
The Roles of Coroners, Police, Crown, and Defence

My recommendations are designed to restore and enhance public confidence in pediatric forensic pathology and its future use in the criminal justice system. It is therefore not surprising that much of the focus must be on forensic pathologists and the issues surrounding their training, education, accreditation, oversight, and accountability. But it must also be recognized that other participants in the criminal justice system have important roles to play in protecting the public against the introduction of flawed or misunderstood pediatric forensic pathology into the system. The unique role of the court is discussed in Chapter 18, The Role of the Court. Here, I address the roles that coroners, police, Crown counsel, and defence counsel can play in helping to achieve the objective.

CORONERS

The coroner has statutory responsibility for the death investigation. However, coroners are not just passive overseers. They perform an active role in the death investigation in cases where a post-mortem examination is done, and their actions may significantly affect the opinion ultimately provided by the pathologist and, therefore, the outcome of the investigation itself.

One need only examine the responsibilities set out in the April 2007 Guidelines for Death Investigation to understand the critical role of the coroner. These include:

- 1 attending at the death scene;
- 2 communicating with the police and others;
- 3 examining the body, if attending the scene;
- 4 recording information about the body, such as its temperature, the presence or absence of rigor mortis, and the presence, type, and pattern of lividity;

- 5 pronouncing death;
- 6 issuing a warrant for post-mortem examination, where appropriate;
- 7 obtaining medical records of the deceased;
- 8 communicating with the pathologist; and
- 9 completing the coroner's investigation statement and the medical certificate of death.

As evidenced by these responsibilities, the coroner can be an important source of information for the forensic pathologist who conducts the autopsy. It follows that deficiencies in the information collected by the coroner may have an adverse impact on the forensic pathologist's work. For example, in Jenna's case, the coroner failed to relay to Dr. Charles Smith, verbally or in the warrant for post-mortem examination, that a hair had been observed in Jenna's vaginal area during resuscitation efforts. Although Dr. Smith had a copy of Jenna's hospital records, which should have alerted him to this information, the coroner and the police should have highlighted it for Dr. Smith.

In Chapter 15, Best Practices, I discuss the importance of accurate and thorough communication of information by the coroner to the forensic pathologist in the warrant of post-mortem examination, verbally and through the provision of all relevant medical records, where feasible. I also discuss how their verbal communications should be documented.

While the coroner and the forensic pathologist must work in close cooperation, it is also vital that the coroner respect the forensic pathologist's expertise and independent professional judgment. In particular, coroners should refrain from expressing medical conclusions in their early communications with the forensic pathologist. Although coroners make final determinations about cause and manner of death, they are well advised to await the considered opinions of forensic pathologists before expressing such conclusions.

Recommendation 101

The coroner and forensic pathologist should work in close cooperation where there is a post-mortem examination. In doing so, the coroner should respect the forensic pathologist's expertise and independent professional judgment.

In addition to the recommendations contained in other chapters, there are two additional features of the coroner's role that require elaboration here: the coroner's role in promoting early and ongoing case conferencing in pediatric forensic cases, and the need for coroners to avoid providing opinions outside their expertise.

Case Conferences

Case conferences are multidisciplinary meetings involving members of the death investigation team. They are intended to promote the participants' awareness of the issues in the case, and they allow for informed decision-making. In complex cases, such as criminally suspicious pediatric death cases, early case conferencing is critical. Case conferences inform police investigators about the scope and limitations of the available science, including forensic pathology. They enable discussion of further testing and ensure prioritization of sample submission to the Centre of Forensic Sciences (CFS). If used correctly, multidisciplinary case conferencing can reduce the danger of confirmation bias – the tendency to test one's theory of the case by looking for instances that confirm it – and be used as a vehicle to critically assess the available information and any deficiencies or weaknesses in that information. This potential benefit of case conferencing depends on the participation of those who understand, through education and training, the importance of an evidence-based approach to death investigations and the need to maintain objectivity. If the participants do not approach case conferences in an objective and non-adversarial manner that seeks the truth and recognizes the limits of the available information, there is a danger that case conferences may reinforce rather than counteract the dangers of confirmation bias or tunnel vision.

The regional coroner generally convenes and chairs case conferences. Police and the investigating coroner always attend. The forensic pathologist need not attend if the cause of death is straightforward and there are no controversial issues related to medical evidence. Representatives from the children's aid society (CAS) and the CFS may also be present. Crown counsel do not usually attend early case conferences, but may do so on rare occasions to gain a better understanding of the medical and forensic issues. Some Crown counsel have raised the legitimate concern that their involvement at this early stage may be incompatible with the important separation between investigation and prosecution. I agree that, generally, Crown counsel will not be involved in early case conferences, but recognize that there may be circumstances where their participation in such conferences will enable them to understand the underlying facts in order to provide early legal advice to the police. When attending case conferences, Crown counsel should of course remain mindful of their independent and quasi-judicial role.

The regional coroner generally keeps notes identifying the participants and the decisions made at the case conference. In the past, there were varying practices respecting disclosure of these notes to the defence. Currently, the Office of the Chief Coroner for Ontario (OCCO) has determined, on the advice of legal counsel, that the notes should form part of the disclosure package provided for

criminal cases. In my view, their inclusion is appropriate. They enhance the transparency of the death investigation and offend no public interest principles, and the notes are likely to contain relevant information.

The evidence at the Inquiry illustrated the important role that case conferencing can play. On November 28, 1997, a case conference (although not formally designated as such) was held regarding Nicholas' case. Attending were Chief Alex McCauley, Deputy Chief Jim Cunningham, Superintendent Fern Kingsley, Inspector Brian Grisdale, Sergeant Robert Keetch, and Sergeant Dave West, all of the Sudbury Regional Police; Dr. Smith; and Crown counsel Greg Rodgers. There was an extensive discussion of the available forensic evidence, most particularly Dr. Smith's opinion that Nicholas had died from cerebral edema caused by blunt force trauma *in the absence of a credible explanation*. Ultimately, it was concluded that the opinion was incompatible with proof beyond a reasonable doubt, resulting in the decision not to proceed criminally against Nicholas' mother.

In Jenna's case, during the second investigation that followed the withdrawal of charges against Jenna's mother, Brenda Waudby, Dr. Michael Pollanen, the Chief Forensic Pathologist, convened a case conference. It included officers from the Ontario Provincial Police (OPP) and the Peterborough Lakefield Community Police Service; the Chief Coroner and the Deputy Chief Coroner; Dr. Robert Wood, the forensic odontologist; and a member of the Suspected Child Abuse and Neglect (SCAN) Program. They discussed the existing medical evidence, most particularly the pathology. The conference generated suggestions as to further opinions to be sought and testing to be done. The renewed investigation, which drew on those suggestions, ultimately led to the arrest and conviction of J.D., Jenna's babysitter.

These examples, although resulting in very different outcomes, demonstrate the value of early and ongoing case conferencing. In addition to the benefits described earlier, case conferences ensure that forensic pathologists correctly appreciate the underlying facts and the real issues in the case. They also represent a further opportunity for forensic pathologists to communicate with the police and ensure that there are no misunderstandings surrounding the scope and limitations of their opinions.

Case conferencing is certainly not a novel idea. In June 1996, Justice Archie Campbell, in his report on the Paul Bernardo police investigation, the *Bernardo Investigation Review: Report of Mr. Justice Archie Campbell*,¹ endorsed the collab-

¹ *Bernardo Investigation Review: Report of Mr. Justice Archie Campbell* (Toronto: Ministry of the Solicitor General and Correctional Services, 1996).

oration of members of various disciplines – including coroners, police, forensic scientists, and forensic pathologists – in homicides and criminally suspicious death investigations. The goal was to pool the work of the different disciplines and provide an opportunity to focus collectively on the key issues.

