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Police-Custody Deaths in India, 2021-2026: A Secondary-Data Analysis of Trends, State Variation and Human-Rights Governance

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Abstract

This paper analyses official data on cases registered in respect of deaths in police custody in India from 2021-22 to 2025-26. The source is the Ministry of Home Affairs response to Lok Sabha Unstarred Question No. 5115, answered on 24 March 2026. The national totals were 176, 163, 157, 140 and 170 respectively, with the final figure covering the period up to 15 March 2026. Across the five reporting periods, 806 cases were recorded. The paper uses descriptive trend analysis and state-level aggregation to examine temporal change and geographical concentration. Maharashtra recorded the highest five-period total, followed by Bihar, Gujarat, Rajasthan and Uttar Pradesh. The analysis is intentionally cautious: a death in police custody is not automatically proof of police brutality, because deaths may arise from illness, suicide, injury or other causes. Nevertheless, every custodial death engages a heightened state duty of care, documentation, independent inquiry and public explanation. The paper argues that official counts are most useful when integrated with population, arrest, custody-volume, medical, inquiry and accountability data. It recommends standardised definitions, timely publication, independent preservation of evidence, stronger oversight and state-level risk indicators. The findings show that apparent national improvement through 2024-25 was not sustained in the nearly complete 2025-26 period, making continued monitoring essential.

Keywords: Custodial deaths, police custody, human rights, secondary data, police accountability, India

1. Introduction

Deaths in police custody are among the most serious events recorded within a criminal-justice system. The detained person is under substantial state control, cannot freely seek medical assistance and may depend on police personnel for safety, communication and access to legal representation. A death in this setting therefore requires more than routine administrative explanation. It demands prompt preservation of evidence, independent medical and legal scrutiny, notification to oversight bodies and transparent follow-up. These duties arise whether the eventual cause is unlawful violence, illness, self-harm, accident or another factor.

Public discussion often treats every custodial death as proof of torture or brutality. That conclusion is not methodologically or legally justified without case-specific evidence. At the same time, it would be equally mistaken to treat official counts as neutral events with no human-rights significance. Custodial death data provide an important indicator of institutional risk. Trends can reveal whether preventive safeguards appear to be improving, whether particular states repeatedly record high numbers, and whether reporting systems are sufficiently consistent to support comparison. This paper examines the most recent consolidated figures presented by the Government of India in March 2026. The data cover cases registered in respect of deaths in police custody from 2021-22 to 2025-26, with the last period reported up to 15 March 2026. The study has four objectives: to describe the national trend; to identify states and Union Territories with the highest cumulative totals; to explain the interpretive limitations of raw counts; and to propose a human-rights data framework capable of supporting prevention and accountability.

2. Custodial Deaths as a Human-Rights Governance Issue

Article 21 of the Constitution protects life and personal liberty, while Articles 20(3) and 22 provide safeguards against compelled self-incrimination and unlawful detention. These guarantees do not end at the entrance to a police station. Custody creates a positive duty because the state controls the conditions in which the person is held. The Supreme Court's decisions in D.K. Basu v. State of West Bengal, Nilabati Behera v. State of Orissa and State of Madhya Pradesh v. Shyamsunder Trivedi recognise the special seriousness of custodial abuse, the preventive role of arrest documentation and the evidentiary difficulty created when relevant information remains within the police institution.

The National Human Rights Commission requires prompt intimation and has developed guidelines relating to custodial deaths, post-mortem examination, videography and inquiry. The Bharatiya Nagarik Suraksha Sanhita, 2023 contains contemporary safeguards on arrest, information, medical examination, health and safety and production before a magistrate. The Supreme Court's CCTV directions in Paramvir Singh Saini v. Baljit Singh add an evidentiary layer by seeking greater visibility inside police stations and investigative offices. Together, these measures recognise that prevention depends on records and independent access to evidence.

International standards point in the same direction. The International Covenant on Civil and Political Rights protects life, liberty and freedom from torture. The Istanbul Protocol provides detailed guidance for investigating and documenting torture and ill-treatment. The United Nations Principles on Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions emphasise prompt, thorough and impartial investigation where state agents may be implicated. These norms support a governance approach in which custody-related mortality is monitored systematically rather than addressed only after public controversy.

3. Data and Method

The analysis uses the state and Union Territory figures reported by the Ministry of Home Affairs in response to Lok Sabha Unstarred Question No. 5115 on 24 March 2026. The official table reports cases registered in respect of deaths in police custody for five periods: 2021-22, 2022-23, 2023-24, 2024-25 and 2025-26 up to 15 March 2026. National totals and state-level figures were transcribed into a structured dataset. Descriptive analysis was then used to calculate annual change, the five-period cumulative total and state rankings.

