HIGH COURT OF AUSTRALIA

BELL, KEANE, NETTLE, GORDON AND EDELMAN JJ

WILLIAM RODNEY SWAN APPELLANT

AND

THE QUEEN RESPONDENT

Swan v The Queen
[2020] HCA 11
Date of Hearing: 13 February 2020
Date of Judgment: 18 March 2020
S291/2019

ORDER

Appeal dismissed.

On appeal from the Supreme Court of New South Wales

Representation

B J Rigg SC with T Quilter for the appellant (instructed by O'Brien Hudson Solicitors)

L A Babb SC with T L Smith SC and B K Baker for the respondent (instructed by Solicitor for Public Prosecutions (NSW))

CATCHWORDS

Swan v The Queen

Criminal law – Murder – Causation – Where appellant's assault caused serious injury to victim – Where victim suffered severe deterioration in quality of life as a consequence of assault – Where victim later suffered fractured femur requiring surgery – Where decision made not to undergo possible life-saving surgery – Whether sufficient evidence for it to be open to jury to convict on basis that low quality of life resulting from assault caused decision not to undergo surgery – Whether appellant's conduct a "substantial or significant cause of death" – Whether appellant legally responsible for death.

Words and phrases – "but for", "causation", "legal responsibility", "murder", "substantial or significant", "sufficiently substantial".

Crimes Act 1900 (NSW), s 18(1)(a).

BELL, KEANE, NETTLE, GORDON AND EDELMAN JJ.

Introduction

1 Mr Kormilets was a 78-year-old man living alone in a Department of Housing apartment in Redfern, New South Wales. He was an active man, in apparently good health, with a caring family. In the early hours of 15 April 2013, he was severely assaulted and robbed in his home by the appellant, a 31-year-old man, and the appellant's accomplice. Armed with a machete, the appellant entered through the balcony of Mr Kormilets' apartment, opened the front door for his accomplice, and then savagely attacked Mr Kormilets, intending to cause him grievous bodily harm. Mr Kormilets suffered immediate and severe injuries including to his brain, his face, his kidneys and his chest.

2 Mr Kormilets spent almost four months in hospital before being transferred to a high-level care facility in August 2013. His mental and physical condition was so poor that he was unable to undertake, or even to comprehend, any daily living activities. On 5 December 2013, he was discovered on the floor next to his bed facing downwards and moaning. Later that day he was transferred back to hospital, where x-rays showed that the neck of his left femur was fractured. His fractured femur was not operated on and he died in hospital from the consequences of the fracture on 10 December 2013.

3 The appellant and his accomplice were charged upon indictment for murder, as defined in s 18(1)(a) of the *Crimes Act 1900* (NSW). They were tried before a judge (N Adams J) and jury in the Supreme Court of New South Wales. The jury returned verdicts of guilty. Appeals to the Court of Criminal Appeal of the Supreme Court of New South Wales (Bathurst CJ, Hoeben CJ at CL and R A Hulme J) and, by special leave, to this Court were brought only by the appellant.

4 The central issue on appeal to the Court of Criminal Appeal was whether it was open to the jury to convict the appellant based upon one of the Crown's pathways to proving that the appellant caused the death of Mr Kormilets. In particular, the question was whether it was open to the jury to reason that the low quality of life caused by the assault was the reason that when Mr Kormilets presented to hospital with a fractured hip a decision was made not to undertake surgery that would reasonably have been expected to save his life, which, in turn, resulted in death. The Court of Criminal Appeal concluded that there was sufficient evidence for it to be open to the jury to reach a conclusion of causation by that route. On appeal to this Court, by grant of special leave, the appellant

challenges that conclusion. The conclusion of the Court of Criminal Appeal was correct. The appeal should be dismissed.

The evidence at trial and the Crown's three causation pathways

5 Mr Kormilets' general practitioner of over 20 years gave evidence that prior to the assault on 15 April 2013, Mr Kormilets lived a comfortable, healthy life. Although Mr Kormilets had a condition called polycythemia which gave rise to an increased risk of blood clots, this was managed with medication and posed no imminent danger to his health. In his autopsy it was also discovered that Mr Kormilets had severe coronary artery disease, with 75 per cent stenosis or blockage to the artery, and a tumour on his left kidney. But there was no evidence or suggestion that these had noticeably affected his lifestyle. His general practitioner described him as a "very fit man" and said that his medical problems were "pretty well managed". He had cared for his wife very well until her death in 2012. He cooked and cleaned for himself, managed his own financial affairs, and had a normal social life. Mr Kormilets was "quite clear in his mind" and "fairly intelligent" and enjoyed walking in the park and driving to Bondi, Coogee or Maroubra. He had a good relationship with his son, Mr Dmitri Zitserman[1], and with his grandchildren. He spoke little English but conversed in his native Russian language with those around him including Dmitri, his general practitioner, and his rabbi.

