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Custodial Death of Under trial Prisoners in India: Human Rights, Healthcare, And The Evolving Jurisprudence of Constitutional Compensation

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Abstract

Custodial death of an undertrial prisoner presents one of the most serious challenges to constitutional governance because it occurs within an environment in which the State exercises direct control over liberty, movement, healthcare, communication, and access to emergency medical assistance. The constitutional position is particularly sensitive where the deceased had not been convicted and was therefore presumed innocent at the time of detention. This paper examines custodial deaths of undertrial prisoners in India through the interconnected dimensions of human rights, healthcare obligations, Article 21 of the Constitution, State accountability, and public-law compensation.

The paper argues that custodial death cannot be examined only through the immediate medical cause of death. A meaningful constitutional inquiry must also examine the institutional chain preceding death: whether illness was detected, whether medical attention was timely, whether treatment was adequate, whether specialist referral was made and completed, whether medicines and follow-up were maintained, and whether the prison administration responded appropriately to deterioration. The jurisprudence of the Supreme Court—from Sunil Batra, Pt. Parmanand Katara, and Paschim Banga to Nilabati Behera, D.K. Basu, Sube Singh, and the Court's later compensation jurisprudence—demonstrates the evolution from formal recognition of prisoners' rights towards positive State obligations and effective constitutional remedies.

The paper further argues that the emerging digitalisation of prison healthcare creates an important opportunity to strengthen constitutional accountability. Electronic health records, telemedicine, digital referral tracking, interoperable prison-health systems, audit trails, and carefully governed artificial intelligence can improve continuity of care and reduce information asymmetry between the prisoner and the State. However, digitalisation also creates risks concerning privacy, surveillance, cybersecurity, data accuracy, and automated decision-making. A rights-based model is therefore necessary.

The paper proposes that digital healthcare governance should be understood not merely as administrative modernisation but as a mechanism of preventive constitutional accountability. Its central proposition is

that digitalisation should make the State's healthcare obligations **continuous, preventive, traceable, and accountable**, while ensuring that technology remains subordinate to dignity, medical judgment, privacy, and constitutional rights.

Keywords: Undertrial prisoners; custodial death; Article 21; human rights; healthcare; constitutional compensation; public-law remedy; digital healthcare; telemedicine; privacy; accountability.

1. INTRODUCTION

The death of a person in State custody is fundamentally different from an ordinary death. The distinction does not mean that every custodial death is necessarily the result of State wrongdoing. Prisoners may die from natural causes, pre-existing illness, infectious disease, or medical conditions that cannot reasonably be prevented. Nevertheless, custody creates a special relationship of dependence. The State controls the prisoner's movement, access to doctors, hospital transfers, medication, specialist consultation, and emergency intervention. Where that control is accompanied by inadequate healthcare, delay, neglect, or failure to respond to known medical needs, the question becomes one of constitutional responsibility.

The issue is even more serious in the case of an **undertrial prisoner**. An undertrial is detained pending trial and has not been convicted. Pre-trial detention is not intended to constitute punishment. The presumption of innocence remains a foundational principle of criminal justice. Accordingly, an undertrial does not lose the basic protections of the Constitution merely because a court has authorised detention.

The Supreme Court's prison-rights jurisprudence has long rejected the proposition that imprisonment places an individual outside the constitutional order. In Sunil Batra v. Delhi Administration, the Court treated prisoners as bearers of fundamental rights subject only to restrictions justified by lawful incarceration.[1] The broader principle is that imprisonment removes or restricts liberty; it does not remove humanity or constitutional personhood.

This principle has direct implications for healthcare. In Pt. Parmanand Katara v. Union of India, the Supreme Court emphasised the primacy of preservation of human life and the need for immediate medical assistance.[2] In Paschim Banga Khet Mazdoor Samity v. State of West Bengal, the Court connected access to medical treatment with Article 21 and recognised positive State obligations concerning the availability of medical facilities.[3] These principles become especially significant in prisons because the individual cannot independently secure medical care in the same manner as a person living outside custody.

