INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

SUBMISSIONS OF AIDWYC and the MULLINS-JOHNSON GROUP

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I - INTRODUCTION

1. Miscarriages of justice are rarely, if ever, the product of single causes or single actors, nor are they confined to single aspects of the criminal justice system. On the contrary, we have learned in this country and elsewhere that they are the result of multiple failures of the systemic safeguards in place in the justice system. In this regard, in his *Report on the Commission on Proceedings Involving Guy Paul Morin,* Commissioner Kaufman wrote:

> The case of Guy Paul Morin is not an aberration…What I mean is that the causes of Mr. Morin's conviction are rooted in systemic problems, as well as the failings of individuals. It is no coincidence that the same systemic problems are those identified in wrongful convictions in other jurisdictions worldwide. It is these systemic issues that must be addressed in the future. As to individual failings, it is to be hoped that they can be prevented by the revelation of what happened in [specific cases]and by education as to the causes of wrongful convictions.

2. In this case, although each of the miscarriages of justice that formed the focus of this inquiry can be traced to the individual failings of Dr. Smith, of equal or greater significance is the failure of the systemic safeguards to prevent his inadequate evidence from being presented to courts and relied upon by judges and juries.

3. The Commission of Inquiry into Pediatric Forensic Pathology in Ontario was tasked with conducting a systemic review into the policies, procedures, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario as they relate to its practice and use in investigations and criminal proceedings, including the evolution and inherent frailties of pediatric forensic pathology. The Commission was also given the responsibility of examining how our justice system interacts with the death

investigation system, and restoring public confidence in the use of pathology in criminal proceedings.[1]

4. This is the seventh commission of inquiry in this country arising from miscarriages of justice, and the sixth that AIDWYC has taken part in. There is much in these submissions that has been said before by AIDWYC and others in the context of the other public inquiries, but nonetheless bears repeating because many of the factors than contribute to miscarriages of justice (e.g. tunnel vision, inadequate scientific evidence, poorly resourced defence counsel, lack of an independent and effective error correction body) continually reappear notwithstanding the good efforts of those commissions. Indeed, at the very same time that the Commission of Inquiry on Proceedings Involving Guy Paul Morin was scrutinizing and reporting on the inadequacies of the Centre For Forensic Sciences that contributed to the wrongful conviction of Guy Paul Morin, many similar or analogous practices were taking place a stone's throw away at the Office of the Chief Coroner for Ontario. It is ironic that at that time, both institutions were headed by the same person.

5. Although the miscarriages of justice which are the focus of this inquiry are based in flawed pediatric forensic pathology evidence, the systemic conditions which permitted these miscarriages of justice to happen exist in a much wider context. Ultimately, the success of this Commission of Inquiry will be judged not only on whether the flaws in the pediatric forensic pathology system are fixed, but whether those larger underlying factors that have repeatedly contributed to miscarriage of

[1] *Order In Council 826/2007 issued effective April 25, 2007*
Opening Statement by Commissioner Goudge – June 18, 2007

justice are addressed. AIDWYC and the Mullins-Johnson Group therefore urge the Commissioner to address this theme in his report to the Attorney General in the hopes that the same lessons will not need to be relearned in yet another public inquiry into miscarriage of justice.

6. AIDWYC is a national volunteer organization dedicated to rectifying and preventing wrongful convictions. Its efforts are aimed at correcting individual wrongful convictions and convincing law and policy makers to improve the conditions that contribute to wrongful convictions.

7. The “Mullins-Johnson Group” are 9 individuals who were convicted of criminal offences in cases in which Dr. Smith provided an opinion. Of those nine, all but one remain convicted, based on pathology evidence that is now known to have been wrong. They need to know why the pediatric forensic pathology and criminal justice systems failed them, and look for accountability, quality control and systemic mechanisms to be put in place to address past, present, and future miscarriages of justice.

8. These submissions are directed to these goals. First, AIDWYC and the Mullins-Johnson Group are concerned that the evidence heard in this inquiry is unequivocal that there is a real and substantial risk that there are more potential miscarriages of justice beyond those cases that were the focus of this inquiry. This inquiry’s core mandate of restoring public confidence in the pediatric forensic pathology system in Ontario cannot be fulfilled until all reasonable steps are taken to identify and correct all of these cases. The first part of these submissions is directed toward suggested recommendations for reviewing these cases to identify potential wrongful convictions

and correcting those cases in which persons have been wrongly convicted.

9. Public confidence can similarly not be restored until all reasonable steps are taken to ensure that pediatric forensic pathology evidence is investigated, prepared and presented at trial in a competent and balanced fashion. The remaining parts of these submissions are therefore directed at what AIDWYC and the Mullins-Johnson Group submit are the core issues surrounding the pretrial, trial and post conviction processes that relate to the miscarriages of justice that were the subject of this inquiry.

II - REVIEWS & CORRECTING ERRORS

(A) Further reviews of the continuing validity of expert pathology opinions that contributed to a criminal prosecution beyond the review of Dr. Smith's cases which has been completed.

RECOMMENDATION 1: Review of all Previous "Shaken Baby" and Head Injury Cases which Resulted in Criminal Convictions in the Province of Ontario

10. Based on the evidence heard at this Inquiry, the Commissioner should recommend that the Province of Ontario undertake an immediate review of all "shaken baby" and fatal pediatric head injury cases which have resulted in criminal convictions in the province. Miscarriages of justice have surely occurred in cases other than those involving Dr. Smith where the diagnosis or cause of death was attributed to shaken baby syndrome or head injury. According to Dr. Pollanen, "apropos of the results of the Smith and the Goldsmith reviews, there is a reasonable basis to believe that problems could exist with other fatal infant head injury cases, including cases certified as SBS".[2]

11. As Dr. Pollanen and others have made clear throughout this inquiry, infant head injury cases are viewed very differently today than in the past, due to advances in research and scientific understanding.[3] In the United Kingdom, the Court of Appeal's authoritative and detailed judgment, *R. v. Harris and Others*[4], summarized the state of the science now and the implications for criminal prosecutions based on earlier opinions. Following the release of that decision, the Right Honourable Lord Goldsmith ordered a review of all cases in England in which a parent had been

[2] PFP032588 at p. 14.
[3] PFP032588 at p. 11.
[4] [2005] EWCA Crim 1980, PFP151105.

convicted of killing a child under 2. A total of 297 cases were reviewed, and 28 were found to raise concerns; a further three cases that were still before the courts were immediately withdrawn by the prosecution.[5] 89 cases of "shaken baby syndrome" were reviewed by Lord Goldsmith, resulting in ten that were determined to require further investigation. Of those, three were recommended for referral to the Criminal Cases Review Commission.[6] Ultimately, a total of 39 cases were referred either to the CCRC or the Court of Appeal.[7] There is no reason to imagine that Ontario is now, or has ever been, immune to this disturbing pattern of scientific and judicial error. Indeed, it appears that pathologists here have been applying the same diagnostic criteria as their British counterparts in cases raising the same issues; it would be difficult to explain how they had avoided the same tragic errors in an appreciable number of cases. The expert evidence heard at the Inquiry made it apparent that there is no assurance we have not replicated those mistakes in some cases, and, indeed, gave every reason to believe we have. These errors are not the result only of "rogue" pathologists such as Dr. Smith – they are a predictable product of incomplete scientific knowledge and a judicial climate ill-equipped to recognize them.

12. Dr. Smith was not the only pathologist in Ontario who made diagnoses of shaken baby syndrome. Dr. Pollanen noted in his January, 2007 memorandum that "many of Dr. Smith's views on Shaken Baby Syndrome were similar to a prevailing view in this controversial area of forensic pathology at the time he gave testimony on the

[5] PFP032560 at p. 1.
[6] PFP033302 at p. 2; PFP 300329 at p. 3.
[7] Evidence of Dr. Milroy, 11/12/07, pp. 181, line 23 – 182, line 2.

issue".[8] Inevitably, many other pathologists, working from the same assumptions, drew similar conclusions. Several witnesses throughout the inquiry, including several pathologists, were of the view that a review similar to the Goldsmith review is necessary in Ontario to restore public confidence in the system[9]. In the words of Dr. Lucas:

> … with the vision of hindsight and our current state of knowledge applying current day approaches, standards, and expectations for how the conclusion would be drawn in these cases to those cases in – in retrospect… conclusions of the pathologist my be different, and as a consequence the conclusions in the criminal justice system may in fact be different.[10]

13. To assure the people of Ontario that no one else has been convicted of a crime that did not occur, a similar review must be carried out here. Further, the Commissioner should go so far as to suggest that a review should be conducted of cases in which infant head injury and shaken baby syndrome have resulted in criminal convictions (albeit in a manner that does not exceed his limited territorial mandate), as was done in the Goldsmith Review. The system has, as Dr. Lauwers testified, a "moral and ethical" obligation to examine each case to make sure "there isn't some family that's come to some significant harm as a result of information which has changed over a period of time".[11]

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[8] PFP032588, at p. 4.
[9] Evidence of Drs. Milroy and Crane, 11/22/07, pp. 182 – 189.
Evidence of Dr. Pollanen, 12/05/07, p. 239, lines 13-18.
[10] Evidence of Dr. Lucas, 01/08/08, p. 79, lines 4-17.
[11] Evidence of Dr. Lauwers, 01/08/08, p. 82, lines 17-22.

RECOMMENDATION 2: Review of All Pediatric Autopsies in the Province of Ontario Since 1981

14. The evidence heard at the Inquiry suggests that, at a minimum, Dr. Smith's work from 1981[12] to 1991[13] must also be reviewed. While efforts have already begun to identify pre-1991 cases, that project must continue.[14] There have been consistent problems in Dr. Smith's cases.[15] His forensic pathology was dreadful, his evidence was over-stated and emotive, and his conclusions were wrong. Dr. Smith's own evidence - that his education and training in forensic pathology was 'woefully inadequate', that he was 'profoundly ignorant' of the role of an expert witness in the courts, and that he did not understand the importance of, nor the procedures for, maintaining the continuity of evidence – suggests that those problems undoubtedly plagued his earlier work.[16] Again, quoting Dr. Smith's own words, he had "extraordinarily limited… knowledge or expertise" and it was "potentially dangerous" for him to work on some cases.[17] His testimony in these cases nonetheless betrayed no uncertainty; he himself described it as "defensive or dogmatic or adversarial".[18] Dr. Pollanen has said the reviews of Dr. Smith's pathology opinions

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[12] Dr. Smith performed autopsies in Ontario prior to 1981, during his training. None were in homicidal or criminally suspicious cases. He joined the full-time staff at the Hospital for Sick Children in 1981 and then commenced doing these kinds of autopsies.
Evidence of Dr. Smith, 01/28/08, pp. 16, lines 18-20, p. 20, line 18, p. 21, lines 2-25, p. 24, lines 14-17.

