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

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Abstract

Sudden Death, whether the death of patient on the operating table, or the death of arrested accused in legal custody, is a matter to introspect, as it is profoundly serious event with extensive ramifications. The implementation of comprehensive guidelines, combined with sincere adherence to these protocols, can significantly reduce the occurrence of such tragic incidents. Moreover, these measures can mitigate the impact when such events do occur. By focusing on preventive strategies and thorough procedural compliance, the healthcare system can enhance patient safety and trust, ultimately leading to better outcomes and a reduction in the frequency and severity of these critical incidents. Similarly the Police department, focusing on prevent the 3rd degree physical torture during interrogation and strict watch by CCTV camera in the Prison, may enhance the sense of security & faith on legal system.

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

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

INTRODUCTION

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

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MATERIAL & METHODS

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

DISCUSSION

Death on the Operation Table

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

completion of surgery, it is considered to be directly related to surgery / anesthesia (unless proved otherwise) and is seen with greater seriousness.

In the United Kingdom (excepting Scotland), approximately 20,000 deaths per annum occur within 30 days of surgery, 2000 of which occur within 24 hrs of surgery. About 100 (5%) of these deaths occur intra-operatively, a figure that has remained consistent throughout the last decade.[1] The data in Indian hospitals is not clear. It is likely to be more than this and a significant number of some cases also go un-reported. Practically all surgery & anesthesia consultants must have encountered one or more DOT during their professional career. Although all cases of hospital death are sad but DOT, especially when unexpected, has special significance. When death occurs intra-operatively or within 24 hrs, it has medical, legal & socio-legal consequences.

The surgeons & anesthetists are indeed trained to prevent deaths or attempt, with dedication, the resuscitation process, but are not trained to handle the situation that develops after such an event has occurred. Their distress, particularly when it was an unexpected event, is immense. They are themselves sad because of death of their patient and at times, when they had put in extra-ordinary amount of effort, may even require some emotional support for themselves, to overcome the depression & stress. They are not adequately trained in grief counseling and in communication skills, especially when they are exposed to a large number of family members & friends of the deceased, with accusing expressions, and aggressive body language. Moreover, the emotional stress on their minds might result in errors when they handle the next case. A questionnaire survey in the British Medical Journal highlighted attitudes of surgeons to intra-operative death.[2] A feeling of sadness, helplessness & guilt tends to affect the surgeons/anesthetists, who indeed are human beings with their limitations. Most surgeons & anesthetists recommend that the concerned surgeon/anesthetist should avoid conducting another procedure for the next 24 hrs after an intra-operative death. It may not be advisable to generalize this for all DOTs, but it does reflect the need for the performer to attain the optimum level of emotional stability before doing the next case. The circumstances in all cases of DOT are not similar. There are high risk situations where DOT was a significant possibility / probability, before hand and the family members were mentally prepared for it. A sympathetic grief counseling is all that is required in such a case and there may be no reason to defer the next surgery for 24 hrs.

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

Whether deaths were 'expected' or 'unexpected', may not be important or relevant in all cases. A death in the hospital itself is unwelcome and if it is directly related to a surgical procedure, the sadness increases many folds. 'Humane' doctors are psychologically conditioned to be sensitive to a mortality and they even run a potential risk of getting into depression & anxiety in some cases.[3] The other view point is that the professionalism in doctors helps them to cope with such situations objectively and without affecting their emotional stability or their professional competence & skills, they can move forwards with their subsequent professional tasks.

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

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

The risk management strategy should include a detailed joint assessment & preparation meeting (including the surgical & anesthesia team, OT nurse & technician allotted for the case, biomedical engineer, blood bank representative, hospital

manager and any other expert relevant for the case) in the pre-operative period, as a routine protocol, prudent & objective counseling of the patient / family members, recounting the safety precautions during surgery and the resuscitation protocol and grief counseling protocol. These guidelines, if properly prepared and honestly implemented will be useful for all the parties involved. Such guidelines should actually be included in the UG & PG curriculum.

Standard Operating Protocols (SOPs) for preventing DOT:

Step by step Guidelines suggested are as under

Honest discussion with the patient / family members about the contemplated procedure, plan of execution, expected benefits and risks involved. Measures adopted to contain the risks and other options with their pros & cons.
Document the counseling and Consent & get their signatures

⇓

Good Pre-operative evaluation & assessment by Surgeon & Anesthetist & support systems ⇒ Good Pre-operative evaluation & assessment by Surgeon & Anesthetist & support systems

⇓

If a complication has occurred during surgery / anesthesia, apart from measures to tackle the complication, some team member should tactfully inform the family, what has happened, condition of the patient, what measures are being taken to handle the complication. Suggest that they all should pray to God to help us.
If it is taking long, such briefing should be done more than once, as required

If DOT has occurred, the operating & circulating team members must collect & be debriefed by the team leader, reminding everybody that it was the will of God the Almighty and we need to bow before Him. The steps to be followed should be as under:

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

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

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Precautions if you sense aggression / violence

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

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Some clarifications

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

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

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

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

Do not talk to the large group of family members together and do not talk to them in the waiting area or in the corridor. Select 2 or 3 responsible members, make them sit in a room and talk to them with all sensitivity & empathy.