In 1998, the Commission on Proceedings Involving Guy Paul Morin (the Morin Commission) endorsed the Campbell model, which contemplated “ongoing case conferences between the various players throughout the investigation. . . . All this is done in order to ensure that information is exchanged, the right forensic tests are being done in the right order, and things are being delivered when they are meant to be delivered.”²

Currently, the OCCO recommends that a case conference be held within two weeks of the autopsy for every homicide and criminally suspicious death, and that case conferences occur before the laying of criminal charges where such charges rely significantly on pathology or toxicology evidence. Where the latter is not possible, case conferences should occur as soon as possible after charges are laid. I endorse this approach. It has particular appeal for pediatric forensic cases, which are generally complex and rely heavily on the pathology.

In addition to early case conferences, subsequent case conferences may be necessary after all the information and test results have been received. Again, I endorse ongoing case conferencing because it encourages, on a continuing basis, dialogue among the members of the death investigation team. New information about cases should not be “sprung on” the forensic pathologist by the police or Crown counsel in court or on the eve of the preliminary hearing or trial. Case conferencing represents one way that forensic pathologists can stay informed of developments that may affect their opinions. It is also an early opportunity to have others scrutinize the forensic pathologist’s opinion.

Of course, regardless of whether further case conferences take place, new information or developments in the case that may affect or invite reconsideration of the forensic pathologist’s opinion should be promptly communicated to the forensic pathologist and recorded by those involved. Such information should also generally be subject to disclosure in the criminal proceedings.

I wish to add a cautionary note with respect to case conferencing. In the earlier chapters on Best Practices (Chapter 15) and Effective Communication with the Criminal Justice System (Chapter 16), I discuss the limited use that forensic pathologists should make of non-pathology information or circumstantial evidence. For example, forensic pathologists should not base an opinion as to cause

² Ontario, *The Commission on Proceedings Involving Guy Paul Morin: Report*, vol. 2 (Toronto: Ontario Ministry of the Attorney General, 1998), 1118 (Commissioner Fred Kaufman).

of death on a confession when the pathology findings do not otherwise support that opinion. The cause of death in such a case should be classified as undetermined. However, coroners determine cause and manner of death in fulfillment of their own statutory responsibilities and, in doing so, may base their decisions on the totality of the evidence collected in the death investigation. They may rely more heavily on a confession or other circumstantial evidence that they regard to be compelling.

Thus, a scenario can arise in which the forensic pathologist properly concludes, based on the existing pathology evidence, that the cause of death is undetermined, but the coroner concludes, based in whole or in large part on a confession, that the deceased was the victim of a homicide. This disparity, if misunderstood, can lead to confusion on the part of the investigators and even tension when the matter is the subject of a case conference.

In my view, there are two important considerations that must guide the police and, later, the Crown in these cases. First, all participants in the justice system must understand that the different conclusions reached by the coroner and the forensic pathologist in the scenario described are not incompatible. On the contrary, they are explained by the different roles played by each. Case conferencing is designed to facilitate an open-minded multidisciplinary discussion of the issues. But pressure should not be exerted on the forensic pathologist at a case conference, or elsewhere, to change his or her opinion to conform to the coroner's determination, particularly when their different roles are properly understood. Second, it must be understood that the coroner's determination is not an expert pathology opinion, and it should not be treated as such. This is important when police determine whether the evidence supports the laying of charges; and when the Crown decides whether there is a reasonable prospect of conviction and, ultimately, what expert evidence is available to the prosecution.

Recommendation 102

The Office of the Chief Coroner for Ontario should continue to facilitate early and ongoing case conferencing, particularly for criminally suspicious pediatric death investigations. Such case conferencing promotes the exchange of relevant information among the participants, an objective and informed investigation, and forensic pathology opinions that are accurate and address the real issues in the case.

Recommendation 103

Case conferences should be recorded in notes that ultimately form part of disclosure in criminal cases.

Recommendation 104

Case conferences are excellent opportunities for members of the death investigation team to communicate among themselves. However, they do not provide the only opportunity for communication. The members of the death investigation team should engage in regular and ongoing communication, particularly when the death investigation uncovers new evidence. That evidence should be presented to the forensic pathologists to allow them to reconsider their opinion in light of the new information. Any such communications should be documented by the parties involved in those communications.

Recommendation 105

Participants at case conferences should understand the respective roles of coroners and forensic pathologists, and how those roles affect the scope and nature of the opinions that they are able to render. A proper understanding of those roles may assist in preventing pressure from being exerted on forensic pathologists to change their opinions in order to conform to a coroner's determination of cause or manner of death. It may also assist in preventing police and Crown counsel from placing unwarranted reliance on non-expert opinions rendered by coroners for purposes other than the criminal justice system.

The Coroner's Expertise

The evidence at this Inquiry provided examples of opinions expressed by coroners that fell outside their expertise. In Nicholas' case, for example, Dr. James Cairns, the Deputy Chief Coroner, swore an affidavit on behalf of the CAS in its proceedings against Nicholas' mother. In the affidavit, Dr. Cairns expressed the opinion that Dr. Smith's characterization of Nicholas' cerebral edema as severe (rather than mild, as described by the local pathologist who performed the original autopsy) was correct. He also confirmed Dr. Smith's finding that Nicholas did not die of sudden infant death syndrome, but of severe cerebral edema caused by the intentional use of force.

As he acknowledged at the Inquiry, Dr. Cairns was unqualified to provide expert opinion evidence on those issues. His stature as Deputy Chief Coroner gave his opinion evidence an added credibility it did not deserve. Dr. Cairns now recognizes that the affidavit was inappropriate and indeed misleading (albeit unintentionally) since it appeared to be based on his own independent expertise when it was, in fact, based entirely on Dr. Smith's views.

In Paolo's case, Dr. Cairns drafted a letter in which he stated he had no concerns regarding Dr. Smith's opinion. The issues in Paolo's case were outside of his expertise, and his support of Dr. Smith ultimately proved to be unwarranted and incorrect.

The Inquiry testimony of former Chief Coroner Dr. James Young concerning the timing of Jenna's fatal injuries reinforced the fact that even highly experienced coroners who are not pathologists have limited qualifications for expressing opinions on forensic pathology issues. As I have described earlier, he misconceived the flaw in Dr. Smith's opinion as to the timing of Jenna's fatal injuries. Dr. Young did not regard it as problematic for an expert to provide too broad a window within which the fatal injuries could be inflicted; he was concerned only if the window was too narrow. He failed to appreciate – in contrast to every forensic pathologist who testified – that providing too broad a window was no less flawed if the pathology could clearly narrow the time frame within which the injuries were inflicted to exclude a part of that window.

The point here is not that only pathologists can give opinions that are relevant to issues surrounding death. Clinicians may have a significant role to play – as Dr. Pollanen and others acknowledged – in advancing the death investigation on issues that are truly within their expertise. Indeed, in Jenna's case and Tyrell's case, the expert opinions of other medical practitioners were instrumental (as they should have been) in the prosecutorial decisions not to proceed to trial. But that being said, as a number of senior coroners themselves acknowledged at this Inquiry, coroners who are not pathologists do not generally possess sufficient expertise to provide forensic pathology opinion evidence to the criminal justice system, and they should avoid doing so. It is for this reason that they also acknowledged that coroners are unable to provide substantive oversight of the work of forensic pathologists, although their experience will often permit them to raise important questions for the forensic pathologists' consideration.

Recommendation 106

Coroners should avoid offering opinions in court proceedings that do not fall within their expertise. The danger is not only that the opinions may be wrong but also that they may be accorded undue weight because they emanate from the coroner's office.

POLICE

The police play a significant role in the investigation of a criminally suspicious pediatric death. They will often respond to the initial 911 call (with other emergency service providers) or attend the hospital if the child has been transported there. They will assume primary responsibility for the preservation and recording of the scene, the collection of much of the evidence, interviews with potential witnesses and suspects, and the determination of whether reasonable grounds exist to lay criminal charges.

