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

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Abstract

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

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

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

INTRODUCTION

The word "custody" means caring and protective care.[1] Thus, the custodian has the legal duty to take care of somebody under their custody. So, the Custodians, whether a police officer or medical officer on duty, are legally bound to provide protective care. And during hospitalization whether for surgery or medical management, the healthcare providers (HCPs) have the legal duty to provide care in the best interest of their patients. Death on the Operation Table (DOT) is rare but a serious condition, not only for the grieving family but also for the surgeon & anesthetist concerned. It has adverse medico-socio-legal consequences. There is a need to prepare guidelines for prevention & anticipation of DOT as also for the overall handling of the situation, as & when it happens.

MATERIAL & METHODS

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

DISCUSSION

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

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

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

Death on the Operation Table

Operative death is **defined** as death occurring within 30 days,[4] of surgery / Anesthesia. The cause of death is generally considered to be directly or indirectly related to surgery. However, if death occurs on the operation table or within 24 hrs. of completion of surgery, it is considered to be directly related to surgery / anesthesia (unless proved otherwise) and is seen with greater seriousness.

Incidence

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

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

Mishaps in OT

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

Deaths in Robotic Surgery

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

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

Preventable Anesthesia Mishaps

A 1978 study by Cooper *et al.*,[11] found that 82% of preventable anesthesia mishaps were the result of human error. The surgeons & 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 (2001), highlighted attitudes of surgeons to intra-operative death.[12] 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, beforehand and the family members were mentally prepared for it. A sympathetic grief counseling is all that is required in such a case and there may be no reason to defer the next surgery for 24 hrs.

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

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

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

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

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

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

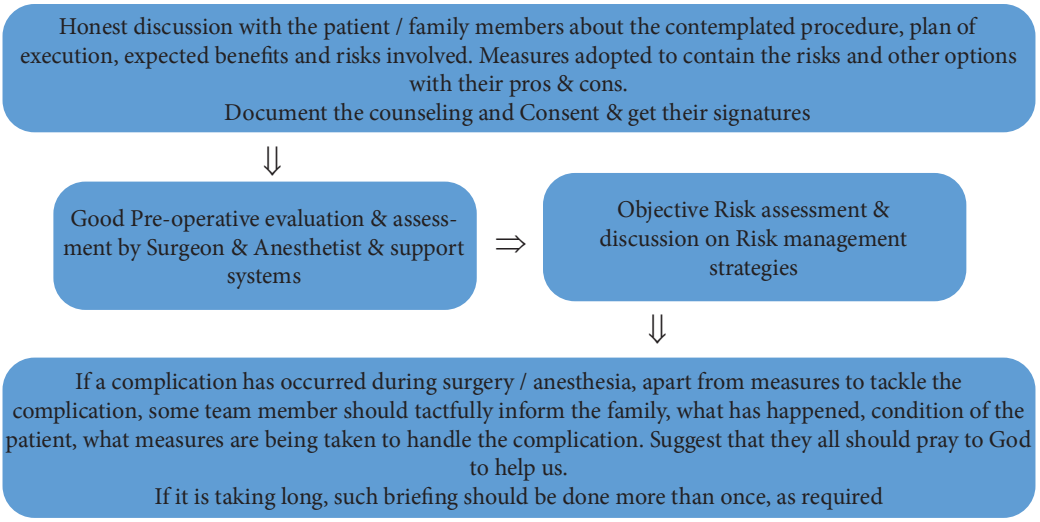
No doubt, these events are rare and heterogenous. There is also some resistance to implementing quasi-judicial directives. In the absence of research and hard evidence, guidelines based on personal clinical & medico-legal experience may be an acceptable approach.

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

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

Suggested Operating Procedure (SOPs) for preventing DOT:

Step by step Guidelines suggested are as under



Debriefing of the Incident

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

A quick debriefing session to ensure

1. Unanimity & Consistency on facts
2. Unanimity & Consistency on possible cause of death
3. Delegate one person to ensure that the OT is not cleaned up till further orders. The broken 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

⇓

Precautions if you sense aggression / violence

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

⇓

Some clarifications

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

Debriefing & Time Out

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

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

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

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

a room and talk to them with all sensitivity & empathy.

