IN THE MATTER OF the *Coroners Act,* R.S.O. 1990, c.C.37;

AND IN THE MATTER OF the Inquest concerning the deaths of Jethro Anderson, Reggie Bushie, Robyn Harper, Kyle Morrisseau, Paul Panacheese, Curran Strang, Jordan Wabasse

AND IN THE MATTER OF an Inquest by Jury

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PRESIDING CORONER: Dr. David Eden

Heard: Tuesday, October 6, 2015

at the Thunder Bay Courthouse, Room 205,

125 Brodie Street North, Thunder Bay, Ontario

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REPRESENTATIVE COUNSEL:

Trevor Jukes, Amy Leaman, Karen Shea	Coroner's Counsel
Brian Gover, Ted Marrocco, Justin Safayeni Gary Hopkinson	City of Thunder Bay Police Services & Thunder Bay Police Services Board
Stephen Wojciechowski, Kathleen Kreps, Dawne Latta	City of Thunder Bay
Lisa La Horey, Erin Rizok	Province of Ontario
Julian Falconer, Meaghan Daniel, Samantha Ramage	Nishnawbe Aski Nation & Deputy Grand Chief Fiddler
Christa D. Big Canoe, Jonathan Rudin	Counsel for the Families

I N D E X

Derek Noyes	Keewaytinook Okimakanak Families
Chantelle Bryson	Provincial Advocate for Children and Youth, Irwin Elman
Kent Elson	Ontario First Nations Young Peoples Council of the Chiefs of Ontario
Gregory Tzemenakis, Agnieszka Zargorska	Aboriginal Affairs & Northern Development Canada
Etienne Esquega	Northern Nishnawbe Education Council
Shelley Garr, Farzin Yousefian	Coroner's Constable

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T A B L E O F C O N T E N T S

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E X H I B I T S

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Legend

[*sic*] - Indicates preceding word has been reproduced–verbatim and is not a transcription error.

(ph) - Indicates preceding word has been spelled phonetically.

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TUESDAY, OCTOBER 6, 2015

U P O N R E S U M I N G :

...JURY PRESENT AND POLLED (10:11 a.m.)

THE CORONER: Thank you, Constable Garr and good morning members of the jury. And you'll notice we are in a larger space this morning and I believe you'll be more comfortable here with a little bit more room than upstairs. At this point I would like to thank the court house for assigning us this space and the assistance with the parties with standing at this inquest in ensuring of that favourable outcome. We have tested the webcasting this morning and it works and we are still looking for some desk space for some counsel and I appreciate your patience. We hope to have that resolved either this afternoon or tomorrow. And I will give a reminder that at the beginning and end of recesses please ensure that the route is by the jury and myself to exit the courtroom is clear and a reminder to counsel to ensure that you speak into the microphone when addressing the court to ensure that the court reporter has a complete record and Madam Court Reporter will advise us if anybody is not audible. And just for the information of those present the amplification system in the courtroom is separate from the recording system used for the transcript. So you may be audible to spectators without being legible on the transcript; so yes, Ms. Shea?

MS. SHEA: Yes, good morning. The witnesses that we're going to be calling this morning are Dr. Toby Rose and Dr. Karen Woodall and they're going to be testifying together so that they can take you through the pathology reports as well as the toxicology reports. So I'll have them come forward, please?

OFFICER GARR: Can you state your name in full and spell your surname?

KAREN WOODALL: Karen Louise Woodall W-O-O-D-A-L-L.

OFFICER GARR: Please state your name in full and spell your surname?

TOBY HELEN ROSE: Toby Helen Rose R-O-S-E.

DR. KAREN LOUISE WOODALL: SWORN

DR. TOBY HELEN ROSE: AFFIRM

MS. SHEA: And Mr. Coroner, in relation to the evidence that we're going to be hearing today, I'm going to ask that both Dr. Rose and Dr. Woodall be qualified as experts in their relevant fields. In relation to Dr. Rose I'm going to be requesting that she be qualified in the area of forensic pathology and in the case of Dr. Woodall I'll be asking that she be qualified in the area of expertise of toxicology. Counsel have been provided with their *curriculum vitae* and I don't believe that they have taken any issue in terms of the expertise of these two witnesses, so I'm not

sure whether or not we need to go through the formal process of qualification in, in their areas of expertise.

MR. FALCONER: On behalf of Nishnawbe Ask Nation, we take no issue with the doctors' qualifications. There is a question around the doctors' mandate, so I'll simply in terms of our position just allow the evidence to address the question and I may be revisiting that with all due respect in terms of what their mandate is later when it's clear.

THE CORONER: Well, is that a matter related to qualification or to evidence, Mr. Falconer?

MR. FALCONER: It's a bit of a blend because depending on what their mandate is it goes to the nature of the opinion being advanced. So you can be an expert in the area, but if your mandate is off line with your expertise then it becomes a different question. So I'm not in any way suggesting that Dr. Eden that these doctors aren't excellent qualified professionals. I'm simply suggesting since their mandate is slightly unclear to me I'm reserving my right with all due respect to raise that issue should it come up because I still don't have clarity on that.

MS. BIG CANOE: Yes and on behalf of the families we are not questioning the qualifications, but make the same request to reserve our right should the issue come up as NAN counsel has pointed out.

THE CORONER: Thank you, Ms. Big Canoe.

MS. SHEA: And I'm not sure if any other counsel has any comments to make in terms of the qualifications of these two witnesses?

THE CORONER: Are there any others?

MR. TZEMENAKIS: Canada takes no position on the qualifications.

MR. GROVER: And certainly the police parties take no position in relation to their qualifications. I'm satisfied that both of these experts are duly qualified.

MS. BRYSON: The Provincial Advocate is as well fine with the qualifications; however, we do share concerns with NAN and ALST and we'll leave it for them to discuss.

MR. WOJIECHOWSKI: And the City takes no position with respect to the qualifications.

MS. LA HOREY: The Province has no issue with the qualifications of these witnesses.

MR. ESQUEGA: NNEC takes no issue with the qualifications; however, we do reserve our right as NAN and ALST has.

THE CORONER: Okay.

MS. SHEA: And Mr. Coroner, I do have copies of their *curriculum vitae* that will be filed as exhibits in relation to this inquest and it is my understanding that both Dr. Rose and Woodall have completed the required Form 5 for the purpose of them giving testimony as experts in these proceedings.

THE CORONER: And so before we proceed further….

MS. SHEA: First of all, the *curriculum vitae*

in relation to Dr. Toby Rose be marked as the next exhibit. I believe we're up to Exhibit 2.
THE CORONER: I believe so.

EXHIBIT NUMBER 2: ***Curriculum Vitae* Dr. Toby Rose – Produced and Marked.**

MS. SHEA: And the *curriculum vitae* in relation to Karen Woodall, if that should be marked as Exhibit 3, please.

EXHIBIT NUMBER 3: ***Curriculum Vitae* of Dr. Karen Woodall – Produced and Marked.**

MR. CORONER: So at this point we'll need a *voir dire*, so I'll ask the members of the jury if we can excuse you for a while and the witnesses as well; if you could step outside the courtroom.
MS. SHEA: Actually….
MR. FALCONER: Dr. Eden, I don't….
MS. SHEA: Actually, Mr. Coroner, given that all counsel have agreed that they are content about the qualifications of these experts, we would not have to embark on a *voir dire* for you to make your ruling.
MR. FALCONER: My, my reservation and position was not intended to convey, and I apologize if I created confusion, was not intended to convey or request for a *voir dire*. It was intended to reserve rights and circumstances where I don't know the answer to the question. And I, with all due respect, would have thought that it's

sufficient for the evidence to unfold in front of the jury. I would have no….

THE CORONER: Actually, let's not lead into an argument, so.

MR. FALCONER: Okay, thanks.

THE CORONER: So let's stop here members of the jury and Dr. Rose and Woodall we'll excuse you briefly and we'll look into this issue.

...JURY EXITS (9:57 a.m.)

R E C E S S

U P O N R E S U M I N G :

...JURY ENTERED AND POLLED (10:00 a.m.)

THE CORONER: Okay, you may be seated. So my concern here is that the Chief Coroner's Rules of Procedure require that the qualification of a witness be completed before the evidence begins and there is in my view a sound basis for that in that if we get halfway through the evidence of the witness and then the witness' expertise is subject to a further degree of challenge, then we could be in a situation where we might need to call another witness or otherwise complicate or delay the inquest. So my preference would be that the qualification is done before the witnesses begin their evidence and my suggestion would be that we take a brief recess for this matter to be discussed amongst counsel to see if it can be resolved.

So let's take 15 minutes for that and actually I will ask if the courtroom can be cleared and we'll turn off the audio on the webcast so that counsel can have a discussion.

R E C E S S

U P O N R E S U M I N G

...JURY ENTERED AND POLLED

MS. SHEA: Yes, thank you, Mr. Coroner. I believe we were able to make use of the break to discuss the issues that were raised and counsel can correct me if I'm wrong; however, it would be my position that it would appear that all counsel are in agreement that both Dr. Rose and Dr. Woodall are qualified in the areas of expertise as identified by me.

THE CORONER: Thank you and I thank all parties for their collaboration. Mr. Falconer?

MR. FALCONER: Yes, based on the advice I received from Ms. Shea at the break and what I understand this evidence she's going to elicit I certainly have clarity around mandate now and I have no issue around these doctors' qualifications.

MR. CORONER: Thank you. So the witnesses are qualified and you may proceed Ms. Shea.

MS. SHEA: Yes, I didn't realize….

MR. CORONER: Yes, the witnesses are qualified, you may proceed.

EXAMINATION IN-CHIEF BY MS. SHEA:

MS. SHEA: So in the case of Dr. Rose, she's now qualified as an expert in the area of forensic pathology and in the case of Dr. Woodall she is now qualified to provide opinion evidence, expert evidence in relation to the area of toxicology. And just so the jury knows, both Dr. Rose and Dr. Woodall have put together a joint Power Point presentation. That they're going to be going through the Power Point presentation itself and at certain times we'll stop and then we'll be referring to reports. 'And in having them both here to testify together we're hoping that that will assist in that if one has already testified she may not be able to be recalled if a question comes up with the other. So if we could start the Power Point and we will start our evidence as well.

THE CORONER: And I'll just intervene here. I understand Ms. Shea that it's certainly open to us to recall these witnesses if need be as the evidence unfolds?

MS. SHEA: Yes, if some questions do arise in the course of the inquest and Dr. Woodall and Dr. Rose are not here, we can have them even attend here or they can testify by videoconference as well.

MR. CORONER: Okay, thank you.

DR. ROSE: Thank you, I'll start. We have a Power Point that's going to tell you a little bit about the kind of work we do and then how we used our expertise, our knowledge to review the autopsies that were done on the

seven young people and come to a conclusion from a pathological and toxicological point of view about their deaths. So we're going to give you our help, our opinions as we go through the, the talks. So we thought we would start a little bit with a little bit of an introduction about the kind of work we do and I should just start by saying what pathology is and what forensic pathology is.

MS. SHEA: Q. I'm just going to stop you there for one moment, Dr. Rose. One thing the jury is going to see when they're going through the documents that I'm going to be providing to them this morning is the fact that both you and Dr. Woodall are not the actual authors of the reports, that being the autopsy reports and the toxicology reports. So could the two of you explain why it is or sorry what your mandate is in terms of reviewing these reports and, and whether or not that is standard practice for you to essentially being peer reviewed of a report that has been prepared by another expert?

DR. ROSE: A. So I can talk about that a little bit. I am the Deputy Chief Forensic Pathologist for the Ontario Forensic Pathology Service which is the service that oversees basically coroners' autopsies for the province. And we have a very robust system of peer review. So this is something that I do every day. We review each other's cases and that means forensic pathologist and pathologists review each other's cases for a couple of different reasons. One is obviously to check to see that everyone is doing the job in the way that they should be doing and that their opinions and conclusions are reasonable ones. It's also a great learning experience for the person who does the review to see how other colleagues state the same things, describe things, so that peer review

is something that we do on a day-to-day basis in the Ontario Forensic Pathology Service. For the purposes of this - of inquests and sometimes even going to court, for some reasons the original pathologist who did the autopsy is not available or sometimes it's felt that for example a more senior person will present the materials or I think for this inquest part of it was organizational that all the autopsies were not done by one pathologist and it might be a good thing to just have one pathologist to review all the cases, come to an opinion about the cases and then present them. So that's how I came to be the one who's presenting the autopsy material based on my review of my colleagues' work. So the autopsies were done locally in Thunder Bay and I received material on all of the autopsies including the coroner's warrant which was information about the case, the final report, the notes or the notes that the pathologist made at the time he was examining the body, some photographs, the toxicology report and I was able to come to my conclusion based on these autopsy reports and I would like to say that the autopsies were done well and that they provided me with the information that I needed to come to my opinion about these cases.

Q. Now, during the opening yesterday, what the jury heard was that of these seven deaths they span almost 11 years; the first death occurring in 2000. In terms of reviewing the reports that were prepared at the time of the autopsies or postmortems, are you also going to be able to assist the jury in terms of whether or not you were able to see whether or not the practice at the time may have differed?

DR. ROSE: A. Well, like in all parts of medicine things in forensic pathology are changing every

day and in fact we like to think that they're improving every day at every year, so that over this long period of time there were slightly different practices and currently we have formalized our practices in the Ontario Forensic Pathology Service and we actually have guidelines for pathologists across the province. The guidelines were first published I believe in 2008 and they were updated last year in 2014 basically to give pathologists around the province a good view of the kinds of cases they personally should be doing and the kinds of things that they should do when they're doing them, things to think about. So in terms of cases that were done in the past before the guidelines I would say that these cases were not precisely - I'm going to change that. In 2015 there might be some differences about the way that we would do these cases; for example, we might actually ask that they be done by a qualified forensic pathologist rather than by a hospital pathologist, but as I said at the beginning, I think that the autopsies were well done and that they provided me with the information I needed to come up to come to my conclusions.

Q. And Dr. Woodall, is it also a commonplace for you to review peers' reports in relation to toxicology?

DR. WOODALL: A. Yes, all toxicology reports are peered reviewed so it's the usual thing that one toxicologist will write a report and another colleague will review it. In an inquest such as this when the seven different cases and different toxicologists have done it, it sometimes makes sense that just one toxicologist to come and provide evidence. In this particular case, all the cases were done by other toxicologists, but I reviewed all of the reports, all of the analysis that were done and also

for many years I was the coroner's coordinator for toxicology, so I've been in charge of reviewing all that investigations that are done in the Province of Ontario and deciding what toxicology testing should be done. So I'm aware of how our guidelines have changed over the years and how things are being done from 2000 when the first case is dated all the way up to 2015.

Q. Now, I'm going to have you both give a little bit of background about yourselves before we embark on the actual Power Point, but sticking with you, it's my understanding that you're employed at the Centre of Forensic Sciences?

DR. WOODALL: A. Yes. I'm employed in the toxicology section there.

Q. And one thing we had discussed in terms of you've got seven different toxicologists who have done the reports. I take it we wouldn't want to clear out your department to have everyone attending here in Thunder Bay to testify in relation to the toxicology?

DR. WOODALL: A. Yes.

Q. All right. Can you tell us a little bit about yourself in terms of background?

DR. WOODALL: A. Yes. Well, I've worked at the Centre of Forensic Sciences since 1999. I, my background is I have a PhD in Pharmacology, so that looks at the effects of drugs, how drugs work, how they act on the body and I have a bachelor degree in biomedical sciences and they were obtained at the University of Bradford in the U.K. Then I moved to Canada and I worked at the Addiction Research Foundation in Toronto for a couple of years and then I became a forensic toxicologist. Now, a toxicologist is somebody that studies the adverse effects of drugs and

poisons and a forensic toxicologist simply means that you do that for purposes of the law.

Q. And Dr. Rose?

DR. ROSE: A. I'm a medical doctor. I graduated from medical school in 1977 and I become a pathologist. So a pathologist is a medical doctor and pathology is the study of, of the appearance of disease and injury in the human body. I was actually a hospital pathologist for quite a number of years and during that time I started doing forensic pathology as well and forensic pathology is a sub-specialty of pathology, again, it is the study of disease and injury in the human body and these diseases and injuries for the most part result in sudden death and also are of interest to the legal system in the broadest sense. In 1998 I became qualified as a forensic pathologist by the American Board of Pathology. At that time there were no equivalent Canadian exams and in - sorry, that was 1997. In 1998 I became a fulltime forensic pathologist. In 2011 I became the Medical Director of the Forensic Pathology Unit in Toronto and in 2013 I became the Deputy Chief Forensic Pathologist.

Q. Now, one thing you said was that your certification in relation to forensic pathology came from the United States and you indicated that Canada didn't have a similar certification program. Is there now a similar certification program in Canada for forensic pathology?

DR. ROSE: A. Yes there is. So I have my qualifications in anatomical pathology, non-forensic pathology from the Royal College of Physicians and Surgeons of Canada and that's the body that qualifies all medical

specialties in the country; pediatricians, anesthetists, all different kinds of medical specialists and since, I'm sorry, since 2009 we now have a training program in Toronto which takes pathologists. So they're already trained and certified as pathologists. We train them for an additional year in forensic pathology and the Royal College actually sponsors an examination in forensic pathology. So young pathologists and forensic pathologists now actually have Canadian qualifications which are recognized across the country and in many other places as well.

Q. Are you responsible for some of the training of the forensic pathologists in their certification?

DR. ROSE: Q. Yes I am. I'm an assistant professor at the University of Toronto in the department of medicine and my main duties as, as the assistant professor are to help train pathologists and forensic pathologists.

Q. Now, when you first started your evidence you talked about sometimes postmortems should be conducted by a forensic pathologist as opposed to a hospital pathologist. Can you please tell us a little bit about that before we get on with your PowerPoint presentation?

DR. ROSE: A. The Ontario Forensic Pathology Service as an organization was set up in 2009 and up until that point interested pathologists across the province could do what we call medical/legal autopsies. That is, autopsies that are ordered by the coroner. So there were many pathologists across the province who were doing that kind of work. In 2009 we started a register of pathologists. So currently if a pathologist wishes to

perform this kind of work they must be named on the register of pathologists. There's an application form. There's a process. The Chief Forensic Pathologist has to approve them. And on the register there are a couple of different types of pathologists. So there are pathologists in hospitals. I think we're up to about 30 something hospitals around the province where there are pathologist who do this kind of work, but these pathologists for the main part do hospital pathology related to living patients. So they do what we call routine autopsies of non-suspicious case. And then there's a smaller group of people we would call forensic pathologists who, like me, are certified, are qualified to do all types of cases and for the most part these types of forensic pathologists are located in forensic pathology units that are affiliated with medical schools. We do have a couple of forensic pathologists on the register who do suspicious cases in places where there is no local medical school and in fact Thunder Bay is one of those places, but for the most part the qualified forensic pathologists are in the cities where there are medical schools so that in, in the present any kind of a suspicious death or would be done by a forensic pathologist and not by a hospital pathologist.

MS. SHEA: We could start your PowerPoint presentation and just so the jury knows, we had to make a change to one of the slides. I do have copies of the PowerPoint presentation for you so you'll have your own copy of the exhibit. There's going to be a DVD that will be filed as an Exhibit, but we're going to have to change one of the pages. So you will have a copy. So don't worry about having to

get that DVD into a computer at any point in time if you want to look at the PowerPoint presentation, okay.

DR. ROSE: A. So the first slide talks about what an autopsy is and the first thing is the term "autopsy" and "postmortem examination" mean the very same thing. So I'm going to use autopsy because it's faster; it's a shorter word. And basically the purpose of an autopsy is to observe, document and interpret the findings on a dead body, so it's an examination of a person who's died for those purposes and basically it's to observe, document, and interpret the findings that indicate to a pathologist that the person has an injury or injuries or some kind of a natural disease. And we usually consider that there are five steps to the autopsy. The first is to find out a little bit about what is thought to have happened to the person who died and we call that the "scene and circumstances". So this is like going to the doctor and giving a history, but of course we can't get the history from the person affected and so we have to rely on other people to provide us with information and those people are the coroner who investigates the case, police who help with the investigation, possibly first responders like ambulance people, fire fighters, health providers, doctors in an emergency department, and of course family members may also give information. So we need to have some idea about what the case is about to help us determine precisely what type of examination we're going to do. Now, the examination consists of an "external examination" and that is an examination of the outside of the body. So clothing, clothing is then removed, the skin surface of the body, again, to look for and to document any evidence of injury

or disease and if there's any trace evidence on the body that can be sampled at that time. The next step, the third step is the "internal examination" and that includes the examination of internal organs such, including, the brain, the organs in the neck, the chest organs, the abdomen organs and the pelvis organs. And at that time samples like blood and urine can also be sampled and those would be sent then to Dr. Woodall's department, the toxicology department for analysis. So now we're finished examining the body and we go onto the fourth step which we call "ancillary tests". So those are, thinking again about going to your doctor, you've given your history, your doctor has examined you and now your doctor is thinking about what lab tests they might want to order. So the most common ones that we do are microscopy and toxicology and I'm going to turn it over to Dr. Woodall in one moment. Microscopy is taking small samples of tissues and organs, sending them to a lab where a technologist will make them into microscope slides and then the pathologist gets the microscope slides back to look at the tissues and see whether there was any evidence of injury or disease that wasn't visible to the naked eye and then after all of those things, the results are back, I have the slides to look at, Dr. Woodall or her colleague has submitted the toxicology results, I may have photographs to review, I think about the case and then I come up with my opinion. I try to think of the medical/legal issues that might arise in this case and I come up with my opinion as to the cause of death. So that's the fifth stage. Sometimes we consider that there's a sixth step and that is testifying at a coroner's inquest or in court. So I'm on the sixth step now and now I'm going to ask Dr. Woodall to talk about toxicology.

