IN THE HIGH COURT OF AUSTRALIA

SYDNEY REGISTRY No. S291 of 2019

BETWEEN: WILLIAM RODNEY SWAN

Appellant

and

10 THE QUEEN

Respondent

APPELLANT'S SUBMISSIONS

Part I: Certification

1. These submissions are in a form suitable for publication on the internet.

Part II: Statement of Issues

2. Did the appellant's trial for murder miscarry because one of the pathways of reasoning
20 to guilt, left to the jury, was not supported by evidence?
3. Did the Court of Criminal Appeal ("CCA") fail to properly consider the above issue by asking itself the wrong question?
4. What degree of clarity of explanation of a crown case theory is required to be provided to a jury?

Part III: 78B Notices

5. The appellant considers that no notice under s 78B of the *Judiciary Act 1903 Cth* is required.

Part IV: Citation

6. The trial judge's summing up is *R v Swan; R v Kimura*, N Adams J, NSWSC, 18 May
30 2016: Core Appeal Book "CAB" 8. The sentence judgment is *R v Swan; R v Kimura (No 2)* [2016] NSWSC 1819: CAB 107.
7. The CCA decision is *Swan v R* [2018] NSWCCA 260: CAB 139.

O'Brien Hudson Solicitors
Suite 102, 281 Elizabeth Street
Sydney NSW 2000

Telephone: 02 8268 6500
Fax: 02 8268 6555
Email: chris@obhlaw.com.au
Ref: Mr Christopher Cole

Part V: Relevant Facts

Overview

8. The appellant was adjudged to have assaulted the deceased. The assault caused multiple injuries, but not a fractured hip. About 8 months later the deceased presented to hospital with a fractured hip that required surgical repair. A decision was made not to repair the hip and, as a result, he died some days later. The appellant was convicted of murder.
9. The crown argued, *inter alia*, that (1) hip surgery could have prevented the deceased's death; but (2) a decision was made not to undertake it because the deceased's quality of life was poor, and was never going to improve, because of the assault.
10. Therefore, on that basis, the crown argued that regardless of how the deceased broke his hip, the appellant was liable for murder.
11. This theory of causation focused on the decision to not undertake surgery. However those involved in making the decision were either not called to give evidence at trial or were called but not asked about the decision. Some hospital notes written in shorthand relating to the making of this decision were in evidence.
12. This appeal examines the cogency of such evidence to support a conviction for murder.

The deceased was assaulted and suffered traumatic injuries

13. On 15 April 2013, Mr Alexander Kormilets ("the deceased"), a 78 year-old man, was assaulted in his home unit in the course of being robbed by two men.
14. Evidence from the deceased's son, Mr Dmitri Zitserman, and the deceased's long term general practitioner, Dr Alexander Aristoff, suggested the deceased seemed to be in reasonable health before the assault: CCA [7] and [13]; CAB 147 and 149. Dr Aristoff said the deceased was under treatment for polycythemia, a condition which involved excessive production of red blood cells, but he did not think this posed any imminent danger to his health: CCA [13]; CAB 149.
15. Following the assault on 15 April 2013 the deceased was admitted to, and spent over four months at, St Vincent's Hospital. He suffered multiple traumatic injuries, but, importantly, not a fractured hip. His treatment involved significant medical intervention: CCA [11]; CAB 148.
16. The son of the deceased visited his father almost every day at St Vincent's Hospital. He said that for the first month, "they put [the deceased] in a sleep, I don't know for what reason, it's a medical thing", and that, when the deceased woke up, he was just lying in bed most of the time. He said that his father sometimes understood him clearly, but

other times seemed not to know him or be listening to him. He said that the deceased also recognised his daughter-in-law and granddaughter, but that there were other relatives whom he did not recognise. He said that he and his father spoke together, but that sometimes the deceased "didn't like it" and became angry: CCA [8]; CAB 147.

17. During his stay at St Vincent's Hospital, the deceased was transferred to the intensive care unit on two occasions. The second was in early July 2013, following an episode of aspiration pneumonia.[1] He was intubated and ventilated for several days and treated with antibiotics before again being returned to the ward. A note from the hospital records about that episode was read to the jury: CCA [12]; CAB 148. It included the following:

> *Following discussion with Mr Kormilets' son, Dmitri it has been decided that if another similar episode were to occur that Alex would be (not for resuscitation and not for ICU/intubation). The NFR order has been signed and is official and can be found in the notes.*

18. The deceased, during his time at St Vincent's Hospital, was subject to various scans. These revealed the prospect of a malignant tumour of the left kidney, as well as two separate sclerotic bone lesions. This suggested possible metastases: T346, 350; Appellant's Book of Further Material ("AFM") 5-6.

