Before Rajiv Sharma, ACJ & Harinder Singh Sidhu, J.

JEEWAN SINGH SIDHU – *Appellant*

versus

STATE OF PUNJAB- *Respondent*

CRA-D-509-DB-2014

September 25, 2019

***Indian Penal Code, 1860—S. 302—Plea of accused that he was suffering from mental disorder namely schizophrenia and entitled benefit under Section 84—Held, plea of insanity not available as from the circumstances which preceded, attended and followed the crime appellant cannot be said to be suffering from unsoundness of mind—Appeal dismissed*.**

Held that the court while taking up the plea of insanity has to see the legal insanity and not medical insanity. It is for the appellant to prove that he was suffering from insanity as per section 105 of the Indian Evidence Act. The appellant has not led any tangible evidence to prove that he was suffering from schizophrenia at the time of commission of the offence.

(Para 26)

Held, that From the circumstances, which preceded, attended and followed the crime, it cannot be said that the appellant was suffering from unsoundness of mind.

(Para 37)

Vinod Ghai, Senior Advocate,
with Kanika Ahuja, Advocate,
for the appellant.

H.S. Grewal, Addl. A.G., Punjab.

RAJIV SHARMA, ACTING CHIEF JUSTICE

(1) This appeal is instituted against the judgment and order dated 17.02.2014, rendered by learned Sessions Judge, Amritsar, in Sessions Trial No. 30 of 2012, whereby appellant Jeewan Singh Sidhu, who was charged with and tried for the offence punishable under Section 302 of the Indian Penal Code (hereinafter referred to as `IPC' for brevity sake), was convicted thereunder and sentenced to undergo imprisonment for life and to pay a fine of Rs.20,000/-, and in default of payment of fine, to undergo further rigorous imprisonment for one

year.

(2) The case of the prosecution, in a nutshell, is that on 03.03.2012, Inspector Sukhwinder Singh, SHO of Police Station Civil Lines, Amritsar City, along with other police officials was present at turning of A-Block, Ranjit Avenue, Amritsar, in a government vehicle. Manjinder Singh complainant accompanied by Shri Baljinder Singh Dhillon came there. He got his statement recorded. According to the statement, he was undergoing Diploma in Computer from Guru Nanak Dev University, Amritsar. His father Baldev Singh was posted as ASI in Police Station at Jhabal. Jeewan Singh Sidhu son of Amarjit Singh was doing MBBS from Government Medical College, Amritsar. He was tenant on first floor of Kothi No. 312-B Block, Ranjit Avenue, Amritsar. On 02.03.2012, complainant's father had gone to the High Court at Chandigarh, in connection with some case. He came back in bus. The complainant received him in the night at Bus Stand. His father told him that he had received a telephonic call from his sister to leave Jeewan Singh Sidhu in the morning at Nawan Shehar. His father was asked to stay with Jeewan Singh Sidhu during night to make him understand. The complainant brought his father to Kothi No. 312, B-Block, Ranjit Avenue. Jeewan Singh Sidhu was present in the house. The complainant went inside the house with his father. He served Jeewan Singh Sidhu and his father dinner. A taxi was hired from Gaurav Taxi Stand, Amritsar, to take Jeewan Singh Sidhu to Nawan Shehar. He came back to his house. In the morning, at about 7.00/7.15 AM, he got call from Gaurav Tax Stand that taxi was parked outside the Kothi. He called his father. His phone was `not reachable'. He requested the taxi driver on his phone to knock at the door. The driver called back and told him that there was no response from inside. He himself went to the Kothi. Taxi driver was standing outside the door of the Kothi. He went at the rear door and climbed the stairs. He saw blood scattered in the room. He called his neighbour Dr. Laddi on phone. Dr. Laddi and Baljinder Singh Dhillon came at Ranjit Avenue. He went inside the Kothi. He noticed that the dead body of his father was lying in the bathroom. There were injury marks on the neck and face of his father. His father was murdered by Jeewan Singh Sidhu. FIR was registered. Finger Prints expert was summoned at the spot along with the photographer. Post mortem examination was got conducted. Blood from the floor was lifted with cotton swab. Finger prints from two broken glasses found near the dead body were also taken by SI Sukhraj Singh, Incharge, Mobile Forensic Science Lab., Amritsar. A secret information was received by the police that a boy was lying near

Pannu hotel. Blood was oozing from his arm. He was got admitted in Guru Nanak Dev Hospital, Amritsar. The investigation was completed and challan was put up after completing all the codal formalities.

(3) The prosecution examined as many as fifteen witnesses in support of its case. The appellant was also examined under Section 313 Cr.P.C. He denied the case of the prosecution. According to him, he was falsely implicated. He examined three witnesses in support of his defence.

(4) The appellant was convicted and sentenced, as noticed here-in- above. Hence, this appeal.

(5) Learned counsel appearing on behalf of the appellant has vehemently argued that the prosecution has failed to prove its case against his client. Learned counsel appearing on behalf of the State has supported the judgment and order of the learned Court below.

(6) We have heard learned counsel for the parties and gone through the judgment and record very carefully.

(7) PW.1 Rishi Ram deposed that he had gone to the spot and prepared scaled site plan Ex.PA using scale 1'=12".

(8) PW.6 Ms. Sharanjit Kaur deposed that she along with her nephew Gurashish Singh was residing in Kothi No. 312, B-Block, Ranjit Avenue, Amritsar, since the year 1998. She rented out the first floor of her Kothi to Jeewan Singh Sidhu son of Amarjit Singh Sidhu from America. He was a student of MBBS in Government Medical College, Amritsar. The monthly rent was ` 6,000/-. She proved the rent agreement Ex.PF.

(9) PW.7 HC Harvinder Singh had taken the photographs of the dead body of Baldev Singh. These were taken into possession vide memo Ex.PG.

(10) PW.8 SI Sukhbaj Singh, Finger Prints Expert lifted finger prints from two glass tumblers. He advised the Investigating Officer to pack glass tumblers properly and send those to Finger Prints Bureau, Phillaur, for further necessary action.

(11) PW.9 Manjinder Singh is a material witness. He was a student of Diploma in Computer at Guru Nanak Dev University, Amritsar. He deposed that his father was serving as Assistant Sub Inspector. Smt. Manjit Kaur wife of Amarjit Singh, cousin sister of his father, was residing in America. Jeewan Singh Sidhu, to whom he

identified in the court, was son of Smt. Manjit Kaur and Amarjit Singh. He was a student of MBBS in Medical College, Amritsar. On 02.03.2012, his father Baldev Singh had gone to the Punjab and Haryana High Court, Chandigarh. Baldev Singh came from Chandigarh. He went to Bus Stand, Amritsar, to pick up his father Baldev Singh. His father told him at Bus Stand, Amritsar, that he had received a telephonic call from his cousin sister Manjit Kaur that her son Jeewan Singh was creating problem. He should be left at Nawan Shehar. Baldev Singh should counsel Jeewan Singh by staying with him for the night. He brought his father Baldev Singh to Kothi No. 312, Ranjit Avenue, B Block, Amritsar. Jeewan Singh was present in the accommodation. His father told Jeewan Singh that he was to be left at Nawan Shehar. Jeewan Singh got agitated. He went to his house. However, his father stayed with Jeewan Singh. On the next day, at about 7.00/7.15 AM, he received a telephonic call from Gaurav Taxi Stand that taxi had come to House No. 312-B Block, Ranjit Avenue, Amritsar. He tried to contact his father on phone. However, mobile phone of his father was not reachable. He made a telephonic call at Gaurav Taxi Stand. He got telephone number of the taxi driver. He then made telephonic call to the taxi driver asking him to knock at the door. The taxi driver made a telephonic call to him stating that the door was not being opened. Then, he himself went to House No. 312, B Block, Ranjit Avenue, Amritsar. He entered the house from the back door. He noticed lot of blood in the room. He made a telephonic call to his neighbour Dr. Laddi, who along with Baljinder Singh Dhillon came on the spot. They observed that dead body of his father was lying in the bathroom. He noticed injury marks on the neck and face of his father. According to him, his father was murdered by Jeewan Singh. He informed the police. The police recorded his statement Ex.PH. Photographer was summoned at the spot. In his cross-examination, he deposed that when he along with his father had gone to the rented accommodation of the accused, the accused was using abusive language stating that he would not go to Nawan Shehar. The aunt and uncle of the accused were putting up at Nawan Shehar. The accused was to be sent to Nawan Shehar. The accused was being treated for mental ailment. He was not aware whether accused Jeewan Singh had suffered a fit of schizophrenia.

(12) PW.10 Dr. Ishwar Tayal conducted post mortem examination on the body of Baldev Singh. He noticed following injuries on the body of the deceased :-

(1) Incised looking lacerated wound 9.5 x 6.5 cm horizontally placed on right side of front of neck, extending from mid line on front to right side of neck, 3 cm below the angle of mandible. Edges of the wound were parallel with lateral end of the wound tapering and medial end was broad and serrated with a skin tag extending upto middle of wound. Large vessels (carotid artery and jugular vein) were found cut near the upper margins and lateral end. Clotted blood was present.

