

**Commission of Inquiry into Pediatric Forensic
Pathology in Ontario**

Submissions of the Criminal Lawyers' Association

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PREFACE

1. The Criminal Lawyers' Association is a non-profit organization which was founded on November 1, 1971. The Association is comprised of over 1000 criminal defence lawyers, many of whom practice in the Province of Ontario, but some of whom are from across Canada. The objects of the Association are to educate, promote and represent the membership on issues relating to criminal and constitutional law. To that end, the Association presents educational workshops and seminars throughout the year, culminating in its annual Fall Convention and Education Programme. This Programme often includes guest speakers and justice system participants from the United States, and, on occasion, the United Kingdom.

2. The Association has routinely been consulted and invited by House of Commons and Senate Committees to share its views on proposed legislation pertaining to issues in criminal and constitutional law. Similarly, the Association is often consulted by the Government of Ontario, and in particular the Attorney General of Ontario, on matters concerning provincial legislation, court management, the Ontario Legal Aid Plan and various other concerns that involve the administration of criminal justice in the Province of Ontario.

3. The Association has been granted standing to participate in many significant criminal appellate cases as well as public inquiries. For example, the Association was granted standing in, and participated throughout, the Commission on Proceedings Involving Guy Paul Morin (the "Kaufman Inquiry") and the Commission of Inquiry into

the Investigation of the Bombing of Air India Flight 182 (the “Major Commission”). The Association has been granted permission to intervene in many appeals heard by the Court of Appeal for Ontario and many others heard by the Supreme Court of Canada. The submissions of the Association have often been referred to by those courts when rendering their decisions.

4. The Criminal Lawyers’ Association finds it to be both a privilege and a pleasure to be given the opportunity to make submissions before This Honourable Commission.

OVERVIEW

5. Pursuant to an Order in Council dated April 25, 2007, this Honourable Commission was established and tasked with the following mandate:

4. The Commission shall conduct a systemic review and assessment and report on:
 - a. the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings;
 - b. the legislative and regulatory provisions in existence that related to, or had implications for, the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and
 - c. any changes to the items referenced in the above two paragraphs, subsequent to 2001

in order to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.

In fulfilling this mandate, this Honourable Commission has set out to consider, *inter alia*, the following issues:

- (a) the evolution, limits and inherent frailties of pediatric forensic pathology, and the developing state of that science, including sudden infant death syndrome and shaken baby syndrome;
- (b) how key institutions within our justice system work together, and how well they do so;
- (c) different models of death investigation and reporting including coroner-based systems and medical examiner-based systems, their strengths and weaknesses, and what we can learn from other jurisdictions;
- (d) how Crown Attorneys and defence counsel obtain and use forensic experts;
- (e) the role of the legal aid system in ensuring that defence counsel has access to competent expertise in pediatric forensic pathology;

- (f) the use of scientific experts by courts in other jurisdictions, including how experts are designated by different regulatory bodies, as well as how courts and juries can evaluate an expert's expertise; and
 - (g) how the courts referee forensic disputes both pre-trial and at trial, and how the courts function as gate-keepers by determining who qualifies as an 'expert' and what counts as 'expertise'.
6. Recommendations on any of these topics will have a profound effect on the manner in which criminal trials are conducted in the future. The recommendations will affect the rights of accused persons in criminal proceedings involving all manner of expert evidence, not just pediatric forensic pathology. The recommendations will also affect criminal defence practice and future interactions between defence and Crown counsel.
7. It is within this context that the CLA respectfully advances the following recommendations.

PROPER RETENTION OF AUTOPSY RESULTS

RECOMMENDATION #1: That the fruits of all autopsies be properly retained so that the results and conclusions of the OCCO pathologist can be independently reviewed by a second pathologist.

8. Dr. Pollanen testified that second opinions provide a mechanism for protecting against wrongful convictions based on bad science¹. Second opinions, however, have little value if the reviewer cannot recreate the autopsy and be placed in the same position as the original pathologist. It is therefore necessary for the OCCO to take all steps necessary to ensure that the defence pathologist be placed in the same position as the original pathologist.

9. In his paper “Defending a pediatric death case: problems and solutions”, Dr. Sherrin wrote that the defence pathologist is almost always at a disadvantage because he/she does not attend the initial autopsy². Drs. Rao, Dexter and Shkrum essentially agreed with this position. They all testified that the ideal circumstance for the defence pathologist is to be at the initial autopsy³. However, it was accepted that in most cases it would not be possible to have the defence pathologist attend the autopsy because often a person is not yet arrested at the time of autopsy, or if someone has been arrested, the accused person would not have had an opportunity to retain counsel by the time the autopsy occurred.

¹ *Evidence of Dr. Pollanen*, December 6, 2007, p. 180

² Sherrin, C., “Defending a paediatric death case: problems and solutions”, p. 34-35

³ *Evidence of Dr. Rao, Dr. Shkrum and Dr. Dexter*, January 18, 2008, p. 104-106

10. In light of this evidence, Dr. Shkrum, Dr. Rao and Dr. Pollanen were asked if there was a way to place the defence pathologist in the same position or as close as a position as possible to the Crown pathologist. All agreed that if the photographs of the autopsy are taken properly and tissue samples and bodily fluids are properly preserved, the reviewing pathologist can be placed in close to the same position as the original pathologist. The real benefit of being at the original autopsy, if the above material is properly preserved, would be to direct what testing is to be done and to catch subtle nuances of the autopsy⁴.

11. This evidence establishes the absolute necessity for preserving the material from the autopsy to ensure that the results reached by the OCCO pathologist are reviewable. While it is the opinion of the CLA that the best way to preserve the entire autopsy would be to video tape the autopsy, it is recognized that this approach was rejected by all the pathologists who testified.⁵ In light of this, the CLA, while continuing to believe that this is the best way to preserve the autopsy, is unable to make this recommendation. The key to reviewability, as was expressed by the pathologists who testified at the inquiry, is to have good photographs from the autopsy, proper tissue samples, samples of bodily fluids, x-rays and a written record of all the evidence and assumptions employed by the OCCO pathologist in reaching his or her conclusions⁶.

12. It is the position of the CLA that the following steps must be taken to ensure full reviewability of the original pathologist's opinion:

⁴ *Evidence of Dr. Rao*, January 18, 2008, p. 111; *Evidence of Dr. Dexter*, January 18, 2008, p. 111; *Evidence of Dr. Shkrum*, January 18, 2008, p. 106-107

⁵ *Evidence of Dr. Shkrum, Dr. Rao and Dr. Dexter*, January 18, 2008, p. 109

⁶ *Evidence of Dr. Rao, Dr. Dexter and Dr. Shkrum*, January 18, 2008, p. 106-112

- a) Proper documentation of observations made by the pathologist, and preservation of the observations and fruits of the autopsy through photography, x-rays, CT scans, retention of tissue samples and retention of bodily fluids;
- b) proper recording of all observations made by the pathologist in support of, and against, the opinion of the pathologist;
- c) disclosure of all original and working notes of the pathologists; and,
- d) disclosure of all discussions with other practitioners, including police, coroners and other medical practitioners, to ensure transparency in the pathologist's process from observations to conclusion.

13. The latter three recommendations go beyond merely preserving the material from the autopsy, but speak to the nature of the paediatric pathologist's process. It became evident during the Inquiry that paediatric pathology is an "interpretative science". Practitioners make observations and then draw conclusions based on their interpretation of the meaning of the observation. A pathologist may make an observation that the child had a broken rib at the time of death. This is an observation that can be medically proven and verified through x-rays. What activities could have caused the broken rib is largely an interpretive issue. For a defence pathologist to address the merits of the original pathologist's opinion properly, there must be a recording of what observations and medical knowledge led to the pathologist's conclusion, and what evidence, if any, does not support the opinion, something that is frequently not in the pathologists report⁷.

⁷ *Evidence of Dr. Pollanen*, November 12, 2007, pp. 156-159, 174-175; December 6, 2008, pp. 177-178

**TIMELINESS OF REPORTS IN CRIMINALLY SUSPICIOUS
AND HOMICIDE CASES**

RECOMMENDATION #2: That the Office of the Chief Coroner create a system for tracking the turnaround time for post-mortem reports in criminally suspicious and homicide cases.

RECOMMENDATION #3: That the Office of the Chief Coroner create a system whereby priority is given to the completion of post-mortem reports in criminally suspicious and homicide cases.

RECOMMENDATION #4: That the Office of the Chief Coroner and the Centre for Forensic Sciences create a protocol whereby priority is given to ancillary tests requested by the forensic pathologists and/or police in criminally suspicious or homicide cases.

RECOMMENDATION #5: That the Ministry of Correctional Services and Community Safety create a written policy requiring all pathologies and/or police to submit samples obtained during the post-mortem for forensic testing forthwith and in any event within 7 days.

RECOMMENDATION #6: That, having established the appropriate mechanisms for tracking and expediting reports in criminally suspicious and homicide cases, the Office of the Chief Coroner establish enforceable guidelines, in the range of 90 days, for the completion of post-mortem reports in criminally suspicious and homicide cases.

RECOMMENDATION #7: That the Office of the Chief Coroner create a system for tracking the turnaround time for supplementary or consultation reports requested by the Crown or defence in criminally suspicious and homicide cases.

RECOMMENDATION #8: That the Office of the Chief Coroner create enforceable guidelines for the timely completion of supplementary or consultation reports requested by the Crown or defence in criminally suspicious and homicide cases.

14. In criminally suspicious and homicide cases, the post-mortem report and supplementary reports are crucial to the prosecution process. These reports must be completed in a timely manner in criminally suspicious and homicide cases to ensure that the defendant's right to a trial within a reasonable time is protected. The need for timely

forensic pathology reports in criminal cases is heightened further when the defendant is detained in custody pending trial.

