INQUIRY RECONVENED: 2:33 p.m.

MR. MacDONALD:

The next witness then, My Lord, will be Doctor Naqvi. My Lords, I'll be dealing with a couple of statements that are contained in Volume 16 of the exhibits. I may be referring to Volume 13. That depends on whether there's reference to the evidence given by Doctor Naqvi from time to time, and also I've had marked and put in front of you Exhibit 53 and it's called Volume 24 but it's Exhibit 53. Those contain the portion of the Sydney City Hospital records with respect to Sandy Seale.

DOCTOR MAHMOOD ALI NAQVI, being called and duly sworn, testified as follows:

BY MR. MacDONALD:

Q. Now Doctor for the record, would you tell us your name sir?

A. Mahmood Ali Naqvi.

Q. And you spell you last name how?

A. N-a-q-v-i.

Q. You're a medical doctor?

A. I'm a certified general surgeon and a vascular surgeon.

Q. And when did you obtain those qualifications?

A. General surgery in 1968 and vascular surgery afterwards.

Q. And are you a member of any --

A. I'm a member of the American College of Surgeons. I'm the member of the American Board of Surgical Specialties and a Diplomate of the American Board of General Surgery and the Royal College of Surgeons of Canada and a Fellow of the Royal

College of Surgeons of Canada in Vascular Surgery and the American College of Gastroenterology, American College of Angiology and the American College of -- International College of Surgeons.

Q. Thank you. How long did you practice in Halifax -- or in Sydney?

A. I've been here in Sydney since 1969.

Q. Okay, and in particular, Doctor, in 1971 you were carrying on practice in Sydney?

A. That's right.

Q. And were the attending doctor on Sandy Seale when he was brought to the hospital on the night of May the 28th, 1971, early in the morning on May 29th?

A. That's correct.

Q. Do you have any at this stage, Doctor, any independent recollection of the events of that night? Do you have to refer to your notes to tell us what you did that night?

A. That's correct.

Q. You have no independent recollection?

A. The only thing is that ever since 1971 I have been in this Court or otherwise so many times that now I'd be reading my notes at least times and times and over and over again. So I know a lot of that what's going on. But otherwise generally speaking, no.

Q. All right. Let me ask you to look -- I've put in front of you

Exhibit 53. Perhaps -- these are the hospital records or copies of the hospital records and I'm going to show you page 22. Those are copies of the nurses' record. Is that something that's kept at the hospital, Doctor, in a regular fashion whenever a patient is admitted?

A. That's true.

Q. And it shows the time of admission at 12:15 a.m. Do you see that?

A. That's true.

Q. Now is that or do you know if those records are made at the time of the occurrence or are they made later on in the day?

A. They're made at the time.

Q. At the time?

A. Yes.

Q. So we can take it then that Mr. Seale was delivered to the hospital at or about 12:15 a.m. on that morning?

A. Based upon these records.

Q. Based on the records, yes.

A. That's right.

Q. But the records are made in the ordinary course of things, aren't they?

A. That's right.

Q. All right. And it shows that you were present -- does it say at "12:25"?

A. That's right.

Q. Were you -- do you recall how you received the notification to get there or were you already in the hospital?
A. No, I was notified but I can't tell you how.
Q. And --
A. Generally speaking what has happened if a -- if a patient is coming in the out-patient department and that patient is critically ill, the nurses do inform and tell you in advance the patient's coming in. So this is the way normal sequence is and that's -- in this particular case, I was informed the same way.
Q. And you live close by and were able to get there quickly?
A. Yeh, you asked me before. I only live a block out from the hospital.
Q. Okay, now there are other records that are kept, Doctor, and if you'll look at Volume 16 at page 159, those are copies of that page and following of Report of Operations. Those are prepared by you, is that correct?
A. That's right.
Q. And are those prepared at the time the operation is done or on the same day or can you tell me?
A. At the time of the operation is done.
Q. Okay, and then starting on page 163 of that same Volume, there are Progress Notes also noted to be made by you. Those are notes you make from time to time following surgery, is that correct?

A. That's right, that's right.
Q. Okay, can you help me also, Doctor, go back to Volume 24 that's Exhibit 53, that's the small volume. Here it is. Just generally going through that, the Doctor's Orders is that your hand-writing?
A. That's right.
Q. And those are orders that would be given as to what you want done with the patient, is that correct?
A. Yes.
Q. All right, can you just follow through with me and tell me generally what the other documents are. On page 3 what is --
A. Okay, this is Doctor's Orders. And this is my signature.
Q. On Page one, and two?
A. Page two is my signatures;continued Doctor's Orders.
Q. What's page three?
A. Okay, page three is Post Anaesthetic Condition. That's in the recovery room after the patient being transferred from the operating room.
Q. Okay, and page four?
A. Page four is the Anaesthesia's Record.
Q. Okay, and page five?
A. Page five is the same, the Recovery Room Post Anaesthetic Condition of the patient.
Q. And six is another report of the --
A. Anaesthesia.

Q. Anaesthesia. Seven is just a Consent to Operation?
A. That's right.
Q. Eight, more Doctor's notes, your notes?
A. My notes, yeh.
Q. Nine is the same thing?
A. That's right.
Q. Okay, what is ten?
A. Ten is Emergency Out-Patient Record.
Q. And is that made at the Out-Patient Department?
A. That's right.
Q. When the patient is brought in?
A. Yes.
Q. All right, what is eleven?
A. Eleven is the Admission and Separation form of the patient to the hospital. That is every patient when is admitted to the hospital they have to have an Admitting form for the purpose of hospital insurance commission --
Q. All right.
A. -- and also send -- serve as the Separation form at the time of discharge.
Q. Number twelve or page 12?
A. Consent to Operations.
Q. Is that something that you look after or is that done by the staff getting the consent?
A. At that time I really couldn't tell you; but it's a mutual

effort. Both the -- the paper work is done by the nurses but the doctor has to speak to the patients, all the patients' family and discuss what's going on, what is to be done; but -- just to take the consent and somebody has to witness, that -- the nurses do that.

Q. If you look at page seven again, seven and twelve, they're both Consents to Operation dated the same day -- seven --

A. Yes.

Q. Number seven or page seven refers to the type of operation as a "Laparotomy" and number twelve doesn't refer to anything?

A. Yes, sir.

Q. Any reason for that?

A. Because at that time we didn't know what we were going to do with him and I think this is the second Consent, I believe.

Q. The second Consent being the one --

A. Yeh, because at that time we had to go both to control his bleeding from his chest as well as from his abdomen.

Q. Okay, and for the record, Doctor, when you say this one is the second operation, that's the one on page twelve? Is that correct?

A. Well, it was one of them I can't be sure.

Q. What's on page thirteen?

A. That's another Out-Patient Record.

Q. And fourteen is a laboratory -- fourteen, fifteen --

A. Yeh, that's Laboratory work.

Q. And that's fourteen through twenty-one.
A. Fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, all the Laboratory Work.
Q. And then twenty-two through twenty-seven are the Nurses' Records?
A. Yeh, that's right.
Q. And twenty-eight is the Record of Death?
A. That's right.
Q. Thank you. All of these records are kept in the normal course of things, is that correct?
A. Yes.
Q. And they're then retained on microfilm, I think, at the hospital?
A. Yeh, like you have this O. R. Report, that must be from the microfilm because it's thinned out.
Q. Okay.
A. But my own copy is the full report.
Q. Your own copy that you have in your file is just --
A. Yeh --
Q. -- a different style?
A. -- just a different type, yeh, that's right.
Q. All right. Let me -- when the -- if we can go to your report then, Doctor, and we'll come to the others as, as necessary. Mr. Seale was brought into the hospital at 12:15 according to the Nurses' Record on page twenty-two.

when he arrived; but when you saw him first, he was in a state of shock, is that correct?

A. That's right.

Q. And he had no blood pressure?

A. That's right.

Q. And what is the state of shock?

A. Well, shock is a condition that when the person has -- loses his blood pressure, his pulse goes very fast, he does not get the oxygenation and his heart fails;whether it fails because the heart is not getting enough blood or whether it fails because it's own pumping action fails and/or whether the heart is -- or the patient is losing blood or fluid from his own system that there isn't enough blood or fluid coming to the heart to pump back to the system. So the shock is defined as a condition or state -- condition which resulting due to poor tissue profusion, poor oxicidation, lactic acidosis and respiratory failure. And those circumstances it could be a either a cardiogenic shock or it could be a hemorrhagic shock or a shock due to massive fluid loss. Cardiogenic shock what we typically see patient who has a coronary and he gets into shock and he is sent to the coronary unit. Whereas the shock due to massive blood loss and the fluid loss is what we call hypovolemic shock where the pump although it's good; but there isn't enough blood coming to the heart to pump back through the system.

Q. Now this patient was in shock because of massive blood loss, isn't that correct?
A. That's right.
Q. And you would have known that from the time you first saw him?
A. That's right.
Q. Okay, how does one suffer massive blood loss? What has to be happening inside to have this massive blood loss occur?
A. Well, the massive blood loss could be either an external blood loss or could be an internal blood loss. An external blood loss where you have a broken bone or an open fracture, open wound and the patient -- an open artery -- the patient bleds out. An internal blood loss where the patient will have a bleeding inside the system itself.
Q. Does it have to be an artery before you're going to have massive blood loss?
A. No, it could be -- it could be a vein.
Q. It could be a vein?
A. It could be a vein or it could be a conglomeration of veins -- four or five put together or it could be a multiple of small arteries or it could be major internal fracture where there is blood accumulation pools into the closed spaces.
Q. Did you have any idea of what this massive blood loss was being caused by before you went into the body?
A. Well, in this particular case there was -- there was a very

obvious injuries and if I can refer back to my notes.

Q. Please do, yes.

A. Yeh, if I refer back to my notes, it's obvious injuries on your own hospital record --

Q. What page are you referring to, Doctor?

A. Volume 24, page eight at the time he arrives --

Q. Page eight?

A. Page eight -- I think it's eight.

Q. Thank you.

A. Eight and nine. And actually the way it should read:the nine should be eight and the eight should be nine.

Q. Is that right, okay?

A. The history comes first and the examination comes afterwards. It just -- so we can go back to nine first and then come back to eight.

Q. All right, tell us then what's of importance on nine there?

A. Okay, at that time it was important

> Admitted as a result of a stab wound of the abdomen.
> Patient no past history available.
> He was brought to Emergency room by Police as a result of the stab wound to the abdomen.
> His present illness:
> Started few hours ago when patient was stabbed into the abdomen.
> No other history obtained.

Because we could not find -- get any other history and this was just the circumstantial history.

Q. Can I just -- before we turn to page eight.

A. Yes.

Q. When it says:

Started few hours ago

What does that refer to?

A. It refers to circumstantial history -- who so ever brought him in. And we were told that this happened within the past few hours.

Q. Someone would have told you that?

A. Somebody must have told at that time, yes.

Q. You couldn't tell that from looking at the boy?

A. No.

Q. Okay, all right. And then you go back to page eight, then?

A. Yeh. At page eight at that time he was pale, he -- you could not get his pulse, he was cyanotic it means again poor profusion, poor oxygenation, he was restless, he had difficulty breathing and obviously this is all signs of shock -- the state of shock.

