THE TAMIL NADU Dr.MGR MEDICAL UNIVERSITY, CHENNAI-600 032.

PRACTICAL RECORD BOOK

Certified Bonafide record of

.....*Reg. No*.....

Year :

Head of the Department

Date :

Signature of the External Examiner

Hippocratic Oath

I swear by Apollo Physician, by Aesculapius, by Hygea, by Panaceia and all the gods and goddesses, making them my witnesses, that I will carry out, according to my ability and judgment, this oath and indenture.

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money, to give him a share of mine, and to regard his offspring as my brothers and to teach them this art – if they desire learn it – without fee and covenant.

To give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who have signed the covenant and have taken the oath according to the medical law but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.

I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but I will withdraw in favour of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, all mischief and in particular of sexual relations with both male and female persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things to be shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

The Declaration of Geneva
(Hippocratic Oath as restated by the 3rd World medical Association in 1948)

1. I solemnly pledge to consecrate my life to the service of Humanity.
2. I will give to my teachers the respect and gratitude which is their due.
3. I will practice my profession with conscience and dignity.
4. The health of my patients will be my first consideration.
5. I will respect the secrets which are confided in me, even after the patient has died.
6. I will maintain by all means in my power, the honour and noble traditions of the medical profession.
7. My colleagues will be my brothers.
8. I will not permit consideration of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.
9. I will maintain the utmost respect for human life from the beginning and even under threat, I will not use my medical knowledge contrary to the laws of humanity.
10. I make these promises solemnly, freely and upon my honour.

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EXAMINATION AND REPORTING OF SKELETAL R

OBJECTIVES OF SKELETAL EXAMINATION :

1. To determine whether the bones are of a Human or not.
2. To determine the race of the individual.
3. To determine the Sex of the individual
4. To determine the age of the individual to whom the bones belonged
5. To determine if the bones belonged to one or more individuals.
6. To determine the Stature of the individual
7. To determine whether the bones have been cut, sawn, gnawed by animals or burnt.
8. To determine the probable cause of death.
9. To determine the time since death.

ORIGIN :

1. Determined from morphological and anatomical features.
2. Origin confirmed by precipitin test :-

   Human Serum injected into animal serum (Rabbit) results in Antigen Antibody reaction.

   Resultant animal serum when in contact with Proteins in Human serum form a precipitate antibodies responsible for precipitation are known as precipitins.

   Positive reaction should appear in ten minutes and read within half an hour.

   PROCEDURE

   Extract of stained material prepared by soaking in normal saline. No other chemicals added. Extract is filtered / centrifuged and diluted to 1 : 100 with normal saline 2 drops of undiluted antiserum is added to 0.75 ml of diluted stain extract in a tapering test tube.

   Antiserum settles down at the bottom and at the junction of two fluids a white precipitate / ring appears if positive.

Race

	Caucasoids	Mongoloids	Negroids
Shape	Elongated	Rounded	Narrow & Elongated
Orbit	Triangular	Rounded	Square
Nasal aperture	Elongated	Rounded	Broad
Palate	Triangular	Rounded	Rectangular
Lower Limbs	Normal in proportion to the height	Smaller	Longer

$$\text{CEPHALIC INDEX} = \frac{\text{Breadth of the Skull (measured between two parietal eminences)}}{\text{Maximum length of skull (measured between external occipital protuberance and glabella)}} \times 100$$

Dolico – Cephalic	Mesati – Cephalic	Brachy Cephalic
Pure Aryan, Caucasian, Negroes and Aboriginal Australians	European, Chinese and Icelanders	Mongolian
70 – 74.9	75 – 79.9	80 – 84.9

SEX

Sex Determination from bones

FEATURES	MALE	FEMALE
	SKULL	
Size and capacity	Heavy with more cranial volume	Smaller and light with less cranial volume
Areas of muscular attachments	Prominent	Less prominent
Glabella	Prominent	Less prominent
Supraorbital ridges	Prominent	Less prominent
Orbital margins	Round	Sharp
Orbit	Small relative to face, square	Large relative to face, rounded
Frontal eminence	Small	Large
Forehead	Sloping with no tendency to bulge	Vertical, with tendency to bulge
Fronto-nasal angle	Distinct angulation	Less distinct
Zygomatic arch & supra mastoid crest	More prominent	Less prominent
Cheek bones	Surface rough and concave	Surface smooth and flat
Parietal eminence	Small	Large
Mastoid process	Large, rough and blunt	Small, smooth and pointed
Occipital protuberance inion	More Marked	Less marked
Nuchal lines	Well marked	Not well marked
Foramen magnum	Larger and long	Small and round
Occipital condyles	Long, large and slender	Small, broad and short
Bony palate	Larger, broader and 'U' shaped	Small and parabolic
External Auditory meatus	Bony ridge along the upper borded	No bony ridge
	MANDIBLE	
Size	Large and heavy	Small and thin
Outline of chin	Square	Rounded
Angle of body with ramus	Less obtuse, prominent and everted	More obtuse, smooth and not everted
Ascending ramus	Broad	Not so broad
Condyles	Large	Small

FEMUR		
	MALE	**FEMALE**
Head	Large, diameter more than 4.5 cm, forms almost 2/3rd of a sphere	Smaller, diameter less than 4.5 cm, forms less than 2/3rd of a sphere
Neck shaft angle	Obtuse angle of about 125° with shaft	Less obtuse angle
Bicondylar width	7.4 to 8.9cm	6.7 – 7.6 cm
Muscular Impressions	Prominent	Less prominent
Angulation of shaft in reference to tibial plateau	Less inclined	More inclined
HIP BONE		
General	Heavy, prominent muscular impressions	Less massive, smooth muscular impressions
Body of pubis	Triangular	Quadrangular
Greater sciatic notch	Narrow and deep	Wide and shallow
Ischiopubic ramus	Slightly everted	Markedly everted
Obturator foramen	Large, oval	Small, triangular
Acetabulum	Large and more lateral	Smaller, slightly anterior
Ilium	High and upright	Low and flaring
Preauricular sulcus	Not prominent	Well prominent
Iliopectineal line	Prominent and rough	Not prominent
Ischiopubic index Length of Pubis X 100 Length of ischium	Less than 90	More than 90
SACRUM		
General	Long and narrow	Short and broad
Curvature	Uniform	Abrupt
Sacral promontory	Prominent	Not prominent
Articular surface	Extends to 2½ to 3 segments	Extends to 2 segments
Breadth of Body of S1	More thanthe breadth of either side of ala	Less than the breadth of either side of ala
	STERNUM	
Body	More than twice the length of manubrium	Shorter, less than twice the length
Mean length of manubrium	52.8 mm	48.4 mm
Mean length of body	96.4 mm	78.6 mm
Combined mean length	149 mm	127 mm
Sternal Index Length of manubrium X 100 Length of body	46.2	54.3

SEX DETERMINATION FROM BONES

BONE	TRAIT	OBSERVATION	INFERENCE

BONE	TRAIT	OBSERVATION	INFERENCE

BONE	TRAIT	OBSERVATION	INFERENCE

BONE	TRAIT	OBSERVATION	INFERENCE

AGE FROM BONES

Ossification data – skeletal remains examination

Pelvis	Iliac crest	**14** years	**18 - 20** years
	Triradiate cartilage		Obliterated by **13 - 15** years
	Ischiopubic ramus		Fusion **6 - 8** years
	Ischial tuberosity	**16** years	Female : **19** years Males : **20-21** years
Femur	Head	**1** year	**17 - 18** years
	Greater trochanter	**4** years	**17 - 18** years
	Lesser trochanter	**14** years	**17 - 18** years
Skull	Anterior fontanellae		Fusion by **2nd** year
	Metopic suture		Fusion by **2 to 8** years
	Basiocciput & Basisphenoid		Males : **20 - 22** years Female : **18 - 20** years
	Sagital suture	The inner aspect of sutures obliterates at 25 – 35 years and outer aspect by 35 – 45 years. Age determination from obliteration of sutures alone is erratic.	Posterior 1/3rd fuse by **30 – 40** years
			Anterior 1/3rd fuse by **40 – 50** years
			Middle 1/3rd fuse by **50 – 60** years
	Coronal suture		Lower half fuse by **40 – 50** years
			Upper half fuse by **50 – 60** years
Mandible	Two halves	Fuse	**2nd** year
	Mental Foramen	Near the lower border in infants, midway between the upper and lower borders in adults and near the alveolar margin in old age.	
Miscellaneous			
Sternum	Manubrium	**5th** month of Intra Uterine life	Xiphoid and Body of sternum fuse at 40th year. Manubrium fuses with the body of sternum >**60** years
	Body-1st piece	**5th** month of Intra Uterine life	
	Body-2nd & 3rd piece	**7th** month of Intra Uterine life	
	Body- 4th piece	**10th** month of Intra Uterine life	

STATURE ESTIMATION

STATURE :

Formula : Height of the skeleton = Length of the Long bone x M.F.

Height of the individual (Length of the Long bone x M.F.) + 2.5 cm to 4 cm (Additive factor)

Multiplication Factor of Long Bones :

BONE	MALE	FEMALE
FEMUR	3.70	3.8
TIBIA	4.48	4.46
FIBULA	4.48	4.43
HUMEROUS	5.3	5.31
RADIUS	6.9	6.7
ULNA	6.3	6.0

EXAMINATION AND REPORTING OF SKELETAL REMAINS

Requisition from.....of.....Police Station, Vide Crime No.....

Brief History :.....

.....

Date : Time : Place :

Number of bones received :

Human or animal :

Race :

Sex :

Age :

Whether the bones belongs to one individual or more :

Stature :

Any injuries or diseases :

Cause of death :

Time since death :

Whether the bones belong to one individual or different individuals

Medico Legal importance :

OPINION :

Station : Signature

Date :

ESTIMATION OF AGE BASED ON PHYSICAL, DENTAL

PHYSICAL EXAMINATION - PARAMETERS TO BE LOOKED INTO

Height :

Weight :

Chest Circumfrence :

Abdominal girth :

BODY HAIR	NORMAL AGE OF APPEARANCE	
	MALE	FEMALE
Adult like pubic hair	13 - 14 years	12 - 13 years
Axillary hair	14 - 15 years	13 - 14 years
Facial hair	15 - 16 years	---
Hair on Chest	> 18 years	---
Greying of Scalp hair	> 40 years	---
Greying of Public hair	> 55 years	> 40 years
Baldness	> 40 years	---
Antero Lateral Regression of Hair	> 16 years	---

DENTAL EXAMINATION

Temporary (deciduous) teeth: China white in colour. Anterior temporary teeth are vertical, regular biting edge

20 in number, include four incisors, two canines and four molars in each jaw.

FDI notation for temporary teeth:

55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75

5 – Right upper quadrant
6 – Left upper quadrant
7 – Left lower quadrant
8 – Right lower quadrant

•	Tooth Present
—	Tooth Missing
A	Artificial denture
O	Cavity
S	Spacing for 3rd molar

Eruption of temporary teeth

Central Incisor – 6 to 7 months.
Lateral Incisor – 7 to 9 moths
Canine – 18 months
First molar – 12 months
Second molar – 24 months

Permanent teeth: ivory white in colour. The anterior teeth are slightly inclined forward with serrated biting edge.

32 in number, consisting of four incisors, two canines, four premolars and six molars in each jaw.

FDI notation for permanent teeth:

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

1 – Right upper quadrant
2 – Left upper quadrant
3 – Left lower quadrant
4 – Right lower quadrant

•	Tooth Present
—	Tooth Missing
A	Artificial denture
O	Cavity
S	Spacing for 3rd molar

Eruption of permanent teeth

First Molar – 6 to 7 year
Central Incisor – 7 to 8 years
Lateral Incisor – 8 to 9 years
First Premolar – 9 to 11 years
Second Premolar – 10 to 12 years
Canine – 11 to 12 years
Second Molar – 12 to 14 years
Third Molar – 17 to 25 years

Modified FDI notation for temporary teeth :

55	54	53	52	51	61	62	63	64	65
75	74	73	72	71	81	82	83	84	85

5 – Right upper quadrant
6 – Left upper quadrant
7 – Right lower quadrant
8 – Left lower quadrant

•	Tooth Present
—	Tooth Missing
A	Artificial denture
O	Cavity
S	Spacing for 3rd molar

Modified FDI notation for permanent teeth :

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
38	37	36	35	34	33	32	31	41	42	43	44	45	46	47	48

1 – Right upper quadrant
2 – Left upper quadrant
3 – Right lower quadrant
4 – Left lower quadrant

•	Tooth Present
—	Tooth Missing
A	Artificial denture
O	Cavity
S	Spacing for 3rd molar

DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY

P S G Institute of Medical Sciences and Research

ESTIMATION OF AGE

(Details to be filled by Student)

Requisition from_____of_____Police Station

Vide Crime No._____dated _____

Date : Time : Place :

1. Name of the individual :
2. Sex :
3. Parent's name :
4. Address :
5. Occupation :
6. Married or single :
7. Age stated by
   a) Individual to be examined :
   b) People or police accompanying:
8. Brought by :
9. Time and place of Examination:
10. Written informed consent :
11. Signature of the individual or left thumb impression :
12. In case of minors, consent of the guardian and his signature or thumb impression :
13. Name of the nurse present :

14.