[13] The Ontario Pediatric Forensic Pathology Unit was founded at the Hospital for Sick Children in by the agreement with the Province (Ministry of the Solicitor General), effective April 1, 1991 (although the agreement was signed September 23, 1991)
PFP117722

[14] Policy Roundtable Discussions ("Potential Wrongful Convictions"), 02/21/08, p. 83, line 16 – p. 87, line 7.

[15] PFP032588 at pp. 4-5; PFP301189, pp. 4-7, 13-16.

[16] Evidence of Dr. Smith, 01/28/08, p. 25, lines 21-26, p. 27, lines 22-28, page 30, line 25 – p. 31, line 6, p. 63, line 23 – page 64, line 10.

[17] Evidence of Dr. Smith, 01/28/08, p. 80, line 16 – page 81, line 5.

[18] Evidence of Dr. Smith, 01/28/08, p. 85, line 4.

established there "is a reasonable basis to believe that problems might exist with Dr. Smith's cases prior to 1991".[19] All cases which relied on pathology opinions rendered by Dr. Smith require review.

15. Dr. Smith was not, however, working in isolation; he was the Director of the Ontario Pediatric Forensic Pathology Unit for over two decades. Several forensic pathologists worked under his influence and administration. He provided countless consultations (many of them undocumented) to pathologists across the province and across the country, and was viewed as an "icon" by pathologists in the field. Throughout his tenure, there was virtually no oversight or peer review of post mortem reports in the province. It is reasonable to conclude, therefore, that errors are likely to have occurred by other pathologists during Dr. Smith's tenure. A review must therefore be undertaken of all pediatric autopsies conducted in Ontario since 1981 in cases that resulted in criminal convictions.

16. Dr. Smith was accorded unparalleled respect and deference by his peers. They were unwilling to challenge him. For example, in the case of Valin, Dr. James Ferris, a respected forensic pathologist who had been retained by the defence at trial, admitted in a recent report that:

> …there's no doubt that, at that time, my opinions were unduly influenced by the apparent authoritative opinions given by Drs. Smith and Mian… I was concerned, at that time, with the opinions expressed by Dr. Smith in the case and, since that time, I found myself disagreeing with his forensic pathology opinion expressed in several cases[20].

[19] PFP032588 at p. 14.
[20] PFP058548 at p. 3.

He continued:

> I'm now aware that his professionalism is being questioned by others, and I was clearly in error to accept, so readily, his opinions in the case.[21]

Finally, his report concluded:

> Having reviewed all the evidence and materials referred to, it's clear that my opinions were unduly influenced by my instructions from [defence counsel] and my ready acceptance of the opinions of Doctors Zehr, Mian, and Smith. It is now clear to me that these influences reduced the level of objectivity of my opinions that would normally be expected from a Forensic Pathologist of my experience.[22]

17. In the case of Baby M, a pathologist consulted by defence counsel who testifed at the Inquiry indicated that Dr. Smith was the foremost expert in forensic pathology, and that she would not be prepared to challenge his findings.[23] If independent pathologists retained by the defence were unwilling to challenge Dr. Smith and allowed their judgment to be clouded by his celebrated status, it is a reasonable inference that physicians working beneath him did too.

18. A particularly disturbing example of this pattern is the meeting that took place regarding Sharon's case between Dr. Smith, Dr. Wood, Dr. Cairns, Dr. Chiasson, Mr. Blenkinsop and Dr. Queen, not long after the autopsy. Each expert at the meeting deferred to Dr. Smith's contention that the wounds were not caused by dog bites, except for Dr. Queen, who believed they might, indeed, have been caused by a dog. He did not advance these views forcefully, however, likely because he was a relatively junior member of Dr. Smith's staff.[24] Dr. Cairns, the Deputy Chief Coroner and Dr. Smith's superior at the time, now belatedly admits that he "put undue faith in

[21] PFP058548 at p. 3.
[22] PFP058548 at p. 6.
[23] Evidence of Dr. Milroy, 11/22/07, p. 131, lines 10-25.
[24] Evidence of Dr. Cairns, 11/26/07, pp. 221, line 9 – 223, line 25.

Dr. Smith", and that he believed that Dr. Smith was *'the'* pathologist, an opinion shared by many in his office, the media, the Crown and defence bar, and the judiciary. It took him "a long time to come to the realization (that there was a problem)… because he had put him on such a pedestal".[25]

19. Dr. Smith was widely consulted by other pathologists around the country, and was seen as the 'go-to guy' in pediatric forensic pathology. Pathologists were advised to call him for a consultation *during* the course of an autopsy, which may well have affected their conclusions. It appears that many of those consultations were unlikely to have been recorded, and therefore identifying only the cases in which Dr. Smith was definitively involved would be impossible. This inability to trace Dr. Smith's influence is one of the factors which demands a comprehensive review.[26]

20. There was no adequate supervision of Dr. Smith during his tenure, *or of any other pathologist conducting medicolegal autopsies under the auspices of the Chief Coroner (OCCO*).[27] Dr. Smith had no proper training in forensic pathology.[28] Yet, he was the one who reviewed every report that came out of the unit. In a telling exchange, Maxine Johnson, the HSC Pathology Unit's administrative coordinator, described the process:

> Commissioner: There was no practice for the CF12 to be reviewed by another pathologist before it was signed out to the OCCO?

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[25] Evidence of Dr. Cairns, 11/27/07, p. 208, lines 5-15.
[26] Evidence of Dr. Cairns, 11/28/07, pp. 49 – 55.
PFP136211 at p. 3.
[27] Evidence of Dr. Cairns, 11/28/07, pp. 191-192.
Evidence of Dr. Cutz, 12/18/07, p. 24, lines 2-21.
[28] Evidence of Dr. Chiasson, 12/07/07, p. 140, lines, 20-25.

> A: Not for Dr. Smith. But the other pathologists had to give theirs to Dr. Smith because he was the Director of the Unit. So the pathologists would, you know, do their case. We'll give it to Dr. Smith. He would review it, you know, make any suggestions to those pathologists –
>
> Q: Right.
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> A: - and – but as far as Dr. Smith –
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> Q: So the practice was it would not be signed out by the case pathologist until the CF12 had been reviewed by Dr. Smith?
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> A: Most of the times, yes.[29]

21. Until 1994, there was absolutely no formal review mechanism for post-mortem reports issued by pathologists working on behalf of the Chief Coroner's Office. In 1995, Dr. Chiasson instituted a bare-bones review process which consisted of simply ensuring the report itself met a basic standard, and attaching a 'checkmark form' - as it came to be known - to each completed report. There was no review of photographs, slides, or underlying histology. As Dr. Chiasson acknowledged, a review of this nature would not have identified a flawed analysis involving a misinterpretation of an injury or pathological conclusions from microscopic or histologic findings. Dr. Chaisson had the sole responsibility for reviewing all 1,500 reports each year, which allowed for no more than a cursory scan of the report.[30] In cross examination by Mr. Campbell, Dr. Chiasson acknowledged that his review process would not have caught many of Dr. Smith's mistakes:

> Q: Knowing now what you didn't know then, it would be fair to say that you needed a bit more insight into the factual substratum of the – the autopsies to identify some of the things that we now know were in error. Is that – would you accept that?

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[29] Evidence of Maxine Johnson, 12/17.07, pp. 109, line 12 – 110, line 3.

[30] Evidence of Dr. Chiasson, 12/07/07, pp. 56, line 19 – 57, line 19; pp. 85, line 24 – p. 85, line 24.
Evidence of Dr. Chiasson, 12/10/07, p. 141, lines 6-9; pp. 150, line 15 – 151, line 5.
Evidence of Dr. Chiasson, 12/10/07, pp. 220, line 23 – 221, line 5.

> A: I would accept that, yes. A lot of the issues revolve – specific questions relating to circumstances of a death that were not information that wasn't provided in the PM reports, yes.[31]

22. Dr. Chiasson also acknowledged that his own lack of expertise with pediatric cases may have contributed to his inability to provide effective oversight.[32] He paid little attention to the reports of pathologists whom he knew and respected. As he candidly explained in his testimony:

> "I was reviewing pathologists who I got to know very quickly. And – and a review in that case may have been simply looking at the bottom line, looking at the summary, and thank you very much".[33]

This admission, while commendable, does not inspire public confidence that no other miscarriages of justice occurred during his tenure. Dr. Smith's errors went undetected by the only review process in place, and common sense dictates that the errors of others did as well.

23. The work of Dr. Brian Johnston, who was, and still is, the Director of the Eastern Ontario Regional Forensic Unit is now the subject of controversy. For over a decade, alarm bells were ringing regarding his competence and his propensity to reach critical conclusions that were not supported by medical or scientific evidence.[34] In one particularly shocking example, which parallels some of Dr. Smith's cases, the natural death of an adult was attributed to strangulation causing an innocent person to be held in custody for some time. Nevertheless, he was

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[31] Evidence of Dr. Chiasson, 12/10/07, pp. 221, line 20 – 222, line 6.
[32] Evidence of Dr. Chiasson, 12/11/07, p. 98, lines 7-12.
[33] Evidence of Dr. Chiasson, 12/11/07, p. 97, lines 2-5.
[34] Evidence of Dr. Chiasson, 12/11/07, pp. 120, line 21 – 121, line 17.
Evidence of Dr. Chiasson, 12/07/07 pp. 175 – 189.

allowed for years to continue conducting the majority of criminally suspicious autopsies at the Eastern Ontario unit simply because there was nobody to take his place.[35] Dr. Chiasson identified persistent problems with the validity of Dr. Johnston's conclusions and his administrative capabilities. He made efforts to engage Dr. Johnson in remedial steps, without success, and his repeated pleas to have him removed as Director were ignored by Dr. Young.[36] It was not until February, 2007 that Dr. Johnston and the rest of the Ottawa staff were formally notified that they were no longer permitted to do homicide or criminally suspicious cases for OCCO.[37] This provides one more reason for a Province-wide review.

24. As well, the lens of the "think dirty" regime that pervaded the death investigation system after the release of "Memo 631" on April 10, 1995 must have tainted the objectivity of pathologists throughout the Province.[38] As Dr. Chiasson and others acknowledged, pathologists would have been vulnerable to pressure from the police to make findings consistent with their pre-existing theory of the case.[39] Recommendations from this Inquiry will help to solve these kinds of problems in the future, but future improvements will not uncover past mistakes.