6 On 15 April 2013, after the assault, Mr Kormilets was admitted to the intensive care unit at St Vincent's Hospital. The attending doctor described him as suffering "severe traumatic life-threatening multi-system injuries". The injuries included multiple fractures of his ribs on both sides of the rib cage, lacerations of his spleen and right kidney, and fractures of his face. His severe chest injuries created difficulty for him to breathe so he underwent a tracheotomy of his throat and a "chest drain", which was a large tube that was inserted into his chest cavity to drain it of blood and other fluids to allow his lungs to reinflate. His general practitioner was "shocked" at Mr Kormilets' condition after his discharge from hospital and he observed how Mr Kormilets had almost completely lost the ability to swallow and was being fed food and medication through a tube.

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1 The materials before this Court spelled Mr Zitserman's first name in different ways. The Court of Criminal Appeal and the respondent spelled his name "Dmitri".

7 Dmitri visited Mr Kormilets almost every day. He said that Mr Kormilets was "put ... in a sleep" for the first month after the assault and that after Mr Kormilets was conscious, he would sometimes appear not to know Dmitri and there were relatives whom Mr Kormilets did not recognise. After a couple of months, Mr Kormilets' tracheotomy tube was removed but he was not able to eat successfully so, for the remainder of his life, he was "PEG fed" through a tube inserted into his stomach. He was doubly incontinent and needed to wear a nappy or continence pads. He was in bed most of the time and could only move around in a wheelchair or "gutter frame" with the assistance of two carers.

8 In July 2013, Mr Kormilets suffered an episode of aspiration pneumonia for which he was intubated and ventilated (a tube being placed down his windpipe and used to mechanically force air into his lungs). A note from St Vincent's Hospital, which bears the printed date of 2 September 2013, recorded the following:

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

9 On 1 August 2013, Mr Kormilets was discharged to a high-level care nursing home for patients requiring extensive physical and clinical support in all aspects of daily living. The nursing home notes referred to his acquired brain injury and observed that he was still fed through PEG feeding. He still had some ability to communicate, including in his native Russian with his son or his rabbi acting as a translator. But the overwhelming evidence was of severe cognitive decline and inability. Mr Kormilets' general practitioner said that Mr Kormilets had lost the ability to communicate properly, to express himself, and to relate to people. On 28 August 2013, his cognitive and verbal skills were assessed as being in the worst category. Care staff required special instructions to speak to him including "[s]tand directly in front of resident, [r]epeat messages until heard, [u]se hand gestures as required". Eventually his cognitive ability became so poor that he could no longer understand how to brush his teeth.

10 Reports from the nursing home that were produced between September and December 2013 showed that Mr Kormilets was "[u]nable to physically undertake any daily living activities" and "[u]nable to mentally comprehend and undertake daily living activities". He needed supervision while he was seated and required the assistance of two staff members to move between his bed and a chair or to go to the toilet. He was described in the following terms: "[c]onstantly physically agitated" at numerous times every day; having incontinence of both

urine and faeces; having "[u]nsteady hands or fingers", an "[u]nsteady gait", and "[p]oor coordination"; and "lack[ing] understanding for [his] personal safety", "forget[ting] to use [his] mobility aid", and "attempt[ing] to get up from bed ... and walk to another area unaided". A verbal behaviour assessment recorded "[p]ain", "[w]anting to get out of bed", "[c]ommunication issues", and "[v]erbal refusal of care". Mr Kormilets was also recorded as "refusing any oral intake orassessment [sic]".

11 While in the nursing home he was described by a social worker as a "[h]igh falls risk" because he "tries to mobilise on his own". On 30 November 2013, Mr Kormilets fell in the lounge area of the nursing home and was found on the floor. Prior to being discharged to the nursing home, Mr Kormilets had also suffered a series of falls from his hospital bed when he tried to get out of bed or to get up from a chair.