15. Identification marks :

a)

16. b)

17.

18. **PHYSICAL EXAMINATION**

19. 1. Height : 2. Weight :

20.

3. Chest girth at the level of nipples

21.

4. Abdominal girth at the level of the navel

22.

5. General build and appearance

23.

6. Voice

24.

7. Teeth

25.

26.

8. Hair

27.

28. Scalp

Beard

Moustache

Axilla

Pubis

9. Mammae – development of breast, milking

29.

10. Generative organs – development of genitals

30.

11. Menstrual History :

31.

12. Date of sending case for Radiological examination and PC No

32.

13. Report from Radiological examination.

33.

34.

35.

14. Opinion:

36.

37.

38.

39. Station :

40.

41. Date : Name :

EXERCISE SHEET FOR DENTAL EXAMINATION

45.

DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY

AGE CERTIFICATE

I am of the opinion that the individual named_____who is_____years old as alleged by him / her, bearing the identification marks

1)

2)

Appears to be aged greater than_____years and less than_____years as evidenced by physical, Dental & Radiological examination.

Station:

Date :

Signature

Original to :

Duplicate to:

OSSIFICATION DATA – RADIOLOGICAL EXAMINATION

		Age of appearance		Age of fusion
Shoulder Joint				
Humerus	Head	**1** year	These three centers fuse to form a composite epiphysis at **6** years	The composite epiphysis fuses with shaft at **18 – 19** years
	Greater Tuberosity	**3** years		
	Lesser Tuberosity	**5** years		
Coracoid		**10 – 11** years		**16** years
Acromion		**14 - 15** years		**17 - 18** years
Medial End of Clavicle		**18 – 19** years		**20 – 22** years
Elbow Joint				
Humerus	Capitulum	**1 - 2** years	Capitulum fuses with trochlea **10-12** years Capitulum, trfochlea, and lateral epicondyle fuse **12-14** yrs	The composite epiphysis fuses with shaft at **14 – 16** years
	Trochlea	**9 - 10** years		
	Lateral epicondyle	**11** years		
	Medial epicondyle	**5 – 7 years**		**14 – 16** years
Radius upper end Radial tubercle		**5-6** years **14** years		**16 – 17** years **16 - 17** years
Ulna upper end (Olecranon)		**9-10** years		**16 – 17** years
Wrist Joint				
Radius lower end		**2** years		**18 – 19** years
Ulna lower end		**5-6** years		**17 – 18** years
Carpal bones	Capitate	**1** month		
	Hamate	**2** month		
	Triquetral	**3** years		
	Lunate	**4** years		
	Scaphoid	**5** years		
	Trapezium	**5** years		
	Trapezoid	**6** years		
	Pisciform	**10-12** years		
Base of first Metacarpal		**2-3** years		**15 – 17** years
Head of the other Metacarpals		**2 – 4** years		**15 – 19** years
Hip Joint				
Femur	Head	**1** year		**17 – 18** years
	Greater trochanter	**4** years		**17 – 18** years
	Lesser trochanter	**14** years		**17 – 18** years
Hip Bone	Iliac crest	**14** years		**18 - 20** years
	Triradiate cartilage			Obliterates by **13 – 15** years
	Ischiopubic ramus			Obliterates by **6** years
	Ischial tuberosity	**16** years		**19** Females **20 - 21** Males

OPINION :

I am of the opinion that the person / boy _____ who is _____ years old as alleged by him, bearing the identification marks

1)

2)

Appears to be aged greater than _____ years and less than _____ years as evidence by Radiological / Physical and Dental Examination

The X-rays belong to

Single person

Different person of same age group

Different person of different age group

Station:

Date :

Signature

MEDICO-LEGAL IMPORTANCE OF AGE

MEDICO-LEGAL IMPORTANCE OF AGE

- Fertilisation - 2 weeks : Embryo
- 2 weeks - birth : It is called Foetus.
- 12 weeks : MTP can be done by single doctor alone.
- 12 - 20 week : MTP must be done with opinion of two RMP's
- 20 weeks : Induction of MPT is not allowed unless for serious maternal causes.
- 28 weeks (7 months IUL) : Viability of foetus.
- Birth - 1 year : Infant (Infanticide)
- 5 yrs : until this age any child shall be under the guardianship of the Mother.
- < 5 yrs : The child is not liable for its act under Indian Railways Act.
- >5 yrs : under Indian Railways act child is liable for punishment.
- 7 yrs : child under this age is presumed to be incapable of committing offence.
- 7-12 yrs : child b/w this age is capable of committing crime if have sufficient maturity to understand the nature & consequences.
- 10 yrs : below this age if the child is taken away from guardian with intention of robbing any movable property-kidnapping.
- 12 yrs : whoever being the parent / guardian of a child <12 yrs leaves the child with the intention to abandon shall be punished.
- 12 yrs : Any consent given by the child under this age for physical examination is invalid.
- 13 yrs : In Manipur sexual intercourse with one's own wife even with her consent is rape if she was below 13 yrs.
- 14 yrs : In Manipur it is the legal age for giving consent to have sexual intercourse by a woman if she is more than this age.
- 14 yrs : A child less than this age cannot be employed in any work.
- 15 yrs : A child is person who has not completed the age of 15 yrs.
- >15 - 18 yrs : A child is an Adolescent.
- 15 yrs : Above this age one can be employed in factory (for not more than 12 hours) provided a fitness certificate must be produced.
- 15 yrs : A police officer cannot compel attendance of a male / female under this age at any place other than his / her residence.
- 15 yrs : Sexual intercourse with one's own wife even with her consent is Rape if she is below 15 yrs of age.
- 16 yrs : Sexual intercourse with a woman less than 16 years, even with her consent is called as Statutory Rape (since the consent is invalid).
- 17 yrs : A candidate seeking admission to M.B.B.S. course must have completed 17 yrs on or before 31st of December of the year of admission.
- 18 yrs : Legal age for giving consent for sexual intercourse by a woman if she is 18 yrs & above.

- 18 yrs : On completion of 18 yrs one becomes Major.
- 18 yrs : A girl should have completed 18 yrs to get married.
- 18 yrs : Taking away a girl below this age from the parent or guardian amounts to kidnapping.
- 18 yrs : A person boy / girl who has not completed 18 yrs is a juvenile.
- 18 yrs : A person on completion of 18 yrs has the Right to Vote.
- 18 yrs : A person of and above this age can give a valid consent.
- 18 yrs : A person of and above this age can make a valid will.
- 18 yrs : A person of and above this age can donate his organ for transplantation.
- 18 yrs : Minimum age for entering into a Government service.
- 21 yrs : A boy should have completed 21 yrs to get married.
- 21 yrs : If a boy / girl shall be a minor if he / she is uder the guardianship of the court.
- 21 yrs : Procuring a girl under this age from outside country or from Jammu Kashmir for illicit intercourse is punishable.
- 25 yrs : Minimum age for contesting for the Member of Parliament or other Legislative assemblies.
- 35 yrs : Minimum age for appointment as the President / Vice-president & Governor of any state.
- 35 yrs : No prenatal diagnostic tests shall b conducted unless the woman is above the age of 35 yrs.
- 56 yrs : Age of retirement of Indian Army Medical corps.
- 58 yrs : Age of retirement from various government services.
- 60 yrs : Age of retirement from central government service.
- 65 yrs : A judge in the District consumer redressal forum can hold office up to the age of 65 yrs.
- 67 yrs : A judge in the State consumer redressal forum can hold office up to the age of 67 yrs.
- 70 yrs : A judge in the National consumer redressal forum can hold office up to age of 70 yrs.
- 70 yrs : Medical Council of India allows a medical teacher to work in a private institution until he completes 70 yrs.

CLINICAL FORENSIC MEDICINE

EXAMINATION OF INJURIES

INSTRUCTIONS FOR FILLING IN WOUND CERTIFICATE

1. After the words “of a” the sex of the person should be given.

2. After the words “sent with” particulars of any documents received from the Magistrate or Police should be entered.

3. When the injured person comes directly to the Hospital, the doctor who examines the person should intimate the matter to the nearest Police Station.

4. When the injured person is accompanied by a constable, the name, number and the rank of the latter should be noted. If no communication in writing is received with the injured person, the fact should be noted as following “who was sent without a written communication by ……..

5. The exact time at which the injured person was first seen by the Certifying officer and also the exact time at which the examination was commenced should be carefully noted and entered in the certificate.

6. Particulars of all the injuries found should be concisely, but sufficiently described in the plainest language.

7. After the words “I am of the opinion that” enter whether the injuries are or are not of a grievous nature and if the former, whether a fatal result or any permanent injury is likely to follow.

8. Identification and scar marks should be entered in the office copy of the certificate.

9. The original certificate should be forwarded at once to the Magistrate and the Police officer who sent the injured person for examination.

10. As the certificate has to be filled in and despatched immediately after the examination, a very carefully considered prognosis should be made especially as regard to injuries to the head or spine.

11. Further details should be entered in the Hospital wound Register.

ACCIDENT REGISTER

No_____Date and hour_____

_____ Name_____

_____Age _____ Sex_____

_____Occupation _____

Address and residence_____

_____ Identification marks 1) _____

2) _____

By whom brought Police informed or not _____

Declaration required or not _____

HISTORY : (How, When, Where & By whom) _____

GENERAL EXAMINATION: _____

INJURIES (HEAD TO FOOT) _____

Station :

Date :

Signature of the Medical Officer making examination

Name & Designation:

Regn. No:

A.R. entry shall be made in Triplicate. Original is retained by the Hospital while copies ar

DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY

INTIMATION OF ACCIDENTS AND INJURIES TO THE POLICE

1. Name of the patient : Age : Gender :
2. Address : Street :
   Village :
   Town :
3. Brought by :
4. Place at which injury or accident occurred :
5. Alleged cause :
6. Treatment - OP / IP :
7. Whether dying declaration necessary :

P S G Institute of Medical Sciences and Research.

Dated:

Signature of the Medical Officer

Name & Designation:

Regn. No:

Telephone information given & received by :

Time of dispatch of intimation to the Police and Magistrate :

WOUND CERTIFICATE

Wounds or injuries found on the person of a _____

calling himself / herself _____

_____aged_____years, an inhabitant of

_____

who was sent with memo No_____

_____

from

_____for report as to

and accompanied by certain _____

_____and due to _____

said to have been caused on

_____

_____

Identification marks

_____

1. _____

2.

The injured person was first seen by the undersigned at

_____

and the examination was conducted at

on_____when the following injuries were found :

I am of the opinion that

Station :

Date :

Signature of Medical Officer

Name and designation:

Regn. No:

Original to :

Duplicate to :

Wound Certificate will be prepared in Triplicate format. Original is given to the court. W

SCHEME OF EXAMINATION AND CERTIFICATION

SEXUAL ASSAULT

DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY

Examination of a Victim in case of sexual assault

Requisition from_____of_____Police Station

vide his letter No._____dated _____

Date : Time : Place :

1.	Name of the Individual	:
2.	Age as alleged by	:
3.	Gender	:
4.	Parent's or Guardian's Name	:
5.	Address and residence	:
6.	Married or single	:
7.	Occupation	:
8.	Persons accompanying or brought by	:
9.	Consent of the individual for Examination	:
10.	Signature of the individual consenting or the left thumb impression	:
11.	In the case of minors, consent of the guardian and his/her signature or left thumb impression	:
12.	Time and place of examination	:
13.	Name of the nurse present at the time of examination	:

Marks of identification 1.

2.

PHYSICAL EXAMINATION

1.	Height		:
2.	Weight		:
3.	Built & Appearance		:
4.	Chest girth at the level of nipples		:
5.	Abdominal girth at the level of navel		:
6.	Voice		:
7.	Teeth		:
8.	Hair	Scalp	:
		Axillary	:
		Pubic	:
9.	Pulse		:
10.	Blood Pressure		:
11.	Temperature		:
12.	Respiratory Rate		:
13.	Skin		:
14.	Mouth		:
15.	Eyes		:
16.	Mammae – development of breasts – milk		:
17.	Generative organs – development of genitals		:
18.	Onset of Puberty		:
19.	Ossification		:
20.	Report from radiological examination – age		:
21.	History		:
22.	Date and hour when the female first made complaint and the precise words employed by her at the time, i.e., a detailed account of the occurrence as given by the woman		:
23.	General behaviour		:
24.	Date and exact time when the incident was said to have been committed		:

25. Place where it occurred :

26. The exact circumstances under which the sexual assault was committed :

27. Whether or not the female was menstruating at the time :

28. Whether she was in senses during the whole time when the offense was committed or under the influence of intoxicating substances :

29. Whether she uttered any cries or was too terrified to do so :

30. Clothing – if changed – when :

31. Stains on clothing and on person :

32. External Injuries on person :

Scars if any :

33. Discharge :

34. Whether bath was taken – when :

35. Whether urine passed – when :

36. Whether motion passed – when :

37. Mental condition :

38. Gait :

39. Intelligence :

40. Demeanor :

41. Examination of the cloths including underclothes worn at the time of incidence and preserved for examination :

    a) Blood :

    b) Semen :

    c) Other discharge :

    d) Mud – dirt :

42. If signs of venereal disease present :

43.