15. In a number of cases reviewed, the post mortem reports were not completed for more than six months after the post-mortem examination was conducted.⁸ This Inquiry also heard about significant delays in the completion of consultation reports.⁹ While there were efforts made by Dr. Chiasson while he was the Chief Forensic Pathologist to reduce the turnaround time for post-mortem reports, these efforts were largely unsuccessful.¹⁰ Dr. Chiasson proposed a target of having 90 percent of post-mortem reports completed within 90 days. Dr. Chiasson testified that this target was never met and still not being met by the pathologists at the Hospital for Sick Children.¹¹

16. This Inquiry has heard significant evidence about the factors which hinder or prevent the timely preparation of reports, including workload, delays in ancillary testing.¹² For example, Dr. Chiasson explained that one of the primary time limiting factors for the completion of a post-mortem report in a pediatric case is the delay in completing ancillary testing such as toxicological testing.¹³ Dr. Lauwers testified that efforts are currently underway to establish a protocol between the Centre for Forensic

⁸ Tamara Overview Report (PFP143345); Kenneth Overview Report (PFP144159); Jenna Overview Report (PFP144684); Sharon Overview Report (PFP144453)

⁹ Memorandum from Dr. Wilson to Dr. Chiasson dated March 18, 1999 (PFP129260); Letter from Dr. Chiasson to Dr. Smith dated November 2, 1998 (PFP056571)

¹⁰ Performance Appraisal of Dr. Smith dated January 7, 1997 (PFP137691); Letter from Dr. Chiasson to Dr. Smith dated April 21, 1998 (PFP056290); Typewritten notes of the May 31, 1998 meeting between Drs. Becker, Smith, Lucas, Cairns and Chiasson (PFP096526)

¹¹ *Testimony of Dr. David Chiasson*, December 7, 2007, p. 170, l. 18 – p. 174, l. 18; p. 190, l. 14 – p. 191, l. 18

¹² *Testimony of Drs. Lucas and Lauwers*, January 7, 2008, p. 125, l. 8 – p. 128, l. 13

¹³ *Testimony of Dr. David Chiasson*, December 11, 2007, p. 166, l. 6 – p. 167, l. 16

Sciences and the Office of the Chief Coroner to reduce the turnaround time for toxicology reports in cases submitted by the Office of the Chief Coroner.¹⁴ At present, the Centre for Forensic Sciences is working towards a benchmark of completing 60 percent of cases within 90 days. Dr. Lauwers also testified that he understood efforts were being made by the Centre of Forensic Sciences to give priority to tests required in criminally suspicious cases.¹⁵ Further efforts need to be made to ensure that criminally suspicious and homicide cases are given priority so the post-mortem report can be completed in a timely fashion and provided to the Crown and defence.

17. Dr. Chiasson also testified that the complexity of pediatric cases and the sheer volume of work cause delays in the completion of reports. Dr. Chiasson acknowledged that priority is often given cases when the Crown, coroner or defence ask for the matter to be expedited or complain about delay (the “squeaky wheel” phenomenon).¹⁶ Sufficient human resources need to be made available to ensure that forensic pathologists have time to complete their reports in criminally suspicious and homicide cases expeditiously so as not to unduly delay criminal proceedings.

18. One final issue that was raised before this Inquiry with regard to forensic testing was the delay in submitting samples for testing. Dr. Lauwers described cases where the samples are not even submitted for testing for weeks or months after the post-mortem examination.¹⁷ Policies must be put in place to eliminate this unnecessary delay.

¹⁴ *Testimony of Dr. Lauwers*, January 7, 2008, p. 137, l. 19 – p. 143, l. 14

¹⁵ *Testimony of Drs. Lauwers and Lucas*, January 8, 2008, p. 138, l. 14 – p. 143, l. 7

¹⁶ *Testimony of Dr. David Chiasson*, December 11, 2007, p. 166, l. 6 – p. 167, l. 16

¹⁷ *Testimony of Dr. Lauwers*, January 8, 2008, p. 141, ll. 17 - 21

Samples collected during the post-mortem examination in a criminally suspicious or homicide case must be submitted immediately for testing. Further, testing of samples submitted in criminally suspicious and homicide cases must be expedited to ensure that the defendant's rights under s. 11(b) of the *Charter* are preserved to the extent possible.

REPORT WRITING

RECOMMENDATION #9: That any witness the Crown plans to call in a criminal case to give expert opinion reduce their opinion to writing in the form of a report or supplementary report at the earliest opportunity and in any event not less than 30 days before their anticipated testimony at the preliminary inquiry or trial. This is an ongoing obligation such that if a new issue arises during the course of preparing for the preliminary inquiry or trial, a further supplementary report must be prepared setting out the new or additional opinion to be proffered.

RECOMMENDATION #10: That each report prepared by a potential expert include not only the opinion to be proffered but also (a) a detailed outline of any information relied on by the expert in reaching that conclusion, (b) any academic/scientific sources consulted by the expert in formulating the opinion that either support or contradict the opinion reached; and (c) a detailed outline of all information received from the Crown or the police or other members of the death investigation team in relation to the opinion rendered whether it was considered in the formulation of the opinion or not.

RECOMMENDATION #11: That proposed experts have an ongoing obligation to provide to the Crown any scientific and/or academic publications they discover that support or contradict the opinions they will likely provide in a criminal trial.

19. Forensic pathologists play two distinct roles in criminally suspicious and homicide cases: First, they must fulfill their statutory obligation to conduct the post-mortem examination and report to their findings in writing to coroner.¹⁸ Second, they usually become expert witnesses for the prosecution. As a witness, forensic pathologists are often asked to render opinions beyond the findings described in the post-mortem

¹⁸ *Coroners Act*, R.S.O. 1990, chap C.37, s. 28

report. Crown counsel ask the forensic pathologist to consider and comment on issues such as the timing of injuries reported in the post-mortem report, the amount of force required to cause the injuries observed, the possible causes of the injuries, the time of death in relation to the infliction of the injuries observed etc. These opinions can be crucial to the Crown's case and are often much more contentious than opinions regarding the cause of the death.

20. Despite the importance of these opinions in a criminal prosecution, there is no standard practice on the part of the Crown to ask for supplementary reports or on the part of forensic pathologists to prepare supplementary reports outlining these opinions in advance of their testimony. Dr. Chiasson testified that his experience is that when additional issues are raised with him by the Crown or police, he provides a verbal opinion and then, if asked, testifies about them at the preliminary inquiry. While Dr. Chiasson is willing to provide supplementary reports, he testified he is not often asked to do so.¹⁹ In fact, Dr. Chiasson testified that, to this day, he often goes to a preliminary inquiry and renders "all sorts of opinions that are not in my post-mortem examination report."²⁰

21. A system where crucial pathological opinions are disclosed to the defence for the first time during the pathologist's testimony at a preliminary inquiry is both unfair to the defendant and inefficient. Without adequate disclosure of these opinions in advance, defence counsel cannot prepare a cross-examination to probe and test the scope, limits and frailties of the pathologist's opinion. Further, counsel cannot consult with an

¹⁹ *Testimony of Dr. David Chiasson*, December 10, 2007, p. 95, l. 17 – p. 100, l. 23

²⁰ *Testimony of Dr. David Chiasson*, December 10, 2007, p. 98, ll. 1 - 4

independent expert to obtain a second opinion or to assist with preparing the cross-examination. In order to discharge their duty under *R. v. Stinchcombe*,²¹ the Crown must be under an obligation to obtain written reports from the forensic pathologist containing any opinion that will be proffered at a preliminary inquiry or trial. The report must also contain the basis upon which the pathologist reached his or her opinion.

22. In terms of promoting the efficiency of the process, Dr. Chiasson acknowledged that providing opinions in writing in advance of testifying at a preliminary inquiry or trial has some real advantages. Reducing an opinion to writing ensures that the opinion to be rendered is clear and the limits of the opinion are also clear. It also provides counsel have an opportunity to adequately prepare. Dr. Chiasson agreed that requiring all opinions to be proffered in court be reduced to writing has the added benefit of affording an opportunity for better quality assurance and review.²²

23. Given the importance of pathologic opinion evidence in many criminal trials, there are significant legal and policy reasons to require that Crown counsel obtain written reports from their proposed experts setting out any opinion to be proffered and the basis upon which that opinion was reached.

²¹ *R. v. Stinchcombe*, [1991] 3 S.C.R. 326 at

²² *Testimony of Dr. Chiasson*, December 11, 2007, p. 154, l. 1 – p. 156, l. 5

DISCLOSURE FROM THE DEATH INVESTIGATION PROCESS

RECOMMENDATION #12: That the Office of the Chief Coroner create a written policy that all information provided to the forensic pathologist by any member of the death investigation team must be either provided in writing or recorded in writing by the pathologist.

RECOMMENDATION #13: That the Office of the Chief Coroner create a written policy that any information provided by the forensic pathologist to any member of the death investigation team must be either provided in writing or recorded in writing. For example, this would require any informal discussions between the police and the forensic pathologist be reduced to writing. It would also require detail notes to be taken during any case conference held to discuss a particular case.

RECOMMENDATION #14: That the Office of the Chief Coroner create a written policy that the following categories of information must be documented, collected and provided by the Office of the Chief Coroner to the Crown in all criminally suspicious and homicide cases for purposes of disclosure to the defence:

- (a) working notes of the forensic pathologist, including notes of the post-mortem examination and any consultations conducted before, during and after the post-mortem examination with the police, other clinicians or the coroner;
- (b) photographs taken by the pathologist or the pathology assistant during the post-mortem examination;
- (c) exhibit list of all items seized by the pathologist, the pathology assistant or the police during the post-mortem examination;
- (d) a list of all slides and biological samples retained from the post-mortem examination and an indication of where these items are being stored;
- (e) a list of all items submitted for further forensic testing;
- (f) all hospital records relating to the deceased that were reviewed or consulted in preparation for the post-mortem examination or in preparation of the post-mortem report;
- (g) notes of any case conference meeting held to discuss the results of the post-mortem examination;
- (h) notes of any peer review of the post-mortem report; and

(i) reports of any committee which reviewed, considered or discussed the results of the post-mortem examination, including but not limited to the Pediatric Death Review Committee and the Death Under 5 Committee.

