SUPREME COURT OF QUEENSLAND

CITATION:	*R v Wyborn* [2013] QCA 400
PARTIES:	**R** **v** **WYBORN, Peggy Louise** (appellant)
FILE NO/S:	CA No 81 of 2013 SC No 820 of 2010
DIVISION:	Court of Appeal
PROCEEDING:	Appeal against Conviction
ORIGINATING COURT:	Supreme Court at Toowoomba
DELIVERED ON:	20 December 2013
DELIVERED AT:	Brisbane
HEARING DATE:	22 November 2013
JUDGES:	Holmes and Muir JJA and Applegarth J Separate reasons for judgment of each member of the Court, each concurring as to the order made
ORDER:	**The appeal against conviction is dismissed.**
CATCHWORDS:	CRIMINAL LAW – APPEAL AND NEW TRIAL – VERDICT UNREASONABLE OR INSUPPORTABLE HAVING REGARD TO EVIDENCE – APPEAL DISMISSED – where the appellant was convicted of manslaughter – where the appellant applied scalding liquid to the deceased's face and head, causing burns in those areas and blistering and swelling to his upper airways – where death was caused by deep venous thrombi which developed after a period of immobility and caused a fatal pulmonary embolism – where, at trial, the issue was the role of the burns in the deceased's death – where two pathologists called for the Crown attributed the thrombosis to the necessary immobilisation of the deceased in the treatment of his burns with infection as a complicating factor – where the pathologist called for the defence posited a theory that a stroke caused by pre-existing conditions independently caused the immobility and resulting thrombosis – whether the jury could have been satisfied that the theory of the defence's pathologist was not a reasonable possibility – whether the jury could be satisfied beyond reasonable doubt that an ordinary person in the appellant's position would reasonably have foreseen the deceased's death as a possible outcome of her actions – whether the excuse of accident under s 23(1)(b) of the *Criminal Code* could be excluded – whether it was

open to the jury on all the evidence to be satisfied beyond reasonable doubt of the appellant's guilt of manslaughter

CRIMINAL LAW – APPEAL AND NEW TRIAL – PARTICULAR GROUNDS OF APPEAL – MISDIRECTION AND NON-DIRECTION – REVIEW OF EVIDENCE – where the appellant was convicted of manslaughter – where the appellant applied scalding liquid to the deceased's face and head, causing burns in those areas and blistering and swelling to his upper airways – where the trial judge, in relation to the excuse of accident, directed the jury that they must be satisfied beyond reasonable doubt that an ordinary person in the appellant's position would reasonably have foreseen death as a possible outcome of applying scalding liquid to the deceased's face – where the appellant contended that the trial judge should have adverted to the particular sequence of events which led to the death – where the appellant contended that the trial judge should have instructed the jury that foreseeability that the injury was life-threatening would not suffice – whether any miscarriage of justice was demonstrated

Criminal Code 1899 (Qld), s 23(1)(b), s 293, s 602

Fingleton v The Queen (2005) 227 CLR 166; [2005] HCA 34, cited
M v The Queen (1994) 181 CLR 487; [1994] HCA 63, cited
MFA v The Queen (2002) 213 CLR 606; [2002] HCA 53, cited
R v Mogg (2000) 112 A Crim R 417; [2000] QCA 244, cited
R v Sherrington & Kuchler [2001] QCA 105, cited
R v Summers [1990] 1 Qd R 92, cited
R v Taiters; ex parte Attorney-General [1997] 1 Qd R 333; [1996] QCA 232, cited
Royall v The Queen (1991) 172 CLR 378; [1991] HCA 27, cited

COUNSEL: J J Allen for the appellant
B G Campbell for the respondent

SOLICITORS: Legal Aid Queensland for the appellant
Director of Public Prosecutions (Queensland) for the respondent

[1] **HOLMES JA**: The appellant was convicted of the manslaughter of Neil Patrick McCarthy. He died on 3 April 2009, three weeks after sustaining burns on his face and head from scalding liquid. The appellant appealed the conviction, firstly, on the ground that the verdict was unreasonable because the evidence did not prove that any act by her caused Mr McCarthy's death and because the excuse of accident under s 23(1)(b) of the *Criminal Code* 1899 could not be excluded; and, secondly, on the ground that the trial judge did not adequately direct the jury on the excuse of accident under s 23(1)(b).

The issues

[2] The Crown case relied on circumstantial evidence to prove that the appellant had in some way applied the scalding liquid to Mr McCarthy's face and head, causing

burns in those areas and blistering and swelling to his upper airways. The jury's conclusion that she was the author of his injuries is not in contest here. What is in issue is the role of the burns in his death. Two pathologists called for the Crown (Drs Olumbe and Ansford) and one for the defence (Dr Duflou) agreed that Mr McCarthy's death was caused by deep venous thrombi which developed after a period of immobility and caused a fatal pulmonary embolism. Drs Olumbe and Ansford attributed the thrombosis to the necessary immobilisation of Mr McCarthy in the treatment of his burns, with the added complication of infection. Dr Duflou, however, raised the possibility that it was a stroke caused by independent and pre-existing conditions of atrial fibrillation and cardiomyopathy which led to the immobility and resulting sequence of deep venous thrombosis, pulmonary emboli and death.

