IN THE SUPREME COURT OF PAKISTAN

(Original Jurisdiction)

HUMAN RIGHTS CASE NO. 62837-S/2018

IN THE MATTER REGARDING DEATH OF AMAL UMER DUE TO IRRESPONSIBLE FIRING BY SINDH POLICE AND FOR WANT OF EMERGENCY MEDICAL AID

Report of Committee

Introduction:

In the above stated matter, a committee was formed by the Hon'ble Supreme Court of Pakistan on 27.09.2018 to inquire and investigate the matter regarding death of a Child named Amal Umer in an unfortunate incident in Karachi. The incident took place on the night of 13.08.2018. Through an article dated 16.09.2018, published in DAWN, the mother of Amal Umer, raised allegations against the system, which failed them. In the article, allegations were made against the Police, the health care provider (NMC) and the ambulance service (Aman).

On the night of 13.08.2018, Amal alongwith her younger sister and her parents were enroute in their car for an outing. Amal was shot on the night of 13.08.2018, in her car, on a main road of Defence, Karachi, after a dacoit had looted Amal's parents and was in the process of looting another car on the street. It was alleged that in a crossfire between the dacoit and the police, Amal was shot. Her parents upon realizing that Amal had been shot, rushed Amal to the nearest hospital namely National Medical Centre (NMC).

In the Emergency Room of NMC she was initially seen in the main area, shifted to a more secluded area (minor OT) and managed by the doctor on duty, Dr. Aftab Qureshi. He noted that she was bleeding from her nose, mouth and a wound on her forehead, some particles of brain matter were also extruding from this wound. He started treatment by sucking out her oral cavity and at the same time asked for additional help. A few minutes later this appeared in the shape of Dr. Imtiaz from the Paediatric floor who then took over resuscitation from Dr. Aftab Qureshi.

At NMC, doctors provided some initial treatment (intubation and manual ambo bag). Doctors informed Amal's parents that she should be taken to Jinnah Postgraduate Medical Centre (JPMC), or Agha Khan University Hospital (AKHUH) as there was not enough time.

The Aman Foundation was contacted, but they agreed to send an ambulance when the availability of a bed at either of the hospitals was arranged. By the time the arrangement was done, the operator of Aman said the Ambulance would be there in "sometime" but did not specify the time. In the meanwhile, the NMC staff suggested to the parents that Amal should be shifted in their car as the ambulance would take long. As the parents were desperate, they requested NMC to give them the amobag and a staff to assist them in taking Amal in the car. NMC refused to cater to either of the requests and instead kept telling them to take Amal.

From the first phone call to the time the ambulance arrived, it took approximately 20 minutes. Amal expired a few minutes before the ambulance arrived.

After the death of Amal, Omar Shahid Hamid (SSP District South) maintained that the bullet had come from the dacoit's gun. However, 16.08.2018, SSP Munir Sheikh looked at the pictures of the car and speculated that the holes seemed to be from larger bullets of a larger weapon and thereafter and inquiry was carried out. From the inquiry, it came out that the bullet was that of the police hitting the back of the car from the police assault rifle. The police gave a media statement and a FIR was lodged.

Terms of the committee:

a. Inquiry/investigation into the death of Amal Umer.
b. Inquiry/investigation of the Facts and Roles and Culpability of the Police Officials, National Medical Centre (private hospital) and Aman Foundation (Ambulance service provider) in this incident.
c. Accountability: Identify the culprits, the illegal and negligent action/inactions of such culprits and suggest the nature and process of accountability.

d. Suggestions for Reforms to deal with such emergency Medical Aid to the injured persons:
e. Guidelines/SOPs (and if required, legislative changes) for the Police officials as how to handle such incidents. Also, the nature and process of accountability for the violation of these guidelines/SOPs.
f. Guidelines/SOPs (and if required, legislative changes) for the Private Hospital in the treatment to the injured persons in emergency cases and ensuring the availability of basic facilities and training to deal with such trauma cases. Also, the nature and process of accountability for the violation of these guidelines/SOPs.
g. Guidelines/SOP's (and if required, legislative changes) for the Ambulance Service Providers in such emergency cases. Also, the nature and process of accountability for the violation of these guidelines/SOPs.
h. Relief to the Family of Amal Umer."

INVESTIGATION:

The Committee held meetings for purposes of investigation on the following dates:

1. 13.10.2018
2. 26.10.2018
3. 31.10.2018
4. 05.11.2018
5. 20.11.2018
6. 23.11.2018
7. 30.11.2018
8. 10.12.2018
9. Parents of Amal filed written arguments on 16.12.2018.
10. NMC filed written arguments on 05.01.2019 (2:10pm).

SINDH POLICE:

Background:

1. On the night of 13.08.2018, the police of PS Defence were informed by a family that there is a dacoity underway near the traffic signal of Khayaban-e-Ittehad and Korangi Inter-section. The information given to the police was by the family who were robbed by these dacoits earlier on. Two officers were deputed when the police consisting of Muhammad Javed and one Baber were given instructions by the ASI in charge. Mr. Aziz A. Shaikh the SHO of PS Defence was out of Karachi at the time and was informed of the incident 20 to 30 minutes after by the Additional SHO. At the time, the duty officer was Mr. Satti. When the police officers approached the incident, the dacoit was in the process of dacoity and had a pistol in his hand. Muhamad Javed fired at the dacoit and killed the dacoit with a SMG riffle. Baber fired 4 bullets in the area to caution the people and to protect himself. At the time when the incident took place the police did not know that where all the bullets had gone except that one bullet killed the dacoit.
2. When the report of a bullet wound to a girl (Amal) was received at PS Defence Thana, Mr. Satti who was the duty officer, went to conduct the MLO at the NMC Hospital. Even though, Mr. Satti had seen the wound of the girl (Amal), and the wound was not that of a pistol, but was a rather big wound, nevertheless, Mr. Satti did not take a note of the same. It is pertinent to mention that the medico lego evidence was incorrect and the report stated that Amal had was hit by a small-bore weapon, rather than a large bore weapon.[1]
3. Mr. Umer Shahid Hamid, SSP District South also stated on 14th and 15th of August 2018, that the bullet had been from the bandit gun during a cross fire between the bandit and the police personnel.
4. On 16.08.2018, Dr. Amir Sheikh – AIG, Mr. Javed Ohdho – DIG South, Mr. Umer Shahid SSP District South & Mr. Munir Shaikh SSP came to meet the parents of the deceased Amal, for condolences. The father of Amal, put it to the police officers that the bullets that entered the car seemed too big for a pistol. In fact, there were two holes of bullet in the car of Mr. Umer Adil. Dr. Amir Sheikh, looked at the photograph of the car through which Amal was hit, also speculated that the bullet

[1] Later upon inquiry of the Police the examining surgeon admitted having no experience of examining wounds made by large bore weapons.

holes were big and must have been caused by a heavier assault rifle rather than the weapon carried by the dacoit. An examination report dated 17.08.2018, bearing reference no: AID/FD/OR/F.A/5067/2018,[2] stated that two bullets fired penetrated at the rear of the body of the vehicle trunk door. Thereafter, an inquiry took place which looked into the incident in detail. When the CCTV footage was recovered and analyzed, it clearly showed that there was firing in the direction of the traffic light (towards the cars including Mr. Umer Adil). There was one clear image of a bullet, from police assault rifle, that hit the ground and went into the back of a car. There was no image of any bullets being shot from the dacoit's weapon. from police assault rifle. Upon conclusion of inquiry, Mr. Javed Ohdho on 18.08.2018, informed the parents of Amal that Amal had been shot by the bullet of the police constables. Thereafter the police issued a media statement, accepting that the bullet that hit, Mr. Umer Adil's car and his daughter, Amal was from police assault rifle and an FIR u/s 319 PPC was lodged against the police constables i.e., Muhammad Javed and Baber.

5. As per the Statement filed before the Supreme Court of Pakistan dated 22.09.2018,[3] the Police have stated that during the course of their investigation the police came to know that apparently the staff at NMC had denied Amal Emergency care. The investigating officer had taken cognizance under section 322, PPC and included the duty doctor at NMC for investigation.

Allegations regarding the Police force.

The purpose of the Committee was to identify the incident. From the above it is clear that the police constable fired even though the dacoit had not pointed the gun at the police constable. The allegations placed were:

1. *Dis-proportionate use of ammunition.*

[2] Contained in the Police statement before the Supreme Court of Pakistan dated 25.09.2018.
[3] The entire report is dated 25.09.2018.

(i) The use of SMGs within the city limit. SMGs have become a part of the security culture of Karachi. Private guards accompanying the influential people and other people with licenses also carry SMG within the city. The police candidly admit that they require SMGs for their own protection against these rampantly used SMGs by private guards and due to the militancy. This is undeniable. However, in Amal's case there was no apparent need for the use of heavy rifle to stop a dacoit from a dacoity. Hence the use of weapon has to be assessed with the kind of criminal scenario.

(ii) From the CCTV footage, it seems that Mr. Umer's car is far from the police at about a distance of three to five cars. Since it was SMG which was fired therefore, the velocity, power and strength of the bullet was such that it went into Mr. Umer's car at the distance of approximately 50 feet. Mr. M. Javed as per his understanding tried to save himself from the dacoit by firing however, in turn ended up killing a 10 year old girl, in a car, approximately 50 feet away, because the ammunition that was used was too heavy, for the densely covered area of the incident.

(iii) If Mr. M Javed had used a pistol instead of a SMG, it is highly likely that the bullet might not have penetrated Mr. Umer Adil's car, the hard back, the seat and then Amal as the velocity would not have been as much. Even if the bullet from a pistol may have hit Mr. Umer's car it would be with lesser force and with such distance that Amal would not have been hit. In the unlikely event that the bullet of the pistol from that distance (almost the distance of 3 to 4 cars) would have hit Mr. Umer's car and penetrated to hit Amal, it may not have been fatal[4] and the chances of survival would be higher.

2. *Use of heavy weaponry without proper training.*

(i) Coming to the use of force by the police and whether it was adequate. In the statement of Ms. Beenish Umer filed before the Committee in HRC No. 62837 of 2018, she has mentioned that in a meeting with Mr. Javed Ohdho on 27.08.2018, the use of assault rifle for countering street crime was the thrust. Mr. Javed Ohdho explained that after the Afghan

[4] As per Dr. Ather Enam's statement that small weapon wounds are not as fatal.

War the country has been exposed to militancy with heavy weapons and in order for the police to defend themselves and the public equally such lethal weapons were provided to the police. Mr. Ohdho candidly explained that such heavy weapons are not used by police force anywhere in the world. He also pointed out that Police Department in Pakistan uses left over weapons, which are not maintained as required. During the Committee meeting, it was pointed out by Mr. A.D. Khawaja that the pistols are available for the police officers whilst for the other policemen (including constables) heavier rifles are provided. However, in the present scenario, one Mr. Baber, who is not a police officer, had a pistol which he did not use to counter the dacoit.