(2) Reddish bruise 5 x 4 cm was present at left occipital parietal area of head. On dissection of scalp diffuse subgaleal haematoma was seen at parietal and occipital area of vault. On removing haematoma, depressed comminuted fracture of skull vault was seen radiating as fissure fracture to parietal, occipital and temporal areas. On removing the skull vault and dura, diffuse contre- coup fronto parietal cerebral contusion was present.

(3) Lips found reddish bruised and swollen with mucosal laceration was present corresponding to fractured and dislocated upper right central and lateral incisors. Right upper lateral incisor was found missing while central incisors found fractured at its lateral and free surface. Clotted blood was present in the sockets. Gums correspondingly found bruised.

(4) Lacerated wound was present on front of left side of face obliquely extending downwards at left malar area 6 x .8 cm above root of nose (2.0 x .2 cm). Wound was bone deep at inner canthus of left eye with reddish abrasion (2.5 x 1.0) obliquely placed between nasal and infra orbital limb of wound on left side of nasal bridge. Wound was tapering at inner canthus of left eye with all corresponding soft tissue lacerated. Clotted blood was present. On palpation abnormal mobility of nasal bones was present. On dissection fracture dislocation of nasal bone was seen with infiltration of blood at fracture site.

(5) Lacerated wounds (three in number) varying in size from 4.5 x 1.0 to 1.0 x 0.2 cm obliquely present at left

supra orbital area of forehead above the lateral half of eyebrow, directed towards inner canthus of left eye, in line with reddish abrasion of injury No.4. Clotted blood was present.

(6) Lacerated wound 3.5 x 0.3 cm obliquely placed at left side of forehead parallel to the anterior hair line 2.5 cm below it. Clotted blood was present.

(7) Reddish bruise 1.5 x 1 cm was present at right side of nasal bridge just above the ala of nose.

(8) Reddish bruise 1.0 x 0.5 cm was present at right malar area of face.

(9) Incised wound 4 x 1 cm spindle shaped horizontally placed at left side of neck, 2 cm below the ear lobule with tapering anterior end of wound as linear reddish abrasion. Muscle deep. Clotted blood was present.

(10) Reddish bruise 4 x 3 cm was present at right parieto temporal area of head with corresponding subgaleal haematoma.

(11) Reddish bruise 3 x 2 cm was present at right occipito parietal area of head with corresponding subgaleal haematoma underneath.

(12) Reddish irregular (linear shaped) abrasion 11.0 x 0.2 cm horizontally placed on front of abdomen at eipgastric area extending towards right hypogastric area.

(13) Reddish abrasion 9 x 2 cm horizontally placed 4 cm below and parallel to injury No.12 on anterior abdominal wall.

(13) The injuries were ante-mortem in nature. The cause of death was haemorrhage and shock as a result of injury No.1 leading to severence of carotid vessel and jugular vein which proved fatal. The probable time that elapsed between injuries and death was within a few minutes and between death and post-mortem examination was within 6 to 12 hours.

(14) PW.11 Inspector Sukhwinder Singh deposed that Manjinder Singh accompanied by Baljinder Singh Dhillon met them in A Block, Ranjit Avenue, Amritsar, on 03.03.2012. Manjinder Singh got his

statement recorded vide Ex.PH. FIR Ex.PH/2 was recorded. He went to the spot. The dead body of ASI Baldev Singh was lying in the bathroom with his face towards the ground on the first floor of the house. The dead body was identified by Shabeg Singh and Narinder Singh. He prepared inquest report Ex.PM. He took into possession blood stained bed sheet after converting it into a parcel. A glass tumbler, which was broken, was lying on the bed. Finger prints therefrom were lifted by SI Sukhbaj Singh. The blood which had got solidified was also lifted from the lobby. Wallet of ASI Baldev Singh was lying in the bathroom, containing his Identity Card, ` 165/- in cash and five tickets issued to the policemen for free bus travel. These were taken into possession. A blood stained chhuri (knife) was lying on the double bed. It was also taken into possession. The body was sent for post mortem examination. They came to know that an injured person was admitted in Guru Nanak Hospital, Amritsar. They went there. The complainant identified the injured person to be Jeewan Singh. Accused Jeewan Singh was unconscious and was being treated in the hospital. He moved an application Ex.PX. From 30.03.2012 till 14.05.2012, various applications for permission to arrest Jeewan Singh Sidhu were moved to the attending doctor. The doctor kept declaring him unfit till 14.05.2012. These applications are Ex.PZ, Ex.PZ/1, Ex.PZ/2, Ex.PZ/3 and Ex.PZ/4. The accused was ultimately arrested, when doctor found him fit. In his cross- examination, he deposed that Jeewan Singh Sidhu was removed to Guru Nanak Hospital, Amritsar, by officials of Police Station Civil Lines, Amritsar. During the course of investigation conducted by him, it had not transpired that the accused was suffering from any mental ailment.

(15) PW.12 ASI Ranjit Singh testified that the police party went to the spot. The Investigating Officer took into possession blood stained bed sheet. A glass tumbler was also taken into possession. Finger prints from the glass tumbler were lifted by SI Sukhbaj Singh. The solidified blood was also lifted from the lobby. A wallet of ASI Baldev Singh was also recovered. A blood stained knife, lying on the double bed, was also taken into possession. On 14.05.2012, the accused was declared fit and arrested.

(16) PW.13 Baljinder Singh deposed that he along with Manjinder Singh went to Kothi at Ranjit Avenue. They noticed foot marks stained with blood on the metalled road outside the Kothi. The outer gate of the Kothi was open. He suggested Manjinder Singh that they should contact the police immediately. He along with Manjinder

Singh went to Police Post, Ranjit Avenue. Police officials came to the spot. He found the dead body of ASI Baldev Singh lying in the bathroom. In his cross-examination, he deposed that mother of complainant Manjinder Singh was also informed regarding the murder of Baldev Singh.

(17) PW.14 Smt. Gurbax Kaur is the wife of deceased Baldev Singh.She testified that Baldev Singh was coming back from Chandigarh to Amritsar on 02.03.2012. He made a telephonic call to her stating that his cousin sister and her husband had asked him telephonically to go to the rented accommodation of their son Jeewan Singh at Ranjit Avenue, Amritsar. Her husband had asked her to send Manjinder Singh to Bus Stand to pick up him. She send her son Manjinder Singh to Bus Stand. Manjinder Singh came back to the house. Her husband had to take accused Jeewan Singh to Nawan Shehar. In the morning, on 03.03.2012, at about 6.30 AM, she went to the house of Nishan Singh at Sandhu Colony, Amritsar. She along with Nishan Singh went towards residence of Jeewan Singh. She observed that Jeewan Singh was running towards them. His clothes and body were smeared with blood. She enquired where he was going. He replied that her husband was interfering in his personal life. He had done away with him. Jeewan Singh ran away.

(18) DW.1 Dr. P.D. Garg deposed that accused Jeewan Singh Sidhu was known to him. He was admitted in the Emergency of Ortho Department of Guru Nanak Dev Hospital, on 03.03.2012, as an unknown patient. He examined the patient on 05.03.2012. He noticed that the patient was sad and too much anxious and worried. The thought contents revealed multiple delusions of the nature of persecution and his insight was impaired. His behaviour was disorganized. He was to be controlled by the attendants. He started his treatment. He proved copy of the original bed head ticket of the patient as Ex.D1. In his opinion, the patient was suffering from paranoid schizophrenia and he was having acute attack of the same, when he examined him on 05.03.2012. However, with the treatment, he improved. He was advised MRI test. The report in this regard is Ex.D2. In his cross- examination, he categorically admitted that he had not collected any medical document to show that since when the patient was suffering from the disease or whether he was taking treatment for the same. As a matter of fact, he did not have any previous history of paranoid schizophrenia. He had come to know that the patient had failed in one of the papers. He was taking a tablet known as `alprazolam .25 MG'. He admitted that such

type of tablets are prescribed to patients of high blood pressure, who suffer from bouts of anxiety. He also admitted that as mentioned in the bed head ticket, patient was addicted to taking drugs and there was history of consumption of alcohol at times.

(19) DW.2 Sandeep Singh testified that he was present at Police Post, Circuit House, Amritsar, on 03.03.2012. A passerby informed that a boy, who had cut the vein of his wrist, was fully naked. He was sitting near a dustbin on a footpath outside Pannu International Hotel on Court Road, Amritsar. He went there. He found that the accused was sitting near the dustbin. The veins of his left wrist were cut. He was bleeding profusely. He controlled him somehow and caught hold of his injured left wrist, so as to prevent flow of blood. He made the accused to put on clothes. He made him to sit in the official vehicle. He got him admitted in Guru Nanak Dev Hospital. He asked from the accused his name and other details. The attending doctor obtained his signatures on the bed head ticket at the time of admission of accused in the Emergency of the hospital. In his cross- examination, he admitted specifically that he had not got any report made in the DDR regarding his taking injured/accused to Guru Nanak Dev Hospital, Amritsar. He alone had gone towards Pannu International Hotel on getting information.