The scale of the undertrial population also makes the question institutionally important. Government data placed before Parliament recorded **389,910 undertrial prisoners as of December 31, 2023**.[4] At the same time, a 2023 parliamentary response stated that specific central data concerning custodial deaths of undertrial prisoners was not available.[5] This combination—large-scale pre-trial detention and incomplete centralised information about deaths—illustrates the accountability problem addressed in this paper. A constitutional system cannot effectively prevent institutional failure if the relevant healthcare events cannot be reliably recorded, connected, analysed, and reviewed.

The paper therefore asks four principal questions:

1. What constitutional and human-rights obligations govern healthcare for undertrial prisoners?
2. How has Indian constitutional jurisprudence developed the remedy of public-law compensation for custodial death?
3. How should healthcare failure be examined when death occurs in custody?
4. Can digital healthcare governance strengthen prevention, continuity of care, evidence, and constitutional accountability without creating new violations of privacy and dignity?

The central argument is that custodial death should be examined through an **institutional healthcare chain**, rather than only through the immediate cause of death. That chain includes medical screening, complaint, diagnosis, treatment, referral, hospitalisation, medication, follow-up, transfer, emergency escalation, and institutional response.

Digitalisation becomes relevant precisely because each of these stages generates information. If properly designed, the information can be transformed into timely action and accountability.

2. UNDERTRIAL PRISONERS, HUMAN RIGHTS, AND ARTICLE 21

A. Imprisonment Does Not Extinguish Fundamental Rights

The constitutional position of prisoners has evolved from a historically disciplinary understanding of incarceration towards a rights-based approach. The Supreme Court's decisions in Sunil Batra and related cases recognise that imprisonment necessarily restricts liberty but does not erase fundamental rights.[6]

This is particularly important for healthcare because physical and mental health are inseparable from the constitutional protection of life and dignity.

A prisoner remains a human being entitled to humane conditions. The State cannot justify medical neglect merely by invoking the fact that the individual is incarcerated.

B. The Special Position of the Undertrial

The undertrial occupies a particularly vulnerable position because detention precedes conviction.

The State may lawfully restrict liberty under the applicable criminal process, but that restriction does not transform detention into punishment. The constitutional presumption of innocence means that the undertrial should not experience avoidable suffering as an additional consequence of detention.

Healthcare therefore has a dual character in undertrial detention. It is both:

a human-rights obligation; and
a safeguard against detention becoming punitive in substance.

The distinction matters in cases where a person dies because necessary treatment was unavailable, delayed, interrupted, or inadequately followed.

C. Article 21 as a Positive Obligation

Article 21 is not merely a negative prohibition against unlawful killing. Its contemporary interpretation imposes positive obligations upon the State where State-controlled institutions create heightened vulnerability.

In Paschim Banga, the Supreme Court held that the State has an obligation to provide adequate medical facilities and that failure to provide timely treatment can engage Article 21.[7] The principle is not confined to hospitals.

It is equally applicable to prisons.
A prisoner who cannot leave the institution freely, independently arrange transport, or choose an alternative medical provider is structurally dependent upon the State's healthcare system.
The State therefore has an obligation to ensure a healthcare system capable of responding to reasonably foreseeable medical needs.

D. Emergency Medical Treatment

The principle in Pt. Parmanand Katara is particularly relevant to custodial emergencies.[8] The preservation of life must take precedence over procedural obstacles.
Within prisons, this principle means that administrative requirements should not become barriers to emergency treatment.
Where a prisoner presents symptoms indicating a medical emergency, the institution must possess mechanisms for:

- prompt recognition;
- immediate medical examination;
- stabilisation;
- specialist consultation where necessary;
- hospital referral;
- transportation;
- emergency intervention; and
- follow-up.

Failure at any of these stages may become relevant to constitutional review.

3. HEALTHCARE FAILURE AND THE CONSTITUTIONAL ANALYSIS OF CUSTODIAL DEATH

A. Cause of Death Is Not the Entire Inquiry

A central problem in custodial-death cases is the tendency to treat the medical cause of death as the end of the inquiry.
The medical cause may be heart failure, infection, trauma, respiratory disease, organ failure, suicide, or another condition.
But the constitutional question can be broader:

Was the death reasonably preventable through the discharge of the State's custodial healthcare obligations?