The method is deliberately limited to description. It does not estimate the rate of custodial death because the official table does not provide a matching denominator such as the number of persons held in police custody, arrests, total custody-hours or station admissions. It also does not classify causes of death, allegations of torture, inquiry outcomes, prosecutions, compensation or disciplinary action. As a result, the analysis cannot determine how many cases involved unlawful violence. Its purpose is to identify patterns that require further inquiry and to evaluate what additional data are needed for responsible interpretation.

The 2025-26 figure is nearly complete but not identical to a full financial-year count because it ends on 15 March 2026. Comparisons with previous full periods should therefore be cautious. State rankings are also based on raw totals. Larger states may record more cases because they have larger populations, more arrests or more police facilities. Conversely, stronger reporting may produce higher official counts than weak reporting. The paper therefore avoids treating rank as a direct measure of police brutality.

4. Results

The national total fell from 176 cases in 2021-22 to 163 in 2022-23, a decline of 7.4 per cent. It fell again to 157 in 2023-24 and to 140 in 2024-25. Across the first four periods, the decline from 176 to 140 was 20.5 per cent. This pattern could suggest improvement in custody management, reporting variation or changing custody volume. The official table alone cannot determine which explanation is correct.

The pattern changed in 2025-26. By 15 March 2026, 170 cases had already been recorded. This was 21.4 per cent higher than the 2024-25 total and only six cases below the 2021-22 figure. Because the reporting period was not fully complete, the final annual total could be higher. The increase indicates that the downward movement observed through 2024-25 should not be treated as a stable trend. It also shows why annual figures should be reviewed alongside state-level variation and case outcomes.

Across all five periods, 806 cases were recorded nationally. The annual average was 161.2, although this figure combines four complete periods with one period ending on 15 March. Maharashtra had the highest cumulative total at 101. Bihar recorded 76, Gujarat 85, Rajasthan 51 and Uttar Pradesh 56. Assam recorded 46, West Bengal 42, Punjab 45 and Madhya Pradesh 44. These states together account for a substantial share of the national total, but their relative position changes across years.

Some states show persistent reporting rather than a single isolated peak. Maharashtra recorded 30 cases in 2021-22, 22 in 2022-23, 21 in 2023-24 and 14 in each of the next two periods. Gujarat recorded 24, 15, 18, 14 and 14. Bihar recorded 18, 16, 13, 10 and then 19. Rajasthan moved from 13 to 4, 7, 9 and 18, showing a marked rise in 2025-26. Uttar Pradesh increased from 8 in 2021-22 to 15 in 2025-26. Punjab also reached 14 in the latest period after recording 9, 10, 6 and 6 in the preceding years.

Raw concentration should not be interpreted without context. Maharashtra, Bihar, Gujarat, Rajasthan and Uttar Pradesh differ greatly in population, number of police stations, arrest volume, crime reporting and health infrastructure. A state with more arrests may have a higher count but a lower custodial-death rate. A state with a low official total may have effective safeguards, lower custody use or weak reporting. These possibilities cannot be separated using the parliamentary table alone.

Table 1: National trend in police-custody death cases

Reporting period	Cases
2021-22	176
2022-23	163
2023-24	157
2024-25	140
2025-26*	170
Five-period total	806

***Source*:** Ministry of Home Affairs, Lok Sabha Unstarred Question No. 5115, 24 March 2026. *Up to 15 March 2026.

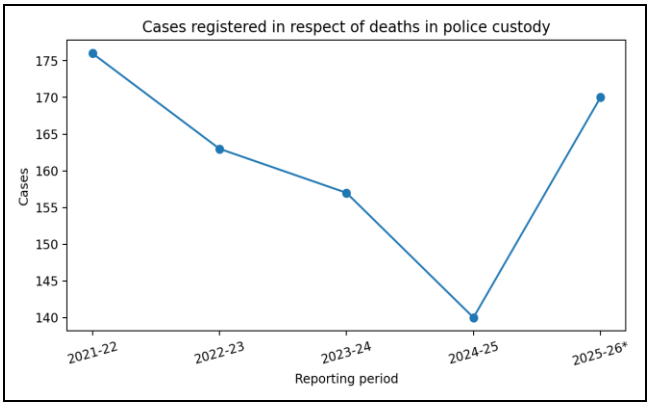

Fig 1: National trend in cases registered in respect of deaths in police custody

Table 2: States with the highest cumulative totals

State	Five-period total
Maharashtra	101
Gujarat	85
Bihar	76
Uttar Pradesh	56
Rajasthan	51
Assam	46
Punjab	45
Madhya Pradesh	44
West Bengal	42
Tamil Nadu	27