(20) DW.3 Dr. Avtar Singh Sidhu testified that he was staying in USA. He had three children. Inderdeep Singh was his younger son. Jeewan Singh Sidhu accused was his real nephew. His younger son Inderdeep Singh was suffering from schizophrenia. He was being treated in USA as well as in India. He produced Mark X, a document regarding his treatment. He also admitted in his cross-examination that he was not in possession of any record to show that the accused was suffering from schizophrenia. Except Inderdeep Singh and Jeewan Singh, all the children in the family were normal.

(21) PW.10 Dr. Ishwar Tayal noticed as many as thirteen injuries on the body of the deceased. The cause of death, in his opinion, was haemorrhage and shock as a result of injury No.1 leading to severence of carotid vessel and jugular vein which proved fatal. He proved post mortem report Ex.PL. The probable time that elapsed between injuries and death was within a few minutes and between death and post-mortem examination was within 6 to 12 hours. The inquest report is Ex.PM. The final report submitted by the Director, Finger Prints Bureau, Phillaur, reads as under :-

> "I have examined the already powdered, encircled and

initialed impressions on the articles noted in the margin received on dated 15.05.2012 from the Commissioner of Police, Amritsar City vide his memo No. 11170/C dated 14.05.2012 in a sealed parcel sealed with two seals of `SS' seals intact and corresponding to the specimen seal and opened by me in Case FIR No. 88 dated 03.03.2012, U/s 302/34 IPC, PS Civil Line Amritsar, Distt. Amritsar through HC Harvinder Singh No. 1321/ASR and the impressions found on them have been photographed vide three copies of photographs (I & II relates to glass tumbler `A' and III relates to glass tumbler `B') are enclosed. The photographed impressions on the photographs are the true representation of the original impressions.

Sample papers bearing clearly recorded fully rolled and plain (impressed upto the top) the ten digit impressions of the suspects with printer's black ink (not pad ink) duly attested by the concerned magistrate may be sent to this office along with photographs for further necessary action.

The articles noted in the margin duly sealed in a parcel (specimen seal enclosed) are returned herewith through the same messenger who brought them here."

(22) PW.9 Manjinder Singh had lodged report Ex.PH. According to him, his father Baldev Singh had gone to the Punjab and Haryana High Court,Chandigarh, on 02.03.2012. On return of his father to Amritsar, he had gone to pick up him at Bus Stand. His father told him at Bus Stand that he had received a telephone call from his cousin sister Manjit Kaur that her son Jeewan Singh was creating problem. He should be dropped at Nawan Shehar. He took his father to Kothi No. 312, Ranjit Avenue, B Block, Amritsar. He arranged meals for them. On the next day, at about 7.00/7.15 AM, he received a telephonic call from Gaurav Taxi Stand that taxi had come to House No. 312-B Block, Ranjit Avenue, Amritsar. Taxi was parked there. He was asked to make telephone contact with his father. He tried to contact his father. The mobile phone of his father was not reachable. He asked the taxi driver on his phone to knock at the door. The taxi driver informed him telephonically that there was no response from inside the house. He himself went to the house. The taxi driver was standing outside. He entered the house from the back door. He noticed lot of blood in the room. He informed his neighbour Dr. Laddi, who along with Baljinder Singh Dhillon came on the spot. He noticed that dead body of his father

was lying in the bathroom. In his cross-examination, he categorically deposed that he did not know that for mental ailment, paternal aunt and uncle of the accused were getting him treated. He did not know that in those days, the accused had suffered a fit of schizophrenia. PW.13 Baljinder Singh also deposed that he had gone to the spot along with Manjinder Singh. PW.14 Smt. Gurbax Kaur had seen the appellant running away from the house. She was told by him that her husband Baldev Singh was interfering in his personal life and he has done away with him. The appellant was closely related to the deceased and his wife. There was no occasion for them to falsely implicate him. PW.6 Ms. Sharanjit Kaur has proved the rent agreement Ex.PF. According to her, she had rented out the first floor of Kothi No. B-312, Ranjit Avenue, Amritsar, to Jeewan Singh Sidhu, who was a student of MBBS in Government Medical College, Amritsar. PW.8 SI Sukhbaj Singh, Finger Prints Expert had developed finger prints from two glass tumblers and sent the same to the Finger Prints Bureau, Phillaur. The Director, Finger Prints Bureau, Phillaur, submitted his report, as quoted above. PW.11 Inspector Sukhwinder Singh submitted applications Ex.PZ, Ex.PZ/1, Ex.PZ/2, Ex.PZ/3 and Ex.PZ/4 before the doctor, who was attending Jeewan Singh Sidhu, to know whether he was fit to be arrested. The last application was made on 14.05.2012, when the doctor declared the accused to be fit. He was arrested. In his cross-examination, he deposed that during the course of investigation conducted by him, it had not transpired that the accused was suffering from any mental ailment.

(23) DW.1 Dr. P.D. Garg, in his examination-in-chief, deposed that he examined the accused. According to him, the thought contents of the accused revealed multiple delusions of the nature of persecution and his insight was impaired. His behaviour was disorganized. He started treating him. He proved his bed head ticket vide Ex.D1. According to him, the accused was suffering from paranoid schizophrenia and was having acute attack of the same, when he examined him on 05.03.2012. He advised MRI test. MRI revealed mild cerebellar and frono parietal cortical atrophic changes. According to him, when a patient of such disease suffers a fit thereof, then he loses mental capacity to know what is right or wrong. However, the fact of the matter is that in his cross-examination, he categorically admitted that the appellant did not have any previous history of paranoid schizophrenia. The accused was only taking a tablet known as `alprazolam .25 MG'. Such type of tablets are prescribed to patients of high blood pressure, who suffer from bouts of anxiety. He also

admitted that as per the bed head ticket, patient was addicted to taking drugs and there was history of consumption of alcohol. DW.2 Sandeep Singh had taken the accused to the hospital. According to him, he was lying naked near Pannu International Hotel. He took him to the hospital. In his cross-examination, he admitted that he had not got any report made in the DDR regarding his taking the accused to Guru Nanak Dev Hospital, Amritsar. DW.3 Dr. Avtar Singh Sidhu only deposed that the accused was suffering from schizophrenia. However, in cross-examination, he admitted that he was not in possession of any record to show that the accused was suffering from schizophrenia.

(24) The appellant has taken the plea of mental disorder, namely schizophrenia, under Section 84 IPC. In such like cases, the Court has to see the mental status of the accused at the time of commission of the offence.

(25) DW.1 Dr. P.D. Garg, as noticed here-in-above, admitted in his cross-examination that as a matter of fact, the appellant was not having any previous history of paranoid schizophrenia. According to him, the appellant had suffered attack of paranoid schizophrenia on 05.03.2012. Dr. Avtar Singh Sidhu, uncle of the appellant, while appearing as DW.3, also tried to project that the appellant was suffering from schizophrenia, but he did not produce any record in this regard. The fact of the matter is that the deceased had stayed at Kothi No. 312-B Block, Ranjit Avenue, Amritsar, with the appellant over-night. The deceased was asking that the appellant is to be dropped at Nawan Shehar in the morning. PW.9 Manjinder Singh had arranged for meals in the night. A taxi was got booked. Thereafter, PW.9 Manjinder Singh went to his house. In the morning, he got telephone call from the taxi driver that there was no response from inside the Kothi. Thereafter, he along with PW.13 Baljinder Singh went inside the Kothi. They noticed that dead body of his father was lying in the bathroom. A knife was got recovered. As per the report of the Director, Finger Print Bureau, Phillaur, the finger prints of the appellant matched with those found on the tumbler. Even as per the MRI report Ex.D2, there were only mild cerebellar and frono parietal cortical atrophic changes. The opinion given in the MRI report Ex.D2, as per the medical literature, is not diagnostic of schizophrenia. The appellant was not suffering from schizophrenia at the time of commission of the offence.

(26) The court while taking up the plea of insanity has to see the legal insanity and not medical insanity. It is for the appellant to prove that he was suffering from insanity as per section 105 of the Indian

Evidence Act. The appellant has not led any tangible evidence to prove that he was suffering from schizophrenia at the time of commission of the offence.