As I emphasize throughout this Report, pediatric death investigations tend to be complex. Cause and manner of death, and the timing of fatal injuries or of the death itself, may not be readily apparent. A natural death may mimic abuse, and vice versa. Simply put, both pediatric forensic pathology and the overall death investigation are severely tested by cases of this kind.

All of this reinforces the desirability that, when these cases present themselves, police investigators have specialized training and expertise. Such expertise, however, will often not be available to the investigating police service. Indeed, for a number of the cases examined at the Inquiry, the police officers who performed the initial investigation and/or attended the autopsy had no specialized training in pediatric death investigations. That is no reflection on the individual officers, but simply the reality. Moreover, some police services may find it difficult to justify the allocation of resources to confer specialized training in pediatric forensic investigations (even if those resources were otherwise available), given the thankfully rare instances of criminally suspicious pediatric deaths in their jurisdictions.

Terri Regimbal, who was the prosecuting Crown counsel in Amber's case, testified that Northern Ontario has many small municipal police forces whose officers do not have the levels of experience or training that members of the Ontario Provincial Police possess. She attributed the differences in training to a lack of resources, including training budgets for smaller police services.

In Joshua's case, Staff Sergeant Greg MacLellan was the investigating officer. He was then the head of the criminal investigations branch for the Trenton Police Force, but he had never previously led a homicide investigation, investigated a suspicious pediatric death, or attended an autopsy. He testified that, had he been experienced in these investigations, he would have resisted Dr. Smith's suggestion that he leave the deceased's body unattended by an officer. He believed then (and believes now) that he should have remained with the deceased's body to preserve continuity. He described his encounters with Dr. Smith over having taken notes at the autopsy and over his insistence that Dr. Smith properly investigate and report on alternative explanations for Joshua's death raised by the evidence. While Staff

Sergeant MacLellan is clearly an excellent officer who was able to overcome any lack of specialized training, it was obvious that he would have preferred to possess sufficient expertise to evaluate the merits of what Dr. Smith told him about report-writing and leaving the deceased's body unattended.

Detective Sergeants Chris Buck and Gary Giroux, both members of the Toronto Police Service (TPS) homicide squad and the Paediatric Death Review and Deaths under Five committees, participated in our policy roundtables. Detective Sergeant Buck explained that TPS policy sets out that the homicide squad is notified whenever a child under the age of five dies in Toronto. The squad's on-call team advises attending officers on investigative procedures to follow at the scene. The on-call team will also contact Detective Sergeant Buck or Giroux for their input because of their expertise (even within the homicide squad) in pediatric deaths. Members of the homicide squad do not attend every death scene because the vast majority of these children's deaths are not homicides.

The expertise that Detective Sergeants Buck and Giroux bring to pediatric cases in Toronto is not available in most Ontario jurisdictions, particularly in smaller communities. Officers from various police services (Peterborough Lakefield Community Police Service, Greater Sudbury Police Service, and Trenton Police Service) all emphasized the desirability that police expertise be made available where needed.

Detective Sergeant Giroux proposed that a team of specially trained investigators be on call at all times to provide advice to any police service that requires assistance with pediatric death investigations. John Ayre, the Crown Attorney for Norfolk County, also supported this approach, as did the police officers referred to earlier.

It is recognized that this expertise is likely to be drawn from the TPS, the OPP, and perhaps a few other large police services. For example, the OPP already has procedures and training in place for death investigations involving children under the age of five years. Investigators must acquire certain knowledge and skills through ongoing training to conduct these investigations.

I endorse the development of specialized training and expertise for police in pediatric death cases. Where it cannot be provided to a police service's investigators, the investigators should have quick and ready access to officers from other police services who have this expertise.

Recommendation 107

The Ministry of Community Safety and Correctional Services, police colleges, and the Ontario Forensic Pathology Service should work together to provide special-

ized training on pediatric forensic death investigations for select officers, and more basic training for other officers on forensic pathology and the issues identified at this Inquiry.

Recommendation 108

Criminally suspicious pediatric death investigations should be conducted, where possible, by officers having specialized training and expertise in such cases.

Recommendation 109

- a) The Ministry of Community Safety and Correctional Services should create and maintain a roster of officers with specialized training and expertise in pediatric death investigations.
- b) Those officers should be available, when needed, to provide advice to any police service in Ontario respecting the investigation of these cases.
- c) This roster, together with 24-hour contact information for the on-call officer(s), should be disseminated to all police services in Ontario.

In Chapter 15, Best Practices, I recommend that forensic pathologists remain vigilant against confirmation bias. In particular, I discuss the danger of confirmation bias as a result of the pre-autopsy communications between the police and the forensic pathologist. Police officers must be equally vigilant against confirmation bias in their own investigative work and in how they communicate with forensic pathologists. This means that even in casual, unguarded conversations, they must objectively present the evidence, with an understanding of how their comments may have an impact on the forensic pathologist. As I note in Chapter 15, the best safeguards against confirmation bias are increased professionalism, an enhanced awareness of the risks of confirmation bias, the promotion of an evidence-based culture, and transparency of the communications between the forensic pathologist and the police. Those principles apply not only to the forensic pathologist but also to the police.

Recommendation 110

The police should be trained to be vigilant against confirmation bias in their investigative work generally, and for pediatric forensic cases in particular. This training is best accomplished through increased professionalism, an enhanced awareness

of the risks of confirmation bias, the promotion of an evidence-based culture, and complete transparency regarding what is communicated between the police and the forensic pathologist.

CROWN

The Ministry of the Attorney General (Criminal Law Division) has recently developed a number of initiatives respecting the prosecution of child homicide cases.³ These initiatives followed the revelation of some of the concerns that brought about this Inquiry. The initiatives were introduced during the Inquiry, and I was invited to comment on them. The key components are summarized below:

- The Criminal Law Division (CLD) will create an eight-person child homicide resource team (Child Homicide Team), chaired by the CLD lead for child homicide cases in the province. The first division lead will be John Ayre. The rest of the team will be made up of senior Crown counsel: six from the regions, one from the Crown Law Office – Criminal, and one from the policy branch. The Child Homicide Team will have an advisory role, assisting prosecuting Crowns at all stages of prosecutions in child homicide cases. It will be mandatory for the prosecuting Crown to consult with the Child Homicide Team at the earliest possible stage and at every stage of the prosecution thereafter. When a prosecuting Crown assigned to a child homicide case contacts the Child Homicide Team, a specific member of the team will be assigned to assist the prosecuting Crown by providing expertise and advice and, possibly, even sitting as second chair at the trial.
- Subject to compliance with freedom of information and individual privacy legislation, the CLD will develop and implement an internal searchable database from which to identify and record all child homicide cases. It will be a performance measure for Crown supervisors and their managers to report on compliance with this initiative. The database will be a “web-based application, which will have all the current case law, articles, [and] references available for the Crowns who are doing those cases.” As well, the internal CLD-Net database will contain information that would allow prosecuting Crowns across the

³ The Ministry of the Attorney General defines “child homicide” for the purpose of these initiatives as “any suspicious death involving a child under the age of 12, where the cause of death or the time of death is not immediately apparent, and where the Crown is consulted by the police or where pediatric forensic pathology evidence services are engaged, whether charges are laid or not.”

province to communicate with one another about their contact with particular experts in child homicide cases.

- The CLD will develop and implement a mandatory reporting process for prosecuting Crowns where there is an adverse judicial comment regarding a pediatric forensic pathology expert witness, or where a prosecuting Crown has procedural or evidentiary issues with a pediatric forensic pathology expert witness. In such cases, the prosecuting Crowns will be required to report both to their supervisor and to the division lead for the Child Homicide Team.
- The CLD will direct local prosecuting Crowns to encourage local police agencies to engage in pre-charge screening with the Crown and relevant experts in all child homicide cases, except in cases where public safety concerns are engaged.
- The CLD will commit to educating prosecuting Crowns at the earliest opportunity on the recommendations of this Inquiry and the division's response to them. The CLD will commit to enhanced education on pediatric forensic pathology issues for the Child Homicide Team. The members of the team can then act as a resource for Crown counsel throughout the province who prosecute pediatric homicide cases.