25. Several highly qualified and knowledgeable witnesses at the Inquiry supported an examination of other cases. Dr. Crane supported it.[40] Dr. Butt suggested that it would be "a prudent thing to do". Dr. Cairns considered a further review to be an

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[35] Evidence of Dr. Chiasson, 12/11/07, p. 129, lines 12-24.
[36] Evidence of Dr. Chiasson, 12/07/07, p. 186, line 2 – p. 188, line 2.
[37] PFP 142038; PFP142040; PFP142036.
[38] PFP032280 at p. 2.
[39] Evidence of Dr. Chiasson, 12/10/07, p. 254, lines 1-7.
Evidence of Drs. Rao, Dexter & Shkrum, 01/18/08, pp. 60, line 25 – 61, line 10.
[40] Evidence of Dr. Crane, 11/22/07, p. 190, lines 3-10.

'ethical duty'.[41] Dr. Pollanen, the Chief Forensic Pathologist of Ontario, agreed that to restore public confidence in pediatric forensic pathology, a range of cases much broader than those of Dr. Smith needed to be examined.[42]

26. There are relatively low numbers of pediatric homicides in Ontario each year. 45 of them have already been examined. A review of the remaining cases is unlikely to be a great deal more demanding than the review that led to this inquiry[43]. The number of pediatric homicides and criminally suspicious deaths in Ontario each year can be estimated at between 10 and 20[44], with 5 to 15 of these occurring in children under the age of five.[45] Of those, only a fraction would have resulted in criminal convictions. The number of criminally suspicious pediatric deaths since 1981 therefore falls into a range of approximately to 200 to 300 at the very most, 45 of which have already been reviewed. In the Goldsmith Review, almost 300 cases were studied within the span of approximately 10 months.

27. This effort has significant systemic value beyond the obvious utility of correcting errors and doing justice in individual cases. The evidence heard at the Inquiry suggests that OCCO has not, until recently, acknowledged, confronted, and worked to correct possible errors resulting from their pathologists' work.

28. This Inquiry heard evidence about a litany of circumstances that ought to have sparked an earlier, comprehensive review of Dr. Smith's work, including the

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[41] Evidence of Dr. Butt, 11/23/07, p. 58, lines 12-13.
Evidence of Dr. Cairns, 11/28/07, p. 29, lines 13-17; p. 195, lines 14-18.
[42] Evidence of Dr. Pollanen, 11/16/07, p. 31, lines 17-23.
[43] Evidence of Dr. Butt, 11/23/07, pp. 54, line 5 – 55, line 10
[44] Evidence of Dr. Butt, 11/23/07, p. 54, lines 12-19.
[45] PFP149431 at p. 24.

following:

- **the judgment delivered by Justice Dunn in 1991 acquitting Amber's babysitter of homicide, which seriously criticized Dr. Smith's work and his lack of objectivity[46];**

- **the 1999 abandonment of the CAS child protection application after the investigation of Nicholas' death and the receipt of sharply conflicting expert opinions, followed by Maurice Gagnon's litany of complaints between 2000 and 2003 to those whom he hoped would listen[47];**

- **the 1999 withdrawal of homicide charges against Jenna's mother once substantial expert evidence emerged that challenged Dr. Smith's opinion[48], and,**

- **the College of Physicians and Surgeons investigations of Dr. Smith which commenced in 1999.[49]**

Instead, in January 2001, after the withdrawal of criminal charges against Tyrell's caregiver and Sharon's mother, an internal review of the pathology in only those two cases was conducted.[50] A broader, external review of Dr. Smith's work was aborted. [51] Dr. Smith wrote to Chief Coroner Dr. Young and requested he be removed from the roster of pathologists doing medico-legal autopsies.[52] (He later started again.[53]) James Lockyer, as a Director of AIDWYC, requested a review following the revelations about these two cases. [54] Dr. Young responded that no comprehensive review would be

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[46] Amber Overview Report, PFP143724, at paras.213-240
[47] Nicholas Overview Report, PFP143263, at paras. 171-192
[48] Jenna Overview Report, PFP144684, at paras.82-102
[49] Amber Overview Report, PFP143724, at paras.242-248; Nicholas Overview Report, PFP143263, at paras. 210-219; Jenna Overview Report, PFP144684, at paras.201-213
[50] Evidence of Dr. McLellan, *Transcript (13 November 2007),* p.23, l.19 - p.27, l.10
[51] Dr. Young is quoted as announcing an "independent review" by an "external reviewer" following the withdrawal of charges against Louise Reynolds in "Lost evidence not reason for withdrawal of charges, says Ontario's top Coroner, "*The Kingston Whig-Standard* (26 January 2001), PFP055831. Evidence of Dr. McLellan, *Transcript (13 November 2007),* pp.27, l.1 - p.28, l.20 10
[52] *Letter from Dr. Smith to Dr. Young* (25 January 2001), PFP127457
[53] Written Evidence of Dr. Charles Smith, PFP 303346, at p.38
[54] *Letter to Dr. Young from James Lockyer* (20 February 2001), PFP115727*; Letter to Dr. Young from James Lockyer* (4 April 2001), PFP115715

performed.[55] Two articles were published in Maclean's Magazine in May 2001, "Dead Wrong" and "The Babysitter Didn't Do It," which set out some of the history[56]. No review followed this adverse publicity; Dr. Cairns' comments quoted in the articles were supportive of Dr. Smith. In December 2001, David Bayliss, as a Director of AIDWYC, wrote to Dr. Cairns[57] to request a review of the pathology in William Mullins-Johnson's case; this would not follow for several years[58]. Another internal review of pathology, later supplemented by an external consultation, at the request of the investigating police service, confirmed difficulties in Jenna's case[59]. It was not until intensifying media scrutiny of the lengthening list of problematic cases in 2003[60], with the stay of proceedings ordered by Justice Trafford in Athena's case in June of that year[61], that Dr. Smith resigned from all coroner's autopsy and committee work, and in July 2004, from his position entirely.[62] A tissue audit was prompted by materials missing in Mullins-Johnson's case[63], and the media attention and public pressure relating to this and controversy over Jenna's case led to the Chief Coroner's June 2005 announcement of his decision, finally, to review and scrutinize Dr. Smith's cases for errors in pathology opinions.[64] A decade and a half had passed since Justice Dunn's ruling.

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[55] *Letter from Dr. Young to James Lockyer* (30 March 2001), PFP115718
[56] Jane O'Hara, "Dead Wrong" and "The Babysitter Didn't Do It," *Maclean's Magazine* (14 May 2001), PFP125639
[57] *Letter from David Bayliss* (28 December 2001), PFP139935
[58] Evidence of Dr. Pollanen, *Transcript (13 November 2007),* p.116, l.22 - p.117, l.14
[59] Evidence of Dr. McLellan, *Transcript (13 November 2007),* p.34, l.3 - p.35, l.9; p.39, l.21 - p.43 l.15
[60] Written Evidence of Dr. Charles Smith, PFP 303346, at p.38; Evidence of Dr. McLellan, *Transcript (13 November 2007),* p.62, l.10 - p.63, l.5; p.64, l.5 - p.66, l.13; *Notes of meeting with Dr. Smith* (2 October 2003), PFP139992
[61] *R. v. Kporwodu and Veno* (2003), 176 C.C.C. (3d) 97 (Ont.Sup.Ct., Trafford J.), PFP014374
[62] Dr. Charles Smith, *Letter of resignation from OPFPU Directorship* (9 July 2004), PFP132422; Written Evidence of Dr. Charles Smith, PFP 303346, at p.38; Evidence of Dr. McLellan, *Transcript (13 November 2007),* p.67, l.14 - p.68, l.4; p.70, l.21 - p.71, l.18
[63] Evidence of Dr. McLellan, *Transcript (13 November 2007),* p.112, l.3 - p.113, l.14; p.122, l.9 - p.124, l.9; p.125, l.22 - p.126, l.23
[64] Office of the Chief Coroner, *Backgrounder: Results of Audit into Tissue Samples arising from Homicide*

29. Part of this Commission's mandate is to make recommendations that will assist to "restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings."[65] Public confidence will be restored not only by changes made to improve the system in the future to avoid the repetition of errors, but also by a scrupulously fair and penetrating review of past cases where those errors may have occurred. The press releases from OCCO in 2005 and 2007, as the review of Dr. Smith's work started and finished, explicitly make this connection. OCCO stated at the outset that, "Conducting this review is an essential step in maintaining the public confidence in all of the important work that is done, day in and day out, by coroners and pathologists who provide service for the Office of the Chief Coroner and the public,"[66] and at the conclusion that, "maintaining public confidence in the Ontario Coroner's System was an underlying reason for conducting this review."[67] The same holds true for a more comprehensive review. Even if a difficult or time-consuming process, these reviews are essential to demonstrate to the public that OCCO has successfully combated the culture of avoidance which created the environment to allow errors to be made and to stand uncorrected.

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and Criminally Suspicious Autopsies Performed at the Hospital for Sick Children (7 June 2005), PFP033962; Evidence of Dr. McLellan, *Transcript (13 November 2007),* p.134, l.16 - p.139, l.4

[65] Order in Council dated April 25, 2007, at para.4

[66] Office of the Chief Coroner, *Backgrounder: Review of Criminally Suspicious and Homicide Cases Where Dr. Charles Smith Conducted Autopsies or Provided Opinions* (1 November 2005), PFP131770 at p.5

[67] Office of the Chief Coroner, *Backgrounder: Public Announcement of Review of Criminally Suspicious and Homicide Cases Where Dr. Charles Smith Conducted Autopsies or Provided Opinions* (19 April 2007), PFP131780 at p.5

RECOMMENDATION 3: A Speedy and Just Resolution of the Cases Examined at this Inquiry

30. Apart from further reviews to be recommended by the Commission, the cases of the nine individuals given standing need to be quickly addressed. The Commissioner should recommend that the Attorney General consent to an extension of time to file an appeal in all of these cases. Case conferences between crown counsel, defence counsel, and the Chief Forensic Pathologist should be held to resolve each case in a non-adversarial and expeditious manner. In Valin's case, such a meeting was held at the Office of the Chief Coroner between Dr. McLellan, Dr. Cairns, Crown and defence counsel. A general agreement was reached as to how the case should proceed once the Ministerial review application had been filed.[68] It led to a joint position taken before the Court of Appeal one year later, shaving years off the review process that Valin's uncle would have otherwise had to endure. While the Commissioner cannot impose on the parties an obligation to join in a consultative, non-adversarial approach to these cases, there can be no doubt that his recommendation to this effect would carry enormous weight with the institutions whose participation is essential to achieving just outcomes.

31. Dr. McLellan and Dr. Pollanen expressed a willingness for their offices to take part in case conferences, and agreed that such a process would help move the cases forward. Thereafter, it will be up to the parties to ensure that all potential

[68] Evidence of Dr. Cairns, 11/28/07, pp 59–61.

miscarriages of justice are remedied as quickly and as painlessly as possible.[69]

RECOMMENDATION 4: Eligible cases for review can be identified and screened by a panel of scientists internal to Office of the Chief Coroner for Ontario (OCCO).

