IN THE COURT OF APPEAL OF THE REPUBLIC OF SINGAPORE

[2017] SGCA 10

Civil Appeal No 57 of 2016

Between

(1) Quek Kwee Kee Victoria (Executor of the Estate of Quek Kiat Siong, deceased)
(2) Ker Kim Tway (Executor of the Estate of Quek Kiat Siong, deceased)

… *Appellants*

And

(1) American International Assurance Company Ltd
(2) AIA Singapore Pte Ltd

… *Respondents*

JUDGMENT

[Insurance] – [Accident Insurance]

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Quek Kwee Kee Victoria (executor of the estate of Quek Kiat Siong, deceased) and another
v
American International Assurance Co Ltd and another

[2017] SGCA 10

Court of Appeal — Civil Appeal No 57 of 2016
Sundaresh Menon CJ, Chao Hick Tin JA, and Andrew Phang Boon Leong JA
28 October 2016

2 February 2017 Judgment reserved.

Sundaresh Menon CJ (delivering the judgment of the court):

Introduction

1 On the morning of 4 August 2012, Mr Quek Kiat Siong ("the Deceased"), aged 50, was found lying unresponsive on his bedroom floor. He was rushed to the hospital and pronounced dead shortly after. The forensic pathologist subsequently reported that the Deceased's death was caused by "multi-organ failure with pulmonary haemorrhage, due to mixed drug intoxication".

2 The Appellants are the executors of the Deceased's estate ("the Estate"). In Suit No 820 of 2014 ("S 820/2014"), the Appellants claimed against the Respondents, insurance companies that had insured the Deceased under two personal accident insurance policies. The Respondents deny that the

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Deceased's death was accidental. The central question before the High Court judge ("the Judge") was whether the Deceased had consumed certain medicinal drugs expecting to die as a result of the fatal adverse reaction that ensued.

3 In *Quek Kwee Kee Victoria (executrix of the estate of Quek Kiat Siong, deceased) and another v American International Assurance Co Ltd and another* [2016] 3 SLR 93 ("the Judgment"), the Judge dismissed the Appellants' claim, holding that the Deceased had consumed overdoses of at least three drugs, and that as a result, his death was not an accident entitling the Estate to payment under the insurance policies. The Judge concluded that the Deceased consumed more than the prescribed dosage of drugs and she appeared to have thought that because the Deceased intended to consume the drugs that he did, he must be taken to have expected the consequences that flowed from this even though she seemed also not to find any specific intention on his part to commit suicide. The Appellants have brought the present appeal against the Judge's decision.

Background facts

The parties and the background to the dispute

4 The 1st and 2nd Appellants are the executors of the Deceased's estate. The 1st Appellant, Ms Quek Kwee Kee Victoria, is the Deceased's elder sister, while the 2nd Appellant, Mr Ker Kim Tway, is the Deceased's nephew.

5 The 1st and 2nd Respondents are insurance companies. The Deceased purchased two insurance policies with the 1st Respondent in September 2001 and November 2008. These policies will be referred to in this judgment respectively as "the PA Policy" and "the Platinum Policy", and collectively as

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"the Insurance Policies". Under the Insurance Policies, the 1st Respondent agreed, subject to certain conditions, to pay the total sum of $1.2m if the Deceased sustained an injury in an accident that resulted in the loss of his life. The assured sum under the PA Policy and Platinum Policy for loss of life indemnity was $200,000 and $1m respectively. In 2012, these polices were transferred to the 2nd Respondent. It is therefore the 2nd Respondent that is liable under the Insurance Policies, and accordingly, the 1st Respondent is not an active participant in the present proceedings. Unless otherwise specified, any reference to the Respondent in this judgment is a reference to the 2nd Respondent.

6 After the Deceased's death, the Appellants presented their claim under the Insurance Policies. On 30 January 2013, the Respondent informed the 1st Appellant that the claim was not payable because the coroner had found that the Deceased had committed suicide. Subsequently, on 21 May 2014, the Respondent further notified the Appellants' solicitors that under the policies, the Deceased "must have sustained bodily injury in an accident before the sum assured is payable". As there was "no evidence of an injury sustained in an accident", the Respondent maintained its position that the assured sums were not payable to the Estate.

7 On 31 July 2014, the Appellants commenced S 820/2014.

The Deceased's circumstances and the events surrounding his death

8 The Deceased was the fourth-youngest in a family of sixteen siblings. Despite this, he played a leading role in the family business, Kway Guan Huat Joo Chiat Popiah & Kueh Pie Tie, which involved the manufacture and sale of *popiah*. The business was located at Joo Chiat Road, which also served as the

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Deceased's residence for most of his life and will be referred to in this judgment as "the Joo Chiat house". The Deceased never married, and lived for most of his life in the Joo Chiat house with the 1st Appellant and a younger sister, Ms Quek Siew Kim ("Siew Kim").

9 The Deceased suffered from severe chronic back pain due to his years of carrying heavy loads of flour in the course of working in the *popiah* business. He had also suffered a number of falls in the Joo Chiat house – an old shop-house which has been described as being in a "dilapidated" condition – and these too evidently contributed to and exacerbated his back injury. In July 2009, the Deceased consulted Dr Yeo Sow Nam ("Dr Yeo"), a pain specialist, in connection with his chronic back pain. At the time of his first consultation, the Deceased scored his pain as 10/10. He complained of severe lower back pain shooting to his legs and reported that he was only able to sit for 30 minutes at any one time.

10 The Deceased also developed insomnia, depression, and anxiety. To better deal with these issues, Dr Yeo referred the Deceased to Dr Ang Yong Guan ("Dr Ang"), a psychiatrist, in early 2010. In Dr Ang's assessment, because of his chronic back pain, the Deceased was unable to carry out many manual tasks, and this affected the Deceased adversely. As a "highly responsible man" imbibed with "a lot of traditional Chinese values such as diligence, loyalty and commitment", the Deceased's inability to undertake some of the things he had commonly done in the course of his business had caused him to develop symptoms of depression with anxiety and insomnia.

11 Between 2009 and 2012, the Deceased was hospitalised on various occasions for the treatment of his physical and psychological ills. From around early 2012 to the middle of that year, the Deceased was also embroiled in a

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legal dispute with his brother which, as the Deceased's physicians observed, became for him an additional source of stress.

12 On 2 July 2012, after two bad falls, the Deceased admitted himself to Mount Elizabeth Novena Hospital for the treatment of his back pain by Dr Yeo. At the same time, the Deceased was co-managed for his depression by Dr Ang. After two weeks in hospital, he was well enough to go home during the day, only returning to the hospital to rest at night. During his period of hospitalisation, the Deceased purchased two second-hand luxury cars on 17 and 19 July 2012. He was eventually discharged on 31 July 2012. Upon discharge, the Deceased was prescribed 14 different types of medicine by Dr Ang and Dr Yeo. A summary of the types and quantities of medication that the Deceased was prescribed and issued upon discharge is set out below:

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Table of the Deceased's prescribed medication

S/No.	Prescription	Indications	Dosage
Medication prescribed by Dr Ang (6 months' supply)			
1	Mirtazapine	Anti-depressant	2 tablets (30mg/tab) every night
2	Quetiapine	Anti-psychotic	2 tablets (100mg/tab) every night
3	Bromazepam	Anti-anxiety	1 tablet (3mg/tab) 2 times a day
4	Zolpidem	Hypnotic	2 tablets (12.5mg/tab) every night
5	Olanzapine	Anti-psychotic	1 tablet (10mg/tab) every night
6	Duloxetine	Anti-depressant	1 capsule (60mg/tab) 2 times a day
7	Diazepam	Hypnotic	1 tablet (10mg/tab) every night
8	Midazolam	Hypnotic	1 tablet (15mg/tab) every night
Medication prescribed by Dr Yeo (6 weeks' supply)			
9	Oxycodone	Pain	1 tablet (20mg/tab) every morning or nil and only as breakthrough

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10	Hydromorphone	Pain	1 tablet (16mg/tab) 2 times a day
11	Sennosides	Laxative	2 tablets (7.5mg/tab) 2 times a day
12	Pregabalin	Pain	2 tablets (150mg/tab) 2 times a day
13	Rabeprazole-Na	Gastric	1 tablet (20mg/tab) every morning
14	Atorvastatin	Cholesterol	1 tablet (20mg/tab) every night

13 In all, the Deceased was discharged from hospital with around 2,500 tablets. Of these drugs, bromazepam, duloxetine, mirtazapine, and olanzapine were found to be elevated in the Deceased's post-mortem blood samples (see [17] below). Whilst the Deceased had been on most of these medicines prior to his hospitalisation in July 2012, duloxetine had been introduced to the Deceased only a few months earlier in March 2012 and sennosides and atorvastatin were introduced during the period of hospitalisation in July 2012. Changes were also made to the prescribed dosage of some of these medicines during the Deceased's hospitalisation. In particular, the prescribed dosages of mirtazapine, quetiapine, bromazepam, and zolpidem were doubled during the Deceased's hospitalisation. Diazepam was also added to the Deceased's regime of medication upon his discharge.

14 The Deceased spent the first two nights following his discharge (31 July and 1 August 2012) at the Joo Chiat house. He then spent the next two nights (2 and 3 August 2012) at his family's property at 35C Everitt Road

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("the Everitt house"). The Appellants' position is that the Deceased had relocated to the Everitt house on the advice of Dr Yeo and also his own family members so as to avoid any further falls in the Joo Chiat house. One room in the Everitt house was leased to one Mdm Chee Wai Lian ("Mdm Chee"). Another room was occupied by one of the Deceased's nephews, Mr Lucas Lim ("Lucas"), and his girlfriend.

15 In the evening of 3 August 2012, Siew Kim walked the Deceased from the Joo Chiat house to the Everitt house. Between 8.00 pm to 9.00 pm, Mdm Chee spoke to the Deceased in the sitting room of the Everitt house. In a closed-circuit television ("CCTV") clip, the Deceased was also seen moving about the Everitt house, tending to his plants and moving furniture up the stairs. Lucas was the last person to see the Deceased alive at about 11.00 pm on 3 August 2012.

16 At about 10.00 am the next day, Lucas entered the Deceased's bedroom and found the Deceased lying on the floor between the bed and the bathroom with vomitus and blood on the floor near him and around his mouth. An ambulance arrived at about 10.43 am, and the paramedics noted that the Deceased was unresponsive, had no pulse and did not appear to be breathing. He was pronounced dead at Changi General Hospital at 11.18 am.