[3] The appellant contends that the jury could not have been satisfied that Dr Duflou's theory was not a reasonable possibility, so that the verdict was unreasonable; that the possibility that Mr McCarthy would die as a result of application of hot water to his face was so remote that the prosecution could not negative the excuse of accident under s 23(1)(b); and that there was a miscarriage of justice because the jury was not instructed to consider whether an ordinary person would have reasonably foreseen the death, in light of the complicated chain of events which led to it.

Mr McCarthy's medical background and treatment

[4] Because the first ground of appeal turns on the specialists' attribution of Mr McCarthy's death to different causes, it is necessary to set out in detail the medical background to it. Mr McCarthy was 70 years old when he died. His general practitioner gave evidence that Mr McCarthy had been his patient since 1995, attending his practice on a regular basis, and he had last seen him on 3 March 2009. Mr McCarthy had no history of deep vein thrombosis, stroke or cardiac problems. He had never complained of symptoms of cardiomyopathy (abnormality of the heart muscle). In 1991, Mr McCarthy was investigated for chest pain which proved to be unrelated to any heart problem, and at that stage was noted to have a partial left bundle branch block (a defect in the electrical impulses controlling contraction of the heart, causing one ventricle to contract fractionally more slowly than the other.) A repeat cardiograph three years later did not show the condition, but it could, the general practitioner noted, be intermittent.

[5] At about 9.00 pm on 12 March 2009, an ambulance was called to attend Mr McCarthy, who was lying semi-conscious on a Toowoomba footpath with severe burns to his face. The paramedics attending him performed an echocardiogram (an ultrasound of the heart) in the ambulance; it revealed no cardiac problems. Mr McCarthy was placed in an oxygen mask because his breathing had become laboured. His breathing difficulties led to his being intubated on his arrival at Toowoomba Hospital. The treating emergency specialist said that he experienced a precipitous drop in the oxygen level in his blood and, had he not been immediately intubated, would have died. To facilitate the intubation process, he was sedated and given a paralysis agent. The specialist noted that he had significant facial and upper airway burns. His Glasgow Coma Scale score was 5 (on a scale running between 3 and 12, with 3 the lowest score). A CT scan of Mr McCarthy's head performed at the hospital showed no sign of intra cranial haemorrhage or infarction.

[6] Mr McCarthy was transferred in the early hours of the following morning to the Royal Brisbane Hospital. A specialist from the burns unit there, Dr Rudd, described

his presenting condition and treatment on arrival. Mr McCarthy was on a ventilator to support his respiratory system, heavily sedated and in a state of paralysis, with intravenous delivery of fluid to support his circulation. He had a Glasgow Coma Scale score of 4 and was deeply unconscious. (Later that day the score was recorded as 3.) The airway above his larynx and his epiglottis was swollen, consistent with his face being scalded and hot liquid entering his mouth. Swelling of the epiglottis could cause airway obstruction and sudden death. The burns to Mr McCarthy's face involved his nose, cheeks, ears, eyelid and forehead, extending over the top of his head towards the back of his skull. The burned skin included areas where the epidermis was lost and the blood vessels in the dermis were damaged.

[7] Mr McCarthy had suffered from hypothermia before medical assistance reached him, a feature which, Dr Rudd said, could cause acceleration of a burn wound. There was evidence of sepsis, which required treatment with antibiotics. Mr McCarthy continued to be sedated to make his ventilation easier and for some period of time remained paralysed. Because of his immobilisation, he was given Heparin, an anti-coagulant, and thromboembolic stockings to prevent deep venous thrombosis (formation of blood clots in the veins). An echocardiogram performed on the day of his admission to the Royal Brisbane Hospital revealed some mild abnormalities of the valves and some signs suggestive of pulmonary hypertension, which Dr Rudd explained as blood pumping at a higher than normal pressure in the right side of the heart. There was no evidence of atrial fibrillation, which Dr Rudd described as an abnormal rhythm in the heart.

[8] On 14 March, Mr McCarthy remained deeply unconscious. There was an attempt on that day to reduce his ventilation, for the purposes of which his sedation was reduced and his paralysis allowed to wear off. Mr McCarthy was not, however, able to breathe for himself, and he developed an infection which required antibiotics. He was given Noradrenaline to maintain his arterial pressure and to avoid his having a stroke. On 15 March, he was still deeply unconscious and another echocardiogram was performed, which indicated atrial fibrillation. The following day, his level of sedation was reduced, but he remained immobilised and ventilated. His heart rate was normal.

[9] On 17 March, there were signs of improvement and it was intended to extubate Mr McCarthy the following day. That step had to wait until his sedation wore off. His coma score was between 8 and 9, which was too low a state of consciousness for safe extubation. Meanwhile, Mr McCarthy was being maintained on prophylaxis against venous thrombosis. On 19 March, Mr McCarthy was still being weaned from sedation. By that afternoon, he was showing signs of consciousness, moving all four limbs and obeying commands. He was able to be extubated that afternoon. Early the next morning, however, he had to be re-intubated because of the worsening of an upper airway obstruction. There was still swelling around his larynx, glottis and vocal chords and evidence of dead tissue near the larynx. His sedation was resumed.