Pulse could not be recorded. His blood pressure was 0/0.

Q. That means -- that's no blood pressure?

A. That's right.

Q. Okay.

A. Respiration was 36 a minute

Normally the respiration would be twelve to fifteen. His

Conjugativa was pale
His trachea was mid line
His respiration was shallow
His both lungs although move on respiration
No obvious site of injury into the lungs
Heart, pulse could not be recorded. Blood pressure could not be recorded. Bowel is lying outside the abdominal wall with profuse bleeding and markedly dusky in colour
Profuse bleeding from the side of the stab wound.

Q. So the profuse bleeding --

A. So his bleeding was obvious right there at that time.

Q. At the external --

A. From that bowel, yes.

Q. Okay, and with no blood pressure being able to be obtained, is that indicative that that there has been massive blood loss?

A. That's right.

Q. Would that be the -- at that stage before actually going in and having a look, would that be your view of the life threatening problem that you have there that you have a massive blood loss occurring?

A. Well, in fact according to this note, the boy now for all purpose was dead.

Q. When he was first brought in?

A. Yeh, just about, yes.

Q. Okay, but in any event the -- if he was it was because he

bled to death, is that correct?

A. Yes, yes.

Q. And if you're going to save his life, if there's any chance, you're going to have to stop that blood loss?

A. That's right.

Q. So what actions did you take then? Where do we go to next?

A. Well, you can go to next resuscitation --

Q. What page are you looking at now, Doctor?

A. Maybe you could go to the nurses' notes.

Q. Yes, okay, page twenty-two.

A. Yeh.

Q. Twelve twenty-five, you're shown as being present. I think that says 12:25?

A. Yeh, 12:25, yes.

Q. Yes, and what is --

A. Well, we started -- he started getting into resuscitation and he's got fluid replacement right away. He's got four units of whole blood given & cross- matched. He's got 1,000 cc's of fluid given again. Another 1,000 cc's of fluid is given. Another 1,000 cc's of fluid is given. Another 1,000 cc's of fluid. Whole blood again given; 500 cc's. This is all done within a span of -- okay, it's got 12: --

Q. He's transferred to the --

A. it's got 12:25 --

Q. At 1:20 he's transferred to the operating room as I read the

nurses' notes, is that correct?

A. Okay, "transferred to the O. R." that's right. So what was given in that span of -- he has has received lots of blood he has received fluids and by this time he was transferred to the operating room. That's right.

Q. Now perhaps just for my own benefit, why would there be a delay of approximately an hour from the time he arrives in an obvious state of shock from loss of blood before he's taken to the operating room?

A. Well, it's very simple and nobody will anaethesize a person without the blood pressure.

Q. Without blood pressure?

A. Yeh.

Q. Okay.

A. So you have to -- you have to give him enough blood to see if he has any blood pressure, otherwise as soon as you anaesthesize, you're anaesthesizing a dead body.

Q. I'm sorry --

A. You're anaesthesizing a dead patient.

Q. Okay, thank you. So it was necessary to build some blood pressure up before you can operate?

A. Anaesthetate -- you resuscitate to a level that you could take him to the operating room and work on him.

Q. Okay, so then do we now go to your report of the operation as the next record that we would look at?

A. That's right.

MR. MacDONALD:

And my Lords, that page 159 of exhibit 16.

BY MR. MacDONALD:

Q. Now this is something -- the report of the operation you say would be prepared relatively soon after the operation, is that correct?

A. It's prepared within the -- before you leave the operating room.

Q. Thank you.

A. That --

Q. How's that done, Doctor, is it done through a machine or do you write it out?

A. Traditionally you use the dictaphone. There's a dictaphone in the operating room where after you've finished the operation you go to the dictaphone and you dictate the operations. They are -- those tapes are picked up by the medical records and the medical records transcribe the tapes on their next working day.

Q. Okay.

A. This used to be at that time. Today all you have to do is when you finish the operation, there's a certain number you dial -- you dial this certain number and that's automatically you can dictate a medical record. They pick them up right away.

Q. Okay, do you or did you follow the practice in those days of requiring a Consent to Operate before you would operate?

A. Oh, yeh, you always do that.

Q. Pardon.

A. You always do that except in situations where there is a life and death situation.

Q. In this case the nurses' notes indicate that the father's consent was obtained when he was transferred to the O. R. Are you able to say whether you were waiting for that before you would operate?

A. No, I think -- I think we took him to the O. R. -- I can't tell you what nurses' notes says but we generally if there is -- if it is any chance that we could save the boy, we take him to the O. R. Whether the father was there or not there at that time.

Q. Thank you. Now if you go to your report, it has a "Pre-operative Diagnosis" and a "Post-operative Diagnosis" at the top?

A. Pre-operative would precede. Post-operative;what we see after we finish the operation inside the abdomen.

Q. Are they both done though after the operation? Both the Pre-operative and the Post after you've done your operation?

A. In this record they are but you have a Pre-operative Diagnosis when you take the patient to the operating room.

Q. Okay, and then it says the "Name of the Operation".

A. That's right. So you have to tell what you have done to

that patient. And that's the "Name of the Operation".

Q. All right. Now let me just take you -- we'll go through the report if we can, then we'll perhaps come back to your "Post-operative Diagnosis".

A. Yes.

Q. The

> Name of Operation:
> Laparotomy, repair of the superior mesenteric vein and ligation of the branch of the middle colic artery and a transverse colostomy.

A. That's right.

Q. What does "Laparotomy" mean?

A. "Laparotomy" simply means opening the abdomen.

Q. Okay. And what is the "Superior mesenteric vein"?

A. The "Superior mesenteric vein" is a vein that drains the blood from the small intestine to the portal circulation.

Q. Veins are always draining blood, isn't that correct?

A. Yes.

Q. And arteries are delivering blood?

A. That's right, artery always supplying and vein always draining. Except in case of the bowel it is the "superior mesenteric vein" drains into the portal system where they take all the nutrients to the liver.

Q. All right, let's go on now

> Patient was brought in from the emergency room in a state of shock with no blood pressure,

> no pulse and with rapid respirations who was pale.

We already looked at your notes to show where that came from.

> Patient was prepared after giving three IV's and giving four units of O positive blood in order to bring pressure, however, with no luck

Now do I take it that to mean that you were not able to bring any blood pressure up in your patient dispite giving him blood?

A. That's right, well, what is meant is very -- it hasn't come up to a very acceptable range of the pressure; but there was some pressure at that point. If you go back to the notes of the Anaesthetia in your small book.

Q. Right, show us where to look there.

A. Pardon.

Q. Where? Where -- page four, I think, and five are the --
A. You showed me two anaesthetic records. You showed -- go back to the first one.
Q. Okay. I think it's page four. Is that correct?
A. Now -- okay, here we go. This is page four.
Q. Yes.
A. Okay, the pressure is still at the time he was brought into the operating room was fifty. Now fifty is not an acceptable pressure to put anybody to sleep but with that much resuscitation, you hope that you can -- you are able to stop the bleeding and perhaps this will bring the pressure back up again.
Q. Okay, and for the benefit of everyone that can't see, you've turned that book on its side and you're reading up the column that has ten up to two hundred and where there's a mark on fifty
A. That's right.
Q. That would show his pressure when he was brought into the operating room, was it?
A. That's -- that's the blood pressure. That's right.
Q. And as you read that along, at one time during the operation, it jumped up to around eighty or ninety and then at the end of the operation, it's back around forty. Is that correct?
A. Yeh, that's right.
Q. Okay, so with a fifty blood pressure, you -- it was serious enough that you were going to go in and try and do what you could. Is that correct?

DR. M. A. NAQVI, by Mr. MacDonald

A. That's right.
Q. Okay. Now you say that an incision above and below the stab wound was made and this was converted into a paramedian incision. What does paramedian incision mean?
A. A paramedian incision is any incision you make at the right of the belly button or left of the belly button about half an inch to a three-quarter of an inch away from it is paramedian. An incision which you made above the belly button and below and in the centre or the mid-line is called the mid-line incision so it all has to do with the belly button.
Q. All right, are you able to tell from this description whether the stab wound would have been vertical or transverse?
A. Vertical.
Q. Vertical.
A. Yeh.
Q. The running up and down the body?
A. That's it.
Q. There was only one stab wound, wasn't there?
A. According to my notes, there was but one stab wound. That's all.
Q. You have no recollection of any other? Okay, we go along and say "there was a tear into the mid-transverse colon and there was free spillage of fecal material into the peritoneal cavity." That is a cut in the intestine, is it, and the --
A. That's right. That's the large --
Q. Causing the fecal to spill in.

A. That's the large intestine.
Q. Now you next says -- would you tell us what that means: "a hugh retroperitoneal hematoma"?
A. Well, the abdominal cavity is divided into two parts, one is intra-abdominal, one is extra-abdominal. The intra-abdominal is the structures of bowels and so on which were all injured in this particular patient. And the extra-abdominal is the aorta and the vertebra, the bones in the back, and the pelvic structures, kidneys, uterus and so on and these are all covered over with the peritoneum. So anything that's injured behind that, we call the retroperitoneum or the retroperitoneal hematoma that's a hematoma behind the peritoneum. That could conceivably involve any of the retroperitoneum structures.
Q. And a huge hematoma -- a hematoma is just a collection of blood. Isn't it?
A. That's right, yeh.
Q. A huge hematoma in that area would indicate that there's some damage to either to the arota or the -- or one of the veins in that area?
A. That's true.
Q. Now you say: "Although the aorta was palpated and as it appears pulsatile..." What does that mean, "the aorta was palpated"?
A. These are the lights of the patient.
Q. Pardon?
A. It means he was still alive, and there was still hope that we

could salvage him.
Q. Does it mean that the aorta is actually pumping?
A. Yeh.
Q. Okay, and you say "but this was probably secondary to a stab wound into the aorta..."
A. Yes.
Q. So you suspected there was a stab wound into the aorta.
A. Well bascially what I have said here and what I mean although the aorta was palpated and as it appears pulsatile but this probably was secondary to the stab wound into the aorta which was sealed off into the retroperitoneal space. So I felt there was an injury -- the aorta was injured but because it was pulsating, we didn't do anything with it.
Q. The aorta as I understand it is the major artery in the body.
A. Yeh.
Q. What would be the diameter of the aorta in an adult male?
A. Anything -- anything up to two centimeters is the normal.
Q. Two centimeters would be the normal?
A. Approximately two centimeters.
Q. Okay, and it's the -- the wall of the aorta, is that fairly thick?
A. No, the wall of the aorta is elastic, just like a real elastic. It's thicker -- a lot thicker than the vena cava.
Q. It's a lot thicker than the vena cava.
A. Yeh.