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

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

d) If they agree for the PME (Postmortem Examination), inform the police and let them take on from there. In most cases of anesthesia-related deaths, autopsy findings are unremarkable, as there are no specific diagnostic changes pathognomonic of anesthetic-related mortality. Absent underlying conditions like myocardial infarction, deaths from anoxia or acute cardiovascular collapse typically lack distinct pathological features, making diagnosis challenging.[15]

e) During Autopsy, the Forensic expert must preserve the viscera for histopathology and toxicology. Histological examination of the brain is crucial, particularly to detect the effects of hypoxia in specific regions like Sommer's area of the hippocampal gyrus and the cerebellum, where changes are likely to occur even with brief hypoxic episodes. In victims who suffered short-term hypoxia but survived for an extended period under anesthesia, brain morphology typically reveals diffuse and severe leuco-encephalopathy in the cerebral hemispheres, with notable sparing of the immediate sub-cortical connecting fibers.[16] In cases of autopsy for suspected Anesthetics deaths, it is essential to send the injection site, blood, and liver samples for toxicological analysis to identify the local anesthetic and its metabolites. When interpreting the toxicology report, it's important to consider that certain drugs can interact with anesthetic agents, either potentiating or altering their effects. Additionally, during autopsy, the distinctive odor of the anesthetic agent used for general anesthesia (e.g., Ether has sweet smelling but pungent odour) may be detectable, providing a crucial clue for medicolegal investigation.[16]

f) If they don't agree to the Autopsy, take their refusal consent. Informing or not informing the police will depend on the level of satisfaction of the family members of the deceased. If they are satisfied with the explanations given and are willing to document it, the police may not be called, and the body may be handed over to the family by following due protocols. However, if they are not satisfied or confused / ambiguous about it, intimation to the police becomes necessary. It is important to convey to them that it is obligatory for them to intimate the police and that the body of the deceased has tobe handed over to the police, in cases of DOT. And they may decide about it by the time the policearrive and discuss with them whether PME is desired or not. The police have the power to waive off a PME and can take a call on the matter.

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

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

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

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

Relevant Case Laws on alleged DOT

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

a) **Iatrogenic Death on Table (DOT):** Pharmacological toxicity resulting in First Indian Lawsuit for alleged Medical Malpractice. In 1953, a 20yrs old male victim of Roadside trauma with femur fracture, was prescribed opioid analgesic in fatal overdose, causing sedation with comatose state & failed to recognise the toxicity, died of due to negligence of the treating doctor, resuscitation initiated after 4 hrs, only when patient's father (who was also a doctor) raised the alarm. Hon'ble Supreme Court held the Hospital & doctor liable.[17]

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

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

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

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

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

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

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

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

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

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

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

c) Court held the anesthetic negligent:[23] In the case of Goyal Hospital and Research Centre Pvt Ltd v Kishan Gopal Shukla,[24] the pregnant patient with preexisting disease: mitral stenosis and regurgitation was carried to full term without early termination advice. A caesarean section under general anesthesia led to coma and death. The National Commission deemed the anaesthetic procedure negligent, highlighting the importance of informed choices. Epidural analgesia could have avoided fatal complications.[25] Similarly, in MC Katare v Bombay Hospital and Medical Research Centre,[26] the choice of general anesthesia over spinal anesthesia for a patient undergoing surgery was deemed an error of

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

Medicolegal Analogy in the Institutional Deaths:

