Proceedings taken in the Court of Queen's Bench of Alberta, Courthouse, Lethbridge, Alberta

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April 18, 2016	Morning Session
The Honourable	Court of Queen's Bench
Mr. Justice Jerke	of Alberta
L.M. Weich	For the Crown
C.O. Giles	For the Crown
S.P. Buckley	For the Accused D. Stephan
S.P. Buckley	For the Accused C. Stephan
J. Stringer	Court Clerk
S. Anderson, CSR(A)	Official Court Reporter

THE COURT: Good morning.

MR. GILES: Morning, My Lord.

MS. WEICH: Morning, Sir.

THE COURT: Please be seated.

Discussion

THE COURT: All right. Before we get started with the voir dire, I did bring along a copy of the attachment I sent to both counsel yesterday afternoon -- or yesterday evening on the proposed issues for decision.

Madam clerk, I'll have you mark the document as Exhibit -- the next judicial exhibit, that being the flawed document that was sent to you in the sense that it's a draft. It's a draft. So there's lots of spellings errors and grammar and stuff like that, but mark it as a judicial exhibit. We'll have some discussion about it at some point.

EXHIBIT J-15 - Six-page Document Titled, Issues For Decision

THE COURT: Defence, are you ready to proceed with the voir dire?

Discussion (Voir Dire)

MR. BUCKLEY: Yes, My Lord, I am. And how I would propose proceeding is putting Dr. Sauvageau on the stand, and I would walk her through her qualifications and some bias issues. My understanding just from *White Burgess* is is that, you know, then my friends have to raise a realistic prospect of the bias issue, so, you know, I'd let them cross-examine and then, if necessary, re-direct or -- you know, on bias issues.

Now, really the only notice I've had is is, you know, what we had at the mid-trial conference where my friends are saying, well, because she's in this legal dispute with the Department of Justice, which is a wrongful-dismissal issue, that there's a case of bias. I do have, you know, pleadings if the Court cares about that. I wasn't planning, unless my friends want to go into great detail about it, of, you know, pulling out of Dr. Sauvageau what it's all about because she actually doesn't want to litigate that in these proceedings unless it's necessary. So I'm not sure how far my friends are going to go so I'm just going to signal I'm not really going to go there at first, but if they raise a reasonable prospect, then I will go there --

THE COURT: I think you're wise, counsel. I think that's the right way to go, and my reading of *White Burgess* would indicate that the procedure you're proposing is the right one. If the witness swears to the various aspects that are mentioned in *White Burgess*. I think it's up to the Crown to do something about that, if it chooses to do so. So proceed in the way that you suggest.

Unless the Crown has a particular comment at this point?

MS. WEICH: So, Sir, we have two comments. Number 1, we received Dr. Sauvageau's final report on Saturday and have been prepping for this event since then to the greatest extent. I can advise that we're not only seeking to attack bias on the issue of the ongoing lawsuit but also the fact that she used to be Dr. Adeagbo's boss.

As well, Sir, I can advise that we will be canvassing the issue of relevance and whether or not her evidence is necessary for the jury to hear, basically going through the *Mohan* factors, and now that we've had the opportunity to review her report and the background basis for her report.

As well, we do have Dr. Adeagbo present, and we would seek the Court's permission to allow him to sit in court and listen to everything that she has to say.

THE COURT: Any objection?

MR. BUCKLEY: I would expect that to happen. So -- and just

so the Court's aware, remember I had indicated that I had given my friends on Friday a copy of her report but that there may be some minor revisions. So I had given it to my friends as a draft, and there have only been very minor revisions that definitely have not changed the substance of the report at all.

THE COURT: Okay.

MR. BUCKLEY: So I will go and grab Dr. Sauvageau.

THE COURT: Thank you.

(WITNESS TAKES THE STAND)

ANNY SAUVAGEAU, Sworn, Examined by Mr. Buckley (Voir Dire) (Qualification)

Q Dr. Sauvageau, I'm going to pass up to you and pass up to the Court a copy of your CV.

A Thank you.

My Lord, can I just please ask permission that I will be using lozenge during this day because I am sick.

THE COURT: I'm sorry?

A Okay. I will be -- if -- with your permission, I will be using lozenge because I'm sick. So sorry --

THE COURT: Yeah.

A -- for the sound sometimes, but --

THE COURT: Thank you.

A -- otherwise I will be coughing.

THE COURT: No, that's fine. Just -- and please keep in mind, Doctor, that the microphone doesn't really amplify. It's basically for recording. So you're perhaps a little quiet, so keep that in mind.

A Thank you.

Discussion (Voir Dire)

MR. BUCKLEY: And, My Lord, when we're -- you had asked me to give you in writing what I was seeking to qualify Dr. Sauvageau as an expert in, and I realized this morning that I did not do that, which -- for which I apologize.

Dr. Sauvageau I'm seeking to qualify his -- her as an expert in forensic pathology.

THE COURT: All right. And entitled to give opinion evidence with respect to which matters?

MR. BUCKLEY: Well, and then also I'm seeking to qualify her as an expert in asphyxia. And the forensic pathology would include, you know, cause of death, things like mechanism, manner, circumstances.

THE COURT: So just a second. Cause of death. Mechanism of death?

MR. BUCKLEY: Yeah. Well, 'cause she explained to me when I was interviewing her that, you know -- so forensic pathologists, they look at the mechanism, they look at the manner, they look at the circumstances to be able to arrive at the cause of death. It's just a qualification that she wanted me to add.

THE COURT: Right. But the ruling generally qualifies her as an expert in forensic pathology entitled to give opinion evidence with respect to certain matters, so --

MR. BUCKLEY: Yes. Right. So cause of death.

THE COURT: Right.

MR. BUCKLEY: Diagnosis of illness, the prognosis of illness, the interpretation of medical documents, and in this case, with the -- both as a forensic pathologist but as an expert in asphyxia to speak about hypoxic and anoxic injuries, including when brain damage and death is caused by hypoxic and anoxic injuries.

THE COURT: Okay.

Mr. Buckley Examines the Witness (Voir Dire) (Qualification)

MR. BUCKLEY: So, Dr. Sauvageau, you are currently a forensic

pathologist?

A Correct.

Q And can you just briefly explain basically what it is that forensic pathologists do and are -- and focus on?

A Yes. So, well, a forensic pathologist first is a doctor, then becomes an anatomical pathologist. And before I move on to explain what is a forensic pathologist, it's easier if I give a few (sic) information on what is an anatomical pathologist.

So an anatomical pathologist is a doctor that serve as a consultant for other doctor (sic) using the tools of looking at organs with their own eyes, either as separate organs or in an autopsy, and looking at -- with the microscope. And with these tools, he answer question from other doctors.

For example, when a surgeon is taking out a cancer, he will ask the forensic pathologist to confirm that everything has been taken out, and the pathologist will look -- as the surgeon is still in the operation room, he will look at the specimens, and he will say, Oh, everything's fine, or, In the left corner slightly in the front, there's still cancer. Take a little bit more there.

Or he will also do, for example, if you have a brown spot on your skin and you're not sure if it's a melanoma, the -- the dermatologist will take a little piece, and he will tell the patient, Come back in a month. This will be looked at by a pathologist, and he will tell the doctor either, That's fine; it's just -- it's just a brown spot of no significance or, It's a melanoma which is a cancer, and if it's a melanoma, he will tell them either that, Well, just what you did is fine, or, You need to go back; you need to take more, or, Maybe even you need to take some lymph nodes with it.

So an anatomical pathologist is a doctor that help other doctors with the tools of looking at organs and looking under the microscope, including the autopsy as one of the tool, but usually for the living, there's no autopsy obviously. So to answer that question and to guide their diagnosis and their prognosis.

Forensic pathologists are anatomical pathologists, but they use the same tool plus further knowledge on injuries to answer question not of other doctors but of police. In the system where they have coroners, we answer question of coroners. We answer question of lawyers, and we answer question of Court so that we can help the Court to make their decision faced with medical legal questions. So it's using the same tool as a pathologist but for medical legal questions.

Q Now, just kind of starting at -- you know, going way back in your training, it's -- my understanding is back in 1996 you graduated with a doctorate in medicine from the University of Montreal?
A You said 1996; correct?

Q Yes.
A Yes.

Q And you were licensed to practice medicine in Quebec from 2002 to 2010?
A Correct.

Q And then in Alberta from 2009 to 2015?
A Correct.

Q And currently, because you're not quite sure where you're going to end up living, you're just basically waiting to see where you're going to be before you apply to be able to practice medicine in a jurisdiction?
A Correct. So in the meantime, I act as a consultant in forensic pathology.

Q And then in 1997, you completed a master of science degree in neurological sciences from the University of Montreal?
A Correct.

Q And as I understand it, your focus was basically on the biology of the brain, almost at a cellular level; is that right?
A Correct. Initially, when I was doing my medicine, I thought I wanted to be a neuropathologist, which is a pathologist that concentrate all his interest in the brain. So I did a master degree as I was doing my medicine, so on nights and weekends, I did my master degree in neurological sciences. And then I started a PhD as I was doing my neuropathology. My PhD was on epilepsy, and I was looking at brains that were had'ing (sic) this disease as I was doing my pathology.

But then I had a change of heart, and I decided to go in forensic pathology. But I did a lot of training through my master degree, through the PhD that I didn't complete, because then I was in forensic, and I did several months of training in neuropathology before the change of heart, and then I went to forensic pathology.

Q Right. And so when you say you did some towards a neuropathologist specialty, so that would be neuropathology?
A Correct.

Q Can you explain for us what neuropathology is and then basically how much training you had done towards getting a neuropathology specialist --
A Yes. So I explain. An anatomical pathologist, we have to do that first. For whatever you will do after as a subspecialty, we -- you have to do anatomical pathology. This is five years, and I did these five years.

Then you can do forensic pathology which is another year, which I did, or you could do neuropathology, and there's other subspecialty that exist. Neuropathology is a year, but I didn't do the full 12 month (sic); I did 10 of the 12 month, and so after 10 months, I changed program, and I went for going to to forensic pathology. So I'm not a neuropathologist. I did 10 of the 12 month, but because I had all this extra training, I was often consulted by my colleagues about the brain because I had all these extra training that usually a pathologist or forensic pathologist don't do.

Q Okay. And then as far as your -- you indicated the anatomical pathology is five years. My understanding is is you did that from 1997 to 2002; does that sound right?
A Correct. To be precise, I had an authorization that one of the year of the five year -- so if I go back, I -- University of Montreal allow for -- not sure which word to use -- particularly good student to go on a faster track.

So, for example, I was authorized that I did my medicine at the same time as I did my master degree, and when I was doing my anatomical pathology, they give me one year -- the year that is more general, they give me the equivalent for my master so that I could do more neuropathology quicker. So because I was on the faster track, they recognized that I was doing things fast than usual students.

Q Okay. And then in 2002, you received your anatomical pathology advanced graduate diploma from the University of Montreal?
A Correct.

Q And then from 2002 to 2009, you were a forensic pathologist at the Forensic Sciences and Legal Medicine Laboratory in Montreal?
A Correct. So the first year I was considered in training, so I was doing what -- what is sometimes referred to as a "fellowship", and then I was a full staff forensic pathologist.

Q Okay. And at the time, back in 2002, what -- I mean, was there a program for forensic pathologist to be basically qualified and licensed in Canada?
A So back in -- back in time, forensic pathologists existed in the sense that there were forensic pathologists presenting in court and doing the work, but it was not officially recognized by the Royal College of Physician (sic) and Surgeons in Canada.

So the first time that they open a program that people can officially be a student in Canada to become a forensic pathologist is in 2009. So when I was, myself, training in 2002, we had two choices as a Canadian: We could train in Canada, which I did, which was kind of an unofficial training -- it was the same, but it was -- it was not officially recognized by the Royal College because it didn't official existed yet, or we could go to United States.

But in Quebec, we were strongly encouraged -- and even that is soft. We were told to stay in Quebec and train in Quebec, which I did, so a trained from 2003 -- I started in 2002, and my first year was considered fellowship, and then I was a full staff.

Q And then so from 2003 to 2009, my understanding is is you would be then doing autopsies as a forensic pathologist?
A Correct. Do you want me to explain how we created the specialty maybe or --

Q Well, we absolutely can. So --
A Okay.

Q -- kind of going out of order, but my understanding is is that there would -- the College of Physicians and Surgeons in Canada decided that they did need to have, you know, specific qualifications for forensic pathologists?
A Well, in 2004, it was decided that we should explore the -- when I say "it", the Royal College of Physicians and Surgeon (sic) of Canada decided to look into if we should create forensic pathology officially in Canada, so they created a working group from 2004 to 2007, and we were -- I was part of that group. So the Royal College nominated me on that group, and our job was to give an official recommendation if we should create the specialty in Canada. Our recommendation was to proceed. The Royal College decided to proceed. In 2007, officially, we created the specialty.

They then created two different committees, one who was the specialty committee. It was -- the goal of that committee -- and, once again, I was named by the Royal College to serve on that committee. That committee had for -- for job to -- to say everything that a forensic pathologist needed to study to become a forensic pathologist. So how many autopsy, what type, how many scenes he should go to, what topic he should make sure he would cover? So we made several documents of how we would train people in Canada, what would be the official learning objective, how we will know if people have met the objectives.

They also created a first board of examination, and the Royal College named me vice chair of that examination board for forensic pathology, and our goal was to produce a

bank of question so that people that wanted to be forensic pathologists could go through that examination.

In 2009, the first program open. It was in Toronto. In -- the second program that open was here in Alberta. So in 2011, I resign as the vice chair of the examination board, because I would have been in conflict of interest, and I created here in Alberta the second official program to train forensic pathologists, and we accredited to do so by the Royal College of Physician and Surgeons of Canada, and we started training new students in two thousand an -- I think I -- I have a blank. I think we received our first in 2012 or 2013. Not sure. Because it took a long time to be ready once you announce you want to do a program.

Q Did that program have any training in, basically, responsibilities when coming to court as a forensic pathologist?

A Correct. When we were describing in the material as a committee what needs to be taught, there was this idea that you need to make -- you need to address with the student what it means to be an expert witness. You need to train them to be a good expert witness, and we were strongly recommending the use of mock trial.

As a program director of the forensic pathology program at University of Alberta, I was training students where I would train them to be a good expert witness, and I have organized for one of the student a mock trial where we -- we had the judge nice enough and two lawyers that played role, and they were challenging the student as if it was a real trial, and I was coaching him so that he would be everything that is expected of a good expert witness.

Q Now, back to you working from 2002 to 2009 at the Forensic Sciences and Legal Medicine Laboratory in Montreal, you had indicated that as of 2003, that would involve about 300 autopsies a year?

A Could you repeat the last part of your question?

Q Okay. So I'm trying to find out how many autopsies a year you would do once you were fully qualified in 2003?

A Okay. Well, from the start -- because I start to do autopsy from Day 1 -- it's just that there's about increasing responsibility on what type of cases I'm allowed. So on Day 1, I can only do more medical, and progressively I'm given more complex cases, and by the end of the year, I can do any -- very complex cases. But I do autopsy on my own from Day 1. It's just that the more complex one are not my own. I look at them and I learn, and then I'm allowed to do it under supervision, and then I do it myself.

In Quebec, we were a very busy lab because there's only one forensic lab for the

whole province and it's a very populus province so I was doing more than 300 autopsy a year, and that included 40 to 50 homicides a year.

I have to say that people sometimes say "cases" instead of "autopsies", and that makes the number look bigger. Because in certain places, like in Alberta, like in United States, they also do external examinations, but it's not the same as an autopsy. You just look at the external of the body. You don't do the autopsy, per se. It's a lot quicker, often can takes (sic) five, ten minutes to do an external when there's nothing special, so your number can look bigger. But an autopsy -- in Quebec, it was really autopsies, so it was a real 300 and more with 40 to 50 homicides.

Q And is there any significant about -- significance about homicides?
A Well, they're -- they're more complex in general. Oh, no, that's not the right term. It's just that forensic pathology is particularly trained to address homicide. We are also trained to address complex medical question that would go to court, but we are most often using court for homicides, though, as I said, sometimes it's for medical question with medical league implication.

So for us, homicide is a good way to address our real experience. Because if you only do 70-year-old people dying of heart attack in their bed, you might have a lot of cases, but you don't necessarily have a complex experience compared to when you do two years (sic) old that might have been killed by their father or 23 that have been strangled and -- so it's a more complex experience.

Q Okay. Now, in your CV, there are a lot of publications that deal with, I will call it, sexual asphyxia, and I'm just curious if you can comment basically on the importance of that, as I'm presenting you as an expert in asphyxia?
A Okay. Actually, there's a lot of paper on asphyxia, and numbers of them are on sexual asphyxia, but it's a mean to an end. And what I mean is that when you're in forensic pathology, you cannot really experiment directly. For obvious reason, you cannot take ten volunteers and start to strangulate them or -- they have done that in -- back then in the 40s, but that was ethically concerning, and we can't do that anymore. So you cannot really experiment with people. And animals, there's a limit of what we can in -- we can take from animals and draw the conclusion to humans.

So one of the -- one of the idea I had way, way back then when I started as a forensic pathologist was to use -- we know that some people like to film themself for sexual reason as they are hanging or doing other thing that affect their respiration, and I started -- I started -- I published a first of these video. Well, my first one was a suicide, but it was a very unique case. And then I -- I was looking more for the sexual one because they are easier to find, and so I -- I created a group called "The

Working Group in Human Asphyxia" where people that had such a video in their lab would call me, and we would add them to the -- to the study.

So though I develop an expertise on sexual asphyxia that is often asked in court. For example, when someone say, Well, I didn't want to strangulate her. It was consensual sex, and then it happened, I'm often asked for that part. But I use that mainly to -- to drag from that information about what happened in -- in hanging, in strangulation, and in other type of asphyxia, and over the years, I've seen other type of asphyxia than just hanging.

Q Okay. And so I just want to understand, is -- it's important because you're actually able to see what's happening to the body while the person is being asphyxiated, and then it -- an -- there's autopsy findings to compare with the film? Is . . .

A Yes. But when I was trained in 2002, there was a lot of things in the textbook that everyone assumed was true but that we didn't really know, and when I started looking at this video, I was able to see that what we were saying was not true, and based on observations, we could change from what people think would happen from what really happens.

So that -- that was material that you can observe firsthand. And just as -- because when I say that, people often think, Well, there was judicial hanging, but judicial hanging are different. They are from height, and they -- they break -- they break the neck basically. They -- they separate the spinal cord so totally different. They are not asphyxia so we can not use judicial hanging.

So most of what we were saying about asphyxia, they were based on old texts of how people felt about asphyxia or French or Germans from the 18th century that did experimentation on themself, but that was kind of old science, not really accurate by modern standards. So we were able to change a lot of the thing we were saying based on true observation of cases.

Q Okay. Now, you then moved from Quebec in 2009, and in 2009, 2010, you were an assistant chief medical examiner at the Office of the Chief Medical Examiner in Edmonton, Alberta?

A Correct. I have to say "assistant chief medical examiner" is a title that seemed bigger than what it really is. It means forensic pathologist. It has no meaning of leadership or management. It's a historical remain from an era that we move from a coroner system to a medical examiner system. So I was a forensic pathologist in Alberta from 2009, 2010.

Q Okay. And what did that involve?

A That involved doing forensic pathology. That involved doing cases. So in Alberta, at the time, I was doing between -- I was doing about 300 cases equivalent. And I say "cases equivalent" because in Alberta we also do external examination, and we consider four external examination to be the equivalent to one autopsy. So some people come and they say, I do 500 or 600 cases a year, yeah, but autopsies. That seems to be a bigger experience than really what it is.

So I was doing about 300 cases equivalent or autopsy equivalent a year, which includes some autopsies and some external examination counted as four equivalent to one.

Q Okay. And then from 2010 to 2011, you were the deputy chief medical examiner at the Office of the Chief Medical Examiner in Edmonton. Can you explain what the difference, then, would be from going from assistant chief medical examiner to deputy chief medical examiner.

A Okay. So an assistant chief medical examiner, as I said, the title seemed to imply something more. It's just a forensic pathologist; however, deputy chief medical examiner is a promotion where you do have some management and leadership. Over time it had meant different thing.

When I was deputy chief, we were two, one in Edmonton, one in Calgary. Our job, apart from doing cases as a forensic pathologist, was to assist the chief, who was back then Dr. Graeme Dowling, and to assist in the management and leadership. My specific role in that, I was responsible for the office of Edmonton, of the morgue, which means the people working in the morgue, the technicians, and I was responsible for the death investigators.

Death investigators, people thinking sometimes they are medical examiner. They are not. They are the non-doctors. So I -- I was responsible for the management and leadership of these two teams on top of my regular cases.

Q Okay. And when you say on top of your regular cases, that would be doing either autopsies or external examinations?

A Correct. And at the time, there was no reduction in workload for being a deputy chief. So you had more work, but you had a little bit more on your salary to compensate, but I was still doing the same amount of cases, about 300 cases equivalent so 300 autopsy equivalent.

Q Okay. And then from 2011 to 2014, you were the chief medical examiner for the province of Alberta?

A Correct.

Q And in that role, the chief medical examiner, you had specific responsibilities under the *Fatalities Inquiries Act* (sic).
A Correct. So the chief medical examiner, of course, is also a forensic pathologist, and he's also doing cases but less number of cases because there's other duty. But that all fall under forensic pathology, but they are just different.

So the role of the chief medical examiner is defined in the *Fatality Inquiries Act*, and the *Act* says that we are responsible for making sure the *Act* is applied properly; making sure all the death certificate are reviewed -- I'm paraphrasing; I'm not citing it quote by quote -- making sure that all the cases that should be reported to us are reported to us; making sure it's investigated, so making sure we have -- sorry, that we have the staff to do these cases; making sure the staffs (sic) are -- are trained.

That's mainly for the non-medical examiner, though, because the medical examiner, when we hire them, are already trained, but we send them to continuous medical education over the years. There's rules about it. And we -- I'm responsible of the building. I'm responsible of making sure we have the proper tool to work. I think I'm -- I might have forget one thing, but that's -- that's the overview of it.

Q Okay. And you indicated that it still involved doing autopsies?
A Correct. But I was -- I was top at 100 autopsy equivalent as the chief in recognition that there was a lot of other work to be done. That's still forensic pathology. For example, I could -- I could write policies on how we should do something or meet with stakeholders that wanted us to evaluate if we could do better in the field or -- so it was still forensic pathology but done differently.

Q And then from 2003 to 2009 -- and I know we're going back in time here, but we're switching area of your qualifications -- you were a clinical assistant professor at the Department of Pathology and Cellular Biology at the Faculty of Medicine at the University of Montreal?
A Correct. If you can simplify that part. When I was in Montreal, I was in the teaching staff of the University of Montreal and the University of McGill, and when I arrive in Alberta, I was at a higher level. I was -- by then I was clinical assistant professor, which is one stop up for the University of Alberta and the University of Calgary. So through all my years of practice, I always add affiliation with universities.

Q Okay. And does that -- did that involve teaching?
A Yes, it does at different degrees over time. Like, in University of Montreal, I was doing a lot of lectures in class to medical student. We do that a lot less in Alberta. But both in Quebec and here, we receive a lot of student in the lab where we do

one-on-one teaching and also small group lecture for people in anatomical pathology. But we don't do as much the big auditorium teaching to hundreds of students in medicine.

Q Okay. And then you --
A Oh, and I forgot one part. This is more unique to my case than to other forensic pathologists. But because I'm also a researcher, I have been director or co-director for students doing master degree or PhD. The one with PhD is not in my CV because she has not completed it yet, and the one in my CV are only the one that have completed their thesis.

Q And then you've spoken about starting the residency program in forensic pathology at the University of Alberta already?
A Correct.

Q And you've spoken about basically your appointments with the Royal College of Physicians and Surgeons concerning forensic pathology?
A Correct. There's just one part on this that I have not mentioned, is as a recognition for our -- I have to step down one step. The Royal College, when they created that specialty, they -- they had two choices. They could grandfather in everyone that was already working in the field in Canada or they could decide that there was no real grandfathering. People would have to sit in exam, but first you review that they are qualified to sit the exam, and then you make them sit the exam. The Royal College decided to go the second way. So they didn't just grandfather people in; they would grandfather that they could sit the exam. So it was in two step. You had to prove that you have done enough to sit the exam, and then you sit the exam.

But the people like me that created the exam, we are not allowed to sit the exam because that would be unfair. We know the questions, and we know the question for many years because it's a bank of question. So to avoid this issues, they, for us, created a special title which is "founder designation". So that's why my CV is written that I have a founder designation of the Royal College of Surgeon and Physician (sic) of Canada in forensic pathology.

Q Now, you have also authored two books?
A Correct.

Q Okay. And one book is called "Human Pathology" which you published in 2004?
A That's a translation. It's in French. That one is in French. It's from when I was in Quebec.

Q Okay. Can you basically tell us what that book covers and what it's meant to do?
A Yes. One of the challenge we face when we are in Quebec is that for a lot of us -- and that was my case when I was younger -- our English is limited, and the good books are in English. So when I was teaching -- it was one of the challenge -- you have to teach something in French, but you have no books to advise people to read.

So over the years, I was making my -- the notes from my students, and at some point, I just collected everything and created a book because people that were not even my students were asking for these because it didn't really existed (sic) in French. So I created a Human -- the translation is "Human Pathology", but it's *Pathology Humaine*, which means all the diseases of the body from an overall point of view, system by system, in French, and that was used by the student in the first areas -- like, I used that when I was doing the long lecture with the -- the student in medicine. I was using that for biomedical students for -- when I was teaching the students in pharmacology, the students in dentistry. So it was used when I was doing my lecture. That was the book that was going with it, and it was also bought by other people, of course, not just by me.

Q And then you've also been involved in four book chapters?
A Correct.

Q And basically what areas would those chapters be focusing on?
A So they're -- they're a little bit diverse. We've talked mainly here about my recognition as asphyxia, so two of them are in asphyxia. One is specifically more on hanging. The other one is more specifically on autoerotic death. The other two -- we have not talk (sic) about it today, but another field where I am known as a researcher, though not to the same level as asphyxia, it's blunt head injury.

So I was asked to do a chapter on accidental falls, and the last one is not related to any specific research team. It's more -- when you -- when we name the big names in the field in the country, my names (sic) come often, and the -- the American Association of Forensic Sciences wanted to do a book on the state of forensic science in the world, and they ask one person per country to be responsible for the chapter for the country, and I was asked for Canada.

So it's kind of an overview of forensic sciences, not just pathology, all the sciences in Canada. I did the chapter for Canada in a book that present the state of the world in forensic sciences. Of course, I -- it was a lot of work so I asked someone to be co-author with me so I asked Dr. Jones, who is from -- at the time, he was the chief toxicologist in the office, and I was not as comfortable with certain lab aspect, and I ask him to help me, and together we did this chapter of the state of forensic sciences

in Canada.

Q Okay. And then you've been involved in 82 published papers, if my math is correct?
A I come to 81.

Q Okay. Well, that's -- let's --
A 81, 82.

Q Let's go with 81. So and --
A It's 76 plus 5.

Q 81. So, yeah, and basically they're outlined in your CV?
A Correct.

Q Okay. And then you've been a journal reviewer for a number of journals. The --
A Correct.

Q *The Journal of Forensic Science*, *Forensic Science International*, *Forensic Sciences, Medicine, and Pathology*, *Journal of Forensic and Legal Medicine*, *Journal de Medicine Legale*, *Addiction*, *Clinical Medicine: Trauma and Intensive Medicine*, *Indian Journal of Medical Sciences*, *Pediatrics*, *Journal of Medicine and Medical Sciences*.

What does a journal reviewer do?
A Okay. So if you're familiar or even if you are not, I'm going to explain how it works. When we publish sciences in a scientific journal, there's a process of peer review. So before a paper is published, depending on the journal, usually it's two, sometime it's three, people that are recognized in the field as being competent and qualified that will review the paper and that will assess if it should be published or not.

The first level is we can say, Don't publish that; there's too many problem. Or we could say, Yes, it's -- it should be published, but here's a list of thing that need to be modified, either because there's an error in methodology or there's a reference that is miscited or a reference that is missing or whatever. We make a list of everything that needs to be changed if it's going to be published. Of course, if it's high quality, we could say upfront, Yes, publishable in that same state, nothing to be changed.

So it's in that process that every time it's on asphyxia, I'm one of the first they ask. In other team, I will be one of the people they ask to review a paper to give that opinion.

Q Okay. And then you have testified as a forensic pathologist over 300 times in various courts and tribunals?
A Correct.

Q And my understanding is is you just stopped counting actually?
A Correct.

Q So after you basically got around 300?
A I stopped counting at 250, and then I start kind of rounding up time to time. I write a little note of where I am at because it became too burdensome at some point to just count. And actually there was -- the reason I stopped counting is because in Quebec there was someone responsible for counting. When I moved to Alberta, I thought someone was responsible for counting, and when I ask, well, they say no one was counting so I lost the number at that point so I had to start rounding up. But I was at that number so . . .

Q Okay. And in Alberta, you've been qualified as an expert in the Court of Queen's Bench?
A Correct.

Q And the Alberta provincial court?
A Correct.

Q And do you recall the levels of court in Quebec that you've been qualified in?
A The equivalents in Quebec terms.

Q Okay. And then you've been qualified as an expert in British Columbia?
A Correct.

Q And do you recall the levels of courts in British Columbia?
A It was a preliminary inquiry.

Q Okay. So I've suggested the provincial court of British Columbia?
A Yes, correct.

Q Now, what is your understanding of the role of an expert witness when testifying in court?
A So an expert witness is a witness that will bring their expertise to help the Court make their mind about some questions. An expert witness must be impartial, must be neutral, though we are asked by one side. And we don't belong to anyone. We are neutral and impartial.

We have to evaluate all the material that is presented to us, keep an open mind in evaluating it, listing it to make sure everyone knows what we have consulted so that if there's something missing, the other side, whoever that side is, can say, But have you seen that?

If new material is presented to us, we have to honestly review it to make sure if it would change our mind, and if it does, be honest about it. Evaluate hypothetical in an open mind -- with an open mind, and because of that, there might be hypothetical presented to us in the middle of an inquiry or a trial that will change our mind if this hypothetical was true. We have to be honest about it. We have to be thorough. We have not make omission that make what we say not totally true. I -- I think that's the gist of it.

Oh, and I will also say we have to also present the science in a way that is understandable, even for layperson. Like, in a jury, there's different backgrounds, and we have to make our science understandable for them because if we speak our -- if it's stated high level with words they don't understand, then it's hard for them to have an opinion at the end of what they will retain from our testimony.

Q Okay. Do you understand that an expert witness has a duty to assist the Court that overrides any obligation to the party calling the expert?
A Totally. Totally.

Q And do you understand that an expert witness has a duty to be fair?
A Totally. That's why you might notice that I don't even look most of the time at who's asking the question. I was trained that you answer, like, if the judge was asking the question, so that you're always neutral, you don't even consider who's asking the question. You always answer as if -- you -- it doesn't -- it's not important who's asking the question. You answer the question.

Q Okay. And do you understand that an expert has a duty to be objective when they testify?
A Sorry. I missed the beginning.

Q So I asked do you understand the expert has a duty to be objective when testifying?
A Totally.

Q And do you understand that an expert has a duty to be nonpartisan when they testify?
A Totally.

Q If you're allowed to testify today in front of the jury, will you fulfill your duty to the Court?
A To the best of my ability and skills, that's my goal as an expert witness.

Q Okay. So will you be fair in your testimony?
A I would.

Q Will you be objective in your testimony?
A I would.

Q And will you be nonpartisan?
A I would.

Q Now, do you know either David or Collet Stephan?
A I don't.

Q Okay. You understand I'm their counsel?
A I -- yes, I've -- I've seen their names written, but I don't know them.

Q Okay. Never met them?
A Never met them.

Q Never spoken to them?
A Never spoken with them.

Q Okay. Do you have any interest in the outcome of this case?
A I don't, apart doing the best I can as an expert witness and be proud of my work when I will exit the stand.

Q Okay. Now, as I understand it, your contract as chief medical examiner when the contract expired wasn't renewed?
A Correct.

Q And currently there are legal proceedings involving the Department of Justice?
A Correct, but very specific names. It's not the Department of Justice as a whole; it's specific people that did thing that I'm alleging was wrong.

Q Okay. And I'm just going to follow up on that because the pleadings were eventually amended to take names out and add Department of Justice in. Can you just quickly --
A Yes.

Q -- comment on that?
A So in the initial lawsuit, we identified specific people that I'm alleging -- I have to -- I'm -- it -- when I say "I'm alleging", it's not because I don't think it's true; it's because I try to be -- I try to not enter in the lawsuit here. So in the paper of the lawsuit, we are alleging they did things that were wrong. They were specific people.

And then some other -- some -- two further people -- well, maybe it's one -- we're trying to clarify that -- did something else that we think was defamation, and we wanted to fuse it together with the first lawsuit.

They didn't want it. They want it separate. And we went in -- I'm not a lawyer so I'm -- I might not use always the right terminology or -- that's my understanding of what happened as a nonlawyer. We went in a judge chambers, and he recommended -- he recommended a lot of things, but one of the thing he recommended is that we put all the lawsuit under one umbrella, that we take the names out, but that we would have a -- guaranteed in written -- in -- in writing that these people will come and will testify, which was one of the concern of my lawyer.

And the judge recommended that since we were not really wanting them, as in their personal names but as in their function they were doing at the time, that we simplify it by putting Government of Alberta. But though it's now more general, it's a list of very specific individuals, and they are no longer in Justice. They have move onto other duty or to somewhere not even in the government -- one is not even in the -- one is not even in the government anymore.

Q Okay. And as I understand it, the lawsuit was filed in February of 2015?
A That's my recollection of the date, correct.

Q Okay. And then so since the lawsuit has been filed, have you been hired by the Department of Justice as an expert witness in the province of Alberta?
A Yes, I have. I -- I -- I was able to find four cases, but there was more than that. There's just some that I can't find back. Last week I testified for two full days in a fatality inquiry. The victim is Lisa Goltman. I was subpoenaed by -- for the Crown. The Crown was Sean McDonough.

Before that, I received a subpoena to testify somewhere between November 23 to December 11, 2015. The victim is -- sorry, the accused is Nyuk Hwang. I might not be pronouncing it correctly. I don't have the name of the Crown, but I have his paralegal who was the one contacting me. Her name is Angela Fillier. But at the last minute, she informed me that the accused would have asked for a new counsel so I didn't testify because we are waiting for new dates for the trial.

There was another case I testified on April 15, 2015. The Crown is Kevin Komosky. He was the one that asked me to testify. The accused is Stefan Johnson. It was at the preliminary inquiry so I'm still -- eventually I -- if there's a trial, I expect to testify, but I have not heard that part yet, but I testified on the preliminary inquiry.

In Edmonton, I don't have the name of the accused, but the victim was William Hill. It was supposed to be March or April 2015. The paralegal is Marty Enokson. I met with the Crown, though I can't remember his name. He was in Edmonton. I met for one hour or two. I was scheduled to testified (sic) the next day or the day after, and then there was a deal so I was told not to come, that they didn't need me anymore.

I remember specifically there was another case on the north that was also cancelled. I think it was Cold Lake. It could be Fort McMurray, but I think it was Cold Lake. I find the email back. It was December or January of this year so either 2015 or 2016. It was cancelled at the last minute. I can't remember if it was cancelled because of a deal or a reschedule, so I don't remember.

And I -- I -- I know there were others. I just can't be specific on the others. I can't find back the other emails that I deleted.

Q Okay. Now, and I'm speaking about your ability to testify for the Crown. So has your lawsuit with the Department of Justice affected your ability to be an objective, fair, and nonpartisan witness when you are asked to testify for the Crown?
A No, it -- it did not. If the specific people were to be named in a specific cause, I would have to declare a conflict of interest. But unless the specific people, I don't have something in general, so, no, I'm a neutral expert witness, and I did, I think, a -- very impartial work when I was working for the Crown. And though I'm asked now by the defence, I don't belong to the defence. I'm neutral and impartial, and that's how I would approach this.

Q Okay. So my next question is is, you know, does your lawsuit with the Department of Justice affect your ability to be objective, fair, and nonpartisan in this case?
A It does not impact in any way my ability to be neutral and objective.

Q Okay. Now, as I understand it, you know, from your resume is now you're basically acting as a forensic pathologist consultant?
A Correct.

Q And who generally is asking you, hiring you, as a forensic pathologist consultant?
A Okay. So there's a variety of people that have contacted me since I've left the office

for consultation. In British Columbia, I've been asked by the RCMP in two different towns, in Kelowna and in Kamloops. I've been asked by the Crown in Kelowna. I'm asked, again, by the Crown in Kelowna for June this year. In Kamloops, I may be called by the Crown. This is not decided yet.

In Alberta, you're the first defence that approached me. I've been approached by -- in civil actions by -- I've been -- most of the time, it was the Crown actually but in cases of mine, I've been also asked in civil action by a multitude of lawyers, but I'm on confidentiality agreement so I cannot be too specific.

The majority of these consultation, they -- they were on files of the office of the chief medical examiner. In the majority of the cases, I reviewed the autopsy report, and I informed the lawyer that the autopsy report was fine. I didn't see any mistake or any problem with it so my job was mainly to make them understand the report and the implication of the report.

In one case that I can be specific today, unless you relieve me of my confidentiality agreement -- in one case, I found problem with a report, and I explained the -- the issues, and I did a counter report. I -- it might go to court, it might not, I'm not sure yet, but this is civil matters.

And in United States, I've -- I'm called in July in one state by the defence. I -- I think I can't say the state because also I have a confidentiality agreement. My understanding is that I cannot reveal yet which state it is.

Q Okay. And I -- you've prepared a report in this matter; am I correct about that?
A Correct.

Q Okay. I'm just going to hand up to you --
A I just made a mistake. I said July for United States, but it's June. Doesn't really matter, but I made a mistake.

Q Okay. I'm just going to hand you a report and going to hand one up to the Court.

MR. BUCKLEY: And, My Lord, I'm not going to go through the report, but I -- I'm going to have the witness review it and adopt it because obviously what's said in the report, you know, will speak to relevance issues, but you're going to be invited to read it, and I don't think I need to go through it.

Q MR. BUCKLEY: So, Dr. Sauvageau, I've handed you report, and just -- I'm going to ask you to review it and ask you to identify if it is your report.

A It is my report. I recognize it.

Q And then is that -- would you adopt that report as basically an explanation of what you've done and your opinion based on what you've done?
A Correct.

MR. BUCKLEY: My Lord, I want to, for the purposes of the voir dire, have both the report and the CV marked as voir dire exhibits.

THE COURT: In the voir dire. Okay.

The CV is the first exhibit in the voir dire, madam clerk, and the report, the second exhibit in the voir dire. I'm not sure what numbers we're at in voir dire exhibits.

THE COURT CLERK: 5 will be next.

THE COURT: So 5 will be the curriculum vitae, and 6 will be the report.

EXHIBIT 5 - 10-page Curriculum Vitae of Dr. Anny Sauvageau, M.D., M.Sc.

EXHIBIT 6 - 17-page Report of Dr. Anny Sauvageau Re: Death of Ezekiel Stephan (OCME File 1018-7289), Page 17, Electronically Signed By Dr. Anny Sauvageau, Dated April 16, 2016

MR. BUCKLEY: My Lord, at this point, those are my questions on the voir dire, subject to my friend raising other issues.

THE COURT: All right. Let's just take a ten-minute break, then, before you proceed, Crown; all right?

MS. WEICH: Thank you, Sir.

(ADJOURNMENT)

THE COURT: Please be seated.

Doctor, you acknowledge that you're still under oath?

A I do.

THE COURT: Thank you.

Crown . . .

MS. WEICH: Thank you.

Ms. Weich Cross-examines the Witness (Voir Dire) (Qualification)

Q So, Doctor, I am very sorry for how often I'm going to mispronounce your name, so I'm going to try very hard to get it right; okay?
A No problem. I will mispronounce a lot of words myself so . . .

Q Now, I'm going to try to talk slowly because you sped through this morning, and I feel kind of bad for madam transcriptionist, and I know how badly my wrists feel when I type at the slow speed that I do, so I'm going to try to slow us down; okay?
A Yes.

Q And I'm not trying to be rude or antagonistic. I'm just trying to be respectful; okay?
A Totally. I understand. And we have our little deal with the transcriptionist that she will make me slow down when necessary. I have to tendency to speak fast, but you're lucky; in French, it's worse.

Q So I understand that you were licensed to practice medicine in Quebec. Are you still currently licensed to practice medicine in Quebec?
A Okay. I am not because -- actually it's a -- it's a -- it's a money thing. When you are licensed in a place, it costs money, and then you have a choice to stay licensed or not if you know you're not going to go work there. If I want to go back there, I just have to apply, pay my dues, I will be licensed again. But when I moved out of Quebec, the goal was not to go back to Quebec so I stopped paying my -- my fees there.

So currently I'm not licensed in Quebec. If I want to, I reapply, pay my due, and I will licensed.

Q And you're currently licensed in Alberta; correct?
A No, I'm no longer licensed in Alberta. Currently, I don't know where my next license is. You have to make a difference between -- a license give you the -- it give you the -- not the authority; it's not the right word. It give you the right to practice medicine, like, in a hospital or, in my case, in an office where I could do an autopsy, all the scalpel and open the body.

In Alberta, I don't have this power under health right now; however, to testify is a

different matter. Like, I'm not licensed in British Columbia. I've never been licensed in British Columbia. If I want to, I can apply, pay my due, and I will be, but I don't work there full time so I don't pay my due there, but I -- I testify, nevertheless, for the Crown there.

So the same here. I don't have currently have a job as a pathologist so I don't pay my due anymore. I also -- I -- my dues finished on 31 of December 2015, and because I don't work for -- I don't work here as an employee right now, I don't pay my dues. I will pay them when I will know where I work next.

So you have to make this distinction. It has nothing to do with Court. It's be an employee that has a link with Health. And I know Justice is not Health, but there's this ambiguity that we have to be under Health when we do our work at Justice. We need letter from Health to the College. It's -- it's complex and irrelevant for this -- this court here today.

Q Now, when you were licensed, you only ever worked as a pathologist; is that correct?
A It's correct. I have always worked as a pathologist.

Q So you've never been a family doctor?
A Correct.

Q You've never been an emergency room doctor?
A Correct. So when you do your training, you -- you go to be trained in this area, but you move on, and I -- I am not specialized in this area. My field of specialty is forensic pathology, and I -- I will stay in forensic pathologies in what I do and what I will testify on.

Q And you've never been a pediatrician; is that correct?
A It's correct.

Q So I'm going to ask you questions about the time that you spent with the Alberta Office of the Chief Medical Examiner and your different roles; okay?
A Okay.

Q So assistant chief medical examiner at the Edmonton office from August 2009 and ending in 2010; correct?
A Correct.

Q And part of your job was to help out other assistant chief medical examiners? I'm not talking about supervising. I'm not talking about managing. But if they had questions

about what to do or what to conclude, they would come and talk to you, and in the same way, you would go and talk to them; right?

A I'm not sure how to answer because the way the -- I'm not sure how to answer because the way the -- the sentence is phrased. It's not -- it was not officially my duty, like, on (sic) black and white, but of course humans are human and colleagues are going to be colleagues. So, yes, we were talking to each other, but if you look at the duty of a medical examiner under the roles define in the *Fatality Inquiries Act*, there's no such thing as an official duty. But humans are humans, and we talked to colleagues, so I'm not sure how to answer your question.

Q So when you were an assistant medical examiner, did any of your assistant medical examiner colleagues come to you and, Hey, you know what? I'm just not too sure about what to do with this exam?

A Yes. It happens that we consult each other, and then the other person drew what they want with your opinion. They can take it. They can not take it. Like, if you say, Well, if I was you, I would phrase it this way or I would add one more task. But you're peers, you're colleagues, so they can decide to take it or not. They can decide to ask three other colleagues. They can discuss with you until you -- yes, but -- yes.

Q So you would answer their questions if you felt you could answer them; right?

A Yes, if I'm asked a question. But we have to be careful here, and -- I'm asked a lot of other question by colleagues that I might refuse to answer in court, so I -- I might -- it's not the same level. I don't know where it's going, but there's things you discuss with colleagues and peers, and there's a different set of question you're going to ask -- you're going to answer as an expert in court.

So you answer a question of your colleague's, yes, you can. You can also refuse to for a different reason, because you're too busy, come another day, or I don't know. It's hard to -- it's so -- so general for now that I have a hard time to be specific or precise or . . .

Q Did you ever have -- or do you have a memory today of back when you were an assistant chief medical examiner you had questions about what you should do, and so you asked your colleague assistant chief medical examiner for their advice or their opinion?

A Yeah. It go both ways. I -- for example, there's one of the colleagues that I had great respect with -- for, Dr. Bannick (phonetic) where often, when I was not sure how to phrase something in English, I would ask him his advice on how to phrase my thought or how do you do things in Alberta. First -- when I arrived, I had the experience of Quebec, which was slightly different, so I would go to him and ask him how we do that in Alberta considering the different context or -- yes. It -- but colleagues consult

colleague. It's not an official duty, but you can consult colleague. There's no law against it, and there's no obligation about it.

Q And you were in tune with what was going on in your office; right?
A Depends what you mean by "in tune with" and depends what you mean by when I was in office. I had different level of knowledge of what was going on depending on what was my role in the office. I'm not sure how to answer that question either. You would have to be more specific.

Q So let's talk about back in 2009 and 2010 when you were an assistant chief medical examiner. Is it fair to say that you knew all the people in your office?
A No. I didn't know everyone because we were in two different town so there's a lot of people I never met before I started being -- at the end of -- when I was deputy chief and I was sent as acting chief. There's a lot of people I -- I had never met before being acting chief just a few months before I was finally the chief, but -- I was acting chief the first time, and that's when I went -- I might have gone also for social event once. I'm not even sure, but there's people I didn't know because they were in a different town.

Q So let's just talk about Edmonton. Did you know everybody in Edmonton?
A I knew everyone working in the office at different degrees, yes.

Q You knew what their roles were?
A Yes.

Q You knew what their duties were?
A Yes. Though, my under -- yes. But I have to be careful on that question too because as an assistant chief, my understanding of the -- of the role of certain people versus when I was deputy and when I was chief, I made that evolve, what was their role, and I had a better knowledge of the role of certain people as chief than I had as assistant chief.

Because it's different. When you're an assistant chief, you're a forensic pathologist. You -- you don't have -- you don't have to know the *Fatalities Inquiries Act* the same way. You don't have to intervene in the role of the other people the same way. So, yeah, it -- it -- it's not a question I can answer yes or no.

Q So it was your office's best interest -- and here I'm talking about the overall Office of the Chief Medical Examiner, to ensure that all forensic pathologists, all assistant chief medical examiners came to a correct conclusion about the cause of death; right?
A I will have to say that I can't say exactly yes. Because there's a principle that -- of

autonomy of practice. As a chief medical -- the medical examiner under the *Fatality Inquiries Act* is responsible for the cause and manner of death. No one can interfere directly with that job. That would be an offence. 20 something, 24 something, but I don't remember the exact number.

The chief medical examiner -- I'm not a lawyer so my understanding is that even the chief medical examiner cannot interfere directly in the work of a medical examiner, but I had certain power. The way I -- I discussed that with my lawyer when I started the job, my understanding of it is that, as the chief, I could assign a case to a medical examiner, I could de-assign a case from a medical examiner, I could recommend that a medical examiner is no longer a medical examiner, but I could not go in their case and tell them what to do, like, in a specific manner.

I could give also policies. I could, for example, say, In that type of -- no. It has to be very umbrella and very high level the policies and the procedures I could put in place, but I respected fully the autonomy of practice of the medical examiner. And one of my work was trying to make sure also that there would be no interference in their work, and I protected that as much as I could, and I protested very strongly when that was actually attacked politically and bureaucratically. Medical examiner must be able to do their work free of all interference, including mine as a chief.

Q So going back just to the time when you were an assistant, okay -- we're not even at the point where you're chief yet; okay? We're still talking about back in 2009 and 2010; okay?

A Yes.

Q So every once in a while something would come out in the newspaper or in the news, and it was about the medical examiner's office, and you'd read it, and it would be disparaging; right?

A I don't recall anything when I was assistant chief, to be honest. I think it started later. I can't -- I -- I remember papers on my office starting when I was deputy. I don't remember anything prior to that.

Q So back when you were assistant chief, it was in your best interest that all the medical exams that you did you came to the correct conclusion about cause of death; right?

A Once again, I have to be careful on that question, though, because there's something that people sometimes don't understand, is that the medical examiner, when we do our work, our job is to find identification, who's dead, when -- when they are -- where and when they were found dead.

But for the cause, we have mainly to address -- we will address the manner for sure.

We have to decide, is it natural, homicide, suicide, accident, an undetermined. But when it's natural and it won't go to court and there's no medical legal question -- and this is not super clear in -- in the current *Fatality Inquiries Act*, and it was supposed to be put in more clear term, the next, but the next has not been out yet, and now I don't know how they (sic) going to phrase it in the next.

It's supposed to be more clear that when it's natural, we have to find the most probable cause of death, not necessarily the cause of death. We'll give you an example. If someone is 76 years old and they died at home in their bed, the -- is alone in the house, the door is locked, all the windows are locked, there's no evidence of forced entry, there's no evidence on trauma at the external examination of the body, we won't even do an autopsy because we have excluded -- we'll do tox, toxicology, but once we have excluded that that can't be a suicide, that can't be an homicide, that can't be an accident, we conclude that it's natural because of the heart, and we will write arthrosclerotic coronary artery disease. We can't be sure that's the cause of the death, but on balance of probability, that's what we do.

If we were to do differently, the cost for Albertans would be enormous. There's about 20,000 death in Alberta a year. At the office, we investigate about 4,000. I don't remember exactly the number of autopsy versus external. Let's say 50-50; though, I think it's maybe slightly more external than autopsy. At the time I was chief, I knew these number by memory. Now I don't remember the exact number.

If we were to do all autopsies on these 4,000 and all autopsy in all the other death, we would always know -- if we do all the other tests and do everything in every case, we would have a better idea of the exact natural cause of death, but it will be too expensive and really don't serve any goal.

So when there's not a goal of finding answer for court, when we know it's natural, and there's no other -- we consider other thing. For example, can it has (sic) an impact for other people in this village or in this family? If there's thing that could be for protecting other people from the health, we will also do it, but if there's no higher goal, and know it's not violent, suicide, homicide, accident, we'll just go with probability.

Q So you talked about how the cost for Albertans will be enormous to run all tests when you concluded that a death is natural; is that correct? Is that what you said?

A If we were to do full autopsy with all the tests necessary to prove -- to the limit of the current science, the disease in every cases on the 20,000 something death in Alberta a year, our current project, which was at the time 12-point-something million for 4,000 cases of which only half -- about -- a little less than half are autopsy would have to be

increased in proportions.

There's no way -- well, there's always a way to pay for something, but you would have to cut elsewhere or increase significantly the taxes. But in this particular case, a full autopsy was done so there's -- my discussion is -- is an overall discussion that has no implication on this specific case as -- unless you bring me somewhere some -- at sometime, but my discussion for now is a very high level. Here there was a full autopsy.

Q For this 76-year-old lady in her bed?
A No. I mean, Ezekiel Stephan had a full autopsy.

Q Okay. Thank you.

So moving aside cause of death, it was in your best interest as the assistant chief medical examiner to come to a correct conclusion about manner of death in each and every investigation that you conducted; right?
A Yes. And once it's -- as I said, when it's natural, we don't go as far necessarily for the cause, but the manner is more important for us. So we will do what -- what we can do based on the information we have at the time. Yes.

Q So you understood that errors made concerning death investigations performed and conclusions come to about manner of death and/or cause of death, that might have a detrimental impact on, for example, next of kin; right?
A Yes.

Q It might have a detrimental impact on the estate of the deceased person; right?
A There's insurance, as an example, that could be affected, so yes.

Q And it might have an impact on the proper administration of justice, specifically when the conclusions that you came to about cause or manner of death, or both, lead to an arrest and a prosecution of a person or persons; right?
A Yes.

Q So now let's talk about your time as a deputy chief medical examiner. So as I understand it, July 1st, 2010, until sometime in 2011; is that correct?
A To July 1st, 2011. Well, the day before because I changed job on July 1st.

Q So part of your job as deputy chief medical examiner was to be responsible along with the chief medical examiner for oversight and management of all investigations conducted by your Edmonton office; is that --

A No.

Q -- fair to say?
A No, not at all. It was not my work. No.

Q So what did you do?
A As I explained before, I was responsible -- the first part was being a forensic pathologist, as I used to be. There was two added part. I was responsible of two teams, the team of the morgue and the team of the death investigator, which are the non-doctors. I was responsible at -- of their team from HR perspective or policies and procedure, though I -- my role was limited on policies and procedures because I was not chief, and the chief at the time didn't really do policies and procedures, so I was mainly responsible of the day-to-day management of the two teams.

Q So --
A That -- sorry. Go ahead.

Q No, no, go ahead. I didn't mean to cut you off.
A So I was not responsible, the way you phrase it, of the death investigation that were not mine.

MS. WEICH: So, Sir, if I may approach, please? Thank you.

Q MS. WEICH: So, Dr. Sauvageau, I'm going to hand you a multipage document. Top right corner says "management job description, management job evaluation plan", and under the heading "Position Summary" says: (as read)

The deputy chief medical examiner, Edmonton.

Are you familiar with this document at all?

A First, this is not a document that has my signature. There's been different definition of deputy chief over the years. As I told you before, when I was deputy chief, I'm not sure if it was the document or not, and this one doesn't have my signature. I would prefer to be referred to -- and I'm sure you can have it through Justice -- my own deputy chief job description. I don't -- I don't -- I don't know. This is not my signature, and I know they have a new definition of what the deputy chief. They have only one. We were two. The definition is different.

This -- my -- when I was deputy chief, I was not responsible for the quality of death investigation; that was the job of the chief. And actually, under the law, this is the job

of the chief. He can decide to delegate it, but that was not delegated to me when I was a deputy chief.

Q So do you want to take the time to review it and see if it refreshes your memory as to whether or not you're familiar with the document, or would you rather not?
A I don't even know if I've ever seen this because it doesn't have my signature. There would -- it's not even -- there would be -- I know there was multiple version of that document over times. I -- I don't think it's very realistic to make me try to remember which one was mine at the time when it doesn't even have my signature.

Can you find mine that I signed? This one is not the one I signed.

Q How many did you sign? Do you remember?
A I would have signed one. When I became deputy chief, I signed one job description. But over time, the job of deputy was interpreted differently by different people.

THE COURT: And you said that -- you're swearing that when you were deputy chief, it was not your responsibility to oversee certain things?

A The death investigation overall of the people that were no -- so I was responsible, as a medical examiner, as a forensic pathologist, of my own cases. But as a deputy, I was not responsible to oversee the quality of the investigation when they were not my cases. So the -- I -- I was not.

Q MS. WEICH: So what, if any, responsibility did you have as deputy chief for training assistant medical examiners?
A None. As deputy, you said? None.

Q That's correct.
A None.

Q What responsibility did you have for supporting the assistant chief medical examiners in doing their jobs?
A None.

Q So you were the deputy; right?
A Yes. As defined by Dr. Dowling at the time, yes, I made two teams, and I was responsible of their -- of these two teams, and I made a lot of work to improve the quality of the work of these two teams in Edmonton only.

Q So I figure that if I have somebody who's higher up than me on the pay scale and I'm

going about my work and I have some questions about what I should do and how I should do it, I might talk to my colleagues, the people who are on the same level as me, but if that doesn't satisfy me, I might go talk to somebody who is a level up higher than me. Does that sound familiar to you, something that you used to do back in the day when you weren't in charge?

A As I said, as a medical examiner, you are -- your work is autonomous. No one can interfere with it, but as a colleague and peers, you can decide to talk to your colleagues, you can decide to talk to your boss or not, you can decide to phone colleagues outside of the province or the country, but you are responsible for your own work. No one can interfere. That's an offence under 24 something.

Q So while you were deputy chief, every once in a while -- I'm not saying every day or every week or every month, but sometimes assistant chief medical examiners would come to you with their questions or concerns about death investigations that they were conducting; right?

A They could. That would be as a peer, not as a superior. I was not their superior as deputy chief as it was defined at the time.

Q And you would listen to them ask their questions; right?

A As -- as a human and as a colleague, if I was -- I -- I might say to them, I'm too busy today. I might say, Yes, I have the time. Come in. We'll chat. My opinion was just my opinion. It had no power on what they will do later. It was just peers discussing -- yes, it could. It was their right, and as human, we can do that.

Q And if you felt like you were able to, you'd give advice or you would give an opinion to these assistant chief medical examiners about what they could do; is that fair to say? Just as a colleague, not telling them what to do because you're a superior?

A You can advise them if they ask so. If they don't really ask, you can decide not to advise because they didn't really ask for it. Then just listen. It depends what the -- it's -- this is nothing about how the job was defined. It's just two humans dealing with -- with each other. It will depend also on the type of relationship. There were people that we would discuss more, people that it would be more factual. It depends. We're talking about human relationship now. This is nothing in their job description or mine. This is nothing as a power in the law. So it's just two humans that decide to discuss with each other.

Q Now, as a deputy, did you have -- and I don't want to say the power, but did you feel like it was your responsibility to bring concerns to your chief medical examiner if you were concerned about a medical examiner's ability to do their job?

A As deputy chief, as it was defined at the time, it was not my job, except when I was acting, which makes it -- but if you go to when I was acting, that would create a

difference in my answer. When I was only an -- a death chief, not acting chief, as defined at the time, it was not my job.

Of course, as a doctor, if you have concern with one of your colleague, you can -- you have to express it, but you have to know about it. So there were problem in the office when I was -- they started when I was deputy, but I was not acting. There was -- they were in a different town. I was not aware of it. When I became acting, I became aware of it, and I did what I had to do, and then I went back to my normal job. This was continued to be dealt with by the chief. Then I became chief myself, and we discovered further issue, which I dealt with.

Q So let me just see if I have it right. You're deputy chief. There's an assistant chief medical examiner in your Edmonton office. Let's call him "John Doe". And you hear some buzzing around the office that he's just not doing things right. Are you going to take the time to sit him down and talk to him about it?

A Okay. Because that -- that hypothetical never happened, but late -- take it as a hypothetical. If -- at the time that I was chief in Edmonton, if there had been rumour about a medical examiner in Edmonton that would have been a problem, as a deputy chief medical examiner, I had no role. As a physician, if it's only rumour, still not my role to sit with him, but I would mention to my chief if he asked -- heard the rumour just so that he's aware. But that's his job to deal with rumour. Rumours are rumours.

If I'm witnessing something that is of concern, then that's different because I have -- I'm not sure how to say that in English -- it's a code of conduct. As a physician, we have to report when a -- when we think a physician has not done their duty properly. We have to. But we don't report rumours, and it's not our job to report rumours.

But if we are firsthand -- we think that we have been firsthand witness or firsthand observer of a fact or of something done, we have to report it. Then it's the job of other people to evaluate it. So -- but that hypothetical, when I was deputy chief in Edmonton, never happened in Edmonton.

Q And so you would make observations about what other doctors were doing --

A Sorry. I was coughing. Could you --

Q That's okay.

A -- please repeat that?

Q So you had observations to see what other doctors, like assistant chief medical examiners, were doing, when you reviewed other medical examiners' autopsy reports; is that fair to say?

A No. Because there was no peer review system before I became chief. So I'm the person that created a peer review system. It didn't exist prior to my time as chief.

Q And when did it start?

A Okay. I don't remember the exact date. Though a media search would probably find it if you're interested in the date because I remember there was a paper -- we did a media release when -- I think we did a media release to announce the good news when we started the peer review.

So I started on July 1st, 2011, and it took at least a year, I would say, top of my head, to create it. Because it's -- it was not -- it's not as easy as it seemed to create a peer review system. We had to be very careful that the peer review system -- well, there's two ways that we had to be careful. Two expert can disagree on a case, and with -- and it's good for the Justice, and we -- we don't want people to be forced into fitting in the same box of agreement.

There's different level that you can disagree, though. If you disagree because you have really concern that the person might not been competent, it's going to be addressed, but if it's more you disagree but that's reasonable, we didn't want that to ended (sic) up all the time as a positive in peer review, and I will explain why in a few seconds.

So the first part -- and I was working with lawyers with that. So I went to my assistant deputy minister. I ask her for a lawyer's support, because there were implication in law, because I wanted to know before you started the peer review, you know, you need to understand what you will do in different scenario so that you cannot come later in a scenario you have not predicted and don't know what to do.

For example, let's say you have the peer review and some -- and a first pathologist do the case. The second pathologist review it, and you agree with it. What do you do? Do you say it to the Crown? Do you say it to the police? Do you report it to the defence? Do you -- they assigned the first medical examiner; put the second. Do you put both on trial?

There was a lot of legal implication. So I work with a lawyer. He's called Eric Tolppanen. He had other lawyer assisting him in this work. It took us, I -- I would say, a year. It might be even a little bit more than that. We were not working, of course, every day on it, but we would have regular meeting, and we ended up with a procedure, a very detailed procedure of how we will do the peer review, how different scenario would be addressed.

And what we did is that the peer review doesn't ask the second pathologist if he agrees or not. We asked if the conclusion are unreasonable or not, which is a different standard; it is a different standard; and, second, we made a box where they have to check what they have reviewed. Because you don't review everything. It's not just -- it's not realistic. If one medical examiner spend, let's say, 45 hours on a death investigation, we cannot ask the reviewer to spend 45 hours on the review. Usually the reviewer will spend, like, one or two hours on the review. Might spend a little bit more on complex cases, a little bit less when they don't seem too complex. But you have to check what they have looked at.

And at the end, the peer review doesn't prove the first medical examiner is right. It means that based on what was reviewed and only on what was reviewed, the conclusion are not unreasonable.

I could have a lot more, but I will stop there for now, but if you have further question, there -- there's a lot I have not said yet on this peer review. It's very complex.

THE COURT: Well, maybe that's because we're just trying to determine if you're qualified and entitled to give opinion evidence. So you do tend to go quite deep and perhaps maybe more deep than you need to. I'll leave that to you, but we are just in a voir dire to determine if you're qualified.

Q MS. WEICH: So this benchmark of whether or not the conclusion of the first pathologist was unreasonable or not, does the word "unreasonable" have a special meaning to you as a forensic pathologist?

A Yes. So when we were developing the system, as I said, for reason I explained, we didn't want to use "disagree with" or "agree with". We use "reasonable" or "unreasonable". And that means that on the current state of the science, the conclusion that the other person has reached is reasonable. Doesn't mean you agree with. Does mean that you can see that on science it's possible and reasonable to come to that conclusion.

Having said that, this is the official paper we fill, but, of course, we will -- if we -- if we see something that is not an unreasonable but that we think can increase the quality, we'll mention it, but that's not part of the official process. To -- for example, someone might tell me that I forgot a 'D' somewhere when I conjugated my verb or I might notice someone has made a typo, so -- but that's not the official process. The official process is what I explained.

Q And when this peer review system came into operation, you -- who was responsible for training everybody in how to go about doing it correctly?

A Okay. A forensic pathologist is hired as an already trained forensic pathologist. The chief does not train forensic pathologists. We train other type of staff, but they come already trained. We send them for meetings once a year so they can do their continuous education, but a doctor is responsible for their own continuous education, though.

For the peer review itself, this is a concept that every doctor should have been trained on, the concept of peer review. We simply explain the form to them and answer all the question on how it should be filled and the -- the idea around it so that they should not, for example, put "disagreement", only is it reasonable. Because we didn't want that to be a discussion of disagreement. Is it reasonable?

MS. WEICH: So as I -- sorry. If this witness -- sorry. If Dr. Sauvageau could please be provided with -- and I want to say it's going to be Exhibit Number 9. It should be the autopsy report of Dr. Adeagbo. If I'm correct about that? And, sorry, if you could just check and see if the last page says "peer review" on it?

THE COURT CLERK: Yeah.

MS. WEICH: Yeah. Okay. Thank you. If you could please provide that.

A Yeah.

Q MS. WEICH: So, Dr. Sauvageau, you were talking about all the boxes on the peer review form; right?
A Yes.

Q Okay. And so as I understand it, the peer reviewer, the second pathologist, makes a mark maybe a cross, maybe a checkmark to --
A Correct.

Q -- indicate all the different parts of the file that they review; is that correct?
A Exactly what I was explaining.

Q And what parts are those?
A There's the parts examination form report. In this case that means the autopsy report. There's the photograph. Here we have 16 pictures. So if I can be specific to this case, here, Dr. Bucholtz, who was the peer reviewer, she looked at the autopsy report. She looked at the 16 pictures. Well, I assume there were 16; that's what I have. She didn't look at the microscopic slides. She didn't look at the medical file. She didn't

look at the death investigation report. Because all the other are that -- she didn't look at it. So the only thing she looked at are the autopsy report and the pictures. That's it.

Q So in a general sense, what are all the boxes on that form that this peer reviewer can mark down whether or not they looked at certain parts of the file?
A Yes. And that's very important because that means that if a peer reviewer was to do a different job later in time, they could come to a different conclusion if they review more material, for example. So that's why it was so important that our form contains what was reviewed.

And in this case, Dr. Bucholtz only reviewed the autopsy report and the photographs. She didn't review the -- the -- the slides and microscopic examination, didn't review the medical file, didn't review the information from the death investigator and all the other material in the medical examiner's file.

Q So what I'm asking you for -- this is the third time I've asked it so maybe I'm just asking it in the wrong way so please tell me if you don't understand; okay? I'm not asking for what Dr. Bucholtz did in this particular case. I'm just asking you to look at the form, and down the left-hand side, there's a number of boxes that list all the different pieces of the file that a peer reviewer can review in order to come to a conclusion about whether or not the first pathologist was unreasonable or not. Does that make sense?
A Correct. I thought I answered the question. I'm sorry if you think I didn't. I can phrase it differently. So there was -- I will read post-mortem examination report. This case means autopsy report. Photograph, which means here autopsy pictures. Microscopic slides or microscopic examination, toxicology report, and other -- and they need to specify because there's a variety of things that can be there like medical file and the other example I gave previously.

Q Anything else?
A Well, "other" can be quite large. I . . .

Q So when you put this peer review operation into place, what, if anything, did you tell the forensic pathologists in your office about how many of those different pieces of the file or how many of those different things they needed to review in order to conduct a successful peer review of the file?
A No formal instruction. It's their best judgment as a physician. I didn't -- I -- but as I said before, it was not expected of them to do a complete review. As I said before, if someone -- if the first medical examiner spent 45 hours on a case, it was not expected of the peer reviewer to spend 45 hours.

The peer review system is to flag the thing that are most obvious, and we know that cases that could be wrong could still slip through a peer review system. Furthermore, a conclusion could be reasonable but not agreed by with a majority of forensic pathologists. Reasonable doesn't mean you agree with. That's a very important distinction.

I -- as a chief, I was not doing peer review myself. I was -- I was kept as a higher level in the process. So if there was a -- if a peer reviewer found something unreasonable, I was the referee. That's why I was not involved on the first degree, and -- I lost my thought here.

Yes. But that's important to note, is that so I didn't do it myself often, but the peer reviewer were very strictly informed that even if they disagree, that's not what they were looking for. So a lot of them were disagreeing, and some came to my office at time (sic) to say, Can I discuss if it's a disagreement or it's an unreasonable at the beginning, but over time, it was clear in their mind the difference between "disagreement" and "unreasonable", though sometimes they could discuss with a peer if they were unsure.

Q So did this policy ever change? So from the time the peer review system started until the time you left the office when you were done being the chief medical examiner, did you ever implement a policy that said, Okay, peer reviewers, you need to look at least at three out of the five things or four out of the five things, or did it always just remain at the discretion of the peer reviewer?

A Actually, yes, it remains a decision of the peer reviewer. You don't expect them -- this is the third time I'm going to say it. We don't expect them to spend the same number of hours, which means that cases that they say are reasonable, if it was a same number of hour review could be unreasonable, or it could be from the start that they disagree with or they would have disagreed but still found it reasonable if they had spent a number of hours. It's a different process.

The goal of this is to flag the very, very obvious cases that are wrong, but it doesn't mean that the cases is (sic) well done. It doesn't mean that everyone will agree with it, and it doesn't even mean that if you had spent all the same hours as the first, you would still found the conclusion reasonable. And there's a difference between "disagreement" and "unreasonable".