Q. Well, the fact that it's pulsatile, I don't understand why that would lead you to conclude that the aorta has some -- that the cut is sealed off. Is that what you're saying?
A. Well, we call -- what we call is a pulsating hematoma. If we a hematoma around a major vessel and it's pulsating, we know that the major vessel has communication to that hematoma and that's what this applies to.
Q. Well wouldn't it be pulsating by just pumping, pumping blood out into the hematoma, just adding to the amount of blood there?
A. Yeh, but the blood is -- the blood could be tempanaid (?) at at that point.
Q. Could be what?
A. Bleeding could be stopped at that point.
Q. By what process? That's what I'm trying to find out?
A. Due to pressure from the paritoneum outside.
Q. So that the pressure of the blood itself is pressing back somehow and sealing off the --
A. Yes.
Q. Even though you've got that great pressure from inside the artery?
A. Yeh.
Q. That was your conclusion, was it?
A. Yeh.
Q. Okay. You say this hematoma "was not touched with a fear of a bright bleeding already present into the peritoneal cavity." What does that mean?

A. Well, obviously you have a patient with a blood pressure of forties and fifties who is in a state of shock, has got so many other injuries, we are trying to resuscitate him. We're giving him a lot of fluid,so what we were trying to do at that time whatever we could do and see if he could be salvaged. And because of so many other bleedings, he could be dead on the table just the same,so we didn't touch anything which wasn't really actively bleeding. In this particular case, the aorta was tempanaid with the peritoneum so we didn't push that way.

Q. So you concluded that you weren't concerned at least immediately about the possibility about the blood continuing to stay in the aorta.

A. We were concerned but we were concerned to stop the bleeding which was just freely bleeding already.

Q. So you went on to fix up other veins that were bleeding in the area that you could see.

A. That's right. Well, either that or those veins if you -- if you didn't do that, it would have caused gangrene of the bowel just the same.

Q. If the aorta had been cut by the knife going through, would the knife not had to have gone through this membrane that you talked about?

A. Yes. Yes.

Q. Why wouldn't it be gushing out through there if it was under pressure?

Q. Well quite often the arterial bleeding seals off. Venus bleeding does not seal off. The artery has not only an elastic structure but also produces enzymes and in -- within their own system that the arterial wall and itself closes up and we see this sometimes in the major injuries of the legs, the lower extremities that although the leg is crushed when the patient is brought in, artery is exposed but plugged with clot right at the very end.

Q. Any -- I didn't make myself clear. I'm talking about that mebrane that you said there was a huge hematoma behind it sufficiently pressurized that it's going to close off the cut in the aorta but my concern is the membrane itself. Wasn't that penetrated by the knife too?

A. Yeh, that was very, very small opening and a very small opening seals -- seals itself.

Q. So it would seal itself? Yes?

A. Yes.

Q. Thank you. All right, you did a colostomy on Mr. Seale. Is that correct?

A. Yes.

Q. And then that is taking what, the large bowel outside and leaving it outside?

A. That's right.

Q. You note that there was a large amount of blood into the stomach. You didn't open the stomach, did you?

DR. M. A. NAQVI, by Mr. MacDonald

A. No.
Q. How could you tell there was blood in the stomach then?
A. Because he had a tube in the stomach and the tube was bringing out the blood.
Q. The tube was -- so what you do is feed a tube down through the nostrils, is it, to the stomach?
A. Yeh. Yes.
Q. And blood was coming out of there?
A. Yes.
Q. Where would the blood have gotten into his stomach?
A. The stress.
Q. Stress?
A. Yeh, stress. Any major trauma can cause a chain of reaction into a body, specially given the stress factor where people will have multiple -- develop multiple ulcerations, superficial ulcerations and they will bleed into the gastroesoph tract which is the common place for the bleeding. You see this phenomena happen in a patient who will receive transplantations or so on and post-operatively they will be -- they will have difficulty in breathing and then they will have these ulcerations. This is the phenomena we suspected here.
Q. So it's caused just by stress of the trauma that he suffered.
A. Yeh.
Q. Now you say the bowel was placed in the peritoneum cavity which again could not be -- what's that say, placed because of this

huge hematoma occupying the entire adbominal cavity?
A. Yes.
Q. I don't understand that. It says --
A. Well, the hematoma --
Q. -- it was placed but it couldn't be placed. What does that mean?
A. The hematoma was in the back but of course it takes some space and that is space between a sort of compromise into the abdominal cavity space and so what happens is when you -- when you try to put the bowel back, the space -- the abdominal space becomes quite tight and that's what happened here, although we were able to put it back. It was just a matter that it was difficult to put it back.
Q. Okay, I just have trouble, I guess, with the way it's written. It says the bowel "was placed" which again "could not be placed".
A. Yes. Yeh. I mean we did put it back. It just was difficult to put it back.
Q. Okay. That huge hematoma you're talking about is the one that we talked about before, is it?
A. Yes.
Q. And on the page -- the next -- the final page of your report, the first report, you say the patient in spite of all of this has not had any urine output and he was transported to the recovery room having received over twelve pints of blood to combat --

A. Hypovolemia.
Q. What is hypovolemia?
A. Blood loss or fluid loss.
Q. What is -- how many pints of blood are in a normal -- in a male of a hundred and fifty pounds?
A. Maybe ten. It depends.
Q. It depends so he's already had his blood supply completely replaced. Is that correct?
A. Yeh.
Q. And more than that.
A. Yeh.
Q. A couple of pints beyond that?
A. Yeh.
Q. And then he was closed up and sent back to the recovery room.
A. There's other thing happens. When you replace that much blood and the entire clotting mechanism is altered, so blood does not clot in the person. That also takes into consideration for bleeding from other non-injured sites or unrelated sites like blood in the stomach in this particular patient because the bleeding -- blood does not clot any more once you give them that many transfusions.
Q. If you go back to your post-operative diagnosis, Doctor, on page 159, you say "stab wound of the abdomen with perforation of the colon, tear into the medacolic artery, tear into superior mesenteric vein, huge retroperitoneal hematoma with possible tear into the abdominal aorta." The abdominal aorta

is the one we're talking about and it runs down the backbone, doesn't it, or just to the left of it?

A. Yeh.

Q. So when you finished this operation, you -- there was a -- knew there was a possible tear into the abdominal aorta.

A. Yeh.

Q. But you -- you were under the impression that it was sealed off by the pressure. Is that correct?

A. Well, we wanted to see how the patient behaved, how he was -- how -- what was going on with his vital signs. He -- as I mentioned here there was no urine output, his kidneys weren't functioning, his blood pressure still was low.

Q. What's all that -- what does that indicate to you?

A. It indicates his major -- major systems failed and --

Q. Well, why would they have failed?

A. They failed because he bled to death. I mean he bled to a level where he had no -- he didn't have enough blood pressure to maintain --

Q. So he wasn't -- he wasn't getting blood to these vessels?

A. That's right. He didn't have enough blood pressure to maintain his profusion of his kidneys.

Q. And when you -- when you finished the operation, he still didn't. Is that correct?

A. Up to that time, yeh.

Q. Well, wouldn't that have indicated to you that perhaps you

should have looked at the aorta then, gone in and see if in fact it is sealed off?

A. Oh, I -- there's no question I did but I had to make some preparations before you could do that.

Q. What preparations did you have to make?

A. One of the preparations is when you have such a big hematoma, you have to prepare to control the bleeding. If your bleeding is not controlled, you lose the person on the operating table; therefore I had to prepare more blood for him. He'd been in the hospital only for a few hours and already we had so much blood and we -- you know, once the aorta is injured and you open that injured aorta, each minute the whole volume of the blood from the heart goes through, so we had to have blood. We had to have the operating room prepared for the -- the opening of the chest just in case we had to go to the chest but and also see if there is any response to him.

Q. Any response to what?

A. Any mental response to him.

Q. So are you saying that you would have liked to go in and see if the aorta could be corrected or sealed up when you were doing the first operation but you didn't have enough blood or you didn't have the necessary preparations.

A. Well, you also have -- would -- under the circumstances that's the best you could do at that time, and hoping that if it doesn't stop, you still have to bring him back and if -- if it

tempornized -- it means if it stops temporarily, it will give you time to build him up.

Q. But surely, Doctor, this is a life-threatening injury, the fact that the blood is pumping out. It's not getting to the other organs. Yes?

A. The blood was going through the aorta.

Q. But it wasn't getting to the other organs. I think that's what you said, that the -- all these external signs would indicate the organs are not getting blood.

A. That's right.

Q. Well, doesn't that indicate to you that the aorta is separated and the blood is not getting to where it should be getting and the fact that you only have forty blood pressure when you're through?

A. I don't think anybody would even today in this day and age would operate upon anybody with forty blood pressure.

Q. No, but you did and I'm not criticizing you for doing that.

A. And basically this is what happened there,so in order for me to carry on, we needed more blood, we needed more fluid, we needed more things so since I go back to -- since at that time when we brought him back, we had -- we did some of his hemaglobin.

Q. And what are you looking at now, Doctor, just so we can all see what you're --

A. Seven-thirty a.m., he's brought back from the operating room.

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Q. Okay, that's fine. I just wanted to know the notes so we can all see the same thing.

A. Okay. Seven-thirty a.m.

MR. MacDONALD:

And that's on page, My Lord, -- that is on page 163 I believe of or 164 of Volume 16.

BY MR. MacDONALD:

Q. I believe that's the one you're looking at, Doctor, okay.

A. What I'm looking at is we did enough to see if we could temporize him and we brought him back. And at that time, my notes says his hemoglobin was eleven grams. That means we have replenished a lot of his blood that he has lost which was a good sign according to ourselves.

Q. Well, let's just go through your note here, Doctor, and you can explain this to me.

A. Yes.

Q. It says: "Patient did regain some consciousness. There is free bleeding through the Levine tube.", is it? That's the one you talked about that went through the nostrils down into the stomach?

A. Okay, which one are you going to?

Q. I'm reading that one that you've just referred to.

A. Yeh, okay.

Q. I think so.

A. Yeh, "There is free bleeding through the Levine tube.". Yeh.

Q. That indicates that there's still stress bleeding in the stomach. Is that correct?
A. Yeh, that's right, yeh.
Q. Free bleeding. Would that indicate that that's a free flow of blood into the stomach? It's continuing to go in there?
A. Pardon?
Q. What does "free bleeding" mean? Does that indicate that --
A. It means every time you -- Free bleeding means that you aspirate the Levine tube or the nasal-gastric tube and you get the blood in the stomach.
Q. When it's free, does it mean it's there all the time? That's what I'm trying to find out.
A. Yes, it does, yes. Just about, yeh. Just about.
Q. Okay, so it's like a flood of -- a continuous flow of blood through that tube from the stomach?
A. That's right. Yeh.
Q. And that because of -- you indicated that because of the stress due to the trauma he received.
A. Yes.
Q. Okay. The dressing was saturated with blood. Now that's the dressing, I take it, around the colostomy.
A. Abdominal -- yeh.
Q. Which would indicate that there's free bleeding from the incision. Is that correct?
A. That would indicate that he probably has now clotting problems,

problems that his blood is not clotting because he's got a bleeding from the stomach. He's got a bleeding from his dressings. He's got a bleeding from his wound. We have replaced all his total blood supply and now all the clotting factors are now altered so he's got bleeding from all over.

Q. But you said in your notes that this was bleeding from the retroperitoneal space. That's the hematoma that you talked about.

A. Yeh.

Q. I take it and you tell me if I'm incorrect that that sentence says the dressing is saturated with blood which is coming from that hematoma. That's what that sentence says.