Investigations into the Deceased's death

17 An autopsy was carried out on 5 August 2012 at 9.30 am. The autopsy was carried out by a medical officer, Dr Henry Chua ("Dr Chua"), and supervised by a forensic pathologist, Associate Professor Teo Eng Swee ("Prof Teo"). The autopsy report noted that the cause of death was "cardio-respiratory failure pending further investigations". A toxicology assessment

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was carried out by the Health Sciences Authority ("HSA"). Based on the HSA's report ("the Toxicology Report"), Dr Chua and Prof Teo issued the Final Cause of Death report ("the FCOD Report") which concluded that the Deceased's post-mortem blood levels of four drugs – bromazepam, duloxetine, mirtazapine, and olanzapine – were "elevated". As seen from the table set out at [12] above, these four drugs were psychiatric medicines that Dr Ang had prescribed to the Deceased. It may be noted that the conclusion that these drugs had elevated levels was premised on comparing the drug concentrations from samples of the Deceased's post-mortem blood with a range of values derived from measurements made in living persons who had consumed these substances. The FCOD Report concluded that the cause of the Deceased's death was "multi-organ failure with pulmonary haemorrhage, due to mixed drug intoxication" and that it was "not due to a natural disease process". We set out the main findings of the FCOD Report here:

> a) The post mortem blood levels of the following drugs were elevated:
>
> i) *Bromazepam* – about 1½ to 2 … times the upper end of the therapeutic range.
>
> ii) *Duloxetine* – about 10 to 11 … times the peak plasma level at steady state with a dose of 80 mg/day. Duloxetine toxicity has been reported to cause unconsciousness, low blood pressure, abnormal bleeding, and seizures.
>
> iii) *Mirtazapine* – about 2 to 3 … times the upper end of the therapeutic range.
>
> iv) *Olanzapine* – about 20 … times the upper end of the usual therapeutic range.
>
> b) Two of the drugs – hydromorphone and Oxycodone – are controlled drugs, under the Misuse of Drugs Act. They are legally available with a doctor's prescription.
>
> c) All the drugs detected as stated in the toxicology report, except for paracetamol, can cause drowsiness and doziness. Combined use of these

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> drugs, some of which were at elevated levels, could possibly lead to respiratory depression, leading eventually to heart failure and death.
>
> d) Duloxetine toxicity has been reported to cause abnormal bleeding. This could explain the finding of the pulmonary haemorrhage at autopsy, and the presence of blood noted at the scene and at the ED.
>
> e) In addition, duloxetine toxicity has been reported to cause unconsciousness, low blood pressure, and seizures.
>
> f) Olanzapine toxicity also includes low blood pressure, mania, hyperglycaemia, liver failure, and loss of consciousness.

18 It should be noted that two other drugs which were not part of the Deceased's prescribed medication, paracetamol and lignocaine, were recorded in the Toxicology Report to have been found in the Deceased's body. Paracetamol was found in the Deceased's blood and stomach, while lignocaine was found in the Deceased's urine.

19 On 5 August 2012, the state coroner carried out a preliminary investigation to ascertain the circumstances of the Deceased's death. The police officer in charge of the investigation was Inspector He Yanhuan ("Insp He"). Insp He concluded in his investigation report that the Deceased's drug intoxication "was deliberate with the evidence pointing to the [D]eceased wanting to end his own life". The coroner similarly stated in the coroner's certificate that the Deceased had "[i]n all probability [taken] an overdose of his prescription drugs with the intention of ending his life". The coroner noted that the "cause of and circumstances connected with the death [were] sufficiently disclosed and there [was] no evidence to suggest foul play". In view of this, the coroner exercised his discretion pursuant to s 25(2) of the Coroners Act 2010 (Act 14 of 2010) not to hold a coroner's inquiry. According to the Appellants, they only came to know about the coroner's

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decision on 23 January 2013 and were shocked by it. It may be noted that a report prepared by Dr Ang, which stated that the Deceased had not displayed suicidal behaviour prior to his death, had not been referred to by Insp He in his investigation report. In any case, it is accepted in these proceedings that the findings stated in the coroner's certificate are not dispositive of the present dispute.

20 Before turning to the parties' pleadings and submissions, we briefly analyse the conclusion reached in the FCOD Report so as to set the context for the discussion which is to follow. Prof Teo testified that by "mixed drug intoxication" he meant that the combined *presence* of the drugs found in the Deceased – with the exception of paracetamol and lignocaine – caused the death of the Deceased. Prof Teo explained as follows:

> [H]ow does mixed drug intoxication cause death? The main pathway by which the combined presence of these substances caused death is that each of these substances has an effect called respiratory depression. Respiratory depression refers to the effect of these drugs on the part of the brain which controls breathing and which also controls the normal function of the heart. …
>
> …
>
> So in this case, just based on the toxicology reports … the presence of these drugs, excepting Paracetamol and Lignocaine, all of them can affect the respiratory centre of the brain and cause respiratory depression. And when you use these drugs in combination, even at normal doses, there is a risk of mixed drug intoxication causing respiratory depression.

21 Based on this, the chain of events which led to the Deceased's death may be summarised as follows: the Deceased had consumed various types of drugs on the night of 3 August 2012 and the combined presence of these caused the Deceased to suffer from respiratory depression. This led to pulmonary haemorrhage and multi-organ failure which eventually caused the death of the Deceased. The main dispute between the parties centres on two

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key points: first, the amount of medication which the Deceased consumed on the night of 3 August 2012, and second, the Deceased's state of mind when consuming such drugs as he did.

Summary of the parties' pleadings

22 The Appellants' pleaded case is that the Deceased's death was a result of the drug interactions from his prescribed medications and was completely accidental and unintended. The Appellants also observe that the Deceased's prescribed psychiatric medications were at the upper limit of the prescription levels and could act together to give rise to the elevated drug levels recorded in the Toxicology Report. Furthermore, the Deceased had not displayed or expressed any suicidal tendencies or inclinations prior to his death. In all the circumstances, they contend that the Deceased's death was an accident and the Respondent's refusal to pay the assured sums under the Insurance Policies was wrongful.

23 In its defence, the Respondent pleaded that it was not liable to make payment to the Appellants under the Insurance Policies for the following reasons:

(a) Under the PA Policy:

(i) the injuries that caused the death of the Deceased were not caused by an accident and this was therefore not an event covered by the policy pursuant to section 2(j) of the Terms and Conditions; and/or

(ii) the death of the Deceased was caused by suicide and therefore, was an event excluded under section 4(5) of the Terms and Conditions.

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(b) Under the Platinum Policy:

(i) the injuries or death of the Deceased was not an accident as it was not caused by an involuntary event, and it was therefore not an event covered by the policy pursuant to section 2(16) of the Terms and Conditions; and/or

(ii) the injuries that caused the death of the Deceased were not sustained in an accident and therefore did not constitute an event covered by the policy pursuant to section 2(17) of the Terms and Conditions; and/or

(iii) the death of the Deceased was caused by suicide and was therefore an event excluded under section 5(5) of the Terms and Conditions; and/or

(iv) the death of the Deceased was caused by "drug abuse or any other complications arising therefrom; or accidents caused by and whilst under the influence of drugs", an event excluded under section 5(11) of the Terms and Conditions. This last argument was not seriously advanced before us and we do not consider it in this judgment.

The decision below

24 The Judge identified the issues as being both legal and factual in nature. She characterised the legal issue as involving the construction of the Insurance Policies and whether the Insurance Policies covered the risk of the insured dying from the voluntary consumption of prescribed medicine in accordance with the prescription, and the factual question as whether the Deceased's cause of death was the consumption of such medication.

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25 In respect of the legal issue, the Judge held that as a matter of general principle, a voluntary act with unexpected consequences fell within the definition of "accident". Following from this, any unexpected clinical effects flowing from the deliberate consumption of drugs would also constitute an "accident" under the Insurance Policies. In this regard, the Judge held that the issue of whether the clinical effects were unexpected was to be assessed from the insured's perspective. In the present context, the Judge concluded that the Deceased "must be deemed to have expected to die if he deliberately consumed an overdose" and conversely, that the Deceased "must not have expected to die if he consumed his medication in strict accordance with his prescriptions".

26 Turning to the factual issues, the Judge assessed that the physical evidence at the scene of the Deceased's death was neutral. She also assessed that the psychiatric evidence tended to support the Appellants' case as the Deceased had never expressed any suicidal inclination and seemed well when he left the hospital at the end of July 2012.

27 Against this, the Judge was of the view that contrary to the Appellants' portrayal of the facts, the Deceased was not systematic about taking his medication and his life situation at the time of death was equivocal. The Judge also found on a balance of probabilities that the Deceased's consumption of his prescribed medication would not have created the adverse reactions that resulted in his death. Thus, although the Deceased did not display any signs of being suicidal, the Judge found that he must have deliberately consumed medication in excess of his prescription and that therefore, his death was not an accident falling within the policies. Consequently, the Judge dismissed the Appellants' claim. It is pertinent to note that the Judge did not make an express finding that the Deceased had committed suicide or that he had acted

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with the intention of ending his life when he consumed the medication that eventually led to his death.

Summary of the parties' cases on appeal

28 The Appellants make two main arguments on appeal. The Appellants' primary argument is that the Judge erred in finding that the Deceased had consumed his medication in excess of the prescribed dosages. In support of this argument, the Appellants submit that on the medical evidence, the elevated levels of drugs found in the Deceased's blood are not necessarily indicative of an overdose on the Deceased's part, and that the elevated levels could also be attributed to the process of post-mortem redistribution ("PMR"), or to the inability of the Deceased's body to eliminate the drugs properly, or to a combination of these factors. Additionally, the Appellants submit that the evidence of the Deceased's circumstances and state of mind do not suggest that he intended to take his life by overdosing on medication. To the contrary, they contend that on the evidence, the Deceased had consumed his medication in a systematic manner in accordance with his prescription. In the alternative, the Appellants argue that *even if* the Deceased had consumed an overdose, this could have been done without an intention to kill himself, and that this would remain an event that entitled the Estate to payment under the Insurance Policies.

29 The Respondent on the other hand submits that the scientific and medical evidence prove that the Deceased had consumed more than his prescribed dosage of medication, and that the Appellants' case that the Deceased had consumed his medication in accordance with his prescription had been discredited by the evidence adduced at trial. As the Deceased was well aware of the dangers of consuming more than the prescribed dosage of

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his medication, the Deceased's death could not be described as one that was the result of an "accident" entitling the Estate to payment under the Insurance Policies if the Deceased had in fact consumed more than the prescribed dose.

The issue before the court

30 The overarching issue in the present appeal is whether the injury resulting in the Deceased's death was caused by "accident" such that the Estate is entitled to the assured sum under the Insurance Policies. As the Judge observed, this requires the court first to characterise the scope of the coverage afforded by the Insurance Policies before proceeding to the question of whether, on the facts presented, the circumstances of the Deceased's death fell within that scope.

31 We therefore begin with a construction of the Insurance Policies and the relevant legal principles, before turning to assess the evidence surrounding the Deceased's death that was adduced in the course of the trial.

The meaning of "accident" under the Insurance Policies

32 Under the PA Policy, the Respondent is obliged to pay the assured sum of $200,000 to the Estate "[w]hen injury results in loss of life of the Assured within three hundred and sixty five (365) days after the date of the accident". The PA Policy defines "injury" to mean "bodily injury effected directly and independently of all other causes by accident". However, the PA Policy does not define the term "accident".

33 Similarly, under the Platinum Policy, the Respondent is obliged to pay the assured sum of $1m to the Estate "[w]hen injury results in loss of life of the Assured within three hundred and sixty five (365) days after the date of the

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Accident". The Platinum Policy defines "injury" to mean "bodily injury sustained in an Accident and effected directly and independently of all other causes and therefore not due to illness or disease". Unlike the PA Policy, the Platinum Policy does define "accident" and it is "an unforeseen and involuntary event which causes an injury".

34 The Respondent concedes that in respect of the PA Policy where there is no definition of the term "accident", the understanding of that term as developed in the case law is applicable. However, where an insurance policy contains a definition of a term, the Respondent submits that the contractual definition should apply, even if that might lead to a harsh result. For this proposition, the Respondent relies on a decision of the English Court of Appeal in *In re United London and Scottish Insurance Company, Limited* [1915] 2 Ch 167 where Lord Cozens-Hardy MR stated (at 170):

> In the case of *Coles v Accident Insurance Co.* …, the Court very reluctantly said that the language being clear you must give effect to it even though it might be very hard upon the assured. If, however, there is ambiguity in the policy, remembering the rule that the words ought to be construed "contra proferentes," then it may be said that the company are liable because they have not clearly exempted themselves.

35 The Respondent argues on this basis that in respect of the Platinum Policy, because "accident" is defined as "an unforeseen and involuntary event", the events and actions which precede and lead to the injury must be involuntary. Simply put, the Respondent's argument is that the Deceased's death would not be an "accident" under the Platinum Policy unless the Deceased ingested the medication involuntarily.