Your tone & tenor, facial expression, body language and the content of communication must reflect sensitivity, sympathy, compassion and empathy. It should certainly NOT give a reflection of guilt, frustration or failure. The communication should follow the dictum, "Doctor can make prudent efforts but the result is in the God's hand".

The content of your communication should be honest but tactful. If a realistic prognosis and outcome possibilities had been communicated in the pre-operative consent counseling, this communication become a bit easier. An example of such a communication could be something like, "I have the unpleasant task to give the bad news. The procedure started well but by the time we had removed the extensive tumor, the patient started bleeding. The bleeding was significant and from multiple places. We packed the area and gave blood transfusion. By the time we removed the packs, we realized that the patient had started bleeding from more areas though the ferociousness of bleeding had got reduced. Taking this to be DIC, we sent for the relevant investigations and gave fresh blood & FFPs to control the situation. We brought in cardiologist & the clinical hematologist on board and made all the possible efforts but unfortunately, we could not save him. We feel sad for this loss. We would like a post mortem examination, with your consent, to know exactly the cause of death". Allow them to ask questions and provide the answers with tactful honesty. Be a good listener. Don't mind their outbursts, in view of the sensitivity of the situation.

If they agree for the PME, inform the police and let them take on from there.

If they don't agree for the PME, take their refusal consent. Informing or not informing the police will depend on the level of satisfaction of the family members of the deceased. If they are satisfied with the explanations given and are willing to document it, the police may not be called and the body may be handed over to the family by following due protocols. However, if they are not satisfied or confused / ambiguous about it, intimation to the police becomes necessary. It is important to convey

to them that it is obligatory for them to intimate the police and that the body of the deceased has to be handed over to the police, in cases of DOT. And they may decide about it by the time police arrives and discuss with them whether PME is desired or not. The police have the power to waive off a PME and can take a call on the matter.

In the meantime, complete your medical records, particularly the operation notes, anesthesia notes, mortality note and death summary.

If the police had been called, they need to be shown the operation room & the other details related to the surgery & the mortality. The police might take photographs, seize used ampules / vials, tubes, catheters, samples etc, following the seizure protocol. They will prepare a panchnama & undertake some other formalities. Depending on the circumstances, the police may allow you to clean up the area or may decide to seal the area.

In case the family members of the deceased have collected a mob, It might be important to not only call the members of the fraternity & other socially important persons but also file a complaint of intimidation & rukus against them. Under these circumstances, avoid direct interaction of the surgeon & anesthetist with the mob and may interact through the hospital manager or a deputed spokesperson.

The surgeon & anesthetist and their team members should be insulated from the mob and taken away to a comfortable place.

Custodial death or Death in Legal Custody (DLC) has some similarities & some differences from Death on Operation Table (DOT). DLC may occur in Police custody or in judicial custody and in both situations, there is a possibility of exploitation of official 'power'.

Similarities between DOT & DLC

1. In both, the access is not available to the person's family
2. In both, the doctor / police or jail official is the dominant party and the person on the table / person in custody is the vulnerable party
3. In both, the person is dependent on the discretion & actions of the dominant party
4. In both, exploitation & human right violations are well known
5. In both, the burden of proof shifts on to the dominant party which is exclusive control of the vulnerable party
6. In both, after the event the victim gets lot of public sympathy in general and media traction in particular. The impact & consequences of both in terms of human rights and penal action are similar.
7. In both, the investigation requires to assess whether the cause of death was illness / natural cause or negligence. In DLC, additional element of suicide & abetment to suicide is also relevant. In DLC, complicity with a 3rd person with an intent to kill, is also investigated where relevant
8. The operating surgeon & Anesthetist are vicariously liable for the actions & omissions of their team members, in civil courts. The SHO is vicariously liable for the acts & omissions of his team members, in civil courts. In criminal courts the vicarious liability will not apply
9. Shifting the patient from OT to ICU to escape liability does not help if death is declared within 24 hrs of shifting & if the cause is directly related to the surgery. Similarly, shifting the prisoner from the lock-up to the hospital to escape the liability does not help if the death is directly related to events against him, in police custody
10. In both, doctrine of egg – shell skull rule may be considered in deciding compensation in civil litigation.[4] This takes into consideration the pre-existing hidden / latent medical conditions which may get triggered or aggravated by the events in the Operation Theater or in the police custody