[10] On 20 March, another echocardiogram was performed which showed signs of atrial fibrillation. Subsequently, however, Mr McCarthy's heart returned to a normal sinus rhythm and his blood pressure was normal. Blood tests were carried out to see if there had been a myocardial infarct; nothing untoward was noted. On 21 March, his level of consciousness had improved. He could not speak, but he could obey commands. His condition was similar the following day: his heart rhythm was normal and his blood pressure good. He was extubated that day, with no immediate

complications. On 23 March, Mr McCarthy's level of consciousness was good, with a coma score of 14, and he was moving all four limbs, but there was some sign of atrial fibrillation. It was noted that he was "alert and co-operative, following most commands", although his speech was not intelligible.

[11] Overnight leading up to 24 March, Mr McCarthy developed a temperature. It was suspected that he had contracted a bloodstream infection and he was given antibiotics. However, he was still able to obey commands and had a coma score of 14. Another echocardiogram was performed on 24 March. According to Dr Rudd, it showed nothing markedly abnormal, but there was some evidence of pulmonary hypertension on the right side of the heart.

[12] That afternoon, Mr McCarthy was discharged from the intensive care unit into the hospital's burns unit. He was able to move all limbs, but remained bed-ridden. His treating physiotherapists endeavoured to keep him in an upright position to prevent production of secretions in his lungs. At one point they moved him into a chair. He was, however, exhibiting mild stridor (noisy breathing) indicative of an airway obstruction and was experiencing atrial fibrillation again. That state of affairs continued on the following day, 25 March. The specialists treating him formed the view that he was suffering paroxysmal atrial fibrillation in conjunction with a blood stream infection.

[13] On 26 March, Mr McCarthy was feverish and producing quantities of secretions from his lungs. He had an abnormal temperature and was showing signs of airway collapse. He was also experiencing atrial fibrillation, but it was not severe. He was returned to the intensive care unit at about 1.30 pm and was re-intubated, paralysed and sedated. It was noted that he was suffering from acute respiratory failure, secondary stridor, upper airway oedema, sputum retention and possible hospital acquired pneumonia. Dr Rudd said that those factors – airway obstruction, respiratory failure and infection – were the primary reason for Mr McCarthy's being moved from the burns unit back to the intensive care unit. A CT scan of his head was taken later that afternoon. It showed no evidence of infarctional haemorrhage or any other intracranial pathology.

[14] On 27 March, a tracheostomy was performed to obviate the need to place a tube through Mr McCarthy's larynx. Some skin grafting was also performed on Mr McCarthy's wounds on that day. The following day, 28 March, Mr McCarthy was still feverish and still suffering from an infection. He was sedated, ventilated and immobile. A CT scan revealed multiple infarcts in the brain, spleen and left kidney. A transoesophageal cardiogram showed that Mr McCarthy was experiencing pulmonary hypertension. The left ventricle of his heart was not contracting as well as it had when he was first admitted. There was a patent foramen ovale (a hole in the wall between the left and right chambers of the heart), which was causing a flow of blood in both directions between the right and left atria of the heart. There was also some reflux of blood from both ventricles into the atria. A further CT scan and ultrasound performed that day showed signs of pulmonary emboli and of thrombosis in Mr McCarthy's femoral veins leading into and through his groin.

[15] On 29 March, an intravenous filter was inserted with the intention of preventing the thrombi in Mr McCarthy's legs from moving through the venous system to the heart and lungs. He was unconscious, ventilated and sedated. Over that day, Mr McCarthy experienced repeated episodes of atrial fibrillation. His sedation was discontinued

so that his neurological functioning could be evaluated. By this stage, his Glasgow Coma score was 9. There was a concern that he might have suffered a brain stem CVA (cerebrovascular accident, or stroke) not apparent on CT scan. His condition remained similar on the following day.

[16] On 31 March, it was noted that the level of oxygen entering Mr McCarthy's blood stream and the level of carbon dioxide being exuded were becoming lower. His lung function was deteriorating and it was likely that he had ventilator-acquired pneumonia. Magnetic resonance imaging (MRI) performed on 1 April on Mr McCarthy's brain revealed evidence of a number of acute and sub-acute cerebral infarcts. Dr Rudd, reading the MRI report, said that it indicated infarcts in several territories on both sides of the brain, but there was no brain stem infarct evident.

[17] On 2 April, a summary of Mr McCarthy's condition recorded that he was having "irretrievable problems". He was suffering from deep venous thrombi in both legs, the effects of the patent foramen ovale with severe pulmonary hypertension, multiple pulmonary emboli, and spleen and kidney infarcts. The note also referred to a brain stem CVA confirmed on MRI. However, that reference seems to have been an error: as Dr Rudd observed, the MRI report did not disclose any brain stem infarct, although there were infarcts in other regions of the brain. The decision was made to discontinue Mr McCarthy's therapy and move him out of the intensive care unit. Before that could occur, he died, on 3 April.