DR. WOODALL: A. So, the role of the toxicologist is to assist the death investigation by analyzing samples for the presence of alcohol and/or drugs. Now, we don't always do the same type of toxicology testing in every case. It's going to depend on the case history. For example, in some cases we might be looking for a cause of death, so it might be a suspected drug overdose and we want to see if that has occurred, but in other cases it might be a cause of death is known, but toxicology might assist in the investigation in other ways. A good example of that would be a fatal motor vehicle collision where there's an obvious cause of death, but did alcohol or drugs play a role in the collision. So was somebody under the influence of alcohol for example and did that contribute to the death. So case history will determine to some extent what analysis we will perform. Other things that can have a role, so the samples available to us, we would typically get blood and urine from an autopsy, sometimes other samples as well, but blood tends to be the most important sample because if we find the presence of alcohol or drugs in the blood and we can quantitate which is to say how much is in the blood, then that indicates that that individual was under the influence of those substances at the time that they died, so obviously that can be very important to the investigation. So when we do drug and alcohol testing we use lots of different methods, so it's not just one easy method, but we can look for everything of interest. So we use lots of different methods and we can test for lots of different types of compounds. Alcohol is one of the common tests that we do routinely in death investigations. We can look for prescription medications. So if somebody is on an antidepressant for example or they have a strong pain

killer prescribed to them, we can look to see if we can identify and quantitate that. We can also look for many over-the-counter medications, so they're the types of things you might buy at your local pharmacy; cough and cold medications, antihistamines such as diphenhydramine. They can all be important things that we have to test for and then important in a lot of different cases can be drugs of abuse. So that could be something like – if somebody's been smoking marijuana we can test for that, we can look for cocaine, opioids such as heroine. So all our testing can look for lots of different types of drugs and medications. I'm just going to talk a little bit about testing for alcohol because it's, it's the most common analysis we perform for death investigations and the term "alcohol" it's a generic term for substances that are obviously called alcohol, but the one we always think of is drinking alcohol or ethanol and in these cases you're going to see reports and it's either listed as ethanol or ethylalkohol and that simply means drinking alcohol. Something else that you're going to see in the cases we're going to be discussing is that when we test blood and urine samples we quite often get different concentrations of alcohol in the two different samples and this can be totally expected. It's definitely not unusual to see a different concentration in blood compared to urine and there's a couple of reasons for that. The first one is simply just because there's different water content between the two samples and alcohol distributes according to, to water content. Urine has slightly higher water content than blood. So you would expect it to have slightly higher alcohol concentration. The other big reason is all to do with how the body absorbs and eliminates alcohol. When you

start consuming alcohol it's absorbed through the stomach and the small intestine and gets into your blood. So as you start to consume alcohol and your blood alcohol concentration increases you often see a higher blood alcohol concentration compared to a urine alcohol concentration. And then as people continue to consume alcohol and perhaps they've stopped drinking the alcohol and then the body starts to be in the declining phase or the - more the elimination phase of alcohol then you start to see higher urine alcohol concentrations compared to blood and that's because the body's eliminating it from the blood, but the urine is a pooled sample. It's collected over time so it takes a while for that to be totally eliminated. And example would be if you've stopped drinking at night, maybe gone to bed and slept it off for a few hours and you haven't voided your bladder, when you wake up the next morning your blood alcohol concentration would be a lot lower than a urine alcohol concentration at that time. So sometimes the toxicology results that can show a difference between blood and urine alcohol, they can actually be useful to giving kind of a general idea about when somebody was consuming alcohol, so had they recently been drinking or had they been drinking many hours earlier. So toxicology can occasionally be used for that. You will be hearing a lot of different alcohol concentration numbers so in the cases we did detect alcohol and so just to put it into perspective for you, one of the common numbers that people generally talk about is this .08 which is the legal limit for driving in Canada. And 0.08 is the common term, but the actual units that we use in Canada is 80 milligrams in 100 milliliters of blood and above that level it's a criminal offence to drive with alcohol above that level in

your blood. Now, the reason why it's a criminal offence to do that is because at that level it's, it's well known and there's lots of studies to show that it is having a significant effect on your body and it's having an impairing effect. So in terms of operating a motor vehicle you're not operating it as well as you would if you had a zero blood alcohol concentration. Now, another alcohol concentration for a toxicologist that's important is a level that has been associated with causing death and the average fatal concentration for alcohol that's been associated with fatalities is 360 milligrams in 100 milliliters of blood. Now, that's an average concentration and some people may die with levels lower than that and some people can survive with levels much higher than that and that mostly comes down to the tolerance of an individual. People that regularly consume large amounts of alcohol can gain a lot of tolerance to alcohol and may be okay at much higher level, but if you've got somebody that's not used to drinking large quantities they can die with levels lower than this average level of 360.

DR. ROSE: A. So I'm just going to say one more thing about toxicology that in general pathologists rely on the concept that what the toxicologist finds in their testing reflects the levels in the body at the time of death. That's kind of a principle of toxicology relied on by pathologists. So I just want to talk a little bit about one of the changes that are natural in the body after death and that is decomposition or the breaking down of the body, and another scientific term is the term putrefaction, so this is a normal process after death or in the postmortem period, excuse me, where tissues begin to break down and mainly, I'm okay thank you, it's mainly caused by the

action of the bacteria that are already in the body. During life these bacteria are in your gut, in your bowels; they stay there, but after death, they begin to leave the gut and to invade other tissues in the body. One of the problems is that advanced decomposition, so decompositional changes that have been going on for a very long time, may make the forensic pathologists' job more difficult because they - those changes may obscure some other findings that were present in the body that would have been easier to detect earlier on when the body was in a fresher state. Another complicating factor is that the bacteria as part of their lifecycle and what their metabolism, they actually produce ethanol as they – as they're doing their job in the body and so we do know that in bodies that are decomposed or are decomposing there may be some alcohol present due to the process of decomposition. So that's a slight negative part of the rule of we, we think that the levels reflect the levels at the time of death and sometimes some of the alcohol present may be due to this natural process of decomposition.

Q. So, just to clarify that last point. If a body is not found at the time of death and there has been the opportunity for decomposition to occur, it may actually skew the numbers of the ethyl alcohol or ethanol that's seen by the toxicologist?

DR. ROSE: A. That's right. It may be higher in the sample than it really was at the time of death.

Q. Can that impact on a pathologist's ability to establish a cause of death when it's suspected to be associated with alcohol?

DR. ROSE: A. It might, but toxicologists have taught us that there's a limit to the amount of alcohol

that will be due to decomposition about .05 or 50 milligrams per 100 milliliters of blood and so we can just subtract that and look at the number. So it, it doesn't prevent us from doing our work. Then I wanted to say that different factors affect the rate of decomposition. So in general, it takes a couple of days anyways for decomposition to be significant enough to make it difficult for us to do our work and one of the most important factors is the temperature of the environment, the air or the water that the body is in because cold temperatures delay – make decomposition proceed more slowly, so that if it's cold either outside or in whatever the environment is that the body is in, the natural processes proceed more slow in cold.

DR. WOODALL: A. I should add that from a toxicology point of view, when we do our alcohol analysis there are other chemicals that we can detect that show that decomposition or putrefaction has occurred and when we see those signs we will always report that on the toxicology report which will alert the forensic pathologist that some of the ethanol produced may be due to putrefaction.

DR. ROSE: A. Now, it's the pathologist or forensic pathologists' job to determine the cause of death. So you'll remember that that was step five of the autopsy writing a summary and coming up with my opinion as to the cause of death and you can define the cause of death as the condition or conditions that resulted in a person's death. And this little chart that I've put on the slide is a copy of the cause of death statements that is used and recommended by the World Health Organization as the way for doctors, including pathologists, to

determine the cause of death and to write it down in a way that other doctors and other people can recognize it. So, it talks about the immediate cause of death and other antecedent or causes that came first and that added or had a role in the death giving rise to the immediate cause and state the underlying cause last. So that sounds very complicated, but in most cases there's actually only one line that we have to fill out and that's Part 1(a) because the cause of death is quite obvious. It's a disease, the name of the disease we, we know or it's an injury, the type of injury that we know. So often we don't actually use all of those lines. Sometimes you might have more than one line; for example, say a person died of an infection and we actually knew the name of the bacteria that caused the infection, then we might say, for example, Part 1(a) meningitis due to meningococcus, which would be one of the bacteria that causes meningitis and sometimes we actually have to even add an extra line or two because there are many factors that we know have added something due to something else, something due to something else, due to something, but in general we don't have to be that complicated. Now, Part II is other significant conditions contributing to the death, but not causally related to the immediate cause. So for example, somebody who has heart disease and who also has diabetes. So we know that diabetes is an underlying factor that can lead to heart disease in some people or somebody who is s cigarette smoker for example, so we might say that 1(a) the type of heart disease and then for Part II we might put cigarette smoking or diabetes. So that's the way we use this chart and it's the recommended way for pathologists in Ontario to give the cause of death.

Q. And is that something new, is this type of reporting something that's a recent change in terms of practice?

DR. ROSE: A. So pathologists have used this type of reporting for many, many, years. Now it's the recommended way to do it for people who weren't doing it before.

Q. Now, yesterday the jury heard that one of their mandatory responsibilities is going to be to answer the five questions, "The Who, the Where, the When, the medical cause of death and then classifying each of the deaths." Are the two of you also going to be in a position to assist them today as we're going through the reports in answering any of those questions?

DR. ROSE: A. Well, I hope that the "who it was" is the names that are on the reports so that we do know, and I have based my reports on the identifications that were given to me; "where and when" I think we'll be able to help them with. I will certainly be able to help you with the cause of death because I am going to give you my opinion as to the cause of death and then the purpose of the inquest is for the, the jury to determine their opinion as to the cause of death. So I hope that my opinion will help them in their job. The "by what means" we may or may not go into today.

Q. And it's my understanding that you will make yourself available at a later date should the jury or, or counsel have further questions in terms of that classification aspect?

DR. ROSE: A. Absolutely.

Q. All right. Now, I believe we're going to be dealing….

DR. ROSE: A. I was just going to say one more thing. So it is the job of the pathologist to determine the cause of death. The toxicologist is a very important helper in that job. The toxicologist gives us the report. They often say that various substances could cause death, but they're not the ones that say that it did cause death because they have a small piece of the puzzle and the forensic pathologist or the pathologist has the whole puzzle to put together.

DR. WOODALL: A. And that's one of the first things you learn when you become a forensic toxicologist. You might think you know what caused the death, but you don't - you only know a small part of the whole picture, so we just give a general opinion about whether it's possible something could cause death.

MS. SHEA: Now, before we start dealing with this next slide, I'm going to distribute to the members of the jury and file as an exhibit copies of the reports to which you'll be referring, as well as more recent reports that were generated in May of this year and just so the jury is aware, the reports, the actual postmortem or autopsy reports that would have been prepared at the time of the examinations have been redacted. Certain elements of them have been removed and those are information that will not assist you in answering the five questions. It might be in terms of internal examination, what organs weighed that sort of thing; however, counsel has the full reports and Dr. Rose has the full reports. So should there be any questions arising out of the full

reports, there will be the opportunity for people to ask questions, but what you're going to be getting are those reports that are in redacted form which will be the exhibit at this point in time.

THE CORONER: And while Ms. Shea is doing that, Ms. Big Canoe, I'm sure you've already stated this, but this evidence could be quite difficult for families and so if any of the families of the deceased need a brief recess during this evidence, I'm open to that.

MS. BIG CANOE: Thank you, Dr. Eden.

THE CORONER: Okay, thank you.

MS. SHEA: Then Mr. Coroner, I'd be asking that this volume of materials be marked as the next exhibit, please.

THE CORONER: Certainly. Thank you.

MR. TZEMENAKIS: Dr. Eden, these materials have been provided to us, but I'm just wondering if for the purposes of the record, can we simply identify the volume and how many tabs it has and what we would generally find in each tab so that in three months from now I'm exercising trying to figure it out.

MS. SHEA: And Mr. Coroner, what I have provided to counsel as opposed to putting together 25 more volumes of this material, counsel have been provided with the documents themselves as well as the index which identifies the tab number that each report can be found. So as we're going through in terms of tabs, they can look at their indexes

that have been provided to them already and they'll know what the witnesses are referring to at that point in time.

THE CORONER: Okay, thank you.

MS. SHEA: And this is Exhibit 4 for Ms. Big Canoe.

MS. BIG CANOE: Thank you.

EXHIBIT NUMBER 4: Book containing Postmortem Reports of Deceased - Produced and Marked.

MS. SHEA: Q. Now, Dr. Rose, dealing with you first, it's my understanding that you obtained certain documents, certain items before you did the review of the reports in relation to all seven of these youths?

DR. ROSE: A. That's correct.

Q. And the first report that we have is in relation to Paul Panacheese?

DR. ROSE: A. Yes.

Q. And would it be easier for us to deal with the report first or with your slide first? I'm going to leave it to you in terms of what you're most comfortable with.

DR. ROSE: A. I think the slide is a summary, so if you'd like to deal with the report first that might be best.

Q. All right. Dealing first with the report and this would be at Tab 1 and this is the medical/legal autopsy report in relation to Paul Panacheese. Oh, and before we actually embark on this evidence, Mr. Falconer did point out something to me. Apparently Thunder Bay shares a medical school I believe with Laurentian in Sudbury.

MR. FALCONER: That's correct.

DR. ROSE: A. Yes it does. I'm sorry; I'd forgotten that and my apologies to the city and the university.

MS. SHEA: I knew that we had a new law school, but I wasn't sure when the medical school was established as well.

MR. FALCONER: I'm an outsider as well. I've just been here long enough to learn that.

MS. SHEA: Q. So dealing first with the report and this would have been - what was seen at Tab 1 would have been the original report that was generated at the time of the postmortem examination or the autopsy?

DR. ROSE: A. That's correct.

Q. What can you tell us in terms of the findings of the original autopsy in relation to Paul Panacheese?

DR. ROSE: A. Well, basically the pathologist based on his examination of the body and then of the microscopy, microscope slides, and the toxicology results did not feel that he was able to determine a cause of death for Paul Panacheese.

Q. Now, in reviewing that report with the jury to assist them, what sort of testing was done to try to determine the cause of death in relation to Paul Panacheese?

DR. ROSE: A. Well, the pathologist did a complete autopsy on Paul Panacheese. He examined the external surface of the body. He examined all the organ systems, all the organs that I've talked about. He did look at many microscope slides under the microscope and he ordered toxicology and he got the results of all of

those examinations and studies and there was no, what we would call, there was no anatomical or pathological cause of death. So I've jumped ahead a little bit, but basically the summary is he was, Mr. Panacheese was 21 years old. He was said to have been drinking and he was witnessed to have collapsed at home. Basically there were no findings either of injury or of natural decease that could account for death and the body was not decomposed. So the body was in a fresh state. The examination under the microscope showed nothing that, that added to the information and then we have the toxicology.

Q. And Dr. Woodall?

DR. WOODALL: A. The toxicology in this case we did full alcohol and drug screening, so that means that we did lots of different testing and one particular drug test that we did has the ability to look for over 300 drugs and metabolites. It covers all the major drugs of abuse and so we, we did as much drug testing as we could in this case. Now, the results that we got was a blood ethanol concentration in the femoral blood sample that was 230 milligrams in 100 milliliters and the urine ethanol concentration was 268 milligrams in 100 milliliters and we also detected the presence of cannabinoid metabolites. Now, cannabinoid metabolites arise from cannabis products such as smoking marijuana. In this particular case we saw that during the screening test, but we didn't go onto confirm that or quantitate it. A substance called THC is the active ingredient which in some cases we may go onto test for, but it's not something that's associated with fatalities, so if we're looking for a cause of death it's not something that we would typically go onto quantitate.

Q. And the report….

THE CORONER: I'm sorry; you referred to femoral blood samples. I wonder if you could explain what you mean by femoral blood samples to the jury, please.

DR. WOODALL: Actually, do you want to?

DR. ROSE: A. Yes, so during the internal examination, it is when we obtain the samples blood and urine that we will send for toxicology. The urine we sample from the bladder. If there's urine in the bladder we sample it and we usually take two types of blood samples, one is directly from the heart and one is from the femoral region which is - the femoral region is the, the thigh, so right where the thigh joins onto the rest of the body. There's some big blood vessels there and we also take blood from that location and the reason we take two samples is first of all so that we have enough blood to send for testing, but there is also a technical reason why the toxicologist prefers the femoral sample to the heart sample and Dr. Woodall will tell you about that.

DR. WOODALL: A. Some drugs there are changes that occur after death and there's something called postmortem retribution and essentially it means after death the concentrations of drugs can change a little bit depending on where the blood sample is taken from. So a heart blood sample sometimes is associated with falsely elevated drug concentrations. So from a toxicology point of view, the femoral blood sample is the best one for us to quantitate drugs. Because we like to have a lot of volume so we can do multiple tests quite often we will screen for the presence of drugs in a heart blood sample, but then we will go on, confirm and quantitate the drugs using the femoral blood.

Q. All right. And if we deal with the report that we see at Tab 2, that would be the toxicology report in relation to, in relation to Paul Panacheese?

DR. WOODALL: A. Yes, that's correct.

Q. And if we do turn to that Tab 2 one of the items listed is the femoral blood and there's the ethylalkohol result that you've got on the screen here.

DR. WOODALL: A. Yes.

Q. And then we'll also see heart blood and that's where we see the drug mentioned?

DR. WOODALL: A. Yes. The, the heart blood was where we did the drug screening and it was in the heart blood sample that we detected the presence of cannabinoid metabolites.

Q. And then we go to the second page and that's where we'll also see the urine sample in terms of the ethylalkohol?

DR. WOODALL: A. Yes.

Q. Okay. Now, in reviewing the original toxicology report, is there any comment that you have to make in terms of the toxicology report, how it's reported in what we see at Tab 2?

DR. WOODALL: A. No, we did full toxicology testing in this case. All the results are listed. In the original toxicology report Paul Panacheese's name was misspelled so there was a later report that had the correct spelling of his name.

Q. And if we could just go back to Tab 1 as well Dr. Rose, the jury is going to be required to answer the "where" question and I see from the postmortem report, the autopsy report that the pathologist who does conduct the autopsy does indicate at page 3 report of

postmortem exam, they'll say place where death pronounced and in this case it's Thunder Bay Regional Health Sciences Centre, emergency department?

DR. ROSE: A. Yes.

Q. So in terms of assisting the jury on the, on the "where" for Paul Panacheese based on your experience, where would the "where" be identified?

DR. ROSE: A. Well, because Mr. Panacheese collapsed at home and ambulance was called and he was brought to the hospital to try to revive him and so he was pronounced dead at the hospital and we usually consider the place where a person was pronounced dead represents the time - the place of death.

Q. On that issue as well, will you be able to - we're going to be going through the reports in detail, but will you be able to assist the jury in terms of "when" with the seven deaths?

DR. ROSE: A. In mystery stories and on TV forensic pathologists can always give a precise time of death. They say things like this person died on Wednesday between 2:15 and 3:45 for the purpose of the show or the book it moves the plot along and so we can accept that the forensic pathologist can do that. In real life forensic pathologists can't give a precise time of death and one of the reasons I've already discussed in terms of decomposition it's because the environment that the person is present in has a great deal of affect on the changes to the body after death. I talked about decomposition, but there are other changes that occur to bodies after death, their natural processes. One of this is *rigor mortis* or stiffening of the body and that - there are many, many, books and scholarly papers that

have been published on that that talk about averages, but every case is unique. And so for example the temperature of the environment and the temperature of the body at the time of death affects how quickly or slowly those processes occur and in general like with the composition the colder the slower and the hotter the faster. So in terms of a time of death, again, we usually presume that the time of death is the time that the death is pronounced by the attending doctor usually or sometimes by the coroner if the coroner is the one who declared them dead; so that is the time. And usually the best that a pathologist can do is say the story when the person was seen last under these circumstances and then when their body was found or when they got to the hospital and were pronounced dead that it fits with that story that in general rather than being able to say a precise time.

Q. And I believe we have the next slide in relation to Paul Panacheese?

DR. ROSE: A. So the original pathologist and I agree, our opinions about the cause of death; although the terminology is slightly different, but we mean the same thing. Basically, Paul Panacheese's death is unexplained. So no anatomical, so that is by looking at the body or looking under the microscope or toxicological cause of death was found and another term for that is that the cause of death is undetermined.

Q. Now, it's my understanding that you prepared your own report dated May 21st in relation to Paul Panacheese and your review of the information that you had?

DR. ROSE: A. I did. I should just say about the toxicology concentrations of ethanol, it was certainly

present, but if you'll remember Dr. Woodall's slide about the average toxicology level for alcohol, the fatal level being around 360, this was nowhere near 360 first of all and so I wouldn't attribute the ethanol, give an attribution to the ethanol. The second thing is people who die of alcohol toxicity, alcohol poisoning don't collapse in front of their family members, that's not the story. The story is that they are unconscious and they stop breathing eventually. So the whole story does not fit. So, and that's part of the reason that it's undetermined.

Q. And in all these cases you did generate a separate report?

DR. ROSE: A. I did. It's in the form of a letter and the report basically lays out what I reviewed, so I reviewed the original postmortem examination report.

Q. And just for the benefit of the jury, this is Tab 3 in the materials and for counsel as well it would be Tab 3 as set out in the index.

DR. ROSE: A. The toxicology report, 25 microscope slides that were provided to me by the pathologist and then the coroner's warrant for a postmortem examination which gave some of the background information that the pathologist had and I, in my opinion, basically the report of postmortem examination is a reasonable report and I agree with the cause of death. My wording vary slightly and I say that the ethanol detected indicates that Mr. Panacheese had been drinking alcohol, but I don't think that fatal alcohol intoxication contributed to his death and then I go onto - so I give as my opinion the cause of death was no anatomical or toxicological cause of death or you could say that it was undetermined. And then I give a little bit of a discussion on page 2. Basically, this is

what we would call a "negative autopsy". So it's a young man who appears to have had a sudden collapse and at the end of the autopsy no cause is found. So a sudden collapse under these circumstances in most cases, in many cases, we will find underlying heart disease that we can give a name to, but that was not true in the case of Paul Panacheese and we do, we do know now that there are cases like this where people die suddenly, an autopsy is done and nothing is found and we know from clinical medicine and also from pathology that there are some heart diseases that don't actually change the way the heart looks to the naked eye or under the microscope, but it changes the way the heart works in the heart cells and in the electrical impulses. So I give - it wasn't well understood in 2006 at the time Paul Panacheese died, but as I said, in my letter this is a fairly well understood circumstances and that we know that some of these people will actually have suffered from a condition that causes them to die suddenly and we also know that some of their relatives can have the same condition and so could be at risk also of dying of this condition. And the relatives would be their parents, brothers and sisters or any children that they have. Currently we send tissue from an autopsy like this to have genetic testing done on the tissue to try and find - so this would be an additional ancillary test that we now can do, but we also know that things don't always show up on those tests and cases done in the past that testing was not available. So we recommend and I recommended in my report that Paul Panacheese's family members, his parents, his brothers and sisters and his children, any of whom are alive, should actually have their hearts tested, should have some cardiologic testing to rule out that they might suffer from

the same condition.