12 On 5 December 2013, at around 1.40 pm, Mr Kormilets was found next to his bed facing downward and moaning. Three staff moved him back to his bed, but by 4.00 pm he was unwell and appeared to acknowledge that he was dizzy. His condition declined and he was transferred to the Prince of Wales Hospital. A note on the transfer form said that he had "rolled out of a Lo Lo bed".

13 On 6 December 2013, handwritten clinical notes from the Prince of Wales Hospital, which were Exhibit AG at trial, recorded as follows:

> "Thanks for consult.
> 78 yo [male] pw 2/7 of L hip
> pain following fall @ NH
> admitted c. aspiration pneumonia
> XRAY displaced subcapital NOF #
> Will require surgical intervention
> once stabilised medically
> D/Q Dr (??) (?) close to
> review. Not for OT this weekend."

The clinical notes also contained the following additional handwritten notes, apparently also made on 6 December 2013:

> "(5) Decision re palliative v operative
> – wife's number disconnected → actually deceased
> – got a hold of son, Dimitry. Feels pt deteriorated significantly since Aug.

Agrees c. previous discussions documented by St Vincent's that pt is not for invasive Rx but for a trial of poabs.

I updated him on the # NOF, possible IC blood / stroke + rapid AF + possible aspiration sepsis. Furthermore he may very well have an underlying malignancy c. bone metastases (+/- this NOF being a pathological #).

Dimitry agreed pt should be for comfort care. Would still like poabs via PEG.
Agreed not for IV fluids.
Agreed for prn morphine, midaz + hyoscine.
Agreed for non-surgical Rx.

Plan, - Cease non essential meds
- poabs via PEG
- Cease IVF
- Oral + PAC.
- Happy to speak to son when he comes in.

In the event of expiration, death cert should read:
Part (1) a – Aspiration sepsis (days)
b – Fractured neck of femur (days)
Part (2) Traumatic brain injury, frailty, atrial fibrillation, recurrent aspiration pneumonia."

14 Consistently with a palliative decision referred to in the clinical notes, no operation was conducted upon Mr Kormilets. In her closing address to the jury, the Crown prosecutor said that "it had been decided that there wouldn't be such intervention ... not because of the tumour on the kidney, but because of his terrible state in every other way".

15 Mr Kormilets died on 10 December 2013. The intern at the Prince of Wales Hospital who completed the death certificate reported on it that the cause of death was aspiration sepsis (to which the clinical notes on 6 December 2013 had also referred) and a fractured neck of the femur. She described other conditions contributing to the death as traumatic brain injury, frailty, atrial fibrillation and recurrent aspiration pneumonia. Professor Cordner, a professor of forensic pathology, said that each of these "debilities", as defence counsel described them, contributed to death to an unknown extent.

16 The evidence from the death certificate about cause of death was contradicted by evidence from Dr Bailey, the specialist forensic pathologist who conducted the post mortem. Dr Bailey said that there was no evidence of aspiration pneumonia or aspiration sepsis in the sections of the lungs that she tested. She explained that the death was caused by respiratory failure. The respiratory failure was the result of fat emboli being released into the blood stream from the high fat content of bone marrow after the fracture of the left femur. Those fat emboli moved to the lungs and compounded Mr Kormilets' pre-existing respiratory failure due to "blunt force injury of the chest". She described as "relatively certain" findings from a microscopic examination of lung tissue of "widespread fat emboli in the lungs".

17 There was considerable medical evidence given at trial concerning the cause of the fracture to Mr Kormilets' left femur. The Crown case relied, as one alternative, upon the fracture being caused by Mr Kormilets falling down. The Crown pointed to Mr Kormilets' agitation, his inability to communicate, the high risk of him falling, and his previous falls. In contrast with the position of the Crown, counsel for each of the accused men raised the possibility that the fracture had not been caused by a fall. Their position was that the fracture might have been pathological, arising independently of the injuries from the assault or any external force, but caused by the metastasis of a 60 mm tumour that Dr Bailey had discovered on Mr Kormilets' left kidney during the autopsy.

18 There was some evidence that supported the position of the accused men that pathological fracture was a possibility. Dr Bailey said that she could not exclude this possibility although she did not see any evidence of metastasis. Dr Watson, a histopathologist, gave evidence that metastasis would likely occur first in the lungs before the bones. However, Dr Watson also said that it was not possible to exclude fully the possibility of metastasis in the left femur even without evidence of metastasis in the renal vein or lungs. Professor Fox, an oncologist, said that metastasis to the bone commonly presents in x-rays as a discrete hole or as a thinning of the bone. However, although Mr Kormilets' left femur had no visible hole or thinning, Professor Fox also could not exclude the possibility that the fracture was pathological, caused by metastasis. The strongest position on the possibility of a pathological fracture was taken by Professor Cordner, who described it as a "reasonable possibility" and said that it was one "that I can easily conceive of and I think should be taken into account".