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

Similarities between DOT & DLC

1) In both, the access is not available to the person's family.
2) In both, the doctor / police or jail official is the dominant party and the person on the table / person in custody is the vulnerable party.
3) In both, the person is dependent on the discretion & actions of the dominant party.
4) In both, exploitation & human right violations are well known.[31]
5) In both, the burden of proof shifts on to the dominant party which is exclusive control of the vulnerable party.
6) In both, after the event the victim gets a lot of public sympathy in general and media attraction in particular. The impact & consequences of both in terms of human rights and penal action are similar.
7) In both, the investigation requires to assess whether the cause of death was illness / natural cause or negligence. In DLC, additional elements of suicide & abetment to suicide are also relevant. In DLC, complicity with a 3rd person with an intent to kill, is also investigated where relevant.[32]
8) The operating surgeon & Anesthetist are vicariously liable for the actions & omissions of their team members, in civil courts.[33] The SHO is vicariously liable for the acts & omissions of his team members, in civil courts. In criminal courts the vicarious liability will not apply.
9) Shifting the patient from OT to ICU to escape liability[34] does not help if death is declared within 24 hrs. of shifting & if the cause is directly related to the surgery.[35] Similarly, shifting the prisoner from the lock-up to the hospital to escape the liability does not help if the death is directly related to events against him, in police custody.
10) In both, doctrine of **egg – shell skull rule** may be considered in deciding compensation in civil litigation.[36] This takes into consideration the pre-existing hidden / latent medical conditions which may get triggered or aggravated by the events in the Operation Theater or in the police custody. In the U.S. the **most common cause of custody death was natural illness** and disease progression such as heart disease and cancer.[37] Similarly, in the (DOT) Death on Operation Table, the most common cause considered is sudden cardiac death,[38] acute exacerbation of the co-existing natural illness (Cancer, Coronary Artery Disease with acute massive myocardial infarction, Acute Exacerbation of Asthma, Allergic anaphylaxis to anesthetic agent, Pulmonary Embolism, Massive Bleeding, Brain Stroke or Ruptured Aneurysm of major vessel), for which patient is admitted and undergoing the surgery.

Differences between DOT & DLC

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

Custodial death:

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

Definition of Custodial Death

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

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

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

Manner of Death in DPC

The manner of death in custodial deaths is closely tied to the cause of death, and the findings often overlap. The manner of death can be classified into six categories: self-inflicted, natural causes, justifiable homicide, unlawful homicide, accidental, or other. Self-inflicted deaths include suicides, such as hangings and self-inflicted gunshot wounds. Justifiable homicide refers to lawful killings, like a prison officer acting in self-defense. Right of private defence of body can be stretched to the extent of voluntarily causing death. Killing without evil or criminal intent: To claim such a right, the accused duty officer must be able to demonstrate the circumstances were such that there existed a reasonable ground to apprehend he would suffer grievous hurt that would even cause death.[43] But wrongfully confining a person by police officer is not justifiable, so if during illegal arrest, death occurs, then it's not acceptable as a legal defence, as per Section 37 of BNS, 2023: Acts against which there is no right to private defence.[44]

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

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

Thorough investigations are essential to determine the cause and culpability of custody deaths, as some may be preventable, while others may not. A total of 669 cases of custodial deaths have been reported in India by National Human Rights Commission (NHRC) during 5 years, from 1.4.2017 to 31.3.2022.[48] According to the National Crime Records Bureau (NCRB) data, over the past decade (2010 to 2019), out of 1,004 deaths in police custody, 69% were attributed to natural causes, with 40% due to illness and 29% classified as suspected suicides.[49] Deaths is police custody are reported initially as suicide, in the news by the concerned police authority, but on postmortem examination by medical board during Magistrate inquest, reveals physical assault and police torture, due to multiple injuries with different delicate sites on victim's body with different duration of injury (Battered Person due to Custodial Violence) as per the colour changes in the Abrasions, Bruise & hematoma in vital areas with passage of time, highly unlikely to be due to self-harm.