32. The model adopted by the Forensic Services Advisory Committee (and its subcommittee addressing this review) to identify and review Dr. Smith's cases post-1991 can serve as a starting point[70]. An internal body would identify all cases which are eligible for the review and perform a preliminary screening.

33. Advertising the development of this process publicly, and to Crown and defence counsel, may help identify cases that may otherwise be missed which are eligible for review. This approach was adopted by the team reviewing infant death prosecutions in England at the direction of Attorney-General Lord Goldsmith[71]. To supplement the list of cases identified in the internal audits by the various prosecutorial agencies across the country, counsel were invited to identify cases which may be eligible for review. Additional cases were located that otherwise may have escaped scrutiny. Given the importance of the assignment and the potential significance of the results, the net must be cast as broadly as possible.

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[69] PFP144327, at para 218.
Evidence of Dr. McLellan, 11/15/07, pp. 238 – 246.
Evidence of Dr. Cairns, 11/28/07, pp. 68-69.

[70] *Minutes of the Forensic Services Advisory Committee* (6 October 2005), PFP034182; *Memorandum from Dr. Pollanen to Dr. McLellan, "The Smith review: Methods, results, and discussion"* (8 January 2007), PFP032588; Evidence of Dr. Pollanen, *Transcript (13 November 2007),* p.197, l.11 - p.228, l.18; *Transcript (14 November 2007),* p.18, l.6 - p.19, l.15; p.21, ll.2 - 12; Evidence of Dr. McLellan, *Transcript (14 November 2007),* p. 17, ll.6-18; p.26, l.21 - p.28, l.13

[71] Attorney-General Lord Goldsmith, *Report on the Review of Infant Death Cases,* 21 December 2004, PFP300329.

RECOMMENDATION 5: Independent, external experts should review the science in cases identified as potentially problematic during the preliminary, internal screening process.

34. Again, the model developed by the Forensic Sciences Advisory Committee (and its dedicated subcommittee) to conduct the review of Dr. Smith's cases is instructive. A panel of external experts would conduct more detailed reviews, confer, and report back about any problematic cases[72].

35. This model was developed through a consultative process with representatives of various stakeholders in the system. A brief paper[73] prepared by Dr. Pollanen after the review confirmed that it was a valid and workable model. (His reservations related to whether the results could be misunderstood as a representative sample of Dr. Smith's cases, or unfairly blamed Dr. Smith alone for failings of the whole death investigation team.)

36. The results generated by the panel of five outside experts retained to conduct the review of Dr. Smith's work demonstrate that this process can be efficient and effective.[74] 45 cases were identified. Ten cases were screened for review by an OCCO pathologist. The remainder were divided between the experts to review independently. They then met in two panels to discuss and reach consensus on

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[72] *Minutes of the Forensic Services Advisory Committee* (6 October 2005), PFP034182; *Memorandum from Dr. Pollanen to Dr. McLellan, "The Smith review: Methods, results, and discussion"* (8 January 2007), PFP032588; Evidence of Dr. Pollanen, *Transcript (13 November 2007),* p.197, l.11 - p.228, l.18; *Transcript (14 November 2007),* p.18, l.6 - p.19, l.15; p.21, ll.2 - 12; Evidence of Dr. McLellan, *Transcript (14 November 2007),* p. 17, ll.6-18; p.26, l.21 - p.28, l.13

[73] *Memorandum from Dr. Pollanen to Dr. McLellan, "The Smith review: Methods, results, and discussion"* (8 January 2007), PFP032588

[74] Office of the Chief Coroner, *Backgrounder: Public Announcement of Review of Criminally Suspicious and Homicidal Cases Where Dr. Smith Conducted Autopsies or Provided Opinions"* (19 April 2007), PFP131780

their conclusions over the course of two weeks[75]. Preliminary reports answering three basic questions[76] were generated and then supplemented by more detailed comments in cases identified to be problematic.

37. It is important to observe that both the internal screening process and the external panel of scientists who review the cases should be limited to assessing the validity of the science and nothing more. Forensic pathologists are not expert in assessing the weight or significance of expert evidence in the context of all the other evidence in a criminal case. They must not be called upon to offer any opinion beyond that of purely forensic scientific work. Its impact on the case at large should be assessed in another forum.

38. AIDWYC and the Mullins-Johnson Group agree with Dr. Pollanen's position that the scientists ought to do only scientific work and appreciates his commitment to ensuring scientists not become advocates for a cause. They are concerned, however, that the discussion about structuring reviews at the "Potential Wrongful Convictions" Policy Roundtable suggested that the pathologist may opine on the significance of the science to the prosecution case in helping settle which files merit closer scrutiny[77]. This is the almost inevitable result of the loose, "discretionary" approach to reviews now adopted, as described by Dr. Pollanen[78]. Scarce

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[75] *Minutes: Review of Dr. Charles R. Smith (Reconciliation Meeting Week One)* (8 December 2006), PFP034053; *Minutes: Review of Dr. Charles R. Smith (Reconciliation Meeting Week Two)* (15 December 2006), PFP057044

[76] The three questions were whether the important examinations were conducted, did the reviewer agree with the facts as reported from those examinations, and whether the reported cause of death was supported by those facts. [Evidence of Dr. McLellan, *Transcript (14 November 2007),* p.36, l.21 - p.37 l.3.] An example of the "Autopsy Report Review Form" that came to be used, with more detail with respect to these basic questions, is found at PFP032634.

[77] Policy Roundtable discussions, "Potential Wrongful Convictions" (21 February 2008), p.28, l.21 - p.31, l.25; p.51, l.24 - p.52, l.7; p.72, l.11 - p.73, l.6; p.83, l.16 - p.85, l.1; p.125, l.15 - p.126, l.4

[78] "Potential Wrongful Convictions" Roundtable (21 February 2008), p.26, l.21 - p.29, l.6

resources within the forensic pathology service would be funneled towards cases where a more compelling case is mounted at the outset that the affected individual may be factually innocent. This invites inconsistent results and inadequate reviews. Dr. Pollanen recognized this when he acknowledged that a policy or protocol on such reviews would be welcomed by OCCO[79].

[79] Potential Wrongful Convictions Roundtable (21 February 2008), p.29 ll.7-14; p.31, ll.16-25; p.124, ll.10-25

(B) Ongoing reviews based on scientific developments should be contemplated and facilitated.

RECOMMENDATION 6: A scientific advisory committee should be convened at OCCO to continually review important changes in the science applied by pathologists and its potential effects on criminal prosecutions.

39. Forensic sciences develop and change with the advance of scientific knowledge[80]. Controversial areas in the science now may be settled at a future date. Conversely, as in the "Shaken Baby Syndrome" analysis, previously accepted notions may become "murky" as research continues[81]. It is scientists in the field who most intimately understand the shifting conclusions and understandings of the science, and who recognize when a previously-accepted notion has been disproven or fundamentally questioned. In such cases, criminal prosecutions or child apprehensions based on these scientific standards rest on unstable foundations. The review process developed for the specific areas identified from the evidence on this Inquiry should be available for parallel circumstances in the future. As scientists know best the important developments in their fields, a scientific advisory committee should be convened at OCCO to advise the leadership of the forensic pathology service when such an internal review should be initiated based on advances in scientific knowledge.

40. This raises the question of what should happen following such a resolution by the

[80] Dr. Stephen Cordner, "Pediatric Forensic Pathology: Limits and Controversies" (Inquiry research paper) at pp.6-12; Evidence of Dr. Pollanen, *Transcript (12 November 2007),* p.219, l.21 - p.220, l.13; *Transcript (5 December 2007),* p.33, l.16 - p.37, l.7; Dr. Pollanen, *Review of the Pediatric Forensic Pathology Reports: Ten Systemic Issues,* PFP301189, at pp.3-4

[81] Evidence of Dr. Pollanen, *Transcript (5 December 2007),* p.210, l.18 - p.241, l.2; *R. v. Harris and Others* [2005] EWCA Crim.1980, PFP151105; Lord Goldsmith, Attorney-General, *The Review of Infant Death Cases, Addendum to the Report: Shaken Baby Syndrome* (14 February 2006), PFP033302; Dr. Stephen Cordner, "Pediatric Forensic Pathology: Limits and Controversies" (Inquiry research paper) at pp.75-85

scientific advisory committee. Within OCCO, this input is best provided to a multi-disciplinary body, as discussed at the "Potential Wrongful Convictions" Policy Roundtable on February 21, 2008[82]. Complex questions of the scope of review and criteria for the prioritization of cases for review will inevitably arise. These questions cannot be answered by scientists alone, but require input from other elements of the justice system. Accordingly, AIDWYC and the Mullins-Johnson Group recommend that the Forensic Services Advisory Committee, the stakeholder committee convened by OCCO in 2004, should assist in directing the process of necessary ongoing reviews as it did with Dr. Smith's cases.[83]

41. The scientific advisory committee ought not be limited to communicating only with the leadership of OCCO. AIDWYC and the Mullins-Johnson Group recommend the formation of a permanent error-correcting body, described below at paragraphs 48-52. Whatever OCCO decides to do with the input from the scientific advisory committee, their conclusions should also be made available to this new body.

42. The development of the science renders it inevitable that circumstances will recur where formerly settled notions are challenged. The repeated experience of criminal justice systems globally with problematic scientific evidence[84] as an ingredient in wrongful convictions demonstrates that, entirely apart from those expected and

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[82] Policy Roundtable discussions, "Potential Wrongful Convictions" (21 February 2008), p.48, l.23 - p.49, l.13; p.51, l.11 - p.52, l.7; p.54, l.9 - p.55, l.16

[83] Evidence of Dr. McLellan, *Transcript (13 November 2007),* pp.187, l.9 - p.190, l.7; p.191, l.1 - p.195, l.5; p.195, l.11 - p.197, l.6; *E-mail exchange between Al O'Marra and Murray Segal* (19 November 2003), PFP140237; Forensic Services Advisory Committee, Office of the Chief Coroner*, Terms of Reference,* PFP134282; Forensic Services Advisory Committee, *Minutes of first meeting* (23 February 2004), PFP140210; Forensic Services Advisory Committee, *Minutes of special meeting regarding Dr. Charles Smith review* (5 July 2005), PFP034168; Dr. Pollanen, *Background Information for Forensic Services Advisory Committee* (26 June 2005), PFP116772

[84] Kathryn Campbell and Clive Walker, "Medical mistakes and miscarriages of justice: Perspectives on the experiences in England and Wales" (Inquiry research paper) at pp.1-8; Hon. Fred Kaufman, Commissioner, The Commission on Proceedings Involving Guy Paul Morin: Report (Toronto: Queen's Printer, 1998) at pp.265-291 *["Morin Report"]*

salutary developments in scientific knowledge, and whatever efforts are made at systemic improvement, failures will likely occur in the future. A considerable effort was required by numerous parties before OCCO announced the review of Dr. Smith's cases in 2005. A standing committee mandated to continually review and identify changing science and the scientific validity of opinions given by OCCO pathologists would help ensure that something less than the perfect storm of media attention around sensational cases (such as that which finally raged around Dr. Smith in 2003-2005) would suffice to trigger a review. It would not be in the interests of the proper administration of justice (including, importantly, the avoidance and correction of wrongful convictions), nor would "public confidence" be restored in the criminal justice system in this province if this Commission concluded its work without recommending institutional change that would catch similar difficulties in future before they reached the "perfect storm" stage.

