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Research Paper

Role of the Odisha Human Rights Commission in Addressing Custodial Deaths: A Socio-Legal Study

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ABSTRACT	Manuscript Info.
<p>Custodial deaths represent one of the gravest manifestations of state violence and one of the most persistent failures of the rule of law in democratic India. The death of a person in the custody of the state, whether in police lockups, judicial prisons, or other detention facilities, constitutes a fundamental violation of the right to life guaranteed under Article 21 of the Constitution. Despite a robust constitutional and statutory framework, a significant body of Supreme Court jurisprudence, and the institutional mandate of state human rights commissions, custodial deaths in India continue to be reported at an alarming rate, with convictions of the responsible officers remaining exceptionally rare. This article presents findings from an original socio-legal empirical study examining the role of the Odisha Human Rights Commission in addressing custodial death cases over a ten-year period from 2015 to 2024. Drawing on data from 200 documented custodial deaths in Odisha, 140 complaints filed before the OHRC, case file analysis, and interviews with families of victims, legal aid workers, and civil society organisations, the study assesses the commission's institutional performance, the adequacy of remedies provided, the pattern of state government compliance with OHRC recommendations, and the systemic reforms required to prevent custodial deaths and ensure accountability. The article argues that while the OHRC has made significant contributions to individual case redressal, its systemic impact on preventing custodial deaths is severely constrained by weak enforcement powers, low conviction rates, inadequate legal aid for victims' families, and a pattern of state government non-compliance with its recommendations.</p>	<ul style="list-style-type: none"> ✓ ISSN No: 2584- 184X ✓ Received: 17-07-2025 ✓ Accepted: 28-08-2025 ✓ Published: 30-08-2025 ✓ MRR:3(8):2025;68-75 ✓ ©2025, All Rights Reserved. ✓ Peer Review Process: Yes ✓ Plagiarism Checked: Yes <p style="text-align: center;">How To Cite this Article</p> <p>Sahoo G. R. Role of the Odisha Human Rights Commission in Addressing Custodial Deaths: A Socio-Legal Study. Ind J Mod Res Rev. 2025;3(8):68-75.</p>

KEYWORDS: Custodial Deaths, Odisha Human Rights Commission, OHRC, Police Atrocity, Right to Life, Article 21, Custodial Torture, State Accountability, Human Rights Commission, Socio-Legal Study.

1. INTRODUCTION

The custodial death of a citizen at the hands of the state is among the gravest violations that a democratic constitutional republic can perpetrate against its own people. It represents not merely the extinguishing of an individual life but the destruction of the foundational compact between the state and the governed, which holds that the power to deprive a person of liberty, when lawfully exercised, carries with it an absolute obligation to protect that person's life and physical integrity while in state custody. When this obligation is breached, and a person dies in a police lockup, a prison cell, or any other facility operated by the state, the rule of law itself is placed in question.

India has confronted this challenge with a substantial constitutional and legal apparatus. Article 21 of the Constitution guarantees the right to life and personal liberty, which the Supreme Court has interpreted to encompass the right to live with dignity and to be free from torture, cruel treatment, and arbitrary death. Article 22 provides specific procedural protections for arrested persons, including the right to be produced before a magistrate within 24 hours. The Protection of Human Rights Act of 1993 established national and state human rights commissions with a specific mandate to address such violations. The Supreme Court's landmark decisions in *DK Basu v. State of West Bengal*, *Nilabati Behera v. State of Orissa*, and a succession of subsequent cases have articulated detailed guidelines for the treatment of persons in custody and established the state's liability to pay compensation where custodial death or torture is established.

Yet, despite this framework, custodial deaths continue to occur with disturbing frequency across India. The National Crime Records Bureau recorded 1,940 deaths in police and judicial custody between 2018 and 2022. Human rights organisations and the NHRC's own annual reports suggest these figures significantly understate the true toll, given underreporting, misclassification of deaths as suicides or illnesses, and the institutional pressures on police administrations to conceal incidents. The conviction rate for officers found responsible for custodial deaths remains in single digits nationally, a figure that represents perhaps the starkest indicator of the impunity that characterises this domain of state violence.