Paul Lindsay, assistant deputy attorney general for Ontario, elaborated on the educational component of these initiatives. He contemplated that the education for prosecuting Crowns generally can be done at the Crown spring and fall conferences; at Crown “summer school,” where a course on prosecuting homicides is offered; and through the internal CLD-Net database – a searchable location for papers, discussions, and updates. As well, members of the Child Homicide Team will seek out educational opportunities relating to pediatric forensic pathology and impart what they learn to the rest of the CLD. It may be helpful, as was done in the aftermath of the Morin Commission in relation to the gathering, preparation, and presentation of physical scientific evidence, for the Ministry of the Attorney General, in conjunction with the OCCO, to draft a memorandum on forensic pathology, and its limits, to be distributed to Crown counsel throughout the province.⁴

I endorse these important initiatives. The Child Homicide Team would not only provide valued experience and expertise to individual prosecutors, but,

⁴ The memorandum was updated most recently on March 31, 2006, and provides guidance to Crown counsel on the following topics: Relationship between Crown Counsel and Forensic Science Witnesses – the Necessity of Impartiality; Retention of Evidence for Replicate Testing; Retaining Other Expert Witnesses; Duty to Obtain Written Record of Information Provided by Scientists; Disclosure; and Presenting Forensic Scientific Evidence at Trial.

armed with the lessons of this Inquiry, could collectively safeguard against the misunderstanding or misinterpretation of pathology evidence – and even overzealousness or tunnel vision, should that occur.

The Crown Attorneys' Association, while generally supportive of the initiative, queried whether the Child Homicide Team should, instead, actually prosecute the pediatric homicide cases, at least on an interim basis. Given the geographic expanse of the province, and the desirability of expanding the pool of expert prosecutors, I favour the current initiative. It recognizes, as I do, that there will be especially difficult cases that may compel a greater involvement on the part of the Child Homicide Team, including assuming the “second chair” or even leading the prosecution.

Marlys Edwardh, a senior defence counsel, also welcomed these initiatives, although she stressed the need for defence counsel to be able to approach the Child Homicide Team directly, should a disagreement arise with the prosecuting Crown. Without some institutional recognition of that right, defence counsel may be hesitant to do so (for fear of alienating the prosecutor), and the team may be hesitant to appear to be inappropriately “second-guessing” the prosecutor. Mr. Lindsay accepted this enhancement to the ministry's initiative, as do I. Defence counsel's right to access the team should be formalized in the Crown policy manual, or elsewhere, and made known to prosecuting Crowns and the defence bar. To state what is perhaps obvious, defence counsel's discussions should commence with the prosecuting Crown. Resort to the Child Homicide Team should be reserved for fundamental issues of concern.

Recommendation 111

The Ministry of the Attorney General (Criminal Law Division) should implement its initiatives on the prosecution of child homicide cases and the use of a Child Homicide Team as soon as possible.

Recommendation 112

Members of the Child Homicide Team should be experienced in homicide prosecutions and knowledgeable about the scientific method generally and pediatric forensic pathology in particular. Their education should be ongoing.

Recommendation 113

Defence counsel should be entitled to approach the Child Homicide Team when significant disagreements between the defence counsel and the prosecutor arise in

individual child homicide cases. That right should be formalized in ministry policies and made known to Crown counsel and the defence bar.

Involvement by the Child Homicide Team, either as part of its mandated consultation at each stage of the prosecution or at the instance of the defence bar, may be particularly important where the prosecution has offered the defence a plea resolution.

A number of the cases examined at this Inquiry involved guilty pleas to lesser charges for likely reduced sentences. One case involved the functional equivalent of a *nolo contendere* (or “no contest”) plea in which, although guilt was not admitted, the defence did not contest the evidence tendered, on consent, to support a finding of guilt. I have been advised that, in a number of these cases, the defendants assert their innocence and explain that they felt compelled to plead guilty to avoid the severe consequences that would follow a conviction on the original charges.

My mandate expressly prevents me from making findings in this regard. However, the concern remains that individuals may plead guilty to crimes they did not commit when, for example, a murder charge with mandatory life imprisonment and lengthy parole ineligibility is reduced to a charge of criminal negligence together with a joint submission of 90 days’ imprisonment. The concern is particularly relevant to the scope of this Inquiry where the case against the defendant is dependent on a flawed pathology opinion.

The Association in Defence of the Wrongly Convicted and the Mullins-Johnson Group urge me to recommend that plea offers by prosecuting Crowns in child homicide cases should require approval of the Child Homicide Team. In my view, the ministry initiative, as expanded on in Recommendation 114, addresses this concern. First, I interpret the ministry’s initiative, which mandates consultation by the prosecuting Crown with the Child Homicide Team at every stage of the prosecution, to include, by necessary implication, plea resolution offers by the Crown. This is a fundamental stage in the prosecution and in the exercise of prosecutorial discretion. In any event, the right of the defence to approach the Child Homicide Team would include those situations in which defence counsel are troubled by the offered plea, and the defendant’s possible innocence, and wish the matter to be reviewed by a member of the team. Mr. Lindsay and Paul McDermott, a senior Crown counsel, agreed that the Child Homicide Team should be accessible to the defence seeking to review a plea resolution offered by the prosecuting Crown.

Counsel for the Province of Ontario accurately noted that the Crown policy manual already prohibits prosecutors from accepting guilty pleas if they believe the

accused is innocent, or when they know that a material element of the offence cannot be proven, unless that fact is fully disclosed to the defence prior to the guilty plea. To be clear, my recommendations should not be read to imply that any prosecuting Crown acted unethically in offering or accepting a guilty plea in the cases examined at the Inquiry. I have made no such finding. Even with the utmost good faith of the prosecuting Crown, a serious injustice may result. My recommendations here and elsewhere in this Report are designed to reduce that possibility.

Similarly, much has been said about the ethical duties of defence counsel. It is clear that defence counsel are ethically prohibited from participating in a client's guilty plea without that client's acknowledgement that he or she committed the offence to be pleaded to, in all its constituent elements. This is particularly so when a guilty plea is coupled with inquiries from the court over whether the accused comprehends the plea and admits the offence pleaded to. Again, it is unnecessary here to discuss more fully those ethical duties and whether they were breached in individual cases. I make no such findings. But the pressures on the accused and their counsel in these cases are enormous, making it even more important that, in doubtful cases, the defence have access to the Child Homicide Team. And for that reason too, as I develop below, it is all the more important that defence counsel have the necessary skills and resources to defend these extraordinarily difficult cases.

Recommendation 114

The Child Homicide Team should, as an important component of its role, review cases in which plea offers have been made to the defence. This role will arise either as part of the mandated consultation by the prosecuting Crown with the team at every stage of the prosecution, or at the initiative of the defence.

Disclosure Issues Arising from the Ministry Initiatives

The ministry initiatives require prosecuting Crowns to report adverse judicial comments regarding pediatric forensic pathology expert witnesses – or procedural or evidentiary issues that the prosecuting Crowns have with these witnesses – to their supervisor and to the division lead of the Child Homicide Team. Had such a mechanism been in place during Dr. Smith's years, perhaps such reports would have alerted Crown officials at an early stage to judicial concerns about his work.

In Chapter 13, *Enhancing Oversight and Accountability*, I recommend that the Chief Forensic Pathologist review any adverse judicial comments brought to his

or her attention by the Crown. To enable the Chief Forensic Pathologist to do so, the division lead of the Child Homicide Team must report to him or her those adverse judicial comments as well as any other significant issues brought to his or her attention.

Apart from the creation of a reporting obligation for the division lead of the Child Homicide Team, there are likely to be criminal disclosure implications associated with the ministry's collection of this kind of information. The ministry initiatives do not currently address these disclosure implications, although several senior Crown counsel who participated in the Inquiry's roundtables thought it likely that disclosure obligations would indeed flow from the collection of this information.

