SUPREME COURT OF QUEENSLAND

CITATION:	*R v Baxter* [2019] QCA 87
PARTIES:	**R** **v** **BAXTER, Nicholas Aaron** (appellant)
FILE NO/S:	CA No 276 of 2017 SC No 74 of 2015
DIVISION:	Court of Appeal
PROCEEDING:	Appeal against Conviction
ORIGINATING COURT:	Supreme Court at Townsville – Date of Conviction: 20 November 2017 (North J)
DELIVERED ON:	17 May 2019
DELIVERED AT:	Brisbane
HEARING DATE:	7 June 2018
JUDGES:	Fraser JA and Jackson and Crow JJ
ORDERS:	**1. Appeal allowed.** **2. Conviction quashed.** **3. A retrial ordered.**
CATCHWORDS:	CRIMINAL LAW – APPEAL AND NEW TRIAL – VERDICT UNREASONABLE OR INSUPPORTABLE HAVING REGARD TO THE EVIDENCE – APPEAL DISMISSED – where the appellant was acquitted of murder but convicted of manslaughter of his child – where the appellant argues the evidence did not establish traumatic injury – where the appellant argues there was no proof that the appellant caused the deceased to collapse – where the appellant argues that there was insufficient evidence to prove beyond reasonable doubt that the medical findings relevant to cause of death could be attributed to anything done by the appellant – whether the verdict was unreasonable or cannot be supported having regard to the evidence CRIMINAL LAW – APPEAL AND NEW TRIAL – PARTICULAR GROUNDS OF APPEAL – IMPROPER ADMISSION OR REJECTION OF EVIDENCE – OTHER CASES – where the appellant was acquitted of murder but convicted of manslaughter – where the deceased sustained rib fractures prior to sustaining the brain injury the subject of the charges – where evidence of the rib fractures was ruled admissible pursuant to s 132B of the *Evidence Act* 1977 (Qld)

subject to the need to give appropriate directions and warnings to the jury – where the appellant challenges the admissibility of the rib fracture evidence on the ground that it did not constitute evidence of the "history of the domestic relationship" because it was disputed who caused the rib fractures – whether evidence of the rib fractures sustained by the deceased should have been admitted pursuant to s 132B

CRIMINAL LAW – APPEAL AND NEW TRIAL – PARTICULAR GROUNDS OF APPEAL – IMPROPER ADMISSION OR REJECTION OF EVIDENCE – OTHER CASES – where the appellant was acquitted of murder but convicted of manslaughter – where the deceased sustained rib fractures prior to sustaining the brain injury the subject of the charges – where the evidence of the rib fractures was ruled admissible pursuant to s 132B of the *Evidence Act* 1977 (Qld) subject to the need to give appropriate directions and warnings to the jury – where the trial judge declined to exercise the discretion in s 130 of the *Evidence Act* 1977 (Qld) as unfairly prejudicial – where the appellant challenges the decision not to exclude the evidence as unfairly prejudicial – where the appellant argues the admission of the rib fracture evidence as relevant evidence of the history of the domestic relationship carried with it a high risk of impermissible reasoning that the appellant caused the death of the deceased – whether it was unfair to the appellant for the rib fracture evidence to be admitted – whether the trial judge erred in failing to exclude the rib fracture evidence pursuant to s 130 of the *Evidence Act* 1977 (Qld)

CRIMINAL LAW – APPEAL AND NEW TRIAL – PARTICULAR GROUNDS OF APPEAL – MISDIRECTION AND NON-DIRECTION – PARTICULAR CASES – OTHER MATTERS – where the deceased sustained rib fractures prior to sustaining the brain injury the subject of the charges – where the evidence of the rib fractures was ruled admissible pursuant to s 132B of the *Evidence Act* 1977 (Qld) subject to the need to give appropriate directions and warnings to the jury – whether the trial judge erred in the directions given to the jury as to the manner in which the rib fractures could be used

Criminal Code (Qld), s 23, s 293, s 302(1)(a)
Evidence Act 1977 (Qld), s 130, s 132B

Attorney-General v B [2003] 1 Qd R 114; [2001] QCA 169, cited
BBH v The Queen (2012) 245 CLR 499; [2012] HCA 9, cited
Dasreef Pty Ltd v Hawchar (2011) 243 CLR 588; [2011] HCA 21, cited
Harriman v The Queen (1989) 167 CLR 590; [1989] HCA 50, cited
HML v The Queen (2008) 235 CLR 334; [2008] HCA 16, cited
Lane v The Queen (2018) 92 ALJR 689; [2018] HCA 28, cited

M v The Queen (1994) 181 CLR 487; [1994] HCA 63, cited
OKS v Western Australia (2019) [2019] HCA 10; [2019] HCA 10, cited
Pfennig v The Queen (1995) 182 CLR 461; [1995] HCA 7, cited
R v Baden-Clay (2016) 258 CLR 308; [2016] HCA 35, cited
R v Bauer (2018) 92 ALJR 846; [2018] HCA 40, cited
R v Bonython (1984) 38 SASR 45, cited
R v Klamo [2008] 18 VR 644; [2008] VSCA 75, cited
R v Mackie (1973) 57 Cr App R 453, cited
R v Macphee [2005] QCA 175, cited
R v Mills [1986] 1 Qd R 77, cited
R v Reed [2014] QCA 207, cited
R v Shoesmith [2011] QCA 352, cited
R v Sica [2014] 2 Qd R 168; [2013] QCA 247, cited
R v Summers [1990] 1 Qd R 92; [1989] QSCCCA 182, cited
Roach v The Queen (2011) 242 CLR 610; [2011] HCA 12, cited
Shepherd v The Queen (1990) 170 CLR 573; [1990] HCA 56, cited
SKA v The Queen (2011) 243 CLR 400; [2011] HCA 13, cited
Wilson v The Queen (1970) 123 CLR 334; [1970] HCA 17, cited

COUNSEL: P J Callaghan SC, and L Crowley, for the appellant
M R Byrne QC for the respondent

SOLICITORS: Michael Bowe Solicitor for the appellant
Director of Public Prosecutions (Queensland) for the respondent

[1] **FRASER JA:** I have had the advantage of reading my colleagues' reasons in draft. For the reasons given by Jackson J, I too would dismiss the appeal on ground 1, allow the appeal on ground 2(b), set aside the conviction, and order a new trial.

[2] **JACKSON J:** Except to the extent necessary to explain these reasons, I adopt the summary of the factual circumstances and evidence in this case contained in the reasons of Crow J.

[3] Although the appellant's plea of not guilty to the charge of the offence of murder raised the general issue on all matters of fact, there were three questions of substance to be resolved, in order to decide his guilt. First, were the jury satisfied beyond reasonable doubt that the appellant "caused the death"[1] of his six week old son, Matthew ("the deceased"), either by shaking him, or by striking his head, or causing an impact of his head against some surface on 3 November 2011, so as to cause injuries inside his cranium that resulted in subdural and subarachnoid haemorrhaging, and generalised swelling of his brain, which in turn caused a cardio-respiratory arrest that caused the death? Second, if "yes" to the first question, were the jury satisfied beyond reasonable doubt that the appellant "intend[ed] to cause the death" of the deceased, or "intend[ed] to do… [him] grievous bodily harm"?[2] Third, if "yes" to the first question but "no" to the second question, were the jury satisfied beyond reasonable doubt that the death was not "an event that… [the

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1 *Criminal Code Act* 1899 (Qld), s 293.
2 *Criminal Code Act* 1899 (Qld), s 302(1)(a).

appellant did] not intend or foresee as a possible consequence and an ordinary person would not reasonably foresee as a possible consequence".[3]

[4] The appellant gave evidence and called witnesses. His defence, in accordance with that evidence, and his counsel's address, was not that he had caused the deceased's death but did not foresee the injuries. It was that he did not shake, strike or cause any impact to the deceased's head and did not cause the injuries or the death. However, the trial judge directed the jury to consider the third question.[4]

[5] The jury's verdict of manslaughter necessarily means that they answered "yes" to the question whether the appellant caused the injuries and the death, "no" to whether he intended to cause the death or do the deceased grievous bodily harm and "yes" to the question whether they were not satisfied that the death was an event that the appellant had not foreseen as a possible consequence and an ordinary person would not reasonably foresee as a possible consequence.

Ground 2

[6] Ground 2 of the amended notice of appeal is that the trial judge erred:

(a) in ruling admissible, pursuant to s 132B of the *Evidence Act* 1977 (Qld), evidence of rib fractures sustained by the deceased, alternatively;

(b) in failing to exclude, pursuant to s 130 of the *Evidence Act* 1977 (Qld), evidence of fractures sustained by the deceased, alternatively;

(c) in the directions given to the jury as to the manner in which evidence of the rib fractures could be used.

[7] On 10 October 2017, the trial judge dismissed an application made under s 590AA of the *Criminal Code* 1899 (Qld) to exclude the evidence of rib fractures sustained by the deceased in the period between seven days and three weeks before 3 November 2011 when he suffered a catastrophic cardio-respiratory arrest, leading to his death a few days later. The rib fracture evidence comprised physical evidence of medical diagnostic images taken by x-ray, expert opinion evidence of medical practitioners that those images showed rib fractures and expert opinion evidence of medical practitioners as to the cause of the rib fractures. However, it should not be overlooked that there was a third component of the rib fracture evidence adduced by the prosecution, namely that in the period during which the rib fractures occurred, in effect, the deceased was exclusively cared for by the appellant and his wife whose evidence was that, subject to one possible exception, there was no event that occurred while she was present and caring for the deceased that might have caused the rib fractures.

[8] The prosecution contended the rib fracture evidence was admissible against the appellant on his trial for murder or manslaughter of the deceased on three bases: first as "propensity" evidence at common law; second, as "relationship" evidence at common law; and third, as evidence of the "history of a domestic relationship" between the appellant and the deceased within the meaning of s 132B of the

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3 *Criminal Code Act* 1899 (Qld), s 23.

4 Appeal Books ("AB") page 1827 lines 30 – page 1828 line 5.

Evidence Act 1977 (Qld). The trial judge rejected the first two bases of tender, but accepted that the evidence was admissible under s 132B.[5]

Ground 2(a)

[9] By ground 2(a), the appellant challenges that decision. I observe that by its written submissions, the respondent contends that the evidence was admissible, in any event, as propensity evidence and in proof of the mental element required for a conviction of murder.[6] That is a challenge to the trial judge's decision as to the permissible basis to admit the rib fracture evidence. The respondent's contention on this point may be put to one side until later in these reasons.

[10] The trial judge's reasoning that the evidence was admissible under s 132B concluded as follows:

> "Subject to the need to give appropriate directions and warnings to the jury with respect to propensity evidence and appropriate instructions to the jury that the basis of the tender is to serve the purpose of s 132B, that is to provide relevant evidence of a history of a relationship so that the event or events contended by the prosecution on the 3rd of November are not seen as isolated events out of a context, … I hold that this evidence is admissible on this ground."[7]

[11] The evidence led on the application and at the trial informs the arguments of the parties on appeal as to three contextual matters. First, it was not in dispute that the x-rays were physical evidence tendered by the prosecution that showed some evidence of rib fractures having been suffered by the deceased. Second, it was in dispute that any rib fractures were caused by the mechanism opined by prosecution's medical expert witnesses, namely that the deceased's rib cage had been encircled and compressed or, for the fractures on the front, that there had been some direct application of force. Third, it was in dispute that the appellant had engaged in any such compression or direct application of force.

[12] Section 132B(1) applies s 132B to criminal proceedings for a range of different offences, including murder and manslaughter. Section 132B(2) provides as follows:

> "Relevant evidence of the history of the domestic relationship between the defendant and the person against whom the offence was committed is admissible in evidence in the proceeding."

[13] The appellant challenges whether the rib fracture evidence was relevant evidence of the "history of the domestic relationship" between the appellant and the deceased, on the ground that it did not establish that the appellant was the person who caused the rib fractures. The appellant submits that any conclusion that he was the person responsible was speculation, notwithstanding the evidence of his wife to the effect that she had not caused any rib fractures, generally speaking,[8] and other evidence that he had opportunity alone with the deceased to do so.[9]

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5 AB pages 67-68.
6 Outline of submissions on behalf of respondent, [82].
7 AB page 68 lines 40-45.
8 See paragraph 63 below.
9 See paragraphs 61 and 62 below.

[14] Ultimately, the appellant's argument is that in the absence of conclusive or stronger proof that the appellant caused the rib fractures, the evidence did not amount to evidence of the "history of the domestic relationship" between the appellant and the deceased, within the meaning of s 132B(2).

[15] There is no doubt that there was a "domestic relationship" between the appellant and the deceased as father and infant son living together as part of a family. The respondent submits that a past incident occurring in the course of that relationship will qualify as "history" of the domestic relationship. Further, the respondent submits that although the rib fracture evidence could only by used by the jury if they were satisfied that the appellant was the person responsible for inflicting the rib fractures, that does not mean that the rib fracture evidence was inadmissible, unless it was first proved that the appellant was the person responsible.

[16] In my view, the respondent's submissions should be accepted. There is a similarity between relevant evidence of the "history of domestic relationship" admitted under s 132B and "propensity" evidence admissible at common law in proof of the offence charged, although their spheres of operation differ as to the purposes for which they may be used. In the case of admissible propensity evidence, where the evidence is in dispute, "it is still relevant to prove the commission of the acts charged",[10] although it must be kept in mind that admissibility in that context also requires that, if the evidence is accepted, "there is [no] rational view of the evidence that is consistent with the innocence of the accused", sometimes described as "the *Pfennig* test".[11]

[17] It was held in *Roach v The Queen*[12] that the *Pfennig* test is not a condition of admissibility of evidence led under s 132B(2) because "the sole basis to be applied for admissibility, relevance, is clearly stated".[13] Compare also *R v Reed*,[14] where an objection to evidence based on similar grounds to the present point was rejected.

[18] It follows, in my view, that the appellant's challenge to the admissibility of the rib fracture evidence on the ground that it could not constitute evidence of the "history of the domestic relationship" between the appellant and the deceased, because it was disputed that the appellant was the person who caused the rib fractures, must fail.

Ground 2(b)

[19] Ground 2(b) challenges the trial judge's decision to admit the rib fracture evidence, subject to the need to give appropriate directions and warnings to the jury with respect to propensity evidence on the limited basis that the event or events contended for by the prosecution on 3 November were not to be seen as isolated events out of context.

[20] Section 130 of the *Evidence Act* 1977 (Qld) provides:

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10 *Pfennig v The Queen* (1995) 182 CLR 461, 482.

11 *Pfennig v The Queen* (1995) 182 CLR 461, 483; see *HML v The Queen* (2008) 235 CLR 334, 383 [107]; *BBH v The Queen* (2012) 245 CLR 499, 534 [106].

12 (2011) 242 CLR 610.

13 *Roach v The Queen* (2011) 242 CLR 610, 622 [31].

14 [2014] QCA 207, [38].

> "Nothing in this Act derogates from the power of the court in a criminal proceeding to exclude evidence, if the court is satisfied that it would be unfair to the person charged to admit that evidence."

[21] The trial judge determined the application under s 130 to exclude the rib fracture evidence otherwise admissible under s 132B as follows:

> "I would decline to exercise any residual power at all or under s 130 of the *Evidence Act* to exclude the evidence as unfairly prejudicial. In my view, a fair trial can be had, provided no improper use is made of the evidence and appropriate instructions and warnings are given. As a consequence, I rule against the defendant's application."[15]

[22] In reaching a conclusion as to the exclusion of evidence under s 130, the question is whether the court is satisfied that it would be unfair to the person charged. What is unfair will be informed by what is fair both to the person charged and to the prosecution. That assessment can only be made having regard to the use or likely use of the evidence and the other evidence to be called at the trial, to the extent that it is known.

[23] In the present case, the trial judge expressed that use to be so that the event or events contended by the prosecution on 3 November are not seen as isolated events out of context.

[24] However, so far as the prosecution was concerned, the evidence of the rib fractures was to be used as:

> "a compelling graduation in the injuries with (sic) which the jury can have regard to in placing the injuries on the 3rd November in their proper context".[16]

[25] Sometimes the drawing of distinctions between what may be called "similar fact" or "propensity" evidence, or "relationship" evidence, and the use or uses of those different expressions in different contexts, serves to confuse rather than to clarify.[17] But in all contexts, in considering the admission of such evidence, including under s 132B, it is critical to keep the use to which the evidence in question may be put squarely in mind, as was done in the case of propensity evidence, for example, by *Harriman v The Queen*.[18] In my view, it is equally important to keep those uses in mind in considering whether the evidence should be excluded as a matter of discretion, including under s 130.

[26] In the present case, to describe the rib fracture evidence as admissible so that the event or events of 3 November were not seen as isolated events out of context did not grapple with the clearly stated intention of the prosecution to use the rib fracture evidence as part of a course of conduct alleged against the appellant, described by the prosecution as a compelling graduation in the injuries sustained by the deceased at the hands of the appellant, with the end point of the death of the deceased from the event or events of 3 November 2011.

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15 AB page 69 lines 1-5.
16 AB page 59, line 22-23.
17 *HML v The Queen* (2008) 235 CLR 334, 388 [125].
18 (1989) 167 CLR 590.

[27] That is to say, the prosecution intended to use the rib fracture evidence as propensity evidence of the appellant having inflicted injuries upon the deceased on 3 November. Once that point is reached, it is difficult to understand the basis of the trial judge's ruling on the application of s 130. In *Harriman*, Dawson J said:

> "A close examination of the cases decided in an effort (ultimately unsuccessful) to avoid the forbidden chain of reasoning will show that when propensity evidence was admitted it was in general because of its relevance as propensity evidence, whatever other label was put upon it."[19]

[28] The trial judge's reference to admission of the rib fracture evidence so that the charged acts "are not seen as isolated events out of context" may be traced to the reasoning in *Roach*,[20] *HML*,[21] and earlier cases. The question in *Roach* was somewhat different from the present case. The charge was one count of assault occasioning bodily harm. Roach and the complainant had been in an intermittent sexual relationship for two and a half years prior to the alleged assault. Roach was the complainant's carer for some of that time. The disputed evidence was of many assaults by Roach upon the complainant, as she summarised them: "if [Roach] had more than one too many Chardonnays, I always copped a flogging."[22] As the reasons in the High Court recognised, such evidence was sometimes admitted as "relationship" evidence at common law. In the Court of Appeal in *Roach*, it was held that although the prosecution disclaimed reliance on propensity, in reality it sought to use the evidence as evidence of Roach's "disposition to aggression" towards the complainant.[23] It was held that although the evidence should be identified as showing that particular propensity, it also made Roach's conduct in relation to the alleged offence "intelligible and not out of the blue".[24]

[29] In the present case, the trial judge reasoned that the evidence should not be admitted as propensity evidence at common law, in particular on the issue of intention to cause death or do grievous bodily harm for the offence of murder, because it was neither sufficiently probative on the issue of intent, and because he did not accept it was sufficiently probative to outweigh the possible prejudice to the appellant.

[30] In so finding, the trial judge reasoned that the rib fracture evidence:

> "At its highest, … is probative of a propensity to offer violence and, as submitted by the prosecutor, perhaps, increasing levels of physical violence by reason of the inference that successively greater degrees of forces were applied".

[31] It cannot be said, therefore, that the trial judge ignored or misunderstood the prejudicial effect to the appellant of admitting the evidence. However, the reasons do not disclose any further analysis of why that effect was not considered to be unfair to the appellant under s 130.

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19 (1989) 167 CLR 590, 600.
20 (2011) 242 CLR 610, 619 [22] and 625-626 [48].
21 (2008) 235 CLR 334, 393 [148], 401-402 [180]-[181], 415 [241], 444-445 [319], 449 [328], 478 [425], 489 [472].
22 (2011) 242 CLR 610, 618 [20].
23 (2011) 242 CLR 610, 619 [22].
24 (2011) 242 CLR 610, 625 [45]. Compare *HML v The Queen* (2008) 235 CLR 334, 496-498 [498]-[501].