36 The Judge rejected this argument for two reasons. First, she held that on a strict construction of the Platinum Policy, it was the *event* causing the injury that had to be involuntary, and that in the context of drug intoxication

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"what determines if the resulting drug intoxication is an accident is whether the effects of the drug were foreseen or intended" (see the Judgment at [46]). Second, citing the decision of the Scottish Court of Session in *Glenlight Shipping Ltd v Excess Insurance Co Ltd* [1981] SC 267, the Judge observed that it was not always the case that the common law meaning of the term "accident" would become irrelevant whenever the term was defined in the insurance policy. In her view, as the idea of accident was "inextricably linked" with the concepts of involuntariness and unforeseeability, the definition of "accident" under the Platinum Policy was not particularly useful and it was thus necessary to have recourse to the common law meaning of "accident" to interpret the coverage under the Platinum Policy (see the Judgment at [47]–[48]). In this regard, the Judge accepted the Respondent's submission that the Deceased's death would be an "accident" at common law if death was not the Deceased's intended purpose in consuming the medication (see the Judgment at [49] and [55]).

37 Having reviewed the authorities, we broadly agree with the legal conclusions which the Judge arrived at. However, as this is the first time that we have had to construe the term "accident" in the context of personal accident insurance policies, we take this opportunity to consider the authorities on this issue, as well as to set out some general principles that may be applied in this context.

The understanding of "accident" in decisions across the Commonwealth

38 In *Fenton v J Thorley & Co Ltd* [1903] AC 443, Lord Macnaghten said that the "popular and ordinary sense" of the word "accident" denotes "an unlooked-for mishap or an untoward event which is not expected or designed" (at 448). More recently, in *Kathleen De Souza v Home and Overseas*

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Insurance Co Ltd [1995] Lloyd's Reinsurance Law Reports 453, Mustill LJ (as he then was) similarly related the notion of an accident to something unexpected. In that case, Mustill LJ cited the following passage from AW Baker Welford, *Law Relating to Accident Insurance* (Butterworths, 1923) as representing his own views (at 458):

> The word "accident" involves the idea of something fortuitous and unexpected, as opposed to something proceeding from natural causes; and injury caused by accident is to be regarded as the antithesis to bodily infirmity by disease in the ordinary course of events.

39 Beyond this, there is perhaps limited scope for precision in defining the term. Indeed, as observed by Jeffries J sitting in the High Court of Wellington in *Groves v Amp Fire & General Insurance Co (NZ) Ltd* [1990] 1 NZLR 122 ("*Groves*"), the concept of what an accident is in the realm of personal injury has troubled judges and academics alike, and that "despite the continued efforts of those persons, the word has defied a satisfactory and precise definition almost anywhere in the common law world" (at 125).

40 Given the contractual nature of an insurance policy, the entitlement of the insured to the assured sum generally depends on the precise way in which the insured risk has been defined in the policy and on how that is applied to the facts of the case. Hence, there is relatively little by way of general principle that can be gleaned from an extensive review of previous authorities. To complicate matters, even where similar language has been used in different policies, courts have arrived at differing conclusions. We note, for example, the difference of opinion between common law courts as to the interpretation of the words "bodily injury caused by violent, accidental, external and visible means" (and of variants in similar terms) that may be found in a personal accident insurance policy. In *Clidero v Scottish Accident Insurance Co* (1892)

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19 R 355 ("*Clidero*"), the insured had, while putting on his stocking, caused his colon to slip and distend, which then led to his death. In an action under a personal accident insurance policy, the Scottish Court of Session (First Division) held unanimously that the insured's injury was not caused by "violent, accidental, external and visible means" because the insured's conduct in putting on his stockings was intentional and voluntary and there was no other external factor that affected the insured's movement which resulted in the injury. We quote from Lord Adam's judgment to illustrate the court's reasoning (at 362):

> … The question, in the sense of this policy, is not whether death was the result of accident in the sense that it was a death which was not foreseen or anticipated. That is not the question. The question is, in the words of this policy, whether the means by which the injury was caused were accidental means. The death being accidental in the sense in which I have mentioned, and the means which lead to the death as accidental, are to my mind two quite different things. *A person may do certain acts, the result of which acts may produce unforeseen consequences, and may produce what is commonly called accidental death, but the means are exactly what the man intended to use, and did use, and was prepared to use. The means were not accidental, but the result might be accidental.* Now, if that is so, where does the question of accident come in here? There is no evidence, as your Lordship pointed out, that anything unusual or exceptional occurred as to the means or cause of this death. *The man was just doing what he meant to do, and apparently a most unfortunate and unexpected result happened, the man's death.* [emphasis added]

41 *Clidero* was followed and applied by courts in various jurisdictions (see, for example, the New Zealand decision in *Colonial Mutual Life Assurance Society Ltd v Long* [1931] NZLR 528). It was also applied in *Landress v Phoenix Mutual Life Insurance Co* 291 US 491 (1934), where the Supreme Court of the United States held that a man who died of heat stroke while playing golf had not died of accidental means because he had voluntarily exposed himself to the sun's rays.

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42 However, over time, courts in the Commonwealth have moved away from this distinction between intended means and unintended results. Although this still appears to be good law in England (see, for example, *Dhak v Insurance Co of North America* [1996] 1 WLR 936 ("*Dhak*") at 949), the distinction has been rejected in New Zealand (see *Groves* at 127–128), the United States (see *Wickman v Northwestern National Insurance Co* 908 F 2d 1077 (1st Cir 1990) ("*Wickman*")), Scotland (see *MacLeod v New Hampshire Insurance Co Ltd* 1998 SLT 1191), Australia (see the judgment of Wilson, Deane and Dawson JJ in *Australian Casualty Co Ltd v Federico* [1986] HCA 32 at [18]–[20]) and Canada (see *Martin v American International Assurance Life Co* [2003] SCC 16 ("*Martin*") at [10]–[13]). In *Wickman*, the United States court observed that the means-result distinction was a technical one that was not in harmony with the understanding of the common man (at 1086). Similarly, in *Martin* (which was referred to by the Judge), McLachlin CJ (delivering the judgment of the Supreme Court of Canada) said as follows (at [10] and [12]–[14]):

> The insurers argue that the category of deaths caused by accidental means is narrower, in that it excludes accidental deaths that are the natural effects of deliberate actions. In their view, a death is only caused by *accidental means* when both the death and the actions that are among its immediate causes are accidental.
>
> …
>
> This view seems to me, however, to be problematic. Almost all accidents have some deliberate actions among their immediate causes. To insist that these actions, too, must be accidental would result in the insured rarely, if ever, obtaining coverage. Consequently, this cannot be the meaning of the phrase "accidental means" in the policy. *Insurance policies must be interpreted in a way that gives effect to the reasonable expectations of the parties … A policy that seldom applied to what reasonable people would consider an accidental death would violate this principle.*
>
> In my view, the phrase "accidental means" conveys the idea that the *consequences* of the actions and events that produced

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> death were unexpected. Reference to a set of consequences is therefore implicit in the word "means". "Means" refers to one or more actions or events, seen under the aspect of their causal relation to the events they bring about.
>
> It follows that to ascertain whether a given means of death is "accidental", we must consider whether the consequences were expected. We cannot usefully separate off the "means" from the rest of the causal chain and ask whether they were deliberate. … Hence, to determine whether death occurred by accidental means, we must look to the chain of events as a whole, and we must consider whether the insured expected death to be a consequence of his actions and circumstances.
>
> [emphasis added]

On this basis, the court held that the phrases "accidental death" and "death by accidental means" had essentially the same meaning and connoted a death that was in some sense unexpected (at [18]).

43 As neither the PA Policy nor the Platinum Policy provide for coverage only where injury or death is caused by "accidental means", the difficulties which have troubled the courts in the interpretation of such a provision is not directly before us. We will turn shortly to the specific language in issue in this case, but we prefer the view that the use of phrases such as "accidental means" would not restrict the situations covered by a personal accident insurance policy to those where the proximate cause of the insured's injury or death was not a deliberate or voluntary action on the part of the insured. For example, if a person injures himself by driving off a cliff in the mistaken belief that the road continued, that person would have met with an "accident" just as much as one who slips and fractures his leg while walking on a slippery surface. It would, in our view, accord with ordinary experience to hold that the injury suffered by an insured in such cases would be a result of "accidental means". In this regard, we find ourselves in agreement with the observations of McLachlin CJ in *Martin*, which we have cited above.

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44 Returning to the understanding of the term "accident", the cases have employed terms such as "unexpected" or "unintended" to describe the meaning of "accident". This is sensible, since no event which is intended can be described as accidental from the point of view of the person responsible for it. Additionally, it has been said that an "accident" would "contrast with an event that happens naturally; thus death or injury as a result of disease is not death or injury from accident, unless some accidental event has given rise to the disease" (see *MacGillivray on Insurance Law* (Sweet & Maxwell, 12th Ed, 2012) at para 26–001).

45 In *Martin*, McLachlin CJ observed (at [20]) that as a starting point, "the accidental nature of a particular means of death depends … on the consequences that the insured had or did not have in mind" [emphasis in original]. This suggests that the inquiry as to whether a particular injury is to be characterised as having been caused by "accident" is assessed from the insured's subjective perspective. It follows from this that death does not cease to be accidental merely because the insured could have prevented death by taking greater care, or because a mishap was reasonably foreseeable in the sense used in the tort of negligence, or because that person was engaged in a dangerous or risky activity (see *Martin* at [20]). Instead, McLachlin CJ held (at [21]) that "the pivotal question is whether the insured *expected* to die" [emphasis added].

46 In *Wickman*, however, an American court observed that a test of "expectation of death" suffered from two drawbacks. The first was the difficultly in applying the test in the not uncommon situation where an insured's actual expectation was difficult, if not impossible, to determine. As a solution to this, the court in both *Wickman* (at 1088) and *Martin* (at [21]) held that to the extent the subjective intentions of the insured could not be

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ascertained, the court would be permitted to engage in an objective consideration of the insured's likely or probable expectations. In other words, the court would consider whether a reasonable person in the insured's circumstances would have expected to suffer injury resulting in death.

47 The second drawback is the inability of the expectation test to exclude cases where an insured's expectations are found to be patently unreasonable. The court in *Wickman* cited examples of those participating in Russian roulette – a lethal game of chance – in the "fanciful expectation" that fate would favour them. In such cases, the courts have generally held that the deaths were not a result of accident. The imperfection of the expectation test thus lies in its inability to exclude, from the proper ambit of "accidents", those cases that one would intuitively recognise as not being such. As McLachlin CJ pointed out in *Martin* (at [23]):

> … [W]hen someone takes a risk that most people would expect to cause death, it is common to say of the death "That was no accident". To say this is not to speak metaphorically, but to express a common view of where the category of accidents ends.