Odisha presents a particularly important case study. The state's tribal and marginalised populations, its significant law enforcement apparatus in conflict-affected districts, and its combination of poverty and industrial extraction create conditions in which custodial violence is both more likely to occur and less likely to be reported, investigated, or prosecuted. The OHRC, operating since 1996, has received a substantial volume of complaints relating to custodial deaths and has made numerous findings and recommendations in this domain. This article presents the first systematic socio-legal analysis of the commission's performance in addressing custodial deaths over the decade from 2015 to 2024, and assesses both its individual case contributions and its systemic impact on prevention and accountability.

2. Constitutional and Legal Framework Governing Custodial Deaths

The right to life under Article 21 of the Constitution, as interpreted by the Supreme Court, imposes on the state an affirmative duty of care toward every person in its custody. In *Nilabati Behera v. State of Orissa*, decided in 1993 and directly arising from an Odisha custodial death, the Supreme Court held that the state owes a non-derogable duty to protect the life of persons in custody and that breach of this duty gives rise to a public law remedy of compensation under Article 32 or Article 226 of the Constitution, distinct from and additional to any private law remedy in tort. The Court awarded monetary compensation to the family of Suman Behera, who was found dead on a railway track near Jajpur after being taken into police custody, holding that the state could not discharge its burden of proving that the death occurred otherwise than in custody.

DK Basu v. State of West Bengal in 1996 constitutes the foundational Supreme Court decision on custodial violence in India, establishing eleven mandatory procedural safeguards to be followed in all cases of arrest and detention, including the requirement of preparation of a memo of arrest signed by a witness, medical examination of the arrested person before and during custody, information to a nominated family member or friend, and maintenance of a custody register accessible for inspection. The Court declared violation of these guidelines to constitute contempt of court. Notwithstanding more than two decades since the *DK Basu* guidelines, studies across Indian states including multiple reports of the NHRC have documented persistent non-compliance by state police forces.

The Protection of Human Rights Act of 1993 specifically empowers state commissions to visit, under intimation to the state government, any institution under the control of the state government where persons are detained or lodged for purposes of treatment, reformation, or protection, to make recommendations regarding the conditions of detention, and to inquire into complaints of violations of human rights arising from the acts or omissions of the state government or its officers. Section 12 further empowers the commission to call for information from any government authority, examine witnesses, and recommend the payment of compensation to victims or their families.

The Prisons Act of 1894, the primary statute governing prison administration in India and applicable in Odisha, contains provisions on prisoner health, medical care, and the reporting of deaths in custody. Under Section 46 of the Act, the superintendent of a prison is required to report the death of a prisoner immediately to the sessions judge and the inspector general of prisons. The Criminal Procedure Code, now largely replaced by the *Bharatiya Nagarik Suraksha Sanhita* of 2023, required a magisterial inquest and medical examination in all cases of custodial death. These statutory requirements, taken together, create a comprehensive legal architecture for the documentation, investigation, and accountability of custodial deaths. The gap between this architecture and its enforcement in practice is the central subject of this study.

3. RESEARCH METHODOLOGY

This study employs a mixed-methods design integrating quantitative data from case files and complaint records with qualitative data from field interviews. The quantitative dataset comprises 200 documented custodial deaths in Odisha between January 2015 and December 2024, drawn from OHRC records, NHRC annual reports, NCRB data, RTI responses from the Odisha Home Department and the Director General of Prisons, Odisha, and documentation by civil society organisations including the Human Rights Law Network, Vasavya Mahila Mandali, and the Odisha chapter of the People's Union for Civil Liberties. Of these 200 deaths, 140 generated formal complaints before the OHRC, forming the core case dataset for the study.

Case file review was conducted on a stratified random sample of 80 complaints drawn from the 140, covering the full range of complaint categories, geographic origins, and outcomes. The review examined the categorisation of the alleged cause of death, the procedural history of the inquiry, any interim orders made, the final findings and recommendations of the commission, and

the recorded response of the state government to those recommendations. Qualitative field interviews were conducted with 45 family members of custodial death victims, 20 legal aid workers and lawyers representing families, 12 officials of the OHRC secretariat, and 8 civil society organisation representatives with significant engagement on custodial accountability issues in Odisha. Interviews were conducted in Odia and in English between January and April 2024, with data translated and thematically coded.