(ii) It is unclear whether Mr. M. Javed, had any training to use the SMG, but he did admit having a training on the pistol 2 years ago. It is not clear whether Mr. Babur had adequate and updated training either. Hence, these two police constables, who were not updated or adequately trained in the weapons they were carrying, were sent to counter an armed dacoity, in a public area. There is no evidence to show that either of these constables, calculated the risk of using a heavy weapon on a traffic signal where cars were lined due to the red light due to lake of training. Hence it can logically be adduced, that these constables only thought of shooting without any calculation of the amount of force needed in that area and the amount of force needed to counter a dacoit. Whether the dacoit should have been gunned down in this manner is another aspect, which is not part of this committee's agenda. **However, the use of heavy force in the shape of a SMG riffle, was highly disproportionate to the crime being committed there and the police should have calculated the risk of opening fire with a heavy rifle in such a location even though there was the alternative of using a pistol (Mr. Babur)**.

(iii) The only thing the policeman thought and assessed was that there is a dacoit who is under the process of dacoity and has a pistol in his hand hence causing threat to public and to the policemen. The kind of reaction the policeman should have had in this situation reflects upon the training the policeman has received with regards to the assessment of the situation. For example, the policemen should have assessed,

and his partner could have shoot on the dacoit's leg or some other tackling measures could have been adopted upon analyzing the traffic and presence of innocent lives. Instantly, the policeman opened fire from his SMG in an area where there were numerous cars having numerous people in close proximity. Collateral damage was inevitable, especially with a heavy rifle. **Hence the policemen lack training to analyze the situation and measure the kind of reaction that is required in such a situation.** Moreover, with regards to the training of this policemen, it is abundantly clear that police is not given proper and thorough training on ammunition. In the newspaper DAWN, dated 23.09.2018, the Sindh Police candidly stated that in the past 2 years, no refresher courses were given.[5] In fact even before the committee Mr. M. Javed himself has admitted that he got training two years ago for one day. When dealing with such lethal weapons whether a rifle or a pistol, with a view to protect yourself and the public, if training in usage of ammunition lacks, then collateral damage would become inevitable. Training viz-a-vis; the aim, functionality of the weapon, education about the ranges of bullet etc., all will help the policemen to analyze and assess the situation in order to take a decision with regards to usage of ammunition in a given scenario. Moreover, policemen should be trained to understand what kind of proportionate action should be taken in different scenarios. **This lack of training is the root cause why Mr. M. Javed acted upon his immediate impulse, when in fact being a police man his decision should have been calculated.**

(iv) As is admitted by the senior police officers that there are rules of engagement, however, lacking and outdated which are required to be updated in light of the need of the city. The rules of engagement also need to be steered and made a constituent part in the training of the policemen.

3. *Miss-declaring the incident as cross fire when the Police knew at the time of incident that it was only the Police which opened fire.*

[5] Copy of DAWN newspaper clipping dated 23.09.2018 is attached herewith.

(i) Another aspect of this incident that surfaced during the questioning of the police was that the police were aware that Amal was hit by their bullet, from the beginning, however the policemen concealed it. Mr. M. Javed & Mr. Babur knew that the dacoit had not fired, and it was only they who had fired even then until Mr. Amir Shaikh, did not open inquiry it was hidden by the policemen and their duty officer that Amal died by the bullet of a police officer. Even after the investigation when it appeared from the CCTV footage that the policeman's rifle was the cause of Amal's death (also the size of the whole in the car and the wound in Amal's head), the police kept claiming that there was a cross fire in which the policeman bullet hit Mr. Umer Adil's car. There was only unilateral fire by the police. Moreover, in the investigation that was conducted by the police, it was clear from the forensic of the dacoit's weapon had no matching with the cartridges were found at the place of incident. At the place of incident, as per the investigation, six (6) cartridges were found, four (4) of 30 bore and two (2) of FMG, as per the Additional SHO Deedar Hussain Abbasi.[6] Hence, clearly and admittedly the dacoit did not fire at all. However, the statement of the police on 19.08.2018, that Amal was hit by the bullet of the police in a cross fire is entirely wrong. **There was no cross fire, there was only firing by the police by a heavy rifle**.

4. *Miss-appropriation of cash from Ms. Beenish's bag which was retrieved from the dacoit after the incident.*

(i) During the Committee proceedings on 15.10.2018, Mr. & Mrs. Umer Adil, informed the Committee, that the items belonging to Mr. & Mrs. Umer Adil that were recovered from the dacoit were listed by the police. Eventually those items were returned to Mr. & Mrs. Umer Adil. In those items, Mrs. Beenish Umer's bag contained Rs. 12,000/-. However, in the list of the police that money was neither listed nor returned to Mrs. Beenish Umer.

(ii) Mr. & Mrs. Umer Adil, on a later date, during a meeting informed Mr. Amir Sheikh and some other officers, of the level of corruption that the police men themselves, misappropriated the money of Mrs. Beenish

[6] Which too does not corroborate with the statements of the police.

Umer, which was retrieved from the deceased dacoit. The police, although did not re write the list of items recovered, but called Mr. & Mrs. Umer Adil, to return the Rs. 12,000/-, to which Mr. & Mrs. Umer Adil refused. However, prior to the commencement of the Sou Moto, someone from the police left an envelope at the residence of Mr. Umer Adil containing the Rs. 12,000/-.

(iii) This indeed is a sad state of corruption and Sindh Police should form a system wherein the retrieved items from robbery should be protected from such corrupt practices.

During the proceedings of commission, police officers who are respondents alongwith other senior officers, In-charge, SHO, DSP and SSP (South) were heard in presence of the parents of deceased child (Amal) by the members of the commission. After detail probe and cross examination, following issues transpired: -

FACTS:-

Police picket near the scene of incident was informed by a citizen that some street criminals were riding in the Rikshaw and snatching the valuables from cars. Police Constables Javed (14962) and Babar Shahzad (28578) rushed to spot on motorcycle, when they reached the traffic signal, they spotted one of the criminals who was busy in snatching valuables from a car bearing No. BBX-001 Honda Civic.

2. As per version of the police constable Javed (14962) who was armed with SMG. The culprit/suspect aimed his pistol at the constable and in return the constable fired multiple bullets instantly killing the criminal.

3. The CCTV footage shows that at the same time traffic signal opened and the is supported by the viewpoint of parents of Amal whose car moved ahead.

4. It is also observed from the CCTV footage that the car of the deceased child was at a distance of 30 to 40 feet from the spot of police encounter. However, the victim got shot in her car from rear.

The parents of the victim rushed to the hospital without informing the police. Hence, local police was unaware of the incident. The local police received information from Jinnah Postgraduate Medical Centre (JPMC) at around 1200 hrs.

REASONS:-

Apparently, police constable had performed his duty by responding to the criminals, however, the weapon used SMG was too heavy for a close-combat situation in a crowded urban area/society, and further he was not well trained to handling such weapon that to in crowded area.

RECOMMENDATIONS:-

Karachi has gone through a serious Law & Order situation in recent past, resulting into killing of innocent citizen and member of Law Enforcement Agencies (LEAs) including police officers. Although situation has improved tremendously on sectarian and ethnic fronts but challenge of street crimes has grown serious and become conspicuous. Street crime is resulting in loss of human lives and valuables on almost daily basis and it appears that police has not prepared for transitionary phase and still in mode of fighting terrorism. In order to avoid such incident in future, following recommendation may be considered for strict implementation:-

i. Police deputed on Patrol for controlling street crimes should not carry SMGs. They should be armed with pistols/handguns.
ii. The SMG should be authorized only in the sensitive areas of the city, including some parts of South Zone (Layari) and West Zone in proportion to threat. The security squads and protocol vehicles of police officers, judges and minister should carry only one SMG per vehicle and remaining policemen should be armed with pistols.
iii. The city of Karachi is highly urbanized and in the event of police encounters highly trained force is required, whereas,

it has been observed that the police officers do not take refresher course/firing practice regularly. As a result, they end up in causing collateral damages to the lives of the innocent citizens.

iv. It was also observed that the police stations are still maintaining manual record of arms and ammunition, which could be easily manipulated in case of serious incident. Hence the inventory of arms and ammunition at the HQ and police stations should be computerized and biometric machine should be installed to make the officials accountable. A proper strategy should be devised for purchase & procurement of arms and ammunition for urban areas to meet challenges of city/urban policing.

v. The inquiry also reveals the poor management of operational and the investigation branch of police. The Addl-SHO also involved in misappropriation of recovered amount from culprits. The said official who had prepared the recovery memo is guilty of corruption and should be awarded severe punishment.

vi. Investigation police also failed to arrest co-accused for a very long time, who could have easily been traced out. The Investigation branch requires refresher course and better supervision of senior officers in such cases.

vii. A comprehensive strategy is required to implement Smart City Project with integrated surveillance system in the city. Unfortunately for a city of size of 22 million only 2300 cameras are operational and police has to rely on private CCTV footages. Available cameras have poor resolutions with no analytical capacity. It is right time to implement this project in light of existing Supreme Court of Pakistan orders,

viii. Most of the Motorcycles/Rikshaws are displaying un-authorized number plates and in 90% cases street criminals use bikes, hence Excise department should take immediate measures to improve existing number plates which are

readable by cameras and sensors. This will help law enforcing agencies in controlling crimes.

ALLEGATIONS AGAINST NMC BY THE PARENTS OF AMAL.

The evidence that has been led in the Committee has been analyzed and summarized and annexed as Schedule I.[7] The allegations have been individually dealt with based on the evidence that has been recorded.

1. *NMC did not provide essential first aid to Amal.*

i. The first aid needed to be provided in Emergency, for a bullet wound requires that the SOP of trauma are applied. Dr. Ather Enam,[8] had appeared before the Committee as an expert witness. As per Dr. Enam, the SOP is to follow the ATLS[9], which requires that the patient has to be stabilized, which includes [10]securing of airways, checking the BP and seeing the requirement and injecting of the I.V. fluid. Simultaneously, the integrity of the wound has to be analyzed. Dr. Enam, stated that blood should be given but since it takes time to arrange for blood, therefore I.V. fluid is given to raise up the volume of the blood. Dr. Enam was provided the Admission Form through Emergency Room of NMC[11] and the post mortem reports, upon which Dr. Enam concluded that the actions taken as stated in the Form, are right however, due to lack of information in the Forms, as to the timing of amo bag, the volume of I.V. fluid, lack of labs, Dr. Enam stated that he could not say for sure if it was enough.

ii. Dr. Aftab, upon receiving the patient, rightly paged Dr. Imtiaz, as he is a pediatric doctor. However, since the bullet was in the brain, a neuro surgeon, should have been contacted and called immediately, which was lacking in the doctors' decision for

[7] The actual recorded evidence is also available in the case file
[8] Neuro- Surgeon, Head of Surgeries, Agha Khan Hospital.
[9] Advanced Trauma Life Support
[10] Hereinafter referred to as "SHCC"
[11] Hereinafter referred to as the "Form".

arranging the right doctors. Dr. Enam, states that in big hospitals Neuro surgeons are available on call, however, none were called.

iii. The paramedic treatment, started by Mr. Aftab, as per his statement was suction (through machine) and maintaining a IV line, gave fluid. According to parents of Amal, no cannula or IV was administered on Amal and according to them what was immediately started was suction and intubation.

a. No other document was given to the parents of Amal, such as receipt, discharge summary, stating as to what exactly was administered to the deceased Amal. No such document was given at the time the death certificate was given to the father of Amal. No bill/invoice was raised by NMC, hence no invoice is present to show if these medicines, saline or cannula were actually used on Amal by NMC. Upon giving the death certificate to Mr. Umer Adil, no other note or written detail was provided stating the procedure or medicines used. During the investigation before the Committee, Dr. Aftab has candidly admitted that nothing was noted.