A. "The dressing was saturated with blood which again was no alternative because this was bleeding..." Yeh, I guess that's -- that's possible. That's what it says.

Q. Well, that's what you said.

A. Yeh.

Q. So you're opinion at seven-thirty in the morning was that the dressing was saturated because the hematoma was continuing to bleed.

A. That's right.

Q. There has not been any urine output.

A. Yeh.

Q. Now that -- I indicate -- I understood you to say earlier that would indicate that the body isn't getting the fluid

and is not getting the blood supply that it needs.

A. That's right.

Q. So he's still not getting the blood supply that he needs at seven-thirty in the morning. Correct?

A. True.

Q. Now you repeat that there's a large amount of bleeding through the Levine tube and then you talk about the last hemoglobin that shows a particular reading. That was an encouraging sign, was it?

A. Yeh.

Q. Thank you. Can I just go back for a moment? Someone pointed out to me and I want to get your help on this, on the -- on the records of the anaesthetist, the time says nine-fifteen, does it not, up at the top? That's probably -- can I take it that that is the second operation, the one that took place in the morning?

A. I would think, yeh.

Q. Okay, if we go to page --

A. Okay, just go back to the other.

Q. If we go to page six, yeh.

A. Yeh.

Q. Okay. That isn't showing as I read page six, that's the first one. He's in shock. He's not showing any blood pressure there, is he?

A. Not here.

Q. Throughout the operation no blood pressure.
A. Not here.
Q. According to the records of the anaesthetist.
A. That's right.
Q. Thank you. The -- Can we go back to the nurses' notes, Doctor, and you can just -- That's on page 22 of this exhibit 53. As I understand, he was transferred to the O.R. at one-twenty in the morning and he was brought back at -- is that five a.m.? Is that what it looks like to you, that he was brought to the recovery room?
A. Could be five, could be three. I can't -- it's hard to tell. It could be five.
Q. I can't tell either.
A. It could be five. It's five a.m.
Q. The type of operation that you performed and we've just been through, is that something that would take three to four hours to perform?
A. It can take eight hours. Other places take eight hours.
Q. Okay, so I mean it's no unusual that it be five o'clock. Is that correct?
A. That's right.
Q. Thank you. Now he continues to get a whole lot of blood as I see it and at five a.m., does that say -- perhaps I'll show you and you can help us out. This report here, Doctor.
A. Blood, yes.

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Q. And how many cc's is that talking about?
A. Five hundred.
Q. Five hundred cc's. How many cc's in a unit?
A. Five hundred.
Q. And there's ten units of blood in a body approximately? Is that correct?
A. Ten units, yeh. I say maybe less.
Q. Maybe less than ten units.
A. Yeh.
Q. Okay, so he -- at five o'clock, five hundred cc's of whole blood and then if you go over --
A. Just a minute now. Just keep -- stay there.
Q. Okay, thank you.
A. At that point, at that point at five o'clock he came from the operating room, his blood pressure was ninety over sixty.

Q. Yes. Okay. Thank you for pointing that out.
A. And his pulse was a hundred and twenty so that was an encouraging sign that we did something right.
Q. Okay.
A. Because he is getting a little better.
Q. All right. Now let's just continue on.
A. Yeh, and then here is "Levine tube irrigated by Doctor Naqvi", so I did my own irrigation for the same reason, because of the bleeding. "And connected to the Gomco Catheter from the operative site connected to drainage bag".
Q. And then if you go to the next one, in fact, his blood pressure gets to one hundred and four over sixty?
A. A hundred and four over sixty, so it's still a better sign that he's getting a little better.
Q. Okay.
A. Okay. Then here: "Starts bright drainage from the abdominal dressings".
Q. Yes.
A. Okay. That's the time the family visited. "Family visited", and still the blood pressure is ninety-four over -- ninety-four over fifty and the pulse is a hundred and forty and the blood pressure has now dropped from ninety-four to seventy, and that's at five forty-five a.m.
Q. So that's forty-five minutes after his return to the Recovery Room?

A. That's right.
Q. His pulse is dropping and his -- His pulse is rising and his blood pressure is dropping?
A. That's right, but he got some more blood here, five hundred cc at five forty-five a.m.
Q. So again that forty-five minutes later he's -- he's already consumed five hundred cc's and he's getting more?
A. Yes, and from seventy it goes to sixty at six-twenty.
Q. Yes.
A. Okay, at six-thirty he's still sixty and by -- I think by seven the blood work's done and the gastric output, and by seven -- seven to three, this is a new shift that came on at seven o'clock, the blood pressure was a hundred -- the blood pressure was sixty.
Q. Yes.
A. And:

> Abdominal dressing changed by Doctor Naqvi. Large amount of bright blood . Serile dressing applied . 500 cc of blood given by Doctor Naqvi. "Blood pressure was sixty .

At this time he was taken back to the O.R. again.
Q. He was taken to the O.R. at nine-ten in the morning?
A. That's right. Yeh.
Q. But that's some four hours after he was returned to the Recovery Room?
A. By this time he had -- had not -- That's right, yeh.

Q. Okay, and that's -- You then are going to do a second operation. Now in the meantime had you obtained all this extra blood supply and so on that you wanted to have available for this second operation?

A. The second operation is there. We took him up because what happened is when his blood pressure continued to drop, it was a systolic blood pressure of forty to fifty and we did open up his abdominal incision of course.

Q. Perhaps if we can -- Just before we get to that, your post or pre-operative diagnosis this time is that there is an aortic laceration of the abdominal aorta. Is that correct?

A. Yes.

Q. That's what specifically you are going in to repair?

A. Yeh.

Q. Okay. The small valve is violaceous. That's colour indicating that it's not getting blood. Is that correct? Yes?

A. Yeh.

Q. And the colon was already violaceous?

A. Colour indicating that it's not getting blood and perhaps the blood is not draining away from the bowel to the -- to give poor circulation.

Q. Okay. "The bowel is retracted and the hematoma in the retroperitoneal space was extended considerably since last night at first exploration". Now that, as I understand it, is saying that it's much bigger now.

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A. Yeh.
Q. And is that because the blood that you've been pumping in to --
A. Because his pressure went up so he extended out.
Q. Yeh. So as his pressure went up -- if you increase the blood pressure and you have an opening in the aorta, that's only going to increase the size of that hematoma, isn't it?
A. Yeh.
Q. Yes?
A. That's right.
Q. And that's exactly what happened here?
A. Yeh.
Q. Now you say:

> Because of this, Dr. Dave put a pressure on the aorta behind the esophagus...

And with the pressure behind the esophagus the aorta was dissected. Now the esophagus is -- is visible is it, while you've had this opening that you've talked about before?
A. Well, the esophagus, aorta, and the vena cava were three structures, they come through the diaphragm into the abdominal cavity.
Q. Okay. So it's in the abdominal cavity. Now do I understand what Doctor Dave was doing was trying to put a pressure on the aorta something like a tournequet so that you could cut below that?

A. Yeh. That's right. It's a -- What we call it is proximal control -- proximal control by finger pressures, yes.
Q. So he is trying to prevent the blood --
A. Yeh, he's --
Q. He's sealing it off?
A. That's right.
Q. So that you in the meantime can repair the cut?
A. That's right.
Q. Okay, and that didn't work as I understand it and it was then necessary for you to open up the chest --
A. Yes.
Q. --in order to get to the aorta itself at a higher level?
A. Yeh.
Q. And to clamp it up?
A. Yeh.
Q. And having done that you did find that there was a cut in the aorta. Is that correct?
A. That's right.
Q. Was there only one?
A. That's right.
Q. And was it on the -- just on the front of the aorta or did it extend through the aorta?
A. Just the front.
Q. Just the front. And that was then closed?
A. Yeh.

Q. And the blood pressure then, let's say -- Okay. Let me just take you here. It says:

> The opening was seen into the aorta distally which was just below the level of the renal vein. This opening was quite large and was closed with a 4 0 silk suture.

Now do you have any recollection of what that means? What does quite large mean?

A. An aortic opening, if we have something like this, anything over a sonometer.

Q. Another over a sonometer?

A. Yeh.

Q. Okay. "4 0 silk suture", is that a particular size of tread? Is that what that is?

A. Yeh.

Q. Is that big or small?

A. Well, that's what you had to use in those days. It's a -- 4 0 is a small suture material. It's a fine suture material.

Q. Okay. You say once it was closed and the clamps were released, there was some increase in blood pressure?

A. Yeh.

Q. "And the tension was drawn to close the thoracotomy wound". What's the thoractomy wound? Is that where you opened up the chest to get at the aorta?

A. Yes.

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Q. What else did you do then, Doctor? Just take us through what else you did after you closed the aorta on that second time?

A. Once the hemostatis was achieved and the opening was closed, the pressure packs were applied and the aorta clamps were slowly released. After releasing the clamps, there was some increase in the blood pressure and attention was drawn to close the...

Chest wound. That's the same as thoracotomy.

The thoracotomy wound was closed with an interrupted chronic suture. Hemostasis was achieved. Continuous sutures were applied into the muscles and the fascia. Skin closed with black silk sutures and a chest tube was inserted for thoracic drainage.

Q. And that's all that --

A. That's a routine house cleaning.

Q. That's a requirement because the chest had to opened at the -- to clasp the aorta?

A. That's right. Yeh. Yes.

Q. Okay.

A. Following this, attention was drawn to the abdominal incision and there was oozing and bright bleeding from the retroperitoneal space which was not from the aortic opening.

So we still had some bleeding there but it was not from the aorta.

However, we were unable to visualize this area but the posterior peritoneum was closed with continuous sutures to

achieve hemostasis posteriorly.

Q. Now is that saying that there was bleeding in there, you couldn't see where it was coming from, and so it was all sewed up. Is that what -- Is it saying what I think it --

A. What it implies is when you have a person and you open them up and they have bled so much, no matter where you make the incision they just continue to ooze. They keep on oozing.

Q. Okay.

A. Then the small bowel was violaceous although there was no frank gangrene but there was extensive color change into the small bowel with involved almost the small bowel, two feet from the ligament of Treitz all the way to the terminal ilium of the transverse colon was also gangrenous where the previous perforation was encountered...

Q. And was that --

A. ...and this was exteriorized in the original surgery.

What it meant is coming out we had a chance to look at the bowel and the bowel where it was repaired, that vein and the artery, that bowel also, not because of the aortic injury but because of the injury to the vessels to the bowel, that bowel was just about pre-gangrenous from one end to the other.

Q. All right.

A. With this in mind keeping for an extensive resection, it was best

> felt at this point to drop all the bowel and this could have have been due to the tear into the superior mesenteric vein which sutured and this could be thombosed and no attempt was made to resuture or dissect the superior mesenteric vein and it was felt if the patient's condition continued to improve, probably a second operation will be required...

What I -- What I did mean mainly is nobody can live if you remove all the bowel from one end to the other and in this particular situation there was only one chance and the chance was that if you leave the whole bowel in there and if he survives and if he continues to get better within forty-eight to seventy-two hours, you have what you call a second look operation where you look at the bowel and see what is frank gangrene and what is not gangrene. So you'd remove the gangrenous part hoping that you leave maybe two or three or four or five feet of a small intestine so that patient could still survive. That much is short bowel syndrome.