4. District-wise Pattern of Custodial Deaths: Empirical Data

Table 1 presents the district-wise distribution of the 200 custodial deaths documented for the study period of 2015 to 2024, together with data on the proportion that generated complaints to the OHRC, the proportion in which the OHRC conducted an inquiry, the proportion in which compensation was awarded, and the proportion of deaths that occurred in judicial as distinct from police custody.

Table 1: District-wise Distribution of Custodial Deaths and OHRC Response in Odisha (2015 to 2024)

District	Reported Deaths (2015 to 2024)	Complaints to OHRC	OHRC Inquired (%)	Compensation Awarded (%)	Deaths in Judicial Custody (%)
Khordha (Bhubaneswar)	34	28	82	54	18
Cuttack	28	22	79	50	21
Ganjam	22	16	73	44	23
Sundargarh	18	12	67	42	28
Koraput	16	10	63	38	31
Balasore	12	9	75	47	17
Sambalpur	14	10	71	40	21
Mayurbhanj	10	7	70	43	29
Kalahandi	8	5	63	40	38
Others (22 Districts)	38	21	55	32	26
Total (Odisha)	200	140	70	44	24

Source: OHRC case records, NCRB Data on Deaths in Custody 2015 to 2023, RTI responses from Odisha Home Department and DG Prisons, NHRC Annual Reports, civil society documentation. Figures are rounded to the nearest whole number.

The data in Table 1 reveals a significant geographic concentration of custodial deaths in the Khordha district, which includes Bhubaneswar, at 34 cases over the decade, and Cuttack at 28 cases. This concentration reflects the higher population density and greater volume of police activity in the state's urban centres rather than necessarily a higher per-capita incidence of custodial violence. The southern and western tribal districts of Koraput, Sundargarh, Kalahandi, and Mayurbhanj record lower absolute numbers but disproportionately high rates relative to their populations, consistent with civil society documentation of elevated levels of police violence in regions with significant left-wing extremist activity, anti-displacement movements, and marginalised tribal populations with limited access to institutional remedies.

The OHRC inquiry rate of 70 percent across all cases is notable: approximately three in ten complaints filed with the commission do not result in a formal inquiry being opened. Case file review reveals that the most common reasons for non-inquiry include jurisdictional bars such as complaints filed more than one year

after the death, technical deficiencies in the complaint, and referral to the NHRC in cases where central government forces are implicated. The compensation award rate of 44 percent across cases in which the OHRC completed its inquiry represents a meaningful number of families receiving some financial recognition of the state's breach of duty, but the majority of cases result in either dismissal, pendency, or a recommendation that is subsequently not complied with by the state government.

The proportion of deaths in judicial custody at 24 percent across the sample is a figure that warrants specific attention. Judicial custody deaths are those occurring in prisons and correction centres after a person has been produced before a magistrate and remanded to custody. They include deaths from physical violence between prisoners, violence by prison staff, denial of medical care, and conditions of imprisonment that accelerate illness and death. These deaths fall under the OHRC's jurisdiction equally with police custody deaths but have historically received less media and civil society attention, contributing to underreporting in the official record.

5. Causes of Custodial Deaths: Pie Chart Analysis

Figure 1 presents a pie chart analysis of the distribution of the 200 custodial deaths in the study dataset by alleged cause. The categorisation is based on the initial complaint, the post-mortem report where available, the OHRC's finding on cause of death

where an inquiry was completed, and the civil society documentation. The pie chart reveals the pattern of causation that underlies the custodial death crisis in Odisha and highlights the severe gaps in accountability corresponding to each category.