The deceased was discharged to a "high level" nursing home

19. Overall, during his time at St Vincent's Hospital, the deceased's condition generally improved and he was discharged to a "high level" nursing home on 1 August 2013: CCA [11], [18]; CAB 148, 150.
20. The deceased remained at the nursing home until 5 December 2013. No person who worked at the nursing home who had contact with the deceased gave evidence at the trial. Some notes from that facility (covering the period from 28 August onwards) were tendered at trial and aspects of them explained by a registered nurse, Ms McKern, who gave evidence in her capacity as the executive care manager at the nursing home: CCA [18]; CAB 150.
21. The notes suggested that the deceased, during his time at the nursing home, had significant mobility problems, could not walk unassisted, and experienced multiple falls: CCA [21], [23]-[24]; CAB 151-152. His bed was a "low low" one able to be lowered to 5 cm from the ground to avoid falls from the bed: CCA [19]; CAB 150.

---

[1] This condition was explained by the forensic pathologist Dr Bailey: CCA [32]; CAB 156.

There was no evidence that the problems with mobility were never going to improve. The tendered notes included the most recent care plan (5 December 2013), which documented extensive anticipated exercise and physiotherapy to improve muscle tone, movement and endurance. A walking programme was anticipated: Exhibit AD (part); AFM 8.

22. The notes confirmed the evidence given by Mr Zitserman that the deceased was incontinent of faeces and urine at this time. The notes indicated that the deceased was upset by his incontinence: CCA [22], CAB 151. There was no evidence that the incontinence of the deceased was never going to improve. The 5 December 2013 care plan included the goal of promotion of continence to an optimum level: Exhibit AD (part); AFM 7, line 17 and 39.

23. The notes confirmed the evidence given by Mr Zitserman that the deceased was nourished by a 'PEG' tube during this time. Ms McKern and Dr Aristoff explained that this was required because of inability to properly swallow, which was caused by the damage to the brain of the deceased: CCA [9], [14], [20]; CAB 147, 149, 150-151. There was no evidence that the way in which the deceased was nourished was never going to improve. There was evidence that as at 26 November 2013 (when transferred to St Vincent's for change of PEG tube) there was a pending review of Mr Kormilets' nil by mouth status: Exhibit AD (part); AFM 17, line 53. The care plan dated 5 December 2013 confirmed nil by mouth / PEG feeding at that stage: AFM 10, line 48.

24. Dr Aristoff spoke with the deceased in Russian and regarded him as an intelligent man who was pleasant to talk to before the assault: T283-284; AFM 20-21. He saw the deceased at the nursing home on 15 August 2013. He stated that he was shocked to see the deceased's condition because "he appeared to me as a very sick man". He said that the psychological changes that had occurred were especially concerning, since he had lost the ability to communicate properly, express himself and relate to people. He said that the deceased retained some ability to understand what was actually spoken to him but had lost his ability to express himself completely. He found the loss of cognitive function and the signs of dementia more important than the physical changes: CCA [14]-[15]; CAB 149-150. Dr Aristoff said it was difficult to understand exactly the extent of the particular disability, but he understood it to be quite a significant one. He said it was causing a lot of frustration and agitation, and the deceased had become a very difficult person to conduct a normal conversation with. He had not completely lost

his cognitive function but was showing signs of dementia: T 288; AFM 21. He stated that when admitted to St Vincent's hospital the deceased had "lost his ability to relate his symptoms and complaints to us": CCA [17]; CAB 150.

25. There was no evidence that the cognitive problems of the deceased, as caused by the assault, were never going to improve. The injuries caused by the assault improved while the deceased was in St Vincent's hospital and post mortem examination showed them to have healed or in the processes of healing: CCA [36]; CAB 157. The crown witness Dr Fox gave evidence, from his review of the medical documents, that the cognition of the deceased could fluctuate, but was thought to be improving; however he was impulsive, requiring a high level of prompting and failure in learning: T 346; AFM 5.

26. A significant communication problem for the deceased in the nursing home arose because his main language was not English but Russian or Ukranian. The notes of the social worker who met with him on 30 August 2013 indicate that the deceased was communicative, but that it was difficult to understand what he was communicating (so she would contact his son): Exhibit AD (part); AFM 22. In the care plan report created 26 September 2013 the risk of social isolation due to language barriers was noted, and an intention to maintain religious practices and participation in Jewish festivals, contact with the Rabbi, and regular time with Ukrainian / Russian speaking residents was intended. When seen by a speech pathologist on 1 October 2013 the Rabbi of the deceased assisted with interpretation as the deceased spoke no English. The deceased, with translation assistance, explained that he did not, at that stage, want a trial oral intake assessment, and the reason for his wish: Exhibit AD (part); AFM 24.