In the United Kingdom, chapter 36 of the Crown Prosecution Service, *Disclosure Manual*, "Expert Witnesses – Prosecution disclosure obligations," provides detailed guidance for both experts and Crown counsel in that jurisdiction. The chapter sets out the disclosure steps that must be taken concerning information that may adversely affect the expert's credibility, competence as a witness, or both. Whenever witnesses are asked to provide expert evidence, they must submit to the investigating or disclosure officer what is known as the expert's self-certificate, revealing whether there is information capable of adversely affecting their competence or credibility as experts. Examples of such information are the discovery that

- the expert has not used established procedure in a scientific process;
- scientific theories that have been applied have been discredited in the mainstream field of expertise; or
- the expert has been partial in the information and material that has been taken into account in arriving at an opinion.

If the expert fails to do so, the manual lists several possible consequences:

- the prosecution may be halted or delayed;
- there may be an adverse judicial comment;
- any conviction may be found unsafe on appeal;
- professional embarrassment;
- disciplinary proceedings; or
- civil action by an accused.

However, revealing such information to the disclosure officer and the prosecution does not automatically mean that the information is disclosed to the defence. The

prosecutor must determine whether it meets the test for disclosure. Any doubt is resolved in favour of disclosure. As well, the decision to disclose or withhold information must be made by designated individuals. Bad character evidence, unresolved complaints, and disciplinary proceedings in relation to the expert will be examined by the prosecutor to determine if they are disclosable.

Any adverse judicial findings by a civil or criminal court, express or by inevitable inference, that an expert witness has knowingly misled the court, whether under oath or otherwise, must be recorded by the prosecutor and a transcript requested, where available. The prosecutor must consider whether this information should be disclosed in current or even in past cases involving the expert.

I do not intend to craft detailed guidelines or protocols in relation to adverse judicial comments or other identified issues with expert witnesses that set out when, and how, they should be disclosed. To underscore the need for the ministry, in consultation with others, to address this issue, I have highlighted the United Kingdom provisions. I am pleased that, in its written submissions, the ministry undertook to work with the OCCO to establish protocols to ensure that proper follow-up occurs when problems with the accuracy or reliability of a forensic pathologist's opinions are identified. The Province of Ontario noted that the protocols between the Crown and the Centre of Forensic Sciences, following the Morin Commission, could be instructive here. Those protocols set out a process for Crown counsel to communicate with the CFS regarding concerns about the credibility or reliability of its experts. I endorse the ministry's commitment to developing the appropriate protocols modelled on those implemented in the aftermath of that Commission.

Recommendation 115

- a) In accordance with Ministry of the Attorney General initiatives, a prosecuting Crown should report to his or her supervisor and to the division lead for child homicide cases adverse judicial comments or his or her own concerns about the participation of a pediatric forensic pathology expert witness in the criminal justice system.
- b) To enhance the oversight and accountability of such witnesses, the division lead for child homicide cases should report such comments or concerns to the Chief Forensic Pathologist.

Recommendation 116

In furtherance of the ministry initiatives, the ministry should develop, in consultation with others, guidelines or protocols modelled on the protocols for the Crown and the Centre of Forensic Sciences that followed the Commission on Proceedings Involving Guy Paul Morin. These would address:

- a) what adverse judicial comments or other identified concerns about pediatric forensic pathology expert witnesses should be reported;
- b) how these comments or concerns should be reported;
- c) what transcripts, if any, should be obtained, and by whom; and
- d) under what circumstances this information is disclosable, and in relation to what categories of cases.

The Crown's Obligations in Preparing for and Tendering Forensic Pathology Evidence

As I discuss earlier, one of the testimonial responsibilities of the forensic pathologist (which was sometimes unfulfilled by Dr. Smith) is always to be prepared for court. Forensic pathologists should meet with examining counsel in advance of the proceeding to review the case and prepare for testimony. This obligation rests, in the main, with the examining counsel. To enable the expert to give due consideration to issues raised in this meeting for the first time, it should, ideally, be held well in advance of the court proceedings. Several experts who appeared at the Inquiry noted the difficulties, not infrequently encountered, when hypothetical questions, scenarios, or potential weapons are presented to the forensic pathologist for the first time on the eve or morning of trial. Preparation of the witness should also focus on ensuring that the evidence is presented in a way that is clear, understandable, and grounded in the witness's expertise. Of course, whenever prosecutors meet with their experts, police officers should generally be present to take notes and facilitate disclosure of new or modified opinions or information provided by the forensic pathologist.

Part of the prosecutors' obligation to meet with expert witnesses, including forensic pathologists, in advance of the court proceeding is to ensure that the prosecutors understand the limitations on their expertise and opinions. Those limitations should be respected during the Crown's examination-in-chief. The transcripts of Dr. Smith's examinations in the cases reviewed at the Inquiry reveal instances in which the Crown's questioning invited responses that

exceeded the scope of even Dr. Smith's generous interpretation of his own expertise.

It was not only Crown counsel who fell into that trap. We saw examples at the Inquiry of both Crown and defence counsel not respecting the limitations of the expert witness. Dr. Smith and other experts were often pushed outside of their expertise and invited to speculate by both Crown and defence counsel. In fairness, on a number of occasions Dr. Smith needed no invitation to speculate. Moreover, we saw examples of both parties not being sufficiently careful in the language they used to question the expert, and even suggesting that the witness adopt troublesome language (for example, "consistent with"). And we were told by a number of forensic pathologists who appeared at the Inquiry of implicit pressure being placed on the expert to respond immediately to new facts, hypothetical scenarios, or both.

Although experienced counsel for both the Crown and the defence may, with the court's approval or acquiescence, permit some latitude to expert witnesses at a preliminary hearing – indeed there may be tactical advantages to doing so – everyone should be vigilant, particularly at trial, to ensure that the experts' opinions are properly confined within their expertise. Counsel must exercise care in not pushing experts to a place that cannot be supported by the science. It is sometimes all too easy to press such experts to abandon limitations or qualifications on their opinions that, in fact, ensure that those opinions are evidence based and reasonable. Counsel should also not introduce, through their questioning, terminology that breeds misunderstanding or misinterpretation; for example, inviting the expert (as was done in one of Dr. Smith's cases reviewed at the Inquiry) to opine that the death was "consistent with" various enumerated criminal events. The experts must also be given time to consider any new facts or hypothetical questions presented to them.

Recommendation 117

Crown counsel should properly prepare forensic pathologists for giving evidence. This preparation involves, among other things, meeting with the pathologist in advance of the court proceedings. Such meetings will assist the Crown in understanding the limitations on the expert's expertise and opinions. The preparation of the expert should also focus on presenting the evidence in a way that is clear, unambiguous, understandable, and grounded in the witness's expertise.

Recommendation 118

The following principles should inform the approach of both parties to the evidence of forensic pathologists:

- a) Both parties should ensure that they understand the scope and limitations of the forensic pathologists' expertise and opinions. They should exercise care not to ask questions that invite forensic pathologists to speculate, or to stray outside of their expertise or the outer boundaries of the science.
- b) Both parties should be vigilant not to introduce, through their questions, terminology that breeds misunderstanding or misinterpretation.
- c) Subject to the court's discretion, both Crown and defence counsel should also allow forensic pathology experts reasonable time to consider their responses to new information that may be relevant to their opinions or any limitation on them.

DEFENCE

I observed earlier that criminal pediatric death cases should be defended by counsel who have the necessary skills and resources for these extraordinarily difficult and serious cases. However, the evidence at the Inquiry suggests that a number of highly skilled counsel are reluctant to take on these cases if they are funded by legal aid.

As of August 2008, the top legal aid tariff, reserved for counsel with 10 or more years of experience in criminal law, is \$96.95 per hour. For counsel with five to 10 years of experience, the hourly rate is \$87.26. Counsel with less than five years' experience are paid \$77.56 per hour. When junior counsel are authorized by Legal Aid Ontario (LAO), they are paid an hourly rate of \$58.17.