19 Evidence was also given concerning the need for surgery and the possible success of surgery. As to the need for surgery, Dr Bailey accepted that fractures such as the one that Mr Kormilets suffered required surgical intervention in every

case and Professor Cordner said that the failure to treat surgically a fractured femur in a 78-year-old man would "probably be fatal".

20 As to the possible success of surgery, Dr Bailey's evidence was that surgical treatment would usually produce a positive outcome for a patient of Mr Kormilets' age. Professor Fox described treatment of hip fractures in elderly people as generally successful. Professor Cordner went further. He was asked whether a hip replacement for a broken femur would be undertaken on a 78-year-old man with an undiagnosed carcinoma of the kidney, polycythemia and "a bit of" coronary atherosclerosis. In other words, he was asked whether Mr Kormilets' medical conditions that existed independently of the assault could have prevented successful surgery. Professor Cordner's answer was that in the ordinary course of events Mr Kormilets would get surgery and his hip replaced, although he noted that Mr Kormilets had more than a "bit" of coronary atherosclerosis; he had a 75 per cent occlusion of one of the coronary vessels. Professor Cordner later clarified that this 75 per cent occlusion would not lead to refusal of surgery. In any event, this occlusion was only discovered during the autopsy so whilst it may have been a relevant factor to consider in assessing the success of any hypothetical surgery it could not have contributed to the reasons for deciding against surgery.

21 In an admirably clear and succinct submission, senior counsel for the appellant described the three causation pathways relied upon by the Crown in closing submissions to support a conclusion that the appellant had caused the death of Mr Kormilets. They were as follows:

(1) The assault by the appellant caused injuries to Mr Kormilets' lungs and respiratory system. After Mr Kormilets fractured his hip, his respiratory failure was caused by the fat emboli that travelled to his lungs compounded with the pre-existing lung injury. This causation pathway relied upon the evidence of Dr Bailey.

(2) The assault by the appellant caused injuries to Mr Kormilets that reduced his cognitive ability and created a propensity for him to fall. If the fracture to the hip resulted from a fall, and was not pathological, then the jury could conclude that the assault caused the fall and, thus, caused the fracture. The assault was therefore a substantial cause of Mr Kormilets' death when the fat emboli travelled to his lungs as a result of the fracture.

(3) The assault by the appellant caused injuries to Mr Kormilets that resulted in a low quality of life for him. This low quality of life was the reason that when Mr Kormilets presented to hospital with a fractured hip a decision

was made not to undertake surgery. Mr Kormilets died as a result of that decision because the lack of surgery permitted the fat emboli to travel to his lungs.

22 The first two pathways were not controversial in this Court. The focus was upon the third.

Causation of death and the trial judge's directions

23 Section 18(1)(a) of the *Crimes Act 1900* (NSW) provides for the circumstances in which murder shall be taken to have been committed. Those circumstances relevantly include "where the act of the accused, ... causing the death charged, was done ... with intent to ... inflict grievous bodily harm upon some person".

24 There was no dispute on this appeal that the requirement that the act of the accused cause the death charged required the jury to be satisfied that the act of the accused was "a substantial or significant cause of death" or a "sufficiently substantial" cause. That formulation, derived from *Royall v The Queen*[2], recognises that boundaries must be drawn for legal responsibility; not every act that is necessary for death to occur is sufficient for the imposition of legal responsibility for the death[3].

25 It was also recognised in *Royall v The Queen*[4] that there are some cases where an accused will be legally responsible for a death even if the act of the accused was not, by itself, necessary for the victim's death but was instead "one of the conditions which were jointly necessary to produce the event". An exceptional example where an accused might be held legally responsible for the death of another even if the act of the accused was not by itself necessary for

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2 (1991) 172 CLR 378 at 411-412, see also at 398, 423, 442. See also *Osland v The Queen* (1998) 197 CLR 316 at 325 [16]; *Patel v The Queen* (2012) 247 CLR 531 at 553 [75]; *Gillard v The Queen* (2014) 88 ALJR 606 at 612 [24]; 308 ALR 190 at 197.