The Crown medical witnesses' opinions as to the cause of death

[18] From a clinical perspective, Dr Rudd gave as the cause of Mr McCarthy's death the fact that he had developed venous thrombi which lodged in his heart and lungs and travelled through the hole in his heart and into his brain, where they caused him to have strokes. He confirmed that Mr McCarthy was bed-bound for the entirety of his hospitalisation because of the dual effects of his weak state of health and the medical intervention in the form of sedation, which was necessary in order to maintain his intubation. Burns could cause physical wasting; the necessity of being ventilated and treated in intensive care could produce a condition known as "critical care polyneuropathy", which would of itself render a patient unable to move his or her limbs. Dr Rudd also made the observation that without intubation on his admission to hospital, Mr McCarthy was likely to have died of an airway obstruction.

[19] Dr Olumbe, a forensic pathologist, performed the autopsy on Mr McCarthy's body. He explained what he regarded as the mechanism of Mr McCarthy's death. The latter's facial and airway burns and the consequent swelling of his airways led to his inability to breathe alone, the need for sedation and the development of infection, all of which contributed to his immobility. That immobility led him to develop deep venous thrombi, particularly in the right leg; infection, too, made the blood more susceptible to forming clots. Thrombi had travelled to the right side of his heart and thence to his lungs, creating pulmonary emboli and blocking the blood vessels, which could cause death in someone who had no heart defect.

[20] Mr McCarthy's blood vessels showed signs of narrowing, which was suggestive of some pre-existing pulmonary hypertension, but the condition could also be produced by pulmonary emboli: an abnormality of that kind in the lungs reduced the capacity of the blood vessels and increased the blood pressure in the right side of the heart, which performed the function of pumping blood to the lungs. Pulmonary

hypertension both played a part in forcing open the patent foramen ovale and made it easier for a blood clot to move through the hole, from the right atrium of the heart to the left (a "paradoxical embolism"). From the left atrium, blood clots could be then pumped into other organs, including the brain. An embolic stroke could occur if a blood clot blocked a blood vessel into the brain.

[21] The presence of brain infarction would have contributed to Mr McCarthy's immobility but it was not a primary causal factor. Dr Olumbe concluded that the cause of death was pulmonary thromboemboli due to deep venous thrombus resulting from Mr McCarthy's unconsciousness and immobility. The burns were thus a substantial cause of the death, in Dr Olumbe's view.

[22] Mr McCarthy's pre-existing cardiomyopathy would have contributed to his death, but Dr Olumbe could not determine the degree of contribution or its magnitude. The stress of the burns could have exacerbated the pre-existing heart condition, which would explain why Mr McCarthy had experienced atrial fibrillation. Atrial fibrillation was an incoordination which affected the atria in pumping blood to the ventricles and could lead to the formation of clots in the atria. A blood clot which formed on the wall of the chamber of the heart was called a "mural thrombus". If it were the result of cardiomyopathy, it would usually form in the ventricles, the lower chambers, of the heart; if it were produced by atrial fibrillation it would commonly form in the atria, the upper chambers.

[23] Dr Olumbe did not see any sign of mural thrombi in Mr McCarthy's heart. On a histological examination of material from the left chamber, he had found a small clot, but in his view, it had occurred post mortem and was not a mural thrombus. There were multiple thromboemboli in the blood vessels of Mr McCarthy's lungs, of ages dating from shortly after he was admitted to hospital until his death. Dr Olumbe's confidence that some of the emboli pre-dated 24 March, the day on which Mr McCarthy had been moved out of the intensive care ward, led to his certainty that the pulmonary emboli had resulted from the primary immobility. Other emboli, however, might have formed after Mr McCarthy suffered a stroke.

[24] Dr Anthony Ansford had supervised Dr Olumbe's performance of the autopsy and co-signed his report. He concurred with Dr Olumbe's opinion as to the cause of death. Dr Ansford agreed also that the thrombus Dr Olumbe had identified from the left chamber of the heart had formed post mortem. He noted, too, that it was not adherent to the wall of the heart; was not at the site of any damage; and was not visible to the naked eye as would be expected of a significant mural thrombosis.

[25] A neuropathologist, Dr Tannenberg, performed a macroscopic and microscopic examination of Mr McCarthy's brain post mortem. He located multiple areas of brain infarction on both sides of the brain and in the posterior fossa, which contained the brain stem. There were seven acute infarcts in the cerebellum on both sides which would have been present for a period between several hours and several days, and three sub-acute infarcts in the right lateral cerebellum. After what he described as a very thorough investigation, he did not find any infarction in the brain stem. The number and variety of areas of infarction indicated that they were the result of emboli. There was an old infarct of several months duration in the right cerebellar hemisphere. That older infarct might simply have produced some level of clumsiness or it might not have been symptomatic at all. There was no way of knowing its cause; it might have been embolic or the result of a blockage of an artery.

