SUPREME COURT OF QUEENSLAND

CITATION:	*R v LM* [2004] QCA 192
PARTIES:	**R** **v** **LM** (appellant/applicant)
FILE NO/S:	CA No 246 of 2003 CA No 314 of 2003 DC No 692 of 2003
DIVISION:	Court of Appeal
PROCEEDING:	Appeal against Conviction & Sentence
ORIGINATING COURT:	District Court at Brisbane
DELIVERED ON:	4 June 2004
DELIVERED AT:	Brisbane
HEARING DATE:	5 April 2004
JUDGES:	McMurdo P, McPherson JA and Holmes J Separate reasons for judgment of each member of the Court, each concurring as to the orders made
ORDERS:	**1. Appeal allowed** **2. Verdicts of guilty set aside** **3. New trial ordered**
CATCHWORDS:	EVIDENCE – ADMISSIBILITY AND RELEVANCY – OPINION EVIDENCE – EXPERT OPINION – IN GENERAL – where appellant convicted of torture of one of her children and unlawful wounding of two of her children through the acts of medical professionals – where prosecution alleged appellant had condition known as Munchausen's Syndrome by Proxy or factitious disorder by proxy – whether general evidence given by psychiatrist as to Munchausen's Syndrome by proxy admissible – whether evidence as to Munchausen's Syndrome by proxy was part of an organised or recognised reliable body of knowledge or experience – whether prejudicial effect of evidence outweighed probative value EVIDENCE – ADMISSIBILITY AND RELEVANCY – OPINION EVIDENCE – EXPERT OPINION – IN GENERAL – where prosecution alleged appellant harmed children by presenting them for unnecessary medical treatment – whether evidence of doctors who treated children that in their opinion this was a case of "Munchausen's

Syndrome by proxy" was admissible

CRIMINAL LAW – EVIDENCE – RELEVANCE – PARTICULAR CASES – where appellant filmed by surveillance camera – whether witnesses could describe own observations of what was recorded on the surveillance video

CRIMINAL LAW – APPEAL AND NEW TRIAL AND INQUIRY AFTER CONVICTION – APPEAL AND NEW TRIAL – PARTICULAR GROUNDS – MISDIRECTION AND NON-DIRECTION – WHERE GROUNDS FOR INTERFERENCE WITH VERDICT – GENERALLY – where appellant convicted on count of torture of child – where charged with respect to 21 month period, relying on three different particulars – whether jury had to be unanimous in their verdict with respect to at least one particularised act on one particularised occasion – whether learned trial judge's redirection to jury was flawed in that it directed that they may be satisfied of the appellant's guilt because of a combination of particularised acts

Criminal Code 1899 (Qld), s 320A

Director of Public Prosecutions v A & BC Chewing Gum Ltd [1968] 1 QB 159, cited
Farrell v The Queen (1998) 194 CLR 286, cited
KBT v The Queen (1997) 191 CLR 417, cited
Murphy v The Queen (1989) 167 CLR 94, cited
Naxakis v Western General Hospital (1999) 197 CLR 269, cited
Osland v The Queen (1998) 197 CLR 316, considered
Pfennig v The Queen (1995) 182 CLR 461, cited
R v Boreman [2000] 1 All ER 307, cited
R v Chard (1971) 56 Crim App R 268, cited
R v Lupien [1970] SCR 263, cited
R v Sitek [1988] 2 Qd R 284, applied
Smith v The Queen (2001) 206 CLR 650, applied

COUNSEL: B W Walker SC with A J Kimmins for the appellant/ applicant
M J Copley for the respondent

SOLICITORS: Jacobson Mahony Lawyers for the appellant/applicant
Director of Public Prosecutions (Queensland) for the respondent

[1] **McMURDO P:** The appellant was charged on an 11 count indictment with four counts of torture (counts 1, 7, 9 and 11), five counts of unlawful wounding (counts 2, 3, 4, 5 and 6), and two counts of causing a noxious thing to be taken with intent to annoy (counts 8 and 10). The charges concerned the appellant's four children, A, B, C and D. The appellant had reported to doctors their various and significant symptoms over a long period. These symptoms were unexplained by the many resulting medical investigations. The prosecution case was that the appellant

deliberately did things to cause her children to display these symptoms and reported false symptoms so that the children were submitted to unnecessary medical procedures. The prosecution had to establish that the appellant committed acts causing symptoms and, or alternatively, falsely reported or fabricated symptoms in the children, with the intention that medical professionals would perform otherwise unnecessary procedures on them.[1]

[2] In a pre-trial ruling,[2] his Honour held that, on the principles developed in *Pfennig v The Queen*,[3] the evidence on count 1, which concerned only A, was not admissible on the joint trial concerning the remaining children. His Honour ordered a separate trial on count 1. The judge found that the evidence of the offence concerning D (count 11) was admissible to prove all the remaining counts which concerned B and C. On 28 May 2003, the Crown indicated it would not proceed further in respect of two counts of unlawfully wounding B (counts 4 and 5). On 25 August 2003, the Crown indicated it would not proceed further on count 1 of the indictment, the charge of torturing A.

[3] On 27 June 2003 after a four and a half week jury trial, the appellant was convicted of three counts of unlawfully wounding B (counts 2, 3 and 6), one count of causing a noxious thing to be taken with intent to annoy B (count 8), a similar count in relation to C (count 10), and one count of torturing D (count 11). She was found not guilty on two counts of torturing B and C (respectively, counts 7 and 9), which were alternatives to counts 8 and 10. She was sentenced on 28 August 2003 to seven years imprisonment on the count of torture of D and to lesser concurrent terms of imprisonment on the remaining counts concerning C and D.

[4] The appellant now appeals against her conviction on three grounds. The first is that the learned trial judge erred in allowing the prosecution to adduce medical evidence of factitious disorder (Munchausen's Syndrome) by proxy. The second is that the judge wrongly allowed witnesses to describe their own observations of what was recorded in a video taped recording. The appellant's final contention is that the judge erred in his redirections to the jury on count 11, the torture of D. She also contends that the sentence imposed was manifestly excessive.

[5] Before returning to each of these grounds of appeal, it is helpful to refer to some of the prosecution evidence.

[6] Paediatrician, Dr Pincus, treated all the appellant's children, both in private practice and as the senior visiting medical officer at the Gold Coast Hospital. During the relevant periods the appellant, not her husband, attended at all appointments. She presented as an extremely dedicated mother who asked appropriate questions. She stayed with the children during hospital admissions.

Dr Reddan's evidence

[7] Psychiatrist Dr Reddan has never met or examined the appellant but gave general evidence about factitious disorder (Munchausen's Syndrome) by proxy, a behaviour which has been a source of medical investigation for many years. That term refers

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1 See s 7(4) *Criminal Code*.

2 Under s 592A, *Criminal Code*. This section was amended and renumbered (now s 590AA) by the *Evidence (Protection of Children) Amendment Act*, Act No 55 of 2003, s 19, operational 5 January 2004.

3 (1995) 182 CLR 461.

to a sub-set of individuals who induce illnesses in themselves (factitious disorder) or in those who are under their care (factitious disorder by proxy). In about 1951, the term Munchausen's Syndrome was coined by Dr Asher, writing in *The Lancet*. The term came from the colourful Baron von Munchausen who was famous for his fanciful storytelling. The correct term used now is factitious disorder by proxy. The behaviour of this sub-group of individuals can be very wide-ranging in its presentation. It may be due to multiple motivations but it involves a conscious deception of others when, by proxy, the care-giver deliberately induces illness in someone under his or her care, usually a child but sometimes the elderly, disabled or even a pet. Factitious disorder is not a recognised psychiatric disorder or mental illness; it is not categorized as such in the American Psychiatric Association's diagnostic and statistical manual of mental disorders.