***Source*:** Calculated from the Ministry of Home Affairs state/UT table. Raw counts are not population-adjusted.

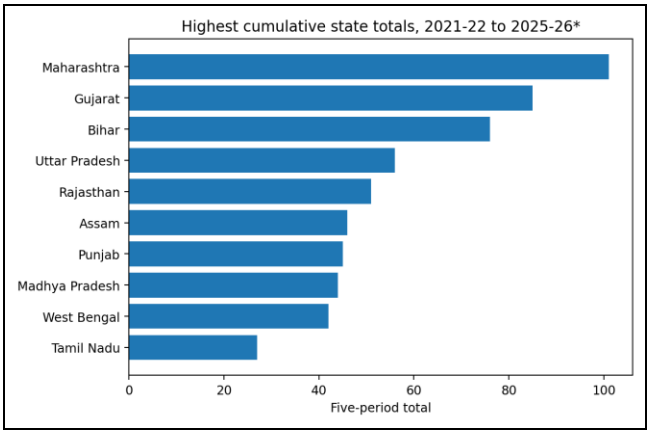

Fig 2: States with the highest cumulative totals

5. Discussion

The results carry two main messages. First, the national pattern is not a simple linear decline. The fall through 2024-25 was followed by a substantial rise in the nearly complete 2025-26 period. This reversal does not prove worsening brutality, but it weakens any claim that the problem has steadily reduced. Sustainable improvement should be demonstrated over several years and supported by information on custody conditions, cause of death, medical care and inquiry outcomes.

Second, repeated high counts in several large states justify state-specific review. National averages can conceal different institutional conditions. Police legislation, complaints authorities, training systems, CCTV implementation, medical access and magisterial practice vary across states. A high cumulative total should trigger examination of whether deaths cluster in particular districts, stations, ranks, arrest categories or time periods. It should also prompt comparison between natural deaths, alleged assault, suicide, self-harm and deaths following delayed medical treatment.

The official language of cases registered in respect of deaths in police custody is important. It indicates administrative recognition of an event, not a finding of guilt. Human-rights analysis must preserve this distinction. However, the burden of explanation is appropriately higher in custody because the state possesses most relevant evidence. Missing station records, unavailable footage, delayed post-mortem examination or failure to notify an oversight body can therefore be significant in themselves, even before final responsibility is determined.

The prison context also demonstrates the wider scale of custodial governance. The same parliamentary response reported 389,910 undertrial prisoners and 135,536 convicted prisoners as on 31 December 2023. Although police custody and judicial custody are legally and institutionally different, the figures show that a large proportion of persons held by the criminal-justice system have not been finally convicted. This strengthens the importance of presumption of innocence, medical care, legal access and judicial review at every stage of detention.

Technology has potential but should not be overestimated. CCTV can deter abuse and help establish the sequence of events, but only if footage is complete, securely retained and independently accessible. State-level data should therefore include camera coverage, functioning rates, retention periods, requests for footage and instances in which relevant footage was unavailable. Without such information, formal installation cannot be equated with effective surveillance of custody practices.

Independent investigation is equally important. When the police unit involved controls the first report, scene, witnesses and records, public confidence may be weak even if the investigation is sincere. Serious custody cases should be investigated by an institutionally separate team with immediate authority to secure evidence. Medical examination and post-mortem documentation should be standardised and sufficiently independent. Inquiry outcomes should be published in aggregate form, including findings, disciplinary action, prosecution and compensation.

6. A Better Custodial-Death Data Framework

A meaningful national database should distinguish police custody from judicial custody and should record the exact date, location and stage of detention. It should classify the preliminary and final cause of death, while separately

recording allegations of assault or torture. It should indicate whether the person was medically examined at arrest, whether injuries were documented, whether family and legal counsel were informed, and whether the person had requested treatment. These variables would allow analysis of preventable medical and procedural failures without prejudging criminal liability.

The database should also record the investigating agency, date of inquiry completion, magisterial or judicial findings, disciplinary proceedings, criminal prosecution, compensation and current case status. Timeliness matters because delayed inquiries weaken evidence and prolong uncertainty for families and officers. Public reporting should present state and district aggregates while protecting personal information. Independent researchers should be able to access anonymised data for evaluation.

Rates should be calculated using multiple denominators. Population-adjusted rates are useful but do not capture police exposure. Rates per 100,000 arrests, per 100,000 persons admitted to police custody and per unit of custody time would provide a fairer basis for comparison. States should also report the proportion of arrests followed by medical examination, legal notification and functioning CCTV coverage. A composite risk dashboard could combine mortality, serious injury, complaint frequency, missing footage and inquiry delay.