Q. At page 2 of your report you also talk about the 2014 *Practice Manual* which you mentioned earlier when you were introducing yourselves?

DR. ROSE: A. Right.

Q. And you indicate that that *Practice Manual* currently recommends sampling the tissue for DNA isolation. Can you just tell us a little bit about that?

DR. ROSE: A. About the *Practice Manual*?

Q. The *Practice Manual* first and then the recommendation itself.

DR. ROSE: A. So the first *Practice Manual* was written in 2008 and it is distributed to all the pathologists in the province who perform coroners' autopsies. Lots of other people have it too. It's not a private document and it was updated last in 2014 and one of the recommendations is that in a case like this, a case that sounds like a sudden collapse in death due to a heart disease where no heart disease is determined by autopsy, that at the time of autopsy the pathologist should think about putting aside little samples of tissue that can have their DNA extracted and analyzed and so that's recommended and I would think that in this kind of a case in Ontario I would hope that all pathologists would think about doing that. That said, if they don't think about it at the time, usually there will also be toxicology because in a young person who dies suddenly that's always a possibility that it could be related to alcohol or drugs and usually there's still a sample left in the lab that we could send for DNA. Unfortunately after this many years has passed there was no sample available to send, so the testing of the family members

is a good substitute.

THE CORONER: I'll just interject here Dr. Rose and this is just to ensure the jury is clear on something. You've used the term "undetermined" and I understand that's with respect to the fourth question…

DR. ROSE: A. Right.

THE CORONER: …which is to say the cause of death and I wonder if you could comment on whether there are situations in which the cause of death is undetermined. Does that – are there situations where a coroner or jury may still legitimately make a decision that the case is natural accident, suicide, or homicide. I'm not asking you to give an opinion in this case, just to say whether there's a possibility?

DR. ROSE: A. Yes, so the cause of death is undetermined, but we are pretty sure based on the circumstances and the findings at autopsy that Mr. Panacheese didn't die of any injuries. There were no significant injuries described and he - so that we've ruled out those – in a case like this we've ruled out accident.

THE CORONER: Actually, that's getting into opinion, but what I'm wondering is…

DR. ROSE: A. So, it would be….

THE CORONER: If you could make clear to the jury….

DR. ROSE: A. In a case like this, in cases like this it would be possible to say that even though we don't know the precise cause of, cause of death that the – it was still a natural disease; we just can't put a name on the natural disease.

THE CORONER: Thank you.

MS. SHEA: Q. And I believe the next slide essentially summarizes what you've just discussed in terms of the report?

DR. ROSE: A. That's right, so it's a negative autopsy meaning a full autopsy was done including looking under the microscope, sending toxicology, but no cause of death was determined, that there are these heart diseases that we refer to as sudden cardiac arrhythmia syndromes and one of the names is a long QT syndrome. We know that these conditions may be - may run in the family and could affect these close relatives, that it would, it would be ideal to be able to do DNA testing, but because we can't do DNA testing we suggest that a cardiologist, a heart doctor or a geneticist who's interested in this kind of a problem screens family members and as far as I understand this recommendation was done once I had written this report.

MS. SHEA: I think this may be the appropriate time to take the morning break, Mr. Coroner.

THE CORONER: Yes, let's do that. So 15 minutes, please.

R E C E S S

U P O N R E S U M I N G :

THE CORONER: Ms. Shea?

MS. SHEA: If we go to the next slide I believe and for the benefit of the jury and for counsel, the information in relation to Robyn Harper is found at Tabs 4 through 7 of the volumes of the materials that you were

given today.

MR. FALCONER: My apologies Dr. Eden, my typical failure to do what I'm supposed to do happened this morning. Ms. Daniel, Meaghan Daniel who is my colleague and ladies and gentlemen of the jury I just wanted you to know she happens to be the smarter of the two of us and will do most of the heavy lifting and I thought I should introduce her and my apologies for my oversight.

THE CORONER: I think that's proper. Welcome, Ms. Daniel.

MS. SHEA: Q. I'm dealing next with Robyn Harper, Dr. Rose. It's my understanding that you received copies of the original autopsy report, toxicology report that we'll be discussing, as well as some ambulance reports and then you generated your own report as well?

DR. ROSE: A. Yes. In addition I received the 28 microscope slides and a copy of the coroner's warrant for postmortem examination. So again I reviewed the case and I produced this slide about Robyn Harper. She was an 18-year-old and was said to have been drinking. On external examination she had a few bruises which I classified as recent minor injuries, so they did not contribute to death and there were no signs of decomposition. On the internal examination the pathologist described foaming fluid in the airways and heavy lungs. And microscope slides were non-contributory so nothing to find under the microscope and then there was the toxicology.

Q. And what would be the significant of the foamy fluid that you had referred to on the previous slide?

DR. ROSE: A. Well, one of the situations where we find foamy fluid, heavy lungs are quite non-specific. They can be found in many, many, different kinds of death. Foamy fluid we sometimes see in actually two different kinds of deaths. One is deaths due to an overdose of a substance that causes a person to stop breathing and actually the other situation we may find it in people who drown.

Q. Now, if we can go to page 2 of the original autopsy report that's located at Tab 4.

DR. ROSE: A. Yes.

Q. There does appear to be a summary that was provided by the pathologist who conducted the autopsy in relation to Miss Harper?

DR. ROSE: A. Sorry, I'm not at the right place in the book, excuse me for a moment. Sorry this is tab?

Q. This is at Tab 4.

DR. ROSE: A. Yes.

Q. Page 2.

DR. ROSE: A. Yes.

Q. It would appear that the pathologist who conducted the autopsy did have some information prior to or at the time of the autopsy?

DR. ROSE: A. Right.

Q. And based on what was set out here, what was your understanding in relation to Miss Harper's circumstances?

DR. ROSE: A. Right. So I understood that she was going to high school here in the city staying with a family and that she had been drinking alcohol in the early morning and was found dead later that morning and

that she was said to be seen at 4:00 a.m. and 5:00 a.m. and to be alive at that time.

Q. All right. And the next slide maybe you've already gone to that?

DR. WOODALL: A. So the toxicology testing for Robyn Harper, we did full drug and alcohol testing and the results were a blood ethanol concentration of 339 milligrams in 100 milliliters, so a very high blood alcohol concentration. Her urine ethanol concentration was 384 milligrams in 100 milliliters and the only other finding was the identification of cannabinoid metabolites.

Q. And the toxicology report is found at Tab 6 of the materials?

DR. WOODALL: A. Yes.

Q. Now, in terms of we know that Robyn Harper had been found at approximately 9:00 a.m. and the samples would have been taken at the time of autopsy. From the perspective of the toxicology, what are you able to tell us about the numbers that we're seeing in the case of Robyn Harper, the blood alcohol versus the urine?

DR. WOODALL: A. Well, they start off by saying in this particular case there were no signs of putrefaction. So both the blood and the urine ethanol concentration represent the concentration at the time of death. Now, in terms of the two numbers, so the fact that the urine alcohol concentration is just slightly higher than the blood alcohol concentration that indicates more that perhaps somebody had been recently drinking and that a long time has not passed since the last drink. If a number of hours had passed, so for example, if drinking had stopped earlier on in the evening and an individual

had been asleep for example for many, many, hours I would expect a higher urine alcohol concentration in comparison to the blood alcohol concentration.

Q. All right and the jury is going to hear evidence from when Robyn Harper was left at her boarding home and if she had been picked up at approximately 1:00, but if she's not found until eight hours later, are you able to help the jury out in terms of assisting on that issue from the toxicology perspective?

DR. WOODALL: A. I mean this definitely is not an exact science and I can't pinpoint exactly when drinking stopped; however, based on these results I'd say it's more likely that death occurred closer to when drinking stopped rather than kind of many, many, hours later.

THE CORONER: And members of the jury, I'll just give you a little bit of assistance here. Do you remember that during my opening remarks I told you that the evidence of expert witnesses was to assist you in interpreting what you believe to be the facts? So during this inquest you may be making a finding about what you believe to be the facts about the last time that Miss Harper drank alcohol and this expert's interpretation will assist you in making your determination of how to interpret that. So the determination of the last time she drank will be up to you and Dr. Woodall will assist you in, in understanding what that means in terms of outcome.

MS. SHEA: Q. Now, one of the other questions that the jury has to answer is the "where" and you've

already said that where death is pronounced is normally where you would identify and if we look at page - I believe it's page 3 of the autopsy report that we have at Tab 4, once again, it would appear that the pathologist who prepared the report has indicated the place where death was pronounced?

DR. ROSE: A. Yes.

Q. And that being at 366 County Boulevard?

DR. ROSE: A. That's what it says in the report.

Q. All right. Based on your review Dr. Rose of the information you had and I know you've generated a report that we see at Tab 7, what would be the cause of death in relation to Robyn Harper?

DR. ROSE: A. Yes, I believe that the cause of Miss Harper's death was acute alcohol toxicity.

Q. Now, given the levels that we've heard about that are associated with fatal ingestion of alcohol, are either of you able to comment on whether or not those levels wouldn't be typical in a death associated with alcohol intoxication?

DR. ROSE: A. So there are two types of drinkers. There are people who are used to drinking and there are people who aren't used to drinking. So people who drink habitually get what Dr. Woodall referred to as tolerant. So their livers, their body chemistry gets used to having alcohol onboard and various, various processes in their body are able to use it more efficiently and they're able to tolerate a higher level of, of ethanol. People who you might refer to as a naïve drinker, so people who drink very often or very much or maybe have never really drank before, they are more susceptible to

the toxic effects of alcohol and so they will tend to die at a lower level. So you'll remember that Dr. Woodall said 360 is the average concentration at which people have used it as a - attributed death to alcohol toxicity. Miss Harper's level is slightly lower, but it's certainly in around the same range. And so I would think that this indicates that she didn't have a lot of tolerance, that she was not a habitual drinker and was more susceptible to the effects.

Q. All right.

THE CORONER: And I've been advised by the coroner's constable that there's a member of the jury that has a question and I'll advise you members of the jury that we expect to go through the evidence for all seven cases before beginning cross-examination and that's because it's a more efficient process. Certainly at this point if there's a technical question about any of the evidence you've heard then I can allow that and just given the unusual circumstances here I'll allow you an opportunity after examination in-chief on each of these cases to, to ask any questions. So do you have any questions at this point that you'd like to ask?

JUROR NO. 1: Yeah, we were curious if the body weight would change the fatal toxicity level?

DR. ROSE: A. No, it's a concentration. So small people need to drink - because they're smaller they don't need to drink as much to get to the same concentration as a big person

would be to drink a bigger volume to get to the same concentration, but it's the concentration.

JUROR NO. 1: Oh.

DR. ROSE: A. It's not the specific amount.

JUROR NO. 1: Thank you.

THE CORONER: Thank you.

MS. SHEA: Q. At your report Tab 7 of the materials what comments if any do you have in terms of the original autopsy report and the cause of death that was listed by the pathologist who conducted the autopsy?

DR. ROSE: A. So my comments were that the postmortem examination includes satisfactory descriptions, appropriate ancillary testing, and a reasonable cause of death. My wording is not precisely the same, but basically it means the same thing that the original pathologist said.

Q. All right. Now, it appears you have a slight in relation to drowning and we're going to be talking about drowning in general terms and it's my understanding that you had provided us with a report in relation to drowning?

DR. ROSE: A. Well, it's not my report.

Q. No.

DR. ROSE: A. But I'm offering it as a reference that people can use. So the Canadian Lifesaving - the Lifesaving Society prepares a drowning report every year and it looks at deaths in Ontario, water related fatalities as they call them and this is the report from 2015 and it looks at drowning deaths between 1990 and 2012 and it gives interesting facts about how drowning occur and what sorts of - under what sort of circumstances people are

more likely to drown.

MS. SHEA: All right. Now, dealing first with the slide and I'd ask that this be marked as the next exhibit please Mr. Coroner, the drowning report.

THE CORONER: Okay, what number will that be?

COURT REPORTER: Five.

EXHIBIT NUMBER 5: Canadian Lifesaving Society Report re: water-related drowning fatalities for the years 1990 to 2012 - Produced and Marked.

DR. ROSE: A. So, drowning basically refers to a body submerged in water and as forensic pathologists we think of water as one of the harmful environments that people can find themselves in. One of the most important questions we have to think about when we are confronted of a case of a person found in water was or is, was the individual dead before they entered the water? For example, it's possible that someone could have died either as a result of intoxication, natural disease or an injury and then been put in the water by someone else. So we wanted, we want to be thinking about that in cases where we're considering bodies from water. And so in our autopsy, in addition to looking for evidence of drowning, we want to be thinking about and ruling out a natural disease that could have caused the person to die, injuries that could have caused them to die, or any sorts of drugs or poisons that could have caused them to die. So we would always do a full autopsy as I outlined it and external examination and an internal examination. And in some cases where people have drowned there are - there is

good findings that indicate that that's what happened to the person. So we would call those positive findings, that is, findings that support the idea that the person drowned and those would be frothy fluid in the airways. So I already mentioned that one of the circumstances where we see this frothy fluid is in cases of drowning and also what we call hyperinflated lungs where the lungs are kind of blown up like a balloon, so they take up more volume in the chest than they usually do. So those would be positive findings and in a person who was found in water that would be good positive evidence that they had drowned. The problem is that in many cases of drowning we don't have that positive evidence.

Q. I see.

DR. ROSE: A. So in that case we think about drowning as, and I've used this term in quotation marks, a "diagnosis of exclusion". So that would be a person found in water. A full autopsy was done including toxicology and all those other alternate case. There's no supporting evidence, so no hyperinflated lungs, no frothy fluid, but there's also no evidence of a natural disease or any injury or any poisons or toxicologic substances that have caused him to die. So in that case we make a diagnosis of exclusion. We've excluded everything else and so the, the conclusion is that the person drowned and that in those circumstances is a reasonable conclusion that the cause of death was drowning. So this is the drowning report that I've referred to and basically if you read it some of the factors that make it more likely that a person is going to drown is that they're male, 80 percent of people who drown are male, that if they weren't actually swimming or boating, that they were

doing something nearby a body of water during the night, during late hours of the day and if you look at the young adult age group in about a third of cases alcohol is a factor. So they've been drinking alcohol.

Q. And it appeared that this report was sort of looking at the statistics from 2006 right through to 2012 and commented on the number of fatalities and then looked at them in terms of age group, gender, what have you?

DR. ROSE: A. Exactly.

Q. Okay. Is there anything else significant about the report that you feel that the jury needs to know about in terms of any recommendations that may come out of this inquest?

DR. ROSE: A. I don't think I can comment on any recommendations. I think it's a very good summary of knowledge about what we would call the epidemiology of drowning. So who drowns and under what circumstances and one of the reasons why it's so good to have this information is that various groups can then think about what things we could change to prevent people from drowning.

Q. So based on what you have on the slide and what we see in the report it would appear that the worst case scenario when it comes to death by drowning is being male, having an activity near the water during the night or nighttime hours and a young male, that being and alcohol being involved?

DR. ROSE: A. Correct.

Q. All right. Dealing next with Jethro Anderson which is found at Tab 9, actually Tab 8 through Tab 10 of the brief, the volume?

DR. ROSE: A. Yes. So again, in the case of Mr. Anderson I was given to review the report of the postmortem examination, the toxicology report, 21 microscope slides, and the coroner's warrant for postmortem examination. And again, I gave my opinion that the report includes satisfactory descriptions, appropriate ancillary testing, and a reasonable cause of death.

Q. Now, when we turn to Tab 8 which is the original autopsy report in relation to Jethro Anderson, we see some observations, the summary of findings and when we look at that summary of findings what can you tell us in terms of what you've already said about positive findings that support a cause of death being drowning?

DR. ROSE: A. So one of them is that there was evidence that he was - had been immersed in water; that is, he was wet. Now, obviously that doesn't go to drowning, that just shows that there's evidence that he was in the water and he did have a few scrapes recent, minor injuries, scrapes or scratches, but again, nothing that would cause or contribute to death. There was early decomposition of this body and the internal examination showed fluid and foam in the airways, so that is positive evidence of drowning. Under the microscope there was nothing that contributed, there was no evidence of any natural disease and then there was the toxicology.

Q. All right.

DR. WOODALL: A. So, the toxicology testing in this case, based on the year that the case was done, history provided. We did not do full drug testing in this case, so we only tested for the presence of alcohol and the results showed a blood ethanol concentration of 233 and a urine ethanol of 314. Now, in this case, we did

also see evidence that there was some decomposition and that means some of the alcohol detected in these samples may have been from postmortem production of alcohol; however, because the alcohol concentrations are significant, it still - this individual definitely had been consuming alcohol prior to death and there was still significant amounts of alcohol in his system when he died. I just can't tell you exactly how much.

Q. And now we're really seeing that difference that you've talked about in terms of blood versus urine levels of, of ethanol. What can you tell us in terms of - you've said there's evidence of decomposition, but is there anything else further that you can explain to the jury that tells us why you have that significant gap as between the blood and the urine sample?

DR. WOODALL: A. In this particular case because of the evidence putrefaction, I wouldn't draw any conclusions about the differences in these two samples. I did explain how it can, it can differ because of if some reason the absorption phase of alcohol or the elimination phase of alcohol and some of the other cases we're going to be discussing where there wasn't putrefaction, I think they would be some clear cases to kind of show exactly what I'm talking about.

Q. All right, thank you. And I know Dr. Rose that your report was produced at Tab 10 of the materials. It's a report dated May 26, 2015 and what can you tell us and tell the jury in terms of your review of the original autopsy report, the practices now, the standards now, in terms of how the death, cause of death was reported?

DR. ROSE: A. Well, I believe that currently we would ask for full toxicology not just alcohol in these

sorts of cases, but given the fact that there was alcohol on-board, I determined that I agreed with the original pathologist and I would give the cause of death as Part I, drowning and then Part II, things that contributed to the death, ethanol intoxication.

Q. So when the jury has to answer that question number four on medical cause of death, how would that be set out with their verdict?

DR. ROSE: A. Well, if they agree and their opinion is the same as mine then I think they would give the cause of death just the way I've outlined it here.

Q. All right, the two aspects to it?

DR. ROSE: A. Yes.

Q. Okay, now, if I can just refer you back to the original postmortem or autopsy report. Once again, to assist the jury with answering the question "where", page 3 of the autopsy report that we see it appears that once again the doctor who prepared this report talked about where the death was pronounced?

DR. ROSE: A. Yes and it says here the Kam River Lookout and I would imagine that that means that the investigating, I'm sorry, the investigating coroner went to the scene at the Kam River Lookout and pronounced Jethro Anderson dead at that location.

Q. All right. Is there anything further that you feel the jury needs to assist in answering the five questions from both of your perspectives in relation to Jethro Anderson?

DR. ROSE: A. I don't think so.

THE CORONER: Members of the jury do you have questions for our witnesses at this point? Okay.

MS. SHEA: And Mr. Coroner, my understanding was that lunch was going to be delivered for the jury at a certain time and it's my understanding it's a hot lunch this time, so we don't want it to get cold and although we'd love to plough through until one o'clock to keep going on this, I would rather that they have a warm or hot lunch.

THE CORONER: Well, is 1:30 enough time for all of us to lunch?

MS. SHEA: Ms. Big Canoe has requested perhaps an additional 15 minutes Mr. Coroner that way she'll be able to speak with her clients in relation to some of the evidence that's been heard this morning.

MR. FALCONER: And Dr. Eden, I appreciate that we all need to keep moving because we have a responsibility to keep the process going, but to be candid, the reality of just the movement to get food because, you know, to get to a store or a restaurant means that an hour is barely enough time for counsel to eat and get back to a table, so an hour and 15 minutes would at least allow us to even to get food and get it back.

THE CORONER: Makes sense, so that'll be 1:45 p.m.

...JURY EXITS (12:26 p.m.)

R E C E S S

U P O N R E S U M I N G :

MS. SHEA: Q. Dr. Rose, prior to moving onto the reports relating to Curran Strang, I just want to ask you one question in relation to Robyn Harper and we do know the levels of alcohol that were found with Robyn Harper from the toxicology results. That would have been after she'd been found at nine o'clock; however, the information that we have is that Robyn had been picked up at another area at approximately 1:00 a.m. Based on the levels of alcohol in Robyn Harper's system, would hospitalization or if some sort of medical care had been provided to her eight hours prior to her being found, would that have made any difference in terms of the circumstances leading to her death?

DR. ROSE: A. It may well have made a difference if she was still breathing, but was unconscious and was taken to hospital then she would have had a breathing tube put in. She would have had mechanical breathing for a while until the alcohol level went down and then she may well have survived.

Q. Thank you. If we can move on now to the reports in relation to Curran Strang and the reports that we have in the volume in relation to Curran Strang are found at Tabs 11 through 13. Now, dealing with Curran Strang I know that you generated a report that we have at Tab 13. What information was available to you in order for you to testify today and assist the jury?

DR. ROSE: A. Yes, I have the original pathologist report, autopsy report. I have the toxicology report. I have 11 microscope slides and I had the coroner's warrant for postmortem examination.

Q. And dealing first with the autopsy report that we have at Tab 11, the extractions from that autopsy

report, what was significant from your report that we see at Tab 11 that we now see on the slide on the PowerPoint presentation?