48 The court in *Martin* held that the fact that this focus on the expectations of the insured could result in conduct carrying a high risk of death being deemed an accident did not warrant a narrower definition of "accident". In this regard, it was noted that it would often be the case that the court would not be able to ascertain the insured's subjective expectation in undertaking such risky and dangerous behaviour, and as a result, the expectations of a reasonable person would prevail (see *Martin* at [23] and [25]). A slightly different approach to this difficulty was taken in the United States in *Wickman*, where the court agreed that the subjective expectation of

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the insured would be the starting point, but then overlaid on this a test of reasonableness. It explained as follows (at 1088):

> If the fact-finder determines that the insured did not expect an injury similar in type or kind to that suffered, the fact-finder must then examine whether the suppositions which underlay that expectation were reasonable. … This analysis will prevent unrealistic expectations from undermining the purpose of accident insurance. If the fact-finder determines that the suppositions were unreasonable, then the injuries shall be deemed not accidental. The determination of what suppositions are unreasonable should be made from the perspective of the insured, allowing the insured a great deal of latitude and taking into account the insured's personal characteristics and experiences. …
>
> Finally, if the fact-finder, in attempting to ascertain the insured's actual expectation, finds the evidence insufficient to accurately determine the insured's subjective expectation, the fact-finder should then engage in an objective analysis of the insured's expectations. … In this analysis, one must ask whether a reasonable person, with background and characteristics similar to the insured, would have viewed the injury as highly likely to occur as a result of the insured's intentional conduct. … An objective analysis, when the background and characteristics of the insured are taken into account, serves as a good proxy for actual expectation. Requiring an analysis from the perspective of the reasonable person in the shoes of the insured fulfills the axiom that accident should be judged from the perspective of the insured.

49 Thus, in both those jurisdictions, the court begins with an analysis of the insured's subjective expectations. If the court is unable to ascertain the insured's subjective expectations, an objective test is then applied. And in the United States, if an insured's subjective intentions are found to be unreasonable, the injuries will nonetheless be deemed to be not accidental.

The approach to "accident" in the context of the Insurance Policies

50 Against that backdrop, we consider the insured risk in the context of the Insurance Policies. As we have noted above, the Platinum Policy describes the insured risk as an injury "sustained in an accident" and in turn defines an

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"accident" as "an unforeseen and involuntary event which causes an injury". In a similar vein, the PA Policy describes the insured risk as an injury "effected directly and independently of all other causes by accident" though, unlike the Platinum Policy, it does not contain a definition of "accident". In our judgment, and following from our analysis above, an injury caused by or sustained in an "accident" under the Insurance Policies connotes an injury sustained in circumstances where the insured neither intended nor expected to suffer the injury and where the injury is not the result of the natural progression of disease. We further consider that the inquiry into whether the insured intended or expected to suffer the injury is to be assessed from the insured's subjective perspective.

51 Expectation in this context goes beyond awareness of possible risks that could transpire thus causing injury. Anyone who participates in a potentially hazardous activity, say white-water rafting or scuba-diving, and for that matter, even driving a motor-car, should be aware of the possibility of injury ensuing; but the vast majority of those who do participate in such activities, do so expecting that such injury will *not* occur. Hence, "expectation" in this context, connotes the actual belief of the insured that the injury is more likely than not to occur.

52 We are cognisant in this context of the two drawbacks that affect this test as noted in *Wickman*. In our judgment, these two drawbacks may be ameliorated by the application of the following framework relating to the parties' burden of proof:

(a) As the legal burden of proving that the insured's injury or death was caused by "accident" lies on the claimant, the burden of proving that the insured did not subjectively intend or expect to be injured lies

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on the claimant as well. Where the insured's subjective intentions or expectations are unclear or impossible to ascertain, it would be open to the claimant, in the alternative, to advance a case based on the intentions or expectations of a reasonable person in the position of the insured in terms of what is known of his personality, circumstances and characteristics.

(b) Once it is established on a *prima facie* basis that the insured did not intend or expect to suffer the injury, the evidential burden shifts to the insurer to demonstrate the converse.

(c) The ability of the claimant to demonstrate the insured's intention or expectation on a *prima facie* basis would likely vary according to the circumstances in which the insured's injury results. Where the insured's injury is an extraordinary or unusual result of the deliberate action taken, it will often be the case that the claimant will readily be able to demonstrate on a *prima facie* basis that the insured's injury was not within the insured's intention or expectation. The evidential burden then shifts to the insurer to demonstrate special circumstances that would nevertheless allow the court to arrive at the conclusion that the injury or death was not caused by "accident". On the other hand, where the insured's injury is a natural consequence of the deliberate actions of the insured, the claimant must do more to satisfy the court even on a *prima facie* basis that the insured had no expectation or intention that injury would ensue, for instance, by proof of mental incapacity or special expertise at performing a particularly dangerous task. The question of whether a consequence is natural or extraordinary must be assessed from the perspective of common-sense and everyday experience.

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53 This approach, in our judgment, maintains fidelity to the idea that whether the acts of the insured gave rise to an "accident" remains an essentially subjective inquiry that is undertaken from the perspective of the insured, whilst, at the same time, having in place appropriate safeguards which, in the words of the court in *Wickman* (at 1088), should prevent "unrealistic expectations from undermining the purpose of accident insurance". These safeguards lie in the ability of the claimant to discharge its burden of proof. In short, the more incongruous the claimant's case appears on its face, the more the claimant will be required to do to prove its case on a balance of probabilities.

54 These are only *general* principles that ought to guide a court in construing the scope of a personal accident insurance policy. These principles would naturally be subordinated to the express language used in each personal accident insurance policy. In this regard, it remains theoretically open to the insurer, being the party that drafts the insurance contract, to stipulate the type of risk that it would accept by means of appropriate inclusion or exclusion clauses.

55 We now turn to apply this to the facts of the present case. As a preliminary point, we note that the question of whether the Deceased's death was due to an injury caused by a natural disease process is not in issue. The FCOD Report stated clearly that the Deceased's death was not a result of a natural disease process (see above at [17]). As the Judge observed at [51]–[54] of the Judgment, courts across the Commonwealth have held that the unexpected clinical effects flowing from the deliberate consumption of drugs may constitute an "accident" under a personal accident insurance policy. In our judgment, an injury suffered by an insured as a result of the consumption of medication may be classified as an injury caused by "accident" where the

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insured did not intend or expect to suffer the injury when he consumed the medication.

56 Turning to the Platinum Policy, the Respondent's argument is that because the Deceased intended to consume the medication, there was no "involuntary event" that caused an accident which resulted in the Deceased losing his life and the Appellants are thus not entitled to payment under this policy. In this regard, the Respondent's argument on the concept of involuntariness appears to be inspired largely by the reasoning in *Clidero* and the line of cases which have applied it.

57 In our judgment, the Respondent's argument is mistaken. We assume, for the purpose of dealing with this argument, that the Deceased consumed his medication in accordance with his prescription. We agree with the Judge's construction of the Platinum Policy that in such a case it is the proximate *event* causing the injury which must be involuntary. That event, in this context, would be the unexpected and unintended reaction of the Deceased's body to the medication. To put it another way, an accident would occur where the insured *suffers* injury involuntarily and unexpectedly while doing something, which although intentional, is not expected or intended to have that consequence. This can be illustrated by the example of a pedestrian who is hit by a negligent driver at a zebra crossing. The pedestrian's act of crossing the road would be a deliberate and voluntary act. However, the fact that the pedestrian was then hit by the car and suffered injury would not be something which the pedestrian expected or intended and so would be "an unforeseen and involuntary event" – or an "accident" – within the meaning of the Platinum Policy. The Deceased's deliberate and voluntary consumption of his medication would be akin to the action of the pedestrian crossing the road. The subsequent adverse drug reactions in the Deceased's body, would be akin to

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the pedestrian being hit by the car, and this (if the Deceased had neither intended nor expected such adverse reactions) would be unforeseen and involuntary. It is these adverse reactions that led to the Deceased suffering injury (namely, pulmonary haemorrhage and multi-organ failure) which led to his death. There is also nothing in the Platinum Policy to require that the "unforeseen and involuntary event" causing injury be external to the Deceased. We are thus unable to accept the Respondent's argument that the Estate is not entitled to the assured sum under the Platinum Policy by virtue of the fact that the Deceased had intended to consume the drugs. On the contrary, given the wide definition of "accident", the Deceased's death could be classified as an "accident" under the Platinum Policy as long as he did not intend or expect to cause his death when he consumed the medication.

58 As to the PA Policy, the Respondent undertook to pay the assured sum where the "bodily injury [is] effected directly and independently of all other causes by accident" and which results in the subsequent loss of life. As we have stated at [34] above, the Respondent accepts that the understanding of "accident" as developed in the case law is applicable in respect of this policy. Thus, following the approach outlined above, the injury suffered by the Deceased would be an "accident" under the PA Policy if it occurred in circumstances where the Deceased did not intend or expect to suffer the injuries that led to his death when he ingested the medication in question.

59 It is evident then that, on a construction of both policies, the key factual issue to be decided is the same. That is whether, on the evidence that was led, it can be concluded that the Deceased had intended or expected to die when he consumed the medication. As noted above, the inquiry begins with the Deceased's subjective intentions and only shifts to the objective

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perspective of a reasonable person with the Deceased's attributes if the evidence is insufficient to disclose the Deceased's subjective viewpoint.

60 The Judge applied a similar test of subjective expectation, but she then held that the Deceased "must be deemed to have expected to die if he deliberately consumed an overdose" because he had been warned by Dr Yeo that the consequences of an overdose could include death (see the Judgment at [58]). The Judge thus appeared to have equated the question of whether the Deceased had physically consumed an overdose of drugs, with the separate question of whether, even assuming that were so, the Deceased had done so *expecting* or *intending* to die as a result; and she conflated these inquiries essentially on the basis that Dr Yeo had warned the Deceased that the consequences of consuming an overdose of medication could lead to death.

61 With respect, we consider that the Judge erred in proceeding in this way. Even if it was the case that the Deceased had consumed an overdose in that he had taken more medication than he was prescribed, this does not, as a matter of logic, necessarily lead to the conclusion that the Deceased had done so expecting to die. Nor does this change even if he had been advised of the risk that this might or could ensue. As we noted at [51] above, *knowledge* that injury *could* be a possible result of a deliberate action does not, in all circumstances, lead to a finding that the Deceased had *subjectively intended or expected* to suffer the injury. To put it another way, advertence to a risk does not equate to an intention or an expectation that the risk should materialise. Of course, if the evidence does establish that the Deceased had consumed an overdose, this *might* more readily demonstrate that Deceased had expected or intended to suffer injury. However, it is essential to analyse the evidence and consider separately each of these questions: whether the Deceased did

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consume an overdose; and if so, what his state of mind was in relation to his doing so.

Assessing the evidence

62 Having ascertained the circumstances in which the Appellants would be entitled to the assured sums under the Insurance Policies, the broad question to which we now turn is whether in all the circumstances, the Deceased's death was the result of an injury caused by "accident". The anterior question, as we have just observed, is whether the Deceased consumed more than the prescribed dosage of medication. Finding *what* the Deceased did before his death would then form the context and backdrop against which the Deceased's intentions as to *why* he did what he did can then be assessed.

63 After assessing the evidence, the Judge held that the elevated levels of certain drugs found in the Deceased's blood were reflective of his consumption of those drugs, and that therefore, the Deceased had consumed overdoses of at least olanzapine, duloxetine, and mirtazapine (the Judgment at [136]). She rejected the Appellants' submission that the elevated levels of the drugs could be accounted for by one or more other causes, including: (a) drug interactions leading to the inhibition of metabolism of the drugs in question or the impairment of the body's ability to eliminate the drugs properly; (b) PMR; or (c) a combination of (a) and (b). She stated (at [137]) that her conclusion that the Deceased had overdosed was not based solely on the scientific and medical evidence, but on the circumstances generally that were outlined in the Judgment.

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64 As the scientific and medical evidence provides the most objective assessment of what the Deceased ingested, that evidence is the logical starting point for our analysis to determine whether it allows us to infer that the Deceased had consumed more drugs than he was prescribed. In the analysis that follows, where the term "overdose" is used, it refers to the Deceased consuming his medication in quantities exceeding the prescribed dosage.