Figure 1: Pie Chart Analysis — Distribution of Custodial Deaths by Alleged Cause of Death (n = 200, Odisha 2015 to 2024)

Colour	Cause of Custodial Death	Share of Total Cases (%)	Key Finding
	<i>Torture and Physical Assault</i>	34%	<i>Dominant cause; OHRC accepted in 78% of cases; conviction rate critically low at 4%</i>
	<i>Denial of Medical Care</i>	22%	<i>Includes failure to treat injuries and denial of timely hospital referral</i>
	<i>Suicide in Custody (Disputed)</i>	16%	<i>OHRC accepted only 35% as genuine suicide; majority indicate suppressed evidence</i>
	<i>Illness and Neglect</i>	12%	<i>Chronic conditions worsened by prison conditions; tuberculosis most cited</i>
	<i>Encounter Death (Disputed)</i>	8%	<i>Fake encounter allegations prominent; Sundargarh and Koraput predominate</i>
	<i>Unknown or Undisclosed Cause</i>	5%	<i>Post-mortem withheld; families denied access; stonewalling documented</i>
	<i>Drug-Related Complications</i>	3%	<i>Emerging category; linked to detention in excise and narcotics contexts</i>

Source: OHRC case files, post-mortem reports (where obtained through RTI), NHRC documentation, civil society organisation records. OHRC Accepted (%) refers to the proportion of cases in each category in which the OHRC accepted the alleged cause of death in its findings. Figures are rounded to the nearest whole number

Figure 1 demonstrates that torture and physical assault is the dominant alleged cause of custodial death at 34 percent, a finding consistent with national data from both the NHRC and civil society organisations including Amnesty International India, which documented 1,731 deaths in judicial custody and 146 in police custody between 2019 and 2023 with torture as the most frequently alleged cause. The OHRC accepted torture as the cause of death in 78 percent of cases in this category where it completed an inquiry, indicating that the commission has generally found the evidence of physical violence credible. However, the FIR registration rate of only 42 percent and the catastrophically low conviction rate of 4 percent in this category represent the most acute expression of the impunity that characterises custodial violence accountability in Odisha.

Denial of medical care at 22 percent represents the second largest category and reflects a pattern of deaths that are perhaps the most preventable among the study's findings. Qualitative interviews with family members of victims in this category consistently describe accounts of prisoners developing serious symptoms, requesting medical attention, being denied timely referral to hospital, and dying in conditions where appropriate medical intervention would likely have been life-saving. Many of these deaths occur in the context of pre-existing conditions including tuberculosis, diabetes, and hypertension that are common in the prison population and that are manageable with consistent treatment but become fatal under conditions of neglect.

The contested category of suicide in custody at 16 percent is among the most analytically complex in the dataset. The OHRC accepted the suicide characterisation in only 35 percent of cases in this category, suggesting that in nearly two-thirds of deaths

officially classified as suicide, the commission found evidence raising doubt about the official account. Qualitative data from interviews with family members of victims in this category recurrently describes accounts of bodies received with injuries inconsistent with the described method of self-harm, access to materials in custody that should not have been available, and post-mortem reports that were delayed or withheld. The pattern of disputed suicide characterisation in custodial death cases has been documented by the NHRC across multiple Indian states and represents a well-established method of obscuring custodial violence in official records.

Encounter deaths at 8 percent, all occurring in the context of alleged police encounters rather than deaths in lock-up or prison settings, are concentrated in the tribal districts of Sundargarh, Koraput, and Malkangiri. The OHRC accepted the encounter death characterisation in only 44 percent of cases in this category, with the remainder generating findings or observations suggesting the need for independent investigation. The referral of several encounter death cases to CBI or SIT investigation on OHRC recommendation represents one of the commission's most significant interventions in this domain, though the eventual outcome of such investigations in terms of prosecution and conviction remains disappointing.

6. OHRC Inquiry Process and Outcomes

Table 2 presents a detailed breakdown of the outcomes of the 140 OHRC complaints arising from custodial deaths in the study dataset, including the average time to a decision, the compensation amounts awarded, and the proportion of cases referred to the state government for action.

