M.C.O.C. SPECIAL CASE NO. 21 OF 2006

DATE: 1ST FEBRUARY 2012 **EXT. NO.2100**

DEPOSITION OF WITNESS NO.181 FOR THE PROSECUTION

I do hereby on solemn affirmation state that:

My Name : Dr. Nandratna Sadashiv Paikrao

Age : 33 years

Occupation : Medical officer (GT Hospital)

Res. Address : Room No.11, Bldg. No.3, Saket Society, Malad (E), Mumbai-97.

Examination-in-chief by SPP Raja Thakare for the Statement

1. I am attached to GT Hospital as medical officer since July 2006. It is a government hospital. The working shifts are morning, evening and night. The morning duty is from 8.00 a.m. to 2.00 p.m., the evening shift is from 2.00 p.m. to 9.00 p.m. and the night shift is from 9.00 p.m. to 8.00 a.m. The names of the medical officers on duty can be found in the EPR , i.e., Emergency Police Register. On duty medical officers examine all the patients who come to the casualty. Interns assist the medical officers on casualty duty. The medical officers examine the patients and the entries are made by

interns as per the dictation of the medical officer. The entries are made chronologically in the ordinary course of duty. The entries of the examination are made in the casualty register. A carbon paper is placed below the concerned page and the OPD case paper is placed below the carbon paper. I have brought the original EPR and the casualty register with me.

2. As per the EPR, I was on morning duty on 06/10/06 and had examined the patients during the period of the duty. As per the casualty register sr. no. 6219 on that day, I had examined patient by name Zameer Ahmed Latifur Rehman, who was brought at 11.00 a.m. by PC-3608. The history is taken from the patient himself. If he is not in a position to give it, then some relative or the person who accompanies him gives it. I was examining the patient and dictating the findings to the intern who was writing it in the casualty register. The said patient was brought for routine medical checkup. On examination, there were no present complaints, general condition was fair, afebrile, TPR and BP normal, systemic examination : CVS-S1, S2 normal, CNS-NAD, RS-clear, AEBE (Air entry bilateral equal) and PA-soft. These findings were correctly recorded as per my

examination. The contents of the photocopy of the entry now shown to me are as per the original entry in the casualty register, it bears the signature of the intern. (It is marked as **Ext. 2101** subject to objection by the learned advocates for the accused on the ground that the document is produced at this stage).

(Adjourned for recess)

Date : 01/02/12 **Special Judge**

Resumed on SA after recess

3. As per the EPR, I was on evening duty on 23/10/06 and had examined the patients during the period of the duty. As per the casualty register sr. no. 6989 on that day, I had examined patient by name Naveed Hussain Rashid Khan, who was brought at 4.50 p.m. by PC-33078. The history is taken from the patient himself. I was examining the patient and dictating the findings to the intern who was writing it in the casualty register. The said patient was brought for routine medical checkup. On examination, there were no fresh complaints, general condition was fair, afebrile, the pulse was 78 per minute, BP was 130/90 mm of Hg, temperature 37 degree Celsius, systemic examination : CVS, CNS, RS-NAD and PA-soft. These

findings were correctly recorded as per my examination. The contents of the photocopy of the entry now shown to me are as per the original entry in the casualty register, it bears the signature of the intern. (It is marked as **Ext. 2102** subject to objection by the learned advocates for the accused on the ground that the document is produced at this stage). The contents of the OPD case paper, Art.344 are as per the contents in the entry in the casualty register. (It is marked as **Ext. 2103**).

4. As per the EPR, Dr. Pradnya Thakur was on evening duty on 05/10/06 and had examined the patients during the period of the duty. As per the casualty register sr. no. 6187 on that day, she had examined patient by name Suhail Mehmood Shaikh, who was brought at 3.15 p.m. by PC-33774. The history is taken from the patient himself. On examination, she had noted the findings that there were no complaints, general condition was fair, TPR, BP normal, systemic examination : CVS, CNS, RS-NAD and PA-soft. The contents of the photocopy of the entry now shown to me are as per the original entry in the casualty register, it bears the signature of the intern. (It is marked as **Ext. 2104** subject to objection by the learned

advocates for the accused on the ground that the document is produced at this stage). The contents of the OPD case paper, Art.338 are as per the contents in the entry in the casualty register. (It is marked as **Ext. 2105**).

