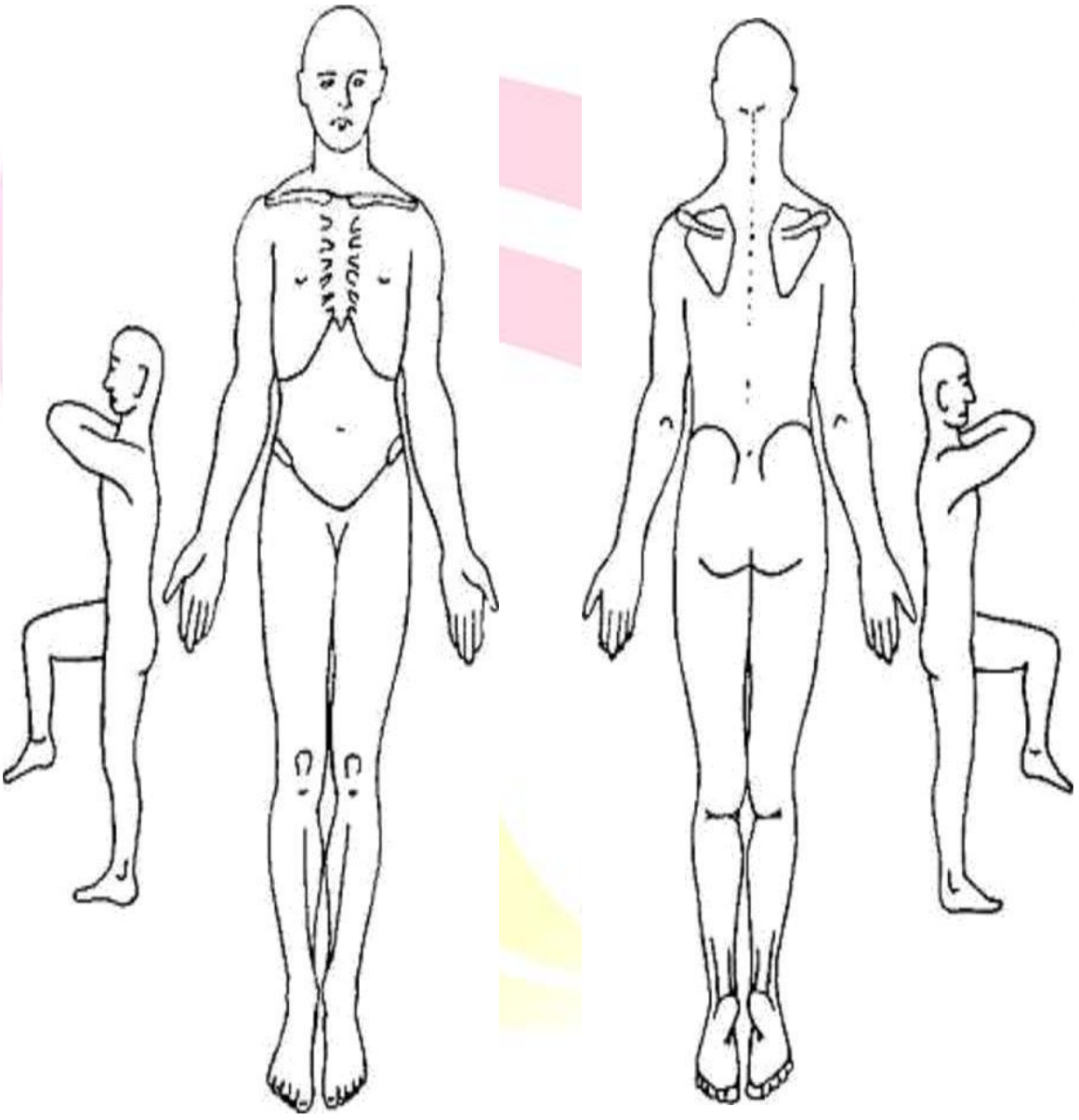
ANNEXURE-1

(Medico legal Case sheet)

RegistrationNo- (No.Year) Date-	Name... ... ... S/o/W/o/D/o... ... ... .Age.. , ... Sex... Occupation... ... . Address ... . Brought by (a)... *(b).* Police stat.ion.. . Case DD/ FIR No... ... Date ... ... Investigation Officer (Name and batch No)
Signature/Thumb Impression of the examinee:(LTI for male and RTI for female)	Consent: Alleged History:

	Examination:
Identification Mark permanent mole /scar /nevus/tattoo)-	Advice:
	Referred to department of(If Required): Specimens preserved:
	Nature of Injures (Simple/ grievous/ Dangerous):
	Signature of Medical Examiner:
	Name:
Specimens and MLC handed Over to: Signature:	Designation
	Place of 'duty: "
Badge No. .. . . Polica station...	Address:

(Medico legal Case sheet)



RE-2

(Intimation of MLC)

From:
Saideep Healthcare Research Pvt Ltd Ahmednagar.Viraj Estate Yashwant colony near DSP Chauk

Pin: 414003

To,
The Sub — Inspector of the Police,
Subject : Information regarding a Medico-legal case

Sir/ Madam,

This is to inform you that patient by name... . .
male/female, aged ... ... , ... years, son/daught.er/wife of...
... .. , ...resident. Of
.....has been brought into the Emergency Department / OPD/ Ward at. . ...
am/pm on. . .. .alleged to have been. ..