[8] There are no agreed sets of symptoms and signs which enable the behaviour to be classified into a recognised, psychiatric diagnostic system. It is a behaviour that occurs occasionally within the community but it is not necessarily within the expertise of a psychiatrist to comment on such behaviour because it is not a disorder. It is akin to recognising that there is a thing such as laughing. It is merely a name for a type of behaviour, comparable to the expressions "malingering" or "engaged in criminal conduct". Those behaving in this way are a very wide ranging and heterogeneous group. They are not out of contact with reality, do not present as having an obvious psychiatric mental condition and appear completely normal. There are a number of levels of factitious production of symptoms: first, when a person reports that he or she or someone under their care has symptoms which the person knows to be untrue; second, where the person feigns an illness personally or in someone under the person's care, for example by putting blood in urine; and third, when the person intentionally and deliberately creates an actual illness through personal harm or harm to another in the person's care. There is no unique characteristic or set of motives necessary to establish the behaviour. The reasons for people behaving in this way can be hugely varied. It may not necessarily be out of malignant parenting. It may be to obtain attention from doctors and nurses; to stabilise a marriage; to get the attention and care of other family members; to obtain a carer's pension or for other financial reasons; or because they enjoy fooling others. A person engaging in such behaviour may not be deceptive in other aspects of their lives.

[9] Psychiatrists do not know how prevalent the behaviour is although it is thought to be uncommon. Those who behave in this way will often initially appear to be people who are willing to allow the child under their care to have quite painful investigations, but that is not a diagnostic behaviour. They will often appear curiously unconcerned about the child's failure to improve, but again not in every case. Most psychiatrists have very limited personal experience in this area. The behaviour is more often recognised by paediatricians and paediatric nurses when the child victim does not recover as he or she should and, for example, continues to get unusual, unexplained infections. It is difficult behaviour to detect. The nature of the behaviour means it is almost invariably concealed and nurses and doctors are reluctant to consider it because it seems unnatural. An indication of the behaviour is when the victim is removed from the person who is thought to be inducing the illness and then recovers. Some literature suggests that if a parent induces illnesses in a child, they may have previously induced illnesses in themselves, although this is not necessarily the case. The inducement of symptoms in one child may, but will not invariably, result in the carer inducing symptoms in other siblings. A person

with factitious disorder, whether or not by proxy, knows what they are doing when they deceive to achieve a goal, such as the deliberate inducement of suffering in a child.

[10] Despite the multitude of potential motives and indicia of factitious disorder by proxy, it is a medically recognised form of behaviour because it involves the provision of medical services and can be very serious in its outcome. The literature suggests that it is most likely to be perpetrated by a mother upon a child, although perpetrators may include fathers who cause harm to children or those who cause harm to pets and the elderly. It is difficult to predict whether factitious disorder by proxy will occur in a particular case.

[11] In cross-examination, Dr Reddan said she had seen about eight examples of factitious disorders and about five factitious disorders by proxy. She repeated that the behaviour is not a disorder. The expression "factitious disorder" is a catchall phrase which has evolved historically because of the potential seriousness of the behaviour and its impact on the medical profession. There is no unique type of person within this category of behaviour. All that can be said is that those within the category are willing to use a vulnerable person for some need of their own and the behaviour involves a failure of empathy towards that person. That is not to say a person exhibiting the behaviour may not on some occasions be empathic to the victim or to others, but the behaviour itself implies a lack of empathy because the dependant victim is used for the perpetrator's gratification, regardless of the victim's wellbeing.

The offences concerning B (counts 2, 3, 6 and 8)

[12] Counts 2, 3, 6 and 8 were particularised as follows. Counts 2 and 6 concerned the appellant's unlawful wounding of her daughter, B, by procuring doctors to perform two bone marrow tests on her. Count 3 was the appellant's unlawful wounding of B by procuring medical practitioners to give B an intramuscular injection. The offence of causing a noxious thing to be taken with intent to annoy, count 8, was the appellant's administration of laxatives to B between October 1996 and February 1999.

[13] B was born in March 1996 about four weeks premature. When she was seen by general practitioner Dr Rowlands on 16 May 1996, she was within the 90th percentile of weight for her age.[4]

[14] By October 1996, when Dr Pincus first saw her, she weighed in the 25th percentile. She was anaemic and iron deficient. She had been prescribed high doses of iron supplements to be administered by the appellant. Dr Pincus was unable to ascertain why B had not responded to this treatment. The appellant told him that B was having large watery bowel motions. He was concerned that the severe diarrhoea was preventing the absorption of the iron. He had never before seen an anaemic child respond so unsatisfactorily to the administration of iron supplements. Her iron shortages were so severe that her liver and spleen were enlarged. He could find no obvious cause.

[15] He arranged for B to be admitted to the Brisbane Royal Children's Hospital and consulted a haematologist and a gastroenterologist. B's bone marrow was examined on 30 October 1996 and a specimen of her bowel was taken in an endoscopy. The

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[4] That is, only ten per cent of babies her age were heavier than her.

bone marrow test is a painful procedure. It involves boring a large needle into the hip bone and sucking out some bone marrow under a general anaesthetic. Before those procedures were conducted, Dr Pincus explained them to the appellant and she consented. The examination eliminated cancer and showed that B had no iron stores in her bone marrow, a surprising result in a child who had been receiving large oral supplements of iron for a lengthy period.

[16] Dr Pincus decided that B must not be absorbing iron through the gut and that the iron must be administered by intramuscular injection. These injections are painful and have potential side effects; there may be an allergic reaction and the iron can permanently stain the skin. After the first of these, the appellant expressed her concern and requested more tests to check the diagnosis. B received further intra-muscular iron injections on 2 and 3 November 1996 as a day patient at the Gold Coast Hospital. The bone marrow aspirate test was repeated on 20 November 1996 and showed some but still small amounts of iron in the bone marrow. This suggested that B was able to absorb iron through the intramuscular injections but not in the normal way through the gut or bowel. The appellant was unsatisfied and requested further tests but Dr Pincus advised that more invasive tests were unwarranted before assessing the response to the intramuscular iron injections. The appellant reluctantly accepted this advice.

[17] On 2 December 1996, Dr Pincus noted B's liver and spleen were no longer enlarged and thought her condition had improved, but the appellant reported that B was still lethargic and not improving. Dr Pincus believed the problem must be the lack of absorption of iron in the gut but he could not ascertain the precise cause of this. By 6 December 1996 her weight had fallen to the 10th percentile.

[18] By January 1997 when B was 10 months old, the appellant reported to Dr Pincus a definite improvement in her energy levels and development, but she was still having five or six bowel motions a day and some vomits. By 29 April 1997, B still had some anaemia and iron deficiency although this had improved. The appellant reported that B had chronic diarrhoea and resulting excoriation, with blood in the stools. Dr Pincus decided that a Meckel scan should be performed on the bowel to eliminate the possibility of Meckel Diverticulum, an out-pocketing of the bowel that occurs in about three per cent of the population and which could be responsible for blood in the stools. This procedure required a cannula insertion into the hand into which is injected a small dose of radiation to indicate the presence of any diverticulum causing bleeding. It is equivalent to the pain level of an injection. The result was normal and the cause of blood in the stools remained unknown.