5. As per the EPR, Dr. Suhail Shaikh was on morning duty on 07/10/06 and had examined the patients during the period of the duty. As per the casualty register sr. no. 6257 on that day, he had examined patient by name Suhail Mehmood Shaikh, who was brought at 11.00 a.m. by PC-33774. The history is taken from the patient himself. On examination, he had noted the findings that there were no complaints, general condition was fair, afebrile, systemic examination : CVS, CNS, RS-NAD and PA-soft. TPR and BP normal. The contents of the true photocopy of the entry now shown to me are as per the original entry in the casualty register, it bears the signature of the intern. (It is marked as **Ext. 2106** subject to objection by the learned advocates for the accused on the ground that the document is produced at this stage). The contents of the OPD case paper, Art.339 are as per the contents in the entry in the casualty register. (It is marked as **Ext. 2107**).

6. As per the EPR, Dr. Suhail Shaikh was on night duty on 05/10/06 and had examined the patients during the period of the duty. As per the casualty register sr. no. 6211 on that day, he had examined patient by name Dr. Tanveer Ahmed Mohd. Ibrahim, who was brought at 10.30 p.m. by PC-30860. The history is taken from the patient himself. On examination, he had noted the findings that there were no complaints, general condition was fair, TPR and BP normal, systemic examination : CVS, CNS, RS-NAD and PA-soft. The contents of the true photocopy of the entry now shown to me are as per the original entry in the casualty register, it bears the signature of the intern. (It is marked as **Ext. 2108** subject to objection by the learned advocates for the accused on the ground that the document is produced at this stage). The contents of the OPD case paper, Art.327 are as per the contents in the entry in the casualty register. (It is marked as **Ext. 2109**).

7. As per the EPR, Dr. Helaskar was on morning duty on 24/10/06 and had examined the patients during the period of the duty. As per the casualty register sr. no. 7012 on that day, he had examined patient by name Mohd. Sajid, who was brought at 12.25 p.m. by PC-

29986. The history is taken from the patient himself. On examination, he had noted the findings that the patient had complaint of fainting, general condition was fair, afebrile, BP 110/70, TPR-normal, systemic examination : CVS, CNS, RS-NAD and PA-soft. The treatment that was given was glucose water, ORS- 2 packets and Rantac tablets. The contents of the true photocopy of the entry now shown to me are as per the original entry in the casualty register, it bears the signature of the intern. (It is marked as **Ext. 2110** subject to objection by the learned advocates for the accused on the ground that the document is produced at this stage). The contents of the OPD case paper are as per the contents in the entry in the casualty register. (It is marked as **Ext. 2111**).

8. As per the EPR, Dr. Helaskar was on evening duty on 25/10/06 and had examined the patients during the period of the duty. As per the casualty register sr. no. 7088 on that day, he had examined patient by name Mohd. Sajid, who was brought at 4.30 p.m. by PC-33078. The history is taken from the patient himself. On examination, he had noted the findings that the patient had complained of giddiness, general condition was fair, afebrile, systemic examination :

CVS, CNS, RS-NAD and PA-soft, TPR-normal and BP 120/80. The treatment that was given was IV D25 stat. The contents of the true photocopy of the entry now shown to me are as per the original entry in the casualty register, it bears the signature of the intern. (It is marked as **Ext. 2112** subject to objection by the learned advocates for the accused on the ground that the document is produced at this stage). The contents of the OPD case paper are as per the contents in the entry in the casualty register. (It is marked as **Ext. 2113**).