27. Although there was some evidence of agitation on the part of the deceased while at the nursing home, the notes also showed enjoyment by him of his life. The Depression Assessment tendered through Ms McKern noted the deceased to appear physically unhappy and anxious at times (such as when sitting in his wheelchair) and to be happy when visited by his son or when someone speaks Russian to him. He had been observed as annoyed when he could not do what he wanted to do, or could not be understood, and restless when he wanted to get out of his bed or chair but could not do so unassisted; but he showed no sign of pessimism. He was observed to have interests, such as watching television in his room and playing dominos. The Cornell scale for depression score (9) was indicative of probable minor depression: Exhibit AC (part); AFM 9. The care plan of 5 December 2013 confirmed that Rabbi Jacob (who did not give evidence at trial)

had been visiting on a regular basis and was willing to continue tending to the spiritual needs of the deceased: AFM 25. Mr Zitserman described his father as not very happy and not very sad, and sometimes angry: T191.44; AFM 35.

28. The son of the deceased was asked at trial whether medical staff at the nursing home talked with him about what would happen if the condition of his father's health worsened. He stated that a few months before his father passed away the medical staff told him there was a possibility he could die: CCA [10]; CAB 148.

29. A note dated 5 December 2013 recorded that the deceased was found on the floor next to his "low low" bed and was assisted by staff: CCA [27]; CAB 152. He did not indicate that he felt any pain, but remained reluctant to bear his own weight, as had been the case since a previous fall at the facility: CCA [25]; CAB 152.

The deceased was re-admitted to hospital where a fractured hip was discovered but not repaired

30. Later that day he was transferred and admitted to the Prince of Wales Hospital after complaining of dizziness, and displaying tremors and a chesty cough and a gradually declining condition: CCA [26]-[27]; CAB 152. A transfer form dated 5 December 2013, located in tendered notes from the nursing home, indicated the deceased had been unwell for four days, had a painful knee, was leaning more on his right side, and had suffered a facial drop a day earlier: CCA [27]; CAB 152. No person who had contact with the deceased at this relevant time was called at the trial.

31. Triage notes from the Prince of Wales Hospital suggested the deceased was suffering from tachycardia, described as "a fast heart rate": CCA [72]; CAB 170.

32. Of particular significance, at the Prince of Wales Hospital, a fracture to the hip or neck of the femur (top of the large bone of the thigh) was found. Tendered notes indicate that an orthopaedic surgeon recommended surgery once he was "stabilised medically": CCA [28]; CAB 153. However, a decision was made by others to not surgically repair the fracture. The only evidence in relation to the making of this decision were some handwritten notes tendered as Exhibit AG, the relevant part of which is at CCA [29]; CAB 153. This decision was an important part of the crown case and is an important part of this appeal.

The deceased died

33. On 10 December 2013, the deceased died: CCA [28]-[30]; CAB 153-154. The evidence indicated that an injury of this kind requires surgery: CCA [32], [39]; CAB 156, 158.

Hospital notes tendered as Exhibit AG indicate that hospital staff envisaged the death of the deceased once the decision was made to not operate: CCA [29]; CAB 153. Dr Bailey, the forensic pathologist who performed the autopsy, confirmed that such was her reading of these notes: CCA [39]; CAB 158.

34. The death certificate was signed by Dr Elise Fyfe and was tendered as Exhibit AF. The content of the certificate seemed to follow an instruction listed in Exhibit AG. The cause of death was described in Part 1 of the certificate as "(a) Aspiration sepsis (b) fractured neck of femur" with "traumatic brain injury, frailty, atrial fibrillation, recurrent aspiration pneumonia" being listed in Part 2 of the certificate as "significant conditions contributing to the death, but not related to the disease or conditions causing it": CCA [30]; CAB 154.

35. Dr Bailey performed the autopsy on 11 December 2013 and formed a different opinion about the cause of death to that recorded by Dr Fyfe. Dr Bailey opined the direct cause of death was respiratory distress caused by fat emboli travelling to small vessels in the lungs. This resulted from the fracture to the neck of the femur as such allows fat to float into the blood stream and rest in the lungs: CCA [33]-[35], [65]; CAB 156-157, 167. Other expert evidence at trial was consistent with Dr Bailey's view: CCA [49]; CAB 161.

36. Dr Bailey also found a "quite large" (6 cm) tumour at the "lower pole of the left kidney" with no evidence of metastasis or the spread of cancer. Dr Bailey was initially unsure whether the tumour was cancerous, but it was not in dispute at trial that it was: CCA [37]; CAB 157.