44. Genitals (female)

45.

46. P

ubic hair – length matted or not :

Vulva :

47. Vagina :

48.

49. Hymen :

50.

51. Fourcehtte:

52.

53. Perineum :

54.

55. Cervix :

56. Injuries to mammae, cheeks,

57. thighs and genitals :

58.

59. Smears taken from vagina :

60.

61. Sterile swabs from cervix :

62.

63. Materials / Samples Collected

64. (for Investigation) :

65.

66. Age report from radiological examination :

67.

68. **OPINION:**

69.

70. Based on the above findings I am of the opinion

that : (Substantiate giving reasons for each opinion)

1. there is no evidence/ evidence of general bodily injuries* suggestive of struggle

71.

72.

2. there is no evidence /evidence of genital injuries

73.

74.

3. there is no evidence / evidence of recent sexual act
(if sperm/semen is detected in the vagina) *

75.

76.

77.

78.

79.

80.

81.

82.

83.

84.

85.

86.

* Strike whichever is not applicable

87.

88.

89.

90. Station :

91.

92. Date : Signature of the Medical Officer

93.

94.

95. Name :

96.

97.

98. Reg
. No. :

99.

100.

101.

102. Original

to : Duplicate

to : Triplicate

to :

103.

104. (Detection of DNA materials of the accused from the samples collected from the person of the victim will be a positive evidence to prove the guilt)

105.

106.

107. **DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY**

108.

109. Examination of a Victim in case of sexual assault

110. Requisition from_____of _____

_____Police Station vide his letter No._____dated _____

_____ Date : Time : Place :

111.
1. Name of the Individual :

112.
2. Age as alleged by :

113.
3. Gender :

114.
4. Parent's or Guardian's Name :

115.
5. Address and residence :

116.
117.
118.
6. Married or single :

119.
7. Occupation :

120.
8. Persons accompanying or brought by :

121.
9. Consent of the individual for Examination :

122.
10. Signature of the individual consenting or the left thumb impression :

123.
11. In the case of minors, consent of the guardian and his/her signature or left thumb
124. impression :

125.
12. Time and place of examination :

126.
13. Name of the nurse present at the time of examination :

127.
Marks of identification 1.

2.

16. PHYSICAL EXAMINATION

1. Height :
17.
2. Weight :
3. Built & Appearance :
18.
4. Chest girth at the level of nipples :
19.
5. Abdominal girth at the level of navel :
20.
6. Voice :
21.
7. Teeth :
22.
8. Hair Scalp :
23.
24. Axillary :
25.
26. Pubic :
27.
9. Pulse :
10. Blood Pressure :
28.
11. Temperature :
29.
12. Respiratory Rate :
30.
13. Skin :
31.
14. Mouth :
15. Eyes :
32.
16. Mammae – development of breasts – milk :
33.
17. Generative organs – development of genitals:
34.
18. Onset of Puberty :
35.
19. Ossification :
36.
37.
20. Report from radiological examination – age :
38.
39.
21. History :
40.
41.
22. Date and hour when the female first made complaint and the precise words employed by her at the time, i.e., a detailed account of
42. the occurrence as given by the woman :

43.

23. General behaviour :

24. Date and exact time when the incident
44. was said to have been committed :

45.

25. Place where it occurred :

46.

26. The exact circumstances under which

47. the sexual assault was committed :

48.

27. Whether or not the female was

49. menstruating at the time :

50.

28. Whether she was in senses during the whole time when the offense was committed or under

51. the influence of intoxicating substances :

52.

29. Whether she uttered any cries or was too terrified to do so :

53.

30. Clothing – if changed – when :

54.

31. Stains on clothing and on person :

55.

32. External Injuries on person :

56.

57.

58.

59. Scars if any :

60.

33. Discharge :

61.

34. Whether bath was taken – when :

62.

35. Whether urine passed – when :

63.

36. Whether motion passed – when :

64.

37. Mental condition :

65.

38. Gait :

66.

39. Intelligence :

67.

40. Demeanor :

68.

41. Examination of the cloths including underclothes worn at the time of incidence and preserved for examination :

69.

a) Blood :

70.

b) Semen :

71.

c) Other discharge :

72.

d) Mud – dirt :

73.

42. If signs of venereal disease present :

43.

44. Genitals (female)

45.

46. P

ubic hair – length matted or not :

Vulva :

47. Vagina :

48.

49. Hymen :

50.

51. Fourcehtte:

52.

53. Perineum :

54.

55. Cervix :

56. Injuries to mammae, cheeks,

57. thighs and genitals :

58.

59. Smears taken from vagina :

60.

61. Sterile swabs from cervix :

62.

63. Materials / Samples Collected

64. (for Investigation) :

65.

66. Age report from radiological examination :

67.

68. **OPINION:**

69.

70. Based on the above findings I am of the opinion that :

(Substantiate giving reasons for each opinion)

1. there is no evidence/ evidence of general bodily injuries* suggestive of struggle

71.

72.

2. there is no evidence /evidence of genital injuries

73.

74.

3. there is no evidence / evidence of recent sexual act (if sperm/semen is detected in the vagina) *

75.

76.

77.

78.

79.

80.

81.

82.

83.

84.

85.

86.

* Strike whichever is not applicable

87.

88.

89.

90. Station :

91.

92. Date : Signature of the Medical Officer

93.

94.

95. Name :

96.

97.

98. Reg . No. :

99.

100.

101.

102. Original

to : Duplicate

to : Triplicate

to :

103.

104. (Detection of DNA materials of the accused from the samples collected from the person of the victim will be a positive evidence to prove the guilt)

105.

106.

107. **DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY**

108.

109. Examination of a Victim in case of sexual assault

110. Requisition from_____of _____

_____Police Station vide his letter No._____dated _____

_____ Date : Time : Place :

111.
1. Name of the Individual :

112.
2. Age as alleged by :

113.
3. Gender :

114.
4. Parent's or Guardian's Name :

115.
5. Address and residence :

116.
117.
118.
6. Married or single :

119.
7. Occupation :

120.
8. Persons accompanying or brought by :

121.
9. Consent of the individual for Examination :

122.
10. Signature of the individual consenting or the left thumb impression :

123.
11. In the case of minors, consent of the guardian and his/her signature or left thumb
124. impression :

125.
12. Time and place of examination :

126.
13. Name of the nurse present at the time of examination :

127.
Marks of identification 1.

2.

128.
129.
130.

132.

133. PHYSICAL EXAMINATION

1. Height :

134.

2. Weight :

3. Built & Appearance :

135.

4. Chest girth at the level of nipples :

136.

5. Abdominal girth at the level of navel :

137.

6. Voice :

138.

7. Teeth :

139.

8. Hair Scalp :

140.

141. Axillary :

142.

143. Pubic :

144.

9. Pulse :

10. Blood Pressure :

145.

11. Temperature :

146.

12. Respiratory Rate :

147.

13. Skin :

148.

14. Mouth :

15. Eyes :

149.

16. Mammae – development of breasts – milk :

150.

17. Generative organs – development of genitals:

151.

18. Onset of Puberty :

152.

19. Ossification :

153.

154.

20. Report from radiological examination – age :

155.

156.

21. History :

157.

158.

22. Date and hour when the female first made complaint and the precise words employed by her at the time, i.e., a detailed account of

159. the occurrence as given by the woman :

160.

23. General behaviour :

24. Date and exact time when the incident
161. was said to have been committed :

25. Place where it occurred :

26. The exact circumstances under which the sexual assault was committed :

27. Whether or not the female was menstruating at the time :

28. Whether she was in senses during the whole time when the offense was committed or under the influence of intoxicating substances :

29. Whether she uttered any cries or was too terrified to do so :

30. Clothing – if changed – when :

31. Stains on clothing and on person :

32. External Injuries on person :

Scars if any :

33. Discharge :

34. Whether bath was taken – when :

35. Whether urine passed – when :

36. Whether motion passed – when :

37. Mental condition :

38. Gait :

39. Intelligence :

40. Demeanor :

41. Examination of the cloths including underclothes worn at the time of incidence and preserved for examination :

a) Blood :

b) Semen :

c) Other discharge :

d) Mud – dirt :

42. If signs of venereal disease present :

43.

44. Genitals (female)

45.

46. P

ubic hair – length matted or not :

Vulva :

47. Vagina :

48.

49. Hymen :

50.

51. Fourcehtte:

52.

53. Perineum :

54.

55. Cervix :

56. Injuries to mammae, cheeks,

57. thighs and genitals :

58.

59. Smears taken from vagina :

60.

61. Sterile swabs from cervix :

62.

63. Materials / Samples Collected

64. (for Investigation) :

65.

66. Age report from radiological examination :

67.

68. **OPINION:**

69.

70. Based on the above findings I am of the opinion that :

(Substantiate giving reasons for each opinion)

1. there is no evidence/ evidence of general bodily injuries* suggestive of struggle

71.

72.

2. there is no evidence /evidence of genital injuries

73.

74.

3. there is no evidence / evidence of recent sexual act (if sperm/semen is detected in the vagina) *

75.

76.

77.

78.

79.

80.

81.

82.

83.

84.

85.

86.

* Strike whichever is not applicable

87.

88.

89.

90. Station :

91.

92. Date : Signature of the Medical Officer

93.

94.

95. Name :

96.

97.

98. Reg . No. :

99.

100.

101.

102. Original

to : Duplicate

to : Triplicate

to :

103.

104. (Detection of DNA materials of the accused from the samples collected from the person of the victim will be a positive evidence to prove the guilt)

105.

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SCHEME OF EXAMINATION AND CERTIFICATION FOR POTENCY

131.

132.

133. **DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY**

134.

135. Examination of a male for potency

136. Requisition from_____of___

_____Police Station vide his letter No. dated _

_____

Date : Time : Place :

137.
138.
139. Name of the Individual :
140.
141. Age as alleged by :
142.
143. Gender :
144.
145. Parent's or Guardian's Name :
146.
147. Address and residence :
148.
149.
150.
151.
152. Occupation :
153.
154. Married or single :
155.
156. Persons accompanying or
157. brought by :
158.
159. Time and place of examination :
160.
161. Informed written consent for
162. physical examination :
163.
164. Signature of the individual
165. consenting or the left thumb
166. impression :
167.
168. In the case of minors, consent
169. of the guardian and his/her
170. signature or left thumb
171. impression :
172.
173. Name of the nurse present at the
174. time of examination :
175.
176. Marks of identification : 1.
177.

2.

187.

188. PHYSICAL EXAMINATION

189.

1. Height :
2. Weight :
3. Chest girth at the level of nipples :
4. Abdominal girth at the level of navel :
5. General build and appearance :
6. Voice :
7. Teeth :
8. Hair Scalp :

   190. Beard :

   191. Moustache :

   192. Axillary :

   193. Pubic :
9. Pulse :

194.

10. Blood Pressure :

195.

11. Temperature :
12. Respiratory Rate :

196.

13. Skin :

197.

14. Mouth :

198.

15. Eyes :

199.

16. Generative organs –

    200. development of genitals :
17. Ossification :

201.

202.

18. Report from radiological

    203. examination – age :

204.

205.

19. History :

    206. Smoking / alcohol intake Diseases / accidents Sexual development Marital

207.

208. 209. Di 210. Smears taken – No of slides
20 scharge .

211. 212. Me 213.
21 ntal condition .

214. 215. Ga 216.
22 it .

217. 218. Int 219.
23 olligence .

220. 221. De 222.
24 meanor .

223. 224. If 225.
25 sign of venereal disease present .

226. 227. Genitals 228.
26

229. 230. Pu 231.
bic hair – length – matted or not .

232. 233. Penis – length & circumfrence 235.
234.
en flaccid .

236. 237. Cir 238.
cumcised or not .

239. 240. S 241.
megma .

242. stis and epididymis : 244.

245. 246. Ge 247.
27 neral and systemic examination .

248. 249. La 250.
28 boratory Examinations .

251.

a) Blood :

252.

b) Semen :

253.

c) Other discharge :

254.

d) Mud – dirt :

e)

f) **POTENCY CERTIFICATE**

g) Appearance found on the person of a male calling himself _____ age stated _____years, an inhabitant of___ _____ who was sent with letter / memo No_____dated _____ from_____and accompanied by_____for report as to the result of Examination of the person etc., for potency / evidence of recent sexual act.

h)

i) CONSENT:

j) Identification marks : 1)

k) 2)

l) The person was first seen by the undersigned at _____ on _____and the examination was commenced at__ on_____when the following were found.

m)

n)

o)

p) OPINION:

1. There is nothing to suggest that the above person is incapable of performing the act like that of sexual intercourse, however psychological cause for impotence has not been evaluated.
2. The above examined person is impotent because of the following impediments.