[19] When B was examined in May and July 1997 her haemoglobin level had fallen on each occasion and she was again becoming iron deficient. The appellant, who was now pregnant with C, reported that B was not eating well and had been vomiting. She wanted an endoscopy performed on B. The appellant was agitated, angry and upset that endoscopic tests had not already been performed. Coeliac Disease (an allergy to wheat or gluten) is a cause of diarrhoea and iron deficiency anaemia but this had been excluded by earlier bowel biopsies. Dr Pincus continued treating B but was unable to determine the cause of her ongoing diarrhoea.

[20] Dr Pincus became aware that D was admitted to the Mater Children's Hospital for treatment on 26 November 2001 and that a surveillance video recording of the appellant showed her tipping D's nasogastric feed into a sink and administering

another liquid consistent with Epsom salts to D's nasogastric feeding line. Dr Pincus then formed the view that B:

> "… was certainly administered some laxative agents … to cause all of these symptoms. I cannot think of any other medical diagnosis that could include all of the symptomatology and all of the findings that we did with all of the tests being negative, and I believe more so that this is almost certain because of, in retrospect, the behaviour of the way that the consultation interactions occurred during my care of [B]."

The appellant, more than any other patient, was enthusiastic to have investigations performed on B. He was of the view that B's symptoms were caused by factitious disorder (Munchausen's Syndrome) by proxy.

The offence concerning C (count 10)

[21] The prosecution particularised count 10 as the appellant administering a noxious thing, magnesium sulphate and/or other laxative or laxatives, to C between September 1997 and February 1999.

[22] C was born in September 1997 some weeks premature. He initially had breathing problems but he progressed well and was prescribed oral iron supplements as a preventative. Dr Pincus examined C on 23 June 1998 when he was nine months old. The appellant reported that C was healthy and progressing well but did not have a great appetite; he was having four to five large bowel motions a day. He was on a high dose of Fergon (iron medication with vitamin C) and was slow in gaining weight. His height and weight were just above the tenth percentile but his weight was appropriate for his length. The appellant agreed to have C tested to determine whether he was able to orally absorb iron. The results were affirmative; he was only mildly anaemic and was generally healthy.

[23] Dr Pincus next saw C on 27 August 1998 about a rash on his cheeks. He seemed to be developing normally, was breast fed, had a good diet and five to six large bowel motions each day. Dr Pincus was concerned that the spots may be caused by a zinc deficiency. Blood tests showed he was now anaemic and iron deficient. He examined him again on 6 October after he had been released from a hospital admission for a chest and ear infection. He was coughing a lot and was not growing well. His length had fallen to the third percentile. Blood tests later that month showed that he was mildly anaemic but his chest infection was of more concern.

[24] C next visited Dr Pincus in February 1999 when he was 17 months old. The appellant had placed him on a coeliac diet because of persistent problems with diarrhoea and she reported that this had resolved the problem. Earlier tests in 1998 had excluded Coeliac Disease. Dr Pincus continued to see C on a number of occasions but only in relation to his chronic asthma.

[25] Dr Pincus had no medical explanation for C's iron deficiency, anaemia and diarrhoea. He suspected that both B and C had a defect in their gut which made them unable to absorb iron and which was associated with their diarrhoea but he was unable to medically prove this diagnosis. As a result of learning of the results of the later surveillance of the appellant and D at the Mater Hospital, he formed the view that C was administered a laxative agent which caused his diarrhoea, anaemia and iron deficiency, as in B's case. There were other remote and unlikely

possibilities but the more likely diagnosis is of factitious disorder (Munchausen's Syndrome) by proxy, where the mother has caused the children to be unwell by administering a poisonous agent.

The offence of torture concerning D (count 11)

[26] The prosecution particularised this offence as occurring between 16 February 2000, the date of D's birth, and 28 November 2001, the day after the completion of the surveillance video which recorded the appellant interfering with D's medical equipment in hospital. The prosecution alleged that the appellant administered magnesium sulphate and/or another laxative or laxatives to D; and/or gave him insufficient nutrients; and/or had invasive medical procedures performed upon him, including Total Parenteral Nutrition ("TPN") procedures (incorporating the insertion and removal of central venous catheters and line repairs), nasogastric tube feed procedures, endoscopies, a sigmoidoscopy, blood tests, blood transfusions and administration of intravenous antibiotics.

[27] D was born on 16 February 2000, six weeks prematurely. Because he was not growing well in utero and the appellant was severely ill with diarrhoea and had a low potassium level, he was delivered early by Caesarean section.

(a) Dr Pincus' evidence concerning D

[28] Dr Pincus first examined D in the special care nursery on 24 February 2000. He was a small baby who had been on oxygen and had breathing difficulties. He was growing and tolerating feeds and his physical examination was normal. D was released home and was breast feeding well with frequent bowel motions.

[29] When Dr Pincus examined D again on 9 May 2000, he was developing well. The appellant described him as a good baby with infrequent bowel motions. Within the next month or two he became increasingly lethargic, was feeding poorly and not gaining weight. A blood test showed low haemoglobin and anaemia. Dr Pincus had D admitted to the Gold Coast Hospital on 3 July 2000. His urine tested normal. He was given a nasogastric tube so that he could be given extra nutrition. This is an unpleasant procedure and although patients become accustomed to the tube once it is inserted, it is regularly prone to dislocation and reinsertion. He was receiving 2ml of iron medication twice a day. On at least one occasion he was given a suppository for constipation.[5] On occasions, D needed blood transfusions because of his severe anaemia.

[30] Dr Pincus next saw D on 13 July 2000, a few days after his discharge from hospital. His muscles were tense and his reflexes brisker than they should have been, suggesting developing cerebral palsy. D had not reached other normal milestones such as laughing and happy vocalising; he was generally mildly miserable. Dr Pincus arranged an ultrascan of the brain and recommended that he be well nourished to try and gain weight. D was discharged from hospital with a nasogastric tube inserted to assist in his nutrition. His weight had fallen even further so that he was by then in the lowest one percentile.

[31] When Dr Pincus saw D on 27 July the appellant reported that D was fighting his breast feeds but she was giving him additional nasogastric feeds each day. She did not feel he had improved and he was having some large vomits. He was not passing

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[5] Later in his evidence, Dr Pincus said that the cessation of purgatives after overuse can cause constipation.

many bowel motions. Dr Pincus next saw D on 18 August when he was six months old. He had surgery for an inguinal hernia two days beforehand. The appellant reported for the first time that D was suffering from diarrhoea with up to five watery bowel motions a day and despite the reported large increases in calories that he had been receiving, his weight had decreased and he was very emaciated. Dr Pincus arranged for D to see a gastroenterologist and to be re-admitted to hospital, initially the Gold Coast Hospital and then the Mater Hospital. Although the appellant was keen to maintain breast feeding, she agreed to a trial of a special formula whilst D was hospitalised. Dr Pincus hoped to obtain some faeces specimens to test but this proved impossible because the faeces were so watery they soaked into the nappy.

[32] Despite extensive testing, it was impossible to find any medical cause for D's failure to thrive. He consulted Dr Withers, a paediatric gastroenterologist, and more tests were conducted. They did not provide any solution.