Professor Michael Code, now a member at the Faculty of Law, University of Toronto, has served as a senior defence counsel and as assistant deputy attorney general. He told the Inquiry that there is a trend away from senior lawyers accepting long and complicated legally funded cases because the funding is inadequate. As a result, junior lawyers who are not ready to defend complex cases have to take those cases on. His comments were echoed by John Struthers, another senior member of the defence bar.

Professor Code was sharply critical of the relatively low increases in the LAO tariff for defence counsel. He noted that three out of the four major players in the criminal justice system, namely the police, the Crown, and the judiciary, have had

dramatic salary increases in the last 20 or 30 years. Meanwhile, the LAO rates for defence counsel have increased only 15 per cent since 1976.

Mr. Struthers also indicated that there are many serious criminal cases in which LAO does not authorize co-counsel or junior counsel. By way of contrast, most murder cases, he said, are prosecuted by two Crown counsel who are also assisted by police investigators.

Both Professor Code and Mr. Struthers expressed the view that it is necessary to address the underfunding of defence counsel on legal aid certificates in order to attract the best lawyers to these complex cases.

Nye Thomas, director of strategic research at LAO, and Rob Buchanan, LAO vice-president for the Greater Toronto Area, participated in a policy roundtable that considered this issue. Mr. Buchanan indicated that senior defence counsel continue to take serious criminal cases on legal aid. However, both men agreed that the current tariff is insufficient and below market rates. Mr. Thomas made the point that although the tariff should be increased, it is currently governed by the province through regulation; without more money overall, it is not possible to fund a higher tariff over the long term. LAO has proposed deregulation of the tariff so that it can establish the rules governing compensation. This would give LAO greater flexibility for making innovations, including the possible creation of a fourth tier of payment that would provide a higher tariff for the most serious matters defended by the most qualified lawyers.

I was also informed that LAO has taken steps toward ensuring that only experienced and competent counsel take on serious criminal matters. In October 2007, it established the “Extremely Serious Criminal Cases Panel.” Eligibility for this panel is limited to lawyers who have five years of continuous criminal practice or the equivalent; have 100 days of contested trial or preliminary hearing work; have acted as counsel, co-counsel, or junior counsel on at least one jury trial; have conducted a minimum of five *voir dire*s relating to the admissibility of evidence; and a minimum of five contested *Charter* applications. These criteria allow the lawyers who qualify to defend serious criminal charges, defined as those that have a mandatory minimum sentence of at least four years’ imprisonment. I note that these would include pediatric death cases where the charge is murder, but not manslaughter or criminal negligence causing death where a firearm was not used.

Professor Code was of the view that the LAO Extremely Serious Criminal Cases Panel is an inadequate measure for ensuring that only competent counsel defend child homicide cases. The current eligibility criteria do not ensure competence in these cases. Moreover, he emphasized that in pediatric forensic pathology cases, counsel must be “strongly qualified to cope” with pediatric forensic pathol-

ogy evidence in order to competently defend such cases. He also stressed the ethical rule that defence counsel cannot take on cases that they are not competent to conduct and suggested that LAO and the Law Society of Upper Canada insist that defence lawyers not take on these cases unless they are trained in pediatric forensic pathology. In an independent research study for the Inquiry, Professor Christopher Sherrin also documented the difficulties that defence counsel have in obtaining training in pediatric forensic pathology.

In my view, the need for highly skilled counsel in pediatric death cases, particularly those cases that involve contested forensic pathology, cannot be overstated. In a similar context, Commissioner Fred Kaufman made the following comment in the *Report of the Commission on Proceedings Involving Guy Paul Morin*:

The success of the adversarial system in preventing miscarriages of justice largely rests upon the existence of well-trained, competent prosecutors and defence counsel. This necessarily involves defence counsel who are adequately compensated for their work and who have adequate resources to ensure that appropriate investigative work is done and appropriate witnesses (particularly expert witnesses) are accessible.⁵

I agree. I also note that Professor Michael Trebilcock's recent *Report of the Legal Aid Review 2008* highlights the need for the legal aid tariff to be increased, particularly for criminal and family lawyers, to help ensure that qualified counsel take on legal aid cases.⁶ He recommends that the tariff be significantly raised in the immediate future.

Although I later make recommendations to promote the education of both Crown and defence counsel on pediatric forensic pathology issues, I do not think that such education need be a precondition for defence counsel to be eligible to take on these cases on legal aid. There are senior counsel whose skills in cross-examination and in dealing with expert witnesses generally equip them well to acquire the needed knowledge in an individual case to defend it successfully. Regardless, steps must be taken to increase the funding available for these cases to assist in ensuring that, so far as possible, they are defended by the best and brightest members of the bar.

⁵ Ontario, *The Commission on Proceedings Involving Guy Paul Morin: Report*, vol. 2 (Toronto: Ontario Ministry of the Attorney General, 1998), 1233–35 (Commissioner Fred Kaufman).

⁶ Michael Trebilcock, *Report of the Legal Aid Review 2008*, http://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/trebilcock/legal_aid_report_2008_EN.pdf (accessed August 14, 2008).

Mr. Buchanan advised me that LAO recognizes that its authorization of junior counsel for these kinds of cases promotes their mentoring by senior counsel and ultimately the development of a larger pool of lawyers who can defend serious cases. He said that LAO has demonstrated greater willingness to authorize junior counsel in serious matters than was previously the case.

Recommendation 119

In accordance with a lawyer's ethical duty of competence, no lawyer should defend a criminal pediatric homicide or similar case that is beyond his or her competence or skills.

Recommendation 120

The Province of Ontario, together with Legal Aid Ontario, should ensure that serious criminal cases involving pediatric forensic pathology are defended by lawyers who possess the necessary skill and experience to do so. This means, among other things, that the compensation for defending these cases should be significantly increased, and that the eligibility criteria for defending these cases should be appropriately defined.

The following represent ways in which these objectives may be achieved:

- a) The Extremely Serious Criminal Cases Panel should be extended to cover all criminal pediatric homicide cases, including charges of manslaughter and criminal negligence causing death, as well as similar cases which involve forensic pathology or other complex medical evidence that must be critically evaluated and potentially challenged.
- b) At least for pediatric homicides or similar cases, the eligibility criteria for Extremely Serious Criminal Cases should be tightened to ensure that these cases are defended by highly skilled lawyers. Although the experience and skills of some lawyers will be sufficient to meet heightened eligibility criteria without specific education and training in pediatric forensic pathology, such education and training should also inform the eligibility criteria.
- c) Legal Aid Ontario should consider the criminal specialty designation by the Law Society of Upper Canada as a factor in determining whether counsel fulfill heightened eligibility criteria.
- d) Legal Aid Ontario should regularly authorize junior or associate counsel for these cases, also to be paid at correspondingly increased rates. These counsel

should not have to meet all of the eligibility criteria applicable to the lead or senior counsel.

Legal aid funding to enable the defence to retain a forensic pathologist or other medical expert must also be addressed. I was advised by Mr. Buchanan that, when the defence requests LAO approval to fund a forensic pathologist, funding is automatically authorized for four hours of the forensic pathologist's time to discuss the case. After the initial consultation, defence counsel can then make a detailed request for additional funding. In most cases, the request for additional funding for the forensic pathologist is approved. Mr. Buchanan indicated that the number of hours to be authorized is sometimes debated, but the ultimate figure is typically agreed on.

On occasion, counsel request authorization for funding more than one defence forensic pathologist. In some cases, this request is granted.

If the appropriate expert cannot be found within the jurisdiction, defence counsel may ask LAO to provide funding for an expert outside of Ontario. Mr. Thomas told the Inquiry that, quite understandably, LAO would prefer to fund local forensic pathologists. However, he said, LAO will fund other experts where there is no qualified local expert available to the defence or where there is a good reason for seeking a forensic pathologist from outside Ontario or even Canada; for example, if local forensic pathologists are reluctant to testify for the defence where the forensic pathologist testifying at the instance of the Crown was retained through the OCCO.