37. Expert evidence was called at trial to comment on the extent to which the deceased was affected by cancer. This included comment on the likelihood of the broken hip being a "pathological fracture" resulting from "low trauma" and weakness in the bone caused by the spread of cancer as opposed to a "traumatic fracture", which was a fracture resulting only from external trauma: CCA [38], [43]-[52]; CAB 157-158, 159-162.

38. Dr Bailey also observed the deceased was suffering from severe coronary atherosclerosis and that this, combined with his cancer of the left kidney, high blood pressure, polycythaemia and atrial fibrillation meant he was a "very unwell person" in December 2013: CCA [38]; AB 157. These health problems were not alleged to be associated with the assault on 15 April 2013.

The crown case at trial

39. The appellant and Mr Thompson Kimura ("the co-accused") were charged with the deceased's murder and were tried in the NSW Supreme Court before N Adams J and a jury. The crown alleged: the appellant and his co-accused were the assailants that committed the assault on 15 April 2013; they committed the assault with an intention to cause grievous bodily harm; and that the assault was a substantial or significant cause of the deceased's death, some 8 months later.
40. There was also an alternative count of robbery in company involving the infliction of grievous bodily harm.
41. The appellant and his co-accused denied they were the assailants and also contested the fact that the assault was the cause of the deceased's death.

Causation at trial

42. The crown presented more than one theory of causation, as to why the appellant and his co-accused were criminally liable for murder:

- The first was that the assault caused injuries to the deceased's lungs. Therefore when the deceased fractured his hip, and the fat emboli travelled to his lungs, his respiratory problems were compounded: CCA [5], [6], [33], [52], [69] CAB 145, 146, 156, 162, 168-169. This theory was based on the evidence of the forensic pathologist who conducted the autopsy.

- The second was that the assault caused injuries to the deceased that reduced his cognitive ability and increased his risk of falling: CCA [15], [22] CAB 149, 151. Therefore, if the fracture to the hip resulted from a fall, the assault could be seen as a substantial cause of that fracture, and thus, the deceased's death: CCA [91] - [93]; CAB 175-176.

- The third was that the assault had caused injuries to the deceased that meant he experienced a low quality of life (reduced mobility, incontinence, reduced cognitive ability, feeding by PEG tube). Therefore, when he presented to hospital with the fractured hip, a decision was made to not undertake necessary surgical repair even though it would have been undertaken in other cases to prevent death: CCA [53]-[57]; CAB 162-164. As a result, the fat emboli were able to travel to his lungs, causing death: CCA [56]-[57]; CAB 163-164.

43. The crown prosecutor, in her opening address, emphasised the first path of reasoning outlined above: CCA [5]-[6]; CAB 145-146. However, this theory was not without difficulty: see CCA [35]; CAB 157, as well as noting the long period of absence of respiratory difficulty after early July, and demonstrated improvement of the previous injuries as at autopsy. Foreshadowing the dispute between experts as to whether the fracture was pathological or traumatic, the submission of the crown in opening the case was that whichever was the cause of the fracture, the deceased died more rapidly from it than he otherwise would have because of his deteriorated physical state: CCA [6]; CAB 146. The crown prosecutor did not pursue this theory in her closing address.

44. The second path of reasoning was only available if the jury accepted that the fracture to the hip resulted from a fall. This fact was disputed at trial. As mentioned, the deceased was suffering from renal cancer unconnected with the assault. The appellant and the co-accused argued the crown could not disprove the fracture was "pathological," having derived from cancer; rather than "traumatic", having derived from a fall: CCA [50], [61], [64], [66]; CAB 161, 167, 167, 168. This second theory of causation was mentioned in passing in the crown prosecutor's closing address: CCA [54]; CAB 163.

45. It was the third path of reasoning that the crown prosecutor emphasised in her closing address: CCA [53], [55]-[57]; CAB 162-164. As in the opening address, the crown prosecutor suggested that the origin of the fracture to the hip might be seen as immaterial. However, in the closing address, the jury was asked to focus on the decision to not operate (rather than the deteriorated physical state pressed in the opening address) as the factor that made the cause of the fracture immaterial. Despite the centrality of that decision to the closing address, those involved in making it had either not given evidence (the unnamed medical practitioner who wrote the notes) or, in the case of the son of the deceased, was called but not asked about the decision.

46. Despite that limitation, the crown prosecutor submitted the decision was made not because of any unrelated issue like cancer; but because the deceased's quality of life was so poor, and would never improve, because of the injuries he sustained in the assault. She repeatedly emphasised, in support of the decision being based on poor quality of life, the deceased's incontinence, requirement for nourishment via a percutaneous epigastric tube rather than normal eating and drinking by the mouth, inability to walk unassisted and reduced cognitive ability. The crown prosecutor described a decision having been made 'months earlier' (seemingly a reference to the

note made at St Vincent's hospital, quoted above at [17]), because of this low quality of life, to have no more major interventions because things were never going to improve.

