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The Jurisprudence of "Insanity" in Criminal Law: Deconstructing Legal Insanity vs. Medical Insanity

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Abstract

The defence of insanity occupies a singular position within the General Exceptions to criminal liability, resting on the premise that the criminal law punishes only those who possessed, at the material time, the capacity to form a guilty mind. This article undertakes a doctrinal examination of the insanity defence under Indian criminal law, tracing its conceptual genesis to the M'Naghten Rules of 1843 and its statutory expression, first as Section 84 of the Indian Penal Code, 1860, and now as Section 22 of the Bharatiya Nyaya Sanhita, 2023 (BNS). The central problem addressed is the persistent conflation, in lay and sometimes in forensic discourse, of "medical insanity" a clinical diagnosis of mental illness with "legal insanity", a narrower construct confined to the accused's incapacity, at the time of the act, to know its nature or that it was wrong or contrary to law. Through an analysis of *State of Madhya Pradesh v Ahmadulla*, *Dahyabhai Chhaganbhai Thakkar v State of Gujarat*, *Jai Lal v Delhi Administration*, *Hari Singh Gond v State of Madhya Pradesh*, *Surendra Mishra v State of Jharkhand*, *Devidas Loka Rathod v State of Maharashtra*, *Prakash Nayi Sen v State of Goa* and *Dashrath Patra v State of Chhattisgarh*, the article shows how the Supreme Court has policed this boundary while progressively easing the evidentiary burden on the accused. That burden is discharged on a preponderance of probabilities under Section 105 of the Indian Evidence Act, 1872 (now Section 108 of the Bharatiya Sakshya Adhiniyam, 2023), leaving the prosecution's overarching burden of proving guilt beyond reasonable doubt undisturbed. *Accused 'X' v State of Maharashtra* is examined separately, as an authority on post-conviction mental illness rather than on the insanity defence itself. The analysis situates the doctrine within the rights-based framework of the Mental Healthcare Act, 2017 in particular Section 3(5), which separates a clinical determination of mental illness from a judicial finding of unsoundness of mind and the procedural provisions of Chapter XXVII (Sections 367–378) of the Bharatiya Nagarik Suraksha Sanhita, 2023. Using doctrinal legal research, the article argues that Section 22 of the BNS preserves doctrinal continuity but inadequately integrates contemporary mental health law. It concludes by proposing calibrated reforms, consideration of a partial defence of diminished responsibility, standardised forensic psychiatric evaluation, and closer coordination between criminal courts and Mental Health Review Boards while addressing the principal objections to each.

Keywords: Legal Insanity; Medical Insanity; Section 22 Bharatiya Nyaya Sanhita; M'Naghten Rules; Mental Healthcare Act 2017; Diminished Responsibility

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1. Introduction

1.1 Background and Historical Foundations: The M'Naghten Principles

The criminal law's treatment of mental incapacity is as old as the concept of culpability itself, for the attribution of blame has always presupposed a rational actor capable of choosing between right and wrong. Early English common law recognised, in rudimentary form, that a "madman" or "lunatic" could not be held to the same standard of responsibility as a person of sound mind, but it was not until the trial of Daniel M'Naghten in 1843 that the common law world acquired a workable, judicially articulated test of criminal insanity. M'Naghten, labouring under an insane delusion that the Tory party was persecuting him, shot and killed Edward Drummond, private secretary to the Prime Minister Sir Robert Peel, having mistaken Drummond for Peel himself. M'Naghten was acquitted on the ground of insanity, provoking considerable public and parliamentary disquiet, including criticism from Queen Victoria. The House of Lords thereafter put a series of abstract questions to the judges, whose answers delivered principally by Tindal CJ crystallised into what is now known as the M'Naghten Rules (*M'Naghten's Case* 1843).

The Rules established what has come to be called the cognitive "right and wrong" test: it must be clearly proved that, at the time of committing the act, the accused was labouring under such a defect of reason, arising from a disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong (*M'Naghten's Case* 1843, 210). This test has two limbs, either of which suffices to exculpate: first, an incapacity arising from mental disease to understand the physical nature and consequences of the act (for instance, a person who strangles another believing, under a delusion, that he is squeezing a lemon); and second, even where the nature of the act is understood, an incapacity to appreciate that the act is wrong. The Rules deliberately confined the inquiry to cognition the capacity to know and excluded any independent inquiry into volition, that is, whether a disease of the mind had destroyed the accused's power of self-control even while leaving his cognitive faculties intact. This exclusion of the "irresistible impulse" doctrine has remained the most persistent point of criticism of the M'Naghten framework (Royal Commission on Capital Punishment 1953; Law Commission 2013), a criticism that, as this article will show, retains its force under the successor Indian provision.

The M'Naghten Rules entered Indian criminal law through the codification project of the mid-nineteenth century, but the chronology requires care. The Indian Law Commission presided over by Thomas Babington Macaulay submitted its Draft Penal Code in 1837 (Indian Law Commissioners 1837), some six years before M'Naghten's trial; the draft therefore could not have incorporated Rules that did not yet exist. The draft was revised over the following two decades and enacted as the Indian Penal Code (IPC) in 1860. The insanity provision of the enacted Code, Section 84, substantially reflected the cognitive approach articulated in M'Naghten, confining exemption to incapacity to know the nature of the act or that it was wrong or contrary to law a correspondence the Supreme Court has repeatedly acknowledged (*Bapu Gajraj Singh v State of Rajasthan* 2007, para 12; *Prakash Nayi Sen v State of Goa* 2023, para 7). The Code thereby gave the substance of the common law rule a statutory existence that it never formally possessed in England, where the Rules

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remained a product of judicial pronouncement and where Parliament later introduced diminished responsibility as a partial defence to murder (Homicide Act 1957, s 2). The statutory wording of Section 84 remained substantially unchanged for more than a century and a half, although Indian courts developed an extensive jurisprudence on its application on the meaning of "unsoundness of mind", on the relevance of conduct before, during and after the act, and on the burden and standard of proof. Any expansion of the defence's substantive scope, such as recognition of volitional incapacity, has nonetheless remained dependent on legislative amendment.