24. It is trite law the Crown is under an obligation to disclosure to the defence any information that is not clearly irrelevant that is within their possession or control. It is also trite law that the Crown has a duty to obtain from the police all relevant information and material concerning a case. The police have a corresponding duty to provide all relevant information and material to the Crown concerning a case.²³ There is a further duty on the police to put information obtained during the investigation in writing so that it can be disclosed to the defence.²⁴ These same principles must apply to the Office of the Chief Coroner.

25. During this Inquiry, a significant amount of evidence has been called about the steps in the death investigation. This process is characterized by ongoing consultation between members of the investigation team, including the police, the coroner and the pathologist. This consultation continues during and after the post-mortem examination. Criminally suspicious and homicide cases are subject to a case management meeting with all members of the team following the post-mortem examination. During that meeting, further investigative steps are discussed. Post-mortem reports are also subject to various levels of review within the Office of the Chief Coroner.

²³ *R. v. T.(L.A.)* (1993), 84 C.C.C. (3d) 90 (Ont. C.A.)

²⁴ *R. v. Stinchcombe*, *supra* at paras. 30 and 33

26. Each step in the death investigation process in criminally suspicious and homicide cases has the potential to general information that is relevant (or at least not clearly irrelevant) to the prosecution. As a result, the Office of the Chief Coroner must have a policy of recording and collecting all relevant information so that it can be provided to the Crown. Similarly, the Crown must have a policy of requesting all relevant information obtained during the death investigation so they can discharge their disclosure obligation.

RECIPROCAL DISCLOSURE

RECOMMENDATION #15: That defence counsel be encouraged, but not required, to make pre-trial disclosure of pathological evidence they intend to elicit at trial so long as such disclosure would not prejudice the defendant's right to make full answer and defence.

RECOMMENDATION #16: That any pathological evidence provided to the Crown by way of voluntary pre-trial disclosure by the defence should not be used by the Crown to gather further evidence to bolster its case against the accused but rather should be used to (a) clarify issues in dispute; (b) narrow issues in dispute; (c) negotiate a just resolution of the case (including the withdrawal of charges); and/or (d) promote efficiency in the administration of justice.

27. The CLA recognizes that, in some cases, perhaps even many cases, there are significant benefits to be gained by early disclosure of pathological evidence obtained by the defence.²⁵ However, defence counsel must retain the discretion, subject to the existing provisions of the *Criminal Code*, to determine the appropriate time and manner to disclosure pathological evidence in its possession to the Crown.²⁶ Imposing a

²⁵ *Testimony of John Struthers*, February 8, 2008, pp. 113 - 1117

²⁶ *Testimony of Marlys Edwardh and Michael Code*, February 19, 2008, p. 52, l. 4 – p. 62, l. 22

mandatory pre-trial disclosure regime for expert evidence generally,²⁷ or pathological evidence more specifically, is unnecessary and would amount to an infringement of the defendant's rights under s. 7 and 11(d) of the *Charter*.

28. The balance of our submissions on this issue will focus on the Constitutional constraints on mandating reciprocal disclosure. These should not be taken as an indication that the CLA resists a recommendation that would encourage and promote early disclosure. This Inquiry has heard evidence from a number of prominent defence counsel who have described their willingness of providing pre-trial disclosure of pathological evidence in appropriate cases. Marlys Edwardh described the practice as follows:

Every lawyer I know who I would consider to be a competent criminal defence counsel, feels very comfortable making a decision, depending tactically on where it is appropriate to make, to go into Crown counsel's office and say, this is what I'd like to tell you now, and this is what I think you should do. And you make that decision based on what the evidence is, who the Crown is, who the expert is that the Crown has.

We do that every day. It narrows the issues, it can resolve cases, and that is not a... problem for any criminal defence counsel to contemplate, and it is a daily event in our Courts.²⁸

John Struthers testified that he generally discloses pathological evidence he intends to call as part of the defence in advance of his cross-examination of the Crown expert to avoid being accused of "bushwhacking the Crown" and to ensure the Crown's expert has an opportunity to adequately and meaningfully respond to his expert's opinion.²⁹

²⁷ While the CLA recognizes that recommendations from this Inquiry will focus on forensic pathology, there does not appear to be any principled reason to think that rules established for the handling of forensic pathology evidence will not be applied to other areas of expert evidence in criminal trials.

²⁸ *Testimony of Marlys Edwardh*, February 19, 2008, p. 52, ll. 5 - 16

²⁹ *Testimony of John Struthers*, February 8, 2008, p. 113, l. 20 – p. 117, l. 10

Professor Code testified that he too has a general practice of disclosing pathological evidence at the earliest possible moment and, in any event, well in advance of trial. Professor Code suggested that fostering professionalism and civility among Crown and defence counsel would likely result in more voluntary pre-trial disclosure by the defence.³⁰

29. The CLA recognizes that “best practices” require defence counsel to consider whether pre-trial disclosure of pathological evidence should be made in order to advance the interests of justice and could be made without prejudice to the defendant. The CLA simply resists the imposition of mandatory pre-trial disclosure.

Current Legislative Context

30. In 2002, the *Criminal Code* was amended to add a notice requirement for expert evidence to be called either by the Crown or the defence in criminal proceedings. Under these amendments, the defence is now required to provide to the Crown with the following information at least 30 days before the commencement of trial:

- (a) the name of the proposed witness;
- (b) the area of expertise of the proposed witness with sufficient particularity to enable the Crown to inform themselves about the area of expertise; and
- (c) a statement of the qualifications of the proposed witness.³¹

The defence is also required to provide the Crown with a report or a summary of the opinion to be given by the proposed witness no later than the close of the Crown’s case.³²

³⁰ *Testimony of Michael Code*, February 19, 2008, p. 59, l. 22 – p. 61, l. 3

³¹ *Criminal Code*, s. 657.3(3)(a)

31. When drafting recommendations, it is important to remember that the legal framework within which expert evidence is called has changed since some of the early cases examined by this Commission. For example, a Crown would no longer find herself in the position Ms Regimbal faced in the Amber case where she had no foreknowledge of the evidence to be given by the experts called by the defence until they took the stand. The Crown now receives sufficient information to be able to research the area of expertise in advance and also investigate the expertise of the proposed witness. The only information that can be withheld by the defence until the close of the Crown's case is the ultimate opinion to be proffered at trial. These amendments avoid the unfairness caused by "advocacy by ambush" while at the same time protecting the defendant's constitutionally protected right to be presumed innocent and to be free from self-incrimination.

Presumption of Innocence and the "case-to-meet" principle

32. Mandatory pre-trial disclosure of defence pathological evidence violates the presumption of innocence and the "case-to-meet" principle, both of which are Constitutionally protected. It has the potential to force the defendant to assist the Crown in building their case against him. This is precisely what the *Charter* protects against. Further, there are no strong policy considerations that would justify over-riding the most fundamental of all rights afforded to an accused person.

³² *Criminal Code*, s. 657,3(3)(c)

33. In *R. v. Oakes*, the Supreme Court of Canada described the presumption of innocence as “a hallowed principle lying at the very heart of criminal law”. The Court explained the importance of the presumption of innocence as follows:

An individual charged with a criminal offence faces grave social and personal consequences, including potential loss of physical liberty, subjection to social stigma and ostracism from the community, as well as other social, psychological and economic harm. In light of the gravity of these consequences, the presumption of innocence is crucial. It ensures that until the State proves an accused’s guilt beyond all reasonable doubt, he or she is innocent. This is essential in a society committed to fairness and social justice. The presumption of innocence confirms our faith in humankind; it reflects our belief that individuals are decent and law abiding members of the community until proven otherwise.³³

The cases examined at this Inquiry catalogue the devastating social and personal consequences experienced by those accused in the death of a child. Individuals were incarcerated for many years. Others lost surviving children through child protection proceedings. Still others suffered from significant social stigma and alienation. The recommendations of this Inquiry must not sacrifice the Constitutional protections properly afforded to these most vulnerable people at the expense of creating a more efficient or convenient system of justice. Mandating pre-trial disclosure of defence pathological evidence runs the risk of violating the presumption of innocence and forcing the accused to reveal his defence before the Crown has established there is a case to meet.

34. The Crown and defence play fundamentally different roles in the criminal justice system. This difference played a large role in the Supreme Court’s decision in *R. v. Stinchcombe*.³⁴ While the Court declined to deal explicitly with the issue of reciprocal disclosure by the defence, Sopinka J. made it clear that “the defence has no obligation to

³³ *R. v. Oakes* (1986), 24 C.C.C. (3d) 321 (S.C.C.) at 333 – 334, per Dickson C.J.C.