DR. ROSE: A. Well, the scene and circumstances are as listed there. This 18-year-old young man had been near the floodway. He was said to have been drinking. He, on external examination there were no findings, so no evidence of any injury or illness and no evidence of decomposition. On internal examination he had good positive evidence of drowning. That is he had froth in his airways and he had voluminous or expanded lungs. Looking at tissues under the microscope was not contributory and then there were the toxicology results.

Q. Okay and in terms of toxicology?

DR. WOODALL: A. Yes the toxicologist in this case again based on the history and the time this case came into our laboratory we only did alcohol testing and the results in this case showed a blood ethanol concentration of 285 milligrams in 100 milliliters and the urine ethanol was 480 milligrams in 100 milliliters. Now there was no evidence decomposition seen on the alcohol analysis so these levels are the levels at the time of death and earlier you asked me about the differences between the two numbers and this case would be a good example to show how the urine ethanol is so much higher than the blood alcohol level and that suggests to me that the person was probably on the declining blood alcohol phase. So it suggested there wasn't recent drinking and it might be many hours since the person had been drinking and the body is gradually eliminating alcohol. So some of it has already been eliminated from the blood, but because the urine is a

pulled sample you still get that higher concentration in the urine.

Q. All right. And the actual report that led to that slide is your report that we see at Tab 12 of the materials?

DR. WOODALL: A. Yes, that's the report at Tab 12.

Q. Now, Dr. Woodall, one thing you said over the last couple of cases that we've reviewed is that at the time there was no typical or routine screening for drugs. Has something changed and I'm just wondering what the circumstances are in terms of the change that the screening for drugs as well as alcohol?

DR. WOODALL: A. Yes, there's been quite a few changes since I think the year 2000 when the first one of these cases came into the laboratory. So years ago the testing was done by the individual scientist determined what analysis it was based on the request from the submitter, but also the case history and the results. And then by about 2007, early 2008 we changed to a different system where all the cases submitted for toxicology analysis were reviewed by a committee and that committee had a toxicologist on it, a forensic pathologist, and a regional, regional supervising coroner and the three of us would discuss each case and decide what testing was appropriate and at that point the drowning deaths or deaths or death that was suspected to be drowning we would do alcohol and some drug testing in those types of cases, but when this particular case came in we didn't have that process so it was based on either the history or what was requested by the submitter.

Q. All right, so as of 2005 when this report

was generated that wouldn't have been standard practice in terms of the screening for drugs?

DR. WOODALL: A. That's correct, yes.

Q. Okay and the next slide and Dr. Rose?

DR. ROSE: A. Well, based on my review of the case I gave him as my opinion the cause of death would be Part 1, drowning and Part 2, ethanol intoxication.

Q. And that's as set out in your report at Tab 13?

DR. ROSE: A. Correct, but just let me make sure...yes.

Q. All right. And dealing now with Reggie Bushie and the reports in relation to Reggie Bushie for the benefit of the jury and for counsel are found at Tabs 14 through to 16 of the materials. And actually I just want to ask you one question Dr. Rose. I saw in the last report there was something referred to as "washermen" and then we also see washerwomen's hands" and it might be when the jury is looking at the reports and they wonder, what exactly is that? What is the significance of washermen or washerwomen's hands?

DR. ROSE: A. So it's a term that I don't use anymore. I mean anybody can wash floors. That's what a washerwoman used to be was somebody who either washed other people's floors or washed other people's laundry and what it referred to though was the change of your hands and feet too for that matter. If they're immersed in water for a long time, so if you sit in the bathtub too long your hands get wrinkled and your feet get wrinkled. It's just an evident - more evidence of having been submerged in water. What I say now in a report if I see that is something like wrinkling of the hands and

feet. We don't have to cast aspersions on people's jobs and what they do.

Q. Or their gender?

DR. ROSE: A. Or their gender, exactly. So that's what it refers to basically that their hands and/or their feet are wrinkled and it's evidence that they were submerged in water.

Q. All right. And dealing now with the reports in relation to Reggie Bushie?

DR. ROSE: A. Right, so Reggie Bush had - was a 15-year-old. It was said that he had been drinking near the river. His external examination showed evidence of immersion in water and he did not show any signs of decomposition. He also had evidence on his internal examination that would support drowning as a cause of death. He had frothy fluid in his airways and he had what were described as wet lungs. Ancillary tests, tissues looked at under the microscope were non-contributory and then there was toxicology.

Q. And if we go to the actual report that we see at Tab 14 and I know you have the full report there as well at it would appear to be page 4 of the autopsy report.

DR. ROSE: A. Yes.

Q. There appears to be some observations. Was there, based on your review of the information that you had, the reports and other information, was there anything in terms of findings about injury in relation to Reggie Bushie?

DR. ROSE: A. Yes there were and I'll have to apologize. I didn't include that on that slide about Reggie Bushie. There were several abrasions or scrapes.

He also had quite a few scars, but scars are healed injuries, so they're things that happened some time ago. So basically the injuries that we see, the recent injuries would be these scratches or abrasions and again I would consider them to be minor and to not have contributed to death.

Q. All right and that's why they've been indicated as superficial?

DR. ROSE: A. Yes, thank you.

Q. All right and the toxicology?

DR. WOODALL: A. So the toxicology for Reggie Bushie in this case we did alcohol and the full drug screening and the results show blood alcohol concentration of 262 milligrams in 100 milliliters and the urine ethanol concentration of 408 milligrams in 100 milliliters. There was no evidence of decomposition; so again, this case is a good example showing the large difference between the blood and the urine ethanol concentration.

Q. All right. One thing I wanted to ask you about because we have - when you look at Tab 15 of the materials which is a toxicology reports, we actually have two separate reports and we have one report dated December the 14th, 2007, and another report March 6th, 2008.

DR. WOODALL: A. Yes.

Q. And would that be as a result of you saying about how you have your committee that reviews and you determine whether or not additional testing should be done? I'm just wondering if you're aware of why it is that as of December 2007 there appears to have been alcohol screening only and then we see that there has

been drug screening as of March 2008?

DR. WOODALL: A. In this particular case the initial testing it was deemed that alcohol only was sufficient, but we always have a policy that if one of the investigators feels that more testing is required, they always have the option to contact us and we can reopen the case and do further analysis. So in this particular case it was at a later date that the laboratory was contacted and asked to do additional testing for drugs. When we do testing we always keep samples for a number of years so we always have the opportunity to reopen a case if additional information comes out and we need to do more testing and that's what happened in this case.

Q. And it would appear from the report that we have dated March 6th, 2008; although there was screening for drugs or poisons none were detected?

DR. WOODALL: A. Yes, that's correct.

Q. All right, the next slide?

DR. ROSE: A. So for Reggie Bushie again in my opinion the cause of death is Part 1, drowning and Part 2, ethanol intoxication.

Q. And that's as reflected at your report dated May 21st, 2015, at Tab 16 of the materials?

DR. ROSE: A. It is and I don't believe we went through this, but about Reggie Bushie I had the original report of postmortem examination, the two toxicology reports, 21 microscope slides, an x-ray report and the coroner's warrant for postmortem examination and I felt that the original autopsy report was satisfactory.

Q. And you also set out in that report that the numerous abrasions and scraps are minor injuries only and did not contribute to death?

DR. ROSE: A. Correct.

Q. And in relation to Kyle Morrisseau for the….

THE CORONER: Actually before we move to Kyle Morrisseau, members of the jury do you have any questions for our witnesses at this point?

JUROR NO. 1: No, thank you.

THE CORONER: Okay, you may continue.

MS. SHEA: Q. And in relation to Kyle Morrisseau the reports in relation to the autopsy and toxicology are found at Tabs 17 through to 19.

DR. ROSE: A. Thank you. So again the history was that Mr. Morrisseau, a 17-year-old was found in the floodway. External examination he had recent minor injuries, again scrapes and evidence of immersion in water and no signs of decomposition. And on the internal examination he also had positive findings of drowning that was fluid and foam in his airways.

Q. And when we look at the report, the autopsy report at Tab 17 at page 7 that appears to discuss the injuries that you've just referred to, the minor injuries?

DR. ROSE: A. Yes. Yes, it talks about some scrapes on his legs.

Q. And the toxicology?

DR. WOODALL: A. And so in this case we did alcohol and I've described it as limited drug screen. So we didn't do the full drug screening that can detect hundreds of different prescriptions and over the counter medications, but the drug screening that we did would see some of the major classes of drugs of abuse, so cocaine

and opioid drugs, also benzodiazepines would be seen with the drug screening that we did in this case and the results that - the only positive findings that we detected were a blood ethanol concentration of 228 milligrams in 100 milliliters and a urine ethanol concentration of 387 milligrams in 100 milliliters.

Q. And what we have at Tab 18, there appears to have been an amended report that was generated from the Centre of Forensic Sciences and that was simply to correct the spelling of the last name?

DR. WOODALL: A. Yes, that's correct.

DR. ROSE: A. So I should mention that I found that the autopsy report of the original pathologist was satisfactory and that he had determined a reasonable cause of death and in my opinion the cause of death was Part 2, drowning and then Part 2, ethanol intoxication.

Q. And that's as reflected in your report at Tab 19 dated May 21st, 2015?

DR. ROSE: A. Yes it is.

MS. SHEA: For the benefit of the jury and for counsel the reports in relation to Jordan Wabasse are at Tabs 20 to 23.

THE CORONER: And members of the jury any questions about Mr. Morrisseau? Okay.

DR. ROSE: A. Mr. Wabasse was 15 years old and he had been missing for about three months before his body was found in the river. And the autopsy report mentioned signs of advanced decomposition so there were quite marked changes of decomposition, but there are specifically mentioned that there were no injuries found, so no injuries on the surface of the body, no broken ribs, no other kinds of internal injuries, no evidence of

bleeding around the brain. So the decomposition made it more difficult to determine whether there were external injuries, there's good evidence to show that there were no significant injuries inside on internal injuries.

Q. So if there had been let's say as we had in the previous cases superficial or minor injuries, could those have not been detected because of the level of decomposition?

DR. ROSE: A. It's possible. As I said in the original slide about decomposition sometimes the changes of decomposition can obscure some findings, but they wouldn't obscure the findings of broken bones for example; so internally again no injuries and changes of decomposition. So the changes that you see in drowning may or may not persist if decomposition occurs. Microscopy, looking at tissues under the microscope was also noncontributory and then there was also toxicology done.

Q. And when you say "noncontributory" what does that mean when we're looking at this?

DR. ROSE: A. That means that the slides that were looked at didn't show anything that didn't support what we'd already seen with the naked eye and no evidence of a disease for example that could only be seen under the microscope.

Q. All right.

DR. WOODALL: A. The toxicology testing in this case we did alcohol and full drug screening. The results showed blood ethanol concentration of 158 milligrams in 100 milliliters and urine ethanol of 241 milligrams in 100 milliliters, but our alcohol analysis did show signs of putrefaction, so some of the alcohol

detected could have been produced after death, so these values are probably elevated compared to the concentration of when Jordan Wabasse died. We also found traces of oxycodone. Oxycodone is a strong pain killer. It's available by a prescription and traces means that we detected a low level, so it wouldn't contribute to a cause of death and I wouldn't expect it to have a strong effect on this individual at the time of death. We also detected the presence of cannabinoid metabolites and if you remember that comes from cannabis or smoking marijuana.

Q. And if I can just refer you to the report that's found at Tab 22 of the materials.

DR. WOODALL: A. Yes.

Q. When we do see that there are certain drugs and the alcohol detected and going down the list it does say with the oxycodone and I'm just wondering, at the bottom of the list it indicates blood ethanol oxycodone. When combined would produced more pronounced CNS depression. In terms of the levels that we're seeing here and this question would be to both of you, would that in some way contribute perhaps to cause of death or what would be the effect of those levels of oxycodone and alcohol in relation to Jordan Wabasse?

DR. WOODALL: A. In some situations if you combine alcohol with strong medications you can get this more pronounced CNS depression, so it slows down the way your brain functions and it can depress respiration; however, even though these two drugs, the ethanol and the oxycodone can have that effect in this particular case because some of the ethanol could have been produced after death and because the oxycodone is there at such a

low concentration, in my opinion I don't think it would have played a significant effect at all.

Q. And the second point that's listed in relation to the cannabinoid metabolites, it says identified tentatively by immunoassay, but not confirmed?

DR. WOODALL: A. Yes, so our initial screen for the presence of cannabinoid metabolites is done by an immunoassay. It's not a very specific method of analysis, so if we wanted to confirm that we would use more detailed analytical methods. Because in death investigations marijuana does not have lot of toxicity associated with it. We don't always go onto confirm that, but I should mention that in all the cases where I've mentioned cannabinoid metabolites they're all unconfirmed and there is always a possibility that additional testing may not have confirmed the presence, so it could indicate, for example, marijuana had been smoked prior to death, but it's not a confirmed finding.

THE CORONER: And I'll just ask one question here. Is it possible for that to reflect inhalation of fumes from somebody else smoking nearby or would you need to be actively inhaling in order to get that level?

DR. WOODALL: A. It's always possible especially in this nonspecific immunoassay test that it could come from what we call "passive inhalation". So if somebody is in a closed environment and somebody else is smoking marijuana, so for example, if you're in the same vehicle and it's quite an enclosed space, you can test positive with some drug screening even though you haven't

smoked it yourself.

MS. SHEA: Q. All right. And Dr. Rose, one of the reports that we have and this is found at Tab 21 of the materials, is a report from Dr. Pynn P-Y-N-N and I'm just wondering what the significance of that report is in terms of identification of Jordan Wabasse.

DR. ROSE: A. Excuse me, all the other young people who died were identified by someone recognizing them, but in a case where someone has died quite a long time ago and there are marked changes of decomposition, it may be very difficult or impossible for a person to recognize them just by looking at them. So one of the ways that we can identify people in those situations is by is by getting their previous dental x-rays that dentists have taken and comparing them to an x-ray we take of the body after death. And trained dentists who are familiar with this kind of work will compare the x-rays taken during life with the x-rays taken after death and will be able to confirm that it's the same person based on the dental x-rays and this is a letter from Dr. Pynn basically attesting to the fact that he believes that this is the body of Jordan Wabasse.

Q. And your report that was prepared on May 21st, 2015, is at Tab 23 of the volume?

DR. ROSE: A. Yes and again I had the following information to review the original report by the autopsy, the pathologist who performed the autopsy, the toxicology report, four microscope slides, this letter from Dr. Pynn about the dental identification and the coroner's warrant and I felt that the report include satisfactory descriptions, appropriate ancillary testing and a reasonable cause of death that there were advanced

changes of decomposition which may have obscured some findings and that there was no evidence of injury including blunt force injury.

Q. Now, in the other cases that involved drowning; you had also included that second aspect of the alcohol as a contributing factor. In the case of Jordan Wabasse would you say in your opinion that that would be something that you would include in your report, the alcohol aspect?

DR. ROSE: A. I did not include it in my report. I, I merely found that Jordan Wabasse had drowned, so I gave as a cause of death Part 1 drowning. I felt that the level, the concentration of alcohol was relatively low and given that up to 50 milligrams per 100 milliliters could be due to decomposition. That would make it even lower. It would actually make it not that much above the, the driving level and so I felt that I couldn't give it even as a contributing cause.

Q. All right.

DR. ROSE: A. So I just said drowning as a cause of death.

Q. Thank you.

DR. ROSE: A. So this is a summary slide that Dr. Woodall and I created and it basically gives the names of the young people who died, their age and their sex and then as a very, very, short summary in my opinion as to the cause of death for each case. The only slightly different one is Paul Panacheese because in brackets I put (possible heart disease) because this is of course what we want his family to be tested for to make sure that they're not in danger as well.

MS. SHEA: All right, thank you very much.

THE CORONER: So members of the jury, do you have any questions about the evidence concerning Jordan Wabasse? No, okay.

MS. BIG CANOE: Dr. Eden, might we just have a short break so that we can organize ourselves in an efficient fashion and make sure that we're not having….

THE CORONER: I think that's a very good idea. Would 10 minutes suffice do you think?

MS. BIG CANOE: Yes.

THE CORONER: Okay, 10 minutes please.

R E C E S S

U P O N R E S U M I N G :

MR. FALCONER: Dr. Eden, I had requested and I think I did it on behalf of all counsel, I didn't actually tell them I was doing it of course, but that's just because we are all of one mind. We wanted to address you on the issue of the time set aside for cross-examination and because this is the first witness we thought it appropriate to address you about it. I think as a matter of protocol and I mean no disrespect to the doctors, when you discussed time for cross-examination it should be done with the greatest of respect in the absence of the witnesses if they don't mind.

MR. CORONER: Yes, if you could step out.

MR. FALCONER: And it's not any aspiration on these good doctors, it's just probably a good

practice.

...WITNESSES EXIT

MR. FALCONER: So the only reason I was - we are raising it is that this is our first effort at trying to be cooperative and to split up time for cross-examination and we got the indication that the theory was that cross-examination would represent a total of the amount of time that it would take for examination. This, call it formula if you will, from the point of view of NAN and other parties I've canvassed, not all, it can work in some cases and it can completely not work in others. It is a function of how contentious the evidence is. As an example, so this should be a very short chat with respect, as an example it does work with this witness because there's a number of parties who do not anticipate being particularly long with the witness, in fact, a few short minutes. So in the case of this witness the two hours allocated amongst and I'm going to desperately try to count the interests here, but I think it's two hours allocated amongst conservatively seven interests, that's seven parties is very ambitious. As I said in this case it works and so we're all trying to work with the process and believe we can make it happen. I don't want to take much of your time to say we agree, but we must say and I'm putting this on the record I anticipate there

will be witnesses that that simply with all due respect is unworkable because of the interests at the table legitimately asking proper relevant questions that would not be able to do so with that time split. An examination can be thorough, but there's a reason parties have standing and legal representation is because it's understood that the cross-examination their lawyer engages in is a substantially different interest than the examination, very competent examination being done by your counsel. In order to do that it may be that the seven or eight interests involved need more than a three to five minute each, so having said that, like in these two doctors we have a time breakdown if it's useful to you. Did you want me to tell you?

THE CORONER: Yes please.

MR. FALCONER: Sorry for the speech. It's the first witness. So in terms of order you asked us to proceed on the basis of the order in the standing unless the parties can agree and I heard you and I've been before you before Dr. Eden and you're extremely supportive of consensus and so the parties did arrive at a consensus sort of generally speaking which is that the interests or parties that have a substantial interest in conducting a lengthier cross-examination would go first and those with a potentially narrower or smaller amount of time they think will be

required if any would go at the backend because we would likely have covered the areas they would require or need to hear that we've opened some big can of worms they never saw and then they're up on their feet saying I couldn't have foreseen that. So the bottom line is Ms. Big Canoe anticipates for the families being approximately 45 minutes, Ms. Bryson on behalf of the Provincial Advocate for Child and Youth anticipates being 30 minutes, on behalf of NNEC I'm told that I believe it's anticipated you're going to be 15 minutes, on behalf of Nishnawbe Aski Nation I anticipate being 20 minutes and so that would be the totals of that, call it for lack of a better word, collective set of interests and then moving on I understood from whether it was the Thunder Bay Police Service, Canada, Ontario, or the City of Thunder Bay that the estimates were in the range of five minutes if things went as its anticipated. So I don't want to speak anymore for my colleagues, but I thought if the package were put to you this way it might speed things up.

THE CORONER: Thank you.

MR. GOVER: If I may say this on behalf of the police parties Mr. Coroner, I suggest that we do maintain as a default the division of time that has been suggested which is that generally the parties with standing be given an equal amount of time to coroner's counsel.

There may be some reason to depart from it in individual cases, but I do suggest that we maintain that going forward and I agree with the approach taken by Mr. Falconer to the extent that those who may be relatively brief in cross-examination and may not have any questions left at all go toward the back of the batting order as it were in order that we save time. I may not have any questions at all, but I simply don't know that at this stage, thank you.

THE CORONER: Thank you, Mr. Gover. And with respect to order given that as you know I've encouraged counsel and jury to ask questions of witnesses about potential recommendations it also makes sense for those who may be receiving recommendations to be later in the cross-examination, but the order will always depend on the witness and what I will suggest and I won't make - there's no formal motion before me, but I won't make a ruling at this point, but I respect the concerns that NAN has expressed on behalf of other parties and what I'll suggest is that there be further discussion with coroner's counsel about ensuring that there is adequate time for cross-examination while ensuring that the inquest proceeds in an efficient fashion.

MR. FALCONER: Thank you, Mr. Coroner.

MS. SHEA: And Mr. Coroner, if we can just deal with one other issue and this is actually a very good time to deal with it so

we don't have to have the jury removed, but it's my understanding that Ms. Bryson wishes to put particular documents to the witness that are not contained within the brief and that have not been produced to the parties. They have been provided to the parties last evening; however, they are not documents that have been reviewed by you in terms of determining whether or not they contain relevant references. Ms. Bryson does have copies made and I think this would probably be a good time to deal with the issue right now so that we're not having a ruling and requiring the jury to be removed from the courtroom.

MS. BRYSON: If I may, I would prefer just to ask my questions and if I feel that I want them entered as exhibits I'll bring a motion at a later time. I don't want to be limited in my cross at this time.

THE CORONER: Okay, thank you. And Ms. Bryson I have no problem with asking questions which might be based on the contents of those documents where the *Chief Coroner's Rules of Procedure* raise a potential issue is if the documents are named or to be put into evidence as exhibits. So if we can recall the jury please and our witnesses too.

...JURY ENTERS

...WITNESSES ENTER

MS. SHEA: Mr. Coroner, just as a matter of

housekeeping prior to Dr. Rose and Dr. Woodall testifying I'd indicated that we have a DVD of the presentation and that it be marked as an exhibit, but in addition to that I would ensure that the jury had copies of the PowerPoint presentation so they wouldn't have to always be accessing a laptop computer to look at the PowerPoint presentation. So I'd ask that the DVD be marked as the next exhibit please.

OFFICER GARR: Number 6.

EXHIBIT NUMBER 6: Copy of the DVD re: PowerPoint presentation re: Dr. Rose and Dr. Woodall - Produced and Marked.