[32] The appellant submits that the trial judge's conclusion was erroneous for a number of different reasons. One of them is that the admission of the rib fracture evidence inevitably opened up a whole new front of factual disputes requiring the appellant to defend himself against two further accusations of serious violence against the deceased, in addition to the accusation of having unlawfully killed the deceased. The appellant referred to the observations of Gleeson CJ in *HML v The Queen*[25] that the form in which most similar fact evidence is admitted may create a serious risk of unfairness. It may be accepted that a significant proportion of the trial and the evidence related to the rib fracture evidence. But that is a consequence of a decision that propensity evidence or relevant evidence of the history of a domestic relationship is admissible. Accordingly, in my view, subject to two points to be made below, the scope of the factual disputes added by the rib fracture evidence was not a consideration that was likely to cause unfair difficulties in this case because the appellant had to defend them, per se.

[33] In support of his submission as to the extent that the rib fracture evidence potentially distracted the jury, the appellant submits that the prosecutor, in his closing address to the jury, referred to "yellowy-browny marks",[26] as supporting the conclusion that the appellant left finger-sized bruises on the deceased near where there were rib fractures. The appellant submits that reference illustrates the risk of unfair prejudice to the appellant in admitting the rib fracture evidence, given the absence of any expert opinion evidence supporting the conclusion that there was such bruising. In my view, if the rib fracture evidence was otherwise admissible, the prosecutor's final address about the evidence did not make it inadmissible. The absence of expert evidence supporting the prosecutor's hypothesis of bruising might have been a matter for further direction by the trial judge, but was not in itself a reason to exclude the rib fracture evidence under s 130 as unfair to the appellant. And it is not a ground of appeal.

[34] However, a submission of greater weight is that admission of the rib fracture evidence as relevant evidence of the history of the domestic relationship carried with it a high risk of impermissible reasoning, not only by the jury, but also by one or more of the prosecution's expert witnesses, by direct use of the rib fracture evidence by way of propensity reasoning as to proof that the appellant caused the cardio-respiratory arrest and death of the deceased.

[35] The point appears from a passage in the cross-examination of an important prosecution expert witness, who was a paediatric radiologist, Dr Lamont. He was asked questions in cross-examination that dealt with combinations of physical observations or findings that might support an opinion that the deceased's death was caused by traumatic shaking. Dr Lamont agreed that a combination of encephalopathy, retinal haemorrhages, and subdural haemorrhages, termed the "triad" in the evidence, cannot be used alone to come to an opinion of a causal mechanism of trauma.[27] There followed a passage of questions and answers in relation to medical publications as to the occurrence of and causes of what was termed "shaken baby syndrome".[28] Along the way, Dr Lamont made a number of points by way of answer that dealt with the physical medical findings in the present case. In response

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25 (2008) 235 CLR 334, 354-355 [13].
26 AB page 1751, line 36.
27 AB page 595, line 20.
28 AB pages 595-600.

to a question as to whether they were enough to conclude that this is a case where there has been trauma through shaking, he answered:

> "It all depends. … here we've got… intracranial bruising. Alongside it we've got subdural collections. Alongside that we've got subarachnoid bleeding, brain stem bleeding. They all fit together, in my opinion, to say that there is significant trauma to this baby's brain."[29]

[36] In answer to another question as to the significance of individual findings that could be associated with traumatic shaking, he said as follows:

> "[T]his is this business of pulling a whole picture apart and then referring to each of the individual bits. So the implication here is that because the triad didn't work, therefore, the subdural haemorrhages here aren't necessarily non-accidental. We do have a whole stack of different things all put together here. You can't separate them out. It's severe trauma to the head."[30]

[37] Later still, in answer to questions from the trial judge about the significance of individual findings, Dr Lamont answered as follows:

> "The point I'm making is you're looking at the whole baby. **You've got all the rib fractures**. You've got the three or four different features within the brain together as a combination."[31] (emphasis added)

[38] In my view, the last passage illustrates the risk of unfair prejudice that attached to admitting the rib fracture evidence on the ground that it was only to be used as relevant evidence of history of the domestic relationship. Even one of the eminent medical experts, whose function was only to give evidence of expert medical opinion, sought to justify reasoning to his conclusion that the deceased suffered trauma by shaking, by relying on the rib fractures (and the unstated necessary assumption that they were inflicted by whoever inflicted trauma by shaking on 3 November). That was a clear direct use of the rib fractures as propensity evidence.

[39] Some of the other medical expert witnesses called by the prosecution appear to have reasoned in the same way.[32]

[40] The point is illustrated further by one of the respondent's written submissions on appeal. The respondent described "the essence" of the contest at trial as "whether the deceased's brain injury… was the consequence of trauma inflicted by the appellant… or whether there was some doubt about that", and submits that "[o]ther findings, such as intracranial bleeding, retinal bleeding, retinochisis, and, to a lesser degree, two sets of earlier rib fractures were relevant to a determination of that issue". (emphasis added)

[41] This, too, is a use of the rib fracture evidence as direct propensity reasoning.

[42] The course of the trial was diverted into that process to the extent that an eminent expert fell into the error of reasoning in a non-expert propensity way towards a conclusion that supported the appellant's guilt. In my view, the risk of that

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29 AB page 595 lines 27-30.
30 AB page 595 lines 35-40.
31 AB page 600 lines 36-38.
32 AB page 775 lines 5-15 (Dr Ireland).

process of reasoning, although perhaps not by any expert medical witness, was always present in admitting the rib fracture evidence, given that evidence and the evidence that was otherwise to be led at the trial as to the cause of the deceased's fatal injuries. It followed, in my view, that there was always a significant risk that it might be unfair to the appellant to admit the rib fracture evidence as anything other than propensity evidence that was of probative force sufficient to satisfy the *Pfennig* test.

[43] The trial judge considered, however, that appropriate directions and warnings to the jury with respect to propensity evidence and appropriate instructions as to the basis of the tender under s 132B supported admission of the rib fracture evidence as evidence of the history of the domestic relationship.

[44] There is a separate ground of appeal based on the adequacy of the relevant directions, if the evidence was admissible only on that basis. But it is relevant at this point to consider what those directions may have been at the time that the trial judge exercised the discretion under s 130 not to exclude the rib fracture evidence, by reference to the directions that were in fact given.

[45] As previously stated, the prosecution's stated purpose in tendering the rib fracture evidence during the hearing of the application to exclude the rib fracture evidence was to support the contention that the appellant engaged in a course of conduct of increasing violence towards the deceased. It was to use the rib fracture evidence to directly reason that it was more likely that the appellant unlawfully killed the deceased. Ultimately, that proposed use was acknowledged in the trial judge's direction summarising the prosecution's case on this point as follows:

> "… the Prosecution contends that the [rib fracture] evidence suggests that the history of the relationship was one of increasing levels of [violence] by the defendant to Matthew. If the timeframe suggested by the doctors for the infliction of the fractures is accurate, some action or actions were perpetrated by the defendant on the Prosecution case on or about the 13th October 2011, about three weeks before the 3 November 2011, resulting in two rib fractures and, subsequently, about seven to 10 days before the 3rd of November 2011, that is, sometime between approximately the 23rd and the 26th of October another actual action brought about Matthew sustaining 15 fractures to his ribs. And, finally, the Prosecution points to the effects on or about the 3rd of November 2011 culminating in the collapse that resulted in Matthew's admission to hospital and ultimate death on the 6th of November 2011."[33]

[46] The trial judge then directed the jury as follows:

> "But although the evidence of the alleged rib fractures on these two separate occasions before the 3rd of November 2011 comes before you as part of the prosecution case concerning an allegation of a history of violence in the relationship, you must not use it to conclude that the defendant is someone who had a tendency to commit the type of offence with which he is charged, that is, murder by act or acts resulting in the death, with the intention to cause death or grievous bodily harm or, for that matter, its alternative,

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33 AB page 1802, lines 5-15.

> manslaughter. It would be quite wrong for you to reason if you are satisfied that he did the act or acts on the occasions when the rib fractures are alleged to have been sustained, that it is likely that he committed the charge, the offence of murder, on a later occasion as alleged.
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> In short, you must not reason that because the defendant caused rib fractures it is likely that he did anything on or about the 3rd of November with the intention to kill Matthew or that he might have unlawfully killed Matthew. As I said to you, the evidence of the rib fractures comes before you as part of the prosecution case concerning an allegation of a history of violence within the domestic relationship that included Matthew and the defendant, and it does not come before you as proof of the charge of murder or its alternative, manslaughter."[34]

[47] Next, the trial judge further explained that:

> "The evidence forming part of the history of the domestic relationship comes before you with the purpose of rendering intelligible or explicable the conduct that is alleged to have occurred on the 3rd of November 2011 which, in the absence of the history of a domestic relationship, would otherwise appear to be out of character and improbable or to have occurred out of the blue."[35]

[48] The trial judge then qualified that direction, saying:

> "Further, and this is very important, you must separately consider the evidence relating to the rib fractures independently of and separately from the evidence concerning the injury or injuries alleged to have resulted in Matthew's collapse and ultimate death. You must not use one body of evidence to bolster the evidence relating to the other issue."[36]

[49] Returning to the decision to admit the rib fracture evidence under s 132B, and not to exclude it as unfair to the appellant under s 130, in my view, the trial judge may have erred in postulating that giving appropriate directions and warnings to the jury with respect to propensity evidence and limiting the basis of admission of the evidence under s 132B would remove any prejudice that was otherwise unfair to the appellant in admitting the rib fracture evidence.

[50] It is at this point that the most difficult question under s 130 arises. Given that an evident purpose of s 132B is to admit evidence of the history of a domestic relationship that does not meet the *Pfennig* test, provided the evidence is relevant to the offence charged, including by way of propensity to engage in violence towards an alleged victim of the offence charged, what is to be taken into account in determining what amounts to evidence that is "unfair"?

[51] With two important exceptions, there is not much guidance as to this question under s 130 in the cases referred to by the parties. The first exception, settled by *Roach*, is that evidence is not unfair merely because it will not elevate a circumstantial case

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34 AB page 1802, lines 17-34.
35 AB page 1802, lines 35-40.
36 AB page 1802, lines 40-44.

against the person charged to one where, if the evidence is accepted, there is no rational view of the evidence that is consistent with the innocence of that person. The second exception, also from *Roach*, is that:

> "… it is difficult to see how unfairness could be tested otherwise than by reference to the more general discretion. That is to say, consideration must be given to whether the prejudicial effect of the evidence exceeds its probative value. In the latter regard, consideration may be given to directions which may be given to the jury which may reduce the prejudicial effect of the evidence."[37]

[52] The considerations that inform the requirements for admissibility of propensity evidence at common law may be relevant in deciding whether to exclude the evidence as unfair under s 130. For example, it seems unlikely that evidence that would satisfy the common law requirements for admissibility as propensity evidence would be excluded as unfair to the person charged under s 130, where that evidence is otherwise admissible under s 132B.

[53] Also by way of example, in *Harriman*, Brennan J, in dealing with propensity evidence of prior involvement in buying and selling heroin and the use of such evidence to support an inference of continuing participation in the acts that constituted the offence charged, had regard to "the extent and duration of past participation, the proximity in time between the past participation and the offence charged and the whole of the circumstances of the case".[38] The power of proximity in time, as a relevant factor, is further illustrated by McHugh J's analysis of the distinction between res gestae cases and circumstantial evidence cases in *Harriman*.[39]

[54] In the present case, the evidence was that the deceased suffered any of the rib fractures in the period of between seven days and three weeks before 3 November 2011 when he suffered the cardio-respiratory arrest. If it were accepted that the appellant caused any of the rib fractures, by compressing the deceased's ribcage or applying direct force to the front of his chest, that supported the conclusion that he may have acted towards the deceased with violence in the few weeks prior to the day of the events which caused the death, which in turn supported the likelihood of the inference that the appellant acted towards the deceased with violence on 3 November 2011.

[55] A greater difficulty lay in assessing the appellant's involvement as the person who caused the rib fractures, because that depended on an inference based on circumstantial evidence, including the appellant's wife's testimonial evidence that tended to exclude her as the person who may have caused the rib fractures. However, under s 132B, the prosecution does not have to cross the threshold for admissibility that if the rib fracture evidence is accepted there is no rational view of the evidence consistent with the innocence of the appellant, because the evidence is only to be deployed as evidence of the history of the relationship. But, depending on the content of the relevant evidence of the history of the domestic relationship and the other evidence to be led at the trial, it may be even more likely, if that threshold is not crossed, that the relevant evidence of the history of the domestic

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37 (2011) 242 CLR 610, 618 [18].
38 *Harriman v The Queen* (1989) 167 CLR 590, 596.
39 *Harriman v The Queen* (1989) 167 CLR 590, 628-634.

relationship will have a prejudicial effect which is disproportionate to its probative value.

[56] The appellant submits that the prosecutor's reliance upon the appellant's involvement in the events of 3 November 2011, as supporting the inference that he caused the rib fractures, was impermissible. However, that submission was made at the pre-trial hearing of the application to exclude the rib fracture evidence.[40] The appellant does not submit that the prosecution addressed the jury on that basis at the trial or that the trial judge's directions to the jury proceeded on that basis. Accordingly, that point may be put to one side, because it did not affect the course of the trial.

[57] In the context of admissibility of propensity evidence at common law, the question may arise whether the propensity evidence is a link in the chain of proof of the offence charged, and whether, if it is, the evidence should not be acted upon unless it amounts to proof of the facts of the alleged propensity beyond reasonable doubt.[41] This consideration may also be relevant in deciding whether to exclude evidence under s 130 as unfair to the person charged.

[58] An allied point arose in *R v Reed*.[42] In that case, the appellant was charged with murder of a sixteen month old infant. Evidence was admitted, under s 132B, as history of the domestic relationship between the appellant and the infant, of injuries sustained resulting in bruising to the infant's buttocks two weeks prior and facial grazes sustained in the day or so before he sustained traumatic abdominal injuries that caused death. The trial judge directed the jury that they were only able to use that evidence as relevant to whether there was a history of violence by the appellant towards the child and they must give separate consideration to whether the appellant committed the offence charged.[43] It was held that it was not necessary for the trial judge to direct the jury that they could use the evidence as proving a history of violence only if they were satisfied beyond a reasonable doubt of those alleged facts.[44]

[59] It follows that not all evidence tendered under s 132B must be excluded under s 130 unless it is capable of proof beyond reasonable doubt. However, in my view, it will be relevant to the exercise of the discretion to exclude evidence under s 130 as unfair if the proof of the facts intended to establish the history of the domestic relationship is highly likely to prejudice the jury against the person charged and to be used by the jury in a process of direct or relatively direct propensity reasoning.

[60] Another relevant factor in exercising the discretion under s 130 is the probative strength of the evidence, if accepted, compared to its prejudicial effect. If accepted, the rib fracture evidence would support an inference that during the few weeks before 3 November 2011 the appellant, on either one or two occasions, applied force to the deceased's ribs by way of encircling his ribcage or directly to the front of his chest that caused the rib fractures. Acceptance of those facts would make it more likely that the fatal injuries suffered by the deceased are to be explained by an application of force to the deceased's body by the appellant, when the jury came to consider the question whether the appellant caused the deceased's death. The

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40 AB 55 lines 16-22.
41 *BBH v The Queen* (2012) 245 CLR 499, 549-550 [167]-[168].
42 [2014] QCA 207.
43 [2014] QCA 207, [60].
44 [2014] QCA 207, [64].

context was one where the appellant denied any involvement in the injuries that caused the death of the deceased. In the absence of evidence of some other rational or reasonable cause of the deceased's injuries, the rib fracture evidence was likely to have a high level or degree of cogency that would see its probative force outweigh its prejudicial effect, in accordance with the *Pfennig* test. Subject to the points to be made below, that would support its admissibility.

[61] Two other features of the rib fracture evidence should be noticed. First, the rib fractures appeared to have occurred without any significant manifestation by way of markings upon the deceased and without anyone noticing that the deceased was unusually distressed or possibly in pain. Second, the time or times at which they occurred was inexact. Accordingly, it was all the more difficult to conclude that it was the appellant who was responsible for the rib fractures. Logically, that conclusion depended upon establishing that there was no-one else who might have caused them. The prosecution's case was that the appellant was sufficiently identified as the person who caused the rib fractures by acceptance of the appellant's wife's evidence that it was not she.

[62] Her evidence was that, on 28 September 2011, she and the deceased were discharged from hospital, after his birth, and went to live with the appellant at their home from then on. The appellant had taken leave from his employment for a period of three months. For a few weeks after the birth, first members of the appellant's family and then members of her family stayed at their home. Her parents left the home on or about 23 October 2011[45] and the appellant went to Adelaide to attend a medical course over the days between 26 and 29 October 2011,[46] before returning home and continuing his leave until 3 November 2011. Over the whole period, the appellant's wife and the appellant split the care of the deceased "fifty-fifty".[47]

[63] On 23 October 2011, the appellant's wife went to a baby shower given for a friend for a couple of hours, leaving the deceased in the appellant's care.[48] On her return, the appellant told his wife that while she was out the appellant heard a "big scream"[49] coming from the deceased "and there was a little bit of a blood spot in his eye".[50]

[64] Between 26 October 2011 and 29 October 2011, while the appellant was in Adelaide, she was manoeuvring around the side of her bed with the deceased in her arms, became unbalanced and fell towards the bed, falling more than 30 centimetres. She pushed the deceased away from her body placing him on the bed with her hand over the top of his ribs with her forearm underneath and running along his back.[51] Generally speaking, she had difficulty getting the deceased in and out of his car seat from time to time.[52] But otherwise she did not hit, harm, shake or strike the deceased.[53]

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45 AB page 1074 line 20.
46 AB page 1090 lines 20-25.
47 AB page 1030 line 38.
48 AB page 1032 line 40.
49 AB page 1033 line 25.
50 AB page 1033 lines 27-28.
51 AB page 1049 line 40 – 1050 line 40 and page 1093 line 40 – 1094 line 42.
52 AB page 1051 lines 17-36.
53 AB page 1049 line 40 and page 1051 lines 18-27, 38 and 40.

[65] A number of family members who were staying at the home three weeks before 3 November 2011 and up to 23 October 2011 were called by the appellant as witnesses at the trial. None of them was asked whether they might have encircled the deceased's rib cage or applied force to the front of his chest.

[66] Some assistance may be obtained from both *Roach* and *Reed*. In both cases evidence of violence within the history of a domestic relationship was admitted under s 132B for the purpose of showing a disposition of the defendant to be violent towards (and thereby injure) the victim. Compare also *R v Mills*,[54] as to relationship evidence at common law.

[67] However, there is a possible distinction to be drawn between those cases and the present case. There was no doubt in any of those cases that the victim had suffered trauma caused injury in the episode that constituted the subject of the charged offence. The question was whether it was the defendant who had inflicted the trauma or whether there was some other accidental application of force. In the present case, the central issue of fact was whether the medical findings supported the prosecution's thesis that they were produced by trauma inflicted by the appellant upon the deceased on 3 November 2011, rather than the defence thesis that the prosecution had not proved beyond reasonable doubt that they were not produced by the deceased's cardio-respiratory arrest or some other underlying condition.

[68] Assistance may also be obtained from a recent decision of the High Court, *R v Bauer*,[55] as to tendency evidence under the Victorian statutory provisions regulating the admissibility of such evidence, as applied to a single complainant sexual offence case. In that context, a number of cases at common law have considered the admissibility of prior sexual misconduct by a defendant towards the complainant as relationship evidence, probative of a sexual interest in the complainant and a willingness to act on it which assists to eliminate doubts that might otherwise attend the complainant's evidence of the charged offence.[56] Of course, post-*Pfennig*, admissibility of such evidence as propensity evidence at common law is permitted only where it supports the inference that the defendant is guilty of the offence charged and permits no other innocent explanation.[57] As to the probative effect of prior sexual misconduct, the court in *Bauer* held:

> "... evidence that an accused has committed one sexual offence against a complainant taken in conjunction with evidence of another sexual offence against the complainant suggests that the accused has a sexual interest in or sexual attraction to the complainant and a tendency to act upon it as occasion presents. And as has been seen, that is so because, where one person is sexually attracted to another and has sought to fulfil that attraction by committing a sexual act with him or her, it is the more likely that the person will continue to seek to fulfil the attraction by committing further sexual acts with the other person as the occasion presents."[58]

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54 [1986] 1 Qd R 77, 83-87.
55 (2018) 92 ALJR 846.
56 (2018) 92 ALJR 846, 860 [46].
57 (2018) 92 ALJR 846, 861 [52].
58 (2018) 92 ALJR 846, 864 [60].