9. The thumb impressions on the OPD case papers are of the patients left thumb.

Cross-examination by Adv P. L. Shetty for A3, 8, 9, 11

10. I am still attached to the GT Hospital. I joined the GT Hospital on 17/07/06. My duty timings as RMO were from 9.30 a.m. to 5.45 p.m. On 03/10/06 I was given CMO duty and on that day I did not work as RMO. I worked as CMO on 05/10/06 from 8.00 a.m. to 2.00 p.m. On that day I did not work as RMO. I did not work as RMO on 06/10/06. I will have to see the EPR to say on which day from 20/10/06 upto 31/10/06 I worked as RMO. The persons brought by police are examined in the casualty department. I will have to see

the EPR to tell the duty timings when I worked as CMO. The writing of casualty register sr. no. 6989 is by the intern of the casualty department. I cannot tell his name. The signature below the entry is of the intern, but I cannot identify whose it is. I was present in the casualty on that day on duty. I had examined the patient. The entry does not bear my writing or signature. My name is also not mentioned. I was the only medical officer at that time. The intern was with me, but I cannot tell his name. The intern had written the BP, pulse rate and the temperature of the patient. I say that the patient was brought at 4.50 p.m. as it is written in the entry. It was written by the intern as per my dictation. I had seen the entry five minutes after it was written. I do not think that the casualty register number, date and time are in different handwriting than the other contents of the entry. The intern may have overwritten the time 4.50 on 5.50.

11. (Learned advocate asks the witness to go through the casualty entry no. 6990). It is in the handwriting of another intern and the timing is 4.50 p.m. It is signed by the intern, but I cannot tell his name. Four-five interns are in the casualty at a time. My name is not mentioned in the casualty entry no. 6987 to 6990. I cannot tell which

doctor examined the patient at entry no. 6990. I now say that the patient was examined by me, but entry was made by an intern, whose name I do not remember. The police gave a requisition when the patient examined at sr. no. 6989 was brought for examination. I cannot tell when that person was arrested and for how long he was in the custody of the police. I did not ask the police and that patient whether he had been taken for medical examination prior to that day. The words 'routine checkup' are written on the OPD case paper as it was so mentioned in the requisition. It was written in the requisition that the person was required to be arrested. That is the reason why I endorsed that the patient is fit for arrest. I do not remember from which police station the accused was brought on that day. I had not examined that patient prior or after that day. The words 'no complaints at present' are written as per my dictation. It was told by the patient. The complaints mean complaints related to health, i.e., headache, bodyache, cough, cold and temperature. It is true that it is not mentioned in any of the entry produced today that the history was taken from the patient. It is not true that it is mandatory to mention 'Inf/self/others'. The buckle number of policeman is not dictated by

me, but it is written on the OPD case paper. The writing on the backside of the OPD case paper Ext. 2103 is of the same intern. Thumb impression of the patient is taken on the OPD case paper as per the guidelines and it is compulsory. It is true that thumb impression is to be attested by writing the name of the person whose it is. The papers produced today bear the thumb impressions of all the patients that were examined. It is true that none of the thumb impression is attested. It is not true that I did not examine the patient by name Naveed Hussain at 4.50 p.m. on 23/10/06, that I prepared false entry on the say of the police.

12. I examined Zameer Ahmed only once on 06/10/06, neither before that date nor after. I cannot say from which police station he was brought. I was on morning duty from 8.00 a.m. to 2.00 p.m. on that day and I was the only medical officer on duty. About 4-5 interns were assisting me. I cannot tell the name of the intern who wrote the entry at sr. no. 6219 and had signed it. The intern who had written the entry no. 6989 on 23/10/06 had not written the entry at sr. no. 6219. As normal is written in front of TPR and BP in the entry at sr. no. 6219, the exact temperature, pulse rate and blood pressure

are not mentioned. In the entry at sr. no. 6989 the figures in front of these items are within the normal range. It is not true that I did not examine the said patient on 06/10/06, therefore, I did not write the exact figures.