[26] The acute infarcts would probably have affected Mr McCarthy's mobility, resulting in some clumsiness and incoordination which impaired his ability to walk and the use of his hands, but they would not have caused paralysis. The sub-acute infarcts might have produced clumsy movement and in that sense contributed to Mr McCarthy's immobility, or they might not have been symptomatic. The acute infarctions definitely occurred while Mr McCarthy was hospitalised; it was probable that the sub-acute infarctions also occurred in that period. Dr Tannenberg did not consider the infarctions to be the primary cause of death, although they might have contributed to Mr McCarthy's immobility and thus to the development of pulmonary thromboemboli. He would have expected at least the subacute infarctions to be evident on the CT scan taken on 26 March 2009. (In fact, no infarcts were reported on that date.)

Dr Duflou's opinion as to the cause of death

[27] The defence called a forensic pathologist, Dr Duflou. He posited a theory in which Mr McCarthy was recovering from his injuries and discharged from the intensive care unit but then suffered a stroke resulting from his pre-existing heart disease: his cardiomyopathy and atrial fibrillation. (Dr Duflou considered Mr McCarthy had probably experienced the latter in the past, on the evidence of the old infarct and a scar in the kidney which might indicate previous embolic damage.) Cardiomyopathy resulted in inadequate contraction in the ventricles and the formation of blood clots, typically mural thrombi on the wall of the heart muscle. Atrial fibrillation also produced a much greater risk of blood clots being produced in the heart and resulting in embolic strokes.

[28] According to Dr Duflou, it was evident from the medical records that the primary problem which Mr McCarthy developed in the burns unit was not a respiratory problem but a loss of consciousness, which indicated that it was his brain which was affected. Dr Rudd, in describing the critical factors as respiratory failure and infection, had overlooked that loss of consciousness. Having suffered a stroke causing severe brain damage, Mr McCarthy's level of consciousness and mobility deteriorated; he developed deep venous thrombus and then the pulmonary emboli which killed him. If Mr McCarthy's condition had been improving, but he had quite separately suffered a stroke which caused significant deterioration in his condition, the burns were not the cause of his death.

[29] Importantly, Dr Duflou said, there was no evidence that Mr McCarthy had suffered from deep venous thrombus before his discharge from the intensive care unit. It followed that it was the stroke which caused the immobility, deep venous thrombosis in the legs and resulting pulmonary emboli. When echocardiograms were performed on 13 and 24 March, there was no sign of the patent foramen ovale, so deep venous thrombi were not the cause of the major stroke Dr Duflou posited; there was no means for the blood to travel from the lungs to the left side of the heart. With the post-stroke deep venous thrombosis and resulting pulmonary hypertension, however, the patent foramen ovale evident on the 28 March cardiogram opened up, allowing the blood to move through the heart.

[30] Dr Duflou's hypothesis was that the clot in the left ventricle which Dr Olumbe identified was a mural thrombus which had developed shortly before death. It was attributable to the presence of cardiomyopathy and supported his view that pre-existing heart disease was responsible for the formation of the clots, leading to embolic stroke. Dr Duflou conceded however, that because the clot had formed so

close to death, it was possible that it had moved from the right side of the heart into the left at a stage where there was movement between the sides of the heart.

[31] In cross-examination, Dr Duflou accepted that there had been no specific tests performed for deep venous thrombus or pulmonary embolism before 28 March 2009, although Mr McCarthy was monitored for those conditions. He acknowledged that, in the absence of testing, it was not possible for him to say whether or not deep venous thrombosis or pulmonary emboli had been present prior to 24 March.

[32] Dr Duflou agreed that there was no specific site identified on Dr Tannenberg's examination of the brain which would be typical of an infarct such as to cause immobility. He was asked whether he accepted Dr Tannenberg's evidence that the brain infarctions would have led to incoordination, not paralysis, and would only have been a part contributor to Mr McCarthy's immobility. He responded:

> "Look, he [Mr McCarthy] lost consciousness. He had a sudden deterioration of his Glasgow coma score. I think that needs to be explained. There was a suspicion - a clinical diagnosis of a brain stem infarct that would absolutely cause immobility and loss of consciousness. The fact that Dr Tannenberg, and for that matter, myself, didn't see specific lesions which are known to result in immobility doesn't mean they weren't there. Because clinically they were there. You know, the - I think that's the bottom line; they were there."

[33] Dr Duflou considered that the infarctions in the brain (other than the old infarct in the cerebellum) had occurred a week or more before death, although he accepted that the possibility that they had occurred after 26 March could not be excluded. The CT scan on 26 March indicated no infarction of the brain, in contrast with the MRI on 1 April, which had shown both acute and subacute cerebral infarcts. However, Dr Duflou observed that CT scans performed within the first few hours of a thrombotic or embolic stroke, or perhaps even within the first day or two, might not show damage. He pointed out that the pre-existing infarct identified by Dr Tannenberg was not evident in the earliest CT scans undertaken of Mr McCarthy's brain, although he recognised also that CT scans were not effective in displaying the area of the brain where that infarct was found.

[34] Dr Duflou acknowledged that in addition to his theory that the immobility which led to Mr McCarthy's fatal pulmonary embolism was the result of a stroke caused by his pre-existing cardiomyopathy and atrial fibrillation, there were two other possibilities: that Mr McCarthy's burns and their sequelae, resulting in his immobility, had caused deep venous thrombosis resulting in the development of pulmonary emboli which killed him; and that both sets of factors – the effects of immobility resulting from the burns and their treatment, and the effects of immobility resulting from stroke – had contributed substantially to Mr McCarthy's death.

