

## Practical Problems Encountered in Conducting Medico-Legal Autopsies in Custodial Deaths: A Research Study

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### Abstract

To ascertain the cause of death is the most important objective behind a medico-legal autopsy. To this objective, ruling out torture or any other form of forceful activity done by the authorities is added while performing the custodial deaths' autopsy. Medico-legal autopsy of custodial deaths has to be prompt and precise, to achieve such objectives and to collect evidences. National Human Rights Commission (NHRC) has laid down certain guidelines at different levels at regular intervals to achieve the objectives behind custodial deaths' autopsy. Authorities working under these guidelines encounter different problems at their level. This study was aimed at identifying few of those problems, analyzing them and find out solutions in the form of recommendations on the basis of conclusions drawn.

**Keywords:** Custodial Death; Autopsy; National Human Rights Commission (NHRC); Problems.

### Introduction

Ascertaining the cause of death is the most important objective behind a medico-legal autopsy. To this objective, ruling out torture or any other form of forceful activity done by the authorities is added while performing the custodial deaths' autopsy. The international community has recognized the growing importance of strengthening national human rights institutions. In this context, in the year 1991, UN-sponsored meeting of representatives of national institutions held in Paris, a detailed set of principles on the status of national institutions was developed, these are commonly known as the Paris Principles. These principles, subsequently endorsed by the UN Commission on Human Rights and the UN General Assembly have become the foundation and reference point for the establishment and operation of national human rights institutions[1]. The principles and

philosophy related to protection of human rights and delivering justice to the victims of custodial deaths is very well reflected in the Protection of Human Rights Act (PHR-Act) [2] and guidelines issued by National Human Rights Commission and Government from time to time.

Delay in transport and inquest, problems pertaining to mandatory requirements of evidence preservation by videography and many more still exists. If the same situation continues, it will defeat the very purpose of giving natural justice, in a just and pure manner to the victims, which off course not expected by PHR-Act and National Human Rights Commission guidance. Finding out cause and manner of death being main objective of autopsies in such important and sensitive cases, the present situation discussed above defeats the very purpose of fulfilment of this objective. This study was aimed at identifying the problems, analyzing them and find out solutions in the form of recommendations on the basis of conclusions drawn.

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Received on 14.07.2017, Accepted on 16.08.2017

### Material and Methods

The present study was conducted at Mortuary of Department of Forensic Medicine & Toxicology at Grant Government Medical College & Sir J.J. Hospital Mumbai, which is an authorized regional referral

centre for conducting autopsies in alleged custodial deaths. The study comprises of total 82 (Eighty Two) autopsies of custodial deaths which were referred for post-mortem examination by the Magistrate from various custodies in the region. The study was carried out for a span of two years. Each and every case under the heading of custodial death and quasi custodial were attended personally and data was collected in the standardized Performa.

### Results

Table 1. It is observed that in maximum number of cases (51 cases) i.e. 62.96% of total cases the time interval for magistrate inquest to commence is 10-24 hours. In 23.46% cases it took 5-10 hour for the magistrate inquest. In only 1 case (1.23%) it took less than five hours for magistrate inquest to commence after death.

Table 2. It is observed that in 74.39% (61 cases) of the total cases, non-availability of magistrate is main reason for delay.

Table 3. Delay in magistrate inquest is significantly related to non-availability of magistrate, (p<0.5). This means that if availability of magistrate is done

properly than the delay in doing magistrate inquest can be minimized to a certain extent.

Graph 1. During this study it is observed that the transportation of body is made available by the hospital authorities (HO) in case of hospital admitted custody death, 39.02% cases. While, in case of deaths which occurred in prison, or at place of custody the arrangement for transportation of body to the authorized centre for autopsy is done by Police (P) in majority of the cases 42.68%. In 18.30% cases this facility is arranged privately (PR) by the help of relatives.

Table 4. This study observed manhandling of body during transport in 28.05% of cases, with most common manner of transport being by road.

Table 5. It is observed that 46.34% of body of custodial deaths were brought from places within a distance of 7 kilometres, while 53.66% cases were from distance more than 7 kilometres. During this study it is observed in total 23 cases, there is presence of evidence of some sort of manhandling. In 12 cases out of 23 cases, breaking of rigor mortis is noted. Abrasions (post-mortem in nature) over the body are noted in 06 cases out of 23 cases. Postmortem lividity is shifted, as corroborated with the history in 05 cases out of 23 cases.

**Table 1:** Range of time interval between death and magistrate inquest

Sr. No.	Time Interval Between Death and Magistrate Inquest(Hours)	Frequency	Percentage
1.	1 - 5 hr	1	1.23%
2.	5-10 hr	19	23.46%
3.	10-24 hr	51	62.96%
4.	>24 hr	10	12.35%
	<b>Total</b>	<b>81</b>	<b>100.00%</b>

**Table 2:** Reason for delay in doing magistrate inquest

Reason for Delay Doing Magistrate Inquest	Frequency	Percentage
Non-availability of Magistrate (NAM)	61	74.39%
Delay in transport+ NAM	18	21.95%
Wrong Inquest + NAM	3	3.66%
<b>Total</b>	<b>82</b>	<b>100.00%</b>

**Table 3:** Fischer T-Test

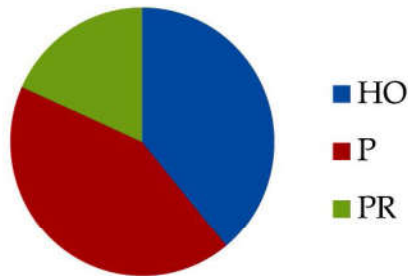
	1 Tailed P	2 Tailed P
Mid-P Exact	6.696E-07	-
Fisher Exact	1.3391E-06	2.6782E-06