³⁴ *R. v. Stinchcombe*, [1991] 3 S.C.R. 326 at para. 11, per Sopinka J.

assist the prosecution and is entitled to assume a purely adversarial role toward the prosecution.” In *R. v. R.J.S.*, the Supreme Court held that the absence of any obligation on the part of a defendant to assist the Crown in the creation of its case is an adjunct to and compliments the right against self-incrimination.³⁵

35. In *R. v. M.B.P.*, the Supreme Court of Canada confirmed that the single most important organizing principle in criminal law is “the right of the accused not to be forced into assisting in his or her own prosecution.”³⁶ In other words, until the Crown has established there is a “case to meet”, an accused person has a right under s. 7 of the *Charter* not to be compelled to respond. In *M.B.P.*, the Crown sought to re-open its case after the defence had announced its intention to call alibi evidence but before any defence evidence was called. The Court held that the trial judge erred in allowing the Crown to re-open the case:

What is so objectionable about allowing the Crown’s case to be reopened after the defence has started to meet the case is that it jeopardizes, indirectly, the principle that an accused not be conscripted against him-or herself.³⁷

After reviewing a number of specific procedural protections afforded to a defendant, the Court summarized the right to be protected against self-incrimination as follows:

All of these protections, which emanate from the broad principle against self-incrimination, recognize that it is up to the state, with its greater resources, to investigate and prove its own case, and that the individual should not be conscripted into helping the state fulfil this task. Once, however, the Crown discharges its obligation to present a prima facie case, such that it cannot be non-suited by a motion for a directed verdict of acquittal, the accused can legitimately be expected to respond, whether by testifying him or herself or calling other evidence, and failure to do so may

³⁵ *R. v. R.J.S.*, [1995]1 S.C.R. 451 at para. 88

³⁶ *R. v. M.B.P.*, [1994] 1 S.C.R. 555 at para. 36, per Lamer C.J.

³⁷ *R. v. M.B.P.*, *supra* at para. 41

serve as the basis for drawing an adverse inference...In other words, once there is a “case to meet” which, if believed, would result in conviction, the accused can no longer remain a passive participant in the prosecutorial process and becomes – in a broad sense – compellable. That is, the accused must answer the case against him or her, or face the possibility of conviction.³⁸

36. Mandatory reciprocal disclosure violates the principles against self-incrimination and the “case-to-meet” enshrined in s. 7 of the *Charter*. Once information is provided to the Crown by way of reciprocal disclosure, it can be used by the Crown to fortify or strengthen its against the defendant. All privilege that attaches to the expert opinion and any information upon which it is based while in the possession of defence counsel is lost. This is particularly problematic in the context of pathological evidence. As Professor Code explained, in order to obtain a forensic pathology opinion, counsel often provides the expert with a hypothetical question based on the defendant’s version of events and the anticipated evidence of the defendant. By mandating pre-trial disclosure of defence pathology reports, the defendant might be forced to disclose his entire defence to the Crown and broadcast in advance the testimony he will likely give. There would be nothing to prevent the Crown from using that information to shore up its case, or to lead evidence in a way to preemptively rebut or defeat the defence disclosed.

37. Obviously, the right to pre-trial silence is not absolute. For example, defendants are expected to disclosure alibi evidence in advance of trial. Unless a defendant provides timely and sufficiently detailed disclosure of alibi evidence to allow the Crown to investigate it, the defence can be given less weight. It is important to note that failure to provide disclosure only weakens the alibi evidence but cannot operate to exclude the

³⁸ *Ibid.*, at para. 40; see also *R. v. R.J.S.*, [1995] 1 S.C.R. 451 at paras. 84 to 95, per Lamer C.J.

evidence. As a result, the defence still retains the discretion to withhold alibi evidence until trial. This rule has been recognized by the Supreme Court as an exception to the accused's right to silence. The policy rationale behind this rule was explained by Iacobucci J. as follows in *R. v. Cleghorn*:

[T]he rule governing disclosure of an alibi is a rule of expediency intended to guard against surprise alibis fabricated in the witness box which the prosecution is almost powerless to challenge.³⁹

There is no similar policy rationale for requiring mandatory pre-trial disclosure of pathological evidence beyond what is already mandated in the *Criminal Code*. The existing notice provisions in s. 657.3 of the *Criminal Code* allow the Crown to research and investigate both the area of expertise proposed and the expertise of the proposed expert in advance of trial. Further, the “scientific record” upon which the expert opinion will be based is fixed at the time of the original autopsy and/or incidental testing. The Crown is in possession of all the materials upon which the expert will opinion, save and except any evidence likely to be given by the defendant him or herself. Finally, Crown is provided with full disclosure once it has closed its case, thereby allowing for further investigation and/or research before the defence expert is called to testify. It cannot be said that under the current legislative regime that Crown counsel is “powerless to challenge” defence expert opinion.

38. The main arguments in support of mandatory reciprocal disclosure are (a) it will promote the early resolution of cases; and (b) it will promote efficiency in the trial process. As can be seen from a number of cases before this Inquiry, including the Sharon case, the Jenna case and the Tyrell case, defence counsel are already providing voluntary

³⁹ *R. v. Cleghorn*, [1995] 3 S.C.R. 175 at para. 4, per Iacobucci J.

disclosure of defence pathology evidence in those cases where they feel there is a real chance the case can be resolved as a result of pre-trial disclosure. When defence counsel feel it is in their client's interest to disclosure forensic pathology evidence in advance of trial to secure a withdrawal of charges or some other favourable resolution, that is already being done and the Commissioner is invited to encourage defence counsel to continue this practice.

39. As for trial efficiency, the Supreme Court of Canada made it clear in a number of cases that administrative convenience is not an adequate reason for sacrificing *Charter* rights. For example, in *Singh v. Canada (Minister of Employment and Immigration)*, Wilson J. held as follows:

Certainly the guarantees of the *Charter* would be illusory if they could be ignored because it was administratively convenient to do so. No doubt considerable time and money could be saved by adopting administrative procedures which ignore the principles of fundamental justice but such an argument, in my view, misses the point of the exercise under s. 1. The principles of natural justice and procedural fairness which have long been espoused by our court, and the constitutional entrenchment of the principles of fundamental justice in s. 7, implicitly recognize that a balance of administrative convenience does not override the need to adhere to these principles.⁴⁰

In *United States v. Controni*, the Court adopted this reasoning and concluded that any limits on the rights set out in the *Charter*, whether under s. 7 or s. 1 should not be based “merely on considerations of administrative convenience.”⁴¹

⁴⁰ *Singh v. Canada (Minister of Employment and Immigration)*, [1985] 1 S.C.R. 177 at 218-219, per Wilson J.

⁴¹ *United States v. Controni*, [1989] 1 S.C.R. 1469 at para. 95, per Wilson J. (dissenting); see also *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483 at 520-521, per LaForest J.

40. As Marlys Edwardh so eloquently stated in her testimony, this Inquiry must be cautious not to “compromise the essential feature of what a criminal defence is about” in an attempt to solve a problem that fundamentally resides in the Crown and pathology system. Mandatory reciprocal disclosure would not have corrected the problems this Inquiry was called to correct. The constitutionally protected tenants of the criminal justice system must not be displaced without compelling evidence that such a change is absolutely necessary to solve the current crisis within the forensic pathology system in Ontario. While mandatory reciprocal disclosure was endorsed by a number of parties to this Inquiry, it is not necessary to solve the systemic problems identified.

TEST FOR ADMISSIBILITY OF SCIENTIFIC EVIDENCE

RECOMMENDATION #17: That the test for the admissibility of expert evidence be modified to account for instances where there is clear controversy in the scientific community on the issue in question. Where there is clear controversy in the scientific community on the principles underlying the proposed expert opinion and where the proposed opinion comes close to the ultimate issue, it should be excluded.

41. Pursuant to *R. v. Mohan*, scientific opinion evidence will be admitted where the following factors are met:

- a) the person providing the evidence is a qualified expert;
- b) the evidence is relevant to a fact in issue;
- c) the evidence is necessary; and,
- d) there is no exclusionary rule prohibiting the admission of the evidence.⁴²

The Ontario Court of Appeal has recognized that the *Mohan* criteria also require that the scientific evidence meet a threshold of reliability. In *R. v. Dimitrov*, the Court of Appeal

⁴² *R. v. Mohan*, [1994] 2 S.C.R. 9

for Ontario held that “the judge must decide, among other things, whether its probative value is overborne by its prejudicial effect, including whether it is misleading in the sense that its effect on the trier of fact is disproportionate to its reliability”.⁴³ In *R. v. Ho*, the Court of Appeal for Ontario held that opinion evidence that does not fall into the category of novel science can still be excluded where the court found it was so unreliable that it would be of no assistance to the court.⁴⁴

42. Where the expert opinion evidence goes to the ultimate issue, or is closely linked to the ultimate issue, there is a greater need for a higher degree of reliability in the science. As was stated by Justice Sopinka in *Mohan*, “The closer the evidence approaches an opinion on an ultimate issue, the stricter the application of this principle”.⁴⁵

43. In *R. v. J.L.J.*, the Supreme Court of Canada outlined the test for admissibility of novel science.⁴⁶ Where the scientific opinion sought to be admitted into evidence involves a novel area of science, the party seeking to adduce the evidence must establish a threshold level of reliability. The party seeking to adduce the evidence must establish, on a balance of probabilities, the following:

- 1) the theory or technique has been tested;
- 2) the theory and/or technique has been subjected to peer review and publication;

⁴³ *R. v. Dimitrov*, [2003] O.J. No. 5243 (Ont.C.A.) at ¶ 48

⁴⁴ *R. v. Ho*⁴⁴ (1999), 141 C.C.C. (3d) 270 (Ont.C.A.)

⁴⁵ *R. v. Mohan*, *supra*, at page 225

⁴⁶ *R. v. J.L.J.* (2000), 148 C.C.C. (3d) 487 (S.C.C.) at ¶34

- 3) there is a known or potential rate of error or the existence of standards; and,
- 4) the theory or technique is generally accepted within the scientific community.

44. Throughout this inquiry it has become evident that there is a third category of scientific opinion evidence that merits special consideration, that is where the science, while not novel, is controversial within the scientific community that relies on that science. This was seen most clearly during this Inquiry with shaken baby syndrome (SBS) but also arises in respect of the timing of injuries in infants and the amount of force required to cause particular injuries in children. There is still substantial dispute in the paediatric forensic community on how to diagnose SBS. While pathology is not a novel science, and SBS is not novel diagnosis, it is not generally accepted as to how to diagnose SBS.