The distinction is critical.
A natural disease does not necessarily exclude State responsibility if inadequate treatment, delay, or failure to refer materially worsened the condition.
Conversely, the occurrence of death from illness does not automatically establish constitutional liability.
The proper inquiry must therefore examine the entire healthcare chronology.

B. The Healthcare Chain

For analytical purposes, custodial healthcare can be represented as:

complaint → examination → diagnosis → treatment → referral → hospitalisation → follow-up → monitoring → emergency response → outcome.

Each stage represents a possible point of institutional responsibility.

A patient may be examined but not referred.

A referral may be issued but not completed.

A prescription may be made but medication may be interrupted.

A specialist may recommend follow-up but no mechanism may exist to ensure it.

An emergency may be recognised but transportation may be delayed.

Consequently, a constitutional review of custodial death should not be restricted to the final hours before death. It should examine the preceding healthcare trajectory.

C. Medical Neglect and Institutional Neglect

There is an important distinction between **clinical error** and **institutional failure**.

Doctors may make reasonable clinical decisions in difficult circumstances. Courts should not convert every adverse medical outcome into constitutional liability.

Institutional neglect is different.

It may include:

- failure to arrange a necessary referral;
- failure to provide prescribed medication;
- failure to act upon repeated complaints;
- failure to monitor a known condition;
- failure to respond to a medical emergency;
- failure to transfer a patient when clinically necessary; or
- failure to maintain continuity of care during prison transfer.

The constitutional inquiry should therefore focus upon whether the healthcare system as a whole discharged its obligation to protect life and dignity.

D. Documentation and Information Asymmetry

Custodial healthcare involves a serious information asymmetry.

The State controls the physical environment and generally controls the medical documentation generated inside the prison.

The prisoner may have limited ability to independently record symptoms, obtain medical opinions, preserve prescriptions, or document delays.

This makes contemporaneous medical records particularly important.

A reliable record should establish:

- the complaint;
- time of complaint;
- medical assessment;
- diagnosis or provisional diagnosis;
- treatment;
- medication;

- referral;
- specialist advice;
- hospitalisation;
- follow-up;
- transfer; and
- final outcome.

The record is therefore more than administrative documentation.
It is part of the institutional architecture of accountability.

4. CUSTODIAL DEATH AND THE EVOLVING JURISPRUDENCE OF CONSTITUTIONAL COMPENSATION

A. From Declaration to Effective Remedy

The evolution of constitutional compensation represents an important development in Indian public law.
In Rudul Sah v. State of Bihar, the Supreme Court demonstrated that a declaration of unlawful State action may be inadequate where fundamental rights have been seriously violated.[9] The constitutional court can grant monetary relief as an effective remedy.
In Nilabati Behera v. State of Orissa, the Court further developed public-law compensation in the context of custodial death.[10] The remedy is distinct from an ordinary civil action for damages. It is rooted in the constitutional obligation to protect fundamental rights.
The significance of this jurisprudence is that State accountability for custodial death is not confined to criminal prosecution or private damages.
Constitutional compensation can serve as a direct remedy for violation of Article 21.

B. D.K. Basu and Custodial Accountability

In D.K. Basu v. State of West Bengal, the Supreme Court established safeguards intended to prevent abuse and to strengthen accountability in custody.[11] The decision is important beyond its immediate factual context because it recognises that State custody creates a heightened duty of transparency.
The same logic applies to healthcare.
When the State controls the prisoner's medical access, it must maintain sufficient documentation to demonstrate that its obligations were discharged.

C. The Threshold for Compensation

Public-law compensation is not an automatic consequence of every custodial death.
In Sube Singh v. State of Haryana, the Supreme Court emphasised that compensation for constitutional violation is appropriate where the violation is established and sufficiently serious.[12]
The constitutional remedy therefore requires careful judicial assessment.
The court must determine:

1. whether a fundamental right was violated;
2. whether the violation is attributable to State action or omission;
3. whether the violation is sufficiently established;
4. whether public-law compensation is appropriate; and
5. whether other civil or criminal remedies remain available.