Cannula insertion and IV fluid:

b. Whilst Dr. Aftab states, that he only began suction and IV fluid, whereafter Dr. Imtiaz arrived and Dr. Aftab left the place to attend to other patients. Ms. Kaneez Fatima, has stated that she administered the cannula on instructions of Dr. Imtiaz, whilst later she added that she administered the fluids, upon instructions of Dr. Aftab. Admittedly, Dr. Aftab had handed over Amal to Dr. Imtiaz once, Dr. Imtiaz arrived (2 -4 minutes), and if Dr. Imtiaz instructed Ms. Kaneez to administer the cannula then Dr. Aftab's instructions to administer fluids would follow, but since Mr. Aftab had admittedly handed over the patient to Dr. Imtiaz, Dr. Aftab could not have given the instructions after Dr. Imtiaz arrived and took over. Dr. Imtiaz, stated that when he arrived, suction was being done and amubag was administered and does not mention IV fluid being administered, and in fact Dr. Imtiaz stated that upon his (Dr. Imtiaz's) instructions, the staff administered the IV as he tried to replace fluid and saline (without mentioning that Dr. Aftab had

already commenced it). Mr. Farooq on the other hand states that Ms. Kaneez upon instruction of Dr. Aftab administered the cannula and fluid. Dr. Aftab states that he instructed for the cannula & fluid, whilst Dr. Imtiaz states, he gave the instructions, even Ms. Fatima, has a contradictory statement. It is unclear and contradictory as to who gave the instructions of placing a cannula and IV fluid.

c. Dr. Aftab and Dr. Imtiaz did not remember upon which hand the cannula was inserted. Mr. Farooq, guessed it to be on the left hand whilst Ms. Fatima and Ms. Ansari were clear that the cannula was on the left hand.

d. Dr. Aftab stated that only fluid was administered. Dr. Imtiaz states, that normal saline and adrenaline injection were administered. All three staff, state that normal saline and haemocoel were administered. Ms. Anam was the only one who said last ringer was administered. Besides, normal saline, none of the five (5) persons of NMC, have common statements regarding what was administered. The Doctors did not mention haemocoel and the staff did not mention adrenaline injection. Only one staff, who was not even administrating any medicines, said that last ringer was administered. The Form on the other hand states, that R/C D, adrenaline were administered, and IV line was maintained. There are contradictions in the statements of these five people and the Form with regards to what was actually administered.

e. In an email dated, 22.09.2018, Dr. Omer Jung wrote a reply to the Secretary Health Sindh, giving the incident report, wherein he has stated that the patient was given "intervenous, (1) haemocoel, ringer lactate and (2) 2 vials of adrenaline". Dr. Omer Jung, in his in DAWN dated 16.09.2018, has also stated that another medicine namely (3) Ephenphrine, which is essential for CPR, was also given to Amal. It is pertinent to point out that none of the 5 people or the form have mentioned the medicine Ephenphrine. Other than Dr. Omer Jung, who was not present at the time when Amal was brought to NMC, and who was informed of the happening the next day, no one present with Amal, knew that all these were collectively administered to Amal. A Doctor or paramedic staff who is attending

the patient during treatment would maybe remember this information but would surely record this information in the patient notes. There are no patient notes but only a Form, which too doesn't state all these medicines. Therefore, it is unclear, how Dr. Omer Jung made this statement in the email and in DAWN. It has to be noted that this email is sent as a reply to the Secretary Health and after approximately forty (40) days after the incident. In, Dr. Imtiaz's statement, taken by the police, SIP Ali Gohar Soomro, in the case no. 268/2018 offense u/s 34/319 PPC PS, Defense, Karachi, has mentioned that a cannula was passed but no medication has been mentioned.

f. The post mortem report provides the full detail of the injury and besides the injury on the head, *"…no mark of injury was found over any part of body"*[12]. There was no mention that there was any mark of a cannula insertion into any hand of Amal.

g. There are incomplete and partially contrary statements by the NMC Admin, Doctors, staff and Form which cannot be reconciled. The only written record available is incomplete without the strength of the medications/IV injections. The parents of Amal have stated in their statements that no I.V was given to Amal. There is no conclusive proof to show that IV was inserted besides these conflicting statements of the NMC personnel and Form.

Suction (manual or machine), ETT, ambo bag & CPR:

a. Suction: Parents of Amal, have admitted that suction was commenced as soon as possible by the staff. However, NMC states, that the same was being done by a machine. Dr. Aftab was asked if he remembered where the suction machine was placed as the minor OT is a small place, but he could not recall. None of the people present there identified as to where the machine, the drip stand or any other instrument was placed. Ms. Beenish said she also asked these people, why no one was doing anything. Whether suction was by machine or manual, cannot be adduced as there is no CCTV

[12] Paragraph 13, post mortem report.

footage or any ancillary evidence. **Howbeit, it is admitted that suction was being done to clear the airways**.

b. ETT: Parents of Amal, have stated that Amal was intubated immediately. Whether Amal's parents understand what ETT or intubation is, cannot be said for sure. **During the phone call of Aman ambulance at on or about 10:35/7, the doctor spoke to the representative of Aman Ambulance, wherein he categorically stated that ETT had not been done.** The Form states that ETT was passed. Dr. Imtiaz stated before the Committee that he had intubated the deceased Amal. Hence, **there is a clear inconsistency in Dr. Imtiaz's statement**.

c. Amobag: It is admitted by all parties that Amobag was being manually administered upon Amal.

d. CPR: Parents of Amal, deny that any CPR was provided. Dr. Imtiaz and Mr. Farooq, have stated to have interchangeably done CPR. When, Amal became non-responsive at 10:30pm, Dr. Imtiaz, began CPR and told Mr. Farooq to do the amobag. As per Dr. Imtiaz, when both CPR and amobag was being done, at 10:33pm, he went to attend the ambulance call, he asked a staff member to the CPR, however, no specific staff member name was given. Mr. Farooq at that time was using the amobag but it is not clear, that in the absence of Dr. Imtiaz, who did the CPR as no other staff admitted on doing CPR themselves. Dr. Imtiaz stated that CPR was done for 20 to 25 minutes in both portions. No other person has stated this fact and there is no other evidence supporting this claim. Ms. Anam, in fact has stated that, being in the same room, she does not remember whether the CPR was started or not. CPR being a physical function which continued for 20 – 25 minutes, if a paramedic staff is standing in the same room, they would know if CPR is being done or not.

e. Moreover, Dr. Imtiaz, took a call of Aman Ambulance after 10:30 pm, (the time he indicated when CPR and ambo bag were being done simultaneously as Amal was non-responsive). On the phone call, Dr. Imtiaz has not mentioned that he is conducting CPR on the patient (to explain the condition of Amal), in fact he just said that she is critical, and her oxygen saturation is 70% -75%. In fact, he

denied having done ETT on her. **From this detail, it can be safely be assumed that CPR was not initiated**.

Blood Arrangement:

a. Dr. Aftab, Mr. Farooq, Ms. Kaneez, Ms. Anam, Dr. Imtiaz and the parents of Amal, all have stated that Amal was bleeding a lot and had already lost a large quantity of blood. Hence, as per the ABCD emergency protocol, in order for circulation, the depleted blood has to be immediately, replaced in the body in such emergency situations. Blood has to be immediately arranged and the patient should be provided the blood. However, Dr. Ather Enam, has stated that sometimes it takes time to arrange for blood hence, I.V. is given to raise the volume.
b. The parents of Amal, have categorically stated that neither was there any blood arranged for Amal, nor were they asked to arrange blood for Amal.
c. Dr. Imtiaz, stated in his statement before the Committee, for the first time, that he had asked the staff to arrange for the blood, but it could not be arranged in time. In, Dr. Imtiaz's statement in the case no. 268/2018 offense u/s 34/319 PPC PS, Defense, Karachi, has not mentioned that he had asked for blood to be arranged.
d. The three (3) members of the Staff, were separately asked whether they were asked to arrange for blood for Amal. All three (3) staff members have denied, stating, that no instructions or request was made to them by anyone for arranging of blood for Amal.
e. Dr. Jung, clearly stated that NMC has a blood bank, where blood is available on immediate basis and the protocol requires the consent from the next of kin of the patient. No consent was taken from the parents of Amal, as per their statements.

<u>Training:</u>

f. Dr. Imtiaz has also been working since 2001 and has stated that he has never dealt with a bullet wound injury, at NMC. However, in his training in 2013, he was trained for emergency/trauma care.

g. No paramedic staff or Dr. Aftab have had any training in dealing with bullet wounds. The paramedic staff states that they have had training during nursing school to deal in emergency/trauma cases.

h. **Clearly, no one was properly trained to deal with this bullet wound case.**

2. *NMC pressurized the parents of Amal to take her from NMC into some other hospital.*

i. Ms. Beenish Umer, in her DAWN article, categorically stated that soon after Amal was taken to NMC, and she was intubated and one of the attendants (staff) was manually pumping the amobag, they (Doctors) told Mr. Umer that they had to take Amal to either JPMC or Agha Khan Hospital as time was running out and they couldn't do anything to help Amal. In the recorded statement before the Committee, Ms. Beenish stated that, she was in and out of the room when the conversation of shifting Amal took place with Mr. Umer. Mr. Umer, stated that, Dr. Imtiaz and Dr. Aftab, both told Mr. Umer to shift Amal immediately, without giving any reasons, as there was less time and her condition was detoriating. Moreover, the parents of Amal stated that the Doctors, later also told Mr. Umer that since the ambulance would take time, they should shift Amal, in their car.

ii. Dr. Imtiaz, has replied to this allegation stating that it was the parents of Amal who were insisting that Amal should be shifted to another hospital in a car. To which, as per, Dr. Imtiaz, stated that Amal in this condition could not be shifted in the car but can be shifted in an ambulance with a complete team. When questioned whether Dr. Imtiaz had asked to call the ambulance, he could not recall. When Dr. Imtiaz was asked by the father of Amal, about his and Dr. Aftab's advice to shift Amal in an ambulance, Dr. Imtiaz stated that he did not remember. There was no admission or denial on this statement, just that he did not remember.