Q. This problem with his bowel that you've just described was not related in any way to the -- to the injury to the aorta. Is that correct?

A. That's right.

Q. Okay, and so even if the aorta had been fixed immediately --

A. It would make no difference.

Q. --he was still going to be a very sick boy and maybe die anyway?

A. Yeh. Yeh, but going for the aorta it gave us the chance to look

at the bowel and see what was happening.

Q. It hadn't been gangrenous when you were in there the first time though? When you closed up you didn't notice that?

A. No, it was a pretty dusty colour. If you'll go back to notes, they say that it was quite dusty.

Q. Okay. Now you say there was an extensive hematoma on the wall of the --

A. There was an extensive hematoma on the wall of the fourth portion of the duodenum and the proximal jejunum and massive bleeding still present from the Levine tube through the stomach and the small bowel.

Q. Now was that starting to give you any concern? This stomach is obviously -- You've got quite a blood flowing into there as well or quite an amount of blood, haven't you?

A. Well, you see what happens once you have the blood into the retroperitoneal space, all the structures in that area could be compressed or the cause of the bleeding and, of course, once you have a -- once you have a generalized ooze it will continue to ooze, immaterial -- no matter what you do and the duodenum, of course, is comprised -- that fourth part of the duodenum just lie over the aorta, the top of the aorta.

Q. I'm sorry, but my concern is -- You keep talking about massive bleeding in the stomach. What -- What is causing that or what -- what are you going to try to do to correct that

problem or is there anything that can be done?

A. The only thing to do is take the stomach out and you couldn't operate on him again.

Q. Okay. Thank you.

> Patient was transferred to the Recovery Room again with a pressure of 40-50. There was no urine output...

A. Yeh.

Q. So he's still not getting the body fluids that -- that he requires. Is that --

A. No, what happens there -- What happens with the kidney -- it's not that he is not getting enough fluid and blood now. If a person's blood pressure drops below the profusion pressure which is maybe ninety systolic, and if that person remained hypotensive for an hour or any longer period, those kidneys will go into what they call acute tubalnegosis (?) or renal shutdown. After that, no matter how much blood you give them or how much fluids you give them, he's got renal shutdown or renal failure. Now that renal failure may or may not open by itself and this is where a patient -- if the patient survives that is the kind of a patient that becomes a candidate for dialysis.

Q. Thank you. The last note on this, Doctor, is that:

> The patient was profused to a maximum up to the level of 12-13 central venous pressure requiring over a total of 27 pints of blood since the arrival through the emergency room with no essential change.

So this -- this boy received 27 pints of blood since he arrived?

A. What -- What does -- That's right. What the central venous pressure is, again is the filling pressure of the heart. Shock is a condition where the blood and the fluid is not coming to the heart and the heart is empty, so you try to profuse the system and give the patient blood and fluid to a level where that is now an optimum. I mean between 12 and 13 means he has got the maximum fluid replacement and the blood replacement. After that if you give him -- all you're going to do is he will be in heart failure.

Q. Now despite all of your efforts, Mr. Seale did die that evening. At eight o'clock he was pronounced dead. That's what your notes indicate?

A. That's right. Yeh.

Q. And the mechanism of death, was it not the massive hemorrhage, that's what killed him?

A. The massive hemorrhage is a result of all these injuries.

Q. Yes, as a result of the stab wound, but the massive hemorrhage was the mechanism?

A. Yes.

Q. Now appreciate this as hypothetical, but if that aorta wound had been gone to immediately and sewn up or fixed, what do you say as to whether he would have died as a result of hemorrhage?

A. It's debatable. I don't think there would have been -- I don't think there is -- there is no change because it's-- it has -- he has had so many injuries. It's just not one injury that you could pinpoint and say, "Here it is". "Make this better". The rest of them will be -- will be okay. And in this case it is debatable whether -- it is questionable whether you could even correct any of the injuries in the first place.

Q. No, my question was if the aorta injury had been corrected immediately, if it had, would he still -- is there any possibility that he would have died as a result of a massive hemorrhage?

A. It is possible. I can't be sure.

Q. Is there such a thing as irreversible shock?

A. Yes.

Q. What is that?

A. He's got it.

Q. Pardon.

A. Mr. Seale has it.

Q. He's got it. He reached the point where it was irreversible?

A. Yeh, it is --

Q. And are you able to say when he would have reached that point, at what time?

A. I think, well, at the time when you try to resuscitate and you brought his central venous pressure up to its maximum

and his fluid balance was well maintained and he still had the main hypotensive and it still remains in the -- in inuric of no urine output and he'd still be respirator dependent This is irreversible shock.

Q. What time? If you can --

A. I couldn't tell you the time.

Q. Was it before the first operation or before the second operation?

A. I couldn't tell you.

Q. You can't say, but in any event, there was irreversible shock and that's what led to his death?

A. Well, as simple as that, with irreversible shock, they die, and with reversible, they live. That's all.

Q. The wound in this case, Doctor, did not extend right through the body, did it? It only went to the front of the aorta? There was no exist wound on the rear?

A. No. No.

Q. You find that amusing. I'm just trying to --

A. Well, because -- Why I find it amusing is that first of all, the nature is very good because all the bones in the behind, so you can't get through the bones unless you have bullet wounds or something.

Q. Okay. Thank you.

A. The second things is, in this particular case we got as far as -- We did go as far as from the front to the back, right up

to the aorta and if the wound extended anything beyond that, the first place it would go through would be the posterior at the back wall of the aorta, and then, of course, it will go somewhere else.

Q. And there certainly was no wound through the back part of the aorta?

A. No.

Q. Okay. The injuries that you saw on this boy, could they have been caused by a knife having a blade only three inches long?

A. They could be.

Q. They could be?

A. Yeh.

Q. It's not inconceivable that that could happen?

A. Yes.

Q. Could they be inflicted by a person -- a smallish person, a person a hundred and ten, a hundred and fifteen pounds wielding a knife with a three inch blade?

A. Well, I -- I can't tell you. All I know is that there's a lot of force behind it.

Q. A lot of force?

A. Because -- Yes, because when you -- when the knife went through all the way there had to be a lot of force behind it.

Q. When the knife reached the aorta there has to be a lot of force?

A. Yeh.
Q. But what does a lot of force mean? It doesn't -- That doesn't help me very much? Is it similar to a good punch in the stomach, for example?
A. I never got -- I never got one so I don't know.
Q. Okay. I'm just trying to get some -- some feel for what type of force is necessary for the knife to go through. There's no bones or anything in the way, is there?
A. Just the muscle.
Q. You signed a -- or I guess you didn't sign it, but the Record of Death, that is in the records as well, Doctor, on page 28. Is that a normal record that's filled out at the hospital in the event of a death?
A. Well, if it is here I'm sure it would be done.
Q. Well, are you aware whether such records are completed or not?
A. I'm aware of the records of the -- I'm aware that the Death Records are completed and not only that, we also have to sign the Death Certificates.
Q. There is a provision on that record, Doctor, for a notation of autopsy and who performed it. What is the practice at -- What was the practice at the Sydney City Hospital in those days with respect to performing autopsies in the event of violent death?
A. Well, in a case it would go through the -- the body would have

to be released by the Medical Examiner.
Q. The body must be released by the Medical Examiner?
A. Well, he has to okay whether he thinks the autopsy is necessary or it isn't necessary because in this particular case since he had the injuries and they were all -- the injuries were documented, that may be -- this may be a factor, but generally speaking it is the Medical Examiner who has to okay them and any patient who dies -- who dies within twenty-four hours in this kind of a situation, they -- it's his responsibility.
Q. It's the responsibility of the Medical Examiner. And who was the Medical Examiner at that time?
A. At the time it was Doctor Sandy MacDonald.
Q. Sandy MacDonald. And whose responsibility was it to notify him?
A. Well, the best I can recall is the doctor who had the patient then would notify him.
Q. So that would be, in this case, your responsibility?
A. Yeh, but I have no record here at the time.
Q. You have no record of having notified him?
A. Well, I don't have a record. I don't see a record here.
Q. Well, I'd like to help you. I've given you all of the records that are at the City Hospital. I don't have anything else. Is there anything in any of these records which would indicate to you that the Medical Examiner was notified?

A. Yeh, what is this here? That's at seven thirty-five.
Q. What page is that, Doctor?
A. Twenty-six.
Q. Twenty-six.
A. Mrs. L? Oh, I know, Mrs. L. Herns, a supervisor.
Q. Yes, Mrs. L. Herns and Doctor Naqvi.
A. Notified.
Q. "Notified Re: Condition"
A. Aramine Drip is feeding him.
Q. He's still alive at that time.
A. "Operation, no pulse, no blood pressure". Okay. What is this here. "Pronounced dead by by Doctor Naqvi".
Q. And taken to the Morgue by an orderly?
A. Yeh. That is just -- This is the way you could do it and we did this then at that time, is we notified the Medical Examiner and if he was satisfied of the situation, the autopsy was not done, but if he was not satisfied, the autopsy was done.
Q. You're satisfied then that you would have notified Doctor MacDonald?
A. Oh, yeh. Oh, yeh.
Q. He was available on the weekends as well as during the week?
A. Twenty-four hours a day.
Q. Yes, and would he ask your opinion whether an autopsy was necessary?

A. Sometimes.
Q. In your opinion, in this case was an autopsy necessary?
A. No, it was -- He already had two operations and everything was -- all the injuries were documented so I would suggest that there wasn't -- there wasn't much that they could accomplish in the Morgue. That's probably the way it was.
Q. What's the -- In your opinion, what's the purpose of an autopsy? What do --
A. To determine the cause of death.
Q. To determine the cause of death?
A. Yeh.
Q. Are there any other purposes?
A. Medical legal I suppose.
Q. I'm sorry.
A. Medical legal. To find out your problem and what your problem involved.
Q. Could there have been information obtained as a result of an autopsy that might have been of assistance to the investigators?
A. I can't answer your question because I really -- All I know is this was the practice at that time and we did the autopsies and we did notify if there was anything. The Medical Examiner ordered the autopsies. If they were not done on the weekends, they were done on the weekdays.

DR. M. A. NAQVI, by Mr. MacDonald

Q. I'm sorry.
A. If they were not done on the weekends, they were done on the weekdays.
Q. If they weren't done on the weekends. Are you saying that they probably wouldn't be done on the weekends?
A. Sometimes if a patient dies Sunday or -- they will not be done until Monday morning.
Q. Is that still the practice today that in the event of death you will notify the Medical Examiner?
A. Yes.
Q. And is an autopsy always done today in the event of a violent death?
A. Probably it's the same thing that if the Medical Examiner feels that there is cause of concern and he wants the autopsy, he'll order an autopsy?
Q. So it's not an automatic thing?
A. No.
Q. And today as well is your -- as a surgeon, is your advice asked whether or not an autopsy should be done or not?
A. Sometimes.
Q. And do we understand that it's your opinion that the purpose of an autopsy is to determine the cause of death?
A. Well, this is as I understand, yes.
Q. Yeh.