3 *Timbu Kolian v The Queen* (1968) 119 CLR 47 at 68-69, quoting Pollock, *The Law of Torts*, 6th ed (1901) at 36; *Royall v The Queen* (1991) 172 CLR 378 at 411, 423, 440, 448.

4 (1991) 172 CLR 378 at 441.

the victim's death is where a victim "dies from the combined effects of ... two wounds", either of which would have been sufficient for death but only one of which was inflicted by the accused[5].

26 The directions of the trial judge concerning causation were not controversial in the courts below and this Court refused leave to amend the notice of appeal to introduce a ground of appeal impugning the trial judge's directions on causation. The trial judge addressed causation in a simple and clear direction to the jury that causation could be satisfied by acts of the appellant that "substantially contributed" or "significantly contributed" to the death of Mr Kormilets. No issue was taken with this direction when the matter was raised with counsel by the trial judge. There was no dispute about it on appeal to the Court of Criminal Appeal, nor is there any issue concerning that direction in the extant grounds of appeal before this Court.

27 The trial judge told the jury that causation was a "live issue" in the trial. Her Honour directed the jury that an essential element of the Crown case for murder was to prove beyond reasonable doubt that a voluntary act of the appellant caused the death of Mr Kormilets. The trial judge said that causation, by substantial or significant contribution to the death of Mr Kormilets, did not require that the acts of the appellant were the only cause of death, the most important cause of death or even the only important cause of death. She directed the jury to consider all the facts including the evidence of the injuries, the evidence of Mr Kormilets' condition before and after the assault, and all the evidence from the experts, which she described in detail including the significant body of evidence concerning whether the fracture might have been pathological, "when deciding whether to attribute legal responsibility" to the appellant.

The Court of Criminal Appeal decision and the central issue in this Court

28 The appellant relied upon two grounds of appeal in this Court and sought leave to amend to raise a third which had not been the subject of the grant of special leave to appeal to this Court.

29 The first ground of appeal raises the same issue as the sole ground of appeal to the Court of Criminal Appeal. That issue is whether a miscarriage of justice occurred because the Crown case on cause of death, as articulated in the

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5 *Burrage v United States* (2014) 571 US 204 at 215.

prosecutor's closing address, left open the third path of causation reasoning, a path which the appellant submits was not open to the jury on the evidence.

30 The appellant's second ground of appeal in this Court asserts that the Court of Criminal Appeal failed to consider the appellant's sole ground of appeal. In this Court, the appellant relied upon two paragraphs in the reasons of the Court of Criminal Appeal to submit that the Court of Criminal Appeal had addressed the wrong question, namely whether it was open to the jury to find that the surgery "could not" happen. The appellant submitted that the correct question raised by the ground of appeal was whether, on the Crown's third causation pathway, it was open to the jury to find that surgery could have prevented death but was not undertaken due to the appellant's low quality of life as a consequence of his injuries from the assault on 15 April 2013.

31 In oral submissions in this Court, senior counsel for the appellant accepted that the first ground of appeal was the determinative issue and that success on the appeal would depend on the first ground. The second ground of appeal can be dismissed briefly.

32 In the passages relied upon by the appellant, Bathurst CJ said that the jury was entitled to conclude that "but for the earlier injuries, [Mr Kormilets] could have been treated" and that "a significant reason for the inability to surgically treat the fracture was the consequence of the injuries suffered from the assault"[6]. The comments by Bathurst CJ were responding to the appellant's submissions to the Court of Criminal Appeal that "the focus of the Crown case on causation ... was the decision to not operate" and that the third pathway to causation was not open to the jury because there was "no evidence about why the decision was made not to operate". Prior to the two comments in his reasons, Bathurst CJ had referred to the Crown submission that an inference was available that a decision not to proceed with surgery had been made due to the low quality of life of Mr Kormilets resulting from his injuries from the assault[7]. After the second comment, the Chief Justice said that the conclusion that the hospital was unable to operate was supported by evidence including the "not for resuscitation" decision made while Mr Kormilets was at St Vincent's Hospital and "the ultimate decision not to operate at Prince of Wales Hospital, which referred back to the

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6 *Swan v The Queen* [2018] NSWCCA 260 at [93], [99].