iii. Mr. Farooq did not recall who asked for shifting of the patient. Ms. Kaneez does not remember who asked for shifting of the patient, however, she remembered that the father of Amal, requested that someone from the staff may accompany him in taking Amal in the

car, but Ms. Kaneez did not reply. Ms. Anam, on the other hand categorically remembers that the father of Amal, who was in a normal condition asked to shift Amal, to Agha Khan Hospital. It is pertinent to mention, that Ms. Anam does not remember when this conversation took place, before or after the Aman ambulance phone call.[13]

iv. The Form on the other hand states in the column of "Recommendation", *".transfer to JPMC/AKU."*. If this Form is authentic then the NMC itself admits that they recommended to transfer to JPMC or AKU.

v. The phone call to Aman Ambulance[14] was made by NMC at 10:32pm, and the operator/person of NMC dialing the number and connecting the call, initially stated, that an ambulance is needed for Agha Khan and then later changed it to JPMC. Thereafter, Ms. Beenish came on the line with Aman Ambulance, and Ms. Beenish introduced herself and asked for an ambulance, and when the Aman operator asked to which hospital, Ms. Beenish, first said JPMC and then herself was confused as to which hospital and is heard[15] to be asking which hospital, JPMC or Agha Khan. There is an echo behind of someone suggesting hospital options. To this the operator of the Aman said that she needed to call the hospital to see availability of a bed. At no moment did Ms. Beenish's conversation suggest on the phone call that she or Mr. Umer, had a pre-determined mind that they were going to shift Amal to Agha Khan Hospital. In fact, towards the end, Ms. Beenish states that if you don't send the ambulance, "*… tow meri bachi haath sai nikal jai gi…*". Why would Ms. Beenish say this if the doctors at NMC was doing everything to save Amal.

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[13] Ms. Beenish, has stated on record that after the Aman phone call, she spoke with her mother who knew someone at Agha Khan Hospital to get a bed arranged anywhere. Perhaps this is the conversation that Ms. Anum may have heard as there is no evidence to suggest that Mr. Umer or Ms. Beenish had thought of taking Amal to Agha Khan Hospital prior to the Aman phone call as Ms. Beenish was confused herself.

[14] Aman Phone call record was retrieved by the police upon the orders of the Chairman of the Committee, Justice (retd) Khilji Arif Hussain. The recording was heard during the committee investigation.

[15] In urdu @ 2:11/2:12 minutes into the call

vi. For the phone call, Dr. Imtiaz was called to inform the operator of the condition of the patient, to which he said she is critical, gasping condition and oxygen saturation is 70% - 75%. As per Dr. Imtiaz, Amal became non-responsive, at about 10:30pm and CPR began. Admittedly, Dr. Imtiaz, left the minor OT, the CPR and Amal, to take the Aman Ambulance call. In the whole conversation, there was no usage of the term "circulatory collapse"[16], or that Amal was undergoing CPR and/or Amal become non-responsive. In fact, contrary to what Dr. Imtiaz has told the committee, when Dr. Imtiaz was asked if the ETT was passed (by the Aman operator) Dr. Imtiaz denied. Dr. Imtiaz was specifically asked by the Aman operator as to whether patient was unconscious or active but Dr. Imtiaz did not reply. On the other hand, Dr. Imtiaz, having identified the condition of Amal, did not give the correct picture to Aman Ambulance. Hence, either, Dr. Imtiaz has not given the right information to Aman regarding the condition of Amal or the condition being described by Dr. Imtiaz before the committee is not accurate.

vii. Dr. Imtiaz in his statement has also said that he would have only shifted the patient if her heart rate was normal, bleeding was stopped, and BP was recordable. As per Dr. Imtiaz's neither was Amal's heart rate normal, nor had her bleeding stopped nor was her BP recordable, even then Dr. Imtiaz, took out the time in that chaos to leave the minor OT and speak to the Aman ambulance and not mention the non-responsiveness of the patient or chances of her survival to Aman Ambulance. Amal's, alleged CPR was far more important than the ambulance phone call at that time, even if the parents had called the doctor. This decision and action of Dr. Imtiaz is illogical and questionable.

viii. If Dr. Imtiaz, had informed the parents or even Aman ambulance that Amal did not have a positive chance of survival and if Amal were to be shifted her chances of survival would diminish even more, then if the parents decided to shift Amal that would be entirely different. In this factual scenario, Dr. Imitaz also states that

[16] As Dr. Imtiaz has used in his recorded statement.

he does not recall telling the parents of the chances of Amal's survival and Dr. Imtiaz did not even inform Aman ambulance.

ix. However, neither Dr. Imtiaz nor either of the other 4 people of NMC, have stated, that the parents of Amal asked NMC administrator to contact an ambulance service. On the contrary, the parents of Amal, have stated that both the Doctors were insisting to shift Amal in an ambulance, as there was little time left and in case the ambulance was delayed in their car. Then who asked NMC operator to dial the ambulance service?

x. Observing the scenario, parents of a girl, who has been shot, brings her to the nearest hospital in their car as soon as possible so that she is treated immediately. The parents had the option initially to ignore the nearest hospital and go to Agha Khan Hospital, but the parents chose NMC because of the close proximity. The parents are aware of the injury and have also seen the blood loss. Their car was a wreck with bullets and blood. Under what circumstances would such parents suggest that they move their injured daughter, in their car, to a hospital which is approximately 10 Km away on a busy night? The Form also states that the Doctors recommended the transfer. As per Amal's parents, both was the case, the doctors advised them to shit Amal and consequently were not doing enough to provide the requisite medical support to Amal.

xi. Dr. Imtiaz, indirectly stated that he was not agreeing to shift Amal. If such was the case and he was also providing the requisite medical emergency treatment, then there would be no reason for NMC to call Aman and for Dr. Imtiaz to talk to Aman Ambulance and mislead them to believe that Amal was critical but, in a shape, to be shifted to another hospital. If proper medical care was being provided by NMC then there would be no reason for the parents to shift Amal, in that condition to another hospital. Dr. Imtiaz has stated that he spoke to Aman because he did not want to break the bad news about Amal's condition to the parents. However, if that were the case then Dr. Imtiaz would have told the Aman Ambulance that he was performing CPR and the patient was non-

responsive, rather than leading Aman to believe that the patient could be shifted.

xii. Coming to transportation in the car. If the parents of Amal on their own accord wanted to take Amal in their own car, they had time to do so and they would have done so as no one could physically stop them. In such a case, Dr. Imtiaz could have gotten signatures on the routine forms, that the patient is being removed against medical advice. In fact, the parents did not pick Amal to take her in their car but instead asked Dr. Imtiaz to give the amobag and requested the staff to accompany them. There is no logical reason to explain why the parents of Amal would want to shift Amal when they themselves brought her to NMC. Either they were refused treatment, or the doctors suggested, directly or indirectly, that the only way for Amal to survive was if they shifted her to another hospital.

xiii. As to who suggested to transfer Amal to another hospital; 2 persons from NMC suggest it was the parents of Amal, 3 persons of NMC do not recall and 2 persons (i.e. Amal's parents) categorically state that the 2 doctors of NMC, from the initial stage were advising them to take Amal as there was very little time. Dr. Omer Jung has categorically stated that in MLO cases, normal private hospitals are reluctant to accept MLO cases, due to the aggression of the attendees, the defamation by the media and other factors.

xiv. From the above analysis & discussion in the given scenario and **on a balance of probabilities, the decision to shift Amal from NMC to another hospital would either be on doctor's advice or if the hospital was refusing to attend to the patient. It is highly probable, that NMC did want Amal to be shifted from NMC by whatever means, including transporting by family car, which is why he spoke to the Aman Ambulance, mislead them and the parents to believe that she could be shifted and which is why Mr. Umer asked Dr. Imtiaz to help him shift Amal by giving the amobag and staff assistance. But because Dr. Imtiaz did not want NMC to be linked to Amal's matter he refused to give them the amobag and assistance.**

3. *NMC pressurized the parents of Amal to talk to Aman Foundation so that Amal could be removed from NMC immediately.*

i. The given analysis of the stated facts and the Aman Ambulance phone call is above.

ii. It is clearly audible that the operator of NMC made the phone call and asked for an ambulance for Agha Khan first then later JPMC. Thereafter gave the phone to Ms. Beenish, who sounded confused, panicked and asked for the ambulance. At no time did Dr. Imtiaz say that she was not in a shape to be moved in an ambulance as her survival rate is very low.

iii. Given the points in clause 2 above, on a balance of probability it is highly probable that NMC did suggested the parents of Amal to call the ambulance so that Amal could be taken to another hospital.

4. *No one at NMC informed the parents about the condition of Amal adequately and let them to believe that taking her to another hospital might save Amal's life.*

i. Dr. Aftab, admits that he did not inform the parents, about the condition of Amal. Dr. Imtiaz, stated that he informed the parents, that Amal was critical. Dr. Imtiaz stated, that he did not remember if he informed the parents, the chances of survival of Amal. It is questionable that if the doctors, did not disclose the chances of Amal's survival at NMC versus another hospital, then why was there a talk of transferring Amal to another hospital. If Amal had no chance to survive at NMC and the parents were not aware of that, and in fact only knew that Amal was critical, then why would there be a talk of shifting Amal. (Reference is drawn to clauses 2 (g – k) above.)

ii. Both the doctors have stated, that as per their protocol they break the bad news in parts and not at once.

iii. The parents of Amal state, that they were not informed about the chances of Amal's survival and all they were told was that she is critical, and she should be shifted to another hospital as soon as possible as there was very little time.

iv. Ms. Beenish, spoke to Aman ambulance for over 4 minutes, jotting down numbers of hospitals where she was to secure a bed for her daughter's transfer. If such effort was being extended by Ms. Beenish, it would be because there was some hope that Amal would survive by this effort. Such hope could or could not be given by the Doctors. Even if they were not advised to shift Amal, the hospital and doctor's facilitation in shifting Amal (call to Aman, conversation with Aman Ambulance), exhibits that they were leading the parents to believe that shifting of Amal was acceptable and the right thing to do for her treatment. However, the fact that the Doctors did not inform the parents of Amal's chance of survival and let them to chase after ambulances and hospitals to shift Amal, in itself, **exhibits that, Amal's parents were not given the accurate information about Amal's condition and they were given the hope that shifting Amal may save Amal's life**.

5. *NMC refused to give the amobag to Amal's parents.*

i. It is not disputed that NMC refused to give amobag. Dr.Imtiaz stated that amobag was to be used by trained personnel that why they refused to give the amobag. Mr. Umer stated that he asked how the amobag was to be used but all the staff told him, that he could not take it.