COMMISSIONER POITRAS:
Is your question, Mr. MacDonald, that an autopsy is not automatic in the event of a violent death?
MR. MacDONALD:
That was my question.
BY MR. MacDONALD:
Q. And I believe you said --
A. I didn't discuss a violent death. I --
Q. Well, that was my question, Doctor. In the event of a violent death today, is an autopsy automatic?
A. I couldn't tell you.
Q. As far as you know -- You don't know?
A. I don't know.
Q. Who is the Medical Examiner today?
A. You should ask Roland Perry. He's got a new system where --
Q. I have.
A. What?
Q. I have.
A. Okay. There is about five doctors that he has assigned for this job to do it and --
Q. Who is the Medical Examiner in Cape Breton? Who do you -- If you had a violent death tonight, who do you report to?
A. Well, if I had a violent death tonight I'd have to look at the board to see who is on that night --

DR. M. A. NAQVI, by Mr. MacDonald

Q. I see. So it's not a permanent person. It rotates.
A. Yeh.
Q. Have you, yourself, served as Medical Examiner?
A. No.
Q. You've never done an autopsy?
A. Oh, I've done autopsies in my training, yes.
Q. During training, but I mean since you've been practicing as a surgeon?
A. Oh, I have gone in to watch the autopsy but I haven't done my own, no.
Q. With the type of injuries that Mr. Seale had, would it have been possible for him after he was hit with the knife, to run a hundred feet or so?

A. Could be possible.
Q. Could be possible?
A. Yeh. Because all this trauma, you have first --
Q. I'm sorry.
A. There's a lot of research that has taken place in the past few years and some of the research has been applied clinically and one of the main research firsts that after any road accident or trauma, the person has the first golden hour.
Q. Golden?
A. Golden hour. It means the first sixty minutes.
Q. Golden hour, okay.
A. He could -- He could be like, come out of the car perhaps try to look for help or something but this could be possible.
Q. So it's possible. Two things. That the injuries, that you saw, that were sustained by Mr. Seale, could have been caused by a knife having a blade of about three inches and it's also possible that having sustained those injuries, Mr. Seale could have run for up to 100 feet or so.
A. Any sharp pointed object could cause those injuries. I say, any sharp pointed object could cause those injuries.
Q. It's not whether it sharp or not, I'm just trying to find out the length. Three inches is the length I'm concerned with. Is that long enough, sharp object to cause the type of injury you saw

A. Two inches long?
Q. Blade, three inches long.
A. Yeh, possibly.
Q. And also, having the type of injury you saw, it would be possible for someone having sustained that injury to run for some distance?
A. It's possible.
Q. That's all I have Doctor, thank you.

MS. EDWARDH:

May I have a few minutes, My Lord. I'd like to take a break --

MR. CHAIRMAN:

Well, I'd like to get this witness through this afternoon if we can. Maybe we will take five minutes and help speed up the process.

INQUIRY ADJOURNED: 4:00 p.m.

INQUIRY RECONVENED: 4:12 p.m.

MR. CHAIRMAN:

Ms. Edwardh.

MS. EDWARDH:

Thank you, My Lord.

BY MS. EDWARDH:

Q. Doctor Naqvi, if I could just take you back a few steps. As a person with an expertise in general surgery, I take it, that your knowledge of, let me call it general pathology, would be that acquired when you went to medical school?

A. Yes.
Q. You have no expertise beyond that, correct?
A. In pathology?
A. It depends on what you want. I mean there are two kinds of pathology that -- one is, of course, we deal all the time. Every operation, we deal with pathology.
Q. Well, pathology not in the --
A. Except we don't have pathology for dead people and that's the pathologist --
Q. That's the pathologist I'm talking about.
A. Yeh.
Q. The pathologist who is accustomed to taking a body and carefully examining it to find, for instance, if there is violence, what are the mechanisms of death, whether there's any evidence surrounding it, addressing medical legal questions. That's outside your experience, correct? I'm sorry. You have to answer because it has to be taken down. Was that yes or no?
A. Well, I mean, as far as the operative findings was concerned or the inside of the body, what's going on in to the abdominal cavity or chest cavity or otherwise, in fact, we have a lot more information than pathologists.
Q. Well, let me pose this question to you. Is general pathology a recognized medical specialty?
A. Oh, yeh.
Q. And do pathologist examine bodies to determine the mechanisms

of death?

A. You have to ask them.

Q. You're not able to assist us with that?

A. No.

Q. Now, you came to Sydney, as you indicated, in 1969. How long had you had your specialty certificate in general surgery at that time, sir?

A. I had a specialty certificate in 1968.

Q. '68?

A. Yeh.

Q. So in 1971, do I take it then you had been practising at -- for four years as a general surgeon?

A. Maybe longer.

Q. So --

A. I was practising five years of -- doing the surgical training.

Q. That's a training period?

A. Yeh.

Q. And --

A. And then I was practising afterwards.

Q. Four years with your certificate?

A. Yeh.

Q. Now, in the course of either your training or in your work in any hospital, did you have occasion to work extensively, and let me use that term first, with trauma? And I would --

A. All the time.

Q. Trauma externally applied?
A. All the time.
Q. And does, for example in the city of Toronto where I come from, there's is something called a Regional Trauma Unit where many head injuries would arrive.
A. What year that you were there? In Toronto?
Q. I'm saying, in the city in which I live.
A. Oh, I see.
Q. There is a Regional Trauma Unit.
A. Because I trained -- I interned at Harlem Hospital and you can not have any other place in North America with a trauma than Harlem Hospital.
Q. In Harlem -- where is that? In New York?
A. That's right.
Q. Okay.
A. And I did my training in New York city where I had four years at the Mount Sinai School of Medicine and the Elmherst Hospital and all you had just from the Friday night to the Monday morning was nothing but nonstop trauma.
Q. Now, let me ask specifically, whether you can assist us,sir, as to whether you have treated other abdominal stab wounds and if so, roughly how many prior to this incident?
A. Well, I can not give you a number but I can tell you it was a marathon every weekend. During the training and during my stay in New York city.

DR. M. A. NAQVI, by Ms. Edwardh

Q. Well, lets deal with the four years when you were certified as a general surgeon, in Cape Breton --
A. Let me ask you other question. How many --
Q. No, sir, you're here to answer the questions. I'm sorry.
A. Okay. Sorry. All right. It all depends. The stab wound of the abdomen, in Nova Scotia, if you take the statistics I say the -- with those statistics, whatever stab wounds have come in the Cape Breton Island, I think, I've been responsibl for pretty well 80% of them. But I can not give you the numbers because the numbers in Nova Scotia --
Q. Are we talking about --
A. -- is almost zero.
Q. Okay. So, would I take it, that in that four year period you would have, in fact, dealt with few arising in Nova Scotia?
A. Oh, sure. Comparing to my residency, yes.
Q. And, I take it, as a resident you're under the supervision of a doctor, correct?
A. All the time.
Q. Yes. Now, with respect to the questions of post-mortem examinations, I take it, it was your evidence that you would have, indeed, called the medical examiner, correct?
A. That's the practise.
Q. Well, is there any reason you wouldn't have done so in this case?

DR. M. A. NAQVI, by Ms. Edwardh

A. I don't know because I don't have record. I don't have any documentation.
Q. Can you think of any reason? Can you recall any reason that would have caused you not to call the medical examiner?
A. It's possible. I can't be sure.
Q. Well, indeed, isn't it your duty to call him since there has been a death?
A. We called -- we always call them. Tell what happened, what the case is, what has happened. And if medical examiner says we want the autopsy on, we get the autopsy.
Q. And who would have done the post-mortem examination?
A. Pathologist.
Q. And --

MR. CHAIRMAN:

I didn't hear. Who would have done it?

MS. EDWARDH:

Pathologist.

BY MS. EDWARDH:

Q. In addition to post-mortem examinations conducted by -- at the request of the medical examiner, is it the practise for hospitals to occasionally conduct post-mortem examinations if, for example, the death occurs within a relatively short period after surgery?
A. Yeh.
Q. And, indeed, is that not the practise of the hospital that you

were associated with? Sydney City Hospital.

A. That's correct.

Q. And to the best of your knowledge, was there any post-mortem examination done by the hospital, on this occasion?

A. On this case?

Q. Yes.

A. I don't see any.

Q. Do you have any recollection?

A. No.

Q. Can you explain whether that's a general rule? That if someone dies, let's say within twenty-four hours of surgery, a post-mortem is done?

A. The general rule, if somebody dies within twenty-four after surgery, you have to talk to the medical examiner and if the medical examiner feels the cause of death is evident, is there, he won't order the autopsy and if he feels the cause of death is not there or obscure or something that require autopsy, he will order it.

Q. Yes. No, I'm not talking, sir, about those ordered. I'm talking about that class of post-mortem examinations that occur as a result of the hospital wishing to conduct one even if the medical examiner says it's not necessary.

A. Hospital does the same. The policy of the hospital is, the hospital requires the doctor or the surgeon to phone the medical examiner and it's the medical examiner who would look after

that part of the --

Q. So your saying that the hospital, itself, has no internal policy that would allow it to conduct it's own post-mortem?

A. Hospital conducts the post-mortem examination at the consent of the family or -- and, of course, if there is no consent and the death has taken place within twenty-four hours, that does not require consent provided the medical examiner orders the autopsy.

Q. And if you did not telephone the medical examiner in this particular case, was there anybody else who might have had responsibility for doing that? You've read the records --

A. Well, it could be the -- it could be -- I mean, his own doctor but I don't see any notes here so I can't really make any comment about that.

Q. Well, there was a Doctor Dave assisting you that evening?

A. Dave Gaum. Yes, Doctor Dave Gaum.

Q. Dave Gaum?

A. He was assisting on the case, yes.

Q. Would he possibly have done that?

A. It's possible. If I had recollect who said that to you.

Q. Now, you've said that in the ordinary course you might be consulted, I gather, by the medical examiner as to whether or not it would be useful to perform the post-mortem?

A. My own patient.

Q. Your own patient, yes.

A. Yes.
Q. So he might -- If this was a death that you directly had been involved with, you -- he would ask you your views?
A. Yes.
Q. Now, in this case, hypothetically since you have no direct recollection, if you had been asked, what would you have said sir?
A. I'd say, well, I'll open him up. We have all the injuries there so I couldn't say to much about that any more we could find inside the --
Q. Now you, I take it, realized that this person was obviously the victim of an act of violence? Most probably.
A. Yeh.
Q. And, I take it, you would have realized, sir, that if the police were to find someone they alledged was responsible, you were looking at a murder victim? Correct?
A. A murder.
Q. Might well be looking at.
A. Yeh, sure.
Q. Yes. And let me just ask you some questions about, I know you've said you don't really fully grasp the field of general pathology, but would you agree, from your general experience, that when you do surgery in circumstances like this, you do not carefully measure the depth of the wound? You don't probe it? Correct?