(27) Their Lordships of the Supreme Court in ***State of Madhya Pradesh*** versus ***Ahmadulla***[1] have held that the crucial point of time at which the unsoundness of mind as defined in section 84 has to be established is when the act was committed. Their Lordships have held as under:

> "2. There is very little dispute about the facts or even about the construction of S. 84 of the Code because both the learned Sessions Judge as well as the learned Judges of the High Court on appeal have held that the crucial point of time at which the unsoundness of mind, as defined in that section, has to be established is when the act was committed. It is the application of this principle to the facts established by the evidence that is the ground of complaint by the appellant-State before us.
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> 8. In this connection we might refer to the decision of the Court of Criminal Appeal in England in Henry Perry 14 Cri App Rep 48 where also the defence was that the accused had been prone to have fits of epileptic insanity. During the course of the argument Reading. C. J., observed :
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> > "The crux of the whole question is whether this man was suffering from epilepsy at the time he committed the crime. Otherwise it would be a most dangerous doctrine if a man could say.' "I once had an epileptic fit, and everything that happens hereafter must be put down to that."
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> In dismissing the appeal the learned Chief Justice said :
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> > "Every man is presumed to be sane and to possess a sufficient degree of reason to be responsible for his acts unless the contrary is proved. To establish insanity it must be clearly proved that at the time of committing the act the party is labouring under such defect of reason as not to know the nature and quality of the act which he is

[1] AIR 1961 SC 998

> committing - that is, the physical nature and quality as distinguished from the moral - or, if he does know the nature and quality of the act he is committing, that he does not know that he is doing wrong There is, however, evidence of a medical character before the jury, and there are statements made by the prisoner himself, that he has suffered from epileptic fits. The Court has had further evidence, especially in the prison records, of his having had attacks of epilepsy. But to establish that is only one step; it must be shown that the man was suffering from an epileptic seizure at the time when he committed the murders; and that has not been proved."

We consider that the situation in the present case is very similar and the observations extracted apply with appositeness. We consider that there was no basis in the evidence before the Court for the finding by the Sessions Judge that at the crucial moment when the accused cut the throat of his mother-in-law and severed her head, he was suffering from unsoundness of mind incapable of knowing that what he was doing was wrong. Even the evidence of the father does not support such a finding. In this connection the Courts below have failed to take into account the circumstances in which the killing was compassed. The accused bore ill will to Bismilla and the act was committed at dead of night when he would not be seen, the accused taking a torch with him, access to the house of the deceased being obtained by stealth by scaling over a wall. Then again, there was the mood of exaltation which the accused exhibited after he had put her out of her life. It was a crime committed not in a sudden mood of insanity but one that was preceded by careful planning and exhibiting cool calculation in execution and directed against a person who was considered to be the enemy."

(28) Their Lordships of the Supreme Court in ***Dahyabhai Chhaganbhai Thakkar*** versus ***State of Gujarat***[2] have held that that when a plea of legal insanity is set up, the Court has to consider whether at the time of commission of the offence the accused, by

[2] AIR 1964 SC 1563

reason of unsoundness of mind, was incapable of knowing the nature of the act or that he was doing what was either wrong or contrary to law. The crucial point of time for ascertaining the state of mind of the accused is the time when the offence was committed. Their Lordships have held as under:

> “9. When a plea of legal insanity is set up, the court has to consider whether at the time of commission of the offence the accused, by reason of unsoundness of mind, was incapable of knowing the nature of the act or that he was doing what was either wrong or contrary to law. The crucial point of time for ascertaining the state of mind of the accused is the time when the offence was committed. Whether the accused was in such a state of mind as to be entitled to the benefit of S. 84 of the Indian Penal Code can only be established from the circumstances which preceded, attended and followed the crime.
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> 14. The subsequent events leading up to the trial make it abundantly clear that the plea of insanity was a belated afterthought and a false case. After the accused came out of the room, he was taken to the chora and was confined in a room in the chora. P. W. 16, the police sub-inspector reached Bherai at about 9.30 a.m. He interrogated the accused; recorded his statement and arrested him at about 10.30 a.m. According to him, as the accused was willing to make a confession, he was sent to the judicial magistrate. This witnesses described the condition of the accused when he met him thus:
>
> "When I went in the Chora he had saluted me and he was completely sane. There was absolutely no sign of insanity and he was not behaving as an insane man. He was not abusing. He had replied to my questions understanding them and was giving relevant replies. And therefore I had sent him to the Magistrate for confession as he wanted to confess."
>
> There is no reason to disbelive this evidence, particularly when this is consistent with the subsequent conduct of the accused. But P. W. 9, who attested the panchanama, Ex. 19, recording the condition of the accused's body and his

clothes, deposed that the accused was murmuring and laughing. But no mention of his condition was described in the panchnama. Thereafter, the accused was sent to the Medical Officer, Matar, for examination and treatment of his injuries. The doctor examined the accused at 9.30 p.m. and gave his evidence as P. W. 11. He proved the certificate issued by him, Ex. 23. Nothing about the mental condition of the accused was noted in that certificate. Not a single question was put to this witnesses in the crossexamination about the mental condition of the accused. On the same day, the accused was sent to the Judicial Magistrate, First Class, for making a confession. On the next day he was produced before the said Magistrate, who asked him the necessary questions and gave him the warning that his confession would be used against him at the trial. The accused was given time for reflection and was produced before the Magistrate on April 13, 1959. On that date he refused to make the confession. His conduct before the Magistrate, as recorded in Ex. 31 indicates that he was in a fit condition to appreciate the questions put to him and finally to make up his mind not to make the confession which he had earlier offered to do. During the enquiry proceedings under Ch. XVIII of the Code of Criminal Procedure, no suggestion was made on behalf of the accused that he was insane. For the first time on June 27, 1959, at the commencement of the trial in the sessions court an application was filed on behalf of the accused alleging that he was suffering from an attack of insanity. On June 29, 1959, the Sessions Judge sent the accused to the Civil Surgeon, Khaira, for observation. On receiving his report, the learned Sessions Judge, by his order dated July 13, 1959, found the accused insane and incapable of making his defence. On August 28, 1959, the court directed the accused to be sent to the Superintendent of Mental Hospital, Baroda, for keeping him under observation with a direction to send his report on or before September 18, 1959. The said Superintendent sent his report on August 27, 1960 to the effect that the accused was capable of understanding the proceedings of the court and of making his defence in the court. On enquiry the court held that the accused could understand the proceedings of the case and was capable of

> making his defence. At the commencement of the trial, the pleader for the accused stated that the accused could understand the proceedings. The proceedings before the Sessions Judge only show that for a short time after the case had commenced before him the accused was insane. But that fact would not establish that the accused was having fits of insanity for 4 or 5 years before the incident and that at the time he killed his wife he had such a fit of insanity as to give him the benefit of S. 84 of the Indian Penal Code. The said entire conduct of the accused from the time he killed his wife upto the time the sessions proceedings commenced is inconsistent with the fact that he had a fit of insanity when he killed his wife."

(29) Their Lordships of the Supreme Court in ***Ratan Lal*** versus ***The State of Madhya Pradesh***[3] have held that the crucial point of time at which unsoundness of mind has to be proved is the time when the crime is actually committed. The burden of proving this can be discharged by the accused from the circumstances which preceded, attended and followed the crime. Their Lordships have held as under:

> "2. It is now well settled that the crucial point of time at which unsoundness of mind should be established is the time when the crime is actually committed and the burden of proving this lies on the accused. (See **State of Madhya Pradesh v. Ahmadullah, (1961) 3 SCR 583 = (AIR 1961 SC** 998)**. In** D. C. Thakkar v. State of Gujarat, (1964) 7 SCR 361 = (AIR 1964 SC 1563)**; it was** laid down that "there is a rebuttable presumption that the accused was not insane, when he committed the crime, in the sense laid down by Section 84 of the Indian Penal Code: the accused may rebut it by placing before the Court all the relevant evidence oral, documentary or circumstantial, but the burden of proof upon him is no higher than that which rests upon a party to civil proceedings." It was further observed:
>
> "The crucial point of time for ascertaining the state of mind of the accused is the time when the offence was committed. Whether the accused was in such a state of mind as to be entitled to the benefit of Section 84 of the Indian Penal Code can only be established from the circumstances which

[3] AIR 1971 SC 778

preceded, attended and followed the crime."

(30) Their Lordships of the Supreme Court in ***Sheralli Wali Mohammed*** versus ***State of Maharashtra***[4] have held that the law presumes every person of the age of discretion to be sane unless the contrary is proved and it would be most dangerous to admit the defence of insanity upon arguments derived merely from the character of the crime. Their Lordships have held as under:

> "12. To establish that the acts done are not offences under S. 84 of the Indian Penal Code, it must be proved clearly that, at the time of the commission of the acts, the appellant, by reason of unsoundness of mind, was incapable of either knowing the nature of the act or that the acts were either morally wrong or contrary to law. The question to be asked is, is there evidence to show that, at the time of the commission of the offence, he was labouring under any such incapacity? On this question, the state of his mind before and after the commission of the offence is relevant. The general burden of proof that an accused person is in a sound state of mind is upon the prosecution. In Dahyabhai Chhaganbhai Thakkar v. The State of Gujarat, (1964) 7 SCR 361 at p. 367 = (AIR 1964 SC 1563), Subba Rao, J., as he then was, speaking for the Court said
>
> "(1) The prosecution must prove beyond reasonable doubt that the accused had committed the offence with the requisite mens rea; and the burden of proving that always rests on the prosecution from the beginning to the end of the trial. (2) there is a rebuttable presumption that the accused was not insane, when he committed the crime, in the sense laid down by S. 84 of the Indian Penal Code: the accused may rebut it by placing before the Court all the relevant evidence oral, documentary or circumstantial, but the burden of proof upon him is no higher than that rests upon a party to civil proceedings. (3) Even if the accused was not able to establish conclusively that he was insane at the time he committed the offence, the evidence placed before the Court by the accused or by the prosecution may raise a reasonable doubt in the mind of the Court as regards one or more of the ingredients of the offence, including mens rea of

[4] AIR 1972 SC 2443

the accused and in that case the Court would be entitled to acquit the accused on the ground that the general burden of proof resting on the prosecution was not discharged."