7 *Swan v The Queen* [2018] NSWCCA 260 at [83].

earlier decision made at St Vincent's Hospital"[8]. In that context, it is clear that the Chief Justice was not describing a surgical inability to operate but was instead referring to an inability to operate due to the refusal of consent to an operation. He held that the jury was entitled to conclude that the refusal of consent was caused by Mr Kormilets' injuries from the assault. He did not fail to address the appellant's ground of appeal.

33 In written and oral submissions before this Court, the appellant sought leave to amend his grounds of appeal to include a third ground alleging that the trial judge failed adequately to identify the issues relevant to causation and to relate the law and evidence with respect to causation to those issues. However, no further directions on causation had been sought from the trial judge. As Bell J said during the hearing, there was a forensic reason for the appellant not to seek further directions on causation. This forensic reason is that the defence is likely to have thought it unattractive to have the trial judge focus more closely on the third pathway. The attention of the jury had been directed in some detail to the capacity of the prosecution to exclude pathological fracture as a reasonable possibility. As explained above, there was a body of evidence upon which the appellant relied to suggest a reasonable possibility of pathological fracture. Further directions on causation might have distracted the jury from this defence case. The likelihood of that being the reason is fortified by the fact that the ground was not raised before the Court of Criminal Appeal. Leave to amend was therefore refused by this Court.

34 The only issue remaining before this Court is whether it was open to the jury to convict the appellant based upon the Crown's third pathway to causation.

Was the Crown's third pathway to causation open to the jury?

35 For the appellant to succeed in establishing that the third causation pathway was not open to the jury, being the "constitutional tribunal for deciding issues of fact"[9], it is necessary that there was no evidence sufficient to support a conclusion of causation by that pathway. The ground of appeal must be dismissed "if there is evidence (even if tenuous or inherently weak or vague)

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8 *Swan v The Queen* [2018] NSWCCA 260 at [100].

9 *R v Baden-Clay* (2016) 258 CLR 308 at 329 [65], quoting *Hocking v Bell* (1945) 71 CLR 430 at 440.

which can be taken into account by the jury in its deliberations and that evidence is capable of supporting a verdict of guilty"[10].

36 The appellant submitted, without dispute, that the third causation pathway required three conclusions to be open to the jury on the evidence: (1) surgery upon Mr Kormilets was available and would reasonably have been expected to be able to save his life; (2) Mr Kormilets or Dmitri made a decision that such available surgery should not be undertaken; and (3) the decision was motivated by Mr Kormilets' low quality of life due to the assault rather than due to other, unrelated considerations. Each of these steps can be considered in turn.

(1) Surgery would reasonably have been expected to save Mr Kormilets' life

37 Neither at trial, nor before the Court of Criminal Appeal, nor before this Court was it suggested that the Crown needed to prove that it was certain or nearly certain that surgery would have been successful in order to satisfy the third causation pathway. The appellant's submission was instead premised upon the Crown being required to prove that surgery would reasonably be expected to have saved Mr Kormilets' life. For two reasons, it was open to the jury to draw this inference from the evidence.

38 First, although, curiously, none of the treating physicians or surgeons from the Prince of Wales Hospital was called by the Crown to give evidence about the prospects or expectations of successful surgery, the handwritten clinical notes from the Prince of Wales Hospital, made on 6 December 2013, support an inference that there was an expectation of success by the unqualified statement that Mr Kormilets "*Will* require surgical intervention once stabilised" (emphasis added).

39 Secondly, there is the evidence of Dr Bailey, Professor Fox, and Professor Cordner that surgical treatment would usually be successful for a person of Mr Kormilets' age. Professor Fox gave evidence that a patient of 78 years of age who had a renal carcinoma but was otherwise healthy would ordinarily undergo a "pretty quick surgical procedure" and recover to the degree of being mobile, "which is a palliative mobilisation", and that if he was in a position to refer them for surgery, he would do so. And, as explained above, in cross-examination Professor Cordner went further still, saying that a person in

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10 *Doney v The Queen* (1990) 171 CLR 207 at 214-215.

Mr Kormilets' condition "would get, in the ordinary course of events, surgery and his hip replaced". The context of the question, which was apparent from previous questions, was the exploration of reasons why surgery was not undertaken. It invited qualification by Professor Cordner if there were real prospects that surgery might not be successful. No qualifications of that kind were made by Professor Cordner. The natural inference from his evidence was that surgery upon Mr Kormilets would reasonably have been expected to be successful.