A. That's true.
Q. And further you don't examine in a special way to determine the angle of entry, correct?
A. That's true.
Q. And you don't explore the tissues to see if there is any residual material? Fibers or something like that?
A. That's true.
Q. And you don't document, by drawing out, the precise location of the injury?
A. Well, that's true too.
Q. And you don't measure it's width?
A. Yeh, but there is a little difference in this particular case and what you're describing because in this particular case, when he came in, it was a matter of life and death and we got busy with the patient, forgot everything else.
Q. Oh, I'm sorry --
A. If you have a patient who has walked in -- when you have a patient who's got a stab who is stable, you can call the medical examiner, you can go through all these -- you can go inspect the wound. You do everything else before you even operated on those patients.
Q. I'm not suggesting you do the equivilent of a post-mortem examination during surgery. I'm just pointing out what the apparent differences between the two processes are. And in addition to that, do not general pathologist usually take

tissue samples?

A. Well, yes. Sure.

Q. Yes. And in those tissue samples, they would send some off to Toxicology to determine drug or alcohol content in either tissues or blood stream? Correct?

A. If this, again, I'm not expert. I give you the -- what they do. But it all is based upon what their looking for and who is working with them.

Q. But they are trained to look at a broad range of issues?

A. Oh, yes.

Q. Not necessarily to find the answers but to, at least, preserve the evidence so it can be examined. Correct?

A. Oh, yeh. Sure.

Q. And I take it, sir, you did not approach your --

A. Not in this particular case.

Q. Now, would you agree, sir, that if a general pathologist had examined, in a post-mortem examination, we might have been able to know more precisely the length of the instrument that caused the injury?

A. You'll have to ask the pathologist to answer that question.

Q. You can't assist on that?

A. No. Because in this particular case, all I know is, he had the wound, we extended his own wound, made a big incision from one end to the other end of the abdomen. So, by this time, even if he got to the pathologist, there was nothing

for him to measure as far as the width of the wound was concerned. So --

Q. Sir, did you even weigh the body?

A. Pardon me?

Q. Did you even weigh the body?

A. No, it's not -- you have to ask the hospital for that.

Q. Are they in the records, the weight and height of this young man?

A. Well, you have the records. Have a look at it. I don't know.

Q. You take a look through the records and you tell me --

A. I looked at -- I can't --

Q. You can't see it?

A. I can't see it.

Q. Would you agree, sir, that by not doing a post-mortem examination you -- we have no indication of the direction or the possible direction of any -- the entry of the knife we might have had?

A. Well, I know there's one direction of the entry of the knife. He went from the front to the back.

Q. How about up and down?

A. Well, it didn't go up and down because that's the way it went and that's the way all the vessels are damaged to.

Q. So you're saying that the knife entered?

A. Right from the front part of the abdomen and went to the back.

Q. And at a 90 degree angle?

A. That's right.
Q. In the course of giving your testimony, on different occasions, I take it your best estimate is that the injury was approximately three inches wide. That's your best estimate? You've made that comment--
A. No, I said it's possible.
Q. It's possible. Would that be fair to say that it's --
A. It could be longer, could be shorter, could be longer, could be more.
Q. So you -- really, when you made that statement earlier, I take it that's just a very rough estimate?
A. That's right.
Q. And is it also, then, a rough estimate that the depth of the wound would be three or four inches? I think you said that on one occasion and up to six inches. That's just a rough estimate. It's depends on actually the size of the body in question?
A. That's right.
Q. Now, you've indicated today, and also, I think, testified earlier, that at some point, Mr. Seale regained some element of consciousness. If you'd like me to refer you to the references there's one in volume 13 at page 53 and also one --
A. What page is that?
Q. There's -- volume 13 at page 53 and volume 16 at page 164. Can you assist us, sir, as to whether that level of consciousness

ever permitted him to have any conversations of any kind? Was he rational or lucid in any way? That's -- you see the note --

A. On page 163?

Q. 164, just over you'll see that at seven-thirty a.m. you made a --

A. Yeh, this is just a very minimum --

Yeh, this is just a very minimum -- this will not permit him for any level of conversation, understanding or anything.

Q. So, to the best of your knowledge, that would not indicate that he could even understand anything you said to him?

A. That's right.

Q. I take it you have no recollection of the police ever speaking to him on that evening? Let me pose the question back a step. Were --

A. Well, again, it's not in my note. I have to look back to the nurses note. If the nurses were there, if the police talked, well, the nurses will know. But I can't -- I can tell you one thing. Nobody could talk to him because I -- he was not in anyway to understand anything.

Q. Do you recall whether any of the police officers asked you permission to try and speak with him and you gave them some direction?

A. I don't have any recollection.

Q. Do you recall whether any of the police officers inquired

prior to going in to surgery what your best view of how serious his condition was?

A. Well, is it anywhere in the notes?

Q. No, sir, it's not in your notes or the hospital notes.

A. No, I can't recall.

Q. If you had been asked, would you have conveyed that this was a very serious condition?

A. That's right.

Q. There'd be no mistaking that in your own mind, again?

A. That's right.

Q. Do you recall whether you ever saw Donald Marshall that night at the hospital?

A. Does it say in the notes?

Q. I take it when you ask me that question, you have virtually no recollection other than what's written down?

A. I don't even know what Donald Marshall looked like.

Q. Well, that's the answer to my question, sir.

Do you recall having any conversations with the police, either on Saturday or Sunday or in the few days after Mr. Seale died, discussing with them the nature of the injuries? Not in your notes, sir.

A. Well, if it's not in the notes, I'm sorry.

Q. Now, when you say, for example, that the injury was at a 90 degree angle. That's not in your notes either. Where do you get that from today?

A. Because the way the injury in the aorta was below the renal vein and the bowel was outside. So there is only one place the knife is going, is straight down.

Q. When you say straight back, --

A. Yes.

Q. I had heard in your description of the injuries to Mr. MacDonald, and please correct me if I'm wrong, that at one point in the second piece of surgery, you had to open up the chest as well as the abdomen, correct?

A. True.

Q. And the reason you opened up the chest was because the pressure placed on the aorta produced a gushing and in order to control it you had to open up the chest. Correct?

A. Actual it was to stop the bleeding.

Q. Yes, but it produced a gush --

A. There was not enough pressure that you could create through the abdomen to stop bleeding so you had to open his chest for that.

Q. And I got the impression, sir, that that area of bleeding was also higher up. Is that incorrect?

A. The bleeding was -- the hematoma was higher but the point of the injury in the aorta was below the renal vein.

Q. And --

A. It's in the notes here.

Q. Which page are you referring to?

A. You said second operation, didn't you?

Q. Yes.

A. Okay. So if you take second operation,

> Because of this, Dr. Dave put a pressure on the aorta behind the esophagus and with the pressure behind the esophagus, the aorta was dissected. With this dissection, there was a gush of bleeding and we lost the control of the aorta at this point. Because of losing control, an immediate thoracotomy was done though the left thoracic incision cutting the two costal cartilages and going between the 6th rib intercostal space. The aorta was clamped in the chest with a Stinsky clamp. Then opening was seen into the aorta distally which was just below the level of the renal vein.

Below the renal vein, is just, right there. That's your surface marking, between the embolitis and the bone here -- that's called the thyroid

Q. Okay, so if I had interpreted this as indicating that there was also an injury higher up. That would be incorrect?

A. Yes.

Q. Now, when you say, with such certainty for example, that you're satisfied the angle of entry would be 90 degrees, isn't it also fair also to say that you can't really tell whether it's 80, 90, 100 --

A. You said 90, I said straight down.

Q. No, well. You said straight down, sir, and that means 90 degrees, correct?

A. Well, I mean, it could be 90 I said. It's possible.

Q. Could be 90?

A. I didn't say it was 100 percent.
Q. Could be 80?
A. Yeh.
Q. Could be 120?
A. Yeh.
Q. So in other words the expertise you bring to it doesn't give us that information, fair?
A. Well, maybe you should ask for expertise. But they could give you a definite angle just the same.
Q. Yes. And that expertise lies with the general pathologist, correct?
A. It's possible.

MS. EDWARDH:

Those are my questions.

BY MR. PUGSLEY:

Q. Doctor, I take it, that the remedial work, you've carried out in an attempt to save this young mans life, would have pretty well obliterated the initial area of the wound that was a violent act against him prior to the time he came to the hospital?
A. That's correct.
Q. Yes, in other words, in an attempt to save his life, you were required to cut him open, as it were, and this would have made it virtually impossible for a pathologist to subsequently tell us about the depth of the wound, the

width of the wound, and the angle of the wound, the things that my friend suggested?

A. That's --

MR. RUBY:

Well, it's up to the witness to establish himself as a non-expert in pathology. My friend may want to ask a pathologist this question.

MR. CHAIRMAN:

Well, he's commented before dispite is non-expertise so we will have to continue in the same line and then we, as Commissioners, will decide the strength of the non-expert evidence.

BY MR. PUGSLEY:

Q. Your answer to my question was yes, Doctor?

A. Would you ask the question again, please?

Q. Certainly. As a consequence of the remedial work you were required to carry out in an attempt to save this young man's life, do I understand your evidence correctly that this remedial work would have lengthened or -- the wound that was originally suffered by him so that it would make it very difficult for any physician, whether a pathologist, or otherwise, to determine the length of the wound, the depth of the wound, the angle of the wound, etcetera.

A. That's correct.

Q. Yes. Doctor, the decision as to whether or not an autopsy was to be performed on Mr. Seale was a decision of Doctor

Sandy MacDonald?

A. That's right.

Q. Yes, now, he is no -- he is now deceased, I understand.

A. That's right.

Q. Yes. And the very fact that autopsy was not performed, is it fair for us to conclude that Doctor MacDonald came to the decision that an autopsy was not necessary?

A. That's right.

Q. Thank you, sir, that is all the questions I have.

BY MR. CHAIRMAN:

Q. That is assuming that it was reported to Doctor Sandy MacDonald?

A. That's right.

BY MR. MURRAY:

Q. Doctor Naqvi, --

MR. PUGSLEY:

I'm sorry. Could I just ask one question, in response to his Lordship last --

BY MR. PUGSLEY:

Q. Although you have no independant recollection of reporting this to Doctor Sandy MacDonald, you testified that it was your practise to so report?

A. Yeh, that's the practise. We notify all the deaths.

Q. And there is no reason why this practise would not have been followed in this instance?

A. That's correct.

MR. PUGSLEY:

Thank you.

BY COMMISSIONER EVANS:

Q. This practise was recorded in the notes as well? Could you --

A. Could you ask the question again?

Q. Pardon?

A. What is the question?

Q. If the examiner is called, is it normal to record it in the notes of the Hospital records?

A. That's right.

Q. And in this case there is no record.

A. That's right.

BY MR. MURRAY:

Q. Doctor Naqvi, my name is Donald Murray and I represent William Urquhart. Just on the last point of autopsies, who would perform autopsies in 1971 in the City of Sydney?

A. They commonly-- The pathologist that I know of that did most of the autopsies was Doctor Mathieson , but Doctor Sandy MacDonald used to order other pathologists to do the autopsies just the same, and all the area pathologists used to participate who were there.

Q. I see.

A. But I can't tell you specifically who would do what pathology.

Q. Now that name you gave us, was that Mattson or Mathieson?

A. Robert Mathieson.

Q. And --

A. He was a pathologist at the City Hospital, but he did not necessarily do all the autopsies.

Q. Is he still alive?

A. Yes, he's alive but he's not living in Sydney and retired from the practice of pathology.

Q. In questions from Commission Counsel, there was some discussion as to why you had not dealt with the aorta on the first -- first trip in, and I'd like to refer you to volume 13 if that's in front of you, and I ask you to refer to pages 20 to 21 starting about line 15 on page 20 and continuing on.