[69] An important factor in exercising the discretion whether to exclude the rib fracture evidence in the present case under s 130 was that acceptance of the rib fracture evidence as showing a disposition of the appellant to injure the deceased was attended with a risk of unfair prejudice to the appellant of using that evidence as probative of the fact that the appellant caused the death of the deceased without the jury being required to be satisfied beyond reasonable doubt that the appellant caused the rib fractures.

[70] In *Bauer*, the High Court considered whether the trial judge was required to direct the jury that they needed to be satisfied of uncharged acts beyond reasonable doubt, observing that "[o]rdinarily, proof of the accused's tendency to act in a particular way will not be an indispensable intermediate step in reasoning to guilt", and that where the common law would require proof beyond reasonable doubt that law has been altered in Victoria by statute.[59] In the course of that consideration, the court referred, by footnote,[60] to a number of passages from *HML* that are relevant, in my view, to the question whether the rib fracture evidence should have been excluded under s 130 as unfair to the appellant in the present case.

[71] Thus, in *HML*, Hayne J said:

> "It was pointed out in *Pfennig* that the purpose of evidence of other discreditable or criminal conduct that is admitted at trial is to establish a step in the proof of the prosecution case; if the evidence is not capable of doing that, it is to be rejected as inadmissible. Because this is the basis for admitting the evidence (that the jury may use it as a step towards inferring guilt), the jury may use it in that way only if persuaded of its truth beyond reasonable doubt. The direction in this case about what standard of proof was to be applied was correct."[61] (footnote omitted)

[72] And:

> "If [evidence] meets the test in *Pfennig*, it may, but need not, be used by the jury as a step in reasoning towards guilt. If it is used by the jury as a step in reasoning towards guilt, the jury must be satisfied beyond reasonable doubt of the premise for that chain of reasoning."[62]

[73] In my view, having regard to the nature of the rib fracture evidence and the use to which the prosecution intended to put it, it was unfair to the appellant, in the circumstances of this case, for the rib fracture evidence to be placed before the jury as relevant evidence of the history of the domestic relationship on the basis that they did not have to be satisfied beyond reasonable doubt that the appellant caused the rib fractures before they used that evidence as probative in relation to whether the defendant caused the death of the deceased.

[74] What is "unfair" in the context of s 130 may be questioned. Neither of the parties made submissions directed to that question. In considering the Victorian statutory discretions to exclude evidence for its "prejudicial effect", or as "unfairly

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59 (2018) 92 ALJR 846, 868 [80].
60 (2018) 92 ALJR 846, 868 [80] footnote 82.
61 (2008) 235 CLR 334, 406 [196].
62 (2008) 235 CLR 334, 416 [244].

prejudicial" or because of "unfair prejudice" the High Court in *Bauer* said of those expressions in their statutory contexts that:

> "… each conveys essentially the same idea of harm to the interests of the accused by reason of a risk that the jury will use the evidence improperly in some unfair way."[63]

[75] In the present case, as the trial judge did not propose to direct the jury that they could only act on the rib fracture evidence if they were satisfied beyond reasonable doubt that the appellant caused the rib fractures (having regard to the directions ultimately made and those foreshadowed by his decision not to reject the evidence under s 130), in my view the trial judge should have excluded the rib fracture evidence under s 130. Alternatively, if the trial judge proposed not to exclude the rib fracture evidence he should have directed the jury that they must be satisfied beyond reasonable doubt that the defendant caused the rib fractures before taking them into account. As that was not proposed, the rib fracture evidence should have been excluded.

[76] Review of whether or not the trial judge erred in exercising the discretion to exclude the rib fracture evidence under s 130 by way of appeal under s 668D and 668E of the *Criminal Code* is an appeal from a "discretionary" decision not to exclude the evidence. It was not argued by the respondent that if this court were of the view that the rib fracture evidence might have been excluded under s 130, *R v Mackie*[64] suggests that still this court "[should] not lightly interfere with a judge's exercise of his discretion to admit relevant evidence". The point does not seem to have arisen under s 130 or in cases in this jurisdiction. At least, the court was not referred to any cases of that kind. I note that the author of *Cross on Evidence* opines that "[i]t is much easier to avoid… injustice… if exclusion is recognised to be by application of a rule, subject to the ordinary processes of appellate review".[65] In my view, whether the question is approached on one basis or the other, in this case the rib fracture evidence should have been excluded under s 130.

[77] It is possible, now, to return to the respondent's submission that the rib fracture evidence was properly admissible, in any event, as propensity evidence (including as to the issue of murderous intent) and as going to identification of the person inflicting the fatal trauma.

[78] In my view, the rib fracture evidence was not admissible to prove the identity of the person who inflicted trauma upon the deceased on 3 November 2011, because there was no issue at the trial that if the deceased sustained trauma shortly before his cardio-respiratory arrest on that day, that trauma occurred when only the appellant was with him. The identity of the person who caused any trauma before the cardio-respiratory arrest was not in issue. The case relied upon by the respondent in this regard, *R v MacPhee*,[66] does not assist in the circumstances of this case.

[79] Whether the rib fracture evidence was admissible as propensity evidence that the appellant caused the death of the deceased and thereby was guilty of an unlawful killing is more difficult. In *R v Reed*,[67] this court held that it was to the advantage of Reed that evidence excluded as propensity evidence for the purpose of proving the

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63 (2018) 92 ALJR 846, 867 [73].
64 (1973) 57 Cr App R 453, 465.
65 Heydon, *Cross on Evidence*, Australian edition, Lexis Nexis Butterworths, 21,105 [21240].
66 [2005] QCA 175, [76].
67 [2014] QCA 207, [42] and [68].

intention of Reed to kill or do grievous bodily harm and as negativing any defence of accident was admitted only as evidence of the history of the domestic relationship between Reed and the infant he was convicted of unlawfully killing. But, in my view, in this case, unlike *Reed*, the likely unfairly prejudicial effect of the rib fracture evidence in the context of the other evidence was such that it should have been excluded as evidence of the history of the domestic relationship. Conversely, if it was to be admitted as propensity evidence to prove that the appellant caused the deceased's death or that he did so intending to kill him or to do him grievous bodily harm, it was necessary that the jury be directed that they must be satisfied beyond reasonable doubt that the appellant caused the rib fractures before they used that evidence for either of those purposes. In this case, the appellant was not advantaged by the rib fracture evidence being admitted only as evidence of the history of the domestic relationship.

[80] Lastly, the respondent submits that because the rib fracture evidence was admissible as propensity evidence, the proviso at s 668D(1A) applies. The submission was not directly made in relation to a finding of error in not excluding the rib fracture evidence under s 130, but was made in relation to any error in the trial judge's directions as to the use to which the evidence might be put.

[81] Had the rib facture evidence been excluded, the appellant would not have been subject to its use at all, and in particular would not have been subject to the non-expert propensity reasoning relied on by Dr Lamont previously mentioned, leaving aside whether that evidence or other evidence of Dr Lamont or any of the other expert witnesses should have been ruled inadmissible because of that process of reasoning.

[82] Alternatively, had the rib fracture evidence been admitted as propensity evidence, the appellant would have been entitled to a direction that the jury must be satisfied beyond reasonable doubt that the appellant caused the rib fractures before they used that evidence as probative in relation to whether the defendant caused the death of the deceased.

[83] Accordingly, I am not "persuaded that the evidence properly admitted at trial proved, beyond reasonable doubt, the accused's guilt of the offence on which the jury returned its verdict".[68] This is a case where "the natural limitations of proceeding on the record do not permit the appellate court to attain that satisfaction".[69] This is not a case to which the proviso should be applied.

[84] In my view, the appeal should be allowed on ground 2(b), the conviction should be set aside and a new trial should be ordered.

Other grounds

[85] Because of my conclusion on ground 2(b) of the appeal, it is unnecessary to decide ground 2(c).

[86] However, if the appellant were entitled to succeed on ground 1 of the appeal that the verdict is unreasonable or cannot be supported having regard to the evidence, he would be entitled to an order of acquittal, not merely an order for a new trial.

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68 *Lane v The Queen* (2018) 92 ALJR 689, 695 [38].

69 *OKS v Western Australia* [2019] HCA 10, 10-11 [31].

[87] Crow J's reasons summarise the evidence upon this ground of appeal to the extent that it is unnecessary for me to repeat it. However, in addition to the matters relied upon in those reasons, I would add the following.

[88] The prosecution called a number of expert medical witnesses who gave evidence of their findings and opinions. There were numerous alternative possibilities as to particular aspects of the medical findings and the possible explanations for those findings that the appellant raised in cross-examination of those witnesses. Many of them do not require mention in order to decide the questions raised upon the appeal. Surprisingly, although the appellant's written submissions were extremely detailed and lengthy, comprising 28 pages of submissions and a further 72 pages of summary of the medical and expert opinion evidence, the appellant's submissions on ground 1 of the appeal was left on the somewhat vague basis that the "whole of the evidence yields a number of reasonable explanations for" the deceased's cardio-respiratory arrest or the medical findings that followed it.

[89] The scope of the power of this court to allow an appeal on the ground that the jury's verdict is unreasonable was reaffirmed in *R v Baden-Clay*[70] with the warning that:

> "…a court of criminal appeal is not to substitute trial by an appeal court for trial by jury. Where there is an appeal against conviction on the ground that the verdict was unreasonable, the ultimate question for the appeal court "must always be whether the [appeal] court thinks that upon the whole of the evidence it was open to the jury to be satisfied beyond reasonable doubt that the accused was guilty. ""[71]

[90] *Baden-Clay* also reiterated the principles for a case where proof of the offence depends upon circumstantial evidence, from which the defendant's guilt is to be inferred, as follows:

> "The principles concerning cases that turn upon circumstantial evidence are well settled. In *Barca v The Queen*, Gibbs, Stephen and Mason JJ said:
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> > 'When the case against an accused person rests substantially upon circumstantial evidence the jury cannot return a verdict of guilty unless the circumstances are 'such as to be inconsistent with any reasonable hypothesis other than the guilt of the accused': *Peacock v The King*. To enable a jury to be satisfied beyond reasonable doubt of the guilt of the accused it is necessary not only that his guilt should be a rational inference but that it should be 'the only rational inference that the circumstances would enable them to draw': *Plomp v The Queen*; see also *Thomas v The Queen*.'"[72] (footnotes omitted)

[91] Crow J's reasons show that there was conflicting evidence on a number of matters which it was within the province of the jury to decide as to whether they were

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70 (2016) 258 CLR 308, 329 [65].
71 (2016) 258 CLR 308, 329 [66].
72 (2016) 258 CLR 308, 323 [46].

satisfied beyond reasonable doubt that the evidence was inconsistent with any reasonable hypothesis other than the guilt of the appellant.

[92] However, there are some relevant aspects of the evidence that are not raised in Crow J's reasons. In particular, the precise aetiology of the death of the deceased was not necessarily consistent among the expert medical witnesses called by the prosecution who gave evidence that the death was caused by trauma either from shaking of the deceased, or impact to the deceased's head, given that there was no visible manifestation of bruising or other injury externally, in particular to the structures and tissues of the deceased's neck or to the extra-cranial tissues of the head, but having regard to the medical findings of injuries inside the deceased's cranium.

[93] As already mentioned, sometimes the process of causation in fact is described as a causal chain, with each step in the chain constituting a link. The metaphor may be apt, but for clarity I prefer to avoid it. Working backwards from each outcome in the process to the cause of the outcome, step by step, the witnesses generally agreed that the deceased's death was caused by hypoxic-ischaemic injuries to his brain that were caused by the cardio-respiratory arrest. These steps were not generally controversial at the trial.

[94] Next, the prosecution's expert witnesses generally agreed (although some of the appellant's medical expert witnesses differed or sought to differ on this point) that the cardio-respiratory arrest was caused by downward pressure on the deceased's brain stem into the base of his skull.

[95] From this point, some of the prosecution's witnesses' evidence differed among themselves. Some opined that the downward pressure was caused by generalised brain swelling, but not by the subdural and subarachnoid swelling;[73] others that it was caused by subdural haemorrhaging on the surface of the brain and subarachnoid haemorrhaging in the brain,[74] or a combination of those things, as medical findings.

[96] In this very brief summary, I have not included the medical findings, by those qualified to make them, that at the time of his death the deceased suffered from extensive retinal haemorrhaging and retinoschisis. That is because although those findings are relevant to whether the other injuries were caused by trauma they were not part of the mechanism of the cause of death as such, and may be put to one side for the purpose of the present analysis.

[97] As to subdural and subarachnoid haemorrhaging, some opined that it was caused by tearing of the bridging blood vessels over the surface of the brain.[75] Those experts opined also that the cause of the tearing of the bridging blood vessels was either rotational brain movement within the cranium from hyperflexion and extension of the deceased's neck joint, caused by shaking, or deceleration forces from an impact of the deceased's head.[76] Hence, the conclusion was that the deceased's death was caused by trauma by shaking or some other impact.

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73 AB page 854 lines 33-40; page 881 lines 18-27.
74 AB page 491 line 44 – page 492 line 2; page 527 lines 9-11.
75 AB page 521 lines 1-5; page 575 lines 5-10; 855 lines 10-15.
76 AB page 856 lines 20 – page 857 line 10.

[98] There was also some evidence that trauma generally might have caused generalised brain swelling.[77] However, other evidence was that shaking and/or impact may produce subdural and subarachnoid haemorrhaging and generalised brain swelling.[78]

[99] There were, in the result, some uncertainties in the precise causal mechanism that led to the death: first, whether the outcome of generalised brain swelling was caused by shaking or impact or both; second, whether the downward pressure on the brain stem was caused by the subdural and subarachnoid swelling or generalised brain swelling or some combination thereof; third whether death was caused by shaking or impact or both.[79]

[100] The appellant submits that one of the principal experts for the prosecution, Dr Donald, gave evidence that the generalised brain swelling might have been caused by the hypoxic-ischaemic injuries that were caused by the cardio-respiratory arrest,[80] rather than the cardio-respiratory arrest being caused by the brain swelling that depressed the brain stem in to the base of the skull and caused the hypo-ischaemic injuries. However, neither that nor the erroneous assumption that Dr Donald had made that pre-mortem bruising of the deceased was observed on post mortem examination,[81] dissuaded Dr Donald from his opinion that the findings were due to injury and nothing else.[82] The same possibility was put to another of the other expert medical witnesses called by the prosecution whose answer was to question what caused the deceased's cardio-respiratory arrest, if it was not the brain swelling.[83]

[101] Despite the uncertainties, in the result, I have formed the view that it was open to the jury to accept the evidence of the expert medical witnesses called by the prosecution so as to find, beyond reasonable doubt, that the appellant's shaking of the deceased or causing some other impact to the deceased's head was the only rational inference as to the cause of the deceased's death.

[102] I note also that the appellant's outline of oral argument and oral submissions were organised on the footing that ground 2 of the appeal was presented for consideration first. Accordingly, in reaching my conclusion on ground 1, I did not exclude the rib fracture evidence from consideration, because I have not formed the view that the rib fracture evidence must be excluded from consideration as propensity evidence on a new trial.

[103] The other point advanced by the appellant orally,[84] is that ground 1 should be sustained on the basis that it was not open to the jury to answer "yes" to the question whether they were satisfied beyond reasonable doubt either that the appellant did not intend or foresee that death of the deceased was a possible consequence of his actions or that an ordinary person would not reasonably foresee death as a possible consequence of those actions.

[104] The argument developed was that conclusion is necessary because it was unclear what the actions of the appellant were that caused the death, including how much

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77 AB page 731 line 40 – page 732 line 10.

78 AB page 859 lines 4-24; page 861 lines 20-29; page 884 line 30 – page 885 line 18; page 961 lines 9-45; page 978 line 2 – page 979 line 45.

79 AB page 861 lines 20-29.

80 AB page 980 line 22 – page 981 line 20.

81 AB page 983 lines 10-45.

82 AB page 993 line 35 – page 994 line 10.

83 AB page 757 lines 15-25.

84 It was also hinted at in paragraph 58 of the appellant's outline of argument, although not developed there.

force his actions applied to the deceased, and because the evidence was unclear as to how much force was required to be applied to cause death by shaking.

[105] The evidence did refer in a number of places to the required force, and it is fair to say that it did not establish with exactness what force was required before death was a possible consequence of shaking.[85]

[106] I note that although the trial judge directed the jury on the question whether the defence of accident was negatived, the appellant's counsel did not rely on it in his submissions to the jury and there is no reason to think that was not a deliberate tactical decision.

[107] I note also that the appellant's point before this court is not that there is a difference between the evidence as to what force may have been applied to the deceased by the appellant compared to other evidence about some accepted standard of force that would be foreseen or reasonably foreseeable as possibly causing death of a six week old baby by shaking.

[108] In any event, in my view, it was open to the jury to decide beyond reasonable doubt that it was not satisfied that the ordinary person would not reasonably foresee that death was a possible consequence of violently shaking a six-week old baby.

[109] In the result, I would dismiss ground 1 of the appeal but allow the appeal on ground 2(b). I would order that the appellant's conviction be set aside and that there be a new trial.

[110] **CROW J:** Matthew Riley Baxter was born on 24 September 2011 in the Townsville Mater Hospital. Matthew died[86] when his life support was turned off at the Townsville General Hospital on 6 November 2011.

[111] On 3 November 2011 Matthew was evacuated by way of ambulance from his home to the Townsville General Hospital where he was found to be suffering from a traumatic brain injury. Attempts to resuscitate Matthew were not successful. On the morning of 3 November 2011, Matthew's father, the appellant, had the sole care and custody of him. Matthew's mother, the appellant's wife, left Matthew in the care of the appellant prior to Matthew falling ill.

[112] No other witnesses were present on the morning of 3 November 2011. The appellant gave sworn evidence that he was a loving and caring father who did not harm his son. The Crown could only prove their case circumstantially on medical evidence. The Crown particularised the death of Matthew as being caused by the conduct of the appellant as the shaking or striking of Matthew causing him to collide with another object or a combination of those mechanisms.

The Trial – 17 October 2017 to 15 November 2017

[113] The trial by jury was conducted over 23 days. In the first 14 days, the Crown proved its medical evidence and called several lay witnesses, including Ms Baxter who was the wife of the appellant and mother of the deceased child. In order to prove its case, the Crown called multiple medical and biomechanical experts.

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85 AB pages 857 line 40 - 858 line 42; page 896 line 17; page 936 line 40; page 968 lines 11-16; page 979 lines 26 – 47; page 660 line 42 – page 661 line 4; page 669 line 5; and page 710 line 35 – page 711 line 3.

86 Aged six weeks and one day.

[114] The defence case consumed days 15 to 22 of the trial. The first defence witness was the appellant who swore he was a capable and loving father who did not injure his son Matthew. In addition, the appellant called ten family members as character witnesses to support the appellant's credit who also testified their observations of the appellant as a loving, caring father.

[115] Had the jury accepted the evidence of the appellant as supported not only by the ten family members he called but also supported by his wife[87] the jury would have acquitted the appellant, as the only possible way the Crown could prove its circumstantial case was by reference to expert medical and biomechanical evidence. The defence also called seven experts to support the appellant's version that he did not harm his son.

[116] The defence called Michael Laposata,[88] Carl Wigren,[89] Julie A Mack,[90] Marvin Elliott Miller,[91] Ronald Auer,[92] Chris Alan Van Ee[93] and David Ayoub.[94] Again had the jury accepted the evidence of any of the seven experts called in the appellant's case it ought to have acquitted the appellant.

[117] The jury acquitted the appellant of murder but found the appellant guilty of manslaughter.

[118] The appellant has appealed against his conviction on the following grounds:

> "1. The verdict is unreasonable or cannot be supported having regard to the evidence as:
>
> (a) The evidence did not establish traumatic injury;
>
> (b) There was no proof that the appellant caused Matthew Baxter to collapse;
>
> (c) There was insufficient evidence to prove beyond reasonable doubt that the medical findings relevant to cause of death could be attributed to anything done by the appellant.
>
> 2. His Honour, the Learned Trial Judge, erred:
>
> (a) in ruling admissible, pursuant to s 132B of the *Evidence Act* 1977 (Qld), evidence of rib fractures sustained by the deceased, alternatively;
>
> (b) in failing to exclude, pursuant to s 130 of the *Evidence Act* 1977 (Qld), evidence of fractures sustained by the deceased, alternatively;
>
> (c) in the directions given to the jury as to the manner in which evidence of the rib fractures could be used."