Q So you can put that down if you'd like. I'm not going to talk about it, at least not for the next little while. So you were the chief medical examiner beginning July 1st, 2011, and ending June 30th, 2014; is that correct?

A It's correct.

Q So at that point when you were chief, you were responsible for overseeing and managing -- and I'm just going to put it in a big-picture term; okay -- every single investigation conducted by members of your office?
A Could it be -- repeat.

Q So you were responsible for overseeing and managing all of the death investigations conducted by the members of your office?
A Yes, at a very high level. The same way that is -- a CEO is responsible for thing that happened in their office. Doesn't mean they know everything that happened at the front desk of a so -- circles (sic) somewhere. But at the very high level, yes.

Except the medical examiner under the *Fatality Inquiries Act* is still responsible for his own conclusion on cause -- on who die, where they die, when they die, and of what have they died, and as the chief, my understanding, after everything discussed with my lawyers at the time --

Q Sorry. Can you just stand back a little bit?
A Yes.

Q Thank you.
A My understanding, after having discussed with my lawyers at the time, is that even as the chief, I couldn't interfere directly in the work of a medical examiner. That -- that would still be an offence. I still had to respect their role as a medical examiner. I could assign a case, take back a case, I could express they should not be medical examiner anymore, but I couldn't do -- like, I couldn't take their death investigation and review it and say you're wrong. That -- I had to respect their autonomy of work, their independence as medical examiners.

Q So in the grand scheme of things or in the big-picture scheme of things, kind of like a CEO like you suggested, you were responsible for the proper conduct of death investigations conducted by members of your office?
A Yes. Except that I realize that the CEO example is not a good example unless there's a CEO somewhere that has this exception. Because CEO usually doesn't have employee that he needs to respect the independence of, and as a chief medical examiner, I needed to respect and not interfere with the work of the medical examiner.

So this is special, and that's my understanding of the *Fatality Inquiries Act* after discussing with my lawyers at the time. And I'm not a lawyer, but that was my understanding.

Q And so, again, big picture, you were responsible for every single autopsy report that was completed by members of your office, bearing in mind, of course, that you had no ability to interfere with the independence of your pathologists?
A Yes. And that -- there's -- there's report that I didn't necessarily agree with, but that I -- there's some that I probably was not even aware of because I was not reading all of them. There's some that I was aware of that I didn't agree with, but they were not unreasonable, which is different, and I couldn't interfere with the work of a medical examiner.

Q So as chief, you were also responsible for recruiting; is that correct?
A Correct.

Q And you were responsible for training?
A You have to be more precise. I'm -- I was training the people acting under the law, but I was not training the forensic pathologists. They arrived fully trained, as I said, and as a doctor, it was their responsibility to do continuing -- continuation -- continuing medical education. My duty of training was more for the other staff. Like, in the morgue, we were hiring people that had never done the work in the morgue before or death investigators who are the non-doctors or the -- the record people. But I was not training my medical examiners; they came fully trained.

Q So grand scheme of things, big picture, you were responsible for overseeing quality assurance in your office?
A If you add -- I was responsible for quality assurance but at the same time respecting the independence of the work the of medical examiner. So if you put the two together, yes.

Q And, again, if somebody had questions about how to do their job properly or questions about conclusions that they've come to, if you had the time and if you had the inclination, you would talk to them; right?
A Yes. In reality, though, when I was the chief, I was extremely busy so there was still -- more in Edmonton, because I was physically located in Edmonton, it would happen that someone would come and say, Do you have five minutes? Particularly when in -- in asphyxia or with the brain, and they say, I would like to pick your brain on something, and I will discuss with them. But not as commonly as when I was a peer. First, it's human. Again, people like to talk with their peer more than with their boss. And, also -- and that's probably the main reason I hope because I think I was not -- I hope I was a boss that was appreciated.

But as a -- as a -- as a chief, I was really busy so often I was not physically there. So

they would consult me less often as a peer when I was a chief than before. But, yes, they could, and I was -- as a peer, it was not my duty to make myself available to my peers, though as a human, I did. As a chief, if someone wanted to talk to me, I was making the time. If I didn't have it now, I would schedule a phone meeting or an in-person meeting.

Q So are you saying that it wasn't part of your responsibilities to make time to talk to your staff that had questions?

A I said that as the chief, it was my duty to talk to the staff that wanted to talk to me. So if someone wanted to talk to me, I would talk to them, but I said that they would consult me less as a peer when I was chief just for the reason I mentioned. But they could, and I -- it was my duty as chief to listen to the staff whereas, as a peer, it was not my duty to do it, though I was doing it because I'm a human.

Q Now, earlier you said that, as chief, you could assign a case, de-assign a case, and -- and here I'm just paraphrasing. What I understood you to say is that you could fire a medical examiner if you felt it was necessary; is that fair to say?

A Assigned, de-assign, yes. Fire, not directly, but indirectly, yes. So it would go through a recommendation. I would work with HR, but it was a more complex process. I -- I didn't -- the chief medical examiner, if we look at the *Fatality Inquiries Act* as independent -- well, should have independence on certain thing but not on HR processes.

So as a chief, I didn't have the power to directly fire someone. I would have to work with human services, which are not inside the office. They are part of the government. There's three areas I didn't have independence, unless I'm missing one, but human resources, finances, and the procurement. These are the three areas where I had absolutely no independence and must work with the processes in places (sic).

Q So what were the options available to you if you had concerns that one of your forensic pathologists wasn't doing a good enough job? What could you do about it as the chief?

A So there's a human resources process. The first step is you talk to them, and usually you talk to them multiple time. At some point, you start to document when you meet with them, and you inform HR when you start to -- have talked to them a couple of time, and it doesn't improve, you talk with human resources.

Then you do a letter of expectation. If it still doesn't work, you can have a -- I'm not remembering the official words used by human resources, but then there's, like, an official letter that say, You need to improve by that date, something like that, and then you can fire them.

I'm not an expert in human resources. I would work very closely with the people in human resources when there was concern with a medical examiner, but I would follow their advice. I'm not an expert in human resources, and there's steps to follow, and I have done it with certain medical examiners going through this process.

Q So let me just see if I understand it. You would talk to your staff member multiple times; right?
A Correct.

Q Then you would start to document. Does that mean you would just write some notes about what you were talking about?
A Initially you -- somewhere you keep the note that you've talked to that person on that date, and at some point, you transfer these note to human resources. The person in charge of keeping the human resources' file is human resources. Yes.

Q So once you transferred those notes to human resources, then you would ask that a letter of expectation be provided to the staff member, or how did that work?
A I'm not sure if the official process is that I ask or they recommend, but it's really done in discussion with them. At some point, we come to the conclusion that a letter of expectation must be done. In -- it's signed by the supervisor.

As I said, I'm -- I'm not an expert on human resources so it's my understanding of the government rules at the time, which might have changed. So they -- human resources would draft a letter, and I would review it and sign it. I would present it to the employee with the presence of the human resources, either in person or by phone because they -- they didn't have a lot of staff in Calgary. So in Edmonton, it was easier. I was working with human resources when there were issue with a medical examiner.

Q And then the next step would be to send -- sorry. So that letter of expectation would say, We expect you to get better at this part of your job by this date?
A Yeah. But I have to make a difference here. The process with continuing with more letters is more applicable to union employees which medical examiner are not. With medical examiner, at some point, we didn't need the same letters all the time. We could also put, like, a -- a probation period. Let's -- we could tell them, for example, If you don't improve soon, I'm -- I will recommend not to renew your contract or to renew it for a shorter period of time so you need to improve.

So unions have more rules that medical examiner, but I was still working with human resource and following their advice, and they are the expert that were telling me at

what point to do what. And actually we did fire some medical examiners, and we did have medical examiners that were in the process of -- we call them having a performance -- I'm not sure the -- I call it to be under performance assessment. I'm not sure it's the right term. As I said, I'm not a human resources specialist, but there were some medical examiner that were under a performance assessment review -- maybe not review; maybe it's just performance assessment period of -- this is not.

Q So -- oh --
A Yeah. Sorry.

Q Sorry. No. Keep going.
A It's just it's not my expertise to say the right term so I might not have used the right -- the -- the right label.

Q So this probation period, you as the chief had the power to not renew forensic pathologists' contracts; is that correct?
A No. I was working with human resources, but it was not my power -- it was not even my power to decide I would do a letter of expectation. I had to work -- human resources -- and it was very clearly expressed to me, and I always respected it -- were not part of my area of independence under the *Fatality Inquiries Act*. When it came to human resources, I was only an employee of the Government of Alberta, and I had to work with human resources from the Government of Alberta, and a lot of what we were doing needed deputy minister's approval or assistant deputy minister's approval.

And I'm not an expert on -- depending on which stage which has to approve it, the -- it was the job of human resources to get the proper probation either by assistant deputy minister or deputy minister.

Q So when you said the words, If you don't improve, then I won't approve your contract or will give you a shorter contract, you didn't -- that's not actually what you did; you didn't say those words because you didn't have the power to do those things --
A That's not --

Q -- is that correct?
A That's not the word I used exactly. I said I will not recommend that you -- we renew your contract. So it was more -- but, in fact, when I did not recommend, usually it was ceased, and if I did recommend, usually it was renewed.

There was one exception at the time I was at the office, and it was not for a medical examiner, where my recommendation were not followed, and I don't think it's relevant to discuss that here today. Usually my recommendation are followed, but they are not

my final decision.

Q So when somebody's on -- and I'm just going to call it probation because it's the easiest way for me to understand it in my own mind; okay?
A Correct. And I use that term too, and I'm not sure if it's the real word -- word that human resources would use, but that's what I use myself.

Q So when somebody's on probation, when a forensic pathologist is on probation, how did you ensure that they actually did perform their work correctly or improve so that they met all the expectations that you required of them?
A It depends what the issue was. So the assessment is geared toward what the specific issue is.

Q So did you ever have one forensic pathologist supervise another forensic pathologist to say, Hey, let me see how you do your work, and let me make sure that you're doing it correctly?
A Well, I can't because a medical examiner can't interfere with the work of a different medical examiner. That's my understanding of the law. So I -- I -- I never did it, and I don't think I could have done it. The only -- I can have a student that is not a medical examiner being supervised. I could have a pathologist that is not a medical examiner, if I created such a position, being supervised, but a medical examiner, my understanding is that they must do their work in an independent manner.

Q So you had a way to put staff members on notice that there were concerns that they needed to do their jobs better, but you didn't have any way to actually figure out whether or not they were doing their jobs better?
A There was way. Depends what the problem is. I'm trying not to be specific here because I'm trying not to -- I'm trying very strongly not to put certain medical examiner that are currently in the office in problems. There were people that were followed for different reason, and the way they were followed was specific to the problem that had been identified, but I don't want to put anyone in trouble unless I'm forced to. I -- I -- what I mean by "forced to" is be careful with your question because I will not lie under oath, and some people were followed.

Q Okay. So I'm not going to ask you for any names or why.
A Please, yes. Thanks.

Q But "followed" to me sounds creepy, like somebody's being stalked. What do you mean when you say "followed"?
A I would have to be specific. Do you want me to be specific? I don't see how to answer without being specific.

Q Okay. I'm going to give you some examples. You'll let me know if I'm right. If I'm right, great; if I'm not, fine.

So a staff member would come to the office, do their work all day long, and there would be a second person next to them all day long while they were doing their work from 8 AM in the morning until 4:30 in the afternoon, and that second person would report, for example, to you about how that first person was doing their job. Is that what followed means?

A No. No, that's not what followed means.

Q So a forensic pathologist would come to work, conduct their death investigations, write their reports. They would be peer-reviewed, and on top of the peer review, a third party would also review it. Is that what followed means?

A That could have been used, though, I -- and that has been used. Yes.

Q So that's something with you're familiar with happening?

A Yes.

Q Okay.

A But in a -- in a different context. It -- and I don't want to be specific because I -- if I explain further, I will have to be too specific, and people can guess who I'm talking about, and I don't think that's appropriate. I -- I have to be very careful. The goal here is not -- is not to stain the reputation of any medical examiner.

Q So it's fair enough to say that there were processes that you could follow to ensure that people were getting better at doing their jobs? Is that fair to say?

A Yes. But the way we were doing it was specific to the problem that had been identified in close relationship with human resources in the limit of what I was able to do or recommend, or I had to follow the process of human resources.

Q So, again, in your time as chief medical examiner, it was in the public's best interest to ensure, as far as possible, that all of the death investigations were conducted correctly, and the conclusions about manner of death and/or cause of death were correct; is that fair to say?

A At a high level, yes.

Q And, again, there was potentially detrimental consequences for people if those investigations weren't done correctly; is that fair to say?

A It is fair to say, and it has had consequences in the past.

MS. WEICH: So, Sir, I'm about to get into a whole other area. I note the time. I know that the jury was told to come back at 2:00. There's no way. Honestly, I'm at the point where I'm -- it's probably going to take the rest of the afternoon.

THE COURT: We'll reconvene at quarter to 2.

THE COURT CLERK: Order in Court. All rise.

THE COURT: Ma'am, just -- you're under oath, and you're in the middle of cross-examination so you --

A I do understand.

THE COURT: -- you're well aware you can't speak with anyone during the break.

A Correct.

PROCEEDINGS ADJOURNED UNTIL 1:45 PM

Certificate of Transcript

I, Sara Anderson, certify that the foregoing pages are a complete and accurate transcript of the proceedings, taken down by me in shorthand and recorded by a sound-recording machine and transcribed from my shorthand notes to the best of my skill and ability.

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Proceedings taken in the Court of Queen's Bench of Alberta, Courthouse, Lethbridge, Alberta

April 18, 2016	Afternoon Session
The Honourable Mr. Justice Jerke	Court of Queen's Bench of Alberta
L.M. Weich	For the Crown
C.O. Giles	For the Crown
S.P. Buckley	For the Accused D. Stephan
S.P. Buckley	For the Accused C. Stephan
J. Stringer	Court Clerk
S. Anderson, CSR(A)	Official Court Reporter

THE COURT: Good afternoon.

MS. WEICH: Good afternoon, Sir.

THE COURT: Counsel, before we get started, I'd like to let the jury know what they should be doing. They're here now. Can you give me some time frames?

MS. WEICH: I'm thinking 4:00, Sir, if we keep going the way we have been; if not, 4:30.

THE COURT: And you might have some re-examination?

MR. BUCKLEY: Well, I don't know what my friends are going to pull out. So far, I don't, so . . .

THE COURT: I'm going to tell the jury to come back at 10 tomorrow morning, and we'll just sit late, start early, do what we need to do so that we can start at 10.

MR. BUCKLEY: And then just another housekeeping thing is somebody brought to my attention that Dr. Adeagbo's been texting, and he probably isn't aware that there's an order preventing even cell phones in the courtroom unless you're media, let alone texting from the court.

THE COURT: Would you let him know that?

MS. WEICH: Thank you.

THE COURT: Madam clerk, we're not going to adjourn court, but just -- would you just let the jury officer know that the jury doesn't -- we can't use them this afternoon, and we'll be back tomorrow at 10.

MR. GILES: I am advised, Sir, that it is not on a telecommunications device, but it's merely his notebook commuter -- computer where he is making notes on, Sir.

THE COURT: Okay. Thank you.

Doctor, you knowledge that you're still under oath?

A I do.

THE COURT: Thank you.

Crown.

MS. WEICH: Thank you, Sir.

ANNY SAUVAGEAU, Previously Sworn, Examined by Ms. Weich (Voir Dire) (Qualification)

Q MS. WEICH: So, Dr. Sauvageau, I believe that earlier my friend, Mr. Buckley, asked you a question about the recent times that you've been subpoenaed to appear in court or before tribunals. Do you remember him asking you that question?

A Correct. I do.

Q And one of answers that you gave was that you testified earlier this month at a fatality inquiry. Do you remember giving that answer?

A Correct.

Q And as I understand it, that fatality inquiry is ongoing due to the fact that the family of the deceased refused to accept the cause of death that you provided and requested that the fatality inquiry occur. Is that correct?

A I'm not sure. I'm -- I think the patient was under the *Mental Health Act*. That could be the real reason there's an inquiry. It is true that the family wanted the cause of

death reviewed, but there was a problem with the access to the medical file, which would be a complex situation to explain. I can explain if you want, but there's no link with this current case. But I testified last week in a fatality inquiries at the request of the Crown.

Q And was that the same case where you came to an original position on cause of death and then changed your position after the fact?

A Correct. Because new information was made available through the inquiries that changed my understanding of the medical fact on the case, and, therefore, I had to change the cause and the manner of death.

So, originally, we made four different requests for medical file, and after the four requests, we still didn't get a complete medical file. The inquiry started, and I was provided still an incomplete medical file. And, finally, I got a more complete medical file, which I still don't know if it's complete or not. But as I said, it's complex and unrelated to this current case.

Q So did you make your original conclusion about cause and manner of death without having the information that you would normally have in front of you?

A I made the initial cause and manner of death based on the medical file that has been made available to me, but I didn't have the whole file. And the reason is it's a complex problem. Here's the -- I will try to make it in a nutshell, but the judge there is well-aware, and will evaluate this, there was also the Health Quality Council of Alberta that evaluated this problem earlier in 2013 when I was already the -- when I was the chief, and I testified, and I explained the problem. The problem, as I understand it, is still remaining today.

In a nutshell, the medical examiners have power under the *Fatality Inquiries Act* to obtain the medical file; however, we don't have access to Netcare, which is the electronic database that Health use. So we have to phone around and try to guess who has custody of medical file we are trying to obtain, and we have to trust that you are sending us everything we need, but we don't have access to the databank, so there's no way for us to know if the medical file we have is everything that is contained.

So I don't -- I don't want to go too far because it -- it's a very complex case. As I said, we made four different requests to Health, and at the end of the four requests, we thought we had the relevant medical information -- medical information, and we didn't. And how many requests can we make when you're not provided correct medical file?

But that's a different issue that has absolutely no link with the case of today where I

had to change my cause and my -- manner of death once I was provided further information that I ignored when I was -- when I say "ignored", I mean I didn't know that I -- I didn't mean that I, kind of, you know, ignored it. It's -- I -- I was not provided it. I was not aware of it.

And a medical examiner or forensic pathologist, I -- I said it earlier, should always keep an open mind, and if you are presented new information, you need to reassess your cause and your manner of death. So that's what happened in the Goltman inquiry.

Q So you're familiar with a Michael -- and I'm sorry; I know I'm going to say it wrong -- Belenky?
A I am familiar with the issue of Dr. Belenky. Not -- I'm -- I'm aware. It will depend what your question are. I didn't play all the roles of it. I played some roles in it.

Do you have further question?

Q He used to be a medical examiner in the Calgary office?
A He was a medical examiner in the Calgary office, and he left when I was deputy chief, just prior that I became acting for about a couple of weeks. So he left before -- before I started as acting, and then I became -- back my deputy chief, but he was gone already.

Q So he left in 2011?
A No. Two thousand -- my memory is that he left in 2010, because he left before January 1st. But I go from memory, and I was not -- I was not in charge of him. I was not working in the same office as him. I was not involved in his departure. I've heard about it, but I was not firsthand into his departure at any point in time. I had an involvement after his departure, involvement that has nothing to do with the case of today.

Q So before he left, he conducted a death investigation into a toddler and ruled that it was a homicide. Are you familiar with that?
A I am familiar with that case. Well, one of these case, 'cause there were multiple ones. I'm familiar with one, but I don't think it's the only one.

Q So as I understand it, you reviewed one of his death investigations and determined that he came to an unreasonable conclusion about cause of death. Is that fair to say?
A No, that's not fair to say. It's more complex than that. Yeah, okay. So if I try to explain the Belenky situation in a few sentences, Michael Belenky was a forensic pathologist at the office of the chief medical examiner. He left the office. I've heard

how, but I'm not -- I don't have firsthand knowledge, so I prefer not to be questioned on that part because that would be gossip.

After he left, I was involved in something that -- in -- where I was made aware of something related to him that we needed to report to the College of Physician and Surgeons of -- sorry, the -- to the College of Physician of Alberta. And they made their investigation very complex, and they couldn't, at the end, decide one way or the other, as far as I understand. So he was -- I -- anyway, it's not my job to say the report of the College.

My implication was I -- when we were made aware of a problem relating to his work, Dr. Graeme Dowling was -- was the chief at the time, was on vacation, and when he left -- and he named me acting for the few weeks he would be on vacation. He said, I will be in New Zealand. There is no way to contact me. Don't even try. When I was made aware of something that I don't even want to mention, if possible, because the College evaluated it. I don't want to stain his reputation further than what he'd already gone through. He been through a lot.

I had to report that to the College. I inform my boss. My real boss was on vacation, so I had to go one step further. I went to the deputy -- to the deputy minister. I made him aware of what we just discovered. I told him that as a physician, my duty was to report to the College for them to investigate. He said that as the Deputy Minister of Justice, his duty was to make that aware -- to -- to make aware the -- I -- I think it was called at the time the Assistant Deputy Minister of Criminal Justice. That's kind of the -- the ADM, the assistant deputy minister, in charge of all the Crown.

And that person, in discussion with the deputy minister, decided that there was a risk for the justice system, that they had to declare to all the lawyers, Crown and defence, in case there would be implication. It's not my decision. It's theirs. As a doctor, I only reported to the College. Then my chief came back. I went back to my job as deputy chief. I was not involved further as an acting chief.

Then they assign a lawyer. Don't remember his name. I know he's retired now. This lawyer was made in charge -- I'm not sure if it was by minister or by deputy minister, but his job was to assess the problem. And through our chief, we were mandated to review -- well, it -- it was declared -- not by me, and I don't think by the chief either. Someone in Justice. Not sure if it's deputy minister, the ADM of Crown, or the minister, or the DM. I'm not sure. It's not my decision. I was just back to be deputy chief. They made the decision that Michael Belenky -- Dr. Michael Belenky could not testify again in Alberta because of the risk that was, at the time, thought for the justice system.

All his cases that could have implication for court were reassigned. Our job was not to say if we agreed or not to him; it was to redo our report because now we were in charge of his cases and were to testify in court.

As a normal forensic pathologist, some of the cases ended up on my desk. We shared -- the chief assigned certain cases to certain people, so kind of a -- it was -- for us, it was a lot of additional workload because we had to redo cases for someone that has left. I was assigned several of them, some where I barely changed -- my conclusion were base -- basically the same as his, a few that my conclusion were different. But I was not assisting him. I was redoing the case. That's my understanding of it. And I was testifying in court, and my understanding is that I was presenting my new report. I was not discussing him versus me.

Q And when you went through his reports, at least one time, you came to a different conclusion?

A Yes. That's -- I think -- I'm not -- it's long time. I think the case I came to the -- the different conclusion is the first case for which we started the warnings sent up. The warning is not in the report. The warning is in something else.

If you want to go further to understand, I would have to say what it is, but I'm -- I'm not sure it is appropriate that I discuss here what we discovered that started the investigation on Mike Belenky, but that has a big implication on why I, in the end, came to a completely different conclusion.

But in his defence in the court -- in the College, he brought new facts that bring new light on what happened that I also think should be kept out of this current court, but at that -- also an implication, but -- yeah. Not sure if you want, I -- I am under oath. If you ask me question, I will try my best to understand, but -- to -- to answer, but I'm also trying my best not to create more problem for some people that have nothing to do with this current case.

Q So as I understand it, eventually the family of one of deceased sued the office of the chief medical examiner or Justice Alberta, the government, they sued the government due to allegations of misconduct by Michael Belenky. Is that fair to say?

A Yes. You -- yes. It -- it refresh my memory that the initial case who was the problem, which is the one that I changed the diagnosis, we were -- we were sued. And I -- when I say "we", it's not me. I'm not sure. There was a lawsuit, but I -- I didn't deal with it. There's -- there's a part of the government that deal with the lawsuit. I think it's called risk management unit, something like that. I didn't deal with the lawsuit myself. I -- I -- I'm aware there was a lawsuit, but that's the end of

it.

I -- I think I answered maybe a question for a lawyer once or twice, but very specific question with very specific answer. Mainly they were dealing with Dr. Dowling because he was the chief when this happened. But because I'm the one that found the case, they had question for me, and I think I became chief when the lawsuit was not solved. I don't know how it ended. I don't have a lot of firsthand implication (sic) in that lawsuit.

Q You're also familiar with Evan Matshes?
A I am.

Q He used to work for the office of the chief medical examiner?
A Correct.

Q He was a forensic pathologist?
A He was.

Q In 2012, a review was conducted of a number of his death investigations; is that correct?
A That's correct.

Q And that --
A Once again, that was not my decision. I -- there was something -- and there's a link between him and Matshes -- between him and Belenky that I don't think we should -- I will not explain it today, unless further questioned on this. I don't think that would be appropriate. We became aware of something again. I reported it to the College so that they can do their work. But, once again, the government decided in that case to -- that they needed to do the same, and they -- for the protection of the justice system, they did ask for a review of some of his cases. And there was an -- an international panel that came completely out of my implication, and they reviewed some of the cases.

Q And you were the chief at that point in time?
A I was not -- I was the chief when the review of the cases was ordered. I was not the chief when these cases were done. There -- there's a slight overlap. From what I recall, I became chief July 1st, 2011. Dr. Matshes had resigned in the spring, March or April. I don't remember the exact date. Then Dr. Dowling stepped down in relation to what was all happening. Then there was the competition. My interview was 31 of May. I remember because that's my birthday. And then I was -- I became chief July 1st.

But when you -- when you do your resignation, you're there for six months, so he was still there when I started as chief, but with the understanding that he was leaving the office. And he left early August, beginning of September. I can't recall the date. So there was a crisscross for a period of time, but he was already off cases, finishing his old cases. So all the cases that were on the review were from predating -- predating when I was chief.

Q Are you familiar --
A And --

Q Oh.
A -- can I just add one more thing?

And it was in reaction to Belenky -- the Belenky situation and the Matshes situation, not only for that, but in part for that, that I created the peer review system, because the justice system couldn't continue to go to situation like that. We had to make sure we would protect better the system. And one of thing -- we did several thing to try to protect the system, and one of the thing was the peer review system.

Q Are you familiar with the conclusion or conclusions that this international panel came to when they reviewed Dr. Matshes' work?
A Yes. They reviewed 14 cases, and they said the conclusion of Dr. Matshes were unreasonable in 13 of the 14 cases. For administrative reason, that was quashed in court. It was supposed to be redone. To my understanding, it has not been redone yet.

Q And eventually Dr. Matshes started a lawsuit for defamation. Does that sound about right?
A That sounds right. Yes, it is. It's correct. He started a lawsuit following the -- well, he started a lawsuit at some point, yes.

Q So is it fair to say, then, that while you were chief medical examiner, it was brought to your attention in a very drastic fashion that you needed to ensure that medical examiners were doing their jobs properly?
A No, it was never brought to me this way, but I understood it was my job to do something to try to protect the system, but I have to balance it with, also, the need to preserve the independence of the medical examiners. So you cannot go from one problem to creating another problem. So you have to balance the two. So that's what we tried to do.

I say "we" because I -- for example, the peer review, I didn't work alone on this. So we -- you have to -- you have to balance protecting the justice system, but also -- I mean, by having quality work of death investigation, and you also have to protect the independence of work of the medical examiners. And it's a fine balance, and I think everyone -- we -- we all try to do our best in coming to a system that would do both.

Q So along with the peer review system, you also instituted a second change in your office that resulted in all death investigations being conducted by forensic pathologists; is that correct?

A That's correct. So that was in -- I thought that was an even bigger danger, and that's one of the first thing I worked on as a chief, was to make sure that all death investigation in Alberta would be done by properly qualified and trained forensic pathologists, because when I started as chief, we had to exhume bodies that were done by people that were doctors but not forensic pathologists, and that was not, in my mind, a good way to do death investigation in Alberta.

It took a while to be able to do it because there was a lot of step implicated in changing the system. Top of my head, it took me about a year, I -- maybe -- maybe a little more than that. I can't recall the exact date we transition, but we transitioned.

Q So does that mean that when you became chief, some of the people performing the death investigations in your office were doctors and -- or just weren't forensic pathologists?

A Yes. So what happened is, historically, in Alberta, initial -- well, I don't think I go -- I need to go that far.

There was a -- there -- when I was chief -- when I became chief, a big proportion of the death investigation in Alberta were done rurally or outside of Edmonton and Calgary by doctors but nonforensic pathologists. One of the problems was they were not trained as forensic pathologists. The other problem was that there were a lot of them, and each of them were not doing a lot of cases. The vast majority were doing less than three cases a year, if I remember correctly the number. But the majority were less than five, but I think it was the majority were less than three.

Some of them were years -- for a full year, they would do zero; the next year, they would do one. You cannot maintain -- even if you were qualified, which they were not, it would be very difficult to maintain the qualification and expertise if you don't do enough cases.

So that's one of the reason we ask -- so there was that, and we -- so for the -- not the proper qualification and because of the way it was spread out, we decided that all the

cases would be done by forensic pathologists in Edmonton or Calgary.

Q So, effectively, you no longer renewed contracts with those doctors and, instead, began contracts with forensic pathologists?

A No. That's the weird thing. They were not under contract. They were named to life (sic) by minister. So -- and -- and you cannot stop them from working. As a chief, I had no power to stop the appointment. If you look at the *Fatal Inquiries Act* (sic), there was no way I could stop their contract. Only the minister could.

So there were situation, for example, where there was one where I went to see with my own eyes because he came one day to do a case in Calgary, and I was hearing rumours, and I couldn't believe it, so I went to see. He was in a wheelchair. The body was higher than him. He couldn't even see the top of the body. And he would ask the people around him, Tell me there's nothing on top of body. And he would then sign that this case was not a violent death. I saw it. I had the power -- zero to do something about it for him because only the minister could. And I was wondering what else is happening in this province that I don't even know about.

So I went to the assistant deputy minister. She brought me to the deputy minister. He brought me to the minister. They all agree with me, and we made the necessary changes.

There's an historical reason why it was like that. It's not -- so -- but I don't want to go into that. It would be long. So it's not that -- it took time to change and improve the system, and we did.

Q And aside from those two, there was still other improvements that you wanted to make; is that right?

A I made a lot of improvement when I started as chief on multiple level. It was made very clear to me that they knew there were a lot of problem with the system I had inherited and that if I could improve it, they would be more than happy and (sic) support me, and that's what I tried to do. I really tried to improve the system the years I was there, and when did not -- when they did not renew my contract, there was still many ideas that could still be explored and that hopefully are -- can -- are now explored, 'cause there's always other people that can continue your work.

So the system -- and don't -- don't -- don't get me wrong. It's not a bad system. We do have a good system in Alberta. But it's not a perfect system, and we need to continue to improve it. We did improve while I was chief, and I hope they continue to improve it now.

Q So as I understand it, Dr. Adeagbo joined the Calgary medical examiner's office in January of 2012. Does that fit with your recollection?
A I -- I don't remember the date. That seems about right. As I said, I became chief in July 1st, 2011. I became chief in a crisis situation where we were only three remaining forensic pathologists in the whole province, all in Edmonton. My first immediate work as chief was to recruit because we had to go from three to nine or ten, and in a year, I rebuilt it from three to nine. I had the permission to go to ten, but with the workload at the time, I decided nine was the right number. So I went from three to nine in a year. And Dr. Adeagbo is one of person that joined the office in that year.

Q So does that mean that you and human resources were responsible for hiring him?
A Correct.

Q Now, when you hire people -- or when you hired people back then, 2011, 2012, I don't know about you, but I had a lot of jobs back in the day where the first six months, the first four months, the first two months, I was on probation to make sure that everybody liked me and that I could do the job appropriately. Did your office have a similar probation period for new forensic pathologists that came onboard?
A It -- it's a little bit different. There was a probation period, but it was not by the office. It was by the College of Physician, because Dr. Adeagbo and -- and he was not the only one come from a different country. So the probation period was done through the College, but I was responsible.

Q Do you remember how long that probation period was?
A I think -- top of my head, I -- I think it might be three -- I don't recall. I think three months, but I'm not sure. The -- there's an official rules, and you have paper to fill at the end. But I -- I can't recall the exact number of month.

Q And he successfully completed that probation period?
A So I -- yes. It -- I -- there was a certain number of cases that I reviewed, and I ask opinions from people how he was more behaving, and at the end of the -- I don't remember how many months, it was thought that, yes, there was -- that was okay, and I signed a paper.

Q So when you say you reviewed his cases, does that mean that you read over his autopsy reports?
A I read some autopsy reports, correct.

Q Did you conduct a peer review of those reports or no?
A It was a different process. It was -- the -- the paperwork was the one of the College.

There was paperwork involved. I did it not just for Dr. Adeagbo. I did it for -- I mainly recruited in United States. We are about 50 forensic pathologists in Canada. So when you want to recruit, stealing from one province to the next, we try, but you don't go very far, so I went to United States, and I hire most of the staff from United States. And everyone that's not -- that had not sitted (sic) the exam in Canada, there's a process where someone has to evaluate their work for a number of months, and there's paperwork from the College.

So it's not the form you showed me this morning. It's a different form. I would have a hard time to remember how it was, but I feel what was given to me by the College. I can't recall exactly the paperwork. There's paperwork involved.

Q Now, in 2013, you and Dr. Adeagbo came to terms or had an issue in that you were concerned he wasn't completing his reports within the time limit imposed on forensic pathologists; correct?
A Can you -- the general gist is correct, but I would appreciate if you can just re -- re -- re-ask the question 'cause there's a lot of little part involved, and I want to make sure all the parts are true.

Q So you were concerned -- you developed a concern at some point in time that Dr. Adeagbo was not completing his reports within the time limits set; is that fair?
A It is fair.

Q And you talked to him about it?
A Correct.

Q And you documented it?
A Correct.

Q And eventually, you had a letter written and given to him concerning his timeliness; is that correct?
A That's correct.

Q And then it was brought to your attention that you were actually incorrect?
A No. So what happened: Multiple, multiple, multiple times, Dr. Adeagbo was unable to respect the performance criteria, who -- which was 90 percent of the cases must be completed in less than three months and all the cases must be completed in less than six months, unless there's something extremely exceptional. And we have documented multiple times that he was struggling with that performance measure.

The one time where the deputy minister -- the assistant deputy minister sent him a

letter is a time where the person that did the stats made an error, and so that letter was retracted. But the fact that before that and after that he was having problem with the performance measure is still true.

Q So a second letter was sent to Dr. Adeagbo. It didn't have the words "apology" on it, but it effectively advised him that the government knew a mistake had been made, and like you said, that letter, the original letter, was destroyed; fair to say?
A Correct. But the issue was still true and was still on -- I'm not sure of the word. We were still following the performance measure very closely.

Q And the performance measure was timeliness of completing reports; is that correct?
A Correct.

Q So you never had a problem with the way Dr. Adeagbo conducted his death investigations, except for the timeliness of his reports; is that fair to say?
A I'm not sure it's fair to say, but I'm -- I'm not sure -- I'm not . . .

Q Let me put it this way. Was there ever any other letter written to him indicating that he needed to do his job better?
A Letters, no. Conversation, yes.

Q Now, you never came to the conclusion while you were chief that he was coming -- that his opinions on manner and cause of death were unreasonable?
A That's correct.

Q You never recommended that, aside from the timeliness issue, he needed to be, I'm going to say, disciplined, even though sending a letter isn't really a disciplinary action. That's the only way I can think of it.
A If you phrase it with "discipline", the answer is that that's correct.

Q You never recommended that he be fired?
A I recommended that we would not do a full extension of his contract.

Q When was that?
A Just a few months before I -- so it -- it was -- it was in 2014, during the springtime. It was before May 12 because the assistant deputy minister was Donavon Young, and there was a switch of the ADM on the May 12. So it was prior. It was in April. Donavon Young left in April. That was in April.

So I recommended that we would do -- he seemed to be getting better, so I said that we would not do a normal three years' renewal, that we will do a two years' and that

we will re-evaluate. And -- but we -- at any point, if there was more issue, we could do the six months' notice.

But the issue or not about -- when I was chief, there was never a case where his conclusion were unreasonable. I'm not aware of a case like that. The issue were different. Mainly around timeliness. He was struggling with the pace.

Q So the two-year contract would have been similar to that probation period that you explained before?
A Yes, kind of.

Q Now, you're familiar -- and you've already mentioned her name. You're familiar with Ann Bucholtz?
A Correct.

Q Now, as I understand it, she conducted the peer review of Dr. Adeagbo's autopsy report that we see here in this case concerning Ezekiel Stephan. Is that correct?
A Correct.

Q And when did she come to work for the office of the chief medical examiner? Do you have any idea?
A I can't recall. She was not -- I -- I hired her, so she was not there on July 1st, 2011. I can't recall when she arrived. No, I can't.

Q And you hired her as a forensic pathologist; is that correct?
A Correct.

Q And is she still at the office today?
A No, she's not. She want back to United States.

Q So while you were chief medical examiner, you never came to the conclusion that her death investigation conclusions were unreasonable; is that fair to say?
A That's fair to say.

Q Did you ever come to the conclusion that her evaluation, as a peer reviewer of other pathologists' death investigations and conclusions, was unreasonable?
A I never had to review her peer review. So I would have had to review her peer review if she had said "unreasonable". Then it would have been brought to my attention, or if someone had any issue with it. But I was -- I never peer reviewed her peer review. I was never the referee, in a cares (sic) of her. I -- I -- I think, actually -- I don't recall to have ever been a referee in the end. I don't recall.

Q A referee for her or a referee for anybody?
A As I explained before, so when we -- when I work with a lawyer to build the system, the first step is that there's a peer reviewer from the office reviewing the case. But not for agree or disagree; for reasonable or unreasonable. If it's found that it's unreasonable, it then come to my desk as the chief to review if I agree with that. But I don't recall that we have ever had an unreasonable case when I was the chief. I -- I can't recall a case.

I remember having -- having been consulted by people that were unsure if it was disagreeing or being unreasonable, but in these few cases, after discussion, we felt that that was more being not in agreement. And as I said, you can be disagreeing without -- without that it's unreasonable.

Like, for example, you have expert doctors coming to court all the time where one says something and the other seems to say something different. That doesn't mean that one should be reported to the College as being incompetent. That could be in certain cases, but in most cases is that they disagree. There's a difference between disagreeing and finding that their conclusion are unreasonable and that the person should be reported to the College.

It's -- you can disagree -- it's -- it's not the same degree. "Unreasonable" means there's no way that someone should come to that conclusion in the current state of science. Impossible. That is the very -- we put the level very high 'cause we didn't want to end up with disagreement all the time that we need to be reported. So we -- we put the -- the bar very high. That's -- and -- and to do that, we -- we look what was done elsewhere.

And I remember talking among many people to Ontario and other places, and that we kind of imitated what they did, 'cause you don't want to be in a system where, all the time, you end up having three people from the medical examiners because they can't agree on something. That doesn't mean they're not good, but they don't agree. Could be on something small; could be on something big.

Q So do you have a copy of your report that we called V-6, first page started April 16th, 2016, Edmonton, Alberta, in front of you?
A I do.

Q And do you have the actual exhibit? Does it have a sticker on the back?
A No.

Q Okay. Sorry.

MS. WEICH: If she could be, please, provided with V-6.

A Thank you.

Q MS. WEICH: Now, on the first page of this document.

THE COURT: Sorry, Doctor. We're in a voir dire, and it's important for me to understand this, particularly in a voir dire.

Just going back. Just because on a peer review you disagree doesn't mean you're right and they're wrong?

A Correct.

THE COURT: Okay.

A But in a peer review, we'll never say we disagree. We will -- this is the point.

THE COURT: Right.

Q MS. WEICH: So what does it take to get to unreasonable, then?

A It takes a lot more. It takes that -- it takes that someone that -- that's from your specialty that know the current state of science can't have arrived at that conclusion. Doesn't mean you agree with them, 'cause otherwise, we would have disagree all the -- well, not all the time, of course, but we would have cases of disagree, and that doesn't mean the other person is not competent. The goal of a peer review system is to make sure there's not someone incompetent that we need to report to the College and maybe even fire immediately.

Actually, when we look at the process, that person, if the chief confirmed that it's unreasonable, my recollection is that they are taken out of the cases until we figure out what's happening. Maybe we will send them for further training, maybe -- I don't know. But we cannot -- they -- they are a threat to the system. But that never happened. That's why we were so careful when we set the system. Disagreement is not the same.

Q And all it takes is one finding of unreasonableness to report that medical examiner to the College?

A Well, in our *Code of Conduct*, as a doctor, if you really think a doctor came to a conclusion not that you disagree with but that is impossible to have come to that conclusion in the current state of science, it's your duty to report.

The problem is -- here is more that when doctor report other doctors to the College, usually this is a confidential matter and no one hear about it. Unfortunately, because our work is linked with the justice system, in two cases in Alberta, people that were -- their duty to protect the justice system decided to make that public, but usually this is something that is confidential. And no one even knows that the doctor has been investigated by the College unless the College find that the person is not competent.

If you don't report someone after been -- after having been aware of something like that, you can be under investigation yourself. This is in the -- this is my understanding of the *Code of Conduct*. You even have to report if you know your colleague is alcoholic. You have to report if you know one of your colleague, for example, has a brain tumour that could affect his work and he doesn't want to talk about it.

There's a lot of thing you need to report. That doesn't mean you make the decision. It's not your job. You have a duty to report. And the College will do their job. And as I said, usually it's confidential. No one knows that this doctor has been assessed. And the College will make the decision basing appropriate. Your duty is only to report.

Q So getting back, then, to Exhibit V-6, which is your report in front of you. On the first page, you've listed ten things that you reviewed in order to form your opinion; is that correct?

A That's correct.

Q Now, two of them, the transcript from the two days of testimony of Dr. Adeagbo and the transcript from the testimony of Mr. Cherniawsky at the preliminary inquiry, at the end of those sentences, it says: (as read)

> I was instructed not to refer to this document in the present report.

A Correct.

Q Do you see that there?

A Yes.

Q So I'm a little bit confused. What does that mean?
A Okay. I said earlier that as an expert witness, I need to list everything I -- I receive and I examined. So I -- I received these two documents, and I've consulted them. Well, I -- I read them. But then I was instructed that in the context of this trial, I couldn't use the material from it nor the knowledge from it. So it's hard to unlearn. But I've seen it, and I couldn't refer to it in my report.

So I tried to keep -- well, I -- I did my best to unlearn what I learned and to only do my report based on the other material, but for seek -- for -- forsake of completeness, I've listed what I've also seen that I can't refer to later. It's just so that everything is in the open and there's nothing hidden. I -- I don't want to have seen something and hide that I've seen it.

Q Now, do you have a recollection about the first time you reviewed the medical examiner's file which is the first thing in the top of your list of ten things?
A What do you mean by a recollection of the first time? Do you mean a date?

Q Well, did you review it for the first time in April?
A Best of my knowledge, yes. It's very recent. Very recent. Yes, it must have been in April or -- I -- I'm just worried to make an error of date. I remember where I was, but I don't remember the date that was.

MS. WEICH: Can I show her this?

MR. BUCKLEY: Oh, yeah, you can show her that.

MS. WEICH: My Lord, if I may, please. Thank you.

Q MS. WEICH: Okay. So I'm going to provide you with a document. I don't know that you've seen it. I don't know that you're familiar with it. But what it is is it's a letter written from Mr. Buckley's law office to my own office. It's dated April 2nd. And if you review it, it appears to have your opinion about what Mr. Buckley anticipates you will say if you're allowed to give your expert opinion in this trial. Do you want to go ahead and review it?
A No. I remember it, and it really helps, because that was April 2, so I would have reviewed the material just at the end of March, a few days prior this. I can't recall the exact date, but that was prior to April 2.

Q Thank you.

So I'm just going to list stuff that you have written down here on your first page, and

you just think about --
A Can -- can I just add one more thing, though?

Q Yeah. Go ahead.
A When this letter was done --

Q M-hm.
A -- I had not been -- from what I remember, I had not been informed yet to ignore the material that in the following report I was told to not refer to it. So there's thing that are in this letter that I don't mention in my new report because I was told not to refer to the preliminary. So that's the explanation.

Q So before April 2nd, you refer -- you reviewed the medical examiner's file; correct?
A Before April 2nd, I reviewed a version that's slightly incomplete of the medical file that was provided to me by Mr. Buckley. The day there was a court order that I could go to the office of the chief medical examiner, I was provided access to a more complete medical file -- a medical examiner's file, I should say. But I -- I went through all of it, but it didn't change. I -- there was one thing that I added to my report after having full access to the complete file, from what I recall.

The rest was the same for the medical examiner's file. So the other -- using more mainly from the microscopic slides that I had accessed that day.

Q So before April 2nd, did you review a report from a CT scan of the head being three pages?
A Yes.

Q And --
A But you -- you said before when? Sorry.

Q April 2nd.
A Yes.

Q And before April 2nd, you reviewed the medical file of Ezekiel Stephan as provided to you by Mr. Buckley?
A Correct. There was one page of interest that I saw in the other version that was at the medical examiner's office.

Q The other version of what?
A There's more information in the complete medical examiner's file at the medical's examiner (sic) office. So there -- there was one -- one scan -- one chest X-ray that I

have noticed in the file at the office of the chief medical examiner that I can't remember I've seen in the medical file provided to me before.

I didn't went and check to make sure it was really not there, but there's one that I noticed in the file at the office that I couldn't recall to have seen before. That's the only thing that was different for the medical information part. There were other stuff in the medical examiner's file at the office that has not been provided to me previously, but that didn't change my opinion on the cause and manner of death.

Q So this X-ray, are you able to say where it was taken?
A Yes, because it's the first, first one. As I said, I didn't went to check back that it has not been provided to me previously, but I really couldn't remember I've seen it before.

So it was the chest X-ray of March 13, 2014, no specific date, and from what I remember, that one was done at Cardston Hospital.

Q Okay. What page number are you looking at there?
A I'm looking at my own report, page 13. It's under the heading "5.1", second paragraph, the first initial chest X-ray. That one, I am not -- I -- I couldn't recall to have seen in the other material. As I said, I didn't went to check back, but I couldn't recall I've seen it before, caught my attention, and I added it.

Q So it's the sentence at -- it's the first sentence of the last paragraph on that page that you're referring to that specific X-ray?
A Sorry. Repeat that.

Q So the last paragraph on page 13?
A Yes.

Q The first sentence. That sentence refers to this X-ray?
A The first two sentences.

Q Okay. And then as you listed on the first page of your report, you reviewed the transcripts of Dr. Adeagbo from the prelim before April 2nd?
A That seemed to be correct.

Q And the transcripts from Mr. Cherniawsky at the preliminary inquiry before April 2nd?
A Yes.

Q You reviewed or you listened to the two 911 calls before April 2nd?
A Yes.

Q You reviewed the report from the Emergency Medical Services, five pages, before April 2nd?
A Yes.

Q And that would be known simply as an ambulance report?
A You can call it this way.

Q And you reviewed the 16 autopsy pictures before April 2nd?
A Correct.

Q And you reviewed the transcript of Dr. Adeagbo's trial evidence before April 2nd?
A No. I don't think so. It was provided to me, I think, the next Wednesday. Yes. I didn't have it at the time. It was later.

Q So about April 6th you reviewed it?
A I -- I think it was the Tuesday or the Wednesday of the following week, but I -- I don't recall it was a Tuesday or the Wednesday, and I don't remember which date that was. Sorry.

Q And the 13 microscopic slides of all major organs, you didn't review those before April 2nd; correct?
A That was last week, so it was not before April 2nd. That was last week, Tuesday, when there was a court order that I could get access to the slides. When I say "slides", that means histological examination or microscopic examination.

Q So before April 2nd, you had already come to conclusions, then, about the state of Ezekiel's lungs; is that fair?
A There were some conclusion that I arrived to prior to April 2nd, and there were conclusion that were slightly modified or changed after I got access to further material. So the -- the -- the report was kind of a work in progress 'cause, as I said before, you have to keep an open mind, and if you have new material, you have to evolve your opinion with the new material. So that's what happened. A lot of the part -- a lot of my report evolved with the new material.

Q So "the new material" being the microscopic slides and the transcript of Dr. Adeagbo's trial evidence?
A Yes. And the one more page that I signed, the medical examiner's file, that I didn't recall to have seen before.

Q So, now, as you mentioned before, you've never been a family doctor; you've always

worked as a pathologist. Right?

A As I said, when you train, you do -- you do months there -- in there, but I was never -- I never worked as a licensed emergency doctor or family doctor. I've always been a pathologist, a forensic pathologist.

Q So in your work as a forensic pathologist, how many times have you encountered viral meningitis when conducting a death investigation?

A Couple of time, but I can't put a number. We were doing -- in Alberta, I have not seen as many, but we were working more closely with hospital -- the kids' hospital in Quebec, and I was doing even more kids' cases there. And because the brain is often important in kids and my colleagues were often feeling uncomfortable with kids, I was doing the majority of the cases of kids in Quebec.

In Alberta, there was not that thing. Everyone was collaboring (sic) equally. But in Quebec, I was doing all the kids when I was there in the office that day.

Q So when you say "a couple", how many is "a couple", if you can ballpark it?

A It's not common -- okay. So viral meningitis, you said. Well, okay. I have to -- I have to change my answer. Sorry. Viral meningitis -- I had bacterial meningitis. Viral meningitis causing death, no, I think that's zero. Sorry. Bacterial meningitis. But viral meningitis, zero. Yes. Zero.

Q Okay. How many bacterial meningitis?

A I can't say. It's not that common to die of a meningitis. I did some. They were bacterial. I can't remember the number. That would not be an astronomic numbers; that's not, like, 100. That -- that would be a small numbers. We don't have that many kids dying of meningitis in Canada. There were not big numbers, but I have seen a few. I can't put a number.

Q Are you able to say how many children that you conducted death investigations on that died of bacterial meningitis were under 3 years old, for example?

A As I said, I can't -- I can't put a number. That would not be many of them. Dying of meningitis in Canada is not that common, but I saw some. I saw some that died in hospital, and I saw some that died at home, but I can't put a number. It's a small number.

Q So I'm going to take you through your report. And I'm going to posit some suggestions to you, and I'd like your opinion on whether or not your conclusion changes; okay?

A You mean you will do hypothetical?

Q No. No. Well, I guess we could call it that way. Basically, you've written your report as if you yourself conducted the death investigation of Ezekiel; is that fair to say?
A Not sure it's the right phrasing. I did it as a second pathologist reviewing completely a case, which is not unusual in our field. It happens often that we review complicated case, and at the end, either we agree with everything or we don't agree with certain part, and -- and sometimes we are asked to do a report, and sometimes we are not after that review. But it's -- I think that's more a fair way to present it.

Q So on page 2 of your report, under the heading "1.1, Croup and Most Likely Infectious Agent", you wrote: (as read)

> Ezekiel presented with intermittent symptoms of croup in the two weeks prior to the respiratory arrest of March 13th.

Do you see that there?

A Correct. Can I comment on this sentence?

Q M-hm.
A This is not --

Q Sure.
A -- my opinion. This is to provide the information I'm basing the rest on. So if that information is incorrect, I have -- you can present me a different set of information, and I will see if it change my opinion.

THE COURT: I think that's what she's getting to.

A Okay.

Q MS. WEICH: Now, further down that same page, you wrote -- sorry. I'm just trying to find it. You wrote -- so underneath the chart, in that little paragraph underneath the chart on the second page -- one, two, three lines in, you wrote: (as read)

> The most likely infectious agent to explain the croup is enterovirus or rhinovirus.

Do you see that there?

A Correct.

Q So you actually came to the conclusion that Ezekiel actually suffered from croup?
A No. I was provided information through the medical file that suggested the first sentence you referred to, that he presented with intermittent symptoms of croup in the two weeks prior to the respiratory arrest. Based on this and the rest, I made the conclusion. If you change the information, I will have to reassess.

Q So you understand from going through all the medical records that Ezekiel was never seen by any medical personnel until the ambulance attendance on March 13th; is that correct?
A My understanding is that from the medical file, it is described that a nurse had seen him but no doctors prior to the respiratory arrest. That's my understanding. And -- and I don't think -- the nurse was not in an official capacity of nurse at the time, the way I understand it. So I might be wrong, but that's my understanding. I think it was more described as a friend or something like that.

Q So understand that he was never diagnosed with croup by any medical personnel while he was alive; is that correct?
A While he was -- prior to the arrest of March 13, that is correct. But there's summary done by doctors that present what I perceived as their interpretation of the information provided, and -- and based on what they were reporting, I also came to my own conclusion, but some of these facts might be wrong, and if these facts are wrong, I would have to re-evaluate.

Q Do you recall which doctors' reports those were?
A If I'm provided a medical file, I could point it, but I don't -- I -- most of time, I can't even read the signature or I -- for me, who it was is not the most important thing. I cannot name the doctor, but I remember to have seen two summaries that were particularly good, though they were not exactly consistent completely with each other, and I remember going through all the earlier notes to have the most information I can.

Having said that, a forensic pathologist often has to work with non-doctors' information from the symptoms because we are dealing with people dying at home often that have not been seen by a doctor, and we still work from the symptoms that are reported to us. We will not necessarily take the diagnosis people think it is, but we will hear the symptoms they are describing.

For example, they were having a headache. We will consider this when we look at the rest or -- so it's not unusual for us to have symptoms described to us by non-doctors, and we know that there can be some errors in it. For example, they use technical

word, like wheezing, we'll try to understand what they mean because they might not be meaning wheezing; it might be meaning stridor, which is different, but for most people, they don't see the difference. So we are used to that, getting information from non-doctors and trying to figure out what that could mean.

Still, the information on which I base my diagnosis might be wrong, and if it's wrong, I will have to be presented different facts, and I will re-evaluate.

Q So to begin right away with, then, if I were to advise you that all of the reports that you read, the doctors' notes that you read, the doctors described that Ezekiel's caregivers described him as having croup-like breathing but no diagnosis was ever made, does that -- does it affect your opinion at all about whether or not he had croup.

A I am aware that no doctors has prior to March 13 made an official diagnosis of croup. When I sit here, yes, symptoms that could go with croup, I don't go with the family saying that they think it's croup. I go with more I was described a kid, from what I remember -- and when I say I was, I mean by the medical file -- I saw that he was having some fever, he was irritable, there was a barking cough. And this one I even wrote the number of the page because it was very important. I think it's page 412, the barking cough.

There was another doctor that says there was no cough, so that one I had to balance out. I'm not sure if there was a cough or no cough, but both didn't see the kid at the time. They write what the parents would have said.

MR. BUCKLEY: Those would be my page numbers, not yours.

MS. WEICH: Oh, okay.

A So --

MS. WEICH: Sorry, Sir. If I may.

Q MS. WEICH: Oh. You don't have copies of the pages in front of you, do you?

A No. I wrote that it's on page 412, but I don't have the medical file with me.

Q Oh, okay. So --

MR. BUCKLEY: And if it helps my friend, My Lord, long ago, I'd asked my friend if we could just use the same file page numbers, and the Crown declined against that, and I had scanned the medical file as disclosed to me with my page

numbers. So that's what the witness obtained, and that's why in her report it says. So it was actually one of the things I suggested when she prepared her report is you might want to mention there defence page numbers, just so that my friends wouldn't be confused with the page numbers.

MS. WEICH: So, Sir, I can also advise that all the hospital medical examiner's records were entered at the preliminary inquiry with page numbers on them.

THE COURT: Let's move on.

MS. WEICH: So, Sir, what I would suggest, then, is we take a bit of a break. I'm going to need to compare and contrast my friend's document with my document and have Dr. Sauvageau go through it all with me so she can point to, well, this is page 80, and I can find it in my book.

THE COURT: Yeah.

MS. WEICH: And there's about --

THE COURT: We'll break. We'll take our afternoon break.

MS. WEICH: -- over 600 pages, so . . .

THE COURT: We'll take our afternoon break right now. 15 minutes.

(ADJOURNMENT)

THE COURT: Please be seated.

Doctor, you acknowledge you're still under oath?

A I do.

THE COURT: Thank you.

Crown?

MS. WEICH: Thank you, Sir. Okay. Thank you very much for that break.

Q MS. WEICH: So, Dr. Sauvageau, if I was to advise you that there's absolutely -- aside from the handwritten note that you read, so take that out of the picture, if I was to advise you that there's absolutely no evidence of a barking cough at all in the two-week period that you canvassed -- or two-and-a-bit-week period that you canvassed leading up to Ezekiel's hospitalization, would that change your opinion in any way at all?

A Was there no barking cough or no cough?

Q There was a little bit of a cough for the first day or two, maybe three, and that is it.

A Can I -- if you don't mind, I will take a pen, and we'll go through the symptoms you want me to consider. I'll . . .

MR. BUCKLEY: Do you need a pad of paper at all, Doctor?

A I do have it. Oh, that would be useful. Okay. Thank you.

So I considered that there's a cough, but you said it was -- if you don't mind to repeat. So it was not barking. That was in there in there -- were in the medical file.

MS. WEICH: If I can have just one second.

MR. BUCKLEY: And, My Lord, I'll let my friend continue with this question, but I'll put my friend on notice that I'm going to ask her to focus. We're in a voir dire that deals with bias which isn't, you know, just to explore the test -- what the testimony would be if allowed to testify and explore different hypotheticals. So I'm not objecting, but I just would invite my friend to try and focus on --

THE COURT: Mr. Buckley, I think you're -- it's a good point.

I'm just wondering, how is this relating to the voir dire?

MS. WEICH: Well, Sir, as I advised earlier, it's the Crown's intention, potentially, depending on the answer, to argue that her evidence will not be able to assist the triers of fact or are not relevant in the circumstances, and part of figuring out whether it will assist and whether it will be relevant is -- it is the background as to the facts or the facts that she -- not necessarily the trial facts, but the facts that she took into consideration in coming to her conclusions, because, according to her list, the only actual trial evidence that she took into consideration was the evidence of Dr. Adeagbo.

And so if what she relied on as evidence to form her opinions in this document is not

actually the evidence at trial, then I would suggest that the Court should seriously doubt whether or not her expert evidence can assist and is relevant.

MR. BUCKLEY: Well, I mean, she's evaluated the medical examiner's file, and the bulk of her evidence is basically explaining why he's incorrect and she has a different opinion. And when -- the medical examiner, he reviews the hospital records to do this. So, basically, my friend is saying they can call a witness that looks at the medical file that accumulates, a medical examiner's file, and they can enter a report for the truth of its contents, have the witness adopt it and testify on it, before any of the evidence is led of what symptoms are, and the jury can consider that, but another forensic pathologist can't do the same thing with the addition of seeing the trial evidence of the first pathologist. And I would suggest that then we need to have a mistrial and not have Dr. Adeagbo testify.

THE COURT: Doctor, would you mind just stepping out for a minute.

A No, I don't.

THE COURT: We'll call you back. Just a second.

(WITNESS STANDS DOWN)

MR. GILES: Perhaps, if that's the case, Dr. Adeagbo should step out as well, Sir.

THE COURT: And Dr. Adeagbo can step out too.

Discussion (Voir Dire) (Qualification)

MR. BUCKLEY: Forensic pathologists don't sit through trials and then do -- give their conclusions on causes of death. Causes of death are determined beforehand. I've had this witness basically examine but with the addition of Dr. Adeagbo's trial testimony the same evidence that he would have reviewed when he came to his conclusions. In my submission, that's a very fair approach for a forensic pathologist.

THE COURT: Crown, there's some merit in that argument in the sense that the witness -- if we're in a voir dire, which we are, the witness has given opinion evidence based on her understanding, and then, typically, if the -- if the evidence is -- if the witness is allowed to give opinion evidence, then you'll try and undermine the

report by putting the actual facts to the witness at -- by way of hypotheticals or recapping that at the trial, and that affects the weight, goes to the weight to be attached to the expert's opinion. So why are we here in this now?

MS. WEICH: So, Sir, if the Court chooses to disallow me not to continue down this path, then, again, I have more questions that concern her conclusions. But it's not based on the medical file as it exists; it's based on the articles that she's using to come to the conclusions.

She references articles that are either in peer review journals or aren't. She actually quotes from some of them very extensively, and then draws her conclusions based on them. And so my next intention is to put those articles to her in order to find out how and why they lead her to the conclusions that they do.

THE COURT: That's just asking her the material that she's based her opinion on, which goes to the value or the weight of the opinion, doesn't it?

MS. WEICH: And, again, Sir, it also goes to, I would submit, is it -- is it going to confuse this jury, is it actually going to assist this jury if she has no basis in the evidence or only slight basis for her conclusions? And is it relevant if she refers to articles, for example, that have absolutely no bearing on this child and these circumstances and this instance in order to form her conclusions about what happened to him, including his cause and manner of death. If you take all of that away or half it or a quarter of it, what is that going to do for the jury?

As well, Sir, there's one further point. It appears that one of her suppositions concerns whether or not a child has been vaccinated, and I know that my friend has tried very hard to keep that issue on the down low, and so have we, but I think it's important to get to the bottom of so that so we can determine as soon as possible whether or not her opinion goes, in its entirety, that far, and my friend can consider whether he would still like it to be put before the jury or whether any one or more portions of her report should be effectively struck down or struck out for that very same reason, Sir.

MR. BUCKLEY: Can my friend point out to me what she's seeing is dealing with vaccination, 'cause I'm certainly not wanting this witness to go there. If it was added between drafts, I've missed it entirely.

MS. WEICH: Would you like to take a break, Sir?

MR. BUCKLEY: And everything else --

THE COURT: I'll come back in five minutes.

MS. WEICH: Thank you.

(ADJOURNMENT)

THE COURT: Please be seated.

MR. GILES: The problem, Sir, that we've tried to identify and as was agreed by both defence and Crown early on in an (sic) order to avoid any kind of difficulties in the polarization on the issue of vaccine is we wouldn't bring that up. What I'm concerned about is that Dr. Sauvageau's opinion is based on a number of articles. One of those articles requires a presumption of a population which actually has been subject to vaccination, essentially. And you don't have a copy of the report, and I --

MR. BUCKLEY: Yes, he does.

MR. GILES: Oh, does he?

THE COURT: Page 3?

MR. GILES: Can I have the report for a second.

Page 3 of the report notes that: (as read)

> Viral men -- with -- when a child presents with symptoms of meningitis, the infection agent -- the infectious agent is more likely to be viral, 95 percent, than bacterial, only 5 percent.

And if I understand correctly, the reasoning is essentially this: It was viral meningitis, because we can't prove that it wasn't viral meningitis, and 95 percent of the meningitidis out there are viral, so she then presumes it's viral meningitis. Then after that, she looks at the sequelae of viral meningitis being far more benign than that of bacterial meningitis; therefore, his life wasn't in danger in any respect as a result of the disease; therefore, the only thing left after factoring out those things is, essentially, medical misadventure; therefore, it was medical misadventure. That appears to be, ultimately, the chain of reasoning we're talking about here. So failure of any one of those premises to be available before the Court would then make the conclusion fail.

So when I look at that particular footnote, it takes us to an article. The article, which I've reproduced in its entire -- and provided to the Court. It's called, "Neuropathology".

Provided a copy to my friend.

My concern, Sir, that this drags in through the backdoor vaccination, which it really ought not to be the case if what we're trying to do is avoid vaccination issues.

So when I look at the neuropathology report, which she has referred to in order to come up with the 95 percent, and I turn to the second page of it -- and I've highlighted it; although, it comes out in grey. (as read)

> The infection may spread to the meninges from an adjacent area infected --

And I'm reading right from the first paragraph. The last five lines to the previous sentence are stuck on the top of that page. But it says: (as read)

> The infection may spread to the meninges from an adjacent infected area, such as sinusitis, otitis media, and mastoiditis, or from the environment through a penetrating injury or congenital defect such as meningomyelocele. Most commonly, however, meningitis results from hematogenous dissemination of bacteria. The most common organisms of bacterial meningitis in children and adults are streptococcus pneumonia and Neisseria meningitidis. Streptococcus pneumonia is declining after the introduction of conjugated vaccines. Haemophilus influenzae, once very common in children, is now rare, thanks to vaccination.

Now . . .

THE COURT: Look, I don't -- Crown, I don't think you need to go there because if this expert testifies with this report, and if this report uses an assumption, figures which relate to a vaccinated population, the Crown's got to be able to examine on that, don't they? They got to be able to say, This is a vaccinated population. Would it be any different if it wasn't a vaccinated child?

MR. GILES: Exactly my point.

THE COURT: Well --

MR. GILES: Except, if we bring that up before the jury, then the difficulty -- and, in fact, what I would like to do is to say either this -- she doesn't have anything particularly relevant to say, and, therefore, she shouldn't be allowed to say

anything, or alternatively, the Crown needs to be able to ask that question in cross-examination, which is now going to bring up the question of vaccination.

I mean, as soon as I saw this article laying underneath the testimony of this particular expert witness, it caused me some very, very significant alarm, indeed. I thought that we were going to be able to avoid this issue, and now we can't because her conclusion that it had to have been medical misadventure is founded ultimately upon a presupposition of an -- of a vaccinated population.

THE COURT: Well, let me just enter this. We're in a voir dire. A voir dire is a trial within a trial, but it's not the trial. As I see it at the moment, the witness has been proposed as an expert in forensic pathology and an expert in asphyxia. And the request -- the motion was that she be entitled to give opinion evidence with respect to the cause of death; the mechanism of death, or the manner of death, I suppose; the diagnosis of illness; prognosis of illness; interpretation of medical doctors; hypoxic and anoxic injury and when brain damage is caused by hypoxic and anoxic injury.

So what I see thus far, and we're not done the voir dire, but we are entitled to be a little bit more summary in our proceedings, I haven't heard anything yet that would allow this witness to give any opinion evidence with respect to diagnosis of illness or prognosis of illness. We're nowhere near the kind of qualifications that we've seen with respect to folks like Gamble and a number of others, so that part troubles me.

What also troubles me -- well, doesn't trouble me. With respect to the bias, if that's all the evidence you got, there's more evidence to come.

MS. WEICH: Okay, Sir. I'll go back there.

THE COURT: And, thirdly, the matter of vaccination's being raised. I mean, do you really want to open that can of worms --

MR. BUCKLEY: Well, and actually --

THE COURT: -- because this is your witness.

MS. WEICH: And, actually, My Lord, I didn't think I was opening that can of worms.

THE COURT: Well --

MR. BUCKLEY: Just so you know. So because, you know, there's not going -- there's -- nobody's going to be able to parse out statistics between vaccinated and unvaccinated populations. The reality is, you know, we're -- when you have meningitis, there's a certain percent that's viral; there's a certain percent that's bacterial. You can't parse it out. How are we raising this as an issue? Would anyone even be able to call a witness in the world to say, Well, statistically here's the difference if we're talking about a single child who may not be vaccinated. So, I mean, it just -- with all due respect, I didn't see how it could possibly be --

THE COURT: Well, with all due respect to our jury, perhaps a medical doctor from another country that says, Over there, there's no vaccinations, we got all kinds of meningitis in little kids. I mean, that's what somebody like Adeagbo might say. He claimed to --

MR. BUCKLEY: Oh, oh, right, but --

THE COURT: -- have a lot of experience with --

MR. BUCKLEY: But we're in North America.

THE COURT: We are.

MR. BUCKLEY: So . . .

THE COURT: In Lethbridge, where there's vaccination -- a vaccination, or maybe there's evidence of that. I don't know this. It hadn't been evidenced. But do we really want to get into that?

MR. BUCKLEY: Maybe we don't. I mean, I can reconsider that. Especially 'cause you're saying you're not viewing that I've met the diagnosis and prognosis test, in any event, which is --

THE COURT: I don't see any reason why this witness should be able to giving opinion evidence on diagnosis and prognosis of illness. How can she? She's never been a family doctor or an ER physician. She's been a pathologist all of her life.

MR. BUCKLEY: And, yet, Dr. Adeagbo -- well, I guess he practiced a little more -- gave prognosis evidence with a very similar background, less intense --

THE COURT: In cross or in chief?

MR. BUCKLEY: Well, in chief.

MS. WEICH: No.

MR. BUCKLEY: I think in chief.

THE COURT: I can go back and check my notes, but I thought it was in cross.

MR. BUCKLEY: Okay.

THE COURT: And you expanded it; that is, you thought to expand his expertise.

MR. BUCKLEY: I thought he was going to follow his prelim evidence. I thought --

THE COURT: Well, I --

MR. BUCKLEY: -- he was going to --

THE COURT: I'm not trying --

MR. BUCKLEY: Yeah.

THE COURT: -- to fault anybody. Mr. Buckley, I'm only saying --

MR. BUCKLEY: M-hm.

THE COURT: -- this is what is before this jury.

MR. BUCKLEY: Yeah.