[33] Dr Pincus next saw D on 4 September 2000. Despite apparently receiving large quantities of the easily digested, non-allergenic formula, Neocate, D was gaining much less weight than he should have been. He looked unhappy, his body was stiff and he was emaciated. He was half the weight he should have been for his age. D looked very unwell and may not have lived more than a few weeks. He discussed with the appellant the use of TPN, a dangerous procedure but one with which she was familiar because it was a discussed option to feed her during her difficult pregnancy with D. Complications with TPN include infections through the central line, damage to the vein causing clots, difficulty in continually inserting the line and permanent damage (cirrhosis) to the liver. The procedure is risky and there is a five to ten per cent mortality rate over a 12 month period amongst children on TPN. The appellant was appropriately concerned about the risks but agreed that it was the only reasonable option in the circumstances. The appellant and D consulted Dr Withers at the Mater Children's Hospital where TPN commenced on 19 September under Dr Withers's supervision. It was hoped that TPN would be only a temporary measure.

[34] Dr Pincus next saw D on 22 September 2000. He was a different child: happy, focussed, vocalising, smiling and with some fat on him. His muscle tone and reflexes were normal and there were no indications of cerebral palsy. Dr Pincus concluded that D's problems were nutritional rather than cerebral and he excluded cerebral palsy. D was in the Gold Coast Hospital for five weeks and continued to thrive, although in late September he developed a fever and possible infection. He underwent many blood tests to ensure the TPN matched his needs. He became more and more anaemic to the stage that he required a blood transfusion. Iron cannot safely be given intravenously. Diarrhoea remained a problem. Because he was generally progressing well, he was taken off the TPN and returned to feeding by nasogastric tube.

[35] When Dr Pincus saw him three days later, he was alarmed by the change. He again looked miserable, cried a lot, did not focus or vocalise and his muscles were stiff. He resisted the appellant when she tried to breast feed him and diarrhoea was a major problem. D's weight had more than doubled over ten weeks and his weight was within the 75th percentile. Because his weight fell when removed from TPN the decision was made to return him to TPN permanently. This involved the insertion of a permanent central venous catheter. He was readmitted to the Gold Coast Hospital on 2 November where he remained until 26 November. He continued to thrive but he suffered complications with fevers. He became very

unwell towards the end of November with a bacterial blood infection. He developed septicemic shock (blood poisoning), caused by organisms which normally reside only in the gut and bowel. This suggested that faeces had somehow entered the central line and the bloodstream. Dr Pincus had never before come across a central line infection associated with these bacteria. D did not respond to intravenous antibiotics and was at risk of death. Because a Brisbane intensive care unit was not immediately available, consideration was given to sending him to Sydney but this was determined to be too dangerous. Less urgent cases were removed from intensive care in the Mater Children's Hospital and D was admitted on 26 November. The specialist surgeon required to remove the catheter was not available. A doctor tried to physically remove the central line but could not because it was held in place by scar tissue. By 30 November the central line had been removed and his septicemic shock had improved with antibiotics.

[36] He was returned to the Gold Coast Hospital. A new central line was inserted under a general anaesthetic. The procedure of inserting or removing a central line is not simple, often taking one or two hours under a general anaesthetic. New insertions will often require different incisions because the blood vessel clots and heals itself after removal of the line. The area would be quite sore for 24 to 48 hours requiring a strong pain killer for the first six to 12 hours and then Panadol for the next 36 hours.

[37] D remained at the Gold Coast Hospital until 7 December when it was decided to treat him at home rather than in hospital, although he needed a high level of care. A child in D's position receiving TPN would ordinarily be treated in hospital but the appellant was trained to look after the central line to prevent infection and he was discharged into her care. He was readmitted six days later with a very high temperature. He had developed another but different central line infection which was treated with intravenous antibiotics. He was discharged on 19 December. Central line infections continued to be an ongoing problem, with D getting more than usual but within the expected range.

[38] Dr Pincus saw D again on 22 December 2000. He was progressing quite well but with five or six watery bowel motions a day. For six hours a day he was unconnected to the central line and could play. For the remaining 18 hours he was connected continuously to a pump, receiving TPN. He was also having five breast feeds a day. He seemed pale but his muscle development was normal and he was progressing well on TPN.

[39] D was readmitted to the Gold Coast Hospital on Christmas Day with a high fever. He remained unwell until 29 December when he was transferred to a Brisbane hospital because of a central line infection. He returned to the Gold Coast Hospital on 2 January 2001. Dr Pincus remained in regular contact with the appellant as to D's treatment and progress over the next few months. D continued to thrive on TPN but was having the serious life-threatening infections which were a recognised side effect. The appellant reported that D had four to six bowel motions a day with consequential nappy rash. He could find no medical reason for the diarrhoea and still believed there must be an underlying problem with D's gut relating to malabsorption. D was readmitted to hospital on 2 February because of a central line infection.

[40] Dr Pincus next saw D on 26 March 2001 in his surgery. D was having difficulty coping with solids but was otherwise well. He continued to monitor D's health and kept in regular contact with the appellant. On about five occasions the appellant reported that the central line had cracked or broken without any apparent explanation. Damage to central lines is very unusual; it generally occurs only through something like an accidental cut because the lines are very flexible and resilient, designed to cope with heavy loads. Dr Pincus began to think that there may be an alternative diagnosis to gut malabsorption.

[41] By 25 May 2001, D was a happy, thriving child. He was in the 75th to 90th percentile and had responded well to the TPN. The appellant reported he had difficulty digesting solids. D had undergone a bowel biopsy and other tests in an attempt to ascertain why he was not absorbing nutrients from the gut. In June 2001, D again became significantly anaemic and iron deficient and was admitted to hospital for a blood transfusion. D was admitted to the Gold Coast Hospital 17 times during the period Dr Pincus was treating him.

[42] Dr Pincus was concerned that the appellant may have been undermining D's medical treatment. D was admitted to the Mater Children's Hospital on 26 November 2001 to attempt to decrease his reliance on TPN and to secretly observe the appellant and D.

[43] Video surveillance on 26 and 27 November 2001 showed the appellant tipping nasogastric feed into a sink on two occasions, injecting something into the nasogastric feed line on three occasions and tampering with the contents of D's soiled nappy.

[44] On 24 January 2002, D came to Dr Pincus's surgery with his father. D was off TPN. He was still a little pale and tired but was eating a good variety of solid foods. His physical and mental development was appropriate for his age. His weight was in the 75th percentile and his head size in the 90th percentile, both well above average. He was a healthy child without the need for TPN and with no absorption problems within his gut.

[45] Dr Pincus observed that as soon as D was not in the care of his mother he was a healthy, thriving child who did not require medical treatment. The video surveillance provided an explanation for D's chronic diarrhoea, namely that he was being administered a laxative. Chronic diarrhoea is a cause of iron deficiency and anaemia. It also explained the recurrent problems with infection of the central line. In Dr Pincus's opinion the faeces tests previously sent to the pathology laboratory had also been tampered with and were unreliable. This suggested that D had not necessarily been receiving the prescribed nasogastric feeds. Dr Pincus would not have prescribed the various invasive procedures such as bone marrow aspirate, intra-muscular iron injections, colonoscopies, endoscopies, sigmoidoscopies, numerous blood tests, Meckel scans, or barium swallows had he known that D was being regularly administered laxatives. In these circumstances, Dr Pincus formed the view that D was suffering from factitious disorder (Munchausen's Syndrome) by proxy caused by his mother administering a noxious substance, namely a purgative, probably Epsom salts.

[46] In cross-examination Dr Pincus said that he did not learn of factitious disorder by proxy as a medical student but in his subsequent studies and practice. He agreed

that the appellant's actions recorded on the surveillance video were central to his diagnosis but he had considered the possibility of factitious disorder by proxy beforehand. He agreed that condition was a matter within the expertise of a psychiatrist insofar as diagnosing the appellant, but his expertise as a paediatrician enabled him to diagnose whether his child patients were ill because of factitious disorder by proxy.