(State brief history and condition of the patient)
at... ... ... .am/pm on (date of incident).....at theplace)
Attending Doctors Name And Designation:... ... ...
Reg.No

Signature of Doctor:

Date and Time
He/She is being treated as out/ in patient in Ward No/OPD/ward/Emergency

This information was already given on telephone to .....Buckle no... ... ...(Name of Police Officer) of police station... . . . on... ... ... .at... ... ... am/pm. Please do the needful.

Date:

Time:

Yours' FaithfullySign :

Name:

Designation of security personnel:

ANNEXURE-3

(Intimation of death in MLC)

From:
Saideep Healthcare Research Pvt Ltd Ahmednagar.Viraj Estate Yashwant colony near DSP Chauk

Pin: 414003

To,
The Sub — Inspector of the Police,
Subject : Information regarding a Medico-legal case

Sir,

This is to inform you that the patient by name..... male/female aged years, son/daughter/wife of resident of ..... who was admitted in this hospit.al in is ward No./OPD/Emergency.....on .....at. ..... a.m. /p.m. as a Medico-legal case has expired on ..... at. a.m./p.m

OR

is brought dead to this hospital on..... at.a.m./p.m.

The information of Medico-legal registration was already sent on. .....at

Please do the needful.

Date:.....

Yours faithfully

Sign:.....
Name:. ..
Designation:

Time:.....

ANNEXURE-4

PROFORMA FOR EXAMINATION AND REPORT OF A CASE OF INJURY

Requisition from SI. of Police ... ... vide letter no. ... ... Dated... ...
for examination of ... ... escorted by P.C. no. ... ... Name .

Place of Examination:

Date and Time of Examination:

1. Name: ... ...
2. S/o/ W/o fD/o... ... .
3. Address: .. .. , ... ,.. ... ... , ... ,.. ... ...
4. Age as stated:
5. Religion: ... ...

6. Occupation:
7. Brought and identified by. ..
8. Consent given in writing:

I ... ... .s/o, d/o, w/o. with complete consciousness, free-will and without any pressure give consent for medical examination. I have been clearly explained about the examination andthe result/findings could be in my favour or against.

Signature

9. Examination in presence of :

10. Identification marks' a... ... ... b ... ...

11. History as given by the patient (if unable to speak by the personaccompanying the patient):

a. How the injury was sustained, if assaulted, no. of persons whoassaulted

b. Whether any weapon was used, if so what type of weapon;if it was hard, blunt or sharp cutting or pointed etc.

e. Date and time of infliction of injury.

d. Whether any first aid treatment was given anywhere

e. Whether dying declaration is/was recorded as required.

12. On Examination:

a. If unconscious: degree of unconsciousness,

b. BP/Pulse:

d. Respiratory rata

f.. RS

g. CVS

h. P/A

i) Any bleeding from nostrils ,ear, mouth etc.

j) Prognosis good/uncertain

13. Physical examination :each Injury is to described as follows:

Sr.No	NATUREDF INJURY	SIZE	SITE	DESCRIPTION, DURATION OF INJURY	SIMPLE, GRIEVOUS OR DANGER OUS	BY TYPE OF WEAPON INFLICTED

Materials preserved

.....

Advice

.....

Final Opinion: ....
....

Name and Signature of M.O SEAL

Annexure -5

Examination Of Weapon

Letter No. Date .

To,
The InvestigatingOfficer,

Subject- Regarding examination of given weapon/ article.

Reference- Your letter no. ....., dated .....
., P.S. .....

In reference to above case and PM report no. ....., received a seal packet bearing
. no. of seal of P.S. ..... For examination and subsequent
opinion.

Along with sealed packet following document are submitted by police-1. Case diary.....
2. P.M. report no. .....
3. MLC report no. .....
4. FSL report no.
5. Any another document.....

Examination of weapon/ articles-

Before opening the packet, describe seal , date , PM No., MLC.No, PoliceStation , DD,

FIR No.

On opening the packet a .....(name of weapon andarticle) is recovered. The detailed examination is as follow:

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

Made up of material .....

Part .....

.....

Weight .....

.....

Blunt or sharp .....

Edges —single / double and/ or serrated/ non serrated: .....

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

In case of lathi, bamboo, rod etc.

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

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

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

Dimensions : As per diagram.

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

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

Date Name and Signature of M.O.

SEAL

ANNEXURE-6

Examination of Case of Drunkenness

No.: MLC No./…/20.