THE COURT: So where do we want to go? You've heard my concerns about diagnosis and prognosis. You've heard my concerns about this report potentially opening the door to cross-examination by the Crown with respect to that aspect.

I mean, the other thing I wonder about in terms of this particular witness, the Crown's revving up to cross-examine, and they may not be allowed to do it now, but they're certainly going to do it -- I mean, we normally don't get into the detail of the report during the voir dire to determine if they can give the report.

MR. BUCKLEY: M-hm.

THE COURT: You're quite right in your objection and -- or your comment on that, Mr. Buckley. You're quite right about that. But at least you know it's coming.

MR. BUCKLEY: M-hm.

THE COURT: It's coming. And proposing the real evidence to the witness at the end of the trial is going to be something that the jury's going to hear all about, and how much of that do you want to have go in? That's your choice, not mine.

MR. BUCKLEY: Yeah. I mean, right now we're dealing with bias.

MS. WEICH: So, Sir, I would submit that if we continue, and I'll speak very specifically to the bias issue, I could be done within 20 minutes.

THE COURT: Crown, I want you to focus on where you have, I think, an onus, according to the folks up in the Supreme Court, deal with the bias, and then let's see where that takes us. Perhaps I need to bifurcate, perhaps not, but let's hear the evidence on that, and then I'll make a ruling. All right?

MS. WEICH: Certainly, Sir.

THE COURT: Thanks.

Please recall the witness, then.

MS. WEICH: If you don't mind, Sir, I'll go and get her.

THE COURT: Thank you.

MS. WEICH: Thank you.

(WITNESS RE-TAKES THE STAND)

THE COURT: Doctor, you acknowledge that you're still under oath?

A I do.

THE COURT: Thank you.

Please proceed, Crown.

MS. WEICH: Thank you, Sir.

Q MS. WEICH: So, Dr. Sauvageau, I understand that, unfortunately, in 2014, you did not leave your position as chief medical examiner of Alberta voluntarily. Is that correct?

A It is correct.

Q And, again, unfortunately, your contract that you expected to be renewed wasn't; correct?

A That is correct.

Q And you were shocked and surprised and, if I can even say, appalled by that; right?

A I was surprised. I was surprised mainly because I was under the *Whistleblower Act* at the time, but it happened.

Q So you thought that the Alberta government was negotiating with you in good faith and that you would eventually get a new contract to continue being the chief medical examiner from 2014 into 2019; correct?

A There was no active negotiation. It's not an accurate statement. So what happened is that my contract, my initial contract, it's -- it's a little complex, and I'm not sure how relevant it really is. I was -- I was -- I was under a written promise for five years, but because the templates were not ready, they were not ready to sign physically, the contract, so under the written promise of a five-year renewal, I was given extension for a shorter period until the new templates were ready for all the medical -- they were changing the template of our contract.

So as we were, one after the other -- as our contract were -- all contract were getting to their deadline or limit in time, we were under short-term extension letter until the new template was ready. They were changing the templates following the Belenky and the Matshes incident. So the lawyers at the government decided to change the

templates.

And these templates were not ready, so I was under a shorter extension letter until the templates were ready, under a written promise of five years, so there was no negotiation, and -- and I -- I -- I -- I -- I went to the public interest commissioner on August 18 and the auditor general to report something which I don't think is relevant for this cause of today.

I was under the understanding that I would still have my five-year renewal. I was under the understanding I was under the *Whistleblower Act* that was -- it's not the name exactly. I can't recall the real term of act, but it -- when they created the public interest office, and on 25th of September, if my memory's right, I received a letter that my contract would not be renewed despite the five-year written promise and despite that I was still under the *Whistleblower Act* and the investigation was not completed. So, yes, I was surprised.

Q And you were out of a job?
A By 31 of December 2014, I was out of a job.

Q And that was the first time in, like, 12 years that you hadn't been working?
A Well, since I was 16 years old.

Q Okay.
A But sometimes it was student, but I was never unemployed apart from being a student before.

Q You were the only medical examiner at that time with a letter of extension whose contract was not renewed?
A That's correct.

Q So then in 2015, you started making it known publicly that you were not impressed with the operations of the medical examiner's office?
A That is not a fair statement. I did a lawsuit, but I never made anything publicly.

Q So in 2015, you made it known that the computer system at the medical examiner's office wasn't secure and the authors of autopsy reports couldn't be sure that their reports weren't changed by other people without their knowledge?
A That's not a fair statement. I had met with the Crown, Mr. Komosky, before testifying for him. He was the Crown in the case. In a side room just before, he asked me, Do you want to talk about your lawsuit today? And I said, No. I -- I want to keep it separate. That was -- it was a homicide case. It was the case . . .

MS. WEICH: Stefan Johnson?

A It was the case of Stefan Johnson. I told him that I would not mix the two, that that would not be appropriate, and he agreed it would not and that he would not go that way.

I told him, however, that if the defence was to ask me question, he -- and if this -- he -- he could try to object if he didn't want to go this way, but that if I was asked a question, I would answer honestly because I'm under oath. Then the inquiry started, and to my greatest, I thought, astonishment, Mr. Komosky himself asked me, knowing the allegation I did in my lawsuit, a question that related directly to the lawsuit. I was under oath. I had to say the truth. This is how it came up.

And I was so stunned, and it's hard to stun me that I'm speechless. I was so speechless that the first person that answered the question was not me but the defence, who, if I remember correctly, was Peter Royal. So it's not a fair statement to say that I went publicly to make such statement. I was asked a question in court by a Crown. When you -- I don't know if he knew. I don't know if the question was made by mistake. I don't know if it was made by purpose. I have no idea. But I was asked a question that went straight into the matter of the lawsuit. No one objected, and I had to answer it. That's what happened.

Q So as I understand it, you were given a copy of an autopsy report and asked if it was, in fact, the autopsy report that you had signed, and your answer was along the lines of, Well, my student prepared it, I signed it, but I can't today agree that it is, in fact, the same copy because other people can go onto the computer system and change things up, and I have no way of knowing. Is that fair?

A I don't remember the exact wording, but it is a fact that the medical examiner system called -- the computer system called "MEDIC" was an issue that I flagged in 2011, that this issue was proven by an external firm called Deloitte, and that anyone that works in the office can go in the computer and change a report or change other facts without any other trail. It is a fact. I -- I can't change the fact. It is a fact. It is among the allegation of my lawsuit.

I -- I never went to the media with it. I never commented in the media about it. But if asked about it in court, like today, I can't lie about it. It is a fact. I couldn't -- I couldn't believe he asked me the question. He knew pretty well what the answer -- well, I don't know if he knew, but that isn't the allegation, and he asked the question, and I had to answer, and it is a fact.

Q So to this day -- or let me just state it this way. When you were dealing with the matter of Mr. Stefan Johnson at that court hearing, you distrusted the honesty and integrity of the people who work in the medical examiner's office so much that you could not confirm on the record that the autopsy report in your hand in court was, in fact, the autopsy report that you had signed off on previously?

A That's not a fair statement. I'm aware of incident where things in the computer were changed. I was specifically asked, Can you -- if he had only ask, Is this your report, or something in -- but he asked if I specifically -- I don't remember the exact phrasing he said, but he -- the way he phrased the question, I had no choice but to answer that I couldn't know.

And if you asked me -- like, I'm trying very hard today not to mix up the lawsuit of very specific people with this current case, but if I'm asked certain questions, I will have to answer honestly. I'm under oath. So that's -- that's what happened at the time, and if it was to happen that someone asked me a question and no one's object (sic), I will have to answer. But I'm -- I'm really trying hard to keep matters separate because it -- they are -- I don't see them as touching -- they should not criss-cross. Those are very different legal matters.

Q So, again, I put it to you that if you were able to trust the people in the office and believe that they were honest, you would have had no problem answering the Crown in that particular hearing, you know, Yeah, this is my report. I'm not worried about it.

A I was not asked if I trust the people of my office in the question he asked. I was asked something more specific, and I can't recall the exact phrasing, and because of the phrasing, I had to say it. It -- I'm -- I'm not -- I'm -- I'm not trying to link the allegation of the other lawsuit with any other matter where I'm an expert witness. But if someone ask me a question that makes it in link -- for example, I -- well, they are a different matter, but there was question today about other lawsuit, like the Matshes lawsuit. And this is not a lawsuit that is solved, as far as I know. I have not been told it's resolved yet.

But if I'm asked question like I was today, I have to answer with honesty on the question that is asked. It doesn't mean I'm running forward to -- to -- to make reference to allegation, but I was asked a specific question that linked to that, and I had to answer. And I was stunned that he asked the question, because I had specifically told him I would try not to link the two, but he chose to ask the question.

To this day I -- I don't understand why he asked the question, and I probably will never know, but he asked the question, and I had to answer.

Q So you also made it known that it was your belief that firearms had gone missing from

a secure facility, that the medical examiner's office operated those firearms were evidence in the custody of the medical examiner's office; correct?

A Correct. And there's people under oath that have confirmed this.

Q Now, while you were working there, while you were chief, you wanted to see more things change; correct?

A Correct.

Q And you took steps to implement change as far as you could; right?

A Not change for the sake of change, but sake -- for improving the system. That's correct.

Q Okay. So just like your peer review system and your changing everything over to forensic pathologists, you wanted to make improvements for the better; right?

A That's correct.

Q And some things that you tried, you got blocked. Is that fair enough to say?

A That is correct to say.

Q Some people actually took it upon themselves to stand in front of you and push you down and let you know that you were never going to get the changes that you wanted; correct?

A No, that's not what happened. I don't remember something like that.

Q I'm not talking about actual physical touching. I'm just saying -- it's an -- it's an analogy. So you were advised by more than one person, you know, Stop trying, never going to happen, don't do it, keep your mouth shut, words to that effect?

A I -- I understood you said an analogy, but -- yeah, I -- I know what you -- but this is not exactly how you phrase it. It's -- it was never said someone that block me and say, This will never happen. This is not what happened. It's -- can we be more -- you're talking about the MEDIC system and the change to the MEDIC system? Okay.

Q Whatever number of things.

A There was -- there was cases -- for example, with -- the MEDIC system is our computer system, so I said I flagged in 2011 that there was a problem with the system. Deloitte confirmed it, as I said. There was no one that stand in front of me and said, This will never happen. The problem was not that. The problem was money. And they said, We all agree with you, it needs to be changed, but we don't have the money now, and before we can afford to change the system, make sure you shut your mouth about it. I'm not -- I -- that's not their phrasing they used. I think they said, Keep it secret so that it's not known. Because they were afraid of the implication it could

have on the court system.

But I'm not running to mention this today. You are asking question about it. And they are part of allegation in the other lawsuit.

Q So, unfortunately, and I do mean that, you think that you were treated inappropriately when you were let go in the manner that you were?
A By certain specific people that are completely unrelated to this lawsuit. There was also, at the same time, a lot of support internally by other employee of the government that were telling me that they thought I was doing the right thing. So it's very specific people that, yes, I think they treated me unfairly, very specific people that are totally unrelated to this current lawsuit.

Q So you are currently seeking special damages or loss of income and benefits from wrongful dismissal, breach of the government's duties to you as an employee, and/or negligent misrepresentation to you, and/or conspiracy against you; correct?
A Correct. But, once again, by very specific people.

Q You're seeking damages for anguish, mental distress, and the intentional infliction of mental suffering; correct?
A That's correct.

Q You are speaking punitive -- oh, sorry.
A Sorry.

Q You are seeking punitive exemplary for aggravated damages?
A I suppose it's -- I don't have the lawsuit in front of me. At some point, it starts to be lawyers' language on what I explained. There's a lawsuit with a lot of language like this.

Q You are currently suffering from profound anguish?
A Can you repeat the question.

Q You are currently suffering from profound anguish?
A It -- do I have to discuss my -- I -- okay. I suppose I have to -- since no one's objecting, I have to discuss how I'm . . .

MR. BUCKLEY: Well, I mean, I'm just -- I'm wondering, My Lord, if -- in fairness to the witness, I'm wondering if my friend is now cross-examining on behalf of the civil branch, and I'm wondering -- I mean, obviously if somebody's started a wrongful dismissal lawsuit, they're unhappy with what happened, and I mean,

I'm happy to concede that, you know, Dr. Sauvageau's not happy with having been -- not have her contract renewed. The issue is -- is is she unwilling or unable to be fair, objective, and nonpartisan in these proceedings.

THE COURT: I take it, Crown, that you'd like to say, Well, in your statement of claim, you claimed that you're suffering profound anguish? Is that about right?

MS. WEICH: So, Sir, my take on it is two things.

THE COURT: Can I ask you to just step out for a moment.

(WITNESS STANDS DOWN)

THE COURT: Thank you, Crown.

All right. Just asking Dr. Adeagbo --

MR. BUCKLEY: Oh, yeah, yeah.

THE COURT: -- to leave as well.

All right. Your take on it.

MS. WEICH: So, Sir, yes, it does -- it does go to her feelings of animosity towards the office and of the people higher up the totem pole that dealt with her. So anguish, insomnia, mental distress, trauma, loss of self-esteem. It also goes to whether or not she's in any sort of position to be able to review the evidence objectively and give an opinion. I mean, I've never been fired like this. I figure she's got to be angry as heck. I don't know that I'd be able to go into that office and sit down at that table and to review all those documents and to remain objective and to not say, No. You know what? Everything is frickin' wrong 'cause everything was wrong when I was here, and it's still wrong.

THE COURT: And it cuts so deep that it prevents her from testifying at all, not just goes to weight?

MS. WEICH: That's what I'd like to ask about, Sir.

MR. BUCKLEY: And, My Lord, I'm just wondering if this can be done in such a way where we're not litigating the civil action --

THE COURT: Exactly.

MR. BUCKLEY: -- on behalf of this witness.

So why doesn't my friend say, You're claiming these things. Do any of these things affect your ability today? Like, you know, like, actually just ask the question.

THE COURT: Crown, I just don't think we should be relitigating -- or litigating the civil action here. I mean --

MS. WEICH: M-hm.

THE COURT: -- you're perfectly entitled to put to her all of the aspects of her claim and maybe even the amount that she's claiming could even -- if she is claiming an amount. I don't know. I have never seen -- I've never heard of the statement of claim until this evidence just now.

But to get into the ins and outs of all of it is a little much, I think, in terms of what we're trying to accomplish today, which is to determine whether her independence or -- is compromised for the purpose of giving this testimony. So I'll let you go ahead, but please keep that in mind, that we're not here to litigate the civil thing; okay?

MS. WEICH: Yes, Sir.

THE COURT: Thank you.

MR. GILES: I'll re-obtain the witness, Sir.

THE COURT: Thank you.

MS. WEICH: So does that preclude me from going through the remaining symptoms?

THE COURT: I don't think I'm -- I don't think your friend's even objecting to that. I think you're entitled to go through them and -- in a general way and then put it to her.

That's what you were saying, wasn't it, Mr. Buckley?

MR. BUCKLEY: Well, yeah. I mean, it's not relevant to what

we're here to decide.

THE COURT: No, but it's nice for me to have a basis. So I don't have a problem with it.

(WITNESS RE-TAKES THE STAND)

THE COURT: Doctor, do you acknowledge that you're still under oath?

A I do.

THE COURT: All right. Please proceed, Crown.

Q MS. WEICH: Thank you, Dr. Sauvageau.

So as I understand it, at the time that you were let go, the government renewed contracts for two medical examiners under the temporary foreign worker program. Is that your recollection as well?

A No. The template were not ready. They kept foreign worker employees, but the template were not ready. So the allegation in the lawsuit is that they kept foreign worker employees when they let go a Canadian.

Q And, unfortunately, that Canadian being you, that didn't sit right with you, did it?

A Of course not, but, once again, it's very specific, specific people.

Q And one of those temporary foreign workers is Dr. Adeagbo; correct?

A Yes, but it's not his fault. I -- I don't have any grudge against my former colleagues. I mean, they were asked on, as me. This is not their decision.

I -- I was in contact with some of them after. Some accepted to be references for me for applying to other jobs. It's not their fault. It's not the fault of Dr. Adeagbo. He has nothing to do in the decision that my contract would not be renewed.

Q Sorry. Are you finished?

A Yes.

Q Okay. So out of what you're seeking from the government, you are seeking reparations to make up for your insomnia, mental distress, trauma, and loss of self-esteem suffered from being let go in the manner that you were; correct?

A Correct.

Q And so when you're asked to go to the medical examiner's office and you have to sit there and you have to review the files and you have to remember all the things that you did, the great things, while you were there, and you think about the incredibly horrible way it ended for you with absolutely no reason, that makes you angry; right?
A If I understand the question correctly, was I angry when I presented myself on court order last week at the office of the chief medical examiner; is it the question?

Q No. My question is when you go there and you remember all the good times that you had and you think about how much better you made it and you think about how they just let you go with such callous disregard, completely failing to stand by what they told you they would do --
A You're very dramatic.

Q -- that makes you angry; right?
A I'm not angry at the office of the chief medical examiner nor my former colleagues nor the Crowns nor a lot of people. I'm angry at very specific people that have nothing to do with this lawsuit. And, yeah, these people make me very angry, but they have nothing to do with the office of -- there's no one inside the office of the chief medical examiner that made that decision. There's no one inside the prosecution office that made that decision.

Actually, I had a lot of support in the office and in the Crown's prosecution office. People that were telling me they felt for me. They thought I was doing the right thing. I -- I have nothing against these institution. I am angry at five specific people, five or -- I don't want to necessarily have to count them, but very specific people.

Q So in all the years that you worked with Dr. Adeagbo, this is the only time that you've come across a report that he wrote and an investigation that he did, and you've decided that he is unreasonable in his conclusions; is that fair to say?
A I don't think I've said he was unreasonable. This is not a word I -- this is a different context. This is not a peer review that I'm doing now, not I disagree with Dr. Adeagbo. I didn't do a peer review to see if it was reasonable or not.

I -- if -- if I used the word "unreasonable", it would not be in the context of a peer review. It's -- this is a different context. This is not a peer review. This is do you agree or not with the conclusion of Dr. Adeagbo, and I disagree.

Q So if you had reviewed his report in the context of a peer review, would you say that it was not unreasonable?
A I was never asked to do that exercise, so it -- I will have to think about it. And, first,

a lot of the disagreement I have with Dr. Adeagbo, the main arguments are not on his report but what he said in court. The disagreement on his report are not as important as the disagreement on the opinions expressed in court. And as a peer reviewer, I would not have seen that.

If I had been in the shoes of Dr. Bucholtz, who did the peer review, if I had only consulted the autopsy report with the pictures, like she did, and she didn't even look at the microscopic slides, she didn't look at the medical file, she didn't look at the death investigation reports, so there's a lot of things I know that she didn't know. If -- if I can put myself in her shoes, I think I would have come to the same conclusion.

The exercise that's difficult to do is to put me in the time she was but with more material than she had but not the complete material that I do have now. This is a difficult exercise to do, and, actually, I would have to really think about it, but it's not -- it's not even relevant because we're not in a peer review now; we are in you -- do you agree or you disagree.

And that is good for the court -- justice system. I will give you an example. In Ontario, where we took the peer review from, they do the peer review for reasonable and unreasonable, but on top of it, in Ontario, it is considered a good thing for the justice system that the forensic pathologists from the office, from the same town or from different town, are both testifying. One is called by the Crown, one is called by the defence, and they express their difference of opinions.

Difference of opinion doesn't mean one is competent and one is incompetent. It could mean that in certain cases, but in most cases, is that there's a disagreement. And if there is a disagreement, it's a good thing for the court system, for the justice system that these disagreements can be heard so that there's just not one opinion that is heard by a jury.

So I share this philosophy, that it's a good thing for the justice system. On the personal level, it is hard for forensic pathologists to be on both sides, but for the court system, it is a good thing.

Q So, Dr. Sauvageau, my office contacted you on or about April 5th and left you a voicemail. Do you recall that?

A Yes. And I answered email that I was available to meet with you if you wished so.

Q And you stated in your email: (as read)

> I have no issue discussing the case with you; however, please take

> note that my fees are $500 for an hour. I will have to charge your office for the time spent with you on the phone or on any preparation time for answering questions that come from you. I would appreciate that you acknowledge in writing that your office will be paying my fees for the work done at your request, including phone meetings.

Do you recall that?

A Correct. And the previous week, it was the previous situation where it was the Crown that was asking me to Court, and they had made it very clear that they would not pay if I was meeting with the other lawyers in the fatality inquiry, their lawyer of the family, that they would not pay, but I was -- I could meet with them if I wished so.

So it's just -- I think it's just a fair thing that no one expect an expert witness to work for free, and the -- and the expert witness do not belong to anyone. My services are available. They -- Mr. Buckley asked for my services, but when Mr. Giles contacted me, I made him aware that I didn't belong to anyone, and if he wanted to consult me, it would be my pleasure to -- to discuss the case with him and answer his questions.

Maybe he had further material. Maybe he had hypothetical he would -- he would want to run by me. I don't belong to anyone. And when I was a forensic pathologist at the office of the chief medical examiner, that was my same understanding. I didn't belong to anyone, and I was available to meet with whoever wanted to meet me.

The difference is now my fees are not paid by -- as an employee of the government of Alberta, and I don't think that anyone is expecting me to be pro bono or a volunteer, so, yes, I expect my fees to be paid at the same fees I always charge anyone that consult me.

For the sake of -- if happens that the fee are difference (sic). It's -- it is when there's a context -- when the fees are set by law. That's the only exception. Or law or -- I don't know. Sometimes there's a fee -- a fee set by something else. Then I respect that fee, and I accept or not the job.

Q You understand that the people who hired you are on trial for committing a crime?
A I understand that I was approached by Mr. Buckley that represent clients that are on a trial for -- yes, I understand that.

Q You understand that your opinions apparently contradict the Crown expert opinion in this case from Dr. Adeagbo?

A I am aware of this.

Q You understand that --
A And can I just rephrase, though? Dr. Adeagbo do not belong to you either, though. So I would not say -- a medical examiner working at the office of the chief medical examiner is asked to testify by the Crown, but that doesn't mean you belong to the Crown, and sometimes what we say fit more the theory of the Crown, but sometimes it fit more the theory of the defence.

So I disagree with Dr. Adeagbo, but I don't see it as disagreeing with the witness of the Crown, though, in this case, he was -- he was asked by the Crown, but he doesn't belong to the Crown, and my understanding is that Mr. Buckley could also have asked question to Dr. Adeagbo, met -- meet with him. I don't know if he did, but he could have. We don't belong to anyone.

Q So given your review of Dr. Adeagbo's file and report, have you reported him to the College?
A As I said, disagreement is not the same as unreasonable. I don't agree with Dr. Adeagbo. I -- I think there's -- when you disagree, you need to express it. I don't think there's a matter to report him for incompetence to the College. There's -- there's a -- a difference in degree.

But if the criteria to not bring a second witness would be that the first one need to be proven incompetent, the justice system would work very differently than how I understand it works currently. We are often in disagreement. Doesn't mean we are incompetent.

MS. WEICH: Just one second, Sir.

Q MS. WEICH: Did any of your trouble in the medical examiner's office stem from finances?
A Depends what -- can you ask the question again? Because I'm not sure how to answer. There was problem with the finances, but they -- please repeat the question.

Q Did any of your problems --
A What do you call my problems? That's where I'm not sure.

Q Did you ever come up against the issues of you wanted more money to be able to take advantage of more resources?
A No. No. Not phrased this way. I never asked -- I asked to fix -- that they fix the computer system; that is true.

The other issue were one -- were not that I was asking for more money. No. That never happened.

Q Now, at the very beginning of when you first gave evidence, you gave an example of a 76-year-old dying of apparent natural causes and how it just wouldn't be worth the taxpayers' time and efforts and money to perform certain tests just to rule out things that, on the face of it, you didn't need to rule out. Is that fair enough to say?

A Well, I have to rephrase what you said because I -- I doubt the taxpayer will spend time on the death of a 76-years-old (sic). So it's -- I have to rephrase.

I said that there's no system in Canada that would do that, and it's okay that we don't do that. So we don't do full autopsy with all the available tests on all death. We do a judgment call. And, yes, in the death of a 76 or a 70 -- 70-year-old man who has nothing at the scene that is -- and -- and nothing suspicious, no trauma visible on the body, nothing suspicious reported to us by either a neighbour, the police, anything, we will not do an autopsy. That's how we -- and that's how it's done in most places in Canada and United States because we -- we cannot invest the money to do autopsy on everyone. That would be useless.

Q Did you ever come up against argument from your other forensic pathologists concerning tests that they wanted to run, but you just didn't have the money for it?

A Unusual test, yes. So when they wanted something very unusual that was (sic) not be doable in the office, they would have to -- to run through me, and in these cases, I had to authorize or not the expense. And though I explained the autonomy of a medical examiner, there's also another thing that's called an expenditure officer. I was the expenditure officer for the office. So I was responsible to -- to authorize or not certain type of expenses. It was very rare, but it happened that I was requested a test that I thought was not -- was not the best decision considering everything in the office. And that decision, I understand, was mine based on my hat of expenditure officer.

So a medical examiner -- actually, in the law, and it's in the law, the -- the medical examiner has the power to do an autopsy, to order toxicology, but the special tests or the special expertise are under the purviews decision of the chief. I don't remember the number, but there's a sentence that says that's the chief's decision. That was my understanding from my discussion with the lawyers. So it happened very, very rarely that I said, No, we will not do this test.

Q Do you remember any specific examples of, like, a rare time when you would say no?

A I remember very vaguely a machine that they wanted to test by some engineer testing. It's very vague in my memory. In which it would have cost several thousands dollars,

and it would, in the end, not have give any real information on the cause and manner of death. It was more about was this machine working properly. It's vague in my memory. Maybe I'm mixing up certain facts. I remember that the cause and the manner were clear enough, and it was not under our umbrella of responsibility to make sure the machine was -- I don't remember what. So I decided no.

Q Sorry --
A That's one of the case I remember, but it's very vague, my memory of it.

Q So the cause and manner of death were clear enough so you thought that it wouldn't be worth it to order this incredibly expensive test of this machine?
A Correct. But, as I said, my -- my recollection of the case is extremely vague. I -- I would need a file if I was to be asked further question on it. An extremely vague recollection. It was a phone call, if I remember correctly.

Q So -- oh, sorry.
A I don't remember more.

Q So it stands to reason, then, that when the cause and manner of death are not clear enough, perhaps you would okay a test being done? I'm not talking about several thousands of dollars or anything, but you might be open or amenable to running a test?
A The question is so vague, and, of course, it's yes, but it's very vague. It will depend on the context, and it will depend if the decision is under my purview or not. That will also depend on the context. And if I'm not sure, I'm going to consult -- I had a lawyer that was assigned to me, and I would call that -- that woman when I had question, 'cause I didn't want to make mistake of law, and I'm not a lawyer.

Q So how about the PCR test?
A Well, that -- I was not asked about that test. But you have to rephrase. Do you call -- do you want to talk about the PCR or the specific 16S rRNA? Because that's different.

Q Well, I think we've already had some discussion about what I'm allowed to go into, and I'm going to leave that alone for now; okay?
A Okay.

Q So if I understand you correctly, earlier you gave evidence that said if you came to the conclusion that a forensic pathologist's conclusions about cause and manner of death were unreasonable, you may feel that you have no choice but to report that forensic pathologist, that doctor, to the College, correct?
A Yes, but as I explained, this is a higher level than disagreeing with -- I really don't

agree with the fact as presented to me. Maybe we were presented different facts. My understanding of the facts is I can't agree with the conclusion of Dr. Adeagbo, but I never said he was incompetent.

Q So since you had the opportunity to review all the material that you list on the first page of your report, you effectively conducted a peer review, even though that's not what you turned your mind to? You reviewed all the material; right?

A I don't agree. That -- those are two different processes. I didn't do a peer review. I did a complete opinion on a case, which is completely different, and that -- this is very important to understand the difference.

When you're asked to do a peer review, no one ask you if you agree or not. You can see huge thing you don't agree with, but if it's -- if you can see -- if you can see how they came to that conclusion, even if you think it's a wrong conclusion, if you can see how they came there, with a certain degree of -- that it was not -- it's not the same level. It -- it's not uncommon that we disagree but still say unreasonable -- that we still say reasonable. There are two different processes. I never did, for this case, a peer review. I did an opinion on a case. Totally different.

Q So after all your years of conducting peer reviews, you just shut that portion of your brain off when you reviewed the material concerning Ezekiel Stephan?

A It's a different process. I was asked to give an opinion on a case, and I gave an opinion on a case. I didn't say Dr. Adeagbo is incompetent. I don't agree with him.

Q And, currently, you have no opinion on whether or not he was reasonable or unreasonable, the way you use that term for a peer review?

A Well, as an expert matter in court, I was recognized in forensic pathology to give an opinion on forensic pathology. I don't think I was asked to give an opinion on the competence of my colleague. It's -- it's different things. I -- it's completely different thing. I -- I -- I did not state that Mr. Adeagbo was incompetent. I said I don't agree with his conclusions.

And as I said, in Ontario, they're more used to that process, and they encourage that process. They don't fire the people the next day because they disagree with them in court the day prior. There -- there's a place for -- there are thing in science where we all agree, there are thing we might not agree, there are thing where the majority will agree on one side, maybe a few are on the other side, and there's a place to express these disagreements.

I think I'm on the right side, and I agree with myself, but that's -- that doesn't mean Dr. Adeagbo is incompetent. I never said he was incompetent.

Q And if the facts put to you do change, you're open-minded enough to be able to perhaps renegotiate with yourself what the proper opinion should be?

A It's not even about renegotiate. As an expert witness in court, it happens all the time. We are presented new facts or we're presented hypothetical that we were never presented before. Sometimes you change the conclusion, sometimes it doesn't, and sometimes, like, they -- they give you three hypothetical. As the expert witness and forensic pathologist, you don't know which one will be proven in court by other means, and you answer for these three.

So my conclusion could be different presented with new material. It could also be expressed (sic) depending on different scenarios of hypothetical. The final decision is not mine. My role is to provide expertise to help the Court make their decision, and that expertise is neutral and impartial. I will evaluate all the facts and answer based on the facts I'm presented.

MS. WEICH: Sir, I have no more questions.

Sorry, Sir, if there could please, perhaps, be a direction -- thinking about what happened last week -- that none of this should be published in any way, shape, or form, given that the jury isn't present.

THE COURT: Well, I thought we were real clear, and I think I was real clear last week that when we are conducting proceedings in this courtroom and the jury is not present that not only is there a provision in the *Criminal Code* that applies which stops publication, but there's also a specific court order, and that court order certainly applies, and I would think the *Code* applies. I'm not here to interpret that.

But my order applies to the proceedings that have been conducted today. It's a voir dire. They're not to be published, and none of the evidence that doesn't go to the jury can be published. I mean, take a look at the order. Take a look at the *Code*. Don't publish what happened today. Ma'am, would you step down for a minute. I'm going to see if I can come to a decision. I think I can come to a decision.

(WITNESS STANDS DOWN)

MR. BUCKLEY: My Lord, do you need to make -- me to make submissions on the bias issue?

THE COURT: Can I just take a look at where I'm at. Let's hear from the Crown first.

MS. WEICH: So, Sir, you heard what Dr. Sauvageau had to say concerning bias, and, honest, she sounded pretty objective, so I have number of further submissions.

THE COURT: Crown, I think you're quite right. The test in *White Burgess* is really quite strict, and it may be that the evidence before me raised, as the case said, a realistic concerning. I'm not sure what the word "realistic" means. But having heard all of that evidence, particularly the last couple of questions sort of summarized it up, Crown, I think that if we were to apply the balance of probability back to the defence, it's met. And this witness, on the balance of probabilities, the test is met such that she can testify as an impartial unbiased witness.

That is not to say that the matters that you've explored in some degree of thoroughness are not going to perhaps come up in front of the jury, and if they do, they may go to weight. But in the meantime, you're going to be entitled to call this witness as an expert. My determination of the voir dire is that the *White Burgess* concern has not been made out here, and you're going to be permitted to call the witness as an expert.

That said, I think I'll call on you to say -- about the areas of opinion because you've heard me make comment on diagnosis and prognosis --

MR. BUCKLEY: I have. And I've -- wondering if, you know, perhaps I could have her clarify. Because I think what the Court doesn't appreciate -- because I think that came up when my friend said, Well, you know, have you practiced family law (sic), have you practiced as a pediatrician, but pathology actually is the study of the progression of disease, and pathologists are called on when doctors can't figure out what's going on to sort that out.

So they actually are the people that -- because how could you give a cause of death if you don't understand how disease progresses? I mean, how could you say someone died of, in this case, bacterial meningitis on the one hand or viral meningitis or anything if you actually don't know how that progresses? Or how could you make -- you know, for example, Dr. Adeagbo was, you know, not willing to say that, you know, the -- what would -- Dr. Sauvageau would call the "medical misadventure" with the ambulance is the cause of death? Well, how could you say that without an understanding of kind of how things work; right? Like, so --

THE COURT: Well, let me just read to you what we saw with Dr. Adeagbo. I qualified him as an expert forensic pathologist entitled to give opinion evidence in forensic pathology, which includes conducting examinations, coming to

conclusions, and explaining cause of death, manner of death, and processes leading to death, which includes the interpretation of diseases and injuries.

And in your cross-examination, you confirmed that he had an understanding of how a disease progresses and what it looks like when it becomes a cause of death. Is that really what you're seeking here?

MR. BUCKLEY: Yeah. Yeah, it really is.

THE COURT: Not so that we're getting into the diagnosis of illness and the prognosis of illness a la Gamble, for example?

MR. BUCKLEY: No. In fact, and just so the Court's aware, I wasn't planning on putting, for example, the, you know, defence's version of events and saying, What would the outcome be. I want, What do you think -- you reviewed the autopsy; what do you think are the causes of death here? And what do you think happened as a forensic pathologist reviewing what you've reviewed?

Just like Dr. Adeagbo didn't -- he -- his autopsy report, the Crown didn't ask -- put, well, you know, this hypothetical, this hypothetical, this hypothetical. They're forensic pathologists, and they look at, you know, cause and manner of death.

THE COURT: So if I were to run past you what I think your motion is and then ask for the Crown for comment on what the position of the Crown is at this point, I understand that you're seeking to have this witness qualified as an expert in forensic pathology and an expert in asphyxia, entitled to give opinion evidence in forensic pathology, which includes conducting examinations, coming to conclusions, and explaining cause of death, manner of death, and processes leading to death, which includes the interpretation of diseases and injuries, how a disease progresses, and what it looks like when it becomes a cause of death, including hypoxic and --

MR. BUCKLEY: Anoxic.

THE COURT: -- anoxic injury and when brain damage is caused by hypoxic and anoxic injury. Is that what you're looking for?

MR. BUCKLEY: Yeah. I can live with that. I would need you to give me the wording again --

THE COURT: Well, and I'm not asking you what -- to live with anything.

MR. BUCKLEY: No, no. But that covers what is in her opinion. And I might ask her to vary that opinion a little bit based on, you know, comments earlier today.

THE COURT: Well, you can do what you want with --

MR. BUCKLEY: You know, so --

THE COURT: -- the opinion but as along as it's confined to the areas of expertise. That's what --

MR. BUCKLEY: Yes, yeah.

THE COURT: -- my job as gatekeeper is at this juncture.

Crown?

MS. WEICH: So, Sir, I believe that Mr. Giles and I were very careful when we qualified Dr. Adeagbo to keep his expert-opinion evidence restricted to death, and what I'm afraid here is that my friend is now trying to be able to qualify Dr. Sauvageau as being able to make clinical diagnoses when a person is alive, and I don't know that he's met that test.

THE COURT: Well, you're not seeking that?

MR. BUCKLEY: No, I'm not. And you don't see it in the report.

MR. GILES: And to be fair, Sir, in fact, we heard her on the stand give some evidence where she was saying, Well, there was this one individual, Dr. Gamble, who had written inside his notes something about a barky cough. That barky cough has never been in evidence one bit, and at the same time, she, in her report, has diagnosed him as having croup, and that's going to be a very significant finding.

THE COURT: Mr. Buckley's going to be looking at that because he's not seeking to have this witness give opinion evidence with respect to -- what did we call it? -- the diagnosis or treatment of chronic disease. Something like that.

MR. GILES: My concern, Sir, is, again, the -- for instance, the report suggests that her presupposition is going to be croup. She's going to have to leave that presupposition behind because there's no evidence of croup in this trial.

MR. BUCKLEY: Well, yeah. And I -- I think we need to be careful here because -- so for instance, I mean, she listens to -- and see we can't -- I don't want her hands tied as a forensic pathologist, and forensic pathologists do look at the medical reports; they do look at the doctors' notes; they do look at, you know, lab reports; they do hear what parents say.

She actually made a big point that she listened to the first 911 call when the phone is held to Ezekiel's breathing, and she found that to be very significant in sorting out, Well, what are possible causes of death here?

So for a forensic pathologist to say, Well, I think here's what was going on with the person when they died, based on the autopsy findings and the medical file, it involves some opinion of what they thought was going on based on the evidence in front of them.

I mean, Dr. Adeagbo's opinion is based on, for example, lab reports that aren't before the jury. They're based on a PCR analysis that's not before the jury. Are you going to direct that --

THE COURT: Sure. And your --

MR. BUCKLEY: Right. Like, but is --

THE COURT: -- witness can do that as well.

MR. BUCKLEY: Well, exactly. So --

THE COURT: But your -- you can't have your witness make up a diagnosis or prognosis because that's different than an assumption. These witnesses are entitled -- they're -- as experts, to use hearsay and to use assumptions, but they're not entitled to give opinions outside of their areas of expertise. That's all we're all saying.

MR. BUCKLEY: Yes.

THE COURT: You may have to look at your report, my -- the little experience that I've had with it.

Ruling (Voir Dire) (Qualification)

THE COURT: But here's my ruling. I'm going to make the ruling, which is that I am going to qualify Dr. Sauvageau as an expert in forensic

pathology and an expert in asphyxia. She will be entitled to give opinion evidence in forensic pathology, which includes conducting examinations, coming to conclusions, and explaining cause of death, manner of death, and processes leading to death, which includes the interpretation of diseases and injuries, how a disease progresses, and what it looks like when it becomes a cause of death, including hypoxic and anoxic injury, and when brain damage is caused by hypoxic and anoxic injury.

Specifically, she will not be entitled -- she is not entitled to give opinion evidence with respect to the diagnosis or prognosis of chronic illness.

MR. BUCKLEY: I'm assuming that "chronic" is really just a superfluous term. You just mean "illness"?

THE COURT: Chronic is before you die, isn't it?

MR. BUCKLEY: Well, I think of chronic as something that's really ongoing. That's why I asked. I think you're just wanting -- you're saying that she can't, for example, say that, I think he had croup.

THE COURT: She can't say, I think he had croup. She can say, Somebody told me he had croup, but she can't say, I think he had croup. That's an example.

MR. BUCKLEY: Right. And so, for example, you know, when we get to the breathing, where Ezekiel stops breathing and 911's called, like, for example, her opinion, listening to that 911 call, is -- is very meaningful, and I think she would say, Well, actually, that's quite suggestive that the croup hadn't ended based on what she heard. But -- so I don't know what to do with that when I have a forensic pathologist saying, Well, I find that actual evidence meaningful.

THE COURT: Counsel, let's get to it when we get to it.

MR. BUCKLEY: Okay.

THE COURT: I can't make all the rulings in advance. Let's get them embodied within a real-life context and see what happens. You have the limits. The limits are there, and they -- that's what we do in these qualification exercises, is we determine the limits. You have the limits, and we'll be hearing from the witness in the morning at 10:00 --

MR. BUCKLEY: Thank you, My Lord.

THE COURT: -- when the jury returns.

MR. GILES: I must say I am still concerned about the fact that her opinion seems to rely on a presupposition of an unvaccinated population -- of a vaccinated population. Because now that milestone has been passed by the Crown in terms of being able to lead evidence about that critical issue in relation to her -- her -- the entire foundation of her report rests upon that focal, and we have gone past the point, by agreement, when the Crown could lead evidence of that focal.

MR. BUCKLEY: I will talk to Dr. Sauvageau and see if that circle -- or square can be circled the other way around and can -- because I understand my friend's point, and I've been adamant on that point, so --

MR. GILES: I'm quite concerned that --

MR. BUCKLEY: -- it's a fair thing for my friend to raise.

MR. GILES: I'm quite concerned that the Crown might need a mistrial now, Sir.

THE COURT: 10:00. How are we doing now? Dr. Sauvageau -- is there estimate, narrowing it down to days I suppose now, on how long she might be on the stand tomorrow?

MR. BUCKLEY: You know, My Lord, I was truly, truly hoping that she could be finished in a day so that I could call my other two witnesses on Wednesday and maybe start submissions and finish them on Thursday and have my friends do their submissions and have you charge the jury this week.

THE COURT: If they don't call Dr. Adeagbo again.

MR. BUCKLEY: Oh, yes, exactly. Exactly. And if Dr. Adeagbo is recalled, I'm going to seek a direction that the entire medical examiner's file be brought, because obviously I'm concerned that perhaps an X-ray report was not disclosed.

Because I gave Dr. Sauvageau everything that I was given, which was represented to me as the entire file, and I can advise that I've been told of other materials that were not spoken of today that may be quite relevant, and so if Dr. Adeagbo was coming back, I think it would be fair for a direction that he bring the entire medical examiner's file.

THE COURT: Full day tomorrow. So you're going to be how long in your chief?

MR. BUCKLEY: I'm not sure. I'll probably go into the early afternoon.

THE COURT: Any ideas?

MS. WEICH: I would take the rest of the afternoon and the next morning, Sir.

THE COURT: All right. We'll see you at 10:00.

PROCEEDINGS ADJOURNED UNTIL 10:00 AM, APRIL 19, 2016

Certificate of Transcript

I, Sara Anderson, certify that the foregoing pages are a complete and accurate transcript of the proceedings, taken down by me in shorthand and recorded by a sound-recording machine and transcribed from my shorthand notes to the best of my skill and ability.

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Proceedings taken in the Court of Queen's Bench of Alberta, Courthouse, Lethbridge, Alberta

April 19, 2016	Morning Session
The Honourable Mr. Justice Jerke	Court of Queen's Bench of Alberta
L.M. Weich	For the Crown
C.O. Giles	For the Crown
S.P. Buckley	For the Accused D. Stephan
S.P. Buckley	For the Accused C. Stephan
J. Stringer	Court Clerk
S. Anderson, CSR(A)	Official Court Reporter

THE COURT: Good morning.

MR. GILES: Morning.

THE COURT: Please be seated.

Submission by Ms. Weich (Qualification)

MS. WEICH: Good morning, Sir. So, Sir, I can advise -- and thank you for coming in early without the jury. This morning, as we walked into this courtroom at 10 AM, we received an edited version of the report of Dr. Sauvageau, which tries to take out references to the original offending statement about the percentage of viral versus bacterial meningitis and, as well, removes all reference to the word "croup". However, Mr. Giles and I have some concerns about what is left in due to the fact that if Mr. Buckley has taken the step to remove --

MR. BUCKLEY: Well, and --

THE COURT: Maybe Dr. Adeagbo could be --

MR. BUCKLEY: That was -- that was just what I was going to say.

MS. WEICH: Oh, I'm sorry, Sir.

THE COURT: Just as --

MS. WEICH: I'm sorry, Sir.

Hi. Sorry. Thank you.

Thank you, Sir. I forgot he was sitting there. So do you have an extra copy for Justice Jerke?

MR. BUCKLEY: Yeah, absolutely.

MS. WEICH: Sorry, Sir. If you wouldn't mind just reviewing along with me so that hopefully what I'm going to say to you makes sense in the circumstances.

THE COURT: All right. So to begin with, on the first page: (as read)

> Ezekiel Stephan suffered from [blank] and meningitis-like symptoms.

And if you turn to the very, very last page under the heading "Summary": (as read)

> This child was suffering from both [blank] and meningitis.

And it states something along those lines several times throughout, Sir. So I would suggest that the inference for the jury to draw is that even if they don't know what that blank word is, they're left with the inference that there was something else there. And then the danger is that they're going to go on to think about that and that maybe the second condition, whatever it was, made things worse, or perhaps it was something that the accuseds couldn't have thought about or couldn't have foreseen.

So, Sir, I would suggest that the Crown would be held to a higher standard and would have to take out any reference to "both" and "and". So I would suggest that, for example, that final sentence under "Summary", point 'A' should state "This child was suffering from meningitis" and leave it at that.

It is -- it shouldn't be too hard to be able to black out those two words. Similarly, on the first page, it should simply state: (as read)

> Ezekiel Stephan suffered from meningitis-like symptoms.

And similar vetting as we go throughout the report. So, Sir, if you want to turn to page 2, under the heading "Most Likely Infectious Agent", we see it again, "[blank] And Most Likely Infectious Agent". Now, then there's a sentence that's been blacked out, and then it says: (as read)

> Furthermore, his respiration can be heard on the first 911 call of March 13th. His characteristic of airway obstruction could be suggestive of [blank, and I don't even now how to say that] laryn -- laryngotracheobronchitis.

So, Sir, I have two things to say about that. Laryngotracheobronchitis is, in effect, croup. It can be more things, but it also includes croup. Secondly, this is a diagnosis. He's still alive, and she's listening to what he sounds like on the telephone, and then she comes to the conclusion that it could be suggestive of laryngotracheobronchitis. And as I understand it, yesterday you ruled that she could not give a diagnosis and prognosis of illness.

So underneath the chart, still on the second page, then we see at "Autopsy", the report from a nasopharyngeal wash swab, and it goes on. So that entire paragraph is explaining her diagnosis of croup and why it is the most likely -- or the most likely infectious agent to explain the croup is enterovirus or rhinovirus. But if you take croup out of there, why is that paragraph in there at all? She's not allowed to diagnose so that should be struck out as well.

Similarly, for the last paragraph of note, Dr. Adeagbo was asked, When you did the autopsy, you didn't see evidence of croup; is that fair to say? She -- Dr. Sauvageau's opinion is that he didn't say that croup was indistinguishable from mechanical ventilation signs. Again, this paragraph goes to show why her diagnosis of croup is or can be correct, on top of listening to it on the phone and on top of the fact that there's this enterovirus. So, Sir, I would suggest that that paragraph has to be taken out.

At the top of page 3, we see: (as read)

> Furthermore, it's important to insist that croup is a clinical diagnosis now.

That paragraph. If she's taken all reference to croup out of this report, why is that paragraph here at all? Again, she is not allowed to diagnose it; therefore, it should be struck out, especially because she's removed all other reference to croup so that paragraph just makes no sense at all.

If you turn to page 8, and, again, this is just what I've already said at the very beginning, more of the "ands" and "both of the". The heading at 1.4: (as read)

> Association of [blank] and meningitis and most likely infectious agent [could read or should read something like] Most likely infectious agent of meningitis [period].

And then in the first paragraph on that page, it -- the reference to [the blank and] should be taken out. And at Heading 2: (as read)

> Expected outcomes of [blank] and meningitis. [The "blank and" --]

THE COURT: Sorry. You've lost me.

MS. WEICH: Sorry, Sir?

THE COURT: You lost me. I was at the heading.

MS. WEICH: Yeah. And then the first paragraph that is not blacked out states: (as read)

> It is not possible in this particular case to confirm which infectious agent caused the [blank] and meningitis.

So "the blank and" should be removed. Are you on page 8, Sir?

THE COURT: No.

MS. WEICH: So Heading 1.4 --

THE COURT: I'm with you, yes. Now I am.

MS. WEICH: Okay. So then again, the heading at 2 "Expected Outcomes of [Blank] and Meningitis", the "blank and" should be removed. And, again, on page 10, there's another reference to "blank and meningitis", and that is at the first line of the second or third paragraph, the paragraph above the 4.1 heading on page 10.

And finally, Sir, on page 16, there's another reference to: (as read)

> However, considering the first 911 call, it seems more likely that the cause of the respiratory arrest on March 13th was related to the respiratory obstruction.

And then the blank portion which referred to croup previously. And, again, what this is saying is, I listened to the 911 call, and I diagnosed. So, Sir, I would suggest that that sentence, which is in the second paragraph at the top of page 16, and it's the last sentence in that paragraph, and it has the big square black block of vetting out at the end of it, that should also be removed.

And again, Sir, it simply -- it goes to fairness, and it goes to making sure that the jury is left with the picture of what the evidence is and what the evidence is allowed to be. So unless you have any questions, Sir, those are my submissions.

THE COURT: No.

Submission by Mr. Buckley (Qualification)

MR. BUCKLEY: My Lord, I'm almost thinking -- well, I am thinking that it might be helpful to have a voir dire this morning and have Dr. Sauvageau address what forensic pathologists do and what they need to do an opinion. Because -- and I -- and I have to apologize. It just did not dawn on me, when I'm calling probably the most qualified forensic pathologist in Canada, with all due respect to Dr. Adeagbo, way more qualified as a forensic pathologist, that she would actually not be able to testify as a forensic pathologist, which she explained to me yesterday after your ruling.

She said, Well, how can anyone come to a cause of death if you don't understand the progression of disease, and you basically form an opinion based on -- she said there's a golden triangle. You look at the autopsy. You look at basically how the body was found, which is important in crime-scene things. She say, We actually educate the police how not to mess things up and how to document so that we can do our job. And we look at the medical history. If there's doctor diagnoses, great; if there's not, we actually listen to the family.

I can walk through publications, peer review publications, where basically she's doing exactly that and obviously recognized by, you know, qualified by peer review as qualified for that. She says, You can't come to a cause of death unless you understand the progression of disease. It's what you do is you form your opinion based on the evidence you have, what was going on, and what the prognosis is.

If you don't know at what point the disease is likely to kill -- because my friends could

take it further and say, I mean, she's of the opinion this is viral meningitis. Well, that's a diagnosis, is it not? And, I mean, so is she going to be precluded from saying, I look at the autopsy pictures; I look at the medical record; I personally look at the slides; the slide from the brain, different parts of the brain. I don't see neutrophils; I see lymphocytes, which tells me it's a viral infection. That is a diagnosis. But that's what forensic pathologists do.

Anatomical pathologists are trained after their doctors. And earlier in this trial, I indicated I would not say that a doctor is not qualified to give prognosis or diagnosis because they can't get licensed if they can't do that because that's what doctors do. She says, Yeah, it's interesting. The first year of pathology residency is basically the same as a doctor then trying to get a specialty in family medicine. You go through all the same stuff because, again, you just have to become a little more qualified in those issues. And then after you've basically got that training, you switch to more traditional pathology things, which, you know, does include a lot of lab work. But they're in the hospital, and they're doing diagnosis and prognosis of patients, and they're advising doctors because they're the experts in this.

So I'm running into a bit of a problem. And I -- obviously no objection to my friend saying, Well, what's the basis of this, what's the basis of that? But I truly do believe that it would be helpful to put Dr. Sauvageau on the stand and basically assist the Court to try to determine the scope of, well, what, as a forensic pathologist, she can testify about. Because the problem for the defence is is basically we've got a highly qualified witness on a very key point in this trial, and she's not really not being permitted to testify in the area of her expertise.

Submission by Ms. Weich (Rebuttal) (Qualification)

MS. WEICH: So, Sir, if I may, you made a ruling yesterday. If my friend wanted her to be able to give evidence in those areas, he could have drawn that out of her. He could have had her give that evidence. When it comes to Dr. Adeagbo, Mr. Giles and I were very careful to only limit his ability to give evidence so that he would look at the body, the tests that were conducted on the body, the slides that were taken from the body, and draw conclusions about death.

It was my friend who himself had him further qualified to talk about the living points, Sir. If my friend wanted Dr. Sauvageau to be able to do that, it should have happened yesterday. If he would like to appeal that your ruling is incorrect in all the circumstances, he can do that. It is -- I would suggest that the voir dire we had yesterday was his opportunity to bring out of his witness all of the reasons he wanted to have her qualified to be able to give different types of evidence.

Now, if she would like to say, I can -- I looked at Ezekiel's body or I looked at all the records about Ezekiel's body, and by looking at all of this, I can conclude that he had croup when he was still alive, and croup caused him potentially to die, along with the meningitis, fine. But she shouldn't be able to refer to any sort of diagnosis while he was alive. That was your ruling. Therefore, she shouldn't be able to rely on anything that happened while he was alive.

Submission by Mr. Buckley (Rebuttal) (Qualification)

MR. BUCKLEY: And in all fairness, and as I've indicated, I wasn't anticipating to have a problem with her expertise qualifications. I was preparing for a bias hearing, and that's -- that's my fault. I did ask you yesterday before your ruling if I could bring her back on the stand to kind of clarify those issues once it became apparent it was an issue.

It is kind of interesting that, you know, what my friend's first objecting to is exactly what Dr. Adeagbo does. If you look at his autopsy report form, he starts with: (as read)

> This 18-month-old previously healthy [there's a redaction] male developed upper-respiratory tract infection two weeks ago and subsequently deteriorated.

That's what pathologists do. They look at the medical records, and they basically, Oh, okay, this is a reasonable history for me to give, truncated albeit, but they rely on the medical records to come to an opinion.

And as I say, the real difficulty here is is she's -- because you ruled that she could testify as a forensic pathologist. I have to say, I mean, I -- her husband was in the courtroom yesterday, and he and I were trying to figure out and actually did not have the same opinion of exactly what your ruling meant.

And this is such a key issue in this trial, cause of death. Pretty important, in my submission, for the jury if I have a properly qualified expert to be able to speak to cause of death. And any forensic pathologist in doing that is going to want to refer to the medical record, basically all the information they have, to say, Well, here's the opinion I have. Here's why I formed the opinion.

It doesn't affect the Crown's right to cross-examine and weaken the weight of that and say, Well, you didn't see Ezekiel, and you don't know if he had whatever; right?

THE COURT: How can a forensic pathologist, even the most qualified one in North America, look at -- opine from a 911 recording and make a diagnosis when three or four diagnosticians were not able to do so? They all testified.

MR. BUCKLEY: What -- so just wait. Are you -- who are you referring to?

THE COURT: Oh, I don't know. Gamble. Ross.

MR. BUCKLEY: Okay. Because I -- I --

THE COURT: I haven't gone over that evidence. I've got it all summarized, but they've never diagnosed -- they were there to give evidence of diagnosis. That's what they were qualified to do, diagnosis and prognosis basically of chronic illness. They were never ever asked --well, we can go back over.

I mean, I shouldn't say never ever asked. But not one of them said, Based on what I heard, he did have croup. It's not an impossibility. It's a possibility on the evidence that he had croup. I certainly accept that. That's all there.

But how can a forensic pathologist -- unless she can look at something as a pathologist and say, Look at, this tells us it was croup, that's okay, but she can't say, as a forensic pathologist -- essentially diagnosing based on current live symptoms, can she?

MR. BUCKLEY: Well, now, the --

THE COURT: How she can (sic) do that?

MR. BUCKLEY: The interesting thing, though, is is all of the doctors -- and, I mean, croup's come up from the doctors saying that it's a real possibility, and it --

THE COURT: Exactly.

MR. BUCKLEY: They're all basically relying on what the Stephans said or what they reviewed in the medical file. And what the Stephans said, all of that is in the medical file. I mean, every -- we've got proof of the documentation as a list of exhibits. So none of them saw Ezekiel beforehand, and yet they're basically doing what you're saying a pathologist, you know, who has the medical doctor training, has basically your first year family residency training and then is trained as a pathologist. You're saying, Well -- and pathologists are the people that doctors go to to get

confirmation of diagnosis -- that a pathologist can't do basically what the doctors have done. And I don't think any of the doctors were asked to listen to the 911 call and listen to Ezekiel's breathing, so that's --

THE COURT: But they were the experts. You could have asked them that. Listen to the 911 call; does that prove that there -- that that was croup? Does that allow you to diagnose croup? You didn't do that.

MR. BUCKLEY: No, I didn't.

THE COURT: Look it, a pathologist can't possibly step in and give a diagnosis when a diagnostician couldn't step in and give a pathologist opinion. Never the twain shall meet --

MR. BUCKLEY: Well --

THE COURT: -- in the sense of qualifications as an expert.

MR. BUCKLEY: In my due respect, I think it would be very helpful to have Dr. Sauvageau explain to the Court what a pathologist does and why and why it's important for her to be able to do what I'm suggesting she be allowed to do.

THE COURT: But you're retrying the voir dire that we spent a full day on yesterday. Remember, we started the voir dire. I said, Counsel, what are you proposing that this expert will be --

MR. BUCKLEY: Yes.

THE COURT: -- entitled to give opinion evidence in relation to? And I made a ruling. That -- and we had the whole day to explore that.

MR. BUCKLEY: That definitely happened, and I indicated to the Court I really did not anticipate that her qualifications to give evidence, except for the bias issue, was going to be at hand. And I think, you know, based on the prior representations, likely the Court thought that we were having -- you know, primarily bias was the issue. And then I asked if I could, you know, re-call her just to flush that out and was not given that opportunity, and you made your ruling.

MS. WEICH: So, Sir, I did mention at the very beginning I was going to canvass relevance and necessity as part of the *Mohan* factors, and as far as relevance goes, that's where my friend's argument would lie, that it's relevant for her to

be able to talk about these things in the way she does her job as a forensic pathologist. So I agree with you, Sir, yesterday was the day to get it all.

MR. BUCKLEY: Well, with all due respect, under the *Mohan* factors, that would be under, you know, a properly qualified expert.

So the defence is in a -- in the position where, you know, the Crown did not say that they were taking issues on the, you know, properly qualified expert test of *Mohan* except on the bias issue.

Well, I mean . . .

MS. WEICH: Sorry, Sir. Last week -- I have a very clear recollection -- you asked what the issue was, and I said bias along with the *Mohan* factors, and then you yourself said, Okay. The *Mohan* factors as usurped -- I can't remember the exact you said -- in *White Burgess*, and agreed. I said, yes --

THE COURT: Interpretive.

MS. WEICH: -- so it was there, Sir, all along.

Submission by Mr. Buckley (Qualification)

MR. BUCKLEY: I did stop speaking because the Crown spoke. If -- I was just making the point, and I think it, you know, is a reasonable point, that from the defence perspective, really the issue yesterday was bias. I ran a voir dire under the understanding that it was bias, really not thinking that I was going to be having problems with Dr. Sauvageau testifying as a forensic pathologist doing what they do. So I have to wear that, but I'm just saying I wasn't anticipating that issue.

In my submission, it would be very helpful to the Court just, you know, to quickly address that issue with her on the stand, give some explanation about that and get a clarification of where she can and can't. I appreciate that, in effect, I'm asking you to reopen a ruling based on, you know, defence counsel not appreciating one of the issues in the voir dire.

MS. WEICH: And, again, Sir, yesterday morning, when asked, I clarified the *Mohan* factors, I would be canvassing those.

THE COURT: I'll be back in a few minutes.

(ADJOURNMENT)

Ruling

THE COURT: Please be seated. The issue which has arisen today really relates to the scope of the qualifications of Dr. Sauvageau as an expert witness. The concern arises very late in the trial process while we are all anxiously hoping to have the jury continue its work. This and a number of the other complexities which we've encountered in this trial are typically dealt with in the pretrial conference process our court employs and by way of pretrial case management under the *Criminal Code* or other hearings such as voir dires in advance of the trial.

Here, as I've indicated a few days ago, only the possibility of presentation of an expert was mentioned in the pretrial conference proceedings. There was not the compliance the *Code* articulates concerning provision of the qualifications of an expert or, in the case of the defence, essentially the substance of the opinion.

I've already ruled that the defence is entitled to and will be calling Dr. Sauvageau, and yesterday we had a voir dire to determine issues relative to her qualifications. At the conclusion of that voir dire, I testified that -- or I ruled that she is an expert in forensic pathology and asphyxia entitled to give opinion evidence in forensic pathology, which includes conducting examinations, coming to conclusions, and explaining cause of death, manner of death, and processes leading to death, which includes the interpretation of diseases and injuries, including hypoxic and anoxic injury. And when brain damage is caused by hypoxic and anoxic injury, I ruled she was not entitled to give opinion evidence on a diagnosis or prognosis of chronic illness.

Two principles flow from that ruling. The first is that the ruling articulates -- rules on the areas of qualification of this witness as an expert and where she's entitled to give opinion evidence. The second is that the scope or meaning of some of these provisions within the qualifications may require some degree of exploration or explanation by the witness.

Typically, in a trial with a jury, the voir dire concerning qualifications of a witness deal with issues such as establishing that the preferred evidence is relevant and necessary or meets the admissibility criteria for novel science articulated in *Mohan*. A voir dire also determines a question of a situation where the claim is that the expert lacks independence and impartiality in making the opinion inadmissible.

That's what I understood we did yesterday, and I made a ruling, and I qualified the witness accordingly. In the normal course and today, the qualifications of a proposed expert are established in a voir dire conducted in the presence of trier of fact, namely the

jury.

What we're going to, therefore, do is exactly -- following exactly that procedure. I'm going to call the jury in. I'm going to advise the jury on what I have ruled. That will include both what I have ruled she's entitled to give opinion evidence in and what she's not entitled to give opinion evidence in.

The defence will then call the witness and proceed through the qualification exercise, and if there is something that the jury needs to know about what the ruling means and what the scope of the opinion can be, they should hear about it, and the Crown will be entitled to cross-examine on that. It won't change the ruling. It may explain the ruling in terms of the scope.

After that, we will then proceed with the substance of the report or the report; however, it may mean that defence will have to reconsider further portions of that report because the ruling concerning qualifications and limitations on qualifications won't change.

On my brief experience with what the Crown articulated, it seemed to me that there were some ways that could -- we could more neutrally manage the words in the report to account for the qualifications of the witness to deal with opinions in her area of expertise and limit her from commenting on things which are not within her areas of expertise. But we'll deal with that in due course.

So for right now we're going to call the jury back in. I'm going to tell them what they're going to hear and what the ruling is and what the ruling is not. And then you can proceed with the qualifications so that the jury knows what the witness is actually going to be -- they know what the ruling is; they need to know what it's all about.

That's nothing unusual, Crown, with respect to the normal process that's engaged. It's perhaps odd in the sense of what we normally encounter, but generally speaking, this process that I'm articulating falls within the way we do things. Not every case is not quite as tangled as this one, but there is -- I'm not breaking any new ground by doing what I'm suggesting. We're going to proceed in that way.

MS. WEICH: So, Sir, I'm really sorry. I don't understand what that last bit was. Mr. Giles just doesn't understand. We don't understand how it's going to work. To me, it sounds like Dr. Sauvageau will be able to interpret and give her interpretation of what your ruling is, but you also said that it won't change, in that she -- so I'm just -- I'm not exactly sure what you expect to see happen or what you would expect to see Dr. Sauvageau give evidence about so that she could explain anything.

MR. BUCKLEY: And my understanding is is I'm not walking through her evidence at -- when the jury's here and we're going through her qualifications, so my understanding is you're going to indicate what she's been qualified as and what she has not been not qualified as. The Court will be reading that. And if the Court won't -- I'll ask you to walk through it again because I don't have it verbatim what your ruling was. And that, you know, my friends will cross-examine, and then perhaps at the end, the Court might give some clarification of, you know, what the scope is, not changing the ruling, but there is some -- you know, so when she can give, you know, cause of death, manner of death, it might be helpful to have that explored, and I likely will be doing some editing before she gives evidence about what her evidence is as opposed to her qualifications.

THE COURT: And if she tries to testify outside of her qualified area of expertise, even if that's -- flesh is put on the bones of that, she'll be stopped during her examination on the substance of her testimony. We all know that. She shouldn't be testifying outside of her area of qualification; right? We'll see how that goes.

I will tell the jury what she's qualified to give opinion evidence in and what she's not entitled to give opinion evidence in. Defence will proceed with the qualification exercise in terms of -- what does that mean?

MR. BUCKLEY: M-hm. Well, I mean, I -- I -- I'm just going to walk through her qualifications much like yesterday, so, you know, maybe expand on a few issues, and I'll just see where my friends go on the cross-examination.

THE COURT: Let's call the jury.

THE COURT CLERK: All rise.

MR. GILES: Sir? Sir? My friend's just left much of the material that she had at the recourse when doing the voir dire back in our office just down the hall. I'd like to be excused to go obtain that --

THE COURT: Thank you.

MR. GILES: -- for her, if I could, Sir.

MR. BUCKLEY: And, My Lord, I'm assuming I can give a copy of the CV of Dr. Sauvageau to the jury?

THE COURT: Yes.

(JURY ENTERS)

THE COURT: Good morning. Please be seated. All right. Members of the jury --

Counsel confirm that all jurors are present, please.

MS. WEICH: Yes, Sir.

MR. BUCKLEY: Yes, My Lord.

Address to the Jury by The Court

THE COURT: Thank you. A couple of things before we get started with the evidence. You may recall that in my opening instructions to you I told you that sometimes certain evidence can only be used for a specific purpose. I told you that if that happens here, I will tell you how you may use the particular evidence in deciding this case. I told you that you must consider the evidence only for the purpose I describe. You must not use it for any other purpose.

David Stephan testified about what some other persons said to him. You may recall that those other persons included Collet Stephan, social workers, and doctors. Collet Stephan testified about what some other persons said to her. Some of -- you may recall that those other persons included David Stephan, social workers, and doctors.

Some of those witnesses have testified, and others were not here to testify. We call that kind of evidence hearsay evidence. You may not use that hearsay evidence as proof that the statement or statements made to David Stephan or to Collet Stephan are true. The evidence given by David Stephan or Collet Stephan about what others said to them has a specific limited purpose. The purpose of that evidence can only be used by you as evidence that those things were said to either David Stephan or Collet Stephan by the other persons. It is up to you to decide, based on all the evidence in the case, if those things, whether they were true or not, were actually said to David Stephan or Collet Stephan.

Secondly, you're now going to hear some evidence from Dr. Sauvageau. I have ruled that Dr. Sauvageau is an expert in forensic pathology and asphyxia, and that she is entitled to give opinion evidence in forensic pathology, which includes conducting examinations, coming to conclusions, and explaining cause of the death, manner of death, and processes leading to death, which includes the interpretation of diseases and injuries, including

hypoxic and anoxic injury and when brain damage is caused by hypoxic and anoxic injury. I've ruled that she is not entitled to give opinion evidence on the diagnosis or prognosis of chronic illness.

All right. Can we call the next witness, please?

MR. BUCKLEY: Yes, My Lord. I'll go and grab Dr. Sauvageau.

THE COURT: Thank you.

MS. WEICH: And, Sir, if may please go and retrieve Dr. Adeagbo.

THE COURT: Oh, yes, please.

MS. WEICH: Thank you.

ANNY SAUVAGEAU, Sworn, Examined by Mr. Buckley (Qualification)

MR. BUCKLEY: My Lord, Dr. Sauvageau is going to be referring to a curriculum vitae, and I was wondering if I could pass one up to the jury?

THE COURT: We should mark it as an exhibit, and then perhaps madam clerk could --

MR. BUCKLEY: So --

THE COURT: -- do that for you.

MR. BUCKLEY: -- My Lord, if we could, I would like the witness to be referred to what was Voir Dire Exhibit 5, and I would ask that that be entered as the next exhibit, and then I would provide the jury with copies of that.

THE COURT: Crown?

MS. WEICH: Crown consents to that, Sir.

THE COURT: All right. Madam clerk, if we could provide the witness with Voir Dire Exhibit Number 5.

A Thank you.

MR. BUCKLEY: And I'll provide madam clerk with 12 copies of that.

THE COURT: Thank you, counsel.

EXHIBIT 22 - 10-page Curriculum Vitae of Dr. Anny Sauvageau, M.D., M.SC. (Formerly Exhibit V-5)

THE COURT: Did we swear the witness, madam clerk?

THE COURT CLERK: Yes.

THE COURT: Thank you. Sorry.

Q MR. BUCKLEY: Dr. Sauvageau, you are a forensic pathologist?
A That's correct.

Q And --
A Can I just mention one thing, if you don't mind. I apologize to the jury. I will be on lozenge all day long. I don't want to be rude, but I'm sick so otherwise I will lose my voice or having coughing spells, so I please -- please accept my apology. Sorry.

Q Thank you, Dr. Sauvageau.

So I want to kind of walk back. My understanding is back in 1996, you graduated with a doctorate in medicine from the University of Montreal?
A That's correct.

Q And then in Quebec, you were licensed to practice medicine from 2002 to 2010?
A That's correct.

Q And then in Alberta from 2009 to 2015?
A That's correct.

Q And I also understand that in 1997, you completed a master of science degree in neurological sciences from the University of Montreal?
A That's correct.

Q And can you just give us some details about basically why you were doing that, you know, personally and what it involved?