13. With this in mind, let us consider the evidence to see whether the accused was in an unsound state of mind at the time of the commission of the acts attributed to him, P. W. 3, one of the brothers of the accused stated that the accused used to become excited and uncontrollable, that sometimes he behaved like a mad man, and that he was treated by Dr. Deshpande and Dr. Malville. P. W. 4, Hyderali, also a brother of the accused, has stated that the accused used to suffer from temporary insanity and that he was treated by Dr. Deshpande and Dr. Malville. The evidence of these two witnesses on the question of the insanity of the accused did not appeal to the trial Court and the Court did not, we think rightly, place any reliance upon it. No attempt was made by the defence to examine the two doctors. There was, therefore, no evidence to show that, at the time of the commission of the acts, the accused was not in a sound state of mind. On the other hand, P. W. 8, Rustom Mirja, has stated in his deposition that the accused has been working with him as an additional motor driver for the last 8 or 10 years and that his work and conduct were normal. He also stated that the accused worked with him on March 6, 1968, till 4 P.M. P. W. 16, Dr. Kaloorkar, who examined the accused at 7.20 A.M. on the day of the occurrence, has stated in his deposition that he found that the accused was in normal condition. His evidence has not been challenged in cross-examination.

We think that not only is there no evidence to show that the accused was insane at the time of the commission of the acts attributed to him, but that there is nothing to indicate that he had not the necessary mens rea when he committed the offence. The law presumes every person of the age of discretion to be sane unless the contrary is proved. It would be most dangerous to admit the defence of insanity upon arguments derived merely from the character of the crime. The mere fact that no motive has been proved why the accused murdered his wife and child or, the fact that he made no attempt to run away when the door was broke

open, would not indicate that he was insane or, that he did not have the necessary mens rea for the commission of the offence. We see no reason to interfere with the concurrent findings on this point either."

(31) The nature and symptom of the this bipolar disease were described by the High Court of Karnataka in ***Nalini Kumari*** versus ***K.S. Bopaiah***[5]**.** The Court has observed as under :

"19. Now let us discuss what is This Bipolar disease and whether it is curable/controllable and treatable disease?

20. In National Institute of Mental Health Publication No. 3679, it is stated:

Introduction:

Bipolar disorder, also known as manicdepressive illness, is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs that everyone goes through, the symptoms of bipolar disorder are severs. They can result in damaged relationships, poor job or school performance, and even suicide. But bipolar disorder can be treated, and people with this illness can lead full and productive lives.

(emphasis supplied) What is the Course of Bipolar Disorder?

Episodes of mania and depression typically recur across the life span. Between episodes, most people with bipolar disorder are free of symptoms, but as many as one-third of people have some residual symptoms. A small percentage of people experience chronic unremitting symptoms despite treatment.

The classic form of the illness, which involves recurrent episodes of mania and depression, is called bipolar I disorder. Some people, however, never develop severe mania but instead experience milder episodes of hypomania that alternate with depression; this form of the illness is called bipolar II disorder. When four or more episodes of illness occur within a 12-month period, a person is said to have rapid-cycling bipolar disorder. Some people

[5] 2007 (1) Kar LJ 342

experience multiple episodes within a single week, or even within a single day. Rapid-cycling tends to develop later in the course of illness and is more common among women than among men.

People with bipolar disorder can lead healthy and productive lives when the illness is effectively treated (see below - "How is Bipolar Disorder Treated"). Without treatment, however, the natural course of bipolar disorder tends to worsen. Over time a person may suffer more frequent (more rapid-cycling) and more severe manic and depressive episodes than those experienced when the illness first appeared. But in most cases, proper treatment can help reduce the frequency and severity of episodes and can help people with bipolar disorder maintain good quality of life.

21. In Health & Medical Information in Psychiatry (Australia's Central Health & Medical Information Resource), it is stated:

Bipolar Affective Disorder (BPAD) is a psychological disease. This condition is characterised by alternating syndromes of depression and mania. Depression is a psychiatric syndrome characterised by a subjective feeling of depression, loss of enjoyment in all activities and overwhelming feelings of guilt and worthlessness.

Mania represents the opposite end of the spectrum characterised by erratic and disinhibiter, behaviour, poor tolerance or frustration, over-extension of responsibility and vegetative signs. These include raised libido, weight loss with anorexia, decreased need for sleep and excessive energy.

Incidence*:*

The prevalence is 1% worldwide. It is equally common in men and women. There is no variation between socioeconomic class or race. The average age of onset is 21. The increased frequency found in divorced people is probably a consequence of the condition.

Predisposing Factors:

The most significant risk factor for the development of BPAD is a family history of either BPAD or depression.

Natural History:

The condition of bipolar usually begins between the ages of 30 to 40 years old. There are two types of bipolar affective disorder - Type I and type II. In type I BPAD, patients will meet the criteria for a full manic episode but may never experience an episode of major depression, type II BPAD, the patient will fulfil the criteria for a major depressive episode but will never experience a full manic episode. They may experience a less form of mania called hypomania.

The patient in an episode of major depression is at increased risk of self-harm and suicidal behaviour and must be monitored closely for risk factors. The duration of depressive episode varies but usually lasts for approximately six months if left untreated. In the majority of cases, the patient experiencing an episode of mania will generally refrain from self-harm behaviour. They will, however, place their finances and social life at risk by indulging in wreckless behaviour. These episodes again last for around 3-6 months if left untreated by medication. The patient with type I BPAD will typically experience 10 episodes of mania throughout their lives.

Prognosis*:*

The average duration of a manic episode is 3-6 months with 95% making a full recovery in time. Recurrence is the rule is bipolar disorders, with up to 90% relapsing within 10 years. In terms of overall prognosis, 15% completely recover from the illness. 50-60% partially recover and one third will retain chronic symptoms resulting in social and occupational dysfunction.

Investigation*:*

Patients should be screened for thyroid function and can produce hypothyroidism. During treatment, lithium levels should be checked for 3 months, along with regular thyroid and renal function rents.

Treatment Overview:

The primary treatment for BPAD involves long- term daily medications. The most commonly used drug in the initial

management of BPAD is lithium. The drug takes about 2 weeks to take effect and is effective in stabilising the patient's mood. Other drugs such as valproate and tegretol are more commonly used in the long term to help prevent the recurrence of mania and depression in patients with BPAD. They may also be combined with lithium for greater effect, if one agent proves inadequate to control the symptoms. Psychotherapy is also helpful in the management of BPAD Group therapy, family therapy and individual psychotherapy have been shown to improve the outcome of this condition when combined with the regular use of medications.

22. In Wikipedia, the free encyclopedia, it is stated:

Bipolar disorder (previously known as Manic Depression) is a psychiatric diagnostic category describing a class of mood disorders in which the person experiences clinical depression and/or mania, hypomania, and/or mixed stated. The disorder can cause great distress among those afflicted and those living with them. Bipolar disorder can be a disabling condition, with a higher-than-average risk of death through suicide.

The difference between bipolar disorder and unipoloar disorder (also called major depression) is that bipolar disorder involves both elevated and depressive mood states. The duration and intensity of mood states varies widely among people with the illness. Fluctuating from one mood state to the next is called "cycling". Mood swings can cause impairment or improved functioning depending on their direction (up or down) and severity (mild to severe). There can be change in one's energy level, sleep pattern, activity level, social rhythms and cognitive functioning. Some people may have difficulty functioning during these times.

Domains of the bipolar spectrum:

Bipolar disorder is often a life-long condition that must be carefully managed. Because there is so much variation in severity and nature of mood problems, it is increasingly being called bipolar spectrum disorder. The spectrum concept refers to subtypes of bipolar disorder or a continuant of mood problems, that can include sub-

syndromal (below the symptom threshold for categorical diagnosis) symptoms. Nassir Ghaemi, M.D., has also contributed to the development of a bipolar spectrum questionnaire. The full bipolar spectrum includes all states or phases of the bipolar disorders.

Kraepelin's (1921) construct is useful for primary care clinicians, patients and families. It describes variations in two directions (mania and depression) and of three aspects: mood, activity and thinking.