(b) Dr Withers' evidence concerning D

[47] Dr Withers, a paediatric gastroenterologist, supervised D's TPN. He examined D in the presence of the appellant on 15 January 2001. D looked well and had gained weight. The appellant said he was having four or five watery stools each day. Dr Withers was keen to end TPN. On 2 March he noted D had four to six stools a day but was still making good progress. On 1 May 2001, D was still having diarrhoea. On 5 September 2001 D's case was referred to the Child Protection Unit for assessment after Dr Withers spoke to another expert in child health, Prof Davidson from Adelaide. Dr Withers attended a Mater team meeting with a Det McNeil, Dr Pincus through a telephone conference link, and others. They decided to admit D to the Mater Children's Hospital with the appellant and to covertly video record what happened between them.

[48] Dr Withers arranged for D to travel with the appellant to consult paediatrician Dr O'Loughlin in Sydney on 7 November 2001. Dr O'Loughlin told Dr Withers that he was concerned D's case was factitious disorder by proxy and advised him to review D's health when he was separated from the appellant.

[49] The medical plan was to admit D to hospital and to decrease and then stop TPN and instead feed him through a nasogastric tube with a new low allergenic formula. His calorie intake was to be determined by the volume of the formula given to him. The appellant was told that the medical team would take stool specimens from D during this period and that she was not to breast feed him. During this period Dr Withers became aware that D was receiving some solid food. He told the nurses and the appellant to stop this. D was to receive only the new formula through the nasogastric tube or the TPN. The appellant seemed to accept this.

[50] Dr Withers viewed a video recording which showed the appellant breast feeding D in the bathroom attached to the hospital room, despite Dr Withers' firm contrary instructions. It also showed her tipping formula from the feed bag on the nasogastric line into the sink, topping up the feed bag with water, mixing something in a cup or glass, syringing this material into the feed line, adding something to D's nappy and wiping the nappy with a small piece of white material, apparently after dipping the material in running water. D's stools were subsequently tested and found to contain very high levels of magnesium sulphate consistent with the ingestion or injection of that substance, an ingredient which is contained in Epsom salts.

[51] After he viewed the video, Dr Withers introduced the appellant to police officers and told her that he thought D did not have any medical problems. A police officer said that the appellant had caused D's problems. The appellant denied this, saying something like, "How could you think this?"

[52] D's nasogastric feeding continued until the following morning when he appeared well. He was changed to normal food without adverse consequences. A few days

later when the central line was surgically removed he became sick and developed a high fever. This was treated with antibiotics but he had no symptoms of diarrhoea and ate a normal toddler diet including pizza. He was discharged on 13 December 2001 into the care of an aunt.

[53] In Dr Withers' opinion, D's diarrhoea and his failure to thrive were due to his mother factitiously producing symptoms through giving laxatives and not providing him with enough calories to grow.

(c) Dr O'Loughlin's evidence concerning D

[54] Dr O'Loughlin is a paediatric gastroenterologist at the Westmead Children's Hospital in Sydney. He examined D on 7 November 2001. The appellant gave him D's history. He particularly noted the complaint of longstanding chronic diarrhoea and that D seemed to be a perfectly healthy little boy, a feature uncommon in those with chronic intestinal diseases requiring long term intravenous feeding. Tests performed on D's stools over a period recorded very low osmolality[6] and this suggested that it was likely they had been diluted with tap water. The osmolality of a stool, even in cases of very severe diarrhoea such as cholera, is approximately 300, whereas in D's case the osmolality was less than half that. Such a reading was simply physiologically impossible without interference. Nor was it physiologically possible for the child to have eaten a biscuit and for undigested portions of the biscuit to come out in the stools. The stools of people with chronic malabsorption problems will contain specific sugars or fat but D's stools did not.

[55] He concluded that D had factitious disorder by proxy. The appellant's false reports of D's symptoms and her tampering with his stools created a medical scenario which required D to have invasive investigations and treatments on her hearsay. Dr O'Loughlin co-authored a medical paper in 1987 which reported three cases of laxative abuse by factitious disorder by proxy and has had many patients with that diagnosis. He has wide experience in the investigation and management of children with chronic malabsorption, a condition which D did not have. He immediately informed Dr Withers of his opinion so that D could be protected.

[56] In cross-examination, Dr O'Loughlin said that his opinion was based on the full history of D's case. There are not really any tell-tale signs of factitious disorder by proxy. Caution was needed once diagnosed because in about ten per cent of cases, if confronted, the mothers will commit suicide or kill their child. His initial clinical diagnosis was a hypothesis about which he felt reasonably confident but he suggested to Dr Withers a plan to definitively prove or disprove that hypothesis, namely a surveillance video recording of the appellant with D in hospital.

(d) The appellant's denial

[57] The appellant gave an exculpatory account to police and in evidence at trial, not disputing her actions recorded on the video tape but denying any intention to harm her children. For the purposes of this appeal, it is not necessary to further consider that evidence.

The grounds of appeal

Was the evidence of factitious disorder by proxy wrongly admitted?

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6 A measure of the concentration of salt and other substances.

[58] The learned primary judge over defence counsel's objection allowed Dr Reddan to give evidence as to the condition of factitious disorder (Munchausen's Syndrome) by proxy and Drs Pincus, Withers and O'Loughlin to give evidence as to their opinion that the appellant had that disorder and that she was responsible for unnecessary medical procedures being performed on B and D and for administering laxatives to B, C and D.

(a) The admissibility of Dr Reddan's evidence

[59] The learned primary judge, in a pre-trial hearing under s 592A *Criminal Code*,[7] allowed the prosecution to call evidence at trial of Dr Reddan on the following basis:

> "Dr Reddan is really describing a condition that is recognised by medical practitioners. This is not just a matter of mere common sense about which the jury could be expected to have knowledge. It is evidence of a condition recognised by experienced medical practitioners and, if accepted, is probative of the Crown case."

[60] Dr Reddan's evidence was only admissible if it was relevant expert psychiatric evidence.

[61] Dr Reddan's evidence was that factitious disorder by proxy is not a recognised medical condition or (despite its name) disorder or syndrome. It is a term used to describe a recognised behaviour: a small number of people in the community will behave in this socially and medically undesirable manner. As Dr Reddan explained, some people are malingerers, some laugh, some engage in criminal conduct and some make false complaints of or induce illnesses in themselves or others under their care; it is not within the expertise of a psychiatrist to comment on such behaviour because it is not a disorder. There is no developed set of criteria to be matched so as to place people in this category; the category is solely determined by the behaviour. In other words, some people intentionally deceive health practitioners about their children's symptoms so that the children are subjected to unnecessary and often painful and dangerous procedures.[8]

[62] The High Court in *Osland v The Queen*[9] discussed the admissibility of expert evidence:

> "Expert evidence is admissible with respect to a relevant matter about which ordinary persons are '[not] able to form a sound judgment … without the assistance of [those] possessing special knowledge or experience in the area' and which is the subject 'of a body of knowledge or experience which is sufficiently organised or recognised to be accepted as a reliable body of knowledge or experience'."

[63] A more liberal approach is taken in respect of expert evidence called in defence in criminal matters: cf *Murphy v The Queen*,[10] *Farrell v The Queen*[11] and *Osland v The Queen*.[12]

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7 See fn 2.

8 Compare Sudden Infant Death Syndrome as discussed in *R v Cannings* [2004] EWCA Crim 01; Case No 200201711D3, 19 January 2004, [9].

9 (1998) 197 CLR 316, 336.