The purpose is not to impose strict liability for every death.
The purpose is to ensure that constitutional rights have an effective remedy when State responsibility is established.

D. The Evolution Continues

Recent Supreme Court jurisprudence continues to affirm that public-law compensation may be awarded for established violations of Article 21 in custodial contexts, while maintaining the requirement that the violation be sufficiently clear and serious.[13]
This evolution demonstrates an important shift:

from custody as a domain of administrative discretion to custody as a domain of constitutional accountability.
The next step should be to strengthen the evidence available for making that accountability meaningful.
That is where healthcare digitalisation becomes significant.

5. WHY DIGITALISATION MATTERS IN CUSTODIAL HEALTHCARE

Digitalisation should not be introduced into prison healthcare merely because electronic systems are technologically modern.
Its constitutional importance lies in its potential to address four structural weaknesses:
fragmentation, delay, information asymmetry, and lack of traceability.

A. Continuity of Care

A prisoner may move between a prison clinic, district hospital, specialist institution, and another prison.
Paper-based systems can result in incomplete information at each transition.
Digital records can provide continuity of clinically necessary information, including:

- chronic conditions;
- allergies;
- current medication;
- diagnostic reports;
- specialist recommendations;
- pending referrals; and
- follow-up requirements.

The objective is not unlimited information sharing.
It is continuity of medically necessary care.

B. Telemedicine

Telemedicine is especially significant in prisons because specialist consultation may be difficult to arrange.
The Ministry of Home Affairs issued an advisory on October 23, 2025 concerning the availability of telemedicine facilities for prison inmates. The advisory encourages prison authorities to establish telemedicine links with government hospitals and medical colleges and identifies timely medical access, continuity of care, and comprehensive medical records as relevant objectives.[14]
This is an important policy development.

Telemedicine can reduce the delay between the recognition of a medical problem and specialist consultation.
However, telemedicine cannot become a substitute for physical healthcare where physical examination, diagnostic investigation, hospitalisation, surgery, or emergency intervention is medically necessary.
A telemedicine consultation must therefore be connected to an effective referral pathway.

C. Digital Referral Tracking

Referral failure is one of the most important areas where digital systems can improve accountability.
A digital referral system can record:

- who made the referral;
- date and urgency;
- reason for referral;
- receiving hospital;
- appointment;
- consultation;
- treatment recommendation;
- follow-up requirement; and
- whether the referral was completed.

The key innovation is that a referral becomes **traceable**.
The system can identify cases in which a referral remains pending beyond a clinically reasonable period.
That converts information into preventive action.

D. Medication Continuity

Electronic medication records can also reduce avoidable treatment interruptions.
A system should record prescribing, dispensing, dosage, discontinuation, and changes in treatment.
For prisoners receiving long-term treatment, interruption can have serious consequences.
A digital alert system could notify healthcare staff when essential medication is due to expire or when a patient has missed scheduled treatment.

E. Transfers

A prison transfer should not become a medical discontinuity.
A digital health record can enable the receiving institution to access clinically necessary information.
This can be especially important where the prisoner has:

- a chronic disease;
- ongoing psychiatric treatment;
- specialist follow-up;
- a recent hospitalisation;
- pending diagnostic testing; or
- prescribed medication.

Digital continuity therefore serves a direct Article 21 function.

F. Prevention Rather Than Post-Mortem Accountability

The most important advantage of digitalisation is not that it can reconstruct what happened after death.
It is that it can help prevent death before it occurs.

Repeated complaints, missed follow-ups, medication interruptions, abnormal test results, and delayed referrals can be treated as warning signals.
A properly designed system can identify such patterns and trigger human medical review.
Digitalisation therefore allows a shift:
from retrospective accountability to preventive accountability.

6. DIGITAL HEALTHCARE GOVERNANCE AND THE FUTURE

A. From Digitisation to Governance

Digitising records is not the same as digital governance.
Digital governance begins when information is connected to responsibility.
A rights-based digital healthcare system should allow the institution to answer:
What happened?
When did it happen?
Who knew?
Who was responsible?
What action was taken?
Was follow-up completed?
These questions are relevant both to healthcare and constitutional accountability.

B. Constitutional Healthcare Auditing

This paper proposes the concept of **constitutional healthcare auditing**.
A conventional technology audit examines whether software functions correctly.
A constitutional healthcare audit should ask whether the system protects:

- life;
- dignity;
- equality;
- privacy;
- continuity of care;
- medical necessity;
- timely intervention; and
- access to effective remedy.

The audit should examine both individual cases and institutional patterns.

C. Digital Evidence After Custodial Death

Where a prisoner dies, digital records can permit reconstruction of the healthcare chronology.
The inquiry can examine:

- when the prisoner complained;
- when the prisoner was examined;
- what diagnosis was made;
- what treatment was prescribed;
- whether referral was initiated;
- whether the referral was completed;
- whether medication was supplied;

- whether symptoms deteriorated;
- whether emergency escalation occurred; and
- what happened immediately before death.

This can substantially improve the quality of constitutional review.
But digital records must not be treated as infallible.
A system can contain inaccurate, incomplete, or incorrectly entered information.
Digital evidence should therefore be subject to verification, medical interpretation, and independent review.

D. Institutional Learning

The greatest value of digital evidence may be institutional learning.
If several custodial deaths reveal similar patterns of delayed referral or interrupted treatment, the issue may not be individual negligence but systemic failure.
A digital governance system can aggregate appropriately anonymised information to identify such patterns.
The purpose is prevention.
A constitutional healthcare system should learn from death rather than merely investigate death.

E. The Role of e-Prisons and Technology

The Ministry of Home Affairs recognises prison administration as primarily a State/Union Territory responsibility while providing national guidance and support, including technology-driven initiatives. It has also developed the Model Prisons and Correctional Services Act, 2023 and maintains guidance on technology in prisons.[15]

This federal structure makes interoperability especially important.
A national digital framework should establish minimum standards while allowing States to adapt implementation to local conditions.

The future should therefore be neither entirely centralised nor completely fragmented.
It should be **interoperable, rights-based, and medically governed**.

7. PRIVACY, DATA PROTECTION, CYBERSECURITY AND AI

Digital healthcare also increases the informational power of the State.
That power requires constitutional restraint.
In Justice K.S. Puttaswamy (Retd.) v. Union of India, the Supreme Court recognised privacy as a fundamental right grounded in dignity, autonomy, and personal liberty.[16] Medical information is among the most sensitive forms of personal information.
The fact that an individual is incarcerated does not eliminate the right to privacy.

A. Purpose Limitation

Health information should be collected and used for legitimate healthcare and lawfully authorised purposes.
Medical information should not automatically become disciplinary or surveillance information.
The guiding principle should be:

necessary data + legitimate purpose + restricted access.

B. Digital Personal Data Protection Framework

The Digital Personal Data Protection Act, 2023 establishes a statutory framework for processing digital personal data and recognises both the right of individuals to protect personal data and the need for lawful processing.[17] The Digital Personal Data Protection Rules, 2025 were notified in November 2025, with provisions coming into force according to the staged commencement schedule.[18]

The prison-health system must therefore be designed consistently with the provisions applicable to the relevant processing.

However, statutory compliance should not be treated as exhausting the constitutional inquiry.

Privacy, dignity, proportionality, confidentiality, and necessity remain relevant.

C. Cybersecurity

A medical-data breach may expose a prisoner to stigma, discrimination, humiliation, or other harm.

Digital prison-health systems should therefore incorporate:

- role-based access;
- authentication;
- encryption;
- secure backups;
- audit logs;
- incident response;
- access monitoring; and
- secure recovery.

Cybersecurity is therefore part of the protection of Article 21 rather than merely an IT issue.

D. Audit Trails

One major advantage of digital systems is the possibility of recording access and modification.

An appropriately designed system should permit authorised review of:

- who accessed a record;
- when it was accessed;
- what information was modified; and
- where necessary, the basis for access.

This is particularly important following a serious medical incident or custodial death.

E. Artificial Intelligence

Artificial intelligence may eventually assist in identifying patterns of deterioration, prioritising medical review, or detecting missed follow-up.

But AI should remain a support mechanism.

It must not replace qualified medical judgment.

Automated systems can reproduce incomplete data, bias, and error.

A rights-based approach therefore requires:

- human oversight;
- explainability appropriate to the use;

- clinical validation;
- error monitoring;
- non-discrimination;
- review mechanisms; and
- a prohibition on purely automated consequential healthcare decisions.

F. Digital Surveillance

There is also a danger that digital healthcare systems become general surveillance systems.
The State already exercises exceptional control over prisoners.
Digitalisation should reduce vulnerability, not increase informational domination.
The system should therefore maintain a strict distinction between **healthcare information** and unrelated forms of institutional surveillance.

8. A RIGHTS-BASED MODEL OF DIGITAL CUSTODIAL HEALTHCARE

The paper proposes eight principles.

1. Constitutional Primacy

Digital systems must remain subordinate to Articles 14 and 21, dignity, equality, privacy, and effective remedies.

2. Medical Necessity

Data should be collected and processed only to the extent reasonably necessary for legitimate healthcare purposes or lawful functions.

3. Continuity of Care

Clinically necessary information should follow the prisoner through lawful transfers and healthcare transitions.

4. Referral Accountability

A significant referral should remain visible until the required medical intervention has occurred or an appropriate medical resolution has been documented.

5. Emergency Escalation

Serious medical risks must trigger immediate human attention and, where necessary, physical medical intervention.

6. Human Clinical Oversight

Telemedicine, analytics, and AI must assist—not replace—qualified medical judgment.

7. Privacy by Design

Confidentiality, access limitation, cybersecurity, and data minimisation should be built into the system from the beginning.

8. Accountability by Design

The system should allow authorised review to determine:

what happened, when it happened, who knew, who was responsible, what action was taken, and whether the required follow-up occurred.

These principles transform digitalisation from an administrative project into a constitutional governance mechanism.

9. RECOMMENDATIONS

The following reforms are proposed.

First, national minimum standards for prison digital healthcare should be developed, covering medical screening, electronic health records, medication, referral, telemedicine, emergency escalation, mental healthcare, transfer, and custodial-death review.

Second, digital health systems should be interoperable with relevant public hospitals and specialist institutions while preserving strict access controls.

Third, every prison should have a designated medical nodal officer responsible for coordinating digital healthcare, telemedicine, referrals, continuity of treatment, and record integrity.

Fourth, referral systems should contain escalation mechanisms for cases remaining unresolved beyond clinically appropriate timeframes.

Fifth, telemedicine should be expanded but never used to deny necessary physical examination, hospitalisation, or specialist treatment.

Sixth, medication systems should contain mechanisms for identifying interruptions in essential treatment.

Seventh, custodial transfers should trigger a structured digital medical handover.

Eighth, custodial deaths should be subjected to an independent healthcare review examining the full medical chronology rather than merely the immediate cause of death.

Ninth, digital records relevant to a serious medical incident should be preserved so that evidence is not lost, altered, or rendered inaccessible.

Tenth, constitutional healthcare audits should be conducted periodically, measuring not only technological performance but also timeliness, equality, dignity, continuity, privacy, referral completion, and outcomes.

Eleventh, aggregated and appropriately anonymised data should be used to identify systemic patterns of preventable healthcare failure.

Twelfth, prisoners must retain a meaningful human pathway for reporting illness. Digitalisation must not exclude prisoners with limited literacy, disability, language barriers, or limited technological familiarity.

Thirteenth, AI-assisted healthcare should remain subject to human clinical oversight, transparency, validation, and non-discrimination safeguards.

Fourteenth, privacy and cybersecurity standards should be treated as integral components of prison-health governance.

Fifteenth, the Union and State authorities should work towards a national custodial-health data standard that enables reliable collection of information on medical complaints, referrals, treatment interruptions, serious medical incidents, and custodial deaths.

Such a framework would address an important weakness demonstrated by the present data environment: the Government has acknowledged the absence of specific central data on custodial deaths of undertrial

prisoners.[19] Better data should not be viewed merely as statistical improvement. It is a prerequisite for prevention and accountability.

10. ORIGINAL CONTRIBUTION AND DISCUSSION

The existing discourse on prisoners' rights, custodial death, healthcare, and digitalisation is often fragmented.
Human-rights scholarship may focus on dignity and State violence.
Prison-reform literature may focus on overcrowding, staffing, infrastructure, and access to healthcare.
Constitutional jurisprudence may focus on compensation after a violation.
Digital-health literature may focus on telemedicine, electronic records, interoperability, and artificial intelligence.
This paper connects these domains through a single proposition:

The constitutional right to life in custody must be supported by a healthcare system capable of detecting need, delivering care, preserving continuity, documenting State action, and enabling accountability.

The paper's principal original contribution is therefore the concept of **digitalisation as preventive constitutional accountability**.
Digital technology can perform at least four constitutional functions.
First, it can make medical need visible.
Second, it can make institutional responsibility traceable.
Third, it can make healthcare continuity more reliable.
Fourth, it can create evidence capable of supporting independent review when harm occurs.
This is particularly significant in the context of undertrial prisoners because the State's responsibility cannot be understood solely through the fact of detention.
The State has imposed the restriction on liberty.
The State controls the environment.
The State controls access to healthcare.
The State therefore assumes a corresponding responsibility to ensure that the deprivation of liberty does not become an avoidable deprivation of life or health.
The concept may be expressed as:
custodial vulnerability → State control → positive healthcare obligation → digital traceability → preventive accountability.
Digitalisation should thus be judged by constitutional outcomes rather than technological sophistication.

11. CONCLUSION

Custodial death of an undertrial prisoner represents a profound constitutional concern because it occurs at the intersection of State power, individual vulnerability, healthcare dependence, and the right to life.
The fact that a prisoner dies in custody does not automatically establish constitutional liability. But the State's control over the conditions of detention creates a heightened obligation to ensure timely, adequate, and continuous healthcare.

For an undertrial prisoner, this obligation has an additional dimension. The individual has not been convicted and therefore cannot legitimately experience pre-trial detention as an additional form of punishment through avoidable medical suffering or neglect.

The jurisprudence of the Supreme Court provides a strong constitutional foundation. Sunil Batra establishes that imprisonment does not extinguish fundamental rights. Pt. Parmanand Katara and Paschim Banga emphasise the importance of timely medical care and positive State obligations. Rudul Sah and Nilabati Behera demonstrate that constitutional courts can provide monetary relief where fundamental rights are violated. D.K. Basu strengthens the principle of custodial transparency and accountability. Sube Singh clarifies that public-law compensation requires a sufficiently established and serious constitutional violation. Puttaswamy adds the indispensable dimension of privacy and informational dignity.

The next challenge is institutional.
The constitutional right to life becomes vulnerable when the system through which healthcare is delivered cannot identify medical need, respond promptly, maintain continuity, preserve records, or establish responsibility.
This is why digitalisation matters.
Digitalisation can connect:

medical complaint → assessment → treatment → referral → follow-up → escalation → outcome.
It can make an unresolved referral visible.
It can identify medication interruption.
It can support telemedicine.
It can preserve medical continuity during prison transfer.
It can create reliable evidence following a custodial death.

Most importantly, it can enable a shift from **retrospective accountability to preventive accountability**.
The Ministry of Home Affairs' recent emphasis on prison telemedicine, technology-driven prison administration, and the Model Prisons and Correctional Services Act demonstrates that digital and institutional reform is already becoming part of India's prison-governance landscape.[20]
But digitalisation is not inherently constitutional.

A digital record that records neglect without preventing it is insufficient.
A telemedicine platform that cannot lead to necessary physical treatment is insufficient.
A database that exposes sensitive medical information is potentially harmful.
An algorithm that replaces professional medical judgment may produce new forms of injustice.

The future therefore requires **rights-based digital healthcare governance**.
The proposed framework combines constitutional primacy, medical necessity, continuity of care, referral accountability, emergency escalation, human clinical oversight, privacy by design, cybersecurity, and accountability by design.
It also requires independent review of serious medical incidents and custodial deaths.
The ultimate purpose is not to make prisons more technologically sophisticated.

It is to make them more constitutionally accountable.

A prisoner should not have to become a constitutional litigant merely to obtain timely medical attention. A family should not have to reconstruct a deceased prisoner's medical history from fragmented institutional documents. A medically necessary referral should not disappear because responsibility is divided among prison authorities, hospitals, and administrative departments. And a custodial death should not become impossible to examine because the information necessary to understand the healthcare chain was never properly recorded.

The constitutional promise of Article 21 therefore demands more than a prohibition against direct State violence.

It demands a system capable of protecting life where the State has assumed control over the individual. Accordingly, the paper's central proposition is:

Digitalisation should not merely modernise custodial healthcare administration; it should make the State's constitutional healthcare obligations continuous, preventive, traceable, and accountable.

The future of custodial healthcare should ultimately be judged not by the sophistication of its software but by whether it makes avoidable medical harm harder to cause, easier to detect, and harder to conceal. The deprivation of liberty must never become a deprivation of timely, dignified, and accountable healthcare.

FOOTNOTES — BLUEBOOK 21ST EDITION

1. Sunil Batra v. Delhi Admin., (1978) 4 SCC 494; Sunil Batra v. Delhi Admin., (1980) 3 SCC 488.
2. Pt. Parmanand Katara v. Union of India, (1989) 4 SCC 286.
3. Paschim Banga Khet Mazdoor Samity v. State of W.B., (1996) 4 SCC 37.
4. Ministry of Home Affairs, Government of India, **Details of Undertrial and Convicted Prisoners as on 31 December 2023**, Lok Sabha Unstarred Question No. 5115, Annexure II (Mar. 24, 2026).
5. Ministry of Home Affairs, Government of India, **Undertrial Prisoners**, Lok Sabha Unstarred Question No. 3297 (Mar. 21, 2023) (stating that specific central data on custodial deaths of undertrial prisoners was not available).
6. Sunil Batra, (1978) 4 SCC 494; Sunil Batra, (1980) 3 SCC 488.
7. Paschim Banga, (1996) 4 SCC 37.
8. Pt. Parmanand Katara, (1989) 4 SCC 286.
9. Rudul Sah v. State of Bihar, (1983) 4 SCC 141.
10. Nilabati Behera v. State of Orissa, (1993) 2 SCC 746.
11. D.K. Basu v. State of W.B., (1997) 1 SCC 416.
12. Sube Singh v. State of Haryana, (2006) 3 SCC 178.
13. See, e.g., Sube Singh, (2006) 3 SCC 178; see also Supreme Court of India, Criminal Appeal arising out of SLP (Crl.) Nos. 13751–13752 of 2023, Judgment (July 21, 2025) (reaffirming that public-law compensation may be awarded for established and sufficiently serious Article 21 violations in custodial contexts).

14. Ministry of Home Affairs, Government of India, **Making Telemedicine Facilities Available for Prison Inmates**, No. V-17013/39/2025-PR (Oct. 23, 2025).
15. Ministry of Home Affairs, Government of India, **Prison Reforms**, noting that prison administration is a State/Union Territory responsibility and describing the Model Prisons and Correctional Services Act, 2023 and technology-driven prison initiatives.
16. Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1.
17. Digital Personal Data Protection Act, No. 22 of 2023, §§ 4–10, India Code.
18. Digital Personal Data Protection Rules, 2025, G.S.R. 843(E), Gazette of India, Nov. 13, 2025; Digital Personal Data Protection Act, 2023, § 1 (staged commencement notification).
19. Ministry of Home Affairs, Government of India, **Undertrial Prisoners**, Lok Sabha Unstarred Question No. 3297 (Mar. 21, 2023).
20. Ministry of Home Affairs, Government of India, **Prison Reforms**, supra note 15; Ministry of Home Affairs, Government of India, **Making Telemedicine Facilities Available for Prison Inmates**, supra note 14.