Bipolar depression:

According to the Mayo Clinic, in the depressive phase, signs and symptoms include: persistent feelings of sadness, anxiety, guilt, anger, isolation and/or hopelessness, disturbances in sleep and appetite, fatigue and loss of interest in daily activities, problems concentrating, irritability, chronic pain without a known cause, recurring thoughts of suicide.

A 2003 study by Robert Hirschfeld, M.D., of the University of Texas Medical Branch, Galveston found bipolar patients fared worse in their depressions than unipolar patients. In terms of disability, lost years of productivity, and potential for suicide, bipolar depression, which is different (in terms of treatment), from unipolar depression, is now recognized as the most insidious aspect of the illness.

Severe depression may be accompanied by symptoms of psychosis. These symptoms include hallucinations (hearing, seeing or otherwise sensing the presence of stimuli that are not there) and delusions (false personal beliefs that are not subject to reason or contradictory evidence and are not explained by a person's cultural concepts). They may also suffer Page 0136 from paranoid thoughts of being persecuted or monitored by some powerful entity such as the government or a hostile force or become paranoid that they'll be abandoned and left by those close to them. Intense and unusual religious beliefs may also be present, such as patients' strong insistence that they have a God-given role to play in the world, a great and historic mission to accomplish, or even that they possess supernatural powers. Delusions in a depression may be far more distressing,

sometimes taking the form of intense guilt for supposed wrongs that the patient believes he or she has inflicted on your others. There are a number of conflicting theories on what can be considered the cause of bipolar depression, and what may be a symptom, none of which are yet widely accepted as correct. It is crucially important to understand that there is no blood test or brain scan that expresses distinctly that this disorder exists.

Diagnosis:

Diagnostic criteria:

Flux is the fundamental nature of bipolar disorder. Both within and between individuals with the illness, energy, mood, thought, sleep, and activity are among the continually changing biological markers of the disorder. The diagnostic subtypes of bipolar disorder are thus static descriptions - snapshots, perhaps - of an illness in continual change. Individuals may stay in one subtype, or change into another, over the course of their illness. The DSMV, to be published in 2011, will likely include further and more accurate sub-typing (Akiskal and Ghaemi, 2006).

There are currently four types of bipolar illness.

The DSM-IV-TR details four categories of bipolar disorder, Bipolar I, Bipolar II, Cyclothemia, and Bipolar Disorder NOS (Not Otherwise Specified).

According to the DSM-IV-TR, a diagnosis of Bipolar I disorder requires one or more manic or mixed episodes. A depressive episode is not required for a diagnosis of BP I disorder, although the overwhelming majority of people with BP I suffer from them as well.

Bipolar II, the more common but by no means less severe type of the disorder, is usually characterized by one or more episodes of hypomania and one or more severe depressions. A diagnosis of bipolar II disorder requires only on hypomanic episode. This stipulation is used mainly to differentiate it from unipolar depression. Although a patient may be depressed, it is very important to find out from the patient or the patient's family or friends if hypomania has ever been present, using careful questioning. This, again,

avoids the antidepressant problem. Recent screening tools such as the Hypomanic Check List Questionnaire (HCL-32) have been developed to assist the quite often difficult detection of Bipolar II disorders.

A diagnosis of Cyclothymic Disorder requires the presence of numerous hypomanic episodes, intermingled with depressive episodes that do not meet full criteria for major depressive episodes. The main idea here is that there is a low-grade cycling of mood which appears to the observer as a personality trait, but interferes with functioning.

If an individual clearly seems to be suffering from some type of bipolar disorder but does not meet the criteria for one of the subtypes above, he or she receives a diagnosis of Bipolar Disorder NOS (Not Otherwise Specified).

Misdiagnosis:

There are many problems with symptom accuracy, relevance, and reliability in making a diagnosis of bipolar disorder using the DSM-IV- TR. These problems all too often lead to misdiagnosis.

Infact, University of California at San Diego's Hagop Akiskal M.D., believes that the way the bipolar disorders in the DSM are conceptualized and presented routinely lead many primary care doctors and mental health professionals to misdiagnose bipolar patients with unipolar depression, when a careful history from patient, family, and/or friends would yield the correct diagnosis.

If misdiagnosed with depression, patients are usually prescribed antidepressants, and the person with bipolar depression can become agitated, angry, hostile, suicidal, and even homicidal (these are all symptoms of hypomania, mania, and mixed states).

Treatment*:*

Currently, bipolar disorder cannot be cured, though psychiatrists and psychologists believe that it can be managed.

The emphasis of treatment is on effective management of the long-term course of the illness, which usually involves

treatment of emergent symptoms. Treatment methods include pharmacological and psychotherapeutic techniques. Leading bipolar specialist, Gillian Townley, has researched the effect of the Ferret Rabbit process.

Prognosis and the goals of long-term treatment:

A good prognosis results from good treatment which, in turn, results, from an accurate diagnosis. Because bipolar disorder continues to have a high rate of both under-diagnosis and misdiagnosis, it is often difficult for individuals with the illness to receive timely and competent treatment.

Bipolar disorder is a severely disabling medical condition. In fact, it is the 6th leading cause of disability in the world, according to the World Health Organization. However, with appropriate treatment, many individuals with bipolar disorder can live full and satisfying lives. Persons with bipolar disorder are likely to have periods of normal or near normal functioning between episodes.

Ultimately one's prognosis depends on many factors, which are, infact, under the individual's control; the right medicines; the right does of each; a very informed patient; a good working relationship with a competent medical doctor; a competent, supportive and warm therapist; a supportive family or significant other; and a balanced lifestyle including a regulated stress level, regular exercise and regular sleep and wake times.

There are obviously other factors that lead to a good prognosis, as well, such as being very aware of small changes in one's energy, mood, sleep and eating behaviors, as well as having a plan in conjunction with one's doctor for how to manage subtle changes that might indicate the beginning of a mood swing. Some people find that keeping a log of their moods can help them in predicting changes.

The goals of long-term optimal treatment are to help the individual achieve the highest level of functioning while avoiding lapse.

23. The following is a quote from a successfully treated individual with bipolar disorder (from the U.S. National

Institute of Mental Health):

Manic-depression distorts moods and thoughts, incites dreadful behaviors, destroys the basis of rational thought, and too often erodes the desire and will to live. It is an illness which is biological yet looks and feels psychological, one that is unique in conferring advantage and pleasure, yet one that brings in its wake almost unendurable suffering and, not infrequently, suicide. I am fortunate that I have not died from my illness, fortunate in having received the best medical care available, and fortunate of having the friends, colleagues, and family that I do.

Bipolar disorder and creativity: Bipolar disorder is found in disproportionate numbers in people with creative talent such as artists, musicians, authors, performers, poets and scientists, and some credit the condition for their creativity. Many famous historical figures gifted with creative talents commonly are believed to have been affected by bipolar disorder, and were "diagnosed" after their deaths based on letters, correspondence, contemporaneous accounts, or other material.

It has been speculated that the mechanisms, which cause the disorder may also spur creativity.

Kay Redfield Jamison, who herself has bipolar disorder and is considered a leading expert on the disease, has written several books that explore this idea, including Touched with Fire. Research indicates that while mania may contribute to creativity (See Andreasen, 1988), hypomanic phases experienced in bipolar I, II, and in cyclothymia appear to have the greatest contribution in creativity (See Richarges, 1988). This is perhaps due to the distress and impairment associated with full-blown mania, which may be preceded by symptoms of hypomania (i.e. increased energy, confidence, activity), but soon spirals into a state much too debilitating to allow creative endeavour.

Hypomanic phases of the illness allow for heightened concentration on activities, and the manic phases allow for around-the-clock work with minimal need for sleep.

Another theory is that the rapid thinking associated with mania generates a higher volume of ideas and as well

> associations drawn between a wide range of seemingly unrelated information. The increased energy also allows for grater volume of production."