(C) Outcomes of the internal reviews need to be effectively managed.

RECOMMENDATION 7: If "bad pathology" is identified in the scientific reviews, a multi-disciplinary panel should review the implications of the new scientific conclusion in the context of the case as a whole, to determine whether it calls into question the soundness of the conviction.

43. The phrase "bad pathology" is used here to refer to both an opinion that was untenable or flawed at the time it was given, and also an opinion which is recognized as no longer valid because of subsequent advances in the science. The difference between the two categories may matter to the professional whose reputation is questioned -- the latter form of "bad pathology" ought not reflect adversely on the expert who delivered it. The difference between the two categories matters not at all to the innocent individual who was prosecuted on the basis of scientific evidence now understood to be faulty. The review to which the individual is entitled thus should not differ.

44. Simply identifying problematic cases and reporting these results to OCCO and/or the individual is not, in itself, sufficient. In some cases, convictions may be sound based on other evidence. Conversely, wrongful convictions may go unremedied if the onus is left on the individual to advance his or her case through the complex criminal justice and child protection legal system.

45. Once "bad pathology" is identified, an administrative panel should review the effect of the science on the outcome of the case as a whole. This panel should be composed of four individuals with various perspectives on the legal system, including a Crown counsel, a senior member of the defence bar with expertise in wrongful conviction cases, a representative of the scientific community and a senior

police officer. AIDWYC will always make itself available to provide advice and assistance in the makeup of any review panel. The panel would consider a broader array of materials than the initial, purely scientific review. In cases where no appeal has been filed, the panel may recommend to the Crown that an application to the Court of Appeal to extend time to appeal should be supported. Similarly the panel may recommend that a s. 696.1 application should be supported.

46. This recommendation borrows heavily from the Manitoba model developed to address potential miscarriages of justice based on hair microscopy evidence[85]. It requires no statutory change or enactment, and engages no jurisdictional issues, as described by Bruce MacFarlane[86]. A provincial government seriously concerned to identify and remedy potential wrongful convictions can develop such an initiative independently and efficiently.

47. This also parallels the process of the reviews[87] directed by the Attorney-General of the United Kingdom, Lord Goldsmith, following the release of the *Clark*[88] and *Cannings*[89] decisions by their Court of Appeal. An important difference is that AIDWYC and the Mullins-Johnson Group recommend construction of a panel with expertise drawn from not only the Crown's office, but from other participants in the justice system. This can only augment the reliability, credibility, and independence of the process.

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[85] Deputy Attorney General of Manitoba, Bruce MacFarlane, *Forensic Evidence Review Terms of Reference* (23 April 2003), PFP176698; Forensic Evidence Review Committee, *Final Report* (19 August 2004), PFP176700

[86] Policy Roundtable discussions, "Potential Wrongful Convictions" (21 February 2008), p.17, l.24 - p.25, l.5

[87] Attorney-General Lord Goldsmith, *Report on the Review of Infant Death Cases,* 21 December 2004, PFP300329.

[88] *R. v. Clark* [2003] EWCA Crim.1020, PFP033146

[89] *R. v. Cannings* [2004] EWCA Crim.01, PFP 151031

(D) <u>A permanent error-correcting mechanism</u> should be institutionalized, building on this experience.

RECOMMENDATION 8: The experience that Ontario develops with the reviews of pediatric forensic pathology necessary in these cases should not go to waste. The external panel established to review the cases identified based on the current evidence should be institutionalized, and made available to initiate reviews based not only on changing science but on any issue which raises the spectre of wrongful convictions.

48. Just as repeated difficulties with forensic science are predictable, it is inevitable that other systemic issues will arise in future casting shadows over the soundness of criminal convictions. An *ad hoc* response was developed to the accumulating concerns about Dr. Smith. Another *ad hoc* response will develop to respond to the recommendations of this Commission and implement the pediatric forensic pathology reviews which will follow this Commission. Lessons should be learned from these experiences to implement an institutional and permanent mechanism to respond to similar concerns in future. The work to devise an appropriate and effective body will have already been done. The institution must be made permanent. It must be independent. It must be adequately funded. It must be multi-disciplinary, so that personnel from the affected field can assist reviewing counsel with their input and expertise in the cases under consideration.

49. Current structures are inadequate. The Ministry of the Attorney General announced in May 2006 the formation of the "Ontario Criminal Conviction Review Committee." Its mandate is described as follows:

- Reviewing criminal convictions where a miscarriage of justice is alleged, including cases that engage reviews by the federal Minister of Justice under the *Criminal Code*

> • Providing expert advice and guidance to Crowns across the province in dealing with some of the difficult issues relating to potential miscarriages of justice
>
> • Developing educational and policy initiatives aimed at the prevention of miscarriages of justice
>
> • Developing protocols and best practices for dealing with these cases and preventing future miscarriages of justice[90]

50. The aspirations for this body may be contrasted with the province's snail-like response to the concerns with hair microscopy comparison evidence highlighted in the *Driskell Report*[91]*.* The Ministry published a memorandum[92] to all Crowns summarizing the *Driskell Report* recommendations and the province's response. The hair microscopy issue was addressed as follows:

> *Recommendation 20: Consider a country-wide review of cases where microscopic hair comparison evidence was used, similar to the reviews conducted by Manitoba.*
>
> ... Ontario actively participates in criminal law reform through its involvement in Federal/Provincial/Territorial (FPT) committees and working groups. Ontario's Ministry of the Attorney General is interested in working with its federal/provincial and territorial counterparts to explore ways to identify possible past miscarriages of justice, and to reduce the risk of miscarriages of justice occurring in the future.

51. To date, nothing has come of this.

52. A permanent error-correcting body could ensure that the lessons imparted by public inquiries in Ontario, across Canada, and globally are actually learned and the knowledge is applied to benefit those who may have been affected. Considerable institutional design and development work must be done, to implement an effective

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[90] Ministry of the Attorney General, *News Release: Attorney General Taking Steps to Help Prevent Wrongful Convictions: Committee Launched to Reduce the Risk Of Miscarriages of Justice* (24 May 2006) PFP171062 (also Tab 30 to the Criminal Law Division, Ministry of the Attorney General Ontario *Institutional Report*)

[91] The Honourable Patrick Lesage Q.C., *Report on the Inquiry into Certain Aspects of the Trial and Conviction of James* Driskell, pp. 146-173

[92] Ontario's Review of the Recommendations of the Driskell Inquiry Report PFP171038 at p.9-10, (also Tab 27 to the Criminal Law Division, Ministry of the Attorney General Ontario *Institutional Report*)

mechanism. AIDWYC and the Mullins-Johnson Group urges the Commissioner to recommend that the Province of Ontario immediately initiate the consultations and studies necessary to develop a permanent error-correcting institution out of the experience with retrospective reviews of cases we now have.

(E) <u>The investigation of potential miscarriages of justice</u> should be conducted by a more effective and fully independent federal body, modeled on the British Criminal Cases Review Commission (CCRC).

RECOMMENDATION 9: The Commissioner should recommend that the current Department of Justice "Criminal Conviction Review Group" (CCRG) / Ministerial Review application-based model for post-conviction review be replaced by an effective, independent conviction review mechanism modeled on the British Criminal Cases Review Commission (CCRC). The Province of Ontario should advocate for this change in dealings with the federal Minister of Justice.

53. The Commissioner should also address the need for a permanent mechanism for investigating and acting on claims of wrongful conviction. The section 696.1 (formerly s. 690) process has been the subject of complaint for decades, and needs to be replaced by an independent review board modeled after the United Kingdom's *Criminal Cases Review Commission* (CCRC). The uncovering of wrongful convictions in this country should be managed on a proactive and systemic basis, rather than a reactive, case-by-case basis. An independent review Board would provide the solution.

54. Several previous provincial Commissions of Inquiry into wrongful convictions in Canada have recommended the creation of an independent review board similar to the CCRC in the United Kingdom. To date, their recommendations have fallen on deaf ears. The creation of such a body, however, is an important step to restoring public confidence not only in pediatric forensic pathology but in the administration of criminal justice as a whole. Full restoration of confidence demands that an appropriate mechanism be put in place to correct previous and future miscarriages. There are likely a number of wrongful convictions yet to be corrected. No matter

what systemic changes are made, wrongful convictions will occur in the future. The public must be assured that there is a mechanism of redress for victims of miscarriages of justice.

55. The Board would serve as an independent mechanism to review cases of persons who claim to be wrongly convicted, and include in its members former and present members of the judiciary, members of the legal profession, and lay members. It should have full powers to compel unhindered access to documents and reports that pertain to the original investigation, and have the power to compel witnesses to attend before it to give evidence. The Board should have the power to refer a case to the Court of Appeal. Submissions on the jurisdiction of the Commissioner to make such a recommendation are included in Appendix A.

Problems with the Current Regime

56. The current Ministerial review process is constrained by its legislative framework. It does not provide a proactive approach to the examination of claims of wrongful conviction. The CCRC rarely reviews a case as a whole, but only “tests” the value of new evidence gathered. Applications for Ministerial relief tend to be viewed through a prism of guilt. An applicant with no legal training, no medical training and no funds to retain counsel and expert assistance is at an obvious disadvantage even if objective examination suggests to the experienced eye sound reasons to doubt the conviction. As Graham Zellick, the current Chairman of the CCRC, recently noted, “one of the greatest impediments to correcting miscarriages of justice is the difficulty faced by those convicted in uncovering the evidence and arguments necessary to

overturn the conviction".[93]

57. In a Court of Appeal, fresh evidence is admissible on appeal if it *could* reasonably be expected to have affected the jury's verdict. However, the rules under s. 696.3 require that an applicant convince the Minster that there is a reasonable basis to conclude that a miscarriage of justice *likely* occurred in order to get a case referred to any level of court. The statutory test to refer a case is, therefore, arguably higher than the test that will be applied *at* an appeal after a Reference.