45. The problem with the admissibility of scientific opinion evidence, where even the experts cannot agree on the science, is that it is near impossible for a trier of fact to form a conclusion about which opinion is right when the experts are not able to do so⁴⁷. One example is where the Crown expert testifies that the cause of death cannot be from a fall as described by the parent, because in his/her opinion babies do not die from household falls, and, the defence expert testifies that in his/her opinion babies can die from household falls, even if the jury is instructed that there is a split in the paediatric forensic pathology community on this issue, how is the jury able to determine which expert is correct? How can the jury rely on this evidence in helping them assess whether the

⁴⁷ Please note that this is to be distinguished from cases where two individual experts disagree about a conclusion, but the area of science involved does not involve controversy in the community.

parent is being truthful when he/she testifies that he/she did not shake his/her baby, and that his/her baby suffered a fatal fall.

46. It is unfair for the judicial system to expect lay people to make a decision about which expert opinion is correct where there is real controversy in the scientific community. They do not have the skills to deal with it and there is a great risk of wrongful convictions. This is particularly so where the evidence goes to the ultimate issue, as is common in paediatric homicide investigations. Throughout this inquiry, we have discovered that in many paediatric pathology cases, the sole issue is whether or not a homicide has occurred and, often times the only evidence on this point comes from the pathologist. This was seen in many cases, including the Sharon case, the Vallin case, the Dustin case and many others considered during this inquiry⁴⁸.

47. If the test for novel science is used to determine the admissibility of such evidence, expert opinion evidence under controversy in the scientific community will generally result in the evidence's exclusion. It will not meet the test established in J.L.J. as set out above:

- a) Where there is a clear controversy within the scientific community, the theory has not been sufficiently tested to determine which side of the controversy is correct;
- b) While the competing theories may have been subjected to peer review, that process has failed to reveal uncontroverted support for the theory;

⁴⁸ See the Medico Legal Report for the Sharon, Vallin and Dustin cases.

- c) If there is controversy within the scientific community, there will be insufficient information to determine the known rate of error. For example, there is no reliable information to determine how often shaken baby syndrome diagnoses have been in error. Without an acceptable method of diagnosis, there is no mechanism to accurately measure error.
- d) Where there is a clear controversy in the scientific community, the science cannot be said to be generally accepted.

48. In light of this analysis, it is the CLA's position that an expert's opinion, to the extent it is based on controversial scientific principles, should always be excluded. The fact of the controversy should be admitted into evidence, so the jury has a full picture of the forensic evidence. However, since the jury is unable to properly determine which side of the controversy is correct, the opinion of the specific expert is irrelevant and ought not be admitted into evidence. To admit this evidence would only increase the risk that the jury would attempt to resolve the controversy themselves which the scientific community has been unable to solve.

49. Under this recommendation, the observations made by the pathologist are clearly still admissible such as, the existence of subdural and/or retinal hemorrhage, the absence of injury to the scalp or, the presence or absence of broken bones. The conclusions to be drawn from these observations, however, should only be permitted where there are clear scientific findings, beyond anecdotal evidence, supporting the opinion. For example, if an expert wants to testify about how much force was required to cause a broken arm, it

must first be established that tests have been conducted determining the amount of force, that there is a known rate of error in determining that amount of force, that the opinion is generally accepted, and that it has been peer reviewed.

50. The trier of fact will not be misled if opinions as described above are excluded. The jury will be aware of the controversy but will not be asked to resolve the controversy. The exclusion of this evidence will ensure that the evidence is not misused by the jury and that the jury will make a decision on reliable scientific evidence only.

51. In many cases, it will be widely known that there is controversy in a certain area of pathology. However, to ensure that both the Crown and the Defence have all the information, the OCCO pathologist should always include in his/her report any information about known controversy in relation to any of his/her opinions. The issue of whether the controversy is strong enough to merit the application of this rule is a legal issue that should be determined by the trial Judge.

52. In the alternative, if opinion evidence is admitted into evidence where the subject matter of the opinion is under clear controversy, it is the position of the CLA that the trial Judge should clearly instruct the jury on the nature of the controversy. The trial Judge should also explain to the jury that they should not just rely on the opinion of the expert whom they liked best, that they are to take as fact that the scientific community as a whole has not made a conclusive determination on what the right interpretation is from the evidence and that they should be very reluctant to draw any conclusion from

the expert opinion evidence. The jury should also be advised of the fact that there have been many wrongful convictions based on bad science. Such an instruction will go a long way to ensuring that the jury does not misuse the scientific opinion evidence.

JURY INSTRUCTIONS ON EXPERT EVIDENCE

RECOMMENDATION #18: That when ever expert opinion evidence is provided by a witness in an area involving an interpretive science, the trial Judge should be required to give a jury instruction explaining the frailties of this kind of evidence, akin to the instruction given in identification cases.

53. The evidence at this inquiry has established that pediatric forensic pathology is part science and part art. It is described as an “interpretative science”, which respectfully means that it is subjective in nature and not based on clear scientific principles. Unlike physics or chemistry, there is no known rate of error in the interpretation of pediatric injuries. It is the nature of this type of evidence that leads to contradictory expert opinions in specific cases. As Dr. Pollanen stated many times throughout this inquiry: it is possible for qualified experts to reach different but reasonable opinions on the same evidence. In such a case, there is no right or wrong, as both opinions are reasonable.

54. Where two experts reach different but reasonable opinions, it is impossible for the trier of fact, who is not an expert, to determine which opinion is correct. No amount of instruction will give the trier of fact this skill and arguably, as both opinions are reasonable, even other experts may be unable to determine which opinion is correct.

Since it is accepted that there is a real risk that the scientific evidence will distort the fact finding process and that jurors place more weight on this evidence than it deserves, there is a real risk of the jury choosing the wrong opinion and placing too much weight on it⁴⁹. In paediatric pathology cases, where often the expert's evidence is close to the ultimate issue, every step should be taken to ensure that the evidence is not misused. It is for this reason, that the CLA recommends that paediatric forensic pathologist be required to explain clearly the difference between an observation, a medical fact and an interpretation based on observations and medical facts.

55. In the charge the jury, the jury must be instructed that where the expert strayed into an area of interpretative science, they should be aware that this evidence is highly subjective, that even the opinion of an expert who is highly qualified, truthful and well respected, where it strays into interpretation, should be treated skeptically.

⁴⁹ *R. v. Ranger* (2003), 178 C.C.C. (3d) 375 (Ont.C.A.) at 61

LEGAL AID AND THE NEED FOR PROPER DEFENCE FUNDING

RECOMMENDATION #19: That the Legal Aid system be changed to provide a fourth tier of counsel who are designated by Legal Aid as sufficiently capable of taking on complex and lengthy criminal cases.

RECOMMENDATION #20: That the hourly rate paid to counsel by Legal Aid be increased at all tier levels. The rate set for the highest experience tier should be close to the market rate for senior experienced criminal defence counsel.

RECOMMENDATION #21: That the hourly rate paid by Legal Aid to experts retained by the defence be raised at least to the rate paid to experts retained by the Crown to ensure that experts of comparable skill are prepared to accept defence retainers.

56. A common theme amongst several witnesses at this Inquiry was that the Legal Aid rate paid to defence counsel is simply inadequate. The hourly rate is set at unrealistically low level and the tariff maximums do not reflect the realities of practice. The tier system does not create any incentive for senior experienced counsel to take on complex criminal cases. The rates paid to experts retained by the defence do not provide adequate or even comparable compensation. These deficiencies must be addressed in order to ensure the effective and also *efficient* delivery of criminal defence services in Ontario

57. Legal Aid Ontario currently pays counsel in a three tier tariff system depending on their years of experience. Simply put, the legal aid rate paid to all counsel is manifestly unfit. The top tier is reserved for counsel with 10 or more years experience in criminal law. The rate of hourly pay for legally aided counsel in this top tier is \$96.75.⁵⁰

⁵⁰ http://www.legalaid.on.ca/en/info/PDF/hourly_rate_chart.pdf - note that the rate for senior counsel taking on a case in remote Northern Ontario is \$106.65/hr.

It is less than the rate charged for an hour of an articling student's time at a Bay Street law firm.

58. It is not only senior counsel that are short changed by the current Legal Aid tariff. The rates for all tier levels are inadequate. Counsel with less than five years' experience are paid at a rate of \$77.56 per hour. For counsel with 5 to 10 years' experience, the rate is \$87.26 per hour.

59. The fallout from this manifestly unfit Legal Aid rate is manifold:

- Counsel with 15 or 20 years experience are reluctant to take on a legally aided case that is hugely complex and anticipated to last for weeks perhaps months.
- Those who continue to take on Legal Aid cases take on fewer cases and are more selective about the cases they take.⁵¹
- With fewer senior counsel taking on serious and complex criminal cases, the caseload is shifted to more junior counsel who may not be at an appropriate experience level to assume lead carriage of such files. Indeed John Struthers noted in his testimony that the average age (in terms of years of experience) for counsel taking on serious cases has been dropping and that instances where individuals charged with murder are being represented by lawyers who have never done a jury trial are not uncommon. He linked this problem with the inadequacy of Legal Aid rates.⁵²

⁵¹ *Testimony of Rob Buchanan*, February 19, 2008, pp. 146-148

⁵² *Testimony of John Struthers*, February 8, 2008, pp. 110 - 113

- The tariff structure does not provide junior counsel with many opportunities to assist in complex cases and learn in the process. Legal Aid rarely authorizes junior counsel to assist in serious cases and in the few cases where they do, junior counsel are paid at a rate \$58.17 for in court time. Not only are fewer junior counsel being authorized, but their rate of pay for in court time is even lower than a first tier lawyer.
- The trial process suffers. In an era where the efficiency of the criminal trial process is under constant scrutiny, the impact of an underfinanced defence system is that trials are not run as efficiently as they should be. Less experienced counsel will not have the confidence required to make tough calls in complex cases. Cases will not be streamlined and issue driven. Instead, trials will be run on a “prove it, everything is in issue” basis.
- The inequality in funding further tilts the playing field against the defence. It is not uncommon for a sole defence lawyer to defend a murder charge. On the other hand, it is standard practice for two Crowns to be assigned to a trial who in turn are assisted by experienced investigators.