13. It is a practice of our hospital to endorse that 'patient is fit for arrest' whenever a person is brought by the police. That is the reason why it is mentioned in entry no. 6219. I did not verify from the police or the patient as to whether he was already arrested. It is written in the memo of the police that the person is brought for medical examination prior to arrest. According to the protocol of the hospital, we have to write as per the memo of the police that the patient is fit for arrest. I do not remember whether in the case of both the patients whom I examined, the memo of the police mentioned that the person is brought for medical examination prior to arrest. In the present case it is so written in both the entries as it may have been so mentioned in the memos. There is no specific reasons why the words 'B/B and the buckle number' is written twice. I cannot say to which lockup the two patients were taken after the medical examination and which police station wanted to arrest the accused.

14. The casualty register is the authentic register of the hospital. Signature or thumb impression of any patient is not taken in this register. I know what is a medico-legal case. The entries of the medico-legal cases pertaining to accidents and unnatural causes of injuries are mentioned in the EPR book and the entries of the accused who are brought for routine checkup are made in the casualty register. It is as per the guidelines of the State Government. I cannot produce it on my own. I cannot tell the date and year in which the circular was issued by the State Government. I know what EPR register is. The casualty medical officer maintains the EPR. Entries of any unnatural cause of injury are made in it. There are policemen on duty for 24 hours in the casualty department. He maintains a register of medico-legal cases. I do not know what it is called. Duty timings of the medical officers are not mentioned in the EPR. The entries in the EPR are not made by the interns, but they are made by the medical officers.

15. Whenever police bring any person for examination, they are required to obtain OPD case paper. Proper entries are made serially in the OPD register. No person will be examined in the

casualty department unless an OPD case paper is obtained. The OPD case paper is given to the police. The contemporary record of the OPD case paper is the OPD register and the casualty register.

16. It is not true that I deposed falsely about examining the two patients mentioned above.

(Adjourned as court time is over)

(Y.D. SHINDE)
Date :01/02/12 **SPECIAL JUDGE**

Date: 06/02/12
Resumed on SA

Cross examination by adv Wahab Khan for A2, 7, 10 & 13

17. It is true that the casualty register is not given serial page numbers. (Learned advocate asks the witness to go through the entries in the casualty register). The date and time when the entries at 6072 to 6075 were made are not written. Same is the case about the entries at sr. no. 6077 to 6083. It is true that name of the patient and buckle number of constable are written in the first entry out of the four at sr. no. 6083 to 6084 and remaining three entries do not show patient's name and buckle number of the constable. The findings of examination are not mentioned at the first entry. The timings are not mentioned in the entries at sr. no. 6084 to 6086. Date and time are not mentioned in the entry at sr. no. 6098. There are two entries in between sr. no. 6146 and 6147, both have the rubber stamp of findings, one is canceled, second is filled up, but date and time is not mentioned.

18. It will not be correct to say that we change our procedure of examining the patients as per the dictates of concerned police officers. Thumb impression is obtained only on the OPD case

paper and not in the casualty register. There is no entry of examining Tanveer Ahmed Ansari on 04/10/06. It is not true that the entry numbers 6233 to 6242 are not changed. The entry before 6233 was 6232, but it was wrongly written as 6233, therefore, it was corrected. The entries at sr. no. 6235 to 6242 were wrongly written as 6635 to 6642. Therefore, they were corrected.

19. The patients were examined by removing their clothes. No such endorsement was made in the entry. The other medical officers who had examined the patients are available. It is true that they did not examine those patients and make the entries in my presence. Therefore, I do not know what procedure they followed. It is true that none of the entries contain the mention as to who gave the history.

20. As per the contents of the entry at sr. no. 7012, Ext.2109, the patient by name Mohd. Sajid was examined and the advise was of tablet Rantac, ORS two packets and glucose water. The history of fainting seems to be given by the patient. I do not know whether the patient was having injury marks on his person when he was examined on that day, i.e., on 24/10/06. I do not know

who made the star mark at the beginning of the entry and for what purpose. As per the entry at sr. no. 7088, the history of giddiness is given. From the contents of both the entries, it cannot be ascertained as to what further steps were taken for investigating the complaints of fainting and giddiness on both days. I do not know whether the prescribed medicines were given to the accused. I can tell the age of the injury on seeing a case paper, if it is mentioned in it. The patients were not examined in the presence of the police.