10 (1989) 167 CLR 94.

11 (1998) 194 CLR 286, [10]-[13], [94].

[64] The issues for the jury's determination at trial were whether the prosecution established that the appellant committed acts causing symptoms in and, or alternatively, falsely reported or fabricated symptoms of B, C and D with the intention that medical professionals would perform otherwise unnecessary procedures on them. It is purely a matter for the jury to decide the question of the appellant's past intentions.[13]

[65] An ordinary person is likely to be puzzled by the concept that an apparently loving mother would lie and perform acts to deceive the treating doctors so that her children were placed in painful, even potentially life-threatening, situations. The appellant made that claim in her explanation to police and in her evidence in court. Ordinary people will, however, often be puzzled at the extent of human depravity revealed in the criminal courts. Who would think that an apparently devoted father could maintain a sexual relationship with his seemingly happy daughter? Who would think a wealthy, successful woman would steal small items of no apparent use to her? Who would think a dedicated, hardworking school teacher would sexually abuse some of his vulnerable young pupils whilst being greatly respected and valued by other students? If evidence could be given in this case that sometimes mothers exhibit behaviour identified by medical practitioners by the term factitious disorder (Munchausen's Syndrome) by proxy, why would not general evidence be given in the other types of cases mentioned, that some fathers rape their daughters, some school teachers sexually abuse their pupils and some wealthy women steal items although they have no need for them?

[66] The effect of allowing this category of evidence to be given is to lead as expert evidence the propensity, not of the accused but of other people, to engage in similar unlawful behaviour. The fact other people have done similar things in the past in unknown places and circumstances is not ordinarily the subject of admissible expert evidence. It has no or very limited relevance to the determination of whether this appellant has done acts or given false reports to intentionally harm her children.

[67] A close examination of Dr Reddan's evidence as to the medical term, factitious disorder (Munchausen's Syndrome) by proxy, used to describe people exhibiting behaviour like that alleged by the prosecution to have been exhibited by the appellant here, demonstrates that it does not relate to matters outside the sound judgment of a reasonable juror without any particular special knowledge or experience. Ordinary people are capable of understanding that some mothers may harm their children through deceitfully manipulating unnecessary medical treatment. As the term factitious disorder (Munchausen's Syndrome) by proxy is merely descriptive of a behaviour, not a psychiatrically identifiable illness or condition, it does not relate to an organised or recognised reliable body of knowledge or experience. Dr Reddan's evidence was inadmissible.

[68] If I am wrong and the evidence was technically admissible, in my view it should, in any case, have been excluded in the exercise of the judge's discretion. Judges and prosecutors must take particular care to ensure fairness in cases of this type where jurors will, naturally, feel sympathy towards the completely vulnerable and dependant child victims and abhorrence towards any mother who might act so unnaturally towards her babies. The danger of admitting the evidence is that lay

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12 (1998) 197 CLR 316, 336-337.

13 *R v Chard* (1971) 56 CrimAppR 268. See *Osland v The Queen* (1998) 197 CLR 316, 366.

jurors may place undue emphasis on its very limited relevance and probative value. It comes from a psychiatrist using impressive medical expressions to address in a general way facts potentially apposite here, for example, that the behaviour known as factitious disorder by proxy is sometimes perpetrated by apparently caring, rational mothers who may sometimes harm themselves and more than one of their children. As Mr Walker SC, who appears for the appellant, points out, the prosecution in its jury address made many references to the expression "Munchausen's Syndrome by proxy" in analysing the issues. A jury was likely to place great weight on the existence of a term to describe the behaviour which the prosecution alleged the appellant exhibited, instead of concentrating on whether the prosecution had established beyond reasonable doubt that the appellant had committed acts causing symptoms, or reported or caused false symptoms, intending to harm the children through subsequent unnecessary medical procedures. The evidence given by Dr Reddan had minimal probative value but it had the potential to be extremely prejudicial. It should have been excluded.[14]

(b) The admissibility of the evidence of Drs Pincus, Withers and O'Loughlin

[69] The opinion evidence of Drs Pincus, Withers and O'Loughlin that the appellant was responsible for deliberately reporting the false symptoms of B and D, under-nourishing D and giving laxatives to B, C and D, answered the question which was for the jury's determination, namely whether the appellant was guilty of the charged offences in respect of her children. This may make the evidence inadmissible: see *R v Lupien*.[15]

[70] There is now a greater willingness than in former times to allow such expert evidence to be given: see *Murphy v The Queen*[16] and *Cross on Evidence*.[17] This is particularly so when such evidence is led in a criminal trial in defence: see *Director of Public Prosecutions v A & BC Chewing Gum Ltd*[18] and *Naxakis v Western General Hospital*.[19]

[71] For the reasons I have given in discussing Dr Reddan's evidence,[20] the diagnosis of Drs Pincus, Withers and O'Loughlin that the appellant intentionally caused her children to receive unnecessary treatment through her own acts and the false reporting of symptoms as factitious disorder (Munchausen's Syndrome) by proxy is not a diagnosis of a recognised medical condition, disorder or syndrome. It is simply placing her within the medical term used for the category of people exhibiting such behaviour. In that sense, their opinions were not expert evidence because they related to matters able to be decided on the evidence by ordinary jurors. The essential issue as to whether the appellant reported or fabricated false symptoms or did acts to intentionally cause unnecessary medical procedures to injure her children was a matter for the jury's determination. The evidence of Drs Pincus, Withers and O'Loughlin that the appellant was exhibiting the behaviour of factitious disorder (Munchausen's Syndrome) by proxy should have been excluded. Those doctors could, of course, give their very significant evidence of the history of

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14 Compare the statistical evidence of Sudden Infant Death Syndrome in *R v Sally Clark* [2003] EWCA Crim 1020; Case No 200203824Y3, 11 April 2003, paras 172-178.

15 (1970) SCR 263.

16 Above.

17 Aust ed, vol 2 at [29105].

18 [1968] 1 QB 159, 164.

19 (1999) 197 CLR 269, Callinan J at 306, [110].

20 These reasons, [64] to [67].

their treatment of the children, the statements by the appellant in the course of that treatment, that no medical reason could be found for the symptoms suffered by the children, that the tests on the stools suggested outside interference, that they suspected the symptoms were being caused by the intervention of a third person, that some symptoms were consistent with the unnecessary administration of laxatives, that they subsequently arranged for the video surveillance, and that once D was removed from the care of his mother he thrived and became a normal healthy boy without the need any special medical attention. It was a question for the jury to determine whether this evidence, when combined with the video taped and other evidence, persuaded them of the appellant's guilt on any or all of the charges beyond reasonable doubt.

[72] Even though the case against the appellant was very strong, I cannot safely conclude that this wrongly admitted evidence, which was likely to have impressed the jury coming as it did from such highly qualified, confident medical experts, did not deprive the appellant of the chance of an acquittal. The appeal must be allowed and a re-trial ordered on this ground alone. It is unfortunate that the extensive resources which went into this four and a half week trial have been wasted, but the appellant is entitled to have the issues in her trial determined according to law and on admissible evidence. It is prudent to consider the remaining grounds of appeal in case they are relevant in the re-trial.

Did the trial judge err in allowing prosecution witnesses to describe their observations of the video surveillance tape?