1)

q) 2)

r)

s)

t)

u) Station :

v) Date : Signature of the Medical Officer Name:

w) Designation:

Regn. No:

x)

y) Original to : Duplicate

to : Triplicate

to :

z)

aa) **DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY**

bb)

cc) **Examination of a male for potency**

dd) Requisition from_____of___

_____Police Station vide his letter No.dated _

_____

Date : Time : Place :

1.	Name of the Individual	:	
2.	Age as alleged by	:	
3.	Gender	:	
4.	Parent's or Guardian's Name	:	
5.	Address and residence	:	
6.	Occupation	:	
7.	Married or single	:	
8.	Persons accompanying or brought by	:	
9.	Time and place of examination	:	
10.	Informed written consent for physical examination	:	
11.	Signature of the individual consenting or the left thumb impression	:	
12.	In the case of minors, consent of the guardian and his/her signature or left thumb impression	:	
13.	Name of the nurse present at the time of examination	:	
14.	Marks of identification	:	1. 2.

ee)

ff) **PHYSICAL EXAMINATION**

gg)

1. Height :
2. Weight :
3. Chest girth at the level of nipples :
4. Abdominal girth at the level of navel :
5. General build and appearance :
6. Voice :
7. Teeth :
8. Hair Scalp :

   hh) Beard :

   ii) Moustache :

   jj) Axillary :

   kk) Pubic :
9. Pulse :

ll)

10. Blood Pressure :

mm)

11. Temperature :
12. Respiratory Rate :

nn)

13. Skin :

oo)

14. Mouth :

pp)

15. Eyes :

qq)

16. Generative organs – development of genitals :

rr)

17. Ossification :

ss)

tt)

18. Report from radiological examination – age :

uu)

vv)

ww)

19. History :

    xx) Smoking / alcohol intake Diseases / accidents Sexual development Marital

status / offspring

yy)

zz) aaa) Di bbb) Smears taken – No of slides

ccc) ddd) Me eee)

fff) ggg) Ga hhh)

iii) jjj) Int kkk)

lll) mmm) De nnn)

ooo) ppp) If qqq)

rrr) sss) Genitals ttt)

uuu) vvv) Pu www)

xxx) yyy) Penis – length & circumfrence aaaa)

bbbb) cccc) Cir dddd)

eeee) ffff) S gggg)

hhhh) stis and epididymis jjjj)

kkkk) llll) Ge mmmm)

nnnn) oooo) La pppp)

qqqq)

a) Blood :

rrrr)

b) Semen :

ssss)

c) Other discharge :

tttt)

d) Mud – dirt :

e)

f) **POTENCY CERTIFICATE**

g) Appearance found on the person of a male calling himself _____ age stated _____years, an inhabitant of___ _____ who was sent with letter / memo No_____dated _____ from_____and accompanied by_____for report as to the result of Examination of the person etc., for potency / evidence of recent sexual act.

h)

i) CONSENT:

j) Identification marks : 1)

k) 2)

l) The person was first seen by the undersigned at _____ on _____and the examination was commenced at__ on_____when the following were found.

m)

n)

o)

p) OPINION:

1. There is nothing to suggest that the above person is incapable of performing the act like that of sexual intercourse, however psychological cause for impotence has not been evaluated.
2. The above examined person is impotent because of the following impediments.

1)

q) 2)

r)

s)

t)

u) Station :

v) Date : Signature of the Medical Officer Name:

w) Designation:

Regn. No:

x)

y) Original

to : Duplicate

to : Triplicate

to :

z)

aa) **DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY**

bb)

cc) **Examination of a male for potency**

dd) Requisition from_____of___

_____Police Station vide his letter No.dated _

_____

Date : Time : Place :

1.	Name of the Individual	:	
2.	Age as alleged by	:	
3.	Gender	:	
4.	Parent's or Guardian's Name	:	
5.	Address and residence	:	
6.	Occupation	:	
7.	Married or single	:	
8.	Persons accompanying or brought by	:	
9.	Time and place of examination	:	
10.	Informed written consent for physical examination	:	
11.	Signature of the individual consenting or the left thumb impression	:	
12.	In the case of minors, consent of the guardian and his/her signature or left thumb impression	:	
13.	Name of the nurse present at the time of examination	:	
14.	Marks of identification	:	1. 2.

ee)

ff) **PHYSICAL EXAMINATION**

gg)

1. Height :
2. Weight :
3. Chest girth at the level of nipples :
4. Abdominal girth at the level of navel :
5. General build and appearance :
6. Voice :
7. Teeth :
8. Hair Scalp :

   hh) Beard :

   ii) Moustache :

   jj) Axillary :

   kk) Pubic :
9. Pulse :

ll)

10. Blood Pressure :

mm)

11. Temperature :
12. Respiratory Rate :

nn)

13. Skin :

oo)

14. Mouth :

pp)

15. Eyes :

qq)

16. Generative organs – development of genitals :

rr)

17. Ossification :

ss)

tt)

18. Report from radiological examination – age :

uu)

vv)

ww)

19. History :

    xx) Smoking / alcohol intake Diseases / accidents Sexual development Marital

status / offspring

yy)

zz) aaa) Di bbb) Smears taken – No of slides

ccc) ddd) Me eee)

fff) ggg) Ga hhh)

iii) jjj) Int kkk)

lll) mmm) De nnn)

ooo) ppp) If qqq)

rrr) sss) Genitals ttt)

uuu) vvv) Pu www)

xxx) yyy) Penis – length & circumfrence aaaa)

bbbb) cccc) Cir dddd)

eeee) ffff) S gggg)

hhhh) stis and epididymis : jjjj)

kkkk) llll) Ge mmmm)

nnnn) oooo) La pppp)

qqqq)

a) Blood :

rrrr)

b) Semen :

ssss)

c) Other discharge :

tttt)

d) Mud – dirt :

e)

f) **POTENCY CERTIFICATE**

g) Appearance found on the person of a male calling himself _____ age stated _____years, an inhabitant of___ _____ who was sent with letter / memo No_____dated _____ from_____and accompanied by_____for report as to the result of Examination of the person etc., for potency / evidence of recent sexual act.

h)

i) CONSENT:

j) Identification marks : 1)

k) 2)

l) The person was first seen by the undersigned at _____ on _____and the examination was commenced at__ on_____when the following were found.

m)

n)

o)

p) OPINION:

1. There is nothing to suggest that the above person is incapable of performing the act like that of sexual intercourse, however psychological cause for impotence has not been evaluated.
2. The above examined person is impotent because of the following impediments.

1)

q) 2)

r)

s)

t)

u) Station :

v) Date : Signature of the Medical Officer Name:

w) Designation:

Regn. No:

x)

y) Original

to : Duplicate

to : Triplicate

to :

z)
aa)
bb)
cc)
dd)
ee)
ff)
gg)
hh)
ii)
jj)
kk)
ll)
mm)
nn)
oo)
pp)
qq)
rr)
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tt)
uu)
vv)

EXAMINATION AND CERTIFICATION OF A CASE

ww)

xx)

yy) **DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY**

zz)

aaa) Examination and Certification of a Case of Drunkenness

bbb) Requisition from_____of_____

_____Police Station vide his letter No._____

_____dated _____ Date : Time :

Place :

ccc)

1. Name of the Individual :

ddd)

2. Gender :

eee)

3. Parent's or Guardian's Name :

fff)

4. Address :

ggg)

hhh)

iii)

jjj)

kkk)

5. Occupation :

lll)

6. Age as alleged by :

mmm)

7. Persons accompanying or

nnn) Brought by :

ooo)

8. Time and place of examination :

ppp)

9. Informed written consent of the Individual for examination :

qqq)

rrr)

sss)

ttt)

10. In the case of minors, consent of the guardian and his/her signature or left thumb impression :

uuu)

11. Name of nurse present at the

vvv) time of examination :

www)

Marks of identification 1)

2)

xxx)
yyy)

aaaa)

bbbb) **PHYSICAL EXAMINATION**

cccc)

1. Height :
2. Weight :
3. Chest girth at the level of nipples :
4. Abdominal girth at the level of navel :
5. General built :
6. Voice :
7. Teeth :
8. Hair Scalp :

dddd) Beard :

eeee) Moustache :

ffff) Axillary :

gggg) Pubic :

9. History :

hhhh)

iiii)

jjjj)

10. General appearance and demenour :
    a) State of clothing :
    b) Deposition :
    c) Speech :
    d) Gait :
11. Memory :

kkkk)

12. Mouth :
    a) Smell of alcohol :
    b) Dribbling of saliva :
    c) Lips :
    d) Tongue :

llll)

13. Eyes :
    a) Visual acuity :
    b) Lateral gaze Nystagmus :
    c) Conjunctivae :
    d) State of pupil :
    e) Light reflex :

f)

14. Ears :
15. Pulse :
16. Blood pressure :
17. Temperature :
18. Respiration :
19. Reflexes :
    a) Superficial :
    b) Deep :
20. Muscular co-ordination :
    a) Walking along a straight line :
    b) Picking up object from the floor :
    c) Finger nose test :
    d) Romberg's sign :
    e) Hand writing :
    f) Copying simple geometric figures :
21. CVS, RS, CNS and GIT :

a)
b)
c)
d)
e)
f)

g) Sample for Investigation

1) Blood :
2) Urine :

3)

4) **CERTIFICATE OF DRUNKENNESS**

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6) This is to certify that I Dr _____ of _____ Hospital have examined a person by name Thiru / Tmt ____ _____ aged ___ _____ residing at _____

7) _____ who was sent with police memo No._____ of _____ PS from _____ and accompanied by _____ for _____

8)

9) He / she was seen by me at____ on _____

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2) Blood & Urine were not collected because _____

15)

16)

17)

18)

19) Station :

20) Date : Signature of the Medical Officer Name & Designation:

21) Regn. No:

22)

23)

24) Original to : MAGISTRATE

25) Copy to : INSPECTOR OF POLICE

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36)
37)
38)
39)
5. Occupation :

40)
6. Age as alleged by :

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7. Persons accompanying or
42) Brought by :

43)
8. Time and place of examination :

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9. Informed written consent of the Individual for examination :

45)
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10. In the case of minors, consent of the guardian and his/her signature or left thumb impression :

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11. Name of nurse present at the
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19. Pubic :

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    d) State of pupil :
    e) Light reflex :

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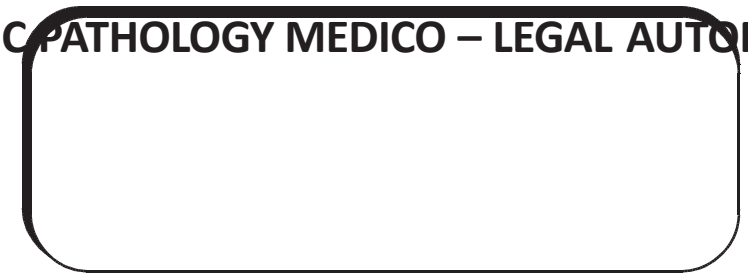
E. FORENSIC PATHOLOGY MEDICO – LEGAL AUTOPSY - ADU



50)

51)

52) **Table of approximate normal organ weights and cardiac dimensions**

53)

54)	55) 56) Newbor	57) 58) F	59) 60)	Adult male
61)	67)	69)	71)	73)
62) Heart weight	68) 23g	70) 150g	72) 305g (275-340g)	74) 260g (230-290g)
63) Valve circumferences :			78)	
Mitral			79) 8 - 10.5 cm	
64) Tricuspid			80) 10 - 12.5 cm	
Aortic			81) 6 - 7.5 cm	
Pulmonary			82) 7 - 9 cm	
65) Left ventricle thickness			83) upto 1.5 cm	
Right			84) upto 0.5 cm	
			85) 0.2 cm	2.3
86) Brain	89) 380g	97) 1300g	105) 1360g (1100-1600g)	113) 1240g (1000-1500g)
Lungs	90) 91) 92) 50g (together) 8g	98) 99) 100) 410g (together) 80g	106) 107) 108) 300-400g (each) 150g	114) 115) 116) 250-350g (each) 140g
87) (very variable) tomach	93) 135g	101) 1400g	109) 1400-1500g	117) 1300-1450g
Liver	94) 4g	102) 40g	110) 100g (80-120g)	118) 90g (70-110g)
Pancreas			111) 140-170g	119) 130-160g
Spleen	10g	95g		
Adrenals	95) 8g	103) 9g	112) 7	120) 5.5-
121) Uterus	123) 3g	125) 8g	127) --	130) 70g (40-125g)
122) Ovaries	124) 0.3g (together) 2g	126) 5g (together) 20g	128) -- 129) 13g (each)	131) 4.5 - 5.5g (each)
133) Thyroid gland	137) 3g	141) 25g	145) 40g (30-70g)	149) 35g (30-70g)
Thymus	13g	35g	146) usually atrophic 0.7g	150) usually atrophic
Pituitary	0.1g	0.6g	147) 148) 0.035 - 0.045g (each) 15-20g	151) upto 1g during prgnancy
134) 135) Parathyroid glands	138) 139) --	142) 143) --		152) 0.03-0.04g (each)
Prostate	140) --	144) --		
136) (very variable)				

154)

155)

156) PROCEDURE OF MEDICOLEGAL POSTMORTEM EXAMINATION

157)

1. A requisition from Police or the Magistrate is necessary in all medicolegal cases for examination

158)

2. Policeman has to identify the dead body before autopsy examination

159)

3. All the entries must be made correctly and detailed records must be kept up-to-date

160)
161)

162) **OBJECTIVES OF A MEDICO-LEGAL AUTOPSY**

163)

1. To establish identity

164)

2. To find out the cause of death

165)

3. To find out the time since death

166)

4. To find out the manner of death viz. Accidental / Suicidal / homicidal / Natural

167)

5. To find out the intrauterine age of a foetus and to determine if it was live born, still born or dead born.

168)
169)
170)
171)

172) These instruments should be sharpened before use.