21. I know about the guidelines to the police for producing the accused for medical examination periodically. The guidelines are issued by the State Government, Health Department in the name of Superintendent, GT hospital. According to the guidelines, the patient has to be stable prior to his arrest and the periodic examination is carried out to identify any health problem or injuries. I am not aware of the guidelines of the Supreme Court to the police in respect of persons in their custody. As per the record, all the patients about whom I gave evidence, were examined as a routine checkup. The endorsement 'fit to arrest' is made in the case of subsequent medical examination also.

22. General condition means questions are asked to the patient to see whether he is oriented and then his blood pressure is examined, pulse is taken and then systemic examination is carried out. I have not heard the word 'policc'. For ascertaining the general condition, pallor of the patient is required to be seen. By examining the pallor, we come to know whether the patient is anemic or not. Blood count and RBC is not required for that purpose. We have to search whether there is any edema, examine whether there is any lymph adenopoathy, examine icterus and cynosis and clubbing to ascertain the general condition.

(Adjourned for recess)

Date : 06/02/12 **Special Judge**

Resumed on SA after recess

23. If a patient is examined on the above lines, then we can get his general condition. I do not know whether the findings of the other medical officers do not show that the patients were examined on the above lines. It is not true that the findings that I gave do not show that I examined the patient on the above lines, because the finding in front of the general condition means that the patient is

examined on these lines. It is true that it is not specifically mentioned that the patient was examined in respect of pallor, edema, lymph adenopathy, etc. It is not true that I did not examine the patient, therefore, I did not mention the specific examinations. It is true that if a patient complains of fainting and giddiness, one of the tests to find out the cause is check the blood sugar lever and hemoglobin glucose test (HGT). Blood pressure, whether it is high or low, CT scan, etc., are some of the other tests. It is not necessary that in case of custody patients the temperature, pulse rate and respiration are to be written in numericals. It is not true that in the absence of findings in numericals, it is not possible to ascertain whether the patient was checked or not.

24. It is not true that the patients were not examined systemically and clinically. In systemic examination in respect of respiratory system, we have to find out whether airway and breathing sound bilateral are equal or not. In CVS, S1 and S2, we have to check first and second heart sound, whether they are normal or abnormal and for S3 and S4, whether murmuring is present or not. In CNS we have to find out whether patient is conscious, unconscious,

oriented, disoriented or drowsy. It is true that all these findings are required to be mentioned individually. We have to find out the response to stimuli if a patient is unconscious or semi-unconscious. It is not necessary to mention whether the sensory and motor nervous system is normal or abnormal. It is one of the ways to ascertain police torture. It is not necessary to mention bowel sound, whether they were hyperactive or present or absent. It is not true that this is one of the ways to find out police torture. It is true that specific regional findings of abdomen are not mentioned in the findings in all the entries. But 'per abdomen' includes everything. I do not know whether examination of regional abdomen is one of the test to ascertain the police torture. It is true that it is not mentioned in any entry that marks of external injury, old or fresh, were seen or not.

25. It is not true that the patients about whom I gave evidence and all others who are mentioned in the casualty register, were not produced before the medical officers to ascertain whether they were fit to be arrested or not. I have not come across any patient who has undergone police torture. It is true that patients are produced by the police before us for medical examination in order to

ascertain whether there is police torture and also to prevent it. This is one of the reasons for their production before us. We ask the patients to put their thumb impressions. I ask them whether they can sign or not. Signature or thumb impression of the patient is not taken in the casualty register. It is not true that if a person complains of police torture or if there is visible injury, then chest x-ray is advised. However, if it is necessary according to the location of the injury complained of, then x-ray, urine tests and CBC is advised.

(Learned advocate requests for deferring the cross-examination of the witness till tomorrow as the accused are not produced and he wants to show some documents to him that are with the accused. Hence, cross-examination is deferred till tomorrow).