1.2 Research Questions

1. To what extent does Section 22 of the Bharatiya Nyaya Sanhita, 2023 (BNS) preserve the text and the judicial interpretation of Section 84 of the IPC, and what are the consequences of that continuity?
2. How has the Supreme Court drawn and applied the distinction between legal insanity and medical insanity, and has the evidentiary burden on the accused shifted in recent decisions?
3. How do Section 22 of the BNS, Section 108 of the Bharatiya Sakshya Adhiniyam, 2023 (BSA), Chapter XXVII of the Bharatiya Nagarik Suraksha Sanhita, 2023 (BNSS) and the Mental Healthcare Act, 2017 (MHCA) interact, and where do gaps arise between them?
4. Should the Indian insanity defence be reformed for instance by a volitional limb or a partial defence of diminished responsibility and what objections would such reform face?

1.3 Objectives

1. To trace the historical development of the insanity defence from the 1837 Draft Penal Code and the M'Naghten Rules of 1843 to Section 22 of the BNS.
2. To analyse the statutory framework governing the defence, including Section 22 BNS, Section 108 BSA, Sections 367–378 BNSS and the relevant provisions of the MHCA.
3. To examine how leading Supreme Court decisions have developed, qualified or applied the legal/medical insanity distinction and the rules on burden of proof.
4. To identify doctrinal and institutional gaps at the interface between criminal law and mental-health law.
5. To evaluate proposals for reform against the counterarguments they must meet.

1.4 Hypothesis

Section 22 of the BNS preserves doctrinal continuity with Section 84 of the IPC, but inadequately integrates contemporary mental-health law, in particular the MHCA, leaving the reconciliation of clinical and legal understandings of mental disorder largely to case-by-case judicial evaluation of evidence.

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2. Research Methodology

This paper adopts a doctrinal (non-empirical) method of legal research. The primary sources are the relevant statutes the IPC, the BNS, the Indian Evidence Act, 1872, the BSA, the Code of Criminal Procedure, 1973 (CrPC), the BNSS and the MHCA and reported decisions of the Supreme Court of India, together with the English authorities from which the Indian defence derives. The secondary sources are textbooks, law-reform materials and scholarly commentary. Judicial decisions are analysed chronologically and thematically, with attention to how later judgments develop, qualify or apply earlier principles. A limited comparative reference to English law is made because the Indian defence originates in English common law and because the English statutory partial defence of diminished responsibility is the model most often proposed for Indian reform. The paper does not undertake an empirical study of trial-court practice, and its conclusions on the operation of the defence at trial level are correspondingly limited. Sources are cited in the author date format prescribed by the Journal; cases and legislation are cited by name and year, with paragraph or section pinpoints where relevant.

3. Statutory Framework and Core Doctrine

3.1 The Transition from Section 84 IPC to Section 22 BNS

For over one hundred and sixty years, Section 84 of the IPC provided: "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" (Indian Penal Code 1860, s 84). The provision is structured as a general exception, placed in Chapter IV of the Code alongside other circumstances such as infancy, intoxication and mistake of fact that negate the culpability of an otherwise prohibited act. The three constituent elements of the defence, as consistently extracted by Indian courts, are: (a) the accused must have been of unsound mind; (b) the unsoundness must have existed at the time of the commission of the act, and not merely before or after it; and (c) as a result of that unsoundness, the accused must have been incapable either of knowing the nature of the act, or of knowing that the act was wrong or contrary to law (*Bapu Gajraj Singh* 2007, para 11; *Prakash Nayi Sen* 2023, para 4).

With the enactment of the BNS, which came into force on 1 July 2024 and replaced the IPC, Section 84 has been re-enacted, in substantially identical words, as Section 22 of the BNS (Bharatiya Nyaya Sanhita 2023, ss 22, 358). Section 22 provides that 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. The legislative continuity is substantial: the BNS did not alter the cognitive threshold, did not introduce a volitional limb, and did not define "unsoundness of mind", "mental illness" or "disease of the mind", leaving these terms just as under the IPC to judicial elaboration and to evaluation of psychiatric evidence led at trial. This continuity is significant for two reasons. First, Section 84 jurisprudence remains generally applicable and highly persuasive in the interpretation of Section 22 because the statutory language has been materially reproduced. That applicability is, however, subject to the changed

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legislative framework within which Section 22 now operates including the BSA, the BNSS and the MHCA and to any divergence that later courts may identify. Second, and more critically from a law-reform perspective, the BNS's failure to revisit Section 84 represents a missed opportunity: despite the wholesale renumbering and restructuring exercise undertaken in 2023, and despite decades of academic and psychiatric criticism of the purely cognitive M'Naghten standard, Parliament chose not to import concepts such as diminished responsibility, volitional incapacity, or a statutory linkage to the MHCA. The new bottle, in this respect, contains largely the old wine.