58. The present (and only) avenue for a wrongly convicted person to have their case addressed is inadequate for other reasons. First and foremost, the role of the Minister of Justice, who as Attorney General is also the country's Chief Prosecutor, is incompatible with a duty to review cases of persons wrongly convicted. That is a function that ought to be filled by an official seen to be capable of judicial objectivity – a quality not easily imputed to even the most skilled and well-intentioned of Ministers. The Ministerial review process is inconsistent with the separation of powers between the courts and the executive. In his report that led to the establishment of the CCRC, Viscount Runciman made a similar point when he said:

> … it is neither necessary nor desirable that the Home Secretary should be directly responsible for the consideration and investigation of alleged miscarriages of justice as well as being responsible for law and order and for the police."[94]

59. The inherent frailty in the current system is that political realities and institutional

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[93] Zellick, G. *Facing up to Miscarriages of Justice* (2006) 31 Man. L.J. 555-564 at para. 9.
[94] *The Royal Commission on Criminal Justice*, at p. 12.

bias weigh on the executive, and allow political considerations to influence the considerations of the victims of miscarriages of justice. It is ironic that this Inquiry has focused in large part on the importance of independence in oversight and accountability mechanisms, yet the only reviewing body available for claimants of miscarriages of justice is the governmental institution responsible for all federal prosecutions in the country. As Graham Zellick recently wrote about Canada's Ministerial review system: "to locate the machinery within central government simply means that the body will never inspire the degree of confidence that is necessary".[95] And as Justice Howden put it, the conflict is obvious, in that the Minister has the "responsibility for the legal status quo and that of post-appellate gate keeper for errors made by the justice system".[96]

60. Professor Zellick further commented:

> There is also the issue of principle, namely, that it is no part of a ministerial role to be involved in the administration of justice as it relates to individual cases… that is to risk infusing an individual criminal conviction with a political dimension, which is entirely undesirable… thus, ministerial responsibility for dealing with miscarriages of justice is inappropriate for practical reasons as well as on grounds of principle.[97]

61. A further difficulty of the Ministerial review process is the length of time that a case takes to be assessed and referred, which is almost certain to be measured in years. According to data collected by AIDWYC, the average length of time taken by the Minister to process an application has been approximately 3.9 years. Some

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[95] Zellick, G. *Facing up to Miscarriages of Justice* (2006) 31 Man. L.J. 555-564 at para. 6.
[96] The Honourable Mr. Justice Peter H. Howden, *Judging Errors of Judgment: Accountability, Independence and Vulnerability in a Post-Appellate Conviction Review Process* (2002) 21 Windsor Y.B. Access Just. 569 at p. 14.
[97] *Supra, note 41,* at para. 7.

cases have taken a decade or more to be reviewed. A chart compiled by AIDWYC details the time taken by the Minister in making a decision pursuant to what is now section 696.1 (cases are listed chronologically according to the date of disposition by the Minister):

Applicant	Date of Application	Date of Disposition by the Minister	Total Time	Disposition by the Minister	Section of Code	Final Result
Fox, Norman (aka Kenneth Warwick) (1) (British Columbia) Rape	April 1979	June 1980	1.2 years	Application denied by the Minister		
Marshall, Donald (Nova Scotia) Non-Capital Murder	March 26, 1982	June 16, 1982	0.2 years	Reference to Nova Scotia Court of Appeal	690(c)	Acquittal entered in Court of Appeal on May 10, 1983
Fox, Norman (aka Kenneth Warwick) (2) (British Columbia) Rape	April 1984	October 11, 1984	0.5 years	Free Pardon	748(2)	Pardon issued by an Order-in-Council as a result of joint recommendation by the Solicitor General and the Minister of Justice
Kinsella, Allen (1) (Ontario) First Degree Murder	November 1981	August 1989	7.8 years	Application denied by the Minister		
Comeau, Gary Sauve, Richard McLeod, Jeff Hurren, Larry Blaker, Murray (Ontario) First Degree Murder	December 1988	December 1990	2.0 years	Application denied by the Minister		
Milgaard, David (1) (Saskatchewan) Non-Capital Murder	December 28, 1988	February 27, 1991	2.2 years	Application denied by the Minister		
Nepoose, Wilson (Alberta) Second Degree Murder	April 11, 1991	June 1991	0.2 years	Reference to Alberta Court of Appeal	690(b)	Court of Appeal ordered new trial; Crown stayed proceedings

Milgaard, David (2) (Saskatchewan) Non-Capital Murder	August 14, 1991	April 14, 1992	0.7 years	Order-in-Council to SCC		Governor-in-Council referred case to Supreme Court of Canada. On April 14, 1992, the Court advised the Minister to quash conviction and order a new trial. Proceedings were subsequently stayed by the Crown on April 18, 1992.
Thatcher, Colin (Saskatchewan) First Degree Murder	October 11, 1989	April 14, 1994	4.5 years	Application Denied by the Minister		
Morrisroe, Sidney (British Columbia) First Degree Murder	June 11, 1992	October 18, 1995	3.4 years	Application Denied by the Minister		
Kelly, Patrick (Ontario) First Degree Murder	December 20, 1993	November 25, 1996	2.9 years	Reference to Ontario Court of Appeal	690(b) and (c)	Court of Appeal (May 21, 1999) split 2:1 dismissing appeal; appeal to SCC dismissed
Beaulieu, Wilfred (Alberta) Rape	August 31, 1994	November 25, 1996	2.2 years	Reference to Alberta Court of Appeal	690(b) and (c)	Beaulieu acquitted in the Court of Appeal on one charge; new trial ordered on second. Crown subsequently stayed proceedings
Gruenke (Breese) Adele R. (Manitoba) Second Degree Murder	July 11, 1997 (Report of the Self-Defence Review by Justice Ratushny was released. No s. 690 application was filed as such)	September 26, 1997	0.2 years	Reference to Manitoba Court of Appeal	690(b) and (c)	Court of Appeal dismissed appeal; SCC dismissed appeal on June 15, 2000
McArthur, Richard (Alberta) Second Degree Murder	Application commenced December 18, 1991; completed March 1992	January 20, 1998	7.1 years	Reference to Alberta Court of Appeal	690(b) and (c)	Appeal allowed by the Court of Appeal and an acquittal entered
Johnson, Clayton (Nova Scotia) First Degree Murder	March 31, 1998	September 21, 1998	0.5 years	Reference to Nova Scotia Court of Appeal	690(b) and (c)	New trial ordered by Court of Appeal; acquittal entered on new trial in February, 2002

Kinsella, Allen (2) (Ontario) First Degree Murder	1994	January 13, 1999	4.5 years	Application denied by the Minister		
Taillefer, Billy Duguay, Hugues (Quebec) First Degree Murder	June, 1999	October 16, 2000	1.3 years	Reference to Quebec Court of Appeal	690	Supreme Court of Canada ordered new trial for Taillefer on December 12, 2003. Acquittal entered in September, 2007 after re-trial. For Duguay, Supreme Court of Canada entered a stay of proceedings on December 12, 2003.
Kaminski, Steven Richard (Alberta) Sexual Assault	July 31, 1996	January 27, 2003	6.5 years	New trial ordered by the Minister	696.1(3) (a)	Proceedings stayed by the Crown at re-trial
Cain, Rodney (Ontario) Second Degree Murder	May 27, 1996	May 19, 2004	8.0 years	New trial ordered by Minister	690	Convicted of manslaughter at retrial in 2007
Truscott, Steven (Ontario) Capital Murder	November 28, 2001	October 28, 2004	3.0 years	Reference to Ontario Court of Appeal	696.1(3) (b)	Court of Appeal entered an acquittal on August 28, 2007
Bjorge, Darcy (Alberta) Stolen Property 1994	June, 2000	February 10, 2005	4.8 years	Application granted; new trial ordered	696.1(3) (a)	Charge stayed in the Alberta Provincial Court
Wood, Daniel (Alberta) First Degree Murder	November 28, 1993	February 10, 2005	11.3 years	Reference to Alberta Court of Appeal	696.1(3) (b)	Court of Appeal ordered a new trial on November 27, 2006; charges stayed by Crown at the re-trial
Driskell, James (Manitoba) First Degree Murder	June 4, 2003	March 5, 2005	1.8 years	New trial ordered by the Minister	696.1(3) (a)	Proceedings stayed in the Manitoba Queen's Bench on the same day as the Minister's Order
Tremblay, Andre (Quebec) First Degree Murder	July 2, 1992	July 12, 2005	13.0 years	Reference to Quebec Court of Appeal	696.1(3) (b)	Court of Appeal ordered a new trial; charge stayed at the re-trial by the Crown

Phillion, Romeo (Ontario) Non-Capital Murder	February 4, 1992	On August 20, 1998, *Innocence Project* requests that Application be put on hold due to new information; Mr. Phillion's application was resubmitted on May 15, 2003. Referred to Court of Appeal in 2004	12 years	Reference to Ontario Court of Appeal	696.3(3)(a)(ii)	Proceedings ongoing in the Court of Appeal
Mullins-Johnson, William (Ontario) First-Degree Murder	September, 2005	July, 2007	1.8 years	Reference to the Ontario Court of Appeal	696.1	Acquittal entered by the Court of Appeal on October 15, 2007
Walsh, Erin (New Brunswick) Non-Capital Murder	2006	February 28, 2008	2 years	Reference to New Brunswick Court of Appeal	696.3(a)	Acquittal entered by Court of Appeal on March 14, 2008
Unger, Kyle (Manitoba) First Degree Murder	September 13, 2004	No decision to date	3.5 years	No decision to date	696.1	

62. Admittedly, these statistics can be misleading. For example, Donald Marshall's case was referred expeditiously, presumably because the RCMP had already concluded that Mr. Marshall was innocent *before* the application was commenced. Mr. Nepoose's case was referred in two months, likely because the Attorney General of Alberta consented to the reference. Ms. Gruenke's matter was referred to the Manitoba Court of Appeal after a thorough investigation and report by Madam Justice Ratushny had already been completed. On the other hand, in Steven Kaminski's case, more than a year passed from the initial filing of the application before Mr. Kaminski's counsel filed the balance of his materials. Mr. Kinsella's first application was filed in 1981, but did not properly get off the ground until April, 1987. While it can be concluded that, overall, the Ministerial review process is very often a lengthy one, the pattern over the last five years has been to decide cases more quickly than in the past.

63. Finally, the Ministerial review process places the onus on the applicant claiming wrongful conviction to conduct an investigation, search for fresh evidence, and retain counsel to properly prepare an application to the Minister. All of these steps are costly and time consuming. Applicants frequently do not have the necessary resources or information, and this concern is particularly acute in cases involving contentious expert evidence. Moreover, as we have seen, there is a dearth of qualified forensic pathologists across Canada and few with the ability and reputation to mount an attack on a wrongful conviction.

Criminal Cases Review Commission

64. Unlike the present regime in Canada, the Criminal Cases Review Commission conducts its own independent investigation, and provides its own resources, all at no cost to the Applicant. In his testimony at the Inquiry, Dr. McLellan agreed that the Office of the Chief Coroner should be involved in post-conviction work for an independent review board, should one be set up in Canada[98].