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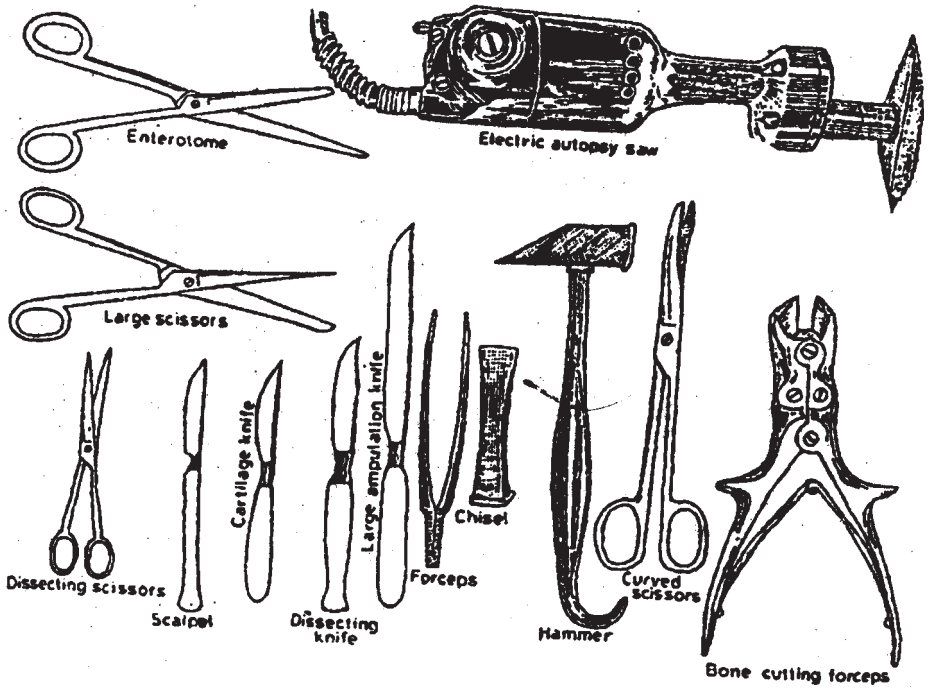


179)

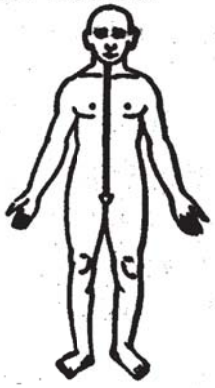
180)

181)

Fig. 1 Postmortan Instruments

182) Opening of the body:

183) Dead bodies are opened by several methods: By the common classical method.



195) **Fig. 2 Primary incision**

197) Starting from chin to symphysis pubis. This is also called as I shaped incision.

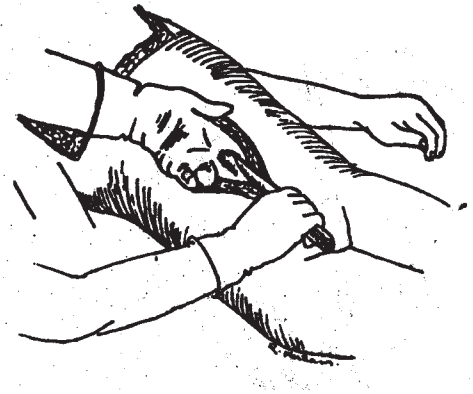
198) There are other methods of opening as called “U” and “Y” methods.

199) Reflection of skin and muscle and opening of abdominal & thoracic cavities.

201) The skin together with muscles are reflected on the chest and abdomen (fig 3a) and the ribs are cut at the constochondral junction(fig.3b)

Fig.3a. Cutting the costal cartilages
Fig. 3b. Cutting the first rib and clavicles

214) The abdominal wall is incised in the middle without injuring the underlaying structures(fig.4a) and the skin and muscles are reflected to the side exposing the organs(fig.4b)



215)

216) **Fig. 4a. Opening the peritoneum and**

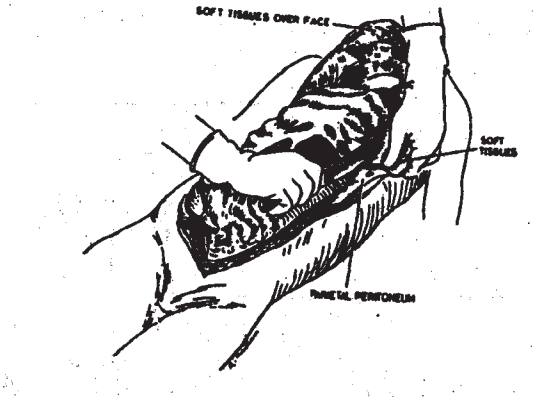


Fig. 4b. Reflecting the chest

217) **abdominal / walls**

219) The sternum is cut at the level of costochondral junction and also the sternoclavicular junction is cut and disarticulated and the sternum is lifted up from the mediastinum and dissected out exposing the thoracic viscera and the abdominal viscera (fig5a and 5b)

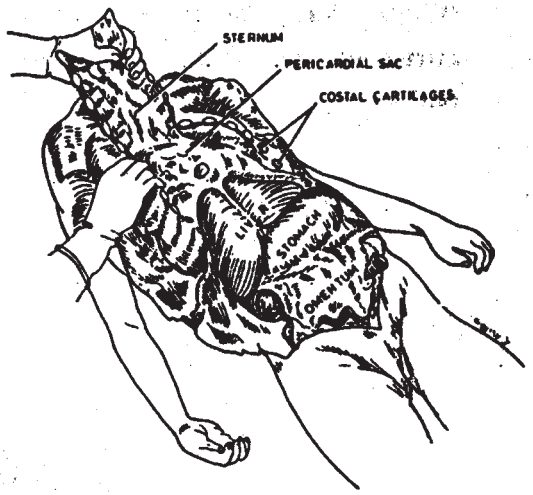


Fig. 5a Removal of Sternum first step **Fig. 5b. removal of sternum second step**

Removal of intestine :

238) The first part of jejunum which is a fixed loop is identified and ligated and severed and is dissected out by cutting the mesentery as close to the intestine as possible by gently pulling the intestine up to the Ileo-coecal junction.(fig.6) Later the caecum and the ascending colon are pulled upwards cutting through their attachments i.e. gastrocolic ligament and later the decending colon and the sigmoid colon are separated after placing a ligature round the rectum and severing it. The intestines are examined for the presence of injuries or other pathological conditions and then opened along the line of mesenteric attachment and the large intestine are washed and mucous membrane is examined. If the intestine is required for chemical analysis,30 cms of proximal part of jejunum is ligated and the loop of that intestine and its contents are preserved for chemical analysis.

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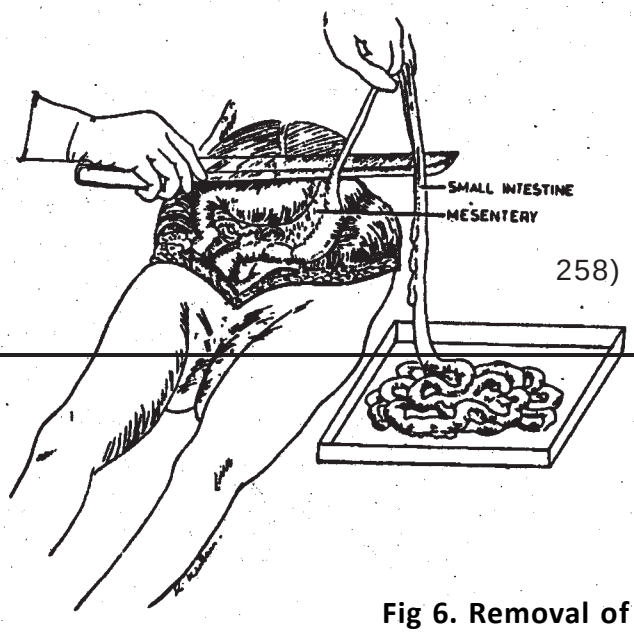


258) **intestines**

259)

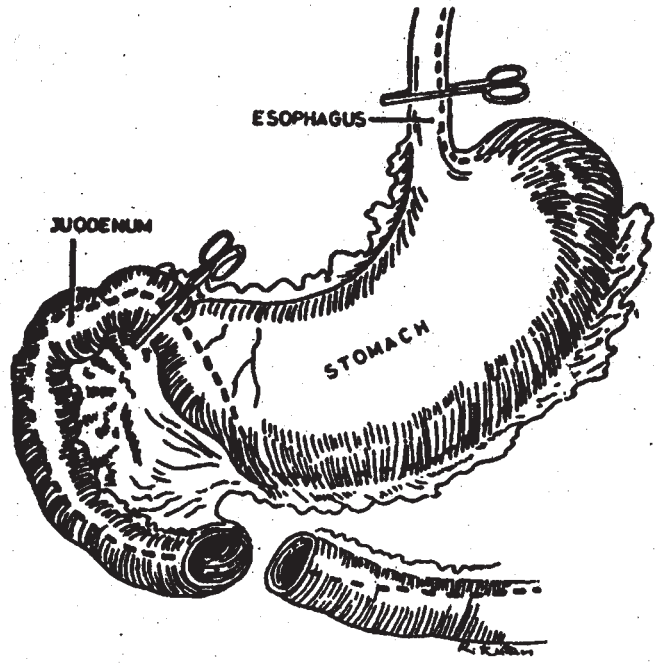
Fig 6. Removal of

261) Preservation of stomach and its contents:

262)

263) The stomach is ligated above the cardiac end and at the pyloric end and severed (fig

264) 7) and kept in a clean container and the stomach is opened along the greater curvature, to examine the stomach contents and the mucous membrane of the stomach walls



265)

266) **Fig 7 - Removal of stomach**

267)
268)

269) Examination of abdominal organs:

270)

271) The biliary tract is examined for the presence of flow of bile and the Gall bladder is removed and examined. The liver is kept on the table after taking the weight and serial sections are made through and through at 1 cm distance cutting through all the lobes. The liver is examined for any evidence of disease processes and if required for chemical analysis , one pound (1b) of liver is cut into small bits and preserved for chemical analysis (Fig 8)

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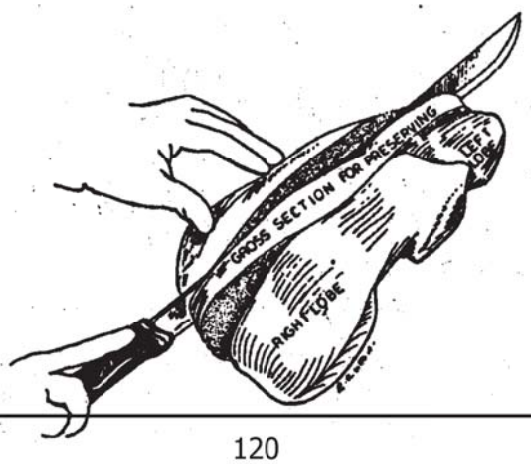

282)

283) **Fig 8 - Sectioning the Liver**

The spleen is cut in a similar way.

The pancreas is cut along its length by serial sections and examined

The adrenals are dissected and examined.

Dissection of Kidneys :

The kidneys are examined regarding their position and severed from their attachments. The kidney is cut along its convex surface towards the pelvis and the capsule is stripped. (Fig.9a and 9b) Inside, the cortex, medulla and pelvis are examined.

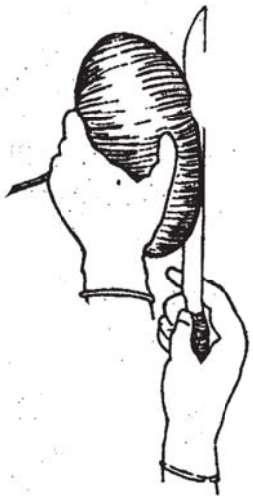

Fig 9a Dissection of Kidney

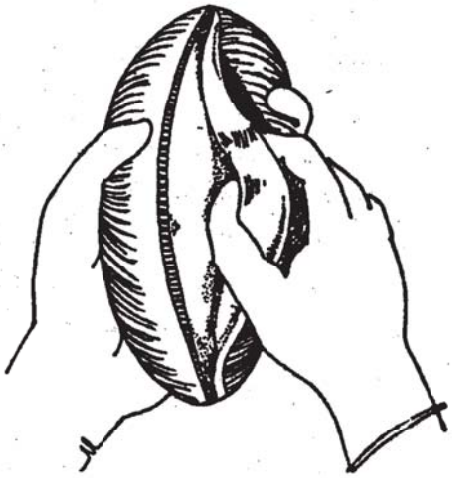

Fig 9b Stripping the capsule of kidney

The Ureters and the urinary bladder are also examined by opening them up.

The prostrate and seminal vesicles are examined while examining the urinary bladder.