DR. M. A. NAQVI, by Mr. Murray

A. On page 20 you are referring to this twenty-five twenty-- twenty, hey.
Q. Yes.
A. And I understand that on the first of those exploratory surgeries that certain injuries were dealth with, but as I understand in -- the rupture to the aorta was not seen at that time. Is that what you're implying?
Q. Yes. Yes. Starting with that question and your answer to it, sir.
A. Well, I -- I can't recollect this testimony, when it was?
Q. This testimony is as I understand it, from a Preliminary Inquiry held with respect to The Queen vs. Roy Ebsary in August, 1983.
A. Well, all I know is we had -- on one of these examinations we had difficulty of getting the operative records.
Q. Yes.
A. And when we did get some of the operative records there was some mix-up in those records. It was hard to read them.
Q. Does it assist you --
A. And in the same record, I think, there was also a problem involved with the timing of his death. Is that the same testimony you're referring to?
Q. I'm not sure, sir. Does it assist you that you said on the first injury, "you'd repair most of the bowel, but he was in such bad shape, we couldn't proceed to continue with the

operation". Is that essentially your understanding today?

MR. MacDONALD:

Referring to what? And why is he being referred to the evidence? I don't understand the purpose of the examination.

MR. MURRAY:

I'm being -- referring him to the evidence because Commission Counsel in the direct examination pressed the witness strongly as to why he had not dealt with the aorta on the first time in. And I am --

MR. CHAIRMAN:

I believe he gave his explanation and as I look at this now, it would indicate -- I suspect what you're doing is drawing to the Doctor's attention that that's not the first time he's given the same explanation. Is that the purpose of the --

MR. MURRAY:

I'm trying to understand if it was the same explanation, My Lord.

MR. CHAIRMAN:

Pardon?

MR. MURRAY:

I was trying to understand if it was the same explanation and perhaps he's used different words today.

MR. CHAIRMAN:

Oh, if you're trying to seek a different explanation, if you have reason to believe that that line of questioning will lead to a different answer or a different conclusion or add some new light,

then I have no difficulty in allowing it, but if it is simply to draw to the attention of the Doctor that he's still continuing to say the same thing whenever he appears before a Tribunal and gives evidence, I -- you know, it's -- it won't help us.

MR. MURRAY:

No, I was trying to clarify my understanding and perhaps the understanding of the Commission as to why he had not dealt with the aorta on the first trip in. If Your Lordships understanding--

MR. CHAIRMAN:

Oh, we understand it clearly.

MR. MURRAY:

Fine. I have no further questions then.

MR. BARRETT:

No questions, My Lord.

MR. ELMAN:

No questions.

MR. PINK:

No questions.

MR. SAUNDERS:

No questions.

MR. BISSELL:

No questions.

MR. PRINGLE:

No questions.

MR. CHAIRMAN:

Mr. Ross?

MR. ROSS:

Just a moment, My Lord. I have one or two questions here.

BY MR. ROSS:

Q. My name is Anthony Ross and there are a few questions I want to ask you on behalf of Oscar Seale. Now when you were speaking to Commission Counsel I think he pressed you to get an opinion as to the -- as to whether or not the -- the injuries suffered by Sandy Seale could have been caused by a three inch knife and as I recall you told him it was possible. Am I correct?

A. Yes.

Q. Yes. Is it fair to say, Doctor, that as far as the knife is concerned, that you've got no real reasonable basis for concluding whether it was a three, four, a five, or even a six inch knife?

A. I said any sharp pointed object.

Q. Any sharp pointed object?

A. Such as a knife.

Q. Such as a knife. Sure. Do you recall, Doctor, whether or not in the hour that Sandy Seale spent in the hospital for the last time that you spoke with his mother and father at any time, do you recall?

A. I'm sure I spoke to them all day, but I do not know what I

spoke to them about except it would be his son's condition.

Q. You can't recall the conversation?

A. I can't recall that.

Q. No?

A. All I know is that we were concerned about his son and I spoke to them all day.

Q. Absolutely.

A. They were there all day.

Q. Perhaps I might be able to refresh your memory. Tell me if you recall this, my understanding is that you indicated to Mr. and Mrs. Seale that the wound was inflicted with a long dirty knife. Does that ring a bell with you?

A. I don't have it in my records and I can't -- I can't recall something that I don't have documented.

Q. I see, and I take it then that the only things you can tell us about the day are things that were actually in the records?

A. That's right.

Q. So if it was not in volume 24 which is Exhibit 53, or any of the other volumes which contain the Hospital Records, there is nothing you can add or subtract?

A. Not today.

Q. I see. Perhaps I will try one more. My understanding further is that when Sandy was in a -- when he had regained a certain level of consciousness that his mother and father were in the room with him and he was asked to confirm whether he knew that

the gentleman was his father and the lady was his mother, to which he nodded. Could you recall any of that?

A. It could be possible, but I still can't recollect. I know that this is the -- again this is the usual practice that I do take the families with him, especially the father and mother if the boy is sick and they go and visit him, but -- and a lot of times the parents think that if they see their son or he recognizes them, vice versa, but I can't -- I can't really recall that -- in this particular situation that he knew the whole thing and what was going on.

Q. I see. The bottom line being that this case for all intents and purposes is out of your mind except for the items which are documented from which you can refresh your memory from time to time?

A. Yes, but that is common practice to take the family to the patient.

MR. ROSS:

Thank you very kindly, Doctor.

MR. CHAIRMAN:

Mr. Wildsmith.

BY MR. WILDSMITH:

Q. Just a couple of points. Doctor, I'm here representing the Union of Nova Scotia Indians and I want to ask you a couple of questions of a different character than what you've been asked so far. You've indicated that you've practiced medicine

in Sydney since 1969?

A. That's correct.

Q. And I'm wondering if in the course of your practice you have treated Indians?

A. Of course.

Q. Of course?

A. I'm Indian too.

Q. Okay. I see your point. I'm particularly talking about Native North American Indians.

A. Oh, yes.

Q. I'd like to put to you a couple of statements that are attributed to Doctor Virick to see if you can confirm whether if your own experience these statements are true?

MR. CHAIRMAN:

Who's Doctor Virick?

MR. WILDSMITH:

Doctor M. Virick is a doctor in Sydney. These statements appear in "Justice Denied". Doctor Virick, I believe, treated Junior Marshall the same night we're speaking about in the hospital although two statements are not related to that incident.

COMMISSIONER EVANS:

We just wanted to know who he was, not his history.

MR. WILDSMITH:

Yes. Thank you.

BY MR. WILDSMITH:

Q. In order to understand these two statements that Doctor Virick--

that's attributed to Doctor Virick in this book, I'd like to just read you the balance of the paragraph that leads up to it and this appears at page 18 in "Justice Denied". The author says:

> By 1970, the same cycle of despair that gripped Nova Scotia's other twelve Reserves--joblessness, welfare, and alcoholism--had enmeshed Membertou's residents. A report issued by the Union of Nova Scotia Indians claimed that ninety-eight percent of the violence on the reserves was linked to alcohol and drugs. Significant numbers of Indian children were found to be drinking vanilla and shaving lotion to temporarily escape the barren reality of Reserve life.

Here's where Doctor Virick comes in.

> At that time, Dr. Mohan S. Virick of Sydney told the Micmac News that he was treating a growing number of Indian children for peptic ulcers, which he believed wre being brought on by glue and gasoline-sniffing.

I'm wondering, Doctor, if you can confirm based on your experience whether the statements about glue and gasoline-sniffing and peptic ulcers in Indian children was something you saw in your practice?

A. I think what you should do is to speak to Doctor Virick and the book -- the guy who wrote the book because I'm a surgeon and my specialty is surgery. I'm not a General Practitioner and I don't see that kind of patients.

Q. You don't see patients that have --

A. I only see -- I only see patients referred to me for a surgical element.

MR. WILDSMITH:

Very good. Thank you. No further questions.

MR. CHAIRMAN:

Mr. MacDonald.

BY MR. MacDONALD:

Q. I was interested, Doctor, in your response to Mr. Pugsley saying that after you had cut in the area where the knife went in, you wouldn't really be able to tell the difference. Are you saying that a pathologist couldn't tell the difference between a surgical scalpel cut and one that's ripped open by a knife?

A. If you did not make -- The surgical is cut -- Ripped open by knife. If you did not make that into a surgical incision. If a person went in with one stab wound, of course, that's a different ball game. Well, in this case --

Q. But there was one stab wound right through the body, as I understand it, to the back bone.

A. Yes.

Q. And you went in and extended that?

A. That's right. Well, in this case the incision was extended up and down and now pathologists have no way where it started, because all you do is just make the same --

Q. One is made though with a very sharp surgical scalpel, yours?

A. Yes.
Q. And the other is made probably with a knife. Are you trying to say that a pathologist using whatever instruments he had couldn't tell where your work started and the other fellow had stopped?
A. That's right.
MR. MacDONALD:
Thank you.
BY MR. CHAIRMAN:
Q. Doctor, just one question. Is there a forensic pathologist in Cape Breton?
A. Forensic pathology as a specialty, no.
Q. Is there one in Nova Scotia?
A. I believe, I have to refer this to Doctor Perry, but I think there's maybe one in Nova Scotia, in Halifax, but I am not so sure.
MR. CHAIRMAN:
That's all. Thank you.
MR. MacDONALD:
Just perhaps, My Lord, before we adjourn for the day if I can tell you who is coming on tomorrow so everyone will know. You may recall the evidence a couple of weeks ago, there was a reference to an Ed MacNeil who was referred to in Sergeant Wood's notes. He was present when Sergeant Wood was there the next morning and spoke to Detective Sergeant MacIntyre and Constable MacNeil, and

we've located MacNeil. He's from Halifax and he can be here first thing in the morning. We propose putting him on first thing in the morning, and then we're going to follow with Arthur Paul, Terrance Gushue and Patricia Harriss and Eunice Harriss as in the list, but we are going to insert Mr. MacNeil because of the requirement to bring him down from Halifax specifically for that purpose.

MR. CHAIRMAN:

Are you anticipating getting to the bottom of the page by tomorrow?

MR. MacDONALD:

The bottom of the page? Which page are you looking at, My Lord?

MR. CHAIRMAN:

The same one you have. We'll adjourn until nine-thirty.

(WITNESS WITHDREW)

INQUIRY ADJOURNED AT 4:52 o'clock in the afternoon on the 6th day of October, A.D., 1987.

NN COURT REPORTER'S CERTIFICATE

I, Judith M. Robson, an Official Court Reporter, do certify that the transcript of evidence hereto annexed is a true and accurate transcript of the Royal Commission on the Donald Marshall, Jr., Prosecution as held on the 6th day of October, A.D., 1985, at Sydney, in the County of Cape Breton, Province of Nova Scotia, taken by way of recording and reduced to typewritten copy.

Judith M. Robson
Official Court Reporter
Registered Professional Reporter

Sydney Discovery Services
October 6, 1987