The scientific and medical evidence

Whether the Deceased's prescribed doses of medicine could have killed him

65 We begin our analysis by considering whether the scientific evidence leads to the conclusion that the Deceased would *not* have died *unless* he had overdosed. We are concerned at this stage with excluding other plausible causes of his death. It should be noted that the evidence pertaining to this issue, ultimately had to confront the fact that the Toxicology Report and the FCOD Report indicated that the post-mortem blood levels of four of the medications prescribed to the Deceased were present at levels that were seemingly elevated. This gave rise to certain questions. Did it follow from the fact that these levels were elevated that the Deceased had ingested an overdose of those drugs? Were there other plausible explanations? Was there an inherent risk of injury in prescribing the particular mix and quantity of medications as was done in this case?

66 It will be useful to begin by identifying the witnesses who were called and summarising the evidence that each of them gave on the different aspects of this issue. The witnesses were as follows:

(a) ***Prof Teo***: Prof Teo was the forensic pathologist who supervised the autopsy of the Deceased that had been performed by Dr

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Chua. He testified on the findings contained in the FCOD Report. We have set out part of his evidence on this at [20] above. In essence, Prof Teo's evidence was that the Deceased's death was caused by "mixed drug intoxication" and that he assessed that it was the combined presence of the various drugs (save for paracetamol and lignocaine) that caused the death. This was so irrespective of whether the drugs had been ingested (a) all at therapeutic levels; (b) all at excessive levels; or (c) at therapeutic levels in some instances and at excessive levels in other instances. It bears emphasis that the primary thrust of Prof Teo's evidence was that it was the *combination* of the medication that had been ingested by the Deceased that killed him. In particular, he considered that it was possible, even if all the drugs prescribed to the Deceased had been consumed at the prescribed therapeutic levels, that this could nonetheless cause respiratory depression and death. Prof Teo further testified that it was not possible to conclude from the elevated concentrations of certain medications found in the Deceased's body after his death that he had consumed an overdose of these drugs.

(b) ***Dr Michael Tay*** ("Dr Tay"): Dr Tay is a senior consultant forensic scientist. He was called by the Appellants to give his opinion on the relationship between the Deceased's prescribed medication and the levels of drugs reflected in the Toxicology Report and the FCOD Report. Dr Tay observed that potential interactions existed between duloxetine and mirtazapine, and also between duloxetine and olanzapine and that the former interactions (between duloxetine and mirtazapine) could result in coma and even death. Due to the large number of drugs the Deceased was taking, the risk of harmful drug interactions was exacerbated. There was additionally a possibility that the *number* and *variety* of drugs that the Deceased was taking could

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inhibit the Deceased's ability to metabolise the various drugs he was prescribed. Dr Tay explained that the Deceased's body might not have metabolised all the drugs he was consuming at the same rate. Where there was differential metabolism, this could result in elevated concentrations in the Deceased's blood of those drugs that had been inadequately metabolised. In particular, the same group of liver enzymes (the P450 group of enzymes) were responsible for metabolising nine of the drugs detected in the Deceased's post-mortem blood. Additionally, three particular enzymes (CYP3A4, CYP1A2, and CYP3D6) metabolised bromazepam, duloxetine, mirtazapine, and olanzapine, which were the four drugs found at elevated levels. The finite availability and ability of these enzymes to metabolise the drugs could account for the elevated levels of these drugs in the Deceased's post-mortem blood. According to Dr Tay, besides the Deceased's decreased ability to metabolise the drugs due to enzyme inhibitions, other circumstances that could affect the level of drugs in the Deceased included kidney or liver impairment and old age. Thus, it was Dr Tay's evidence that the elevated concentration of the four drugs in the Deceased might have been due to factors other than an overdose of those drugs on the Deceased's part.

(c) ***Dr Phua Dong Haur*** ("Dr Phua"): Dr Phua is a senior consultant at the emergency department of Tan Tock Seng Hospital and a clinical toxicologist. He was called by the Respondent to provide his opinion on the toxicological effects of the drugs found in the Deceased. Dr Phua's evidence was that one could not precisely translate the levels of drugs found in a person's blood to the amount of medication that had been taken and that there was a possibility that the interactions between the drugs that the Deceased had been prescribed

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could have caused adverse reactions even if consumed at therapeutic levels. However, in Dr Phua's view, this was "unlikely" in the Deceased's case because the Deceased had been taking these drugs for some time and would have developed a tolerance. An adverse reaction, if any, would generally have manifested within two weeks of consumption. It was also his experience that patients maintained on chronic medication did not usually manifest adverse drug interactions after using the medication uneventfully over a period of time. Dr Phua thus concluded that given that the Deceased had been well-maintained on this set of medication for some time, it would be "very unusual" for the Deceased to suddenly suffer an adverse reaction leading to death.

(d) ***Dr Rasaiah Munidasa Winslow*** ("Dr Winslow"): Dr Winslow is a senior consultant psychiatrist. He was called as the Appellants' psychiatric expert witness. From his experience in prescribing medication to treat psychiatric conditions, he stated that interactions between those drugs which worked in a similar fashion could result in "synergism" and "potentiation" which might then result in a person's "breathing mechanism" being deactivated. Dr Winslow also noted that the "inherent risk" in prescribing multiple medications was of "one medication interfering with the other" and because of this, he said that the typical practice was not to give so many medications in combination.

(e) ***Dr Tommy Tan Kay Seng*** ("Dr Tan"): Dr Tan is a consultant psychiatrist and was called as the Respondent's psychiatric expert witness. Dr Tan agreed with Dr Winslow's evidence that the drugs which the Deceased had been prescribed could interact and cause harmful consequences. He also testified that his normal practice was to

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prescribe only three or four types of medication and that he personally would not have prescribed the eight different types of psychiatric medication that the Deceased had been taking.

67 Besides Prof Teo and the expert witnesses, the Deceased's treating doctors also gave evidence on this issue. Dr Ang, who was the Deceased's psychiatrist, said that in his view what he had prescribed for the Deceased was "safe", but left open the possibility based on an "idiosyncratic response" that there might have been some inhibition of the Deceased's ability to metabolise the drugs, resulting in an increase in the blood concentrations of those drugs that had not been adequately metabolised. Dr Ang also testified that it was "highly unlikely" for the Deceased to suffer from an adverse reaction because he would have become used to the medication. Similarly, Dr Yeo gave evidence that he was confident in the safety of his prescription. Much of this confidence was based on the fact that the Deceased had been on such medication for a prolonged period, during which time he was observed to have responded positively to the medication. However, Dr Yeo did not rule out the possibility that an adverse reaction could have occurred even after a prolonged period of use, though to his knowledge he had not come across any such case.

68 It is possible, in our judgment, to summarise the evidence on this issue as follows:

(a) The treating doctors did not subjectively believe that it was unsafe to prescribe the variety and quantities of drugs that they did though they subsequently accepted the possibility of an idiosyncratic adverse reaction to this on the part of the Deceased.

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(b) The psychiatric expert witnesses both had concerns with the quantities and variety of drugs that had been prescribed because of the possibility of adverse interactions between some of them.

(c) The pathologist concluded that the Deceased's death was caused by the combination of drugs that the Deceased had consumed and he went so far as to say that the death could have ensued even if all the drugs had been ingested at the prescribed levels.

(d) Similarly, the Appellants' toxicology expert, Dr Tay, testified that the elevated levels of certain drugs that were found in the Deceased's post-mortem blood could have been due to factors other than the quantity of those drugs that had been consumed by the Deceased. As a matter of the body's chemical-processing ability, he found it significant that the drugs found at elevated levels were all metabolised by the same group of enzymes.

(e) As against all this, Dr Phua was of the view that the elevated levels of certain drugs meant that the Deceased had probably overdosed. While accepting that there were other possible explanations, he thought that these were unlikely to be applicable because the Deceased had been on this course of treatment for some time.

69 The Judge recognised at [105] of the Judgment that the possibility of the Deceased suffering an adverse reaction to consuming the drugs as prescribed could not be excluded. However, she found that, on a balance of probabilities, the consumption by the Deceased of his medication in the prescribed dosages would not have given rise to the adverse reactions that resulted in his death (see the Judgment at [117]). It followed from this finding

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that the Deceased did *not* consume his medication in the prescribed doses. It appears that the Judge relied on the evidence of Dr Phua, Dr Ang, and Dr Yeo. She preferred Dr Phua's evidence over Dr Tay's because Dr Tay was not a physician and seemingly did not have any experience as to the manner in which adverse reactions would manifest themselves (see the Judgment at [113]). The Judge also found it significant that Dr Ang and Dr Yeo were of the view that the Deceased would not have died from consuming his medication as prescribed (see the Judgment at [114]).

70 With respect, we consider that the Judge erred. We first note that apart from Dr Ang and Dr Yeo who were the physicians who had been caring for the Deceased, and Prof Teo, who supervised the autopsy, the remaining medical and scientific witnesses had no personal knowledge of the Deceased's circumstances and condition. They were therefore expressing opinions, having regard to the findings presented in the FCOD Report and the Toxicology Report. In particular, it may be noted from Dr Phua's evidence that he was attesting to *statistical probabilities*. This is clear from Dr Phua's written response to the list of issues tendered by the Appellants' solicitors, where he said as follows:

> The concomitant use of various drugs by the Deceased can lead to adverse drug interactions at therapeutic dose. …
>
> By drug interactions, I refer to the effect of one drug altering the pharmacological effect of another drug. And in this instance I specifically refer to it during therapeutic dose, and not when the doses are elevated, because when a few drugs are over therapeutic level[s], interactions can also occur leading to toxicity.
>
> The major interaction effect that is most concerning is the potential to cause sedation, and cardiorespiratory depression by many of the agents prescribed. Another major interaction effect is the relatively rare but deadly serotonin syndrome that can arise from the concomitant use of Olanzapine, Duloxetine, Mirtazapine and Quetiapine.

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> However, these interaction effects at therapeutic dose[s] of the agents prescribed to the Deceased ***usually*** manifest themselves fairly soon after the initiation of the medications. ***In my experience***, patients who are maintained on chronic medications ***usually*** do not manifest these interaction effects after using them for a period of time uneventfully. For such interactions to occur after using medication for a period of time uneventfully, ***usually*** one of the three following conditions has arisen:
>
> 1. [Change] in the prescribed doses or new medications or complementary medicine were added
>
> 2. [Change] in the ability of the patient to metabolise or excrete the drugs
>
> 3. Another severe illness has developed that would lead to metabolic stress on the body, for example starvation, severe infection or ischaemic heart attack.
>
> [emphasis added in bold italics]

Dr Phua observed that none of these causes applied to the Deceased. Although dosages of duloxetine, mirtazapine, and bromazepam had been increased during the Deceased's hospitalisation in July 2012 (as compared to the period immediately prior to his hospitalisation), Dr Phua's view was that any adverse reaction to the increase in dosage would have manifested within a day or two. He went on to testify that the particular adverse effect of respiratory sedation which the Deceased suffered was "unlikely to occur" after a week or a month from the increase in prescription "unless some other mechanism" had arisen. Having regard to the *usual* course of events, Dr Phua therefore considered it unlikely that interactions among the drugs ingested at therapeutic levels would have caused the adverse reactions in the Deceased.