A So when I was doing my medicine, I thought I wanted to be a neuropathologist. We have not explained what is a pathologist yet, so we'll explain that later, but it's -- it implicate a lot of the brain. And because I wanted to be well prepared, and I wanted to also have a career as a researcher, not just as a doctor, I went to do a master degree in neurological sciences.

So I was doing my medicine during the day, and I was doing my master degree at night and weekends and summers. And so that was studying all the disease of the brain -- well, it -- not all. It was studying the disease of the brain; studying how a normal brain works; how the synapse talk to each other chemically, electrically; studying what happens in monkeys or -- usually it's monkeys that were used neurological sciences; looking at historically all the research that we have learned from monkeys; when they do different type of injuries, what that means for human; what do you expect when you have injuries at different degrees.

So it was a -- kind of a comprehensive understanding of the neurological sciences which means the science of your brain and your nerves.

Q And then you started but did not complete a PhD?

A That's correct. So I was still in neuropathology, which is more the site on the brain, and I started a PhD where I was studying epilepsy. But then I had a change of heart, and I wanted to do forensic pathology instead so I changed my focus. And there was no researcher in forensic pathology in -- in Quebec, in the whole province. Well, they are very rare, the forensic pathology researcher, in Canada.

So I couldn't find a director, so instead I didn't complete the PhD, and I started my own program of research, and I had student in master degree and PhD that I was directing their study, though I don't have myself have a PhD, because I couldn't find a director.

Having said that, if you look further in my CV, you will see that I don't list a student with a PhD. It's because they have not completed yet, but I did have student with PhD. The one that are listed are the one that have completed their thesis. So for now it's only master degree students that are listed as -- that I was director or codirector.

Q Okay. So just so I understand, you are supervising a PhD student, but it's not listed because you only list on your resume once they finish?

A Correct. Because you have students that start and they drop out. Those will never end up on your CV. The one that completes go on your CV. But until they have completed, even if you think they are going to complete, you cannot put them on your CV. Well, most people do it this way. There's certain people that will list the enrolled

but not completed. I don't.

Q Okay. Now, you started in 1997, and it continued to 2002, a residency in what is called "anatomical pathology"?
A Correct.

Q And I'm going to ask if you can explain, first of all, what anatomical pathology is and basically what that residency involved?
A Yes. So most people know what a family doctor is because you see them, but most people don't understand what an anatomical pathologist do because you won't see them. Basically, we are consultant for the doctors. Later I will talk about forensic pathologists, which is what I am, but to become that, you have to go through the middle step of being anatomical pathologist.

So a patho -- an anatomical pathologist, which I will often contract to simply "pathologist", is a consultant for the other doctors. You use different tools like the microscope or looking with -- to the organs with their eyes to answer questions for other doctor.

For example, if you have a cancer and the surgeon is taking the cancer out in a surgery room, the surgeon cannot trust what he sees, but -- well, to a certain extent he will do what he can with his eyes, but at some point, he will need guidance from the pathologist to know what he needs to do more. So he will send the specimen he's taking out to a little elevator directly to the pathologist, and the pathologist will look at that under the microscope, and he will tell him, for example, that all the front is nice. There's no more cancer, but at the back on the right there's a little bit more. Take more from there.

Actually, even if we went one step before that, when the surgeon took a little piece of what he thought was a cancer -- we call it doing a biopsy -- the surgeon cannot say it's a cancer by himself. He need a pathologist that will look at it and will confirm that, yes, it's a cancer or, no, it's not. And if it is a cancer, he will also tell him what type it is, and because of that type, he will tell him what type of treatment needs to be done.

There's type of cancer that you do surgery, and I explain how it's then done also with the help of the pathologist, but there's other cancer where we know that it's more chemotherapy or radiotherapy. Or it could be because there's metastasis. Metastasis are also something that the surgeon is sending for the pathologist to confirm.

So there's really a help -- like, a team work between the surgeon and the pathologist,

and the pathologist is there to help in the diagnosis. He makes the diagnosis, and he help with understanding that type of cancer, what is the usual treatment for it.

Another example in a different field. Let's say you have a little brown spot, and you're wondering if you have a melanoma, you will go to your dermatologist, and he will take a little piece of it, and he will say come back in a month. What happens during that month or two, depending, the length of time can vary, is that he will send that to a pathologist. The pathologist will answer to the dermatologist, Is it something benign? Just a brown spot, no importance, and then your doctor will just reassure you. Or the pathologist might say, Well, actually, it's a cancer. It's a melanoma. And he will tell the dermatologist, depending on different criteria, it's just -- taking it out was sufficient, or do we need to take more? Do we maybe even need to go and take the lymph nodes out?

So the pathologist, people don't have a direct link with them, but we are the consultant for the doctors. We help them with the diagnosis. We help them with the prognosis and understanding what treatment must be done depending what we see with our tools as a pathologist.

Q Okay. So you do this residency in anatomical pathology. Am I also correct that you had done 12 of -- 10 of 12 months towards a neuropathologist specialty? And so I'll ask you to confirm or deny.

A Yes. So as I said, I wanted to become a neuropathologist at the time. We all -- all pathologists first do anatomical pathology. Then you can add one year, and that year will give you a subspecialty. Forensic pathology, that we have not explained yet, is one of them.

Initially, what I wanted to do was neuropathology. To do that, you need 12 month (sic). I did 10 of the 12 month. So I am not a neuropathologist, but I have done 10 of the 12 month so I have more knowledge in neuropathology than a usual pathologist because of these 10 months, but I'm not officially a neuropathologist.

Despite that, when I work as a forensic pathologist and there's question around brains, my colleague will often consult me because they know I have this extra training that is not the normal training of a forensic pathologist. Usually, it's two to three months, depending on universities.

Q And can you just kind of outline just in a little more detail what the study of neuropathology is verus just anatomical pathology?

A Well, an anatomical pathology do all the organs. The subspecialty make you more training in one area. Neuropathology, the area we look more at is the brain and the

nerves and the muscle, but in the context of today, the brain was the part where I have extra expertise. We also do muscle and nerves. That have no meaning for today.

Q Okay. And then in 2002, you received an anatomical pathology advanced graduate diploma from the University of Montreal?
A That is correct.

Q And that would be in the province of Quebec?
A Correct.

Q And at the time, was there in Canada a -- could a person be designated as a forensic pathologist back in 2002?
A Okay. In 2002 in Canada, the subspecialty of forensic pathology was not officially recognized by the Royal College of Physician (sic) and Surgeons of Canada. That doesn't mean forensic pathologists didn't exist. That just mean there was not an official recognition.

So there was no university at the time that were officially recognized as being training centre. We had two choices as Canadian. We could train in Canada, but we -- it was not official, but it was the same; it was just it was not official, or we could go to United States.

In Quebec, it was strongly favourized or strongly suggested that we train in house in Quebec, so that's what I did. I trained in Quebec as a forensic pathologist instead of going to United States. So there's a mixture in Canada of people that stayed here and people that went there, but we studied the same thing. It's just in Canada it didn't exist officially at the time. It became -- the first training program accredited in Canada is in 2009.

Q And so my understanding is is from 2002 to 2009 you were a forensic pathologist at the Forensic Sciences and Legal Medicine Laboratory in Montreal?
A That's the translation of the real term, but, yes, that's what I did. So the first year I was considered a fellow, which means someone that is in training, and then I was a full staff forensic pathologist.

Q Okay. And so the first year the fellow is training, that's the type of training that you were talking about that would happen in Canada?
A Correct.

Q And can you share with us what that involved?
A It involve one-on-one -- we are one student at a time because it's a tiny specialty. We

are only about 50 working in that field in Canada so we don't have big lecture rooms. It's one-on-one teaching. Someone's sitting with you asking you questions, presenting you cases. So there's a lot of teaching to make sure you cover all the aspect of the field.

So, for example, we -- we covered the sharp object, the blunt object, the fire, the electricity, the explosion. All the field that is inside forensic pathology. Or complex medical cases with medical legal question.

Can I explain what a forensic pathologist is maybe because --

Q Oh, absolutely.
A -- it's hard to make . . .

Q Absolutely. Sorry.
A It's kind of a -- yes. To explain that, I need to explain what is a forensic pathologist. So I said before what is anatomical pathologist, so a forensic pathologist is a doctor, is an anatomical pathologist, but instead of answering the question of other doctor, he will use his knowledge and he will use the tool of autopsy and microscope to answer question of medical legal importance. So he will answer the question not of the other doctors, though sometimes it can happen, but usually he will answer the question of the police. In other provinces it could be to the coroners. Here it's also to the lawyers, the Crown, the defence. It could be to a judge, like, in -- in a fatality inquiry.

So we answer questions in the context of medicine legal questions. So that's why our training involved a lot of the injuries that will end up in court that could be murders, but that -- that also involved cases that have medical legal question, like, malpractice of doctor, negligent treatment of doctor, among many, many other thing.

Q Okay. So --
A Oh, so I was explaining the training we are having. So we are covering all these subject. One on one, they evaluate our knowledge regularly, and we also do the autopsies, and we are progressively autonomous for our own cases. So the first day you will do only the cases you could do as a normal anatomical pathologist, and you look at your senior colleagues, how they do the other cases. Then they let you do it, but they -- they observe you, and they comment on your work.

When they think you are ready, they let you do it, but they review your report, and when they are -- when they think you are ready, they let do -- they let you do all the cases. So you have a progression on what you are authorized to do.

They also train you to present in court. So they organize mock trial, fake trial, where people are playing roles, and you're testifying, and you learn to testify. You learn to be an expert witness because it's different than other type of witness, and I -- I don't need to explain that to you as part of my expertise today. So we learn all of this as we do the training.

Q So that's the first year of this 2002 to 2009. So from 2003 to 2009, am I correct that basically you're then working as a forensic pathologist at the forensic -- or the Forensic Sciences and Legal Medicine Laboratory in Montreal?

A Correct.

Q And basically what did that involve? So your training's now done. What's happening during those years?

A So I'm a forensic pathologist. I do the autopsies for the cases. And sometimes we do some question on the living, but it's not as common. The majority of the job is to do the autopsy, and when we do that, as forensic a pathologist, we evaluate different things. We -- we use what is called a golden triangle, so we use the autopsy itself, the body, what -- what information we can get from the body.

But we have to also look at the scene, how it was found, what is described at the scene, and we have to look at the medical information that are available, either through a medical file, if the person was known by a doctor or was in the hospital, but sometimes death happened in a frame where there was no doctor involved. Someone can die suddenly and never went to the doctor before for different reason.

We also look at what is reported to us by the witnesses or the family or it depends. So we take these three element, the golden triangle, and from that, we make a conclusion on, first, who died, but that's not important for -- for today so I will let that one out. Often it's who died. That is the main question. We don't know who the person is. Where they died, when they died, the cause of their death, the mechanism. That means from this cause, I'll do everything involved so that they died. Their circumstances of death also. Different contacts will have different answer. For example, we are asked things like, Was the killer right-handed, left-handed? Was he attacked from the front, from the back?

So there's a lot of thing about circumstances. Here it's -- it won't be about someone having a weapon. It's going to be more about medical context, but we are -- we have to interpret this context so that we can explain the death. Cause, mechanism, and circumstances.

Q Okay. So I just -- I -- I want to make sure that we fully understand this golden

triangle. So one of the -- one of the three parts of the triangle is the body, so can you just explain for us why that's important in the job as a forensic pathologist?

A Okay. First we always have to look at the three, but depending on the cases, one can be more important than the other. It will vary from one case to the next. For example, if someone died of a sudden hemorrhage bleeding in their head, and we see the bleeding in their head at autopsy and it was really sudden, they were really feeling well and, poof, they are on the ground, the autopsy -- the body will speak. The scene, well, he just dropped there. He was talking, and he dropped dead. There was nothing at the scene. And the history, maybe it will say he was fine. I don't understand. He just dropped dead. That's a case where the body's talking. The other are not.

I can take the other side. In reality, often the three are talking a little bit. We have to put them together. I'm giving example that are kind of just to understand. An example on the understand where it's the scene. Let's say someone is really, really drunk or very intoxicated by something else and they fall on the stairs. The fall itself is not very important, but they end up -- kind of crunches in a little bundle, and from the position they are in, they can't breathe.

If they were not that intoxicated, they would realize they can't breathe, and they will take a different position. But they are so intoxicated that they don't realize they're going to die because they can't breathe, and they stay like this.

In a case like that, not always but most of the time, there's nothing at autopsy that you can see. The history -- if there was no witness and he's found like that, the history is just that he was maybe known to be drunk or intoxicated often, maybe not, depends.

And here what you have is scene, and that's going to be the most important thing. The police will tell us how they found the person, and we'll have pictures often, and we'll say, Okay, I have nothing at autopsy, nothing really medically so maybe it's known that he was an alcoholic, but the scene is what helped me the most.

And sometimes it's more the history of the medical file that will help us. An example of that is a sudden death. It's called sudden unexplained death in epilepsy. We know that some people that have epilepsy can die suddenly. And if we exclude everything else and they are known to be epileptic, that's going to be the cause of death. The autopsy, in a majority of the time, we see nothing because most type of -- of epilepsy we don't see it in the brain. There are type we can see, but there's a lot of type epilepsy that we can't see.

The scene, they're dead in their bed. There -- there's nothing special. All the -- their doors are locked, the windows are closed, there's no scene of violence, no forced

entry, and they're just in their bed. No blood, no nothing. But the medical file about this epilepsy will give us the clue.

Like I said, I give you, like, three example that were kind of pure, but in the majority of the time, we have to integrate these three to make the cause and the circumstances of death.

Q Now, you spoke about, you know, cause of death, so the golden triangle is used to determine cause of death. But you also spoke about mechanism of death, and I'm just wondering if you can fully explain for the jury, you know, what you mean when you're speaking about mechanism of death?

A Okay. I can give you one example. If you have a cause of death that would be stabbing to the heart, a knife in the middle of the heart, that is the cause of death, but that doesn't explain the mechanism. Maybe the mechanism in this case is that of the about 6 litres of blood we have in the heart, there's 4 litres on the ground beside him. So the mechanism is bleeding mainly. So he lost his blood.

But in another case, maybe the mechanism is that this knife went straight where the electricity is passing, and it cut the electricity, and the death was quicker. So we analyze, once again, all the three parts to also answer question like, Did he die quickly or did it take a long time before he died?

We're not a perfect science. You will have to forgot what you seen on TV show. We're really not that good, but we do our best to answer the question with the availability of the science, and when there's a doubt, we express that.

So sometimes I will say, This is certainty, this is probable, this is possible, this is impossible. We kind of use language to -- to help you understand how certain we are of certain things. And depending on the cases, we are more certain or less certain and depending on the question also.

Q Okay. And then you also listed circumstances as something that -- you said cause, mechanism, and circumstances.

A Yes. And I forgot one because it's not important here, but I should have add manner. But it has no impact here so I forgot. But I should have said also manner.

So circumstances is more everything else around it. It can be very variable. For example, let's say someone has been killed by a blunt object. A blunt object is anything that is not sharp like a knife, so it's more crushing than opening. I won't go too much in detail because it's not -- you don't have to understand the difference between sharp and blunt.

But let's say it's blunt object. The circumstances that I will describe in court could be what type of weapon? Do I think more of a hammer, do I think more of a baseball bat, or do I think he was kicked? Sometimes I can't make the difference, sometime I can't. Was he attacked from the front or from the back? Did he try to protect himself or not? All type of questions that are around the circumstances. Here, it's not a weapon so the circumstances are more around the medical history, but it's still circumstances, and we still have to take that into account.

Q I'm going to completely just change -- segue into something else and then come back. Your first language is French; am I correct?
A Yes.

Q And in --
A I'm trying hard, but I can't hide it.

Q No. But in French, there are, you know, female and male words; am I correct? And --
A That is true.

Q And you're speaking, you know, he, he, he, and that's because your first language is French and -- am I correct about that?
A When I -- maybe I use always, in the example, a male. I'm not sure. If I did, the victim can be a female, of course. Having said that, there's more men that ends up on the table of a forensic pathologist than men (sic), for reasons that I don't think --

Q Okay.
A -- we should enter today.

Q And -- and --
A But when I said "he", it could be "she", and we do see women as well as victims and as accused. So it was just to simplify the discussion, so I'm not sexist, being a woman.

Q Okay. So then -- and I'm just -- not wanting the jury to think you are; that's why I went there.

So I want to kind of go back through more into kind of your background. I will circle back to a couple questions about pathology -- or forensic pathologist. When the jury flips through your curriculum vitae, they're going to notice that you have a lot of publications. I think it's 81. Am I right about that?
A Yes, I think it is.

Q Okay. But they're also going to notice that, you know, several of those publications deal with sexual asphyxia, and I'm wanting you to explain, well, why, as a forensic pathologist, you might be looking at sexual asphyxia cases. Because they might think it has to do with, you know, the sexual part when you might have a different answer.

A Well, of course, sexual asphyxia is about sexual asphyxia, but there's a reason I was interested in it. It's because my -- I have two main field of interest in research. I will talk only about one of these two today, and that's the one for which I'm more known as a researcher; it's asphyxia.

I was trying to figure out a way to learn more about what happens in a body when there is a strangulation. It could be like a hanging or it could be by the hands or it could be by a ligature. And the limit we have as researcher in forensic pathology, for obvious reason, we cannot take volunteer -- though it happened in the '40s, but that's a different story, and it was not in the context of the war; it's completely different story. You cannot take volunteer and start to experiment on them and hang them and put them in the place, like, in water or -- you cannot experiment on humans.

So -- and we could do animals, but it's very difficult to do good experimentation for forensic on animals that we can then relate to humans. For example, the vasculature in the neck of a dog is completely different than on humans so you're just killing dog for nothing. You will learn nothing. The rats and the rabbits are more similar. But I remember looking at the rats, and they -- the search -- the researcher that are very interested in rats found that at some point of the hanging, the tail of the rat goes up, and I was trying to figure out what does that mean in a human, and I -- no idea. So there's very limited thing -- you -- you can do good models, but it has not been done yet, and what you will be able to learn from them will be very limited.

So I was trying to find a way to learn from asphyxia in human, and it happened that there was video in the lab in Montreal of a professional cameraman that, for reason that are hard to explain, decided to film his suicide. So we had this video, and I look at it, and what I saw didn't match with what I had been trained to think so I started to think that we should look at more of these videos.

Most people -- well, back then, there was not the cell phones. Nowadays we start to have more suicides that are filmed. But back then, they were -- they was not that common that people filmed things so you don't have a lot of suicides on video. But we had people that, for sexual reason, liked to experiment with asphyxia, and they filmed themselves because, for sexual reason that I don't have to explain today, they then relook at the video. And sometime they then die, and when we find them, we find the video where they died, and we find the collection of thing that happened

before.

And that was extremely useful to learn from it, to learn what happened if you hang yourself for three minutes, what happens if you fell after two minutes, what happened when you will finally die? So I use these sexual video to learn more about hanging and strangulation.

So in the end, the sexual part, I also developed an expertise on it. So when they are -- trial on manual strangulation, and one of the line of the defence is about, Well, it was consensual sex, I'm often asked if that could match the description or not. But this is something -- this is something else. My main reason why I was interested was because I wanted to learn more about the asphyxia process.

Q Now, in 2009, you moved from Montreal to Edmonton, and from 2009 to 2010, you were, I will say, a (sic) assistant chief medical examiner at the Office of Chief Medicine Examiner in Edmonton?

A Yes. The title seemed bigger than really what it is. It's just a historical remain. That's why in Alberta, instead of being called "forensic pathologists", we are called "assistant chief medical examiner". But at the stage of assistant chief medical examiner, you are a forensic pathologist, so you do the work of the forensic pathologist. Despite the term, you don't have leadership or management. It's not in -- a hierarchy position compared to the other pathologist. So when I arrive in Alberta, I was one of the forensic pathologists.

Q Okay. So you do that 2009 to 2010?

A Correct.

Q What did that involve, that job involve?

A So as an assistant chief medical examiner or slash forensic pathologist, I was doing autopsies and external examination of bodies, so I was doing the work of a forensic pathologist. On occasion, but it's not as common, I was also doing expertise on living people with injuries, but that's really not as common as autopsies and external examination.

Q Okay. And then from 2010 to 2011, you were the deputy chief medical examiner at the Office of the Chief Medical Examiner in Edmonton?

A Correct.

Q And so what was the difference, then, between being deputy chief medical examiner and being an assistant chief medical examiner?

A As I said, assistant chief -- often when we post a job, people call because they think

it's a deputy chief, and they want to apply to a promotion, and we have to explain that, no, assistant chief medical examiner is the entry level. It's being a forensic pathologist.

Deputy chief, which I became in 2010, is a hierarchy position. The person above you is the chief, and the job implied -- the definition of what do (sic) a deputy chief varied over time. It's defined by the chief. So when I was a deputy chief, the chief was Graeme Dowling at the time, and what he assigned me was two team. I was in charge of morgue team, so that means the -- the technician that help with doing an autopsy, and the death investigators team. Death investigators, people think they are doctors, but they are not. They are the non-doctors that help us to gain all the information we need to interpret the autopsy. So I was in charge of these two team, and I was doing still the same amount of autopsy and external examinations.

Q And I'm just wondering if you can elaborate a little bit on basically the types of information the death investigators come -- you know, assembled and why that's helpful in interpreting the autopsies?

A Okay. So I described the golden triangle. The autopsy is done by the forensic pathologist with the help of technician but who are really responsible. (UNREPORTABLE SOUND) Sorry.

Q And, Dr. Sauvageau --

A For --

Q -- I've had to take a break during these proceedings because my cold, so if you get there, please just let us know.

A Thank you. So that part, we are really doing it mostly, as I said, with the support of technician, but we -- we are really more responsible. The scene and the medical file, we are not the one calling to see where there's a medical file, calling if the police has information, being by the fax to make sure the -- the pages arrive.

So these we are assisted by mainly the death investigators. So they will make sure we have everything we need. They will make sure -- if someone has an information, they are on the phones, and they will tell us that person called, and they said that, whatever "that" is, and we will evaluate if it's important or not. So to help us doing these two things, the scene and the medical file, we have the support of the death investigator.

Of course we can ask them -- for example, if there's a case and I found something or I have an idea by looking at something else, I can ask them, Could you please call the police and ask if this, this, this, or, Could you please obtain more picture for this, this, this, or, Could you check the medical file if he was known for this, this, this. It really

depends on the case.

Q Okay. And then did that job still involve doing autopsies?
A As deputy chief, I was doing the same amount of autopsies as when I was an assistant chief.

Q And roughly how many autopsies would that be in year?
A Okay. So when I was in Quebec, it was an even busier lab; I was doing 300 autopsies a year. Upfront, I have to say that people will sometimes say a higher number than what I just said, but they won't say "autopsies"; they will say "cases", and that's a huge difference. Between -- when you say "cases", that means there's also external examination in it. So when -- if someone tells you they're doing 600-something cases a year, then that's not autopsy. That would be dangerous to do that amount of autopsies.

So when I was in Quebec, because it's a different system -- and I'm not saying it's better; it's just different -- we were more busy, and I was doing 300 -- about 300 autopsy a year, including about 40 to 50 homicides a year. When I moved to Alberta, the system is different, and we do autopsies, but we also do external examinations. So I cannot give you a number of cases. Instead, what we ask people to do in the office when we count their workload is that we do an autopsy equivalent. Four external examination is counted as equivalent to one autopsy. So I don't really know the number of cases, but I was doing about 300 case -- autopsy equivalent a year, so more cases but some are externals. And that's -- when I will be chief, once again, I will use the term "autopsy equivalent".

Q Okay. And what is an external examination, just so the jury understands.
A Okay. So when you do an autopsy, first you look at all the external aspect of the body, all the skin. That's what we call an external examination. If you don't then go in, that's only an external examination. You can complete it with certain tasks. You can do X-rays. You can maybe go with a needle just to see if there's blood coming out, but you don't open up. That's called "external examination". If you open up and look at all the organs, then that is an autopsy.

Q Now, then from 2011 to 2014, you were promoted, and you became the chief medical examiner for the province of Alberta?
A That is correct.

Q Okay. And can you explain what that position is, the chief medical examiner, and then the responsibilities under the *Fatal Inquiries Act* (sic).
A Yes. So the medical examiner and the chief medical examiner have their role defined

in the law called the *Fatality Inquiries Act*. The medical examiner, we defined already, he's responsible of who die, where they die, when they died, what they died?

The chief is still doing some cases because we -- we don't have a system where a chief could be just doing management and leadership. We still have time to do some cases, not as many. I was -- top off at 100 because I had other duty.

The other duty are defined in the law. It is making sure that the law is applied. I -- I will paraphrasing (sic). I don't know the law exactly word by word. So making sure the law is applied, making sure all the death that should be reported to us are reported to us, making sure we review all the death certificate to make sure we don't loss -- lose cases.

Of course, I -- that doesn't mean I'm sitting with 20,000 death a year in Alberta, and look at the paper. I'm delegating to different people as I'm responsible for that. And I'm also responsible for the building, making sure we have the equipment, making sure I have proper staff, making sure the staff that are non-doctor are properly trained, all that type of surrounding work that is -- and doing policies, doing guidelines, doing -- so it's more like an overall umbrella of the death investigation system in Alberta.

Having said that, there's also a principle that I needed to be very aware of, is that a medical examiner do his work with independence. So I'm the chief, but that doesn't give me the right to go and interfere with the work of a medical examiner. I have -- I won't go in details because it's not important in this case. I have certain powers under the law, but I don't have the power to interfere directly in a case. I have to also respect the work, independence, of the medical examiners.

There can be some exception at time, but I don't -- I don't think we should go into there. It's not important at this point.

Q Okay. So when you were appointed as the chief medical examiner for the province of Alberta, did that also then include supervising the medical examiners below you?

A Then it becomes relevant. Yes and no. I was supervising with performance measures. So, for example, how many cases did they do? I would make sure they don't do too low so that their colleagues are left with the work but that they won't go above a certain limit.

So I was following the parameter every month, and I would, for example, say to one person, You have to speed up a little bit because your colleagues are taking the work for you, or telling someone else, You've worked a little too much. You have to slow down a bit because you might reach the dangerous zone. There's a dangerous zone

that has been defined in the guideline so we have to make sure.

I would also check that they were doing their reports on time. If there were complaints that they would be rude, I would evaluate that. If there were -- there's never been that, but if -- if they had been bullying, harassment, all the human resources thing. I would work -- I -- I -- I would not be independent on this, though, because as the chief medical examiner, I had a sphere of independence, but there were three thing on which I was not independent and human resources was one.

What I would not do as a chief is interfere directly in a case. I can assign a case, I can even de-assign a case, but I cannot tell a medical examiner what is the cause of death. So it's -- I have to respect their independence. But I can give them a case or, for a reason, I can take the case out (sic) of them.

Q Okay. And then as chief medical examiner, were you involved in the hiring of other medical examiners?

A Yes, but with human resources. So there was a process to -- for example, the ads that will go to the newspaper was never written by me. It's written by the Government of Alberta, the people in human resources. I would read it to make sure it's all right because people in human resources don't have the knowledge of the work as much as I do. So it was a work in -- like, in a team, but the human resources processes was under the purview of the Government of Alberta, but I was working with them. We will do the interview together. They were making sure the process was followed.

I was making sure who we would hire but not the process of how we would end up at that person. I'm not sure it's -- it's hard to explain in a few sentences, but I think it's the gist of it.

Q Okay. So, for example, we have Dr. Adeagbo in court today. Were you involved in his high hiring?

A Yes. So I -- I approach -- it's a -- it's a field where there's not a lot of people working in the field. So what I will say to you might seem surprising, but we don't just put an ad and wait (sic) people to answer 'cause if you do that, well, that took them, like, seven years to find me when I had my job here. So you have to be really proactive.

So I was meeting a lot of people saying, Do you want to apply in Alberta? Alberta is a wonderful place and saying all nice things to convince them it was a nice place to come to work, and some people would say, Well, yes, I'm interested. When I had enough people interested, then I put -- we would go and do a competition, and then the process will apply.

In the case of Dr. Adeagbo, I had met him at meeting. I would heard of him from someone else. I met with him. Tried to convince him Alberta was the right place to go -- to go. Initially, he was not interested. Eventually he became interested. Eventually he applied to the process, and eventually he was one of the chosen person.

THE COURT: Doctor, can I just get you to slow down the pace a little bit. The court reporter's having a little trouble keeping up with you.

A I will try.

THE COURT: Thank you.

MR. BUCKLEY: Thank you, My Lord.

Q MR. BUCKLEY: So, Dr. Sauvageau, I'm going to kind of still just -- I'm going to a new different area of your qualifications. Is -- from 2003 to 2009, you were a clinical assistant professor of the Department of Pathology and Cellular Biology at the Faculty of Medicine at the University of Montreal?

A Correct.

Q And in the same period of time, you were an assistant professor at the pathology department, Faculty of Medicine at the McGill University?

A Correct.

Q Can you just briefly, for the jury, explain what that entailed?

A If you don't mind, I will put them also together with -- when I arrive here, I also was the -- the title was one level up at that time. I was clinical associate professor for University of Calgary and University of Alberta.

When I was in Montreal, the teaching involved a more -- teaching in big auditorium to the medical students than what we do in Alberta. As pathologists in Alberta, we don't do as much the lecturing of medical students. In Quebec I was doing that a lot so I was lecturing to the big auditorium with the medical students. I was in charge of certain areas. Among other, I was responsible for the lung lecture on pathology. And so we -- I was doing lecture to medical student, pharmacology student, dentistry, medical legal sciences, and other that I'm just forgetting.

I was also teaching -- and this is what continued when I moved to Alberta -- one-on-one teaching of student coming to the office. So we have people that want to become an anatomical pathologist or people -- well, at the time it was them or lower

in their student -- in their studies that would come to the lab, and we will train them one on one, so it's not big auditorium.

Or we would take together all the anatomical pathologist students -- it's a very small group per year -- and we will give them kind of lectures, but it's more like a discussion when you have three people with you in a room. So it's less big auditorium. It's more personalized, one-on-one or small group type of teaching, making them do autopsy, supervising their work, commenting also on their report, stuff like that.

Q Okay. And then for committee appointments, 2004 to 2007, you were a committee member, Forensic Pathology Working Group of the Royal College of Physicians and Surgeons, and I'm wanting to spend a little bit of time explaining, first of all, why the College formed this committee, about your appointment, and then what the committee was doing.

A So I mentioned previously that before 2009 there was no training in forensic pathology in Canada. When I trained in 2002, I told to you -- I told earlier that forensic pathology didn't exist officially in Canada.

So in 2004, the Royal College of Physician and Surgeons of Canada -- and they -- because they knew it was different elsewhere, like in United States -- they wanted to explore the idea if we should make it official in Canada. So they made a committee together, and they named people on that committee, and the Royal College -- among the people they called, I was called to serve on that committee.

So from 2004 to 2007, we -- I work on this committee where our task was to evaluate if the Royal College should make forensic pathology an official specialty, and, if so, how? We recommended that they proceeded with how. So then the work on that committee ended in 2007, and the Royal College accepted our recommendation and forensic pathology officially existed in Canada in 2007.

Okay. That's good, but what do you do next? So now they did two other committees, and they named me on those two committees again. So they choose people from Canada, and I was among the people chosen. The first committee, now that it's official that it exist, it was called the "committee program" committee. So our job was, for this new subspecialty -- it's a subspecialty because you need to first do anatomical pathology. What do you need to study?

So we made guidelines so that university that wanted to develop the program would know what they need to do. How many autopsy you need to do as a student? What type? What do you need to study? How many scenes do you need to go to? And

the -- how -- what do you need to study was pages and pages of detailed thing that you need to have learned during your studies.

So we made this, and then the program -- the university started to develop program. I will come to that. That was the first -- and the goal also of that committee is to then assess if the university can be accredited. So we look at their proposition and we see if we can accept them as being an accredited program to teach forensic pathology.

The other committee is the examination. Because when you want to be accredited by the Royal College, after your training of accredited program, you need to sit an exam. So they have to make a committee for the examination, and I was vice-chair for this examination board. It's called an "examination board".

And we made the questions. We made a big bank of question that over time are going to be rotating. And the committee is ongoing so they continue to add question to the bank so that, at some point, if people collect the question, they won't have all the question. And it's become kind of a big exam so they continue to add new question to the bank.

Then I had to resign from these committees in 2011. Because I said that in 2009 university started to start programs. In 2009, University of Toronto started the first program, and they started to train their own people. And I was here trying to find forensic pathologists, and I was thinking, Why not train our own?

So I had to resign because if you're vice-chair of an examination board and then you train people, you're in a conflict of interest because you know the question, and it's an unfair advantage for your student. So I had to resign. And I applied to the College so that we could create, in Alberta, the second program in forensic pathology. They accredited it, and now it's a running program. So I founded it. I directed it until I left the office at the end of two thousand -- well, actually I stayed over a little bit because it's a university appointment, and early 2015 someone took over from me because I was no longer at the office.

THE COURT: Doctor, you're still really --

A Still too fast?

THE COURT: -- going quickly.

Q MR. BUCKLEY: And then did you have to sit the exam to become qualified as a forensic pathologist?

A That's the issue. If you made the question, the College decide -- I have to go back one step. The College had two choice for the people that were already working as forensic pathologist. They could have decided to grandfather all of them, or they could decide to grandfather that they were qualified and then make them sit the exam. This was their decision, and they decided not to grandfather everyone.

So to be board certified, as a forensic pathologist working in Canada from the older generation -- that means before 2009, so we're not that old, but that's the older generation -- you have to sit the exam. But when you were on the examination board, you're not allowed to take the exam.

So to go around they it, they created what they call a founder designation certification, so that's what I have. In many years -- I -- I don't recall when -- I could sit the exam, but no one of us would because you would have to let go of your founder designation, which is more unique and more valuable, in our eyes, because we're very proud to have founded that certification in Canada.

So, no, I have not sitted (sic) the exam because I know all the question and therefore all the answers.

Q Now, you have authored two books, and --
A I did.

Q -- the first one translates into English. Basically the title would be *Human Pathology*?
A That's correct.

Q And that was published in 2004?
A The official stamping, that's correct.

Q Okay. And can you tell us about that book and how that book's been used?
A So one of the struggle we have in Quebec when you are on the Francophone side, which is the larger side, there's not a lot of good books in French so we have to often use English book. And for my students and for when I was a student, it can be a struggle. My English was not that good when I was younger, and it's -- it's really hard that -- if you have to learn something not even in your own language.

So to go around it, over the years, I was writing notes for my students, and eventually people were saying, Can I have your notes? Can I have your notes? And other teacher, Can I have your notes? Other institution that were teaching. So eventually I collected them in a book so that it could be available to people that want the book.

When I was giving my own lecture, like, in the lung pathology to the medical students, I was using the chapter from -- from that book, but other people were using it as well. So it's a book -- there's a book in English that cover, like, in one book, an overall view of all the pathology from a pathologist point of view. That's the equivalent. It's not a translation. It's my own view on it -- on it, but it covers all the disease in the human in French from a pathology point of view.

Q And then you've been involved in writing four book chapters?
A That's correct.

Q Can you just briefly tell us about those? And if you're referring to your CV, can you let the jury know where you're referring.
A So I'm on page 3, the top of the page where there's four book chapters. There's two of them, that's Number 2 and Number 4, where I was asked to do the -- one chapter on something related to asphyxia. I told you before that I'm an expert in asphyxia. So usually I'm considered the world expert right now on asphyxia so I'm often asked to write chapters. I don't always have the time to write chapters, but I did two for these two people that were writing books.

The other one -- there's another topic for which I'm known as a researcher, though there's other people. We're kind of a group working on this. I'm -- I'm not the -- the most known; I'm just among a group of people. That's the blunt trauma to the head. So the first chapter, "Accident Falls", I was asked to do a chapter on how to distinguish a fall from blows, and what do you see in falls.

The other one is Number 3, so the American *Association of Forensic Sciences*. I did a book -- they published it in 2015 -- where they wanted to -- kind of having one book, an overall view of the forensic sciences, not just pathology, all the forensic sciences in the world.

So they made a list of country (sic), and actually I -- I collaborated on the list of country because the idea started when I was in a meeting with the main author, and we were, on piece of paper -- it was a meeting in foreign language so we couldn't often understand everything so we would chat on piece of paper not to disturb other people, and we started making a list of the country that could be there. And -- and he is the author for theAmerican Association of Forensic Sciences, and so he assigned Canada to me, and my job for that book was to do an overview of all the forensic sciences in Canada, how they were developed, who -- what kind of work we were doing, where people in that field are working, what kind of challenge they face, very overview.

Because it's a huge job to cover coast to coast. I mean, this is the type of chapter where you wish you were in Belgium because it's easier. Canada is a lot of differences, a lot of forensic sciences so I asked the help of one colleague, Dr. Jones, who's a toxicologist, so together we wrote the chapter.

Q Okay. And then there's a list of 81 papers; I'm just not going to go through those. But you've also been a journal reviewer. So my understanding is is you've been a journal reviewer for the *Journal of Forensic Science*, for *Forensic Science International*, for *Forensic Sciences, Medicine, and Pathology*, *Journal of Forensic and Legal Medicine*, *Journal De Medicine Legale*, *Addiction*, *Clinical Medicine: Trauma and Intensive Medicine*, *Indian Journal of Medical Sciences*, *Pediatrics*, *Journal of Medicine and Medical Sciences*.

Can you explain for the jury what basically a journal reviewer is?

A Yes. So when you publish a scientific paper, there's a process where you cannot just publish it. You have to have -- depending on the journal, it's going to be two or three people that gonna review the paper. That is called to be a "peer reviewer".

The first step we do as a peer reviewer is -- and it's all -- it's all anonymous. We don't know who we are reviewing. Some journals are making that mistake. But usually we receive a paper, we don't know who wrote it, and our comment will be sent to the other, and they won't know who we are. So we -- so that's -- it's a -- it's all done based on science.

So when we receive a paper, as a peer reviewer, the first step is we have to recommend to the journal if we -- if they should publish it or not. If they should publish it, we have different option. 'Cause the first option is to reject it. The other would be to accept it as it is. That means it's super good, nothing to say. Most of the time it's going to be accepted with modification, and you make the list of what you think the other should change. Maybe there's an error or something you don't agree in the methodology that you think could be done better. Maybe there's a statistical test that was overinterpreted. Maybe there's a reference that is not there. Maybe there's a reference that is miscited. So it depends, but you evaluate the equality of the paper to see if it should be published or not.

Q Okay. And then you have been qualified as an expert in various courts before; am I correct?

A Correct.

Q Do you have any idea how many times you've been qualified as an expert witness as a forensic pathologist?

A It's over 300 times, but I don't know the exact number. At some point, I stopped counting.

Q And you have been qualified in Alberta in both the Court of Queen's Bench and provincial court?
A That's correct.

Q And then basically the equivalent courts in Quebec?
A That's correct.

Q And then you've also testified in British Columbia provincial court?
A That's correct.

Q Now, I just want to circle back a little bit to what forensic pathology is, and you've spoken about this golden triangle. I'm just curious, now, do you have to have a -- obviously you have to have an understanding of things like blunt-trauma injury and stabbing and stuff like that. But when it's a different type of process, so a bacterial or some infectious process or some other disease process, do forensic pathologists have to have an understanding of those processes to be able to come up with cause of death?
A Yes. The reality is that the majority of the people that will die suddenly or unexpectedly, which is usually what comes to our attention, will end up having a natural disease that caused their death.

We are also involved in -- if there's an allegation of negligence by a doctor or malpractice by a doctor, we'll also have to evaluate these cases. Or if there's negligence or maltreatment, not necessarily physically but by not caring properly, by either parents or foster care or hospital or elderly houses or -- we will be involved in evaluating these things.

Q So I'll just take you back. Like, so, for example, malpractice, you're referring to malpractice of medical doctors?
A It could be malpractice of medical doctor. It could be an issue with how care was done by a nurse. Could be how care was done by a non-nurse but, like, a frontline employee. We call them "prepose" in French. I'm not sure how to call them in English, but they are non-nurse doing the care on frontline. That could be all these people.

That could be other people too. That could be a prison guard. Prison guard. It depends, depends on the context.

Q Okay. So -- but I'm just curious primarily with medical doctors. So have you had the

occasion, then, when you're basically being asked to evaluate what a medical doctor has done?

A Yes. When -- when there's allegation that a death might be related to a doctor malpractice, the College will ask for our autopsy report, and our autopsy report must address the question if the allegation is some type of malpractice. It depends what the question of malpractice is, but if it -- if it's directly related to death, we have to evaluate because that's around the circumstances of death then.

Q Okay. So basically you have been called on as -- in your job as a forensic pathologist to basically assess whether medical doctors have acted appropriately?

A Yes. We -- we're not asked this question that way, but, yes, we have to evaluate the -- if there was malpractice or negligence by a doctor that caused death.

Q And so am I correct that you would have to know about different disease processes and how diseases progress to be able to come up with a cause of death?

A Correct. Pathology means the knowledge of disease so this is what we do. We -- we understand what the disease do from the symptoms to -- up to the cellular level. So we -- we understand all the levels of a disease from the cells to the organs to the whole body to the symptoms.

Q And why is that necessary to come up with a cause of death?

A Because you cannot look at the human and look at just one cell or just one organ or ignore the symptoms. You will not find the cause of death; it has to be all put together.

I gave, for example, the -- I gave earlier the example of a sudden unexplained death in epilepsy. If you choose to ignore the medical file, you won't find the cause of death. You need to put everything back together. But if he's known for epilepsy and he has the bleeding in his head from a disease or trauma, then you will conclude something else. But taken all together, you -- you need the medical file to come to the cause of death.

Q And then do some of your publications that are listed in your CV starting at page 3 basically involve, you know, you determining, you know, some very difficult causes of death and then being published through a peer review process on that?

A Correct. So though the majority of my research is around asphyxia, there are very unique medical cases that I felt needed to be published.

Q Can you just point out some of them and kind of explain to us, you know, why that required a -- you know, a knowledge of the disease process or injury process?

A Okay. I will go from memory. So when you publish 81 paper, you don't have all the

details of all the cases really fresh in your mind so I -- I might make some little mistake in the cases, so I will do my best.

For example, Publication Number 2, *Fatal Acute Hepatitis in Infectious Mononucleosis in Forensic Setting*. The reason I felt we needed to publish that case -- and, sorry, I need another -- so mononucleosis is an infection by a virus, and usually people have symptoms, and usually people know you have the disease before you die. But that was a young woman. I don't remember her age, but I think she was a student at university or maybe it was -- was just before in Quebec called CEGEP, but I think it was university. So that gives you the idea of the age.

And she was found dead, from what I remember, in her dorm room. There was nothing special, but because it was unexplained and sudden, we had to do the autopsy, and I just discovered that she had mononucleosis with a fatal acute hepatitis, which means it -- it created a problem in her live that make her died (sic) of it very suddenly.

And that's -- that is known that it can happen, but it's not the usual presentation of the disease. So we published it so that people can be more aware that you can have people that never went to a doctor, never had symptoms that they complain about before, so she was not feeling her top shape for a few days, but who -- whom of us are feeling the top shape all the time? So she didn't think she was that thick and -- sick, and she ended up dead of a mononucleosis. There's others --

Q So I'll just stop you. So did you have to understand both -- you know, how hepatitis progresses and how mononucleosis progresses to be able to reach the cause of death?

A Yes. And that is discussed in the paper to a certain extent, though I don't have it fresh in my memory at this time. But, yes, to -- to come to that conclusion, as I said before, you have to go from the cell where I can see the virus to the organ where I can see the liver -- it's not the right colour; it's not the right -- it's too soft, to the system, to the whole body, where there's (sic) was nothing else, to the symptoms of how she presented before her death. And putting that with -- and I have to go back with the scene, the medical history, which in this case was nothing; the scene was nothing, and the body. At the end of it all, this is the cause of death.

Q Okay.

A And it was proven by certain tests.

Q And you were to refer us to another one?

A There's Number 4. Number 4 is another unique case. There's disease in your heart that can make you die suddenly, but this woman died in very usual circumstances.

She -- she had -- once again, I'm going from memory, so I might have some details not right.

From what I remember, there was a boyfriend that was very violent, and he had tell -- told different people he was going to kill her. And she go to a bar, and people see her be -- going to the bathroom, and when she comes, something stressed her out. She saw something or someone. People thought that maybe she saw him, in retrospect, but we were not sure.

And then she's found in the snow dead, pants down. The underwear's down, and it looks like it's been a rape/homicide. So I do this autopsy. Nothing when I look with my eyes. The scene is very suspicious. She had certain symptoms but very vague, but I had to consider them, and I don't recall all of them right now.

But then I look at the -- the heart under the microscope, and when we put it all back together, she died of a heart issue. And in retrospect, what happened is that when you go -- she -- we -- we found the -- as I was doing this work and I came to that conclusion, the police were doing their work, and they found other thing.

So if I put it all back together now, what really happened is that she took a -- a cab, fighted with the driver on the fees of the cab, decided to go out of the cab, walk in the snow. Decided she needed to pee because she had drank a lot of numbers of beers in the bar, pulled her pants down, pull her pantie downs (sic). She's a little secluded because she doesn't want to do that just by the road, and she pee there.

A lot of beer, alcohol, the cold, the -- the fact that she was pushing with her belly. That's called doing a valsalva, so it's put pressure. All of this together, the disease she had in her heart, that was too much. It was like having a bomb ticking, and that's where she died.

There was other element that made it even more weird, but this is not about that case. I will stop there.

Q No. I'm just asking you questions to kind of try and get a feel for, you know, how you have to have knowledge of different disease processes to be able to come to cause of death.

A So in that case, I needed to put it all together, including that she had certain symptoms that no one has noticed before that could go with a heart problem, and I don't remember -- I don't remember the details today.

Q Okay. Are there any others that you --

A I think she had symptoms in her heart. I would have had to evaluated (sic) if she had problem in her heart. But it's 2005; that means I wrote it probably in 2004 so I don't remember all the details.

Q Okay. Are there any others that jump out at you?
A There's another one that is even more -- let me find it.

Q Number 30 and 40?
A Yes. 30 is a very good example of how we need the information from the medical file or the people that were there. So 30 is a death from an anaphylactic shock by ecstasy.

This is a young girl. Don't remember the age, top of my head maybe 13 to 15. Something like that, but I don't remember the exact age. Maybe she's a little bit older. She go to a party. She take some pills, which are sold to her as being ecstasy, and she died a few hours later. Autopsy, nothing, except we have toxicology that show the substance that is usually in ecstasy, MDMA, but in a concentration that would not kill.

The scene, she just dropped dead in front of her friend. That's not very useful. But in that case, what was very useful is -- she doesn't have a medical file that was relevant. She was a healthy person. But there's people that were with her when she died that described that before she died she started to have the lips that got swollen, and she start to say that her -- her tongue was feeling swollen and other thing that I don't recall now what was swollen. And now that I put that together, more than in two minutes like I'm doing here, we ended up with a conclusion that, in this case, the cause of death was more likely an anaphylactic shock on something that was on that pill. She was allergic to something.

So when you do a pill, there's not just the MDMA. There's other substances, and I can't be sure which one in the pill she was allergic to. Maybe I knew at the time. I don't remember. She was allergic to something.

But if I had only the body and the scene, I couldn't do the cause of the death. It would have been undetermined, which means, I don't know, but because I had the other piece, the people that are telling me the symptoms -- they are not doctors obviously, but what they described -- so if they use -- when we use information from non-doctors, what we do is we try to have description that are not using diagnosis.

For example, if they tell me, Well, it was a -- a heart attack, I would say, What did you -- what did you see? What did you observe? Because I don't want them to use diagnosis. They -- they might use it the wrong way. But if they describe to me that the lips are swollen or that someone was holding their throat and couldn't breathe, or

if they say that he was holding his head and was saying that it was hurting, this is good because that give us information on the symptoms. And if we don't have a doctor observing the symptoms, we have to take the next best thing, which is the description from the people around, as long as they are credible. So we have to evaluate if we believe them or not.

MR. BUCKLEY: My Lord, I'm cognizant of the time. I'm just wondering if it would be appropriate to take the lunch break?

THE COURT: How much longer will you be in your qualifications?

MR. BUCKLEY: I actually might --

THE COURT: -- because then the Crown will --

MR. BUCKLEY: I actually might be done, and I just thought I'd review that over the lunch break so -- which is why I just kept pressing ahead.

THE COURT: All right. So we will break, then, for our lunch break, and we'll come back -- you can complete your examination on qualifications. Crown will then cross-examine on qualifications after that. All right.

2:00, jury.

PROCEEDINGS ADJOURNED UNTIL 2:00 PM

Proceedings taken in the Court of Queen's Bench of Alberta, Courthouse, Lethbridge, Alberta

April 19, 2016	Afternoon Session
The Honourable Mr. Justice Jerke	Court of Queen's Bench of Alberta
L.M. Weich	For the Crown
C.O. Giles	For the Crown
S.P. Buckley	For the Accused D. Stephan
S.P. Buckley	For the Accused C. Stephan
J. Stringer	Court Clerk
S. Anderson, CSR(A)	Official Court Reporter

(JURY ENTERS)

THE COURT: Please be seated. Counsel please confirm that all jurors are present?

MS. WEICH: Yes, Sir.

MR. BUCKLEY: Yes, My Lord.

(WITNESS RE-TAKES THE STAND)

THE COURT: Thank you.

Doctor, you acknowledge that you're still under oath?

A I do.

THE COURT: Thank you.

Counsel?

MR. BUCKLEY: And, Your Honour, I just have a few questions for this witness.

ANNY SAUVAGEAU, Previously Sworn, Examined by Mr. Buckley (Qualification)

Q So, Dr. Sauvageau, my understanding from your resume is, is right now you're acting as a consultant in forensic pathology?
A That is correct.

Q And obviously you're here today testifying in this proceeding. Other than this proceeding, when was the last time you testified as an expert forensic pathologist?
A Last week on Thursday and Friday, I testified, asked by the Crown in a fatality inquiries -- fatality inquiry. Singular. Sorry.

Q Okay. And do you recall what court that was in?
A It was in Edmonton. So it was in a provincial court. I -- I'm not a lawyer. I couldn't be more precise, but there's a *Fatality Inquiries Act* in -- in Alberta. Judge preside over fatality inquiry under that law so that's what it was.

Q So you said it was the Crown that had called you as a witness in that matter?
A That is correct.

Q Okay. Has the Crown called you as a witness at other times since you left the job as chief medical examiner?
A Yes, they did. So for -- in Alberta, they asked me again, the Crown, to testified (sic) or they asked me to testify, but in the end, it didn't happen because they changed or there was a deal or things like that. But I was asked multiple times -- sometimes I testified; sometimes at the last minute I didn't have to testified (sic) -- for my cases in Alberta.

Q Okay. And then are you being consulted from other provinces?
A I'm consulted by other people than the Crown in Alberta and by different -- a variety of people outside of Alberta. For example, I've been asked two times by the RCMP in British Columbia. I'm talking since I have left the office. I've -- I've been asked by the Crown in -- in British Columbia. I have been asked by defence in United States, and I have been asked by different lawyers in civil matters, but that -- that have a link with forensic pathology.

Q And you've told us you've -- you've testified over 300 times as a forensic pathologist?
A That is correct. Oh, and I forgot. Since I left the office, I've -- I was also consulted in Quebec and Ontario, but I have not testified and -- I have testified in Quebec since I have left, and I will testify again this year. In Ontario I have not testified yet.

Q I have no further questions. Thank you.

THE COURT: Thank you, counsel.

MR. BUCKLEY: On the qualifications voir dire.

THE COURT: Of course, yes.

Crown, do you have any cross-examination on qualifications.

MS. WEICH: I do, Sir.

THE COURT: Thank you.

Ms. Weich Cross-examines the Witness (Qualification)

Q So, Dr. Sauvageau -- and I'm very sorry. I don't mean to pronounce your name -- I'm just going to say it "Sauvageau" because that's the way I can pronounce it; okay?
A That's good enough.

Q So for as long you've been a doctor, you've practiced as a pathologist; is that correct?
A I've always practiced as -- as a forensic pathologist. Having said that, we have a training that crisscross the training of other doctor initially, and so it -- for example, if we -- if we went back, the generation before me, when you are a family doctor, they didn't do a single month more than my training. It's just that they were not doing a specialty, and they went to practice immediately as a family doctor.

So the training is -- now they do -- I think it's two years to become a family doctor in between -- there was a period where they were doing one year, and before they were doing no more than I do. I don't recall, when I was training, where it was. But the training is not different, but I always worked as a forensic pathologist. This is correct. But I trained during -- the same way initially.

Q So as far as you being a practicing physician, you've never dealt personally with patients who are alive; correct?
A This is not a -- a true statement, though. Because as a forensic pathologist, for example, I often -- it's not as common as autopsy, but I had to review injuries on living people, for example, to say if I thought it was a bite mark, to say if it was a -- in people that survive from strangulation, if it was consistent -- for example, if a woman is allegedly strangulated by her husband and she survives, there are no doctors to evaluate this, and as a forensic pathologist, I would look into living people at times because it also fell under our specialty. So we do, at times, living for these reasons.

Q So that concerns injuries; is that correct?

A It does concern injuries. That's correct.

Q Anything else?
A We don't do clinic with living people coming to us if that's what you mean.

Q And "clinic" means what to you?
A When I meant -- in that sentence, I don't have an office with a door but -- with my name on it, and people come and take an appointment, and they come and they talk to me as a living person. I don't do that.

Q So you've never diagnosed a person who is alive with an infection in that sort of circumstance that you just described; is that fair to say?
A This is such a misleading statement. Let me explain. If you mean that I never diagnose someone that is alive, then that means when they are dead and they are on my table, what am I doing? Of course what I -- I'm diagnosing as a cause of death happened when they were alive because otherwise what am I doing? Everyone knows they're dead. They don't -- well, there was a doctor that called them dead, but they don't ask me if they're dead. That's not what they ask me. They ask me, when they were alive, what did they died (sic) of?

So I do that all the time. I diagnose diseases of people that were alive at the time that they were having the disease and that killed them. Because otherwise -- otherwise no one need me to tell them, yes, he's dead. Yes, he's dead.

Q So the examples that you provided about attending court recently when you were asked by the Crown in Alberta specifically, do you recall answering my friend's question about the recent times that you've been in court?
A I do.

Q And you talked about specific circumstances where the Crown in Alberta got you to give evidence in court; is that correct?
A I do.

Q Now, when that happened, those recent examples, that's because it was a followup to the work that you had completed while you were employed as a medical examiner here in Alberta; is that correct?
A In Alberta, that is correct. The Crown asked me for the cases I did when I was still in the office.

Q So you were chief medical examiner beginning on July 1st of 2011; right?
A Yes.

Q And ending on June 30th of 2014; right?
A No. 31 of December 2014.

Q Oh, sorry. And as you previously explained, you were actually responsible for hiring Dr. Adeagbo; correct?
A Correct.

Q And he showed up in your office in 2012; correct?
A I don't remember the date. That seems about right.

MS. WEICH: Sorry. Could this witness please be provided with Exhibit 8. It's the resume of Dr. Adeagbo.

THE COURT: What exhibit is that?

MS. WEICH: Exhibit 8, Sir.

THE COURT: Exhibit 8.

Q MS. WEICH: Okay. And if you just review the top of the first page where it states his -- his career experience basically. Do you see how it says there "Medical Examiner, Alberta 2012".
A Correct.

Q Okay. So you have -- you have no worry that he started in 2013 or 2014 or 2011 or anything like that?
A Well, as I said, I don't remember the date. I became chief July 1st, 2011, and he was not there yet. I recruited him. It was not immediate. It takes a long time just to get your licence to work in Alberta when you're from a different country. So January 2012 seems right to me, but I don't have a recollection of the date. And he was -- he was there for more than a year, I would say, when I left, which is 31 of December 2014, but I don't remember the dates. That's the best I can do.

Q So even before Dr. Adeagbo was interested in applying for the job with your office, you tried to give him some reasons about why he should come to Alberta; is that fair enough?
A Well, not specific to him. I was going to United States and trying to convince everyone to apply so that we could have a good competition and that we could try to have the best; however, there's not that many people that were applying so -- this is not a comment on Dr. Adeagbo. It's just a comment on the process. So it's not like I

specifically tried to have him; I tried to have people, and he's one of the people I was trying to have.

Q So before he began working for you, he was working as a pathologist in the United States; correct?

A That is correct. That's my understanding, yes.

Q So when he moved to Alberta and began working for you, the Alberta College of Physicians and Surgeons imposed a period of probation on him; is that fair to say?

A I'm not sure if the word -- it's the word "probation", but there's a period when people have trained outside of Canada, but our -- so it's a little complex. So there's country where you can't even work in Canada without retraining. In United States you can work in Canada, but you have to be -- if you don't have exam from Canada, you have to be kind of -- I think the word to use is more "supervise" or -- but it's not the -- it's not supervised like over the shoulder.

They have rules that they send you as the person that's going to evaluate the work. Not sure if they call it probation or supervision or -- I can't recall the word. And they send you a documentation of what you will need to do. And I don't remember the rules, but I remember what I ended up doing is that I reviewed certain amount of cases. I can't tell you the number. I don't recall.

And I was also asking question -- the review of the report was more for the intellectual part of the work, I would say, or the -- the medical part of the work, but I would also ask question about behaviour to other staff to make sure that it was a -- that -- and I -- that there was no behaviour issue. Because you have to evaluate both, and I was satisfied and I signed the paper -- I don't recall if it was three months or six month. I think it was three, but I can't recalled (sic). It was that period. And then I -- I signed the paper, and he was okay to work in Canada.

Q So by signing it off, do you mean to say that he successfully completed the requirements that the College of Alberta (sic) Physicians and Surgeons wanted him to meet?

A Yes. But I have to separate two thing here. In no way will I say ever that Dr. Adeagbo is not competent so you can take this out. I'm not saying Dr. Adeagbo is incompetent. The College gave me certain guidelines of what I need to evaluate, but at the same time, I was not, like, giving him a formal exam or -- it's different.

So I respected what -- what we did, but I was not, like, judging him on the rule of 10. Is he the best forensic pathologist ever? Is he an average one? Or is he -- it was just, Is he good enough for the standard? That's what I did. That was my job. There's a

lot of room -- and it's not comment on him. I don't -- I don't want to be commenting on him. That would not be appropriate. But he met the criteria that I signed the paper.

Q So in the two and somewhat or almost three years that he worked for you, you never took issue with any of the conclusions that he came to concerning cause and manner of death as far as that went to him being able to do his job in your office?

A This is a little bit an overstatement so I have to rephrase it. I'm not against the statement, but -- okay. I have to rephrase it so that I can say it's right. Initially, because he was under the College of Physician of Alberta, I had to review his work. I reviewed his work. That was for a limited amount of month (sic).

Then he was working as a medical examiner, and in that capacity, I was never made aware that there were issues with his conclusions. However, I explained to you that medical examiner have to work in an independent manner, so I was not reviewing his case to see if there were issue with his work. I -- I made him work independently. But no one made me aware that there was a problem with his conclusions.

Q In 2014, you did not leave your position as chief medical examiner of Alberta voluntarily; correct?

A That is correct.

Q To put it simply, you were made to leave?

A My contract was not renewed, will be the right statement.

Q And the time that that happened you were surprised; right?

A Yes, I was surprised. But there's a -- I need to maybe explain in two sentences what that mean. So we had contracts that were all to be renewed, but for reason way too long to explain and unrelated to the discussion of today, the government wanted to change the templates on which we were signing the contract. So they were telling us, and we had it in writing, Don't worry. You are all being renewed, but we cannot sign the contract now because we're working on templates. And in the meantime, they were doing letters of extension for short period of time, but I had the written promise for another five year. So I was under the understanding that my contract was renewed for another five year.

And then something happened that for now I don't think I need to explain for which I went to the public interest commissioner and the auditor general, and so I was under the *Whistleblower Act*. And I thought I would still be renewed but at least that no nonrenewal would happen until the investigation was completed from the public interest commissioner considering that the *Whistleblower Act* is supposed to protect

you at least for the duration of the investigation, and then it -- I'm not an expert on that law. But at least for the duration and after, depending on the conclusion, I thought I was under a *Whistleblower Act* protection, and so, yes, I was surprised when my contract was not renewed as I was under the *Whistleblower Act*.

Q And so at the time your contract was not renewed, you were the only medical examiner with a letter of extension whose contract was not renewed; correct?
A Correct.

Q In December of 2015, you filed a lawsuit against Her Majesty the Queen in Right of Alberta as represented by the Department of Justice and Solicitor General; correct?
A Misleading statement in the sense that actually it was filed in February of 2015, so in December, it's just a new version of it because it -- it's a -- I think this one is amended, amended, amended, something like that. So it was filed initially in February 2015, but there's a new version of it in December of 2015.

Q Okay.
A I say February 2015 from memory; so I think it's correct, but I don't have it front of me.

Q The Office of the Chief Medical Examiner, the office that you used to work for, falls under the umbrella of the Department of Justice and Solicitor General; correct?
A That is correct.

MS. WEICH: So, Sir, if I may approach?

THE COURT: Yes.

MR. BUCKLEY: Yeah. No, we had, in the absence of the jury, agreed we didn't have to ask for permission --

THE COURT: Yeah.

MR. BUCKLEY: -- to approach witnesses, so I'm fine.

THE COURT: Right. You can do that without requesting.

A Thank you.

Q MS. WEICH: You can review the whole document.

THE COURT: It's one -- jury, it's just one of those niceties of court that we observe, so we're not worrying about that permission to approach the witness in this case. All right.

MR. BUCKLEY: What did you hand up?

MS. WEICH: Just her lawsuit because she said she wanted to read it before she answered questions about it.

MR. BUCKLEY: Which version?

MS. WEICH: This version.

MR. BUCKLEY: Oh, December. Okay.

Q MS. WEICH: So in your lawsuit, which is currently ongoing; correct?
A Correct.

Q You are seeking special damages of $2.1 million for loss of income and benefits arising from wrongful dismiss --
A I'm sorry. Could you just tell me which -- I don't want to comment today here on thing that will have a civil court. So if you can refer me to a specific letter you're reading --

Q Okay.
A -- and I will confirm I can read the same. I don't want to be interpreting, and I'm not a lawyer.

Q If you look at the very last page, that's page 29, and I'm going to start from point 'A', which is the very top of the page; okay?
A Correct.

Q (as read)

> Special damages for loss of income and benefits in the amount of . . . [and I'm summarizing that dollar value as 2.1 million]

Do you see that there?

A I do.

Q (as read)

> Arising from wrongful dismissal in the alternative, breach of the good-faith implied term in the alternative, breach of the arm's-length implied term.

Do you see that there?

A It's written there.

Q So basically we have wrongful dismissal and breach of the government's duties to you, in that they told you they were going to do one thing, and then they did another?

A I have to add, though, initially the lawsuit has named very specific people, and during the process that it goes through during the civil lawsuit, we went into chamber to a judge. That means it's not a big room like this. They're just -- their lawyer, my lawyer, and the judge. And he recommended, for reason that I don't need to explain to you I think, that we should remove the specific names because we were not suing them in their personal name but as their job in the government that -- which we should replace that by Government of Alberta.

But I think it's very important to understand the distinction. I am suing very specific people, and the -- the people that I think wronged me are no longer at Justice and Solicitor General. Some are still in government but in areas that are totally unrelated like Service Alberta or jobs and skills something, and one is not even in the government anymore because he has not been re-elected. So they are very specific people.

I -- so we have to make the distinction. I have nothing on -- against Justice and Solicitor General as a whole. Actually, when my issue started, I was having a lot of support from people in Justice and Solicitor General that were telling me they were feeling for me and actually were having some problem of their own with some of these specific people. So we have to make this distinction.

Q So if you go further down the page, you're also asking for special damages for loss of income and benefits of $2.1 million for --

A Could you just --

Q Oh, if you look --

A -- say the letter.

Q -- at 'B'. Look at 'B'.
A 'B'? Okay.

Q Okay. (as read)

> Special damages for loss of income and benefits in the amount of 2.1 million for negligent misrepresentation to you.

Do you see that there?

A I see that there.

Q If you go to 'C' --
A You -- you forgot to write -- to read, though, "further or in the alternative", which has some meaning in law. And I -- so you -- you cannot just, like, add these numbers, but I'm -- I should not be commenting today on how these number will be interpreted in the lawsuit. But if you read, please read it all, not just pick and choose the part of the letter you're citing. But I -- I should not be commenting today on the civil lawsuit. It's just not appropriate. I can only confirm what's written there.

Q So in point 'C': (as read)

> Further or in the alternative, special damages for loss of income and benefits in the amount of 2.1 million for conspiracy.

A Correct. And you can't see the -- the page, for the members of the jury, and on every (sic) these letter that -- that -- so 'A', 'B', and 'C' that she read, there's little marks. They look like -- because I know my hands are not on a transcript. They look like smaller than and bigger than, and it means something has been taken out, and it's the specific names that were taken out at the advice of the judge when we were in chambers, but we're still questioning very specific people. In -- it -- it's -- my feeling of having been wronged is to very specific people.

Q So if you go down to 'D': (as read)

> General damages in the amount of $200,000 for anguish and mental distress arising from the manner of the plaintiff's dismissal or, alternatively, for breach of the

good-faith implied term and the arm's-length implied term.

Correct. And, once again, there was the little sign that were -- a name was taken out or names that were taken out.

Q And under 'E': (as read)

> General damages in the amount of $200,000 for intentional infliction of mental suffering.

A Correct. With the same little signs.

Q So I'm going to skip 'G' unless you want me to read it?
A You're the one that wants to read it.

Q So then I'm going to go to 'H': (as read)

> Punitive, exemplary, or aggravated damages in the amount of $250,000.

A Correct. With, again, the little signs.

Q Now, when you were approached by the Crown, by my specific office here in Lethbridge, when we wanted to talk to you about the opinion that we learned from defence counsel you were going to give in this case, you advised us that you would be happy to speak to us or email with us but that the cost of your time and effort is $500 an hour; is that correct?
A That is correct, and that's what the Crown is paying me when I do work for them. That's what the RCMP is paying me when I do work for them. That's what every firm of (sic) lawyer is paying for my time.

The only exception in when there's a fee set by law, so then I respect the fees. For example, last week they told me that in a fatality inquiries, there's a -- a fee that would have been set.

So usually the Crown was paying me $500 per hour, but for last week, it was a fee that apparently was set at the lower fee. But that's -- I'm always paid that fee, which is -- might seem high for certain people and not for other. Lawyers are often -- like, an average lawyer is something above $300 per hour in '95 -- in 2005, I think. So it's not -- it's not an inappropriate amount. In the field, no one is surprised by that fee, and no one has ever commented that that was too much. It's just a cost.

And I'm -- to go back to the specific question of when I -- you contacted me, my understanding -- and it's very important, as an expert witness, we do not belong to anyone. We are neutral. We are impartial.

In reality, of course, someone is asking us to do an opinion, and that person is paying our time. So if the other side wants to talk to us and discuss with us, because we don't belong to anyone, we will discuss with that person. But our time will be paid by the person asking it. For example, last week I was asked by the Crown to do the work in the fatality inquiries, and they made it very clear that they were paying my time when I was working for them but that they would not be doing -- paying my time if the other lawyer, who represented the family, wanted to meet with me.

So I think, on one level, no one is expecting an expert to work for free. We have to -- we have to buy our bread and our milk and pay our houses like everyone else, and on the other side, the person that is requesting our service will have to pay our fee.

So when you ask if I would be ready to meet with you, I don't belong to the defence, Mr. Chukney, so -- Mr. Buckney (sic). Sorry. I took the first letter and combined it. I don't belong to him, so when my -- Mr. Gile (sic) ask me if I would meet with him, the answer was yes, but he would need to pay my fee when I was working for him.

Q And by inference, according to what you've already said, you've been hired to give evidence here today, to give your opinion in this case, by the defence; correct?

A Correct. But as I said, Dr. Adeagbo was asked by the Crown, and I expect him -- and I have no reason to think he was not neutral and impartial, and I'm called by the defence, but I will be neutral and impartial.

So expert witness do not belong to anyone, and we have to ask -- to answer all the question and give our opinion regardless of who's asking these question or asking this opinion.

Q Testifying in court is currently your only actual source of income? Not anticipated. I'm not saying you're not going to get to do other jobs in the future but right now?

A Actually, no. Testifying is the least amount of my working time. Well, the most cases I'm consulted on I agree with the report I see, so it -- then I'm not hired to go to court. I help the people that have asked me to understand the report so that they are better -- so they -- they understand better what is going on.