[73] Defence counsel objected to the following police officers, nurses and doctors giving evidence of their interpretation of the actions of the appellant in the video recorded surveillance tape. The appellant contends that evidence was inadmissible, relying on these observations of Gleeson CJ, Gaudron, Gummow and Hayne JJ in *Smith v The Queen*[21] where police officers who knew Smith gave evidence identifying him as a robber depicted in bank security photographs:

> "Because the witness's assertion of identity was founded on material no different from the material available to the jury from its own observation, the witness's assertion that he recognised the appellant is not evidence that could rationally affect the assessment by the jury of the question ['Is the person standing trial the person who is depicted in the photographs?'] The fact that someone else has reached a conclusion about the identity of the accused and the person in the picture does not provide any logical basis for affecting the jury's assessment of the probability of the existence of that fact when the conclusion is based only on material that is not different in any substantial way from what is available to the jury."

[74] Police officer McNeil became involved in the investigation when she attended a team meeting at the Mater Hospital on 5 September 2001 with Drs Withers, Pincus and others. As a result, video surveillance equipment was secreted in a room and en suite bathroom at the Mater Children's Hospital to record the behaviour of the appellant towards D. Once activated, the three video screens were constantly monitored by police officers Triggs, Doyle, Price (now Wheeley) and McNeil working in shifts from a room attached to the child protection unit within the

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21 (2001) 206 CLR 650, 655.

hospital. The screens displayed live what was transpiring at each of the sites as they recorded.

[75] Police officer Triggs relieved police officer McNeil at about 4.00pm on 26 November 2001. He took contemporaneous notes of his observations of the appellant's actions shown live on the monitors in the surveillance log. He mistakenly believed the tapes were eight hour tapes and, as a result, there was no recording from 5.40pm until about 9.30pm when he changed the tapes. He saw a nurse fit the nasogastric tube to D at about 4.41pm. At about 6.00pm he saw the appellant prepare a feed bag but he was unsure whether this was the nasogastric feed bag or a TPN feed bag. At 6.35pm the appellant changed D's urinary collection bag. At 6.51pm the appellant fed the child with a bottle later found to contain apple juice. At 7.06pm the appellant gave the child a drink from her bag. At 9.20pm he realised the tapes were not recording and he replaced them.

[76] Police officer Doyle took over the monitoring of the tapes from police officer Triggs at 10.00pm on 26 November 2001. She too kept a contemporaneous surveillance log whilst she watched the live monitors. She did not give evidence of what she first saw on the screens and nor did she attempt to interpret the tendered recording of the video surveillance.

[77] Police officer Wheeley (formerly Price) replaced police officer Doyle in monitoring the screens and the tape recording at about 6.00am on 27 November 2001. She noted her observations of the appellant in a surveillance logbook and in her police note book. She referred to those notes to give the following evidence. At 6.46am she saw the appellant in the bathroom apparently interfering with D's feed line and pressing buttons on the machine to which it was attached. The appellant took a bag off the trolley, unscrewed it, did something at the sink, screwed the top back on the bag and replaced it on the trolley. She could not make out what the appellant did at the sink. The appellant returned to the bedroom. At 6.52am she saw the appellant remove the baby's nappy, put something in the nappy from a packet and replace the nappy. At 7.22am the appellant took a container from beside the cot to the sink in the bathroom where she did something but she was unable to see exactly what. The appellant returned and handed the training cup to the child. At 7.25am the appellant took the training cup from the child and emptied it in the bathroom sink. At 9.52am the appellant took D into the bathroom. She took a container out of her bag, unscrewed it, took a syringe from her bag and injected it into the feed line. Wheeley related her observations to still photographs taken from the video recordings and pointed out the various items that she saw the appellant use and the position of D's body in the still photos. At 1.21pm she saw the appellant take D into the bathroom, disconnect the feed bag, appear to empty it into the sink, do something with the bag at the sink and then reconnect the bag to the feed line. At 1.31pm the appellant entered the bathroom alone and appeared to dissolve something in a cup. At 1.36pm the appellant re-entered the bathroom and swilled the liquid around in the cup. Wheeley identified photographs of the bathroom area showing the sink and small shelf beside the sink. At 1.38pm the appellant left the hospital room and Nurse Williams entered, removed a training cup with a blue top from the bathroom and showed it to police officer Wheeley. The cup was empty. Nurse Williams returned the cup to the room and came back with another cup containing a small amount of liquid. Nurse Williams transferred the contents of that cup into a sterile container and handed it to police officer Lenz. At 2.02pm she saw the appellant go into the bathroom with D, get a syringe from the toiletry bag, draw

fluid up from the cup without a lid on the sink (its contents had been replaced by Nurse Williams) and inject that into the nasogastric feed line; she repeated that with the remaining fluid in the cup. Wheeley related what she observed to still photographs taken from the video recording. At 2.18pm she changed the tapes monitoring the bathroom and gave the completed tape to Dr Jones, who viewed it with Nurse Ehmer. At about 3.04pm after the social worker who had been present in the hospital room left, the appellant took one of D's soiled nappies into the bathroom sink where the tap was running. She appeared to be adding something to the nappy and wiping it with a white tissue. Wheeley arranged for Nurse Ehmer to collect the nappy and it was handed to police officer Williams. She related these events to still photographs taken from the video. Police officer Wheeley answered questions about the compilation tape such as, "Is that Nurse Williams entering the room … ?" and "She is replacing the cup without the lid?"

[78] Police officer McNeil also viewed the monitors displaying live images of the appellant and D in the bathroom on the morning of 27 November 2001. She saw the appellant unhook what appeared to be the nasogastric feed from the trolley, unscrew the lid and pour a portion of the liquid into the bathroom sink. She then screwed the lid back on, rehooked it to the trolley and left the bathroom with D. Later, she saw the appellant carry D into the bathroom, remove what appeared to be a syringe from a toiletry bag, place it in a cup, draw back the syringe and inject it into the tube which appeared to be D's nasogastric line. Later again, she observed the appellant enter the bathroom carrying D and once more take a syringe from the toiletry bag, place it into a cup, pull back the plunger, place the needle into the nasogastric tube, and then return the syringe into the toiletry bag. She also observed the appellant removing the bag from the nasogastric feed line a second time, unscrew it, pour its contents into the sink and then replace it.

[79] Later that morning, when the appellant was not in the room, McNeil went into the bathroom, removed the syringe from the toiletry bag and attempted to collect the few drops of liquid left in the cup. She replaced the syringe with a fresh, sterile syringe.

[80] Police officer Lenz monitored the video surveillance screens for a short time on the afternoon of 27 November 2001. He referred to notes made contemporaneously in his notebook and described what he observed live on the screens. On two occasions a nurse walked into the bathroom, took possession of a cup and replaced it.

[81] Nurse Ehmer gave evidence of her observations when she viewed brief portions of the video recording at the child protection unit on 27 November.

[82] Police officer Williams took possession of various relevant items in the bathroom including cups, a toiletries bag containing a syringe, drinking glasses, chocolate laxettes and an open packet of Faulding's Epsom salts. He identified these items from photographs apparently taken in his presence. He prepared a compilation video tape from the actual surveillance tapes which contained those portions of the video tapes upon which the prosecution relied. The original tapes were available in court if the defence wished to refer to them. He related some of the items he collected in the bathroom to items depicted in the video compilation tape. The prosecution led evidence from him as to the actions of the appellant recorded on the compilation video whilst he was monitoring the live screens.

[83] As I have recorded earlier in these reasons,[22] medical practitioners treating the children made their diagnoses aware of the general content of the surveillance video tapes and after viewing portions of them. This was an important factor in them forming their opinions that the symptomatology of B, C and D were induced by factitious disorder by proxy on the part of the appellant. For the reasons given earlier,[23] that evidence was inadmissible as expert evidence but witnesses giving admissible expert evidence commonly refer to tape recorded evidence in forming or to explain or qualify their opinions.