The response to Dr Duflou's opinion

[35] Each of the pathologists appearing for the Crown was asked to comment on Dr Duflou's theory. Dr Olumbe said he did not regard Mr McCarthy's brain infarctions as the primary cause of death; they would have contributed to immobility, but it was the burns which were the primary factor. He did not agree

with the theory that stroke caused by clots formed in the left atrium and pumped to the brain was responsible for Mr McCarthy's immobility, because the pulmonary emboli produced by that immobility pre-dated the time at which Mr McCarthy was moved out of the intensive care ward.

[36] Dr Olumbe considered that most, if not all, of the clots which caused the brain infarcts emanated from the deep venous thrombus and moved from the right side of the heart to the left. Even if some left-sided clots had been dispatched to the brain, that would simply have worsened the situation: the pulmonary emboli had caused progressive deterioration which was compounded by the strokes Mr McCarthy experienced and his underlying cardiomyopathy. Dr Olumbe did not agree with Dr Duflou's view that the clot seen on histological examination had formed antemortem.

[37] Dr Ansford said that in order to assess Dr Duflou's theory, it was necessary to obtain the views of Mr McCarthy's treating doctors as to the degree of immobility he experienced prior to and during his final illness. He gave his reasons for considering that the clot Dr Duflou relied on as a mural thrombus had, in fact, formed post mortem. He agreed that the fact that mural thrombi were not seen post mortem did not mean that atrial fibrillation had not caused a stroke.

[38] In cross-examination, Dr Tannenberg agreed that he had made these observations in his written report:

> "Dr Duflou's theory as to stroke caused by mural thrombi leading to immobility and giving rise to DVT is entirely plausible. But as mentioned above, hospital and confinement to a bed or wheelchair, without much ambulation would be expected to be [a] predisposing factor to DVT."

Asked whether multiple cerebral infractions due to thromboemboli could have produced a contribution to Mr McCarthy's immobility, he agreed, but also said this:

> "[B]asically the infarcts that were there would not have paralysed. There would have still been movement available. So it would only be a contribution. It wouldn't be the kind of total contribution; it would only be a part contribution."

[39] Dr Rudd was asked about the possibility that Mr McCarthy had had a stroke on one of the days he was out of intensive care, which had caused the respiratory failure leading to his re-admission to the intensive care unit. He agreed it was possible, but said that it would be expected that there would be some signs of it. Re-examined, Dr Rudd said that it was possible that Mr McCarthy had a stroke so small that it was not visible on the CT scans on 26 March. It also was possible that the deterioration in Mr McCarthy's condition was the result of a pulmonary embolism or, alternatively, exhaustion which had led to respiratory failure. It was common that patients who had been maintained on ventilation would, over a one or two day period unventilated, become fatigued and unable to sustain their own respiratory functioning, discharge lung secretions and maintain their airways.

The "unreasonable verdict" ground

[40] Section 293 of the *Criminal Code* provides that:

> "...any person who causes the death of another, directly or indirectly, by any means whatever, is deemed to have killed that other person."

It was necessary in this case for the Crown to prove that the appellant's act in scalding Mr McCarthy's head and face with hot liquid was a substantial or significant cause of death or substantially contributed to the death.[1] The Crown had to exclude every reasonable possibility of innocence; but the existence of a very remote possibility would not necessitate a reasonable doubt of guilt.[2] It was also necessary that the Crown exclude the excuse of accident under s 23(1)(b). In the context of this case, that meant satisfying the jury beyond a reasonable doubt that an ordinary person in the appellant's position would reasonably have foreseen Mr McCarthy's death as a possible outcome of her actions.[3]

[41] The appellant argued that the jury could not be satisfied that the prosecution had excluded as a reasonable possibility Dr Duflou's theory of a heart condition – stroke – immobility – pulmonary embolism chain of events. It was based largely on undisputed facts. There was a dispute as to Dr Duflou's characterisation of the heart blood clot as antemortem, but that was not essential to his ultimate opinion. The other experts did not say that the theory was not worthy of credence.

[42] However, the other experts, while accepting that Dr Duflou's theory of stroke resulting in immobility was plausible, did not express any view that it could provide the sole explanation for Mr McCarthy's condition. To reach a view that the jury's verdict was unreasonable, it would be necessary to conclude that the Crown had failed to exclude Dr Duflou's hypothesis as describing the only substantial cause of death, because if the jury accepted his theory of stroke as a reasonable possibility, but remained satisfied of the substantial contribution of the sequelae of the burns, it would properly convict.