Dissection of Genitals:

In the females uterus and the adenexa are examined. The uterus is dissected out of the pelvis after cutting its attachments. The vagina is opened and examined. Later the cervix is opened. The Uterus is opened along the midline and the incision is extended to the fornices. The uterine cavity and the endometrium are examined (fig 10)

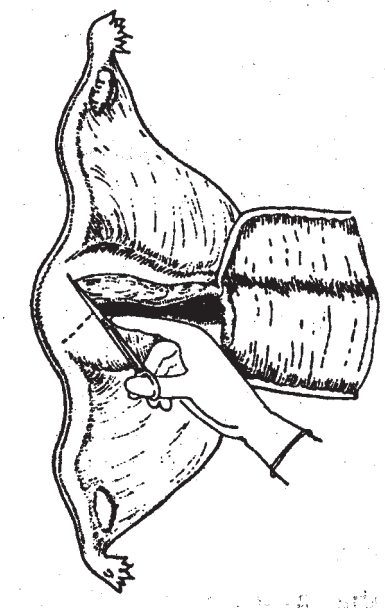

Fig 10 - Opening the Uterus

The inguinal canal is opened and the external inguinal opening is enlarged. The spermatic cord is identified and by gentle traction the testis is pulled up and brought out through the external inguinal ring. The testis together with the spermatic cord, and the Epididymes are examined. The testis is examined on its external surface and later cutting through and through the cut surface is examined. The abdominal aorta is opened up together with its important branches i.e. the renal, the superior mesenteric, the coeliac arteries and also the external and internal iliac arteries. Weight and size of each of the abdominal organ is recorded.

Examination of thoracic viscera:

After dissecting the neck structures i.e. Thyroid, parathyroid, the Epiglotis vocal cods are examined. The trachea is opened and all the Bronchi or Bronchioles are opened up as far down as possible. Then the lungs are separated, severed from the hilum and each lung is kept on the table is kept on the table and sectioned from outer aspect towards the hilum and cut surfaces are examined.(fig 11)

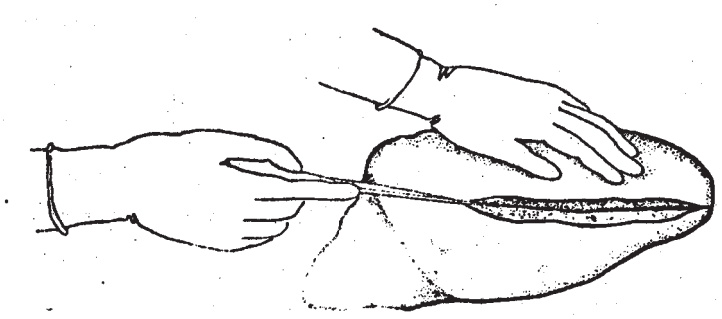

Fig 11 Dissection of Lung

The Pericardium is opened up and the heart is exposed. The heart can be opened along the blood flow. The superior vena cava, the inferior vena cava and the right atrium are opened(fig 12a) Then the right ventricle is opened (fig 12b)

Fig 12a Opening the right artium

Fig 12b Opening the right

by joining the vena cavae

Ventricle

Then the pulmonary artery is opened cutting along the side of the intraventricular septum and pulmonary trunk and its main branches and opened to look for any pulmonary embolism(fig 13a) Then the left ventricle is opened along with the interventricular septum extending into the Aorta (fig 13b)

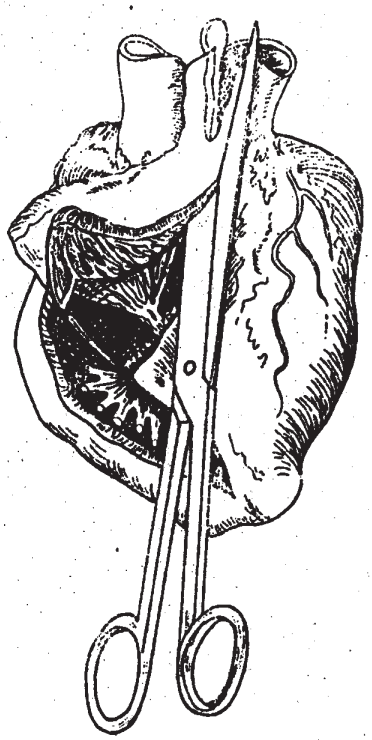

Fig. 13a Opening the pulmonary artery

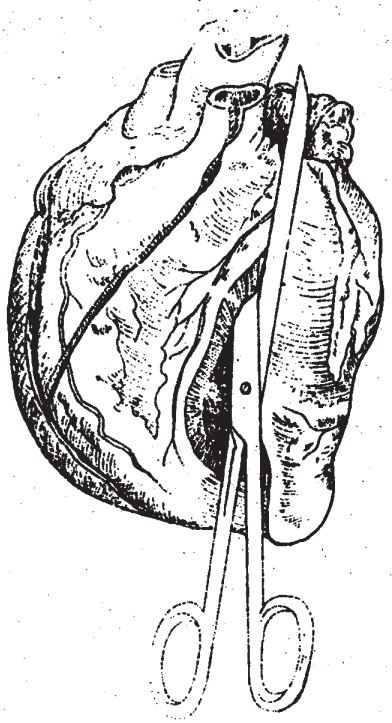

Fig. 13b Opening the left ventricle and aorta

The Coronaries, both right and left and the anterior descending branch are opened by making serial coronal sections to look for any thrombus or internal haemorrhages(fig 14). The Myocardium is dissected by serial sections on the endocardial surface at a distance of ½ cm to note for any old and fresh infarcts.

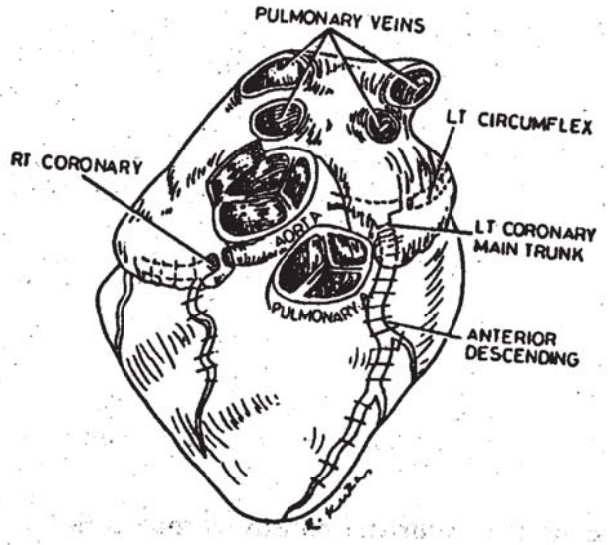

Fig. 14 - Disection of coronary arteries - serial sectioning

Opening of the head:

The head is raised by keeping wooden blocks under the neck. The scalp hair is separated and the scalp is incised across the head from one ear to the other (fig.15a) The skin flaps arereflected one in front and one to the back (fig 15b). The muscular attachments to the skull in the temporal region are cleaned by dissecting them out.

The skull is cut around with a saw.

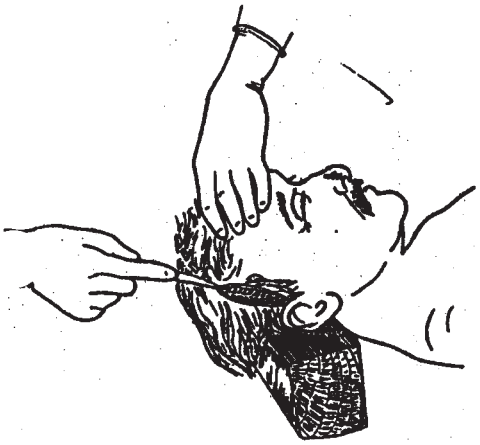

Fig. 15a Dissection of scalp ear to ear incision

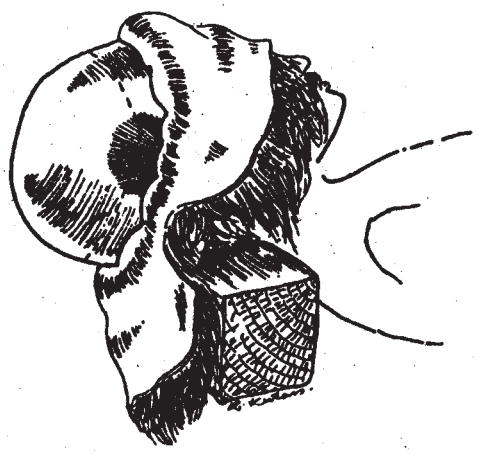

Fig. 15b Reflection of scalp and removal of skull cap

The duramater is exposed and incised one cm on either side of the midline and around and is reflected(fig 16a) The brain is exposed. The fingers are introduced under the frontal lobe and the brain is gently lifted up and the nerves at the base are severed. The Tentorium cerebelli also severed. Figures are introduced under the cerebellum and the medulla is incised and the brain is removed.(fig. 16b) for observation of the base and the surface.

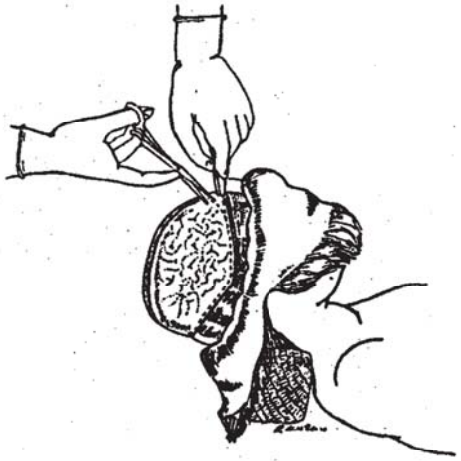

Fig. 16a - Cutting the duramater

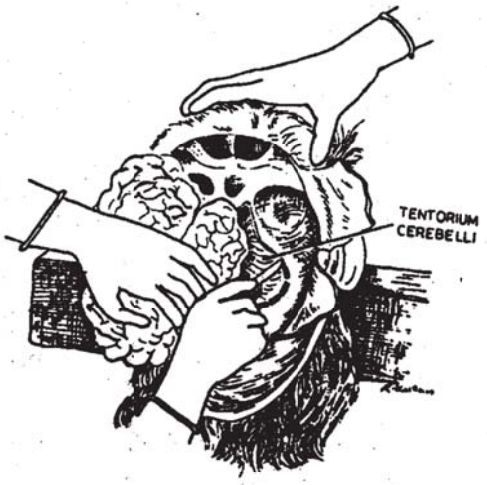

Fig. 16b - Removal of Brain

The brain is sectioned in the midline over the corpus callosum and sectioned across (fig 17a) Serial Coronal sections are made from frontal to the occipital lobe after separate ng the cerebellum and pons from the brain which are separately sectioned to note the presence of any haemorrhages and exudates etc.,

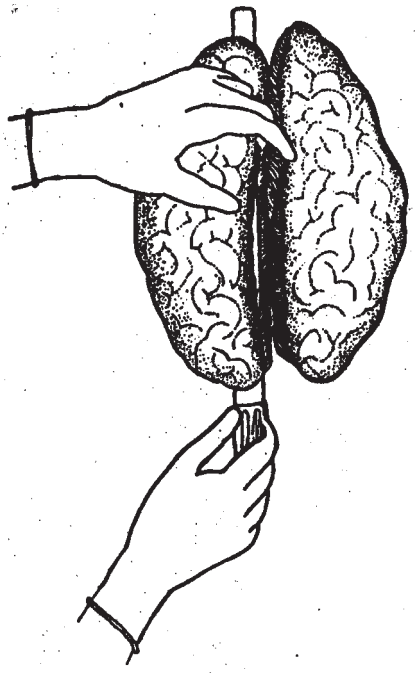

Fig 17a - Exposing the corpus callosum

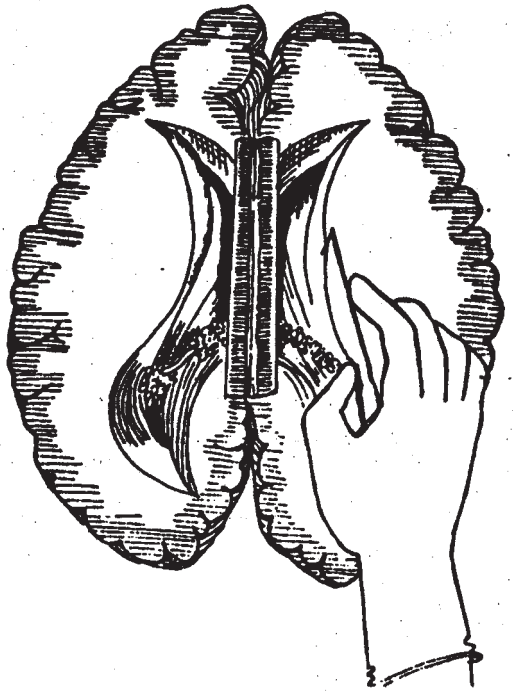

Fig. 17b - Exposing the ventricles

Opening of the spinal cord.