3.2 Legal Insanity versus Medical Insanity

The single most important doctrinal proposition in this field repeated in a long line of Supreme Court judgments on Section 84 IPC is that legal insanity and medical insanity are not coextensive, and that only the former affords a defence to criminal liability (*Hari Singh Gond v State of Madhya Pradesh* 2008, para 10; *Surendra Mishra v State of Jharkhand* 2011, para 11; *Prakash Nayi Sen* 2023, para 5). Medical insanity is a clinical or psychiatric construct: it refers to any diagnosable mental illness, disorder or disability recognised by psychiatric nosology (schizophrenia, bipolar disorder, major depressive disorder with psychotic features, and so on), assessed according to prevailing standards such as the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM) (cf Mental Healthcare Act 2017, s 3(1)), without regard to whether that illness affected the person's understanding of a specific act at a specific moment. Legal insanity, by contrast, is a forensic and normative construct defined by the statutory text: it exists only where the unsoundness of mind, at the time of the commission of the offence, deprived the accused of the capacity either to know the nature of the act or to know that it was wrong or contrary to law.

The practical consequence of this distinction is that a person may be gravely and diagnosably mentally ill may be under long-term psychiatric treatment, may have a documented history of hospitalisation, and may exhibit abnormal or even violent behaviour and yet fail to establish the defence under Section 22 BNS, because the specific cognitive incapacity required by the section is not proved to have existed at the operative moment. Conversely, and more rarely, a person without any prior psychiatric history could, in principle, satisfy the legal test if an acute episode of unsoundness at the time of the act produced the requisite cognitive incapacity, though the absence of a prior history makes such a case difficult to prove. The Supreme Court has held that conduct which is odd, irascible or queer, a weakened intellect, or intermittent fits do not by themselves attract the exception (*Surendra Mishra* 2011, para 11). Likewise, a diagnosis alone does not establish the statutory incapacity required by Section 22; what matters is whether the condition, at the material time, produced the incapacity that the section specifies. As the Court explained in *Hari Singh Gond*, because "insanity" describes varying degrees of mental disorder, not every person who is mentally diseased is exempted from criminal responsibility; the court is concerned with legal and not medical insanity (*Hari Singh Gond* 2008, para 10).

This distinction serves an important gatekeeping function. If medical insanity alone sufficed as a defence, the exception could extend to a significant portion of ordinary criminal liability, given

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the prevalence of diagnosable mental illness and the ease with which psychiatric evidence might be marshalled, in hindsight, to explain almost any anti-social act. By confining the defence to the narrower, act-specific and moment-specific cognitive incapacity, Indian law preserves the general presumption of sanity while still carving out a principled space for those genuinely incapable, at the material time, of forming the requisite culpable mental state.

3.3 Burden of Proof and Evidentiary Standard

Indian evidence law begins from a presumption of sanity: every person is presumed to be of sound mind at the time of doing any act until the contrary is proved. This presumption operates through Section 105 of the Indian Evidence Act, 1872, now re-enacted as Section 108 of the BSA, which provides that when a person is accused of an offence, the burden of proving the existence of circumstances bringing the case within any of the General Exceptions lies upon the accused, and the court shall presume the absence of such circumstances (Indian Evidence Act 1872, s 105; Bharatiya Sakshya Adhiniyam 2023, s 108). Section 109 of the BSA, by contrast, re-enacts the rule in Section 106 of the Indian Evidence Act, 1872 concerning facts especially within the knowledge of a person, and is not the provision governing the burden in respect of General Exceptions (Bharatiya Sakshya Adhiniyam 2023, s 109; Indian Evidence Act 1872, s 106).

The Supreme Court, in *Dahyabhai Chhaganbhai Thakkar v State of Gujarat*, undertook a definitive analysis of how this burden interacts with the prosecution's separate and independent burden of proving guilt beyond reasonable doubt (*Dahyabhai Chhaganbhai Thakkar v State of Gujarat* 1964, para 7). The Court held that the prosecution must prove beyond reasonable doubt that the accused committed the offence with the requisite mens rea, and that this burden rests on it throughout the trial; that there is a rebuttable presumption that the accused was not insane in the sense contemplated by Section 84 IPC, which the accused may rebut by placing before the court all relevant evidence oral, documentary or circumstantial but that the burden on him is no higher than that which rests upon a party in civil proceedings; and that even where the accused fails to establish insanity conclusively, the evidence adduced whether by the defence or emerging from the prosecution's own case may raise a reasonable doubt as to one or more ingredients of the offence, including mens rea, in which case the accused is entitled to acquittal because the prosecution has not discharged its general burden. This is a doctrinally important bifurcation: the "preponderance of probabilities" standard governs only the accused's burden of bringing the case within the general exception; it does not dilute or displace the prosecution's constant burden of proving every ingredient of the offence, including mens rea, beyond reasonable doubt.