Role of NHRC in Reporting DPC & Autopsy Mandatory

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

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

Autopsy in DPC

Properly conducted autopsies and post-mortem reports can serve as powerful evidence of police abuse in custody. **Postmortem** of Custodial Deaths is mandatory, to be done by a medical board of senior Medical Officers including one Forensic Medicine Expert, appointed by Medical superintendent of the District Hospital/ Principal of Government Medical College, and Complete Digital Videography by a professional photographer, recording the whole procedure of postmortem examination is recommended by NHRC, which should be submitted by the investigating Magistrate to the concerned Court, with his investigation report. A review of autopsy reports on young girls and women died in police custody, reveals forensic biases and stereotypes about rape during these examinations.[56] The 2014 guidelines by the Ministry of Health and Family Welfare for the medico-legal examination of survivors and victims of sexual violence need to be followed even in cases of death.[57] These guidelines should also include specific instructions for examining lesbian, gay, bisexual, transgender, queer, and intersex individuals. An analysis of post-mortem reports on custodial deaths highlights existing gaps in documentation, such as the absence of provisional medical opinions or explanations for possible causes of injuries, persistent comments on the status of the hymen and vaginal introitus, and a lack of understanding regarding the limitations of medical evidence.[58] Though when in judicial custody there is no direct control of the police, the circumstances are similar. Death in Legal Custody (DLC) can occur due to various causes such as use of excessive force, neglect, or abuse by the authorities and includes cases pushed into suicide as also complicity with a 3rd person intending to kill. Some medicolegal cases do go un-reported also or get mired in the ambiguities of investigations and cover-ups. The state is accountable when it fails to protect, preserve, or respect the right to life and must investigate such unlawful deaths. Healthcare providers play a crucial role in this investigation process through their thorough documentation of autopsies in cases of custodial deaths.

In the British India (before independence), the early incidence of custody death was reported in Madras in theyear 1678.[59] Thus it is popularly known as, the **first recorded instance of custodial death in India, reported in the Journal** and its certification by medical practitioners occurred in Madras in 1678. The JP Modi's Textbook of Medical Jurisprudence and Toxicology, 27th Ed. 2022,[60] describes the first reported case of custodial death in Indian History, as per the records: Thomas Savage, a British Soldier posted in Indian subcontinent, abused his superior officer in a drunken brawl and was tied to a cot, with his neck and heels bound, hands behind, and knees on shoulders. This physical restraint for conducting the third-degree torture led to his death, as per preliminary investigations. William Langhorne (Governor) ordered an inspection of Savage's body by expert surgeons. Surgeons who conducted the postmortem examination of the Tortured Dead in Legal Custody, included Dr. John Waldo and Dr. Bezaliel Sherman, who both examined the body and issued **India's first death certificate,**[61] describing the victim's cause of death: "We, the undersigned, being immediately to assist there about said Thomas Savage, found him dead with apparent marks of binding about his neck, which we judge to be the cause of his death."

Guidelines for Postmortem in DPC

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

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

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

Duties and Obligations of Doctors

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

Aims of Autopsy in Custodial Deaths

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

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

Who Can Carry Out the Post-Mortem Examination

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

Information to Next of Kin About Autopsy Procedures

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

Key Principles in Carrying Out an Autopsy

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

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

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

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

Precautions Before Conducting a Post-Mortem Examination

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

Post-Autopsy Procedures in Custodial Deaths

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

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

post-collection fermentation and putrefaction.

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

Legal Provisions & Procedures for Preventing the Custodial Deaths:

New Bharatiya Criminal laws, 2024

The constitutional provisions (Article 21 & 22)[64] of the Human Rights Act 1993,[65] CrPC, 1973 Section: 41-51 (now BNSS Act, 2023 Section: 35-49),[66] IPC Section. 330, 331 (now BNS Act 2023, Section-120) Voluntary causing hurt or grievous hurt to the arrested person, by physically torturing to extort the confession,[67] Indian evidence Act Section: 25, 26 (now BSA Act, 2023 Section: 22, 23) for Accused's confession is irrelevant if taken under threat, coercion or intoxication caused by police officer,[68] and Indian Police Act 1861 (Section: 7, 29),[69] have touched upon the rights of the arrested persons and duties of the Police / Jail authorities, to prevent the exploitation of powers, to torture the accused person, arrested in alleged criminal act.

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

Section 35: Circumstances Allowing Police to Arrest Without a Warrant
- A police officer can arrest a person without a magistrate's order or a warrant if the person commits a cognizable offense.
- In situations where arrest under sub-section (1) is not necessary, the police officer shall issue a directive for the person to attend before him.
- If the punishment for the offense is less than 3 years and the accused is either suffering from a serious illness or is over 60 years old, an arrest can only be made with the permission of the Deputy Superintendent of Police (DSP).

Section 36: Procedure for Arrest and Duties of the Arresting Officer
- Every police officer making an arrest must wear identification clearly showing their name and rank.
- An arrest memorandum will be prepared, which must be signed by a witness and the person arrested.