An incision is given from the occiput to the sacrum on the midline along the vertebral spines(fig 18)

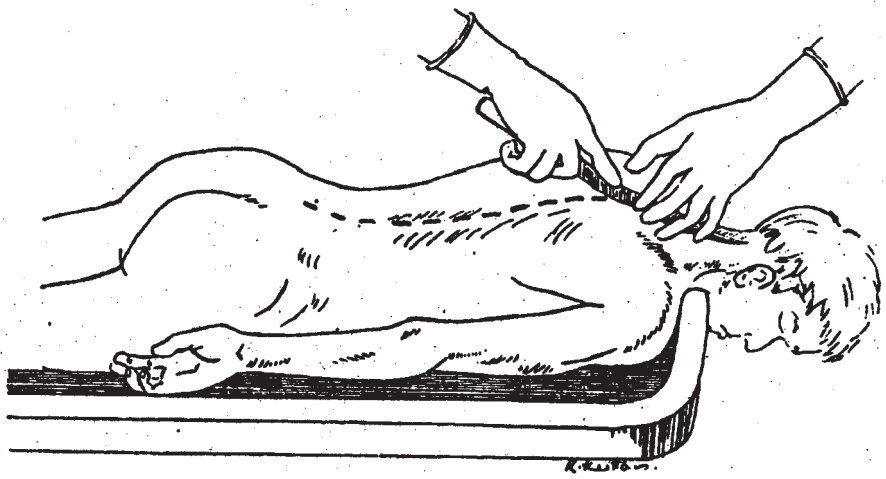

Fig. 18 - Incision to expose the vertebral column

The muscles on the back are dissected . The lamina of the vertebrae are cut and the spinal cord is exposed and is gently lifted after its covering and it is severed (fig 19)

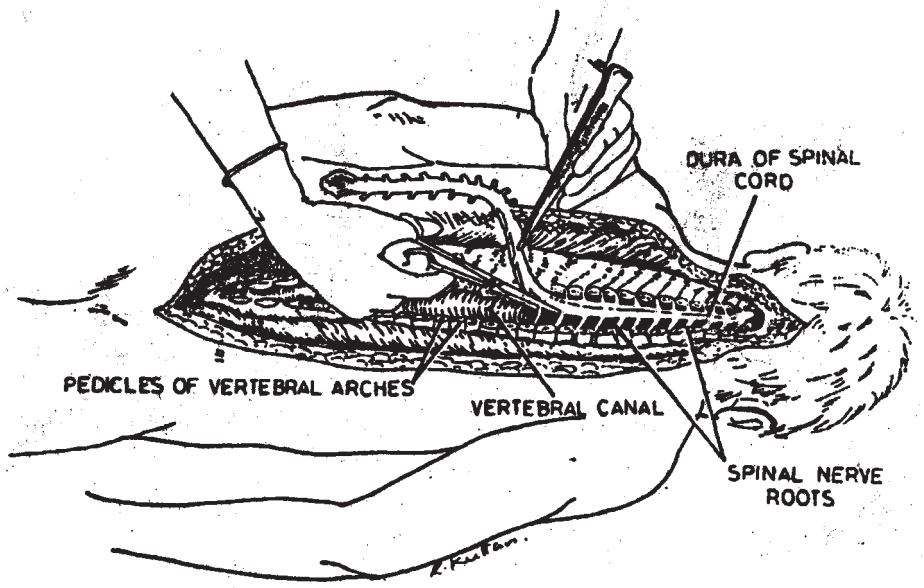

Fig. 19 The laminae are cut on both sides and teh spinal cord is exposed

Stitching the body after postmortem:

Dead bodies must be properly stitched usually with continuous sutures using a curved needle and needle holder and all the parts are opened should be stitched again and body should be handed over in a proper condition after washing the body and should be wrapped in clean bed sheet (fig 20)

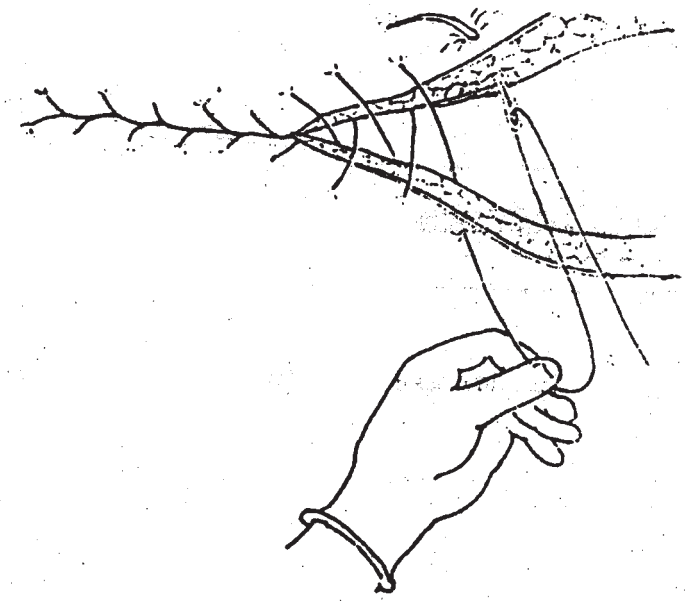

Fig. 20 Stitching the body after postmortem

PRESERVATIVES

1. Saturated Sodium Chloride solution - (except)
    - Heavy metals
    - Aconite
    - Vegetable poisons
    - Corrosive acids
2. Rectified Spirit – In all conditions except
    - Carbolic Acid
    - Carbon tetrachloride
    - Paraldehyde
    - Alcohol
    - Acetic Acid
    - Phosphorus
    - Kerosene

POISONING	VISCERA TO BE PRESERVED
ALL CASES OF POISONING	• Entire stomach & its contents • Intestines 30 cm & its contents (infants entire small intestine) • Liver 500 gm • Kidney each half (infants both kidnesy as a whole) • Urine 50 - 100 ml • Blood 10 ml • CONTROL OF PRESERVATIVE
D Heavy Metals	Long bones preferably Femur 10 cm Scalp Hair - with roots (15 - 20) Nail clippings
D Organo phosphorus	100 gm cerebrum Perinephric fat 100 gm
D Aconite and Digitalis	Heart

DStrychnine	Entire length of spinal cord Entire spleen
DCyanide	One lung in an air tight container Blood covered with the layer of liquid paraffin
DInhaled poisons	100 gm of brain Bile
DBarbiturates	Blood 10 ml - 100 mg of NaF + 20 mg of Potassium oxalate CSF 5 ml Vitreous 2 ml - lat angle of eye
DAlcohol	

- All cases of poisons the skull is opened first
- Skin - 2.5 cm2 injected poisons/snake bite (with control skin)
- Muscles - Heavy metals
- Vitreous for chloroform
- Uterus and vagina for abortifacients
- Maggots - Barbiturates, cocaine (iso prophyl alcohol or 70% alcohol)
- DNA - 1.5 ml of blood on EDTA tube stored at 4 degrees
- Spleen is the best for DNA
- In skeletal remains DNA - tooth
- FTA paper for DNA analysis - Latest
- Blood from femoral and subclavian veins
- Muscles - Heavy metal poisons
- Stains - scrapped - tissue paper
- Nails clippings - folded within a tissue paper
- No need to preserve in cases of analysis <24 hours, cold storage possible and hair and nails
- Never store in poly ethylene
- Histopathology - 10% NBF or 95% alcohol
- Virology - 80% glycerol in buffered saline
- Lungs - Trachea ligated and complete lung is preserved
- Bite marks - cotton swab and dried
- Buccal epithelial - brush - left and right buccal sides
- Urine - supra pubic puncture
- Bile with Gall bladder : Marphine, Opioids, Chlorpromazine
- CSF - Cisternal puncture

TIME SINCE DEATH

1. Fall in body temperature @ 1.5° F per hour.

2. Post mortem staining:

- Starts by .....2 to 4 hrs
- Well established by .....4 to 8 hrs.

Fixation by .....6 to 12 hrs.

3. Rigor Mortis

- Facial muscles .....1 – 2 hrs
- Upper limbs ..... 2 – 4 hrs
- Lower limbs ..... 4-6 hrs
- Entire body ..... 6 hrs.
- Disappearance starts by .....18 hrs
- Compleately passes off by .....36 – 48 hrs.

4. Decomposition

a. Greenish discoloration of R Iliac fossa..... 24 hrs ± 6

b. Marbling ..... 36 hrs ±6

- c. Postmortem blisters ..... 36 – 48 hrs.
- d. Peeling of Cuticle ..... 36 – 48 hrs.
- e. Bloating up of body ..... 36 – 72 hrs
- f. Protrusion of eyes, tongue ..... 3 - 5

days g. Maggots 3

– 5 days

- h. Loosening of hair, nail, teeth ..... 3 – 5 days
- i. Liquefaction of brain ..... 3 days
- j. Liquefaction of other internal organs ..... 3 – 5 days
- k. Skeletonisation

.....	1 – 2 months

DEPT. OF FORENSIC MEDICINE P.M. NO :

DATE:

Civil Medical form No.66 (vide para 110.C.M. Code)

Form in which to report post-mortem examinations, to be used when forwarding viscera to the Chemical Examiner.

From the .....

To the .....

..... Dated .....

20 .

.....

Description of viscera forwarded for examination.

Mode of Packing Weight of parcel	Copy of label attached to each article	Impression of Seal
Mode of dispatch	Date of Despatch	Date of receipt in Chemical Examiner's Office

INFORMATION FURNISHED BY POLICE OR PRECISE OF CASE

Name .....

Sex.....Age.....Caste..... Town or village.....

- History of case

Date and hour of Dispatch of body	Date and hour of autopsy	Name of officer by whom examination was actually made.
Date of Receipt		Medical Officer Dept. of Forensic Medicine

- Appearance of body
- Muscularity Stout
Emaciated

- Special Marks
- Scars Tattooing
- Amount of hair, etc.,

- Signs of decomposition

- Wounds and bruises- a – position

- b –

Character c –

Size

- State of natural orifices

Mouth	Eye	Ears	Nostrils	Anus	Vagina

Urethra State of limbs, etc.,

- Rigor mortis Position
- Contents of hands, if clenched
- Features…..
  - Relaxed
  - Contracted*
- E yelids Pupils
- Contents of mouth Position of tongue State of teeth

- Thor ax- Rib Cartilages
- Pleura — Shape and Appearance
- Pericardium — Cavities
- Heart — Clots, ante or post-mortem Muscular Structure
- Vessels — Clots
  - Aneurysm Atheroma, etc., Appearance Colour
- Lungs — Consistency
  - Adhesions
- Larynx, trachea and bronchi foreign bodies or disease

- Abdomen Peritoneum
- Peritoneal cavity, Contents,
- Liver and gall bladder- from and size, disease or

injury Pancreas, disease or injury

- Spleen, disease or injury

Kidney, disease or injury

- Stomach….
  - Size and general appearance, Appearance of coats
  - Contents appearance, colour and quantity General appearance, contents
- Intestines … Appearance of coat

- Generative organs
- Bladder and contents
- Uterus, appearance, size and contents Vagina

- Head

- Scalp
- Bones- diseases, injuries
- Membranes
- Brain substance and ventricles
- Base of skull fractions, caries, extravasation, etc.,

- The spinal canal need not be examined unless any indication of disease or injury exists.

- Fractures and dislocations

- More detailed description of injury or disease

- OPINION AS TO CAUSE OF DEATH

- Station: Medical Officer – in-charge Dated :

COLLECTION, PRESERVATION AND FORWARDING OF

PROCEDURE FOR COLLECTION & PRESERVATION OF VISCERA FOR CHEMICAL ANALYSIS

After receiving requisition from the investigating authority, the body is identified by the police constable. Postmortem is done by the medical officer and the following viscera are preserved for chemical analysis in deaths due to suspected cases of poisoning.

The Viscera collected and preserved in glass bottles having a capacity of 1 litre

Viscera are removed and preserved into different bottles and numbered as follows:

No: 1 – Stomach and its contents

No: 2 – Proximal part of small intestine 30 cms and its contents } 1 bottle

No: 3 – 500 gms of liver and 1 half of each kidney

No: 4 – Special viscera if required

No: 5 – Blood – 10 ml – Red top tube / Gray top tube (Sodium oxalate & NaF and Purple top (EDTA)

No: 6 – Urine 200 ml

No: 7 – Vitreous – 10 ml if required

No: 8 – Sample of preservative

Preservative is added into the bottles upon 2/3 rds of the bottle. Bottles are sealed and labeled. This is packed in another wooden viscera box which is also sealed. The viscera box is send through a messenger (police constable) who is incharge of the body, to the Assistant Director of THE REGIONAL FORENSIC SCIENCE LABORATORY, along with the following documents.

1. CASE HISTORY
2. COPY OF POSTMORTEM CERTIFICATE / CIVIL MEDICAL FORM 66
3. AUTHORISATION LETTER FROM THE MAGISTRATE FOR THE POLICE CONSTABLE TO TAKE THE VISCERA BOXES
4. REQUISITION LETTER FROM THE MAGISTRATE REQUESTING THE ASSISTANT DIRECTOR TO ANALYSE THE VISCERA AND SEND THE REPORT.
5. IMPRESSION OF THE SEAL
6. ADDITIONAL SET OF LABLES DULY FILLED IN.