Ground 1: The verdict is unreasonable, or cannot be supported by the evidence

[119] Section 668E(1) of the *Criminal Code* 1899 (Qld) provides:

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87 Who was called in the Crown case.
88 Chairman of the Department of Haematology and Pathology at the University of Texas.
89 Forensic pathologist from Seattle Washington.
90 Paediatric radiologist.
91 Professor of Paediatrics from Ohio.
92 Clinical Neuro Scientist from Canada.
93 Professor from the Wayne State University, a biomedical engineer.
94 A radiologist.

"**668E Determination of appeal in ordinary cases**

(1) The Court on any such appeal against conviction 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 can not be supported having regard to the evidence, or that the judgment of the court of trial should be set aside on the ground of the wrong decision of any question of law, or that on any ground whatsoever there was a miscarriage of justice, and in any other case shall dismiss the appeal."

[120] In *Attorney-General v B*[95] Wilson J said:

> "Our system of criminal law accords primacy to the decision of a jury on questions of fact, subject only to limited rights of appeal…"

[121] In *R v Shoesmith*[96] Fraser JA said:

> "… The test is whether upon the whole of the evidence it was open to the jury to be satisfied beyond reasonable doubt that the accused was guilty. The Court must conduct an independent review of the evidence, but it must also bear in mind that the jury had the benefit of seeing and hearing the witnesses give their evidence and it must accord respect to the jury's resolution of the contested factual questions reflected in the guilty verdict. …"

[122] As identified in *R v Shoesmith*[97] the task for the Court of Appeal on review is to conduct an independent review of the evidence in order to determine whether upon "the whole of the evidence" it was open to the jury to be satisfied beyond reasonable doubt that the accused was guilty. In doing so, respect must be accorded to the jury's resolution of contested factual questions reflected in the guilty verdict.

[123] In support of its argument, the appellant has provided a 72-page summary of the medical and expert opinion evidence arguing that the evidence did not support the verdict.

[124] Prior to considering the relevant evidence it is helpful to understand that it was not an issue at trial that Matthew suffered a cardiac and respiratory arrest which caused a hypoxic ischaemic injury which in turn caused the death of Matthew. The essential factual issue to be determined beyond reasonable doubt by the jury at trial was the cause of the cardiac and respiratory arrest. Was it proven beyond reasonable doubt, as the Crown alleged, by the shaking or striking of Matthew or causing him to collide with another object or a combination of those mechanisms? Or was it as the appellant alleged, a cardiac and respiratory arrest that occurred independently of any criminal act of the appellant.

[125] The appellant[98] submits that on a review of the whole of the evidence there are several reasonable explanations for Matthew's collapse "and for that which was

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95 [2003] 1 Qd R 114 at 133 [84].
96 [2011] QCA 352 at [30]. Footnotes omitted.
97 [2011] QCA 352.
98 See paragraphs 12 to 85 of the appellant's written submissions.

subsequently learned in medical examinations". These leave open, it is argued, a reasonable possibility that it was not the appellant who caused the death of his son and it was not therefore open for the jury to hold that the appellant's guilt had been proved beyond reasonable doubt. The appellant then cites *SKA v The Queen*[99] in support of its proposition of law.

[126] Where the evidence accepted by the jury leaves open a reasonable possibility that it was not the appellant who caused the death of his son then it is clear that it was not open for the jury to hold the appellant's guilt had been proven beyond reasonable doubt. However, the test as cited above is whether on the whole of the evidence it is open for the jury to be satisfied beyond reasonable doubt, that the appellant was guilty. As this test recognises, the jury may prefer one body of expert evidence over another, but in order to convict, the jury must be satisfied to the standard of beyond reasonable doubt.

[127] The jury is duty bound to consider all of the evidence, assess it and in doing so bring to bear their respective life experiences and common sense. Each of the seven experts called in the appellant's case opined Matthew's death was caused by a process which is consistent with a natural cause and absent any act of the accused. Absent a body of contrary evidence, the tribunal of fact was, no doubt, duty bound to acquit, however, there was a large body of contrary expert evidence.

[128] It is helpful to recall the common law requirements for the reception of expert evidence. They are as set out in the comprehensive reasons of Heydon J in *Dasreef Pty Ltd v Hawchar*.[100] It is also important to note that Heydon J cited both civil and criminal cases in describing the logic behind the reception of expert evidence and the importance of the Court (whether constituted by a judge or by a judge and jury) guarding its function as the decision maker and not delegating this important role to an expert or panel of experts.

[129] Expert evidence is not admissible unless it concerns matters that are outside the ordinary human experience such that a person would not be able to form a "sound judgment on the matter without the assistance of witnesses possessing special knowledge or experience in the area".[101] Where a field of expertise is established it is then necessary to prove that the person providing evidence is qualified in that science. It is then necessary for the party attempting to prove the expert opinion to ensure the expert clearly sets out the assumptions upon which the expert opinion is based (the assumption identification rule) and then it is necessary for the party to prove the assumptions (proof of assumption rule). The next and perhaps most important requirement of admissibility of expert opinion is the reasoning rule. That is, the expert must state his or her process of reasoning so that the triers of fact (a judge or a jury) are placed in a position where they can judge whether they accept the reasoning process of the expert called by one party or another party and thus form a "sound judgment".

[130] In a jury trial, matters of admissibility of evidence are matters for the judge. Accordingly, where an expert's reasoning is not stated or is not logical, the expert evidence is not admissible, that is the jury will not hear it all. In that sense whenever expert evidence is admitted in a criminal trial, it must always be based on

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99 (2011) 243 CLR 400 at 409 at [22] – [24] per French CJ, Gummow and Kiefel JJ; *M v The Queen* (1994) 181 CLR 487 at 492 – 495 per Mason CJ, Deane, Dawson and Toohey JJ.

100 (2011) 243 CLR 588 at 612 – 624 [61] – [94].

101 *R v Sica* [2014] 2 Qd R 168 at 194 [127]; *R v Bonython* (1984) 38 SASR 45.

a reasoning process and in that sense is always "reasonable", that is "able to be reasoned". However, the law is not that whenever "reasonable" defence medical evidence is technically admissible the accused must be acquitted because the reasoned expert evidence called in the defence case admits to a possibility of innocence. Expert evidence is to be judged by the trier of fact in the careful way in which the trier of fact tries all other evidence. The common law admissibility rules are designed to equip a trier of fact with the means to determine whether the evidence of any expert is accepted or rejected, in whole or in part.

[131] That any expert may give opinion evidence which is admissible and admits to a reasonable possibility consistent with innocence is not the test. This is because the jury must take into account the whole of the evidence, and the jury, as the tribunal of fact, determines for itself which expert evidence it accepts and which expert evidence it rejects.

[132] In according due respect to the jury's decision in the present appeal, it must be concluded that the jury were satisfied beyond reasonable doubt of the appellant's guilt. In doing so, it can be concluded that the jury preferred the expert evidence called by the Crown to prove a circumstantial case and rejected the expert evidence called in the appellant's case as well as the appellant's own evidence that he did his son no harm.

[133] In terms of the test to be applied on appeal, it is necessary to determine, after reviewing the evidence, whether the whole of the evidence left it "open to the jury" to conclude that a traumatic injury was established and if so whether the appellant caused the traumatic injury.

The Crown Case

[134] In *SKA v The Queen*[102] the High Court restated the necessity for a Court of Appeal in performing its statutory function to weigh "the competing evidence" to ensure that it was open to the jury to be satisfied beyond reasonable doubt as to the guilt of an accused.

[135] In this case, the Crown called 41 witnesses consisting of five lay witnesses, a police officer and 35 medical and allied health witnesses. Of the 35 medical and allied health witnesses only 12 provided purely expert evidence, with 23 witnesses attesting to facts or a mixture of evidence as to facts and expert opinion.

[136] In examining the whole of the evidence it may be seen that the appellant swore that he cared properly for his son and was a man of good credit. The appellant's credit was, as observed in paragraphs [114] and [115] above, supported not only by the ten family members he called but also by the appellant's wife called in the Crown case and three of the lay witnesses called in the Crown case.[103] The rejection of the appellant's testimony, having the considerable benefit of the weight of numerous character witnesses, could only reasonably be made by the jury if the jury accepted the factual evidence and expert evidence proved in the Crown's case over the factual and expert evidence proved in the defence case.

[137] The Crown called four lay witnesses who were able to testify that on their observations of Matthew prior to 3 November 2011, he appeared to be an ordinarily

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102 (2011) 243 CLR 400 at 409 [22] – [24] per French CJ, Gummow & Kiefel JJ.

103 Nicola Rothwell, Mark Jeffrey Crocker and Bree Dale Godfrey.

healthy child. The same four witnesses,[104] were not challenged. The uncontested facts were therefore, to outward appearance, Matthew was a perfectly healthy child prior to 3 November 2011 and after several hours in his father's care and custody on the morning of 3 November 2011 Matthew presented at the Townsville General Hospital where the medical evidence showed that he was gravely ill.

[138] At approximately 7.00 am on 3 November 2011 Ms Baxter attended at a boat licencing course in Townsville.[105] Ms Baxter did not see Matthew again until he was in the intensive care unit at the Townsville Hospital after 3.00 pm on 3 November 2011. Ms Baxter passed her boating course and received her licence at 2.26 pm. The appellant and Ms Baxter communicated by way of text messages between 11.18 am and 11.21 am and a further text message was sent at midday. There was no suggestion in the text messages that Matthew was suffering from any adverse condition.

[139] At 1.35 pm the appellant telephoned Blue Water Medical Centre in Townsville[106] describing Matthew as having a weakened state of consciousness. Prudently, office staff at the Blue Water Medical Centre advised the appellant to call an ambulance. The ambulance was despatched at 1.42 pm[107] and the ambulance arrived at the appellant's residence at 1.50 pm.[108] The paramedics O'Meara and Rathbone were the first persons to observe Matthew (and the appellant) since Ms Baxter left the residence at 7.00 am. On attendance[109] the paramedics observed the appellant using two fingers to give compressions to Matthew's chest and the appellant gave the paramedics "a very good clinical handover" described more specifically as follows:[110]

> "…he said he'd been doing CPR for seven minutes, the baby had – was alert and orientated, had been behaving normally, made some gurgling noises, went to check him and he looked like he had difficulty breathing, then he became unresponsive, his eyes were unreactive and he stopped breathing."

[140] Paramedic O'Meara observed that the baby Matthew was "a bit more floppy than usual".[111] She carefully picked up the infant, continued giving chest compressions and carried Matthew to the ambulance.

[141] After Matthew was evacuated by ambulance to the Townsville General Hospital he was examined and underwent emergency resuscitation. The results of the examination and scans showed that Matthew presented with:

(a) Diffuse brain swelling;

(b) Intracranial haemorrhaging including subdural and subarachnoid haemorrhaging;

(c) Extensive retinal haemorrhaging;

(d) Retinoschisis (an abnormal splitting of the neurosensory layer of retina);

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104 Nicola Rothwell, Mark Jeffrey Crocker, Bree Dale Godfrey and the appellant's wife, Tenae Emma Baxter.
105 AB 1098.
106 AB 1124.
107 AB 331/24.
108 AB 331/33.
109 AB 334.
110 AB 335/32-36.
111 AB 337/13-14.

(e) Fractures of the posterior ninth and tenth left ribs;

(f) Fifteen anterior rib fractures.

[142] It was not disputed that Matthew presented with the above medical conditions. What was in issue was the cause of the medical conditions. It was further not in dispute that the bilateral rib fractures were not in any way causally related to Matthew's death. The basis of the admission of the fractures is discussed in ground 2(a) of the appeal below.

[143] The need for a vast body of expert medical evidence was necessary in the prosecution case to provide evidence as to what occurred on 3 November 2011 namely within a period of about seven hours, where an apparently healthy infant became severely brain damaged. Similarly in the defence case the defence had argued there were several potential causes all consistent with the presumption of innocence which explained Matthew's catastrophic loss of health. The alternate innocent medical causes suggested by the experts called in the defence case were:

(a) Diffuse brain swelling caused by an infection;

(b) Hypoxia in turn causing both subdural and subarachnoid haemorrhage;

(c) Reperfusion causing intracranial and retinal haemorrhaging;

(d) A vitamin K deficiency being responsible for spontaneous swelling of the brain;

(e) Birth trauma and subsequent re-bleeding being the cause of the intracranial haemorrhage.

The Medical Evidence

Dr Steve Richard Mokrzecki

[144] The first medical expert to be called was Dr Mokrzecki, the obstetrician and gynaecologist of Ms Baxter, whose evidence assisted in negativing the defence thesis of birth trauma being a potential cause for intracranial haemorrhaging. Dr Mokrzecki had diagnosed Ms Baxter as suffering gestational diabetes and Dr Mokrzecki agreed there is documented link between gestational diabetes and a higher risk of vitamin D deficiency.

[145] It was part of the defence case that a vitamin D deficiency in a mother may lead to the child (Matthew) having weakened bones thus providing an innocent explanation for the multiple ribs fractures. A problem with this argument was that there was no evidence to suggest Ms Baxter actually had a vitamin D deficiency; rather all that could be said was that it was a theoretical possibility.

Dr Yong Mong Tan

[146] The second expert called in the Crown case was Dr Tan, an endocrinologist at Townsville. Dr Tan's evidence related to Ms Baxter's theoretical potential vitamin D deficiency.

[147] The effect of Dr Tan's evidence is that he acknowledged that there were academic articles confirming gestational diabetes as a risk factor for vitamin D deficiency, however, Dr Tan was able to differentiate between the academic articles which were based on patients in America and Sydney and their application to Townsville.[112]

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[112] AB 104 and AB 106/6-13.

[148] Dr Tan said "we've got a lot more sun here than in Sydney"[113] and was able to refer to his own studies conducted in Townsville which showed that vitamin D deficiencies were extremely rare in pregnant women in Townsville, i.e. 1.05 per cent of those that were tested in a study of 285 patients in Townsville were suspected of having a vitamin D deficiency.[114] Dr Tan acknowledged that it is possible to have reduced bone strength with a vitamin D deficiency, however, there was no evidence that Ms Baxter was vitamin D deficient and according to Dr Tan, statistically, the prospects of that were 1.05 per cent.

Dr Erwin Jimmy Heymann

[149] The third medical expert called was Dr Heymann, an obstetrician. Dr Heymann attended upon Ms Baxter and delivered Matthew on 24 September 2011. Dr Heymann, with reference to his notes, gave detailed evidence concerning the birth of Matthew and did not note any features of concern[115]. Dr Heymann did concede that he could not recollect directly the observations of the baby Matthew and that his routine practice was following the delivery of the baby to merely give the baby to the midwife who would then give it to the paediatrician to assess. Dr Heymann also spoke of the practice following birth that the midwives "nearly always" give the infant a vitamin K injection soon after delivery.[116]

[150] It was suggested to Dr Heymann in cross-examination[117] that literature confirmed that the use of the vacuum extraction delivery (which occurred in Matthew's case) could cause a subdural haematoma in more than half of the children that were studied. Dr Heymann rejected this suggestion.[118]

[151] Dr Heymann received his medical degree in 1991, commencing training as an obstetrician in 1996 and completing his training in England in 2001. Dr Heymann then received his fellowship in Australia as an obstetrician in 2002. The import of Dr Heymann's evidence is that the birth of Matthew was a routine birth and that birth trauma could not be reasonably accepted as a cause of Matthew's brain injury.

[152] Dr Heymann's evidence was that forceps deliveries are relatively safe i.e. a subdural haematoma in one in 10,000 cases,[119] vacuum extraction was much safer and as it was a normal vacuum extraction[120] of Matthew there was no suggestion that there was any birth trauma at all let alone sufficient to cause any intracranial bleeding or brain damage.

[153] The midwife who assisted Dr Heymann with the delivery was Fiona Montgomery. Nurse Down had been qualified as a midwife since February 1994 thus Nurse Montgomery had 17 years and nine months experience as a midwife when she assisted in the delivery of Matthew. Nurse Montgomery confirmed she did give Matthew the intramuscular vitamin K injection and that Matthew was born a healthy baby. The vitamin K deficiency theory of the defence as a cause of the rib fractures was debunked.

Dr William John Frischman

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113 AB 106/9.
114 AB 104/20.
115 AB 126/1-2.
116 AB 128/34-37.
117 AB 137/6-13.
118 AB 137/8-9.
119 AB 125/31.
120 AB 211/24.

[154] Dr Frischman, a paediatrician, gave evidence that on 25 September 2011[121] he examined Matthew and had reference to the birthing notes and was aware of Ms Baxter's gestational diabetes.[122] Dr Frischman performed a "top to toe examination"[123] which confirmed that Matthew was a healthy baby. Dr Frischman was attacked on the basis of the use of the vacuum extraction procedure causing head trauma which Dr Frischman rejected. On examination of Matthew Dr Frischman was "perfectly happy"[124] that Matthew was healthy.

Dr Jennifer Bayman Smith

[155] Dr Jennifer Smith, paediatrician, provided evidence that after Dr Frischman attended to Matthew, she then took over the care of Matthew and "saw the baby and Tenae every day"[125] and noted that the baby was "progressing well".[126]

[156] Dr Smith had been qualified as a paediatrician in Australia since 2001[127] and prior to that was qualified as a paediatrician in England.[128]

[157] The birth trauma theory was not pursued robustly in closing addresses, it had no factual basis.

Dr Gary Stuart Alcock

[158] Dr Alcock, neonatal paediatrician, was called to contest the defence theory that Matthew's brain injury was caused by infection. Dr Alcock gave evidence[129] that increased intracranial pressure could be caused by oedema, infection or "an inflammation response for any reason - - if it's severe enough". Dr Alcock was questioned about blood results of Matthew and in particular an increased monocyte level. Dr Alcock said of the increased monocyte level that it was "a rough guide, may be an indication of infection but it's not a reliable test."[130]

[159] Similarly there was a slightly raised metamyelocyte level which Dr Alcock accepted could be an indication of an infection before adding: [131]

> "… although I wouldn't say that a metamyelocyte count of .36 was significant […] That would not lead me to think a person had an infection. I would see that very often in full blood counts for all sorts of presentations. It could be an infection but it's not a reliable indicator."

[160] Dr Alcock rejected the suggestion that Matthew was suffering from an infection despite the blood results raising it as a possibility. In robust evidence Dr Alcock said:[132]

> "… infection is our bread and butter in the neonatal unit, if you want to say that. We have babies with infections all the time, and that

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121 AB 205/33
122 AB 207/41.
123 AB 208/12.
124 AB 211/42.
125 AB 219/23.
126 AB 219/41-46.
127 AB 218/35.
128 AB 218/41.
129 AB 458.
130 AB 466/45-46.
131 AB 467/5-6; AB 467.
132 AB 467/19-23.

> result is not, to me, significant of infection. But you're right, it could be infection. But you could present me with a completely normal white blood cell count, and that could be consistent with infection."

[161] Dr Alcock confirmed, at length, that Matthew was given vitamin K after presentation at hospital on 3 November at approximately 6.15 pm because the haematology results showed that "there might be some problem going on with blood coagulation" which was suggested by an elevated prothrombin time result which could have been caused by a vitamin K deficiency.[133] Dr Alcock confirmed that on presentation at hospital on 3 November it was possible that Matthew was suffering from a herpes infection as "infection was a possibility and herpes was, yes, a possibility"[134] and so "[w]e put Matthew on intravenous antibiotics."[135] However, Dr Alcock explained that Matthew did not have an actual infection and did not have herpes.

[162] Dr Alcock accepted generally that a person who has a herpes virus may become infected by it and the infection may "travel up to the brain … causing inflammation … and swelling."[136] Further Dr Alcock accepted that in an infant, a viral infection of a baby's brain may cause irritability and crying, as well as other problems such as difficulty with feeding.[137]

[163] Defence counsel leapt upon Matthew's blood results of IGG antibodies as proof "as it were" that Matthew was infected with herpes. Dr Alcock rejected this suggestion[138] and explained why he rejected the suggestion:[139]

> "The most likely explanation for IGG antibodies being present in the baby's blood at six weeks of age is passive transfer of those antibodies from the mother's blood stream via the placenta. IGG antibodies take some weeks to develop, to be made by the body. So it's incorrect to say that a – the presence of IGG antibodies to herpes Simplex 1 indicates past infection, and they are potentially offers [sic] some – not complete, but some – protection against herpes simplex 1 infection, not herpes simplex 2."