Section 38: **The arrested person has the right to meet an advocate of their choice during interrogation.**
- The arrested person has the right to meet with a lawyer of their choice during police interrogation, though not for the entire duration.
- If the name and address of the arrested person cannot be determined within 24 hours, they will be brought before a Magistrate.

Section 43: How Arrests are Made
- The arrest of a woman shall be carried out by a female police officer. In extreme circumstances, a male police officer may be involved but should avoid physical contact.
- A police officer may use handcuffs during the arrest or while presenting the individual in court, considering the nature and severity of the offense, especially for habitual offenders, terrorists, those involved in drug-related offenses, acid attacks, counterfeiting currency, human trafficking, child sexual offenses, or offenses against the state.
- In critical or forceful situations, if a woman's arrest must be made at night, written permission must be obtained from a Magistrate of the First Class.

Section 44: Searching a Place Entered by a Person Sought for Arrest
- If a person acting under a warrant of arrest, or any police officer with the authority to arrest, believes that the individual sought has entered or is within a place, any resident or person in charge of that place must, upon the officer's request, allow free entry and provide all reasonable facilities for a search.

Section 47: Persons arrested must be informed of the grounds for their arrest and their right to bail by the arresting police officer.
- Every police officer who arrests a person must inform them of the reasons for their arrest and their right to seek bail.

Section 48: Duty of Person Making Arrest to Inform Relatives or Friends.
- The police officer or any other person making the arrest must promptly provide information about the arrest and the location where the arrested person is being held to any of their relatives or a person nominated by the arrested individual. If the offense is bailable, they must also inform the arrested person about their right to seek bail.

Section 52: Medical Examination of Accused arrested in Rape Cases
- When an individual is arrested on suspicion of committing rape or attempted rape, they shall undergo a medical examination conducted by a Registered Medical Practitioner at the request of a police officer.
- The medical professional shall promptly prepare a report containing all relevant information, including DNA profiling of the accused, and forward it to the investigating officer.

Section 53: Medical Examination of Arrested Persons.
- Upon arrest, a medical officer shall conduct an examination of the individual and provide a copy of the report to the arrestee or their designated representative.
- In cases where the arrestee is female, the examination shall be performed by a female medical officer.

Section 55: Procedure for Arrest without Warrant by Subordinate Officer.
- When the officer in charge of a police station requires a subordinate officer to make an arrest without a warrant, the request shall be made in writing, and the subordinate officer shall be provided with a written order to that effect.

Section 56: Health and Safety of Arrested Persons.
- The officer responsible for detaining the accused has a duty to ensure the health and well-being of the individual in custody and shall take all necessary precautions to guarantee their safety and access to medical attention if needed.

Section 57: Presentation of Arrested Person before Magistrate or Officer in Charge.
- A police officer who makes an arrest without a warrant shall, without undue delay, present the arrested person before either the officer in charge of the police station or a Magistrate, as soon as practicable.

Section 58: Maximum Detention Period for Arrested Persons.
A person arrested without a warrant shall not be detained for more than 24 hours and shall be produced before a Magistrate within that timeframe, unless a longer detention period is authorized by law or a judicial order.

Section 61: Authority to Pursue and Re-Arrest Escaped Detainees.
- If a person in lawful custody escapes or is rescued, the authorities may immediately pursue and re-arrest them in any location within India, to restore the person to lawful custody.

Section 62: Arrests to be Made in Accordance with Established Procedures in the Sanhita.
- All arrests shall be carried out strictly in accordance with the provisions outlined in this code of Sanhita or any other applicable laws in force, which govern the procedures for arrest.

Section 196: Magistrate's Inquest.
- inquests in cases of deaths occurring:
  - in prison,
  - in police custody,
  - due to police firing,
  - exhumation, and
  - as dowry deaths.

Magistrate's Inquest:

According to Black's Law Dictionary,[71] an inquest is an investigation by medical officers, sometimes with a jury's assistance, into the manner of death of a person who died under suspicious circumstances or in prison. Since Police Officers on duty are the culprit accused of custodial deaths, thus another police officer if assigned for legal investigation, will be biased towards his/ her colleague police officer, happen to be working in the same state police department. So, the death in Police custody should ideally be conducted by an external agency, who can supersede the Police Officer.