THE CORONER: So members of the jury, the witnesses will now be cross-examined by counsel for persons with standing and counsel for families will be cross-examining for 45 minutes, the Provincial Advocate for Children and Youth for 30 minutes, Northern Nishnawbe Education Council for 15 minutes, Nishnawbe Aski Nation for 20 minutes and the rest of the parties for five minutes and as I mentioned the amount of time for cross-examination, the actual order may change by witness, but that will be the time allotment for this witness; so, Ms. Big Canoe?

CROSS-EXAMINATION BY MS. CHRISTA BIG CANOE:

Q. Good afternoon, Dr. Rose, Dr. Woodall. I'm Christa Big Canoe. I am counsel for six of the families as it's been indicated and specifically I am counsel for the Anderson family. So again, I'll go basically through this list, for the Anderson family, the Panacheese family, the Harper family, the Bushie family, the Morrisseau family and the Jacob family who are the parents of Jordan Wabasse. Each of these families is having granted standing in this inquest. And so what I'd like to start with is I'm just going to give you a little roadmap of my approach. So what I'd like to start with is some more general questions just to find out some more information. It is a bit of a step back, but it's so that we're sure we understand because I'm not a doctor. I'm just a lawyer and even at times when I'm hearing some of this evidence I'm trying to wrap my head around it, so we want to ensure that the families who are in attendance as well as others understand. So I may be going over some of that and then I'm going to kindly ask at one point to go back into your presentation to ask questions particular to each family. And so as a starting point, one of the things that both of you have discussed in terms of the COD, the cause of death, has been the secondary and the secondary or what you had on the slides there the number two. So in each instant with the exception of Robyn Harper there was an indication that there was another cause of death other than intoxication, other than Robyn Harper which was acute ethanol toxicity. So as a primary is your Part 1 question, Part 1 answer.

DR. ROSE: A. So that's not quite correct. Paul Panacheese there's only one.

Q. Yes, thank you.

DR. ROSE: A. And also Jordan Wabasse only one.

Q. Okay. And so in all other instances though as Part 1 there was no finding of ethanol intoxication?

DR. ROSE: A. Correct. I didn't feel that it was a contributing factor.

Q. So in terms and I want to turn my attention to the drowning report. So the drowning report that I believe went in as Exhibit 4, sorry my apologies it's Exhibit 5, the Ontario Drowning Report. It's the four-page document.

DR. ROSE: A. I have it.

Q. Perfect and if we could maybe take a step back because although Ms. Shea did raise and put it in as an exhibit, can you please tell me where this report comes out of; just a little background information?

DR. ROSE: A. Yes. It's published by the Lifesaving Society Canada, so.

Q. Okay and so this report mostly looks at statistical information regarding drownings in Ontario as was pointed out between specific years. Having familiarity with the report and referencing it in your presentation, what were the water-related death rates by age? What were the findings in relation to that?

DR. ROSE: A. I need my glasses.

Q. No worries.

DR. ROSE: A. And I just need to look a little bit more closely. So if you go to page 2 of this report.

Q. It is on page 2.

DR. ROSE: A. There is a chart in the bottom left-hand corner called "water related death rate by age" and these are between 2008 and 2012 and that shows that there is a peak of drowning; there are really two peaks of drowning. One is in young people between about the ages of 15 and 29 and then again later in the very elderly group of people.

Q. Okay and the larger peak that occurs with the age range of 15 to 24 or is that the older age range?

DR. ROSE: A. Well, it's a higher peak, that is, it's more people per 1000 population in the older age group, but and that is 2.7 individuals per 100,000 people and in the younger age group it's 1.7 people per 100,000.

Q. Okay and so the reason I, I wanted to ask a couple of questions in relation to this report because it's a four-page report that indicates statistical numbers, but as you've pointed out Dr. Rose there were some high level lessons that we should take out of the report. And so one of the ones that is easy to see on the second page is "who is drowning" and that you indicated that is 80 percent are male?

DR. ROSE: A. Correct.

Q. Okay. And the second thing you were discussing was the vicinity to water or waterways.

DR. ROSE: A. Well, if you're not around water you can't drown, so that's correct. It could be rivers, lakes, bathtubs or swimming pools.

Q. And so what do you ascertain from where - from the report where they were drowning in terms of your presentation?

DR. ROSE: A. Well, from my understanding

those young men who drowned was all near a river or a lake or a waterway.

Q. Is that according to the report or your understanding of the report, is that where most commonly drownings are occurring?

DR. ROSE: A. Well, private pools, bathtubs are also important, but it does say again on page 2 at the top of the second column "where are they drowning", natural bodies of water continue to account for the largest proportion of drownings in Ontario. That's almost 70 percent, lakes were 48 percent and rivers and streams 21 percent.

Q. Okay, thank you. And so you found that this report was of assistance to sort of raise those high level issues as they correlate these particular deaths?

DR. ROSE: A. Yes, it's just some epidemiological or population studies showing all the people who drowned in Ontario.

Q. Right and now you sort of answered that, but I'm going to ask you now what do you mean by epidemiological, not just population because I'm sure a number of us don't know what that word means.

DR. ROSE: A. So epidemiology is a sub-study used in medicine to look at - instead of just saying that this person has this disease or condition and this person has the same or another condition or disease and this third person has another one, it's looking at population and the trends of diseases and injuries among them and it's to understand what the burden of disease and injury is in the community and also ultimately that kind of information may be able to be used to decrease the level of injury and disease.

Q. Right and so you had answered Ms. Shea earlier that when she asked about if there's recommendations on this that the reason that something like this is written is to help inform recommendations, but that you were taking no position or opinion on such recommendations as a result of just this report; did I understand that correctly?

DR. ROSE: A. That's correct.

Q. Now, in terms of - some questions in terms of drowning if I might and some of the physiological or the evidence-based indicators of drowning. And it may be easier to actually go back in the slides at this point even though - and so I'm not sure who operates that.

DR. ROSE: A. We will.

Q. Perfect, okay. So if we could go back to the first instance of drowning which was the Jethro Anderson, the first one and one more slide please. Okay and there we go, thank you. That's what I'm looking for yes and again, thank you for your explanations around what certain things mean such as drowning. That is, that is helpful, but one of the things that a number of the family members are interested in is just a little more explanation particularly around the certainty of knowing someone wasn't dead before they entered the water. Now, you've explained the lungs and the fluid in the throat or the foam in the throat, but is there any way that you can also explain how you know with certainty no one was - if they were dead prior to entering into the water?

DR. ROSE: A. So people who are found in the water and have positive findings that is frothy fluid in the airways and/or hyperinflated lungs that's good

evidence that they were alive when they went into the water and that they drowned. The, the problem for the forensic pathologist is in cases of people found in the water where there is no positive evidence of drowning and so it becomes what we would call an inference. That is, we have a certain amount of information, positive information a person was found in water was dead and then we have a lot of negative information. So we have looked very hard to determine whether they could have died of something else before they were placed or fell into the water and those three possibilities, the large group of possibilities, the reason for which people could be in the water already dead would be - that they died of a natural disease beside the water and fell into the water, that they were under the influence of some kind of a drug or alcohol that caused them to die and then they either were put in the water or they fell into the water or someone killed them by another mechanism or they had an injury, either an accidental injury, an injury they caused to themselves or an injury that someone else caused to them that caused them to die and then they either fell into the water or were put in the water. So by ruling out, by looking carefully for all of those things, evidence of natural disease, evidence of toxicology and evidence of injury and saying I've looked as, as hard as I can for any of those things, I can't find any and here's a person who is in the water and in several circumstances has a fair amount of alcohol onboard and for example we know that if you have been drinking you may fall more frequently, you may also not be able to get up or think clearly enough to look after yourself, so under these circumstances it is a reasonable

conclusion that the person drowned and I have no evidence to support that there's another reasonable cause of death.

Q. Thank you. And when you were just responding now you had mentioned like you can make an inference that if someone had alcohol in them they, they may fall, but – have fallen into the water, but aside from any injury that would contribute to the actual cause of death you can't – can you know that simply by looking in the examination either the external or the internal postmortem?

DR. ROSE: A. That I know what?

Q. So for example if someone fell into the water as you'd indicated we know that individuals may, if they have toxicity may not be able to stand or stagger. In absence of an injury you can't know how they fell into the water simply by looking at the….

DR. ROSE: A. Absolutely. I'm not - I'm not saying that that's necessarily what happened. The absence of an injury is not – is negative evidence, but many of the diagnosis we make are this kind of an inference, for example, I'll give you a case not related to this inquest, but that we see certainly every week if not every day. Someone who dies suddenly either in front of their family or is found dead we look, we don't see any evidence of injury depending on the case we may or may not do toxicology, but let's assume we do toxicology and they have a bad coronary artery, you know, with arthrosclerosis, with hardening of the artery where there's hardly any blood going through that artery. Well, we know that it takes many, many, months or years for an abnormality of the coronary artery to form like that, so

we know that that person had that disorder yesterday and the day before and the day before that and they were alive and now today they still have the same abnormality, but now they're dead. So looking at the circumstances, looking at all the studies, the external examination, the internal examination, the microscope slides, the toxicology if we have it, it is then an inference, a deduction really that we have something that we know kills people, that is hardening of the artery, the story fits and we have no other reasonable cause. We have no evidence that something else happened to that person and so we give as the cause of death coronary artery disease. So that's not the case in any of these cases – these circumstances, but this is not an infrequent thing where we look at the story. Does it fit the story? We look at our findings. Some of them are positive, some of them are negative. We look at the ancillary tests and then we put them together and we come up with our best opinion. It would be wonderful if in every case and every kind of death there was a little checkmark and once we found that little change it would – we would know what the cause of death was. It would make being a forensic pathologist a lot easier, maybe not as, as challenging or as interesting, but it isn't. So it is the big picture of many cases that allows us to come up with a cause of death.

Q. Thank you. And again, I'm not trying to jump around, but I do want to get under some definitions for explanation purposes. And so I'm going to ask you to turn your attention to what I believe is Tab 4, the Robyn Harper Medical Legal Autopsy Report.

DR. ROSE: A. Yes.

Q. And I'm going to count the pages because I'm not sure mine are numbered the same as yours. It's the third page in.

DR. ROSE: A. Okay.

Q. I apologize, one moment. Thank you, it's at the top of the page. There's a description sort of the external….

DR. ROSE: A. So is this the page that says near the top of the page "identification" and then just below it says "an external examination"?

Q. No, I'm sorry, it's under the "external features", but it's the first full paragraph at the top that begins with "consistent with either", yeah.

DR. ROSE: A. So towards the middle of the page it says "evidence of therapy, evidence of injury"?

Q. Yes, so just above that.

DR. ROSE: A. Yes, I've got it.

Q. Okay, thank you. There's a reference and honestly we're just - I'm just looking for an explanation and not to be morbid or bring up anything inappropriate, but there's a description of "bubbly frothy material emanating from the mouth and a small amount of emesis material mixed in." Ms. Shea did ask you a question in regards to this, but you said it was not conclusive, but can we take a small step back and just maybe explain what - why there would be a bubbly frothy material emanating from the mouth and what the sentence means, please?

DR. ROSE: A. So bubbly frothy, when you're breathing air one of the things that has to happen is the air has to go into your lungs and your lungs can't collapse like a balloon. They have to actually stay open

a little bit for the air to go in and out and there's actually a chemical material that your body makes that allows the little spaces to stay open. One of the things we know that happens in the body is if the heart and lung start to fail, so you start to get heart failure and maybe respiratory failure, the lungs can't clear the fluid and they don't stay expanded quite as nicely and frothy fluid starts to form, sort of ooze out of the lungs and go into the airways and that is because the, the breathing mechanisms aren't - are failing and the reason people die of acute alcohol toxicity and also many other drugs that have a very similar action on the body is because eventually the, the alcohol or the other drug affects the, the areas in the brain that keep you breathing, the respiratory centers, the breathing centers of the brain, they - it stops working properly and you forget how to breathe. You're unconscious and your brain doesn't remember how to breathe and so your heart and your lungs start to fail and fluid starts to collect. So this is one of the circumstances that we see frothy fluid.

Q. Thank you and more generally there is references to frothy fluid when we're discussing drowning. So the big difference I think you've already explained, but would you like to add if there's any differences between the bubbly frothy material you've just discussed and any frothy substance or liquids in a drowning circumstance?

DR. ROSE: A. So in drowning it looks the same. It can look very similar to the naked eye, but of course it's hard - it's easy to understand how fluid gets in because you're in water and so fluid is going to enter

your mouth and wash down into your airways and it will then mix with this chemical that your body has made while you're alive to help your lungs stay expanded and it gets frothy because of that fluid. It's almost like soap. This material has similar chemical properties and so it gets sort of bubbly the way soap makes water bubbly.

Q. Thank you for that explanation. In terms of - I have a couple of questions regarding decomposition. I think you did have a slide about that if we can pull it up?

DR. ROSE: A. Yes I did.

MS. SHEA: There we go.

MS. BIG CANOE: Q. Thank you. Throughout your testimony Dr. Rose you indicated and explained slides and how you take pieces of tissues. When you look at the slides you had referenced you could tell when there's certain injuries or stuff in the tissue, but is this one of the methods and how do you determine decomposition that you can't see externally or through a blood sample?

DR. ROSE: A. Well, in general if you can't see decomposition through externally or internally through - with the naked eye and the toxicologist doesn't see it, it's not there, but if it is there, if we see it with the naked eye there's evidence to be seen by the toxicologist there will usually be changes visible under the microscope too.

Q. Okay and so if - is there any affects, so if there's even just superficial scratches or abrasions, does decomposition have any effect on changing those or changing the appearance of those?

DR. ROSE: A. It can in the sense of making them more difficult to interpret especially the longer,

the more advance the decomposition is the more difficult it will be to interpret certainly minor injuries like scratches, yes.

Q. And so we've heard throughout both your testimony at points that they're, they're in certain cases there was some superficial and, and Ms. Shea asked about superficial and it's clear that that doesn't contribute to the death itself, but it may be of assistance to sort of express or define a little bit about what a superficial abrasion or scrape would look like?

DR. ROSE: A. So, everybody in this room has had a scrape or a scratch before, some people may even have one today. Scrapes and scratches are what we call one of the blunt force injuries. Blunt force injuries occur when a, a solid object strikes the body or the body strikes a solid object. For example if you're walking under a tree and a branch falls off and hits you on the head that is a solid object striking your body and when I get up, when I'm finished testifying if I bump into the coroner of that desk that's me striking a solid object. So those are what blunt force injuries are and there's basically four kinds of blunt force injuries: there's scratches or scrapes; we call those abrasions in medicine. There are contusions, that's what we call bruises. There are lacerations or tears of the skin, those are splits; for example, if you fall and cut your knee that's really a split of the skin and then the fourth type is a fracture or a break of a bone. So none of the people here had any lacerations or any fractures, but there were a few abrasions or scrapes and a few contusions or bruises. These are minor. People have them

every day. They walk around with them and they, they might – there might be part of the story that can explain them; for example, somebody on a riverbank who bumps into a tree or a bush might get a scrape or an abrasion, but it doesn't contribute to death. They're not serious injuries and you can't – you don't die of having an abrasion or a contusion.

Q. And so it's fair to say because I think you expressed this earlier sort of the TV version and the reality version sometimes can confuse people and very often the TV version, you know, has a whole theory about how scrapes and abrasions placed in a certain part of the body are indicative of a finding of death. I, I just want to make it clear in looking at your reviewing, reviewing of the pathological reports and the reports themselves, nothing speaks to what those scrapes and abrasions mean other than to remove them from a cause of death; is that correct?

DR. ROSE: A. Right, there's no – and there's no evidence that anyone else caused these injuries to – they're not evidence of an assault for example in any of the cases. Something happened. The person either fell down and got a scrape or a bruise or bumped into something and got a scrape or a bruise or something fell or hit them and they got a scrape or a bruise, but I can't – on TV you're right. They have these flashbacks on TV on those shows where they have an idea and they know precisely what happened to the person. I can't do that, but I can while recognizing them and acknowledging that they're present, assure people that they're not significant in the sense of having contributing to the person's death.

Q. Thank you. Now, I have a related question and it may seem like a simple question, but I think an explanation would be helpful. Is – can people bruise or get contusions after they've already drowned, so after death that appear?

DR. ROSE: A. In general no.

Q. So, so anything that may have shown up within the reports likely occurred prior to death and not postmortem?

DR. ROSE: A. Correct. In fact, some injuries for example if a body gets scraped against something after they're dead usually there's a different appearance of the scrape than one that happens around the time of death or before death.

MS. BIG CANOE: Thank you. And okay at this point if I can ask you to pull the – if we can start at the first one on Jethro Anderson and I apologize. I have a number of pages I'm flipping through up here.

Q. And I'm starting with Jethro Anderson, but this may actually apply to any of the drownings and I'm starting with Jethro because you had indicated there have been some minor differences and when you look at reports now and some of the steps you've done and I'm not going to revisit that so much. Remembering that Jethro's original postmortem or autopsy occurred in December 2000, was there anything else remarkable in terms of steps or things that may or may not have been done at the time of the original pathology or sorry the postmortem and steps we take now a days or in the current context the most recent guidelines?

DR. ROSE: A. Because we are aware of water

being a harmful environment, we actually prefer, recommend, that autopsies of people who are believed to have drowned be done by forensic pathologists currently rather than hospital pathologists. So that is one difference currently than was true in 2000.

MR. FALCONER: My apologies, Dr. Eden. The last words used by the doctor was "harmful environment, water is a harmful environment"?

DR. ROSE: A. Well there are other harmful environments…

MR. FALCONER: Thank you.

DR. ROSE: A. …fire is a harmful environment, yes.

MR. FALCONER: Thank you.

DR. ROSE: A. So water is a harmful environment and because of this question that I mentioned, you know, always having to have in mind could the person have died of something else before they went into the water, we actually prefer that these cases not stay in the local communities unless there is a qualified forensic pathologist locally.

MS. BIG CANOE: Q. And so as I've said this would be true in, in any of the others when we're, we're looking at – you have talked about and indicated some of the changes, but are there any other remarkable changes we haven't – so we know in drowning circumstances from 2000 'til the most recent report I believe you said is 2014 or guideline I'm sorry is 2014 that's one of the major ones. Are there any other major differences as it relates to drowning death?

DR. ROSE: A. Well, in drownings in particular we would expect that there would be usually

the police would be present and photographs would be taken during the course of the autopsy.

Q. Was that always true in terms of the, the postmortems that were before you because you've indicated in some circumstances you had slides, the warrants, and photographs before, but did you have photographs before you in each?

DR. ROSE: A. I didn't. In fact, I didn't have them in - I'm not sure that I have them in any, so it would be something that we would want to have and that's one of the things about peer review that makes cases reviewable is that you document things not only in writing and by diagrams, but also by photographs.

Q. Okay. And now I only have a few questions in relation and these are probably going to go more to Dr. Woodall, the toxicology. If I could just get some sort of general clarity around a couple of things that might be of assistance and then I may refer you back to your own presentation as the issues or questions may come up. And I think you've explained for the most part very well the difference between blood, when the alcohol is in blood, so the ethanol is in blood and when it's in the urine. A question to understand is when you explained when the body's eliminating the alcohol essentially what's happening is sometimes it will pool within the bladder and so your body - but again it sounds like a very basic question, but it's one that's come up. Does the, the ethanol that's in your urine travel back through your bloodstream ever or does it always stay within the bladder?

DR. WOODALL: A. No. Once it's in the bladder it's stored in the bladder until it's eliminated, but

it's removed from the rest of the body so the elimination at that point has stopped from the body and it remains in the bladder.

Q. Okay and you, you provide an example where, you know, you fall asleep and you hadn't voided the next day you could actually have a really high ethanol or alcohol level within the urine sample, but not necessarily in the blood?

DR. WOODALL: A. Yes.

Q. Is there a point or anyway to determine the height of alcohol in the system based on those two numbers and you explained well and so I apologize. I know I'm taking a step back and I'm really just trying to ensure that people understand the process the body's going through when they eliminate alcohol from it or if we can tell when someone gets to a certain range or, or rate milligrams and I know it's going to be a case-to-case answer, but maybe you can provide us with some insight on that?

DR. WOODALL: A. So just in general, when you start consuming alcohol within a very short period of time it's going to start appearing in the blood, so it gets absorbed very quickly and as soon as your body starts to absorb the alcohol it will start to eliminate alcohol, but when you start consuming alcohol originally or, or what happen is people consume alcohol and they're consuming faster than your body can eliminate, so your blood alcohol concentration rises. How quickly it rises and how high your blood alcohol concentration gets is going to depend on how quickly you're drinking, how much alcohol and also the body rate of the individual. Once you've stopped consuming alcohol and as you're consuming

alcohol your body is, is always eliminating it, but once you've stopped consuming alcohol the elimination rate then becomes faster than the rate of absorption into the body and that's when you get this declining alcohol phase. So when you get that peek and having that peek you can't really estimate. It's a case specific. Now, when we have a urine alcohol concentration earlier on when I was explaining how it's got a little bit more water than blood, so we can do a calculation and essentially we just divide the urine alcohol concentration by 1.3 because urine has 1.3 times more water in it than blood. So when we divide that concentration by 1.3 that gives us the blood alcohol concentration sometime prior and then what we'll do with that is we simply compare it to the blood alcohol concentration that's taken at the same time and we see whether it's higher or lower than the blood alcohol concentration and based on that simple calculation we'll determine whether somebody was in the rising phase or whether they were obviously in the elimination phase of alcohol. So some of the drowning deaths where the urine alcohol was so much higher than the blood that makes it clearer that they were clearly in the elimination phase so their blood alcohol concentration was declining at the time of death.

Q. So, but there's no exactitude or certainty you can pin what - like and clarify if I'm wrong; please correct me. But looking at the toxicology is there any way that you can determine how much there was at the height of consumption with exactitude?

DR. WOODALL: A. No, not with doing the testing that we, we've got here because these are just samples taken at one particular moment in time, so you can't answer

that kind of question with any certainty.