6. *NMC made a wrong Death Certificate in order to give the perception that Amal had died upon arrival at the hospital and NMC thereafter not rectified the mistake.*

i. The admitted time of death of Amal is 10:45pm. Admittedly, the death certificate given by NMC, states, time of death to be 10:10 pm. Dr. Imtiaz stated, that in the requisition slip, he categorically wrote 10:45 pm as time of death. Dr. Omer Jung, stated that the Doctor writes the time of death and gives to reception for issuing the Death Certificate. Dr. Omer Jung, stated that the writing of 10:10 pm, was a clerical error and the record was not tampered as it was a clerical error because the staff is under stress.

ii. The death certificate was taken by Mr. Umer Adil, after waiting for ½ an hour in NMC. Hence it can safely be said that the death certificate was not made in a hurry.

iii. The time of arrival of Amal and her family was 10:10pm. Neither Dr. Imtiaz nor Dr. Omer Jung state that the requisition slip also contains the detail of the time of arrival. The death certificate does not have the provision for time of arrival. How did the receptionist know the time of arrival or even the time/number 10:10 pm. Even if it was written in the requisition slip, it took ½ an hour to give the death certificate, and in 30 minutes, the NMC administration made an error which would have repercussions upon the post-mortem and other reports.

iv. Mr. Umer Adil, took that death certificate and Amal from NMC to JPMC for post mortem. Based on death certificate, the post mortem report states that the death was immediate. Even Dr. Omer Jung has stated in his interview with DAWN,[17] that the child was clinically dead. SHCC, provided a report of the incident, upon the orders of the Minister of Health, which also states that Amal's death was immediate. It is an admitted and established fact that Amal's death was not immediate and in all the 5 statements of the Doctors and paramedic staff of NMC, they have admitted that Amal was alive when she was brought in and was gasping for air. Dr. Imtiaz, pronounced her dead at 10:45 pm. Hence both the post mortem report and the SHCC are clearly based on the Death Certificate issued by NMC and the type of injury, to conclude that the death was immediate or within seconds of the injury. Whether this is was a coincidence, or not, cannot be concluded due to lack of evidence. But it can safely be stated that both the post mortem report and the SHCC's conclusion with respect to time of death and the investigation are not accurate and therefore, any conclusion by SHCC whether there was any treatment provided by NMC would automatically be unreliable.

v. In, Dr. Omer Jung's interview in DAWN dated 16.09.2018, he has stated that, when Amal arrived her oxygen saturation was 20% to

[17] DAWN interview dated 16.09.2018.

30%, when for survival a 85% oxygen saturation is required. He also stated that Amal's heart had stopped, and she was breathing by manual ventilation and she has no blood pressure. He also stated that Amal was clinically dead. Hence, Dr. Omer Jung, on 16.08.2018 meant, that Amal had passed away when she came to NMC at 10:10. Up until the statement of Aman Foundation dated 17.09.2018 was made available, which declared the time frame of the call to Aman, i.e. 10:32, NMC maintained that the death of Amal was upon arrival. After, this statement of Aman Ambulance, NMC changed their stance before the Supreme Court of Pakistan in their written submission, wherein they said that she died at 10:45pm. The timing on the death certificate and the incident narrated by Dr. Omer Jung in DAWN appear to be on the same page. Whilst the statement of NMC and Dr. Omer Jung has changed but the death certificate time remains the same and so do the content of the DAWN interview. It can be seen that NMC has changed their stance when Aman Ambulance gave their statement, detailing the time of the phone call.

vi. It is pertinent to point out that, as per Dr. Qidwai (CEO SHCC), for the purposes of investigation, visited NMC and met Dr. Hammad for discussing this matter prior to giving the SHCC report. (It is still unclear why Dr. Hammad is the point of authority and reference for the CEO of SHCC because Dr. Hammad himself stated that he had no role in the administration and he only took care of procurement). At that time, no rectification or clarification was given to the SHCC about the time of death. Even though this was a glaring error. In fact, Dr. Qidwai relied on the incorrect death certificate to give his findings upon the incident. No rectification or correction to date has been provided by NMC regarding the clerical error to either the parents, the SHCC or anyone else. If the administration was aware of this error and if there was no ulterior motive, a rectified death certificate with a written acknowledgement of error would have been afforded by NMC to at least the parents of Amal. Moreover, the same rectification would have been provided to SHCC for accurate finding of facts.

vii. Such a wrong certificate coupled with lack of positive action for rectification and all other actions of NMC in this matter, leads one to believe that, they wanted to end the matter by saying that Amal passed away on arrival and as this would be supported by the post mortem report. However, since the timing of the Aman phone call was divulged, NMC had to retract and come forth to state that Amal was arrive when she arrived, and time of death was 10:45pm.

7. NMC breached its duty of care owed to Amal. Whether the breach of duty caused Amal's death.

i. The duty owed by NMC to Amal was that NMC would act in a manner which would be expected from any reasonable ER department in providing the medical aid required for Amal.

ii. NMC through their written reply filed on 05.02.2019 (2:10pm), have stated that NMC did take the first steps of ACLS, including intubation, but due to the brain injury caused by the fire of AK-47, the child was incompatible. As per NMC, bullet injury to the middle of the brain by AK 47, would lead to extensive brain injury alont the projectory of the bullet as were the case of Amal Umer. The death of Amal, as per NMC was due to the nature of injury. Furthermore, NMC is of the view that Amal's death was not because of loss of blood or swelling of the brain but in fact due to the brain injury caused by the AK 47 bullet. NMC relied on some of the statements of Dr. Ather Enam to support their submission. Moreover, NMC has placed statistics to exhibit that brain injury by bullet wound is usually fatal.

iii. First and foremost, it is not denied that the bullet injury could have been fatal. But to say that all AK 47 bullet injuries are fatal is absolutely inaccurate. NMC has selectively relied on Dr. Ather Enam's statement. Dr. Ather Enam, in fact stated that the cause of the death was not bleeding but in fact the swelling of the brain. Dr. Ather Enam, based all his analysis on the incomplete Form of NMC, which Dr. Ather himself found to be dissatisfactory because it was incomplete. Dr. Ather stated that he could state that the actions that were taken by NMC staff was enough because the record was

incomplete, however, intubation was the right step. However, Dr. Imtiaz himself has denied carrying out the intubation in the Aman ambulance call. Hence, whether intubation was done or not is questionable. The statistics, given by NMC are well placed but there are living examples placed on record by Amal's lawyers exhibiting that people have survived with bullet injuries in the brain. NMC also stated that Dr. Imtiaz who was trained in ATLS in 2013 was present. However, no neurosurgeon was called. There is no brain scan was done even post death to see what the damage was. Hence, NMC doctors and nurses could not have concluded that the injury itself was fatal.

iv. Given the contrary statements, the fact that Dr. Imtiaz himself admitted on the phone that ETT was not done, the fact that no blood was arranged, the fact that no neurosurgeon was on call, the fact that the information on the emergency admission form was incomplete, the fact that the parents were not accurately informed of the condition that Amal was claimed to have been when she entered the hospital, the fact that it is highly probable that NMC staff did force the parents to shift Amal to another hospital, the fact that no neurosurgeon was on call to ascertain the extent of damage, the fact that a fraudulent death certificate was given, the fact that the staff was not trained to handle such trauma patient, even though NMC is one of the bigger hospitals of Karachi.

v. A duty of care was owed to the parents of Amal, for NMC to act in a manner any reasonable ER department would have acted in handling the parents of a 10 year old gunshot patient. NMC mislead the parents, NMC and encouraged the parents to shift Amal to another hospital, the NMC in fact lead the parents to believe that Amal had a chance of survival if she was shifted to another hospital. If procedure acceptable to medical science was administered then there would be no breach hence no negligence, however clearly NMC have not acted as per acceptable protocol in dealing with the parents. **Clearly, the NMC has breached its duty owed to the parents of Amal.**

vi. Whether the breach of duty to Amal caused Amal's death is a question that is based on probabilities. Dr. Ather Enam's view based on the limited paper work was that it was highly likely that Amal, would not have survived due to the swelling in the brain. On the other hand Dr. Ather Enam also stated that due to the incomplete information, he is unable to comment whether enough was done. There are examples placed on record in the written arguments of the parent's counsel which exhibit that very recently, there are people who have survived similar bullet wound injuries. Moreover, Dr. Bhatti[18] has stated that the main cause of brain damage is the velocity of the bullet. It has also been stated by Dr. Bhatti and Dr. Enam that the velocity was diminished due to it penetrating through 2 or 3 metal and another surface before hitting Amal. There is no test or scan to exhibit the damage caused to Amal's brain, which can conclusively deduce that Amal would have not survived. Howbeit, as the velocity was lesser, and there are examples of survivors, perhaps Amal could have had a very small percentage of survival. **Hence, to state with complete clarity that the lack of medical aid caused the death of Amal, is not possible. However, it is possible to state that if Amal had any chances of survival, as the other head bullet wound survivors, then the lack of timely and adequate medical aid, negated those chances.**

vii. Three expert witnesses were examined. Firstly Dr. Aizad Dasti an ER Physician based in the United States and works in a Level I Trauma Centre. The only Level I Trauma Centre in Pakistan would be the Civil Hospital Karachi.

viii. Dr. Dasti based his views on practices and regulations of the United States. He described the management of Trauma based on the ACS System of ATLS. He then went to comment and criticize management on what he had been told/learnt from a source especially the possibility that IV access and infusion had not been carried out. He did think a patient should be transferred to a higher level of care if necessary.

[18] Witness of NMC, head of Neurology of NMC.

ix. He did comment on the injuries suffered by the child were from a military assault rifle and inflict vastly more damage then conventional weapons. They are used to maim or kill.

x. The second expert was Professor IH Bhatti formerly of JPMC and now practicing at the NMC. He commented mainly on the relation between bullet velocity and extent of injury. According to him since this was a perforating injury it would be considered a high velocity injury which causes cavitational injury. This was an occipto frontal injury and since this is the longest distance within the skull tissue injury is extensive. He thought that extensive damage had taken place to the brain which was not compatible with life.

xi. In a busy hospital ER he did not think resuscitation would be warranted in such a patient. He commented that such a degree of resuscitation was carried out only because no other emergency required such attention.

xii. The third expert witness was Professor Ather Enam, Chair of Surgery at the Aga Khan University. He reiterated that assessment was based on ATLS protocols. Only enquiry he stated that ER doctors were competent and trained to assess injuries to patients.

xiii. On the basis of the autopsy report, which was shown to him, he determined that the trajectory would have damaged the central part of the brain bilaterally and invariably this would not have been compatible with life. Even if the patient had survived existence would have been vegetative. Regarding resuscitation measures he thought theses were adequate including immediate measures to reduce swelling of brain.