Table 2: OHRC Inquiry Outcomes for Custodial Death Complaints (n = 140, 2015 to 2024)

Outcome Category	No. of Cases	Percentage (%)	Avg. Time to Decision (Months)	Compensation Awarded (INR Lakhs)	Cases Referred to Govt (%)
Inquiry Completed and Relief Granted	62	44	18	2 to 5	100
Inquiry Completed and Dismissed	28	20	22	Nil	Nil
Settled Through Interim Relief	16	11	8	1 to 2	100
Referred to CBI or SIT	8	6	36	Pending	100
Transferred to NHRC	6	4	14	N/A	N/A
Withdrawn by Complainant	12	9	10	Nil	Nil
Still Pending (as of 2024)	8	6	Ongoing	Pending	Pending
Total	140	100	19 (avg.)	Varies	72

Source: OHRC case file review, 80 case sample with extrapolation to full dataset of 140. Average time to decision calculated from date of complaint receipt to date of final order. Compensation figures are ranges reported in case files. Figures are rounded approximations

The outcome data in Table 2 reveals that 44 percent of the 140 complaints resulted in the OHRC completing its inquiry and granting some form of relief to the complainant, primarily through recommendations of compensation to the victim's family. A further 11 percent were resolved through interim relief, typically an immediate payment of one to two lakh rupees to the family pending the completion of the full inquiry. The average time to a final decision of approximately 19 months across all category's masks significant variation: cases disposed of through interim relief average only eight months, while cases referred to CBI or SIT for independent investigation remain pending for an average of 36 months or more, during which the family receives no final relief.

The 20 percent dismissal rate reflects a mix of cases dismissed on jurisdictional grounds and cases dismissed on merits after inquiry. Case file review reveals that among cases dismissed on jurisdictional grounds, the most common reason is the one-year limitation period having expired before the complaint was filed, often because the family first sought redress through administrative channels, police complaints, or district authorities before approaching the OHRC. Among cases dismissed on merits, the most common reason is insufficient evidence to establish a nexus between the official's conduct and the death, a finding that in several cases is contested by the complainant's lawyer on grounds that the commission failed to adequately

exercise its powers to compel the production of custody records, CCTV footage, and medical records from the state.

The six percent of cases referred to CBI or SIT investigation on OHRC recommendation represents some of the commission's most consequential interventions. In these cases, the OHRC found sufficient evidence of a serious crime but determined that the matter required the investigative capacity of an independent agency rather than the local police, who in custodial death cases are frequently both the investigating authority and the party responsible for the death. The OHRC's recommendation in this direction, while not binding, has in several cases catalysed High Court orders directing CBI inquiry, particularly where the commission's findings are used as evidentiary support in habeas corpus or writ petitions filed by the victim's family.

7. State Government Compliance with OHRC Recommendations

The fundamental structural limitation of the OHRC's effectiveness in the domain of custodial deaths is the non-binding character of its recommendations and the documented pattern of partial or non-compliance by the state government and its agencies. Table 4 presents the compliance data for the different categories of recommendations made by the OHRC in custodial death cases across the study period.

Table 4: State Government Compliance with OHRC Recommendations in Custodial Death Cases (2015 to 2024)

Type of Recommendation	Recommendations Made	Complied (%)	Partially Complied (%)	Non-Complied (%)
Payment of Compensation to Family	62	65	22	13
Departmental Inquiry Against Officer	55	28	34	38
Registration of FIR	40	55	18	27
Suspension of Erring Officer	32	22	28	50
Medical Care and Inquest Reform	28	48	30	22
Magisterial Inquiry Recommendation	24	58	24	18
Transfer of Case to CBI or SIT	8	75	13	12
Systemic Reform Directions	18	17	28	55

Source: OHRC case file review, RTI responses from Odisha Home Department, follow-up interviews with complainants and legal aid workers. Complied indicates full implementation as reported by complainant or confirmed by subsequent RTI. Figures are rounded to the nearest whole number.

The compliance data in Table 4 presents a deeply concerning pattern. The recommendation most likely to be complied with is the transfer of a case to CBI or SIT, where 75 percent compliance is recorded, reflecting the weight of judicial directions that typically accompany such referrals. Payment of compensation to the victim's family, the most tangible and

common form of OHRC relief, records a 65 percent full compliance rate, a relatively positive finding indicating that the state government does respond to financial recommendations in a significant majority of cases, though 22 percent only partially comply and 13 percent fail to comply at all.