[84] The remaining evidence to which objection is taken falls into three categories. The first category is Triggs' evidence[24] of his live observations of the appellant and D on the monitor which was not recorded. This evidence was effectively an eyewitness account of the appellant's actions viewed through the video monitor, no different from witnesses describing what they saw through a window, key hole or one way mirror. There was no video recording to which the jury could refer; Triggs' evidence about these matters was the only evidence of the appellant's actions at the time. The principles relied on in *Smith* have no application.

[85] The second category is the evidence of those witnesses describing what they saw live through the video monitors. Like Triggs, they are effectively giving eyewitness evidence of what they viewed through the monitor and this evidence is admissible: see *R v Sitek*.[25] The jury had the additional benefit of a tape recording of exactly what these witnesses saw. The jury were required to view the tape to make up their own mind as to the accuracy of the eye witness account, if in dispute. This category of evidence is quite different from the inadmissible identification evidence in *Smith* as it is evidence of what the witness observed live through the monitor. Witnesses are entitled to give evidence of their live observations through a monitor and are entitled to look at contemporaneous notes or at the recorded video tapes to refresh their memories. They are also entitled to explain or clarify what is depicted in the tapes, especially where, as here, the tapes are not clear and the witnesses were generally more familiar than the jury with the environment, the protagonists and the items depicted. If there is any dispute at trial as to the witness's description of events, the jury should be instructed that the tapes are the best evidence and that if the tapes depict something which differs from the eye witness's account, in the absence of any satisfactory explanation, they must act on what they observe in the recorded tape.

[86] The last category is interpretative evidence from witnesses who, like the jury, have merely viewed the recording and then given evidence of what they saw on the tape which is before the jury. This category of evidence will not ordinarily be admissible unless the witnesses have some special knowledge to explain or clarify something in the tape recording or to assist the jury in understanding it. If the witnesses merely describe their own perceptions of what is depicted on the tape, their evidence is not admissible because they jury could observe the tape and decide for themselves whether the appellant was committing acts to harm D: see *Smith v The Queen*.[26]

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22 Paras [20], [25], [43], [45], [46], [50] and [51].
23 Paras [69]-[72].
24 See these reasons, [75].
25 [1988] 2 QdR 284, 291-292.
26 (2001) 206 CLR 650, 655.

[87] These issues may not necessarily arise in a retrial. Although there was an objection to the evidence originally, the accuracy of the evidence as to what was depicted in the tapes was not in dispute in this trial. The major contentious issue was whether the appellant intended to harm her children by her actions.

The re-direction by the primary judge

[88] The appellant's final ground of appeal is that his Honour erred in re-directing the jury in respect of the count of torture concerning D.

[89] The offence covered the period from 16 February 2000 (the date of D's birth) to 28 November 2001 (when the appellant was charged with these offences). The prosecution relied on three particulars: (a) the administration of magnesium sulphate and/or other laxative or laxative to him; and/or (b) giving him insufficient nutrients; and/or (c) invasive medical procedures. The learned primary judge was prepared to take a special verdict in the event of a guilty verdict to determine whether that related to the full period covered by the torture or only to the period when D and the appellant were in hospital and their conduct monitored on 26 and 27 November.

[90] No objection was taken to his Honour's directions to the jury as to the elements of torture required to be established by the prosecution in the main body of the summing up. After the jury retired to consider their verdict, they asked the judge for assistance in these terms:

> "If the jury decided, for example, that a guilty verdict is unanimous for [this count] does it follow that they must all be unanimous that the verdict was as a result of the events of 26th and 27th and/or a longer period and/or particulars (a), (b) and (c)?"

[91] The trial judge gave the following re-directions about which there is also no complaint:

> "As I said to you, your verdict has to be unanimous in relation to verdicts sought in relation to [this count], that is, whether it may be the result of particular events, whether it relates to a particular period and whether it relates to particulars (a), (b) and (c) or a combination thereof, again, your decision should be unanimous in respect of those matters."

[92] The prosecution asked for a further re-direction and the learned trial judge had the jury return to the court room and said:

> "So far as the particulars are concerned, members of the jury, it may be – and I am not suggesting at all that this would be the case, I am simply here giving you a direction of law – it may be that although you are unanimously satisfied as to the guilt of the accused during the whole of the period, some of you may be satisfied of that guilt because of particular (a), others because of particular (b), others because of particular (c), or some combination thereof. In such a situation it would be open to you to answer the final question by indicating that the basis of your verdict is a combination of particulars (a), (b) and (c). That was something, I think, I needed to clarify from what I had said to you last night.

> So, members of the jury, to put that another way, if you are satisfied of the guilt of the accused, or if you are satisfied that the accused having the necessary intention to inflict severe pain or suffering by whatever of the means particularised in paragraph (a), (b) and (c) achieved that result, then it would be open to you to return that verdict in respect of the whole of the period."

[93] In due course, the jury returned with their verdict. They were asked, "Is your verdict on the basis of particular (a), (b) or (c) or a combination thereof? And if so, what combination?" They answered, "A combination of (a), (b) and (c)."

[94] Torture under s 320A *Criminal Code* is the intentional infliction of severe pain or suffering on a person by an act or series of acts done on one or more than one occasion. To establish the offence of torture the prosecution must prove that the accused person intentionally inflicted severe pain or suffering on the complainant by at least one act. It is not necessary to establish a course of conduct as in trafficking in prohibited drugs. To convict the appellant, the jury must have been unanimously agreed beyond reasonable doubt that she did at least one of the particularised acts intending to inflict severe pain or suffering: *KBT v The Queen*[27] and *R v Boreman*.[28] The re-direction given by the learned primary judge at the instigation of the prosecution was flawed in that it allowed the jury to convict if some jurors were satisfied that the appellant intentionally inflicted severe pain or suffering on D by administering laxatives, some by giving him insufficient nutrients or some by invasive medical procedures, without all jurors necessarily being satisfied of the intentional infliction of severe pain or suffering on the same particular occasion. To convict the appellant, there must have been unanimity as to the intentional infliction of severe pain or suffering on D on at least one particularised occasion. This error alone is sufficient to quash the verdict of guilty on the charge of torture.

[95] For the reasons given the appeal must be allowed and a new trial ordered. In those circumstances, there is no utility in considering the appellant's application for leave to appeal against sentence.

Orders

(1) Appeal allowed.

(2) Verdicts of guilty set aside.

(3) New trial ordered.

[96] **McPHERSON JA:** I agree that for the reasons given by McMurdo P there should be a new trial of the counts in the indictments on which the appellant was convicted. In respect of those counts, the appeal should be allowed and the verdicts set aside and a new trial to follow.

[97] **HOLMES J:** I have read the reasons for judgment of the President and agree with them on all points of the appeal. I merely wish to add some observations concerning the evidence as to the collection of behaviours loosely described as

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27 (1997) 191 CLR 417, 422.

28 [2000] 1 All ER 307, 317.

Munchausen's syndrome by proxy. The Crown advanced that evidence as explaining what, on its case, was the appellant's criminal behaviour, but in fact it explained nothing; it merely gave the alleged behaviour a label. And the reasoning process behind the Crown's argument for admission was inherently circular: one had to assume the occurrence of the behaviour before the label could be applied to it. Quite apart from whether the evidence was properly characterised as expert, the existence at large of the syndrome did nothing to prove criminal conduct by the appellant here.

[98] I agree with the orders proposed by the President.