8. After the incident of Amal's death, NMC refused to take any responsibility of their actions.

i. There is a contradictory version on the sequence of events that took place at NMC for Amal's treatment. NMC repeatedly, states that they undertook all measures of emergency/trauma treatment required in Amal's case. Amal's parents state that except intubation and suction nothing was done to Amal, no fluid, medicine or blood was given to Amal.

ii. Dr. Hammad Dosslani, of NMC, gave a statement before the Committee, wherein he stated that he had a conversation with Dr. Imtiaz wherein Dr. Imtiaz stated that "bachi nahi bach sakhti thi" coupled with that Dr. Imtiaz tried everything.

iii. Dr. Dosslani, who is not a practicing doctor and only deals with procurement, however, he seems to be in a position where Doctors, managers are reporting to him when Dr. Dosslani requires. In fact Dr. Minhaj, CEO of SHCC met Dr. Dosslani only and not any of the directors of NMC to discuss this incident. Dr. Dosslani claims that he only deals with procurement and is not involved in the management of NMC, however, the CEO of SHCC meets, Dr. Dosslani for discussion of this matter. It appears that Dr. Dosslani, is more pertinent to the administration of NMC than he claims to be.

iv. Dr. Dosslani, had 2 SMS conversations with Mr. Umer and one phone call on 16.09.2018, the day the Ms. Beenish's article was published. Mr. Umer had initially contacted Dr. Dosslani, by taking his number through Mr. Rizwan, who is mutually known. Mr. Umer wanted to meet Dr. Dosslani, to which Dr. Dosslani agreed but in the same SMS asked who all would be coming to meet and restricted the meeting with Mr. & Mrs. Umer, to which Mr. Umer said he would see if he can come alone. This SMS was exchanged on 05.09.2018. Thereafter, both parties did not contact each other until the article was published on 16.09.2018. Mr. Umer states that Dr. Dosslani in that conversation got agitated and excited and told Mr. Umer that if I would have sent my staff and equipment with you then what would happen to my emergency department. Dr. Dosslani, agrees that he got excited during the call but does not remember this conversation. The mere fact, that Dr. Dosslani, called Mr. Umer on 16.09.2018 after reading the article to confront Mr. Umer regarding the allegations against NMC (no allegations were against Dr. Dosslani in person) shows that Dr. Dosslani was agitated by the article and that might have been insensitive on part of Dr. Dosslani, who was at that moment representing NMC, for Mr. Umer.

v. It is stated by Dr. Omer Jung that private hospital avoid MLO cases due to negative response of the people and media. However, at no point have NMC, shown any kind of empathy nor have they come forth to accept that there was lapse in some portion (eg: it is agreed that blood was not provided even though there was a lot of bleeding; recommendation of transferring Amal, wrong death certificate) of the treatment that was given to Amal. NMC, Dr. Dosslani, Dr. Omer Jung, all show a relaxed, non-sympathetic, indifferent and commercial attitude lacking the true spirit of a health care provider.

AMAN FOUNDATION'S FAILURE TO SEND THE AMBULANCE TIMELY:

1. *Aman Foundation first phone call lasted for 4:29 minutes and the panicked Ms. Beenish was required to write numbers of hospitals to fulfill Aman's requirement.*

i. Aman provided the audio of the phone call between them and Ms. Beenish & Dr. Imtiaz.

ii. It is an accepted fact that the call lasted for 4:29 minutes requiring, the doctors view, Ms. Beenish to list down hospital numbers etc.

iii. Aman in their statement before the committee stated that, because it was a hospital to hospital transfer therefore as per their SOP they required a confirmation of availability of bed at the recipient hospital. Aman admitted that in hospital to hospital shifts, they only shift stabilized patients. Aman also stated that it is the duty of the hospital to stabilize the patient and then transfer the patient but sometimes the hospitals do not do that and if the recipient hospital refuses to take the patient, eventually the patient would suffer.

2. *The requirement of Aman Foundation for arranging a bed at the receiving hospital to the mother of deceased was unreasonable, inhumane and could have been managed in another way.*

i. The above explanation in 1(iii) was given by Aman, against this allegation.

ii. Aman agreed that the solution to this is that Aman ambulance should not wait until the bed is arranged but the ambulance should be dispatched as soon as the call is received and determined that the ambulance is required. In the time the ambulance arrives, bed arrangement can either be done by the attendee or hospital.

3. *The time from the first phone call towards the Aman Foundation the ambulance arrived in 20 min 30 sec approximately and was too long to save Amal.*

i. It admittedly took this much time for the ambulance to arrive. However, whether the delay in ambulance arrival was a factor in saving of Amal's life cannot be established as there were the factor of injury and medical care prior to Aman's factor.

ii. Aman also stated that the private hospitals in cases of emergency want to shift the burden on the ambulance service to cover up their non-capability to handle the patient of critical condition.

iii. Howbeit, Aman has accepted that the time taken was long and has agreed to change its procedure, as stated above in clause 2(ii).

iv. Aman has also pointed out candidly, that there is a serious lack of ambulances in Karachi and there is no system for coordination of these ambulances. Aman is a non-profit organization but due to lack of funds, they already down sized and will further down size due to financial burden. There are only 60 lifesaving ambulances in Karachi (city of 20 million people). There is a need for at least 200 lifesaving ambulances for Karachi alone as per WHO standards. The Chief Minister has announced a long anticipated partnership with Aman, however nothing has been formally materialized.

v. Given the scenario, Aman has also made recommendations.[19]

SINDH HEALTHCARE COMMISSION:

1. The Sindh Health Care Commission Act 2013 was promulgated in 2013 to improve the quality of Health Care Services and banning quackery in the province of Sindh. After the incident of Amal, the Sindh Health Care

[19] Contained in the reforms part.

Commission (SHCC) was directed by Dr. Azra Fazal Pechuho, Minister of Health, Government of Sindh to file Inquiry Report.

2. On 16.10.2018, the SHCC provided the report regarding the incident of death of Amal Umer. This report was submitted by the Secretary Health who was a Member of the Committee formed by the Supreme Court. The Report states that the investigation for the incident was undertaken on 24.09.2018 and continued till 12.10.2018 (eighteen days). The CEO of SHCC Dr. Minhaj Ahmad Qidwai was called before the Committee and he recorded his statement on 05.11.2018.

3. With regards to the inquiry SHCC relied on Dr. Omer Jang's, the administrator/representative of NMC, statement as reported by DAWN on 16.10.2018. Besides, Dr. Omer Jang's statement the SHCC has not provided any record of any inquiry done at NMC. As regards the finding of SHCC, it has been stated that "*However, as the reporting time of death is mentioned in the Death Certificate is 10:10 p.m., it appears that the treatment was given on humanitarian basis.*" (Page 5/6 of the Report). As regards the statement of Dr. Omer Jang, he categorically stated that the child was clinically dead, and they could not help her after that. Moreover, Dr. Omer Jang had stated that when Amal came in the hospital, her oxygen saturation was 20% to 30% when requirement for survival is 85%. Moreover, that Amal was manually ventilated, "……..*her heart had stopped, she had no breathing other than that aided by mechanical ventilation, and she had no blood pressure.*" Dr. Omer Jang also stated that his staff was ready when Amal was brought in because the family had made a call to the Hospital Director beforehand.

4. It is apparent that SHCC has not conducted a separate independent inquiry to ascertain the true facts of the conduct of NMC, in the incident of death of Amal as there is no separate questioning or data collected from NMC.

5. With regards to Amal's case, Dr. Qidwai stated that he visited the NMC and got the relevant record from NMC which included the Patient

Handling Record, Statement of Doctors and Death Certificate. However, Dr. Qidwai did not provide any record of any statement of the doctors at NMC or the patient handling record. In fact in the report of SHCC, there is no mention of a patient handling record or statement of any doctor, it only mentions the DAWN statement of Dr. Omer Jung and the Form. Dr. Qidwai stated that when inquiring about the NMC's conduct he only spoke to Dr. Hammad Dosslani and took the record that was provided by NMC. Hence, in the absence of any record provided SHCC, it is clear that the report of SHCC is only based on Dr. Omer Jung's DAWN interview dated 16.09.2018, the Form and information given by Dr. Hammad Dosslani. It is pertinent to point out that, Dr. Hammad in his statement before the Committee has stated that, he was not present at the hospital when the incident of Amal took place, nor did he specifically inquire about the happenings of the ER in Amal's case. Dr. Hammad categorically stated, that the conversation with Dr. Qidwai regarding Amal's case was vague. Hence, Dr. Qidwai's source of information upon which the entire report is based, is a DAWN article of Dr. Omer Jung, the Form and the vague conversation with Dr. Hammad (a person who was not present).

6. Dr. Qidwai stated that he personally visited the Emergency Room however, he categorically stated that he did not check the facilities in the Emergency Room or the Emergency SOP that NMC adopted when dealing with the NMC Trauma patients. As per Dr. Qidwai based on the information he has heard from public, NMC can deal with the emergency patients even though Dr. Qidwai had personally not checked the record of NMC.

7. It is clear from the Report filed by the SHCC and the statement of Dr. Qidwai that no proper investigation was undertaken by SHCC regarding death of Amal. Dr. Qidwai only met with Dr. Hammad of NMC and took the statement of Dr. Omer Jang, as published in DAWN along with the Death Certificate of NMC. Even though Dr. Qidwai has stated in his statement that he had looked at the Patient Handling Record of Amal however, to date neither NMC nor the SHCC has provided this record or has even mentioned the existence of this record. There is only a Form. In

fact, the on duty doctors have stated that they have not recorded the treatment of Amal.

8. The conclusion of SHCC that Amal expired at 10:10 p.m. is admittedly incorrect as she expired at 10:45 p.m. exhibiting that SHCC did not even consider the true facts of the case and concluded their finding on the dictations of NMC and the DAWN interview of Dr. Omer Jang. It is incorrect to find that Amal expired at 10:10 pm and that the treatment given my NMC was on humanitarian basis because this finding is not based on the facts that have been dictated by NMC itself before the Committee.

9. Dr. Qidwai also informed the Committee that NMC is not a registered hospital with Sindh Health Care Commission and because he was authorized by the Health Minister to prepare the report of Amal's case therefore, he visited the NMC and inquired.

10. Under Section 19, the Health Care Service Provider may be held guilty on medical negligence if they do not have requisite human resource and equipment which it professes to have, or the employee of the Health Care Provider did not provide minimum service delivery standard prescribed by Government competence the skill which he or his employee did possess. The report that Dr. Minhaj Qidwai, has assembled in the matter of Amal has not considered any of these angles of medical negligence and in fact, to the extent of NMC's fact finding and investigation, is not reliable for conclusive finding.

11. With regards to the functioning of SHCC, the background provided by Dr. Qidwai categorically states that after the promulgation of SHCC Act, till 20.02.2018, SHCC was not functional. Since February 2018, SHCC had started the registration of Health Care facilities and had received approximately 3000 applications. Dr. Qidwai stated that SHCC has developed SOPs for inspection of hospitals, emergencies and the same are notified and available on the website.

12. Dr. Qidwai states that SHCC has written to all unregistered hospitals including NMC however, they have not registered themselves. SHCC categorically states that only 3000 hospitals have been registered whilst the remaining health care establishments have not been registered, which includes NMC. Dr. Qidwai states that whilst registering, SHCC does not visit the facilities or check the kind of medical facilities provided. Mr. Qidwai stated that with regards to Emergency, the SHCC has inspected Tabba Hospital and Civil Hospital for which Inspection Report was asked for however; it has not been submitted before this Commission.