60. Any comprehensive attempt to address the systemic failings under review by the Commission must examine the limitations of the current Legal Aid system. At a minimum, the hourly rates and tariff maximums need to be raised to levels where it makes some basic business sense for experienced counsel to take on complex criminal cases. A homicide trial should not be seen as a “practice killer”.

61. Consideration should also be given to ensuring that counsel undertaking complex criminal cases have the requisite degree of skill to deal with the cases. In this regard, the CLA suggests the creation of a fourth tier of Legal Aid pay rates restricted to counsel with sufficient years of experience and who also meet performance standards aimed at ensuring the requisite degree of experience and competence. The hourly rate in this fourth tier should be high enough to attract experienced senior counsel.

62. In terms of the proper funding of defence experts, the CLA respectfully adopts the proposals made by Prof. Christopher Sherrin in his research paper prepared for the Commission:

Proposal 11. Legal Aid Ontario should increase the hourly rate paid to pathologists to a rate closer to the rates commonly charged by pathologists to private clients. The Government of Ontario should provide Legal Aid with funding for this purpose.

Proposal 12. In compelling circumstances, such as where pathology evidence is critical to a case and seriously in dispute, the pathology issues are especially complex, or a preliminary inquiry transcript of the “Crown” pathologist’s testimony is not available, Legal Aid Ontario should be open to providing funding for the “defence” pathologist to attend court and assist defence counsel during the time when a pathologist is testifying for the Crown. The Government of Ontario should provide Legal Aid with funding for this purpose.

Proposal 13. Defence counsel should ensure that retained pathologists are fully informed of the terms of any Legal Aid funding authorization and that pathologists’ accounts are submitted and paid out promptly. Legal Aid should ensure that all funding terms are communicated clearly to defence counsel in a format that counsel can easily pass on to the retained expert.

Proposal 14. Legal Aid Ontario, perhaps in conjunction with the Criminal Lawyers’ Association, should commission a study to ascertain the experiences of defence counsel in obtaining funding for the services of pathologists and the actual practices of Legal Aid officials in responding to requests for such funding.

63. With respect to Proposal 11, the CLA acknowledges that the rate of remuneration needs to be balanced against the public duty that is being performed and that as a result a reduced private rate is most often appropriate. However, in appropriate cases Legal Aid should consider whether full private rates ought to be paid. In addition, Legal Aid should consider providing fair compensation for travel including where appropriate out of province travel. As this Inquiry has amply demonstrated, at times it is essential to involve experts from outside the province and even outside the country in order to ensure a fair and proper assessment of proffered expert evidence.

64. With respect to Proposal 12, the CLA respectfully submits that in cases where it is feasible, Legal Aid should be prepared to fund a pathology expert's personal attendance at an autopsy as well as other disbursements reasonably related to the proper review of expert evidence obtained by the Crown.

ROSTER OF APPROVED PATHOLOGISTS

RECOMMENDATION #22: That a list be established of qualified forensic pathologists who will have the responsibility for the performing post-mortem examinations and providing opinion evidence in related court proceedings for both the Crown and the defence.

RECOMMENDATION #23: That the composition of the list be based on the recommendation of the Chief Forensic Pathologist in consultation with the Forensic Services Advisory Committee.

RECOMMENDATION #24: That forensic pathologists included on the list be required to receive periodic training on (a) the adversarial system; (b) the role of expert witnesses in criminal proceedings; (c) effective report writing for use in criminal cases; and (d) testifying as an expert witnesses.

RECOMMENDATION #25: That, notwithstanding the creation of the list, defence counsel are free to consult with and call as witnesses forensic pathologists not included on the list and no adverse inference or comment can be made about the fact that the expert retained by the defence is not on the list.

65. In contrast to the system in place in the United Kingdom, whereby the Home Office has on its staff forensic pathologists who may from time to time be retained by either the prosecution or the defence for all services including the performance of a second post-mortem, defence counsel seeking to retain an Ontario pathologist are limited to those who may be willing to be retained by the defence. As indicated in his research paper, Prof. Sherrin found that these are relatively few in number⁵³ As a result, the defence is left to seek assistance out of province or from those retired pathologists prepared to accept such retainers.

66. It is understood that there is an ongoing shortage of forensic pathologists in Ontario at present and that there will be continued challenges to attract sufficient numbers of qualified medical practitioners to serve in this discipline. It is also acknowledged that there is a measure of inconvenience associated with the disruption of regular professional duties by participation in the criminal trial process, particularly having regard to the difficulties involved in the scheduling and presentation of evidence at trial. The relatively-small number of qualified forensic pathologists in Ontario make it that much more critical that they be required to accept defence retainers assuming that their level of expertise in the particular facts of the case would enable them to give opinion evidence and there is no conflict of interest.

⁵³ Sherrin, C, “Defending a Pediatric Death Case: Problems and Solutions”, PFP Inquiry Paper, pp. 16-22

PLEA BARGAINING

RECOMMENDATION #26: That the threshold test for commencing or continuing a prosecution must include a specific assessment of strength or weakness of anticipated expert evidence and particularly expert pediatric pathology evidence.

RECOMMENDATION #27: That both Crown and defence counsel remain at all times cognizant of the need to undertake plea discussions with the utmost integrity and competence, with a view, where appropriate, to the potential frailties of expert evidence.

RECOMMENDATION #28: That the Crown's position on the appropriate charge and facts for a guilty plea not be formulated simply for reasons of expediency, and not otherwise bring the administration of justice into disrepute.

RECOMMENDATION #29: That the process of pre- and post-charge screening continue to be fostered and made more effective by including screening based on a current understanding of the complexities of prosecuting cases involving pediatric forensic pathology.

RECOMMENDATION #30: That the Criminal Law Division Initiatives put forward by the Crown Attorneys include a clear statement that the process is accessible to the defence and that all information obtained on the pathologists be disclosed to the defence.

67. The evidence at this Inquiry has highlighted some of the potential dangers of our plea bargaining system. An assessment of this issue requires a brief overview of framework for our current plea bargaining system.

68. In 1993, the Martin Committee, headed by esteemed jurist G. Arthur Martin, released an extensive and thoroughly researched report entitled The Report of the Attorney General's Advisory Committee on Charge Screening, Disclosure and

Resolution Discussions.⁵⁴ The Report created a blue print for the efficient administration of the criminal pre-trial process and openly acknowledged the pressure of expediency, albeit expressed as the constitutionally entrenched goal of “prompt justice”. The Report also provided a number of recommendations aimed at establishing efficient charge screening, disclosure and resolution discussion protocols which would together insure that the values of fairness and justice would not be unduly affected or sacrificed in furtherance of efficiency or expediency. Most importantly, the Martin Committee Report provided perhaps the first clearly authoritative approval of the plea bargaining process in Canada. In the years that have followed the Report, plea bargaining has become a recognized staple of the criminal justice system.

69. The arguments for and against plea bargaining range from the theoretical to the practical. It is a debate that has consumed innumerable pages of academic journals as well as the occasional judicial pronouncement. Indeed, it has been noted that the debate between the proponents and the abolitionists has only yielded one commonality; all agree that plea bargaining in some form will remain a permanent component of the criminal justice system.⁵⁵ Moreover, all agree that as long as plea bargaining exists, people will question its legitimacy.

⁵⁴ Ontario, Report of the Attorney General’s Advisory Committee on Charge Screening, Disclosure, and Resolution Discussions (Toronto: Queen’s Printer, 1993) (Chair: G.A. Martin) [hereinafter the Martin Committee Report or the Report]

⁵⁵ J. Palmer, *Abolishing Plea Bargaining: An End to the Same Old Song and Dance*, (1999), 26 *Am.J.Crim.L.* 505 at p.512

70. Critics have also suggested that the risk of convicting the innocent increases when the coercive elements surrounding plea bargaining are left unchecked.⁵⁶ Excessive periods of pre-trial custody, overcharging and large sentence differentials between trials and guilty pleas are powerful incentives to accused persons.⁵⁷ The risk of convicting the innocent is a constant theme in most academic writing on the topic of plea bargaining. While many commentators note that it is difficult to quantify how many innocent people plead guilty, they all agree that the problem exists at least to some degree. Indeed, the prospect of an innocent person pleading guilty has been squarely raised in the testimony before this Honourable Commission.⁵⁸

71. The Martin Committee Report was aware of the potential drawbacks of a plea bargaining system and outlined some fundamental concerns in this regard. First, sentences handed out as the result of guilty pleas in early stages of the justice system had to be fundamentally fair to both the accused and to society. The Committee noted that the competency and responsibility of the counsel involved in resolution discussions was of key importance in ensuring this element of fairness. Second, the Committee emphasized that the optics of the resolution discussion system required that counsel discharge their duties “with flawless integrity and competence” such that the information eventually

⁵⁶ See D. L. Martin, “Distorting the Prosecution Process: Informers, Mandatory Minimum Sentences, and Wrongful Convictions”, (2001) 39 Osgoode H.L.J. 513 at p. 526. The conviction of the innocent is an especially relevant topic in the United States where the trial penalty is in many cases extraordinary. See McCoy, Candace. 2003. “Bargaining in the Shadow of the Hammer: The Trial Penalty in the USA,” in Douglas Koski (ed.), *THE CRIMINAL JURY TRIAL IN AMERICA*. Raleigh: Carolina Academic Press, wherein she suggests that in some states the trial penalty can be as high as 500%.