Legal Aid Ontario sets the tariff for experts, including forensic pathologists. This tariff is not the subject of government regulation. Currently, LAO forensic pathologists are paid \$100 per hour. In terms of court time, a forensic pathologist testifying for the Crown is paid \$125 per hour (\$650 per day, and \$325 per half day).

There are multiple disincentives for forensic pathologists in Ontario to work for the defence. Some are reluctant to testify against a colleague. Indeed, the Inquiry was told that testifying for the defence can create tension with, or even generate overt hostility from, Crown counsel and the police. Some forensic pathologists will agree to be retained by the defence only on the basis that they will not be called as a witness. I hope that some of these issues will be addressed through the creation of a Registry with eligibility criteria that include a commitment to accept criminal defence work. I also believe that a better understanding by all participants within the criminal justice system of the role of the forensic pathologist as a non-partisan expert, whether tendered by the Crown or the defence, will assist in the long term.

All that being said, the low legal aid tariff for forensic pathologists retained by the defence operates as a further disincentive. It also sends the message that defence experts are less valuable than experts retained by the prosecution. This disparity should be remedied.

An important role for a forensic pathologist retained by the defence is to attend in court (particularly at trial) to observe the testimony of other experts, primarily the forensic pathologist retained by the Crown. This role serves several functions. First, it allows the defence to consult with its expert in “real time,” enabling an effective cross-examination of the expert tendered by the prosecution. This opportunity may otherwise be lost. Second, as Dr. Christopher Milroy noted at the Inquiry, the presence of an opposing expert can have a dramatic effect in ensuring that an expert’s evidence is given in a responsible manner. It would appear that the Crown not infrequently has its forensic pathologist attend court when a forensic pathologist retained by the defence is testifying.

Legal Aid Ontario has only rarely funded forensic pathologists to attend at court to observe the evidence of the pathologist retained by the Crown. Mr. Buchanan indicated, however, that LAO would be willing to reconsider funding for this purpose.

Recommendation 121

For criminal pediatric homicides and similar cases, Legal Aid Ontario normally should, if requested, fund the attendance of forensic pathologists in court when pathologists retained by the Crown or other significant experts relevant to the pathology issues present testimony in the case.

Recommendation 122

Legal Aid Ontario’s hourly tariff rates for forensic pathologists and similar experts should be increased to ensure defence access to their expertise and provide relative equivalence to the fees paid by the Crown. As well, in determining the number of hours to be authorized, whether an out-of-province forensic pathologist should be authorized, or whether more than one forensic pathologist or expert should be authorized, Legal Aid Ontario’s discretion should be informed by the lessons learned at this Inquiry – including the complexity of criminal pediatric homicide cases and the potential for miscarriages of justice where forensic pathology evidence cannot be skilfully evaluated and, if necessary, challenged.

Recommendation 123

The total funding available to Legal Aid Ontario should be sufficient to enable the recommendations in this chapter to be implemented.

Defence Counsel Meeting with Experts

A number of the forensic experts described their willingness, as witnesses to be called by the Crown, to meet with defence counsel in advance of the court proceedings to discuss their opinions and their anticipated evidence. Their experience, however, was that defence counsel generally do not approach them before their testimony. Professor Katherine Gruspier, a leading forensic anthropologist, said that defence counsel rarely make this request. When they do, she is more than pleased to answer directly the most significant question they should pose: “What are the limitations on your opinion?” Dr. David Ranson, deputy director of the Victorian Institute for Forensic Medicine, indicated that the more experienced defence counsel do contact him in advance about his opinion; the less experienced do not.

In my view, expert witnesses to be called by the Crown should make themselves available to meet with defence counsel in advance of the court proceedings to explain their opinions and any limitations on them. I believe that many forensic pathologists and other expert witnesses are prepared to do so. But the responsibility to initiate such meetings rests, in the main, with the defence bar. This initiative can be an important step in preparing for trial and in ensuring, for forensic pathology cases, that the scope and limits of forensic pathology generally, and the pathologist’s opinion in particular, are well understood.

Defence counsel are sometimes reluctant to meet with these experts for fear of “tipping their hand” and inducing the experts to “firm up” their evidence to successfully resist cross-examination. I am hopeful that, with the increased professionalism of forensic pathologists, the new Ontario Forensic Pathology Service (OFPS), and the renewed emphasis on the forensic pathologists’ duties to the court, as opposed to their duties to the prosecution, these concerns will be significantly minimized and defence counsel will be more willing to meet with these experts in advance of trial.

Recommendation 124

Expert witnesses to be called by the prosecution should make themselves available to meet with defence counsel in advance of the court proceedings to explain their

opinions and any limitations on them. As part of their trial preparation, defence counsel should seriously consider meeting with such experts. This is particularly appropriate in forensic pathology cases.

Disclosure of Expert Reports and Meetings between Experts

Subsection 657.3(3) of the *Criminal Code*, RSC 1985, c. C-46, provides that, “for the purpose of promoting the fair, orderly and efficient presentation of the testimony of witnesses,” each party who intends to call expert testimony shall give notice of this intention to the other parties at least 30 days before the commencement of the trial or within any other period fixed by the court. This notice should include the name of the proposed witness, a description of the witness’s area of expertise sufficient to permit the other parties to inform themselves about that area of expertise, and a statement of the qualifications of the witness as an expert.

In addition, the prosecutor shall, within a reasonable time before the trial, provide the other party or parties with a copy of the witness’s report or, if no report has been prepared, a summary of the anticipated opinion and the grounds on which it is based. The defence shall provide such material no later than the close of the case for the prosecution. Without the consent of the accused, the prosecutor may not produce this defence material in evidence if the proposed defence witness does not testify.

One of the contentious issues at the Inquiry was whether additional provisions should be introduced to compel the defence to provide early disclosure of its anticipated expert testimony before the trial begins. Such provisions exist in the United Kingdom and in a number of other jurisdictions outside Canada. All the forensic pathologists who participated in the work of the Inquiry supported early disclosure as a means of promoting the best scientific dialogue between Crown and defence experts.

For several reasons, I do not propose to recommend mandatory early disclosure of anticipated defence expert testimony. It is arguable that such mandated early disclosure, before the defence has available to it the full “case to meet,” may infringe the *Charter*. In *R. v. Rose*, Justices Cory, Iacobucci, and Bastarache stated:

In our view, it is useful to distinguish here between two discrete aspects of the right to make full answer and defence. One aspect is the right of the accused to have before him or her the full “case to meet” before answering the Crown’s case by adducing defence evidence. The right to know the case to meet is long settled, and it is satisfied once the Crown has called all of its evidence, because at that point all of the facts that are relied upon as probative of guilt are available to the

accused in order that he or she may make a case in reply: see *R. v. Krause*, [1986] 2 S.C.R. 466, at p. 473, *per* McIntyre J.; John Sopinka, Sidney Lederman and Alan Bryant, *The Law of Evidence in Canada* (1992), at p. 880. This aspect of the right to make full answer and defence has links with the right to full disclosure and the right to engage in a full cross-examination of Crown witnesses, and is concerned with the right to respond, in a very direct and particularized form, to the Crown's evidence. Inherent in this aspect of the right to make full answer and defence is the requirement that the Crown act prior to the defence's response.

A second and broader aspect of the right to make full answer and defence, which might be understood as encompassing the first aspect, is the right of an accused person to defend himself or herself against all of the state's efforts to achieve a conviction. The Crown is not entitled to engage in activities aimed at convicting an accused unless that accused is permitted to defend against those state acts. [Emphasis in original.]⁷

The Ontario Crown Attorneys' Association agreed that early mandatory disclosure by the defence may raise *Charter* issues. But both the association and the Ministry of the Attorney General suggested that early defence disclosure of expert reports be encouraged.