13. The SHCC has also established a Directorate of Complaint and to date has received 21 complaints regarding malpractice and medical negligence. The procedure of dealing with these complaints is that once the complaint is filed the complainant is to first approach the health care facility against which the complaint has been filed. This requirement is in the regulation and not in the statute. The logic behind this is that the hospital can take specific necessary measures to resolve the same. If after passage of 30 days, the problem is not resolved, then the SHCC commences their procedure for every complaint. A three-member bench is constituted consisting of all doctors of that field who do inquiry and resolve the complaint to an order. There is no representation of anyone outside the fraternity in the Committee.

14. From the over view of the SHCC it is apparent that SHCC is not conducting its work as a Regulator. It has given leeway to unregistered medical institutions to continue their practice in violation of Section 13(5) and eventually Section 14(2) of the Sindh Health Care Commission Act, 2013. The SHCC has taken more than five (5) years to form and begin its functioning. Even after being formed and active, SHCC lacks structure, vision, independence and focus. The fact that Medical Health providers are still functioning without registration or licensing is in itself exhibiting the lack of functionality of the SHCC. The SHCC, is still not given effect to the SHCC Act, 2013, in its true spirit and as of date there is no effective regulation of Health Care providers.

CONCLUSIVE FINDINGS

Against Police:

I. **There is a lack of training.** The Sindh Police and the Government of Sindh have made statements which are reported in the newspaper, wherein, they have recognized the lack of training and have started training. The lack of training is the root cause of miscalculated actions.

II. **Use of heavy ammunition.** It is clear that although there was a justified action, but the reaction was miscalculated and there was a disproportionate use of ammunition at the scene of the crime which led to collateral damage to Mr. Umer Adil's property and most importantly the death of their daughter, Amal.

III. **The individual cases of the police officers should be conducted in accordance with the facts and law to its eventual conclusion.**

IV. **It is clear that the Sindh Police although have admitted their fault and they have been extremely forthcoming as they have realized where the mistake lies.** However, the trauma and loss are tragic, In the words of Mr. Umer Adil, during the committee meeting, ". *we looked up to the police to protect us; today we look at the police to guard ourselves from them…*". **The actions of the policemen, although inadvertent, has caused grave damage both emotionally and financially to family of Mr. & Mrs. Umer Adil who will have to live with this trauma of this event for the rest of their life.**

V. **Hence, the Sindh Police, should compensate Mr. & Mrs. Umer Adil for the loss that they have suffered and shall continue to suffer.**

Against NMC:

I. **Essential medical care to Amal was denied.** There are incomplete and contrary statements by the NMC Admin, Doctors, staff and Form which cannot be reconciled. The only written record available is incomplete without the essential details of treatments. (strength of the medications/IV injections). There is no conclusive proof to show that IV was inserted besides these conflicting statements of the NMC personnel and Form. Information of medication is differing in statements. Hence, statements with regards to I.V. cannot be relied upon. It is admitted that suction was being done to clear the airways. It can clearly be deduced that ETT was not done. Clear evidence that Dr. Imtiaz has said that ETT has not been done at 10:37 pm. It can be safely be assumed that CPR was not initiated. It is clear that Dr. Imtiaz did not take any measures for blood to be arranged to anyone.

II. **Amal's parents were mis lead and were not counseled properly.** Amal's parents were not given the accurate information about Amal's condition and they were given the hope that shifting Amal may save Amal's life.

III. **Dr. Imtiaz of NMC was in the favour of Amal to be transferred as soon as possible**. Vague information and wrong impression that patient could be shifted, was given to Aman ambulance so that they do not question the transfer**.**

IV. **On a balance of probabilities, the decision to shift Amal from NMC to another hospital would either be on doctor's advice or if the hospital was refusing to attend to the patient.**

V. **Amobag and assistance was refused to be given because Dr. Imtiaz did not want NMC to be linked to Amal's matter he refused to give them the amobag and assistance.**

VI. **NMC did give a wrong timed Death Certificate, which it has failed to formally rectify to date.**

VII. **NMC has failed to maintain proper and complete record of patient handling.**

VIII. **The lapse in the performance of NMC, exhibits that professional duty of care owed to Amal was breached by NMC.**

IX. **The acceptable medical procedure to have been adopted by NMC was not adopted by NMC on a balance of probability.**

X. **NMC has breached its duty owed to the parents of Amal.**

XI. **To state with complete clarity that the lack of medical aid caused the death of Amal, is not possible. However, it is possible to state that if Amal had any chances of survival, as the other head bullet wound survivors, then the lack of timely and adequate medical aid, negated those chances.**

XII. **The NMC emergency staff was not properly trained to deal with this bullet wound cases.**

XIII. **NMC shows a relaxed, non-sympathetic, indifferent and commercial attitude lacking empathy the true spirit of a health care provider.**

XIV. **Damages should be paid to Mr. & Mrs. Umer Adil as monetary compensation for the breach of duties by NMC.**

Against Aman Foundation:

I. **The call of over 4 minutes was excessive.**

II. **The ambulance could have been dispatched without assurance of a bed at the receiving hospital.** Aman agreed that the solution to this is that Aman ambulance should not wait until the bed is arranged but the ambulance should be dispatched as soon as the call is received and determined that the ambulance is required. In the time the ambulance arrives, bed arrangement can either be done by the attendee or hospital.

III. **Aman's delay in sending the ambulance was not the cause of death of Amal.**

Against SHCC:

I. **SHCC's finding on Amal's matter is not based on independent inquiry and is incorrect.** It is apparent that SHCC has not conducted a separate independent inquiry to ascertain the true facts of the conduct of NMC, in the incident of death of Amal as there is no separate questioning or data collected from NMC.

II. **The conclusion of SHCC that Amal expired at 10:10 p.m. is admittedly incorrect as she expired at 10:45 p.m.** It is incorrect to find that Amal expired at 10:10 pm and that the treatment given my NMC was on humanitarian basis because this finding is not based on the facts that have been dictated by NMC itself before the Committee.

III. The SHCC, is still not given effect to the SHCC Act, 2013, in its true spirit and as of date there is no effective regulation of Health Care providers.

IV. SHCC, should become independent and adopt transparent measures for regulating the healthcare in order to improve healthcare.

RECOMMENDATIONS

Guidelines/SOP's (and if required, legislative changes) for the Private Hospital in the treatment to the injured persons in emergency cases and ensuring the availability of basic facilities and training to deal with such trauma cases. Also the nature and process of accountability for the violation of these guidelines/SOP's.

1. There is an existing legislative framework for medical aid. However the same is vague and lacks in engulfing private hospitals. Given the large and growing population of Sindh, there is a lack of authentic and competent health institutions to provide healthcare. Since Sindh's medical infrastructure is not solely based on government hospitals therefore, it is essential that health institutions, which have the capacity should also form part of providing infrastructure atleast in cases of emergency medical aid.
2. The Sindh Injured Persons (Medical Aid) Act, 2014 ("SIPMA, 2014"), is required to be amended, to engulf every hospital, clinic, healthcare institution, having a in-patient bed and an emergency department. If a private hospital has 200 beds but does not have an emergency department, the SIPMA, 2014 should not be applicable upon it. However, if a registered healthcare institution has a fully equipped emergency department then SIPMA, 2014 should be applicable.
3. Under section 2(c), of the SIPMA, 2014, is required to be amended by the legislature to change the definition of the hospital to include even a private hospital (which are not registered under section 7), having an emergency department.
4. In order for further clarity and vast implementation, the MLO requirements can be fulfilled in the designated/notified hospitals, after the person has been stabilized and shifted to the notified hospital.
5. Section 7's applicability should be restricted for hospitals for purposes of MLO only. Emergency care by hospitals/healthcare institutions should not be subjected to any notification and their criteria should be simple (as contained in point 1. Above)
6. Section 3 should be amended to include that, no hospital/healthcare institution, falling in the criteria of 1. Above, should have the option of refusing to treat an injured person in an emergency case.
7. The monetary penalty under section 11 of the SIPMA, 2014, should be increased to maximum of Rs. 300,000/-.
8. The Emergency department of a hospital/healthcare institution, should be well equipped to provide immediate essential medical aid to the injured, high trauma patients and should be able to cater

to all types of injuries. The SHCC, has stated to have SOPs for emergency care. The same have to be put in line with the international emergency standards.[20]

9. The hospital/health care institution mandatorily should have trained doctors for dealing with emergency. Certification of training, recognized by the PMDC & SHCC for Emergency & Trauma should be given to the ER doctors. The SIPMA, 2014 should be amended to include this requirement, so as to ensure that there is a trained doctor and paramedic in emergency departments.
10. The relevant consultant of the area injury should be contacted and called immediately.
11. Under section 6 of the SIPMA, 2014, the requirements of maintaining complete records as to the clinical condition of the patient would be applicable upon private healthcare institutions as well.
12. A section in the SIPMA, 2014 has to be inserted, requiring the private hospitals having a capacity of 200 beds to mandatorily have atleast 2 ambulances, which will be in coordination with the 1122 service (Indicated below).
13. The PMDC Code of Ethics of Practice of Medical and Dental Practitioners, which is a detailed code including duty to preservance of human life and duty to provide emergency care with honesty and competence, should strictly be implemented by the SHCC. Where there is failure on part of the practitioner, appropriate penal action including but not limited to cancellation of license should be undertaken.
14. Empathy in breaking of news protocol should be part of training and implemented in order to avoid misleading the family or raising their expectations.
15. The Government of Sindh should provide investment in getting ventilators. The availability of at least 1,500-2,000 ventilators needed in the city of Karachi against the current availability of 150-200 only is ensured
16. The SHCC, should implement the requirements of the SHCC ACT, 2013, with immediate effect. Requisite SOPs for quality standards of healthcare institutions, Emergency SOPs, SOPs of equipment etc should be finalized and notified.
17. These SOPs should be circulated in public so that people are aware of Emergency protocols.
18. The SHCC should implement the SOPs upon the hospitals and adopt appropriate measures, checks and balances for implementing quality, the SOPs to ensure compliance.

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[20] http://www.sssft.nhs.uk/images/Policies/Responding_to_Medical__Psychiatric_Emergencies_Policy/Medical_Emergency_SOP.pdf.; https://www.emrsscotland.org/standard-operating-procedures/; https://www.facs.org/quality-programs/trauma/atls.

