

1 **Sudden Unexpected Cardiac Death in the Emergency Department: Navigating the Medico-**  
2 **Legal Dilemma of Death Certification and Autopsy Waiver under the Bharatiya *Nagarik***  
3 ***Suraksha Sanhita, 2023.***

4 **Abstract**

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

14 **Introduction**

15 Sudden unexpected natural deaths accounts for roughly 10% of overall mortality worldwide,  
16 with coronary artery disease acting as the primary anatomical substrate in greater than 80% of  
17 adult cardiac mortalities (1). When a patient collapses and dies immediately upon arriving at a  
18 healthcare facility without a prior diagnostic footprint, the treating doctor cannot legally certify  
19 the cause of death. Under Indian jurisprudence, certifying an unverified, sudden death as  
20 "natural" without objective documentation exposes the practitioner to criminal liability. This

21 paper evaluates the delicate intersection of terminal clinical care, statutory protocols under the  
22 newly enforced Bharatiya Nagarik Suraksha Sanhita (BNSS), and bereavement management.

### 23 **Case Presentation**

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

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

### 31 **Resuscitative Intervention**

32 Cardiopulmonary resuscitation (CPR) was initiated instantly as per the American Heart  
33 Association (AHA) Advanced Cardiovascular Life Support (ACLS) guidelines.

- 34 • **Initial Rhythm Analysis:** The cardiac monitor revealed Ventricular Fibrillation (VF).
- 35 • **Defibrillation & Pharmacotherapy:** The patient was delivered a 200J biphasic shock,  
36 followed immediately by high-quality chest compressions and bag-mask ventilation.  
37 Endotracheal intubation was secured seamlessly. Continuous rhythm checks alternating  
38 every 2 minutes revealed persistent VF, requiring two subsequent shocks alongside the  
39 administration of 1 mg Intravenous (IV) Epinephrine and 300 mg IV Amiodarone.

40 • **Terminal Shift:** Following the third shock and a total of 12 minutes of active  
41 resuscitation, the cardiac rhythm degenerated into a flat line (Asystole).

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

#### 45 **The Medico-Legal Dilemma**

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

#### 53 **Discussion**

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

58 When a patient arrives in a state of terminal collapse and dies within a brief window, the event  
59 legally qualifies as an "unexplained sudden death." According to Indian forensic medicine

60 directives, if a physician has not treated the patient for an active illness within the immediate past  
61 or lacks authenticated diagnostic records confirming an irreversible natural disease, they cannot  
62 sign Form 4/4A of the MCCD (3).

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

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

82 Grieving relatives often exert immense emotional or social pressure on Emergency Clinicians to  
83 directly issue an MCCD to bypass a forensic post-mortem, citing religious customs or emotional  
84 distress. Yielding to these requests out of sympathy or professional convenience exposes the  
85 medical practitioner to severe liability under the **Bharatiya Nyaya Sanhita (BNS), 2023** (which  
86 replaced the Indian Penal Code) (8). Signing an unverified or intentionally speculative death  
87 certificate can be prosecuted as fabricating a fraudulent public document or making a false  
88 statement under **Section 228 of the BNS, 2023** (10). This legal vulnerability stems from the risk  
89 that an apparent sudden cardiac death could mask an unnatural underlying etiology, such as  
90 homicidal poisoning, concealed trauma, or foul play, which can only be safely identified or ruled  
91 out through an expert autopsy (6, 7).

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

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

## 106 **Conclusion**

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

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