Later decisions have reaffirmed and refined this position. In *Devidas Loka Rathod v State of Maharashtra*, the Court held that the accused need establish the defence only on a preponderance of probability, after which the onus shifts to the prosecution to establish the inapplicability of the exception, and that a reasonable doubt as to the accused's mental condition at the time of occurrence entitles him to acquittal (*Devidas Loka Rathod v State of Maharashtra* 2018, paras 11–13, relying on *Vijayee Singh v State of Uttar Pradesh* 1990). In *Prakash Nayi*, the Court held that the burden is discharged on a prima facie case and reasonable material produced by the accused, and described

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proof of insanity as a collective responsibility of the accused, the prosecution and the court rather than a purely adversarial exercise (*Prakash Nayi Sen* 2023, paras 8–11). More recently, in *Rupesh Manger (Thapa) v State of Sikkim* and *Dashrath Patra v State of Chhattisgarh*, the Court described the standard as one of raising a reasonable doubt about the accused's mental state at the time of the offence (*Rupesh Manger (Thapa) v State of Sikkim* 2023; *Dashrath Patra v State of Chhattisgarh* 2025, paras 8, 10). The evidentiary inquiry thus remains two-staged: first, whether the accused has brought the case within the statutory exception; and second, and independently, whether the prosecution has nonetheless proved beyond reasonable doubt every ingredient of the offence, including the requisite guilty mind. The recent "reasonable doubt" formulation, however, sits uneasily with *Dahyabhai*'s second proposition, which treats the accused's burden as a civil one. It is best understood as merging *Dahyabhai*'s second and third propositions a reasonable doubt on the evidence as to mental condition defeats the prosecution's proof of mens rea rather than as displacing Section 108 of the BSA. This tension is considered further in Sections 4.9 and 8.

4. Judicial Interpretation and Case Law Analysis

4.1 M'Naghten's Case (1843)

The foundational case, discussed in Section 1.1 above, established the cognitive test that has, via colonial codification, become Section 22 of the BNS (*M'Naghten's Case* 1843). Its enduring doctrinal legacy in India lies in two propositions that Indian courts continue to apply: first, the presumption of sanity that places the initial burden on the party asserting insanity; and second, the strictly cognitive framing of the incapacity required knowledge of the nature of the act, or knowledge of its wrongfulness to the exclusion of any inquiry into volitional or affective impairment (*Bapu Gajraj Singh* 2007, para 12).

4.2 *State of Madhya Pradesh v Ahmadulla* (1961)

In *Ahmadulla*, the Supreme Court articulated what has since become one of the most frequently cited formulations in the field: that the crucial point of time at which unsoundness of mind must be established is the time when the offence is actually committed, and that the burden of proving this lies upon the accused (*State of Madhya Pradesh v Ahmadulla* 1961). The Court emphasised that evidence of the accused's mental condition before or after the commission of the offence is relevant only insofar as it assists the court in drawing an inference about his mental state at the moment of the act; such evidence cannot, by itself, substitute for proof of unsoundness at the material time. The proposition was later restated in *Ratan Lal v State of Madhya Pradesh* (1970, para 2). *Ahmadulla* is significant for anchoring the temporal specificity of the legal insanity inquiry a specificity that is often lost when lay observers assume that a documented psychiatric history should, by itself, exonerate an accused person.

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4.3 Dahyabhai Chhaganbhai Thakkar v State of Gujarat (1964)

Already discussed in the context of burden of proof, *Dahyabhai* is equally important for its exposition of how courts should approach the totality of circumstantial evidence surrounding an act to infer the accused's state of mind. The Supreme Court held that whether the accused was in such a state of mind as to be entitled to the benefit of Section 84 can only be established from the circumstances which preceded, attended and followed the crime (*Dahyabhai* 1964; applied in *Devidas Loka Rathod* 2018, para 12 and *Prakash Nayi Sen* 2023, para 9). This "before, during and after" framework has become the standard analytical template applied by Indian courts: evidence of preparation, concealment, motive, flight, or a coherent narrative of events tends to negate legal insanity, since these are indicators of a mind capable of forming intent, appreciating consequences and recognising wrongdoing, whereas evidence of disorganised, purposeless, or delusion-driven conduct tends to support it.

4.4 Jai Lal v Delhi Administration (1969)

In *Jai Lal*, the appellant had a documented history of schizophrenia for which he had been treated and declared cured well before the date of the offence, on which he fatally attacked a young girl and injured others (*Jai Lal v Delhi Administration* 1969). The Supreme Court held that the appellant was not entitled to the benefit of Section 84, notwithstanding his psychiatric history, because his conduct before, during and after the incident did not establish that he was suffering from the requisite unsoundness of mind at the time of the offence. *Jai Lal* is a clear illustration of the legal-versus-medical insanity distinction: a prior, even serious, psychiatric diagnosis does not translate automatically into a successful insanity defence unless the accused can show that the same or a recurring condition had, at the material time, produced the specific cognitive incapacity required by the statute. The case also underscores that a lucid interval understood not merely as a cessation of violent symptoms but as a restoration of the faculties sufficient to enable the person soundly to judge the act can defeat the defence even where the underlying illness has not been permanently cured (*Bapu Gajraj Singh* 2007, para 12).

4.5 Consolidating the Distinction: Bapu, Hari Singh Gond and Surendra Mishra

Four decades after *Ahmadulla*, a series of decisions consolidated the legal/medical distinction into a settled formula. In *Bapu Gajraj Singh v State of Rajasthan*, the Court identified the maxim *actus non facit reum nisi mens sit rea* as the foundation of Section 84, held that the crucial point of time is the material time of the offence, and importantly for the critique developed in this article observed that mere abnormality of mind, partial delusion, irresistible impulse or the compulsive behaviour of a psychopath affords no protection under the section, which it described as still based on the outdated M'Naghten Rules (*Bapu Gajraj Singh* 2007, paras 10–12). *Bapu* also recognised a significant qualification on the investigative side: where a previous history of insanity is revealed during investigation, an honest investigator must have the accused medically examined and place that

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evidence before the court, failing which a serious infirmity arises in the prosecution case and the benefit of doubt must go to the accused (*Bapu Gajraj Singh* 2007, para 8).