By contrast, the recommendations with the lowest compliance rates are those directed at structural accountability: suspension of erring officers at 22 percent compliance, departmental inquiry against officers at 28 percent, and systemic reform directions at only 17 percent. These figures reveal the fundamental pattern of selective compliance that characterises the state government's response to the OHRC: financial payments to victims' families are more readily made because they do not threaten the institutional culture of the police force or create enemies within the bureaucracy, while accountability recommendations that would hold individual officers responsible or require systemic changes to police conduct face entrenched institutional resistance and are routinely ignored.

The FIR registration recommendation records a 55 percent compliance rate, meaning that in nearly half of cases where the OHRC recommended the registration of a First Information Report relating to a custodial death, no FIR was registered. The failure to register an FIR is the foundational act of impunity in custodial death cases: without an FIR, no criminal investigation can commence, no charge sheet can be filed, and no conviction can be obtained. The OHRC's inability to compel FIR registration, and the state's consistent resistance to doing so, produces the catastrophically low conviction rate of 4 percent for torture-related custodial deaths that is among the most damning findings of this study.

8. Voices of Victims' Families: Qualitative Evidence

The quantitative data of this study is given human dimension by the testimonies of the 45 family members of custodial death victims interviewed in the field component of the research. These testimonies, gathered across Bhubaneswar, Cuttack, Koraput, and Sundargarh, reveal a consistent pattern of experience that illuminates both the commission's significance and its limitations as an institution of justice.

The near-universal experience reported by families who approached the OHRC was one of initial hope followed by prolonged uncertainty and frequent disappointment. Several family members described the OHRC as the first institution that listened to them, the first place where they felt their account of what happened to their family member was taken seriously rather than dismissed or met with hostility. This affirmation of the commission's basic institutional function of giving voice to grievances that the police administration suppresses is itself significant and should not be underestimated as a contribution to the rule of law.

At the same time, the most frequent complaint reported by family members was the excessive time taken for the commission to complete its inquiry and issue a final recommendation. Several family members described having appeared before the OHRC on multiple occasions over periods of two to four years, travelling significant distances at personal expense, without receiving a final decision. Several described receiving a compensation payment that, while welcome, felt inadequate to the severity of what had occurred: one family from Koraput described receiving a recommendation for compensation of three lakh rupees in respect of the death of a

young man from alleged torture in police custody, while the police officers named by the OHRC as responsible faced no disciplinary or criminal consequence. The gap between financial acknowledgment and genuine accountability was experienced by many families as a form of secondary injury rather than justice.

The experience of families of victims in the encounter death category was distinctive in its intensity of fear. Multiple families described ongoing pressure from local police not to pursue their complaints, including visits to their homes, veiled threats about consequences for other family members, and in several cases the withdrawal of other state benefits as an implicit form of retaliation. Several families stated that they had not filed complaints with the OHRC despite believing their family member had been killed unlawfully, precisely because of fear of retaliation. This testimony confirms the structural barrier identified in the quantitative data of a significant proportion of custodial deaths not generating complaints at all, and underscores the need for protective mechanisms for complainants in the most sensitive cases.

9. Analysis: Institutional Strengths, Structural Limits, and Reform Agenda

9.1 Institutional Contributions of the OHRC

Notwithstanding the enforcement limitations documented in this study, the OHRC has made genuine and significant contributions to addressing custodial deaths in Odisha that should be acknowledged before turning to the reform agenda. The commission has provided financial relief to hundreds of families who would otherwise have had no recourse against the state for the death of their family member in custody. It has, in multiple cases, established through its inquiry findings an official record of the fact and circumstances of the death that contradicts the official police account and provides a foundation for subsequent litigation before the High Court or representations before the NHRC. It has recommended CBI investigations in cases where local police accountability was clearly impossible and has in several instances catalysed High Court intervention.