⁵⁷ J. Palmer, *Abolishing Plea Bargaining: An End to the Same Old Song and Dance*, (1999), 26 *Am.J.Crim.L.* 505 at p. 519

⁵⁸ *Evidence of David Gorrell, Bruce Hillyer, and John Struthers*, February 8, 2008

placed before the court in brief sentencing hearings was “properly responsive to the events in issue.”⁵⁹

72. The Committee suggested that principle, policy and practicality were all in favour of open resolution discussions in our justice system. In particular, Committee appeared to take great comfort from the fact that the discretionary nature of our system required that all counsel act with responsibility and integrity. The “proper” conduct of “competent” counsel participating in resolution discussions was the central basis upon which the Committee rested its blessing of resolution discussions. In fact, the Committee explicitly recognized that “improperly” conducted resolution discussions ran the risk of undermining the public’s confidence in the administration of justice.

73. The Committee reviewed four structural features of our system which, in its opinion, were conducive to resolution discussions; the carefully defined but broad right to waive constitutional rights; the broad discretion that counsel possess within the adversarial system; the mitigation that an early guilty plea brings and the right to full and timely disclosure. The Committee suggested that in light of structural features, a system of early resolution discussions could exist within or alongside our traditional adversarial system:

Our Continued commitment to an adversarial system of justice rests upon the conviction that it provides a manner of seeking out the truth for the purpose of attributing criminal responsibility in a way that is both effective and fair. However, without detracting from the virtues of the adversarial system, it is, in the Committee’s view, unquestionable that the existence of that system does not exclude resolution discussions as a different but equally appropriate way, in some

⁵⁹ The Martin Committee Report, at p.18-19

circumstances, of accomplishing the objectives that our criminal justice system pursues.

It is the Committee's view that resolution discussions can, in appropriate cases, be an important method of accomplishing the aims of criminal law. Assuming full disclosure by the Crown, two officers of the Court, who have familiarized themselves with the evidence uncovered during the investigation, are, in the Committee's view, entirely capable of reaching a responsible professional assessment of the practical realities of an accused person's position, both in fact and in law. Those same two officers of the Court may also be readily able to agree upon a more or less limited range of disposition for such an accused that will responsibly reflect the prevailing sentencing principles, subject, of course, to the fact that the trial judge is the final arbiter of the propriety of both the plea and the sentence imposed. In many such cases, the full panoply of procedures accompanying a criminal trial, if permitted to run their course, would add nothing to counsel's initial assessment. It is, therefore, appropriate, in the Committee's view to recognize these cases for what they are, and permit their resolution without the expense, inconvenience, and trauma of a full trial. The expertise and experience of Crown and defence counsel, each of whom agrees on an outcome that fulfills their respective duties to the community and the accused, are important assets in the administration of justice which should not be overlooked or minimized.⁶⁰

74. In order to guide the proper conduct of plea bargaining, the Martin Committee made a number of recommendations, some of which bear repeating:

1. The Committee recommends that for the purposes of a threshold test regarding the screening of charges by the prosecutor, the test of a "reasonable prospect of conviction" be adopted for all offences.⁶¹
2. The review to determine whether the threshold test has been met should include an assessment of the probative value of evidence, including some assessment of the credibility of witnesses.⁶²
3. The review to determine whether the threshold test has been met should include a consideration of the admissibility of evidence. The threshold test will not be met where evidence necessary to the prosecution is clearly or obviously inadmissible.⁶³

⁶⁰ Ibid., at p.287-8

⁶¹ Ibid., at p. 65

⁶² Ibid.

⁶³ Ibid.

4. The review to determine whether the threshold test has been met should include a consideration of any defences, for example alibi, that should reasonably be known of that have come to the attention of the Crown.⁶⁴

47. The Committee recommends that Crown counsel should not accept a plea of guilty to a charge where he or she knows that the accused is innocent.⁶⁵

48. Where Crown counsel knows that the prosecution will never be able to prove a material element of the case, Crown counsel has a duty to disclose this to the defence.⁶⁶

49. The Committee recommends that Crown counsel can accept a plea of guilty where he or she is aware that the prosecution will never be able to prove a material element of the offence provided this state of affairs is fully disclosed to the defence.⁶⁷

In view of the evidence before this Inquiry, the CLA respectfully submits that the Martin Committee recommendations for fair and efficient plea bargaining are in need of further refinement.

75. As a starting point, the threshold test for starting and continuing a prosecution should be further refined to include an assessment of the strengths and weaknesses of expert evidence and in particular forensic pediatric pathology evidence. While it may be that this is currently occurring any time a Crown assesses the viability of case involving expert evidence, a formal statement linking the concept of the reasonable prospect of conviction with a consideration of expert evidence is nonetheless warranted.

76. While the CLA accepts that it is difficult to draw a clear line demarcating when expert evidence will be too suspect or unreliable to form the basis of a prosecution, it

⁶⁴ Ibid.

⁶⁵ Ibid., at p. 291

⁶⁶ Ibid., at p. 295

⁶⁷ Ibid., at p. 299

remains important that the Crowns having carriage of case realistically assess the substance of proposed expert evidence, in combination with any contrary evidence that may be disclosed or be otherwise available. One of the lessons to be taken from this Inquiry is that Crown counsel need to maintain a healthy degree of skepticism in assessing expert evidence to avoid history repeating itself. To borrow a phrase, the Crowns need to “think dirty” when dealing with forensic expert evidence. A Crown faced with two reputable but competing experts opining on the main issue in a criminal trial should be extremely cautious about pursuing a prosecution.

77. In terms of plea bargaining, the CLA acknowledges that the integrity of the plea bargaining system rests in large part on the integrity and competence of the Crown and defence counsel who participate in the process. All counsel engaging in plea discussions need to be cognizant of the potential frailties of expert evidence and in particular forensic pediatric pathology evidence. More importantly, all counsel need to be cognizant of the risk that plea bargaining can easily create an incentive for an innocent person to plead guilty.

78. The Crown should not resort to plea bargaining to salvage a weak case. The potential for a miscarriage of justice is simply too great. In the context of child death cases, the prospect of facing a jury and a potential life sentence creates a manifest danger that an accused person will act by seeking to minimize and rationalize that risk and not on the basis of guilt or innocence.

79. In this regard, the CLA requests a recommendation that seeks to limit plea bargaining on the basis of expediency. The Crown should be prohibited from offering a plea to reduced charges or facts solely on the basis of expediency. If a plea is offered it should be realistically and substantively tied to provable facts. A plea should not be used by the Crown as a means of attenuating the risk of proceeding to trial on the basis of weak or potentially unreliable expert evidence. Most importantly, in offering a plea, the Crown should be cognizant of and factor in the potential that in certain cases the incentives of a guilty plea may compel an innocent person to forego a trial. This risk is especially pressing where the differential between the available sentence after trial and that offered on a plea is extreme and where the plea involves an offence that is emotionally charged, like child abuse or death.

80. The CLA also encourages effective and realistic pre and post charge screening. This screening function should remain ongoing and be undertaken by Crown counsel with appropriate experience and skill levels as well as ability to freely exercise principled discretion. Simply put, the charges laid should match the available evidence. Crown should be encouraged to reduce charges wherever appropriate. Proper and ongoing charge screening complements effective plea bargaining and reduces the risk of miscarriages of justice.

81. The steps taken by the Crown Attorney's in creating the Criminal Law Division Initiatives should be applauded. However, it is the position of the CLA that they need to be expanded to include two additional points.

82. First, it should be made clear that The Criminal Law Division Child Homicide Resource Team will be accessible to defence counsel who want an independent review of the case against their client or who want the team to consider the appropriateness of a plea offer put forward by the assigned crown on the case⁶⁸. While an informal process of defence initiated review is already in place, the process should be formalized. The defence should be in a position to obtain a “second opinion” on a prosecution. Accessibility to the defence is vital. The adversarial system is accepted as a tool of truth seeking in our justice system. However, the adversarial system also has a proven tendency to polarize and entrench parties. This tendency creates a challenge for the prosecutors who are tasked to rise above the adversarial fray and undertake quasi-ministerial duties. The CLA notes that the vast majority of Crowns undertake their duties with great skill and high regard for ethics. Nonetheless, the challenge posed by the nature of the adversarial system coupled with the exigencies of prosecuting emotionally charged cases would be alleviated if the defence had access to system of review.

83. Second, the material obtained on any specific pathologist as contemplated by initiative 4 of the Criminal Law Division Initiatives should be disclosed to the defence whenever they have a case involving a pathologist in the data base.

JOINT EDUCATION PROGRAMS

RECOMMENDATION #31: That joint education programs on forensic pathology, including pediatric forensic pathology, be provided for Crown Attorneys and defence lawyers and funded by the Ministry of the Attorney General

⁶⁸ *Evidence of M. Edwardh*, February 19, 2008 at pages 129-131

84. Throughout this inquiry, many witnesses have testified that lawyers need to have a better understanding of pathology, in particular paediatric forensic pathology, in order to prosecute and defend cases better. As Christopher Sherrin noted “nothing guarantees the conviction of the innocent more than a bad lawyer”.⁶⁹ It is through education that lawyers can arm themselves with sufficient information to represent their clients to the best of their abilities.

85. All the pathologists and lawyers that testified at this inquiry agreed that educating lawyers about science in general, and about paediatric forensic pathology in particular, is absolutely necessary to protect better against wrongful convictions based on bad pathology. This recommendation was also made by Professor Sherrin in his paper that he wrote specifically for this inquiry⁷⁰.

86. While the solution seems simple, there is an obvious hurdle. The cost of continuing legal education is high. Given the low level of Legal Aid rates, many lawyers do not attend continuing legal education programs.⁷¹ It is therefore recommended that the Ministry of the Attorney General hold an annual free program, for Crowns and Defence lawyers, on pediatric forensic pathology. This is the best way to ensure equal access to education, and to guarantee that lawyers are properly trained to represent their clients.