Q. Right and so you look at all the results from the other conditions when - and this would be Dr. Rose or the pathologist that was conducting the postmortem has to take into consideration all of the other factors and when determining the toxicology and they can only really work with the numbers that are provided in the blood and urine samples and the opinion of the toxicologist?

DR. WOODALL: A. Yes.

Q. Okay, so and the reason I'm clarifying this is because sometimes, you know, a medical report or a doctor's report it, it - they're the experts, you're the experts and so there's a lot of reliance on exactitude or being completely correct, so I'm just trying to make sure that we all know that there's a number of factors or contributing factors when formulating any of these opinions or coming up with even the COD or the Part 2. And again, these might seem like basic questions and it's a similar one that I asked Dr. Rose. There's no way to determine - there's no way to determine based on what you do as a toxicologist what state the individual was actually in by simply looking at the blood work; is there?

DR. WOODALL: A. I'm not sure exactly what you mean by that question.

Q. I can rephrase.

DR. WOODALL: A. Yes.

Q. So is there a way, I mean you can make some inferences or assumptions about a way a person may have been behaving given their alcohol content, but there's no way to know exactly what impact it was having

on them in life when you just look at the readings; is that true?

DR. WOODALL: A. To some degree because I don't have all the information, I can't take a blood alcohol concentration and tell you how somebody was behaving. So for example if somebody had a blood alcohol concentration of 150, in some individuals they may appear to be extremely intoxicated. Another individual that's very tolerant to alcohol may not look as if they're under the influence of alcohol at all, so in that respect I, I can't assist with that. In general though I know as a toxicologist how alcohol affects the body and even if somebody is tolerant to alcohol, the more alcohol you consume the more alcohol is going to affect your body and it can have affects on you even if you don't appear intoxicated. So for example, some of the cases I work on are impaired driving cases even without having information on how somebody is acting I would give an opinion and say that this blood alcohol concentration in my opinion somebody would be impaired and that's, and that's not related to tolerance because some of the impairing effects are not subject to tolerance the same way some of those outward signs of intoxication.

Q. Thank you that helps. This question will be addressed to either or both of you. Because we know based on what was in the report that you provided at least on a high level what some of the risk factors or issues are and there was an indication that 34 percent of that age range had ever alcohol involved or had consumed alcohol prior to death, but is there any way to know and again this may sound very simple and basic, but is there any way for you to know exact circumstance that happened

prior to the drowning?

DR. ROSE: A. No, there isn't, no.

MS. BIG CANOE: If I could happen to have one moment.

THE CORONER: Yes.

MS. BIG CANOE: And I believe other counsel will be happy because I've completed not only within my time, but shorter than my time limit and I thank you both for answering the questions that the families had.

THE CORONER: And thank you, Ms. Big Canoe.

MS. BRYSON: I'm just thinking everyone here looks a little weary. Do you want to allow them a short break before the….

THE CORONER: Yes, let's take our afternoon break at this point then and do you need….

MS. SHEA: I'm just wondering if the jury is weary, if they're not weary and they wish to soldier on I think that….

MR. FALCONER: Well, I want to address that for a moment. There's a lot of people in this room who are under tremendous stress as we hear this evidence so while I do think the jury's important, there's people that are really struggling through this, so breaks in this type of particular evidence make a lot of sense.

THE CORONER: So let's resume in 15 minutes sharp please.

R E C E S S

U P O N R E S U M I N G :

THE COURT: Ms. Bryson, you may proceed.

MS. BRYSON: Thank you.

CROSS-EXAMINATION BY MS. BRYSON:

Q. Chantelle Bryson for the Provincial Advocate for Children and Youth and I just have a few questions, clarifications and of course you've covered some so that'll shorten it up. So yesterday in the introduction to the jury and again today in your evidence we've heard a lot of comments presented to the jury with regard to your findings and repeated references to alcohol intoxication. Wouldn't you agree that we need to know what actually happened to these youths, not what people think, not what they assume and not what they suspect happened?

THE CORONER: That sounds more like an argument than a question for this witness. Can you rephrase it in a way that will allow the witness to give evidence?

MS. BRYSON: Q. Don't you feel the cause of death and any contributing factor linked to the cause of death should be accurate?

DR. ROSE: A. Yes I do.

Q. Wouldn't you agree that we need to make absolutely sure that we're accurate on those stats in order for the jury to determine the cause of death and also to ensure that the later systemic and contextual evidence, the relevance of that is accurate because it's going to flow from the cause of death, right, as will preventative recommendations?

THE CORONER: Actually, that sounds like you're asking the witness a legal question.

MS. BRYSON: Okay.

THE CORONER: So again I'll ask you to rephrase.

MS. BRYSON: Q. So are the postmortem, toxicology, and autopsy materials listed in your review reports the only evidence you've reviewed in reaching your conclusions as to the cause of death and "other significant conditions contributing to the death, but not causally related to the immediate cause"?

DR. ROSE: A. Yes, they were the materials that I reviewed.

Q. So you didn't have any conversations with the original pathologist?

DR. ROSE: A. I did not.

Q. Okay and are you aware if the original pathologist had any conversations or any information beyond the warrant, the postmortem warrant with police, witnesses, family members, medical history?

DR. ROSE: A. They may have had access to medical history. They may have had access to conversations with the police. I doubt if they spoke to any family members or other witnesses.

Q. But your practice guidelines that were referred to this morning as well as *Goudge* best practices suggest that should have occurred in the case of suspicious deaths including deaths in public places, correct?

DR. ROSE: A. The guidelines did not exist at the time that these autopsies were performed.

Q. But the 2003 and 2007 Coroner's Investigation Guidelines do refer to that, correct?

DR. ROSE: A. Coroner's Investigations are not, are not guidelines for forensic pathologists or pathologists. The first guidelines for pathologists were issued in 2008.

Q. Right, but are you familiar with the Coroner's Investigation Guidelines that govern them when they are contacted about a death?

DR. ROSE: A. Well, the coroner I'm sure spoke to the police, but I don't know if the pathologist spoke to the police.

Q. But I'm asking if you're familiar with those guidelines?

DR. ROSE: A. I am familiar with them, yes.

Q. And don't they say that those inquiries should be made and then that information should be passed onto the pathologist before they make their findings?

DR. ROSE: A. So I did say that the, the pathologist may have spoken to the police or had access to police records. I don't know.

Q. But I'm asking if the guidelines say that should happen…

DR. ROSE: A. Yes.

Q. …in the case of suspicious deaths including deaths in public places, water, and deaths where people don't know what happened?

DR. ROSE: A. Yes they do.

THE CORONER: Again, that's a layered question.

MS. BRYSON: Okay.

THE CORONER: I'm having….

MS. BRYSON: Actually I got a yes on the guidelines say that should happen.

THE CORONER: No, but I'm - the concern that I have here is the use of the words "suspicious death" and exactly what that means and what it meant in 2008-2010, so can you clarify your understanding of the term "suspicious death"?

DR. ROSE: A. I can and so we use suspicious - we usually use the term suspicious deaths and homicides as a phrase. So homicides are cases where it is clear that someone, that someone has died as a result of the actions of another person, that doesn't mean we're not lawyers, it's not culpable, that's the definition and then cases that appear to be suspicious, that appear to be possible homicides, so other cases are maybe mysterious and unclear, but they aren't necessarily suspicious.

Q. But doesn't the - those guidelines talk about suspicious deaths to include those just in public places and in water that have no clear explanation?

DR. ROSE: A. So those are cases that one should at least address as possibly suspicious, yes.

Q. Okay, so we've - I think we've answered - the causes of death for Jethro, Curran, Reggie, Kyle, and Jordan and Paul are not due to acute alcohol intoxication, but drowning and undetermined respectively, correct?

A. That's correct.

Q. Okay, so earlier you referred to a drowning report in your testimony. Wouldn't you agree

and, and I'll just reference that report at the second page where it lists "what are they doing", okay, so this is about the relevance here, as I see it as what they're doing. So it lists swimming, walking, running, playing near water, power boating, fishing, canoeing, diving, snowmobiling. Wouldn't you agree that there's no evidence that Jethro, Curran, Reggie, Kyle, or Jordan were undertaking a water activity?

DR. ROSE: A. To my - I don't know what they were doing by the water.

Q. So you don't know that there's any connection between being intoxicated and ending up in the water, correct?

DR. ROSE: A. I know that there is evidence or at least that I can make the diagnosis of drowning based on the findings of the autopsy and I know that there's evidence that they have been drinking alcohol.

Q. But you do not know because you don't have any evidence whatsoever that being intoxicated led them to being in the water?

DR. ROSE: A. I, I know that people who are - have a high concentration of alcohol are more likely to drown no matter what the circumstances are that lead them to be nearing the - near the water whether they're in a boat, whether they're swimming, or whether they're near the water if they - we know that from the report that a high percentage of people who have alcohol onboard drown.

Q. Right, it's 22 percent in these limited years from 2008 to 2012, correct?

DR. ROSE: A. No, in young people it's about 35 percent.

Q. For specifically being near water?

DR. ROSE: A. Umm….

Q. As opposed to being on the water or in the water in an activity?

DR. ROSE: A. Again, I'm not sure what, I'm not sure what the number is that you're giving me here.

Q. Well, we know that they were not undertaking a water activity, right?

THE CORONER: Perhaps you can define water?

MS. BRYSON: Well, I refer to the report the list of water activities in the report.

Q. So we know aside from being near the water which is 22 percent that they were not boating, fishing, canoeing, jumping, snowmobiling, or swimming, right?

DR. ROSE: A. To my knowledge they weren't doing any of those things.

Q. Right and regardless you were not privy to any information from - that was included in the notes of the original pathologist which would reference what the background that pathologist was provided that there is any connection between their drinking like any direct evidence that that was the reason they fell in the water or put themselves in the water?

DR. ROSE: A. So in the report the original pathologist does mention in each case that they were known to have been drinking. So that is a fact that they were told, that the pathologists were told. That was upheld by the toxicology report that showed that indeed there was a significant concentration of alcohol in several of them and so I felt that it was a reasonable inference that whatever the circumstances were that made

them be near the water, whatever it was they were doing by the water, it would be more likely because they have this concentration of alcohol onboard that they either went into the water because they had poor judgment, fell into the water because they had poor balance or because of those things were not able to rescue themselves and save themselves from being in the water.

Q. And, and how do you know that? Do you know how close they were to the water?

DR. ROSE: A. Well, at some point they were in the water, so I know they were close enough to be in the water.

Q. But you don't know how they got in the water, right?

MS. SHEA: Mr. Coroner, I believe that Dr. Rose has not only answered this question during her examination in-chief, but she also canvasses with Ms. Big Canoe when she was asked specifically you're able to say what the cause of death is, you're able to make observations; however, are you able to say how the person actually ended up in the water and she was quite clear saying I don't know how the person ended up in the water. I just know they were found in the water.

MS. BRYSON: So we don't know.

THE CORONER: And I'll say at this point the questioning is not unduly repetitious…

MS. BRYSON: Okay.

THE CORONER: …but it is getting there, Ms. Bryson.

MS. BRYSON: Q. So we don't know, but you included it in your reports, okay. Injuries and I just want to find my list of – I want to get this correct, excuse me for one second. So Jethro Anderson, Reggie Bushie, Robyn Harper, and Kyle Morrisseau all had injuries noted in their postmortem warrants in original postmortem examinations, correct?

DR. ROSE: A. Correct.

Q. So you don't know how they got in the water. Why did you exclude injuries in your consideration of how they got in the water? Isn't it possible they were pushed in the water; they had an altercation that landed them in the water? Isn't that equally as possible as falling in the water?

DR. ROSE: A. Well, I have evidence to show that they had a substance in their body that causes people to fall. I also – there were minor injuries. They were not of a pattern that would indicate that they had been assaulted, so I have no evidence to support that.

Q. And again, we know you don't know how they got in the water as related to alcohol. But again, if the original pathologist had better background information perhaps they would know more information about altercations and injuries, correct?

DR. ROSE: A. Oh, you can be told that a person has been in an altercation, but as a pathologist you can only support that by finding evidence of injury caused by that altercation.

Q. Right.

DR. ROSE: A. We don't have that.

Q. But you wouldn't need a significant injury to end up in the water, right? You could be pushed?

DR. ROSE: A. Absolutely and that is not a question that a pathologist can ever answer.

Q. Right.

DR. ROSE: A. Of whether a person fell or was pushed because it doesn't leave a mark.

Q. Right, but in the absence of evidence of, of causation of being intoxicated and landing then in the water you felt you could put that in, but you could exclude any other hypothetical cause that also had no evidence?

DR. ROSE: A. Well, if someone had said to me or if there was a witness who says he was pushed then I might put in my report I don’t see any evidence of any physical altercation, but I would not put that as a cause, I would not list that as a cause even if it was on a camera for example, I would just say I don’t have any evidence to support it from the pathological point of view. That is then evidence that someone else has to gather for example investigating police.

Q. Right or a coroner attending at the scene?

DR. ROSE: A. Well, a coroner attending at the scene would not be there at the time of the altercation and he’s not - he or she is not the one who does that particular part of the investigation that would be the police who would be investigating a possible altercation.

Q. But you said you were familiar with the coroner’s investigation guidelines which recommend they attend at the scene to specifically gather that information, correct?

DR. ROSE: A. From the police who are the ones who gather it primarily.

Q. And from witnesses and from family members?

DR. ROSE: A. If they're, if they're present, that's right.

Q. And to the best of your knowledge that was not done in any of these cases of drowning?

DR. ROSE: A. Well, as far as I know the coroner did go to the scene. I don't know who they spoke to, but the coroner did go to the scene.

Q. In any of the postmortem warrants did they list speaking to any of those people?

DR. ROSE: A. I'd have to go through the warrants again. I'm not sure.

Q. Okay. I've gone through them and they, and they don't.

THE CORONER: Well, then that's you giving evidence.

MS. BRYSON: Okay.

THE CORONER: And members of the jury I'll remind you it's the witness's answer that's the evidence.

MS. BRYSON: Q. So did you participate in the writing of the Ontario Forensic Pathology Service 2014 Practice Manual for pathologists?

DR. ROSE: A. Yes, I did.

Q. All right, so you're familiar with the contents of those and the basic requirements?

DR. ROSE: A. Yes.

Q. In regard to describing the cause of death the 2014 Practice Manual says that a pathologist

should use the World Health Organization ICD-10 Nomenclature specific naming system, correct?

DR. ROSE: A. Yes.

Q. Okay and since you helped develop the manual requirements you have a good understanding of what that naming system is?

DR. ROSE: A. Yes.

Q. Okay. With that being the case I'm just confused because when I look at the World Health Organization documents there's nothing to support any naming inclusion of alcohol intoxication in the manner that happened in the five deaths that you included it.

DR. ROSE: A. So giving a cause of death statement is the opinion of the pathologist or the forensic pathologist, given all the circumstances as they understand them and the evidence from the autopsy, both positive and negative and it's stating their opinion what the cause of death was and if there were any factors that contributed and in the opinion of the original pathologist in those cases where that's true and in my opinion in one, two, three, four cases, the ethanol - we considered that the ethanol intoxication was a factor in the death.

Q. And you based that on they could be compromised and fall in the water or go in the water, so in four cases Jethro Anderson, Curran Strang, Reggie Bushie and Kyle Morrisseau you felt that being compromised could reasonably be the reason they ended up in the water?

DR. ROSE: A. Or the reason they couldn't get out of the water.

Q. Right, but in Jordan Wabasse's case you didn't why?

DR. ROSE: A. I told you during examination in-chief I said that the concentration was relatively lower and there was also decomposition which meant that up to 50 milligrams per 100 milliliters of blood alcohol could be due to decomposition and so it was a relatively low comparatively to the others and so I didn't feel that I could use it as a contributing factor.

Q. Okay.

DR. ROSE: A. But that doesn't mean that it wasn't present.

Q. Right.

DR. ROSE: A. Of course it was present.

Q. So someone earlier referred to the toxicology report of Robyn Harper and the qualification and you spoke to this as well Dr. Woodall, the qualification therein of levels of intoxication and effects depend on, on many factors including history of use and tolerance, correct?

DR. WOODALL: A. Yes.

Q. So do either of you in the evidence have any evidence whatsoever about the history of use of alcohol by these individuals or their tolerance level?

DR. ROSE: A. No.

DR. WOODALL: A. No.

Q. So what is your evidence basis for concluding that they were so intoxicated that they ended up in the water due to it?

DR. ROSE: A. Well, whether they were….

THE CORONER: Actually, I think you mentioned Miss Harper and Miss Harper didn't end up in

the water; so just for clarity of the question.

MS. BRYSON: Oh, I didn't mean to mention Miss Harper. I meant the five drowning deaths, right.

THE CORONER: And there were four of them, not all five that that was an issue. So just so we're clear on what's being asked here.

DR. ROSE: A. So to….

MS. SHEA: And Mr. Coroner, once again it appears that Ms. Bryson is trying to get doctor Dr. Rose to explain to the jury how it is that each of these young people ended up in the water and she's been very clear in her evidence that she does not know whether or not they ended up in the water due to the level of intoxication; however, it was certainly a factor that's identified during the autopsy report.

MS. BRYSON: Q. My question is the qualification of those levels in your view of the level of the intoxication of the five individuals that drowned, even though you did not conclude it was a causal or a contributing factor with Jordan Wabasse. My question is given your lack of evidence and lack of knowledge of any history of use or tolerance of these individuals how could you know how intoxicated they were, how compromised they were and reach a conclusion for the four that it was a reasonable cause of how they ended up in the water?

DR. ROSE: A. Well, maybe Dr. Woodall will address the numbers and then I can address the interpretation.

Q. Okay.

DR. WOODALL: A. So the numbers, the ethanol concentrations in this case, the ones where it was listed as an additional factor, they're all extremely high ethanol concentrations. Now, the specific effects on an individual will depend to some degree on the tolerance and one of the factors of tolerance is if those outward signs of intoxication, so how drunk somebody looks, the more you drink the, the less you show those outward signs of effect, but there's lots of research out there that show even in the absence of those outward signs of intoxication alcohol still affects many areas of the brain, how quickly you can react to situations, how your brain processes information. So there's lots of evidence out there to show that even if somebody is tolerant to alcohol at the concentration seen in these cases that it would be causing some impairing effects, so judgment of distances or somebody's ability to kind of react to a situation. So for example if they're getting too close to the water and they slipped, they're not going to be able to react as quickly as if they were at zero blood alcohol concentration. So even without knowing exactly what an individual's tolerance was and not knowing exactly what happened when these individuals died, as a toxicologist I can say it's a significant amount of alcohol and it, it may have contributed to why they ended up in the water. You know, nobody knows for sure, they weren't there of how it happened, but even without knowing the specific information the high alcohol concentrations is enough for my point of view to say it could be a significant factor.

Q. In?

DR. WOODALL: A. In perhaps getting too close to the water or not being able to get out of the water, so I can't say for sure if, if that's what happened, but it's a significant level of alcohol that could contribute. Just to use a different kind of case as an example, as a toxicologist I often give opinions on the effects of alcohol on somebody's driving ability and whether they were impaired in a collision. I don't know what happened for any particular collision, but I can tell you based on an actual blood alcohol concentration that they were impaired, they wouldn't be able to react as quickly and it would increase their chances of being involved in a collision. Same way with this kind of case, I don't know whether alcohol caused them to maybe fall in the water, but it could – they're going to be impaired to some degree, so it may increase their chances of being in that situation.

Q. Do you have anything to add?

DR. ROSE: A. I think Dr. Woodall answered it….

Q. So given that you don't know, do you feel it was appropriate to include that in your reports?

DR. ROSE: A. Yes I do.

Q. But you don't know, right?

DR. ROSE: A. I couldn't ignore it as a factor that contributed to their death. Those boys died of drowning and a factor that contributed to their drowning was the fact that they had a significant concentration of alcohol in their blood.

Q. But you said you don't know that, right. You don't know how they got in the water, so how do you know that?

THE CORONER: I think that - I think we're now in the realm of unduly repetitious, so why don't you move onto another area, Ms. Bryson.

MS. BRYSON: Okay, I'll leave it for the jury to interpret those answers.

THE CORONER: Well and again, Ms. Bryson, just question the witness at this point, please.

MS. BRYSON: Q. Okay. In the case of Robyn Harper, you know, you determined the cause of death as acute ethanol toxicity and I'm trying not to be repetitious, but because she didn't drown and there was a qualification in her original toxicology report, can you be certain that with no knowledge of her history of alcohol use or tolerance that she in fact died of acute alcohol toxicity?

DR. ROSE: A. Yes I can be. In my opinion based on the results of the examination, so there's no competing cause of death in a previously healthy young woman, she has a concentration of ethanol in her blood that is within the range of the fatal range as published in the evidence-based literature, I can give as my opinion that she died of acute alcohol intoxication or toxicity.

Q. And would weight affect that determination? I know we talked about - or no, sorry, we talked about weight. Would stomach contents affect your view of how the alcohol affected her?

DR. ROSE: A. No.

Q. So in the postmortem warrant for Robyn Harper which you reviewed it indicated she had vomit on

her face and in her hair and I'm wondering because I'm not a doctor how this is excluded, how aspiration or asphyxiation due to vomit was excluded?

DR. ROSE: A. So it's quite common that people who are intoxicated with alcohol vomit, so that's certainly not unheard of and there's evidence that she did vomit at some time because there's material in her hair and on her face. Now, people who are under the influence of alcohol or other drugs may vomit and some of that vomit may go into their, into their airways and people refer to that as aspiration. Now, there's two things about that. We do have evidence that while she was still alive she vomited because she's got material in her hair. It's quite common for us to see food and stomach contents in people's airways. Now, this is a bit graphic so I'll just warn people here. When bodies are being moved after death, the material in their stomach can actually move and it can move up and into their airways, so just having food in your airway does not mean you aspirated, so, but given that people sometimes do vomit and breathe in their stomach contents because they're under the influence of a drug or alcohol, the cause of death is not aspiration of stomach contents because people who are healthy and who are not under the influence of alcohol and/or drugs, don't aspirate their stomach contents. So if I was convinced that a person had vomited, breathed in their stomach contents as an end result of being intoxicated, I might put as the cause of death aspiration of stomach contents, but number b) would be due to acute alcohol intoxication and that is actually the underlying cause of death.