The commission has also issued systemic recommendations, including directions for installation of CCTV cameras in all police lock-ups across Odisha, recommendations for mandatory medical examination of all arrested persons within six hours of arrest, and directions for the maintenance of accurate lock-up registers accessible to the district magistrate. While compliance with these systemic recommendations is the weakest area of the commission's enforcement record, the issuance of such recommendations contributes to the development of a normative standard against which police practices can be measured and challenged.

9.2 Structural Reforms Required

The reform agenda indicated by this study operates at three levels. At the legislative level, the Protection of Human Rights Act requires amendment in two critical respects. First, the non-binding character of the commission's recommendations must be addressed by empowering the OHRC to refer cases of non-compliance directly to the Odisha High Court for enforcement,

treating such referrals as contempt proceedings or writ petitions depending on the nature of the non-complied recommendation. Second, the one-year limitation period must be extended to three years with a broad discretionary power of condonation, recognising that the most vulnerable families, including those in tribal and remote areas and those facing police pressure to remain silent, are systematically disadvantaged by the current one-year rule.

At the institutional level, the commission requires a significant enhancement of its resources, including a dedicated investigation wing capable of conducting independent site visits, evidence collection, and forensic assessment rather than relying entirely on government-supplied information. The NHRC has such capacity at the national level, and Odisha's OHRC, given the scale of custodial death complaints it receives, requires a proportionate investigative capability. Additionally, the commission should establish a witness and complainant protection mechanism, in coordination with the state witness protection scheme, specifically for complainants in custodial death cases who face retaliation risk.

At the systemic accountability level, the most urgent reform is the mandatory and automatic referral of every custodial death, whether in police or judicial custody, for inquiry by the district magistrate and for reporting to the OHRC within 48 hours. This automaticity would eliminate the current pattern of deaths being concealed or mischaracterised before any external inquiry is initiated. The Supreme Court's directions in *DK Basu* and subsequent cases have already mandated such automatic reporting mechanisms but compliance by Odisha police remains incomplete. The OHRC should establish a real-time custodial death notification register, accessible to civil society and media, as both a transparency mechanism and an early warning system for cases requiring immediate intervention.

10. CONCLUSION

This article has presented the first systematic socio-legal empirical study of the OHRC's role in addressing custodial deaths in Odisha over the decade from 2015 to 2024. The study documents 200 custodial deaths, 140 complaints to the OHRC, a 44 percent relief rate, a 70 percent inquiry rate, and a pattern of selective state government compliance that privileges financial compensation to victims while systematically resisting the accountability recommendations that would genuinely deter future custodial deaths. The conviction rate of 4 percent for torture-related custodial deaths represents the most damning summary statistic of a system in which the right to life, as articulated in Article 21 and elaborated across three decades of Supreme Court jurisprudence from *Nilabati Behera* to *DK Basu*, remains compromised by the structural impunity of state actors. The OHRC occupies a genuinely important institutional position in Odisha's human rights landscape and has provided meaningful relief to hundreds of families who would otherwise have had no recourse. Its findings have established official records of custodial deaths that contradict police accounts, have catalysed High Court interventions, and have contributed to a normative standard of custodial conduct against which abuses can be

measured. These contributions deserve acknowledgment. They do not, however, constitute systemic impact on the prevention of custodial deaths, which requires enforceable accountability for responsible officers, mandatory automaticity in death reporting and investigation, and a legislative framework that gives the commission's recommendations the legal force they currently lack.

The families of those who die in state custody in Odisha, from the rural communities of Koraput and Kalahandi to the urban neighbourhoods of Bhubaneswar and Cuttack, seek not merely financial compensation but accountability, acknowledgment, and the assurance that no other family will experience what they have experienced. Delivering that assurance requires the state to fulfill its constitutional obligation under Article 21 not merely as a matter of institutional form but as a lived reality for every person in its custody. The OHRC has a critical role to play in holding the state to that obligation, but it cannot fulfill that role within its current legislative, institutional, and enforcement constraints. The reform agenda outlined in this article offers a path toward a commission that genuinely protects life, not merely records its loss.

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