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*RESEARCH ARTICLE*

# SUDDEN UNEXPECTED CARDIAC DEATH IN THE EMERGENCY DEPARTMENT: NAVIGATING THE MEDICO-LEGAL DILEMMA OF DEATH CERTIFICATION AND AUTOPSY WAIVER UNDER THE BHARATIYA NAGARIK SURAKSHA SANHITA, 2023

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***Abstract***

Sudden cardiac death (SCD) presenting to an emergency department without prior medical history creates profound legal and ethical dilemmas for physicians in India. We report the case of a 62-year-old male who suffered a terminal collapse due to acute coronary syndrome/ ventricular fibrillation within an hour of symptom onset. Despite robust resuscitative measures, the patient could not be revived. Due to the lack of baseline medical records, the treating emergency physician appropria tely invoked statutory provisions under Section 194 of the Bharatiya Nagarik Suraksha Sanhita, 2023, shifting the authority for determining the necessity of an autopsy to the state's legal apparatus. This report details the medical management, the statutory obligations governing modern Indian clinical practice, and the ethical parameters involved.



## Introduction:-

Sudden unexpected natural deaths accounts for roughly 10% of overall mortality worldwide, with coronary artery disease acting as the primary anatomical substrate in greater than 80% of adult cardiac mortalities (1). When a patient collapses and dies immediately upon arriving at a healthcare facility without a prior diagnostic footprint, the treating doctor cannot legally certify the cause of death. Under Indian jurisprudence, certifying an unverified, sudden death as "natural" without objective documentation exposes the practitioner to criminal liability. This paper evaluates the delicate intersection of terminal clinical care, statutory protocols under the newly enforced Bharatiya Nagarik Suraksha Sanhita (BNSS), and bereavement management.

**Case Presentation:-**

A 62-year-old gentleman was brought by his relatives to the Emergency Department of a tertiary care hospital in a metropolitan city in India. The relatives recounted a 1-hour history of sudden-onset, crushing retrosternal chest pain radiating to the left arm, accompanied by profound shortness of breath (SOB) and diaphoresis.

Immediately upon passing through the triage bay entry gates, the patient collapsed into sudden cardiac arrest. He was unresponsive, pulseless, and apneic. He was immediately moved to the resuscitation bay.

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**Resuscitative Intervention:-**
Cardiopulmonary resuscitation (CPR) was initiated instantly as per the American Heart Association (AHA) Advanced Cardiovascular Life Support (ACLS) guidelines.

- **Initial Rhythm Analysis:** The cardiac monitor revealed Ventricular Fibrillation (VF).
- **Defibrillation & Pharmacotherapy:** The patient was delivered a 200J biphasic shock, followed immediately by high-quality chest compressions and bag-mask ventilation. Endotracheal intubation was secured seamlessly. Continuous rhythm checks alternating every 2 minutes revealed persistent VF, requiring two subsequent shocks alongside the administration of 1 mg Intravenous (IV) Epinephrine and 300 mg IV Amiodarone.
- **Terminal Shift:** Following the third shock and a total of 12 minutes of active resuscitation, the cardiac rhythm degenerated into a flat line (Asystole).

CPR and standard ACLS protocols for asystole were rigorously continued for an additional 18 minutes. Despite a total of 30 minutes of advanced life support, there was no return of spontaneous circulation (ROSC). The patient was clinically declared dead at 22:00 hours.

**The Medico-Legal Dilemma:-**
Following the declaration of death, the patient's relatives vehemently requested the direct issuance of a death certificate to bypass an autopsy, citing cultural sensitivities and a clear, witnessed history of chest pain. However, the patient had no previous medical records, prescriptions, or treating physicians available to corroborate a history of chronic ischemic heart disease or comorbidities. The emergency physician was faced with an undocumented sudden death, rendering an immediate Medical Certificate of Cause of Death (MCCD) legally impossible.

## Discussion:-

The management of sudden death in an Indian emergency setting requires absolute adherence to legislative guidelines. Historically governed by the Code of Criminal Procedure (CrPC), 1973, procedural forensic protocols are now governed by the Bharatiya Nagarik Suraksha Sanhita (BNSS), 2023 (2).