Q. Right, so why was it not mentioned in

your report?

DR. ROSE: A. Because it doesn't - because the underlying cause, whatever the mechanism was and I have no evidence to say that she did - there's evidence that she vomited, but there's no evidence that the - that vomit ended up in her airways, but even if there was, the significant underlying cause and that is the cause that we're always looking for was the fact that she had acute alcohol toxicity.

Q. But we're also concerned with the secondary causes and contributing factors, right?

DR. ROSE: A. No, that's different.

Q. Because you listed them in your other reports.

DR. ROSE: A. So that's different. This is a mechanism you're talking about. So there are several mechanisms that alcohol poisoning can kill you by. The most common is that it stops you breathing, it affects your breathing centers in your brain and you stop breathing eventually, but there are some other mechanisms, for example, you may aspirate material from your stomach and die because of that, but the underlying cause is always alcohol toxicity. There's another possibility. You can fall in to a position say between the bed and the wall in your, in your room where there's a very tight fit and you can't breathe because your, your chest can't expand, but the reason you fell and the reason you can't get out of that position is because of acute alcohol toxicity. So the underlying cause is what we're looking for, not the specific mechanism. So in the case that you're giving me if there was significant evidence and I don't agree that there was, that she had

breathed in stomach contents, the cause of death would remain alcohol toxicity.

Q. Do you know from – could you tell from the documents you reviewed whether the original pathologist even examined aspiration as a mechanism?

DR. ROSE: A. Well, he – let me just look at the report for a moment, excuse me.

Q. I'm sorry I don't have a reference handy for you and I should.

DR. ROSE: A. No, that's okay. I've got all the reports here. I just need a minute. So you're saying that you think that she may have aspirated her stomach….

Q. I'm, I'm asking….

DR. ROSE: A. So let me – so there is very good evidence that he did in fact do a very good examination. On the page that has closest to the top on her autopsy report "circulatory system" and it's about page….

MS. SHEA: And just so the jury knows Mr. Coroner that is not included in the brief that they have. This is the full report she's speaking of.

DR. ROSE: A. Yeah, so page 5 of the autopsy report on Robyn Harper near the middle says "abdominal cavity gastrointestinal system" and the second line says "stomach and contents". And he actually describes in quite detail the kind of food that she had in her stomach and then if you go to the page before that at the bottom of the page under "thorax respiratory system" about halfway down "trachea contained the moderate amount of white foam; bronchia contained white foam" so that's the airway, the upper airway and the lower airway. So he

examined it enough to see that it had white foam and he didn't mention any food, so.

Q. And….

THE CORONER: One minute, Ms. Bryson.

MS. BRYSON: Q. And I just noticed in the paragraph at the top of that page he does mention that there was "bubbly frothing material emanating from the mouth with a small amount of emesis material mixed in". Is that vomit?

DR. ROSE: A. Yes, but there's none in her airways.

Q. Okay, thank you. And just back to the alcohol and decomposition effects. So decomposition effects were noted in Jethro Anderson and Reggie Bushie and Kyle Morrisseau in addition to Jordan Wabasse. So in Jordan Wabasse it was taken into account he did have lower levels and to exclude that as a contributing factor, but wouldn't the decomposition taken into account with Jethro Anderson, Reggie Bushie and Kyle Morrisseau bring reasonable, perhaps bring bare levels down to not being a contributing factor?

DR. ROSE: A. So Dr. Woodall said that the maximum that she would subtract from any alcohol because of decomposition would be about 50 and if you subtract 50 from those who did have - whose where I used ethanol intoxication, it is still a significant number even if you subtract 50, so that's why I included them.

Q. Okay, but just one more question.

THE CORONER: That's fine, Ms. Bryson. All right, I'll allow one more.

MS. BRYSON: Q. I just want to get the title correct. Are you familiar with the inquiry into *Pediatric*

Forensic Pathology and Ontario; the Goudge Report?

DR. ROSE: A. I am.

Q. And its extreme cautions against reaching conclusions without evidence?

DR. ROSE: A. Yes I'm aware of that.

Q. And you still feel that it was reasonable and correct given that you don't know how they got in the water, the five drowning victims, to reference alcohol in your reports?

DR. ROSE: A. I do.

THE CORONER: So that's been asked and answered.

MS. BRYSON: Thank you.

THE CORONER: Thank you, Ms. Bryson. And members of the jury, again, I'll remind you that the evidence is the answer of the witness to the question.

CROSS-EXAMINATION BY MR. ESQUEGA:

Q. Good afternoon?

DR. ROSE: A. Good afternoon.

DR. WOODALL: A. Good afternoon.

Q. My name is Etienne Esquega and I represent Northern Nishnawbe Education Council. They operate and run Dennis Franklin Cromarty High School in Thunder Bay. Six of the students who passed away here were attending that school at the time of death. First, just a general question, I looked at your CV and you're also a coroner; is that right?

A. I am.

Q. So you're a coroner and you're a pathologist and a forensic pathologist?

A. That's correct.

Q. So a very, very, qualified and you can talk about all the stuff we're dealing with here today, thank you. In terms of Thunder Bay Services, just a general question for everyone here, what type of pathological services are available here now?

A. So we do have pathologists who do what we would call routine cases, so non-suspicious cases and we do have one pathologist locally who does some suspicious cases and homicides and from a forensic pathology point of view of course no death is routine to the family that experiences it, but he would do more straightforward suspicious cases and homicides, any very complicated cases would go to a unit usually in Toronto.

Q. So is he a forensic pathologist?

A. He is not. He, he has worked in forensic pathology for many years, so he does continue to do some cases like that, but he is not certified by examination.

Q. And if there was a need for a forensic pathologist to attend Thunder Bay to do an autopsy, how long would it take to get one here?

A. Usually it's not the forensic pathology who travels. It's usually we have an arrangement for the body to come to Toronto and then to be brought back and then of course it takes as long as it takes.

Q. And normally when you're doing an autopsy you'd want to be conducting that as soon as possible…

A. Well, yes.

Q. …as soon as you retrieve the body, right?

A. We do yes, but in general as long as the body is in a cool temperature it's okay if we have to wait a day or two.

Q. And how cool is that temperature?

A. Refrigerated temperature.

Q. So that's about - I think my refrigerator at home is three degrees?

A. Something like that.

Q. Yeah. Now, just turning to your mandate we've already had some questions, but I want to be very specific with you in terms of what you were asked to review. And turning to Curran Strang's report, your May 21st, 2005, report, it's my understanding that you itemized in detail exactly what you reviewed, number one being the report to the postmortem examination?

A. Yes.

Q. Dated December 8th, 2005. The toxicology report from the Centre of Forensic Sciences and I believe that's the one that was also done in 2005?

A. Yes.

Q. The microscope slides?

A. Yes.

Q. And those were probably prepared in 2005 as well around the same time as the forensic report?

A. Yes, they were prepared in the hospital. All the microscope slides were prepared locally in the hospital here.

Q. Okay. And also you reviewed the coroner's warrant for postmortem examination?

A. Correct.

Q. And that's the - that warrant is prepared at the scene basically, right?

A. Yes.

Q. When, when the body is recovered the coroner attends and I think Dr. Dupuis' the coroner in

this case who attended there.

A. Dr. Dupuis is the coroner and I would have to look at his warrants, but it certainly appears - I do have his warrant here and it certainly sounds as if he attended the scene, correct.

Q. And just to be very clear, you weren't provided with any police notes?

A. That's correct.

Q. You weren't provided with any coroner's reports or notes to do your review?

A. Only warrant that….

Q. The stuff that's listed in that…

A. That's right.

Q. …in the front of that letter? Okay and when we look at the coroner - the pathologic - sorry, the report of Dr. Dupuis on the second page….

A. So the report is by Dr. Jani.

Q. Sorry, Dr. Jani, yes.

A. The pathologist.

Q. That's right. He signed that December 8, 2005, the second page we have "Summary of the present episode" and it appears to me that's the only piece of information that you have which describes the scene and circumstances surrounding the finding of Mr. Strang; is that correct?

A. So I have - this is Dr. Jani's summary of what he understands happens and then I have the coroner's warrant that explains what he knows; that's correct. That's the information I have.

Q. It's my understanding that the coroner's warrant is pretty limited in terms of the information that's on there; is that….

A. It is fairly limited.

Q. What's, what's on - maybe you can just walk the jury through what is on that piece of - well, first, before you go there, let's look at what he summarizes and its three sentences long. He says, "18-year-old male was drinking too much alcohol on the 22nd day of September 2005 by the side of river along with his friends, he was too intoxicated and was left by his friends, as he was too drunk to walk he was found by O.P.P. police staff in McIntyre Floodway..." and there's an abbreviation there "...and there was no evidence of external trauma." So that's what he has there, just basically describing what the circumstances were at the scene and when the body's pulled out. Now, the medical warrant can we summarize what was in that?

A. The coroner's warrant says similar information it says, "18-year-old First Nations male, Thursday, September 22nd, '05, drinking ++..." then it's a short form for alcohol "...by river, was ++ intoxicated, left by his friends as he was too drunk to walk, found today by O.P.P. dragging river, McIntyre or floodway no evidence of external trauma query drowned."

Q. Thank you. So again, the evidence is very limited and it doesn't talk about any weather conditions. It doesn't say whether it's cold that day, whether it was hot that day or even the night before; is that correct?

DR. ROSE: A. It doesn't.

Q. And that information was not provided to you at any point prior to you doing that review of the material?

DR. ROSE: A. That's true.

Q. Thank you. Now, I want to talk to you, given that you're a coroner and also a pathologist, I suspect you've dealt with hypothermia?

DR. ROSE: A. Yes.

Q. At some point someone must have unfortunately passed away from that condition, is that correct, and you've had to make that finding that someone died of hypothermia?

DR. ROSE: A. So hypothermia sometimes people call that exposure, exposure to cold weather, yes.

Q. And generally I, I'm not an expert on this so I'm going to walk you through some stuff and hopefully you can help me explain this about my understanding of hypothermia. So basically there's three stages from what I gather. Stage one talks about your body temperature drops one or two degrees and you start to shiver and you also get Goosebumps on your skin and your hands become numb. Does that sound like a first stage of hypothermia, yes?

DR. ROSE: A. Yes.

Q. Your breath becomes quick and shallow and you may feel tired or sick to your stomach; is that right?

DR. ROSE: A. I think so.

Q. Yeah, okay. So that's the first stage. So it's not a big drop. That's one or two degrees. Stage two from what I understand says that your body temperature has dropped two to four degrees by this point and you're shivering is strong; does that sound right?

DR. ROSE: A. Yes.

Q. Muscles are uncoordinated and movements are slow and labored. Does that sound like a symptom of -

or an affect of hypothermia at stage two?

DR. ROSE: A. Yes.

Q. Finally, stage three we get to body temperatures below 32 degree Celsius. The shivering will stop, but the person will most likely have trouble speaking, thinking, and walking. Would you agree with that?

DR. ROSE: A. Yes.

Q. They may even develop amnesia. Would you agree with that as well?

DR. ROSE: A. Yes.

Q. Have you ever heard of the term "paradoxical undressing"?

DR. ROSE: A. I have.

Q. And that's a term that's associated with hypothermia; is that right?

DR. ROSE: A. Yes.

Q. And my understanding of paradoxical undressing is that once you get to that stage three or even the latter part of stage two, people begin to start undressing themselves. They will remove clothing and they will not know that they're doing this, but they will do that because that's what their body's telling them to do; is that correct?

DR. ROSE: A. That's right. We assume that they begin to feel hot even though they're very cold and they start to take their clothes off.

Q. Thank you. And also in some rare incidents from what I understand, will engage in an activity or conduct that's known as "terminal burrowing behaviour". Have you heard of that before?

DR. ROSE: A. I have.

Q. And that's where they're so cold I understand that they will try to go into nicks and crevices or spots where they think they can get warm; is that….

DR. ROSE: A. I don't exactly know what their thinking is, but we know that they show evidence of that kind of behaviour; scratching at the ground.

Q. And then eventually you'll find they'll be found unfortunately deceased at some point?

DR. ROSE: A. Right.

Q. Because they've suffered from the elements. Now, I want to bring you to Curran Strang's file and there's some information that - as we know from your testimony here already that was not provided to you but I want to provide you some factors which, which we know from the materials that have been provided to us so far. On September 23rd, 2005, we know that the temperature that night dropped at three o'clock in the morning it was down to negative zero point three.

DR. ROSE: A. Just a moment. I think it was the 22nd was the night of - it says in the autopsy report that it was, it was September 22nd.

Q. Okay. So we know that night that - so it was the night of the 22nd that he was out with his friends?

DR. ROSE: A. That's what it says in the autopsy report.

Q. And then at that night we know the temperature dropped to five degrees Celsius?

DR. ROSE: A. Yes, okay.

Q. Okay and in the early morning of the 23rd we know that the temperature - I'm just trying to get

back up to my….

THE CORONER: And this sounds like you're giving evidence. I think it would be better to give it as a hypothetical because the…

MR. ESQUEGA: Okay.

THE CORONER: …actual temperatures haven't been entered, but certainly legitimate to ask for an expert opinion on that basis.

MR. ESQUEGA: Q. So then on the 23rd if the temperature was around minus three, minus 0.3 at three o'clock in the morning would you agree that's pretty cold?

DR. ROSE: A. It's cold.

Q. And if you were intoxicated and sleeping on the side of a shore do you think you would as most of the public would feel cold after a while being exposed to those types of elements; wouldn't you agree?

DR. ROSE: A. I would agree.

Q. Now, we know also if someone had been found in the river without a shirt on, without - with a sandal missing, with their pants unbuttoned but yet still up around their waist and they'd been out - we know that he'd been out all night during those temperatures would you agree with me that perhaps a contributing factor to the death would be hypothermia?

DR. ROSE: A. Well, it's possible, but I'll just tell you that there are findings in autopsies of hypothermia and Mr. Strang didn't have those findings at his autopsy and he did have findings of drowning so that it makes more sense to me to say that the cause of death was drowning.

Q. Can you explain how those findings with respect to hypothermia – explain how those findings that were used in the autopsy limited and excluded hypothermia then, please?

DR. ROSE: A. So one of the findings, now granted they don't happen in all cases, but we see a particular pattern in the stomach in people who die of hypothermia; he didn't have that. He did have froth in his airways which is a sign of drowning and I'm just looking and give me a moment.

Q. I'm not, I'm not, doctor just so I can….

DR. ROSE: A. So I, I don't think there's good evidence of hypothermia and I didn't feel that it was a reasonable conclusion and I don't feel it's – the story you've given me is not an unreasonable one, but think the evidence shows that he died of drowning.

Q. Well, with all due respect doctor, we know that you were provided with very limited information. We know you weren't provided with the full story as to his – what elements were that night and I'm not asking you to say that hypothermia was a cause, I'm asking you to agree just like you did - noted with alcohol that alcohol was a contributing factor, but quite frankly hypothermia could have been a condition that was getting severe that evening which would have caused him to stumble as we know it's a condition into the river that night; is that right?

DR. ROSE: A. But I have evidence that he had alcohol onboard. I have the toxicological evidence. I don't have evidence that he had hypothermia. So although it's a story that does make some sense, I don't have evidence to support it and so I wouldn't put it in my

cause of death statement.

THE CORONER: You have less than a minute left, Mr. Esquega.

MR. ESQUEGA: Sure, thank you.

Q. I'll leave it at that. We know that a couple of the other students also passed away unfortunately much later in the year; end of October/November found in the river again cold weather, cold water. If there's factors such as what I went through here today, would it be unreasonable for the jury to determine that hypothermia was possible as a cause?

DR. ROSE: A. I don't think most forensic pathologists would, would list it without evidence to support it in this situation. If these young men were found away from the water, no evidence of drowning, then hypothermia would be a very important thing to consider, but that's not the case. They were all found in water. They have more or less good evidence of drowning and so drowning is the cause of death. Hypothermia in many cases of drowning may be a minor factor, because people do get cold in the water as well, but drowning is the ultimate cause of death is being submerged in water.

Q. Okay and just like you're not saying that alcohol is an ultimate cause of death, but what I'm saying here is the stage two, hypothermia, could have been just as equally a contributing factor as alcohol was in terms of losing your motor functions and falling into a river?

DR. ROSE: A. But I have evidence to support the alcohol in the toxicological report and I don't have evidence to support hypothermia.

THE CORONER: And Mr. Esquega, I think that's been asked and answered and that's time, so….

MR. ESQUEGA: And if I may just ask….

THE CORONER: No, no, that's…

MR. ESQUEGA: And if I could just ask….

THE CORONER: You're done, Mr. Esquega, thank you.

CROSS-EXAMINATION BY MR. FALCONER:

Q. Good afternoon Doctor's Woodall and Dr. Rose. My name is Julian Falconer. I represent, along with Meaghan Daniel and Samantha Ramage who's a student in our office. Could you stand up Samantha so the jury meets you? Of course Samantha does the lion's share work as well. We have the honour or representing Nishnawbe Aski Nation and in fact Deputy Grand Chief Derek Fox whose portfolio includes education with us today. I just need to understand something quickly. In the case of - I'm lying; I'm not going to be that quick. In the case of Jordan Wabasse, you wrote in your report on May 21st, 2015, second to last line, first page, "I cannot determinate whether alcohol intoxication contributed to his death." Did you write that?

DR. ROSE: A. Oh I did and I'm sorry. Determinate is not actually a word. I meant determine.

Q. Okay. So you and I can agree on the English language. Secondly, "I cannot determine whether alcohol intoxication contributed to his death", correct?

DR. ROSE: A. Correct.

Q. You cannot determine whether murder contributed to his death, correct?

DR. ROSE: A. Yes I can.

Q. You can?

DR. ROSE: A. The way people are murdered in Ontario is they're shot, they're beaten, they're stabbed, or they're strangled and there's no evidence that anyone did any of those things to Mr. Wabasse.

Q. So those are the only ways people are murdered in this province; is that right?

DR. ROSE: A. Those are the very most common.

Q. But they're not the only ways?

DR. ROSE: A. Well, people - okay….

Q. Agreed?

DR. ROSE: A. People might be poisoned. There's no evidence that he was poisoned.

Q. Other ways? There's many, many, ways people can be murdered. There's no limit. There's no pathological limit on how you can be murdered, agreed?

DR. ROSE: A. Well, I'd like you to give me some examples.

Q. Sure. If an individual were in an intoxicated condition say - let's use Mr. Morrisseau that's up here. He died at the age of 17. If Mr. Morrisseau were in an intoxicated condition and he was lying beside the McIntyre River with a blood alcohol concentration of 228 and he was cold and he'd fallen asleep and somebody came along and rolled him into the river. Would that be murder?

THE CORONER: Well, actually that calls for….

DR. ROSE: A. That's, that's a legal….

THE CORONER: Sorry, I'm not going to allow the witness to answer that.

MR. FALCONER: I was asked by the witness to

give her an example.

THE CORONER: No, but you can rephrase the question in such a way that…

MR. FALCONER: Fair enough.

THE CORONER: …it's not asking our expert witness to make a finding of law.

MR. FALCONER: Fair enough.

Q. Would that be….

DR. ROSE: A. I can answer the question.

THE CORONER: Well, no. I've already….

MR. FALCONER: Q. No, because Dr. Eden ultimately is….

DR. ROSE: A. No, I can answer that.

Q. Sorry Dr. Rose, Dr. Eden is the adjudicator. I'm the lawyer. You're the witness, okay?

DR. ROSE: A. Okay.

Q. He's made a ruling and we have to live by it.

DR. ROSE: A. Okay.

Q. Thank you. So Dr. Rose, an individual could have peri and postmortem injuries, right, to their bodies; they can have abrasions on them?

DR. ROSE: A. Yes.

Q. And those….

DR. ROSE: A. Perimortem. Postmortem injuries are different.

Q. You would expect a competent autopsy such as you called these ones good, right. You'd expect a good autopsy to actually distinguish between the peri and the postmortem injuries, correct?

DR. ROSE: A. Yes.

Q. Yes. And you'd expect that if abrasions

are found there would be a particularization about whether the abrasions were perimortem or postmortem, correct?

DR. ROSE: A. No. I wouldn't say that if the pathologist felt that they were postmortem they should distinguish that, but otherwise by - you would assume that they are perimortem around the time of death.

Q. But you would expect the report to reflect a distinction that was discernible so we'd understand which is being described, correct?

DR. ROSE: A. Umm….

Q. We're not turning to pages yet, I just asked you a general question, correct?

DR. ROSE: A. Well, in my reports if there are no postmortem injuries and they're all perimortem, I don't refer to postmortem exam injuries at all.

Q. Right, so that it's possible to be able to determine that those are perimortem, correct?

DR. ROSE: A. I just said I don't distinguish them. I don't even mention that postmortem injuries.

Q. The report in respect of Kyle Morrisseau who's ultimately drowned in the McIntyre River in 2009 the report in respect of him states the following under injuries and the jury has this. I'm reading from the original report under the title Evidence of Injury as Described Above, Skin Features, "Perimortem or postmortem abrasions of the left shin." Do you see that?

DR. ROSE: A. Yes and sometimes it can be very difficult….

Q. Can I ask my question now? Thanks and then under that "A single peri or postmortem abrasion of the right shin". Do you see that?

DR. ROSE: A. I do.

Q. Do you see any explanation or distinction advising us as to whether that abrasion is either peri or postmortem? Can we determine from this report on those lines whether it's peri or postmortem?

DR. ROSE: A. No and that pathologist couldn't determine it either and that's why he refers to it that way.

Q. All right. So this is good, this is good work?

DR. ROSE: A. That's fine.

Q. All right. So to be honest, contrary to what you said before that it's apparent whether it's post or perimortem, in this case, in this case there are abrasions that Mr. Morrisseau suffers that we can't tell whether he suffered them before or after he died, correct?

DR. ROSE: A. That's correct.