Data quality must be audited. Zero or very low counts should not automatically be interpreted as success, because under-reporting is possible. Records from police departments, human-rights commissions, magistrates, hospitals and courts should be reconciled. Differences should be explained publicly. A transparent system would support both prevention and fairness by identifying genuine risk while avoiding unsupported assumptions about individual officers or entire state forces.

The data also invite a distinction between prevention indicators and outcome indicators. Death is a final and relatively rare outcome, while failures such as missing arrest records, delayed medical examination or unavailable footage may occur more frequently. Monitoring these earlier failures can help institutions intervene before serious harm occurs. A prevention-oriented system should therefore treat procedural non-compliance as a measurable warning sign rather than waiting for a death or public scandal.

Public interpretation should remain cautious when yearly numbers fluctuate. A rise may reflect deteriorating conditions, increased arrest volume, improved reporting or a combination of factors. A decline may reflect genuine prevention, reduced custody use or incomplete registration. The answer lies in linking mortality figures with denominators, cause classifications and inquiry outcomes. Transparency does not mean publishing a single number; it means publishing enough connected information to allow fair explanation.

7. Policy Implications

The first policy implication is that every custodial death should activate a standard response independent of public attention. Notification, scene preservation, medical documentation, collection of CCTV footage, identification of personnel on duty and independent inquiry should occur automatically. Families should receive information about procedures and should not be required to depend on the police unit under examination for access to basic records.

The second implication is that prevention must be monitored through process indicators. States should be evaluated not only by the number of deaths but also by whether arrest memos, family notification, medical examinations, legal access and CCTV retention are consistently completed. A lower death count combined with poor procedural compliance may not indicate a sustainable improvement. Conversely, stronger reporting may temporarily increase recorded cases while improving accountability.

Third, national and state oversight bodies should identify repeated patterns. Stations or districts with recurrent custody deaths, serious injuries, complaints or unavailable footage require targeted inspection. Training and staffing should be reviewed, but repeated procedural failure should also lead to supervisory accountability. Human-rights training is most effective when connected to field supervision, appraisal and consequences.

Finally, custodial-death reporting should form part of a broader police-reform agenda. Independent Police Complaints Authorities, fixed tenure, separation of investigation from routine law-and-order duties, forensic capacity and protection from improper political interference can reduce the organisational conditions in which coercive shortcuts develop. Data are valuable only when institutions are willing and able to act on the risks they reveal.

8. Limitations

The study is limited by the categories available in the parliamentary response. It cannot identify cause of death, allegation type, inquiry outcome or custody denominator. The 2025-26 period is incomplete by approximately two weeks. State totals are not adjusted for population or arrest volume. The analysis therefore does not estimate brutality and does not rank the quality of state police systems. Its contribution is descriptive: it identifies temporal and geographical patterns and clarifies the additional evidence needed for responsible human-rights assessment.

9. Conclusion

Official data show that India recorded 806 cases in respect of deaths in police custody across the five reporting periods from 2021-22 to 2025-26 up to 15 March 2026. National totals declined for three consecutive periods but rose sharply in the latest nearly complete period. Several large states recorded persistently high cumulative counts. These findings do not establish the cause or legality of individual deaths, yet they demonstrate that custody-related mortality remains an important governance concern.

Future reporting should distinguish institutional improvement from changes in recording practice. Consistency across states, independent verification and timely publication are central to the credibility of national custodial-death statistics.

A national dashboard could present both absolute numbers and rates based on arrests or custody admissions. It should allow users to compare trends over time without encouraging simplistic league tables. Explanatory notes are necessary where definitions, coverage or reporting systems change.

Cause-of-death information should be updated when a final medical or judicial conclusion replaces a preliminary classification. Retaining both stages would show how often early explanations change and would strengthen confidence that official records reflect completed inquiries rather than initial assumptions.

Data should also identify the time between arrest, admission to the police station, medical examination and death. This sequence can reveal whether risk concentrates during transport, interrogation, overnight detention or delayed transfer to hospital. Such detail would support targeted preventive action.

Independent oversight bodies should be able to audit the completeness of state submissions. Where police, hospital, magistrate and human-rights records differ, the discrepancy should be recorded and resolved. Reconciliation is essential because a national total is only as reliable as the local reporting chain.

Families and legal representatives should have a clear route to correct factual errors in public records without interfering with an investigation. A transparent correction process would improve accuracy and reduce the risk that incomplete administrative information becomes permanent.

The central policy requirement is to move from counting events to explaining and preventing them. Standardised cause-of-death classification, reliable custody denominators, independent evidence preservation, timely inquiry outcomes and transparent state-level reporting are necessary. Human-rights accountability is strongest when official data are precise enough to guide prevention and fair enough to avoid unsupported conclusions. Every custodial death should therefore be treated as both an individual case requiring justice and a potential institutional signal requiring reform.

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