In Alberta, in other provinces, and in United States, I'm often consulted, but most of the time -- so it -- it means that you receive an autopsy report from one of your

colleague with other material, pictures, slides, medical file, scene information, police report. It depends on the case. You review all of it, and then you see if you come to all the same conclusion as the other pathologist or if there's differences.

In the large majority of cases, there's no differences. So you -- you have been consulted, but you just explaining that there's no issue. You agree with everything, and -- and that's the end of the story.

Sometimes you have minor disagreement, sometimes you have bigger disagreement, and you explain them. And then the person decide if they want a report or not and if they -- if they want you to testify or not. So the majority of my consultation do not end up in court.

Q So when you do your reviews, is it possible that when you come to your conclusion, you might have a different conclusion than the first person, but the first person isn't necessarily totally and completely wrong?

A I have to rephrase that because two -- if the question is black or white -- I'm just picking black or white instead of medical diagnosis -- two people cannot be right at the same time. It's either one or the other. Maybe it's grey in certain case, but usually it's one or the other.

However, what I think you mean is that the other doctor is incompetent. For example, I will take an example for the -- from when you go see your own doctor because it's just easier to understand. If you're diagnosed with a cancer that is very, very severe and can kill you rapidly, there's a chance that your doctor might even suggest if you would like a second opinion. That means go to see another doctor to see what he thinks. You might decide it by yourself. You might even suggest it. And you see this other doctor who might agree or who might not agree with the first diagnosis. That doesn't mean one of them should be fired from the College of Physician; they just came to different conclusion.

Sometimes it -- it can mean one is incompetent, but most of the time, it means that they came to different conclusion. So that you come to a different conclusion doesn't necessarily mean one is competent and one is not incompetent (sic). In the proceeding of court, it's not unusual that expert witness expose different opinions, and it's your job as the jury -- and I won't instruct you; it's not my role; it's the role of the judge. You will be instructed how to deal with that.

It's -- it happens that different opinions are presented, and that's good for justice so that you're not hearing only one opinion if there's another one opinion that exists out there. So it's not unusual.

MS. WEICH: I have no further questions, Sir.

THE COURT: Thank you.

Defence? Anything in reply?

Mr. Buckley Re-examines the Witness (Qualification)

MR. BUCKLEY: Yes. Just in fairness to the witness, I want to ask a couple of questions about the lawsuit, which I hadn't raised.

Q MR. BUCKLEY: So, Dr. Sauvageau, I'm just curious -- and I appreciate you don't want in any proceedings, including this, to basically talk about your civil lawsuit?

A Well, first it has no link whatsoever with the current case. That's the first thing. And second, it's not the appropriate place for me to discuss the detail of the lawsuit that will eventually be heard in court but not in this court.

Q Right. So, you know, I don't want you to go into much detail, but I did want to ask, why were you under the *Whistleblower Act*? And if you don't want to answer that, just please --

A Well, I'm under oath. If you ask the question and no one's object (sic), I'm going to answer. So the -- I'm going to answer.

MS. WEICH: Well, Sir, I don't believe that I have a legal basis for an objection, but if she would like to take the time to -- I mean, other than it's probably not relevant, but I don't want to put her in an uncomfortable position like that, so --

A Which you already did, though.

Q MS. WEICH: Because it does go to a relevant --

MS. WEICH: Sorry. I won't argue with the witness, Sir. But how it is that she's under the *Whistleblower Act*, I don't know that that's relevant.

THE COURT: So really up to you, defence. I mean, she's your witness, and the Crown's . . .

MR. BUCKLEY: Crown's raised it so I think --

THE COURT: Take -- taking the -- well --

MR. BUCKLEY: I was just giving the witness the opportunity to signal that if it was really going to create a problem . . .

A I can -- I can say it. In brief -- and I will phrase it as I'm -- my allegation because it has not been heard in court yet. So my -- so I went to the -- I will phrase it differently because this way I don't have to link it with the lawsuit.

I went to public interest commissioner and the auditor general and the police for a list of allegation on very specific people. I alleged that there was political -- well, I -- I don't have to use the word "allege" because that was my complaint so I think I don't have to use the word "allege" in this context. So I -- to the auditor general, the public interest commissioner, and the RCMP. The allegation that -- the complaint was political interference with the work of medical examiner. Think -- things like Premier writing to us asking that we change -- that we review a cause of death; example like very bureaucrats, deputy ministers, calling the office at night so that we change our usual policies for friends of the government; things like forcing me to re-open a body-transportation contract because I was said (sic) my job was to make the minister look good, that I thought too much of the taxpayer, and that -- sorry. I will become emotive.

And I was forced to re-open it, I was told, because in rural areas, funeral homes were putting money in the electoral funding and that they were very important for the upcoming election. And I said -- I was the chief medical examiner and the expenditure officer. I had to sign on this, and I refused.

I was threatened that I would lose my job. Then I said, My soul is not for sale. I'm sorry. I told them my soul was not for sale, and I went to do the complaint, and I lost my job. But I did what, in my conscience, I couldn't do differently. If I had to redo it, I would redo it. Can I have five minutes?

Q Yes.

MR. BUCKLEY: My Lord, is that okay? I've responded without addressing the Court. The witness just asked if she could have some time, and it's not my place to . . .

THE COURT: Let's take five minutes.

(JURY RETIRES)

(WITNESS STANDS DOWN)

THE COURT: Dr. Adeagbo, I'll have you step out as well.

How are you doing on your re-examination? Are you --

MR. BUCKLEY: I really just had one more question as to whether or not the lawsuit would affect her testimony today.

Discission (Other)

THE COURT: All right. Well, you're welcome to that, then. This might be a good time for me to just tell you what my thoughts are concerning the earlier discussion related to limits or scope of the opinion. So I went back, counsel, and I looked at the -- my notes at least with respect to some of the other witnesses, in particular Dr. Gamble, who was qualified by me really to give opinion evidence with respect -- I didn't bring that along but opinion evidence with respect to diagnosis and prognosis, and I took a look back at some of the areas that he opined in. That was helpful, and here's what I think is the fair way going forward.

Once the re-examination concerning the qualifications is completed, I would anticipate that the examination and cross-examination concerning Dr. Sauvageau's -- the main part of her evidence will proceed. My ruling concerning the areas in which she's entitled to give expert evidence has been stated earlier, and I would expect that defence will now proceed to adduce viva voce testimony and a report or potentially a report from Dr. Sauvageau.

I would expect that if the Crown feels she is providing opinion evidence, viva voce opinion evidence, outside her areas of qualification, that the Crown may cross-examine or object or possibly both, and if there's an objection made concerning --

Doctor . . .

A Should I wait outside?

THE COURT: Please.

And, of course, if there's an objection made during the viva voce testimony, a ruling will have to be made concerning that.

If the defence wishes to put in her report, of course, you're entitled to do so, counsel. If the Crown is of the opinion, at the end of Dr. Sauvageau's testimony, that portions of the report fall outside the areas in which Dr. Sauvageau is entitled to provide an opinion, the matter can then be addressed. If I agree, after hearing both counsel obviously, but if I agree, I will instruct the jury by way of a mid-trial instruction that they place -- that they can place no weight on any portions of the report that I find to be outside the area of expertise. The reason for that is because opinion evidence is only allowed to be provided by an expert within the areas that she is -- she or he is qualified; otherwise it's inadmissible.

And so that's where I see it. You can proceed accordingly, defence. I'm not sure how that plays out for you, and I -- I really haven't had -- properly addressed, in terms of what portions -- I mean, the Crown raised some concerns, and I haven't heard from you, and I've only had a limited amount of time to look at it myself, but I think if we leave it on that basis, that's the best we can do going forward. That -- those questions may become informed by the evidence as it unfolds.

Submission by Mr. Giles (Other)

MR. GILES: And, Sir, much as when my friend was arguing in relation to the Crown making redactions to the reports which its witnesses had prepared far in advance of the trial, I would be concerned, as well, that if an unredacted report is given to the jury, that the bell has been rung, and it is often difficult to unsee what one has seen, to unhear the ringing of the bell.

And so my question now becomes whether or not Mr. Buckley is intending to, (a), provide the report as it has been redacted and provided this morning; (b), provide the report subject to the redacted suggestions which are made by my colleague this morning; or, (3) (sic), whether he now intends to, in fact, feeling prompted by the Court's -- and immediately proceeding the comments, to provide a completely unredacted report thinking that that would be a good thing, which we would suggested would be a very bad thing.

Submission by Mr. Buckley (Other)

MR. BUCKLEY: I can assist my friend, if that helps. My -- what I -- you know, just based on what you said, what I would like to do is proceed with the redacted report, as I provided to the Court and my friend. And then also direct the witness before we begin, you know, You're allowed to do cause of death, manner of death, and stuff like that within your golden triangle, but, you know, try to refrain from saying, Okay, anything out of that that would go to prognosis or diagnosis.

THE COURT: You're welcome to do that. Off the top of my head, I can tell you that the portion on page 2, the sentence under 1.1 that talks about a diagnosis of the potential symptom seems to me to be a diagnosis of which this witness is not entitled to make.

MR. BUCKLEY: So which --

THE COURT: And we'll hear --

MR. BUCKLEY: Where are you, My Lord?

THE COURT: Page 2.

MR. BUCKLEY: Yeah.

THE COURT: 1.1: (as read)

> Furthermore, his respiration as can be heard on the first 911 call of March 13 is characteristic of airway obstruction which could be suggestive of laryngotracheal bronchitis.

MR. BUCKLEY: And, see, and here's where we run into difficulty because if that's important for her for arriving at cause of death, how do I -- how do I have her testify on cause of death and not -- I mean, she's got an opinion of different things that happened, and that's a piece of the evidence she's relying on, and I'm -- so I'm just wondering how does she give, you know, cause and manner of death and not rely on the evidence that she's reviewed. Like, I understand where you're saying, I mean, you basically don't want her saying, I believe Ezekiel had croup.

THE COURT: Well, here's an example: (as read)

> February 27th Dr. Gamble said most of the symptoms are unconcerning, [I'm not reading verbatim] but difficulty swallowing or choking on saliva may indicate epiglottis, the swelling of parts of the upper airway, namely the epiglottis (sic), which can result in suffocation. The upper airway should be evaluated and possibly initiate antibiotics. The symptoms could also be viral or croup. Prognosis is very good. Epiglottis is, however, potentially lethal.

So, I mean, you're having her listen to one thing, the airway breathing on the first 911 call, and come up with an opinion that that is a possible diagnosis, and she's not entitled to do that. There's another example. I mean --

MR. GILES: This is very -- a side note, Sir, but I believe that that was actually epiglottitis, and the only reason I --

THE COURT: Epiglottitis. Thank you.

MR. GILES: Yeah.

THE COURT: A lot of medical words. Page 16, the same theme on the second paragraph, last sentence: (as read)

> However, considering the first 911 call --

So she's then using a diagnosis from a -- one potential symptom to -- she's making a diagnosis from one potential symptom and linking it then and coming up with a view. She can't diagnose.

MR. BUCKLEY: Okay. Can she testify as to why that is significant in her cause of death?

THE COURT: I don't know how that would all work out, counsel. I just . . .

MR. BUCKLEY: See, because here I have a world expert on -- possibly the world expert on asphyxiation who is telling me that what she hears on that 911 call when the phone is held up to Ezekiel's mouth, and it's recorded, is very important in her assessment of what the cause of death was, that it's an important piece of evidence, and I would be very concerned if this expert cannot rely on that piece of evidence. It was always open to my friends to have their experts review that piece of evidence.

THE COURT: Well, any of the actual evidence is open to the experts, isn't it, to comment on.

MR. BUCKLEY: Well, that tape and that sound is entered as an exhibit in these proceedings. In fact, the media has a copy. So I have an expert who studies asphyxiation telling me that is a very important piece of evidence.

THE COURT: Well, maybe the one word that's objectionable is in -- the last part of the sentence, "the respiratory obstruction". Let's remember he stopped breathing. He actually stopped breathing twice before the first 911 call on the evidence before us.

MR. BUCKLEY: And let's not forgot Collet Stephan's --

THE COURT: So he's already had respiratory arrest.

MR. BUCKLEY: Yes. And Collet Stephan's evidence was -- is that when he first stopped breathing, he then choked up a bunch of mucous, and she was very clear about that. You recall he was sitting up --

THE COURT: This is why I don't think I can rule on it. Now, I'm just giving you a heads-up that if the stuff is outside of her area of expertise, what she's qualified and entitled to give opinion evidence on, I will instruct the jury just as I would with respect to any other person giving an opinion. If it's opinion evidence by someone not qualified to give that opinion, the jury has to then put no weight on it.

Just like we did with hearsay this morning. We said, Look it, David Stephan may have said something that Collet told him. That's hearsay. You can't use it as proof of the truth of what Collet said. You can only use it as proof that Collet may have said it. So there's a limit there. That's a limiting instruction. I don't see how this is any different.

MR. BUCKLEY: Well, I mean -- but I think the difficulty is is that when, you know, whether it's a doctor or a pathologist, is asked, Well, why do you think a specific result happened, and, in this case, it's having to do with breathing stopped, they will look at all of the evidence there and say, Well, based on this or that, this is what my opinion of why that is.

And, I mean, obviously him stopping breathing is pretty important on cause-of-death issues, and she's finding that as fairly important. And clearly she will say, Well, when I hear that, I'm thinking of a respiratory obstruction. That's what she -- that's her opinion. But how -- how can a pathologist not give that opinion when she's allowed to speak about cause of death?

THE COURT: Well, we'll revisit it after she gives -- I mean, you've got to just play your case the way you wish to do it, counsel, and I'm -- I'm cutting you maximum latitude, and you can proceed accordingly. But the limits are going to be based on the qualifications that --

MR. BUCKLEY: So --

THE COURT: -- are currently in place.

MR. BUCKLEY: Fair enough. What I would suggest just to -- hopefully this could go as smoothly as possible. We could recall the jury. I'll ask that one question that I had on the voir dire. Then I would like a break just to show Dr. Sauvageau those two areas that the Court's raised as a concern and just talk to her about the direction I'm going to give her when her evidence starts just so that her -- she can try to avoid those two areas as best she can while still giving an opinion of --

THE COURT: Well, you've only got one question left for her?

MR. BUCKLEY: Yeah.

THE COURT: And that question was what?

MR. BUCKLEY: Well, basically it's whether the lawsuit would affect her ability to give unbiassed objective evidence today.

MR. GILES: As long as that's the only question he's going to ask --

THE COURT: Yeah.

MR. GILES: -- why not just go do it now. I know that the rules would normally say, because of where she's at in her testimony, we're going to have to do it this far more cumbersome way. But if that's the only question he's going to ask, I think it --

THE COURT: Well, we have --

MR. GILES: -- should be asked now.

THE COURT: Crown?

MS. WEICH: I'm fine with that, Sir. I'm just a little bit worried. I believe you instructed my friend that he wouldn't be able to enter the report, and therefore the jury wouldn't be able to get copies of it until after Dr. Sauvageau was done and I would be guessing after we had --

THE COURT: No, I didn't -- I didn't say that.

MS. WEICH: Oh, okay. Maybe I --

THE COURT: I said you can put the report in --

MS. WEICH: -- misinterpreted it.

THE COURT: Put the report in but I may instruct the jury to disregard portions or to put little weight on it, as we do with --

MR. BUCKLEY: Yeah. No, no, fair enough. And I've heard the Court on that, so I am planning on giving the jury a redacted copy.

THE COURT: You're welcome to speak -- you're welcome to speak to the doctor now, and we'll break until 3:15.

Crown, so you're still on your hind legs, as they say?

MS. WEICH: Sorry. Say that one more time, Sir?

THE COURT: Do you have something further?

Submission by Ms. Weich (Other)

MS. WEICH: Well, I believe my friend, Mr. Giles, already said it, the bell ringing, Sir. And I don't know that if we were -- if the Crown was under the gun here if we would be allowed to do such a thing. We're all held to a very high standard, Sir, and I don't see the Crown -- I don't see the Crown being able to put such a report forward to the jury when there are all the inferences in the world to be drawn from it the way it's redacted. That's my submission, Sir.

Submission by Mr. Giles (Other)

MR. GILES: One thing comes to mind as just a potential. There was the one time where there was a report which had been provided to the jury, and then afterwards my friend took issue with some of the things that were in the report after the redactions and wanted further redactions.

Perhaps what it could be -- and I'm trying to pull a King Soloman here -- is that the report, the way that it's already redacted, could be provided to the jury, and then if there

needs to be further redactions, it can be taken from them, redacted further, and then provided back to them. That's what happened with the Crown when we were in a similar situation. Perhaps that's what --

MR. BUCKLEY: I have no objection to that.

MR. GILES: -- could happen there.

MR. BUCKLEY: I'd have no objection. We did do that. I would have no objection to that.

THE COURT: That's what we're going to do. But for now you're just going to use the currently redacted version?

MR. BUCKLEY: Yes.

THE COURT: All right. 3:15, and we will reconvene at that time.

(ADJOURNMENT)

(WITNESS RE-TAKES THE STAND)

(JURY ENTERS)

THE COURT: Please be seated. Counsel, please confirm that all jurors are present.

MS. WEICH: Yes, Sir.

MR. BUCKLEY: Yes, My Lord.

THE COURT: Thank you.

Doctor, you acknowledge that you're still under oath?

A I do.

THE COURT: Thank you.

Counsel . . .

MR. BUCKLEY: And, My Lord, I actually only had one more question on the voir dire.

Q MR. BUCKLEY: And so, Doctor, my last question is, you know, I -- before the break, I had asked you about, you know, why you were under the *Whistleblower Act*, and just my final question is, is the fact that there's a lawsuit and that, you know, what you've explained has happened -- or alleged has happened is out there, does that in any way affect your ability to testify fairly and objectively on this case?

A It doesn't. Because as I said before, they are very specific people, and they are no longer in Justice, and so it doesn't change anything. And even then, they didn't represent Justice. They're were just in Justice. They're no longer in Justice. But I -- I have always been and I will always be an expert witness that is neutral and impartial as I approach a case. So in this case, I don't see any problem. I don't see any conflict of interest in this case.

Q Thank you.

MR. BUCKLEY: And, My Lord, those are my questions on re-direct on the voir dire.

THE COURT: Thank you. Well, I've already made the ruling with respect to qualifications of Dr. Sauvageau. And I'll just -- as a reminder, since we've now completed the qualifications portion, Dr. Sauvageau is an expert in forensic pathology and asphyxia entitled to give opinion evidence in forensic pathology, which includes conducting examinations, coming to conclusions, and explaining cause of death, manner of death, and processes leading to death which includes the interpretation of diseases and injuries, including hypoxic and anoxic injury, and when brain damage is caused by hypoxic and anoxic injury. And she is not entitled to give opinion evidence on the diagnosis or prognosis of chronic illness. Okay.

MR. BUCKLEY: Thank you, My Lord. Now, My Lord, Dr. Sauvageau is going to, in giving her testimony, follow a report, and the report has been redacted, and with the Court's permission, I was going to give the clerk copies so the jury can follow what Dr. Sauvageau is speaking about.

THE COURT: Thank you.

Crown, are you resisting that the report be marked as an exhibit at this point?

MS. WEICH: No, Sir.

MR. BUCKLEY: Yeah. So if I could move to enter it as an exhibit. Perhaps -- Dr. Sauvageau, I believe, has kind of written all over her copy so perhaps --

MS. WEICH: Sorry, Sir. Perhaps I misspoke. If things need to be redacted out of it afterwards, should it be actually entered once everything's been redacted?

THE COURT: That might make sense.

MR. BUCKLEY: Well, I'm wondering is, is perhaps it could be marked as an exhibit, and if there's any redactions that need to be done, then the redacted copy could be entered as a separate exhibit, and if the jury retires, they would only be allowed to have the redacted copy?

THE COURT: How about if we mark it for identification.

MR. BUCKLEY: We could do that, definitely do that.

THE COURT: Let's mark it for identification at this point, and that way we can take into account all of the -- all of the matters.

MS. WEICH: Thank you, Sir.

THE COURT: So, madam clerk, that will be Exhibit For Identification Number -- yes, what number for identification?

MR. BUCKLEY: My Lord, I know I'm looking at my notes. The last time we marked something for identification, at least according to my notes, was when -- before the CT scan was entered as Exhibit 15, and it was Exhibit A. I don't know if we had an Exhibit B For Identification.

THE COURT CLERK: I think he's right.

THE COURT: 'B'? Exhibit B for Identification. And, counsel, is that the same version that I have a copy of?

MR. BUCKLEY: Well, the copy that went to the jury is exactly the same. The copy that Dr. Sauvageau's working off I think she's made notes on.

A I do --

THE COURT: Right. So do we have an original of Exhibit A For -- or Exhibit B For --

MR. BUCKLEY: Oh, you have a blank one?

A I do have.

MR. BUCKLEY: Okay.

THE COURT: Do you have a . . .

MR. BUCKLEY: So if -- this one isn't stapled so you have another one close --

A Yes.

MR. BUCKLEY: Okay.

So, yes, we have -- get this . . .

THE COURT: Mark that as Exhibit B, then, madam clerk. And may I just see it, then.

MS. WEICH: Did she just say she has notes, or did she --

MR. BUCKLEY: She has a copy that, but she -- just notes to herself just like I've got highlighted notes in my copy.

MS. WEICH: Okay. So just have her . . .

MR. BUCKLEY: So . . .

THE COURT: Madam clerk, that will be Exhibit B.

EXHIBIT B - FOR IDENTIFICATION - 17-page Redacted Version of the Report of Dr. Anny Sauvageau Re: Death of Ezekiel Stephan (OCME File 1018-7289), Page 17, Electronically Signed By Dr. Anny Sauvageau, Dated April 16, 2016

MR. GILES: I do believe, Sir, that my friend had just suggested that the witness might have a copy with some notes on it. If she's going to refer to any additional notes, certainly she ought to advise us, of course.

MR. BUCKLEY: That's a little unusual. Just like I've got notes and highlighting on my copy to ask questions, the witness tells me that she, on her own copy, just kind of highlights some things just to flag that she, you know, needs to perhaps go into a deeper explanation. So I think that would be a little unusual to mark an expert's copy as a separate exhibit.

MS. WEICH: No. No, no, no. We're not asking --

MR. BUCKLEY: Okay.

MS. WEICH: No.

MR. BUCKLEY: All right.

THE COURT: They don't want to make it, but she should really be referring to --

MS. WEICH: Her memory.

THE COURT: -- a copy of the exhibit that's before the Court.

MR. BUCKLEY: Okay. Okay. Do you want to refer --

A Can I explain?

THE COURT: Madam clerk, give her Exhibit B, and we'll take it from there. Sometimes experts will request permission to check their file or something. That can raise other issues, but . . .

MR. BUCKLEY: Yeah. And I'm just working off of -- I mean, my style is I like to lead the expert through everything. And Dr. Sauvageau, who's almost a Crown witness, says, no, my practice is I just work off my copy of the report and off I go, which is what I was planning on doing so . . .

THE COURT: Well, it's one thing for you to do it.

MR. BUCKLEY: No, no --

THE COURT: It's another for the witness.

MR. BUCKLEY: -- I understand that.

Q MR. BUCKLEY: So, Dr. Sauvageau, my understanding is is you've got a copy of what's now Exhibit B?
A Correct.

Q And you have your own copy of Exhibit B that you've just kind of highlighted to -- and made some notes on to kind of flag you to go into further explanations of some things?
A It -- it -- if I can explain, it's just, for example, that I will highlight a word so that -- because it's -- it's a text. So when you try to speak to a jury, you don't want to be reading to a jury so I -- there's word (sic) that I put yellow. Sometimes I put 1, 2, 3, 4 to remember the logical order to explain things verbally.

It's just to help me so that when I explain my report, it makes sense to them. I will not refer to these. It's just like -- it's (sic) look like if you had the speaking notes in front of you, but instead of having them in a block, you have something to -- so that your eye can jump from one point to the next otherwise you might miss a certain point, which is not good to have. Because telling the truth is also by not (sic) omission of the truth so I need to say everything. It needs to be in an order that will make sense for them, and I need to have a way so that I don't read, that my eye can go to places so that I'm following in order. That -- that's all it means.

If I'm going with this one that is completely unmark, it's going to be less easy for me to make something that will make sense for the jury. That -- that's all. I've always testified like this, and it never been a problem before.

MR. GILES: I just -- when --

THE COURT: Should we just ask the jury to --

MR. GILES: Yeah.

THE COURT: -- step out for a moment.

(JURY RETIRES)

THE COURT: Just have a seat. Doctor, maybe I should ask

you to just step out for a moment and . . .

A Okay.

(WITNESS STANDS DOWN)

MR. GILES: Dr. Adeagbo seems to have become accustomed to the process as well. He's just leaving as well.

THE COURT: Thank you.

Submission by Mr. Giles (Other)

MR. GILES: The concern that I have, Sir, is that whenever in the last couple of decades I've ever asked any of my witnesses questions, I certainly do not ask them to have any notes with them, and I ask for permission for the -- them to be able to refer to those notes. Those notes should have been made contemporaneously at the time and advise of -- of what they're doing.

Now, I realize that this is something a bit different. This isn't past-memory refresh. This isn't a recollection recorded. But at the same time, she's got a document, which is clearly the result of her -- or at least I'm presuming is a result of her work. She's already organized this, and I don't see how she should be referring to anything unless she's letting us know that she is referring to something else before she is providing testimony.

I have no idea what kind of notes that she might be making on it. I have no idea what sort of markings she might be making on this paper that might be twigging her to something else.

But ultimately she's here to answer my friend's questions. My friend has perfect capability, as he's shown numerous times, of being able to assist any witnesses in organizing the information. My friend knows where he wants her to go, and my friend is perfectly capable of navigating her along that way.

And, frankly, I think that that's the way that the procedure ought to be if she's going to be referring to a document, it ought to be the same document that everybody has. That's my feelings on the subject, Sir.

MR. BUCKLEY: And, My Lord, I'm not --

THE COURT: What I'm used to, Mr. Buckley --

MR. BUCKLEY: I'm not aware of any rule of law that says a witness can't have an exact same copy as the exhibit. She can verify it's the same except she's done some highlighting and written some numbers on it to assist her in giving her evidence.

I -- I really am at a loss as to the purpose of the objection. She's already told the jury what she's done. I mean, I --

THE COURT: Well, you --

MR. BUCKLEY: -- if I -- if I have to --

THE COURT: Do you have an objection to the Crown seeing that document, for example?

MR. BUCKLEY: No, I don't.

THE COURT: Crown?

MR. GILES: I suppose I could take a look at it. Is it still up there?

THE COURT: Mr. Buckley, can you retrieve it and --

MR. BUCKLEY: Well, I'll have to get it from Dr. Sauvageau. I think she's taken that with her.

THE COURT: Will that address your concerns, Crown?

MR. GILES: It may. It depends what was written on there, Sir. I haven't the faintest clue.

MR. BUCKLEY: Can we just stand down? My friend and I can go and look at the document with Dr. Sauvageau.

THE COURT: Let's do that.

(ADJOURNMENT)

(JURY ENTERS)

(WITNESS RE-TAKES THE STAND)

THE COURT: Please be seated. Counsel, please confirm that all jurors are present.

MS. WEICH: Yes, Sir.

MR. BUCKLEY: Yes, My Lord.

THE COURT: Thank you. Doctor, you acknowledge that you're still under oath?

A I do.

THE COURT: Thank you. Counsel, please --

Q MR. BUCKLEY: So, Doctor --

THE COURT: Please continue.

MR. BUCKLEY: Oh, I'm sorry, My Lord.

Q MR. BUCKLEY: So, Dr. Sauvageau, you have a copy of Exhibit B in front of you?
A I do, yeah.

Q Okay. And so my understanding is is you like to just kind of run through a report and then be asked specific questions afterwards?
A That's the way I usually testify so I'm sure I can present all the evidence, yes.

Q Okay.
A And it's easier to follow a certain logical order for the jury to understand.

Q Okay. And Exhibit B is a document that you've prepared?
A That's correct.

Q Okay. And is it true?
A It is true.

Q Okay. So do you want to maybe start at the beginning where you outline --

A Can I -- it's my opinion. I should --

Q Right.
A -- have phrased it this way. Because if it's true or not will be for the Court to determine. It is my opinion based on the fact known to me at the time when I did that report. If the -- if some of the information available to me was to change, my opinion might change.

Q Okay. So do you want to maybe start on page 1 and kind of outline the different things that you reviewed in preparing this opinion?
A Yes. So -- and the jury has my report, correct, the -- the blacked-out version?

Q Yes.
A Okay. So as you can see on my report, I list material that was available to me, and some of the material I mentioned that, though, I have it -- and I have to say I have it so that it's all out there in the open; nothing is hidden. Despite that I have it, I was instructed not to consider it. So when that's (sic) happened, I'm mentioning.

So I had a copy of the medical examiner's file. I had -- and to be precise on this one, I had a copy that I received electronically. It was not totally complete, but when I went in the Office of the Chief Medical Examiner, I was allowed access to the complete file. So I've seen the complete file. There were things missing in the electronic version.

There's a report from a CT scan of the head, three pages. There's a medical file --

Q I'm sorry. Can I just stop you there.

MR. BUCKLEY: Madam clerk, could you give the witness Exhibit 15.

Q MR. BUCKLEY: I'm sorry to break your stride. I just want you to --
A That's good.

Q -- confirm whether or not that's the CT scan.

MS. WEICH: Do you have a copy for us?

MR. BUCKLEY: Exhibit 15.

MS. WEICH: Yeah. But she -- we didn't bring the stuff. She -- stuff . . .

MR. BUCKLEY: Oh, do you want -- oh, you need a copy? I'm sure I have one.

MR. GILES: Which document is it?

MS. WEICH: 15.

MR. BUCKLEY: No, I don't, because it's an exhibit. So you should have it. I can give you a copy of mine.

Q MR. BUCKLEY: Does that look like the CT scan that you reviewed?

A Correct. Just to be precise, on these three pages that were sent to me as being the CT scan of the head, there is a CT scan of the head, but there's also a report on the lungs. But it was identified to me as being the CT scan of the head, and I kept that label, but it includes a CT scan -- or examination of the lungs as well.

Q Okay. And sorry for interrupting you. If you want to carry on.

A I had the medical file of Ezekiel Stephan as originally disclosed to the defence. My understanding is that there might be a different version. I'm not sure. This is the version I received. So in my report, when I -- when I'm indicating a number of a page, it goes with that version.

I also received a transcript. I'm not sure if the jury's familiar; for example, when I talk right now, there is someone that has their job of trying to follow up -- and I speak too fast for her unfortunately. So she has -- she's writing everything, and there will be a product of everything that I say today, and that's the same for every witness. That's called a transcript.

So I had the transcript for when Dr. Adeagbo testified at the preliminary inquiry, and that -- I've read it, I know about it, but I will never refer to it in my report unless extra have been -- have been -- been -- have been brought to the trial. It's the way I've been instructed to work. So I list it so that it's all in the open so that everyone knows what I have but what I can use.

I also receive a transcript from the testimony of Mr. Cherniawsky, who is one of the paramedic, and that transcript was also from the preliminary inquiry. I don't have the transcript from the trial so I will not refer to it in my report nor in my testimony.

I have two 911 calls. One that is the first one, which is 3 -- 43 minutes, and a second one of eleven fifty-nine minutes. I have a report from the Emergency Medical Services, five pages. I have 16 autopsy pictures, and I have -- I don't have them with me, but I've had access to 13 microscopic slides so I went at the Office of the Chief Medical Examiner to review the slides. And I had the transcript from the testimony of Dr. Adeagbo in trial, and that one I'm allowed to refer to it in my report and in my testimony.

Q And just one of the things you referred to is the report from the Emergency Medical Services.

MR. BUCKLEY: And, madam clerk, could you give the witness a copy of Exhibit 13.

Should be page 5. Just -- that's just -- and you entered it as Exhibit 13.

MS. WEICH: Thanks.

A Thank you.

Q MR. BUCKLEY: And, Dr. Sauvageau, I just want to ask you if that's the -- what is now Exhibit 13 is what you're referring to as the report from Emergency Medical Services?

A It's look like it, yes.

Q Okay. Okay. So I'm sorry to interrupt you. If you want to just kind of carry on and pick up where you would like to.

A Okay. So I will explain to you my report on my opinion today. I will try to do it as flowing as possible, but I -- I don't have speaking notes like I used to, but I will try to do my best that it's still flowing nicely.

So in the case of the death of Ezekiel -- and just -- just before I start, I will present the view of forensic pathologist and an asphyxia expert. This is where I will limit my opinion.

So in the death of Ezekiel, Ezekiel was presenting symptoms that I won't comment that were presented to you by other people for, let's say, about two weeks. And then on March 13, as he was in the -- the car of his parents as they were apparently driving toward a hospital, there was a first respiratory arrest that happened.

I've heard this 911 call, and I will comment later on what it inform us about the respiratory arrest. As a forensic pathologist, that I will have to deal with the death later on the cause of death, this is where -- one of the events that we will have to address. We will have to address in two ways because this -- this respiratory arrest could be caused by something that will then cause his death, or he could be sick of something that caused the respiratory arrest. But in this case, we know that something happened -- sorry. I went to -- this is when I don't have my notes. I went one step too fast.

So we had the first respiratory arrest that I will be able to hear on the 911 call, but he will then breathe again. And then they are driving toward the ambulance. The ambulance is driving toward them, and this is all in the second 911 call, and at that -- can I start again?

Q Yeah, please.
A Sorry. Okay. I start again.

So Ezekiel was sick of something for about two weeks. He was with his parents in the car, and he had a first respiratory arrest on March 13. That first respiratory arrest -- so he stopped breathing. They call 911, and he start again breathing, and this is what we have on the 911 call that will be important because we have the opportunity to hear his breathing. I will come back to this.

So he start breathing again, and they drive toward the hospital, and then he stop breathing again. That's the second 911 call. That one he's not breathing. So on the 911 call, the timing will help us because they call, from what I understand, immediately when he start again to stop breathing until the ambulance arrive.

So often when I work as a forensic pathologist people tell me, I feel they stopped breathing for about -- and they say a number, top of their head, but here we have a good indication because of the length of the 911 call. Ambulance arrive. He is in respiratory arrest. They will try to re-animate him, but there will be some problem with the supplies in the ambulance. I can see that in the medical examiner file, and I can see that on the ambulance report, or Medical Medical Services Report.

Okay. The 911 call I will -- the first one where he breathe again will be very important for me for the following reason: We will have to address as a forensic pathologist when he stop breathing the first time because of a disease. Is it what is in link with what will be finally his cause of death? Or is it that he was sick enough to get a respiratory arrest that in a different -- if things had been different, he would have been re-animated; he would have survive? Or did something happen because of the

intervention that was not successful because of the supply issue that is related to his death?

So we will have to decide at the end, Is it a death related directly to his disease, or could it also instead or in conjunction be related to the paramedic misadventure? We call it "medical" or "paramedic misadventure" in my language.

So we will -- and when he was in the hospital -- he arrive in the hospital. He was already -- so he had at some point been re-animated, was breathing again, but he was at this time neurologically very impaired, extremely unstable. On March 16, he will be declared brain dead, and on March 18, he will be taken out (sic) of life support, and on March 19, there will be an autopsy.

At autopsy, the big thing there is -- there's something in the brain itself. I will describe it as a lack of oxygen. We'll come back to this. There's an infection. We will discuss the meninginitis. There is an infection around his lung. There is an empyema; we'll come to this. And my opinion there's something also in his lung. So these are the pieces we'll go through together.

There is a disagreement between me and Dr. Adeagbo on how to interpret certain things. The main difference of opinion is on what is the source of the infection. So he presented to you, for reason that we will discuss again together, that he thinks it's a bacteria; and for reason that I will explain to you, I think it's a virus. This difference is very important because it change what would happen.

If it's a bacteria, you can prescribe antibiotic that could have an impact, maybe or maybe not -- we'll also address that -- on his survival. If it's a virus and even if you give antibiotic, it doesn't change anything. So that's an important difference.

The other difference is that, my understanding from reading what he said in court, is at that, for him, the paramedic misadventure didn't play a role in the death, and I disagree. So we'll discuss also this.

So this is the general overview, and now we'll jump into it. So I will start on page 2. "Most Likely Infectious Agent". Before I go there, I said "bacteria" and I said "virus". I will explain the difference between a bacteria and a virus because it will have importance for several of what is coming -- for several of the points that are coming.

Both are infectious agents. There are others. We will talk at some point of fungi; that's a different one. We will never talk together of other, like, parasites or prion; we'll only discuss virus and bacteria and a little bit, at some point, the fungi. But all

these organism are thing that can infect you as a human.

A virus is very simple in the sense that it's tiny, tiny and very simple in their constitution. It's only a piece of genetic material. For people that are not familiar with genetic materials, stay there. For some people that can follow me one step further, it can be DNA or RNA, two different type of genetic material.

This genetic material -- so there's a piece of genetic material into an envelope of protein that we call a capsid. That's all it is, a virus. So, in fact, it's not really living in the sense that it can't do much by itself. So what they do, the viruses, is they come to our cells. They enter our cells, and then they use our own cells to reproduce themself. There's an equipment in our cell to do proteins and -- and to replicate everything we need to replicate.

The virus don't have that. So what they do is they come, they enter in our cell, and they use our own factory to reproduce viruses. And they reproduce, reproduce, so our cells are sick because instead of doing (sic) the protein they need to do their own function -- let's say -- let's say it's a cell in the liver. They are supposed to clean the blood, but now they're not cleaning the blood; they are making viruses.

So our body is sick because our cells are not doing what they should be doing. And on top of it, the viruses will reproduce until it's so full of viruses that the cell explodes, and the viruses go the next cells and do the same process. That will become important later. Viruses don't have the factory to do the proteins. That's called our ribosomes.

Bacteria: Bacteria are bigger. They are also more complex. They are a cell, so they -- like, we have cells that makes our body. Bacteria are a cell. So they can do their own proteins. They don't enter our cell like a virus do, but the reason they make us sick is they send chemicals that destroy our tissue, and they can feed on us. They can use our cells as food. So they destroy our cells, and that produce food for them. So the mechanism are different.

Now we start the report, per se. There were symptoms, as I said, for the first two weeks, but I won't discuss with -- with you the symptoms from these two weeks. The only part I can discuss with you is the phone call where Ezekiel, on the first 911 phone call, he stopped breathing, and their (sic) parents are on the phone with the paramedic, and then he start breathing again, and the paramedic -- the -- I say "paramedic", but actually it's a responder on the phone. I'm not sure of her exact training, but there's a responder on the phone when they call 911. This responder, when the father tell her that the baby has started breathing again, she wants to make

sure, and the father suggests that he can put the phone near the baby and --

MS. WEICH: Sorry, Sir. I don't know how much it matters, but I believe she's misrepresenting what the responder said, and I'm afraid that she's --

THE COURT: Well, look -- we can take a look at the transcript instead --

MR. BUCKLEY: Yes. Yeah, we can.

THE COURT: -- of getting into that. Let's . . .

A If I made a mistake, the important point for me is that the phone was near the baby. That's the important point. If something else is misrepresented, I apologize. It was not on purpose. For me, the important part is I can hear the breathing of the baby which is not a normal breathing. And as an expert on asphyxia, I can hear that abnormal type of breathing and recognize it as an obstructive phenomenon. And I will come back later. Because if someone sees breathing by other mechanism, like a meningitis, it do a different sound. So I will park it for now. We'll come back to that later, but it's -- I can hear the obstruction. I can hear that the air has a trouble going through the airways.

At autopsy, we'll try to find why there will be that obstruction in the airways. So the autopsy will look at the different things that were not found here. For example, when there's this sound, that doesn't tell you what it is. You know there's an obstruction; you need to find why there's an obstruction. As I said, it doesn't sound like a meningitis. And by the way, I'm not saying there's not a meningitis. There is. I will come to this. I'm just for now doing this block. We'll do the brain block later. We'll do the lung block later. So now I'm at the respiration. There's something there that is obstructive, and the meningitis would not do that sound.

So there's no foreign object. There's not a peanut or a penny that was dropped in the airways. There's not --

THE COURT: Just hang on, Doctor.

MR. GILES: I do have an objection. I believe this is diagnosis. She's just -- she's, in fact, testifying as to the nature of an obstruction or what it's not. She's excluding obstructions.

THE COURT: Can we ask you to step out for a sec?

(WITNESS STANDS DOWN)

THE COURT: If I can ask you to . . .

(JURY RETIRES)

Submission by Mr. Giles

MR. GILES: The evidence that I just heard this individual provide was essentially that a living person, who she has admittedly had very, very little experience with, the vast majority, with a few notable exceptions, in relation to choking that she had provided -- the vast majority of her patients having been diseased prior to her seeing them. And now she is trying to provide testimony that the sound that she hears over a cellular telephone through a recording -- she's trying to provide evidence as to what, through elimination, is actually providing such an obstruction.

And that, I'm going to suggest, Sir, is not within the expertise that she had -- that we've heard about here in any way, shape, or form.

Submission by Mr. Buckley

MR. BUCKLEY: I'm not interpreting it that way, and maybe the Court is. So we do have a world expert in asphyxia who was saying that when she hears a specific sound she's interpreting it a specific way. So is -- I mean, is she not allowed to testify on her interpretation of the sound?

MS. WEICH: So --

THE COURT: Well, how can she testify about the sound? She hears a sound -- leave aside the other matters the Crown has brought up, but she hears a sound and gives an opinion, that it is, that it is a symptom or a consequence of a particular disease process. How can she do that?

MR. BUCKLEY: What is the scope of the ruling that she's an expert on asphyxia? Is that just if you don't have air for -- like, are we limited in the reasons? Are we -- so -- and this speaks to cause of death, so really she can't, then, give an opinion on the cause of death because it plays into her reasons of why -- you know, what she thinks cause of death was. Definitely speaks to, you know, mechanism of what she believed was happening at the time.

Submission by Mr. Giles

MR. GILES: My friend, I'm quite sure, knew that he was going to go here, that this was part of his expert's report and that this was something important to him as he's just pointed out. When he was leading the qualifications of this individual, he -- she had provided much evidence about watching the videos or things such as that of people who were asphyxiated. She talked about adults, autoerotic asphyxiation, and persons hanging themselves. I heard nothing in there whatsoever about babies being recorded making the sounds that they make when they're choking.

If he wanted to draw that evidence out, if he wanted to draw that basis, that foundation for the evidence she's now providing, it was certainly open for him to have done so, especially if he knew, (a), he was going there, which I'm going to suggest he did, and, (b), that it was important, which he says now, and I'm guessing he thought that yesterday as well. But that's not what we have. So here I'm going to suggest she's going way beyond anything that she had been qualified in relation thereto.

Submission by Mr. Buckley

MR. BUCKLEY: Well, I mean, I think, then, no expert would be allowed to testify because nobody's going to qualify them on every little piece of evidence that they could possibly give. So do -- maybe I need to qualify her on her ability to observe organization for a right pleural empyema. I haven't done that. I haven't qualified her on her ability to recognize meningitis in the brain, specific questions about that. We -- I mean, we could have qualifications all day.

So is she -- and here's where we run into problems. So here I've got an eminently qualified forensic pathologist who is trying -- and an -- an expert on asphyxia who is basically trying to explain one of the pieces of evidence that is important to her for cause of death.

THE COURT: Are you intending to go beyond this kind of -- for example, on this sort of evidence, that the doctor heard the recording, and based on what she heard, she would -- can give an opinion that that's characteristic of airway obstruction without attributing it to a particular cause at that point of the airway obstruction. That sounds like what a . . .

MR. BUCKLEY: Well, in fact, as I understand her evidence is is what she's saying is there's not an obstruction, that there's a constriction of the airway. So when she's saying there's no peanut, no penny, that's no obstruction, and it -- and what she's hearing is important on her opinion as to whether or not meningitis was the

cause of the breathing being stopped and, if so, what the mechanism of that would be. Because you see in her report that she's of the opinion that because the CAT scan and autopsy showed no herniation, that it wasn't brainstem compression.

THE COURT: How far did -- how far is she going to be going, then?

MR. BUCKLEY: I actually thought that she was basically almost done. She was just basically saying there's no obstruction. She used peanut and penny as an example, and my friends objected. So I -- I actually thought that she was going to then be moving on.

Although the -- you know, the next part in her report is that a nasopharyngeal swab is taken to look for viruses.

THE COURT: Right.

MR. BUCKLEY: And enterovirus and rhinovirus is found -- she thinks that obstruction is an infection, and, oh, well, here we find viruses in the nasopharyngeal swap at the time of autopsy. And as a forensic pathologist, I would say, well, logically you would look at that as a candidate for the cause. So she's saying, I hear an upper respiratory tract infection, is really -- she's not using terms like that because the Court is constraining her so she's just basically -- I'm sensing a restricted airway.

I would be surprised that an upper respiratory tract infection is beyond even a general GP's area of expertise, let alone a forensic pathologist's. It's -- do you see the difficulties that the defence is having in having the witness try to present evidence.

Submission by Mr. Giles

MR. GILES: The problem is the extrapolation from a mere sound over a cellular telephone, which is then being recorded, and where -- in a moving vehicle where she has said he has obstructed breathing, and now she's trying to -- and she was providing evidence about what kind of obstruction it wasn't.

MR. BUCKLEY: And --

MR. GILES: That was my difficulty.

MR. BUCKLEY: With all due respect, that would go to weight, and that 911 call is when they're at home; they're not in the vehicle at that time.

MS. WEICH: Oh, yeah. Sorry.

MR. GILES: Oh, yes.

MR. BUCKLEY: But that's a matter of weight, isn't it? I mean, my friends can cross-examine on that point and say, You're basically finding this as important based on an audio recording of poor quality. I mean, that's -- isn't that -- doesn't that go to weight?

THE COURT: So I think she can testify as a forensic pathologist and an expert in asphyxia that when she listened to the sound, in her opinion, this was not a sound characteristic of airway obstruction. It must have been something else. But I don't think she can go beyond that. There could be a number of possibilities, couldn't there?

Submission by Mr. Buckley

MR. BUCKLEY: So is the Court saying she can't say, Well, and they find a virus that regularly causes constricted airway similar to what I hear? Is my expert not going to be able to say that?

MR. GILES: She may be able -- well and may be able to say it was consistent with it.

THE COURT: I think she can give her opinion, can't she, on what, in her opinion, isn't. Maybe even -- I mean, as an expert in asphyxia, in my opinion, it isn't, but it could be. Isn't that . . .

MR. BUCKLEY: Well, and this is the interesting thing, is if you're saying it's not 'A', 'B', and 'C', that's a diagnosis too, isn't it? Well, I'm ruling out this, I'm ruling out this, and I'm ruling out that. That's giving a diagnosis. Here's where -- and as I say, here's where it gets very difficult, is, you know, she's trying to assess cause of death based on the evidence that she's had, and she has found a sound of, you know, a constricted airway to be very important. And then as a forensic pathologist, you go, Oh, well, okay, there was nasopharyngeal swab which would basically be identifying what's going on in that area. What does it find? It finds virus that commonly causes a constriction in the upper airway.

THE COURT: I'm going to let her -- I'm going to let her -- I'm -- that you ask the question and her give an answer on what -- so she's testified about

what she's heard. She can give an opinion on her conclusion, namely, In my opinion, it was not. You can even have her say what it -- what she thinks it was. Not the disease but what might cause that sound. I think that's fair. What might cause the sound?

MR. BUCKLEY: Okay. But if she's going to say that it's basically an upper respiratory tract infection or, you know, medical terms to that effect, is that going to be allowed?

THE COURT: Crown?

MR. GILES: Certainly does sound like diagnosis to me. I . . .

MS. WEICH: And regardless of how important Mr. Buckley may think it is, and it very well might be, if she's not qualified, she's not qualified, Sir.

MR. BUCKLEY: Which is interesting. So she is the chief medical examiner at the time, could have done this autopsy and come to that conclusion, and nobody would have had any issue with her testifying for the Crown saying she's not qualified to be --

MR. GILES: That's speculation, Sir.

MR. BUCKLEY: -- to give her opinion on -- well --

MS. WEICH: We would have -- we would have needed to be able to qualify her so that she could give this evidence appropriately. We're always required to do that. Everybody who wants to bring an expert witness has to qualify them properly.

THE COURT: I think you're too far into diagnosis. I think she's entitled to listen to the call. She can say from her specialty of asphyxia something to the effect of, On my hearing, this is not asphyxiation. It could be that the sound is not normal. Everyone -- no one would have difficulty with that. But attributed it to a particular -- as a symptom of a particular disease for a -- in a chronic illness when you -- you need to leave it wide open. I don't think it stops you from proceeding with the rest of your report, counsel.

But she can't possibly make a diagnosis of upper respiratory tract infection because she's not -- she's not qualified to give diagnosis. That's what doctors who are diagnosticians do.

I think you can still get through your report without the need to deal with that, and you can't have her opine as to what's beyond her expertise. She's confined to that.

Submission by Mr. Buckley

MR. BUCKLEY: It's just interesting that we have somebody that likely -- well, does train forensic pathologists to give evidence on causes of death who basically can't say, I hear an upper respiratory tract infection, and, Oh, by the way, we find virus in the nasopharyngeal swab that is routinely found that causes upper respiratory tract infections. I mean, basically that's what the Court is saying she can't do. Because that's what she does in her report, saying it's likely enterovirus or rhinovirus what is found.

And every other expert in this trial has been given very wide latitude, including Dr. Clarke, who's just, you know, a GP, and everyone's been given extremely wide latitude. But for Dr. Sauvageau who, despite her experience and qualifications, apparently is not qualified to say that, I hear an upper respiratory tract infection or what sounds like it, and, Oh, by the way, the autopsy tests for that area finds a virus that routinely causes that; ergo, you know, as a forensic pathologist, I suspect that that's a causative agent.

I mean, forensic pathologists try to determine what's going on based on the evidence they have, which includes saying, I think the person was suffering from this. I mean, you're going to let her testify, I think it -- he was suffering from viral meningitis, not bacterial. Here's why. But basically the Court's saying, but she can't say, Oh, I think he had an upper respiratory tract infection based on a sound I heard.

And with all due respect, My Lord, that -- I think you're unduly constraining this witness because that's a matter that goes to cause of death. And she was very clear that's what she's trained to do as a forensic pathologist. That's what forensic pathologists do. They know about the diseases. She testified that's what pathology is, the study of the progression of disease, and we're just -- we're talking about an upper respiratory tract infection caused by a virus that routinely does that.

Submission by Ms. Weich

MS. WEICH: So, Sir, with all due respect to my friend, he's simply making the exact same argument he made this morning when you were already very clear for the second time that diagnosis and prognosis is out of the question for this witness.

I note the time, Sir. I know that we didn't -- I don't know if we said anything to the jury

yesterday about staying late -- or, no, they didn't even come in yesterday. So perhaps the best course of action would be to let them go home and start fresh tomorrow. And I would also submit, Sir, taking away the report from them.

MR. BUCKLEY: I may need to check with Dr. Sauvageau because she's available tomorrow, but I don't believe she's available Thursday so we might be in a similar situation like we were with Dr. Adeagbo.

THE COURT: Just give me five minutes. I just want to re-read this.

(ADJOURNMENT)

Ruling (Qualification)

THE COURT: Please be seated. I had a bit better opportunity to look at the report and think about the questions and keeping in mind the actual qualifications of this particular expert. So remembering that she is an expert in forensic pathology and asphyxia and also the limits on her ability to give opinion evidence, namely she cannot give opinion evidence on the diagnosis or prognosis of chronic illness, I'm of the view that the witness is permitted to testify that when she essentially listened to the 911 call, based on her hearing, she can give her opinion on what the respiration sounded like to her. That's part of her job with her specialty in asphyxia.

And as a medical doctor, she can go as far as to say that that could be consistent with or suggestive of upper respiratory tract infection, but she's not permitted to go beyond that and diagnosis whether there was a upper respiratory tract infection.

We'll deal with that later if we have to, but at least we can get through this part of the question.

MR. BUCKLEY: And would the Court like me to give instructions on your directions just to ensure that she stays within them.

THE COURT: And then we'll -- and then bring her back in, and we'll call the jury in; okay?

MR. BUCKLEY: Thank you.

MR. GILES: Perhaps --

MS. WEICH: Sir, if I could please go retrieve Dr. Adeagbo as well?

THE COURT: Oh, yes, thank you.

MS. WEICH: Thank you.

(WITNESS RE-TAKES THE STAND)

MR. BUCKLEY: Yeah.

THE COURT: Call the jury back, madam clerk.

(JURY ENTERS)

THE COURT: Please be seated. Counsel, please confirm all jurors are present.

MS. WEICH: Yes, My Lord.

MR. BUCKLEY: Yes, My Lord.

THE COURT: Thank you. Doctor, you acknowledge that you're still under oath?

A I do, My Lord.

THE COURT: Thank you.

Q MR. BUCKLEY: Now, Dr. Sauvageau, before we took the break, we were on page 2 of your report, and you were talking about listening on the 911 call --

A Correct.

Q -- to -- you refer to as the baby. So could you just kind of pick it up from there and continue?

A Yes. So as I said, when I -- when I heard the 911 call, as a forensic pathologist but even more as an asphyxia expert, it sounds like an obstructive issue. Then you have several thing you need to think of that will correlate at autopsy. So at autopsy, we need to look for a -- causes for that obstruction.

I will tell you what it is not from the autopsy that we have to think of. It is not a foreign body so there's not a penny or a peanut in it. It would not make sense, though we have to consider it, that it's an allergy, because there's no reason to think that just randomly he was allergic to something right now, and I don't have information that would correlate well with an allergy.

So we're thinking of a lot of thing. Like, it's not a chemical burn, and it's not -- we go through a lot of lists of, It's not, it's not, it's not. Among the "it's not", we have to considered (sic), at the end, we are in the infection category. So it's suggestive, because we have eliminated the other thing, that it's an infection.

I will not be able to tell you just from looking at the throat if it would be a virus or a bacteria. But usually bacteria in the throat can make kind of big membranes. It's kind of a -- the dead cells make something on top of your airways that we can see with our eyes, and it was not there. When I say "it was not there", I rely on the report of Dr. Adeagbo, so I -- I don't have a picture of this. But I trust that it was not there. He would have described it, and that would have gone well with the bacteria. That it's not there doesn't mean it's not a bacteria.

So when we look at the throat, we don't find something with our eyes that we can say, This is the cause of the obstruction, so there's really nothing that was described at autopsy. However, we did -- well, I say "we", but actually it's not me. Dr. Adeagbo, with the team he was working with, did a swab or a wash. I say one or the other because I know that verbally he said he did a wash of the nasopharynx, but on the report, it's written that it's a swab. But it doesn't really matter so let's not get into if it's a swab or a wash; that's not the important part.

They took a sample, wash or swab, of the back of the nose and the back of the throat, mainly towards the nose, but it's at the back of the throat, and this was positive for the presence of a virus. The genetics is not precise so it's either enterovirus or rhinovirus. These two viruses, when we test them, they look the same genetically so often we can't make the difference.

So in the report, the microbiologist writes that it's positive for enterovirus or rhinovirus. So if we put that together now, the most -- the most likely conclusion -- so it's suggestive, but I can't -- it's not a 100 percent -- but it's suggestive, because it's positive and there's nothing else that the cause of the obstruction of the airway would be because of a viral infection. Is it 100 percent certain? No. It's on balance of probability, this is the most likely. We're moving on.

Q Okay. And, Dr. Sauvageau, I'm just going to ask, just because of kind of the

limitations, if, you know, you could maybe just say suggestive or things like that, but kind of just limit it to that if that's possible.

A Can you explain what you mean?

Q Well, just be careful because you're not supposed --

A Okay.

Q -- to give a diagnosis so . . .

A Cause of death is a diagnosis, so I will -- I will try to be careful, but a cause of death is a diagnosis.

Q Okay.

A So I'm on page 2 of my report. Am I allowed to read what was asked of Dr. Adeagbo since it was read to Dr. Adeagbo in --

Q Yeah. Please carry on.

A Okay. Bottom of page 2 of my report. So this is an extract from something you -- you would have heard earlier in the trial. Dr. -- last page -- past paragraph of page 2 Dr. Adeagbo was asked: (as read)

> When you did the autopsy, you didn't see evidence of croup; is that fair to say? [He answered] I did not see evidence of croup.

I want to comment on this because he said it at the trial. Croup is a clinical diagnosis. That means a forensic pathologist doesn't diagnose croup because this is something that is clinical. It's a symptom. The same way we don't diagnose a headache; we diagnose the cause for the headache. A path -- a forensic pathologist would not write on his report that there's a headache. He will write that there's a brain tumour or that there's a bleeding in the brain -- we'll use other words to say that -- that caused the headache.

Q But, Doctor --

A So croup is a clinical word.

Q Can you just be a little away from the mic.

A Oh, yes.

Q Okay. Thank you.

A Sorry.

Q Sorry.
A The -- but -- but having said that -- so I have to change the word here. So when Dr. Adeagbo answered that question, he was asked croup because it's a word used by people in clinic. But for a forensic pathologist or a pathologist, what you -- what we can see is actually an infection of the larynx, the trachea, and the bronchus.

So in medicine when it's an infection, we add "itis" to it. For example, you have a little part of your gut called an "appendix". If it gets infected, we call it an "appendicitis". So we don't diagnose a croup. We diagnose if it's there. But I will comment on his comment because he says it's not there -- a tracheo -- a lary -- it's first the larynx -- laryngotracheobronchitis. So the larynx, the trachea and the bronchi plus "itis". That's the word we use. And it was not there.

However, we -- I want to add that there's a logical explanation for that. If you do have a viral laryngotracheobronchitis, the only thing you see at autopsy is that the mucosa, the -- the -- kind of the surface of the airways, is a little bit too red and a little bit swollen, and the problem is that if you are intubated, you see also a mucosa that is a little bit too red and a little bit swollen.

So the fact that we don't really see something at autopsy doesn't mean anything. In the end, I cannot tell you if there was or was not a viral infection here of the laryngotracheobronchitis, but on balance of probability, this is what I believe.

I continue. I'm now at 1.1. Once again, Ezekiel presented symptoms that you have heard that will not come from me. You have heard the symptoms. At autopsy, there is a meningitis. This meningitis could explain some of the symptoms, but that they were explaining or not, let -- I think I'm not allowed to go there so let's stick with the meningitis. There is a meningitis at autopsy. Dr. Adeagbo diagnosed it as one of his cause of death, and I agree with him that there is a meningitis. The disagreement between me and him on this is, on balance of probability, is it more likely that it's a virus or a bacteria.

Viral meningitis are pretty common. Bacterial meningitis tend to be more dangerous but not as common. My understanding is that I'm not allowed to give you percentage. If it was to be a viral meningitis, the large majority are enterovirus, which is the same virus we have already identified in the back of his throat or nose. If it was to be bacterial, my understanding is that I'm not allowed to tell you which bacteria are the more common.

In this particular case, no one will be able to tell you for certain at 100 percent what infectious agent it is. The reason for that is because when he entered the hospital, he

was too unstable so that they couldn't do a lumbar puncture. If that had been done -- and I'm not saying it should have been done. Doctor, in their best judgment, decided he was too unstable for that. It's not on my expertise to judge this, and I respect this decision. The fact is that because of that we don't have proof of what it was in the cerebral spinal fluid.

I should go back one step. I didn't explain what the meningitis is, and it might be clear for you, and it might not be. A meningitis is an infection in the surrounding the -- their -- okay. You have the brain in your skull, and there's two layers that protects the brain. These three layers -- they are called the "meninges" -- so, once again, when they come infected, we will add a "itis", meningitis. The first big one is very thick. It's called the "dura", will have no importance in this case.

The second layer is called the arachnoid. It's a very thin layer, and below it, there's a space. We call it the "subarachnoid" space because it's below, so subarachnoid. And then you have another layer that's called the "pia", and that one is stick to the brain. So there's no real space between the pia and the brain.

When there's pus between the sub -- the -- the arachnoid and the brain, we call this "meningitis". So there's infection with pus between the -- the arachnoid and the brain. I said "pus". Sometimes it -- I -- sometimes it's really like pus. Sometimes it's more like a fluid that our eyes can't really see as pus.

What is pus? Pus is a fluid. In it there's infectious material, but mainly it's dead cells. When you have a viral meningitis, in general, it tends to be more slightly fluid, so less thick, but it can be thick. It can be. It can look exactly like a bacterial meningitis. When you do have a bacterial meningitis, it can be -- the pus can be whitish or yellowish like you can also have in a viral meningitis, but it can also be more greenish. If it's more greenish, then it's really more a bacterial (sic).

But the -- the way to diagnose if it's a virus or a bacteria is not by assessing the colour of the pus. It's by other means that we will discuss later, but mainly by identifying through a test the agent. Okay. So I go back to where I was. They couldn't do a lumbar puncture when he was still living because he was unstable, so they couldn't prove the bacteria or the virus that caused his disease.

At autopsy, before he arrived to autopsy, he has been on antibiotics, which means that if it was a bacteria, there's a high chance that we can't see it by the time it arrived at autopsy. If it was a virus, you could still test for it. At autopsy, they tested in the CSF, the cerebral spinal fluid, for bacteria, but they didn't test for virus.

The bacteria -- there's one test that will come later that is a very special test. I'm not talking about the 16S rRNA. I will keep it for later. The usual culture that were done on -- on the pus around the brain couldn't show bacteria. As I said, doesn't mean it's not a bacteria. He was on antibiotic. And they didn't test for virus so I can't say one way or the other by that. They did culture for the lungs and culture for the blood, and they couldn't see bacteria there either. They couldn't identify on culture a bacteria.

On the gram test, there is a gram-negative bacilli. I will come to that later, but it was not on a culture with a specific bacteria identified. For example, you could have a meningitis, we put the pus, and it grows a bacteria, and they can identify that the cause of death, meningitis, is streptococcus pneumoniae or something like that. In that case, they couldn't do that. The culture didn't work.

I am now at 1.2.1. Oh, I forgot one thing. So as I said, in the cerebral spinal fluid, they couldn't identify a bacteria or a virus. The culture of the blood and on the lungs couldn't identify a virus. But when it's a viral meningitis, the large majority are enteroviruses, and we know there was a positive swab or wash at the back of the nasopharynx. I will come later to say that because of that, on balance of probability, I think that's the cause of the meningitis, but we will go through several step before we come to this final conclusion on the meningitis.

1.2.1. The last paragraph on that page is another extract from trial where Dr. Adeagbo made some statement. So he described that at autopsy he had described that there was a predominance of neutrophils. We'll stop there. What are neutrophils, and what are lymphocytes? Because you will need to understand that so that we can proceed.

In your blood, you have different type of cells. You have, among the cells, the white blood cells. The white blood cells are your soldiers that are going to fight against infection. There is five types. We will need only a few to discuss today. There are a lymphocyte, which when you look at them under the microscope, they have a nice round nuclei so that's the nucleus of the cell, and you don't see a lot of cytoplasm around them. You don't see a lot of thing around.

And you have a neutrophils. You will see that in certain references, they call them "polymorphonuclears" because they're nucleus instead of being a good round. It's kind of little projection in different directions. So when we cut them on a slide, we see a lot of small circle, usually two, sometimes three, sometimes four. That will have an importance because that can -- that can looks (sic) like debris sometimes if you're not careful.

So the lymphocyte -- in general, the lymphocyte are more often there if you come -- if

you're combatting a virus, and in general, the neutrophils are more there if you're combatting a bacteria, but the key word here is "in general". There's a lot of exception.

Okay. So Dr. Adeagbo said -- I am on page 3, paragraph at the bottom of the page. Dr. Adeagbo -- so at the autopsy, he had described that there was mainly neutrophils in the pus, and he said at trial -- he was asked -- I'm on fourth line: (as read)

> Did a virus cause Ezekiel to die? [He answered] No. [He was then asked] Why do you say that? [He answered] I say that because all the findings, they are not -- the autopsy findings are more in -- more consistent with a bacteria infection. [I skip a passage; that's why there's a bracket with three little dots] The histologic assessment of the cells, that means lymphocyte or neutrophils, that were involved in the reaction also support a bacteria rather than a virus.

Dr. Adeagbo said at trial that, in his opinion, it was more likely to be a bacteria than a neutrophil based on two argument. We will discuss the first one now, which is the abundance of neutrophils versus lymphocyte. I put in the bracket that -- there -- there's another argument. We'll come to the other argument later, which is that there was gram-negative bacilli in -- in the gram stain. We'll come that later.

Let's address the first argument. Is it true that because there's more neutrophil, we can conclude it's a bacteria? Next page. The first thing I'm addressing on that page is that when there's pus, some people think by mistake that that means there's bacteria and that there's neutrophils, but you have to be more careful than that because pus mean dead cell, and even if you have a viral infection, you can have pus. The bacteria can kill your cells, and if they end up in this fluid, it's pus. So pus will not help.

Does neutrophil helps (sic)? I will do the argument in two part. First, I will discuss if it was true that there were more neutrophils in the pus, would it necessarily means that it's a bacteria? And, second, I will explain to you that I don't agree that there were more neutrophil in this case, but I will explain both thing. So he said that if there was more neutrophil, that would mean it's a bacteria. And I told you upfront, in general, it is true that neutrophil are more there for bacteria, and lymphocyte are more there for virus.

But there's one exception we know that behave differently, and that's the enterovirus. In particular -- I say one exception; it's not one exception; it's one of the virus that can behave this way. We know that he has a tendency that he can attract neutrophils.

So you have to be careful when you have a lot of neutrophils and it's an enterovirus. And I told you if it's a viral meningitis, 85 to 95 percent are going to be enterovirus. In -- with the enterovirus, the neutrophil doesn't have the same meaning.

So I'm putting here, for example, in practical surgical neuropathology, they -- they speak about the spectrum that we can see, and they say that -- when say PMN, polymorphonuclears, I already told you that that means, in this context, neutrophils. In other context, there's two other polymorphonuclears. They have no importance for you in this case.

So he said that at the other end of the spectrum, some cases of viral meningitis in their acute phases manifest with the CSFs -- it means cerebral spinal fluid -- profile that includes considerable amount of polymorphonuclears, and in these instances, neutrophils are also found in the meninges by the pathologist.

I cite a lot of other study then. I will only insist on two. The first one is very interesting. It's Tan et al. (sic), 2016. The -- the title of their paper is -- so it's a Reference Number 7: (as read)

> Cerebral spinal fluid white cell count discriminatory or otherwise for enteroviral meningitis in infant and young children.

So they specifically wanted to know, when we can't find an infectious agent or if we don't have, for different reason, an infectious agent, can we rely on things like polymorphonuclears or neutrophils to make the distinction between a virus and a bacteria? And their conclusion -- so it's the third paragraph -- the fourth paragraph start by Tan et al. (sic), I will read the last part where it's in italics, so it's a citation, and they say: (as read)

> With some pleocytosis [that means with a lot of white cells], levels suggestive of bacterial meningitis, [and they had] it might be challenging to differentiate between bacteria and enterovirus meningitis based on the initial CSF [cerebral spinal fluid] analysis.

So they tried, and their conclusion was with the enterovirus, we can't really make the difference based on neutrophil. I will give you one more study, but there's other in the report, but I -- I don't want to just study -- describe studies all day long.

The last paragraph, there was an outbreak of the enterovirus, and they studied 20

patient, and in these 20 patient, 12 out of the 20, which means 60 percent, they had a predominance of their neutrophils instead of their lymphocytes.

So, in general, yes, neutrophils are more associated with bacteria, but in the case of the enterovirus, that would not be a true assertion. So we cannot use the neutrophils to make the difference.

Having said that, next page, I had an opportunity to review the microscopic slides that had been looked at by Dr. Adeagbo. I look at the pus. What I found is that it's mainly dead cells. The -- there's kind of a big thick layer. I say "thick", but it's on -- it's on -- on the slide. You can see that there's a part that is now on the slide where the pus was. Now the pus is on the slide. This is mainly dead cells, and dead cells, you can't say where they were. They're -- they don't look like when they were living cells. You can't recognize them.

So the majority of the pus is debris, but that debris -- there's kind of little black spot all over the place in this debris, and if you're not careful enough, that can look like neutrophils. I don't know if that's what happened here. I can't be in the head of Dr. Adeagbo. When I look at that slide, I don't see a lot of living cells. I see mainly dead cells that -- or debris that we can't interpret anymore. When you look carefully, there are certain areas where there's still white cells, the little solider that went to come to do the -- to try to get rid of the meningitis, that are still there, and their type is not mainly neutrophils; it's mainly lymphocytes and some monocytes. I have not mentioned this one yet. I don't think it's worth that I describe what it look like, but it also go with more a virus than a bacteria usually.