⁶⁹ Sherrin, C., “Defending a Pediatric Death Case: Problems and Solutions”, p. 6

⁷⁰ *Ibid.*, p. 8

⁷¹ *Evidence of Mr. Edwardh*, February 19, 2008, p. 160-161; Legal Aid Rates as outlined by Mr. Nye Thomas, February 19, 2008, .

87. In order to ensure that the topics addressed at the continuing legal education are relevant to both the Crown and the Defence, a conference committee should be struck consisting of at least one Crown, one Defence counsel and one pathologist. This committee could then address issues regarding course content and enrolment.

ACCOUNTABILITY AND OVERSIGHT

RECOMMENDATION #32: That a clearly-defined mechanism of oversight and accountability for forensic pathologists in Ontario be established.

RECOMMENDATION #33: That the Chief Forensic Pathologist be given the statutory or regulatory authority to require compliance by forensic pathologists with provincial policies and practice directions on issues such as, but not limited to, the timely completion of post-mortem, supplementary and consultation reports or the release of materials to defence counsel for independent testing or examination.

RECOMMENDATION #34: That court monitoring letters, similar to those utilized by the Centre of Forensic Sciences, be sent to all counsel involved in court proceedings in which forensic pathologists have participated. Responses received which result in remedial action, including but not limited to removal from the list, by either the Chief Forensic Pathologist or any Board or Council, as may be established by the Office of the Chief Coroner of Ontario to deal with such issues, should be the subject of report to the Forensic Services Advisory Committee.

RECOMMENDATION #35: That a testimony review program be established whereby the testimony of forensic pathologists is observed or transcripts of evidence are reviewed by the Chief Forensic Pathologist or his or her designate on a regular basis.

RECOMMENDATION #36: That any errors, omissions or misstatements found in testimony given by a forensic pathologist be immediately reported to the forensic pathologist, the prosecuting Crown and the defence counsel involved in the case.

RECOMMENDATION #37: That a judgment review program be established whereby court rulings on the qualifications of a forensic pathologist, the admissibility of forensic pathology evidence or the quality of forensic pathology evidence are reviewed by the Chief Forensic Pathologist or his or her designate on a regular basis.

RECOMMENDATION #38: That the results of the court monitoring letters, the testimony review program and the judgment review program be reported to the Forensic Services Advisory Committee on a periodic basis.

RECOMMENDATION #39: That the results of the court monitoring letters, the testimony review program and the judgment review program be reported to the Criminal Law Division Homicide Resource Team on a periodic basis.

RECOMMENDATION #40: That the report prepared to the Forensic Services Advisory Committee or the Criminal Law Division Homicide Resource Team be made available to defence counsel on request.

RECOMMENDATION #41: That the Criminal Law Division Initiatives be amended to require the prosecuting Crown to report any adverse judicial comment made in respect of the qualifications or evidence of a forensic pathologist to the Chief Forensic Pathologist.

88. A significant aspect of the systemic problems revealed during the course of the Inquiry was the lack of any meaningful oversight regarding the work of Dr. Smith. Neither the Chief Coroner nor the Deputy Chief Coroners were pathologists. As a result, they were not qualified to assess the complexities of pediatric pathology involved in the deaths of the children and the opinions expressed by Smith in his post-mortem reports and evidence. For the most part, they were not made aware of such opinions unless brought to their attention by media or complaint. Even then, whether as a result of delegation of responsibilities to others, acceptance of the explanations offered by Smith to negative or minimize criticisms, reluctance to inhibit the recruitment of forensic pathologists or the fact that the Ontario Pediatric Forensic Pathology Unit was based at the Hospital for Sick Children rather than the OCCO, no-one, including the Chief Forensic Pathologist, ever held Dr. Smith truly accountable for problems which arose over the years.

89. The evidence heard during the Inquiry confirms the observation of Prof. Sossin in his research paper on accountability:

The reach of the CFP in terms of oversight to regional offices and to the many part-time fee-for-service pathologists is uncertain and appears to depend on the personality of the CFP and the willingness of fee-for-service pathologists to accept guidance and direction. While the CFP can and has set policy and issued guidelines relating to autopsies and other aspects of death investigations, the fee-for-service pathologists do not report to the CFP and the CFP lacks the capacity to monitor compliance with these policies and guidelines across the province.⁷²

A similar lack of meaningful oversight was identified by Prof. Sossin with respect to the role of the OPFPU. The location of the Unit at the HSC, rather than in the OCCO, has resulted in the lack of clear supervisory guidelines, complaint mechanisms and effective measures for rectification.⁷³

90. The CLA adopts the comment of Prof. Sossin that the Chief Forensic Pathologist must be the “voice for all forensic pathology in Ontario.”⁷⁴ In that capacity, he should have the authority to require adherence to the policies established by his office and the responsibility to take such action as may be necessary to deal with complaints in the event of non-compliance. This may be established either by statutory/regulatory authority or by a contractual relationship between the OCCO and all regional and fee-for-service pathologists.

⁷² Sossin, L. , “Accountability and Oversight for Death Investigations in Ontario”, PFP Inquiry paper, p. 24; Evidence of Dr. Pollanen, 12/11/07, p. 85 l.14-18

⁷³ Sossin, *supra* at pp.48-9

⁷⁴ Policy Roundtable on Accountability, 13/02/08, p. 154 l.17-20

91. The record from this Inquiry is replete with examples of a fundamental lack of oversight. For example, the timely production of reports was an ongoing problem that was never adequately addressed. Dr. Smith testified that his repeated failure to produce reports in a timely manner was the product of his disorganization and procrastination. He pointed out that there were no enforceable time-lines or effective mechanisms in place to correct the problem.⁷⁵ Measures ranging from repeated telephone messages from police and Crowns, letters urging Dr. Smith to supply the needed opinions or materials and even a Court order requiring the completion of a report (in the case of Taylor) were used in the absence of some alternative recourse which could have elicited a more timely response.

92. At no time did Dr. Smith review transcripts of his evidence with any of his professional colleagues, either for comment on the substance of his opinions or his performance as a witness. He testified that he occasionally received transcripts from his evidence at preliminary hearings which he received and reviewed in order to prepare for his testimony at trial. Transcripts were never used as a means of quality assurance of his work as an expert witness. Dr. Smith suggested that such a review could well have been beneficial for his professional development, assuming that he would have been receptive to criticism.⁷⁶

While many of Dr. Smith's cases were revised by the "Pediatric Death Review Committee" (PDRC) and/or the "Death Under Five Committee" (DUFC), these

⁷⁵ *Testimony of Dr. Smith*, February 1, 2008, pp. 73-5

⁷⁶ *Testimony of Dr. Smith*, February 1, 2008, pp. 78 - 85

committees failed to provide a meaningful mechanism for oversight and accountability. While procedures implemented by Dr. Pollanen with respect to his reviews of post-mortems, particularly on difficult cases, have provided regional pathologists such as Drs. Rao, Shkrum and Dexter with the benefit of his expertise, reports submitted to the PDRC and the DUFC have not led to meaningful feedback regarding the post-mortem reports submitted.

93. The Morin Inquiry resulted in recommendations which have been implemented by the Centre of Forensic Sciences and which the CLA submits would be valuable aides to accountability. An administrative process of court monitoring has been established whereby the Centre issues a letter to Crown and defence counsel in every case in which a staff member has testified.⁷⁷ The letter requests comment by counsel on various aspects of the witness' participation. Dr. Ray Prime, Director of the Centre, reported that there was a substantial level of response to the request for this information and that the process was beneficial to the work done by his scientists.⁷⁸ The Forensic Advisory Committee, which was also established as a result of recommendations from the Morin Inquiry, receives an audit report on complaints received.⁷⁹

⁷⁷ PFP140213

⁷⁸ *Testimony of Dr. Prime*, February 13, 2008, p. 64 - 66

⁷⁹ Policy Roundtable on Accountability, *supra* at p.64 1.8-65 1.5; 74 1.24-76 1.6; 98 1.20-99 1.4; 107 1.16-23. A program of recording complaints as part of the Quality Review Committee known as CIRCA, was also discussed at the Roundtable by Prof. Cordner at pp.82-3.

94. Dr. Prime also described a court review program that was also established following the Morin Inquiry. Under this program, one of his staff goes to court with another scientist to observe and provide insight on his or her testimony.⁸⁰

95. The CLA recommends that an equivalent program be established by the CFP with the results of the audit of complaints received being reported to the Forensic Services Advisory Committee. With representation on the Committee by the Crown, defence counsel, police, pathologists and the Chief Coroner, the implementation of such a procedure could provide equivalent insight into possible problems encountered by those who interact with forensic pathologists in the criminal justice system.

96. Having regard to the fact that court proceedings involving the death of a child may most often result in a trial by jury, circumstances akin to those in Amber's case, where the trial Judge gives reasons for judgment addressing expert forensic pathology evidence, may arise infrequently. However, in light of the issues identified through this Inquiry, it is likely that there will be increased challenges to either the qualification of a pathologist to give opinion evidence on a particular issue or to the admissibility of the opinion being tendered. Accordingly, transcripts of reasons for judgment relating to the qualifications of an expert or the admissibility/reliability of his or her evidence should be ordered for review by the CFP.

⁸⁰ Policy Roundtable on Accountability, supra at p.63 1.17- 64 1.7 Similar programs of court monitoring were described by Prof. Cordner at pp.66-70 and Dr. Ranson at pp.72-73

97. The CLA recognizes the challenges which would result from the need for personal attendance by a forensic pathologist at proceedings in which another pathologist may give testimony. However, the advantages of personal observation of not only the content of the evidence but the demeanour of the witness cannot be overstated. Accordingly, the CLA recommends that a program of court monitoring be established by the OCCO with personal observation where possible and the ordering of all transcripts and regular review of a representative sampling of the testimony of all forensic pathologists be conducted by the CFP or his designate.

All of which is respectfully submitted this 20th day of March, 2008.

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