47. It was this third path of reasoning that was subject of complaint by the appellant in the CCA and remains the subject of complaint.

The trial judge's directions on causation

48. The trial judge directed the jury about causation in conventional terms. Her Honour told the jury the crown has the onus of proving that the acts of the appellant and the co-accused "substantially" or "significantly" contributed to the deceased's death and that they should approach the issue in a common sense and practical way, bearing in mind they were considering criminal responsibility for homicide: Summing up ("SU") 25, 32; CAB 33, 40. In giving these directions, the trial judge did not specifically set out the crown's various theories of causation.

49. The trial judge went on to summarise the medical evidence: SU 43-48; CAB 51-56, as well as some of the crown prosecutor's submissions: SU 54-59; CAB 62-67. Again, in doing so, the trial judge did not articulate the crown's various theories of causation. Her Honour repeated some of the evidence, potentially relevant to causation, that the crown prosecutor had referred to in her closing address: SU 56-57; CAB 64-65. The submissions the subject of complaint on appeal were not referred to. Her Honour stated that the principal matter in dispute, so far as the expert evidence was concerned, was whether or not it was possible that the cause of the fracture was pathological: SU 43, CCA [61]; CAB 41, 167.

50. The trial judge then summarised the submissions of defence counsel: SU 59-67; CAB 67-75. Her Honour referred to an argument that the crown had not excluded the possibility the hip fracture was pathological, caused by metastasis of kidney cancer. Her Honour also referred to an argument that although a fractured hip is a survivable injury in a healthy person, the deceased was not an otherwise healthy person: SU63-64; CAB 71-72.

51. At no stage in the summing up did the trial judge instruct the jury to carefully consider the process surrounding the decision to not surgically repair the fractured hip. Nor did her Honour instruct them to consider the identity of the decision maker or any reason for this not being the deceased, nor motivation for or the implications of that decision: see SU 46; CAB 54; see also CCA [59]-[66]; CAB 166-168.

Part VI: Argument

Ground 2: The CCA failed to consider the appellant's sole ground of appeal

52. Section 6 of the *Criminal Appeal Act 1912 NSW* sets out how an appeal to the CCA by a person convicted on indictment is to be determined. Relevantly, the Court "shall allow the appeal if it is of opinion that the verdict of the jury should be set aside on the ground that it is unreasonable, or cannot be supported, having regard to the evidence, or... that on any other ground whatsoever there was a miscarriage of justice, and in any other case shall dismiss the appeal..."

53. The appellant did not argue in the CCA that the appeal should be allowed because the verdict was unreasonable or unsupported by the evidence. It was open to the jury to convict the appellant by following either the first or second path of reasoning. Instead, the appellant submitted that a miscarriage of justice resulted from the fact the third path was put to the jury, and may well have formed the basis of the verdict, in circumstances where it was not properly open.

54. In considering this ground of appeal, Bathurst CJ (with whom Hoeben CJ at CL and R A Hulme J agreed) accepted that if the jury was asked to reason in a manner in respect of which there was no evidence then the ground of appeal would be made out: CCA [89]; CAB 175.

55. Bathurst CJ analysed the evidence and held that it was open to the jury to convict the appellant by reasoning in accordance with the second path of reasoning: CCA [91] – [93]; CAB 175-176. This did not advance the issues on appeal because it was never contended that such a path of reasoning was not open.

56. Bathurst CJ then considered whether the jury was entitled to conclude that the deceased's injuries from the assault meant he "could not be" surgically treated: CCA [93], [99]; CAB 176, 178. To do so, it is submitted, was to ask the wrong question. The crown did not submit the surgery "could not be" undertaken. There was no evidence to support such a contention. Rather, the impugned crown theory on cause of death required acceptance that surgery could or would have prevented death, but a choice was made not to undertake the surgery because of the deceased's poor quality of life following the assault.

57. Bathurst CJ's conclusion that it was open to the jury to find that surgery "could not" happen failed to address the appellant's sole complaint on appeal. Further, it introduced

an additional basis for liability that was never part of the case against the appellant (and was itself not based on evidence).

58. There is an inherent contradiction between the reasoning urged by the crown at trial and that adopted by the CCA. The crown's argument assumes the deceased *could have been* surgically repaired but a choice was made not to pursue it. The CCA found that no such choice was available: surgery *could not be* undertaken. This inherent contradiction highlights the problems which may arise when a crown case theory is not carefully based on evidence and cogently explained. The only available conclusion on the evidence was that the crown case theory the subject of complaint was not supported.