(32) Their Lordships of the Supreme Court in ***Hari Singh Gond*** versus ***State of Madhya Pradesh***[6] have held that Section 84 IPC lays down the legal test of responsibility in cases of alleged unsoundness of mind. There is no definition of unsoundness of mind in the Indian Penal Code. Courts have, however, mainly treated this expression as equivalent to insanity. Their Lordships have further held that every person, who is mentally diseased, is not ipso facto exempted from criminal responsibility. Their Lordships have held as under:

> "7. Section 84 lays down the legal test of responsibility in cases of alleged unsoundness of mind. There, is no definition of "unsoundness of mind" in the IPC. Courts have, however, mainly treated this expression as equivalent to insanity. But the term "insanity" itself has no precise definition. It is a term used to describe varying degrees of mental disorder. So, every person, who is mentally diseased, is not ipso facto exempted from criminal responsibility. A distinction is to be made between legal insanity and medical insanity. A Court is concerned with legal insanity, and not with medical insanity. The burden of proof rests on an accused to prove his insanity, which arises by virtue of Section 105 of the Evidence Act, 1872 (in short the `Evidence Act') and is not so onerous as that upon the prosecution to prove that the accused committed the act with which he is charged. The burden on the accused is no higher than that resting upon a plaintiff or a defendant in a civil proceeding. (See Dahyabhai Chhaganbhai Thakkar v. State of Gujarat AIR 1964 SC 1563). In dealing with cases involving a defence of insanity, distinction must be made between cases, in which insanity is more or less proved and the question is only as to the degree of irresponsibility, and cases, in which insanity is sought to be proved in respect of a person, who for all intents and purposes, appears sane. In all cases, where previous insanity is proved or admitted, certain considerations have to be borne in mind. Mayne summarises them as follows:

[6] 2008 (16) SCC 109

"Whether there was deliberation and preparation for the act; whether it was done in a manner which showed a desire to concealment ; whether after the crime, the offender showed consciousness of guilt and made efforts to avoid detections, whether after his arrest, he offered false excuses and made false statements. All facts of this sort are material as bearing on the test, which Bramwall, submitted to a jury in such a case: "Would the prisoner have committed the act if there had been a policeman at his elbow?" It is to be remembered that these tests are good for cases in which previous insanity is more or less established. These tests are not always reliable where there is, what Mayne calls, "inferential insanity".

8. Under Section 84 IPC, a person is exonerated from liability for doing an act on the ground of unsoundness of mind if he, at the time of doing the act, is either incapable of knowing (a) the nature of the act, or (b) that he is doing what is either wrong or contrary to law. The accused is protected not only when, on account of insanity, he was incapable of knowing the nature of the act, but also when he did not know either that the act was wrong or that it was contrary to law, although he might know the nature of the act itself. He is, however, not protected if he knew that what he was doing was wrong, even if he did not know that it was contrary to law, and also if he knew that what he was doing was contrary to law even though he did not know that it was wrong. The onus of proving unsoundness of mind is on the accused. But where during the investigation previous history of insanity is revealed, it is the duty of an honest investigator to subject the accused to a medical examination and place that evidence before the Court and if this is not done, it creates a serious infirmity in the prosecution case and the benefit of doubt has to be given to the accused. The onus, however, has to be discharged by producing evidence as to the conduct of the accused shortly prior to the offence and his conduct at the time or immediately afterwards, also by evidence of his mental condition and other relevant factors. Every person is presumed to know the natural consequences of his act. Similarly every person is also presumed to know the law. The prosecution has not to establish these facts.

9. There are four kinds of persons who may be said to be non compos mentis (not of sound mind), i.e., (1) an idiot; (2) one made non compos by illness (3) a lunatic or a mad man and (4.) one who is drunk. An idiot is one who is of non-sane memory from his birth, by a perpetual infirmity, without lucid intervals; and those are said to be idiots who cannot count twenty, or tell the days of the week, or who do not know their fathers or mothers, or the like, (See Archbold's Criminal Pleadings, Evidence and Practice, 35th Edn. pp.31-32; Russell on Crimes and Misdemeanors, 12th Edn. Vol.1, p.105; 1 Hale's Pleas of the Crown 34). A person made non compos mentis by illness is excused in criminal cases from such acts as are committed while under the influence of this disorder, (See 1 Hale PC 30). A lunatic is one who is afflicted by mental disorder only at certain periods and vicissitudes, having intervals of reason, (See Russell, 12 Edn. Vol. 1, p. 103; Hale PC 31). Madness is permanent. Lunacy and madness are spoken of as acquired insanity, and idiocy as natural insanity.

10. Section 84 embodies the fundamental maxim of criminal law, i.e., actus non reum facit nisi mens sit rea" (an act does not constitute guilt unless done with a guilty intention). In order to constitute an offence, the intent and act must concur; but in the case of insane persons, no culpability is fastened on them as they have no free will (furios is nulla voluntas est).

11. The section itself provides that the benefit is available only after it is proved that at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or that even if he did not know it, it was either wrong or contrary to law then this section must be applied. The crucial point of time for deciding whether the benefit of this section should be given or not, is the material time when the offence takes place. In coming to that conclusion, the relevant circumstances are to be taken into consideration, it would be dangerous to admit the defence of insanity upon arguments derived merely from the character of the crime. It is only unsoundness of mind which naturally impairs the cognitive faculties of the mind

that can form a ground of exemption from criminal responsibility. Stephen in `History of the Criminal Law of England, Vol. II, page 166 has observed that if a person cuts off the head of a sleeping man because it would be great fun to see him looking for it when he woke up, would obviously be a case where the perpetrator of the act would be incapable of knowing the physical effects of his act. The law recognizes nothing but incapacity to realise the nature of the act and presumes that where a man's mind or his faculties of ratiocination are sufficiently dim to apprehend what he is doing, he must always be presumed to intend the consequence of the action he takes. Mere absence of motive for a crime, howsoever atrocious it may be, cannot in the absence of plea and proof of legal insanity, bring the case within this section This Court in Sheralli Wali Mohammed v. State of Maharashtra: (1972 Cri.LJ 1523), held that "the mere fact that no motive has been proved why the accused murdered his wife and children or the fact that he made no attempt to run away when the door was broken open, would not indicate that he was insane or that he did not have necessary mens rea for the commission of offence.

12. Mere abnormality of mind or partial delusion, irresistible impulse or compulsive behaviour of a psychopath affords no protection under Section 84 as the law contained in that section is still squarely based on the outdated M' Naughton rules of 19th Century England. The provisions of Section 84 are in substance the same as that laid down in the answers of the Judges to the questions put to them by the House of Lords, in M' Naughton's case (1843) 4 St. Tr. (NS) 847 (HL). Behaviour, antecedent, attendant and subsequent to the event, may be relevant in finding the mental condition of the accused at the time of the event, but not that remote in time. It is difficult to prove the precise state of the offender's mind at the time of the commission of the offence, but some indication thereof is often furnished by the conduct of the offender while committing it or immediately after the commission of the offence. A lucid interval of an insane person is not merely a cessation of the violent symptoms of the disorder, but a restoration of the faculties of the mind sufficiently to enable the person soundly to judge the act; but the expression does

not necessarily mean complete or prefect restoration of the mental faculties to their original condition. So, if there is such a restoration, the person concerned can do the act with such reason, memory and judgment as to make it a legal act ; but merely a cessation of the violent symptoms of the disorder is not sufficient.

13. The standard to be applied is whether according to the ordinary standard, adopted by reasonable men, the act was right or wrong. The mere fact that an accused is conceited, odd irascible and his brain is not quite all right, or that the physical and mental ailments from which he suffered had rendered his intellect weak and had affected his emotions and will, or that he had committed certain unusual acts, in the past or that he was liable to recurring fits of insanity at short intervals, or that he was subject to getting epileptic fits but there was nothing abnormal in his behaviour, or that his behaviour was queer, cannot be sufficient to attract the application of this section."

(33) Their Lordships of the Supreme Court in **Sudhakaran** versus **State *of Kerala***[7] have distinguished the legal insanity with medical insanity as under:

"26. The defence of insanity has been well known in the English Legal System for many centuries. In the earlier times, it was usually advanced as a justification for seeking pardon. Over a period of time, it was used as a complete defence to criminal liability in offences involving mens rea. It is also accepted that insanity in medical terms is distinguishable from legal insanity. In most cases, in India, the defence of insanity seems to be pleaded where the offender is said to be suffering from the disease of Schizophrenia.

27. *The plea taken in the present case was also* that the appellant was suffering from "paranoid schizophrenia". The term has been defined in Modi's Medical Jurisprudence and Toxicology 23rd Edn. P. 1077 as follows:

"Paranoia is now regarded as a mild form of paranoid schizophrenia. It occurs more in males than in females. The

[7] 2010 (10) SCC 582

main characteristic of this illness is a wellelaborated delusional system in a personality that is otherwise well preserved. The delusions are of persecutory type. The true nature of this illness may go unrecognized for a long time because the personality is well preserved, and some of these paranoiacs may pass off as a social reformers or founders of queer pseudoreligious sects. The classical picture is rare and generally takes a chronic course.

Paranoid Schizophrenia, in the vast majority of case, starts in the fourth decade and develops insidiously. Suspiciousness is the characteristic symptom of the early stage. Ideas of reference occur, which gradually develop into delusions of persecution. Auditory hallucinations follow which in the beginning, start as sound or noises in the ears, but later change into abuses or insults. Delusions are at first indefinite, but gradually they become fixed and definite, to lead the patient to believe that he is persecuted by some unknown person or 1 [23rd Ed. Page 1077] some superhuman agency. He believes that his food is being poisoned, some noxious gases are blown into his room and people are plotting against him to ruin him. Disturbances of general sensation give rise to hallucinations which are attributed to the effects of hypnotism, electricity, wireless telegraphy or atomic agencies. The patient gets very irritated and excited owing to these painful and disagreeable hallucinations and delusions. "

28. The medical profession would undoubtedly treat the appellant herein as a mentally sick person. However, for the purposes of claiming the benefit of the defence of insanity in law, the appellant would have to prove that his cognitive faculties were so impaired, at the time when the crime was committed, as not to know the nature of the act.