[164] Dr Alcock made it perfectly clear when the question was asked:[140]

> "Q: But doesn't the fact that there is herpes antibodies present in the system, doesn't that mean there has been an actual infection of the virus in the system?
>
> A: Not in Matthew's system. No it doesn't."

[165] It was further put to Dr Alcock that there "was a possibility that Matthew had a herpes infection" to which Dr Alcock answered:[141]

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133 AB 468.
134 AB 469/20-40.
135 AB 469/38-39.
136 AB 471/16-20.
137 AB 471/22.
138 AB 471/42.
139 AB 472/2-8.
140 AB 472 l 10-13.
141 AB 472/30 – 473/3.

> "I'm not aware of any indication in Matthew that he had had herpes infection. It is possible for a baby to – it's possible for a baby to catch herpes infection before they're born, before labour but I'm not aware – and that is a very – usually a very serious illness to get, and usually would occur – so you maybe – may get a better answer from an infectious diseases specialist, but that's usually an infection that would occur in a baby with a mother's very first herpes infection, when she has herpes virus spreading throughout her body, not just localised to the nervous system and then skin or mucous membrane ulcers. So for a – I don't there's any indication that Matthew had had herpes infection in the past. I don't think he had congenital herpes. I don't think he – or caught herpes before he was born and that's a – that's often a fatal infection. It's a serious thing. And there's no indication that he had herpes, that he caught herpes around the time of birth, and IGG antibodies would not be produced within a few days of an acute infection. So I don't believe – so it's just a difficult question to answer. It's an odd question, I'm sorry. But I don't believe there's any evidence that Matthew had previously had herpes. It is a possibility that the illness he presented with was an infection which – and herpes was a possibility. But that's irrelevant. That's not related to the result of that blood test. So I agree, you're correct, herpes could have been a cause of Matthew's illness or any child getting seriously unwell. But I don't think you can draw that conclusion or any conclusions from the result of that blood test."

[166] Dr Alcock explained that the chance of infection was very low[142] as a result of the urine and blood tests and furthermore Dr Alcock's evidence was that the bleeding in the MRI scan and bleeding behind the eyes was not consistent with an infection.[143]

Professor David John Williams

[167] Professor David Williams, a forensic pathologist with over 30 years[144] experience, performed the autopsy on Matthew. Professor Williams detailed his findings consequent on the autopsy in the 18 pages[145] before concluding that the death was due to head injury as follows:

> "Well, this child has sustained injuries to his eyes, his optic nerve on the right side at least. And he sustained a subdural haemorrhage inside the cranial cavity which has caused the brain to be pushed down and that brain has suffered irredeemable pressure effects causing death".[146]

[168] Professor Williams opined:[147]

> "Well, this is a head injury without much in the way of overt trauma to the skin […] So it's not as though some kind of weapon has been used. I feel that there has been trauma to the brain sustained by

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142 AB 482/20.
143 AB 482.
144 AB 485/1.
145 AB 484-502.
146 AB 502/46 – 503/3.
147 AB 503/31-35.

> a mechanism that doesn't involve say an instrument. It's just perhaps the way the child has been manipulated."

[169] Of his findings of a subarachnoid and subdural haemorrhage, Professor Williams said that "together are common in trauma in general".[148] It was suggested to Professor Williams that an infection often causes subdural haemorrhage, to which Professor Williams replied in his 30 years' experience:[149]

> "I can't remember ever seeing a subdural haemorrhage in somebody who had an infection".

[170] Professor Williams also opined that it was fairly unusual for an inflammation of the brain tissue to lead to a subdural haemorrhage.

[171] The appellant argues[150] reasonable doubt should attach to the opinion of Professor Williams because his opinions as to traumatic causation were unexplained and unsupported by the evidence. The appellant further argues that Professor Williams has accepted that his opinions are based on speculation.

[172] In considering the evidence of Professor Williams, it is important to bear in mind that Professor Williams gave 40 transcript pages of detailed evidence[151]. Professor Williams was cross-examined as to the basis of his "ultimate conclusion" as to "the cause of death was a head injury"[152]. Professor Williams was able to form an opinion based on the pathology "that I've seen"[153] of the head injury suffered by Matthew "caused not only the subdural haemorrhage, but has caused the injuries to the eyes and the optic nerve on the right side".[154]

[173] As to the identifiable process of reasoning, it can be observed[155] Professor Williams identified his process of reasoning as the pathological evidence of the nature and type of injuries as observed directly by himself[156] combined with the examination results with respect to the injuries to Matthew's eyes, the paediatric radiological evidence from Professor Lamont,[157] as well as the neuropathological evidence from Dr Robertson.

[174] Professor Williams' evidence that he "can only speculate"[158] was asked specifically in respect to the autopsy examination results. That is, Professor Williams did provide evidence that, excluding all other information (that is the radiological information, the history, the ophthalmic evidence, the neuropathology evidence) and based solely on the autopsy examination results, the cause of "any of those head injuries" could not be discerned precisely, or as Professor Williams said "I can't really sort of tell you exactly how this subdural haemorrhage became manifest."[159] Professor Williams, however, never resiled from his opinion that the head injury

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148 AB 523/9.
149 AB 523/20-21.
150 See paragraphs 25 - 27 of the appellant's written outline.
151 AB 490 – 530.
152 AB 528/43-44.
153 AB 529/7-8. "that I've seen".
154 AB 529/6-7.
155 AB 529/10-30.
156 AB 529/30.
157 AB 529/20-21.
158 AB 529/47.
159 AB 530/1-2.

was caused by way of trauma which was inflicted without recourse to any "instrument" was caused by "the way the child had been manipulated."[160]

[175] The inability of the pathology alone to explain Matthew's death must be understood in terms of post-mortem examination on a 44-day-old infant. When the post mortem is undertaken the tissue tends to be going off, i.e. the putrefaction process has commenced.[161] The nature of Matthew's injury and the death of Matthew's brain caused Matthew's brain to "sink down further down and it starts to break up, becomes very fragile and may be in pieces eventually."[162] Accordingly, pathology alone is not enough.

Professor Anthony Charles Lamont

[176] Professor Anthony Lamont, paediatric radiologist at the Townsville Hospital, on examining the MRI scans of the brain, formed the opinion that the cause of the death was "the brain bouncing back and forth"[163] before adding, "probably but not absolutely. It could be two blows. Two separate bruises."[164] With respect to the haemorrhaging within the brain stem, Professor Lamont opined that it may be caused in several ways, "[o]ne is by the – shaking mechanism".[165] Importantly, Professor Lamont said:[166]

> "Q: Now are you able to say – given the combination of bleeding that you observed – the mechanism for causing that – for causing those injuries to the head?
>
> A: Yeah. That's – that's always a hard one to try and identify. The – the contrecoup injuries suggests strongly that this – this head has been impacted on – on something. Quite what, I don't know. Something might have impacted the head or it might have impacted the head. With the extensive bleeding of the surface of the brain, I am – I'm really thinking that there's been quite a lot of tearing to those bridging veins with bleeding from that, and that really is an indicator towards shaking. Now, did the shaking occur separately or did it occur as part of the impact blow that occurred to cause the contrecoup injury? Again, hard to say. […] There's – there's been long controversy over retinal haemorrhages. People will say they were caused by a whole load of things. There's a lot of people who will say that that is specific to shaking. There are other people that say, well, it's as a result of a whole stack of – of other things like the intracranial ischaemia. I have to say, I've seen a fair number of babies die from intracranial pressure like this, and I've seen lots of babies who – where the clinicians tell me that there's retinal haemorrhages, but this is one of the first cases where I've seen such substantial retinal haemorrhages. Whatever caused that has been a huge disaster or – effect."

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160 AB 1849/33.
161 AB 527/5-7.
162 AB 492/42-45.
163 AB 572/1.
164 AB 572/1-2.
165 AB 573/10-11.
166 AB 574/46 – 575/26.

[177] It was put to Professor Lamont that damage to the brain could be "from a hypoxic injury, hypoxic damage",[167] to which the following exchange took place:[168]

> "A: Intraventricular bleeding – bleeding into the CS of the brain from ischaemia – very unlikely. You really need to get breakage of a blood vessel in there for some reason. Ischaemia - no. I'm – I - I don't go along with that.
>
> Q: You don't go with it?
>
> A: No.
>
> Q: Could be?
>
> A: Beyond reasonable doubt? I don't think it's beyond reasonable doubt.
>
> Q: Well, do you, as a radiologist, express your opinions, again, beyond reasonable doubt?
>
> A: Absolutely. The whole of medicine's – it runs like that. You – it's very seldom you can say 100 per cent anything. This patient has pneumonia, and it's most likely caused by such and such. We treat it with such-and-such a drug. That's the way you work. Ninety-nine point nine per cent, you're going to be right. Occasionally, you're going to be wrong, and you have to treat them with something else to – to get them right. Medicine is a – is managing uncertainty. It's not engineering; it's not physics; it's not precise. And, sadly, in this situation, the lawyers are always asking for absolute precision, and you can't give it. […] It's because we're dealing with – with biological systems, and biological systems are always a range of things."

[178] In defence of "lawyers", the law does not and has not required "absolute precision" or "complete scientific accuracy" of expert opinion to prove a fact or issue beyond reasonable doubt.[169] Furthermore, it is a matter for the jury (and not the expert) to determine if they accept a matter beyond reasonable doubt.

[179] The appellant argues that "[t]he factual foundation and assumptions for Dr Lamont's opinions as to the mechanisms of suggested trauma were not established" and that "[t]here was no pathological evidence of contrecoup injuries or bruising and contusions to the brain. There was no evidence of bleeding or tears within the brain parenchyma. No torn bridging veins were found."[170] This submission cannot be accepted.

[180] Professor Lamont's evidence is detailed and set out in 113 pages of transcript.[171] Professor Lamont explained as a radiologist it was his "job" to look at the x-rays and other scans that had been produced and to interpret them in a medical context.[172] That is precisely what Professor Lamont did in a very thorough manner.

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167 AB 584/45-46.
168 AB 584/46 – 585/16.
169 *R v Summers* [1990] 1 Qd R 92.
170 See paragraph 23 of the appellant's written outline.
171 AB 533 – 646.
172 AB 535/37-40.

Professor Lamont's opinion does not sit upon any factual foundation of pathological evidence of a contrecoup injury bruise or contusion to the brain, nor on evidence of bleeding or tears within the brain parenchyma. Whilst Professor Lamont did accept that confirmation of radiological findings with reference to pathology would be "good",[173] that does not form the factual foundation for Professor Lamont's opinion.

[181] Professor Lamont explained[174] the clearly defined features on the radiology images of collections of blood that had been disbursed within Matthew's brain. Professor Lamont explained with respect to the disbursal of the collections of blood shown on the radiological imaging:[175]

> "[I]t's got these, sort of, little black blobs and grey blobs all round it. It means that the bleeding is going into the – the tissue. The tissue's a bit mushed up around – around there and around here. So this is – these are two separate areas of – of bruising in the – in the brain."

[182] Professor Lamont then further explained[176] by making reference to contrecoup it was misleading in that he was not opining it was a contrecoup injury, but rather two areas of bleeding in the front of the brain and the back of the brain and when that is shown upon imaging, radiologists "give the name contrecoup to this particular image".

[183] Defence counsel was very fair in specifically putting his case to Professor Lamont with respect to his interpretation of radiology as follows:[177]

> "Q: Your interpretation that this is bruising inside the brain tissue?
>
> A: Yes.
>
> Q: [T]hat is not necessarily so, isn't it? You're not correct about that?
>
> A: I think you're wrong there. I think that this is bruising – bleeding into the soft tissues of the brain.
>
> Q: You may be misinterpreting the image?
>
> A: I think that's so unlikely as to be wrong."

[184] Professor Lamont opined in respect of the radiological scans: [178]

> "It tells us it's a localised area of bruising within the brain. Ninety-nine point nine nine per cent of cases of bruising in the brain are caused by trauma."

[185] With respect to the bleeding in Matthew's retina,[179] Professor Lamont said, "I've never seen bleeding into the retina as severe as this."

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173 AB 589/1-8.
174 AB 589/1-8.
175 AB 589/5-8.
176 AB 589 l 16.
177 AB 589/20-25.
178 AB 587/21-22.
179 AB 590/12-13.

[186] The challenge to Professor Lamont with respect to the relationship between fatal intracranial haemorrhage and retinal damage was thoroughly explored. In cross examination the following exchange took place:[180]

> "Q: The two things don't necessarily relate to each other, do they?"
>
> A: Well, yes, they do. There's a lot of discussion about the causes of retinal haemorrhages, whether they're attributed to shaking, whether they're attributed simply to the raised intracranial pressure and – and what – and as I said before, I know that there's this controversy. I'm not going to get involved in the – the discussion about that. All I can say here is, there's lots of bleeding in those retinas of – of those eyes and it's more than I've seen previously, and I've had a long experience with – with non-accidental injury. I've seen a lot of cases, and this is unusual."

[187] It was put to Professor Lamont that his suggestion that shaking could cause the injuries was "simply a speculative theory". Professor Lamont's answer was:[181]

> "No. We know from babies that have been shaken by parents who tell us what they've done that we see changes very similar to these. I've had the situation where I've been in the presence of a – a father who tearfully admitted to picking up the baby and shaking it until it got severe intracranial haemorrhages. So it's not speculative. This is from the experience which I have had and it's also drawn from the experience of many other paediatricians, paediatric radiologists, who see similar changes and have had similar sorts of confessions, as it were, from the parents."

Dr Harry Stalewski

[188] Dr Harry Stalewski, paediatric surgeon and neurologist was called to give evidence that on 28 September 2011 he performed a circumcision on the infant Matthew and he reported that there was not at all any abnormal bleeding.[182] This evidence was lead against the defence theory that Matthew suffered from a bleeding disorder or vitamin K deficiency.

Dr Klaus John Loibl

[189] The consultant ophthalmologist Dr Klaus Loibl examined Matthew on 4 November 2011 and said of the haemorrhages that he observed in Matthew's eye:[183]

> "I couldn't count them […] It was like counting the stars, unfortunately. But they weren't discreet, as, like, separate stars. There was – it was just a bloodbath, really."

[190] Dr Loibl was asked whether the haemorrhaging was normal or abnormal and he answered, "[n]o it's completely abnormal. And like I said, it's the worst case of retinal haemorrhages I've ever seen."[184]

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180 AB 590/15-22.
181 AB 591/20-27.
182 AB 647/38-39.
183 AB 653/46 – 654/2.
184 AB 654/15-16.

[191] Dr Loibl confirmed that both eyes were just as severely injured.[185] In addition there was "…a big schisis cavity over his macula, where the haemorrhage had just collected. So it was a – basically, a split in his retina, and the haemorrhage was sitting between his retina and his vitreous."[186]

[192] Dr Loibl described the macula split as a very large one. It was found bilaterally and he said that "[y]ou rarely see it."[187] Dr Loibl opined that the damage had been caused by some type of rotational forces[188] and they were not caused from birth.[189]

[193] With respect to the cause of the retinal haemorrhages, in cross-examination Dr Loibl gave the following evidence:[190]

> "Q: Well, you can have a retinal haemorrhage with causes which are non-traumatic, can't you?
>
> A: Absolutely. I mean, there's infectious, there's Leukaemia, there's diabetes. You don't see diabetic haemorrhages in kid, but you do see haemorrhages from non-traumatic causes. But not to the extent that Matthew had in the context that Matthew had.
>
> Q: And then if we are talking about a traumatic cause?
>
> A: Yes.
>
> Q: [T]here can be accidental causes which can lead to bleeding in the eye too, can't there?
>
> A: Absolutely. There are four cases that I know of with retinoschisis, similar to what Matthew had, but not to the extent of retinal haemorrhages that he had and they are a 63-kilogram person falling on a kid; a young 10-week-old baby getting crushed by his mother in one of those papoose things between a wooden barrier; A young 14-month-old child falling out of his mother's hands, down two flights of stairs and whacking its head; and a motor vehicle accident, as well as a dumbbell incident. But, yeah, trauma can occur."

[194] Dr Loibl gave evidence that he saw retinal haemorrhages every day and that retinal haemorrhages may be caused by a severe trauma. Dr Loibl was asked a series of questions about the extent of retinal haemorrhages in persons who had suffered from severe trauma which had been documented in ophthalmic literature case studies. Dr Loibl accepted, on multiple occasions, that accidental trauma could cause severe haemorrhages in the retina but repeatedly said "But not to the extent Matthew had."[191]

[195] Dr Loibl conceded in evidence[192] that it had been widely held ophthalmic view in the past that a retinoschisis could not be caused by an accident but must always be caused by severe trauma. Dr Loibl noted that the research had changed more

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185 AB 655/5.
186 AB 655/10-13.
187 AB 655/40-41.
188 AB 658/12.
189 AB 658/20.
190 AB 660/36 – 661/4.
191 AB 661 – 663.
192 AB 663 – 664.

recently to suggest that a retinoschisis can be caused by accident as long as it is a severe accident.

[196] The defence did not call an ophthalmic surgeon to counter this opinion and so the jury were left with the evidence from Dr Loibl that:

1. Matthew had suffered from the most severe case of retinal haemorrhaging he had ever seen; and

2. Matthew was suffering from a bilateral retinoschisis which could only be caused by trauma or by an accident as long as the accident was extremely severe.

[197] The appellant and Ms Baxter testified that Matthew had never been in an accident, let alone a severe accident.

Dr Glen Anthony Gole

[198] Dr Glen Gole is a paediatric ophthalmologist who has been medically qualified since 1973, has published over 100 peer-reviewed medical papers. Dr Gole has worked overseas and has been employed at the Lady Cilento Children's Hospital in Brisbane and its predecessor, the Children's Hospital, for 27 years. Of the haemorrhages detected in Matthew's eyes, Dr Gole said "there might be 40 or 50 haemorrhages".[193]

[199] Of the extensive haemorrhages, the evidence of Dr Gole was:[194]

> "A: This is a very unusual event, and just not seen in ordinary systemic disease.
>
> Q: Okay. And just so we are clear, is it seen in birth haemorrhaging?
>
> A: Almost never.
>
> Q: Is it seen in – well, even Leukaemia?
>
> A: In severe Leukaemia. The sort of Leukaemia you'd be talking about, you – the child would be nearly dead from it so they'd would be very severely ill. I personally can't recall a case where – where it was that bad, but it is described."

[200] Dr Gole went on to describe the haemorrhaging that he had seen as being consistent with abusive head trauma or inflicted trauma, or a mechanism of "either a forceful impact"[195] "or a to-and-fro movement of the head, which has been – you know, it's called shaken baby."[196]

[201] Dr Gole explained the mechanics of a shaking injury by reference to the anatomy of an infant's eye. Namely, the vitreous of the eye, the jelly attaches firmly at the front of the eye and firmly around the optic nerve at the macular:[197]

> "[S]o if the head's going backwards and forwards, when the eye gets to the – to the end of the head shaking, there's inertia in the vitreous

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193 AB 684/20.
194 AB 685/11-29.
195 AB 685/33.
196 AB 685/35-36.
197 AB 685 l 44-50.

> and the vitreous moves forward and causes a shearing force upon the retina."

[202] Dr Gole also described the retinal haemorrhages as being similar to the type that would be observed if an infant was to fall from 11 metres, or suffer a crush injury where a big old-fashioned television fell on top of a child and crushes their head, or a mother trips and falls over the top of a child, or a roll over car accident. Dr Gole said of the bilateral retinoschisis (splitting of the retina) that it was "…a marker for a severe trauma to the head. The most common, by far, way to this is in an non-accidental injury."[198]

[203] Dr Gole said of retinoschisis, "[a]lmost all of the cases reported in literature have been reported with non-accidental injury."[199]

[204] Dr Gole said that in his 27 years of practice, all of the severe retinal haemorrhages suffered by infants, were observed "in the context of non-accidental injury"[200] before conceding that he had one infant where he thought the cause was non-accidental injury, however the mechanism after further investigation showed the child actually had meningitis.[201] Importantly however, in that case, although the child had retinal haemorrhaging, the child did not have retinoschisis.[202]

[205] In cross-examination it was put to Dr Gole that there could be an accidental cause for the retinal haemorrhage, to which Dr Gole replied, "accidental presentations are usually much less severe than this."[203]

[206] Importantly, it was Dr Gole's evidence:[204]

> "Q: Well, it's the case, isn't it, that retinoschisis can be produced by non-traumatic causes?
>
> A: Fairly – retinoschisis as in the retinoschisis we see in the back of the eye?
>
> Q: Yes?
>
> A: They're exceptionally rare. Exceptionally rare. And always in the context of some other fatal condition. Pretty much every description in literature about retinoschisis relates to some traumatic event."