In *Hari Singh Gond*, the Court explained that because "unsoundness of mind" is undefined in the Code and has been treated as equivalent to insanity itself a term describing varying degrees of mental disorder a distinction must be drawn between legal and medical insanity, and the court is concerned only with the former (*Hari Singh Gond* 2008, para 10). *Surendra Mishra* then crystallised the formula most often quoted today: an accused who seeks exoneration under Section 84 must prove legal insanity and not medical insanity (*Surendra Mishra* 2011, para 11). Read together, these decisions do not so much create new law as systematise *Ahmadulla* and *Dahyabhai*. Their principal contribution is to convert the legal/medical distinction from an analytical observation into a threshold test applied at the outset of the inquiry, while *Bapu*'s investigative duty begins to shift attention towards the prosecution's own obligations.

4.6 Devidas Loka Rathod v State of Maharashtra (2018)

Devidas Loka Rathod marks a shift in emphasis from the accused's burden to the quality of the prosecution's case. The Court reaffirmed that the standard is one of legal and not medical insanity, but held that the accused's onus under Section 105 of the Indian Evidence Act, 1872 is not as stringent as the prosecution's, that it is discharged on a preponderance of probability after which the onus shifts to the prosecution, and that a reasonable doubt about the accused's mental condition at the time of occurrence entitles him to acquittal (*Devidas Loka Rathod* 2018, paras 11–13). Where *Surendra Mishra* emphasises what the accused must show, *Devidas* emphasises what the prosecution must answer once credible material on mental condition is on record a qualification of, rather than a departure from, the earlier line.

4.7 Prakash Nayi Sen v State of Goa (2023)

Prakash Nayi is the most important recent Supreme Court authority on legal insanity. The appellant had been convicted of murder for an unprovoked attack on a relative at the shop where he worked; there was no apparent motive, and after the incident he walked to a bus stand, returned to the shop, left the weapon there and sat at the bus stand without attempting to escape (*Prakash Nayi Sen* 2023, para 21). He had earlier been treated as an in-patient, and a government doctor deposed at trial that he suffered from chronic schizophrenia and had initially been unfit to stand trial (*Prakash Nayi Sen* 2023, paras 22–23). The trial court and the High Court rejected the plea; the Supreme Court set aside the conviction and acquitted him (*Prakash Nayi Sen* 2023, paras 24–30).

Three aspects of the decision are significant. First, on the legal/medical distinction, the Court reaffirmed that mere medical insanity does not amount to unsoundness of mind for the purposes of Section 84; the test is one of legal insanity, requiring incapacity to know the nature of the act or that it is wrong or contrary to law (*Prakash Nayi Sen* 2023, paras 4–5). The Court drew on forensic-psychiatric literature to explain that medical and legal insanity are not necessarily congruent, and that the expert's role is to inform, not to supply, the legal conclusion (*Prakash Nayi*

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Sen 2023, para 18, citing Modi 2018). Second, on psychiatric evidence and the burden of proof, the Court held that the accused's burden is discharged on a prima facie case and reasonable material, on a preponderance of probability, and that proof of insanity is a collective responsibility of the accused, the prosecution and the court (*Prakash Nayi Sen* 2023, paras 8–11). It criticised the courts below for brushing aside the evidence of the government psychiatrist and for being influenced by the nature of the act while ignoring the condition of the appellant (*Prakash Nayi Sen* 2023, paras 25, 27). Third, on the material time, the Court examined conduct before, during and after the occurrence, and treated the fact that the appellant later became fit to stand trial as indicative of his prior insanity (*Prakash Nayi Sen* 2023, paras 9, 27). It also characterised the procedural chapter on accused persons of unsound mind (then Chapter XXV of the CrPC, now Chapter XXVII of the BNSS) as substantive in character, emphasising the court's own duty to ascertain fitness to stand trial (*Prakash Nayi Sen* 2023, paras 15–17).

The decision is open to critique. The inference that later fitness to stand trial indicates insanity at the time of the act arguably conflates two distinct inquiries fitness to plead and responsibility at the material time which the doctrine elsewhere insists on keeping apart. Its collective-responsibility framing also sits uneasily with the text of Section 105 of the Indian Evidence Act, 1872 (now Section 108 of the BSA), which places the burden on the accused. Nonetheless, the practical message of *Prakash Nayi* is clear: where credible psychiatric evidence exists, courts should not allow the gravity of the act to displace a careful evaluation of the accused's mental condition at the material time.

4.8 Recent Development: Dashrath Patra v State of Chhattisgarh (2025)

The Supreme Court's 2025 decision in *Dashrath Patra* continues the trajectory of *Devidas* and *Prakash Nayi*. The appellant, sentenced to life imprisonment for murder, relied on the depositions of prosecution witnesses that his mental condition was unstable at the relevant time. The Court held that although the burden of proving legal insanity lies on the accused, it is enough that a reasonable doubt is created about his mental state at the time of the offence (*Dashrath Patra* 2025, paras 8, 10). It regarded a medical examination conducted in 2023, some five years after the 2018 incident, as of little relevance to the appellant's condition at the material time, criticised the prosecution's failure to have him medically examined promptly despite evidence of mental instability and, extending the benefit of doubt, acquitted him. The Court also linked the principle to Article 21 of the Constitution, reasoning that a person who is legally insane cannot meaningfully exercise his right to defend himself.