Date:

Name : …… s/o, d/o, .Age: ……..w/o……

Sex: M / F Marital stat

Address……

Brought by: Nome - , Batch No. - ,PS-

Identification marks

(2)Date & Time of examination
consent

I ... ... .s/o, d/o, w/o ..... with complete consciousness, free-will and without any pressure give consent for medical examination. I have been clearly explained about the examination and the result/findings could be in my favouror against.

Signature

History……

Examination -

General behavior ……

Clothing……..

Speech……

Self control……

Memory and mental status…….

Writing

Pulse ……

Skin

B.P.... Temp,……..

Mouth

Teeth,,,,

.

Conjunctiva

Pupil...

Lateral gaze nystagmusGait ...

Mr.Evan's sign

... . .

Ears ..

Reflexes .

Stance ...

.. .

Muscle coordinationC v s

Respiratory system

Abdominalexamination

Collection of samples - (1). Blood(2). Urine

opinion -

1. Person has not consumed alcohol
2. Person has consumed alcohol, and
   (a) not under the influence of alcohol, or
   (b) under the influence of alcohol, or
   (c) intoxicated with alcohol

Date

Signature & Seal of M.O.

Place

ANNEXURE-7

SEXUAL OFFENCE- EXAMINATION OF ACCUSED/EXAMINATION OF POTENCY

PHDTOGRAPH

No.MLI/sex/...../20.....

To,
P.S.
District.....

Subject: Regarding medical examination of .....s/oin connection with Cr. No..... U/S:

Reference : Tour letter No .....dated .....,,,,.,., P.S.....

Date:
Particulars-

Name: .....S/o .....

Age: ..... Sex:Male Marital Status
Address:

.....

...

B/B : Name- ..... Batch No.....P/S-
Identification mark: 1. ....
Date and time of examination:

Consent:

I ... . .s/o ..... ,with complete consciousness, free-will and without any pressure give consent formedical examination. I have been clearly explained about the examination and the result/findings could be in my favour or against.

Signature

History : [as per ..... (name of informent)]

(1) General physical examination —

i. Built.....
ii. Height .....,.....
iii. weight.....
iv. Central nervous system:.....
v. Cardio vascular system:.....
vi. Respiratory system.....
vii. Abdomen.....

(2) Secondary sexual characters-

i. Voice : feminine/crackling/hoarse
ii. Adam's apple: prominent/non prominent
iii. Beard:
iv. Mustaches:
v. Chest hair:
vi. Auxiliary hair:

(3) Examination of clothing- the peraon under examination is wearing/not wearing (Colour) under garment. Which

shows ..... stains

on

.....region on naked eye examination

(4) Genito —perineal examination

i. Development of genitals.....
ii. Pubic hair.....
iii. Penis.....
a. Condition.....
b. Injuries of frenulum/prepuce/glans.....

c. Smegma.....

Scrotum.....

iv. Testis and epididymis.....

v. Cremastric reflex.....

Superficial abdominal reoex ....

VI. Signs of veneral diseases.....

V.

(5) Injuries on body

(6) materials collected for investigation-

- Undergarment/clothing
  - Penile smear slide and swab
  - Material preserved for DNA
  - Any other sample

Opinion : nothing could be found significant to suggest that theperson under examination is not capable / capable to perform sexual intercourse under normal circumstances.

Date:..... Seal and Signature of M.O.

Place.....

NEXURE-8

FORM NO. 4(See Rule 7)

Medical certificate of cause of death

Hospital in-patients not to be used for still birth
[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 belowdied in The hospital in ward No. ....

on .... at am/pm.

NâME OF DECEABED					
Sex	Age at Death				For useof statistical Office
	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 inHours	
1. Iale 2. Femae					
Cause of Death				Interval between onset & death (approx)	
I. **Immediate cause** State the disease, injury or complication which	a....				

caused death, not the mode of dying such as heart failure, asthenia etc.	Due to (or as a consequences of)		
Antecedent cause Morbid conditions, if any,giving rise to the above Cause, skating underlying condition last	b.... . Due to (or as a consequences of)		
II. Other significant Condition contributingto the death. but not related tothe disease or conditions causing II			

Manner .of Death How did the injury occur?
1. Natural 2. Accident 3. Suicide 4. Homicide
S. Pending Investigation

If deceased was a female, was pregnancy the death associated with? 1. Yes 2. No If yes, wins.there a delivery? 1. Yes *. No

Name and signature of the Medico l Attendantcertifying the cause of death Date of verification

---

(To be detached and handed over to the related of. the deceased) Certified that Shri/Smt/km ... . S/w/D of Shri. ....

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

(Medical Supdt.)Name of Hospital

ANNEXURE-9

Form for medical examination of survivor of sexual assault:

https://mohfw.gov.in/sites/default/files/953522324.pdf

Note : The given forms in the manual must be used by the doctors in respective cases as they are standardized and approved by the expertsof Ministry Of Health And Family welfare.

IMPORTANT CONTACTS

1. Police Chowki/ Post Ahmednagar :

2 Emergency

3. Medical superintendent:

4. Director office

5. Mortuary: