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FROM CUSTODY TO CARE: RETHINKING HEALTHCARE SYSTEMS TO ADDRESS POTENTIALLY PREVENTABLE CUSTODIAL DEATHS IN THE DIGITAL ERA

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Abstract

Custodial death raises an unusually demanding constitutional question because the person who dies has been living under the State's control. Most writing on the subject begins with torture, prison discipline, criminal liability, or compensation after death. Those issues remain central, but they do not fully account for deaths preceded by missed symptoms, interrupted medication, delayed referral, poor mental-health care, or a breakdown between a prison and a public hospital. This article approaches such cases as failures of constitutional healthcare governance, with particular attention to undertrial prisoners, who have not been convicted and who cannot arrange treatment for themselves. Article 21, on this account, requires the State to maintain a system that can notice illness, continue existing treatment, obtain specialist help, respond to emergencies, and keep records capable of independent scrutiny. The medical label assigned after death is relevant, but it cannot replace examination of the preceding course of care. Electronic records, telemedicine, referral tracking, and audit trails may make delay easier to detect, although none of them can remedy a shortage of clinicians, transport, medicines, or institutional concern. The article develops a Constitutional Healthcare Governance Doctrine (CHGD) from existing law. Its six concerns are dignity, continuity of care, responsible use of digital systems, institutional accountability, constitutional compensation, and institutional learning. The doctrine is meant to direct attention from the final event to the arrangements that either protected life or failed to do so.

Keywords: Custodial deaths; Undertrial prisoners; Article 21; Prison healthcare; Constitutional compensation; Healthcare governance; Digital health; Human dignity; Clinical independence; Universal Health Coverage.

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1. Introduction

A person who dies in custody does so in circumstances that differ materially from ordinary civilian life. Outside detention, an ill person may change doctors, ask relatives for help, buy medicine, travel to another hospital, or seek a second opinion. A detainee cannot normally do any of those things without permission and assistance. Once liberty is taken away, the ordinary means of protecting one's health are also restricted. The authority to confine must therefore be accompanied by responsibility for the basic conditions on which life and dignity depend.1

That relationship of dependence is why prison healthcare cannot be reduced to benevolence or administrative convenience. A prisoner cannot simply walk out of an ill-equipped clinic or arrange a specialist appointment when officials fail to act. A decision that looks routine on a file - whether to call a doctor, renew a prescription, provide transport, or carry out a referral - can decide whether a manageable condition becomes dangerous. Humane detention consequently includes a working route to medical care, not merely the formal existence of a prison dispensary.2

The constitutional basis for this duty lies in the development of Article 21. Its language once attracted a narrow, procedural reading, but later decisions treated life as more than biological survival and procedure as more than a valid order of detention. Dignity, bodily integrity, humane conditions, and fair treatment came within the provision's reach. That shift matters most where public power is concentrated. A prison sentence or remand order limits liberty; it does not cancel the prisoner's status as a constitutional person.3

Direct violence is only one route by which custody may end in death. Torture and assault demand a firm legal response, yet a detainee may also die after repeated complaints were dismissed, essential medicines were stopped, psychiatric symptoms were treated as indiscipline, or a hospital transfer came too late. In those cases the inquiry cannot stop at the absence of external injury. Nor should the expression 'natural death' be allowed to decide the legal issue. The immediate pathology and the adequacy of the State's response are separate questions, and both require evidence.4,5

1 INDIA CONST. art. 21; International Covenant on Civil and Political Rights art. 10(1), Dec. 16, 1966, 999 U.N.T.S. 171.

2 United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), G.A. Res. 70/175, annex, rules 24–27 (Dec. 17, 2015); Ministry of Home Affairs, Government of India, Model Prison Manual 2016, ch. VII.

3 Maneka Gandhi v. Union of India, (1978) 1 SCC 248; Francis Coralie Mullin v. Adm'r, Union Territory of Delhi, (1981) 1 SCC 608.

4 National Human Rights Commission, Understanding Health Care in Custody (2018); Nelson Mandela Rules, supra note 2, rules 30–35.

5 Sube Singh v. State of Haryana, (2006) 3 SCC 178; State of Punjab v. Ram Lubhaya Bagga, (1998) 4 SCC 117.

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Undertrial prisoners make this problem especially acute. They are confined before conviction, and their detention is intended to secure the criminal process, not to add punishment in advance of trial. Illness may of course arise during lawful detention, but avoidable deterioration cannot be treated as an ordinary incident of remand. The presumption of innocence does not create immunity from disease; it does reinforce the duty to ensure that a temporary loss of liberty is not converted into needless medical suffering.6

Legal discussion often places criminal responsibility, prison reform, public health, compensation, and digital policy in separate compartments. A serious custodial illness cuts across all of them. This article follows the patient's route through the institution: admission screening, continuation of earlier treatment, clinical examination, referral, mental-health care, emergency transfer, and review after a grave incident. Digital systems appear in the analysis because they may preserve that route, expose a missed step, or, if badly designed, widen surveillance while producing little actual care.7

I use the term Constitutional Healthcare Governance Doctrine to bring these connected duties into one frame. CHGD is not offered as a new fundamental right or as a judicially created medical code. It asks a more practical constitutional question: did the State organise custody in a manner reasonably capable of protecting life while respecting dignity, privacy, and independent clinical judgment? The framework is deliberately preventive. Its value lies in identifying weak points while a patient can still be treated, rather than explaining them only after death.8

The method is doctrinal but not exclusively case-centred. Constitutional decisions are read with prison standards, patient-safety literature, public-health administration, and current digital-health policy. This combination is necessary because no single source describes how a deteriorating prisoner actually moves from complaint to treatment. The argument remains modest in one respect: neither technology nor compensation can cure every institutional weakness. The task is to identify what follows from State control, what evidence should demonstrate compliance, and where legal remedies can prompt practical change.

6 Hussainara Khatoon (I) v. Home Sec'y, State of Bihar, (1980) 1 SCC 81; ICCPR, supra note 1, art. 10(2)(a).

7 Ministry of Health & Family Welfare, Government of India, National Digital Health Blueprint (2019); National Health Authority, Ayushman Bharat Digital Mission, Health Data Management Policy (2020).

8 See generally Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1; Paschim Banga Khet Mazdoor Samity v. State of W.B., (1996) 4 SCC 37; Nilabati Behera v. State of Orissa, (1993) 2 SCC 746.

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2. Custodial Mortality as a Healthcare Governance Problem

Custodial deaths are commonly examined backwards from the endpoint. Investigators look first at the post-mortem diagnosis, the last hours of detention, visible injuries, or the conduct of a named officer. These matters are indispensable, particularly where violence is suspected. They may nevertheless leave out the history that made the final event possible. A fatal infection, cardiac episode, suicide, or organ failure may have been preceded by inadequate screening, unavailable medicine, an unreviewed test result, a referral left in a register, or confusion over who had authority to send the patient to hospital.9

A healthcare-governance inquiry changes the object of scrutiny from a single act to the arrangement of care. It asks who receives a complaint, whether clinicians are available, how medicines are supplied, who can order transport, how referrals are followed, and whether medical judgment can operate without custodial pressure. In an open healthcare market a patient may sometimes avoid a failing provider. In prison there is no such exit. International principles of equivalent care and clinical independence therefore have particular force in a closed institution.10

The medical needs of people entering custody also make a crisis-only service inadequate. Many detainees arrive after periods of poverty, unstable housing, interrupted treatment, substance use, or limited access to preventive care. Chronic disease may be poorly controlled, and confinement itself can worsen anxiety, depression, or withdrawal. The system must begin with competent admission assessment, but it cannot end there. Long-term medicines, infectious-disease treatment, mental-health support, rehabilitation, and preparation for transfer or release are all part of the same course of care.11

It is important not to convert this argument into a claim that every custodial death was preventable. Medicine does not promise survival, and constitutional liability cannot be inferred from outcome alone. The more defensible test is whether, in the circumstances known at the time, the institution offered a reasonable opportunity for protection. That assessment requires a chronology: what symptoms were reported, what findings were recorded, which possibilities were considered, what treatment was ordered, whether it was actually delivered, and how staff

9 National Human Rights Commission, Guidelines—Death in Custody/Encounter, including reporting, post-mortem, videography, and magisterial-enquiry requirements.

10 Nelson Mandela Rules, supra note 2, rules 24–27 (requiring health-care services, clinical independence, and equivalence of care).

11 Ministry of Home Affairs, Model Prison Manual 2016, ch. VII; Mental Healthcare Act, No. 10 of 2017, §§ 18, 103, INDIA CODE.

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responded when the condition changed.12,13

The chronology is difficult to reconstruct because most of the evidence is held by the State. A prisoner may not keep prescriptions, obtain copies of test results, or record the time at which help was requested. Medical and administrative records should therefore show the complaint, assessment, treatment, medicine supply, referral, hospital attendance, specialist advice, follow-up, transfer, and outcome. A record is not beyond challenge; entries can be incomplete, late, or inconsistent with what happened. Even so, an institution that cannot produce a credible account of care has a serious accountability problem.14

Poor documentation harms the patient before it harms the later inquiry. The next clinician may not know that symptoms are worsening, that a medicine was stopped, or that a specialist wanted urgent review. After death, the same gaps may prevent the family from testing the official explanation. A sound system should allow information to be entered promptly, corrected transparently, preserved after a serious incident, and made available to an authorised independent reviewer. In custody, record keeping is part of treatment as well as proof.

A systems approach must also distinguish clinical judgment from institutional neglect. Doctors often make difficult choices with incomplete information, and a reasonable decision that later proves wrong is not automatically a constitutional tort. Institutional failure has a different character. It may involve the absence of any clinician, non-supply of prescribed medicine, a referral that no one executes, denial of a necessary transfer, inadequate suicide precautions, or loss of treatment during movement between facilities. Individual fault remains relevant, but recurring failures point to defects that discipline alone will not cure.15

This distinction is familiar in patient-safety work, where serious harm is often traced to several smaller breakdowns rather than one spectacular mistake. An incomplete handover, a result that reaches no doctor, an unavailable vehicle, and uncertainty over who must telephone the hospital may combine into a fatal delay. Looking at the sequence does not excuse deliberate or reckless conduct. It reveals how an institution can continue producing risk even after one employee has been blamed.

Continuity of care is a useful way to test the system because custody involves repeated

12 World Health Organization, Patient Safety (2023); World Health Organization, Patient Safety Incident Reporting and Learning Systems: Technical Report and Guidance (2020).

13 Nelson Mandela Rules, supra note 2, rules 30–31; Ministry of Home Affairs, Model Prison Manual 2016, ch. VII.

14 Nelson Mandela Rules, supra note 2, rule 26; National Human Rights Commission, Guidelines—Death in Custody/Encounter.

15 Nelson Mandela Rules, supra note 2, rules 27 and 32; Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

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transitions. A person may move from a police station to a prison, from one prison to another, and between prison and hospital. At each point, medical history, prescriptions, pending investigations, and specialist advice can disappear. Continuity requires both information and responsibility to travel with the patient. Digital tools may help with the first, but they are of little value if medicines, clinicians, transport, and referral agreements are absent. Custodial mortality should accordingly prompt examination of whether the surrounding system could recognise vulnerability early enough to act.16

3. Constitutional Foundations of Custodial Healthcare: Reimagining Article 21 in the Digital Era

Custodial healthcare rests on the broader constitutional movement from formal legality to life with dignity. Maneka Gandhi required procedure affecting liberty to be fair, while Francis Coralie Mullin treated life as including conditions necessary for human dignity. In prison these propositions are not abstract. The State controls the person's surroundings and, in practice, the route to medical assistance. A duty that may be shared among several actors in ordinary life becomes more concentrated once the patient is confined.17

Positive obligation should not be misunderstood as a guarantee that illness will never occur. It requires reasonable preparation for foreseeable needs among the population the State chooses to confine. Admission screening, access to essential medicines, staff who can recognise an emergency, mental-health precautions, and a workable connection to public hospitals are not luxurious additions. They are the arrangements through which lawful detention avoids becoming exposure to preventable injury.

The prison cases give this duty a specific constitutional setting. In Sunil Batra, the Supreme Court rejected the idea that the prison gate marks the end of fundamental rights. Confinement authorises restrictions that follow from lawful custody, but not degradation or arbitrary suffering. Applied to healthcare, the point is straightforward: treatment must be determined by medical need, and discipline cannot be used to explain away a delay that places life or serious health at risk.18

Pt. Parmanand Katara and Paschim Banga supply the medical dimension. The first insisted that preservation of life should not be postponed by procedural hesitation. The second treated timely

16 Nelson Mandela Rules, supra note 2, rule 24(2); National Digital Health Blueprint, supra note 7.
17 Maneka Gandhi, (1978) 1 SCC 248; Francis Coralie Mullin, (1981) 1 SCC 608.
18 Sunil Batra v. Delhi Admin., (1978) 4 SCC 494; Sunil Batra v. Delhi Admin., (1980) 3 SCC 488.

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access to public medical facilities as part of Article 21. Paschim Banga did not concern a prison, but its reasoning has greater practical force where the patient cannot approach another hospital. Custodial care must include a path from complaint to assessment, treatment, referral, and emergency intervention, rather than a promise that treatment exists somewhere outside the institution.19

Emergency protection depends on arrangements made before a crisis. Staff must know how to recognise danger, reach a clinician, stabilise the patient, obtain transport, secure hospital admission, and pass relevant information to the receiving team. Authority cannot remain unclear until symptoms become critical. Security procedures are necessary, but permission, escort availability, or disputes over payment should not become reasons for delay when life or serious health is threatened.

Article 21 does not demand a fully equipped tertiary hospital inside every prison, nor does it dictate a particular clinical result. Resource choices and professional judgment remain legitimate considerations. Ram Lubhaya Bagga acknowledges that health policy involves allocation, but scarcity cannot operate as a general defence to a foreseeable and serious risk. The minimum obligation is organisational: use available resources rationally, maintain essential services, and provide a realistic route to the wider public-health system when the prison clinic cannot meet the need.20

The undertrial's status adds another limit on State action. Detention before conviction is not a sentence, so its practical conditions should not become punitive. Repeated court production, transfer, or uncertainty about the period of remand must not interrupt chronic treatment or psychiatric care. Decisions should follow clinical need, not assumptions about the person's alleged offence or custodial category. healthcare equality gives concrete effect to the presumption of innocence.

Clinical independence is central to the arrangement. Prison doctors must cooperate with security personnel, yet medical conclusions cannot be subordinated to convenience or discipline. Whether a patient requires referral, hospitalisation, confidential consultation, release from restraint, or emergency treatment is primarily a professional question. International prison-health standards and medical ethics protect this space because the dependent patient has little ability to resist institutional pressure.21

19 Pt. Parmanand Katara v. Union of India, (1989) 4 SCC 286; Paschim Banga, (1996) 4 SCC 37.

20 State of Punjab v. Ram Lubhaya Bagga, (1998) 4 SCC 117 (recognising the right to health while acknowledging legitimate questions of public resources and policy).

21 Nelson Mandela Rules, supra note 2, rules 27 and 32; Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

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The remedial cases add another part to the constitutional account. Rudul Sah, Nilabati Behera, and D.K. Basu show that a constitutional court may grant public-law compensation for a serious and established violation of life or liberty. Such relief is different from prosecution or a civil damages claim: it addresses the breach by public authority itself. In a healthcare-related death, however, the award must rest on proof of a grave failure in the custodial duty of care, not simply on the fact that the person died while detained.

Digital care introduces a second side of Article 21. Better records may improve treatment and make public action more visible, but medical information is intimate. Puttaswamy, the Digital Personal Data Protection Act, and the 2025 Rules require attention to purpose, access, security, and proportionality. The constitutional inquiry is therefore double-edged: did the prisoner obtain necessary care, and was sensitive information handled in a manner consistent with privacy and dignity? A system that improves continuity by exposing a patient's entire medical history to unrelated custodial staff would solve one problem by creating another.22

4. Digital Health Governance and Continuity of Care in Correctional Institutions

Custodial healthcare is fragmented across police facilities, prisons, government hospitals, mental-health institutions, and courts. Each movement can separate the patient from diagnoses, prescriptions, test results, and follow-up instructions. The National Digital Health Blueprint and the Ayushman Bharat Digital Mission offer useful ideas about interoperability and controlled exchange, although those ideas require careful adaptation to an environment where consent is constrained and the same institution exercises both care and coercive power.23

An electronic record should carry the limited information needed for treatment when the prisoner moves: chronic conditions, allergies, current medicines, recent investigations, specialist advice, pending referrals, and clinically significant mental-health risk. Its purpose is continuity, not general institutional visibility. The e-Prisons framework and the Model Prisons and Correctional Services Act provide an administrative base on which stronger health functions might be built, but medical records should not simply become another searchable

22 Justice K.S. Puttaswamy (Retd.), (2017) 10 SCC 1; Digital Personal Data Protection Act, No. 22 of 2023, INDIA CODE; Digital Personal Data Protection Rules, 2025, G.S.R. 846(E), Gazette of India, Nov. 13, 2025.

23 Ministry of Health & Family Welfare, National Digital Health Blueprint (2019); National Health Authority, Ayushman Bharat Digital Mission, Health Data Management Policy (2020).

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field in a security database.24,25

Medication is a practical test of whether continuity works. A useful system records what was prescribed, what was dispensed, changes in dosage, the expected duration, and clinically important missed doses. Transfer should trigger a medical handover and enough essential medicine to bridge the period before the receiving institution takes over. This matters particularly for tuberculosis, HIV, epilepsy, diabetes, hypertension, and psychiatric treatment, where an apparently short interruption may carry disproportionate risk.

Telemedicine can reduce the distance between a remote prison and specialist advice. The Home Ministry's 2025 advisory and the national telemedicine guidelines make structured links with government hospitals and medical colleges possible. Remote review may be valuable for psychiatry, neurology, infectious disease, and follow-up. It cannot substitute for physical examination, imaging, laboratory work, surgery, or urgent hospital transfer when those are clinically required. A video consultation has constitutional value only if its recommendation leads to actual care.26

Referral tracking deals with a less visible but common failure: advice is given, yet the patient never reaches the next stage. A digital referral should remain unresolved until the receiving facility accepts the case, the appointment takes place, advice is returned, and required follow-up is completed. An urgent case that remains pending should trigger human escalation to a clinician and a responsible administrator. The record should show where delay occurred, but an automated priority score must never displace clinical judgment.27

Privacy and cybersecurity are part of the same design, not a technical appendix. Prison medical records may disclose mental illness, disability, communicable disease, reproductive history, substance dependence, or experiences of violence. Wider access can lead to stigma, disciplinary misuse, or personal harm. Role-based permissions, reliable authentication, encryption, correction procedures, audit histories, retention limits, secure backup, and a credible breach response are therefore elements of lawful care. The prisoner's dependence on

24 Ministry of Home Affairs, Model Prisons and Correctional Services Act, 2023, § 18; Ministry of Home Affairs, Technical Guidelines for Implementation of the e-Prisons Project (2018).

25 Ayushman Bharat Digital Mission, Health Data Management Policy (2020); Nelson Mandela Rules, supra note 2, rule 26.

26 Ministry of Home Affairs, Making Telemedicine Facilities Available for Prison Inmates, No. V-17013/39/2025-PR (Oct. 23, 2025); Board of Governors in Supersession of the Medical Council of India, Telemedicine Practice Guidelines (2020).

27 World Health Organization, Ethics and Governance of Artificial Intelligence for Health (2021).

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the institution makes weak safeguards more, not less, serious.28,29

After a grave incident, digital records can help reconstruct when symptoms were reported, what treatment was ordered, whether medicines were supplied, and how a referral progressed. They do not establish adequate care merely because a box was completed. Investigators must compare the record with clinical findings, testimony, hospital material, and the physical realities of the institution. Independent death review and the magisterial process remain necessary, especially where entries are incomplete, inconsistent, or disputed.30

Integrity of the record requires protection against quiet alteration. A sound system retains earlier versions, identifies who entered or changed information, and preserves relevant data once a serious incident occurs. Oversight access should follow lawful procedures and avoid exposing unrelated confidential material. These protections serve both sides of a later inquiry: the family can test the institutional account, while clinicians and staff are assessed against a stable record rather than an allegation reconstructed without reliable evidence.

Artificial intelligence may eventually assist by drawing attention to a missed appointment, repeated abnormal results, or an interruption in medicine. That role should remain limited and supportive. Models trained on incomplete or biased prison data may reproduce the very failures they are meant to detect. Validation, identifiable human responsibility, monitoring for error, and an explanation proportionate to the consequence are essential. No treatment, denial of treatment, or emergency decision should rest solely on an automated output. Digitalisation is justified only when it increases the chance of receiving care rather than the reach of surveillance.

5. Constitutional Accountability and Compensatory Jurisprudence: From Monetary Relief to Systemic Healthcare Reform

Constitutional compensation developed because ordinary mechanisms do not always answer a violation committed inside a State-controlled institution. Criminal proceedings address culpability, departmental action addresses service discipline, and civil litigation may provide damages, but each can be slow or ill-suited to an immediate constitutional wrong. Rudul Sah, Nilabati Behera, and D.K. Basu confirm that a constitutional court may award monetary relief

28 Justice K.S. Puttaswamy (Retd.), (2017) 10 SCC 1; Digital Personal Data Protection Act, 2023; Ayushman Bharat Digital Mission, Health Data Management Policy (2020).

29 Digital Personal Data Protection Act, 2023, § 8; Digital Personal Data Protection Rules, 2025, G.S.R. 846(E).

30 National Human Rights Commission, Guidelines—Death in Custody/Encounter; National Human Rights Commission, Guidelines Regarding Conducting of Magisterial Enquiry in Cases of Death in Custody or in the Course of Police Action.

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where infringement of a fundamental right is clearly established. The award vindicates the right without replacing other lawful proceedings.31,32

These remedies have different purposes and should remain distinct. A compensation order does not excuse an official from prosecution, and it should not prevent the family from pursuing a civil claim where one is available. Conversely, acquittal in a criminal case does not necessarily answer whether the State failed in a public-law duty, because the standards and purposes differ. A single custodial death may therefore require several forms of accountability operating in parallel.

Healthcare-related death calls for restraint as well as responsiveness in the exercise of this jurisdiction. Custody and death, without more, do not prove a constitutional breach. The court must identify the duty, reconstruct the course of care, decide whether State action or omission materially denied a reasonable opportunity for treatment, and determine whether the failure was sufficiently serious. Sube Singh warns against awarding public-law compensation on a doubtful factual foundation while preserving the remedy for proved custodial violations.33

The medical classification should not dominate that inquiry. A death from disease may still disclose a constitutional failure if repeated symptoms went unanswered, prescribed medicine was unavailable, a referral was never carried out, or emergency transport was unreasonably delayed. The reverse is equally important: a severe illness may prove fatal despite timely and competent care. Public-law compensation should follow a demonstrated breach of duty, not a rule of automatic State liability for every death in custody.

Causation will often be contested because clinical and administrative failures can overlap. Courts need not claim impossible certainty, but they should insist on evidence showing that the omission materially reduced the opportunity for treatment or survival. Expert opinion, contemporaneous notes, referral history, medicine records, and proof of ordinary institutional practice may all be relevant. The importance of Article 21 is a reason for careful fact-finding, not a reason to dispense with it.

Money matters to a bereaved family, but payment cannot by itself repair the system that produced the injury. In re Inhuman Conditions in 1382 Prisons illustrates that rights adjudication may be accompanied by directions concerning prison administration. Where the evidence reveals a recurring defect - insufficient clinical staff, absent psychiatric support,

31 Rudul Sah, (1983) 4 SCC 141; Nilabati Behera, (1993) 2 SCC 746; D.K. Basu, (1997) 1 SCC 416.

32 Nilabati Behera, (1993) 2 SCC 746 (distinguishing public-law compensation for fundamental-rights violations from private-law damages).

33 Sube Singh, (2006) 3 SCC 178.

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unreliable referral, or poor records - a proportionate order may require correction and reporting. The remedy should be tied to the failure proved in the case rather than expanding into permanent judicial management.34

Digital information can support that structural task by revealing patterns that are difficult to see in isolated files. Protected aggregate data may show repeated referral delay, missed medication, or recurring failure in emergency transfer. Patient-safety methods favour multidisciplinary review that identifies clinical and administrative causes, assigns corrective action, and later checks whether change occurred. The process should promote learning without using the language of systems failure to hide deliberate neglect or individual misconduct.35,36

Constitutional compensation is best understood as one part of structural justice. It recognises the individual injury and the State's responsibility, while leaving space for prosecution, professional discipline, civil claims, and institutional reform. Courts should remain attentive to competence: they can require a lawful and accountable system without prescribing each clinical decision. The strongest remedy combines immediate relief with targeted correction of the weakness demonstrated by the evidence.

6. Constitutional Healthcare Governance Doctrine (CHGD): A Normative Framework for Preventing Potentially Preventable Custodial Deaths

Prisoners' rights, medical care, privacy, compensation, and patient safety are already recognised in Indian law and relevant standards, but they are usually discussed in separate fields. The Constitutional Healthcare Governance Doctrine brings them together as a way of asking whether custodial institutions are capable of protecting life before harm becomes irreversible. It is not a free-standing right and does not depend on inventing a new constitutional text. Its foundation remains Article 21, prison law, medical ethics, and public-health governance.37

CHGD is not meant to turn every disagreement over diagnosis or treatment into constitutional litigation. Nor does it impose one clinical protocol on institutions with different capacities. The doctrine becomes relevant because the patient is dependent on the State and cannot correct a

34 In re Inhuman Conditions in 1382 Prisons, W.P. (C) No. 406 of 2013, orders dated Feb. 5, 2016, Oct. 3, 2016, and Sept. 15, 2017 (Supreme Court of India).

35 World Health Organization, Patient Safety Incident Reporting and Learning Systems (2020); National Human Rights Commission, Guidelines—Death in Custody/Encounter.

36 World Health Organization, Patient Safety (2023) (emphasising systems-based analysis and learning from adverse events).

37 Ministry of Home Affairs, Model Prison Manual 2016; Ministry of Home Affairs, Model Prisons and Correctional Services Act, 2023.

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failing arrangement by leaving it. Its application should remain sensitive to medical evidence, foreseeability, available resources, and what officials reasonably knew at the time. Hindsight should not become a substitute for proof.

Its first concern is dignity. A prisoner is a patient and a person, not merely an object of administration. Treatment should respond to medical need, seek consent as far as circumstances allow, preserve confidentiality, and avoid discrimination. The point has special force for undertrial detainees, whose confinement precedes conviction. Conditions of remand cannot legitimately add avoidable medical suffering to a restriction imposed only for the purposes of criminal procedure.38

The second concern is continuity. Responsibility begins when the person enters custody and does not disappear at a prison gate, hospital door, transfer order, or release date. Screening, medication, investigations, referral, mental-health support, emergency care, and handover form one course of treatment. A significant referral should remain visible until a clinician records completion or a reasoned resolution, and essential treatment should follow the patient through each lawful movement.39

The third concern is responsible digital governance. A system should have a defined healthcare purpose, gather no more information than that purpose requires, restrict access, protect the data, and leave an auditable record. Telemedicine and decision-support software may assist clinicians; they should not replace them. An application that works efficiently while exposing confidential information or feeding general surveillance would fail the doctrine even if its technical performance were excellent.40

The fourth concern is institutional accountability. Personal misconduct and negligent clinical practice must have consequences, but a serious review also asks about staffing, medicine supply, transport, emergency planning, hospital agreements, communication, and record integrity. The fifth concern is compensation as structural justice. Public-law relief should recognise the wrong done to the individual and, where the evidence supports it, prompt correction of the institutional condition that allowed the wrong to occur.

The sixth concern is learning. Deaths, attempted suicides, medication errors, and delayed transfers should generate a root-cause review rather than a file that closes after responsibility is nominally fixed. Corrective action must be assigned to an identifiable authority and checked

38 Sunil Batra, (1978) 4 SCC 494; Sunil Batra, (1980) 3 SCC 488; Nelson Mandela Rules, supra note 2, rule 1.

39 Nelson Mandela Rules, supra note 2, rule 24(2); Ministry of Home Affairs, Model Prison Manual 2016, ch. VII.

40 Justice K.S. Puttaswamy (Retd.), (2017) 10 SCC 1; Digital Personal Data Protection Act, 2023; Ayushman Bharat Digital Mission, Health Data Management Policy (2020).

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after implementation. Patient-safety guidance supports learning from adverse events, but learning cannot mean impunity. Deliberate, reckless, or dishonest conduct remains subject to personal accountability.41

These concerns need to be considered together. Continuity without confidentiality may become surveillance; digital records without clinicians may merely document neglect; compensation without institutional learning may end the case while leaving its cause untouched. CHGD therefore asks connected questions: was vulnerability recognised, did care continue across transitions, did technology assist treatment, was responsibility allocated, was the injury effectively remedied, and did the institution change after failure? That combination is the doctrine's practical contribution.

Used prospectively, the framework can inform legislation, inspections, hospital agreements, procurement, and budget choices. Used after a death, it can help distinguish a tragic outcome following appropriate care from harm linked to an avoidable institutional breakdown. This dual use also sets a limit: the doctrine links adjudication with administration, but it does not invite courts to become clinicians or prison superintendents.

7. Policy and Regulatory Roadmap: Operationalising Constitutional Healthcare Governance in Custodial Institutions

Constitutional principle has to be reflected in routines that work in ordinary prison administration. A judgment cannot supply a medicine, execute a referral, or place an ill prisoner in an ambulance. Reform must connect prison administration with public hospitals, professional standards, digital infrastructure, and independent review. The Model Prison Manual and the Model Prisons and Correctional Services Act offer a starting point, but prisons remain primarily a State responsibility, making common minimum standards and local implementation equally important.

Federalism does not require either complete uniformity or complete fragmentation. The Union can frame model standards, common data definitions, technical guidance, and financial support. States can adapt delivery to their prison network and public-health capacity. A national floor should specify the result to be achieved without requiring every institution to purchase the same software or follow an identical operational model. Comparable indicators published at intervals would make performance visible while preserving this division of responsibility.

Prison clinics should be linked to government hospitals, medical colleges, mental-health

41 World Health Organization, Patient Safety Incident Reporting and Learning Systems (2020).

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institutions, and community services rather than treated as a separate health system. No prison can provide every investigation or specialist service. Formal agreements should state who secures appointments, transport, escorts, emergency admission, clinical communication, and follow-up. Equivalence of care means that entering custody must not sever a patient from medically necessary services that the public system is capable of providing.42

National and State standards should cover admission assessment, chronic and communicable disease, essential medicines, disability, emergencies, mental health, specialist referral, transfer, release, and review of serious incidents. Standards should contain measurable minimums but leave room for clinical judgment. Undertrial prisoners need an explicit handover rule because court production and frequent transfer can interrupt treatment. Every movement should carry essential medical information, current medication, and responsibility for pending care.43

A digital continuity system should allow authorised clinicians in prisons and linked hospitals to retrieve the information necessary for care. Implementation should be phased and should retain workable paper procedures during outages. Referral records should show acceptance, appointment, attendance, advice, and follow-up, with human escalation where an urgent case remains unresolved. Privacy-by-design, role-based access, correction, audit history, retention control, and cybersecurity must be part of the system from the beginning, rather than being introduced only after a breach.

Telemedicine should be expanded where it actually improves specialist access, especially in remote institutions. Protocols should deal with consent, confidentiality, documentation, clinical responsibility, follow-up, and the circumstances in which physical transfer is compulsory. Remote advice is an additional doorway into care; it is and should not be used to avoid examination, diagnostics, surgery, or hospitalisation. A designated prison medical officer should remain accountable for turning the specialist's recommendation into treatment.

Mental healthcare requires its own capacity and cannot be left as an afterthought to physical illness. Admission assessment should identify acute risk, substance withdrawal, earlier treatment, and vulnerability to self-harm. Screening must lead to counselling, psychiatric review, medicine, suicide-prevention measures, and continuity after transfer or release. Telepsychiatry may extend access, but therapeutic contact, confidentiality, and accountable professional judgment remain essential. Custodial staff also need training to recognise crisis rather than treating its symptoms as simple misconduct.44

42 Nelson Mandela Rules, supra note 2, rule 24(1)–(2) (equivalence and continuity of care).

43 Ministry of Home Affairs, Model Prison Manual 2016, ch. VII; Mental Healthcare Act, 2017, §§ 18, 103.

44 Mental Healthcare Act, 2017, §§ 18, 103; Ministry of Home Affairs, Advisory on Dealing with Mental Health

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Every custodial death, and every other grave medical incident, should lead to an independent multidisciplinary review of the whole course of care. The review should not stop at the immediate cause. It should examine admission screening, complaints, treatment, medicine supply, referral, emergency response, records, staffing, and communication, and should identify corrective action with a timetable. Existing NHRC reporting and magisterial-enquiry procedures can be strengthened by making this healthcare-governance analysis an express part of the inquiry.45

Institutional culture matters as much as written procedure. Prison officers, clinicians, police personnel, and administrators should train together on constitutional duties, emergencies, confidentiality, mental-health crises, and the boundary between security and clinical judgment. Public-health emergency plans must include prisons in surveillance for disease, vaccination, essential supplies, isolation, referral, and disaster response. Periodic audits should measure delay, continuity, privacy, equality, completed referral, and outcomes rather than merely counting equipment or software licences.

Training is ineffective unless staff have clear authority to act. An officer who fears punishment for arranging an outside hospital visit may wait too long; a doctor who cannot speak directly to the decision-maker may be unable to escalate risk. Institutions should name medical nodal officers, define urgent escalation channels, and protect good-faith reporting of safety concerns. Families and legal representatives should also have a workable route for supplying verified medical information and drawing attention to urgent deterioration.

Courts and oversight bodies should match the remedy to the proved failure. Where evidence shows a systemic defect, compensation may be accompanied by directions on staffing, referral, mental-health care, records, or independent monitoring. Day-to-day compliance should return to competent prison and health authorities, but subject to transparent reporting and review. The object is not judicial administration of prisons. It is an arrangement in which responsibility is identifiable, performance can be tested, and a recurring failure cannot remain hidden behind institutional boundaries.

Issues of Prisoners and Prison Officers (June 24, 2021).

45 National Human Rights Commission, Guidelines—Death in Custody/Encounter; National Human Rights Commission, Guidelines Regarding Conducting of Magisterial Enquiry in Cases of Death in Custody or in the Course of Police Action.

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8. Conclusion: From Custody to Care

Custodial mortality cannot be explained solely by violence, criminal fault, or the final medical diagnosis. Because the State controls a detainee's practical access to treatment, the constitutional inquiry must consider whether illness was noticed, medicine continued, referral completed, deterioration answered, and care preserved across transitions. A death in custody does not, by itself, establish liability. At the same time, describing a death as 'natural' does not answer the separate question of whether the State met its Article 21 obligations.

The existing cases provide a useful, though measured, foundation for this approach. Sunil Batra rejects the loss of rights at the prison gate. Pt. Parmanand Katara and Paschim Banga place timely treatment within the protection of life. Nilabati Behera, D.K. Basu, and Sube Singh define both the availability and the limits of public-law compensation, while Puttaswamy protects informational dignity. Read together, they require the State to organise custody so that a person under its exclusive control has a reasonable and real opportunity to receive life-preserving care.

Digital health can support that obligation by carrying clinical history across institutions, showing an unresolved referral, enabling specialist advice, and preserving evidence for review. It cannot replace doctors, medicines, transport, hospitals, or independent judgment. A digital record that merely captures neglect, without prompting a response, does little to advance constitutional healthcare. Nor is a system legitimate if continuity is purchased by exposing sensitive medical information to unnecessary access. Technology should support care, while decisions about treatment and access remain subject to privacy safeguards and human accountability.

CHGD draws these ideas together through six linked concerns: dignity, continuity, responsible digital governance, institutional accountability, compensation, and learning. The framework does not assume that every custodial death can be prevented. It asks institutions to make warning signs harder to ignore, treatment harder to interrupt, responsibility harder to obscure, and repeated failure more likely to result in reform. Its orientation is preventive, but its conclusions remain dependent on evidence in the individual case.

The movement from custody to care is ultimately a different understanding of State authority. Security is indispensable, yet lawful control creates duties towards those least able to protect themselves. The duty is especially compelling for undertrial prisoners, who have not been convicted and whose detention should not acquire a punitive character through ignored illness or broken treatment. Protecting health is not separate from lawful custody; it is one of the conditions that make custody constitutionally defensible.

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Custodial healthcare should ultimately be assessed by how the system responds when someone becomes ill. The sophistication of its software or the length of its manual is secondary to that practical response. A constitutionally adequate institution preserves dignity, gives timely access to appropriate treatment, records decisions honestly, and learns when care fails. The goal is not simply to document death more efficiently. The more important question is whether the system responds to medical need while intervention can still protect life.

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