When a patient arrives in a state of terminal collapse and dies within a brief window, the event legally qualifies as an "unexplained sudden death." According to Indian forensic medicine directives, if a physician has not treated the patient for an active illness within the immediate past or lacks authenticated diagnostic records confirming an irreversible natural disease, they cannot sign Form 4/4A of the MCCD (3).

In India, the legal framework governing the declaration and subsequent registration of death is highly structured. According to the Registration of Births and Deaths Act, 1969, a Medical Certificate of Cause of Death (MCCD) on Form 4 (for institutional deaths) must strictly be issued only by a registered medical practitioner who has actively attended to the deceased during their "last illness" (3,6). In the index case, the patient was brought to the ED in a state of collapse and died during active resuscitation without prior medical documentation, authenticated history, or baseline investigative profiles. Because the primary Emergency Physician had no pre-existing clinical relationship with the patient, they lacked the objective scientific criteria needed to confidently isolate the physiological trajectory leading to cardiac arrest. Presuming a diagnosis of myocardial infarction solely based on sudden chest pain violates statutory obligations and can heavily pollute vital national mortality statistics (6).

Crucially, under Indian law, any death that is sudden, unexpected, unexplained, or where the cause is doubtful or unknown, must legally be designated as a Medico-Legal Case (MLC) (6,7). Section 194 of the BNSS mandates that any person—including a medical professional—who becomes aware of a sudden, accidental, or suspicious death must immediately intimate the nearest Executive Magistrate or police station (3, 7). This triggers a legal process known as a Police Inquest. The primary objective of the inquest and subsequent medicolegal autopsy is to definitively delineate the manner of death (natural vs. unnatural) and rule out foul play, accidental poisoning, or hidden physical trauma (8).

Grieving relatives often exert immense emotional or social pressure on Emergency Clinicians to directly issue an MCCD to bypass a forensic post-mortem, citing religious customs or emotional distress. Yielding to these requests out of sympathy or professional convenience exposes the medical practitioner to severe liability under the Bharatiya Nyaya Sanhita (BNS), 2023 (which replaced the Indian Penal Code) (8). Signing an unverified or intentionally speculative death certificate can be prosecuted as fabricating a fraudulent public document or making a false statement under Section 228 of the BNS, 2023 (10). This legal vulnerability stems from the risk that an apparent

sudden cardiac death could mask an unnatural underlying etiology, such as homicidal poisoning, concealed trauma, or foul play, which can only be safely identified or ruled out through an expert autopsy (6, 7).

The legal authority to determine whether a post-mortem is necessary or can be safely bypassed does not belong to the treating emergency physician, nor does it belong to the family. Under Section 194 of the BNSS, 2023, that power is vested exclusively in the investigating police officer (Inquest Officer) or the empowered Executive Magistrate (such as the Sub-Divisional Magistrate) (9). The ideal, law-abiding protocol for the emergency physician is to formally classify the case as an MLC, catalog the detailed 30-minute ACLS resuscitative efforts within the hospital's "Brought Dead/Dead on Arrival" registry, and hand over custody of the body to the local police booth. If the police inquest and circumstantial evidence thoroughly exclude foul play, the family can formally petition the investigating authorities. The law enforcement apparatus can then officially waive the autopsy and take legal responsibility for releasing the body to the family for final rites (6, 7, 9). This system preserves both the integrity of the medical workforce and the statutory requirements of the criminal justice system.

Through this mechanism, the physician remains ethically aligned with the family by providing maximum clinical clarity while staying protected within the bounds of Indian federal law.

## Conclusion:-

In cases of sudden cardiac arrest where a patient dies in an emergency facility without prior documentation, the emergency physician must not assume the role of the legal investigator. The ideal path is to refuse the immediate issuance of a death certificate, formally preserve the body, and notify the police under Section 194 of the BNSS. The ultimate decision to execute or waive a forensic autopsy rests exclusively with state legal authorities, preserving both the integrity of the clinical workforce and the statutory requirements of the criminal justice system.

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