[207] With respect to the retinal haemorrhages, Dr Gole was of the opinion that they were consistent with being caused by severe shaking and that because of the severe level of haemorrhaging, it was plain to Dr Gole that the handling of Matthew was "well beyond normal handling."[205]

[208] In a telling question and answer:[206]

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198 AB 687/4-5.
199 AB 688/2-3.
200 AB 688/32-33.
201 AB 688/33-34.
202 AB 689/6.
203 AB 692/31-32.
204 AB 706/4-9.
205 AB 711/3.
206 AB 711/31-35. AB 711/42-44.

> "Q: And in terms of your opinion about the traumatic cause, you can't exclude the possibility that there may be a non-traumatic cause here which led to the retinal findings?
>
> A: Except that neither the history, nor the examination of the child, nor the autopsy, I believe – and we'll leave that to forensic paediatricians again – provide us with another cause.
>
> […]
>
> Q: But it may not be the only explanation here that would account for those findings?
>
> A: That is correct. The likelihood of that – of that being not the explanation is in very small single digit percentages."

Dr Thomas Edward Robertson

[209] Dr Thomas Edward Robertson, neuropathologist,[207] is the director of neuropathology at Queensland Health. Dr Robertson has been qualified as a medical doctor since 1993, and qualified as a specialist pathologist in 2001. Dr Robertson was the pathologist who examined Matthew's brain. In response to questions from the learned trial Judge, Dr Robertson described the mechanism of Matthew's death as follows:[208]

> "Q: I may not be following you, Doctor. Are you postulating that first of all something happened that cause the brain to swell?
>
> A: Yes.
>
> Q: And that the swelling then caused downward pressure on the brain stem?
>
> A: Yes.
>
> Q: And the result was – of the pressure and the crush to the brain stem – that the infant stopped breathing?
>
> A: Yeah. So
>
> Q: Causing oxygen deprivation?
>
> A: Yep.
>
> Q: [A]nd damage and that, as a result of that, the heart stopped beating?
>
> A: As well.
>
> Q: Yeah, but it's, first, the oxygen deprivation before the heart stops or?
>
> A: Often, they
>
> Q: Or is it simultaneous?
>
> A: Often, they do go simultaneously."

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207 A specialist in diseases of the nervous system.

208 AB 731/18-33.

[210] Dr Robertson confirmed that medically, he would attribute the swelling of the brain to trauma in the absence of any other cause. With respect to the other causes such as infection, Dr Robertson confirmed there was no evidence of any infection,[209] and that an infection would have been "obvious".[210]

[211] Dr Robertson did not see any other medical cause such as an aneurysm. With respect to the large clot observed within Matthew's brain, Dr Robertson thought it "looked acute when I saw it, and then the histology under the microscope was all acute"[211] by which Dr Robertson clarified meant within a few hours to a few days. Dr Robertson thought that the clot "happened… not long before the kid became unconscious."[212]

[212] Dr Robertson confirmed that Matthew did not suffer from herpes which he described as being obvious, "often macroscopically, but certainly microscopically."[213] Dr Robertson thought that the larger blood clot was acute.[214]

[213] It was suggested to Dr Robertson that non-traumatic causes would be consistent with his findings of pathology, to which Dr Robertson answered:[215]

> "Non-traumatic causes can give, I suppose, components of that. There's not many that gives that whole picture of swollen brain, acute subdural, acute subarachnoid, and obviously, I'm aware, you know, from the autopsy report, that the child had retinal haemorrhages."

[214] After considering the pathology and all other available information and by process of elimination, Dr Robertson formed the opinion that "other non-traumatic causes could be excluded" for Matthew's death.[216] Dr Robertson added that even if he excluded the information relating to the retinal haemorrhages (as he did not examine Matthew's eyes) he would remain of the opinion that the injury to Matthew's brain leading to his death was caused by trauma.[217]

Dr Catherine Yvette Skellern

[215] Dr Skellern obtained her primary medical qualifications with a Bachelor of Human Biology in 1989, and then obtained a Bachelor of Medicine and a Bachelor of Surgery in 1992. Dr Skellern then obtained specialist qualifications as a paediatric specialist and as a forensic pathologist. Dr Skellern is one of approximately five specialists in Australia with dual qualification of being both a forensic pathologist and a physician specialising in paediatrics. Dr Skellern is best described as a paediatric forensic specialist. Dr Skellern explained:[218]

> "…so the important thing from a forensic point of view is that they were thin film subdural collections and/or subarachnoid, and they didn't have – of itself, they weren't big collections that were causing

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209 AB 732/33.
210 AB 733/2.
211 AB 734/41-42.
212 AB 735/6.
213 AB 738/27-28.
214 AB 752/36.
215 AB 759/39-42.
216 AB 761/3.
217 AB 764/42.
218 AB 854/33-40.

> a pressure effect on the brain. So the cause of this baby's raised pressure, raised intracranial pressure, which caused his death, was actually because the brain was so swollen. So the relevance of those – the bleeding around the brain that was seen prior to death and at post-mortem as well informs us that it's a head injury, i.e., there's a mechanism of trauma that's involved, rather than actually causing the raised intracranial pressure."

[216] Whilst not being a cause of Matthew's death, Dr Skellern explained the importance of subdural haematomas:[219]

> "Now, when we see subdurals of a different type, which I would classify as a mass effect subdural, that happens with impact, they are quite different. They usually – I wouldn't expect to see them on both sides, for a start. The fact that you've got subdural collections, in Matthew's case, on both sides tells me that the blood's come from the brain rotating inside the skull. There's been a tearing of the bridging veins, which connect the brain itself to the collection reservoirs, that's caused stretching and then tearing, and for the blood to leak out. But it's quite – if I was looking at a mass effect subdural, I would expect one side of the brain to have it and in a very small location, not over the whole entire convexity of the brain, let alone over both sides."

[217] Dr Skellern went on to explain the damage to the bridging veins was likely caused by an inertial mechanism[220] which means that the brain has rotated inside the baby's skull. Dr Skellern then explained in technical terms the injury was likely caused by the generation of angular acceleration/deceleration force in the sagittal plane[221] i.e. that is by a shaking injury.

[218] With respect to pathology to Matthew's eyes, Dr Skellern gave evidence:[222]

> "Q: So the pattern of retinal haemorrhaging here and the retinoschisis that you've described, the folding, what does that tell you about Matthew's presentation or how they were caused?
>
> A: That they were caused by trauma. An application of high energy trauma, of which there was no injury account whatsoever to explain that."

[219] Of Matthew's eye injuries, Dr Skellern said:[223]

> "So the key findings with Matthew was that he had multiple – he had bleeding in the pre-retina, the front of the retina; he had bleeding within the retina; and he had that retinoschisis, the splitting. So it was multiple layers and it was widely distributed, right out to the periphery, and they were too numerous to count. And that literally happens when there are so many bleeding – so much bleeding that it's actually not possible to count them individually. And they also can be seen on the neuroimaging, as well."

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219 AB 855/8-15.
220 AB 855/47.
221 That is back to front.
222 AB 860/38-41.
223 AB 860/27-34.

[220] It was suggested to Dr Skellern that she was in effect biased, in that, her task was to "confirm suspicions of abuse"[224] which Dr Skellern rejected in emphatic terms. Dr Skellern said:[225]

> "…I'm a forensic specialist, so my task is simply to look at the facts and then to make relevant interpretations, and so my starting point is not to confirm abuse, and that's not the way in which I'm trained to do this work; that's not the way in which I do this work. […] I will not give an opinion that's specific – that's designed to be helpful to either party in a legal proceeding. I will give the same opinion, whether it's defence that's asking me or the prosecution, and I do give the evidence for the defence when I'm asked, because it should be the same, regardless of which side is asking me. The inferences that I make from a set of facts should just be the same."

[221] It was specifically put to Dr Skellern that the findings "could be from a non-traumatic cause, couldn't they"[226] to which Dr Skellern answered "No… In entirety. I am qualifying my opinion by the findings taken as a whole."[227] Thus Dr Skellern reasoned her opinion by reference to the totality of Matthew's injuries. Dr Skellern said that Matthew was "particularly vulnerable" to shaking as he was only six weeks old.[228] Dr Skellern was firm in her view that shaking "…would be a well-accepted explanation for the findings that were found in Matthew Baxter."[229]

[222] The appellant alleges[230] significant factual foundations relied upon by Dr Skellern have not been established. It is alleged that, as Dr Skellern relied on Professor Lamont's interpretation of the MRI, Dr Skellern's opinion did not have a proper basis. It is argued that as Dr Skellern's opinions on the suggested mechanisms of traumatic causation conflict with Dr Terence Donald's they could not be accepted by the jury. It is argued that the timing of the onset of the injuries is a bare opinion with no reasoning, i.e. *bare ipse dixit*. It is argued that as Dr Skellern could not identify the level of force required to cause the injuries to Matthew, that was a fundamental shortcoming in her reasoning process.

[223] The articulated criticisms, however, cannot be accepted. Dr Skellern identified her process concerning the MRIs.[231] Dr Skellern advised that she relied on Professor Lamont's expertise as a radiologist in detecting the abnormalities, and then Dr Skellern used her own medical knowledge to review the MRI scans to see the abnormalities for herself. Dr Skellern explained that whilst she is able to herself detect abnormalities, she utilises paediatric radiologist expertise to ensure she has located all of the abnormalities. Dr Skellern then explained that it is in the realm of her dual specialist qualifications as a paediatric forensic pathologist, to make interpretations of those abnormalities.[232] Professor Lamont's interpretation of the MRIs does not suffer from any deficiencies.

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224 AB 874/46-47.
225 AB 875/1-10.
226 AB 875/46.
227 AB 875/46 – 876/2.
228 AB 885/16.
229 AB 885/17-18.
230 See paragraphs 56 to 58 appellant's written outline.
231 AB 877.
232 AB 877/14.

[224] As discussed below,[233] there is, in the present case, a consistent view concerning the theories of traumatic causation advanced by Drs Skellern and Donald.

[225] The inability to specifically identify the precise level of force required to cause Matthew's injuries cannot be a fundamental shortcoming of Dr Skellern's opinion evidence because absent an experiment on a live infant, the specific level of force can never be known. What Dr Skellern and Dr Donald are able to do, however, is to provide expert evidence as to the very delicate nature of the structure of the brain of a young infant and why a young infant is particularly susceptible to traumatic injury due to shaking.

Dr Terence George Donald

[226] Dr T G Donald is a clinical forensic paediatrician who qualified as a medical doctor in 1972, has been a specialist paediatrician since 1980 and a fellow of the Faculty of Clinical Forensic Medicine of the College of Pathologists in Australia since 2014. Dr Donald is in private practice and has been providing expert opinions for 17 years.[234]

[227] Dr Donald's opinion is that he concurred with the opinion of the pathologist that Matthew's death was due to a head injury.[235] Dr Donald's original opinion was that the mechanism causing the brain swelling and haemorrhaging was the result of an injury being caused by forceful shaking and/or a forceful shaking accompanied by Matthew being thrown onto a firm, but not hard, surface.[236] Dr Donald originally favoured an opinion that it was an impact which produced the findings in Matthew's case, but did accept, because of Matthew's age at only six weeks "if shaking does cause this kind of problem, then it would happen in this – in a child of this age, more so than I would be prepared to accept in a child of, say, six months where I'd have significant reservations".

[228] Dr Donald's original opinion was based upon the acceptance as a fact that Matthew was found on post mortem to have bruising on his head; hence the preference towards an impact above forceful shaking. When it was pointed out to Dr Donald that Professor Williams' evidence was that the vague bruising was "possibly a post mortem artefact", Dr Donald did change his opinion[237]. Dr Donald explained:[238]

> "…I could also assert – and it becomes more necessary if there was no sign of impact – that this is the kind of age group in which shaking might produce the intracranial injuries that were described in Matthew.
>
> […]
>
> Yeah, I think I'm - I'm quite convinced that the inju – the findings were due to injury, and nothing else, other than injury; that the haemorrhages inside the head, the retinal haemorrhages, plus the injury to the brain substance, yes.

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233 At [118] – [120] of this decision.
234 AB 954.
235 AB 956/2-3.
236 AB 960/47 – 961/2.
237 AB 983/36-45.
238 AB 993/42 – 994/8.

> Q: But they could all be, those findings, present from non-traumatic causes?
>
> A: Oh, individual cases, but not, I don't think, in – in Matthew's situation, for the reasons I've talked about before. I mean, you've - you've raised quite a number of appropriate alternative scenarios which I think can be most – I think – yeah, I think, all of them, readily discounted."

[229] Properly construed, Dr Donald's opinion is the same as Dr Skellern's opinion, namely that if you looked at each of the findings of injuries sustained by Matthew in isolation, you could find an innocent explanation and would have to conclude that the appellant did not injure his son, however if you look at all of the findings or take the findings "as a whole" both Drs Skellern and Donald concluded Matthew's death could only be caused by traumatic injury. Dr Skellern and Dr Donald gave their evidence in great detail and with care. Dr Donald's evidence makes it clear that he is ordinarily a strong critic of the "shaken baby syndrome" however, for the detailed reasons, Dr Donald's opinion was that Matthew's death was a case of shaken baby syndrome.

Dr Eric Peter Guazzo

[230] The last medical expert called in the Crown case was Dr Guazzo. Dr Guazzo was the director of neurosurgery at the Townsville Hospital and has over 25 years' experience as a consultant neurosurgeon.[239] Apart from his long experience, Dr Guazzo had the benefit of an examination of Matthew on 5 November 2011. After examining Matthew and examining the radiological imaging, in particular the MRI imaging, Dr Guazzo was asked to provide an opinion as to the causation of Matthew's condition and Matthew's prognosis. Dr Guazzo's opinion was that Matthew had suffered from a very severe traumatic brain injury, that the cause of Matthew's condition was trauma or injury, and that the prognosis was so poor as a result of the injury that Matthew's condition was "not compatible with life".[240]

[231] Importantly Dr Guazzo opined that from the infliction of the brain injury the infant would have shown obvious signs of a medical condition immediately; that is, Matthew would have been unable to vocalise or cry.[241] In the cross-examination of Dr Guazzo[242] it was not put to Dr Guazzo that his opinion was incorrect, however, the basis of Dr Guazzo's opinion was tested. Dr Guazzo confirmed[243] that an important contributing factor to the diagnosis was the "presence of intracranial blood on the MRI".[244] As to that important factor Dr Guazzo fairly conceded:[245]

> "Q: Those bleedings within the brain are not solely caused by – in a general sense, they're not solely caused by trauma, are they?
>
> A: No, there – there can be other causes for subarachnoid and subdural bleeding, other than trauma."

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239 AB 997.
240 AB 998/27.
241 AB 998/39-41.
242 AB 999 – 1004.
243 AB 1001.
244 AB 1001/38.
245 AB 1002/7-9.

[232] In addition Dr Guazzo accepted that "[i]t could be possible that there would be a developing neurological dysfunction over time which culminates at a point where the child collapses because their breathing has stopped".[246] It is important to note however that there was no attempt to quantify the prospects of that possibility i.e. whether it was remote or likely.

[233] Dr Guazzo's evidence was that after careful examination of Matthew he formed the opinion that Matthew did suffer from a very severe traumatic brain injury, which ought to have been immediately obvious. It was also Dr Guazzo's evidence that, it was from that point forward Matthew would have been non-communicative. Dr Guazzo did however concede an unquantified possibility that Matthew had died from a developing neurological dysfunction which occurred over a period of time. The jury were entitled to consider the "whole" of Dr Guazzo's evidence and were not bound to acquit the appellant or reject Dr Guazzo's opinion on the basis of an unquantified possibility.

Dr Michael Laposata

[234] Dr Michael Laposata, the chairman of the pathology department at the University of Texas in Galverston was the first medical witness called in the defence case. Dr Laposata has a specialty in bleeding and clotting disorders and has "been involved in more than 50 cases of questionable child abuse" because of his expertise in bleeding.[247]

[235] Dr Laposata interpreted Matthew's blood tests as being consistent with a vitamin K deficiency and "missing coagulation factors".[248] In Dr Laposata's opinion, the patient's mother has missing coagulation factors that pre-disposes Matthew to bleeding.[249] Dr Laposata said that vitamin K deficiency is associated with bleeding throughout the body and vitamin K deficiency is known to result in bleeding within the brain. Dr Laposata cited a study which suggested that bleeding within the head was a spontaneous event.[250] Dr Laposata gave evidence of a phenomenon of a late-onset vitamin K deficiency which occurs between the eighth day of life and six months.[251] Dr Laposata was asked to assume, a fact proven by Ms Baxter, that when Matthew was about two weeks of age, he had a vomit with "wispy blood in it".[252] Dr Laposata referred to such a bleed as a "warning bleed".[253] Dr Laposata's evidence was "I believe now, considering all the data, that the late onset vitamin K deficiency is a far more likely explanation for the gastrointestinal bleed than DIC."[254]

[236] Dr Laposata is certified as a laboratory medical specialist, not as a paediatrician. Of the one hundred odd peer-reviewed academic articles written by Dr Laposata, only four related to paediatric blood issues. In his letter outlining his qualifications, Dr Laposata had proclaimed himself as "an expert in the incorrect diagnosis of child abuse."[255]

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246 AB 1004/14-16.
247 AB 1301/5.
248 AB 1307/29-33.
249 AB 1308/15-18.
250 AB 1309/24.
251 AB 1309/31-32.
252 AB 1312/3.
253 AB 1312/9.
254 AB 1317 l 3 – 5. DIC is an acronym for Disseminated Intravascular Coagulation.
255 AB 1320/18-19.

[237] Dr Laposata did add in respect of this claim that "most cases that come to me are rejected because they represent child abuse in my opinion."[256] In relation to his thesis concerning vitamin K deficiency, Dr Laposata agreed that vitamin K deficiency was rare and that late vitamin K deficiency is even rarer.[257] One of the papers accepted and reviewed by Dr Laposata cited a statistic that "without vitamin K prophylaxis, the incidence of late vitamin K deficiency in Europe is four to seven cases per 100,000 cases."[258] Dr Laposata agreed with that statistic and agreed with the proposition that vitamin K deficiency is a "significantly rare deficiency disorder".[259]

[238] The evidence at trial, as cited above, was that Matthew was provided with vitamin K prophylaxis in the terms of an intramuscular injection by Nurse Montgomery and so the statistical chance of Matthew having late-onset vitamin K deficiency was somewhere less than 0.007 per cent. Furthermore, Dr Laposata accepted that if an infant was suffering from vitamin K malabsorption, it would be expected that the baby would not be growing at the proper rates[260] and may be jaundiced[261] leading Dr Laposata to accept that if it was shown that a child did receive a vitamin K injection at birth intramuscularly and that the baby received formula as well as breast milk from mum, the baby was growing within normal limits "that would be fairly good indicators that the child is receiving sufficient vitamin K".[262] All of these matters were proved in evidence.

[239] In his evidence-in-chief, Dr Laposata said that Matthew's blood results showing a prothrombin time (PT) of 19 seconds was significant,[263] whereas in cross-examination Dr Laposata accepted that the PT of 19 seconds was "only slightly elevated"[264] given that a PT for a new born may be ordinarily as high as 16. Furthermore, on cross-examination Dr Laposata agreed that Matthew's INR[265] was only moderately elevated.[266] The significance of these concessions is that the reasoning of Dr Laposata's was shown to be weak.