Date : 06/02/2012 **Special Judge**

Date : 07/02/2012
Resumed on SA :

26. (Ld. Adv. shows Ext.1744 to the witness and asks him to go through it). The document shows 11 injuries and all are external injuries. The patient was examined on 25/10/06 at the J. J. Hospital. The injuries were 5-7 days old. (Ld. Adv. asks the witness to go through Exts.2110 and 2112). As per these entries, the patient by name Mohd. Sajid was examined on 24/10/06 and 25/10/06 at the request of the police. The injuries noted in Ext.1744 are not noted by the medical officer in Exts. 2110 and 2112. I cannot assign any reason why they are not shown. I cannot say that they are not shown because the entries in our registers are bogus. (Ld. Adv. asks the witness to go through the documents obtained by the accused under RTI produced today alongwith application Ext.2133). It is true that the Health Screening Sheet issued by the Byculla District Prison shows four injuries aged one week back. (Ld. Adv. requests that the documents obtained under the RTI produced with the application Ext. 2133 be exhibited. They are received in evidence as since the documents are true attested copies supplied by a Government

Hospital. The forwarding letter from the Information Officer of the Byculla District Prison is marked as **Ext.2134**. The Health Screening Sheet of accused Mohd. Sajid is marked as **Ext.2135**. The copies of inward and outward register of the prison dtd.26/10/06 and 27/10/06 are marked as **Ext.2136 and 2137**. The Health Screening Sheets of A5 Mohd. Majid, A8 Abdul Wahid, A6 Mohd. Ali and A12 Naved Hussain are marked as **Exts. 2138 to 2141**). (Ld. Adv. asks the witness to go through the entries sr. no. 7083 to 7087 in the casualty register and to tell which medical officer had examined these patients). As per the EPR record, Dr. Helaskar was the medical officer who had examined these patients.

27. We require about 6-7 minutes to examine a custody patient by removing his clothes and two minutes for writing the entries. The oral examination, medical examination and writing the findings is done within 8-10 minutes. We examine 1-2 patients at a time, which requires about 15 minutes. As per the record of the entries at sr. nos. 7083 to 7085, three patients were examined at the same time. The patients at sr. nos. 7086 and 7087 were examined with a gap of five minutes at 3.50 p.m. (Ld. Adv. asks the witness to

go through entries at sr. no. 6215 and 6216). Both these patients were examined at 12.50 a.m. As per the EPR record, Dr. Helaskar had examined these patients on 6/10/06. The entry at sr. no. 6217 shows that the patient was examined at 9.15 a.m. The entry at sr. no. 6219 shows that the patient was examined at 11.00 a.m. The mistake in writing the chronological timings might be writing mistake by concerned person.

28. (Ld. Adv. asks the witness to go through Ext.2109). It is not true that the findings are not carbon impression of the entry in the casualty register. It is true that 'the name of the patient, age and brought by' are handwritten. It is true that the signature below the findings is in blue ink. It is not true that the first line starting with the letter B/B in the findings is different from the first line in the entry in the register. This patient was not examined by me, therefore, I cannot say whether Ext. 2109 was prepared later on at the request of PI Mohite. It is true that we have to maintain the identity of the patient by taking his thumb impression or signature or distinctive identification marks in the casualty register. It is not true that the patients about whom I deposed were not examined in our hospital,

therefore, their thumb impressions or signatures or distinctive identification marks are not mentioned in the casualty register. It is not true that all the entries were made at the dictates of the police officers and that I gave false evidence at the behest of the ATS officers.

Cross-examination by Adv Rasal for A1 & 4 to 6

Declined.

No re-examination.

R.O.

(Y.D. SHINDE)
Special Judge **SPECIAL JUDGE**
UNDER MCOC ACT,99,
Date:-07/02/2012 **MUMBAI.**

" Taken before me and signed by me in the presence of the accused, to whom the deposition was explained and opportunity given to cross examine".

(Y.D. SHINDE)
Special Judge **SPECIAL JUDGE**
UNDER MCOC ACT,99,
Date:-07/02/2012 **MUMBAI.**