NAME OF THE INSTITUTION:

POSTMORTEM No : Date :

Crime No. : Name : Police Station :

Name of the Viscera : Age : Sex :

Preservative Used : Saturated sodium chloride / rectified spirit

Station: Date:

Signature of M. O

- For Blood - Potassium oxalate (anticoagulant) or
  - Sodium Fluoride (Enzyme inhibitor) or
  - Sodium citrate, EDTA

For urine, Thymol is used as preservative.

- Hairs, Nails, Bones, brain, Lungs, Spinal cord and heart are the special viscera which are preserved in special circumstances.

- OPINION:

- 1, BEFORE RECEIVING VISCERAL ANALYSIS REPORT :

  - VISCERA PRESERVED AND SENT FOR CHEMICAL ANALYSIS, OPINION AS TO THE CAUSE OF DEATH IS RESERVED PENDING.

2. SUBSEQUENT OPINION :

   a) If the Visceral analysis report is positive :

      - Postmortem findings are consistent with death due to ..... poisoning.

   b) If the Visceral analysis report is negative :

      - Rule out other causes of death (Natural / Injuries)
      - A definite opinion as to cause of death cannot be given, however death due to poisoning cannot be ruled out.

FORWARDING LETTER

DEPARTMENT OF FORENSIC MEDICINE

Dated :

From

Medical Officer
Department of Forensic Medicine,

To
The Assistant Director
Regional Forensic Science Laboratory

Sub : CHEMICAL EXAMINATION AND REPORT – Requested for:

R P. M. No: Dated :

C.R. No. Police Station :

—xxx—

I have the honour to forward the Viscera of..... Aged..... Sex.....

of P.M.No.....Dated.....

for favour of Chemical Examination and report.

The specimen of the Seal used is enclosed herewith.

Yours faithfully,

Encl : Civil Medical Form (Form 66) / Certified Copy of P.M.

report

- Authorization Letter from Magistrate
- Requisition Letter to the RFSL, Asst. Director
- Medical Report
- Case History
- Sample of labels (Duplicate copies)
- Sample of seal impression

FORENSIC MEDICINE DEPARTMENT

P.M.No. Dated:

Name: Age: Se

Stomach and contents in 400ml. of rectified Sprit/ saturated saline

Police station:
Cr. No:
Date:

Professor of Forensic Medicine

FORENSIC MEDICINE DEPARTMENT

II. P.M.No. Dated:

Name: Age: Sex:

Intestine and contents in 300ml. of rectified Sprit/ saturated saline

Police station:
Cr. No:
Date:

Professor of Forensic Medicine

FORENSIC MEDICINE DEPARTMENT

III. P.M.No. Dated:

Name: Age: Sex:

Liver and Kidney in 400ml of rectified Sprit/ saturated saline

Police station:
Cr. No:
Date:

Professor of Forensic Medicine

FORENSIC MEDICINE DEPARTMENT

IV. P.M.No. Dated:

Name: Age: Sex:

Brain – 500gms. in rectified Sprit/ saturated saline

Police station:
Cr. No:
Date:

Professor of Forensic Medicine

FORENSIC MEDICINE DEPARTMENT

V. P.M.No. Dated:
Name: Age: Sex:
Sample of blood 100c.c Preservative Sodium Fluoride
Police station:
Cr. No:
Date:

Professor of Forensic Medicine

FORENSIC MEDICINE DEPARTMENT

VI. P.M.No. Dated:
Name: Age: Sex:
Urine 100c.c Preservative Sodium Fluoride

Police station:
Cr. No:
Date:

Professor of Forensic Medicine

FORENSIC MEDICINE DEPARTMENT

VII. P.M.No. Dated:
Name: Age: Sex:
Sample of preservative used 100ml.of rectified Sprit/ saturated saline

Police station:
Cr. No:
Date:

Professor of Forensic Medicine

DEPT. OF FORENSIC MEDICINE

FINAL OPINION

P.M. No..... Date :.....

Police Station :..... Cr. No..... Date :.....

Name :

Age :

Sex :

Chemical Analysis, Number and date

Report.....

.....

.....

The deceased would appear to have died of.....

.....

Signature of Medical Officer
Dept. of forensic Medicine

Date :.....

EXAMINATION OF FOETUS

FOETAL AUTOPSY AND DETERMINATION OF AGE OF FOETUS

(INTRA UTERINE PERIOD)

Foetal autopsy is done to determine the age of the foetus and the cause of its death. It helps to determine whether the baby is still born, dead or live born. It also helps to find out whether the (foetus) baby is viable or not viable.

Legal Aspects:

As in any other autopsy, the investigating officer gives the requisition for autopsy along with a brief history of the case.

A. External examination:

1. Clothes and wrappings for identify
2. Length, weight, body hair, genitalia, vernix caseosa, eyes, eyebrows
3. Colour of the nails, length of nails related to the tip of fingers.
4. Postmortem changes
5. Signs of maceration
6. Umbilical cord position- tied or torn; if tied - nature and the material used to tie
7. Placenta – attached or not, its weight, infarcts, diseases etc.,
8. Signs of maturity
9. Marks of violence
10. Caput succedaneum
11. Examination of orifices – free or blocked, any discharge

B. Internal Examination

Examination of skull and brain for malformation, injuries or disease; Non-alignment, Caput Succedaneum…

Examination of mouth, nostrils, trachea for evidence of foreign bodies;

Lungs	-	Floatation test (Hydrostatic test) Weight – colour - consistency – edges Crepitation – collapse – consolidation
Heart	-	For any abnormality
Stomach	-	Stomach – bowel test (BRESLOW'S SECOND LIFE TEST)

CHANGES IN THE UMBILICAL CORD;

Umbilical cord is tied and cut at the time of delivery, under aseptic precautions to prevent any infection.

Time period	-	Changes in the Umbilical cord
12-24 hours	-	Begins to dry
24-36 hours	-	a well defined demarcation encircling the origin of the cord in the anterior abdominal wall appears
3rd –to 4th day	-	Dries completely
4th to 5th day	-	Separation starts from the origin
6th to 7th day	-	An ulcer is formed which heals with scarring

Ossification centres:

During foetal autopsy, the following bones are examined for the evidence of ossification centres.

1. Sternum:

The sternum is placed flat on the table and cut along its long axis with a cartilage knife, Between 5th and 10th month of Intra Uterine Life ossification centres appear in the sternum.

2. Around Knee:

Lower end of femur & upper end of tibia
The leg is flexed against the thigh and a transverse incision is made into the knee joint. Patella is removed. The end of femur is pushed forward. A number of parallel cross sections are made to find out whether the ossification centre has appeared in the lower end of femur.

The centre appears in the lower end of femur during 9th month of intra uterine life.

Similar cross sections are made in the upper end of tibia to expose the ossification centre, which normally appears at full term or at birth.

3. **Bones of Foot**:

The foot is grasped by its heel, the sole facing the dissector and the toes facing forwards. An incision is made between the 3rd & 4th inter space upto the sole and heel and it is deepened along the talus and calcaneum.

Ossification centre for calcaneum appears at the end of 5th month, for talus at 7th month and for cuboid at 9th month.

Age of Foetus:

Determination of age of foetus is required in cases of:

1. **Infaniticide** – Infanticide means unlawful destruction of a live born child after it has attained the age of viability any within 1 year of llife.

2 **Viability** - Viability means the physical ability of a foetus to lead a separate existence after birth apart from its mother by virtue of certain degree of development.

3. A child is viable after 210 days of intra- uterine life and in some cases after 180 days. It means feto- maternal circulation is not necessary for existence and the child can be survived by artificial means.

4.

5. A charge of infanticide can be sustained only it is proved that,

   a. The child was born alive and viable
   b. It was killed by criminal acts of commission of omission.

6.

2. In criminal abortion – to know whether the mother was “Quick with the child”

7. At about 14 to 18 weeks of pregnancy, the mother feels the movements of the foetus within the uterus. Abortion induced after this period is liable for enhanced punishment. The foetus is examined and its age determined in such cases.

8.

9. **Rule of haase (1985)**

10.

11. It is a rough method to estimate the age of the foetus.

12.

13. The length of the foetus from crown to heel is measured in centimeters. During the first 5 months of gestation period, the square root of the length in centimeter gives the age in months.

14.

15. For example, if the foetus is 16 cms in length, its age will be square root of 16=4 months. (Morison Rule)

16.

17. After 5th month, the length of a foetus in centimeter divided by 5 gives the age in month.

18.

19. For example, If the length is 35 centimeters, the age will be 35/5=7 months.

20. Age of the foetus & features:

21.

22. **End of 1st month**:

23. Length
1cm Weight 2.5
gms
24. Eyes are 2 dark
spots Mouth as a cleft

25.
26.

27. **End of 2nd month**

28. Length 4
cms Weight 10 gms
29. Hands & feet webbed
Placenta begins to be formed
Anus is seen as a dark spot

30.
31.

32. **End of 3rd month**

33. Length 9
cms Weight 30 gms
34. Eyes are closed – Pupillary membrane

appears Nails appear

35.
36.
37. **End of 4th month**

38. Length 16 cms Weight 120 gms
39. Sex can be recognized Lanugo hair seen on the body Meconium in the duodenum
40. Brain – convolutions begins to appear

41.
42.
43. **End of 5th month**

44. Length 25 cms Weight 400 gms Nails – distinct & soft
45. Light hair appears on the head Skin covered with Vernix Caseosa.
46. Meconium in the beginning of large intestine

47.
48.
49. **End of 6th month**

50. Length- 30 cms Weight – 700 gms
51. Eye brow 7 eyelashes appear, Skin red and wrinkled Subcutaneous begins to appear
52. Testes are seen close to the kidneys (on psoas muscle)

53.
54.
55. **End of 7th month**

56. Length- 35 cms Weight – 1to 1.2 kg Eyelid – opened
57. Pupillary membrane disappears Skin – dusky red
58. Meconium in entire large intestine Testes near the internal

ring

59. Gall bladder contains bile Caecum in right iliac fossa

60.

61. **End of 8th month**

62. Length- 40 cms Weight – 1.5 to 2 kgs

63. Nails reach tip of fingers Scalp hair thick

64. Skin not wrinkled Placenta 500 gms

65. Testes in Canal (L before R)

66.

67.

68.

69. **End of 9th month**

70. Length 45 cms

71. Weight 1.5 to 3 kgs

Posterior fontanelle closed

Scalp hair dark

72. Nail – Project over fingers

73. Meconeum at the end of large intestine

74. Testes in the scrotum; scrotal skin wrinkled (L before R)

75.

76.

77. **Full term**

78. (at the end at the 10th month)

79. Length 50 cms Weight 2.5 kg to 4 kg

80. Head Circumference 35 cms

81.

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109. WEAPONS

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2. **WET SPECIMENS**

(Identification, Natural Death, Mechanical Injuries)

3. **TOXICOLOGY**

(Poisonous Plants, Seeds & Wet Specimens)

4. **PHOTOGRAPHS**

5.

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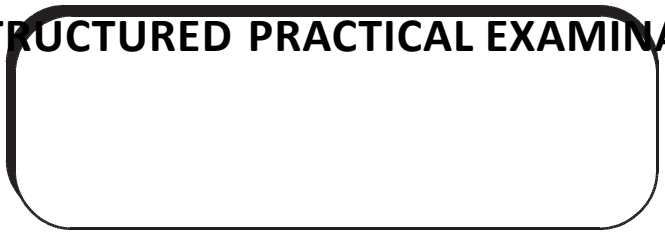

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60.

61. **FORM No. 4A**

62. (See Rule 7)

63. MEDICAL CERTIFICATE OF CAUSE OF DEATH

64. (For non-institutional deaths Not to be used for still births) To be sent to Registrar along with Form No. 2 (Death Report)

65. I hereby certify that the deceased Shri / Smti / Km.....

66. son of / wife of / daughter of..... resident of.....

67. was under my treatment from.....to.....and he / she died on..... at.....A.M. / P.M.

68. NAME OF DECEASED					
69. SEX	Age of Death				For use of Statical Office
70.	Age in completed year	If less than 1 Year age in Month	If less than 1 Month age in Day	If less than one day age in Hour	
71. 1. Male 2. Female					
72. CAUSE OF DEATH		CAUSE OF DEATH			
73. I Immediate cause State the disease, injury or complication which cause death not the mode of dying as heart failure, asthema, etc.		(a)..... due to (or as a consequences of)			
74. Antecedent cause Morbid condition, if any, giving rise to the above Cause, stating underlying conditions last		(b)..... due to (or as a consequences of)			
75.		(c).....			
76. II Other significant conditions contribution to the death but not related to the disease or conditions causing it					

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96. If diseased was a female, was pregnancy the death associated with?

1 Yes 2 No If yes, was there a delivery? 1 Yes 2 No

97.

99.

100. Name and signature of the Medical Practitioner certifying the cause of death Date of Certification.....

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102. SEE REVERSE FOR INSTRUCTIONS

103.

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105. (To be detached and handed over to the relative of the deceased)

106. Certified that Shri/Smti./Kum.....S.W.D. of Shri.....R/O.....

107. was under my treatment from.....to.....and he / she expired on.....at.....AM / PM

108.

109.

110. Doctor

111. Signature and address of Medical Practitioner / Medical attendance with Registration No.