Dashrath Patra should be read with care. It is a short, fact-specific decision, and its formulation of the standard is best understood against *Dahyabhai*'s three propositions rather than as a silent departure from them. Its lasting significance lies less in any restatement of the burden than in its emphasis on timely medical examination: an evaluation undertaken years after the event says little about the accused's cognitive capacity at the moment of the act, which is the only question Section 22 asks.

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4.9 Development of the Case Law: A Synthesis

Read chronologically, the cases reveal three movements. First, the definition of legal insanity has remained stable: from *Ahmadulla* to *Prakash Nayi*, the Court has applied a cognitive, act-specific and moment-specific test, and the later decisions in *Hari Singh Gond* and *Surendra Mishra* formalise rather than alter it. Secondly, the evidentiary burden on the accused has progressively eased: *Dahyabhai*'s civil standard, *Bapu*'s investigative duty, *Devidas*'s shifting onus, *Prakash Nayi*'s prima facie discharge and collective responsibility, and *Dashrath Patra*'s reasonable-doubt formulation each move further toward protecting the accused from the practical difficulty of proving a past mental state. Thirdly, the Court has increasingly treated the conduct of the prosecution and of the trial court failure to investigate, failure to order timely examination, failure to evaluate defence psychiatric evidence as grounds for acquittal. The resulting tension is that the substantive test remains narrow while its proof has become easier. Whether this is a principled accommodation or an indirect means of mitigating the rigidity of the M'Naghten test is a question to which Section 8 returns.

5. Mental Illness after Conviction: *Accused 'X' v State of Maharashtra* (2019)

Accused 'X' v State of Maharashtra is real and relevant to this article's broader theme, but it is not a Section 84 insanity-defence case and is therefore treated separately (*Accused 'X' v State of Maharashtra* 2019). The decision, delivered on 12 April 2019 by a bench of Ramana, Shantanagoudar and Banerjee JJ in a review petition arising from a death sentence for the rape and murder of two minor girls, addresses an analytically distinct question: the relevance of mental illness developed by a death-row convict after conviction, as a factor at the sentencing and execution stage. Building on *Shatrughan Chauhan v Union of India*, which had recognised post-sentence mental illness as a supervening circumstance (*Shatrughan Chauhan v Union of India* 2014), the Court, invoking Article 21 of the Constitution and the rights-based framework of the MHCA, held that post-conviction severe mental illness is a mitigating factor that may warrant commutation of a death sentence. It laid down a "test of severity", requiring that the illness be of such a degree that the convict is unable to understand the nature and purpose of the punishment, and directed that the accused's identity be withheld in light of the confidentiality protected by Section 23 of that Act (*Accused 'X'* 2019; Mental Healthcare Act 2017, s 23). *Accused 'X'* does not modify the Section 22 BNS cognitive test. It is included because it demonstrates the judiciary's willingness to engage substantively with contemporary mental-health legislation at later stages of the criminal process, and it illustrates the broader thesis of this article: that the interface between psychiatric science and criminal law extends beyond the moment of the M'Naghten inquiry into sentencing, execution and post-conviction detention.

6. Critical Evaluation: Interplay with the MHCA and the BNSS

The MHCA represents a paradigm shift in Indian mental health law, moving away from a custodial model towards a rights-based framework centred on the dignity, autonomy and informed consent of

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persons with mental illness (Duffy and Kelly 2020). Section 2(1)(s) of the Act defines "mental illness" in clinical terms, as a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life; the definition includes mental conditions associated with the abuse of alcohol and drugs, but excludes mental retardation (Mental Healthcare Act 2017, s 2(1)(s)). This clinical definition sits in evident tension with the far narrower, act-specific, cognition-only standard embedded in Section 22 of the BNS.

Section 3 of the Act deals separately with the determination of mental illness. It requires that mental illness be determined in accordance with nationally or internationally accepted medical standards notified by the Central Government (Mental Healthcare Act 2017, s 3(1)), and it contains important safeguards: mental illness may not be determined on the basis of political, economic or social status, membership of a cultural, racial or religious group, or non-conformity with prevailing moral, social, cultural or political values or religious beliefs; and past treatment or hospitalisation, though relevant, does not by itself justify a present or future determination of mental illness (Mental Healthcare Act 2017, s 3(2)–(4)). Most significantly for this article, Section 3(5) provides that the determination of a person's mental illness shall not alone imply, or be taken to mean, that the person is of unsound mind unless he has been declared as such by a competent court (Mental Healthcare Act 2017, s 3(5)).

Section 3(5) is doubly significant for the medical-insanity/legal-insanity argument. On one hand, it confirms, from the side of mental-health law, the very distinction the Supreme Court has drawn from the side of criminal law: a clinical determination under the MHCA is not a legal finding of unsoundness of mind, and it therefore provides no support for the argument that an MHCA diagnosis should automatically establish the Section 22 defence. On the other hand, it expressly reserves the declaration of unsoundness of mind to a competent court, acknowledging that a legal determination is required and that clinical evidence is the material from which it is made. The two statutes thus operate in parallel the MHCA addressing treatment, consent and rights, and the BNS addressing culpability. The connection between them is limited. Section 105 of the MHCA provides that where proof of mental illness is produced in a judicial process and is challenged by the other party, the court shall refer it to the Mental Health Review Board for its opinion (Mental Healthcare Act 2017, s 105), but this is a procedural reference mechanism rather than a substantive bridge between clinical determination and criminal responsibility. Section 23, which protects the confidentiality of information about a person's mental health, is also engaged whenever psychiatric evidence is led in a criminal trial (Mental Healthcare Act 2017, s 23).