65. The CCRC was established in 1997 to replace a post-appellate regime that was almost identical to that currently in place in Canada, and was found to be inadequate after an inquiry by Lord Runciman[99]. This Commission's mandate includes investigating all allegations of wrongful conviction in summary or indictable proceedings, including findings of not guilty by reason of insanity. The Commission is an independent body and has wide ranging investigative powers, including the

[98] Evidence of Dr. McLellan, 11/16/07, p. 47, line 2 – p. 48, line 23.
[99] Evidence of Dr. Milroy, 11/22/07, pp. 165, line 21 – 167, line 2.

power to retain police officers and experts to reassess the evidence in a case. At the conclusion of its review, the Commission must consider whether "there is a real possibility that the conclusion, verdict, finding or sentence would not be upheld were the reference to be made".[100] While s. 696.1, unlike its predecessor, allows the Minister to conduct a full investigation, it is not mandatory, and many applications are dismissed without an investigation being undertaken. The CCRC has the exclusive power to refer a case to the Court of Appeal, and has proven to be an excellent model for uncovering wrongful convictions.

66. Since its inception in March, 1997, the CCRC has reviewed 10,532 applications[101], and has referred 380 cases to the Court of Appeal. 134 of the referrals have been homicide cases. As of January 31, 2008, 354 of those cases had been heard by the Court of Appeal, resulting in 245 convictions being quashed, 106 being upheld, with 3 under reserve. Included within the 245 quashed convictions are 80 homicide convictions.[102] When asked why the Commission has been relatively successful in its rate of convictions quashed, former Commission Member L.H. Leigh answered "we benefit from the ability to investigate cases at public expense without, at least to date, any overt pressure to restrict expenditure".[103]

67. During the same time period in Canada, there have been a total of 15 cases

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[100] *Criminal Appeal Act*, 1995, ss. 9(5) and (6), 10(6) and (7), 13(1)
PFP300030 at pp. 1-5.
http://www.ccrc.gov.uk/

[101] Of those, 279 were cases transferred from the Home Office when the Commission was set up in 1997.

[102] See *Criminal Cases Review Commission;* www.ccrc.gov.uk

[103] *Leigh, L.H.* Correcting Miscarriages of Justice: The Role of the Criminal Cases Review Commission. (2000) 38 Alta. L. Rev. 365 at para 36.

referred back to appellate courts across the country. In fact, since 1961, the Ministerial review process has produced a remedy in, on average, 0.63 cases per year.[104] While the population of the UK is more than double that of Canada[105], this does not make up for the difference. Even taking into account the population divergence, the rate of referrals in the United Kingdom since the CCRC's inception is about 14:1. The disparity is alarming, and suggests that many wrongful convictions in Canada go undetected and uncorrected. As Dr. McFarlane suggested at a policy roundtable, public confidence in the conviction review process in Canada is low.[106] During the most recent fiscal year for which statistics are available, only four completed applications to the Minister were even made. During the same period, eight preliminary assessments were completed, and failed to progress to the investigation stage.[107] Professor Zellick explains the statistical state of affairs in Canada by stating:

> The number of applications [the Minister] receives is so astonishingly small that it can only support the conclusion that its positioning within central government seriously diminishes its standing in the eyes of those who feel they have been wrongly convicted.[108]

68. The Court of Appeal in England has applauded the implementation of the CCRC. In its decision in *R. v. Mattan,* the Court described it as "a necessary and welcome

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[104] The Honourable Justice Peter H. Howden, *Judging Errors of Judgment: Accountability, Independence & Vulnerability in a Post-Appellate Conviction Review Process* (2002) 21 Windsor Y.B. Access Just. 569 at p. 10.
[105] http://www.census.gov/cgi-bin/ipc/idbrank.pl
[106] *Commentary of Dr. Bruce MacFarlane,* Policy Roundtable, February 21, 2008, p. 112.
[107] http://www.justice.gc.ca/en/ps/ccr/report_07/05.html - 2007 Annual Report (statistics for April 1, 2006 to March 31, 2007). Statistics for preliminary investigations include those commenced prior to April 1, 2006 that were completed during the fiscal year.
[108] Zellick, G. *Facing up to Miscarriages of Justice* (2006) 31 Man. L.J. 555-564 at para. 6.

body, without whose work the injustice in this case might never have been identified".[109] In a later decision, the CCRC was referred to as "essential to the health and proper functioning of a modern democracy".[110] Members of the judiciary in Canada also appear anxious for change. Justice Howden wrote:

> The determination of whether there is a real possibility of injustice having been done to someone subject to our court system, a person deserving of equal human dignity under our constitution, seems to me uniquely suited to an expert body, acting collegially from an informed mix of experience and training and removed from the adversarial and political winds of influence. Accountability to Parliament and, through it, to Canadians can readily be provided for an independent review body by the legislation that constitutes it. The informative reports of the CCRC indicate a regular level of public accounting unknown in the Canadian experience of section 690.[111]

69. An additional advantage to the implementation of an independent review body is of relevance to the circumstances leading to this Inquiry. The CCRC also has a statutory duty to investigate any matter referred to it by the Court of Appeal. As of 2002, there had been three occasions in which the Court of Appeal referred cases to the Commission that required forensic science investigations. Former Commission Member L.H. Rose explained "the Courts of Appeal are beginning to regard us as a useful instrument for determining where, in disputed matters of fact and in particular allegations for malpractice, the truth may lie.[112]

70. In the most recent Commission of Inquiry into a wrongful conviction in Canada,

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[109] *R. v. Mattan* (1998) *The Times* 5 March.
[110] *R. v. Criminal Cases Review Commission, ex parte Pearson* [2000] 1 Cr. App. R. 141.
[111] The Honourable Justice Peter H. Howden, *Judging Errors of Judgment: Accountability, Independence & Vulnerability in a Post-Appellate Conviction Review Process* (2002) 21 Windsor Y.B. Access Just. 569 at p. 18.
[112] Letter from L. Leigh to the Honourable Mr. Justice Peter H. Howden (January 21, 2002) in The Honourable Justice Peter H. Howden, *Judging Errors of Judgment: Accountability, Independence & Vulnerability in a Post-Appellate Conviction Review Process* (2002) 21 Windsor Y.B. Access Just. 569 at p. 22.

Justice LeSage emphasized the difficulties with the current conviction review process, and suggested that an independent review body similar to the CCRC would be an appropriate solution:

> I am concerned about the adversarial nature of the present process. Driskell could not launch an application until he had sufficient disclosure to satisfy the Department of Justice standard for launching a section 696.2 review. However, the [Winnipeg Police Service] would not make disclosure for purposes of a section 696.2 review until Driskell's application was made. This is a classic 'catch 22' situation. If there was an independent inquisitorial body, as in the U.K., it could, after being satisfied that a threshold, not necessarily a high threshold, has been met, commence the section 696.2 process of its own initiative. In this way, information that is unavailable to the application because of their inability to compel disclosure, would be available to the independent agency to allow them to make a better determination of whether a miscarriage of justice occurred.

71. Despite the repeated recommendations of previous Commissions of Inquiry, nothing has happened, and s. 696.1 remains the only available review process. Kathryn Campbell and Clive Walker commented in their policy paper prepared for the Commission as follows: "the CCRC has been a powerful agency for the correction of miscarriages of justice in sudden infant death cases".[113] We therefore request that the Commissioner add his voice to those who have already considered this issue in past Inquiries, and recommend the creation of an independent tribunal to review, assess, and adjudicate wrongful conviction claims in the same, or similar, manner as the *Criminal Cases Review Commission.* In the words of Professor Zellick, "such a body should be a conspicuous feature of any developed system of criminal justice".[114]

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[113] Campbell, K. & Walker, C. *Medical mistakes and miscarriages of justice: Perspectives on the experiences in England and Wales.* Prepared for the Commission into Pediatric Forensic Pathology in Ontario (2008).

[114] Zellick, G. *Facing up to Miscarriages of Justice* (2006) 31 Man. L.J. 555-564 at para. 35.

RECOMMENDATION 10: The Commissioner should recommend that adequate funding structure for the post conviction review process.

72. Applicants who wish to make an application for Ministerial review are not entitled to any financial assistance for the investigation, preparation or presentation of their applications. While organizations such as AIDWYC are in place to assist, it is unacceptable for an applicant who may be the victim of a miscarriage of justice to rely on the goodwill of lawyers willing to work *pro bono* and experts willing to donate their services.

73. Legal Aid Ontario has sometimes funded the making of an application itself, but only if the applicant is still serving a sentence of imprisonment. In his report, Justice Howden recommended that "applicants across Canada should have access to legal aid to assist in *determining their eligibility* and in the preparation of their applications and responses invited or required by the process (emphasis added)."[115] Those who claim to have been wrongly convicted should not be left to fend for themselves in determining whether they may be eligible to apply for a Ministerial review. They should have access to legal counsel from the outset, to assist and advise them at all stages of the process.

[115] The Honourable Justice Peter H. Howden, *Judging Errors of Judgment: Accountability, Independence & Vulnerability in a Post-Appellate Conviction Review Process* (2002) 21 Windsor Y.B. Access Just. 569 at p. 18.

74. Post-conviction consultations and reviews by pathologists in cases where a miscarriage of justice may have occurred should be conducted by, and paid for by, the Office of the Chief Coroner, if its assistance is sought by the Applicant, in the same way that the Centre of Forensic Sciences conducts post-conviction forensic testing. In the Morin report, Commissioner Kaufman stated:

> In the *Morin* and *Milgaard* cases, protocols were established to permit the DNA testing of original evidence in a way that was satisfactory to all parties. It would be advisable that protocols be generally established to address these kinds of situations, particularly where there is a defence request for DNA testing after conviction.[116]

75. The Centre of Forensic Sciences has now implemented a policy in which they conduct and pay for all post-conviction testing. Dr. Pollanen testified that there should be "a harmonization between the policies in post-conviction DNA testing circumstances and post-conviction… pathology reviews".[117] However, it seems that the Office of the Chief Coroner requires direction as to the role it should play in the post-conviction process. When asked why they refused to conduct a review of "Jeff's case", a case in which Dr. Smith provided an oral consultation and of which AIDWYC requested a review, Dr. McLellan responded that OCCO should not be taking a lead in post-conviction reviews. He then acknowledged that had the request come from the Crown's office, he would have agreed to do it, and stated his position to be that any request for a post-conviction review should come from the Attorney General's office.[118] A recommendation should therefore be made that a

[116] *The Commission on Proceedings Involving Guy Paul Morin Report,* Vol. 1, p. 395.
[117] Evidence of Dr. Pollanen, 12/05/07, p. 252 lines 4-10.
[118] Evidence of Dr. Pollanen and Dr. McLellan, 11/16/07, pp. 63-74.

policy similar to that at the CFS be instituted at the Coroner's Office, and that defence requests for post-conviction reviews be conducted, and paid for, by the office if their assistance is requested by the Applicant.