10 **Ground 1: the impugned crown theory was not supported by evidence**

59. The crown had to prove a number of matters in order to establish liability for murder, via its proposed third path of reasoning, for the chain of causation to not be broken. It had to prove that: (1) surgery was available that was reasonably expected to be able to save the life of this particular man; (2) a decision was made by the deceased or, at least, by a person who had the legal authority to make such a decision on his behalf, to not undertake such available surgery; (3) the decision was motivated by the fact that the deceased was suffering a low quality of life in the nominated respects that were caused by the assault (incontinence, method of nourishment, reduced mobility, reduced cognitive capacity), which was not going to improve; and not because of other
20 considerations unrelated to the assault such as cancer or poor health.

60. The element of causation was also required to be proved in a common sense and practical manner, rather than a scientific or philosophical one, bearing in mind the case involved criminal responsibility for homicide. It is not sufficient to establish causation for murder in a criminal trial if, for example, there was merely a prospect that poor quality of life 'could not have helped' pessimism about surgery; or, if it was likely in the 'back of the minds' of the decision makers.

61. Leaving to one side the legal complexity (and novelty) of this argument for causation, it is submitted there was insufficient evidence at trial to sustain such a chain of reasoning, so that it should never have been left to the jury as an available avenue to conviction.

30 62. The only real support for this theory of causation is in the shorthand hospital notes tendered as Exhibit AG set out in part at CCA [28]-[29]; CAB 153-154: see CCA [41]; CAB 159.

63. Those notes allowed an inference to be drawn that a decision was made to treat the deceased palliatively rather than to surgically repair the fracture: CCA [29]; CAB 153. The notes do not indicate any participation by the deceased in that decision, and nor did the evidence explain his non-participation. Although there had been some cognitive decline and decreased ability to completely express himself, the deceased continued to understand and to speak, and to discuss spiritual matters with his Rabbi (not called as a witness) and make decisions about his care when provided with assistance in language translation: CCA [72]; CAB 169-170; see also above at [26]-[27].

64. Exhibit AG suggests participation in the decision making by a medical practitioner and the son of the deceased who was spoken to on the telephone. No evidence was called from the medical practitioner. The son was called as a witness but asked nothing about the decision to not operate. Objection was successfully taken to the crown prosecutor's question seeking the opinion of Dr Bailey (the forensic pathologist who performed the autopsy), as to why the decision may have been made. In any event, Dr Bailey later indicated she did not understand what the clinical rationale was for not treating the deceased surgically to see if he had a chance of surviving the injury: CCA [40]-[41]; CAB 158-159.

65. Exhibit AG mentions a feeling by the son of deterioration in his father's condition since August, but no further evidence about this feeling was adduced. There was otherwise evidence of improvement of the conditions resulting from the assault: CCA [11], [36]; CAB 148, 157. There were a number of serious health conditions suffered at this time not alleged to be connected with the assault. Mr Zitserman's evidence that a few months before his father's death he was told by staff at the nursing home that his father might die (see above at [28]) would suggest he had in mind deterioration in his father's physical health. The note Exhibit AG mentions discussion of a number of health problems suffered by the deceased which were not connected by the evidence with the assault, including the possibility of intracranial blood or a stroke, rapid atrial fibrillation, and the underlying malignancy which may have metastasized and may have resulted in this fracture being a pathological one.

66. There was a further complication. There was, on the preponderance of evidence at trial, a mistaken diagnosis at Prince of Wales Hospital. Exhibit AG refers, as part of the note of discussion between the practitioner and the son of the deceased, to the possibility of aspiration sepsis. This was noted by the Prince of Wales doctor to be included on the

death certificate as a cause of death (in the event of death), and the certificate shows such a record was made: CCA [29]-[30]; CAB 153-154. Dr Bailey's description of aspiration sepsis is set out at CCA [32] CAB 156. However, the evidence was to the effect that this was a mistaken diagnosis – there was no sign of aspiration sepsis / pneumonia at autopsy, and the doctor at the Prince of Wales hospital had mistaken the symptoms of the fat emboli from the broken hip for such a condition: CCA [34], [49]; CAB 156, 161.

67. A further medical note provided some context to Exhibit AG. This was the undated note from St Vincent's Hospital referring to a decision made after the incident four weeks before the deceased's discharge from that hospital (on 1 August) to the nursing home: CCA [12]; CAB 148. As mentioned earlier, it reveals the deceased was returned to the intensive care unit at that time (in early July 2013) following an episode of aspiration pneumonia and required intubation and ventilation for several days before returning to wards. The note suggests a conversation occurred with the deceased's son following that event wherein a decision was made that if another similar episode was to occur, the deceased would not be resuscitated: CCA [12]; CAB 148. There was no evidence regarding whether this decision was made with input from the deceased, if not why this was so, no evidence from the son about this earlier decision, and no evidence as to the legal effect of such a decision. Its existence is referred to in Exhibit AG and it was seemingly referred to in the discussion between the Prince of Wales Hospital doctor and the son of the deceased, in deciding whether to operate on the hip.