This limited connection produces a genuine doctrinal gap that this article regards as a central weakness of the current framework. An accused person may be assessed under the procedures of the MHCA as suffering from a severe mental illness, and may even be receiving treatment in a mental health establishment at or around the time of the alleged offence, and yet the criminal court must apply the separate and narrower Section 22 inquiry. The procedural provisions of the BNSS offer some safeguards in this respect. Chapter XXVII of the BNSS (Sections 367–378), which substantially re-enacts Chapter XXV (Sections 328–339) of the CrPC, governs accused persons of unsound mind, and now extends expressly to persons with intellectual disability in place

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of the CrPC's reference to mental retardation (Bharatiya Nagarik Suraksha Sanhita 2023, ch XXVII, ss 367–378; cf Code of Criminal Procedure 1973, ch XXV, ss 328–339). Sections 367 and 368 require a Magistrate or Court that has reason to believe that an accused is of unsound mind to have him examined by a civil surgeon and, where necessary, a psychiatrist or clinical psychologist and, where he is incapable of entering his defence, to postpone the inquiry or trial (Bharatiya Nagarik Suraksha Sanhita 2023, ss 367–368). Section 369 provides for release pending investigation or trial or, where release cannot be ordered, transfer to a residential facility; Section 370 provides for resumption once the person ceases to be of unsound mind; Section 372 deals with the case where the accused appears to have been of unsound mind when the act was done; Section 373 requires a judgment of acquittal on the ground of unsoundness of mind to record whether the accused committed the act; and Sections 374–378 govern the safe custody, release and delivery to relatives of persons so acquitted (Bharatiya Nagarik Suraksha Sanhita 2023, ss 369–378). These provisions primarily address fitness to stand trial and post-acquittal custody, which are distinct from the substantive Section 22 defence, although, as *Prakash Nayi* shows, the Supreme Court regards them as substantive in character and as informing the court's larger role when the defence is pleaded (*Prakash Nayi Sen* 2023, paras 15–17).

7. Comparative Perspective: Diminished Responsibility in English Law

A further critical dimension concerns the absence, in Indian criminal law, of a doctrine of diminished or partial responsibility. The comparison with English law is relevant for two reasons: the Indian defence derives from the same M'Naghten source, and the English statutory partial defence is the model most frequently proposed for Indian reform. In England and Wales, Section 2 of the Homicide Act 1957, as substituted by Section 52 of the Coroners and Justice Act 2009, provides that a person who kills is not to be convicted of murder if he was suffering from an abnormality of mental functioning which arose from a recognised medical condition, substantially impaired his ability to understand the nature of his conduct, to form a rational judgment or to exercise self-control, and provides an explanation for his acts or omissions in doing or being a party to the killing (Homicide Act 1957, s 2(1), (1A), (1B), as substituted by Coroners and Justice Act 2009, s 52). The defence, which the defendant must prove, reduces murder to manslaughter (Homicide Act 1957, s 2(2)–(3)), and the Supreme Court of the United Kingdom has held that "substantially" denotes an impairment that is important or weighty, rather than one that is merely more than trivial (*R v Golds* 2016). Its scope is limited: it is a partial defence to murder only, and English law retains the M'Naghten Rules for the complete defence of insanity, a position the Law Commission has criticised (Law Commission 2013).

Indian law offers no equivalent intermediate category at the stage of conviction: the Section 22 defence either produces a complete acquittal or does not apply. This does not mean that mental illness falling short of legal insanity is legally irrelevant. It may, on the evidence, raise a reasonable doubt as to mens rea, in accordance with *Dahyabhai*'s third proposition (*Dahyabhai* 1964, para 7); it may be relevant at sentencing, including as a mitigating circumstance in capital cases (*Bachan Singh v State of Punjab* 1980, para 206); and it may be relevant after conviction, as *Accused 'X'* demonstrates. What Indian law lacks is a structured mechanism by which substantially impaired but not absent

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capacity reduces the offence of conviction, notwithstanding that forensic psychiatry recognises a broad spectrum of impaired-but-not-absent cognitive and volitional capacity. This gap is compounded by the entirely cognitive framing of Section 22, which, following M'Naghten, excludes volitional impairment the "irresistible impulse" scenario in which an accused understands that an act is wrong but is, by reason of a genuine disease of the mind, unable to control the impulse to commit it (*Bapu Gajraj Singh* 2007, para 12). Contemporary psychiatric understanding of conditions such as impulse-control disorders, certain manifestations of bipolar disorder, and some forms of organic brain damage recognises this species of impairment, yet Section 22, mirroring its 1860 antecedent, has no vocabulary to address it.

8. Counterarguments to Reform

The reform proposals advanced in this article must meet several serious objections, which are considered here before the conclusions are drawn.

First, medical illness cannot automatically equal legal insanity. Psychiatric diagnosis answers a clinical question whether a person meets the criteria for a disorder and what treatment is indicated whereas Section 22 answers a normative question about responsibility for a particular act at a particular moment. Many persons with serious diagnosed illness retain, at the time of a given act, the capacity to know its nature and wrongfulness; to treat diagnosis as dispositive would exempt them from liability for conduct they understood. The MHCA itself adopts this position in Section 3(5), and the Supreme Court's consistent insistence on legal rather than medical insanity reflects the same premise. Any reform must therefore work through, not around, the requirement of an act-specific assessment.