**Table 4:** Evidence of Manhandling during transportation of body

Manhandling During Transport	Frequency	Percent
No (No)	59	71.95%
Yes (Ye)	23	28.05%
<b>Total</b>	<b>82</b>	<b>100.00%</b>

**Table 5:** Correlation between distance of transportation and manhandling

Distance of Transportation	Manhandling	
	Absent	Present
Less than Seven Kilometer (< 7 km)	38	0
More than Seven Kilometer (> 7 km)	21	23
Total	59	23

**Graph 1:** Arrangement for transportation of body.

## Discussion

Total cases studied during this study were 82. 72 deaths were pure custodial deaths. The remaining 10 deaths were from other facilities which are directly under Magistrate / Judicial authority / power. These facilities included Orphanages, Beggar Homes, and Reformatories. 2 deaths occurred in the beggar home under the Beggar's Act, 7 cases were from the orphanages which are under State Government and 1 case from reformatory. In cases of death at above mentioned places the police usually come with Police inquest and panchnama for the autopsy, though these places are under control of State or Judiciary. But, there has been no specific mention about these places in the NHRC guidelines. These places need to be brought under the NHRC guidelines.

In 1993 National Human Rights Commission after its formation observed the rising numbers of incidents of custodial deaths and custodial rapes. The Commission in order to suppress this picture, determined to lay down directives to the District Magistrates and Superintendent of Police of every district to report about such incident within 24hrs to the Secretary General of the Commission. Failure to report promptly would give rise to presumption that there was an attempt to suppress the incident [3].

During this study it was noted that the mean time interval between the death and start of the magistrate inquest of 23.75 hours. The minimum time interval was of 3.5 hours. The maximum time interval was of 408 hours. This maximum time interval was seen in case where police inquest was done in a case of death from beggar home. This can be attributed, firstly to the wrong inquest done, secondly making the

magistrate available for doing inquest and also to time passed while making a decision regarding doing magistrate inquest. In this current study it is observed that in 74.39% (61 cases) of the total cases, non-availability of magistrate is main reason for delay.

The problem which can arise from this delay since the time of death is the post-mortem changes, which keeps on increasing with the passage of time. Post-mortem changes can make it difficult for the doctor doing autopsy to misinterpret some of the findings or sometimes actual finding can get obscured due to postmortem changes. By the misinterpretation sometimes the accused in certain cases cannot be brought to justice. Bringing justice to the deceased is the aim behind doing autopsy in custodial deaths, by the NHRC. This thing can destroy the very purpose of doing autopsy in custodial deaths.

The dead body should be covered in special Body Bags having zip pouches for proper transportation. Clothing on the body of the deceased should not be removed by the police or any other person. It should be collected, examined as well as preserved and sealed by the doctor conducting the autopsy, and should be sent for further examination at the concerned forensic science laboratory [4]. In case of deaths which occurred in prison or at place of custody the arrangement for transportation of body to the authorized centre for autopsy was done by Police in majority of the cases 42.68%.

In 18.30% cases this facility was arranged privately by the help of relatives. This included the cases who died in police custody and those who died in beggar homes, which was under direct supervision of the state or of the magistrates. In all the transportation to the centre (except for hospital admitted) it was observed that there had been no cold chain preservation of the body was done.

Artefact is defined as any change or feature introduced in a body after death that is either accidentally or physiologically unrelated finding to the natural state of body. Artefacts are broadly classified under two heads (a) Introduced between death and autopsy. (b) Introduced during autopsy [5]. During this study it is observed that artefacts were introduced that at various level. The observed artefact related to loss of rigor, postmortem abrasion

was noted. There is significantly higher manhandling found if the distance of transportation is more than 7 km, with p value < 0.05. That means as the distance of transportation increases from the centre, the chances of manhandling increases.

### Conclusion

Delay in information to magistrate and subsequent inquest by magistrate causes inconvenience to the relatives and also creates problems in scientific interpretation of autopsy findings. Hence, the custodians of deceased and the Magistrates doing inquest need to be made accountable for this problem. In view of this, the Revenue and Home Department of the State should bring out a Government Resolution directing Police Officers, Jail authorities and Magistrates doing inquest to avoid delay in performance of their respective role in such cases. The custodian of the deceased must immediately notify the death to the Sub-divisional Magistrate / Taluka Magistrate under intimation to District Magistrate and the authorized autopsy centre.

The dead body needs to be wrapped in a bed-sheet and transported to the autopsy centre in water-proof rexin bag, with instructions to the accompanying care-takers to restrain from undue manhandling, which causes artefacts after death. Hence, these persons must be instructed to handle the body with care and caution during transit.

It has been observed and also noted in this study that the dead bodies from Beggar

Homes and Orphanages are also brought for post-mortem examination. Government being custodian of such establishments a Government resolution specifying as to whether or not magistrate inquest

and videography is necessary in such cases needs to be issued to avoid confusion, disrespect to the cadaver and subsequent delay.

Every District Police Head Quarter / District Hospital should have a hearses van with cold storing facility which will help in avoiding the decomposition changes during transit.

*Conflict of Interest:* None

*Funding:* None

### Acknowledgement

Dr. Rajesh V. Bardale, Prof. and Head, Dept of Forensic Medicine, Miraj, Dist: Sangli, Maharashtra, India.

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