Q. Right. This person is lying beside the McIntyre River. They're suffering from a blood alcohol concentration that renders them highly vulnerable in extremely cold conditions, okay.

DR. ROSE: A. Okay.

Q. And someone walks along and turns them over and rolls them into the river, okay?

DR. ROSE: A. Yes.

Q. Would you agree with me leaving aside legal definitions that that would be an example of a deliberate killing that wouldn't fall into any of the categories that you previously described?

DR. ROSE: A. Yes, people are drowned homicidally in Ontario.

Q. Right.

DR. ROSE: A. But the circumstances - but the pathological evidence does not allow a forensic pathologist to distinguish between accidental drowning, suicidal drowning, or homicidal drowning and that's up to other investigators to determine that.

Q. Very fair and what you're really trying to tell us is that you're here to help us, but there is a limit to the science that you're offering to this jury, correct?

DR. ROSE: A. Correct.

Q. Correct. And accepting that there is a limit to the science that you're offering this jury we have to look to other investigators to help us with what you termed before in the story, correct?

DR. ROSE: A. Yes.

Q. And that means that we can't count on high degree of delivery from those other investigators at the time of the incident, correct?

DR. ROSE: A. Yes.

Q. Right. Now, you'd agree with me that it's no surprise that a community the size of Thunder Bay with the NAN communities involved in this case should and would - you're a coroner, should and would have grave concerns when in 2005 a youth is found dead in the McIntyre River, in 2007 two youths are found dead in the McIntyre River, in 2009 another youth is found dead in the McIntyre River and finally in 2011 a youth is found dead in the Kam River, 2005, 2007, 2009, and 2011. That's quite a pattern of deaths, agreed?

DR. ROSE: A. Yes.

Q. A small community produces that many dead people the same way?

DR. ROSE: A. Is that a question?

Q. Yes.

DR. ROSE: A. I don't know what….

Q. Troubling isn't it?

DR. ROSE: A. It is troubling.

Q. All right. So we would want to be satisfied that we had looked at all possibilities, correct?

DR. ROSE: A. Yes.

Q. Right. And you'd agree with me that one of those possibilities would be what Mr. Esquega talked about hypothermia, correct?

DR. ROSE: A. Yes.

Q. And you'd agree with me just as you stated in your report, how did you put it? "I cannot determine whether alcohol intoxication contributed to this death". You would also equally say you cannot determine how hypothermia contributed to Mr. Wabasse's death?

DR. ROSE: A. No, I would say I have no evidence…

Q. Fair enough.

DR. ROSE: A. …that hypothermia contributed to his death.

Q. But you'd also agree with me that indications for hypothermia vary quite extensively, don't they?

DR. ROSE: A. Yes.

Q. Yes and that in fact it's one of those, it's one of those conclusions that often escapes definition. There are some evidence of patterns in the stomach, but there are hypothermia cases where there are

not evidences of patterns in the stomach, agreed?

DR. ROSE: A. Yes.

Q. Right. So again, I put it to you and I'm asking you to be as objective as possible notwithstanding you never put it in these reports, I'm asking you to agree with me that you can't really determine whether hypothermia contributed to this death; isn't that true?

DR. ROSE: A. I think that's fair to say.

Q. Now, I have another question and this is the one I'm stuck on. There are actually injuries in the case of many of these youth and on their face there's somewhat superficial injuries and by that I mean, and I'm just going to run through them for you. In the case of - and I'm now dealing - I'm trying to sort of do apples and apples and I mean all of the respect in the world for the family of Paul Panacheese and the family of Robyn Harper, but I'm talking about the situations with the youth along the lines that I've just described. So those five deaths are different than the other two and I want to be fair to you because I don't want to ask questions that look like I'm balling it up. I have tremendous respect for all the families and there are different cases that call for different questions. I'm now addressing the questions with the findings in the river, okay? I need to understand something from you. In the case of these youth starting with Jethro Anderson, laceration to the left eyebrow, abrasion to the left lower lip, bruise with abrasion to the left lip. That's Jethro Anderson.

DR. ROSE: A. Just a moment, please.

Q. Okay.

DR. ROSE: A. Yes.

Q. All right. You'd agree with me that that's a superficial injury that on its - on, on - that just directly looking at it would not cause death, agreed?

DR. ROSE: A. Yes.

Q. On the other hand that's a superficial injury that could be entirely reflective of a physical struggle or assault, could be?

DR. ROSE: A. Could be.

Q. Right and a person who's vulnerable along the lines you've described, a person whose blood alcohol concentration is 233, who's lying beside the Kaministiquia River may have tried to put up struggle, but it might not be much of a struggle and they could be rolled into the river, yes?

DR. ROSE: A. It's possible.

Q. Right and I want to be clear and responsible as counsel for NAN to the jury and as an officer of this court, I have no evidence, I have no evidence for example in the case of Jethro Anderson that he was deliberately killed. We just don't know. We just don't know and I'm asking you these questions because there is a limit to the science you're offering today, isn't there?

DR. ROSE: A. I've already said that forensic pathology cannot distinguish based on pathology findings between drownings that occur by accident, as a result of suicide, or by someone else by homicide.

Q. In the case of Curran Strang, contusions to both knees, correct?

DR. ROSE: A. Yes.

Q. In the case of Reggie Bushie, multiple abrasions, multiple rashes, correct?

DR. ROSE: A. Hang on a moment.

Q. You can take my word for it. I'll undertake to you as an officer of the court that I'm….

DR. ROSE: A. Well, rashes are not injuries.

Q. Oh, fair enough, all right and multiple abrasions in the case of Reggie Bushie?

DR. ROSE: A. Just a moment.

Q. It's just I have this limited time for cross, so I have to make lots of undertakings to you so we can get through it fast.

DR. ROSE: A. Yes, multiple abrasions.

Q. Thank you. In the case of Jordan Wabasse there's an actual statement that they can't tell what the injuries are on the body due to decomposition, correct?

DR. ROSE: A. Yes.

Q. And I say that with all due respect and sympathies to the family of Jordan Wabasse and I've already referred to the eye brow abrasions to the lips et cetera for Jethro Anderson. Now, Kyle Morrisseau we discussed the fact that there are injuries to his shins and there was actually a story told that there was some suggestion that he was actually in an altercation before his death; isn't that right?

DR. ROSE: A. I believe there was.

Q. Yes. So we actually have an example of potentially assaultive behaviour, in other words, physical interactions with somebody before they end up in the river and we know that the examples of the assault don't produce injuries that readily tell us they're life threatening, right?

DR. ROSE: A. I'm sorry I don't understand what the question is.

Q. It was a terrible question. It's my fault. We have an example of someone who died in the river and was in a fight before they died in the river, correct?

DR. ROSE: A. Someone said that he was in a fight, yes.

Q. Yes. And we know what the injuries look like, correct?

DR. ROSE: A. Yes.

Q. Yes. And what it tells us is that injuries or assaults can lead to injuries of the most superficial nature, correct?

DR. ROSE: A. They can.

Q. Yes. And a person suffering - a person suffering from the blood alcohol concentration that these individuals were suffering from are particularly vulnerable in terms of their abilities to protect themselves, correct?

DR. ROSE: A. They are.

Q. All right. I want to ask you one last area of cross-examination and it really pertains to the question again of the limits of the science and what we really mean by cause of death, all right. A person dies, a child dies. This is an example out of this case, all right. It's a hypothetical I'm putting to you to try to understand what cause of death scientifically means. A child dies tragically because that child was simply deprived of the necessities of life. They weren't fed properly; they were abused, okay. Your cause of death would not say neglect would it?

DR. ROSE: A. Probably not.

Q. No. It would identify malnutrition, correct?

DR. ROSE: A. Yes.

Q. It would identify evidence of physical abuse, correct?

DR. ROSE: A. Only if there were injuries.

Q. Yes.

DR. ROSE: A. I would identify the injuries.

Q. Yes. And these would all be physical examples of what we say pathologically are causes of death, right?

DR. ROSE: A. I'm not sure - I'm sorry I'm not sure what the question is.

Q. Sorry physical examples of injuries that we say pathologically lead to death, correct?

DR. ROSE: A. Well, they were contributors to death.

Q. Fair enough. Nowhere in your cause of death would it say neglect, right?

DR. ROSE: A. Correct.

Q. Right. These youth actually died from neglect, didn't they?

DR. ROSE: A. Well, I….

THE CORONER: Actually Mr. Falconer….

MR. FALCONER: I'll withdraw the question.

Q. It's fair to say that this jury is charged with a much larger function than ascertaining an anatomical reason for the death of these youth, right?

DR. ROSE: A. Right.

Q. This jury is charged with actually looking at why these kids died, right?

DR. ROSE: A. Right.

Q. And they're charged with trying to make sure another child doesn't die, right?

DR. ROSE: A. Right.

Q. And when you look at a youth drinking alcohol it may be a canary in the mind to tell us the youth is in trouble, but that isn't the cause of their death is it, the alcohol is it?

DR. ROSE: A. From a pathological point of view the cause of death is the condition or the disease or the injury that that led to death. The underlying social conditions there, underlying social conditions for many cases that I see every day and I can't - that's not part of my pathology that I can address.

Q. And the neglect, the psychological starvation, the mental starvation, the emotional starvation, those aren't a part of your science are they?

DR. ROSE: A. Correct.

MR. FALCONER: Thank you, those are my questions thank you.

THE CORONER: Thank you, Mr. Falconer. And at this point Constable Murphy could you ask the court house if they could give us a few minutes leeway so we can see if we can finish off this evidence today, thank you. And who will be cross-examining next? Mr. Grover.

MR. GROVER: Thank you, Dr. Eden.

CROSS-EXAMINATION BY MR. GOVER:

Q. Dr. Woodall and Dr. Rose, my name is Brian Gover. I act for the Thunder Bay Police Service Board and the Thunder Bay Police Service and the

leadership current and former of the Thunder Bay Police Service. And Dr. Woodall I won't have any questions for you, but I will for you Dr. Rose and we've met before; is that right?

DR. ROSE: A. Yes we have.

Q. And Dr. Rose and I might say, together with my colleague Mr. Marrocco I act for those clients I've named. Dr. Rose, you used a term in the course of answering a question asked by Ms. Bryson where you referred to evidence-based literature which had resorted to in the course of forming your view concerning Robyn Harper and the concentration of alcohol in her blood. You said that she had a concentration of alcohol in her blood that according to the evidence-based literature can be fatal; did I get that correctly?

DR. ROSE: A. You did.

Q. And overall as a forensic pathologist you strived to use an evidence-based approach; is that fair?

DR. ROSE: A. Correct.

Q. And for the jury's benefit and a few of the seconds of my minutes can you please explain what an evidence-based approach is?

DR. ROSE: A. So evidence-based means when I give an opinion an interpretation, I wanted not to just be well I've seen it before or I'm an old pathologist and I've done a lot of cases. I want there to be some scientific background. So the first bit of evidence that I rely on is the evidence that I see at the autopsy. So there are things that I see and there's things that I don't see, so positive evidence and negative evidence, thinking about the kind of case considering what I know and what I expect to see. So that's the first evidence.

Then after I have gathered all the evidence based on what I see, what I see under the microscope, what I see when I read the toxicology reports then I think about the case and if I can then - sometimes there are cases that are straightforward in the sense that I'm already familiar with the evidence in the medical literature, sometimes I have to look up the medical literature to see what other pathologists and forensic pathologists have thought in similar cases and what they've published, so what they have written up in articles for me and other people to benefit from. So that's really the idea of evidence-based forensic pathology and it's the type of medicine that in the western world at least, doctors feel they should be practicing, that they want to do things for their patients and also for, in the case of forensic pathology for deceased people and their families things that are scientifically sound.

Q. Now, you were asked some questions by Ms. Big Canoe about cases where there was some evidence of blunt force trauma. Do you remember those questions that Ms. Big Canoe asked?

DR. ROSE: A. I do.

Q. And my colleague has been endeavoring to take good notes for me and he noted you as saying "There's no evidence that anyone has caused these injuries. The person either fell down or bumped into something or hit them and they got a scrape and a bruise. I can assure you they are not significant as having contributed to death". Did we get that down correctly, Dr. Rose?

DR. ROSE: A. You did.

Q. And when you say that you can assure that

these injuries were not significant as having contributed to death, what did you mean?

DR. ROSE: A. Well, everybody once in awhile has a scrape or a bruise or a laceration and unless you are extraordinary unlucky for example the laceration is to your scalp in a particular area where there's a big blood vessel, you get knocked out and you bleed to death, you're not going to die from any of those injuries. They're superficial and they're minor; they hurt and they may not look very nice, but they don't cause you to die. So that's really what I meant by it.

Q. And you were asked by Ms. Bryson about suspicious deaths and homicides. Do you recall being asked about that?

DR. ROSE: A. I do.

Q. And the question was asked about homicide and you gave a definition from a pathologist's point of view, you said it was where it was clear someone has died as a result of the actions of others; do you recall that?

DR. ROSE: A. I do.

Q. And would comprise a suspicious death for, for the purposes of the discussion you were having with Ms. Bryson?

DR. ROSE: A. So Ms. Bryson actually mentioned that one of the circumstances might be death in an uncontrolled environment, so outdoors. That would make it suspicious. It doesn't necessarily make it a homicide, but it is a case where people should turn their minds to the possibility of someone having done something to that person. Other circumstances would be more than one dead person at a scene at the same time for example. That would be suspicious, a young woman dead in a hotel completely

naked. That would be a suspicious circumstance. They won't all turn out to be homicides. Some of them may have natural causes, some of them may have accidental causes, but some of them might turn out to be homicides, but they are the kind of cases that people should turn their minds to ruling out.

Q. And I take it some of those cases will turn out to be cases where there has been no anatomical or toxicological case of death - toxicological cause of death; am I correct?

DR. ROSE: A. Occasionally, they might actually turn out to be that.

Q. And they may turn out be cases….

THE CORONER: That's five minutes Mr. Gover, so this is your last question. Sorry about interrupting you in the middle of it.

MR. GOVER: Q. They may turn out to be cases that are otherwise described in the last line on the PowerPoint deck; is that fair?

DR. ROSE: A. It's possible.

MR. GOVER: Thank you Dr. Eden.

THE CORONER: Thank you, Mr. Gover. Are there other parties that wish to cross-examine?

MR. WOJIECHOWSKI: No questions from the City, Mr. Coroner.

CROSS-EXAMINATION BY GREGORY TZEMENAKIS:

Q. I just have three quick questions if I may. My name is Gregory Tzemenakis. I'm counsel for the Attorney General of Canada on behalf of Aboriginal Affairs and Northern Development Canada. Thank you for taking the time to be here today. And my questions are

directed to Ms. Rose, to Dr. Rose, sorry and perhaps start with the simplest question. Have any of the questions put to you during cross-examination by anyone here today caused you to question the findings you've made in respect of these seven young people?

MR. FALCONER: I object to that question. That is so imprecise and so broad that if the witness even tried to answer it I would have follow-up questions on certain things that she said that clearly were inconsistent with what I saw in the report. You can't ask such a big question that nobody can figure out what the answer means.

THE CORONER: Well, I heard - actually, I'll allow the question and the witness can answer it. Did you hear the question, Dr. Rose?

DR. ROSE: A. What has happened today at this inquest has not caused me to change my mind about any of the causes of death that I wrote down.

MR. TZEMENAKIS: Q. And just by way of background then, how many peer reviews or autopsies have you personally conducted during the course of your career?

DR. ROSE: A. I've conducted more than 5,000 autopsies, medical/legal autopsies. I can't answer the question about how many peer reviews, but it certainly must be in the dozens, possibly hundreds.

MR. TZEMENAKIS: Thank you. Those are my questions.

THE CORONER: Thank you, Mr. Tzemenakis and any other party wishing to cross-examine? Okay. Members of the jury do you have

questions for these witnesses?
JUROR NO. 2: Dr. Rose, just to clarify, rigor, could you please tell me when it starts?
DR. ROSE: A. So the question is and I'm not sure everybody heard, when does *rigor mortis* start. Very
good question. I can't really answer very well, so it's one of those postmortem changes, one of those changes that naturally occurs in the body after death. It's stiffening of the muscles and it has a chemical basis because of chemical changes in the muscles. If you look at the books there's a nice curve where it starts and then it gets to its, to its strongest where it's hard to, to move the joints and the limbs and then it tapers off, but what that time course is, is very variable and in fact there are some cases where it happens basically right at the time of death. So usually it happens within a few hours to many hours, but again, if you'll remember one of the things that slow down decomposition is cool temperatures and by the same token cool temperatures slow down *rigor mortis*.
JUROR NO. 2: So that's what your variables would be, would be the cool temperatures?
DR. ROSE: A. So cool temperatures, also the temperature of the person themselves. Did they have a fever, were they at normal body temperatures, were they hypothermic when they

died, how well they're dressed, are they naked, are they full dressed for winter in Thunder Bay.

JUROR NO. 2: What could a variable be for somebody that was found in their home dead?

DR. ROSE: A. Whether the furnace was on and whether the windows are opened, whether they're wearing their underwear or whether they're fully dressed to go outside in the winter.

JUROR NO. 2: Dr. Woodall, we were wondering if in the case of Paul if you checked taurine and caffeine levels?

DR. WOODALL: A. Caffeine is something that we see on our general drug screen. We see on practically every case that we test for because so many people consume caffeine and even if they don't drink coffee it's in, you know soft drinks. We, we don't usually quantitate caffeine so unless there's a suspected case of caffeine overdose which is very, very unusual we see the presence of it, but we don't quantitate it.

JUROR NO. 2: And taurine?

DR. WOODALL: A. I'm not sure whether we would see the presence of it and we definitely don't quantitate it.

DR. ROSE: What was the second substance?

JUROR NO. 2: The taurine, something that would be found like in bread bowl.

DR. ROSE: A. Oh, okay.

THE CORONER: Okay, any other questions

members of the jury?
JUROR NO. 2: No.
THE CORONER: I have a couple of closing questions. First for Dr. Woodall, with respect to Robyn Harper I think counsel have asked and I understand you've answered that you don't have information about the - the extent to which Miss Harper was familiar with alcohol before her death. If the jury was to conclude on the basis of other evidence that she had little or no exposure to alcohol would that effect the likelihood that she had died of alcohol poisoning at that level?
DR. WOODALL: A. The more naive she is to alcohol the more likely that she would die of acute alcohol intoxication at that level. It's a significant amount of alcohol and somebody that wasn't tolerant to it could die even at lower concentrations in the ones that we detected in her sample.
THE CORONER: Okay, thank you. And for Dr. Rose, first, I think you'll agree with me that coroner's don't make findings of murder?
DR. ROSE: A. They don't.
THE CORONER: Okay, but coroner's can make findings of homicide?
DR. ROSE: A. Yes. That is listed in the *Coroner's Act* and that is among the responsibilities of the coroner.
THE CORONER: So some of the questions you were asked were about the potential relationship of superficial injuries to a

homicide scenario and what I'm wondering is whether the homicide scenario discussed would leave any injuries at all?

DR. ROSE: A. So I believe this was a hypothetical about someone possibly lying by the river under the influence of alcohol on a cold night maybe unable to defend him or herself and somebody comes along and roles him into the river. That may leave no mark at all and might look exactly like the drownings that we have here.

THE CORONER: So based on that, does the presence of superficial injuries or their absence help the jury at all in distinguishing between whether or not this was a homicide?

DR. ROSE: A. It, it really doesn't. For one thing many people have superficial injuries and under the circumstances being by the river at night, there's plants, there's trees, there's rocks, there's things that people can stumble against or bump into so that - and I did mention that none of the patterns of injury were the ones that we would be likely to see in someone who had been assaulted. Now, again, with the story, the hypothetical that I was given of somebody being rolled into the river that might not leave any marks at all, but there is nothing in the autopsies of any of these young people that would lead me to, to determine that someone had done something deliberately to

cause them to drown.

THE CORONER: Okay, thank you. Ms. Shea?

RE-EXAMINATION BY MS. SHEA:

Q. Okay. I just have one question Dr. Rose about the reports that you reviewed. There are a lot of questions in terms of what information the pathologist would have had at the time of conducting the autopsy, but I note even by looking at the index, the dates for the reports are quite a bit after the autopsies themselves, so it's not as if the pathologist is generating the report the day after the autopsy's been conducted and in one case I believe it was even four or five months afterwards. So what happens in between the autopsy being conducted because each and every report also was able to give a summary of the episode? Where would that information come from?

DR. ROSE: A. Well, I would think that in addition to the coroner's warrant that a police report or a police conversation was held between the pathologist and the, the pathologist and the police to give them a little bit more information that was present on the coroner's warrant.

Q. And I'm not going to go through all the reports, but is it normal for a police officer to be present at an autopsy?

DR. ROSE: A. Some autopsies, but in - but cases where it is a suspicious case or a known homicide we would expect the police to be there under the current guidelines.

Q. And what we can see from these reports is that the pathologist who conducted the autopsy itself

would have identified who else was present at the autopsy, so if a police officer was present that would be indicated on the report?

DR. ROSE: A. That's correct and I should just say that of course much of the determination of whether a case is suspicious or not comes from the police. They are the people who are doing the investigation and so for the, for the - in general terms in the majority of cases it is the police who determine that it is suspicious for a homicide. There are a few cases where it's the pathologist that determines it's a homicide. It was apparent at the beginning, but usually it's the police who say that it's, it's suspicious.

MS. SHEA: Thank you very much.

THE CORONER: Thank you very much Dr. Rose, Dr. Woodall and thank you members of the jury for your indulgence in doing a little past our time and Dr. Rose and Dr. Woodall you'll still be under oath and I expect that we'll be hearing further evidence from you for a degree of likelihood. Thank you very much.

INQUEST ADJOURNED (5:15 p.m.)

FORM 2

CERTIFICATE OF TRANSCRIPT (SUBSECTION 5(2))

Evidence Act

I, **Margote Tristan Olson,** certify that this is a true and accurate transcript of the recording of the Inquest with Jury on October 6, 2015, taken from Recording #2015-10-06-02-Eden

December 23, 2015

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Date

Margote Tristan Olson,
Certified Court Reporter/
Court Transcriptionist

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