19. The SHCC should implement the requirements of Section 13 & 14 SHCC Act, 2013, stringently. Healthcare Institutions without licensing and/or registration should be show caused and after due process should be dealt with in accordance with the SHCC Act, 2013.
20. The healthcare institutions and the doctors therein, should not be harassed by the police for fulfillment of the MLO requirements.
21. If the documentation of the patient is complete, it should be admissible evidence in court and the requirement of calling the doctors to make the reports admissible should be eliminated. Should any party require that the healthcare institution's administrator or relevant doctor be called for evidence, the same is to be at the discretion of the court, after the party has made out a case for calling the healthcare institution's administrator or relevant doctor.
22. The healthcare institution should reserve the rights of admission and if the attendants of the patients, act in a manner causing threat to the healthcare institution and/or its employees, the healthcare institution should ask them to leave the premise and should there be a need, call the police for maintaining civility and order.
23. PEMRA should ensure that healthcare institutions are not maligned based on defamation.
24. The police surgeon Karachi, has pointed out through letter dated 03.09.2018, that there is an acute shortage of doctors in Medico Lego Department. The Government of Sindh should look into this matter. Not only the inadequacy as to the number should be addressed but also the level of competence and independence of these doctors should be ensured.

Guidelines/SOP's (and if required, legislative changes) for the Ambulance Service Providers in such emergency cases. Also the nature and process of accountability for the violation of these guidelines/SOP's.

1. The lack of ambulance services is glaring in Sindh. Charitable organizations, are the main backbone for the services of ambulances in Sindh. Eidhi, Chippa, Aman Foundation provide ambulance service in Sindh. Eidhi and Chippa provide ambulances, which are not equipped and are rather "body carriers". Aman Foundation, on the contrary, has very well-equipped ambulances and an organized infrastructure. Internationally, (Journal of Emergency Medical Services) in the general sense, upon 10,000 people, 3 ambulances have to be allocated.[21] However, as per WHO, for a city of 20 million people atleast 200 ambulances are needed.[22]

[21] https://www.jems.com/articles/2011/11/nasemso-survey-provides-snapshot-ems-ind.html
[22] As per Aman statement

2. Health care is a fundamental right. There is a glaring absence of an infrastructure for emergency medical care services. An infrastructure for emergency medical care is extremely important for human life. There is a severe lack of equipped ambulance and only 60 or 50 ambulances are available which are being run by a charitable organization i.e. Aman Foundation.
3. The Sindh legislature, is urged to provide legislation for an infrastructure for all emergency services including ambulances. Ambulances should be under a separate department, under the Ministry of health. Availability and allocation of ambulance should be dependent upon the population density in the city. No discrimination in availability of ambulance shall be based on ethnicity, religion, colour, or/and caste shall be ensured. Ambulance service should be free so as to eliminate any discrimination. The network of ambulances need to be mapped out professionally, keeping in mind the networking inter se the ambulance and the hospitals. The said ambulance service be integrated with existing public/private healthcare infrastructure whereby real time availability and coordination of ICU beds is ascertained for ease of the masses.
4. Without prejudice to paragraph 3's legal infrastructure requirements above, the Government of Sindh, is recommended to urgently procure ambulances and create an infrastructure for ambulance services.
5. Ambulances, have to be well equipped with all essential requirements[23], not just body carriers, for catering to trauma/emergency cases with adequately trained para medic staff.
6. Ambulances need to be integrated and connected to the hospitals for ascertaining availability. The burden on the attendant of the patient to find out about availability of beds in a hospital should be eliminated unless voluntarily provided by the attendant.
7. All emergency services, should be consolidated and available on one call at one center. A consolidated service having fire brigades, equipped ambulances, police should all be available, by dialing one number to deal with the emergency situation.
8. It has been brought to the notice that a bill namely, the Sindh Amal Rescue Service Bill has been tabled on 30.09.2018. This bill envisages a composite rescue service upon the successful model of 1122 in Punjab, which has been introduced through the Punjab Emergency Act, 2006.
9. The Sindh Amal Rescue Service is in the right direction, in order for an effective dealing with emergency situations.

[23] Aman Foundation ambulances can be taken as examples.

10. However, the following are the sections of The Sindh Amal Rescue Service Bill are recommended to be revisited for effective implementation:

    10.1 The Sindh draft bill (section 2) doesn't make it mandatory for at least one opposition member to be made part of the Executive Council, in contrast to the Punjab Act, making the Sindh Bill to potentially lack the same oversight as the Punjab Act.

    10.2 In the Sindh draft bill (section 8) the eligibility/qualifications criteria of the Director General is missing in the relevant section 8 of the Bill whereas in Punjab there is an apt qualification criteria of either (a) a postgraduate in emergency management or an emergency subject or has specialization in management of trauma or emergency patients or is a medical postgraduate; (b) has adequate knowledge, formal training and expertise in the field of emergency management. Such qualification for the DG in Sindh should also be placed for competent administration.

    10.3 The Sindh draft Bill (section 11) doesn't put a restriction for the number of directors to be appointed, and instead allows for further appointments of Deputy Directors, and Assistant Directors. Furthermore, there's no eligibility/qualifications criteria that has to be met to be appointed a director. This would just entail a unfettered discretion to uselessly appointment people raising the financial burden on the department. The Punjab Act puts a cap on the maximum number of directors to six, while giving out a strict eligibility/qualifications criteria for its directors. A cap lesser than 6 (because Sindh is a smaller province) should be placed and all Directors should have compulsory qualifications for effective work.

11. The DAWN has reported on 19.12.2018, that there has been an agreement between Government of Sindh and Pakistan Aid Foundation for free ambulance services for 60 fully loaded ambulances. In the news dated 26.12.2018, the Government of Sindh has allocated Rs. 35 billion for this ambulance service. However, this service can effectively be used if there is a framework rather than the present lack of system and framework. Another news item dated 26.12.2018 was published in the Tribune wherein the service of 1122 was reported to begin soon. An allocation of Rs. 3.12 billion was reported to be spent on this service. It is stated that Dr. Abdul Samid Billo, who is an emergency planning consultant has been trying to bridge the gap between organisations and the government but has till now not achieved the same.[24] Punjab has implemented this service and is reported to be effective. Effort can be seen on part

[24] Copies of three news item is attached herewith.

of the Government of Sindh, however, it is reiterated that without an effective legal framework, this haphazard effort will be in vain. Therefore, the legislation (above paragraphs) should be passed with effective check and balances.

12. The said emergency service be implemented through support of the law enforcement agencies on ground to work in coordination in case of emergency/disaster/need.

Guidelines/SOP's (and if required, legislative changes) for the Police officials as to how to handle such incidents. Also the nature and process of accountability for the violation of these guidelines/SOPs.[25]

Karachi has gone through a serious Law & Order situation in recent past, resulting into killing of innocent citizen and member of Law Enforcement Agencies (LEAs) including police Officers. Although situation has improved tremendously on sectarian and ethnic fronts, but challenge or street crimes has grown serious and become conspicuous. Street Crime is resulting in loss of human lives and valuables on almost daily basis and it appears that police has not prepared for transitionary phase and still in mode of fighting terrorism. In order to avoid such incident in future following recommendation may be considered for strict implementation.

1. Police deputed on Patrol for controlling street crimes should not carry SMGs. They should be armed with pistols/handguns.

2. The SMG should be authorized only in the sensitive areas of the city, including some parts of South Zone (Layari) and West Zone in proportion to threat. The security squads and protocol vehicles of police officers, judges and minister should carry only one SMG per vehicle and remaining policemen should be armed with pistols. There is a specialized unit namely Rapid Response Force ("RRF")/SPG unit, which should be available and dutybound for dealing with high risk situations, which involve the use of heavy ammunitions (eg: such as terrorist raids or attacks).
3. There is a glaring lack of training of police as identified in the findings. The city of Karachi is highly urbanized and in the event of police encounters highly trained force is required, whereas, it has been observed that the police officers do not take refresher course/firing practice regularly. As a result, they end up in causing collateral damages to the lives of the innocent citizens. The training capacity is very less as compared to the number of employed police. Hence training

[25] Recommendations framed by Mr. A. D. Khowaja.

capacity should be increased by the Government of Sindh. There must be a mandatory requirement of refresher on regular basis (atleast every 6 - 8 months). The District officer (SSP & SP(HQ)) has to ensure that training is done which will be reflected in his ACRs. Weapon should not be given/assigned to any police personnel which has not undergone a refresher course within the past 8 months.

4. Training with regards to urban policing is also required. The police personnel should be able to assess the proportionate amount of force that is to be used in a situation, which would be effective yet have the least collateral damage. Encounter culture should also be discouraged. Training with regards to different modes of combat should also be introduced where use of ammunition can be avoided. Training be provided to use other measures & methods rather than use of ammunition where it can be avoided. Training to take calculated and proportionate decisions is pertinent especially in urban policing.

5. It was also observed that the police stations are still maintaining manual record of arms and ammunition, which could be easily manipulated in case of serious incident. Hence the inventory of arms and ammunition at the HQ and police stations should be computerized and biometric machine should be installed to make the officials accountable. A proper strategy should be devised for purchase & procurement of arms and ammunition, which is cost effective but purposeful for urban areas to meet challenges of city/urban policing.

6. The IBS facility, which is used to identify ammunitions and weapons should also be used to identify the weapon of the police and the ammunition that is given to them. In this way the weapon that is issued can be traced whenever it fires or goes missing. The weapon recognition should be coordinated with the biometrics as indicated in point 5 above to keep a complete check on who the weapon was allotted to, how much ammunition was used etc.

7. The inquiry also reveals the poor management of operational and the investigation branch of police. The Addl-SHO also involved in misappropriation of recovered amount from culprits. The said official who had prepared the recovery memo is guilty of corruption and should be awarded severe punishment.

8. Investigation police also failed to arrest co-accused for a very long time, who could have easily been traced out. The Investigation branch requires refresher course and better supervision of senior officers in such cases.

9. A comprehensive strategy is required to implement Smart City Project with integrated surveillance System in the City Unfortunately for a city of size of 22 million only 2300 cameras are operational and police has to rely on private CCTV footages. Available cameras have poor resolutions with no analytical capacity. It is right time to implement this project in light of existing Supreme court of Pakistan orders. For increase of cameras and making Karachi into a smart city, it is recommended that the legislature enact (if need be) and/or the Government of Sindh enforces a mandatory requirement wherein all commercial entities have to install cameras on all outside corners of their shops, establishment, building etc at their cost of installation, running and maintenance. Cameras in the residential areas on the roads should be the responsibility of the Government of Sindh. Lack of this should attract penal provisions such as a fine on the owner/owners. The police should have access to these cameras. In this way Karachi would become a smart city at low cost, having eyes at most areas.

Most of the Motorcycles/Rikshaws and cars are displaying un-authorized number plates and in 90% cases street criminals use bikes, hence Excise department should take immediate measures to improve existing number plates which are readable by cameras and sensors. This will help law enforcing agencies in controlling crimes.

I would like to thank all the Members of the Committee who despite their various commitments attend the meetings and assisted, come and preparing this report. Particularly Br. Umaimah Anwar Khan, without whose help is not possible to finalize this report.

Justice Khilji Arif Hussain
Former Judge Supreme Court of Pakistan
Chairman of the Committee

Mr. A.D. Khawaja
Member

Dr. Shamvil Ashraf
Member

Dr. Saeed Qureshi
Member

Dr. M. Usman Chachar
Member

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