[43] But it was, in my view, open to the jury to reject parts of Dr Duflou's thesis. A significant component of it was that Mr McCarthy had suffered no deep venous thrombosis before his movement out of the intensive care unit. The jury was entitled, however, to accept Dr Olumbe's evidence that he had been able to date emboli in the lungs resulting from venous thrombi to before 24 March, and on that basis to reject Dr Duflou's reasoning. The theory further depended on the premise that the cause of Mr McCarthy's deterioration and further immobility was a stroke on 24 or 25 March while he was being nursed in the burns unit. That premise is at odds with Dr Rudd's evidence; while conceding the possibility of a stroke causing respiratory failure, he said that he would have expected to see some signs of it. He regarded respiratory failure as a predictable result of simple fatigue from the difficulty of maintaining an airway unventilated.

[44] More significantly, Dr Tannenberg's view of the acute and subacute infarcts apparent in the brain was that they might have produced incoordination and clumsiness, but they would not stop all movement; they might, at best, have contributed to Mr McCarthy's immobility. Dr Duflou conceded that neither he nor Dr Tannenberg had seen on post mortem examination of the brain any specific lesion which would result in immobility. He relied, instead, on the clinical significance of the deterioration in Mr McCarthy's consciousness as indicating that he must have had a stroke. There is an element of circular reasoning: attributing the clinically observable unconsciousness and immobility to a stroke because of the clinical signs of unconsciousness and immobility.

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1 *Royall v The Queen* (1991) 172 CLR 378 at 411 per Deane and Dawson JJ; *R v Sherrington* [2001] QCA 105 at [4] and [8].

2 *R v Summers* [1990] 1 Qd R 92 at 98-99.

3 *R v Taiters* [1997] 1 Qd R 333. (These events pre-dated the amendment of s 23 (1)(b) by s 4 of the *Criminal Code and Other Legislation Amendment Act* 2011, incorporating the *Taiters* test.).

[45] The jury was entitled to conclude from Dr Rudd's and Dr Tannenberg's evidence that Mr McCarthy had not suffered a stroke of such proportions as to render him immobile, independent of his burns-related problems. If they preferred that evidence, or Dr Olumbe's evidence that Mr McCarthy was already suffering from pulmonary emboli at the time he was moved out of the intensive care ward, it was open to them to reject as a reasonable possibility Dr Duflou's theory of stroke from pre-existing cardiac problems as the only substantial contributor to death.

[46] The appellant's second argument on this ground was that the possibility that Mr McCarthy would die from the application of hot water to his face was so remote or speculative that the prosecution could not negative the excuse of accident under s 23(1)(b). It was argued that it would not be sufficient that the injuries might reasonably have been foreseen to be life-threatening; it was necessary that they be reasonably foreseeable as fatal. The Crown case on causation had involved a complicated sequence of events involving the water entering Mr McCarthy's upper airway causing swelling which compromised his breathing, requiring his immobilisation which, in turn, caused deep vein thrombosis and, despite prophylaxis, the development of pulmonary emboli. The evidence did not, it was submitted, point to any other possible ways in which death might have occurred as a result of the burns. Dr Rudd had given evidence that it was "unlikely that [Mr McCarthy] would have died from [his head and facial burns] had he remained healthy in every other aspect".

[47] The argument was, in essence, that the chain of events leading to Mr McCarthy's death was, on the evidence, unique and hence was not foreseeable. However, there were apparent from the evidence, other scenarios in which severe burns might prove fatal. Dr Rudd said that Mr McCarthy was already suffering from hypothermia when he was found by the ambulance crew; suggesting a real prospect that he would have succumbed to his injuries without medical intervention. Dr Rudd also pointed out that Mr McCarthy's epiglottis was swollen because the water had entered his airway, and that a swollen epiglottis could cause airway obstruction and sudden death. Both he and the Toowoomba specialist were of the view that Mr McCarthy was likely to have died without intubation at the time he was first admitted to hospital. Dr Olumbe noted that burns inflicted on someone with a pre-existing heart disease could produce atrial fibrillation and also referred to the susceptibility to infection of someone who had suffered a burned airway because of the need for assistance in breathing and sedation, factors which would "certainly compromise one's life".

[48] There were, it seems, a number of pathways to possible death. It was not necessary that the actual mechanism of death be foreseeable, but this was not a case in which there was only a single particularly complicated set of events by which death might occur. The distinction which the appellant sought to draw between the foreseeability of the injuries proving life-threatening and of their proving fatal does not advance the argument. It is difficult to see how one would foresee the possibility of an individual's life being at risk without necessarily foreseeing the possibility of his death; but in any event the proposed gloss on the *Taiters* test is unhelpful.

[49] In my view, it was open to the jury to be satisfied beyond reasonable doubt of the general proposition that the death of an elderly man to whose face scalding water had been applied was a foreseeable outcome. It was, correspondingly, open to the jury on all the evidence to be satisfied beyond a reasonable doubt of the appellant's guilt of manslaughter.[4]

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4 *M v The Queen* (1994) 181 CLR 487 at 493; *MFA v The Queen* (2002) 213 CLR 606 at 615.

The ground concerning the accident direction

[50] The learned trial judge directed the jury in conventional terms that in order to conclude that the appellant killed Mr McCarthy, it was necessary that they find she did an act that was a substantial or significant cause of death or substantially contributed to it. As to the excuse of accident, her Honour directed the jury in these terms:

> "In order to convict, the Crown must satisfy you beyond reasonable doubt that an ordinary person in the defendant's position would reasonably have foreseen Mr McCarthy's death as a possible outcome of causing hot liquid to come into contact with the deceased's face, and in determining whether death would reasonably have been foreseen as a possible consequence, you disregard possibilities that are remote or speculative."