(2) Mr Kormilets or Dmitri made a decision not to undertake such available surgery

40 The appellant submitted that there was a paucity of evidence from which the jury could have inferred that a decision was made by Mr Kormilets, or by his son, that surgery not be undertaken because of the disabilities Mr Kormilets suffered due to the assault. Although Dmitri was called by the Crown and gave evidence he was not asked about the decision not to operate either in examination in chief or in cross-examination. However, in circumstances in which the jury could have concluded that there was a reasonable expectation that surgery would be successful, there was evidence which, in combination, was sufficient for the jury to have concluded that a decision not to operate was made by either Mr Kormilets or Dmitri.

41 First, the likelihood of such a decision being made by either Mr Kormilets or Dmitri, despite the reasonable expectation that surgery would be successful, is supported by the evidence of the extraordinarily poor quality of life for Mr Kormilets, his agitation and frustration, the pain that he was experiencing, and the records of his communicated refusal of care and refusal of assessment. Underlying these matters was his inability to undertake, or to mentally comprehend, any daily living activities; his inability to communicate properly, to express himself, and to relate to people; his inability to eat without a PEG tube; his double incontinence; and his confinement to a bed for most of the time.

42 Secondly, there was evidence to support an inference that a decision had been made by Dmitri and that this decision was considered, and given weight, by the attending doctors at the Prince of Wales Hospital. Neither at trial nor on appeal to the Court of Criminal Appeal or this Court was it suggested by the appellant that Dmitri might have lacked formal legal authority to make this decision and that the absence of such formal authority prevented the appellant being responsible for the death of Mr Kormilets.

43 As explained above, the notes comprising Exhibit AG record that a decision whether to undergo "palliative v operative" care was made by or with

Dmitri. Further, the note from St Vincent's Hospital, with the printed date of 2 September 2013, had described the instructions from Dmitri after the episode of aspiration pneumonia that if another, similar episode were to occur then his father should not be resuscitated. The note had described the "not for resuscitation" order as "signed and ... official and can be found in the notes".

44 In this context, the natural inference to be drawn from the clinical note on 6 December 2013 recording the "[d]ecision re palliative v operative", saying that the writer "got a hold of son, Dimitry. Feels pt [Mr Kormilets] deteriorated significantly since Aug" and also saying that Dmitri "agreed pt should be for comfort care" and "[a]greed for non-surgical Rx", is that a positive decision was made by Dmitri in consultation with doctors for palliative care rather than to operate.

(3) The decision was motivated by Mr Kormilets' low quality of life due to the assault

45 The appellant submitted that a decision might have been made due to any or all of the following matters, which were not excluded by the Crown beyond reasonable doubt: (i) a mistaken belief that Mr Kormilets was suffering from aspiration sepsis, the treatment for which, by intubation and ventilation, would be distressing for him; (ii) the prospect of ongoing pathological fractures from the cancer; (iii) the potential for Mr Kormilets not to be sufficiently stabilised for surgery, and the distress that stabilisation might involve; (iv) the effect of his multiple health conditions meaning that there was a poor prospect of him living for any length of time after surgery; or (v) the "not for resuscitation" note being made contrary to the wishes of Mr Kormilets or misunderstood or misrepresented by the doctor at the Prince of Wales Hospital.

46 As explained earlier in these reasons, there was no dispute at trial, on appeal to the Court of Criminal Appeal, or on appeal to this Court that the appellant would be legally responsible for the death of Mr Kormilets if his assault upon Mr Kormilets substantially or significantly contributed to Mr Kormilets' death. It was never suggested that the jury should, or could, have filleted the factors within the decision-making process to attempt to isolate the relative contribution of some or all of the five matters above upon which the appellant relied. Instead, on the undisputed direction given by the trial judge, it was sufficient that the effects of the assault substantially or significantly contributed to the decision which, in turn, on the third causation pathway, prevented the surgery that was reasonably expected to save Mr Kormilets' life.

47 The inference is irresistible that the decision was taken to treat palliatively rather than surgically based substantially or significantly upon the persistent, long-term, and catastrophic effects of the assault. Even putting to one side the persistent physical effects of the assault, the cognitive decline suffered by Mr Kormilets, leading to his inability to communicate properly, to express himself, and to relate to people, was described by his general practitioner as the "most important thing". As Professor Cordner said in examination in chief, Mr Kormilets' "severe cognitive decline" as a result of the assault was operative at the time of his death.

Conclusion

48 The appeal should be dismissed.