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

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

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

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

Flowchart for Investigating Deaths in Police Custody:

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

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

1. **Incident Occurs**
   - Death in police custody reported.
2. **Initial Response**
   - Secure the scene.
   - Notify relevant authorities (internal affairs, external oversight bodies).
   - Preserve evidence.
3. **Immediate Actions**
   - Separate and interview involved officers.
   - Provide medical aid if applicable.
   - Notify the family of the deceased.
4. **Preliminary Investigation**
   - Conduct a preliminary review of the incident.
   - Gather initial statements from witnesses.
   - Collect physical evidence (CCTV footage, body cam footage, etc.).
5. **Assign Investigation Team**
   - Internal Affairs or external independent investigation unit takes charge.
   - Appoint lead investigator.
6. **Detailed Investigation**
   - Conduct thorough interviews (officers, witnesses, medical personnel).
   - Review all physical evidence (autopsy report, forensic analysis).
   - Analyze documentation (arrest records, detention logs).
7. **Consult Experts**
   - Engage forensic experts, medical examiners, legal advisors.
   - Obtain expert opinions on cause of death and procedural adherence.
8. **Review Policies and Procedures**
   - Examine compliance with existing policies.
   - Identify any breaches or gaps in procedures.
9. **Compile Findings**
   - Summarize evidence and findings.
   - Prepare a detailed investigation report.
10. **Decision Point**
    - Determine if the death was due to natural causes, accident, suicide, or foul play.
    - Identify any criminal or administrative liability.
11. **Recommendations**
    - Suggest disciplinary actions, policy changes, or further investigations.
    - Recommend training or procedural improvements.
12. **Report to Authorities**
    - Submit findings to relevant authorities (police department, oversight bodies, prosecutor's office).
    - Notify the family of the deceased and provide a summary of findings.
13. **Public Disclosure**
    - Release information to the public, ensuring transparency.
    - Conduct a press briefing if necessary.
14. **Follow-Up**
    - Monitor implementation of recommendations.
    - Review the effectiveness of changes and improvements.

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

Case Laws for Preventing Deaths in Police Custody:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Roadmap for Implementing Human Rights Safeguards in Police Custody:

I. Establishment of State Human Rights Commissions (SHRCs)

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

II. Human Rights Courts

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

III. CCTV Cameras in Prisons

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

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

IV. Non-Official Visitors

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

V. Prosecution for Human Rights Violations

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

Table 1: Medicolegal Riddle in Rhymes on DOT & DPC

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

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

The violation of these guidelines would attract not only departmental action but also the contempt of court proceedings in a High Court having the jurisdiction over the matter. To ensure the protection of arrestees' rights and uphold transparency in police procedures, several essential guidelines have been established. Under Section 302/304 IPC (updated as Section 103/ 105 of BNS, 2023), in each case where the enquiry establishes culpability in custodial death and framing of uniform definition of custodial death and mandatory deployment of at least two women constables in each district were also recommended by the Amicus. These measures aim to enhance accountability and provide safeguards during the arrest and interrogation process.

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

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

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

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

CONCLUSION

Death on the Operating Table (as also Death in Legal Custody) is rare but a very serious event with far reaching consequences. A proper set of guidelines and sincere implementation of the same can go a long way in reducing not only the incidence of these events but also help in lowering their impact. To prevent the death/ torture in police custody, regular medical examination of the arrested, to check his/ her wellbeing, by a Registered Medical Practitioner is mandatory. And vice versa, for investigating the alleged medical malpractice, criminal negligence, including patient's Death on the Operating Table, the patient's attendants may file a legal complaint to the Police Officer, in the Hospital's jurisdiction. Public Awareness to their human rights, including the right to live, of the admitted patients/ arrested persons, is the key for prevention of sudden institutional deaths related with medicolegal scenarios. Some of the guidelines,[30] unfortunately, have been limited to mere paper regulations. The authors hope that the guidelines will be taken seriously, at all levels and followed in letter & in spirit.

Conflict of Interest: *Nil*

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