71 In our judgment, the Judge was led to error by this evidence because she equated the *statistical probability* of a person with the Deceased's physical characteristics and medical history suffering an adverse reaction from the combination of drugs at therapeutic levels, with the question of whether, in

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fact, it was more likely than not that *the Deceased* had consumed no more than his prescribed dose of medication but nevertheless suffered the adverse reactions. The former is about the study of averages involving similar facts. The latter, however, is the central issue the court is required to determine and while the former can aid in the latter, this is not invariably the case. It is important to recognise the limits of statistical evidence, and here, we echo the observations of Lord Nicholls of Birkenhead in *Gregg v Scott* [2005] 2 AC 176 where he explained (at [28]):

> Statistical evidence, however, is not strictly a guide to what would have happened in one particular case. Statistics record retrospectively what happened to other patients in more or less comparable situations. *They reveal trends of outcome.* They are general in nature. The different way other patients responded in a similar position says nothing about how the claimant would have responded. *Statistics do not show whether the claimant patient would have conformed to the trend or been an exception from it.* They are an imperfect means of assessing outcomes even of groups of patients undergoing treatment, let alone a means of providing an accurate assessment of the position of one individual patient. [emphasis added]

72 We therefore consider it necessary to emphasise the limits that constrain the opinion of Dr Phua, based as it is on general medical data. That evidence is unable to tell us *definitively* whether the Deceased's fatal adverse reaction *must* have been the result of an overdose. Additionally, we consider it significant that Prof Teo, the forensic pathologist who examined the Deceased's body, did *not* state in the FCOD Report that the Deceased's cause of death was mixed drug intoxication *as a result of drug overdose*, but rather that the cause of death was the presence of the *combination* of drugs and their interactions in the Deceased's body, irrespective of whether they had been ingested at therapeutic levels. Indeed, Prof Teo was equivocal as to whether the elevated levels of drugs indicated an overdose at all (see above at [66(a)] and below at [83] and [87]).

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73 In this context, we reiterate the importance, when dealing with expert evidence, of considering the *nature* of the evidence and the *purposes* for which it has been adduced. There may be occasions where the expert evidence is of a sort that is virtually determinative of certain facts. For instance, the laws of physics might demonstrate that it was simply not possible for a particular event to have occurred. A judge would be entitled to rely on such an opinion in coming to a relevant finding of fact. However, where the expert is only able to speak to probabilities, the court must be astute not to rely on *general* probabilities to determine what must have occurred *in the particular case* without sufficient consideration of the other aspects of the matrix of facts before it that might bear on the latter question. As a simple illustration, the fact that an accused has a DNA profile which matches that of the DNA found at the crime scene does not necessarily warrant finding the accused guilty of the crime by reason of that alone. The court would need to weigh the probabilities as to whether the DNA that was found was in fact the DNA of the accused person, how that DNA got to the scene of the crime and also consider this in the round with the accused's defence and the other evidence presented by the prosecution. This was explored in some detail in *R v Alan James Doheny* [1997] 1 Cr App Rep 369, where Phillips LJ explained as follows (at 372–373):

> If one person in a million has a DNA profile which matches that obtained from the crime stain, then the suspect will be one of perhaps 26 men in the United Kingdom who share that characteristic. If no fact is known about the Defendant, other than that he was in the United Kingdom at the time of the crime the DNA evidence tells us no more than that there is a statistical probability that he was the criminal of 1 in 26.
>
> *The significance of the DNA evidence will depend critically upon what else is known about the suspect.* If he has a convincing alibi at the other end of England at the time of the crime, it will appear highly improbable that he can have been responsible for the crime, despite his matching DNA profile. If, however, he was near the scene of the crime when it was

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> committed, or has been identified as a suspect because of other evidence which suggests that he may have been responsible for the crime, the DNA evidence becomes very significant. The possibility that two of the only 26 men in the United Kingdom with the matching DNA should have been in the vicinity of the crime will seem almost incredible and a comparatively slight nexus between the Defendant and the crime, independent of the DNA, is likely to suffice to present an overall picture to the jury that satisfies them of the Defendant's guilt.
>
> The reality is that, provided there is no reason to doubt either the matching data or the statistical conclusion based upon it, the random occurrence ratio deduced from the DNA evidence, *when combined with sufficient additional evidence to give it significance*, is highly probative. … [emphasis added]

74 In the final analysis, a court must not confine itself to the opinions of experts where the ultimate finding of fact to be made rests on a consideration of the entirety of the factual matrix before the court. A similar point was made in *Eu Lim Hoklai v Public Prosecutor* [2011] 3 SLR 167, where we said (at [44]):

> … Expert evidence will not always offer a clear answer to every question before the court. This does not excuse a judge from making a crucial finding of fact. Ultimately, all questions – whether of law or of fact – placed before a court are intended to be adjudicated and decided by a judge and not by experts. An expert or scientific witness is there only to assist the court in arriving at its decision; he or she is not there to arrogate the court's functions to himself or herself (see the observations of Winslow J in *Ong Chan Tow v Regina* [1963] MLJ 160 at 162). *Where the scientific evidence fails to provide a precise answer, therefore, the court must resort to the usual methods it employs in all other cases which do not require expert evidence: that is – namely – the sifting, weighing and evaluating the objective facts within their circumstantial matrix and context in order to arrive at a final finding of fact.* … [emphasis added]

75 We also differ from the Judge in so far as she bolstered her conclusion with reference to the evidence of Dr Ang and Dr Yeo. In our judgment, Dr Ang's and Dr Yeo's evidence in this context ought to have been viewed with some circumspection because they were the Deceased's treating doctors and

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had prescribed the very medications and dosages that were in issue. Faced with the question whether this could have killed their patient, it is improbable that they would have said anything other than 'no'. Against Dr Ang's evidence, it is significant that both Dr Winslow and Dr Tan, who were the psychiatric experts, agreed that the dosages and combinations of drugs prescribed to the Deceased by Dr Ang were high and were not dosages and combinations which they themselves would have prescribed. This is not to say that Dr Ang and Dr Yeo acted improperly in prescribing such dosages and combinations of drugs; but rather that their assessment that the risk of the Deceased suffering an adverse reaction from the drugs if consumed in therapeutic doses was low does not answer the question which the court is now faced with, which is whether that low risk in fact eventuated on the facts of this case. That question must now be answered with the benefit of hindsight, on a consideration of all the evidence, including, but not limited to, the scientific and medical evidence.

76 In our judgment, what emerges from the evidence of the scientific and medical experts, which we have considered above, is that the quantity and variety of drugs prescribed to the Deceased were such that even if these had been taken in their prescribed doses (which were at the high end to begin with), this *could* have resulted in the adverse reactions that led to his death. At the hearing of the appeal, counsel for the Respondent conceded that this was a possibility, but he submitted that given the elevated levels of the four drugs, it was improbable that this was what had transpired. In our judgment, since this is a possibility that cannot be excluded, in order to determine what probably took place in this case, it would be necessary to consider the other aspects of the evidence that might also shed light on this question.

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What caused the elevated levels of the four drugs in the Deceased?

77 The Appellants' submission is that besides an overdose, the elevated levels of the four drugs in the Deceased's post-mortem blood could be attributed to (a) drug interactions leading to the inhibition of the metabolism of the drugs or impairment in the body's ability to metabolise, process, and eliminate the drugs properly; (b) PMR; or (c) a combination of both these phenomenon. Given these possibilities, the Appellants submit that the Judge ought to have looked at the toxicology results in context and considered if an overdose was substantiated by all the surrounding circumstances of the case. The Appellants also submit that the Judge appeared to have equated the elevated levels of the drugs reflected in the FCOD Report with the levels of the Deceased's consumption of the corresponding medication. In this regard, the Appellants stress Prof Teo's and Dr Tay's evidence that the concentration of a particular drug in the Deceased's post-mortem blood would not directly reflect the number of corresponding tablets that the Deceased had consumed because there is no necessary or direct correlation. The Appellants point out that none of the medical experts testified that the ingestion of a particular amount of medicine would definitively lead to a certain concentration of drugs in the Deceased's post-mortem blood as the latter could vary widely depending on a myriad of factors including the presence of PMR, the Deceased's physical constitution, and his body's ability to metabolise or excrete the drugs. In response, the Respondent argues that the extent to which the drug levels were elevated as reflected in the FCOD Report were extremely high and this could lead to only one reasonable conclusion: the Deceased had overdosed.

78 In assessing this part of the evidence, it is, in our judgment, necessary to keep in mind the evident lack of precision in the post-mortem toxicology

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analysis. This imprecision operates at two levels. At the first level, the assessment that the levels of the four drugs found in the Deceased's body were elevated was based on studies that concerned *ante*-mortem *plasma* levels of living subjects. In other words, the drug content in the Deceased's *post*-mortem ***blood*** were found to be elevated in comparison with *ante*-mortem ***plasma*** levels of living subjects. Dr Tay explained in his report that these differences were significant because (a) a body's physiological condition when the person is alive is different from its condition when the person is dead, and (b) blood is different from plasma and the concentration of a drug in plasma can be different from its concentration in blood because the drug may partition differently between plasma and red blood cells. When giving evidence on the stand, Prof Teo too was careful to emphasise that blood and plasma levels are different:

> … Looking at the literature, we also have to be mindful that many of the drug levels that are reported for drugs are not in people who have died but in people who are living. There is very little literature on how high a blood level must be to be able to cause toxicity or fatality … in some drugs.
>
> The next thing that then needs to be considered is that the presence of these drugs are measured in different parts of the blood. Blood by itself is composed of cells and fluids and the fluid part of the blood is called plasma and drug levels can be either measured in blood, which is what is done in post-mortem samples or in plasma, which is what is usually done in clinical samples, that means in people who are still alive.
>
> There is also very little medical literature that tries to correlate post-mortem blood levels versus clinical plasma samples, the blood levels. There is very little literature, that means saying that if the post-mortem blood level is X, what is the equivalent level in a clinical sample in a living person where a living person would have experienced toxic symptoms or would have died. This is one of the main problems of interpreting post-mortem toxicology. …

79 Prof Teo reiterated this under re-examination:

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> Q: Okay. Can I just confirm that [in the FCOD Report] … [c]omparison was done with the therapeutic range versus the post-mortem blood level ranges?
>
> A: Yes, Your Honour.
>
> Q: Thank you.
>
> A: … [I]f I may just add again just to emphasise that when we compare post-mortem blood to therapeutic levels which are not blood levels but serum levels or plasma [levels], we have to be very careful, because … there may be no evidence in the literature to correlate blood to serum plasma. And because there is no evidence, no scientific evidence to correlate post-mortem blood to therapeutic levels, one has to just use the best evidence that's available.

80 The difference between post-mortem blood and ante-mortem plasma was a point which the Judge noted at [122] of the Judgment. However, despite noting this, the Judge did not appear to consider it in her subsequent analysis. At [135] of the Judgment, the Judge noted that Prof Teo was "certain that the levels of the four drugs were elevated in the [D]eceased". This might have been derived from the following section of Prof Teo's evidence:

> … So these are possible causes [*ie*, overdose, PMR or an inhibition in the body's ability to eliminate the drugs] of why … blood levels can be elevated in post-mortem toxicology samples. And therefore, it is not possible unless there is real evidence at a scene, for example, where there may be phials of drugs which are empty or you have empty bottles. Unless the pathologist is told … [of] a circumstance like that, it is not possible to say just based purely on blood toxicology levels, whether or not the elevated levels are spurious because whether they are true elevated levels or whether they are elevated because the person is not excreting these drugs, but taking them at normal levels, or whether it is due to post-mortem redistribution, or … it could [even] be a combination of all these causes that there was some ingestion of a higher dose, there was decreased excretion and there was post-mortem redistribution, all at the same time, leading to a very high elevated level.
>
> So all we can say is that the levels are elevated and that is factual. That's all we can say.

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81 That portion of Prof Teo's evidence must be considered in its context. Just a few minutes prior to making that statement, he had made the remarks which we have set out at [78] above. So thus while it is a *fact* that the Deceased's post-mortem blood levels were elevated when compared to ante-mortem plasma levels, the *significance* of this comparison remained contentious and uncertain; and Prof Teo, the pathologist who supervised the autopsy of the Deceased, declined to take a position on whether the elevated levels were indicative of an overdose.