So in this case, at the end of it all, the neutrophils would not have meant it's more a bacteria. But in this case, there're not more neutrophils, and there was a -- we don't have anything positive. I will come to the 16S rRNA later. If we look at the culture, nothing positive, and we have the positive throat swab or wash. So on balance of probability, for me, that meningitis is a viral meningitis.

But my words are important. I didn't say it is a viral meningitis; I said "on balance of probability". I -- I can't say it is or it is not at the end because we don't have here a positive test in the cerebral spinal fluid.

MR. BUCKLEY: And, My Lord, I'm just noting the time, and I think the witness is at a subject change. How long do you want me to proceed this afternoon? I'm happening to go quite late actually.

THE COURT: I would like to continue.

MR. BUCKLEY: Okay.

THE COURT: We're --

MR. BUCKLEY: Agreed.

THE COURT: -- challenged with the schedule.

Madam clerk, are you okay to continue? Madam reporter, are you still all right?

THE COURT REPORTER: Yeah.

THE COURT: We'll continue for a while. I'll just keep an eye on the jury.

MR. BUCKLEY: Thank you, My Lord.

A So I'm now at 1.3. So I'm aware that you were told that the bacteria in this case -- I'm aware that you were told that it was a bacterial meningitis caused by Haemophilus influenzae. My expert opinion is that there is absolutely no scientific evidence to support that. Once again, check my words. I didn't say it's impossible that it is Haemophilus influenzae. I told you, at the end, no one will able to tell what it is, but there's no evidence to support that we can make this affirmation that it is Haemophilus influenzae. On balance of probability, I still this it's enterovirus virus, but let's look at this assertion. Let's look at why it was said that there was evidence.

Dr. Adeagbo based himself on two things here: mainly a test called 16S rRNA. I know I'm keeping (sic) mentioning it. We are almost at this test. But he mention also another thing, that when they were doing a gram test on the CSF, the cerebral spinal fluid -- and also I have to refer exactly where it was. Sorry.

Okay. So in the right lung and the cerebral spinal fluid there was on the gram stain gram-negative bacilli. So it's not a culture. It's a few bacteria that can be seen when you spread the fluid or the piece of the lung onto a slide. It's not done by a forensic pathologist. It's done by a microbiologist. They do a special stain on it, and they give us a report.

We wanted them to be able to grow a bacteria or -- but they couldn't. There was nothing growing. But they tell us that there was a few gram-negative bacilli. I will come back to what I think these are later.

The two argument of Dr. Adeagbo to say it's Haemophilus influenzae are that there are some gram-negative bacilli on the gram test and the 16S rRNA. Let's look at the gram stain first. Upfront, neither I nor Dr. Adeagbo are microbiologist. We are not, so we rely on their report. So the first part is seen as a forensic pathologist to answer Dr. Adeagbo. If you had the opportunity to hear a microbiologist instead, that would be better, but I will do only my part as a forensic pathologist answering Dr. Adeagbo. That's all I will limit myself to. So he says --

MS. WEICH: Can you get her to back up a little bit?

Q Oh, yeah. Again, just when you get close to the mic -- good. That works too. Very practical.

MR. BUCKLEY: Thanks, Lisa.

MS. WEICH: You're welcome.

A So he said -- maybe it's too far now. Okay. I'm on page 5, the one paragraph before the last. So he stated at trial: (as read)

> Based on the DNA, we found out that that gram-negative bacilli was Haemophilus influenzae.

Then next paragraph, he also said -- he was explaining what a bacilli is, and he said: (as read)

> We have a gram-negative organism, and the shape is described as "bacilli". Bacilli actually means rod. Rod is -- usually there are -- there are two types of shapes. A circular shape called the "cocci" or "coccus" and a rod shape called the "bacilli".

As -- there's more than two shape, but I will admit to three. There's the rod shape as he described, so they are kind of elongated shape, and they are called "bacillus" when singular, "bacilli" when plural. There's a small round shape that we call cocci or coccus, depending plural or singular, but there's also an in-between. This is a "coccobacillus". It means it's not a long rod like the usual rod. It's a tiny, tiny, tiny rod so that if it's not cut in the right way, it look like a cocci.

So when you have that on the slide, you have some that look like a tiny rod and some

like -- look like a normal cocci. The part I'm not sure of if I was the pathologist on that case at the Office of the Chief Medical Examiner and I wanted to make the conclusion that that could go with Haemophilus influenzae, which I would not do for reason I will explain later, I would have taken the phone to ask him, Is it possible your language was not precise enough and actually you don't mean bacilli, but you mean coccobacilli? Which I doubt, but I would have had to check.

I'm not a microbiologist nor is Dr. Adeagbo, but what I know is that Haemophilus influenzae is not a bacilli; it's a coccobacilli. But I will stop there because I'm not a microbiologist. But I know it's not a bacilli.

I'm on page 6, 1.3.2. We'll finally discuss this test 16S rRNA. It's a relatively new test used to identified (sic) bacteria. The way it works is -- there's one thing about bacteria I have not told you yet. Bacteria are very good to exchange genetic material, so one bacteria will exchange with even other species of bacteria, genetic material, and that's how they become so much -- violent or aggressive or resistant to bacteria -- or to antibiotics, because they exchange genetic material all the time.

So if a bacteria finally gets the good way to come back, one of (sic) antibiotic, they will send it -- I don't think they think about it; it's just -- it happened this way. They send the genetic material, the other bacteria take it, and if it does them good, they keep it. So they can exchange genetic material. Imagine the difficulty when microbiologists need to identify these bacteria because the genetic material in them might not be from the same species. They might have taken it from another bacteria.

So they developed a test that -- it's -- they took a gene that has not evolved a lot, so that way this gene doesn't have the same change as the other genes, and because it doesn't change as much over time, they are able to tell which bacteria it is by looking at it.

That genes -- and this is where we go to the 16S. 16S means something. It's a little part of the little part of the ribosome. I've mention that word once already. You might have forgotten. I said that ribosome are the factory to do proteins. In our cells -- and virus don't have that; they use our own cells -- bacteria in humans have ribosomes to produce proteins. So a ribosome is a little ball, and on top, a big ball. Or it could be the opposite, top or bottom is not important, depends. There's a small ball and a big ball.

The genetic material, which you can think as a blueprint, will enter in between the two balls. The small part will read it. The big part will go and find the building block. Like, think Legos. They go and they find the Lego. They are amino acids. And with

this, they will construct the proteins.

In the small part, there's a part that is called 16S. This is what they're looking for. This test, 16S rRNA, has started to be used in -- for trying to find which bacteria. There's two problem with the test, one that I won't discuss today because it has no importance in this case; the other problem with the test -- and that's why it's not widely used yet -- it's too sensitive. It find too many bacteria. Here's the problem. If there's already a bacteria and you know the culture is positive, but if you have a hard time to which bacteria it is, it is a good test.

If I exclude the other issue that I don't want to discuss because it's not relevant for you, it is a good test to say which bacteria it is. But when the culture is negative, the test is so good at, we call it, "amplification". They will take the DNA, and they will try to find DNA, and they amplificate (sic), amplificate, amplificate, make it more detectable until they detect something. Which means that, for example, if I take my blood right now in which there's absolutely no bacteria, if one bacteria, only one, enter the specimen, maybe because we didn't disinfect enough, maybe because I breathe near it, and when I breathe, there's bacteria in the air, maybe because on the glove, when I put it -- I didn't -- was (sic) careful enough, and one bacteria touched my glove, or maybe the fluid, when we do the test, one bacteria went -- so there's a lot of possibility from one little tiny bacteria to enter it. If it does, this help -- we'll find it. That's the problem with the test. That's why it's not used widely yet because it's too good to find bacteria. So that's the problem.

Dr. Adeagbo said -- so I'm on page 6 under 1.3.2. Dr. Adeagbo concluded: (as read)

> Based on the DNA, we found out that gram-negative bacilli was a Haemophilus influenzae.

Then he acknowledged, in different part of trial report, that this is a research tool, that we don't use it in clinical yet. It's -- so on -- I have a first edition here. Okay. That's from the trial -- no. That's from the preliminary inquiry cited at trial. I decided to speak with a microbiology expert on this. We have this research technology that we are working on. And the "we" refer to the microbiologist, not Dr. Adeagbo. Then there's also another extract, "therefore a nonclinical research methodology". In his own autopsy report, it's written: (as read)

> Given that the microbiological culture did not produce positive culture report; therefore, a nonclinical research methodology to detect microorganism DNA coding was

> utilized, and this resulted in identification of Haemophilus influenzae in the cerebral spinal fluid.

When Dr. Adeagbo had a conversation with Dr. Chan (sic) on the phone, Dr. Chan then followed that with email, and we have the email in the medical -- we have the email in the medical examiner's file. So Dr. Chan felt the need to send this email after having spoken with Dr. Adeagbo, and he says --

MS. WEICH: Sorry, Sir. I don't know that she can speak to what another person felt the need that he had to do. There might be -- have been any number of reasons for that email.

THE COURT: It's in the file. That's the --

A Correct. Right.

MR. BUCKLEY: Yeah. And, actually, My Lord, I also think I read that email to Dr. Adeagbo on the stand also just to verify that --

THE COURT: She can refer to the email, but she can't --

MR. BUCKLEY: -- that that was his reference. Yeah.

THE COURT: -- be postulating why it was sent or --

MR. BUCKLEY: No. No, that's a fair objection.

THE COURT: Yeah.

A So it's written: (as read)

> Broad ran -- broad range PCR and sequencing for the DNA sequence coding for 16S rRNA revealed the presence of Haemophilus influenzae; however, as we discussed, while validated as an in-house as safe, this test was not been verified for clinical use, especially in the specimen type of cerebral spinal fluid and, as such, should be regarded as for research use only.

So Dr. Chan warned Dr. Adeagbo that the test was not ready for clinic. He warned him that that was particularly true for CSF --

MS. WEICH: Sorry, Sir. I'm sorry. "Warning" has an implication. The words are there in the email. But "warning" imputes a reason behind it to the person who wrote the email. The only person who can give that evidence Dr. Chan.

Q MR. BUCKLEY: Well, Dr. Sauvageau, I'll just ask you, you know, if you were doing this and this email came, you know, to you doing an autopsy, how would you interpret it?

A As a warning how to interpret the test. But I can take the word "warning" out. It's really not the important message. There was an information that the test is not ready for clinical use. There was an information that that was particularly true for CSF, cerebral spinal fluid, and as a forensic pathologist, I have one more worry about using such a test yet. It's that once it's going to be used in the clinic, the next day we won't use it in the autopsy room.

Because I will explain later that once you're dead, you don't protect yourself the same way against bacteria and viruses, and there's a lot more bacteria going around in your body. So when it would be ready for clinic, when it's going to be ready for CSF, we will then have to assess it for the dead body before we can use it.

So anything -- well, not anything. You can present things to Court, but you have to say what is the scientific validity so that you can have a just understanding. Haemophilus influenzae, with the test that was done, is not a valid test at this time in -- at this point in time to prove that it's Haemophilus influenzae because it's a too sensitive test to be used that way yet. So you cannot conclude from that test that it is Haemophilus influence.

Another point, Dr. Adeagbo continued -- I'm at 1.3.3. He was asked if -- I will not say what he was asked because I don't have the question here, so I will only read what he said. He was talking about the 16S rRNA, and he said: (as read)

> It did not tell me or provide me any other bacterial infection or any other viral infection.

And this statement reflect a misunderstanding of the test. Because the 16S rRNA cannot test for virus because virus don't have ribosome, and they don't have the genetic material to do ribosomes. So this test will never tell you if it's a virus or not, only a bacteria.

MR. GILES: Sir, I wonder if I might have an objection

outside of the jury's presence.

THE COURT: Jury, if you wouldn't mind stepping out for a moment.

(JURY RETIRES)

THE COURT: Doctor, if you could step out for a moment, please.

(WITNESS STANDS DOWN)

THE COURT: Yes, Crown?

Submission by Mr. Giles

MR. GILES: One of the difficulties with a witness like this is, to use the vernacular, Sir, she just kind of winds up and goes. It's not really in response to a question. Had this been to a question, I might have been able to catch this in time, but the horse is somewhat out of the gate -- or out of the barn, and closing the doors now, though, seems to be a bit proper.

She's already testified that she is not a microbiologist, but now she's talking about what this particular microbiological test tests for and what it doesn't test for. I'm a bit concerned about that. And not only that, how the entire test works.

Now, by the time I realized and have -- even made a note and realized what she said, she's already said it. I'm going to suggest, Sir, that evidence that she just gave is going to have to be subject to a limiting instruction of some sort, some sort of jury instruction. She's providing evidence about a matter which ought to be the subject of a microbiologist's evidence, not that of a forensic pathologist.

Submission by Mr. Buckley

MR. BUCKLEY: Well, I guess my friend is assuming that forensic pathologists don't know the limits of the tests that they might order. So maybe -- when they order a gram stain, they can't testify about what it might mean to them as a forensic pathologist because they're not microbiologists. So if they order an 16 rRNA (sic) test, well, that -- they can't use that at all in forming an opinion because obviously they're not trained about the -- how to do those tests.

My friend is suggesting that a forensic pathologist who -- you know, who can order different tests for different things, doesn't understand the limitations of the test, which would be pretty surprising because how would you even know how to use the test if you don't know the limitations.

If my friend wants to cross-examine this witness on her evidence (sic) of the test, that's great, but if a forensic pathologist can't testify on tests done by others that they order, then Dr. Adeagbo -- we need to strike Dr. Adeagbo's evidence about the gram staining and this test also because he's not a microbiologist. I'm just -- obviously that is silly because this can be tested on cross-examination. It's not a proper objection. She's not saying she's in --

THE COURT: I agree with you, defence.

MR. BUCKLEY: Okay.

THE COURT: I think it's fair for the witness to give that evidence, and it is going to be subject to cross-examination. She's not a microbiologist. So we'll -- she's saying, as a forensic pathologist, I ordered that test. That's what I think it does show and doesn't show. We'll see how that stands up.

Yesterday when we talked about the timing for this witness, you thought you'd be the day. I know we got a little sidetracked with some other things, but I mean to proceed so that you can finish your direct examination today.

MR. BUCKLEY: Okay. Well, let's go 'til she's done.

MS. WEICH: Sorry.

MR. GILES: I do note that we're at page 7 of an 18-page report. If we are going to be sitting until 8 or 9:00, I have a phone call I have to make so that people can make alternative arrangements for their care and feeding.

MS. WEICH: It's true of me as well, Sir, not arrangements --

THE COURT: Can you get --

MR. BUCKLEY: -- for other people, but --

THE COURT: Madam clerk?

Can you go another half an hour before we break?

MR. GILES: I think I can probably push that, yes.

THE COURT: Okay. We're going to go another half an hour before we break. We will break to let the jury have a break and madam reporter and the rest of us, and then we'll continue after that. But we mean -- I mean to have this witness complete her in-chief today. All right.

Madam clerk, call the jury, please.

(JURY ENTERS)

THE COURT: Please be seated.

MR. BUCKLEY: My Lord, I will go retrieve the two doctors.

THE COURT: Thank you.

(WITNESS RE-TAKES THE STAND)

THE COURT: Counsel, please acknowledge that the jurors are all present.

MS. WEICH: Yes, Sir.

MR. BUCKLEY: Yes, My Lord.

THE COURT: Thank you.

Doctor --

Q MR. BUCKLEY: So --

THE COURT: -- you acknowledge that you're still under oath?

A I do, My Lord.

Q MR. BUCKLEY: Dr. Sauvageau, before we took the break, you were giving a discussion of this 16 rRNA test. Can you continue with that explanation that you were giving us, please?

A I was done. So I was going to the next topic, the next -- can I continue to the next topic, then?

Q Yes, please.

A Okay. So I'm now on page 7 of my report. I will now talk about these gram-negative bacilli that were found on the gram stains. As I said before, there was no culture of bacteria that were positive, but on the gram stain, they could see some microscopically that there were some bacteria.

Dr. Adeagbo said that it was a bacterial death, a bacterial meningitis, based on two arguments. The first one we have already discussed, the neutrophils predominance, and I explained why I don't agree with this first argument.

The second argument was because of these gram-negative bacilli on the gram stain. So I am on page 7, third paragraph, or you -- or if you prefer second paragraph under the heading 1.3.4. When asked: (as read)

> Does a virus cause Ezekiel to die? [He answered] No. [He was then asked] Why do you say that?

We already addressed the part on neutrophils so let's look what he said apart from that. (as read)

> I say that because all the findings, they are not -- the autopsy findings are more in -- more correlate with the microbiology studies that are performed which is the gram-negative bacilli that we found in the cerebral -- the cerebral spinal fluid, as well as in the lung.

So let's address that statement because I don't agree with it. I agree that there was a gram stain done on the cerebral spinal fluid and in the lung, and that this show a few -- they use one time "few" and one time "scant" gram-negative bacilli.

To see that at autopsy do not surprise me at all. There is something called "bacterial translocation". It -- this is something very well known. So when you are -- when you are living, you do have bacteria in your body, but you don't let them go unless you become sick. You don't let them go in places they should not go. For example, in your guts, all your intestine is full of bacteria, but you don't let them, unless you're sick, cross the -- the wall of your intestine to go into your other organs and your blood. Your mouth is full of bacteria. Your nose is full of bacteria.

But the -- one of the intestines are the one I will mainly talk about because the intestine is very, very long, and there's a lot of bacteria in the intestine. As you are living, they stay there. When you die, they start to spread around. That's called bacterial translocation. They will go from your intestine, and you can't combat them. You're dead. So they will go out and will start to spread. When we do culture at autopsy, we even found some, often, bacteria from the guts everywhere.

So it's not like in a living patient. We have to think, Okay. Is it a contamination from the bacteria from the guts that are moving around? Is it bacterial translocation? Gram-negative bacilli, a lot of the bacteria in your intestine, the majority of them, they are gram-negative bacilli. If you don't know these names, just forget I've mentioned them, but maybe it will ring some bells: Escherichia coli, lactobacillus, proteus mirabilis. Those are types of bacteria in your intestine that are gram-negative bacilli. When you're dead, they move around. That we found some on the gram stain, it's not surprising. Bacteria are moving around.

There's another phenomenon called agonal spread. I have to tell you upfront, bacterial translocation there is absolutely no controversy. Everyone's (sic) agree with it. Agonal spread, the majority of people think it exist. Some people are not 100 percent sure. So I'm telling you that so that you can consider it. But bacterial translocation, no one disagrees with it. It's widely known.

Agonal spread is -- agonal means as you are dying. This is what it means. As you are dying, maybe the bacteria start already to spread, but this -- majority believes it can happen but not everyone agrees.

So when you are on life support for several days like Ezekiel was for several days, maybe the bacteria started earlier than death to move around. Having said that, I could have never said that part, and we still have the bacterial translocation. That does happen in everyone once they are dead. So the fact that we see gram-negative bacilli scant or few is of no particularly meaning in this case.

Last paragraph of page 7, Dr. Adeagbo recognized that you can have post-mortem contamination from stuff that starts to grow in your body. You recognize that for yeast but not for gram-negative bacilli. So I will read what he says: (as read)

> We found scant yeast in the right lung. It's usually a post-mortem contamination, and in this case, it might as well be. [And I totally agree with him on this one] The yeast we found in the lung are most likely a contaminant post-mortem through the same process, but instead of

bacteria, the fungi in the yeast --

The yeast is a special type of fungi. I don't think we need to go into defining what this fungi, what this yeast, an example. I don't think we need to go there. But the saying that once you're living you don't let -- you don't let yeast that are growing on you, like in your mouth, taking -- spreading around. When you're dead, they will. Same -- so same as bacteria. And Dr. Adeagbo, the yeast that is found in the lung, he think it's a post-mortem, which means after death phenomenon, and I agree with it. The part I don't agree is I think it was the same for the gram-negative bacilli.

Page 8, so if we take together all that we said already together -- and there's part that I can't discuss with you, but even if I exclude the part I can't discuss with you, at the end of it all, on balance of probability -- because I can't tell you which infectious agent it is, but on balance or probability, it is, in my opinion, a viral meningitis by an enterovirus. It can be a different virus. It can be a bacteria. But on balance of probability, it's more likely that it's a virus. And because we identified enterovirus or rhinovirus -- but the part I didn't tell you yet is that enterovirus very often cause meningitis. The large majority of meningitis are by enterovirus. The rhinovirus doesn't do that. It stay there. So that's why, on balance of probability, I say it is an enteroviral meningitis.

Next step. I'm -- I'm not sure -- I'm not sure . . .

Q Yeah, that's a good question because you --
A Am I allowed? Can I explain the context, why I need this?

MS. WEICH: What is she on? Page 8?

A So --

MR. BUCKLEY: Page 8, Number 2.

A So there is a viral meningitis, and there will be -- we said it already, there's also a paramedic misadventure. To find the cause of death, I have to see from these two thing what is more likely to cause death because both can cause death. So I have go back to what happened usually when you have an enterovirus meningitis or a different type of meningitis, what happened when you have that type of paramedic misadventure, and what is the most likely reason why at the end he is brain dead. Because most meningitis, people survive. We don't see that many on our autopsy tables, so that's why we have to go back --

THE COURT: Hang on a second.

Justice objected to the answer... This is a little odd especially given the fact that its a criminal trial and he did not do this during any other medical testimony that was outside of the experts expertese.

MR. BUCKLEY: Yeah.

MR. GILES: I think perhaps we should discuss this area of evidence and whether or not -- if this is something that this person --

THE COURT: All right.

MR. GILES: -- can attest to before we go any further.

THE COURT: Could be a bit contentious.

Jury, I'll ask you to step out.

(JURY RETIRES)

THE COURT: Doctor, I'll ask you --

A I leave? Yeah.

THE COURT: But could you just -- yes. Just leave your exhibits there.

A Yes. Sorry.

THE COURT: Thank you.

(WITNESS STANDS DOWN)

THE COURT: Have a seat.

Submission by Mr. Giles

MR. GILES: My concern is that we're not talking about prognosis. And now ultimately, my friend, I'm sure, has a significantly more familiarity with precisely what this witness intends to actually say than I do because it's his witness. But if she cannot provide evidence as to prognosis, however, I suppose to some extent statics are fine. As long as we keep it to that and we're not talking about this particular individual, then I don't really have a particular issue with that.

But if she's saying, This person would most likely or that person would most likely, based on these symptoms, or something like, that would be problematic because she's talking about statistics, and, frankly, I think ultimately that's where she's going to be. I would hope that perhaps my friend might just take a brief moment and just ensure that's where we're at if, in fact, that's what the Court feels is appropriate as well. And --

Submission by Ms. Weich

MS. WEICH: So, Sir, there's one further thing that I have to add to that. Even though it was struck out of the report, and even though -- I'm assuming -- I shouldn't assume; that's a terrible thing to do. Because it was struck out of the report, I have to assume that Mr. Buckley told her, Don't mention this about how there's more viral -- the percentage of viral meningitis versus the percentage of bacterial. But she very clearly said, Viral meningitis are pretty common; bacterial meningitis are not as common, which brings us back to the original point concerning is that in a in --

THE COURT: In what population.

MS. WEICH: -- vaccinated population. Exactly. And so, Sir, if she's turning -- and then we get to the point of prognosis, Sir. And even though it's the least of our worries, in the middle of page 8, there is a reference to croup being a benign condition, and my friend seems to have missed vetting it out, unless he left it there on purpose for some reason.

MR. BUCKLEY: No. No, croup was never left in on purpose.

MS. WEICH: So that whole two lines needs to be taken out in the middle of page 8. But I'm more worried, Sir, about here statement, Viral meningitis is pretty common; bacterial meningitis are not as common. So -- and, again, this whole, Viral meningitis are usually mild, in what type of population, Sir?

Submission Mr. Buckley

MR. BUCKLEY: Well, there's no vaccine for viral meningitis so I don't know that issue comes up there, unless my friends can correct me on that. So -- so I don't think we're dealing with a vaccination issue. And, I mean, she's already indicated that -- you know, the reason why she needs to discuss this evidence, and my -- I anticipate she's really just following the report. Is -- she can't give a cause of death without that understanding, basically the mortality -- expected mortality of viral meningitis versus bacterial meningitis.

And, I mean, every single doctor, except for, I mean -- every doctor from Alberta Children's Hospital has talked about how dangerous bacterial meningitis is, and, I mean, they're not going to be specific experts on meningitis and how virulent it is or isn't so -- but she needs this evidence to do a comparison. I mean, if viral meningitis obviously was very fatal, then that would affect her opinion.

THE COURT: Well, I don't think -- the first state of: (as read)

> Viral meningitis are usually mild and resolve without treatment.

That's not as contentious as other aspects. Thinking back on the body of evidence that we've had, if I started at the top, looking through the Crown's objections, the first sentence: (as read)

> In the absence of the medical misadventure during the paramedic intervention, the expected outcome for this child was good.

I mean, she might be able to say something like, In the absence of the medical misadventure during the paramedic intervention, if there was one. I mean, the jury has to decide that.

MR. BUCKLEY: Oh, yeah, absolutely.

THE COURT: And assuming it is viral meningitis, the expected outcome for this child was good. I think she could say that. She -- she's trying to buttress her finding that it's viral meningitis based on the fact that the child, if I read it through, he died. You don't usually die of viral meningitis. You might die of bacterial.

MR. BUCKLEY: Well, actually, with due respect --

THE COURT: I mean --

MR. BUCKLEY: -- I don't think that's where she's going, is she's -- I mean she's been asked to assess the autopsy report and -- you know, and everything that she needs to and give the defence an opinion on cause of death. And her opinion is actually the cause of death was he didn't have air in the ambulance for 8 minutes and 11 seconds. That -- that's full stop cause of death, but she's -- and I think she was just trying to tell the Court, but I actually can't go there.

Like, what if the meningitis, in her opinion, was going to be fatal anyway, then that would be a cause of death also? So her understanding actually on, Well, what are the typical outcomes for the different types of meningitis, speak to her opinion on cause of death.

THE COURT: I see it linked, though, counsel. I mean, she's taken the first eight pages to demonstrate that in her opinion it's, on the balance of probabilities, more likely that it was viral meningitis. Then Section 2 she comes out with the bold statement as to outcome, which is -- there's an element of prognosis there. She's got it down to two possibilities. And then she talks about how viral meningitis usually resolves, compares bacterial meningitis, which has a higher -- a higher rate of death, but it -- it's the -- I don't know what population it is. Is it this child's population or a general population? I mean, that could be anything. She's using it to buttress that view, that it's viral meningitis.

MR. BUCKLEY: Well, actually, I mean, with due respect, I -- without knowing and appreciating and identifying for the jury what are the expected outcomes if you have viral meningitis or bacterial meningitis? Because she's not ruling out bacterial. She's saying her opinion is it's viral, but she's been very careful both in the report and in her testimony to -- not to rule out bacterial meningitis. She's been careful about that.

So it would be somewhat odd if we said, Well, okay, viral, here's kind of what we would expect; and, well, let's leave out bacterial, which she's left as a possibility, and we know that's Dr. Adeagbo's evidence, that it was bacterial meningitis; and she's, you know, of the opinion that actually the problem with the ambulance not having the right equipment to get an airway for an infant is really the deciding factor. But if he would have died regardless of the ambulance because of the outcomes of potential viral meningitis or bacterial meningitis, that would affect her opinion.

So I -- I guess where I'm going is how -- and she said this already on the stand. How can she give an opinion of cause of death without having the jury appreciate, Well, if it's viral meningitis, here's the typical outcomes; if it's bacterial meningitis, here's the typical outcomes?

And like I say, for argument sake, let's say everyone who had meningitis at the stage she sees at the autopsy dies anyway, well, then who cares about the ambulance? How is that relevant, then, at that -- at that point? But if what she sees, she think, Well, just wait. Ezekiel very likely could have lived without any difficulty but for the ambulance intervention, it's not meaningful without this information.

THE COURT: Crown?

Submission by Ms. Weich

MS. WEICH: Okay. My friend, Mr. Giles, might have something different to say about this so I invite him to pop up and stop me if I'm going down the wrong road. She has not explained -- other than on the swab there's enterovirus, she has not said, I looked at this, this, this, this; this is what I found. What she talked about was Dr. Adeagbo said this, here's why I think he's wrong, but she hasn't done the backwards route that you hear from pathologists so often. I conducted my examination. Based on my findings here, what is my reasonable conclusion?

So I'm a little bit concerned that, like the Court has pointed out, she's buttressing her point of viral versus anything else not -- based on the very, very, very little that is actually there that she sees in the medical file, and her assumption, which she -- or her statement about how viral's common, bacterial isn't. And then, yeah, the -- what her -- what the expected outcome is, being diagnostic. I just don't see how we get away from all of that.

MR. BUCKLEY: If I may respond to my friend?

THE COURT: Yes.

Submission by Mr. Buckley (Rebuttal)

MR. BUCKLEY: So, I mean, I don't see this as giving a diagnosis on Ezekiel, and my friend is being a little disingenuous because obviously Dr. Sauvageau didn't do the autopsy, and she's critical that Dr. Adeagbo didn't do more tests, especially of things like the right lung or a virus test on the cerebral spinal fluid or the -- you know, the pus on the brain.

So the fact that, you know, the pathologist that did the autopsy didn't order a whole bunch of tests can't be held against Dr. Sauvageau. She can only rely on what was done, and she is not here saying Ezekiel had this or this or this. She's not giving a diagnosis of Ezekiel.

It could be argued that it's, you know, prognosis evidence out the -- you know, but how can she give a cause of death with -- I mean, there's meningitis there. It's viral or it's bacterial, and without weighing what the likely outcomes of that was, with what she terms as the "medical misadventure", how can she give an opinion?

THE COURT: Well, I think to make it straightforward and to deal with the objection and the other things, I think we can -- we can adequately deal with it by simply saying, in the first sentence of Section 2, In the absence of the medical misadventure during the paramedic intervention, assuming viral meningitis, the expected outcome for this child was good. She can then give her stats on what happens with the viral meningitis.

But the stats with respect to bacterial meningitis give rise to too many concerns, counsel, that are -- we've had to stay away from because of the way the case has been limited and the matter has been prosecuted. It's been prosecuted --

MR. BUCKLEY: Well --

THE COURT: -- in a limited way to the advantage of the accuseds persons.

MR. BUCKLEY: Right. But she's giving stats once people have bacterial meningitis. Like, once you have bacterial meningitis, it doesn't matter whether you're vaccinated or not, does it? How does vaccination come into play? If you have bacterial meningitis, you have bacterial meningitis. She's just giving stats of the death rate for people that have bacterial meningitis, not of who contracts it, what population contracts it. This -- these are people that have bacterial meningitis.

So how does that bring a vaccination issue into play?

Submission by Ms. Weich

MS. WEICH: So unfortunately we honestly don't know, Sir. For example, perhaps some -- the population of people who are vaccinated and then develop it anyways, maybe it's lighter for them. Maybe it's not as bad for them. Who knows. The problem is we just don't know.

THE COURT: Madam clerk . . .

Counsel, I'm going to -- I'm going to have madam clerk tell the jury that we'll let them stay out until quarter to 7, and I'll just deal with this, and then we'll take a break so that you can make your phone calls, and then we'll bring the jury back in at quarter 7 after they've had a chance to be a bit refreshed; all right?

MR. BUCKLEY: And I would suggest that we deal with the next

section which seems to be connected.

THE COURT: Madam clerk, please tell the jury that we'll get them in at quarter to 7; all right?

Okay. Counsel, the next section, and you wanted to deal with a potential objection there?

Discussion

MR. GILES: The impact of the delay of antibiotics, a treatments question, Sir. I know that we didn't specifically exclude treatment, but I don't see how a forensic pathologist can give expert evidence about treatment. I mean, granted she, like me, can yank quotes out of various different articles. That's a very different thing from providing opinion evidence.

Opinion evidence should be based more on simply plucking out articles. Anybody can do that. We could have an engineer here do that. This isn't a question of that. She should not be able to provide opinion evidence about the impact of the delay of antibiotics in my view, Sir.

MR. BUCKLEY: It speaks to cause of death. Because the Crown's basically saying that my clients are criminally liable and should go to gaol because they didn't go to a doctor soon enough. And I have an expert on cause and progression of disease who wants to say, You know, actually, when you look at the scientific evidence and -- are they going to say she's not qualified to do that, being that she's been a journal reviewer for almost every journal under the sun and on editorial boards?

So basically I can't call, through a forensic pathologist, evidence to say, You know, actually, it's not as meaningful as the Crown has been saying, you know, this quick need to get antibiotics. I mean, that's what I'm hearing my friends say. It speaks to cause of death. Because my -- the Crown's case is they didn't seek medical attention soon enough; that's the cause of death.

MR. GILES: The fact that my friend wants a conclusion doesn't justify the means for which he obtains it. I -- we've had doctor after doctor after doctor who have had decades of experience treating this who could provide their evidence about what the appropriate treatment is. Now, to put on somebody who doesn't treat people provide that evidence, I don't know why we would do that.

MR. BUCKLEY: But the doctors can't even say it's meningitis

until there's an autopsy. That's crystal clear. It's crystal clear in the medical records. It's crystal clear on their evidence. They can't even say that it's meningitis until a forensic pathologist tells them it's meningitis. They can't. That's the Crown's case, not the defence case.

So clearly forensic pathologists are able to come up with a diagnosis of meningitis. And I'm sorry; that's a diagnosis. It is. And they're there to say cause of death so they can say, Oh, I find meningitis, but I can't say whether or not that's the cause of death because I can't go to whether or not any intervening factors would have had a play here versus what I know about this, you know, brain injury.

And basically what my friends are asking the Court is to basically say that Dr. Sauvageau can not give her opinion evidence on what the cause of death here is.

MS. WEICH: So, Sir, when it comes to the antibiotic issue, we didn't put any of that to our doctors. Mr. Buckley did in cross. He asked them, you know, Can you say for sure, if the antibiotics had started the day before or two days before or three days before -- we left that alone. Regardless, that's what doctors are for, as Mr. Giles already said.

MR. BUCKLEY: And I'd say, with all due respect, my friends -- my friends have clearly led evidence saying bacterial meningitis killed Ezekiel -- that's cause of death -- and he should have seen a doctor earlier. So to suggest the defence is raising an issue by saying, Well, when? When would it have made a difference, by asking the doctors is a little stretching things.

THE COURT: So I don't think there's any concern about the issue being raised. I think the concern is about who can testify to it. How can she testify to the potential success of a treatment regime on a chronically ill, actively ill, acutely ill -- not maybe chronic but an acute illness? That's not her area. She's not a treating, she's not a diagnostician, she's not a treating physician. She doesn't have the expertise to do that. It hasn't been demonstrated. It just -- she doesn't have that expertise.

MR. BUCKLEY: Well, I guess -- so a forensic pathologist who, you know -- involved in setting standards -- I guess forensic pathologists -- how do they give a cause of death if they don't -- if they don't have an appreciation of which diseases and illnesses lead to death, at what point, and when? I mean, I guess that's what it comes down to.

THE COURT: It's about the same as her idea that she could -- came up in qualification, she talked about commenting on medical malpractice. Well, we

didn't go into that, but it -- I almost got the feeling that she thought she could say, A particular doctor may or may not be negligent, i.e., the standard the care, and that's just not the way we did that.

MR. BUCKLEY: Well, but her evidence --

THE COURT: She can't do that.

MR. BUCKLEY: Her evidence would -- at the College would ask her for that opinion.

THE COURT: She's not qualified in my courtroom to give opinion, and she's not qualified to give this opinion. She's been qualified to provide certain opinion evidence, and she needs to stick to it.

MR. BUCKLEY: Well, I need the Court's direction on what she can do with these two sections. For the one --

THE COURT: She can do what she --

MR. BUCKLEY: -- you said that I have to tell her to assume meningitis and to avoid stats on bacterial, but she can speak to stats on viral; am I correct about that?

THE COURT: Well, first of all, she has to -- she has to assume viral meningitis, for example, in the first sentence of Item Number 2.

MR. BUCKLEY: Right. I got that. That's what I meant by --

THE COURT: (as read)

> In the absence of a medical misadventure during the paramedic intervention, assuming viral meningitis, the expected outcome for the child was good.

Then at the bottom of the page she says the same thing: (as read)

> Therefore, without the medical misadventure during the paramedic intervention, assuming viral meningitis, the outcome of the case would have most likely been good.

She can -- she should say that.

MR. BUCKLEY: Okay. And I believe --

THE COURT: That's her assumption.

MR. BUCKLEY: I believe you would allow her to speak to viral meningitis but not bacterial meningitis? I just mean --

THE COURT: Well, it's certainly evidence that bacterial meningitis is known to be more aggressive than viral meningitis.

Is the Crown really concerned about the death rates?

MR. GILES: After reading the article, I certainly am.

THE COURT: So she can say, In bacterial meningitis, which is known to be more aggressive than viral meningitis.

She can say that. That's consistent with what everybody has said already. But to get into the ins and outs of it, I think is unfair to the process, and it's -- leads us potentially into that area that we've striven to avoid.

And the impact of the delay of antibiotics, counsel, I cannot see how she is qualified to speak on that. We heard form the diagnosticians and treating physicians about that, and they gave you opinions. They said, If somebody comes in with meningitis, we start full -- broad spectrum antibiotics ASAP, and when the patient is stabilized enough to tolerate it, we do a lumbar spinal tab so that we can try and determine if it is or is not meningitis.

You -- or somebody, I don't have all the questions -- said, Well, is it going to work? Well, we're not sure, but the chances are better, basically is what they've said throughout. Those are the guys that do that job. The intensivists. The pediatric intensivists are the ones that do that work. They give those opinions. They're the ones qualified. She can't do that. I can't see how she can do that.

MS. WEICH: So, Sir, earlier when you were talking about the top and bottom paragraphs under Point 2 on page 8, I really liked your addition when you said, The paramedic intervention, if there was one. Or we could even say, Assuming that there was one. So I'd appreciate that addition to both of those sentences as well, as well as assuming viral meningitis.

THE COURT: Counsel, we know, the evidence is clear there was a medical misadventure during the paramedic intervention. We know that. There's a -- the evidence is not controversial on that, is it?

MS. WEICH: No, Sir.

THE COURT: They couldn't get a trach tube in because they didn't have them in the ambulance, and there's reasons for that which aren't very pretty.

MS. WEICH: We had a number of doctors who gave evidence that said it didn't make any difference --

THE COURT: Sure. But it was still a medical misadventure during the paramedic intervention.

MS. WEICH: I get your point, Sir. Thank you.

THE COURT: So I'm not going to change that. I mean . . .

MR. BUCKLEY: Okay. So I just want to make sure that I understand this. So I have to instruct the witness -- and I can instruct her on the stand -- that, you know, for her first sentence, she has to add that it's an assumption that there was -- that it was viral meningitis.

THE COURT: Right.

MR. BUCKLEY: Okay. And then she can speak to the second paragraph about viral meningitis, but the third paragraph she's just limited to, In bacterial meningitis, which is known to be -- it -- I guess, is known to be more aggressive than viral meningitis. Full stop. Can't give any stats.

THE COURT: Right.

MR. BUCKLEY: Okay. And then she can't go anywhere near Number 3.

THE COURT: Right. But on that very last paragraph as well: (as read)

> Therefore, without the medical misadventure during the paramedic intervention, assuming viral meningitis --

That assumption prevails.

MR. BUCKLEY: Okay.

THE COURT: So that we're clear on it. And then nowhere near paragraph 3.

Madam clerk, are we adjourned until quarter 6:15, then -- or, sorry, quarter to 7? All right. Anything before we take a bit of a break? Let's get back together at quarter to 7.

(ADJOURNMENT)

(JURY ENTERS)

(WITNESS RE-TAKES THE STAND)

THE COURT: Please be seated. Counsel, please confirm that all jurors are present.

MS. WEICH: Yes, Sir.

MR. BUCKLEY: Yes, My Lord.

THE COURT: Doctor, you acknowledge that you're still under oath?

A I do, My Lord.

THE COURT: Thank you.

Counsel, please proceed.

MR. BUCKLEY: Thank you, My Lord.

Q MR. BUCKLEY: Dr. Sauvageau, we were on page 8 of your report.
A Correct.

Q And there's a Heading "Two Expected Outcomes of [blank] and Meningitis"?
A Correct.

Q And I have to give you some instructions before you continue so -- and I don't want you to write on your copy because yours is the court copy.
A Correct.

Q But there's a first sentence there which reads: (as read)

> In the absence of the medical misadventure during the paramedic intervention, the expected outcome for this child was good.

And I'm giving you an instruction that you are just going to add in there that that is -- that there's an assumption of viral meningitis.

A That's not true.

Q But, no, just hang on. But I'm telling you that for the purposes of your testimony, I'm directing you -- just please work with me for a second.
A Okay.

Q Because we've just got -- we've got some limitations we need to work with. So what I'm going to do is I'm just going to ask you about what your evidence would be if we were just assuming viral meningitis -- because that -- your opinion is that it -- it's most -- it's more likely, on the balance of probabilities, to be viral meningitis than bacterial?
A That is correct.

Q Okay. So I'm just saying let's just ignore bacterial at all. Just assume viral.
A Okay. I can do this exercise.

Q Okay. So that's what --
A Usually are more multiple option when we considered our final opinions. But for the exercise, if that's what I -- is ask of me, I'm going to discuss only the items for viral meningitis.

Q Right. So my understanding is is you're to assume for that first sentence that there is an assumption that it's viral meningitis, and then also, to comment on the last paragraph there, that's "therefore, without medical misadventure", also making that assumption that it's viral meningitis.
A So, once again, when I did my opinion, I was more wide than that, but if the -- if it's the exercise that I'm asked to do, that's unusual, but I'm going to do it if that's what

the Court is asking me.

Q Yes. So I'm basically, on behalf of the Court, giving you that direction. So I want you to completely ignore the second-last paragraph there that says "in bacterial meningitis". So if you could -- and then I'm directing you to completely ignore -- on the next page, page 9, there's a heading "Three Impacts of the Delay of Antibiotics".
A Correct.

Q Okay. So I'm just -- I'm instructing you to completely avoid that section altogether.
A Okay.

Q So. So I'm just going to --

MS. WEICH: 'Cause you didn't vet it out.

MR. BUCKLEY: What you mean? It's gone.

MS. WEICH: Oh, okay.

Q MR. BUCKLEY: So with the assumption of viral meningitis and avoiding bacterial meningitis, could you comment with those constraints basically on expected outcomes?
A Yes. I -- I'm just worried because I need to be impartial and neutral, and I need to evaluate all the options. So just to make it clear, I am forced into a corner where I have to be less neutral and less impartial than I intended to be, but it's not my decision. It's apparently a Court decision. So --

Q Okay. Well, please let's not comment --
A -- I need to say that --

Q Okay.
A -- because I -- my integrity is -- as an expert witness, your integrity must come first, and no one can force you to say something that's not true, and that's including the Court. So I'm forced now into a corner where what I will say is not all the truth. It might be the truth, but it's not all the truth, but that's not my decision.

MR. BUCKLEY: Right. I mean, just treat it like a hypothetical where I've, you now, limited your options.

A Yes. You can limit -- you can do hypothetical with information like, What if the weapon was hold in that end instead of that end, or, What if -- but you cannot ask me

to retract from my brain -- I don't know how to phrase. I will do it, but for the record, this is very unusual, and that makes me less neutral and less partial -- less impartial than I should have been allowed to be.

Q Okay. But please -- and just please work with me. I'd ask you not to give --
A I will.

Q -- not to give any more editorial comments.
A I will --

Q Please.
A -- not. Not.

Q And so but, you know, I am still asking for, you know, your evidence because it is important on -- okay. Assuming it's viral meningitis, you know, you know, as best as you can give an opinion, well, what would the -- what would you view the expected outcome to be?
A Okay. So from this point on, I will exclude totally the possibility of a bacterial meningitis because I'm asked to do so.

In a viral meningitis, the outcome is almost -- virtually always good. It's 100 percent good. So you -- you can have severe cases. You can have cases where the child or even the adult will go into seizure. They could even go into coma. They can lose consciousness. They can have to be intubated. But with the medical support that they will require, the result is almost -- is virtually 100 percent survival. So the outcome is very, very good.

Q Now, in your report there, the top -- the second paragraph under Heading 2 which begins "Viral Meningitis", you --
A Sorry. You are where?

Q On page 8.
A Yeah.

Q So you see there's the heading "Two Expected Outcomes", and then there's --
A Yes.

Q -- the first paragraph there's a blocked-out paragraph, and then there's a paragraph "Viral Meningitis"?
A Correct.

Q Third line down, you basically say what you've told us. You say: (as read)

> Nevertheless, studies of enterovirus outbreaks have shown that the expected outcome is virtually a hundred percent survival with no sequela.

And can you explain that word for us?

A Okay. So not only with a viral meningitis will -- virtually everyone will survive, even if they need some intubation, which is not common that they need so, but that can happen. They will survive with any sequela which means there will be nothing of an impairment that you (sic) will have for the rest of their life. Like, they won't be blind. They won't be having a leg that doesn't walk with them or they won't have neurological symptoms for the rest of their life. That's what means sequela.

Q Okay. So did you have anything else to say about this Section 2?

A I have one more thing to add, is that when we will balance the -- because he is brain dead. This is a fact. On March 16, he's going to be declared brain dead. Two thing will -- we will discuss later that two thing could bring to this point. The viral meningitis as a cause of this is very unlikely because usually that doesn't happen.

It doesn't mean it's totally impossible. Even though it's virtually impossible, there might be an exception somewhere, and it might be that exception, but it's virtually impossible that that's the cause. But we'll come back to this later. But there are cases where it can happen, and it could have happened in this case. We will discuss that later.

Q Actually, I think because we're skipping Section 3 that we're likely discussing it now.

A Well, I have a comment still based on viral meningitis on 3. So I won't comment what would be the impact of antibiotics on a bacterial meningitis, but if it is a viral meningitis, antibiotics are of no use because they don't act against viruses. There are some antiviral substances, if I can call them so, but not against the enterovirus. So it's just supporting the person through the disease, and they will all virtually survive if you support them through the disease. And by support, it really depends on the case. The majority is not doing much. In certain cases, it could be, like, helping with the -- the fluid or -- and in certain cases, it might mean going to intensive care and be intubated. But if you support them through this, they will survive virtually -- virtually always.

Q Okay. So can we jump ahead to Number 4?

A Yes. So Ezekiel was brain -- declared brain dead on March 16, and at autopsy, there is what we call hypoxic and anoxic brain injury. I will discuss later that there's a

disagreement on this point between Dr. Adeagbo and me, but I will explain my opinion, and then we'll come to the point of the disagreement.

An hypoxic and anoxic injury means "hypoxia", or the adjective "hypoxic", means that in the blood, there's less oxygen than usually; "anoxia", or "anoxic" or the adjective, means there's no oxygen left in the blood.

There's another word that sometimes we put into the three. It's really a personal style that you use all three or two or one because they are always in the same -- well, they go in the same context. Some also use the word "ischemic", which means lack of blood. But if you have no blood, then you have no oxygen so it kind of all goes together.

So when I say "hypoxic" and "anoxic", we put them together because they go on a spectrum. You might have a reduction in your oxygen or you might have no oxygen. The point is really not about measuring the oxygen because at death we are past that point. We know there's been a lack of oxygen, but we -- we can't say if it was total or partial, but the damage is there. That's the point. We see the damage in the brain, and that's called hypoxic and anoxic brain injury.

So he is brain dead because something caused that he didn't have enough oxygen in his brain. Why? This is where we have to go back to what caused the brain death, which is really why he died, his brain death. So we have to go back to what caused this, and what caused the brain death is the cause of death in this case.

Brain death is not a cause of death. It's an observation. His brain is dead. Physically that's a way to find that he's dead. We have to find that (sic) why. There's two possibility, and one of them can be subdivided in two different. One is that he was so sick -- I will start by being vague, and I will go more specific. One is that he was so sick that the disease caused him to stop breathing. That part we know happened. And maybe by the time the paramedic arrive, maybe it was too late, nothing could be done, and he was already brain dead.

The second possibility is that he had the disease that caused him to stop breathing, but that the paramedic who arrive could still have saved him at that point, and if they had done so, he would have maybe survived through the disease and would have survived, but because there was a paramedic misadventure that he died.

So these are the two possibility. The first one, that the disease caused it all, can be subdivided in two. He could have stopped breathing because of his meningitis. He could have -- he could have stopped breathing because of an obstruction of -- because

of the infection in his laryngotracheobronchitis, but it could be maybe a mixture of the two. But usually disease don't -- there's one more than the other.

Before I divide the two later -- I think I do -- let's look more at the paramedic misadventure. I won't be able to tell you today exactly the number of minutes it takes so that you are brain dead if your blood is not circulated. The science doesn't allow us that degree of precision. What we know is that we usually consider that it takes about 20 minutes. Don't start the clock and measure and at 19 minutes hoping you're still okay. It's not that precise. And maybe in certain other people it could be 23, 24, 25. It's not a precise number. It's just an idea of how many minutes it takes.

What we know, though, is that we have surgeon that go and clamp the carotid, the carotide (sic), so the big vessel in your neck, because they do surgery on arthrosclerosis.

As an asphyxia expert, I look at this very closely because that gives us good information that we can not just do on other people to experiment. The surgeon, when they block these vessel with clamping, like little metallic thing that would completely block the blood, they know they have 5 to 10 minutes. Doesn't mean at 11 the patient would be dead or would have a damage in their brain, but that means that's the window that's considered still safe.

So we know that usually, if you clamp the vessels, which is worse than having just a respiratory arrest, you do have about 5 to 10 minutes, but by 20 -- these numbers are not precise as I said -- by 20, it's too late. Let's go back to the case of Ezekiel. Usually we are -- we're having a problem to have good timing, as I said earlier, because if you're sitting at the kitchen table and suddenly someone stopped breathing, no one's starting a clock to see how much time it would be before the next step.

But in this case, because there were phone calls at 911 that documented certain steps, we have more information than usual. So when the first call was done to 911, Ezekiel had stopped breathing, and then he start breathing again. So the -- one more thing I can tell you from asphyxia is that when you're not familiar with the -- with the feel, you might think that if you stop breathing once, it creates -- it will be worse the second time, but, no, it's not true. We know that sexual asphyxia actually because in sexual asphyxia, they play with the hanging, for example, and they go out of the stool and go back on the stool again. So they hang and then go back, and then they play again, and they stop. And we measured how much time it takes that you lose consciousness when they (sic) do that compared to someone that never did this playing and went straight into a hanging.

And what we discovered is that actually every time you start again to breathe and let your blood circulate, you go back to point zero. It takes several, several attempt that there's certain differences. Some when you stop breathing and you breathe again, it -- it start back to point zero for the timing. And then you stop breathing again. If we take, for the -- my understanding -- and if the facts change, that might change my opinion. My understanding is that after this first call, when he stopped breathing again, 911 is called immediately. Okay. That's not one second. It's not that degree of precision because that's still very quick. And this second phone call is eleven fifty-nine seconds, 11 minutes 59 seconds. And then the paramedic arrive.

When they arrive, he was still in great part in the zone of safety and actually more than the cases I was explaining to you. Because this is not someone that we have clamped the two vessel; this is someone that put -- eleven and fifty-nine -- 11 minutes and 59 seconds there's someone doing CPR. CPR is protective. You can go further than the 20 minutes if you have CPR. So that was protective. So that at 11 minutes, 59 seconds, on balance of probability, if he's immediately intubated, I don't expect him to be brain dead at the hospital.

However, this is not what will happen. When the paramedic arrive, they try to intubate by different method that I don't enter -- that I won't enter in here, and that will prolong the time by about eight minutes during which they are concentrating on the airways. And my understanding is that there's not the same amount of pumping of the heart during that period because -- and they arrive to do so. They are really trying hard for the respiration.

Now, we are past the safe zone. So when he arrive at the hospital and that he is brain dead, on balance of probability, it is because of the paramedic misadventure. Can I say 100 percent that it is? No, I can't. It's still possible that for some reason he would have died, been brain dead nevertheless, but on balance of probability, knowing everything we know in this case, as an asphyxia expert, it's my opinion that it's strongly in favour that the cause of death, why he is brain dead, is the paramedic misadventure, and that without the paramedic misadventure, he would have survived through the meningitis with proper support.

Q Now, Dr. Sauvageau, can I just interject into, you know, the fact pattern and just -- so just hypothetically, but what if -- so, you know, the ambulance isn't able to get an airway, but they really are trying to be and are being diligent on, you know, chest compressions while they're trying to get an airway.

A It makes the zone of safety slightly bigger, but the fact is still that he will be out of the safety zone at some point since he's brain dead so the main -- at some point, he need oxygen in his brain, and he didn't get it. So that doesn't change the balance of

probability, even if my understanding was wrong, and that they were still pumping the heart. It would change if they had obtained airways earlier than my understanding is.

Q Okay. So carry on.

A Okay. So now I will be on page 10 of my report. So my opinion is that he has this brain damage and hypoxic and anoxic brain injury, and there's a disagreement there between Dr. Adeagbo and me. So I will read the part that was told to you before, and then I will explain further. So there will be term that you might not understand fully at this point; I will explain them after.

So on page 10, I start after the heading of 4.1. So Dr. Adeagbo is asked: (as read)

> It's just hypothetically speaking, though, is -- if -- if the ambulance couldn't get air into Ezekiel -- you had used the figure seven minutes when I had suggested eight minutes so let's go with your seven minutes -- then in itself could cause brain damage; right? [And Dr. Adeagbo answered] Yes, it could.

And that I agree fully with him. But then he asked: (as read)

> You see, from the pathology point of view, there are actually -- there are actually findings in the brain that would indicate hypoxic and syphilopathy that will indicate that the brain is as -- is sufficient blood supply or oxygen. When I did autopsy, I look at the brain. There is nothing in the brain, in the spinal canal, on the brain, the substance of the brain, that shows that the cells in the brain, the neurons, are actually behaving like neurons that lack oxygen.
>
> They're not eosinophilic. They don't have that change that will suggest to me there is hypoxic and syphilopathy in the neuron. There is nowhere you see eosinophilic neurons. There is nowhere you see changes sufficient enough to -- I mean, changes that will suggest hypoxic and syphilopathy. If there's hypoxic and syphilopathy in this case, I would mention it, but there's not there -- but it -- but it's not there. [Sorry]

So, yeah, I agree with you of that possibility and, to mention, who actually made that statement when a brain is not functioning, but the fact is the brain dead in this case

can be attributed to the meningitis, not to the hypoxic and syphilopathy. Then continued: (as read)

> Eosinophilic neuron, what does that look like? It's a particle change in the brain cells that makes it to change colours for the cytoplasm and the brain cells and the nucleus change colours. They become more pinkish.

I do agree with Dr. Adeagbo that in hypoxic and anoxic encephalopathy or brain injury -- that's a synonym by the way. You can say hypoxic and anoxic brain injury or hypoxic and anoxic encephalopathy. Encephalopathy means disease of the brain. Brain injury is a disease of the brain. That's the same thing. We're talking the same thing.

So I agree with him that when you have an hypoxic and anoxic brain injury, you can see eosinophilic neurons. What I don't agree with is that this is expected in this case considering the particularity of this case. Let me explain.

When you die of hypoxic/anoxic injury, if it's immediate, like, if I drop dead of this, there's nothing to see in my brain. My brain is totally normal. To be totally exact, there's a slight change in it, but that is exactly the same image from being dead so we can't make a difference with our eyes. There's kind of little space in -- in -- in the cytoplasm, but that -- we can't see the difference; it's just being dead. So we don't see anything.

If instead of dropping dead, I survive a certain amount of hours -- it's not precise. I can't tell you it started at that number of hours and it stop at that numbers of hours; it's not that precise. We say something like a few hours up to six hours or so. The "or so" is important. Then your neurons have the time to suffer the lack of oxygen and to show changes. What happens is that when we look at them under the microscope with the colouring we use, the part around the nucleus become very, very vividly pink. For us, it's calls eosinophilic because we use two colour on our slides. Our slides are coloured with 'H' and 'E', which means hematoxylin and eosin. Hematoxylin is blue; eosin is pink. When we put these two colours, certain thing become pink, certain thing become blue.

Because if we just take a piece of our tissue and put it on a slide and look under the microscope, it's transparent. We see nothing. So we use chemical to -- to see the tissue.

When a neuron is dying of -- of a lack of oxygen, it become very, very pink, and

because that's coloured with eosin, we call it "eosinophilic" because they express more the pink, and his nucleus will suffer and will shrink and become darker. These are the eosinophilic neurons. We see that if you survive a couple of hours but -- about up to six hours and (sic) so; it could -- it could stay longer.

If you survive longer than that, like on life support, at about 24 hours -- not a precise number once again -- at about 24 hours, this cell is dead. You're brain dead maybe, but you're still living through this life support. Your white cells are cleaning the mess. They go and they take out the dead neurons. By doing that progressively, the eosinophilic neurons will disappear.

The first thing we will see is that their cytoplasm around them will become paler and paler, and we won't see as much the red or the pink. Red and pink. It's just -- some people see it more red; some people see it more pink. It's just our -- the way our eyes are done in humans.

The neuron will continue to shrink. Eventually they will disappear, and there will be a scar that will appear in the brain. The scars in the brain are like -- are not like a scar on -- on the skin. The cells that do that are called astrocytes, and when they go and they fill the empty spot where the neurons was -- were, we call that "gliosis".

So if you die immediately, I don't see anything in your brain. If you survive a number of hours on life support, or if you survive but your brain is having already damages, I can see the eosinophilic neurons. If -- if you survive longer but either you have part of your brain that are damaged but you're still living or you're on life support, I progressly (sic) lose the eosinophilic neurons, and instead I see ghost cell, the cells that are disappearing; I see gliosis, the astrocyte that are filling the emptiness; and I see that you're lacking neurons. There's not enough neurons anymore.

Let's go back to the case. In this case, Dr. Adeagbo said it's not hypoxic and anoxic -- sorry. I start to be tired. It's not hypoxic and anoxic brain injury because there was no eosinophilic neurons. In this case, five days on life support, I don't expect to see a lot of remaining eosinophilic neurons.

I look at the slides. There are a few remaining ones, really not that many, but it's normal because they have been taken out. But we see something else. We see -- so first we have to look at three parts of the brain. When you have a damage by lack of oxygen in your brain, there's three area that are particularly vulnerable. So as a pathologist that has a good knowledge of neuropathology, this is where I look for it. Pathologists should look at these areas. There's the -- you don't need to know these area. It's just I will name them because there will be an importance. We look at

hippocampus, at the cerebellum, and at the parietal cortex. Dr. Adeagbo has prepared slides of the brain where I can see the hippocampus, where I can see the cerebellum, but there's not the parietal cortex. It shows elsewhere. It's written in his report he has the frontal lobe, he has the temporal lobe, but it didn't take the parietal lobe. So if you're looking for hypoxic and anoxic brain injury, that should have been taken, and I don't have it, and he doesn't have it either. It's not on the slide. So I will only comment on the other two areas.

In the hippocampus, there's very few remaining eosinophilic neurons. I agree with him. But he describe in his autopsy reports that he see more lymphocytes. He said elsewhere it was neutrophils, but there I see lymphocyte, and this is where I don't agree with him. There's no lymphocyte in the -- if there was lymphocyte in the hippocampus this way, that would be an infection of the brain. That would be an encephalitis by a virus or he would have to find a cause. That's -- that's not normal to have lymphocyte in your hippocampus. And he didn't say there was an encephalitis, and I agree with him; there's no encephalitis. The brain itself is not infected, just around the brain.

But what looks like a lymphocyte, which means just a big black nucleus, are the astrocytes, the cells that are filling the holes. They are cells that have very long projection, but you don't see that. It's just like a pinkish/brown run, but you see they're nucleus. Are there's not enough neurons compared to a normal hippocampus.

So now the mess has been cleaned by the body of Ezekiel. There's not -- there's a loss of the neurons, and that has been filled by those gliosis, the astrocytes. And there's some ghost cells, disappearing neurons, that we can see. And there's a cerebellum. The cerebellum is really neat because what you have is big neurons. They have a particular name in the cerebellum; they are in the Purkinje cells. Just their name, but it's a neuron. It's a big bulky neurons, and under them there's other type of neurons that have a very different aspect. It's kind of a line of a little back points. They are called granular layers. And the Purkinje cells are on top, and they form a perfect line. When they start to disappear, you can see that there's not that line. They become pink initially, eosinophilic, and then they start to sink into the granulars instead of being on top of it, and then they disappear.

Here, I can see that there's not that neat line of Purkinje cell. The majority of them have disappeared so there's a loss of neuron by this lack of oxygen. The few that are remaining are very, very pink, and they start to sink.

If I put all that together now, this is typical of hypoxic and anoxic brain injury after that many days on life support. Having said that, I should have phrased it differently,

last sentence. Sorry. I can't tell you the number of days by looking at the brain. It is not that precise. But it is characteristic of what we expect if someone is past the point where there's a survival of more than 24 hours. But I can't be precise with that 24 hours, and I can't date how many days on life support based on the brain alone. But there is definitively hypoxic and anoxic brain injury. If you know what you should look for and don't look only for the eosinophilic neurons.

Now, I'm at point 5. So another thing at autopsy is the pleural empyema. I noticed sometimes the word "empyema" had been used alone in this trial, and we have to be careful because an empyema doesn't tell you where it is. I will define "abscess" and "empyema", and it will help to -- to understand. Empyema and abscess are both pus and infection in a hole. The difference is if the hole is natural or cavity the -- cavity or the hole is natural, that's an -- that's an empyema, and if it's not a natural cavity or a natural hole, this is an -- sorry. I start to be tired. If it's a natural one, it's empyema. If it's not a natural one, it's an abscess.

Example: I don't have a hole in the skin of my thumb. If suddenly there's a hole that's filled with pus, that's an abscess. If I have pus around my lungs, there's a cavity there, that's called a "pleural cavity". Pus in a natural cavity, that is "empyema". But empyema, when you have pus below the arachnoid around the brain in the meningitis, that's also an empyema, but in that context we call it "meningitis".

In this case, we have an empyema. We have to call it pleural empyema because it's in the pleural cavity around the lung. So it's a -- it's a specific location. Why would you have pleural empyema? Why would you have pus around your lung? There's multiple causes, but almost always it's because of a pneumonia. The other causes might -- you need to have an explanation why the bacteria or the viruses there. It could be because they have been brought by something, like if you're stabbed or if you have a disease of your esophagus, which is the tube that bring the food from your mouth to your stomach. If it explode by an injury or by a disease, it brings -- it can bring the bacteria into your pleural space. Could be during a surgery.

But usually, and in the case of Ezekiel, there's no other reason. It -- it was because it was of a pneumonia. It has to be. This is usually the cause. You don't have just an empyema.

New evidence surrounding the air leak and puncture in Ezekiels trachea speak to this point. Of note is the fact that there was evidence of aspiration as early as the 911 call

I'm on page 11, bottom of the page. Dr. Adeagbo said -- he was talking about the empyema, and he said that it evolved in two phases: (as read)

> So what really what happened is that they now becoming organized, so you have the first phase, the second phase.

Actually, empyema don't evolve in two phases but in three phases, and these phases have names. The first one is called "exudate". Just -- I -- I've put you to the text from one article. I could have chosen many. Just a clarification, because if you read the sentence too quickly, you might think, like, early, intermediate, and late go with the name, but it doesn't. It's just -- they say the "first one" or "early", the "second one" or "intermediate", the "last one" or "late". The name is following these terms.

So the first phase is called "exudative". That means you have a fluid that look like a fluid. It's just like a liquid, but it can test if there's bacteria or a virus in it. The second phase it will become thicker with pus, and in that phase, during the formation of the pus, it's called "fibrinopurulent" because purulent is the pus, but fibrino is because you have a protein in your body. You have it in your blood, actually, and that's what cause the blood clot. It's a protein that help to make things stick together. It's a sticking protein.

When you have an infection, often this protein will help to kind of making things stick together, and that's what will happen in the empyema. In the second phase, you have this protein that will make the pus sticky.

In the third phase, which is called "organizing", you will have cells that will come. They are called "fibroblast". Their name is not that important, but they will start to make the -- the pus solid, not just sticky, completely solid, and under the microscope, you can see the cells. It's not just the fibrin, the protein; it's cells.

In the case of Ezekiel, it was described as being organizing by Dr. Adeagbo. I've looked at it under the microscope. He said there were two phases so he said he thought it was the second. I agree it's the second, but I -- on three, not on two. It -- it is in the medium stage. It is the fibrinopurulent. We can see that it's -- we can see the fibrin under the microscope. They are kind of long, reddish, pinkish lines, but I don't see the fibroblast yet so it's not as late in the process as was described to you. I can't put numbers of days on that, but it's a lot quicker than if it was on the third phase. That takes more time.

In this case, I will read you what was said about empyema, and I don't agree with that. Page 12, third paragraph: (as read)

> So why do you say that it -- [sorry]. So why do you say that this empyema in the right lower lung lobe is a cause of death or a reason for death of Ezekiel Stephan? [Dr. Adeagbo answer] The reason why I say that is because a

> lung with encased empyema cannot function the way it should, which means that Ezekiel would be short of breath, would be weak because of inadequate oxygenation

That is not the usual symptoms on an empyema. An empyema, particularly when it's on only one lobe, particularly when it's not in the last phase where it become more solid, you don't have respiration issue. If you do, it's because of a pneumonia, not because of the empyema.

So I won't read you all the citation, but the empyema itself don't make you lacking oxygen, unless it's at the last stage where it's very, very rigid, but it's not what we have here, and it will have to be in -- on more than one lobe.

You can even have a surgery. We can take one lobe of your lungs out, and you will be relatively fine. So a little empyema or a big empyema on one lobe at the stage of fibrinopurulent do not cause these symptoms.

Then can it cause death? Empyema -- pleural empyema can cause death, but we are talking in terms of month and years of evolution, not in terms of two weeks. That's just not what we see. It has to be in terms of month and years. If we look at the adult population, at three months, the rate of death is 1.5 percent, but if we look at children, it's virtually -- they never die of empyema, virtually never die of empyema. So the rate is close to zero.

I don't think the empyema here is a cause of death. I think the cause of death, as I explained, is that the -- following something that we'll explore further, he stopped breathing. Yes, he had meningitis. He would have survived through it, but there was a paramedic misadventure, and he went into being brain death (sic).

Of note, the best place to find a virus of (sic) a bacteria, if you were of the opinion that this empyema was the cause death, was to take a swab of the pus in the pleura, and that has not been done. When I look at the reports, we have the lung, we have the -- we have the blood, we have the cerebral spinal fluid, but it was not swabbed. That was the best place. I don't think it was related to his death. I will explain later why I think there's an empyema, but I don't think it's relate to his death. I don't even think it was there on March 13. It started to evolve later that night. I will explain why.

But if you ask -- if you are of the opinion, like Adeagbo is, that it's related to his cause of death, this is the best place to do a swab. This is a bit controversial, but the majority of people -- well, no. I have to be very careful how I phrase this. We know

that antibiotics have some difficulty to enter in the pleural cavity because this is an empty space, and there's nothing there. So the antibiotic have a difficulty to go there. So to -- if the antibiotic -- if it was bacterial infection and you have antibiotic that kills it so that you cannot see anymore the bacteria elsewhere, you will have still a good chance to see it in the pleural cavity. That doesn't mean that necessarily it would have still been there.

And actually some people prescribe antibiotics in empyema, and there's a disagreement between them if they are doing it mainly for the pneumonia or if -- because it could go into the pleural cavity. Nevertheless, that -- wherever you stand on that disagreement -- and that's not a disagreement in forensic pathology; this is a disagreement between clinician -- as a forensic pathology (sic) you should take your chance because that's the best chance you have to try to identify a bacteria, and that was not done.

Now, why would he have an empyema? In my opinion, it's because there was an aspiration pneumonia. I will explain what I mean. So we know at autopsy there is an empyema, but when we look at the medical file and we look at the chest X-rays he had prior to being -- coming to the hospital brain dead, there's multiple evolution chest X-rays. Initially, there's no pneumonia, and there's no empyema, and over time, they -- they see it developing. If he had had an empyema at the time of his respiratory arrest, that would have been seen on the first chest X-ray, and it was not there. So we can be pretty sure, pretty safe, to exclude that there was an empyema at the time he stopped breathing. And that's for us the important point because this is from there that he will become brain dead.