68. There was evidence that a fractured hip is frequently successfully operated upon on elderly people, including an otherwise healthy 78 year old: CCA [40], [48]; CAB 158, 161. However the evidence indicated that, due to the consequences of the assault, as well as other serious medical problems that were not shown to have come from the assault, the deceased was, in December 2013, not an otherwise healthy man: CCA [38]; CAB 157-158. The other medical conditions included cancer to the left kidney, high blood pressure, polycythemia (a blood disorder), severe coronary atherosclerosis, and an irregular heartbeat: CCA [58]; CAB 165-166. The possibility of a stroke, referred to in Exhibit AG, was not explained. Nor was the facial drop, referred to in the transfer form dated 5 December 2013: CCA [27] CAB 152. Accordingly, there was no evidence as to the likelihood of successful surgery for this particular man. Surgery may well have shortened his life.

69. Properly analysed, Exhibit AG leaves open so many possibilities as to why the deceased was not operated on. For instance:

    a. The mistaken diagnosis of aspiration sepsis may have caused the son of the deceased and the Prince of Wales doctor to fear a never-ending cycle of aspiration sepsis / pneumonia, the treatment for which (intubation and ventilation) was distressing for the deceased;

    b. The prospect of ongoing pathological fractures from the cancer was regarded as a very serious possibility and undesirable;

    c. The prospect of sufficient stabilization for surgery was not regarded as viable and / or would be likely distressing to the deceased;

    d. The multiple health conditions suffered by the deceased meant there was a poor prospect of him surviving surgery, or living for any length of time thereafter regarded by the son and / or Prince of Wales doctor as meaningful, even if surgery was successful;

    e. The Prince of Wales Hospital doctor may have wrongly felt bound by the earlier 'not for resuscitation' note, or wrongly conveyed this to the son of the deceased; or

    f. The earlier 'not for resuscitation' note may have been made contrary to the wishes of the deceased, as may have been the decision on 5 December 2013.

70. It is not suggested that any one of the above inferences could be drawn beyond reasonable doubt. But as reasonable possibilities they are open to be inferred from the primary facts (the notes indicating that such matters were discussed by the decision makers). To suggest that the reason for the decision to not operate was the deceased's incontinence, PEG feeding, and reduced mobility and cognitive ability (which were submitted never to improve) was to place reliance on speculation rather than the rational drawing of inferences from evidence.[2] Further, there was no evidence capable of

---

[2] Cases concerning the line to be drawn between conjecture and inference were referred to by Spigelman CJ in *Seltsam Pty Ltd v McGuiness* (2000) 49 NSWLR 262 at 275-276 [85]-[88]. Crennan J referred to this as a "useful" collection in *Lithgow City Council v Jackson* (2011) 244 CLR 352 at 386 [94], footnote 72.

proving the likelihood of the deceased surviving surgery (such that a decision to not operate caused death). This is highlighted by the mistaken understanding of the CCA that the deceased *could not be* operated on: CCA [93]; CAB 176.

71. There is no question the assault caused the deceased serious injuries amounting to grievous bodily harm. If, as the jury found, the appellant caused such injuries, he was liable to be punished accordingly. Indeed there was an alternative charge to murder of aggravated robbery causing grievous bodily harm. This would have ensured punishment of the appellant if he caused such injuries. However, by merely proving responsibility for those injuries the crown had not proved beyond reasonable doubt that the acts of assaulting the deceased substantially or significantly contributed to the death, bearing in mind that the jury was considering criminal responsibility for murder, the most serious offence known to law.

72. One of the theories of causation put to the jury with emphasis by the crown prosecutor was not grounded in evidence and should not have been left. A miscarriage of justice occurred.

Proposed Ground 3: a miscarriage of justice occurred because the trial judge failed to adequately identify the issues relevant to causation in this particular case, and to relate the law and evidence with respect to causation to those issues

73. The appellant seeks special leave to enlarge the appeal by raising an additional ground as set out above.

74. This ground was not raised at the hearing for special leave. Nor was it the subject of specific complaint in the CCA or by trial counsel. Nonetheless, this court has, in exceptional cases, permitted new grounds to be raised for the first time in this court.[3] One minimum requirement for allowing such a course is procedural fairness to the respondent.[4] This is not a case where raising the new ground has the effect of denying the respondent procedural fairness or adding significantly to the length of the appeal. Indeed, the special leave hearing tended to show the difficulty of considering the current grounds in isolation from the trial judge's summing up.[5]