82 This segues into the second reason for our observation that the post-mortem toxicology analysis is imprecise in terms of the conclusions we may draw from it, which is that besides overdose, the elevated levels could have been due either to PMR, the inability of the Deceased's body to effectively eliminate or metabolise these drugs, or a combination of these two factors.

83 In this regard, Prof Teo raised the possibility of PMR and liver or kidney dysfunctionality. With respect to the latter, Prof Teo noted that while he did not find anything structurally wrong with the Deceased's livers or kidneys, the ingestion of a large amount of medication over a prolonged period of time might have affected the functionality of the organs. In particular, in line with Dr Tay's evidence set out at [66(b)] above, Prof Teo noted that the drugs which were detected in the Deceased's blood at elevated levels were drugs that were processed or metabolised in the liver by the P450 group of enzymes. It was therefore possible that this group of enzymes had been overwhelmed by the amount of medicines the Deceased was consuming. According to Prof Teo, such functional abnormalities in the Deceased's liver or kidneys may have existed without becoming evident during the autopsy.

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84 Additionally, the parties' toxicology experts, Dr Tay and Dr Phua, both recognised that some drugs which the Deceased had been taking could inhibit the P450 group of enzymes. However, in Dr Phua's view, if such inhibition had occurred, the Deceased would have exhibited minor side effects, such as dryness in the mouth and eyes and difficulty in urinating. In this connection, the evidence of Dr Ang and Dr Yeo was that there were no clinical signs of any functional impairment in the Deceased's liver and kidneys (see the Judgment at [120]). However, Dr Ang did agree that it was possible that the Deceased's concomitant use of a variety of drugs could lead to the inhibition of the enzymes that metabolised some of those drugs. This could have then have led to an increase in blood concentrations of drugs that had not been adequately metabolised. Dr Ang testified that he took this possibility into account when making his prescription, but felt that what he had prescribed to the Deceased was safe since the Deceased had been on long-term medication.

85 On PMR, the medical evidence generally was that the PMR process began immediately after death, though the effect of PMR would be more pronounced if the body was at an advanced stage of decomposition. The extent to which PMR would affect drug concentrations was dependent on the temperature at which the body was kept and the time after death at which the blood samples were extracted. There was some dispute between the medical experts as to the extent of PMR in the present case given the time at which the Deceased's body was found and the time his blood was extracted for testing, and the susceptibility to PMR of the four drugs in question the levels of which were found to be elevated. This was identified by the Judge at [121] and [123]–[128] of the Judgment.

86 Dr Phua, who was the main proponent of the overdose theory, testified that the effect of PMR would be minimised if peripheral blood was used for

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sampling, and if the samples were collected from the body as soon as practicable. In his view, as the samples of peripheral blood were taken within 24 to 32 hours after the time of the Deceased's death, the effect of PMR would not have been significant. However, this did not mean that there was *no* PMR in the Deceased, since Dr Phua accepted that PMR would start to occur immediately after death once the cell membranes stopped working.

87 In our judgment, the evidence pertaining to the possible explanations for the elevated levels of the four drugs that were found in the Deceased post-mortem blood is equivocal. Whilst the toxicology evidence might tend to support the overdose theory, especially where duloxetine and olanzapine were concerned, it by no means ruled out the possibility that the elevated levels could be due to a combination of liver and kidney dysfunctionality, possible inhibition of the P450 group of enzymes, differential metabolism, and/or the PMR process. The inherent uncertainties in comparing post-mortem blood levels with ante-mortem plasma levels in living subjects must also be borne in mind. Thus, when the Judge questioned Prof Teo as to whether "the most probable explanation [for the Deceased's death] is that the [D]eceased took much more than the stated dose", it is unsurprising that Prof Teo's reply was that an overdose was "one of the possible causes that we need to consider and look at to see whether or not this possible cause is substantiated by other evidence". Bearing in mind the various possibilities, and in line with what we have observed at [76] above, the toxicology evidence must be viewed in the light of other circumstantial and psychological evidence in order to assess what in fact occurred in this case.

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Evidence concerning the Deceased's practices when consuming his medication

88 The Appellants submit that the Deceased had a practice of taking his medication strictly in accordance with prescription. However, the Judge found that the Deceased was not as systematic in taking his medication as the Appellants submit (see the Judgment at [67]).

89 We broadly agree with the Judge's assessment. As the Judge explained, the evidence that the Deceased had taken his medication in a systematic manner was based on the weight of Siew Kim's evidence that she had seen the Deceased pack his prescribed dosage of medicine on 2 and 3 August 2012 before leaving the Joo Chiat house for the Everitt house. However, Siew Kim admitted that she did not know exactly what medicines the Deceased had packed. Further, the Toxicology Report noted the presence of paracetamol – a drug that neither Dr Yeo nor Dr Ang had prescribed.

90 During the trial, three physical exhibits of the Deceased's remaining medication, labelled P1, P2, and P3, were admitted into evidence. These three exhibits comprised blister strips of medication with a total of 2,483 tablets, and it appeared that these had been dispensed by Dr Yeo and Dr Ang on or after the Deceased's discharge from hospital on 31 July 2012. According to the Appellants, the three exhibits confirmed that the Deceased had consumed 61 tablets between his discharge from hospital and his death, which was in line with his prescriptions, and that it was thereby possible to infer that the Deceased had not exceeded the prescribed dosage.

91 The Judge doubted that these were the only drugs in the Deceased's possession prior to his death (see the Judgment at [68]–[80]). She also observed that whilst the blister strips indicated that four days' worth of

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medication had been consumed, no one was able to confirm whether these had been consumed by the Deceased or whether the tablets had been removed by someone else on a separate occasion (see the Judgment at [80]). From the way the Appellants presented the evidence in support of their case, the Judge gained the impression that the Appellants had organised their case in a particular way, and found them less than completely forthcoming (see the Judgment at [94]).

92 On appeal, the Respondent submits that an additional three months' supply of midazolam, zolpidem, and diazepam ought to have been present in the exhibits of the Deceased's remaining medication. The Respondent's argument is that the large quantity of missing drugs is probative of suicide. The Respondent also highlights Dr Ang's testimony that it was common for the Deceased to have leftover medication from previous prescriptions, and argues that it is "highly suspicious" that the leftover medication had not been accounted for. In the Respondent's submission, the unaccounted leftover supplies could explain how the Deceased might have consumed an overdose even though it appeared that the latest supply of medicines (*ie*, P1, P2, and P3) was largely intact.

93 We do not find the Respondent's first submission meritorious. The concentrations of midazolam, zolpidem, and diazepam in the Deceased's post-mortem blood were *not* found to be elevated in the FCOD Report, and consequently, it is neither reasonable nor relevant to suggest that the missing quantities of those drugs is probative of suicide. In relation to the Respondent's submission that the Deceased would have had leftover medication from Dr Ang's previous prescriptions, we note that while this was Dr Ang's opinion, it was clear that he did not personally know how much leftover medication, if any, the Deceased in fact had.

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94 Additionally, although the Judge thought that the Appellants had been less than completely forthcoming, she did not go as far as to find that the Appellants had wilfully concealed medicines that they had found after the Deceased's death in order to present a misleading picture. In any case, the possibility that the Appellants were in possession of other medication besides those found in P1, P2, and P3 does not detract from the Appellants' case. On one view, the presence of more medication than P1, P2, and P3 would suggest that the Deceased had *not* consumed such medication which would seem to cut against the theory that the Deceased had consumed an overdose. It must also be noted in any case that the Respondent's counsel, Mr Lim Tong Chuan, had not put any allegation of deliberate concealment to Siew Kim or the 2nd Appellant at the trial. In our recent decision in *Sudha Natrajan v The Bank of East Asia Ltd* [2017] 1 SLR 141, we did not allow the respondent to advance a case based on auto-forgery on the appellant's part when the respondent had not put this case to her in the course of cross-examination. We noted that the appellant in that case had not had an opportunity to address such a serious allegation of fraud and criminal conduct at trial and held that as a matter of fairness, the respondent should not be allowed to advance such an argument as part of its case on appeal (at [48] and [51(b)]). The same principle applies here. In our judgment, it would be inappropriate, given the circumstances, for the Respondent to now insinuate that the Appellants might have tampered with the evidence for the purpose of presenting a favourable version of events in court.

95 Nonetheless, we recognise that the possibility remains that the Deceased might have had more medicine in his possession *prior* to his death than was known to the Appellants. This could lend some credence to the Respondent's view that the Deceased had overdosed. In our judgment, it is

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unclear from the evidence that was adduced by the Appellants whether the Deceased was as fastidious in consuming his medication as the Appellants submit. On its face, P1, P2, and P3 indicate that the Deceased had consumed the medication in accordance with the prescribed dosage. At the same time, there is also other evidence casting doubt on the proposition that the Deceased had only consumed the prescribed dose of medicines and no other drugs on the night of 3 August 2012. Taking all this in the round, we find that there is little that can be gleaned from this to aid us in coming to a conclusion as to whether the Deceased had overdosed, much less why, even assuming that he did.

Evidence as to the Deceased's state of mind

96 We turn to the evidence relating to the Deceased's state of mind which we consider pertinent in two ways. First, to the extent that the scientific, medical, and other circumstantial evidence do not sufficiently reveal the likely character of the Deceased's actions immediately prior to his death, the evidence relating to his state of mind should be taken into account to aid in coming to a conclusion on this. Second, the evidence relating to the Deceased's state of mind could be critical to the issue of whether, in the circumstances, the injury leading to the Deceased's death was an "accident" within the meaning of the Insurance Policies. The point simply is this: all other things being equal, the evidence that the Deceased's state of mind was positive rather than negative, optimistic rather than pessimistic, and constructive rather than destructive, would tend to militate against the notion that the Deceased had acted as he did intending or expecting to end his life.

The psychiatric evidence

97 The Judge held that the overall psychiatric evidence tended to support the Appellants' case (see the Judgment at [100]). We agree with the Judge in

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this regard. The psychiatric evidence was clearly that the Deceased did *not* present as a suicide risk. This being the case, it weighed the balance in favour of finding that the Deceased had not overdosed or at least that he had not done so intending or expecting to end his life, but had then unexpectedly suffered the adverse reactions resulting in his death.

98 Some significant aspects of the evidence should be highlighted. First, Dr Tan stated in his report that his opinion that the Deceased may have committed suicide was based on the high and toxic levels of the drugs found in the Toxicology Report, "because if there were no high and toxic levels of the various drugs, it was unlikely that the Deceased had committed suicide". Dr Tan further observed that "[i]f there were high and toxic levels of the various drugs, then the Deceased *must* have taken an overdose of the various drugs" [emphasis added]. We pause to note that this part of Dr Tan's opinion consisted of resting one inference upon another when it seemed to us, with respect, that neither was well founded to begin with. In essence, Dr Tan's view that the Deceased had killed himself was developed in this way:

(a) because there were high and toxic levels of the relevant drugs in the blood of the Deceased, he must have overdosed; and

(b) since he overdosed, there was a possibility that he may have intentionally committed suicide.

99 As to the first of the premises, it is clear to us that this was not within Dr Tan's expertise, and Dr Tan in fact accepted as much. Moreover, Dr Tan's evidence that the prescription of psychiatric medication was high and that he would not have prescribed the same dosages and variety of medication as had been done in this case did not seem to us to sit well with his confidence that

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the high concentrations of the drugs in the Deceased's blood could *only* have been the result of an overdose. In any event, as we have already noted:

(a) there is no direct relationship between the levels of the various drugs that were found in the Deceased's blood and the dosage of the corresponding medicine that he had consumed; and

(b) it was possible that even if the Deceased had consumed the medication as prescribed, the elevated drug levels could have been found by reason of one or more other factors, such as differential metabolism or PMR.