29. Section 84 of the Indian Penal Code recognizes the defence of insanity. It is defined as under:-

> "Nothing is an offence which is done by a person who at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law."

30. A bare perusal of the aforesaid section would show

> that in order to succeed, the appellant would have to prove that by reason of unsoundness of mind, he was incapable of knowing the nature of the act committed by him. In the alternate case, he would have to prove that he was incapable of knowing that he was doing what is either wrong or contrary to law."

(34) Their Lordships of the Supreme Court in ***Elavarasan*** versus ***State***[8] have held that while determining whether the accused is entitled to the benefit of Section 84 IPC, the Court has to consider the circumstances that proceeded, attended or followed the crime but it is equally true that such circumstances must be established by credible evidence. Their Lordships have held as under:

> "21. From the deposition of the above two witnesses who happen to be the close family members of the appellant it is not possible to infer that the appellant was of unsound mind at the time of the incident or at any time before that. The fact that the appellant was working as a government servant and was posted as a Watchman with no history of any complaint as to his mental health from anyone supervising his duties, is significant. Equally important is the fact that his spouse Smt. Dhanalakshim who was living with him under the same roof also did not suggest any ailment afflicting the appellant except sleeplessness which was diagnosed by the doctor to be the effect of excessive drinking. The deposition of PW3, Valli that her son was getting treatment for mental disorder is also much too vague and deficient for this Court to record a finding of unsoundness of mind especially when the witness had turned hostile at the trial despite multiple injuries sustained by her which she tried to attribute to a fall inside her house. The statement of the witness that her son was getting treatment for some mental disorder cannot in the circumstances be accepted on its face value, to rest an order of acquittal in favour of the appellant on the basis thereof. It is obvious that the mother has switched sides to save her son from the consequences flowing from his criminal act.
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> 25. What is important is that the depositions of the two

[8] AIR 2011 SC 2816

doctors examined as court witnesses during the trial deal with the mental health condition of the appellant at the time of the examination by the doctors and not the commission of the offence which is the relevant point of time for claiming the benefit of Section 84 I.P.C. The medical opinion available on record simply deals with the question whether the appellant is suffering from any disease, mental or otherwise that could prevent him from making his defence at the trial. It is true that while determining whether the accused is entitled to the benefit of Section 84 I.P.C. the Court has to consider the circumstances that proceeded, attended or followed the crime but it is equally true that such circumstances must be established by credible evidence. No such evidence has been led in this case. On the contrary expert evidence comprising the deposition and certificates of Dr. Chandrashekhar of JIPMER unequivocally establish that the appellant did not suffer from any medical symptoms that could interfere with his capability of making his defence. There is no evidence suggesting any mental derangement of the appellant at the time of the commission of the crime for neither the wife nor even his mother have in so many words suggested any unsoundness of mind leave alone a mental debility that would prevent him from understanding the nature and consequences of his actions. The doctor, who is alleged to have treated him for insomnia, has also not been examined nor has anyone familiar with the state of his mental health stepped into the witness box to support the plea of insanity. There is no gainsaying that insanity is a medical condition that cannot for long be concealed from friends and relatives of the person concerned. Non- production of anyone who noticed any irrational or eccentric behaviour on the part of the appellant in that view is noteworthy. Suffice it to say that the plea of insanity taken by the appellant was neither substantiated nor probablised.

26. Mr. Mani, as a last ditch attempt relied upon certain observations made in Mahazar Ex.P3 in support of the argument that the appellant was indeed insane at the time of commission of the offences. He submitted that the Mahazar referred to certain writings on the inner walls of the appellant's house which suggested that the appellant was

insane. A similar argument was advanced even before the Courts below and was rejected for reasons which we find to be fairly sound and acceptable especially when evidence on record establishes that the appellant was an alcoholic, who could scribble any message or request on the walls of his house while under the influence of alcohol. The Courts below were, therefore, justified in holding that the plea of insanity had not been proved and the burden of proof cast upon the appellant under Section 105 of the Evidence Act remained undischarged. The High Court has also correctly held that the mere fact that the appellant had assaulted his wife, mother and child was not ipso facto suggestive of his being an insane person."

(35) Their Lordships of the Supreme Court in ***Surendra Mishra*** versus ***State of Jharkhand***[9] have held that to discharge the onus under section 84, accused must prove his conduct prior to offence, at the time or immediately after offence, with reference to his medical condition. Whether accused knew that what he was doing was wrong or that it was contrary to law is of great importance and may attract culpability despite mental unsoundness having been established. Their Lordships have held as under:

"13. In law, the presumption is that every person is sane to the extent that he knows the natural consequences of his act. The burden of proof in the face of Section 105 of the Evidence Act is on the accused. Though the burden is on the accused but he is not required to prove the same beyond all reasonable doubt, but merely satisfy the preponderance of probabilities. The onus has to be discharged by producing evidence as to the conduct of the accused prior to the offence, his conduct at the time or immediately after the offence with reference to his medical condition by production of medical evidence and other relevant factors. Even if the accused establishes unsoundness of mind, Section 84 of the Indian Penal Code will not come to its rescue, in case it is found that the accused knew that what he was doing was wrong or that it was contrary to law. In order to ascertain that, it is imperative to take into consideration the circumstances and the behaviour preceding, attending

[9] (2011) 11 SCC 495

and following the crime. Behaviour of an accused pertaining to a desire for concealment of the weapon of offence and conduct to avoid detection of crime go a long way to ascertain as to whether, he knew the consequences of the act done by him.

14. Reference in this connection can be made to a decision of this Court in the case of **T.N. Lakshmaiah v. State of Karnataka, (2002) 1 SCC 219**, in which it has been held as follows:

"9. Under the Evidence Act, the onus of proving any of the exceptions mentioned in the Chapter lies on the accused though the requisite standard of proof is not the same as expected from the prosecution. It is sufficient if an accused is able to bring his case within the ambit of any of the general exceptions by the standard of preponderance of probabilities, as a result of which he may succeed not because that he proves his case to the hilt but because the version given by him casts a doubt on the prosecution case.

10. In State of M.P. v. Ahmadulla, AIR 1961 SC 998, this Court held that the burden of proof that the mental condition of the accused was, at the crucial point of time, such as is described by the section, lies on the accused who claims the benefit of this exemption vide Section 105 of the Evidence Act [Illustration (a)]. The settled position of law is that every man is presumed to be sane and to possess a sufficient degree of reason to be responsible for his acts unless the contrary is proved. Mere ipse dixit of the accused is not enough for availing of the benefit of the exceptions under Chapter IV.

11. In a case where the exception under Section 84 of the Indian Penal Code is claimed, the court has to consider whether, at the time of commission of the offence, the accused, by reason of unsoundness of mind, was incapable of knowing the nature of the act or that he is doing what is either wrong or contrary to law. The entire conduct of the accused, from the time of the commission of the offence up to the time the sessions proceedings commenced, is relevant for the purpose of ascertaining as to whether plea raised was genuine, bona fide or an afterthought."

(36) Their Lordships of the Supreme Court in ***Mariappan*** versus ***State of Tamil Nadu***[10] have held that burden of proving the case of accused comes within exceptions under section 105 of the Evidence Act, 1872 lies on the accused. Their Lordships have held as under:

> "13. The evidence of PWs 1 and 2 - the eye-witnesses, the evidence of PWs 3 and 4, who saw the accused running after the occurrence with Aruval (M.O.-1) and the recovery of the weapon at the instance of the accused which was found to be stained with human blood of "O" group, as per the serologist report (Ex.P.12), tallied with the blood group of the deceased as the clothes of the deceased viz., M.O.s 1 to 4 were also stained with human blood "O" group clearly prove the case of the prosecution. Further, the medical evidence through PW-9-the Doctor, who conducted the post-mortem and issued the report (Ex.P-3) strengthened the version of PWs 1 and 2.
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> 14. From the materials analyzed, discussed and concluded by the trial Court and the High Court, it clearly establishes that it was the accused-appellant who committed the murder."

(37) In the present case, plea of insanity is not available to the appellant under Section 84 IPC. He knew what he was doing. From the circumstances, which preceded, attended and followed the crime, it cannot be said that the appellant was suffering from unsoundness of mind.

(38) Accordingly, the prosecution has proved its case against the appellant beyond reasonable doubt. There is no merit in this appeal and same is dismissed. The impugned judgment and order dated 17.02.2014 are upheld. Appellant Jeewan Singh Sidhu is on bail. His bail bond and surety bond are cancelled. He is directed to surrender before the concerned Chief Judicial Magistrate forthwith to undergo remaining part of his sentence.

Angel Sharma

[10] (2013) 12 SCC 270