Secondly, a lighter burden based solely on admission under the MHCA could be problematic. Admission decisions are made for therapeutic purposes, on criteria such as the need for care and treatment, or risk to self or others that do not correspond to the cognitive incapacity required by Section 22. Admission may also be independent (voluntary). A presumption linked to admission status could produce arbitrary distinctions between equally unwell persons depending on whether they had access to a mental health establishment, a concern that is acute where access to services is uneven. It could also create an incentive for strategic admission after the event and draw treating clinicians into a forensic role in tension with the confidentiality protected by Section 23. For these reasons, the more defensible form of the proposal is not a presumption based on admission status, but a rule that credible evidence of contemporaneous treatment triggers the prosecution's and the court's duty to investigate a duty the Supreme Court has already recognised in *Bapu*, *Prakash Nayi* and *Dashrath Patra*.

Thirdly, a volitional or "irresistible impulse" limb is notoriously difficult to apply. It is hard to distinguish an impulse that could not be resisted from one that was not resisted, and psychiatric evidence on volitional capacity is frequently contested. A volitional limb in a complete defence would therefore carry a real risk of inconsistent outcomes.

Fourthly, diminished responsibility carries its own costs. In England it has generated extensive litigation over the meaning of "substantially" and the role of expert evidence (*R v Golds*

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2016). In India, where the sentence for murder is not mandatorily death, much of the mitigating work that a partial defence performs can arguably be done at sentencing, as *Bachan Singh* (1980) already permits. A partial defence may also increase reliance on expert testimony in a system where forensic psychiatric capacity is limited.

Fifthly, the recent easing of the evidentiary burden itself invites critique. If an accused need only raise a reasonable doubt, the practical difference between Section 108 of the BSA and an ordinary evidential burden narrows. This may be justified by the difficulty of proving a past mental state, but it risks inconsistency unless the Supreme Court clarifies how *Dashrath Patra* is to be reconciled with *Dahyabhai*.

These objections do not defeat the case for reform, but they shape it. They favour better-structured evidence-gathering and a carefully limited partial defence over any automatic linkage between clinical status and criminal responsibility.

9. Conclusion

This article has traced the trajectory of the insanity defence in Indian criminal law from the 1837 Draft Penal Code and the M'Naghten Rules of 1843, through its codification as Section 84 of the IPC, to its substantially unaltered re-enactment as Section 22 of the BNS. Three findings emerge. First, the distinction between legal insanity and medical insanity is the doctrinal fulcrum of the entire defence: Indian courts, from *Ahmadulla* and *Dahyabhai* through *Jai Lal*, *Hari Singh Gond* and *Surendra Mishra* to *Prakash Nayi*, have consistently insisted that only a cognitive incapacity existing at the time of the offence not a general or even severe psychiatric diagnosis can ground an acquittal. In this article's assessment, that insistence is sound in principle for the reasons set out in Section 8, although the narrowness of the cognitive test leaves real forms of impairment unaddressed. Second, the evidentiary architecture surrounding the defence is carefully calibrated but evolving: the presumption of sanity places a burden on the accused under Section 108 of the BSA, discharged on a preponderance of probabilities, while the prosecution's independent burden of proving guilt beyond reasonable doubt including the mental element remains, providing a secondary safety valve for cases falling short of a complete defence. Recent decisions, culminating in *Dashrath Patra*, have eased the accused's burden further, a development that calls for doctrinal clarification. Third, and most significantly for law reform, the BNS's decision to re-enact Section 84 in substantially identical form, without engaging with the MHCA's understanding of mental illness or with comparative developments such as England's statutory doctrine of diminished responsibility, represents a missed opportunity for modernisation at the very moment when Parliament undertook a wholesale recodification of India's substantive criminal law. The hypothesis stated at the outset that Section 22 preserves doctrinal continuity but inadequately integrates contemporary mental health law is therefore substantially supported.

Several recommendations follow. First, Parliament should consider introducing a carefully limited statutory doctrine of diminished responsibility, applicable at least to offences carrying the death penalty or life imprisonment, permitting courts to record a lesser degree of culpability where an abnormality of mental functioning substantially impaired, without wholly negating, the accused's

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cognitive or volitional capacity. Such a reform would address the gap between complete exculpation under Section 22 and undiminished liability, subject to the objections considered in Section 8. Second, Parliament should consider whether Section 22 should be amended to incorporate a narrowly confined volitional limb recognising cases of genuine incapacity for self-control arising from a diagnosed disease of the mind; given the statutory text and the Supreme Court's position in *Bapu*, this is a matter for legislation rather than judicial construction. Third, closer coordination should be established between the MHCA and the BNS/BNSS framework. Rather than a presumption based solely on MHCA admission, which would be vulnerable to the objections noted above, credible evidence of contemporaneous psychiatric treatment should trigger a mandatory, time-bound forensic evaluation directed specifically to the Section 22 question, with the expertise of the Mental Health Review Board available to the court. Fourth, courts should institutionalise forensic psychiatric evaluation protocols conducted by government-empanelled multidisciplinary boards rather than by ad hoc practitioners whenever a plea under Section 22 is raised, to reduce the evidentiary inconsistency and delay criticised in *Prakash Nayi* and *Dashrath Patra*. Finally, judicial training programmes should sensitise trial judges and prosecutors to the distinction between medical and legal insanity, ensuring that the doctrine is applied with the rigour that *Ahmadulla*, *Dahyabhai* and *Jai Lal* demand, while remaining alert, as *Accused 'X'* shows, to the continuing relevance of mental illness at sentencing and at every subsequent stage of the criminal process. Only through such calibrated legislative and institutional reform can Indian criminal law achieve a coherent accommodation between the demands of psychiatric science and the normative structure of criminal responsibility.

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