Differences between DOT & DLC

1. In DOT, the patient had approached the doctor voluntarily for help and consented for the procedure. In DLC, the police had approached the person and took him along against his wishes, without his consent
2. In DOT, intention for the process was for the benefit of the person concerned. In DLC, the intention for the process was for judicial action against this person
3. In DOT, report of the medical negligence board, besides the PME is very important. In DLC, the PME & opinion of Forensic experts is very important
4. In DOT, surgery for life threatening conditions with proper DOT consent absolves the doctor, if he dies despite best efforts. In DLC, if the arrested person is ill, he needs to be hospitalized & he can be kept in custody at the hospital.

Custodial death:

Custodial death is a death that occurs while a person is in the custody of law enforcement agency. Though when in judicial custody there is no direct control of the police yet the circumstances are similar. Death in Legal Custody (DLC) can occur due to various causes such as use of excessive force, neglect, or abuse by the authorities and includes cases pushed into suicide as also complicity with a 3rd person intending to kill. Some cases do get un-reported also or get mired into the ambiguities of investigations and cover-ups. A total of 669 cases of custodial deaths have been reported in India in 5 years, from 1.4.2017 to 31.3.2022.[5]

The constitutional provisions (Article 21 & 22), the Human Rights Act 1993, CrPC S.41 (now BNSS S-33-38), IPC 330, 331 (now BNS S-120), Indian evidence Act S-25, 26 (now BSA S- 22, 23) and Indian Police Act 1861 (S-7, 29) have touched upon the rights of the arrested persons and duties of the Police / Jail authorities. Some detailed guidelines have also been given by the courts & other authorities. However, there should be some mechanism to ensure strict compliance with those guidelines.

The DK Basu case is regarded as the most landmark case of the criminal jurisprudence.[6] The Apex Court laid down the following guidelines and said that arrest and detention will be subject to the guidelines. The violation of these guidelines would attract not only the departmental action but also the contempt of court proceedings in a High Court having the jurisdiction over the matter. The guidelines are as follows:

1. The police officer who arrests and handles the interrogation of the arrestee must wear accurate, visible and clear identification and name tags with their designations. The details of all such police personnel who handle interrogation must be recorded in a register.
2. The police officer carrying out the arrest must prepare a memo of arrest at the time of arrest and it shall be attested by at least one witness who may be either a member of the family of the arrestee or a respectable person of the locality from where the arrest is made. It shall also be countersigned by the arrested person and shall contain the time and date of arrest.
3. A person who has been arrested and is being held in custody in a police station or interrogation centre or other lock-up shall be entitled to have one friend or relative or other person known to him or having an interest in his welfare be informed, as soon as possible, about his arrest and detention in a particular place, unless the attesting witness of the memo of arrest is himself such a friend or a relative of the arrestee.
4. The time, place of arrest and venue of custody of an arrestee must be notified by the police where the next friend or relative of the arrestee lives outside the district or town through the Legal Aid Organisation in the District and the police station of the area concerned telegraphically within a period of 8 to 12 hours after the arrest.
5. The person arrested must be made aware of his right to have someone informed of his arrest or detention as soon he is put under arrest or is detained.
6. An entry must be made in the case diary at the place of detention regarding the arrest which shall also disclose the name of his next friend who has been informed of the arrest and the names and details of the police officials in whose custody the arrestee is.

7. On request, the arrestee should be also examined at the time of his arrest and any major and minor injuries, if any present on his/her body, must be recorded at that time. The "Inspection Memo" must be signed both by the arrestee and the police officer and a copy must be given to the arrestee.
8. The arrestee should be subjected to a medical examination by a trained doctor every 48 hours during his detention in custody by a doctor on the panel of approved doctors appointed by the Director, Health Services of the concerned State or Union Territory. Director, Health Services should prepare such a penal for all Tehsils and Districts as well.
9. Copies of all the documents including the memo of arrest, referred to above, should be sent to the Magistrate for his record.
10. The arrestee may be allowed to meet his attorney during interrogation, although not throughout the interrogation.
11. A police control room should be provided at all district and state headquarters, where information regarding the arrest and the place of custody of the arrestee shall be communicated by the officer who was in charge of the arrest, within 12 hours of effecting the arrest and at the police control room it should be displayed on a visible notice board.

However, after this case, the instances of custodial death and violence have reduced but it didn't stop. Some of the guidelines unfortunately, have been limited to mere paper regulations. The authors hope that the guidelines will be taken seriously, at all levels and followed in letter & in spirit.

CONCLUSION

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

Conflict of Interest: Nil

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