Dr Carl Wigren

[240] Dr Carl Wigren was first licensed as a medical doctor in 2001. Dr Wigren is an American board-certified specialist in forensic pathology and anatomic pathology. Dr Wigren has a private practice in Seattle, Washington, where he undertakes medico-legal consulting and autopsies. Dr Wigren said that he has provided sworn testimony in one hundred cases. Dr Wigren was provided with Matthew's autopsy reports and results and photographs.

[241] With respect to the radiology, the x-rays and MRIs, Dr Wigren was not qualified to interpret the scans, but rather did "simply focus on the actual reports of the radiology"[267] and relied on the radiologist's report of no abnormality detected in the

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256 AB 1320/20-21.
257 AB 1320/44.
258 AB 1321/8-9.
259 AB 1321/13.
260 AB 1324/9.
261 AB 1323/35-42.
262 AB 1324/28-29.
263 AB 1307/14.
264 AB 1322/5-6.
265 International Normalised Ratio – that is the time taken for a blood clot to form.
266 AB 1322/8.
267 AB 1343/34-35.

x-ray of Matthew's neck. With respect to the MRI scan reports, Dr Wigren relied upon the reports and also the opinion of the radiologist Dr Julie Mack, who was retained by the defence to review the MRIs.[268] Dr Wigren's opinion was that as there was no demonstrated injury to the neck, it was unlikely that Matthew suffered any trauma because "if you impart enough force or energy to the head to cause subdural bleeding, then it is – it is very unlikely that you will not suffer a neck injury."[269]

[242] Dr Wigren also proffered opinion that:[270]

> "The biomechanical literature does not support the evolution of a subdural, or the causation of a subdural from shaking alone. The forces generated just aren't great enough, and if you were able to generate the forces great enough to cause a subdural by shaking, then one would expect neck injury, and in this case we don't have any neck injury."

[243] Dr Wigren obtained his medical board certifications and his specialties in 2012, i.e. quite recently, and had some difficulties in his medical career, i.e. performing autopsies without a permit.[271] On his website, Wigren Forensics, Dr Wigren advertises his expertise in diverse areas, such as asbestos, DNA banking, genetic testing and assistance with claims in relation to the *Hanford Recovery Act*.[272] However, Dr Wigren did not advertise and does not suggest expertise in paediatrics, abusive head trauma, shaken baby syndrome or retinal haemorrhages.[273]

[244] With respect to paediatrics, as Dr Wigren did not have a specialty, he relied on his medical training as an undergraduate and attending medical conferences for three to four days.

[245] Dr Wigren admitted he based his opinion on a limited number of dated biomechanical studies[274] referred to as the Bandak Study, the Duhaime Study and the Lloyd and Ommaya Studies, all of which concluded that if you generate forces great enough to cause injuries to the head, then you are going to have injury to the neck.[275]

[246] On cross-examination it was established that Dr Wigren did not have reference to any more recent studies taking a contrary view. Thus it was established that Dr Wigren was unable to comment on a number of leading studies[276] and based his opinion upon a limited number of studies, all of which supported his thesis without reference to the many prior and subsequent studies rejecting his thesis, and upon an MRI report[277] along with the opinion of Dr Julie Mack, who is a specialist radiologist.[278]

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268 AB 1345/46.
269 AB 1346/21-23.
270 AB 1346/26-30.
271 AB 1355/42-43.
272 AB 1356/16. The *Hanford Recovery Act* relates to the recovery of personal injuries for the factory workers in the 1940s, 1950s, 1960s, who worked developing the atomic bomb.
273 AB 1356/35-36.
274 AB 1359.
275 AB 1360/20-23.
276 AB 1362.
277 As Dr Wigren was unable to read the MRI imaging.
278 AB 1363/45-46.

[247] It need hardly be said that the jury were not bound to accept this opinion and it would be illogical to afford Dr Wigren's opinion much weight.

Dr Julie A. Mack

[248] Dr Julie Mack is a qualified specialist radiologist from Lancaster Pennsylvania. Dr Mack did qualify as a paediatric radiologist in 1996,[279] however for the 10 years prior to the trial, had been working part time (2.5 days per week) as a specialist breast radiologist who would only occasionally see children in relation to breast disease.[280]

[249] Dr Mack was of the opinion that both subarachnoid bleeding and subdural bleeding may be observed in non-traumatic conditions.[281] Dr Mack cited research suggesting that in 50 per cent of normal births, the infant suffers from dural bleeding and that re-bleeding may occur spontaneously without any trauma.[282] Dr Mack conceded that "you can get bleeding like this in the brain from trauma, it's just not specific to that."[283]

[250] Dr Mack relied upon a Swedish study, referred to as the Lino paper, but accepted it was controversial, insofar as most paediatric organisations, including the American category of paediatrics, disputed its conclusions. As Dr Mack said, the Swedish study caused "quite a hullabaloo."[284]

Dr Marvin Elliott Miller

[251] Dr Marvin Elliott Miller was called by video link in the defence case. Dr Miller has been a licensed medical doctor for 44 years and at the time of giving his evidence, Dr Miller was the Professor of Paediatrics at the Wright State University and the Director of Medical Genetics at the Dayton Children's Hospital in Dayton, Ohio.[285]

[252] Dr Miller has published papers regarding multiple unexplained fractures in infants and unexplained intracranial bleeding.[286] As a paediatrician however, Dr Miller deferred to his colleague, Dr Ayub in interpreting radiology.[287] Dr Miller described the process, with respect to interpreting x-rays, that "[y]es, I typically will look at it, form an opinion, and then ask David [Ayub] if he agrees with me or he finds other findings that I missed."[288] That was a wise course as Dr Miller has not been formally trained in radiology. Dr Miller offered an opinion that "there are too many things that just don't make sense… as far as trying to say this was somebody who beat on their child."[289]

[253] When asked to explain his opinion, Dr Miller said that Matthew was anaemic because he had a haematocrit level of 21. It was put to Dr Miller that the cause of the anaemia may be bleeding, or may be the administration of 40mls of the saline

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279 AB 1399/9-13.
280 AB 1399/33-34.
281 AB 1385/9-34.
282 AB 1386/35-36.
283 AB 1390/22-23.
284 AB 1411/43-44.
285 AB 1527/14-26.
286 AB 1518/11-16.
287 AB 1519/25.
288 AB 1519/34-35.
289 AB 1552/22-24.

solution by the paramedic as well as a combination of factors which may demonstrate why the haemoglobin count was reduced to 21. On this, Dr Miller explained:

> "Well, again, there are certain numbers that are pretty straightforward and the anaemia to me is one of them. This child was anaemic, and we need an explanation, and I'm not certain I can give you the explanation, but that's not child abuse. Something is going on medically with this child."[290]

[254] Dr Miller was cross-examined about Matthew's MCA (Mean Corpuscular Volume) being normal, which according to the haematologist would suggest there was an acute bleed and that would be responsible for the reduced haematocrit level. Dr Miller's response was that he did not know, as that was in the realm of a haematologist and he was not aware of that relationship. Whilst it was open for the jury to accept Dr Miller's opinions, as Dr Miller himself had deferred to both the haematologists and the radiologists, it was logical for the jury to take the same approach.

Dr Roland Auer

[255] Dr Auer has been a medical practitioner since 1977 and is currently a neuropathologist at the Royal University Hospital in the University of Saskatchewan, Canada.[291] As a neuropathologist, Dr Auer's work concerns the biopsy and autopsy of brains, eyes, spinal cords, nerves, and muscles.[292] In the present case, however, Dr Auer was unable to perform any of his usual experiments, he did not see Matthew's brain[293] but rather based his evidence on a file review of the available medical information. Dr Auer has been called as an expert in legal cases since 1985.[294]

[256] Dr Auer's evidence was that when Matthew engaged in lip-smacking on 2 November 2011, that was a hypoxic fit, proving that Matthew was chronically ill.[295] Dr Auer also opined that when Matthew, on 2 November 2011, rolled his head or shook his head from side to side, that again was a hypoxic fit, proving Matthew was chronically ill. Dr Auer opined that Matthew's brain was decompensating and it was those two events on 2 November 2011 which were critical because their timing was proximate to the emergency admission. Dr Auer said of those events:[296]

> "They are yet more evidence that this child had an antecedent illness and was chronically ill, and using the retrospectoscope, looking backward, we can say that these were the harbinger of the acute life-threatening event which happened the next day."

[257] It is the case that Dr Auer was able to offer an explanation that all of the medical conditions suffered by Matthew were not the product of injury or trauma, but rather were the product of hypoxic fits and abnormal blood results.

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290 AB 1552/39-43.
291 AB 1555/15-17.
292 AB 1557/2.
293 AB1574/30.
294 AB 1556/15.
295 AB 1572.
296 AB 1573/4-7.

[258] It was a matter for the jury to determine whether it accepted Dr Auer's evidence that when Matthew smacked his lips he was having an hypoxic seizure. It was Dr Auer's opinion that the eye injuries, being the widespread haemorrhages and retinoschisis were not caused by trauma, but rather:[297]

> "They're caused by anaemia, hyperperfusion, hypoxic hyperperfusion, cardiac arrest with reperfusion, a hyperdynamic circulation with adrenaline, all of those factors."

[259] It was open to the jury to accept Dr Auer's opinion, or reject it in favour of the opinions of the specialist ophthalmologist, Dr Gole, which supports the view that Dr Auer's theories concerning eye injuries held no scientific basis whatsoever. According to Dr Auer, who never examined Matthew, Matthew had evidence of chronic inflammation.[298] However, according to every doctor who actually examined Matthew, he did not.

[260] There are inaccuracies in Dr Auer's report. The most significant is that in his report, Dr Auer opined of Matthew: "[t]here is evidence of disseminated intravascular coagulation (DIC)."[299]

[261] In his evidence-in-chief, Dr Auer minimised the role of DIC, saying it was "if anything, a minor component to this case."[300] Matthew, however, did not have DIC. In summary, Dr Auer wrote a report based on his research of the records, opining an important fact was that Matthew had DIC, in evidence-in-chief affirmed his opinion that Matthew suffered from DIC, but suggested its role was minimal before, in cross-examination, accepting that there was categorically "no DIC in this baby."[301]

[262] The exposition of such an obvious error may not have filled the jury with confidence in Dr Auer's opinions. The jury may logically have accepted the evidence of the multiple experts that actually examined Matthew in preference to Dr Auer's paper opinion.

Dr Chris Alan Van Ee

[263] The appellant called Dr Van Ee, a biomedical and mechanical engineer and adjunct professor at the Wayne State University, Michigan, USA. Dr Van Ee did not review any of the material in the case, but rather gave general evidence. Dr Van Ee gave evidence from the perspective of his field of expertise, biomechanics, which neither assisted the prosecution nor the defence. A summary of Dr Van Ee's opinion was:

> "…despite what has been undertaken in the field of biomechanics to date, that we still don't know if shaking can or cannot result in the injuries that are said to be associated with that shaken baby mechanism…"[302]

Dr David Ayoub

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297 AB 1570/43-45.
298 AB 1581/21.
299 AB 1582/29.
300 AB 1570/40.
301 AB 1582/21.
302 AB 1595 l 10 – 12; AB 1599/33-35.

[264] Dr Ayoub has been a medical practitioner since 1986 and became American board certified as a specialist radiologist in 1990.[303] Dr Ayoub is in the employ of a private corporation called Clinical Radiologists at Springfield, Illinois. Dr Ayoub reviewed Matthew's x-rays and MRIs.

[265] According to Dr Ayoub, infantile rickets is quite common, with studies suggesting between six per cent to 50 per cent of infants display a rachitic rosary as an indicator of rickets. Dr Ayoub considered that:[304]

> "…this pattern of changes to the costochondral junction, so the anterior ribs, this is – in my opinion it's highly, highly characteristics [sic] of rickets involved in the ribs."

[266] Dr Ayoub rejected the opinion of the other radiologist, that if an infant has rickets it will be seen throughout most of the bones of the body.[305] Dr Ayoub qualified his opinion by stating that "you would like to see at least two signs of rickets on a skeleton in order to establish the diagnosis."[306]

[267] Dr Ayoub was of the opinion that:[307]

> "I think there are probably some real fractures to the thick perichondral ring, but most of those protuberant structures, in my opinion, are just thickened perichondral rings and the normal irregularity you get with rickets."

[268] Dr Ayoub was of the opinion based on the x-ray radiology of the abnormalities in Matthew's chest, that Matthew suffered from rickets.[308] Further, that it was not at all unusual that the signs of rickets were confined to Matthew's chest rather than inherent in other bones in Matthew's body.[309]

[269] Dr Ayoub described the important role of vitamin D, namely "it enhances calcium and phosphate absorption in the gut"[310] as an important but "not an absolute requirement" for the diagnosis of rickets.[311] Dr Ayoub dated the posterior rib fractures as being between 5 to 15 days old, based on "faint periosteal reaction".[312] Dr Ayoub did however later add that "I don't know if you can really date a deformity."[313] Although Dr Ayoub remained of the opinion that Matthew had rickets, Dr Ayoub conceded that some of the fractures could be as a result of secondary trauma.[314]

[270] Dr Ayoub also accepted that several of the deformities which he observed on x-rays of the ribs could resemble fractures.[315] Dr Ayoub said that his opinion concerning the nature and extent of the cause of the fractures was based on his examination of the chest x-rays and would accept that "in some of these I would yield to the

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303 AB 1601/39-40.
304 AB 1612/2-4.
305 AB 1612/7-8.
306 AB 1612/1-2.
307 AB 1613/5-8.
308 AB 1613.
309 AB 1632/46.
310 AB 1634.
311 AB 1633/47.
312 AB 1635/40.
313 AB 1622/29-30.
314 AB 1635/36-37.
315 AB 1635/6-24.

autopsy with regards to the acuteness of these fractures, if they indeed saw bleeding in histological fracture".[316]

[271] Dr Ayoub said that as Matthew suffered from rickets, he would have expected Matthew to have suffered from chest fractures as a result of the CPR administered by not only the accused, but also the ambulance officers who tended to Matthew. However Matthew did not suffer any rib fractures from CPR and the jury may have considered that important.

Conclusion on Ground 1:

[272] It cannot be presumed that the jury would not be alive to the difficulties raised by expert evidence, which have been summarised by Heydon J in *Dasreef Pty Ltd v Hawchar*.[317] There are many good and logical reasons for the jury to have accepted the expert evidence brought in the prosecution case and rejected the expert evidence brought in the defence case.

[273] The acceptance of the expert evidence brought in the prosecution case establishes not only that Matthew died as a result of traumatic injury, but that trauma inflicted upon Matthew caused Matthew to suffer from diffuse brain swelling, intracranial haemorrhaging including both subdural and subarachnoid haemorrhaging, extensive retinal haemorrhaging and bilateral retinoschisis.

[274] Accepting the expert evidence brought in the prosecution case, particularly from Doctors Mokrzecki, Tan, Heymann, Frischman, Smith, Alcock, Stalewski, Loibl, Gole, Robertson, Skellern, Donald, Guazzo and Professors Williams and Lamont, the jury was entitled to conclude, and beyond reasonable doubt, that the evidence did establish that the traumatic injury which caused the infant Matthew Baxter to collapse, was inflicted upon Matthew by the appellant.

[275] The jury also had to weigh the impressive expert evidence in the prosecution case against the evidence of the appellant and the expert witnesses in the defence case.

[276] The appellant's argument that the prosecution case suffered from a fundamental shortcoming, due to the inability of the expert evidence to identify the level of force required to cause Matthew's injuries, is particularly unattractive. The appellant argues because the level of force cannot be specifically identified, that it:

> "[L]eft the jury without a proper basis upon which they could form any conclusions about what the appellant might have intended or foreseen, or what a reasonable person would have reasonably foreseen as a possible consequence of any willed act."[318]

[277] The appellant calls in aid of this submission the Victorian Court of Appeal's decision in *R v Klamo* as follows:[319]

> "Apart from the lack of evidence as to the alleged unlawful acts, I also consider that the evidence raised doubts with respect to the mental element of the crime. As noted earlier, Professor Cordner had

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316 AB 1637/46 – 1638/1.
317 (2011) 243 CLR 588 at 610 – 611.
318 See paragraph 58 of the appellant's written outline.
319 [2008] 18 VR 644, 659 at [66] to [67]. Footnote omitted.

> stated that there was continuing controversy among experts about the mechanism by which shaking a baby could cause a brain haemorrhage and — equally — about the degree of force required for that to occur. Professor Cordner added that this controversy was directly relevant to:
>
> > … the question, is it always the case that the shaking has to be so severe that the person doing it would have some understanding that some harm might result.
>
> The Crown's "second shaking" hypothesis required the jury to postulate a shaking event about which nothing was known other than that it had — on this hypothesis — caused the child's death. In the face of Professor Cordner's evidence, I do not see how the jury could have been satisfied beyond reasonable doubt that the force used in the postulated shaking was such that a reasonable person in the applicant's position *must have known* that it would expose the baby to an appreciable risk of serious harm."

[278] Klamo's case differs considerably from the present case because Klamo admitted to a minor shaking of his infant child some weeks before the child passed away. In that case, however,[320] the medical evidence did not purport to establish any informative conclusion as to the cause of death. The medical evidence was materially different. In the present case, the appellant denies any shaking or ill treatment of Matthew, yet Matthew was shown to suffer from catastrophic injuries. It is the degree of injury sustained by Matthew in the present case which has compelled Dr Skellern and Dr Donald to opine that the injuries were in fact caused by shaking.

[279] It has not been demonstrated on review of the whole of the evidence that it was not open to, or unreasonable for, the jury to have accepted the prosecution case, and accordingly it cannot be concluded that the verdict is unreasonable, nor unsupported, by the evidence.

Ground 2(a): Error admitting evidence of rib fractures sustained by the deceased

[280] After Matthew was admitted to the Townsville General Hospital on 3 November 2011, a series of x-rays were taken. The x-rays revealed two fractures to the posterior ninth and tenth left ribs which radiologically were shown to be in a state of advanced healing and were estimated to be about three weeks old at the time of the x-rays (that is occurring at or around 13 October 2011).

[281] The x-rays revealed Matthew suffered from 15 anterior rib fractures, some of which showed evidence of healing, and from which it could be estimated that the rib fractures occurred seven to ten days prior to the date of x-rays being taken on 3 November 2011 (that is the 15 anterior fractures are likely to have been suffered between 24 and 27 October 2011).

[282] The appellant brought a pre-trial application, pursuant to s 590AA of the *Criminal Code* 1899 (Qld) seeking the exclusion of the evidence of the rib fractures and the opinion evidence of the cause or likely mechanism of the rib fractures.

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320 See paragraph 53 of the appellant's written outline.

[283] The pre-trial hearing was conducted on 10 October 2017 and included oral evidence from Dr Van Ee and extensive written and oral submissions. On the application, defence counsel successfully argued that the evidence of the rib fractures ought not to be admitted on the basis that they demonstrated propensity to be violent to Matthew. The Crown however succeeded in persuading the primary judge that the rib fracture evidence was admissible pursuant to s 132B of the *Evidence Act* 1977 (Qld). Defence counsel then argued that the rib fracture evidence ought to be excluded pursuant to s 130 of the *Evidence Act* 1977 (Qld) (as being more prejudicial than probative).

[284] In his argument for the admission pursuant to s 132B of the *Evidence Act* 1977 (Qld), the prosecutor conceded that appropriate directions would need to be provided by the trial judge to the jury to ensure the proper use of the rib fracture evidence.[321] The primary judge accepted that submission, ruling:[322]

> "Subject to the need to give appropriate directions and warnings to the jury with respect to propensity evidence and appropriate instructions to the jury that the basis of the tender is to serve the purpose of s 132B, that is to provide relevant evidence of a history of a relationship so that the event or events contended by the prosecution on the 3rd of November are not seen as isolated events out of a context, I propose to - I hold this evidence is admissible on this ground."

[285] Section 132B of the *Evidence Act* 1977 (Qld) provides:

> "**132B Evidence of domestic violence**
>
> (1) This section applies to a criminal proceeding against a person for an offence defined in the Criminal Code, chapters 28 to 30.
>
> (2) Relevant evidence of the history of the domestic relationship between the defendant and the person against whom the offence was committed is admissible in evidence in the proceeding.
>
> (3) In this section—
>
> ***domestic relationship*** means a relevant relationship under the *Domestic and Family Violence Protection Act 2012*, section 13.
>
> Note—
>
> Under the *Domestic and Family Violence Protection Act 2012*, section 13, a relevant relationship means an intimate personal relationship, a family relationship or an informal care relationship, as defined under that Act."