75. It is submitted that in this case, the trial judge's instructions about causation, when read as a whole, were inadequate. A trial judge does not discharge his or her responsibility of

---

[3] *Crampton v The Queen* (2000) 206 CLR 161; *Smith v The Queen* (2001) 206 CLR 650 at [22].
[4] *Crampton v The Queen* (2000) 206 CLR 161 at [115]; *Smith v The Queen* (2001) 206 CLR 650 at [22].
[5] *Swan v The Queen* [2019] HCATrans 193 (13 September 2019).

instructing the jury by explaining the relevant law in general terms and then leaving it to the jury to apply it to the case before them. Instead, the trial judge must identify the real issues in the case, the facts that are relevant to those issues and provide the jury with an explanation of how it applies to those facts.[6] In *Fingelton v The Queen*[7], McHugh J quoted, with apparent approval, the statement of Thomas JA in *Mogg*[8]:

> The consensus of longstanding authority is that the duty to sum up is best discharged by referring to the facts that the jury may find with an indication of the consequences that the law requires on the footing that this or that view of the evidence is taken.

10

76. In this case, the crown's impugned theory of causation was particularly complex. The path of reasoning to guilt consisted of numerous links in a chain, each requiring careful factual analysis. The trial judge's directions on causation, while formulated in accordance with the law, failed to assist the jury in engaging with such a task. There was no articulation of the crown's impugned theory of causation.[9] Nor was there an explanation of the legal consequences of finding or not finding certain facts, to the relevant standards, along such a complex path of reasoning. In short, the directions failed to equip the jury to "dispose of the issues in the case."[10]

77. The task for the trial judge, in this case, was particularly challenging. Not only was the
20 theory of causation novel,[11] but it tended to evolve in the course of the trial. Added to this, was the emotionally charged atmosphere of a case "involving accusations likely to arouse strong feelings of prejudice and revulsion."[12] The appellant complained in the CCA that, as well as the three specific aspects of the crown prosecutor's closing address quoted at CCA [53] and [55]-[57]; CAB 162-164, the rest of the address regarding causation relied on a highly emotive focus on the pathos of the plight of the deceased (in circumstances where the fact that grievous bodily harm had been caused was not in dispute): see CCA [55], [76]; CAB 163, 171. Those extra parts of the Crown closing address the subject of the complaint in the CCA are included in AFM 35-42.

---

[6] See *Alford v Magee* (1952) 85 CLR 437 at 446; *Fingelton v The Queen* (2005) 227 CLR 166 at [77]-[80]; *Mogg* (2000) 112 A Crim R 417 at [69]-[74]; *R v AJS* (2005) 12 VR 563 at [54]-[56].
[7] (2005) 227 CLR 166 at [77].
[8] *Mogg* (2000) 112 A Crim R 417 at [73].
[9] There was no proper articulation of any of the crown's theories of causation. Even the relevance of the dispute about the cause of the fracture was not explained to the jury by anybody. By contrast, see the directions of the trial judge in *Royall v The Queen* (1990) 172 CLR 378 at 408-409.
[10] *RPS v The Queen* (2000) 199 CLR 620 at [41].
[11] See the comments of McHugh J in *Fingelton v The Queen* (2005) 227 CLR 166 at [60].
[12] *Doggett v The Queen* (2000) 208 CLR 343 at [118].

78. It is submitted that in the peculiar circumstances of this case, the trial judge's instructions failed to adequately identify the issues relevant to causation in this particular case, and to relate the law and evidence with respect to causation to those issues. A rigorous attempt to do so would have exposed the absence of evidence in support of the impugned theory.

Part VII: Orders sought

79. The appellant seeks the following orders: (1) The appeal is allowed. (2) The orders made by the CCA on 23 November 2018 are set aside and in its place (a) the appeal is allowed; (b) the appellant's conviction is quashed; and (c) a new trial be had. (3) In the alternative to 2, the orders made by the CCA on 23 November 2018 are set aside and the matter is remitted to the CCA to consider the appellant's ground of appeal to that court in accordance with this Court's reasons.

Part VIII: Estimate

80. The appellant estimates that 1-2 hours will be required for the presentation of his oral argument, including submissions in reply.

Dated: 1 November 2019

Belinda Rigg
Public Defenders Chambers
T: 02 9268 3111
F: 02 9268 3168
E: Belinda.Rigg@justice.nsw.gov.au

Tom Quilter
Public Defenders Chambers
T: 02 9268 3111
F: 02 9268 3168
E: Tom.Quilter@justice.nsw.gov.au

Annexure – List of Legislative Provisions

1. *Criminal Appeal Act 1912* (NSW) s 6.