I think the effective functioning of the adversarial system, which is essential for fair criminal trials, requires that the decision whether to disclose an expert's report earlier than when currently required by the *Criminal Code* should remain within the control of counsel. Many of the recommendations I make will, I hope, be sufficient to ensure that the court receives scientific evidence that has benefited from some exchange of ideas between conflicting experts. It is clear that the defence is often well served (as is the forensic testimony presented to the criminal justice system) by early, voluntary disclosure of its anticipated forensic evidence. Indeed, in several of the cases examined at this Inquiry, such disclosure contributed to or resulted in decisions by prosecutors to terminate the criminal proceedings. The cases involving Jenna, Joshua, and Sharon are illustrative.

Such early defence disclosure not only may have an impact on the prosecution's reasonable prospect of conviction (as it did in the above examples). It may also narrow or clarify the issues in dispute; promote the efficient use of judicial resources; and cause forensic pathologists retained by the Crown to re-evaluate their opinions or the justifiable level of confidence in those opinions, or to con-

⁷ *R. v. Rose*, [1998] 3 SCR 262 at paras. 102–103. Justice Charles Gonthier concurred with these reasons. Justice Claire L'Heureux-Dubé was in substantial agreement with these concerns. (See para. 61.)

sider appropriate qualifications or limitations on those opinions and the existence of alternative explanations.

Concern was raised at the Inquiry that early defence disclosure might allow the Crown to recast or strengthen its case by inducing the forensic pathologists to be called by the Crown to “firm up” their evidence. This concern is similar to that expressed in connection with defence counsel meeting with Crown experts in advance of trial, and it prompts a similar response: namely, that in the future, the professionalism of forensic pathologists will significantly minimize this concern.

I recognize that there will be cases in which the defence will choose, for tactical reasons, not to provide early disclosure of its anticipated expert evidence. Sometimes, these tactical reasons are influenced by the personalities involved and whether the defence has confidence in the open-mindedness of the prosecutor or the forensic pathologist involved. But I am again hopeful that, with the growing professionalism of forensic pathologists and the new OFPS, the renewed emphasis on forensic pathologists’ duties to the court (as opposed to the prosecution), and the enhanced expertise and education of prosecutors dealing with these difficult cases, early reciprocal disclosure will become the norm.

As well, the need for forensic pathologists to document additions or modifications to their opinions (discussed in Chapter 15 (Best Practices) and Chapter 16 (Effective Communication with the Criminal Justice System)), both as a best practice and as a means to enhance effective communications between forensic pathologists and the criminal justice system, will ensure that the defence is well situated to challenge an opinion based on when and how it was formed, and in response to what information.

Recommendation 125

The defence is often well served (as is the forensic testimony presented to the criminal justice system) by early, voluntary disclosure of its anticipated forensic evidence. The defence should be encouraged, in its own interest, to provide such early disclosure. It should not be compelled to do so.

Counsel Evaluations of Expert Witnesses

One proposal advanced at the Inquiry is that trial counsel assist the new OFPS in evaluating the performance of its pathologists by completing questionnaires after their cases have concluded. Defence and Crown counsel are obviously well placed to provide an assessment to the OFPS regarding the forensic pathologist’s performance in connection with testimony. They can address, for example, the time-

liness of report preparation and whether forensic pathologists were easily accessible for pretrial meetings, as well as their objectivity and their communication skills in and out of court.

This proposed evaluation of forensic pathologists would be similar to the court-monitoring letters sent to counsel respecting CFS expert witnesses in the aftermath of the Morin Commission. Dr. Ray Prime, director of the CFS, reported that there is substantial response by counsel to the court-monitoring letters and that the information received through this process has proven beneficial to the work done by CFS scientists. Justice John McMahon, formerly the director of Crown operations for the Toronto region and director of the implementations committee of the recommendations of the *Report of the Commission on Proceedings Involving Guy Paul Morin*, confirmed that the court-monitoring program has proven very effective.

In my view, it would be of considerable assistance to the OFPS, and ultimately to the criminal justice system, if both Crown and defence counsel provide feedback to the OFPS on the quality of the forensic pathologist's work. To allow for meaningful assessments of the work of forensic pathologists in the criminal justice system, the information should be considered by the Chief Forensic Pathologist, and, if appropriate, the Child Homicide Team as well.

Recommendation 126

A court-monitoring program for forensic pathologists should be established by the Office of the Chief Coroner for Ontario, in consultation with the Ministry of the Attorney General and the Criminal Lawyers' Association.

Education in Forensic Pathology

As I recommend throughout this Report, it is imperative that both Crown and defence counsel participate in continuing legal education programs on forensic pathology and pediatric forensic pathology to better equip them to understand and litigate these difficult cases. However, the reality is that defence counsel are at a disadvantage in accessing continuing legal education programs. Educational programs organized and funded by the Ministry of the Attorney General are often available for Crown counsel, but there is no single institution that assists defence counsel in accessing similar programming. Consequently, a number of the parties suggested a pooling of resources for joint education programs for Crown and defence counsel. I agree wholeheartedly with that suggestion.

To their credit, the Ministry of the Attorney General and the Ministry of

Community Safety and Correctional Services told us they would work together to develop joint education programs, dealing with pediatric forensic pathology issues, for Crown and defence counsel, police, the judiciary, and scientists. The Ministry of the Attorney General suggested that these programs would be similar to those held in relation to forensic science that grew out of the recommendations of the Morin Commission

I am of the view that there should be regular – annual or biannual – joint courses on forensic pathology funded by the Ministry of the Attorney General and the Ministry of Community Safety and Correctional Services. This education should address the specialized knowledge necessary for pediatric forensic pathology cases. These courses could also address other critical or emerging issues involving the interaction between forensic pathology and the law. It was suggested that these programs be web based so that counsel could access the materials whenever needed. I agree with both suggestions.

However, as a general principle, the training and education of lawyers should begin at a much earlier stage – namely, at law school. Professor Sherrin indicated that, in 2007, only one Ontario law school offered a course on forensic science. Ms. Edwardh expressed the view that law schools “fail everyone in the Province of Ontario because they do not have curricula that are designed to deliver scientific literacy, and I think ... that is a big issue.” She noted that most lawyers come out of undergraduate education in the social sciences, and so they do not have adequate training in the pure sciences. Ms. Edwardh recommended the creation of a law school course that would provide law students with basic scientific literacy. She acknowledged that such a course could not cover all areas of science that may potentially be of relevance to lawyers in their future legal careers, but she thought that it would still be beneficial to provide basic scientific literacy. I agree with Ms. Edwardh.

Recommendation 127

- a) **The Ministry of the Attorney General and the Ministry of Community Safety and Correctional Services should fund regular joint courses for defence counsel and the Crown dealing with forensic pathology generally and pediatric forensic pathology in particular.**
- b) **This education should assist lawyers in developing the specialized knowledge necessary to act as counsel in pediatric forensic pathology cases. Educational programs could be live or online, but there should also be web-based materials so that lawyers in pediatric forensic pathology cases may access them as a resource when the course is not being offered.**

Recommendation 128

Law schools should be encouraged to offer courses in basic scientific literacy and the interaction of science and the law.

The focus in this chapter has not been on forensic pathologists and the needed measures to promote their training, education, accreditation, and oversight by fellow scientists. The introduction of the most robust of these measures, while critically important, provides no guarantee against the introduction of flawed pediatric forensic pathology into the criminal justice system. These measures must be complemented by the important roles that others – coroners, police, and Crown and defence counsel – can play in protecting the public from flawed or misunderstood pediatric forensic pathology. The recommendations here are intended to assist them to perform these roles well. But, they are not the only participants in the justice system who must be expected to be objective, independent, vigilant, and skilful in resisting the introduction of bad science, including flawed pediatric forensic pathology, into the court system. The courts should be expected to perform an equally vital role. It is, accordingly, to the courts that I now turn in Chapter 18.