[286] It is plain that the accused and his deceased son Matthew stood in a domestic relationship. The issue to be determined was whether the "rib fracture evidence" was properly construed as "relevant evidence of the history of the domestic relationship". The touchstone is relevance, the prosecutor submitting that the use of

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321 AB 59 – 60.

322 AB 68/41-46.

"the rib fracture evidence" was "that it makes the injury sustained on the 3rd of November more intelligible or explicable, for without that context, such events may appear improbable or to have occurred out of the blue."[323] The primary judge accepted this submission, subject to appropriate directions.

[287] On appeal the appellant argues that the rib fracture evidence cannot be properly construed as evidence "of the history" of any relationship as:[324]

> "[T]hese fractures could have been a residual symptom of events which occurred in the course of the relationship. But to be "relevant", and to be a part of a "history of" their relationship, it had to be established that the fractures were in fact the product of deliberate trauma inflicted by the appellant upon Matthew."

[288] Section 132B (and s 132A) were inserted by the *Criminal Law Amendment Act* 1977 (Qld). As observed by Heydon J in *Roach v The Queen*,[325] the Queensland Legislature evinced a disinclination to embrace the rule in *Pfennig v The Queen*. Section 132B(2) is curiously drafted insofar as it utilises the word "relevant" as descriptive of the type of evidence which is admissible. That is hardly surprising as no one would suggest that "irrelevant" evidence of a history of a domestic relationship ought to be admitted.

[289] The word "relevant" can only be given meaning if s 132B(2) is read in its broadest form. That is evidence of what may or may not have occurred between participants in a domestic relationship is admissible as long as it bears a sufficient rational connection to an issue at trial.

[290] One can see examples of some use being put to the word "relevant", in particular as s 132B(1) applies in relation to proceedings against a person in respect of violence, i.e. chapters 28 to 30 of the *Criminal Code* 1899 (Qld).

[291] It may readily be accepted that evidence of non-violent sexual misconduct between the relevant persons to the domestic relationship, would not be relevant to the issue of the nature of the domestic relationship where the offence charged is one of violence. Even then, one would accept there is room for debate as to what was and what was not relevant. However, on the text of the subsection it is clearly the legislature's intent that the section would be given a broad meaning.

[292] In *Roach v The Queen*, the plurality said: [326]

> "The first requirement which must be fulfilled, for evidence to be admissible, is that it be relevant. The question as to relevance is whether the evidence, if accepted, could rationally affect the assessment by the jury of the probability of the existence of a fact in issue. It may do so indirectly. As Gleeson CJ observed in *HML v The Queen*, evidence may be relevant if it assists in the evaluation of other evidence.

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323 AB 59/20-22.
324 Paragraph 99 of the appellant's written outline.
325 (2011) 242 CLR 610 at p 630.
326 (2011) 242 CLR 610 at 616 – 617 [12] – [13]; 621 – 622 [31]; 624 [42] – [43]; 625 [45]. Emphasis added. Footnotes omitted.

In *Smith v The Queen* it was said that evidence is relevant or it is not; no question of discretion arises. If it is not relevant, no further question arises about its admissibility, for irrelevant evidence may not be received. It was then said that:

> "These propositions are fundamental to the law of evidence and well settled. They reflect two axioms propounded by Thayer and adopted by Wigmore: 'None but facts having rational probative value are admissible,' and 'All facts having rational probative value are admissible, unless some specific rule forbids.'"

…

The section therefore has a potentially wide operation. It is not restricted in its application to similar fact evidence tendered to prove propensity on the part of the accused, which is the focus of this appeal. Its purpose is to ensure that in criminal trials evidence of the history of domestic violence is put before a jury, or other arbiter of fact, so long as it is relevant to an issue in those proceedings. Relevance is the only requirement stated for admissibility. It may be assumed that that legislative choice was made with knowledge of the decision in *Pfennig*, which had been made some two years earlier and which effected an important change. It was not necessary for the rule in that case to be expressly excluded, as the appellant submitted. The sole basis to be applied for admissibility, relevance, is clearly stated.

…

The purpose of the evidence in *Pfennig* may be contrasted with that for which the evidence in question was tendered in the present case. Here the complainant gave direct evidence both of the alleged offence and of the 'relationship' evidence. The latter evidence, which included evidence of other assaults, was tendered to explain the circumstance of the offence charged. It was tendered so that she could give a full account and so that her statement of the appellant's conduct on the day of the offence would not appear '**out of the blue**' to the jury and inexplicable on that account, which may readily occur where there is only one charge. It allowed the prosecution, and the complainant, to meet a question which would naturally arise in the minds of the jury.

It is difficult to resist the conclusion that it was intended, by the insertion of s 132B, that persons suffering from domestic violence not be disadvantaged in the giving of their evidence and that they be able to tell their story comprehensively. It may be taken to express a perception that it is in the public interest that they be able to do so and that the prosecution of offences which involve a history of domestic violence be thereby enabled. The reception of the evidence operates more fairly to a complainant. Unfairness to the accused, by its reception, is to be considered by reference to s 130.

…

> In the present case the evidence, if accepted, was capable of showing that the relationship between the appellant and the complainant was a violent one, punctuated as it was with acts of violence on the part of the appellant when affected by alcohol. Without this inference being drawn, the jury would most likely have misunderstood the complainant's account of the alleged offence and what was said by the appellant and the complainant in the course of it. To an extent Holmes JA acknowledged this in the conclusions to her reasons. Whilst her Honour identified the relevance of the evidence as showing the particular propensity of the appellant, she also concluded that it made the appellant's conduct in relation to the alleged offence intelligible and not out of the blue."

[293] Although the present case is factually markedly different from *Roach*, as the victim is a dead infant, the principles remain the same. In particular, the breadth of s 132B, together with the conclusion discussed by the plurality in *Roach*[327] that the proper conclusion is that s 132B is intended to allow persons suffering from domestic violence to tell their whole story is still applicable in the present case. The death in infancy of the victim prevents that occurring by way of direct evidence. However, the "rib fracture evidence" coupled with the evidence of Matthew only being in the care of the accused or his mother, Ms Baxter, enjoined with Ms Baxter's evidence, if accepted by the jury, that she did not ever visit violence upon her infant son, provides proper factual basis for the correct finding that the "fractured ribs" was admissible as directly relevant within the proper meaning of s 132B.

Ground 2(b): Failing to exclude the evidence pursuant to s 130 of the *Evidence Act* 1977

[294] Section 130 of the *Evidence Act* 1977 (Qld) provides:

> "**130 Rejection of evidence in criminal proceedings**
>
> Nothing in this Act derogates from the power of the court in a criminal proceeding to exclude evidence if the court is satisfied that it would be unfair to the person charged to admit that evidence."

[295] As stated by the plurality in *Roach*,[328] the effect of s 130 is to preserve the common law discretion to exclude evidence on the ground of unfairness which provides a discretion of the trial judge to reject otherwise admissible evidence under s 130 "if a trial judge considers that the evidence will be productive of unfairness in the trial of the accused."[329]

[296] The power reposed in a trial judge pursuant to s 130 of the *Evidence Act* must be exercised according to the ordinary plain words of s 130, that is, it is for the accused to satisfy the trial judge of the unfairness in permitting the evidence to be placed before the jury. This is made plain by the plurality in *Roach*.[330]

[297] Admission of evidence which is prejudicial to an accused cannot, *ipso facto*, be a basis for unfairness. The adjective "probative" simply means "serving to prove". If

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327 At 624 [43].
328 At 622 [32].
329 *Roach v The Queen* (2011) 242 CLR 610 at 622 [32].
330 At 622 [32].

evidence serves to prove an important element in a criminal offence, then it is highly probative and must therefore be additionally highly prejudicial. It cannot, be, "unfair" to the person charged to admit highly prejudicial evidence, simply because it is highly probative.

[298] To paraphrase the reasons of Menzies J in *Wilson v The Queen*[331] and cited with approval by the plurality in *Roach*[332] "to shut the jury off from the rib fracture evidence" which may shed light upon the relationship between the appellant and Matthew, would require the jury to make important factual decisions upon what actually occurred on 3 November 2011 in a vacuum; particularly where one would consider it "out of the blue" for any father to act violently towards his infant son.

[299] As in many cases where s 132B is deployed, the major concern with respect to fairness to the accused relates to the use of that other occasion evidence as showing a propensity to commit the crime which is the subject of the trial. It is because of a concern that juries may use propensity reasoning, directions are important. In this regard, appeal ground 2(b) and 2(c) cannot be considered in isolation.

[300] If there were no adequate directions provided in respect of the rib fracture evidence, then it may readily be concluded that there was "unfairness" to the appellant which ought to have been the subject of the exercise of a s 130 discretion to exclude the "rib fracture" evidence. As the plurality said in *Roach*, it must therefore be concluded that there is no unfairness as long as there are proper directions to the jury:[333]

> "The importance of directions in cases where evidence may show propensity should not be underestimated. It is necessary in such a case that a trial judge give a clear and comprehensible warning about the misuse of the evidence for that purpose and explain the purpose for which it is tendered. A trial judge should identify the inferences which may be open from it or the questions which may have occurred to the jury without the evidence. Those inferences and those questions should be identified by the prosecution at an early point in the trial. And it should be explained to the jury that the evidence is to allow the complainant to tell her, or his, story but that they will need to consider whether it is true."

Ground 2(c): Error in directions as to manner in which evidence of the rib fractures could be used

[301] In considering whether the primary judge "gave a clear and comprehensible warning about the misuse of the evidence [and explanation as to] the purpose for which it [was] tendered" one must not lose sight of the fact that the trial was conducted with 21 days of evidence from 16 October 2017 until 13 November 2017. There were then two days of closing addresses on 14 and 15 November 2017 before the summing up commenced. The summing commenced on 16 November 2017 which proceeded essentially over the entirety of the following day, 17 November 2017.

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331 (1970) 123 CLR 334.
332 At 624 – 625 [44].
333 At 625 [47].

[302] The primary judge's directions therefore must be read as a whole in order to have a proper understanding of their effect.

[303] It could barely be suggested that the primary judge's directions on the issue of the use of the "rib fracture" evidence was not comprehensive.[334]

[304] The primary judge's direction to the jury was based on a direction approved by the Court of Appeal in *R v Mills*[335] which provided in part:

> "… but if a person, standing in the place of a parent, on one occasion used such force or violence to a child who was a member of his household so as to fracture that child's arm, you might think that it is common sense that one is entitled to take into account, in deciding whether it is more likely or less likely that that person acted with violence towards the same child in the household on a later occasion; it is really to draw an inference based on one's knowledge of human behaviour."

[305] In the present case, the primary judge's directions concerning the use of the "rib fracture" evidence are set out in 14 paragraphs on transcript pages 1800 to 1802 of the Appeal Record Book. It is too comprehensive to set out in full detail. Pertinently it included:

> "But I must now give you a direction at law about the limited use you can make of the evidence concerning the X-rays of the chest, and the rib fractures, if they be rib fractures, and the related matters, even if you conclude that the Prosecution has proved that Matthew sustained rib fractures as a result of the actions of the defendant.[336]
>
> …
>
> [Y]ou must not use it to conclude that the defendant is someone who has a tendency to commit this type of offence with which he is charged, that is, murder by act or acts resulting in the death, with the intention to cause death or grievous bodily harm or, for that matter, its alternative, manslaughter. It would be quite wrong for you to reason that if you are satisfied that he did the act or acts on the occasions when the rib fractures are alleged to have been sustained, that it is likely that he committed the charge, the offence of murder, on a later occasion as alleged.
>
> In short, you must not reason that because the defendant caused rib fractures, it is likely that he did anything on or about the 3rd of November with the intention to kill Matthew or that he might have an unlawfully killed Matthew. As I said to you, the evidence of rib fractures comes before you as a part of the Prosecution case concerning an allegation of a history of violence within the domestic relationship that included Matthew and the defendant, and it does not come before you as proof of the charge of murder or its alternative, manslaughter.

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334 The direction is set out in full in AB 1800 – AB 1802.
335 [1986] 1 Qd R 77 at 83 – 84.
336 AB1081/40-44.

> The evidence forming part of the history of the domestic relationship comes before you with the purpose of rendering intelligible or explicable the conduct that is alleged to have occurred on the 3rd of November 2011 which, in the absence of a history of a domestic relationship, would otherwise appear to be out of character and improbable or to have occurred out of the blue. Further, and this is very important, you must separately consider the evidence relating to the rib fractures independently of and separately from the evidence concerning the injury or injuries alleged to have resulted in Matthew's collapse and ultimate death. You must not use one body of evidence to bolster the evidence relating to the other issue."[337]

[306] Sight must not be lost of the central plank in the appellant's defence, namely he was considered a man of good character and credit. The appellant, with the support of his wife and his family and others, provided considerable good character evidence for the appellant. As the trial noted, the appellant's trial counsel:[338]

> "[P]laced great emphasis upon his client's character and background and he reminded you of the evidence of his client's military service, the love his wife had for him and regard for him and the regard that the family and extended family had for him and what they said about his good character. And he submitted to you that what is alleged against him is not consistent with the character of the defendant."

[307] I have had benefit of the draft reasons of Jackson J, (with whom Fraser JA agrees), who has concluded that the rib fracture evidence ought to have been excluded by the primary judge exercising his discretion under s 130 of the *Evidence Act*. As Jackson J pointed out Dr Lamont did state in evidence that "[t]he point I'm making is you're looking at the whole baby. You've got all the rib fractures.[339] You've got the three or four different features within the brain together as a – as a combination." However, this evidence was stated by Dr Lamont on the sixty-seventh page[340] of Dr Lamont's 113 pages of testimony.[341] Dr Lamont's answer was directed to a question by the primary judge about the "triad" of features the subject of Swedish research on shaken baby syndrome. Importantly fractures are not one of the triad features referred to in that study. Fractures are not mentioned to at all in that study.[342] The question was put by the primary judge in relation to the mechanism of the injury as being potentially caused by "violent shaking". In that context rib fractures may be seen as relevant, as Dr Lamont put it "as a combination". However as Dr Lamont explained where there are combinations of features:

> "[a] variety of things, my suspicion for non-accidental injury then climbs, unless there's a good story behind it. They've been crushed by – by rolling a car or something. If there's no good story behind it, then the suspicion climbs. And at some stage you've got to say this is – this is highly indicative of – of non-accidental injury."[343]

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337 AB1802/19-44.
338 AB1886/4-8.
339 AB 600/36.
340 AB 600.
341 AB 533 - AB 646.
342 AB 597; AB 2012 – 2018.
343 AB 601/1-15.

[308] When that passage of Dr Lamont's evidence is read as a whole it is, to my mind, nothing more than an assertion by Dr Lamont that where there are a combination of injuries an enquiry is called for to examine the cause of the injuries, that is, one looks to the "story behind it". In the present case the story antecedent to it from the appellant was that he was a man of good character who loved and cared for his son and did not harm his son in any way. In my view it is not unfair to the appellant to admit evidence of the rib fractures so that the jury were entitled to hear all of the relevant relationship evidence and assess it as directed by the primary judge. The jury heard from Ms Baxter who swore that she did not injure Matthew[344] and that her husband, the appellant, and father to Matthew, was a loving, nurturing and caring father[345] and a calm man[346] of good character.[347]

[309] Jackson J concluded that it was unfair to the appellant to admit the rib fracture evidence as relevant evidence of the history of the domestic relationship without instructing the jury that they ought to have been satisfied beyond reasonable doubt that it was the appellant who caused the rib fractures.

[310] In declining to exercise his discretion pursuant to s 130 of the *Evidence Act* the primary judge said[348] "[i]n my view, a fair trial can be had, provided no improper use is made of the evidence and appropriate instructions and warnings are given."

[311] In his direction to the jury the primary judge did not direct the jury that they ought only consider the rib fracture evidence if they were persuaded beyond reasonable doubt that the appellant had caused the rib fractures. The primary judge said in part of his direction to the jury on this issue:[349]

> "… There is a debate between the experts which you have to grapple with about the proper interpretation of the X-rays and the other evidence, and what can be drawn – and what conclusions can be drawn. And it is simply not a matter of making a choice between the evidence of one body, for example, the witnesses called by the Prosecution on the issue, and the expert witnesses for the Defence. Even after careful deliberation, if you reject the evidence of the Defence experts on this issue, it does not follow that you can simply proceed to accept the evidence given by the Prosecution witnesses on this issue. You must evaluate the evidence and be satisfied of its reliability and accuracy. One possible outcome after considerable deliberation of both bodies of evidence may be you are not persuaded by either. It is a matter for you. If you are unpersuaded by the Prosecution evidence upon this issue, you should ignore all the evidence relating to the chest X-rays, and the alleged rib fractures, the bleeding in the eye and its possible cause, and with it goes all the evidence about Vitamin D deficiency and so forth. And put all that evidence and that issue out of your mind altogether when deliberating upon whether the Prosecution has proved beyond reasonable doubt that the defendant murdered Matthew."

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344 AB 1049 - AB 1052.
345 AB 1106.
346 AB 1107.
347 AB 1106.
348 AB 69/2-4.
349 AB 1801/20-38.

[312] After the summing up to the jury there was no request for a redirection upon the rib fracture issue and in particular no submission seeking a direction that the jury ought only act upon the rib fracture evidence if it was satisfied the appellant caused the fractures to Matthew's ribs beyond reasonable doubt. In *Roach* the plurality (at 49) concluded on the facts in that case that "it was neither necessary nor appropriate for the trial judge to give the jury any direction about the standard of proof to be applied to that evidence".

[313] In *Shepherd v The Queen* [350]Dawson J (with whom Mason CJ, Toohey and Gauldron JJ agreed) said:

> "Circumstantial evidence is evidence of a basic fact or facts from which the jury is asked to infer a further fact or facts … The inference which the jury may actually be asked to make in a case turning upon circumstantial evidence may simply be that of the guilt of the accused. However, in most, if not all, cases, that ultimate inference must be drawn from some intermediate factual conclusion, whether identified expressly or not. Proof of an intermediate fact will depend upon the evidence, usually a body of individual items of evidence, and it may itself be a matter of inference. More than one intermediate fact may be identifiable; indeed the number will depend to some extent upon how minutely the elements of the crime in question are dissected, bearing in mind that the ultimate burden which lies upon the prosecution is proof of those elements. For example, with most crimes it is a necessary fact that the accused was present when the crime was committed. But it may be possible for a jury to conclude that the accused was guilty as a matter of inference beyond reasonable doubt from evidence of opportunity, capacity and motive without expressly identifying the intermediate fact that the accused was present when the crime was committed.
>
> On the other hand, it may sometimes be necessary or desirable to identify those intermediate facts which constitute indispensable links in a chain of reasoning towards an inference of guilt. Not every possible intermediate conclusion of fact will be of that character. If it is appropriate to identify an intermediate fact as indispensable it may well be appropriate to tell the jury that that fact must be found beyond reasonable doubt before the ultimate inference can be drawn. But where – to use the metaphor referred to by *Wigmore on Evidence*, vol. 9 (Chadbourn rev. 1981), par. 2497, pp. 412-414 – the evidence consists of strands in a cable rather than links in a chain it will not be appropriate to give such a warning."

[314] In my view as the rib fracture evidence was not an "indispensable link" in a chain of reasoning towards an inference of guilt and accordingly the trial judge was not required to direct the jury that it could only act on the rib fracture evidence if it was satisfied of its truth beyond reasonable doubt. To require a direction that the jury must be satisfied beyond reasonable doubt that the appellant caused Matthew's rib fractures elevates that issue to the status of an indispensable intermediate fact when in my view, it is not. It was explained by the primary judge that the rib fracture

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350 (1990) 170 CLR 573 at 579.

evidence was admitted as relationship evidence pursuant to s 132B with a comprehensive direction that the evidence could not be used by way of propensity reasoning.

[315] A consideration of directions provided by the primary judge show that they are both clear and include a comprehensive warning with respect to the misuse of the "rib fracture evidence". The primary judge fully and properly explained the purpose for which the "rib fracture evidence" was tendered. Grounds 2(a), (b) and (c) of the appeal therefore ought not succeed.

[316] I would dismiss the appeal.