Her Honour, sayig that she would deal with causation and the medical evidence, went on to review in detail the medical treatment described by Dr Rudd and the evidence of the pathologists. The alternative hypotheses put forward by the pathologists were explained at length.

[51] The appellant submitted that the trial judge in giving that direction had not complied with her duty of instruction of the jury under s 620(1) of the *Criminal Code*. The section provides:

> "**620 Summing up**
>
> (1) After the evidence is concluded and the counsel or the accused person or persons, as the case may be, have addressed the jury, it is the duty of the court to instruct the jury as to the law applicable to the case, with such observations upon the evidence as the court thinks fit to make.
>
> ..."

Counsel adverted to McMurdo P's statement in *R v Mogg*:[5]

> "The onerous duties of a trial judge will ordinarily include identifying the issues, relating the issues to the relevant law and the facts of the case and outlining the main arguments of counsel."[6]

approved by McHugh J in *Fingleton v The Queen*:[7]

> "The court does not discharge that duty by merely referring the jury to the law that governs the case and leaving it to them to apply it to the facts of the case. The key term is 'instruct'. That requires the court to identify the real issues in the case, the facts that are relevant to those issues and an explanation as to how the law applies to the facts."[8]

[52] The appellant contended that the jury should have been instructed to consider the reasonable foreseeability of the chain of events which led to Mr McCarthy's death

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5 (2000) 112 A Crim R 417.
6 At 427.
7 (2005) 227 CLR 166.
8 At 197.

in determining whether accident had been excluded. They should have been directed that no other particular mechanism of death was suggested and reminded of Dr Rudd's opinion that it was unlikely Mr McCarthy would have died from the head and facial burns had he "remained healthy in every other aspect". It was also submitted that the jury should have been told it was not sufficient that an ordinary person would have foreseen a life-threatening injury; it was necessary that a fatal injury was foreseen.

[53] Defence counsel at trial (not counsel on the appeal) did not seek any re-direction from the trial judge, so the question is whether the appellant lost a real chance of acquittal from the trial judge's failure to say more on the subject. The effect of Dr Rudd's evidence was that burns did not exist in isolation; that they were worsened by hypothermia; that airway burns were apt to produce epiglottal swelling which could be fatal; that it was likely that Mr McCarthy would have died without intubation; and that there were the attendant problems of having to ventilate and sedate. To take out of that context what he said as to the burns to the face and head not being fatal per se would have been misleading. Nor would it have assisted the jury to attempt some distinction between what was life-threatening and what was fatal.

[54] As has already been outlined, there were a number of means apparent on the evidence by which severe burns might prove fatal. The chain of medical complications relied on by the Crown was explained in considerable detail in the context of causation. It would have been an error to suggest to the jury that they consider that series of events as the subject of what must be foreseen in the context of accident, because that was not the issue. The question for the jury was broader: whether a reasonable person would foresee death as a possible outcome of the act of applying the scalding water to Mr McCarthy. Her Honour put the issue correctly.

Conclusion

[55] The verdict was not unreasonable, and no miscarriage of justice by virtue of the direction on accident has been demonstrated. I would dismiss the appeal against conviction.

[56] **MUIR JA:** I agree that the appeal should be dismissed for the reasons given by Holmes JA.

[57] **APPLEGARTH J:** I have had the advantage of reading the reasons of Holmes JA which describe the complex expert evidence with great clarity. I agree with her Honour's analysis of the evidence, and her reasons as to why the appeal should be dismissed.

[58] On the issue of whether the Crown proved that the appellant caused Mr McCarthy's death, it was open to the jury to accept Dr Duflou's hypothesis that atrial fibrillation, unconnected with the incident in which Mr McCarthy was burnt, contributed to his immobility. However, if the jury accepted that hypothesis it could reasonably convict because it was satisfied beyond reasonable doubt that the appellant's act substantially contributed to his immobility. His immobility gave rise to deep vein thrombosis and caused the death.

[59] Pre-existing or coincidental atrial fibrillation may have contributed to Mr McCarthy's immobility according to Dr Duflou's theory. However, for the reasons which Holmes JA has given, the Crown excluded such a condition as being the only substantial cause of death in the circumstances. The conclusion that the appellant's

act also substantially contributed to the death or was a significant cause of death was open to the jury.

[60] The possibility raised by Dr Duflou that Mr McCarthy's fatal pulmonary thromboemboli was caused by a condition such as atrial fibrillation was "not sufficient to introduce a reasonable doubt precluding the jury from being satisfied to the requisite standard of the proof of guilt."[9] It was not sufficient because the evidence permitted the jury to reasonably conclude beyond reasonable doubt that the appellant's act was also a substantial cause of Mr McCarthy's immobility. The jury's verdict was not unreasonable.

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9 *R v Summers* [1990] 1 Qd R 92 at 99.