But when you are -- when people are trying to intubate you, particularly if they have difficulty but not necessarily -- let's say you have a surgery tomorrow morning. What do you expect the surgeon to tell you? Do not eat from that hour. Why do they ask you to have an empty stomach, is because they know that when they will intubate you, there's too much risk that the food will go up and go in your airways.

Of course, if you're in an emergency, they won't ask you to wait another 24 hours or to stop eating. They will go in. They will do their best to intubate you without the food going from the stomach into the airways, but this is a risk very well known. And when you have -- particularly if you have -- it can happen even if the intubation goes well. But particularly if there's some issue during the intubation, the risk goes up.

So because there was nothing initially on the chest X-ray and it's developing, because there was problems during the -- particularly, not because -- particularly because there were problems during the intubation, the most likely cause for the empyema is an

aspiration pneumonia.

Dr. Adeagbo said -- well, when he did the autopsy, on the day he did the autopsy -- when you finish the autopsy, you go in the computer in the office and you write what you saw, but then you -- a few months later you have other thing, and you do your final report. When he went out of the autopsy room that day, he wrote right -- conso -- ah, let me read it correctly.

MS. WEICH: Sorry. What's she referring to.

MR. BUCKLEY: She's going to look to it right now.

MS. WEICH: But is it something that came out of the trial or just something that's . . .

MR. BUCKLEY: I don't recall if it came from the trial.

A That's on page 14, and it's likely out of order so I will go back on page 14 above in a few minutes. On page 14, fifth paragraph, fourth line, middle of the line: (as read)

However, he had written earlier in a continuation note --

Those continuation note -- this is the name we have for the notes you go and you write at the end of the autopsy. They mean other thing too, but this is a continuation note.

I'm too fast again? Sorry.

This is called a continuation note. So when he exited the autopsy room, he wrote "right lung consolidation". Right lung consolidation, for a pathologist, that means pneumonia. But we don't see pneumonia yet; we wait for the slides, the microscopic examination.

In a normal lung, a lung is like a sponge. It is very subtle. Like, you can -- not subtle. It's very elastic and soft, if I can say so. When you have a pneumonia, it becomes solid. That's why we say "consolidation"; it's now solid. And actually on the autopsy picture, I can see it myself. There's a -- around the lungs near the empyema, there's a -- a line of a -- a big chunk of the lung on the right lower lobe where there -- there's this consolidation, which means pneumonia.

Dr. Adeagbo said about this -- because he considered the aspiration pneumonia

apparently. So this is on page 14, fourth paragraph: (as read)

> And this possibility would be that the -- the right lung -- the inertia of the right lung is -- is that it is the way it is postured in the body -- is that if somebody tends to aspirate, they aspirate into the right lung because of the anatomy of the right lung. But in this case, we don't see any evidence of aspiration.

I agree with all the first part. I don't agree with the last sentence. Our -- so we have our trachea, and then it goes in two bronchi, but because of the position of our heart, there's an anatomy difference. On the right side, it go down almost in direct line, but on the left side, because of the heart, it do a kink at 90 degree. Not exactly 90 degree but almost.

So when we aspirate food, it's very rare that it would take this bend and go on the left. It almost way -- go straight down in the right lower lobe. So when you have a pneumonia there, there's all the cause, but in this context, you have to think aspiration. Anything -- think about it.

When you look at the microscopic slides of the lung, we don't have the acute version. We don't have the version that if I aspirate and I die right now. What is expected in that case means I would see food in the lung and some reaction or infection around it. We don't see it here; that, I agree with him. But we are five days later on life support, so, once again, your white cells will clean the mess.

So they go -- and there's one type of white cells. It's -- it's -- I didn't talk to you about this one yet. It's called a giant cell. It's bigger than the other, and his role is to eat the foreign bodies. We call it "phagocytosis". They go around, and whatever is not supposed to be there, you (sic) will eat it up. It could be something like a suture from a surgeon. It could be a splinter that is in your body. Whatever is not supposed to be there, they going to go around, and they will eat it up.

When I look at that lung, it is full in the area where there's this -- in the right -- okay. I don't see on the slide what is the left, what is the right. I have two slides. One has two pieces completely normal. One has -- can I just refer to refresh 'cause -- it doesn't matter. The other one has --

Q MR. BUCKLEY: No. I think you --

A -- abnormal --

Q I think you can.
A I can?

MR. BUCKLEY: We'll just see if the Crown has an objection first.

MS. WEICH: What is she planning --

Q MR. BUCKLEY: So --

MS. WEICH: -- on referring to?

Q MR. BUCKLEY: What is this you --
A I just want to see if it's -- it doesn't matter. I don't remember if the other line was two or three piece, and I can't remember if it was two or three that were abnormal. So that doesn't matter.

So they are pieces of the lung that show a pneumonia of aspiration. Because I see these big giant cells, and in it, they are full of little, we call this, "vacuoles". It's like big -- little holes filled of something that my eyes cannot recognize anymore. It could -- it could be a variety of thing. We can't recognize it at that stage, but they had eaten something that was in the lung. It's not bacteria or virus that they have eaten. It doesn't look like that.

So it could be -- in theory, it could be oil, it could be a juice that went there, it could be food. But apart from aspiration -- or even oil; that would be a type of aspiration -- there's not much that can look like that. So these big cells have eaten something, and that is a sign of aspiration pneumonia.

So what I think happened, my -- my opinion, is on March 13th -- well, on March 13 when there's a respiratory arrest, it's a fact that there was nothing yet on the chest X-ray to say that it was already a full-blown empyema. That developed during March 13 and March 14, and at autopsy, you can really see an empyema of the right lower lobe of the lung, and you can see an aspiration pneumonia.

So this, in my opinion, is something that happened during the paramedic intervention. It happens often, and if he had not been brain dead for the other reason we have explained, he would have survived through this. Because this is not something you often die of, to have just one part of your right lower lobe that is affected. I'm almost done.

Next, so I'm now at page 14, bottom of the page. At autopsy, in his report, Dr. Adeagbo described petechiae of the pleura and pleural cardia. Petechiae are a pinpoint hemorrhage. Like, when it's bigger, we call it a bruise, but when it's very, very tiny, it has different causes. If it's 1 to 2 millimetres in diameter, the little blood spot, we call it a "petechiae". In this case, you can see it on top of the heart, which is the pericardium, and on top of the lungs, like the -- the -- the -- kind of the layers that are around your ribs and go back and goes on the side of your lungs that leave pleural cavity, you can see the petechiae there. And he says about this, page 14, bottom of the page: (as read)

> Petechiae, it could be different ways but usually indicate lack of oxygen. [He added] I would think this would be due to the depression of respiration from the brain, as well as the lung not be (sic) able to expand properly.

This statement is false. Petechiae is not -- he's not the only one that say that from time to time, but you know it's a false statement. Petechiae have nothing to do with the lack of oxygen as a cause. It's a hyperpressure in the vessel that made them explode. We can see that in cases that have nothing to do with asphyxia. For example, if you vomit a lot, if you're in child birth, if you (sic) weight -- big, big weight, anything that you -- make you very force and put too much pressure in the vessel, some vessel will explode, and we will see these little tiny points emerge like petechiae, often around the eyes, but they can be elsewhere. In this case, they are more in the pleura or the pericardium, but that's the same principle.

I can easily prove that they are not caused by asphyxia because if you put a bag over your head -- don't do that tonight, but if you put a bag over your head and you die like this, you will be dead by a lack of oxygen because you will -- so you will -- you will exhale CO2. You will re-inhale -- you will re-inhale -- at some point, there's not enough oxygen because you always take the oxygen by putting back CO2. At some point, you die of a lack of oxygen. There would be no petechiae. There's not a case of plastic bag with petechiae.

On the opposite, if someone tried to strangulate someone and they survive, they will have petechiae, but they are not dead of a lack of oxygen because they have fought back. But the pressure during the aggression will cause the petechiae.

I studied that myself, actually, in hanging, and the citation I put is from my own paper -- later, is from my own paper, but for this exact one, I will cite someone else. So it's from his Ely and Hirsh, and they state: (as read)

> The speculation that hypoxia must play a role has generated erogenous conclusion that petechiae and asphyxia are causally related.

But they are not. It is the pressure. He also said that petechiae were caused by CPR. This is more controversial, but historically nowadays the majority of expert now agrees though there's still a controversy that CPR do not cause petechiae, that if you match people, when you do your study, by cause of death -- for example, the -- that's the one I was referring to my own paper. When you take hanging, so that's the same cause of death, and we compare people that had CPR with people that didn't have CPR, CPR doesn't cause more petechiae. The petechiae in this case have absolutely no importance. It don't tell you anything. Just forget about them.

I have two more points and I'm done. There -- I -- I now want to talk about something called "brain herniation". There was a CT scan done on March 14. I'm on page 15 just below the title 6.2. That head scan clearly say: (as read)

> This is in keeping with a diffuse cerebral edema as a result of a diffuse hypoxic insult.

I've already discussed this brain as being lacking oxygen, and the point I have not said so far, that makes them swell a little bit. That's what they call cerebral edema, and the CT scan said that it would be hypoxic, lack of oxygen. The scan adds: (as read)

> There's no tonsillar in herniation scene, no cerebellar tonsils, herniation.

Let explain what that means. If your brain starts to swell, either because hypoxia or because by meningitis, because of hypoxia, because when you lack oxygen, it creates irritation, and you start -- the brain start to swell.

In meningitis, either virus or bacteria, the -- there's irritation by the infectious agent, but mainly it's your own white cells that to kill the bad gays, the virus or the bacteria, they use chemical warfare. They use chemicals, and these chemicals are going to maybe save you, but in the meantime, they create a lot of irritation, and the brain will start to swell.

When the brain start to swell, there's something that can happen that didn't happen. Your skull is a closed environment. But not in children actually. In children they can have open fontanelle. That means that there can be holes that are still open, and in Ezekiel, we know from the autopsy that the one at the front is still open. I will

explain the adult first because it's easier. Then we will go to a children (sic) like Ezekiel.

In an adult, your skull is completely closed. So if your brain start to swell, it's like a closed Tupperware. You cannot put more soup in it. You just can't. It's -- it's -- it's physical. So the brain will have to go somewhere, and when the brain try to go somewhere, that's called a herniation. The only I will talk about today, because that is the only one that is interesting for this case, is at the base of your skull, there's a hole called the "foramen magnum", and your cerebellum, which is part of your brain, will try to go there if there's not space for it anymore.

When they do that, the little part of the cerebellum that will try to fit in this hole is called the tonsil of the cerebellum. If it do that, we call it a tonsillar herniation because it went to herniate to go where it didn't have to go. When it does that, well, now there -- he has -- he has succeeded in fitting somewhere else, but the brainstem is there. This is your centre for breathing and for your heart, and by pressing on it, you can stop breathing, and your heart can stop.

In this case, the CT scan says no tonsillar herniation, and they say the same thing in different language later, no cerebral tonsils herniations. At autopsy, Dr. Adeagbo said in his report that there was no herniation. I've looked at the picture, and I agree with him. So the scan, Dr. Adeagbo, and me, we all agree there's no herniation in this case.

But then he said -- oh, and we have to apply that to Ezekiel, I said. If there was too much pressure by the swelling of the brain in Ezekiel, not only would we have seen this tonsillar herniation, but the hole that is still open here would bulge out. We would have a bulging fontanelle. And the Dr. Adeagbo said that it was not there.

I have to believe him. I was not there. I can't see it. But it was described as non-bulging. And that goes with the scan so I have no problem with that. If the scan had shown differently, that would be different, but in this case, there was no -- we know there was no much -- there was not an excess of pressure because there was no herniation.

Okay. So page 15, paragraph at the bottom. So Dr. Adeagbo was trying to explain why there would have been a respiratory arrest, and he said: (as read)

> So if you now have a pus collecting in the brain, what happen is that that is something that it's not designed for. That is something occupying a space that is not there, that

is not available. So what happened is that that pus re-affect the brain. It pushes the brain down. [He then continued] It affects the function of the brain. It affects -- because the brain now becoming squish (sic) now becoming squeezed in the process. The part of the brain affecting the -- controlling the respiration become weak so the person have shallow breathing, tired breathing.

The part of the brain that control the heart become weak, so the heart start not working fine, losing beats, getting weaker. [He adds] The brainstem is in the low (sic) almost position of the brain so that it could be pushed down, which you (sic) evidently in any brain edema; it could be pushed down.

But here there was no such thing as the brainstem being squashed or squeezed by the herniation. He said himself there was no herniation at autopsy, and the CT scan showed no herniation.

So we have to explain why did Ezekiel stop breathing. We have other mechanism. I won't be able to tell you that it's 100 percent sure that it's not the meningitis, but I'm pretty certain it's not the meningitis because I've heard the 911 call. If you do have a respiratory arrest in a meningitis, it could be by the herniation as was described here, but that didn't happen. We know that. So we have to explore another mechanism. There's two other ways that you can stop breathing because of a meningitis. The one with the herniation, it's not possible in this case. You can completely exclude it. We would have seen it, and it's not there.

The other two reason are you could have an infection shock where because of -- do I still go with only virus or do I add bacteria?

Q Let's stick with virus for the purposes of arguing.

A Then I will go -- I will let that one out. I will go straight to the other reason you could stop breathing. The -- your white blood cells that are doing the -- the warfare against the viruses that -- in that case, it would be the same. It would change it for bacteria, but I will stick with viruses. They chemically irritate your brain. Your brain start to swell not a little bit, not enough to cause the herniation we said but enough that that can, in itself, cause chemical issue, irritation issue, in the tissue. So it's -- it's an -- we call it metabolic -- toxic metabolic encephalopathy. So your brain is diseased by the chemical -- the chemical that are produced to kill the infectious agent that irritates your brain and your brainstem not by herniation but by chemical irritation

directly.

If this happens, the -- what we will hear is completely different than if you stop breathing because of an obstruction. When I hear the 911 call, this is an obstruction in the airways. An obstruction in your airways, you can hear that there's something that doesn't allow the air to pass.

If you stop breathing because of a meningitis, you have two thing: You can just progressively being more shallow in your breathing and stop breathing, or you can have another pattern that have a big name; it's called Cheyne-Stokes, and you will did (sic) the spatter (sic).

I'm doing it quicker, but it could be more spread in time. You will stop breathing, and then you start again but progressively bigger and smaller. So (UNREPORTABLE SOUND), and you stop again. This is called a "Cheyne-Stoke". I know it's not on the transcript so I will describe that I went from more shallow to deeper and then the other way from deeper to shallower and then stopped breathing again.

This is what we see in a meningitis that cause a toxic -- a -- that cause a toxic metabolic encephalopathy. On the 911 call, this is not what I hear. I hear obstruction. So my opinion -- but I can't prove it 100 percent. My opinion is that -- on that, it is more likely that the infection in the airways is -- is the cause why he stopped breathing. He does have meningitis. That is a fact, but I don't think that's why he stopped breathing on March 13.

I -- I don't -- well, there was one more point in my report. I can address it very quickly. It's really not as important, in my opinion, as the rest. Just under 6.3, Dr. Adeagbo was asked why he didn't mention the brain hypoxia or -- because he said it's not there so he was asked why it was not there, and he said: (as read)

> It's about me only trying to write positive things. That's my style at the time.

Q And can I just stop you. You're speaking about why it's not in the autopsy --
A Correct.

Q -- form and documents?
A Correct.

Q Okay.
A And I was surprised by that statement for two reason: first, because forensic

pathologists know that in a report we have to put all the positive finding and the relevant negative finding. The -- the relevant -- not all the negative. Like, we won't say everything that's not there, but the one that are of importance need to be in the report. So that's the first thing. We know we need to put relevant negative.

And the second reason is that he actually does it. There's a lot of thing that are negative that are in his report. For example, on page 16, one paragraph before the last, I gave some example from his own autopsy report where he say negative, like "free of arthrosclerosis". That means no arthrosclerosis. It's a negative, it's important, and he said it.

Or no opposive (sic) thrombi. Atrial and ventricular chambers are not dilated. So we know that he needs to put his important, relevant negative finding, and he did, but with that one, he did not. And I'm not in his head. I don't know why he did not, but I'm very surprised that the paramedic misadventure, which is an extremely important fact that you need to assess -- whatever the conclusion at the end, you need to have addressed that issue to see if it can have caused death or can have played a role in the cause of death. You find it in his summary of the event in his autopsy report nowhere, so I was surprised by this total omission of a fact that is really to be considered in this cause of death.

So summary: In the case of Ezekiel, my expert opinion is that he was suffering something in the airways that caused obstruction, and he had the meningitis on March the 13. On March the 13, he didn't have yet, when he stopped breathing, an empyema of his pleural cavity, and he didn't have a pneumonia yet.

Then he stopped breathing. My expert opinion is that he stopped breathing because of a problem in the airways that caused an obstruction. The infection caused an obstruction.

There's one point -- I'm sorry. I just forgot one point. I should have told you earlier that an infection of this area I do have myself currently, a tracheobronchitis. That's why I'm needing to have these candies to stay alive -- not stay alive but stop coughing -- that was an exaggeration obviously -- to -- to not cough and to be able to talk. But my airways are bigger than my thumb. They are slightly bigger than a big man's thumb. The airways of a kid like Ezekiel is about my little finger.

So it doesn't take much irritation or inflammation to cause obstruction. If you put on that, mucous and saliva. Like, when I start coughing at night, when it's worse for me, my disease, I -- I feel the mucus moving around, but I -- I have to cough to take it away. But in a kid where the airways aren't that big, it doesn't take much mucous so

that it can block.

Sorry. I go back to my summary. So on the night -- so on the day that he stopped breathing, on March 13th, I think he stopped breathing because of this infection in his airways, though he also had meningitis. I think that when he stopped breathing, if there was not the paramedic misadventure, we (sic) could have made survive through the disease on balance of probability. On balance of possibility, I think that his meningitis was viral, and that that usually you survive without any sequela. And we explained the word "sequela".

Let me just check if I forgot -- I think that the empyema is secondary to an aspiration pneumonia which happened during the intervention, but that he would have survived through because usually you survive through this. I don't think there's any scientific evidence to say that it's Haemophilus influenzae. His -- he was brain dead. He was having a hypoxic and anoxic brain injury, and the reason for that, on balance of probability -- I'm pretty sure that it is because of the paramedic -- the paramedic misadventure. I have completed to go through my report.

Q Yeah. I have a few more questions for you.

The first thing is is I just want to be absolutely certain of when you use the term "paramedic misadventure" or "medical misadventure" exactly what you're referring to?

A I'm referring to the event that I can find in both the mental -- medical examiner's file and -- so we have a death investigator that writes kind of the basic information we need for the autopsy, and it's there. And also have the EMS, I think, the Emergency Medical Services, the file pages.

I can see that there was a wrong supply apparently in the -- in the ambulance that day that caused that three different thing needed to be used, and two of these things, didn't have the proper size for a child of the size and age of Ezekiel.

Q Okay.

A So that prolonged the breath -- the respiratory arrest by eight minutes. That's my understanding.

Q Okay. And then I -- with all due respect to your earlier explanation, I think you lost the jury on one of the points, and I just want to circle back to it.

A Okay.

Q And that was you were explaining that one of Dr. Adeagbo's reasons for believing that -- or forming the opinion that the meningitis in this case was bacterial was a

predominance of neutrophils. Do you understand that was one of his reasons?
A Correct.

Q And you were you -- you were, I guess, explaining why neutrophils would be important for that, but I just think you lost the jury on, Okay, what do lymphocytes mean, what do neutrophils mean, and I'm just wondering if you could kind of --
A Quickly?

Q -- really layperson explain -- try to explain that bit again. Just -- I just had the impression that -- I know I was getting lost, so I'm just assuming . . .
A Yeah. I will do a quick overview, and if you think it's not sufficient, I could dig further, but I think maybe what's needed is more bigger review.

Usually neutrophils go with bacteria. Usually lymphocyte goes with virus. But there's exception. There's an overlap. Particularly with enteroviruses we know they can present with more neutrophils. So the first part is that even if there was more neutrophil, it doesn't mean it would be bacterial. But the second part -- I don't think there's more neutrophil in this case. When I look at it, I think there's more lymphocyte which actually go well with a virus.

Q And then I'm wondering if you can be shown the autopsy report, which is Exhibit Number 9, and on the last page of Exhibit 9, there's what's called a "peer review form"?
A Correct.

Q And I'm wondering if you can explain to the jury, first of all, who -- which -- who is the chief medical examiner that brought that form in and explain what its purpose is?
A Okay.

Q So I kind of need you -- I know you don't want to name names. I'm not asking --
A I won't, I won't.

Q -- you to name names. But to explain, first of all, which chief medical examiner brought this in --
A Yeah.

Q -- and to explain why, and then explain what the form means.
A Okay. When I was named chief medical examiner in 2011, my job was to try to improve the system and make the changes I thought were needed, and one of these changes was I introduced a peer review system. A peer review system, you -- you have to understand -- there's two thing you need to understand about this sheet. First

is what does that mean when we use the word "reasonable", and the second thing is to look at what was reviewed by the peer reviewer. Let's start with reasonable.

Q Can I just get you to explain why the form was brought about --
A Oh, yes.

Q -- and who brought it in?
A Yes. You might be aware that we had some issues prior to my nomination as chief, and that in the past, there were two individual that I won't name, and it's (sic) relevant to this case to name them, where there was question about maybe the quality of their work, and the justice system, so the Minister of Justice and the Deputy Minister of Justice had order (sic) a review of cases done by medical exam -- by these medical examiner in Alberta.

Not -- in one case, it was -- in both cases, it was not all the cases that we reviewed. It was the cases that could have an implication for court or for -- we had lists that were -- there was a lawyer in both case that was assigned to be in charge of the review. That's not the important part.

The important part is that as a new chief, I wanted to make a system in place -- because I told you medical examiner must work with independence. Even as the chief, I don't go and interfere with their work on a daily basis. But I need to have a system to try to avoid some similar problems in the future. So kind of a net, a safety net, so that if there was someone that would not be good enough, we could catch it, that there was issue. That's why I created the peer review system, like a safety net for quality.

And it's not unique. Actually, this form is very close to one that is used in Ontario. We -- it's -- modification a bit. We took different peer review form for different lab, and we kind of fixed one that met our need.

Q Okay. Now, so can you explain to the jury, then, whether or not -- so if a peer review is done like as shown here, does that mean there's agreement with the opinions or anything like that? Or what does "reasonable" mean? You were --
A Okay.

Q -- kind of going there.
A Yeah. I said earlier that, for example, when you are sick, your doctor might say, You might want a second opinion. Doctor can disagree with each other. That doesn't mean they are incompetent and that we need to take back their licence. It happens. I know some lay -- lay -- people that are non-doctors, sometimes they're thinking that doctor must always agree with each other and always -- but that's not the case. We

can disagree on certain things. There's a level. There's a level at which that's incompetent, but there's a level where it's disagreement.

When we do a peer review, we don't want to end up with people saying all the time, I disagree, I disagree, so that's not the level we take. It's -- the level we take is the word "reasonable" so you can -- in the grey box, do you --

Do they have it or not? Doesn't --

Q Yes.
A They do?

Q Yes, they do.
A I would recommend that you look at it. Perfect. The grey box, the last three lines -- because the first three are more, like, general. The last three are really where it's going to be played. Is the manner of death reasonable? Is the cause of death reasonable? Are the other opinion reasonable? It is not, do you agree with?

And we clearly explain to every pathologist that (sic) we're filling this sheet that the criteria is not if you agree. It's, Can you see, with the current state of science, how another doctor could come to that conclusion even if you think he's wrong. Is it reasonable, or should it be reported to -- if there's an unreasonable, that was brought to my attention as chief. I would be the referee, and if I thought it was unreasonable, I would have to fire that person. I -- well, it's a little complex. I didn't have the power to fire someone so I told you a power to recommend, but anyway that's not the important thing. And it would have be to reported to the College. So the first thing to understand here, it's not about agreeing or disagreeing.

Second thing, when you do a case, you spend a lot of hours. Let's say a pathologist spent 45 hours on a case because it's a case that's complex, and you really -- you want to understand all the part, like Ezekiel. It's complex case medically. The peer reviewer is not expected to spend 45 hours. We just can't do that on our workload. So they will review certain things at a higher level to make sure there's nothing unreasonable. But that doesn't mean they agree with everything.

That's why the first box just -- not the first box. Sorry. The one just above the grey box, it is where they have to say what they have looked for. In this case, so in the grey box, nothing was thought unreasonable. That doesn't mean Dr. Bucholtz agreed with everything. It just means that it was not unreasonable to have come to that conclusion.

Above, you can see that what she has looked at is the autopsy report. So when they say post-mortem examination report, we use this language because sometimes it's an autopsy report and sometimes an external examination form, but in this case, it's an autopsy report.

And she looked at the photograph. She never looked at microscopic slides. She never looked at the toxicology report. She never looked at the Emergency Medical Services, the paramedic misadventure that we have in these file pages. She never read the death investigation report that summarized the information. So only from looking at the report of Dr. Adeagbo, she won't even know about it. It's not there. She will never have read all what he will say to her at inquiry in trial.

So this sheet doesn't mean Dr. Bucholtz agreed with Dr. Adeagbo. This is -- this is a different process for different purpose done on very limited material.

Q And so when you were chief medical examiner, did any forms ever come to you where a peer reviewer had found either the manner of death, cause of death, or other opinions unreasonable?

A There were discussion at times if it was unreasonable or a disagreement, so sometime we would discuss is it one or the other. But in the end, from the -- this form that was used in the office, we never had an unreasonable conclusion. Never. If we had, we had a process to -- to address it, but it never happened.

MR. BUCKLEY: I think those are my questions, My Lord. I just want to review my notes quickly?

THE COURT: Take your time, counsel.

Q MR. BUCKLEY: One other question that does come up is, you've spoken about listening to the second 911 call. Just hypothetically speaking, if the first time Ezekiel stops breathing -- so he's still at home -- if he coughed up, you know, mucous after stopping breathing, does that affect your opinion at all?

A No. It actually goes with it.

Q What do you mean it goes with it?

A Okay. If you have an infection of the laryngotracheobronchitis, you can have a little more mucous than usually, and the objective process that I was describing can be in part by the inflammation itself, that it's thicker, because of the infection and inflammation, but also by the mucous blocking it. So that you're coughing mucous goes well with it. It's not a 100 percent because you naturally mucous, and you can have mucous without having a disease underlying it, but it goes well with it.

Q Thank you.

MR. BUCKLEY: And I have no further questions.

THE COURT: Counsel, I anticipate that you'll be moving to have Exhibit B, then, made a full exhibit, and that will probably be best accomplished tomorrow after the -- counsel will have a chance to look at it. Would that be fair?

MR. BUCKLEY: So we're referring to what is now Exhibit B?

THE COURT: Exhibit B, yes.

MR. BUCKLEY: Yeah. So, I mean, as long as I don't lose the opportunity to make that application. I appreciate that --

THE COURT: Crown is signaling no, of course, and of course you won't. I think what I should do, then, counsel, all counsel, is ask the jury to give us back their copy of Exhibit B because until counsel have had an opportunity to look at --

MR. BUCKLEY: M-hm.

THE COURT: -- what Exhibit B will become as a full exhibit. It's only an exhibit for identification.

MR. BUCKLEY: Right. So all I'm saying is, is being that I'm, you know, about to close my direct --

THE COURT: Oh, yeah.

MR. BUCKLEY: -- I just don't want to lose the opportunity to apply to enter it as an exhibit after we've dealt with some objections.

THE COURT: You've reserved it. I'm told you you reserved it, and the Crown is signalling they completely understand that and agree with it.

MR. BUCKLEY: Thank you.

THE COURT: You have not jeopardized anything in any way.

MR. GILES: I wonder if we might suggest, because I know

we ran into this problem before, just in case a replacement exhibit is provided, if perhaps their exhibits might be numbered with their juror numbers so that they --

THE COURT: Oh, yes.

MR. GILES: -- can keep track of their notations.

THE COURT: That might be the case.

So, jury --

MR. BUCKLEY: Yes, it is.

THE COURT: Jurors, if you would please put your juror number on the document, and then madam clerk will pick up your copy. They will be stored -- they will be sealed -- they're going to be sealed in the court file, and we'll see what, if anything, we need to do about them. But if there are any notes, and I don't know if there are, nor should any of us even know -- but if there are juror notes on the document, then they need to be kept confidential as everything is that goes on in the jury room; all right?

So, madam clerk, would you please get those copies of the exhibits right now from the jury members.

MS. WEICH: Sorry, Sir. Do we want to let Dr. Sauvageau go? She's still standing there.

THE COURT: We'll see you in the morning.

A Thank you, My Lord.

THE COURT: So, ma'am, you're excused for the day. You're well aware of the usual warning concerning you're under oath?

A Totally.

THE COURT: We're going to reconvene at 10. All right.

A Thank you, My Lord.

THE COURT: Thank you very much --

MS. WEICH: Sorry --

THE COURT: -- for enduring a long day.

MS. WEICH: Sir, if you don't mind, I actually wanted to have a very quick five-minute discussion about starting time tomorrow.

THE COURT: Without the jury? So don't --

MS. WEICH: No.

THE COURT: -- run away until someone has talked to you then. You can leave the --

A I --

THE COURT: -- stand, Doctor --

A Okay.

THE COURT: -- but we'll talk about the jury time, then.

A Thank you, My Lord.

(WITNESS STANDS DOWN)

THE COURT: Did you want with the jury here or the jury away?

MS. WEICH: I would appreciate five minutes to talk to you. I would appreciate if Dr. Sauvageau comes back early because I might have some -- oh, and if she could hang around, because I do have some materials to present her tonight. I might have more tomorrow.

THE COURT: Okay. So don't leave the courthouse, just out the door.

And, Dr. Adeagbo, you should leave as well if we're having these conversations.

Should we send the jury out until we know when to tell them to come back?

MS. WEICH: Yes, please, Sir, and I'm very sorry. It'll be very brief.

THE COURT: Okay. So just wait in the jury room for one minute. I'll let you know when we're going to be starting tomorrow. Thank you, members of the jury, for enduring a long day.

(JURY RETIRES)

THE COURT: Please be seated.

Yes?

MS. WEICH: So, Sir, as you heard yourself, and this was more talked about yesterday, defence counsel provided us with a list of what he anticipated Dr. Sauvageau's opinion would be on April 2nd, but he did not provide us with his draft report until Friday, four days ago. He didn't provide us with his full report until Saturday, three days ago. Unfortunately, Dr. Adeagbo was out, away, from the office, and every time I sent him an email, I got an out-of-office reply.

The first time I was able to talk to him about the report was yesterday. Based on that discussion, I do have a number of articles that I would like to put to Dr. Sauvageau, which I'm happy to give her tonight. However, given everything that she just said, I'm going to hope that Dr. Adeagbo will give me the time to talk to him again tonight, and I might come up with more articles overnight, which I would like her to be able to read before I start cross-examining on her, just to be fair because the ones that I actually have are actually pretty lengthy.

I don't think it would be in the jury's best interest to be here at 10. I don't know how quick of a reader Dr. Sauvageau is. She's been amazing so far, but I just don't know, Sir. So I highly -- I don't think having them here at 10 AM is going to be any good because if I show up with more articles for her to read, she's going to have to take the time to read them.

THE COURT: So when do you think you need to start so that you can finish tomorrow?

MS. WEICH: If they wanted to show up at 11 or 11:30 and then we did an hour or an hour and a half before lunch, and I will see if Dr. Sauvageau doesn't mind coming here at 9:30.

THE COURT: Okay. 11:00. Counsel, do you think that makes sense?

MR. BUCKLEY: Well, obviously I'm in my friend's hands as far as the time that -- excuse me; I'm losing my voice -- you know, with the time that she's going to need. I would ask if she could provide me with copies of what she has tonight.

THE COURT: Of course. Before they go to the witness.

MR. BUCKLEY: And -- yeah. And then I'll show up around 9:30 too or maybe closer to 10, whatever, and see if I can obtain any other things that she may have at that time.

THE COURT: So we're going to tell the jury to come back at 11. You can give copies of the articles that you now have to your friend and to Dr. Sauvageau now, and then folks can arrange to re-meet back at the courthouse at, say, 9:30 in case there are more articles or more work to do in the meantime. Does that make sense?

MR. BUCKLEY: M-hm.

MS. WEICH: Thank you, Sir.

THE COURT: So just tell the jury they can come back at 11. Let me see if there's anything else that we need to deal with before we adjourn court today. Okay. Just let them know right now so they can go. 11:00.

The only thing I had in mind that I just wanted to raise is -- again, is a matter of scheduling and timing. Let's be optimistic and say we might finish Dr. Sauvageau tomorrow. How much longer do we have for defence evidence?

MR. BUCKLEY: Well, if we finish Dr. Sauvageau tomorrow -- and I'm not going to tell any witnesses, other witnesses, to be here tomorrow because I think it's likely we're going late tomorrow to try and finish Dr. Sauvageau.

I mean, I think my final two witnesses could be finished in the morning. Definitely direct wouldn't be very long for either of them which would then be the close of the defence case on Thursday. I don't know if my friends are planning on calling Dr. Adeagbo after.

MS. WEICH: We'll have to see how it goes tomorrow, Sir.

MR. BUCKLEY: So -- yeah. But from the defence perspective, I just have two witnesses that I don't anticipate to be very long.

THE COURT: So can I ask that you be ready to at least start your closing address Thursday afternoon?

MS. WEICH: So, Sir, if you don't mind -- and I haven't talked to my friend about this so I'm very sorry, and if he disagrees, that's fine. I put a lot of thought into it. The same way we had a voluntariness voir dire in the beginning and we decided it wasn't fair to have to do our opening without knowing what the outcome of that was, if we don't have an agreement on what the elements of the offence are --

MR. BUCKLEY: Very good point.

MS. WEICH: -- I don't know that we can adequately address the jury. Now, I know we're not going to talk about the law. (UNREPORTABLE SOUND) Shoot. Sorry. I guess everybody expected court would be over for the day. Very sorry about that, Sir.

So as I was saying, if we don't know what the elements of offence are, I don't know that we can appropriately address the jury about what is relevant and what is not relevant as the elements of the offence are concerned. Our closing remarks are --

THE COURT: I agree. When did I last give you my last version of the elements?

MR. BUCKLEY: Well, it would have been Sunday evening, and it's Tuesday evening, and --

MS. WEICH: So, Sir -- oh.

MR. BUCKLEY: And I don't know about my friend, but I say that I'm -- I'm not in agreement with the elements as they currently sit --

THE COURT: You might not be.

MR. BUCKLEY: -- and would like to speak to you about it.

THE COURT: But you might not be able to make much traction. I've spent many days examining --

MR. BUCKLEY: I -- I --

THE COURT: -- what I think the law is.

MR. BUCKLEY: I'm particularly concerned about, you know, what I was submitting in my written submissions to be, you know, it has to be at a time it would made a difference.

MS. WEICH: So, Sir, here's what I suggest for timing. If my friend finishes on Thursday morning -- and, again, I'm in the same boat as my friend because I was preparing for this all week -- perhaps if we could take the Thursday afternoon to form our arguments about elements, or if you want us to argue on Thursday afternoon, we can do that. And then we either argue on Thursday or we take the evening to think about it and come back on Friday morning and argue. Because the first --

THE COURT: So what is there to argue beyond the written -- I've received written submissions already.

MS. WEICH: That's correct, Sir, and I can advise that having seen my friend's written submission, which I got at the same time as you, I disagree with it. I have a lot to argue on it, and unfortunately, Sir, I'm in the same boat as my friend. Not to be disrespectful, Sir, but there are portions of your latest draft that I would like to provide the Crown's opinion on.

MR. BUCKLEY: And then if the Crown re-calls Dr. Adeagbo, the defence position would be that the Crown would open first having called evidence last.

THE COURT: That's true.

MR. BUCKLEY: So --

THE COURT: Which changes everything again.

MR. BUCKLEY: Yes.

THE COURT: Right. Well, it makes sense now that I get the full picture. Let's aspire for completion of the defence evidence and hope -- not walk away from the hope that that will be the end of the evidence. And then we'll spend Thursday afternoon talking about the elements.

In the meantime, I will -- I think I probably made some additional changes to the elements since you've seen the last version. I don't remember. But I'll bring copies so that everyone has current copies of where I'm at. You can be ready to argue that, both of you, on Thursday afternoon, and we'll deal it at that time.

Additionally, when can I expect to receive the succinct summary of position from each party? I supposed you'll say, Well, not until after we figure out what the elements are.

MR. BUCKLEY: You read my mind, My Lord, so . . .

THE COURT: What about issues -- special instructions? I've been working on those as well, as you will not be surprised to learn. You gave me written submissions on it, which I'm quite familiar with. I can say that.

MR. GILES: Although, of course, Sir, there is that *Browne v. Dunn* instruction as a result of what Ms. Stephan had to say at -- without having previously cross-examined Terrie Meynders on that same issue that --

MR. BUCKLEY: So --

MR. GILES: -- she had spoken to her about.

MR. BUCKLEY: So my friend's position is, is that if the defence doesn't raise it in direct and it comes up in cross-examination that there's a *Browne v. Dunn*. I would respectfully disagree. Because they're speaking -- that came out on cross-examination, and my friend kept pressing it. I didn't -- I didn't raise it on direct, so with all due respect to my friend, I would be very concerned about aBrowne v. Dunn --

THE COURT: Mr. Buckley, with due respect to your submissions, I've got to tell you, at this hour of the day, for me to shift my brain into *Browne v. Dunn*, I know the words, but. Candidly, I haven't much brain power left on those.

MR. BUCKLEY: Agreed.

THE COURT: Look, could I ask -- and we mentioned this earlier in the week, if you have additional special instructions, Crown, that you wish me to consider, a succinct statement much like what you've done already would be very helpful. You may trust that I have read and thought about each and every one of the ones you've already mentioned, and you'll be seeing some version or some things or maybe

not all, but at least there will be aspects of what you've talked about in the ultimate draft that you get.

Similarly, Mr. Buckley, I've thought about the two brief oral submissions you made.

Each side, please, provide me with something brief and in writing concerning additional special instructions that you wish me to consider for the final charge, and that will make my job a little bit easier, beyond which it's what I'm requiring you to do.

So I want to know where you're coming from, and then hopefully we'll be able to wrestle the elements aspect, which I understand is a keen -- there's keen division about that, and no one seems happy with what I've produced so far, so that -- sometimes the way it is.

Thank you, Mr. Buckley, for getting the direct examination done today. The jury and I appreciate that as do all of us.

Crown, we'll look forward to what you do tomorrow as well, and hopefully we can get this witness, at least, finished tomorrow. That's really important I think, if we can do it.

Adjourned until 11. Thank you.

PROCEEDINGS ADJOURNED UNTIL 11:00 AM, APRIL 20, 2016

Certificate of Transcript

I, Sara Anderson, certify that the foregoing pages are a complete and accurate transcript of the proceedings, taken down by me in shorthand and recorded by a sound-recording machine and transcribed from my shorthand notes to the best of my skill and ability.

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Proceedings taken in the Court of Queen's Bench of Alberta, Courthouse, Lethbridge, Alberta

April 20, 2016	Morning Session
The Honourable Mr. Justice Jerke	Court of Queen's Bench of Alberta
L.M. Weich	For the Crown
C.O. Giles	For the Crown
S.P. Buckley	For the Accused D. Stephan
S.P. Buckley	For the Accused C. Stephan
J. Stringer	Court Clerk
S. Anderson, CSR(A)	Official Court Reporter

THE COURT CLERK: Order in court. All rise.

MS. WEICH: Good morning, Sir.

THE COURT: Please be seated.

MR. GILES: Morning, Sir.

THE COURT: Crown, just have a seat for a moment before we get started.

Order

THE COURT: Ladies and gentlemen, I want to acknowledge that the Court understands that this is a very emotional and controversial case for many people. However, while respecting the loss of Ezekiel to his family and friends by this tragic loss and honouring that each of us has a right to our own opinions, we must remember we are in a court of law.

Accordingly, while we understand the emotions and opinions of everyone, we will not allow those emotions and opinions to interfere with the proceedings by interruptions or disruptive conduct. Anyone who cannot abide by that rule should now leave the courtroom. Anyone staying in the courtroom who does not respect this will be asked to leave or escorted from the courtroom. No interruptions or disruptive conduct will be allowed.

Crown.

Submission by Mr. Giles (Other)

MR. GILES: Thank you very much, Sir.

I just -- and I advised my friend I wanted the opportunity to speak because just yesterday, towards the end of day, while everybody was very tired, the issue of the *Browne and Dunn* in relation to what Ms. Collet Stephans' evidence had come up, and my friend has taken a position which, while not seeming on the face of it to be in disaccord with the established principles about who goes first, I thought it would be best -- when it comes to providing closing arguments, I thought it would be best to put the Crown's position on the record after I had the opportunity to digest what my friend had suggested, and that being, if I remember correctly, that essentially if the Crown calls evidence last by rebuttal evidence or otherwise, then it must argue first. And, in fact, I'm going to suggest that that's simply not the case.

There is another aspect that I'd also like to provide about -- my friend and the Court some case in relation to, just for their perusal, so that when we get to the point of arguing that -- because I don't think we're really there yet -- at least the Crown will have put its position on the record giving some forewarning so that we don't have another difficulty where everybody's fighting over something and then having to go back and get cases and come back and then make this whole matter take longer than it needs to.

The first thing that I noted was in Section 6515 of the *Criminal Code*, and that appears to be what deals with summing up by Prosecutor, and I'm looking at particularly the Section 651(2), but perhaps it might be useful to just read through the whole thing. 651(1) says: (as read)

> Where an accused, or any one of several accuseds being tried together, is defended by counsel, the counsel shall, at the end of case for the prosecution, declare whether or not he intends to adduce evidence on behalf of the accuseds for whom he appears, and if he does not announce his intention to adduce evidence, Prosecutor may address the jury by way of summing up.

Fair enough. Section Number 2 states: (as read)

> Counsel for the accuseds, or the accuseds, where he is not defended by counsel, is entitled, if he thinks fit, to open the case for the defence and, after the conclusion of that opening, to

> examine such evidence as he thinks fit, and when all the evidence is concluded, to sum up the evidence.

Number 3 states: (as read)

> Where no witnesses are examined for an accused, he, or his counsel, is entitled to address the jury last, but, otherwise, counsel for the prosecution is entitled to address the jury last.

That clearly states then, Sir, that where the accused calls evidence, and both accuseds have called evidence, counsel for the prosecution is entitled to address the jury last.

Now, I know that often we -- because we don't think of rebuttal evidence, the standard rule of thumb that rolls through everybody's head is he who called evidence last, argues first, but that isn't really an accurate statement.

Submission by Mr. Buckley (Other)

MR. BUCKLEY: My Lord, can I interrupt? I'm not prepared to argue this. I have a witness that is only available today, who we expect is going to be all day. Can we deal with these issues at another time? I'm not anticipating -- I'm not prepared to argue this, and I was hoping that we could proceed with Dr. Sauvageau and get the jury in, so. . .

Submission by Mr. Giles (Other)

MR. GILES: And, frankly, Sir, I'll be there in five minutes. I just wanted to be able to give my friend the benefit of letting him know what my position was and the basis for it so that he can go and obtain whatever cases that he wants. I'm not even suggesting that we're arguing this. I'm just putting my position on the record.

THE COURT: Thank you.

MR. GILES: Now, I do happen to have some cases that I can provide the Court and my friend in relation to whether or not there's a constitutional right to argue last, *R. v.* --

THE COURT: Well, instead of bringing them to me now, just give them to your friend. He may not have even had an opportunity to think about this.

MR. GILES: Absolutely, Sir.

THE COURT: And I'm not sure it's an issue until someone objects to it, you know, I understand where you're headed. Give Mr. Buckley an opportunity to think it through.

MR. GILES: Absolutely, Sir, and the only reason I bring it up now is because, just, the last thing that was said, essentially, last night was that he was taking that position, that we would argue last, and I wanted to put on the record our position is that we don't, and we think it's on a plain reading of the *Criminal Code*.

That being said, I will leave that issue for now, and we can now move on to the trial proper.

THE COURT: Thank you.

All right. Are we ready, then, to bring the jury back in?

MR. BUCKLEY: To my understanding we are. Dr. Sauvageau is outside. I can go and grab her before the jury comes in.

THE COURT: Would you mind, Counsel, and I'm going to ask madam clerk to ask the jury to come in.

THE COURT CLERK: All rise.

(WITNESS RE-TAKES THE STAND)

(JURY ENTERS)

THE COURT: Good morning. Please be seated.

Counsel acknowledge that all jurors are present?

MS. WEICH: Yes, Sir.

MR. BUCKLEY: Yes, My Lord.

THE COURT: Thank you, Counsel.

Doctor, perhaps given the -- do we need the witness re-sworn?

MS. WEICH: I would appreciate it, Sir.

THE COURT: All right.

MS. WEICH: Thank you.

THE COURT: We've been doing that, so let's have the witness re-sworn.

ANNY SAUVAGEAU, Re-sworn, Cross-examined by Ms. Weich

Q So, Dr. Sauvageau, I'm just going to ask you some questions to try to confirm for myself about some of the information that you provided yesterday, which was brand-spanking new to me in a lot of respects, so I assume it was also brand-spanking new for other people in the room; okay?

A Yes. Can I just please ask if I could be allowed to have the exhibit of my reports, since I'm not allowed my own copy?

Q Oh, certainly. Yes.

THE COURT: Yes.

Could you give the witness Exhibit B, please?

MS. WEICH: Thank you.

Q MS. WEICH: Now, what I'm going to talk to you about right now is just based on my own notes about what I took about what you said yesterday, so if I'm wrong, you just let me know; okay?

A Okay.

Q So when I was thinking it through in my head, I was trying to see your reasoning about how you go from 'A' to 'B'; okay?

A Okay.

Q So what I think I heard you say is in the grand scheme of things, in the world at large, people suffer more from viral infections than they do bacterial infections; is that about right?

A That is a true statement.

Q Is that what you were trying to tell us yesterday?
A Depends what you mean by it is what -- is it what you tried to tell us yesterday? When I came to the conclusion that it was, on the balance of probability, more a virus than a bacteria, that is not the only factor and, I would say, the least important factor, because there was a lot more things specific than this very general statement about all diseases, all organisms, and all humans, so I can't -- we can't even try that statement, then everything else I said would still true -- be true in my opinion.

Q So one of the factors that you took into account when you decided that in this particular case, this child suffered from viral meningitis, and it wasn't the most important factor, and it was just one of several, but one factor that you did take into account was that people suffer from viral infections more than bacterial infections.
A It -- it's not an important factor in the decision in this specific case. If we go to in the meningitis, it's more often viral. If we go in the infection of the laryngotracheobronchitis, it's more often viral, then this statement become more important. But if we stay at the very big umbrella, I don't think -- I don't think it really could put weight on my opinion. I was more spec -- I was more having this disease in mind when I continued the rest of the argument.

Q So I put it to you again. When you were coming to your conclusions about whether or not this child suffered from viral meningitis or bacterial meningitis, one of factors that you took into consideration -- just one, and it might have been a very minuscule amount -- was that in the grand scheme of things, people suffer more from viral infections than bacterial infections?
A I would -- I would really prefer that we rephrase it as I take the first part of your sentence in -- in the -- in the meningitis, but the second part is that meningitis are usually viral. I -- I don't like that we go in the big scheme of thing, because if you stay at that level, you will be wrong depending which disease you're talking about, so I have to rephrase it in this -- in this context; otherwise, I -- it -- it's not -- I'm not comfortable. This is -- this is where I am comfortable.

MS. WEICH: All right, Sir. So I'm very sorry to do it so early in the morning, but I think I would ask for the jury to step out and to canvass an issue that we sort of canvassed yesterday afternoon.

THE COURT CLERK: All rise.

(JURY RETIRES)

THE COURT: Doctor, I'll have to ask to you step out as well.

(WITNESS STANDS DOWN)

Submissions by Ms. Weich (Other)

MS. WEICH: So, Sir, I did bring it up yesterday afternoon, her statement: (as read)

> Viral meningitis are pretty common; bacterial meningitis are not as common.

And the fact that we had that portion of her report taken out, and I can only just assume that Mr. Buckley advised her appropriately.

Now I'm afraid. I don't want to have to go on to answer -- to ask her the next questions about, Well, as far as you're concerned, the reading that you've done concerns vaccinated populations, so I would submit, Sir, that both her one sentence yesterday and the comment she just made, the -- the jury needs to be instructed to not consider it, and if the Court agrees, I would appreciate that instruction as soon as possible, and I will do my best not to bring it out of her again.

THE COURT: Just you lost me a bit. She did at one stage in your cross-examination just say that it was the least important factor. I think she gave that answer --

MS. WEICH: Yes.

THE COURT: -- as part of it, and then she's not wanting to agree with you. I'm not completely clear on what she said otherwise, but she's not wanting to agree. So what is your concern, then?

MS. WEICH: So my concern is what she told -- what she said yesterday coupled with what she just said today, that she said it would be true -- what I put to her would be true in the context of viral meningitis and bacterial meningitis. She wouldn't agree with me in the grand scheme of things overall, viral infection more so than bacterial infection, so when it comes to -- but her belief is that viral meningitis is more common than bacterial meningitis -- she didn't say those exact words. That's just my paraphrasing of what she just said.

THE COURT: But don't you think she was talking about the idea that -- I think she agrees with you on viral versus bacterial. It's when you expanded that to include all infections, which is what your question did. I think that's what she was

responding to. I think that's what her concern was. Isn't that right?

MS. WEICH: So I posed the exact same question to her three times. I always said, Viral infection, there's more viral infection out there in the world than bacterial infection.

THE COURT: Are you meaning all kinds of infection or just meninginitis infection?

MS. WEICH: No. I -- I said the word "infection" very specifically for infection, because "infection" doesn't have to be meningitis. It can be any sort of infection out there because my understanding of her evidence yesterday evidence was that was one big thing that she posited overall.

So, Sir, I'd simply like to direct the Court's attention that that might be an issue, that it might be necessary to provide the jury with an instruction to ignore that small portion.

Submissions by Mr. Buckley (Other)

MR. BUCKLEY: And, My Lord, I'm very concerned that actually -- because that type of thing will undermine the credibility of the defence expert witness, and so my friends have been all adamant, you know, and you know I've edited the report, so we're not going anywhere near that, the untouchable issue. In her opening question, I think I heard you say, In the grand scheme of things, people suffer more from viral infections than bacterial infections, which is really circling back towards that. I mean, she's inviting that issue to come up.

And then I made a note, because she said she asked three times and used the term "infection". I wrote down one of her questions. She actually switched the viral meningitis and bacterial meningitis, so that's --

Submissions by Ms. Weich (Other)

MS. WEICH: I'm really sorry, Sir. I did not.

THE COURT: Well --

MS. WEICH: I was very, very clear.

Submissions by Mr. Buckley (Other)

MR. BUCKLEY: We can replay the tape.

THE COURT: Let's just decide what we're --

MR. BUCKLEY: Yeah.

THE COURT: How we're going to go about it.

MR. BUCKLEY: Yeah. We can replay the transcript. Like, I mean, I'm assuming we can. We've got a person here who is taking contemporaneous notes to determine whether or not I made my notes incorrectly or whether my friend actually then switched in one of them to say viral meningitis and bacterial meningitis, which would be inviting the issue that she's saying the witness should be avoid -- avoiding and re-charged on that, so I -- I'm really concerned. So we open on that issue, and then my friend's saying, Let's have a charge to the jury which will undermine this witness's credibility. Why is she asking the question, then? Why are we circling there?

THE COURT: Is there a concern if two questions are asked instead of one so that I'm clear at least on it? Did she use, as a least important factor, that viral meningitis is more common than bacterial meningitis? Because I think she's agreed with you on that.

And then a second question, to deal generally with viral and bacterial infections overall. Is that a concern?

MR. BUCKLEY: Well, what my friend I think is trying to communicate is, is that you have not allowed her to -- we've excised from the -- the report that basically she can't say that viral meningitis is more common than bacterial meningitis. That's a no-go area, although it seems very unlikely, with the questions that are asked, especially if I'm correct that she did actually use the words "viral" and "bacterial" in the question later on, how can that not come up?

So my concern is, is my friend is cross-examining in a way that is almost certainly going to bring up the issue that my friend says we need to avoid, which -- and then it going to ask for a charge to the jury that the evidence be ignored, which, in my submission, really will -- will be very prejudicial to the defence. That -- that's my concern.

I -- I'm not -- I'm not taking issue with the fact that she was directed to stay away from that. It's just now my friend is focusing the witness in that area and then is going to be asking for a charge that the jury ignore the evidence that my friend just elicits, and I'm just concerned that that would be very prejudicial. That's my -- that's the defence

concern.

THE COURT: Crown, I still am not completely clear on what you're trying to get to. With the question, what are you trying to get to?

Submissions by Ms. Weich (Other)

MS. WEICH: So my plan is to walk her through everything -- well, not everything -- is to walk her through her points from yesterday as to what she took into consideration when she decided that it was the enterovirus, one factor out of many, that leads to viral meningitis, and I was just going to do it in four different steps. But, Sir, if we don't see it as an issue, I'm happy to move on.

THE COURT: Obviously I can't see it as an issue. I can't see the clarity of your question, is the problem. That's my difficulty, Counsel. I can't see the -- I'm not sure what you're asking for. Are you asking to get into the comparison of the incidents of viral meninginitis and bacterial meningitis in the world and then in -- potentially opening what we've all agreed we will not go to? Is that what you're trying to get at?

MS. WEICH: I'm asking her if my understanding is correct in that yesterday, one of her points was that, overall, in the grand scheme of things, viral infection, there's more of them than --

THE COURT: Viral meningitis infection?

MS. WEICH: No, Sir. Infection, because infection is not just meningitis. Infection can be a whole host of different diseases, and that's why I picked the word "infection", but I will move on, Sir.

THE COURT: Thank you.

MR. BUCKLEY: I'll go grab the witness.

THE COURT: Thank you.

MR. BUCKLEY: And Dr. Adeagbo.

THE COURT: Madam clerk.

THE COURT CLERK: All rise.

(JURY ENTERS)

(WITNESS RE-TAKES THE STAND)

THE COURT: Please be seated.

Counsel confirm all jurors are present please.

MS. WEICH: Yes, Sir.

MR. BUCKLEY: Yes, My Lord.

THE COURT: Doctor, you acknowledge that you're still under oath?

A I do, My Lord.

THE COURT: Crown, could you please proceed.

Q MS. WEICH: Doctor, do you still have your report in front of you or did you give that back?
A I still have the exhibit.

Q Okay. So I believe that yesterday, when you were giving your evidence, you said when it's a virus the majority are enteroviruses. Do you recall that?
A I have to put it back into context. In the viral meningitis, nin -- 85 to 95 percent are enteroviruses, but if we change context, it might not be true. It was the specific context of viral meningitis.

Q So what I wrote down about what you said is in the cerebral spinal fluid, they couldn't identify a bacteria or a virus. The culture on the blood and on lungs couldn't identify a virus, but when it's a virus --
A Could -- sorry. Could you please start again but a little bit slower because I'm trying to follow --

Q Okay.
A -- and compare what you say with what I remember, and it was a bit rapid.

Q Okay. In the cerebral spinal fluid, they couldn't identify a bacteria or a virus. The culture --

A That is not true. Well, yes. They couldn't identify a bacteria, and they didn't test for a virus. That is the little precision I have to -- to say. So they didn't find a bacteria or a virus. One part, because they couldn't find it. The other part, because they didn't test for it. Correct.

Q So you went on to say in that same breath, The culture on the blood and on the lungs couldn't identify a virus, but when it's the virus, the majority are enteroviruses, and we know that the swab at the back of throat, because of that, on balance of probability, I think that is the cause of the meningitis. Do you recall that?

A Yes. But it's all in the context of the meningitis. So in the cerebral -- cerebral spinal fluid, they can't find anything by not testing virus, by looking for bacteria, and not finding anything.

The blood in the lung, if they didn't find any bacteria -- I don't think they tested for virus, actually. They only tested for virus, from what I remember, at the back of the throat and nasopharynx, and it was positive for enteroviruses.

When you put all that together, on balance of probability, the infectious agent is an enterovirus. Is it 100-percent sure? Like I said yesterday, no, but on balance of probability, that is the most likely infectious agent. Correct.

Q So you also listed a number of things, and I'm not saying this is all the things, and I'm not putting them in order of importance for you, but what I wrote down about what you said is if we look at the culture, nothing positive. We have a swab with enterovirus or rhinovirus. We have the positive throat swab or wash. On balance of probability, for me, that meningitis is virus. I didn't say it is a viral meningitis. I said on balance of probability. I can't say it is or is not because we don't have here a positive test in the -- and I just put down "CSF", and I can't remember if you said "CSF" or cerebral spinal fluid.

A And that's correct. So studies, if you look at authors in the literature, what they say is that when you -- either because you couldn't do it or for some reason it didn't work, in the -- the cerebral spinal fluid, if you do have a positive throat or nasopharynx for enterovirus, they say that then it's strongly suggested of enteroviruses. But they warn you, though, if there's been another infection by enteroviruses in the weeks before, that it can, in some cases, continue to shed viruses. That's why we cannot do it 100 percent, because maybe there was two infection.

So it's not 100 percent, but it's strongly suggested, but we have to say things that we could be wrong, because here we are not -- because we try to do our diagnosis of balance of probability, but when we are in court, you are out of a reasonable doubt, so we have to say everything that could change this decision, not just on balance of

probability, but other respect.

So it's not a 100 percent here that it's an enterovirus, but it's -- on balance of probability, it is an enterovirus. There's a small percentage of chance that the kid had infection by an enterovirus in the -- I can't say exactly. Like, maybe a week, two week, three week, kind of maximum-ish four weeks. I can't be precise, and I'm not a microbiologist, but if he had another infection there, he could continue to shed the virus. But on balance of probability, that must be an enterovirus, but I can't exclude that he got two infection, instead of one.

Q So, sorry. I don't know anything about shedding. When you say "shedding", I think of a dog, so what are you talking about?

A Okay. I -- thank you. Yes. I didn't explain what shedding is. It's not hair, and it's not a dog or -- I explained yesterday that viruses, they go in our cells, and they use the factories we have in our cells, and they produce virus, and when the cell is completely full of virus, the cell explode and all these virus goes outside. We're shedding viruses, so when you doing a swab, you're taking the shedding of viruses that can continue. Even when once you're not sick anymore the -- the shedding, the viruses have been can still be there.

If you want to further for the explanation, you need a microbiologist. This is where I need to stop. I'm not microbiologist.

Q So as I understand it, me, you, everyone in this room might have enterovirus or rhinovirus inside of us if we take a swab and send it off for a test; is that correct?

A Yes and no. This is why they have to develop -- they have to be more careful about the contamination by something that is not the infectious agent. That's why I use the word "shedding". You can have -- and I will do part, but if you want to go further, once again, you will need a microbiologist.

I explained yesterday they have to set the test so that if there's just one or two bac -- bacteria or virus, depending on the test, that are there, you don't want that to be a positive when you are looking for an infection, so they set the test that if it's just that you have this virus living there, but you're not sick of it, it shouldn't be positive usually. You have to be shedding more of this that the test is positive, but I don't want to go further. I'm not a microbiologist.

Q So --

A So, for example, they tested Ezekiel for a list of viruses. There's only one that was positive as an infectious agent. I very much doubt that he only one virus on his whole body. Of course not, but the other one were not, on balance of probability, an

infectious agent. To go further, you need a microbiologist.

Q So all of the material that you reviewed in order to come to your conclusion, you've listed that all on the first page of your report; is that correct?
A That's correct.

Q You even listed some documents that you reviewed and then were advised, No, no, no, shut your brain off about those things; you can't take them into consideration? Is that correct?
A That is correct.

Q And that was a whole lot of documents; right?
A That is correct.

Q So I think that the medical examiner file had about 204 pages?
A I don't recall the number of pages. In the one I study in the office was even slightly thicker than the one that is available in court.

Q And the hospital medical records from the three different hospitals was about 661 pages?
A I don't recall the number of pages, but that was several hours of careful reading.

Q And then you had all the -- the transcripts; right?
A That is correct, but not all. I had the one I listed.

Q Okay. So please correct me if I'm wrong; okay. A person who is brain dead can still test positive -- or, no. Let me rephrase that.

A person who is brain dead can still pick up or contract enterovirus or rhinovirus if that person is exposed to it while they're brain dead; is that fair enough?
A It is fair enough. It's not something we usually have as a hospitally (sic) acquired type of infection. There's other bugs that are more common. As we divide the blood -- the -- the infectious agents into hospitally acquired and in-the-community acquired. This is not as common, to have it hospital acquired, but it's not impossible, but we will still remain with there is nothing -- nothing else going. You cannot prove a bacteria. And on balance of probability, the one that is the most common for a viral meningitis is still enterovirus, and viral meningitis are still the most common.

Q So you're not saying that it's impossible to get meningitis from rhinovirus? You're just saying it's more probable that it's enterovirus?
A Ah, no. That part I can say, though, because rhinovirus are known not to spread;

whereas, enterovirus are spreading. This is why when they say enterovirus or -- is enterovirus or rhinovirus virus because I will go, but, once again, I will draw a line where I won't go further.

Genetically, they are very similar, so they look the same for the microbiologist. If you want more explanation, a microbiologist will be needed, but what a pathologist know is that the rhinovirus will stay there; whereas, the enterovirus will spread. So if it's spreading, in our opinion, then it can't be the rhinovirus.

Q So -- and please correct me if I'm wrong; okay. All of the hospital records and the medical examiner records, in all the records that you reviewed that were medical records, there was no test for rhinovirus or enterovirus before March 13th -

A No.

Q -- of 2012?

A No. There was one test, but it's a test. Like, they didn't test at the same level. Mine -- if I can be given the test; it's going to be easier. There's one test at the hospital where it was negative, but it's lower. They were -- my understanding is they were looking if there was something infecting the intubation, so lower in the tracts than what was done at the nasopharynx, so there is one negative test in the hospital record.

Q And that was before March 13?

A Oh, before? No, he was not in the hospital before March 13. Sorry. It was when he was in the hospital.

Q Okay. So you talked about this two-week period before he got to the hospital; right?

A Sorry. I'm confused. I'm not speaking about anything. I'm answering questions. So can you -- so can you start again with the new question with the context, because now I'm a little bit confused.

Q So, yesterday, you said, Ezekiel was presenting symptoms for about two weeks, and then on March 13th, as he was in the car of his parents, as they were apparently driving towards the hospital, there was the first respiratory arrest that happened. Do you recall saying that?

A Yes.

Q Okay. So for that two-week period leading up to when he's in the car with his parents, there's no medical records concerning any test that was done for enterovirus or rhinovirus; is that correct?

A To my knowledge, there's none that I'm aware of.

Q Now, you referred to a test done at the hospital?

MR. BUCKLEY: And I don't want to interrupt my friend. It just dawned on me that the witness did say that but then clarified later the first 911 call was from home, and I just don't want -- that was my understanding of her evidence yesterday.

MS. WEICH: Sorry, Sir. It's not my intent to misrepresent her. I'm just -- that is in fact what she said, and then she went on to clarify. I'm just trying to get that two-week portion out of it. If you'd like, I could read the rest of what I wrote down.

THE COURT: Please clarify that.

MS. WEICH: Okay.

Q MS. WEICH: So then you went on to say, I've heard the 911 call, and I will comment later about what it inform us about the respiratory arrest. As a forensic pathologist, this is one of the event that we will have to address. This respiratory arrest could be caused by something that then causes death, or he could be sick of something that caused the respiratory arrest, but, in this case, we know that something happened, so we had a first respiratory arrest that I will be able to hear on the 911 call, but he will breathe again, and then they are driving toward the ambulance. The ambulance is driving toward them.

This is all in the second 911 call. Ezekiel was sick of something for about two weeks.

A Yes.

Q Oh.

A Yes. Just to clarify because there's -- there seems to be a disagreement if the first call was in the home or the car. For me, it's not important if the first one was in the home or in the car. What's important is that he stopped breathing, and I could hear the breathing on that first -- after he started again breathing.

The other part that's important for me is that when there's a second respiratory arrest. Because of the 911 call, and I'm referring to the second 911 call, we have an evaluation of the duration because of the precision of the EMS system.

So that the first one is at home or not, I might have misspoke. It's not an important factor for me, the location of the first one.

Q So I'm going to provide with you a document; okay.

MR. BUCKLEY: And I -- just, it is interesting. I'm not objecting to this document being given to the witness, but my friends were objecting to me giving this document to the witness yesterday, so I just -- just, it's interesting --

MS. WEICH: No, Sir --

MR. BUCKLEY: -- that --

MS. WEICH: -- we never objected to him putting anything to her. Sorry, Sir. I don't want to argue in front of her.

THE COURT: Just give it to the witness.

Q MS. WEICH: Are you familiar with that document?
A I've seen a similar document in the medical file, and I -- I ment -- I mention it a few minutes ago that I was aware there was a negative one when he was in the hospital.

Q Okay. So I'm going to give you a second page; okay.

MS. WEICH: And again, Sir, I'm not to seeking to enter it as an exhibit, just to have her refer to it.

Q MS. WEICH: So as I understand it, the page that on the top right-hand corner says "Page 13 of 204", do you see which one I'm looking at?
A Correct, yeah. It's the one of the medical examiner's file.

Q So this refers to a swab, a nasopharyngeal swab?
A Or wash, because there was a discrepancy between what's written on the sheet and was -- which was presented verbally at trial, so I'm not sure. I was not there. I didn't do it myself. Either a swab, like written here, or a wash like Dr. Adeagbo said it verbally.

Q But do you agree with me that the word on the paper is "swab"?
A Yes, but I -- I can't ignore the other source of information, so I have to be precise. It's the truth, the whole truth, and nothing but the truth, so it doesn't change the end -- the end interpretation, but it's not necessarily a swab. It could being a wash. And I said yesterday, in the end, it doesn't really matter that it's a swab or a wash.

Q Do you doubt that the word on the page is "swab"?

A I don't doubt, but the page -- I don't doubt that the word on the page is "swab", but Dr. Adeagbo said that he didn't do a swab, but a wash, but it doesn't really matter, but there's a difference, and I can't decide which one is the right one.

My job as an expert witness is not to choose what I believe between two things when they -- there's a discrepancy. My job is to point out the discrepancy, explain what I can explain. If there's a way in forensic pathology to solve that issue, if it's a forensic-pathology issue, I can solve it. This is not the case. I don't know if it was a swab or a wash, but it doesn't really matter, but you can't make me say it's a swab. I'm not sure it's a swab.

Q Just referring to the words on the page, though?
A It is written "swab".

Q Okay. So this is the particular test-result page that you looked at when you came to the conclusion that Ezekiel was suffering from either an enterovirus or a rhinovirus; is that correct?
A That is correct.

Q And that's because on this page, the result of the test for enterovirus or rhinovirus is positive; is that correct?
A That is correct, and I was mentioning verbally before that there's a list of other viruses, and they are negative.

Q And what you said yesterday was that, basically -- and correct me if I'm wrong -- the DNA of these things are a little bit finicky, and that's why they put "either/or enterovirus or rhinovirus"?
A That, I'm not sure. I'm comfortable with the word. What I said is that they're -- genetically, they can be similar, so they don't make a distinction -- distinction with this kit, the Luminex kit they are using. If you want further information, you need a microbiologist.

Q And in this particular case for this swab or wash taken by Dr. Adeagbo on March 19th, 2012, which is the date set out here on this document; correct?
A Can you repeat the date? I was not expecting that I had to check the date.

Q So it says, "Collected: 19/03/ --
A Correct.

Q -- 2012"?
A Correct.

Q And that --
A The date of the autopsy.

Q Okay. So you're willing to rely on that document and that positive test result as being correct; right?
A Correct, but as I said, this is just supporting more the diagnosis of enterovirus. Having said that, even if we had not test for the viruses in this area, on balance of probability, the enterovirus was already the most likely agent, but this goes to support it further.

Q Now, you don't know anything about how they actually conduct these tests; do you?
A They use a kit that they buy from a company called Luminex. Any further detail, you need the microbiologist. Dr. Adeagbo and me are not microbiologists. We interpret results. We don't do the test.

Q So looking now at the second page that I gave you, it says "Page 254 of 661" in the top right-hand corner. Do you see that there?
A I see it.

Q So here, instead of a swab, we have something that says "fluid". Do you see that there?
A Correct.

Q And then underneath that, instead of nasopharyngeal, we have "aspirate endotracheal" and then "TU [star]". Do you see that there?
A Yes, which would mean tube.

Q So what I understand that to mean is that a medical worker took some fluid -- or, sorry, and the date on this is -- where it says "Collected", it says 14/03/2012. Do you see that there?
A I see that.