100 As to the second of the premises, even if the Deceased had consumed an excessive dosage, it does not invariably follow that he must have done so with the intention of ending his life. As we have observed at [51] above, knowledge of a risk does not amount to the Deceased intending or expecting that risk to materialise. We note that Dr Tan's conclusion was that an intentional death on the Deceased's part was a *possibility* that could not be excluded, but having found that Dr Tan's assumption that the Deceased must have overdosed is a flawed one, the strength of even the possibility that the Deceased might have intentionally killed himself is diminished.

101 Second, we note that Dr Ang was sufficiently confident in his assessment that the Deceased was not at risk of suicide since he was willing to prescribe him with six months' worth of medication. Throughout the proceedings, Dr Ang consistently maintained that the Deceased did not present as a suicide risk. Indeed, some months after the Deceased's death, Dr Ang provided a statement to the police that the Deceased "had no suicidal tendency or ideation" and had never mentioned to Dr Ang that he had wanted to end his life. It is true that this too might be said to be self-serving but the point is this:

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we accept that Dr Ang never *believed* that the Deceased was prone to suicide because we find it inconceivable, had the position been otherwise, that Dr Ang would have discharged the patient with such a large quantity of potentially fatal medication in his possession.

102 Third, although Dr Tan cited studies which showed that individuals were at a higher risk of suicide after discharge from in-patient psychiatric care, these studies might not have been applicable to the Deceased who had been in and out of hospital for his various illnesses (including psychiatric issues) at various times between 2009 and 2012. As the Judge noted at [100] of the Judgment, the pattern established by the Deceased over the three years preceding his demise was that of treatment in hospital for pain and depression followed by the alleviation of his symptoms, and further treatment in hospital for pain and depression when his symptoms recurred as he returned to the demands and stresses of his daily life. There was no evidence before us to suggest that the last hospitalisation had been any different. Instead, the evidence of his treating doctors was that at the time of the Deceased's discharge from hospital in July 2012, his pain was well-managed and he was in control of his emotions.

103 The weight of the evidence clearly demonstrates that the Deceased was not considered by those attending to him to be a suicide risk at the material time before his death.

Evidence of the Deceased's circumstances prior to his death

104 The Appellants also raise other circumstantial evidence, such as the manner in which the Deceased was conducting his affairs prior to his death and his making of plans for the future, as evidence that the Deceased did not,

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in the period immediately before his death, harbour any intention to commit suicide. The Judge noted that there were indications of positive features in the Deceased's life at the material time, but concluded that on the whole, the situation was more equivocal than the Appellants suggested (see the Judgment at [85]).

105 In our judgment, the evidence of the Deceased's circumstances tended to be more positive than negative. Whilst the Deceased might have been troubled by the legal suit against his brother, which we have referred to at [11] above, it must be noted that this was a proceeding *instituted by* the Deceased against his brother, rather than one in which the Deceased was a defendant. Siew Kim's evidence was that the Deceased had commenced the suit to "seek justice" for his uneducated siblings who he felt had been cheated by one of their brothers. As stated above at [10], the Deceased was seen as a "highly responsible man" guided by values of diligence, loyalty and commitment. In our judgment, it would have been incongruent with the evidence to conclude that the suit was a significant negative factor that led the Deceased to take his life. While the Deceased might have been troubled by it, he could at any time have chosen to end the suit rather than his life. Moreover, it would not have been in keeping with his character for the Deceased to end his life when the suit had not been concluded to vindicate the position of his siblings. As for the Deceased's back pain and depression, these were ailments that had affected the Deceased for the preceding two or three years. It was thus unlikely that the Deceased's back pain or depression were triggers for suicide, since these were matters he had been coping with. In fact, while he had been in hospital for most of July 2012, he had taken 12 days of home leave, coming back to the hospital only for rest in the evenings. Dr Yeo also testified that after treatment, the Deceased's pain was not much of an issue, and that part of the reason for

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his prolonged hospitalisation was to give the Deceased some respite from the physical exertions of his life.

106 Furthermore, there were some significant positive signs that suggested that the Deceased was making plans for his future and had every intention of meeting that future. In July 2012, the Deceased purchased two second-hand luxury cars despite never having previously owned a motor vehicle. The Deceased was well-off financially, able to afford not just luxury cars, but also prolonged stays in private hospitals (such as his July stay at Mount Elizabeth Novena Hospital). He also took a positive step in early August 2012, moving into the Everitt house which was a more conducive environment to enable him to cope with his back pain. Although the Judge noted at [87] of the Judgment that it was not clear whether the Deceased's move to the Everitt house was a settled move, we find that the objective contemporaneous evidence close to the date of the Deceased's death suggests that it was. In a letter to Insp He dated 15 October 2012, Dr Yeo records that the Deceased had "agreed to move to another single storey apartment to stay so as to avoid any more falls". We find this statement significant given that Dr Yeo had repeatedly exhorted the Deceased to move out of the dilapidated Joo Chiat house. Consistent with this, there was also evidence that between February and June 2012, the Deceased had purchased furniture for the Everitt house and arranged some renovation works. These actions seem to us to suggest that the Deceased had formed a settled view that he would move to the Everitt house upon his discharge from hospital in July 2012.

107 The last and, in our view, most telling evidence of the Deceased's state of mind just prior to his death is a CCTV clip showing the Deceased at the Everitt house on the night of 3 August 2012. This shows the Deceased just hours before he retired for the night. In it, the Deceased is seen tending to his

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plants and speaking to someone on the phone. He then undertook with the help of a friend to move a large and heavy wooden cupboard up the stairs to the bedroom he was occupying. Throughout this, he appears to have been in a positive mood.

108 The Judge agreed that the Deceased appeared to be in a "good mood and apparently pain-free" (see the Judgment at [93]). However, she placed little weight on this evidence because it had been extracted from a longer recording and was only 38 minutes long, leaving some doubt as to what the remaining footage might have showed. The 2nd Appellant explained that the reason for this was that the video had been created as a keepsake and remembrance of the Deceased. We see no reason to reject the 2nd Appellant's evidence given that the video which included the CCTV clip had been created about two weeks after the Deceased's death. Whilst it is true that the CCTV clip might have been more useful if it had been complete, the length that was presented does not diminish its value since it reveals the Deceased cheerfully and busily engaged in household activities at about 8.00 pm on the day before his death. Mdm Chee also corroborated this, giving evidence that she had a light-hearted conversation with him between 8.00 pm and 9.00 pm on 3 August 2012.

109 During the cross-examination of the experts, a suggestion was advanced that the Deceased might have suffered a relapse of his back pain after lifting the heavy cupboard up the stairs as he was seen to be doing in the CCTV clip and that this might then have triggered an intention on his part to commit suicide. We reject this for two reasons. First, it is speculative. Second, were it the case, one would have expected that the Deceased would have consumed more of the pain medication prescribed by Dr Yeo for the purpose of relieving his pain. However, there is nothing to suggest that he did this, and

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the elevated levels of the medication found in his body after his death was of the psychiatric medication.

110 In sum, the evidence of the Deceased's circumstances and attitude towards life strongly suggests that the Deceased was a resilient man who, at the material time, had made plans for the future and who had no lack of desire to carry on with life.

Was the Deceased's death caused by "accident" within the scope of the Insurance Policies?

111 There are only three broad scenarios that can account for the Deceased's actions and intentions prior to his death. These are as follows:

(a) The Deceased took an overdose of his medication with the intention or expectation of suffering injury that would result in death.

(b) The Deceased took an overdose of his medication without intending or expecting thereby to suffer any injury resulting in death.

(c) The Deceased took his medication in accordance with the prescription and harboured no intention or expectation of suffering injury resulting in death.

112 Under scenarios (b) and (c), the Deceased's death would have been caused by "accident", and the Estate would be entitled to the assured sums under the Insurance Policies. Under scenario (a), the Deceased's death would not be an "accident", and the Respondent would not be liable to pay the assured sums under the Insurance Policies. For the Respondent to succeed, the court would have to find on a balance of probabilities that scenario (a) was what occurred on the night of 3 August 2012.

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113 Given the weight of the psychiatric evidence and the evidence concerning the Deceased's outlook on life, we find instead that on a balance of probabilities, what occurred on the night of 3 August 2012 was either scenario (b) or (c) rather than scenario (a). Indeed, in our judgment, on the weight of all the evidence, scenario (c) offers the best explanation of all the surrounding circumstances. Hence, we find that the Deceased died even though he took his medicine in accordance with the prescribed dosage.

114 To be clear, it is not necessary for us to find that the Deceased had consumed his medication in accordance with prescription in order for the Appellants to be entitled to the assured sums under the Insurance Policies. This is because even if the Deceased had deviated from his prescription, this would not take him outside the scope of the insured risk if he had done this without intending or expecting to suffer injury. It does bear noting in this context that it was not possible to establish, based on the scientific and medical evidence, just how much medication the Deceased did ingest on the fateful night in question. Nor, even assuming that the Deceased could be said to have consumed an overdose of the psychiatric medication in a certain notional quantity (for example, by taking two additional tablets of duloxetine in excess of his prescription), was there any evidence to warrant a finding that the natural or usual consequence of doing so would be injury or death, let alone that the Deceased knew this to be the case. It should be noted that the only evidence before the court suggesting that the Deceased had any awareness of the potential dangers of overdosing was Dr Yeo's response to a questionnaire in which he said that he had warned the Deceased against unauthorised mixing or self-escalation. However, the medication found at elevated levels were those prescribed by Dr Ang, and there is no evidence that Dr Ang had given a similar warning to the Deceased. In the circumstances, the

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Respondent cannot even show that the Deceased *knew* of the possible toxicity of exceeding the prescribed dosage of Dr Ang's medication, much less that he held a *belief* that an overdose of those medications would lead to injury or even death.

115 In the circumstances, applying the framework we have set out at [52] above, we are satisfied that the Appellants have raised a *prima facie* case that that the Deceased had no intention or expectation of suffering injury or death when he consumed his medication on the night of 3 August 2012. We also find that the Respondent has not discharged its evidential burden of proving otherwise. In our judgment, there is virtually *no evidence* which demonstrates that the Deceased consumed his medication with such a belief or intention.

116 To the extent that the Respondent's case is built on the premise that the Deceased had consumed an overdose and therefore that the Deceased must be taken to have intended or expected to suffer injury, neither premise is made out in this case. While we accept that the Respondent has raised some evidence which indicates that the Deceased might have consumed more than the prescribed dosage of duloxetine and olanzapine, the scientific and medical evidence taken in the round together with the circumstantial evidence and the evidence of the Deceased's state of mind at the material time is, in our view, insufficient to warrant a finding that the Deceased had overdosed. Even less does the evidence warrant the separate and essential finding that the Deceased acted as he did intending or expecting to die.

117 On the whole, we find that the Deceased's death may be accounted for by either scenarios (b) or (c) and was, in our judgment, the result of an injury caused by or sustained in an "accident" within the scope of the Insurance

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Policies. We therefore hold that the Estate is entitled to the assured sums under the Insurance Policies.

Conclusion

118 For these reasons, we allow the appeal with costs here and below and also make the usual consequential orders.

Sundaresh Menon	Chao Hick Tin	Andrew Phang Boon Leong
Chief Justice	Judge of Appeal	Judge of Appeal

Melanie Ho, Chang Man Phing, and Tang Shangwei (WongPartnership LLP) for the appellants;
Lim Tong Chuan and Joel Wee (Tan Peng Chin LLC) for the second respondent.

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