Q So March 14th of 2012?
A Correct.

Q So what I take this to mean, and, again, correct me if I'm wrong, that on March 14th, a medical worker collected some fluid from the endotracheal tube that was either inside of Ezekiel or had been removed and exchanged from Ezekiel; is that about right?
A Correct. And I mentioned already that I was aware of this test.

Q So on this collection of fluid, it was sent to a lab somewhere and tests conducted; right?
A Correct.

Q And the results also came back while he was in the hospital; right?
A Correct.

Q And looking down the list of results, when we get to enterovirus or rhinovirus, we see "negative"; right?
A Correct.

Q So -- so I'm going to take you back.
A Can I explain? I thought there would be a next question. Does this -- if we stop it there, it's very misleading. I need to be provided an opportunity to explain why this still makes sense with the other one, and why despite I was aware of it, it didn't change that, on balance of probability, it was still an enterovirus? Can I do that?

MS. WEICH: Well, Sir, I can't cut her off, if she still wants to keep going.

THE COURT: Go ahead.

A Because that needs -- needs explaining, so it's very different.

First, the first test is higher. The second test is lower, but even more important, the second test doesn't swab or wash the mucosa. If there's swell -- if there's shedding on the mucosa, it might not be tested on the test done at the hospital, because what they do is they go inside the tube, and the tube is in the airways. The outside of tube touched the mucosa. The inside of the tube doesn't touch the mucosa, so if there's no enterovirus -- enterovirus shedding inside the tube, that doesn't mean there's no virus -- enterovirus shedding outside of the tube, so I knew about this test, but that doesn't help me much. It -- it -- I considered that this is not something that can help me for a higher infection and for an infection that's on -- directly on the mucosa.

So if you want further detail on how they do the test and how they -- I'm not the right expert, but I was aware of that test, but that doesn't change how I interpreted, because they are different tests. The way they take -- what I mean by "different tests" is that in the lab, it's how they took the sample is different, and when you interpret the result, you cannot interpret it independently of where and how it was sampled.

Q MS. WEICH: So have you ever conducted -- like, collected

specimen and then conducted the test yourself?

A We do that at autopsy room all the time, collecting specimens. All the specimen collected at autopsy were collected by a forensic pathologist, and we are very careful, usually, that the word of where we take the sample is the right word and the right location because it has a meaning later when we'll interpret.

So, for example, when you -- even when -- when you do a swab of the nose, you can even (sic) precise that one is very low, and one is at the back of the nose, or one is at the back of the throat, or you can make different level, depending -- it depends on the case and what you're looking for, but your sample -- the -- the sample you do will affect the result that you got and will affect the interpretation of the result -- the result you get.

Q So here's an example of a negative result; correct?

A It's a negative result in a specific context of a specific sample.

Q And it was something that you took into consideration when you came to your conclusion; right?

A I did exclude this one because it was done in the tube.

Q But you didn't write about it in your report; right?

A I didn't summarize any part of the medical file, apart from the chest x-ray, when I did my report, so there's only the chest x-ray that you can find all the steps. I was not asked to do a summary of the medical file.

Q And you didn't tell us about it yesterday; right?

A I didn't summarize. I didn't say everything that are in the 600-something pages that you said yourself and the 256-something pages of the medical examiner files, so I -- I pointed to you the thing I thought were relevant to come to the conclusion, and I didn't mention everything that exists in the medical file or the medical examiner's file.

Q So to take you back, when you were talking about -- and I'm really sorry. I'm going to say it wrong -- laryngotracheobronchitis.

A Correct.

Q Laryngotracheobronchitis, so the larynx, the trachea, the bronchi, plus, I guess, there's a logical explanation for that. If you do have a laryngotracheobronchitis, the only thing that you see on the surface of the airways is a little bit red and a little bit swollen, and if you are intubated, then you see a mucosa that is a little bit red and a little bit swollen.

In the end, I cannot tell you if there was or was not a viral infection here in the laryn -- laryngeo -- laryngotracheobronchitis, but, on probability, I think there was. Do you remember saying that.

A Correct.

Q So if an autopsy --

A Sorry. I -- I missed what you said. There was another sound.

Q So if the autopsy is performed, and there is no evidence of -- and here I'm going to say two things, so just let me finish; okay. So if there's no evidence of the surface of the airway being a little bit red and a little bit swollen -- that's the first thing -- and there is no evidence of the mucosa being a little bit red and a little bit swollen -- that's the second thing.

A Sorry. I -- I heard only one thing, that it was not a little bit red and a little bit swollen, so what was the second thing?

Q So the first one is the airway, because first you said airway, and then next you talked about mucosa, when it came to intubation?

A Okay.

Q Okay. So airway and mucosa.

A They're the same thing, by the way, airway and mucosa.

Q Okay. All right. Well, then, let's just talk about the one thing.

A Okay.

Q If there's no evidence, on autopsy, of that airway or mucosa -- however you want to call it -- being a little bit red and a little bit swollen, then would you agree with me that there is no evidence that you can see, by looking at it, that there is a viral infection taking place, such as laryngotracheobronchitis or bronchis (sic)?

A He was intubated. It's impossible that it was not a little bit red and a little bit swollen. The reason it was not described is because you can't see the difference, so if someone was to tell you it was not a little bit red and a little bit swollen, when we know he was intubated, then he didn't look, because it will be a little bit red and a little bit swollen after five days on the life support, so I can't make this exclusion. It's -- it will be there. It will be there.

Q So let me put it to you like a hypothetical then. Hypothetically, in the far outer reaches of scientific reason, there is no such evidence, would you agree with me, then, that just by looking at the airway, you can't say, Okay, viral infection of the laryngotracheobronchitis?

A I would think -- I would not conclude that. I would conclude either one of two things: He was not intubated, or it was not looked enough to find it.

Q I'm not saying that just because you can't see it with your eyes, it's not there. I'm just saying if you can't see that particular part.
A What I'm saying, you need to see it with your eyes. It's there, but it doesn't matter because it's always there when you're intubated, so our brain kind of not even realize that it's there when he's intubated sometimes, if we're not careful, because it's going to be there. If you're intubated, it's going to irritate your airways. You're not suppose to have a tube in the middle of airways, particularly in a kid where the airways are very small, unless he was not intubated in the airways. So if my fact is wrong, then that's different, but my understanding is that he was intubated in the airways.

Q So, yesterday, you talked about neutrophils. Do you remember that?
A I do.

Q And I think you said -- you referred to one of your articles, the Tan et al. article?
A Yeah. When you say mine, "mine" meant that it was my reference. It's not a paper I've written.

Q Sorry. You referred to -- one of the articles that you referenced in the report that you wrote, and it was -- the particular one that I'm talking about is Tan et al.; okay?
A Yes.

Q So you said -- you talked about that article, and you said, So, in general, yes, neutrophils are more common with bacteria, but in the case of enterovirus, we can't use neutrophils to make the decision about viral versus bacterial. Do you recall that?
A I recall having said that.

Q So what I take it to mean is that if all you're looking at it is what's the preponderance of neutrophils in this patient, you can't use that number of neutrophils in order to conclude viral or bacterial meningitis; is that correct?
A So, in general, there is a significance, but when you're talking in the meningitis of distinguishing enterovirus meninges versus a bacteria, we know there's too much overlap, so it's not -- it's not a good way. That's why they concluded that it was not -- their conclusion is it might be challenging to different -- differentiate between bacterial and enterovirus meningitis based on initial CSF analysis.

And the goal of their paper, as in the -- is -- as is in the title was "Cerebral -- Cerebral Spinal Fluids White Cell Count Discrimin -- Discriminatory or Otherwise". The

conclusion is otherwise.

Q So you also said about when you were looking at the microscopic slides, if you look carefully, you can see white cells, and their type is not mainly neutrophils. They are mainly lymphocytes and monocytes, which goes with the virus usually. In this case, there are not more neutrophils. Do you remember saying that?
A Correct. So there are neutrophils, but they are not in the majority, so there's -- there's not a lot of surviving cells. That's the first challenge. The majority of the cells are dead, and the one that were surviving, I feel there's slightly more lymphocyte, so it's not a clear, like, big disproportion, but it's clearly not a big disproporate -- disproportion towards neutrophils as was presented earlier by Dr. Adeagbo.

Q And, again, you looked at all the hospital records; right?
A I did, and I'm aware that in the blood, it's different. They had high neutrophils, but he also have high monocytes. High neutrophils, in general, go more with a bacteria. High monocyte go more with a virus.

Q Thank you.

So I'm going to refer you to a page that, as I understand it, comes out of the Alberta Children's Hospital records, okay, and I'm going to ask you very specifically to refer to the date of March 14th of 2012, and I'm going to ask you some questions; okay?
A Okay.

Q So are there arrows on that piece of paper? Did I draw arrows?
A Yes, you did.

Q Okay. So looking first at where it says "WBC", that stands for white blood cell; correct?
A Correct.

Q And if we go all the way over to March 14th of 2012, the -- the readout or the result, I'm going to say, and correct me if I'm wrong about that word, is 27.6. Do you see that there?
A Sorry, repeat. Where do I look for what?

Q So if you look at WBC --
A Yes. 27.6 yes.

Q And the reference range is 6 to 16. Do you see that there?
A Correct. So there's an increase in number of his white blood cells, which is typical

in -- well, not. Which goes with an infection.

Q Then underneath WB -- oh, sorry. And so next to 27.6, there's an "H" for high, right, because it's higher than the reference range?
A Correct.

Q It's about -- it's just over 10 points higher than the reference range?
A I wouldn't interpret that. I'm not a hematologist. It's high; it's high. I can see it, and I can take into account during my autopsy, but not to the point of interpreting as a hema -- hematologist.

Q Okay. So if you go underneath "WBC", we see "neutrophil". Do you see that there?
A Correct.

Q Okay. We go all the way over to March 14th of 2012 where we see it reads 22.4. Do you see that there?
A I do.

Q And the reference range goes from 0.6 to 5.1. Do you see that there?
A Correct.

Q So, again, there's an "H" next to the printout of 22.4 because that's high, too; right?
A Correct.

Q Underneath that, we have "lymphocyte". Do you see that?
A Correct.

Q If you go over to March 14th, we see 2.5. Do you see that?
A Correct.

Q The reference range is 2.7 to 12?
A Correct.

Q And, of course, 2.5 being less than 2.7, there's an "L" next to that because it's low; right?
A Correct.

Q And underneath that, we get to "monocyte"; right?
A Correct.

Q If you go all the way over to March 14th, we see 2.7; right?

A Correct.

Q Then we see the reference range, and it has 0.2 to 1.4; right?
A Correct. I just add one comment here. The range of difference, if you look just at the plain number, like, for example, the neutrophils, 27.6 -- I just need to rely on -- 22.4, and usually it's 0.6 to 5.1, and we said for the monocyte, it seems less impressive if you look at the number because it says 2.7, but the normal is 0.2 to 1.4, but actually the increase is significant in both. It's just that naturally we have less monocytes.

Here, it's very hard to interpret at this blood tests. On one side, you have the neutrophils that are increased. Usually that goes more with the bacteria. But you have the monocyte that are increased, and usually that goes more with a virus. And then you have the lymphocyte that are low. Why are they low, and it could be because of two reason: Maybe because they are diluted because of the neutrophil and the monocyte that are increased, or maybe -- sorry. I have to slow down -- maybe it's because they went, and they were killed. If you want further detail, you need a hematologist.

Q So would I be correct if I suggest that those numbers on March 14th are consistent with a viral infection?
A From this blood test alone, my understanding is that you cannot make the decision between a virus or a bacteria, and none of the doctor wrote for sure that it was a virus or a bacteria in the medical file. They discussed possibility.

My understanding is that I can't even present to you these possibility, but they never excluded a virus. They've never proven the bacteria, and they are better to interrupt this than I am. This is more something clinical than forensic pathology, but when I look at the slide of the puss around the brain, that's my specialty, and their proportion is that there's not a lot of surviving cells. Most of -- are white cells that went to -- or died.

The few remaining ones, they are not a striking amount of neutrophils. It's hard to say which one dominate, but there's a favour -- there's more lymphocyte and monocyte from what I can see, but not a striking amount compared to the neutrophils. A slightly more amount.

Q So you don't feel that it's within your area of expertise to answer my question about whether or not those numbers are consistent with a viral infection; is that fair to say?
A They're consistent with both. They don't prove one. They don't exclude one. By "one", I mean virus versus bacteria. I feel comfortable to go that far.

Q Okay. So they're consistent with a bacterial infection as well as a viral infection?
A Correct. They don't prove one. They don't -- they don't prove one. They don't ruled out. They don't -- "ruled out" for us means it's -- we have to ignore it. It's not possible. So they don't prove out. They don't ruled out one. Both are still possible from this blood test.

Q Now, I'm going to switch to a different portion; okay?
A Okay.

Q Now, yesterday, you talked about how you were able to hear this, and you called him a baby, breathe over the telephone on the 911 call. Do you remember that?
A I remember describing hearing him after his first respiratory arrest on the phone. I don't recall if I said "baby" or "children". I should have said "children", if I said "baby". He's an 18-month children -- child. Child, sorry.

Q Okay. And then -- sorry. Can I -- I can just clarify, if I can. That was the only time you had any direct evidence of breathing; is that correct?
A That is correct. There's no doctor, that I'm aware of, that described a respiration before the -- the second respiratory arrest, when he went into being eventually brain dead. I didn't personally -- am aware of any other place where I can have evidence of the respiration. That is correct.

Q Okay. And then you referred to -- and this -- this isn't the order. I'm not trying to misrepresent what order you were talking about things in yesterday. You referred to -- you said, Why did Ezekiel stop breathing? We have other tools to figure it out. I'm pretty sure, because I heard the 911 call. There's two other ways you can stop breathing because of meningitis.

The first way, you said herniation, but this didn't happen. That was your opinion; correct?
A When I said "two ways", we had already excluded herniation. The other two, there's one that -- my understanding is that I'm not allowed. Yesterday, I was not allowed to talk about it, so there was one remaining, which was the toxic-metabolic encephalopathy.

These are the three ways. One that I'm not -- my understanding is that I'm not allowed to talk about it. Three ways that you can stop breathing because of a meningitis.

Q So you said, Your white blood cells that are doing the work there against the viruses are chemically irritating your brain. The brain starts to swell enough that that can

cause chemical-irritation issue in the tissue, which is toxic-metabolic -- and I know I'm not going to say it right -- encephalopathy.

A Okay. If that's exactly what I said. There's one word then that is a little -- if we go back to the two ways I'm allowed to talk about, in the first one, it swells so much that it starts to herniate. In the other way, it swells but there's not just so much that; it's more that it's also chemically irritated.

So if I said that exactly, then maybe one word was -- but I -- I don't know if it's exactly what I said yesterday, so I'm re-explaining it.

Q Okay. So when you have this ware -- warfare going on, you also have brain swelling; is that what you just said?

A In -- in a meningitis, there's this word "chemical warfare". It's just the way I phrase it so that everyone understand, and it creates the swelling, and it creates chemical irritation. From one person to the next, from one situation to the next, in one person, in a context, maybe there will be a lot of swelling and then herniation. In another person, it might be mainly chemical. It could be a combination of both.

In Ezekiel, the swelling is not enough to create herniation, but the swelling -- or the chemical irritation, I should say, not the swelling. The chemical irritation that caused some swelling also caused chemical irritation that can stop the breathing by itself. Toxic ence -- toxic-metabolic encephalopathy. That's one of the possibilities in Ezekiel. We cannot consider the brain herniation, because we know it's not there. There's another one, but I'm not allowed to talk about it.

Q So, in Ezekiel, potentially, the chemical irritation that caused the swelling stopped the breathing; that's one possibility?

A That is correct. As I explained yesterday, I can't exclude it based on autopsy. The only way I thought the other one was more likely, and by "the other one", I mean a non-meningitis cause, would be because -- is because of the first 911 call where the sound of it is obstructive. Just as if we were to have someone that stopped breathing because of a meningitis, it doesn't sound the same, and if they were to breathe again, it will still not sound the same.

So in this case, because of the first 911 call, on balance of probability, it's a lot more likely that it's an obstructive phenomenon. I can said (sic) that.

Even if we were -- for the sake of discussing, if we were to consider that it was a respiratory arrest because of a meningitis, it will still not change the most important piece in this case, which is that with a proper paramedic intervention, without the eight additional minutes of non-breathing, he would, on balance of probability, have

survived through the meningitis, even a meningitis that would have caused, in a different scenario, his breathing arrest. But in this case, I think it's more likely that it was not the meningitis that made him stop breathing.

Q Now, when you refer to obstruction, yesterday you said, I can hear the obstruction that the air has trouble going through the airways. Do you remember saying that?
A Correct.

Q Now, obstruction in this case, what you heard, all you can say is --
A Sorry. Repeat. I missed a part of the sentence.

Q So based on what you heard on the 911 audio, all you can say is that -- or, no. Let me rephrase it. When you use the word "obstruction", do you mean his airway was restricted somehow?
A As I explained yesterday, when I hear obstruction, there's then a list of differential. "Differential" for us means a list of diagnosis we have to consider and decide which one it is.

In this case, just hearing the obstruction phenomenon on the phone call doesn't give you the cause yet, so have to go through the list. There's no foreign object. There's no peanut. There's no penny.

Q Okay.
A There's no --

Q Hang on. Sorry. I think we're getting into an area where you were explicit told not to talk about.
A Then I --

Q So I'm just going to retract --
A Then how --

Q I'm going to retract my question; okay. You don't need to answer it.

Now, I'm just a regular person. I'm not a doctor. When I hear the word "obstruction", I'm not going to think about differential diagnosis. When you say the word "obstruction", do you always only think about differential diagnosis?
A I don't understand the question.

Q So when you -- when I hear the word "obstruction", I think there's something going on. I don't know what it is, but it's making it harder for this person, with an

obstructed airway, to breathe. That's what I think. Is that a possible way of thinking about it when you use the word "obstruction"?

A I run into the problem that to answer the question, I will have to refer again to the part I'm not allowed to talk about, so it's kind of going circle, so I can't answer this question by saying the truth, the whole truth, and nothing but the truth, so I -- I'm kind of stuck.

Q Okay. Then I'll take back that question, too, okay, so just forget about it.

So I'm going to take you back to when you were talking about breathing. You were talking about how you listened to the breathing on 911, and then -- and I just read it back to you about the white blood cells and the warfare and the toxic-metabolic encephalopathy, and then you went on -- and tell me if I have it wrong -- Your brain is diseased by the chemicals that are used to kill the infectious agent.

If this happens, what we will hear is completely different than what we will hear because of an obstruction. You can hear that there's something that doesn't allow the air to pass. If it's because of meningitis, it can just be shallow, or it can be Cheyne-Stokes. And as I understand it, "Cheyne" is C-H-E-Y-N-E.

A Correct.

Q And "Stokes" is S-T-O-K-E-S?

A That's it. It's a one word, so it could be, as I described yesterday, the Cheyne-Stoke, or it could be just it's shallow and it disappear. It's kind of very -- some people -- some call it at times, also, agonal breathing. There can be some gasping in it or not. It could just disappear or just be lower and lower and disappear, or it can be Cheyne-Stoke. That's correct.

Q So agonal breathing is not the same as Cheyne-Stokes? Do I have that right?

A Well, this is where we went to. "Agonal" mean dying. "Breathing" mean breathing. Agonal breathing is just the breathing you have as you die. Some people use it is to refer to something a little bit more specific as a pattern. Some don't. You have agonal breathing when you're dying and your breathing is dying, if I can say so.

Cheyne-Stoke is more specific. Obstruction of breathing is also more specific. Agonal breathing can be used as a general term or more for something with it gas pain. It depends on the authors.

Q Now, I don't recall you giving a -- a description yesterday about what agonal breathing sounds like or what you hear when it happens. Like, so, for example, for Cheyne-Stoke, this is what I wrote down about what about you said: More shallow to

deeper, and then the other way, from deeper to shallower, and then you will stop breathing again. Is that a fair recitation about how you described Cheyne-Stoke yesterday?

A Correct. And it starts again and again and again, this pattern of shallow to deep to shallow and stop, shallow to deep, shallow, and stop. Whereas, agonal, I didn't use the word yesterday, but I said it could also just be shallow and disappear.

Q So Cheyne-Stoke, it can go on for a number of minutes?

A It could.

Q It could go on for a number of hours?

A It could.

Q It could --

A I have to say one thing, though. You can eventually -- and I don't know if it happened here, but, eventually, it is obstructive. Then he is brain dead. If he start breathing again after being brain dead, you could then have a Cheyne-Stoke or not, or you could have another version of it called, Biot that is not -- it doesn't just -- it's kind of a version of the Cheyne-Stoke because now he's brain dead, and he might have some areas of his brain dead is affected. He might have. He might not have.

He might be hyperventilating a bit. He might not be. I'm not sure. But when the doctor will see him after the paramedic misadventure, this is not what happened before. This is now the breathing after the trauma, the hypoxic and anoxic brain injury has happened.

So at that stage, the breathing is different. Now you have the breathing of being brain dead. It might be there. It might not be there. I don't recall to have seen someone describing a pattern.

Q So Cheyne-Stokes breathing can go on for days?

A It could. It depends on the cases.

Q So you just heard me describe what you said about Cheyne-Stokes breathing. Are you able to provide us with a description of agonal breathing?

A In the way I will use it, some author has some gasping in it and some twitching of the muscle. In the way I usually use it is just that progressively, the breathing disappear, so you -- you don't breathe out.

It depends. One person to the next could be different. In some person, it could be just that it's shallower and shallower and shallower and disappear, when other person,

it could be that you're missing some respiration, and over time, you're missing more and more, and then you don't breathe. In other person, it could be that it's going down, or there's these period of emptiness, and you can have, on top of it, some gasping, and some -- sometimes they make some noises as they are dying and stopping breathing.

So that's an all kind of variation of agonal breathing that are not the Cheyne-Stokes and that are not the obstructive way.

Q So I'm really sorry. You talked really fast, and I couldn't write it all down.
A Sorry.

Q No, no, no. It was just too fast for me, not too fast for everybody else. I'm just slow like that.

So you described it as shallower and shallower and then it disappeared? That was the first thing you said?
A Yes.

Q So by "disappear", do you mean the breathing just stops all together?
A Yes. That's at what point you -- once you're -- once you're dead, you don't breathe anymore, so if you -- your breathing can just go shallower and shallower and shallower, and then it's not there. That's one version of it. Then I described other possibility.

Q Okay. What's the other possibility?
A Instead, you could be breathing and missing some respiration, so instead of doing all of the respiration you should do in a minute, you do less and less and less. You -- it's kind of skipping some breathing. You can end up doing, like, one every 30 seconds or one every minutes, and then you don't even breathe anymore, so instead of -- and -- and it could be combined with -- I'm not -- it's just kind of big pattern. You could combine it with shallower. It could be shallower and shallower and less numerous and less numerous and then you stop breathing.

And I said that some people could also do gasp or noises and -- and intermixed with these respiration going away. If you were there when someone died, you might have heard that. Sometimes as they are breathing less and less, they make some noises that are not -- they are not talking. It's not voluntarily -- voluntary. It's kind of unvoluntarily (sic) noises that they make as they are breathing less and less.

Q Sorry. So let me just make sure I have this correct. So for the second description that

you provided, breathing and missing some respiration, instead of doing all the breathing you should be doing in a minute, you wait 30 seconds or a minute?

A That's not what I said.

Q Okay. Could you say it again? Sorry. I just didn't write it down correctly?

A And -- and I have to say upfront that when you say "the first type", "the second type" it's just because I'm trying to describe pattern, but you -- you can't find, like, a list of first type, a second type, a third type. It can be all intermixed. I'm just trying to give different variation of what could happen, and they can be mixed together. There's no, like, an official one, two, three, four.

So in the second type is -- is that instead of doing all the breathing that are rhythmical and normal, they start skipping some. There's some breathing that there's a pause. There's an actually -- there's a period where they don't breathe, and then they start again.

When they start again, it could be a normal breathing, or it could be a shallower breathing. It depends, and there's no rules about it. And, in between, they can make some noises. Maybe they don't. It depends. There's no rules about it.

Q Okay. This is the last time I'm going to ask you. I promise.

So then when it comes to the third description -- and, again, keeping in mind that these can all be mixed up together.

A Correct.

Q The third one you said maybe they're gasping or making some noises?

A Correct.

Q Does -- does this third description also include -- so, sorry. Your third description is just gasping or making noises? Nothing else?

A Well, it never happen in itself. It's mixed with the other two. I'm trying to describe that in ways, but, really, all of this happens together, and you never have only the gasping.

Q Okay. So you might hear -- if you're listening to what happened, you might hear what you described in Number 1; correct?

A Correct.

Q You might hear what you described in Number 2; correct?

A Correct.

Q You might hear a mixture of 1 and 2?
A Yes, because I was just trying to put words on a phenomenon. It's not official 1 and official 2. It's just trying to describe.

Q And at the same -- the same way, you might hear a combination of 1 and 3?
A Correct. As I said, it's not 1 and 3. It's my way of describing it, yes.

Q Now, how long can this -- before, when we were talking about Cheyne-Stokes, I asked you about minutes, hours, and days. How long can this agonal breathing go on for?
A Okay. Maybe I should say -- and it's true also for the Cheyne-Stoke. It depend why you are doing these sounds, because the why is very important. If it's something that killed you quickly, you won't do that for days. If it's something that you are unconscious, in a coma, and you will be in a coma for a month, you might be in Cheyne-Stoke, but they will -- they will reverse your respiration by using medicine and support; but you could be in that for a longer period, so it depends.

For example, I remember a case where there was a man who was under an intoxication, and all night long, he was on a Cheyne-Stoke pattern because of his brain damage from the drug, and it's an interesting case because the woman was sleeping beside him thought he was doing it on purpose; and at some point, she decided she had enough of him, and she thought she killed him because she just so (UNREPORTABEL SOUND), but she didn't kill him. He was already dying, so that was an interesting thing. He did it for almost a full night, but that was a Cheyne-Stoke, and we could prove that, actually, she might have accelerated it slightly, but he was dying of his intoxication. It depends on the cause.

In another case, it could be just a few seconds or a few minutes. It depends on why you are doing this agonal breathing. By the agonal breathing itself, you can't conclude.

Even in obstruction, you have to go to why there's an obstruction, but obstruction is more severe, if the obstruction is severe. Like when you can hear it, usually you have less time. You need to -- you need to re-establish the respiration, on average.

Q Sorry. And I -- I promise I won't keep harping on this.

In your second description about pausing, there's a pause. The -- the length of the pauses, are they always the exact same? It's always one-second pause? It's always two-second pause? It's always three-second pause?
A There -- there's variation. But don't forget that if there's a total apnea to the lung,

that is dangerous. Then you end up having damage to the brain. So there's a limit. You cannot be in apnea for 30 or 40 minutes and then start breathing again and just going back doing your normal activities.

Q Okay. So that takes care of Cheyne-Stokes, agonal, and you mentioned Biot. How do you spell that?

A B-I-O-T. It's just a variation on Cheyne-Stoke. Let's keep it simple. Unless you really insist, I don't think it's necessary we go into Biot. It's not a training course in breathing, but it's -- it's a different type, but if you insist, I can describe it, but it's really a different type of Cheyne-Stoke.

Q So when I asked you about how long you would be breathing or how long you could potentially be breathing, agonal breathing, you said it all depends on what's causing you to be breathing that way; correct?

A Correct. There's people that take three days in an agonal phase before they die, and there's people that die in five seconds, and there are people that die in two hours. It doesn't depend on their respiration. It depends on the cause for being dying.

Q Okay. So as much as I know you don't think it might apply, could you just humour me and tell me what Biot is?

A Totally, yes. So a Biot is like a Cheyne-Stoke in the sense that there's a pattern of respiration, and then there's a pause, and then you start again. In the Cheyne-Stoke, it starts, as I said, like a -- it's -- it's a crescendo decrescendo. In the Biot, it's all -- it's all above the normal, when it is, so I will -- know the transcriptionist cannot put the sound on it, but I think I will do it and then describe it. It's still easier, so I will do it.

It can be longer, as I said yesterday, but I will just do it shortly so that it's easier to understand. A Cheyne-Stoke is a pause (UNREPORTABLE SOUND) a pause. A Biot is a pause (UNREPORTABLE SOUND) a pause. So it's straight to the crescendo, to the top of crescendo. There's not the going up and the going down. It's already to the top, but from what it means, it means the same thing as a Cheyne-Stoke.

Q Okay. Thank you very much. I appreciate it.

A If you want all the breathing, there's another one, but it's totally irrelevant in this case, and it's called the "Kussmaul". But I didn't even went there because it's in diabetes and kidney failure, so I think we can safely exclude that here.

Q Okay. Oh, did you mention cosmos yesterday?

A No, because it's irrelevant to this case, and I'm not doing a course on breathing. I'm -- I'm explaining the case.

Q Okay. Thank you.

So if this breathing -- let's just take Cheyne-Stoke for example. If I understand you correctly, what you said yesterday is that if you're suffering from meningitis -- well, I don't think you said this yesterday, so I'm not going to put words into your mouth. I'm just going to suggest it to you; okay?

A Okay. That's easier.

Q If a patient is suffering from, let's say, viral meningitis --

A Okay.

Q -- and has this Cheyne-Stoke breathing, is that an indication that the damage -- I'm going to use that word, and you can correct me if I'm wrong -- the swelling, and the chemical warfare on the brain is affecting the ability of that patient to breathe properly?

A Okay. So if I understand correctly, we are taking the hypothetical of a viral meningitis, and now the person is doing the Cheyne-Stoke. In -- if it would -- that means there's a reason why there's a Cheyne-Stoke. There's -- if -- in the -- in the viral meningitis, it's nice because there is two option. The one that I can't talk is not there. Usually it's not there, so it's either because of a brain herniation or because it's a chemical irritation.

Once there is a Cheyne-Stoke, it could persist like that for a long time or not. It will really depend on the damage on the brain itself, so I can't tell you how long it would take; but for the time they are doing the Cheyne-Stoke, there's enough breathing to not have a damage to the brain, so it's when they will stop breathing that it's going to be important.

So as I said before, in this case, I don't think it is the meningitis that stopped breathing, but if we take this as a hypothetical, it still remain that when they finally completely stopped breathing, their 11 minutes, 59 seconds, they were, on balance of probability, still -- they could have been saved, and it's the additional 8 minutes that made them reach out of the safety period.

So the Cheyne-Stoke, there's still enough breathing to keep your brain okay, in general, because you're still doing -- it depends. Of course, if you're do -- if you're at the stage where you're doing one breathing every six hours, that's a different story. But usually a Cheyne -- a Cheyne-Stoke is more regular than that, so you are still putting oxygen enough to not have brain damage. It -- I -- I will stop there.

Q So given this 11 minutes and 59 seconds, if there was evidence that there -- sorry, just

taking you back to what you said yesterday about how every time the patient breathes, he goes back to point zero --

A Correct.

Q -- and you start the clock all over again for considering how long it will take for brain damage to happen; is that fair?

A That is correct, and we -- we didn't know that years ago. We know that from looking at the sexual asphyxia, actually.

Q So if during that 11 minutes and 59 seconds, in this particular case that we're talking about, there is evidence that Ezekiel did, in fact, breathe, then that would push the safe zone a little bit farther along? You said yesterday -- sorry. Let me just get it all straight.

You said yesterday 5-to 10-minutes safe zone; correct?

A Yes, but as I said, don't try it at home. It's -- the surgeon know they have 5 to 10 minutes to be in the safe zone, but I would not try to clock and see if I can go at 10 minutes just for the fun of it, but we consider that is the safe zone.

Q And when you have somebody providing CPR, as in blowing into the mouth --

A Can I just add something, too?

Q Yeah. Sure.

A In the 5 to 10 minutes of the safe zone, it's when you clamp the arteries, but not the veins, so that might also affect that if you have a total, maybe it's 9 minutes. Maybe it's not 10, so it's not a precise 5-to 10-minutes safe zone. It's just an indication of a length of time, so don't start the clock and test it. It's not that precise.

Q So, sorry, now I can't remember where I was going.

A I'm so sorry.

Q That's okay. It happens.

So if you have a person providing CPR to a patient -- I'm going to call him "a patient" -- that stops breathing, the breath goes into the airway, into the chest, the chest rises and falls, then they go back to pumping the heart, does that chest rise and fall take you back to point zero?

A I can't answer that. What I can say -- and when I -- when I say "I can't", it's this -- I don't -- I've never seen science that allow us to answer this question for -- with a firm answer.

What I can say is that this is a protective factor. If you really succeed in putting air, so if it's really rising -- if this with blocks, then it's not as protecting. If it really goes, is protecting your safe zone will be longer. The safe zone to not have brain damage can go up to 20 minutes. Once again, don't start a clock. That's for the breathing.

You also have the circulation. The fact that you're pumping might allow some circulation of the blood, might make the safe zone a bit longer, but I cannot tell you by how much, and I cannot say in a specific patient, in a specific event, if it was successful. So it's on balance of probability. It can have -- it can lengthen the safety period. That's all I can say.

Q So every time you start breathing, you go back to zero?

A Yes, but not in CPR. That's different. What I mean is I gave the example for -- for example, of someone that is hanging themselves for sexual reason. They go in a hanging, and then they go back, and then they -- they decrease. They are not under CPR. It's a real normal breathing for a few minutes, and then they -- or a few seconds, depends, but it's normal breathing. I've never seen seconds. It was usually -- sorry, I have to go slower.

Usually, it's a little bit longer. I can't recall from memory how long, but if they breathe, and when they feel they want to do it again, they do it again. That puts back the clock to zero, but I'm not aware of experimentation with CPR that allow me to answer the question if CPR puts it back to zero. I don't think it does put it back to zero, but that's -- that's different than having your own breathing putting it back to zero.

What I meant when I said that yesterday, I meant when the patient start breathing again by himself, like on the first 911 call when Ezekiel started breathing again by himself. If the breathing is sufficient, then, yes, that can put him back to zero.

Q And then CPR with breaths into the airway, chest rise and fall, and pumps on the chest can extend that safe zone, but you can't say for how long?

A We think it can. That's why we're doing it. I can't say formally that it will in everyone, but that's why we're doing it. We think it can, and, yes, I can't say for how long.

Q And then chest pumps without any oxygen into the airway can help a little bit, but you can't say how long that could extend the safe zone?

A Correct, because let's say no new oxygen was to reach the blood. Just for the sake of exercise, let's say their airways really are not working. The fact that you're pumping,

you're moving the blood around, and your brain has new blood that is not as fresh as if it was always adding new oxygen, but there's still a bit of oxygen left moving around.

Eventually, if you don't put the airways back, you will need more oxygen, but there's a period where there's still oxygen in your blood. That's why we call it hypoxic and anoxic, because at the beginning, there's less oxygen, and eventually there's no oxygen. But I can't tell you how many minutes, and I can't tell you, by doing the pumping, how long you're going to accelerate it. It depends. We -- I can't say. There's no studies that allow me to give a firm answer to that question.

Discussion

MS. WEICH: So, Sir, I think that's everything for the morning. I note the time, and our expert witness has been here for almost two hours.

THE COURT: A bit longer than that.

MS. WEICH: I would appreciate a lunch break, Sir.

THE COURT: Counsel, I think we should break until 2:15 to give the witness and the jury a break. It's quarter --

MS. WEICH: I'd be happy --

THE COURT: -- to 1.

MS. WEICH: -- with 2:30, Sir. Honestly. I -- I won't.

THE COURT: If we go until 2:30, will you still finish?

MS. WEICH: I will, Sir.

THE COURT: 2:30, Counsel?

MR. BUCKLEY: Yes. That's fine, My Lord.

THE COURT: The jury will come back at 2:30.

THE COURT CLERK: Order in court. All rise.

(JURY RETIRES)

THE COURT: Doctor, you can be excused. Just bear in mind you're in the middle of cross-examination, so --

Please be seated everyone.

-- this is an important time not to have any conversations with anyone concerning this matter; all right, Doctor? Doctor?

A I was excused, no?

THE COURT: You're in the middle -- yes. You're in the middle of cross-examination, so please bear that in mind. It's important --

A Oh, yes.

THE COURT: -- not to have any conversations.

A Yes, My Lord.

THE COURT: Thank you very much.

(WITNESS STANDS DOWN)

Question by the Jury

THE COURT: Just have a seat, Counsel. I just want to look at something here.

A question from the jury. I'll read it, and then you can let me know how we should -- or you think we should answer. (as read)

Are we allowed to have --

UNIDENTIFIED SPEAKER: Oh -- oh . . .

MR. GILES: Hm?

MR. BUCKLEY: Dr. Adeagbo.

MR. GILES: Oh, yes. Thank you very much from the gallery.

THE COURT: Thank you, Gallery.

(as read)

Are we allowed to have Sauvageau's report back to follow along?

MR. GILES: Could we think about that over the lunch and then address that when they come back?

THE COURT: All right.

Madam clerk, I'm going to get you to mark that as the next judicial exhibit; all right?

EXHIBIT J-16 - Jury Question, Original, Handwritten on Lined Paper, Black Ink, Are We Allowed to Have Sauvageau's Report Back to Follow Along?, in Manila Envelope Dated 16-04-20, 11:30 Am, DW Written in Black Ink on Outside of Envelope

THE COURT: 2:30. We'll see you, Counsel, at that time.

PROCEEDINGS ADJOURNED UNTIL 2:30 PM

Certificate of Transcript

I, Sara Anderson, certify that the foregoing pages are a complete and accurate transcript of the proceedings, taken down by me in shorthand and recorded by a sound-recording machine and transcribed from my shorthand notes to the best of my skill and ability.

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Sara Anderson, CSR(A)
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Proceedings taken in the Court of Queen's Bench of Alberta, Courthouse, Lethbridge, Alberta

April 20, 2016	Afternoon Session
The Honourable Mr. Justice Jerke	Court of Queen's Bench of Alberta
L.M. Weich	For the Crown
C.O. Giles	For the Crown
S.P. Buckley	For the Accused D. Stephan
S.P. Buckley	For the Accused C. Stephan
J. Stringer	Court Clerk
S. Anderson, CSR(A)	Official Court Reporter

THE COURT CLERK: Order in court. All rise.

(WITNESS RE-TAKES THE STAND)

THE COURT: Please be seated.

Discussion

THE COURT: How are we going to deal with the question from the jury?

MS. WEICH: So, Sir, while I would still like to make some recommendations as to appropriate vetting before I --

THE COURT: Doctor, could I ask you just to step out --

MS. WEICH: Sorry.

THE COURT: -- for just a minute.

A Yeah.

(WITNESS STANDS DOWN)

MS. WEICH: While I would still like to make some suggestions about appropriate vetting, I would that submit that it can go to them for the

afternoon so that they have the opportunity to review it, if they want to.

THE COURT: So that would be a copy of the redacted version which will ultimately be offered as a full exhibit?

MR. BUCKLEY: Well, I -- I anticipate it will be redacted further, as I understand my friend's position.

THE COURT: So how do we do that?

MS. WEICH: Well, we could argue about it now, if you want to.

THE COURT: No. But you're saying that the currently redacted version can go to them?

MS. WEICH: Yes. The copy that they received yesterday for the purposes of direct examination.

THE COURT: That's the unredacted version, Exhibit A?

MS. WEICH: No, no, no. They got --

MR. BUCKLEY: They have a redacted version.

MS. WEICH: They have a redacted version, yes.

THE COURT: Have they got a redacted version?

MR. BUCKLEY: So what is Exhibit B --

MS. WEICH: Yes.

MR. BUCKLEY: -- right now is a redacted version.

THE COURT: Is the currently redacted version?

MR. BUCKLEY: And so it's the same as what the witness is viewing on the stand.

THE COURT: Okay.

MR. BUCKLEY: They have a copy of -- of Exhibit B.

MS. WEICH: So, Sir, sorry. Now that I think about it, I think a jury instruction about what they can and can't think about should work just fine as well, so if we're going to argue about anything in the long run, I'm happy argue that it should be subject to a jury instruction about what they can and cannot take into consideration.

THE COURT: Let's let the jury have Exhibit B if they want it, and we'll deal with it later; all right?

MS. WEICH: Certainly.

MR. BUCKLEY: Should I go get Dr. Sauvageau then?

THE COURT: Would you mind, Counsel.

MR. BUCKLEY: Not at all.

THE COURT: And, madam clerk, would you call the jury in, please.

THE COURT CLERK: All rise.

(WITNESS RE-TAKES THE STAND)

(JURY ENTERS)

THE COURT: Good afternoon. Please be seated.

Response to Questions

THE COURT: Jury, I've received your question and discussed it with counsel, and, yes, you can have back your copies of Exhibit B, and those will be handed back to you. We'll gather them back in, because there may be some other things that we have to do with it, but for the meantime, as per your request, you're permitted to have your copy of Exhibit B back. Madam clerk will give you your copy.

Discussion

MR. BUCKLEY: My Lord, it's going to be a minute for Dr. Adeagbo, so I will go and make sure he come in when he's -- oh, there he is. Okay. I thought --

THE COURT: Yeah.

MR. BUCKLEY: -- he was still out.

THE COURT: Counsel, please confirm that all jurors are present.

MS. WEICH: Yes, Sir.

MR. BUCKLEY: Yes, My Lord.

THE COURT: Thank you, Counsel.

Doctor, you acknowledge that you're still under oath?

A I do, My Lord.

THE COURT: Thank you.

Please proceed, Counsel.

ANNY SAUVAGEAU, Previously Sworn, Cross-examined by Ms. Weich

Q So, Dr. Sauvageau, I'm going to turn your mind to Heading 1.3.1 of your report; okay?

A Yes.

Q And specifically the paragraph that you wrote at the top of page 6, which says: (as read)

> However, Haemophilus influenzae [and I'm sorry if I'm saying it wrong] is a gram-negative coccobacillus, which means that this bacteria has an intermediate shape between cocci, spherical bacteria, and bacilli, rod-shaped bacteria.

Do you see that there?

A I do.

Q And, yesterday, you gave evidence an Haemophilus -- again, I'm sorry. I don't know want how to say it -- is not a bacilli. It's a coccobacilli.
A Okay.

Q Do you remember saying that?
A Yes. I want to add to this a little bit. So I mentioned there was -- for -- for simplification of the discussion, I mentioned that there was three shape I would talk to you about, but that there were other shape that existed. I -- I -- I made the example of a classic bacilli.

The classic coccobac -- the classic bacilli, the classic cocci, and the coccobacilli, if you want to be more precise, it's a subtype of bacilli, but it is so different that you have to call it coccobacilli. You cannot call it just bacilli. It's a coccobacilli.

The reason it's still under bacilli is because I explained yesterday, it is kind of a little rod shape, but compared to the classic, the real bacilli that are big, this one is so tiny that depending how you cut it, it can look like a bacilli, but it can also look as a cocci. That's why it's a coccobacilli, but in the textbook of microbiologists, sometimes they are separate as a coccobacilli, sometimes they fell under bacilli, but that is type that is very special and that you need to recognize as being special.

Q Thank you. So let me just make sure I have it straight. Bacilli, general heading; coccobacilli special type?
A If you say it this way, then it's not necessarily true. When I look at -- when I have a report of a gram stain, if it's a Haemophilus influenzae, I expect that it's going -- going to be described as a coccobacilli and not as a bacilli but as a coccobacilli.

And I said yesterday I'm not a microbiologist, and I said that if I was the pathologist on the case, and for some reason I still think it's a Haemophilus influenzae, I would have called a microbiologist to ask, Were you just being unprecise (sic), because, usually, this is not a bacilli. This is a coccobacilli.

And, actually, there's all the literature on -- well, I can't say I look at all, so the literature I'm aware of in the Haemophilus influenzae do not describe it as a bacilli on the gram stain, but as a coccobacilli.

Q So as I understand it, you are now familiar with a World Health Organization manual published in 2011 titled *Laboratory Methods For the Diagnosis of Meningitis Caused By Neisseria Meningitidis, Streptococcus Pneumoniae, and Haemophilus Influenzae*; is

that correct?

A Correct, and if you look at page 89 of that paper that you gave me yesterday, you will see exactly that. There's a diagnostic tree. Can -- am I allowed to refer to the copy?

Q Well, you can talk about what you know?

A Can I look at it to describe it, or I can say by memories.

Q So I haven't asked you a question about the contents. I've just asked you if you're familiar with it.

A I am. And it contains a -- Decision 3 that says exactly what I described, that if -- if you have a gram stem (sic), and they say if it's a coccobacilli Haemophilus influenzae, and it says if it's another shape, not Haemophilus influenzae. From memory it's on page 89 -- maybe I have the wrong page from memory, but it's in the document you provided to me yesterday.

Q Okay. So now I'm going to move on to the heading 1.3.2 in your report; okay. So this is about the rRNA Gene Sequence Analysis.

Now, I wrote down a lot about what you had to say about this yesterday, and if you would like to, I will read it all out to you, but I'm just mostly concerned with your conclusion. So generally summarizing what you said yesterday, you would not rely on the outcome of that test because -- and here I'm quoting you: (as read)

> It's two -- there's two problems with the test, but I will only talk about one. It's too sensitive. It finds too many bacteria. If there's a problem, if you know it's a bacteria, it's a good test to say which bacteria it is, but when the culture is negative, the test is so good at amplification they will amplificate until they detect something.

Do you remember saying that?

A Correct. And, actually, if you look at the -- the literature, there's many paper that say that. One of most recent one is Simon and all (sic), 2014, where they tried the SR -- R -- 16s rRNA on the cerebral spinal fluid to see if they could detect infection, and their conclusion is that for now, it didn't give any advantage over a culture because it was -- there was several problem, and one was that, for now, this is too sensitive. It was finding too many cases that were false positive, which means you're diagnosed with something that you don't really have.

So it is a well-known fact that the 16S rRNA -- the first 'R' is for ribosomal, which is

the adjective that go with ribosome, and we explained yesterday what that is. This test is not ready yet for Haemophilus influenzae in the CSF as far as I know, and Dr. Chan (phonetic) wrote the same thing in his email.

If you want to go further, though, Dr. Chan is a better expert than me on this. He's a microbiologist.

Q So in this particular case, you were not able to say how many times the amplification occurred; correct?

A Okay. I'm not an expert on molecular diagnosis. My understanding is that PCR to millions with a big 'S' of copies. I can go further. I'm not an ex -- there's -- there's a way that they can know. There's different type. Maybe I should say that.

PCR is not necessarily the same thing as another PCR. PCR is a very general technique. To make you understand that, let's change that word with -- let's make an analogy. Let's take the example of blood test.

If you go for a blood test, and you tell your friend, I've been for a blood test, you don't really know what they have gone through, so maybe, for example, what they did was a cholesterol, and now we know their cholesterol is normal; but if they just tell you, I had a blood test yesterday, and you asked them, Oh, does that mean you don't have diabetes? Well, not necessarily because the blood test might not have tested for sugar.

I think that is easier to understand. But PCR, because it's more complex and we're more -- less familiar, for most of us, the layperson with a PCR, it seems that one PCR is the same as another PCR, but there's multitude of different PCR. There's PCR, Conventional PCR, Realtime PCR, Multiplex PCR, 16S rRNA PCR, and I'm so not an expert. There probably a longer list than that.

So, for example, I told you yesterday that the 16S rRNA PCR -- I have to go to slower. I'll try -- doesn't test for virus, and I'm still saying the same today, but there are other PCR, like the one that we discussed this morning, the one that at autopsy and the one done at the hospital that tests for viruses, but I never talked about the other type of PCR. There's a variety of type of PCR, and I lost where I was going.

Can you repeat what the question was so that I know why I was explaining all of this? Sorry.

Q In this particular case --

A Yes.

Q -- you do not know how many amplifications occurred?
A Okay. I don't know because I'm not a specialist of molecular diagnosis. The microbiologist will be able to tell you in this test. Maybe he knows. Probably he doesn't know unless he deal -- he -- he use one of the form of PCR that kind of track in realtime how many copies, but I am now out of the field of my specialty.

Let's say that it's a very complex technique. There's multiple PCRs that exist, and I cannot say how many amplification there will be in a 16S rRNA, and as a pathologist, I don't need to know that. What I need to know is that, today, the technique of 16S rRNA, which is one of the multiple other test -- tests of PCR that are ready for clinical use. That one is not ready yet, particularly in the cerebral spinal fluid, and Dr. Chan said it, and he's a better expert than me on this. He's a microbiologist, and I am not, and Dr. Adeagbo is not.

Q So going on to what you said yesterday about agonal spread, do you remember that?
A Yes.

Q Okay. So you said the majority of people think it exists; some people are not 100-percent sure; bacterial translocation, no one disagrees with it. "Agonal" means as you are dying. Maybe the bacteria start to spread as you are dying. When you were on life support for several days, maybe the bacteria started earlier than death to move around. The fact that we see gram-negative bacilli, scant or few, is of no particular meaning in this case. Is that correct; that's what you said?
A It is correct, an extract of a larger, but it is correct.

Q So while you see it potentially happening that way, that is translocation, it's also possible that these gram-negative bacilli were detected because, in fact, they were present due to a bacterial infection? I know that it's not your most likely option because you keep saying how more likely than not and in all probability, but it's possible?
A And I said it yesterday. I cannot completely ruled out the possibility of a bacterial infection, but if it is a bacterial infection of the type gram-negative bacilli, then it's not a Haemophilus influenzae because that's a coccobacilli. And if you are -- if you forget the test 16S rRNA, who's not ready for clinical use, the most bac -- the -- the most common bacteria that will come to mind is not necessarily that one, but I know. I remember I cannot discuss bacteria. Sorry. I'm not allowed.

Q So, yesterday, you were describing about how when it comes to viral meningitis -- and this is just a summary. It's not your exact words -- the outcomes are almost always good; right?

A Could you repeat the beginning?

Q Yesterday --
A Yes.

Q -- when you were talking about -- I'm going to call it the chances of survival with viral meningitis?
A Okay.

Q The chances or the outcome is almost always good?
A Correct. Just for the sake of completeness, I said that you could have cases that are more severe. They can have seizure. They can have coma. But with the proper life sup -- proper support, medical support, virtually all of them will go through it.

I adding this because when I said it will have a good outcome, it doesn't mean they will necessarily all be good if they stay at home. At some point, some of them might need medical care. The majority will never need medical care. Some might need medical care. With proper medical care, virt -- virtually all of them will go through at the end. Some by themself (sic). Some with some help from the medical care.

The people that need medical care is a tiny fraction of the iceberg of the viral meningitis, but they exist.

Q Now, in all of your years of conducting death investigations, am I correct if I say you have never encountered viral meningitis in children?
A As a cause of death. I've never seen a death, in my practice, that a child die of a viral meningitis, but, as I said, it is not expected that they will die of it. When you look at big outbreaks of enteroviruses, or if you look at children's series of viral enteroviruses meningitis --

MS. WEICH: So --

A -- the children all survive --

MS. WEICH: So, Sir --

A -- so they don't end up on my table.

MS. WEICH: Sorry, Sir. I know I'm not supposed to interrupt her, but. . .

THE COURT: It was a fairly straightforward question.

A No, I've never seen it, but I don't expect to see it because if they don't die --

MS. WEICH: Again --

A -- I don't see them.

MS. WEICH: Okay. Sorry, Sir. I don't mean to cut her off. I just don't want her to start going into areas she's not supposed to go to --

A Oh.

MS. WEICH: -- so I'll just move on.

Q MS. WEICH: Now, is it -- if I understand it correctly, you've encountered bacterial meningitis a couple of times when conducting a death investigation; is that correct?

A That is correct.

Q So all totaled, you discounted the negative test result for enterovirus or rhinovirus on March 14th, and you described your reasons for doing that; and you discounted the PCR test result that concluded it was Haemophilus influenzae, and you described your reasons for doing that. But all taken in total, it still could have been bacterial meningitis; correct?

A I cannot ex -- exclude. I cannot ruled (sic) out a bacterial meningitis. I only said it on balance of probability.

Q And as I understand it, your explanation for why swelling in the brain did not stop breathing is because there was no tonsillar herniation; is that correct?

A Repeat that, please.

Q So -- and maybe I'm misquoting you or maybe I'm misphrasing you, and if I am, please correct me. I thought that yesterday you said there was no tonsillar herniation?

A That part is true.

Q And you said there was no bulging fontanel?

A That part is true.

Q Hence, the brain just wasn't that swollen when this patient stopped breathing?

A That is correct. So the reason for stopping breathing in this case, it can't be because

the brain is too swollen. It's not by herniation that would kind of squish or squeeze the respiratory or cardiac centres, so it's not the case here. There's other explanation possible. Not that one.

Q So let me just see if I can sum it up. This child passed away. He had meningitis, which you can tell; you can --
A That part is correct.

Q You can't or your office or Dr. Adeagbo or a pathologist can't prove that it's bacterial?
A That is correct.

Q It's not that it's entirely inconsistent with bacterial; you just can't say a hundred percent say for sure it's bacterial?
A That is correct, so then you go on balance of probability.

Q So, therefore, it was viral?
A On balance of possibility. I repeated that word many times yesterday, and I repeat it many times that I cannot exclude another virus, and I cannot exclude a bacteria, and I'm forbidden to talk more about the bacteria.

Q And in the grand scheme of things, more often than not, viral meningitis just doesn't kill you?
A Yes. But I add, again, you can have a viral meningitis that make you stop breathing, but if you had been intubated on time, you would have survived; but, here, something else happened, which made this case different and more complex.

Q So it was the ambulance that killed him?
A On balance of probability, I cannot tell you at 100 percent the cause of his brain death, which means the cause of his death. On balance of possibility, my opinion, is that it's directly related to the paramedic intervention, that without that, on balance of probability, he would have survived.

Can I exclude something else? No. Can I assure that at 100 percent that there had not been a paramedic misadventure, he would have survived? No. I'm working on balance of possibility.

MS. WEICH: Those are all my questions, Sir.

Discussion

THE COURT: Counsel, do you have any re-examination?

MR. BUCKLEY: I don't believe so, but let me just flip through my notes.

THE COURT: Yes.

MR. BUCKLEY: No, I don't, My Lord.

THE COURT: Thank you.

Doctor, I don't have any questions for you. You can be excused, but, you know, could you just stay in the hall for just a couple minutes? I just want to make sure that we get things, that nothing goes sideways with respect to the exhibit, in case we need you.

A Yeah.

THE COURT: So you can be excused. I don't think you'll have to testify again. Thank you very much for coming.

A My Lord, just -- just for sake of precision, do I wait for someone confirming I can go?

THE COURT: Yes.

A Okay.

THE COURT: We'll let you know right away.

A Thank you.

THE COURT: It shouldn't be very long. I don't think it'll be long.

A Thank you, My Lord.

THE COURT: Okay.

A My shoes are not following me. Sorry.

(WITNESS STANDS DOWN)

MR. BUCKLEY: And, My Lord, I can advise the Court I anticipated, based on my friend's representations, that they would be all day with Dr. Sauvageau, so I did not arrange for another witness to be here.

MS. WEICH: I take full responsibility for that, Sir. I did say yesterday I thought I would be all day.

THE COURT: You did, yeah.

Let's deal with the exhibit first so that we know if we can let Dr. Sauvageau go.

Is there any issue with respect to marking the Exhibit B as a full exhibit in the trial?

MS. WEICH: Would you like to discuss it in front of the jury or . . .

THE COURT: Well, I didn't -- I just -- is there something to discuss? And, if so, it should not be in front of the jury.

MS. WEICH: There is two paragraphs, I'd --

THE COURT: Yeah. All right. Let's --

MS. WEICH: -- simply like to point out.

THE COURT: Rather than encumber the jury, members of the jury, let's just -- I'll get you to give madam clerk back your copy to put in the envelope, please, and we'll just get you to wait for a couple of minutes.

(JURY RETIRES)

THE COURT: Please be seated.

Counsel?

Submission by Ms. Weich (Admissibility of Evidence)

MS. WEICH: And, again, Sir, I'm happy with the jury instruction. Your order was to remove all reference to croup, and it's simply the last paragraph on page 2 and the top paragraph on page 3, and it's the only two references to croup in the whole rest of the paper, and I just don't see how it follows. They make

absolutely no sense. There's no reason for them being there, since all other reference to croup has been removed.

Submission by Ms. Buckley (Admissibility of Evidence)

MR. BUCKLEY: My Lord, do you have a copy of page 2 in front of you?

THE COURT: Yes.

MR. BUCKLEY: Because my concern with that, and likely why when I asked Dr. Sauvageau to -- kind of edit out any reference to croup, is she's quoting Dr. Adeagbo, and that's in the context of her explanation of, you know, why you wouldn't see evidence of croup if there was intubation. And so my concern there is, is she's not giving a diagnosis in that context. She's -- it's being used to explain. I mean, I don't have a problem with page 3 --

THE COURT: She's specifically saying she --

MR. BUCKLEY: I mean, I don't have a problem with page 3 --

THE COURT: She -- well --

MR. BUCKLEY: -- being excised.

THE COURT: Well, she's specifically saying on page 3 she can't give a diagnosis because it's a clinical diagnosis.

MR. BUCKLEY: Yeah.

THE COURT: Which is what she can't do.

MR. BUCKLEY: Yeah. But you see how, on page 2 of the --

THE COURT: I do.

MR. BUCKLEY: Yeah.

THE COURT: No, Defence, I agree with you.

MR. BUCKLEY: So . . .

Ruling (Admissibility of Evidence)

THE COURT: I think that the context is such that it may or may not stick out, but there's nothing about those particular paragraphs in that report that are offensive of the limits of this particular witness, and I'm going to leave them in. We're going to leave them in.

Discussion

THE COURT: The one thing that I don't know if we dealt with was heading "Item Number 3", which the witness did not refer to.

MR. BUCKLEY: Well, you --

THE COURT: My direction of Mr. --

MR. BUCKLEY: -- directed me that I could not, so I didn't even think I was -- or had a right to --

THE COURT: Exactly.

MR. BUCKLEY: -- fight about that one.

THE COURT: And, accordingly, she did not, in her summary, include Item G from the summary as well, which is consistent with that instruction.

MS. WEICH: Sorry, what's 'G', Sir?

MR. BUCKLEY: In the summary.

THE COURT: In the summary, the last page, Summary G.

MR. GILES: Well, it would seem, Sir, that out of an abundance of caution, it might make a lot of sense to have that vetted some way. I don't know how that could happen on a practical sense, whether or not that means we have to foist upon madam clerk the necessity of blocking that out with, I don't know, Wite-Out or something like that, but if it's not properly before -- the Court has some portion of her opinion, it's certainly not proper for the trier of fact. It could be distracting. It very well may not make it, certainly without the subject of testimony, but there is a risk that I think it would be better to avoid it, if we possibly can, both in relation to Item G of the

summary as well as to Paragraph Number 3.

So I suppose it could be a limiting instruction, but then again, once again, once they're in their deliberations, if somehow that gets lost, and somebody keeps their eye and keep getting -- keeps getting attracted to the paragraph that's there, it would seem most prudent to somehow excise or redact those potions.

THE COURT: Well, it's fair to everybody, particularly the defence who weren't even allowed to ask about it. I mean, if somehow it sticks out, why weren't they asked. I mean, it should not be part of the report, I wouldn't think, Defence; would you?

MR. BUCKLEY: Well, I -- just to be candid, I was fully expecting, based on the dialogue that I had with the Court yesterday, that it would be excised.

THE COURT: That it would be?

MR. BUCKLEY: Excised.

THE COURT: Exactly. So how can we do that, perhaps, with -- do we need an all new exhibit for the jury; do you think?

MR. GILES: I only see a pragmatic difficulty with that. I see -- in fact, that would be the most -- the best, in principle, thing. The difficulty is they put notes on things. Now, I would be quite surprised if they put notes on that section because, of course, their attention was never drawn to that section. Is it possible, in any way, shape, or form to have that section of each individual report, and I add hazard of having madam clerk be angry at me, to simply block that out with a piece of paper and photocopy each individual report that they have with that one section --

THE COURT: Well, at the risk of --

MR. GILES: -- blocked out, and they could have their notes back?

THE COURT: Not even the clerk or the Court should be seeing if there even are notes.

MR. GILES: Ah.

THE COURT: That concerns me, you know.

MR. GILES: Yeah. I do see --

THE COURT: None of us should know even if the jury has notes.

MR. GILES: I wonder if perhaps they might be given the opportunity, if we could have a redacted copy of that page, and then that provided to each individual, and they can transfer their notes from one to the other, or something along those lines? Because I don't want them -- because they -- they may have made notes. An individual juror may have made notes about Section 4, which starts on that page, and I don't want them to be --

MR. BUCKLEY: Yeah.

MR. GILES: -- left without their notes.

MR. BUCKLEY: And -- and I -- I could provide both, for page 17, you know, a copy, copies for the jury where 'G' is excised.

THE COURT: Right.

MR. BUCKLEY: And then obviously it should be fairly simple for me to do the same with Section 3, and I can bring copies to court tomorrow, and we could deal with it that way, and then the jury is replacing the pages and giving the old ones to the clerk, and then also, if there are any notes, like, for example, on the bottom of page 9, then they can transcribe their notes.

THE COURT: That would make it the easiest.

MR. GILES: And, of course, we -- and so that Dr. Sauvageau can leave, we could, of course, undertake not to put any further blockages before the introduction of that copy that we just essentially established.

THE COURT: Well, Mr. Buckley's offered to do it, and it's right that you should. It's your exhibit.

MR. BUCKLEY: Yes.

THE COURT: If you'll make those copies for me --

MR. BUCKLEY: And my friends.

THE COURT: -- for the original exhibit and for the jury, then we'll deal with it first thing tomorrow morning. We'll mark a redacted version of Exhibit B.

MR. BUCKLEY: Yeah, because perhaps what I should do is just bring -- because 'B' is a specific copy --

THE COURT: Yes.

MR. BUCKLEY: -- that you've entered, is just me bring another copy that has the revision to enter as a new exhibit?

THE COURT: Precisely.

MR. BUCKLEY: Okay.

THE COURT: And we'll enter it as Exhibit 20 -- whatever it is -- four or something, madam. We'll enter it as a full exhibit, and then in order to redact the jury's copy, we'll say, Essentially Exhibit B is going to become the new exhibit with two redactions and give them instructions to take their old page 9 out, we'll give them a staple remover, and we'll give them a stapler, and they can take it apart, replace 9 and 17, and we're done, and then I'll have them return 9 and 17 to the clerk.

Does that sound reasonable?

MR. GILES: And that, of course, give them the opportunity to transfer any markings that they may or may not have individually made on that page 9 onto the new page 9. They should have that opportunity, I would think.

THE COURT: Yes.

MR. GILES: Perfect.

THE COURT: And when they give them to the clerk, I'll seal them and put them on the clerk file, then. We've got another set of potential notes. We don't even know if there are notes, but --

MR. GILES: There might not be any.

THE COURT: -- just so that there is something on --

MR. BUCKLEY: I think it's very appropriate to keep track of the pages, so I'm --

THE COURT: All right.

MR. BUCKLEY: -- I'm in agreement.

I'm just wondering if we can speak to scheduling? I'm planning on having two witnesses here tomorrow morning, which I anticipate we'd finish tomorrow morning. I was hoping that then we could speak to the elements' issue because, as with my friends, it's really -- not knowing is making it difficult for me to proceed with preparations for submissions, and then it would be helpful for me, you know, as soon as my friends have made a decision on whether they're calling Dr. Adeagbo, because that would then cause me to prepare to cross-examine him.

THE COURT: Well, let's find out right now.

Have you come to a conclusion, or did you want to --

MR. GILES: I think --

THE COURT: -- caucus about that?

MR. GILES: -- we would prefer to speak about that in the morning, Sir, or to provide the decision in the morning.

MS. WEICH: Or we could take 15 right now and discuss it.

THE COURT: You know, how long do you need, because if you're not going to be calling Dr. Adeagbo, it makes a world of difference to the defence -- well, to everybody. If you are, it makes a world of difference. So why don't you take till 3:30. I wonder whether you'll want to speak with Dr. Adeagbo. You can consider that, and then we'll come back.

In the meantime, what I will do, Counsel, is I'll print my current version of the elements for you so that everybody knows where I am at the moment. It may be where I was. Candidly, I've lost track of some of the paper and some of the time on this, but I'll do that in the break. We'll reconvene at 3:30.

MR. BUCKLEY: And I'll let Dr. Sauvageau know that she can depart.

THE COURT: Right. Thank you.

MS. WEICH: Can we please dismiss the jury for the day?

THE COURT: We won't be needing the jury anymore.

MR. BUCKLEY: No.

THE COURT: Until 10:00 tomorrow morning.

MS. WEICH: Thank you.

THE COURT: All right. So let's bring them -- do you need me to bring them in to let them go, or --

MR. BUCKLEY: I don't.

THE COURT: -- can I just have madam clerk instruct the jury officer that they can leave?

MS. WEICH: I'm happy with the instruction, Sir.

THE COURT: That's what I'm going to do, and I'll instruct them to be back at 10; all right.

Thank you. We'll reconvene at 3:30 then.

THE COURT CLERK: Order in court. All rise.

(ADJOURNMENT)

THE COURT CLERK: Order in court. All rise.

THE COURT: Good afternoon again. Please be seated.

I'll have madam clerk mark, as the next judicial exhibit, a copy of the current version of the issues for decision and pass a copy to each counsel, please, and we don't have time to

talk about that today, but just so that you've got it.

MR. GILES: Thank you very much.

MS. WEICH: Thank you, Sir.

MR. BUCKLEY: Thank you.

EXHIBIT J-17 - Six-page Document Titled, Five Issues For Decision

MS. WEICH: So, Sir, I can advise that the Crown does not intend to call any new witnesses or recall any old witnesses.

THE COURT: Thank you.

MR. BUCKLEY: Okay. So I --

THE COURT: Will we be done the evidence tomorrow morning?

MR. BUCKLEY: So I -- and I -- I did misspoke (sic) about two witnesses. I have that one RN from the doctor's office just on entering that exhibit, so he'll be very quick, so I'll have three witnesses tomorrow.

THE COURT: Three witnesses? We can still do it in the morning?

MR. BUCKLEY: Yeah.

THE COURT: Start at 10; all right. Good. And then we'll spend the afternoon. We'll talk about the elements at that time, and any other pre-charge issues that you want to draw to my attention, I can tell you that in light of that, my plan would be to have you do your closing address to the jury Friday. My plan would be to have you do your closing address to the jury Saturday morning. We would then adjourn until Monday, perhaps in the afternoon so that we can have a further pre-charge conference before I give my charge in case there are any changes that come out of what you do, and I'll give you my full charge at that time. In fact, I'll give it to you both after you've completed your address on Saturday.

That'll get us as close as I can get us to the aspiration I had last week of completing this week.

Any concerns or questions about that?

MS. WEICH: So I was just wondering, Sir, if we would be getting the entirety of your proposed jury instructions?

THE COURT: Not before you do your closings.

MS. WEICH: Okay. And then but --

THE COURT: So here's the process: We'll talk tomorrow about the elements. Both of you need to do that. You need that for your closing and for your closing.

We'll talk about that as our first priority tomorrow afternoon. You can bring any general other special instructions to me at that time. We've talked about that. We can talk about them tomorrow afternoon, if we need to.

Then you'll do your closing on Friday. You'll do your closing on Saturday, and then I will provide you with a full copy of my proposed charge of the jury. I don't think I'll be able to have it done for Saturday. I need to hear what you folks have to say, but I'll do a draft of it. We'll plan to get together probably on Monday morning so that I can provide you with a full draft, let you have a read and offer any comments in advance of me delivering my instructions to the jury. That's kind of the usual process, or at least my usual process, and if we wait until, say, 1:00 or something to charge the jury, we should be able to meet that schedule.

MR. GILES: One thing that just occurred to me, while I was sitting here, Sir, I know that there are some things going on this weekend at the courthouse, and I don't know how that might --

THE COURT: You needn't worry.

MR. GILES: All right. Just checking, Sir.

THE COURT: You needn't worry. In anticipation of this possibility, I've made inquiries. We're going to do what I've just suggested; all right.

Thank you very much. We'll look forward to seeing you at 10:00 tomorrow morning. Good day.

THE COURT CLERK: Order in court. All rise.

PROCEEDINGS ADJOURNED UNTIL 10:00 AM, APRIL 21, 2016

Certificate of Transcript

I, Sara Anderson, certify that the foregoing pages are a complete and accurate transcript of the proceedings, taken down by me in shorthand and recorded by a sound-recording machine and transcribed from my shorthand notes to the best of my skill and ability.

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