(F) <u>Compensation</u> should be provided to individuals and families affected by flawed pathology opinions.

RECOMMENDATION 11: The Commission should recommend that a mechanism be developed by the Government of Ontario to investigate and settle claims for compensation.

76. It is clearly beyond the mandate of the Commission to recommend compensation for any individual or family affected by the testimony or opinions of Dr. Smith. No evidence was called related to compensation schemes or appropriate considerations. However, it is clear that the tragedies and injustices visited on innocent families by Dr. Smith's "bad pathology" invite compensation in some form. Civil litigation of each of the individual claims may be neither efficient nor effective. Considerable evidence was heard on this Inquiry that need not be repeated in multiple proceedings. The Commission should recommend that an alternative mechanism be established to consider claims.

77. In his report on the *Arar Inquiry* Justice O'Connor made the following comments and offered the following recommendation.

> First, in addressing the issue of compensation, the Government of Canada should avoid applying a strictly legal assessment to its potential liability. It should recognize the suffering that Mr. Arar has suffered, even since his return to Canada…
>
> Based on the assumption that holding a public inquiry has served the public interest, Mr. Arar's role in it and the additional suffering he has experienced because of it should be recognized as a relevant factor in deciding whether compensation is warranted…

Recommendation 23

The Government of Canada should assess Mr. Arar's claim for compensation in the light of the findings in this report and respond accordingly. [119]

[119] The Honourable Dennis O'Connor, *Report on the Commission of Inquiry into the Actions of Canadian Officials in Relation to Mahar Arar*,

III - PRE-TRIAL CRIMINAL INVESTIGATION AND PATHOLOGY

78. AIDWYC and the Mullins-Johnson Group submit that an integral aspect of improving the quality of pediatric forensic pathology evidence in Ontario is the promotion of an enhanced culture of professionalism among forensic pathologists in Ontario. To this end AIDWYC and the Mullins-Johnson Group support and endorse Dr. Pollanen's suggestions to Improve Forensic Pathology In Ontario.[120]

(A) All inputs to the pathologist as the foundation for the scientific opinion must be transparent.

RECOMMENDATION 12: OCCO's "Guidelines on autopsy practice for forensic pathologists ~ Criminally suspicious cases and homicides" should be amended to require that all information made available to the pathologist by investigators, coroners, clinicians, or any other source must be carefully recorded and provided to Crown Counsel for disclosure to defence counsel.

79. All information relayed to the pathologist must be recorded. This is an essential step in ensuring that the opinion ultimately generated can be subject to appropriate scrutiny. Independent reviewability is a hallmark of the scientific method[121] and only this record-keeping style permits it for the post-mortem examination. The goal of this process is to ensure that a clear and complete record is made of all information provided to the pathologist which may have informed his or her opinion. Replication and review of results requires that both what was and what was not available be transparent. A later, reviewing expert requires this information to assess the opinion given. The initial pathologist requires this information to explain the limitations on the opinion.

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[120] PFP176766
[121] Evidence of Dr. Pollanen, *Transcript (12 November 2007),* p.156, ll.5-20

80. Relying on "filtering" by the responsible pathologist[122] is inadequate and unrealistic. Prejudicial material shared with the pathologist can have profound effects. The biases generated by prejudicial information may operate unconsciously, even when honest best efforts are made to disregard the information.

81. The evidence on this Inquiry raises a question as to whether Dr. Smith made such honest best efforts. At the very least, his firmly held personal views were reinforced by what he understood to be conclusions in the social science research. This may have made him particularly vulnerable to the forms of cognitive bias discussed by Mr. MacFarlane. In his evidence, Dr. Smith testified that his personal beliefs and views of the social science did not affect his pathology opinions. As Mr. MacFarlane points out[123], unconscious psychological effects can be profoundly powerful and uniquely difficult to identify.

82. While there are thus risks inherent in fulsome disclosure of investigatory information to the pathologist, AIDWYC and the Mullins-Johnson Group do not support the recommendation that pathologists should work in isolation from the rest of the investigation.

83. All of the scientists asked about this issue explained the importance of information-sharing. Dr. Pollanen described "consideration of the scene and history" as the first step in a medical-legal autopsy[124] and explained as follows:

> One of the myths that is very difficult to overcome in forensic pathology is the view that the forensic pathologist is presented with the body and then somehow goes through a procedure that magically produces a self-evident answer; that is most definitely not what we do. What is an absolutely critical step along the way

[122] Evidence of Dr. Pollanen, *Transcript (12 November 2007),* p.152, ll.24 - p.153, l.11; p.155, ll.1-9; *Transcript (13 November 2007),* p.178, l.15 - p.179, l.19

[123] MacFarland, *Wrongful Convictions: The effective tunnel vision and predisposing circumstances in the criminal justice* system, p. 36-46

[124] Evidence of Dr. Pollanen, *Transcript (12 November 2007),* p.150, ll.17- p.152, l.13

> is obtaining information about the context of the case. This includes the scene appearance, the medical history including illnesses, medications, the events surrounding the case. These all become very critically important to the point that, in many circumstances, the information is best obtained by the pathologist actually attending the scene.

84. Investigation information is not appropriately entirely kept from the pathologist; it may well point to examination techniques or sampling that would not otherwise have been done[125]. It is difficult to assess what is "analysis-irrelevant material" in advance, particularly as it is the investigator or coroner making that decision, rather than the pathologist who knows what his or her analysis requires.[126]

85. Once these risks are identified and understood, it is clear they must be carefully managed. The best way to do this is by ensuring a complete and accurate record is made of all external or investigative information relayed to the pathologist. It is only in exposing the range of information shared with the pathologist that inappropriate influences may be detected. The current Guidelines[127] emphasize information-gathering and sharing, without instructing pathologists that they must record all information received. This should be amended.

(B) <u>All outputs from the pathologist</u> to investigators and other justice system participants must be in writing.

RECOMMENDATION 13: OCCO "Guidelines on autopsy practice for forensic pathologists ~ Criminally suspicious cases and homicides" should be amended to require that all expressions of pathology opinion, from the very initial and preliminary stages of an investigation onward, must be provided to investigators or other interested justice system participants in writing. OCCO Guidelines should include guidance for pathologists on the use of standardized language to promote effective and accurate communication of their opinions.

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[125] Evidence of Dr. Pollanen, *Transcript (12 November 2007),* p.153, l.12 - p.154, l.8; p.158, ll.4-18
[126] MacFarlane, pp. 26-29
[127] Office of the Chief Coroner, "Guidelines on autopsy practice for forensic pathologists ~ Criminally suspicious cases and homicides" (2nd ed., October 2007) <u>PFP139350</u> at pp.8-10

86. Verbal reports of preliminary opinions may be misunderstood or poorly communicated. Accurate and complete communication of forensic opinions and the limitations on those opinions, is necessary for a fair investigation. Communication difficulties between forensic scientists, police, and Crown counsel were identified in the *Morin Report* as particularly problematic[128]; the failure to fully and fairly convey the forensic trace evidence conclusions led the police to arrest Mr. Morin, when they otherwise might not have. The oral communication of findings attracted particular scrutiny from Commissioner Kaufman.:

> Apart from any inadequacies in [the scientist's] communications of her findings, the oral communication of complicated and subtle findings and, more important, the limitations on those findings, may lead to gross misunderstanding. The recipients of the information (like the investigators here), whose attitudes are no doubt coloured by their own preconceptions, may well misinterpret the scientist's opinions, even if accurately expressed. Inadequately expressed oral opinions and their limitations make it even easier for the listeners to hear what they want to hear.[129]

87. These disputes and misunderstandings must be avoided. This is easily done. Opinions should be recorded. There are various means available to accomplish this goal. Pathologists may review and sign police notebooks to confirm the accuracy of notes taken of post-autopsy meetings, provide brief written reports, or provide for third-party minuting of meetings, perhaps by the autopsy assistant. Whatever mechanism is chosen by the pathologist, the written record is essential to ensure both sound, informed investigation and effective scrutiny of developing opinions. This mirrors the recommendation made by Commissioner Kaufman about the forensic sciences in the *Morin Report*[130].

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[128] *Morin Report, supra* at 29, 87-91, 96-103
[129] *Morin Report, supra* at 110
[130] *Morin Report, recommendation #6 p. 329*

88. While this recommendation appears straightforward and uncontroversial, a meeting held on September 20, 2005 at the Office of the Chief Coroner suggests otherwise. The meeting was between Dr. Pollanen, Dr. Ray Prime of the Centre for Forensic Sciences, and Crown counsel Shawn Porter, for the purpose of reviewing the applicability of the *Morin Report* recommendations to forensic pathology[131]. In response to the recommendation that forensic opinions should be acted upon only when they are in writing, the following concerns are noted:

> This many [sic] represent a fundamental difference between forensic pathology and forensic science, i.e., a verbal report on certain causes of death is often sufficient for action, such as a gunshot wound of the head. Some of the issues, however, are not as clear such as when the cause of death is subtle or the case involves infants, children, or sex crimes.

89. AIDWYC and the Mullins-Johnson Group submit that this view is misguided (and, indeed, may no longer reflect the institution's view, as the current Guidelines require that at least the cause of death be provided in writing.[132]) If the case is as straightforward as the gunshot example, writing that single sentence down as the cause of death is not an onerous task. The mandatory, blanket requirement recommended here, while it may not assist the parties in the gunshot case, allows for consistency in practice and avoids the risks inherent in a discretionary, case-by-case and pathologist-by-pathologist model for reporting opinions. It is also important that any opinion offered to the investigator be provided in writing, not merely the statement of cause of death.

90. Once opinions are offered in writing, precision in the use of language is invited.

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[131] "Agenda: Special Meeting, Exploring the Implications of the Kaufman Inquiry (Commission of Proceedings Involving Guy Paul Morin) to the Toronto Forensic Pathology Unit" (20 September 2005), PFP032569, at pp.1-2

[132] Office of the Chief Coroner, "Guidelines on autopsy practice for forensic pathologists ~ Criminally suspicious cases and homicides" (2nd ed., October 2007) PFP139350 at pp.8-10

The precise framing of conclusions in terms of degrees of certainty, inclusionary and exclusionary results, and differential diagnoses is more likely when pathologists are required to commit these observations to writing which they know will be carefully scrutinized. Recommendations from OCCO to its pathologists can eliminate inconsistently used phrasing which invites miscommunication (such as "consistent with" and "could be"). More accurate, and less suggestive, formulations of these phrases should be adopted. In the *Morin Report,* Commissioner Kaufman suggested that the phrase "may be or may not be" more effectively communicated the intended strength of the scientific conclusion in such cases[133]. Whatever language is adopted, it should be carefully defined and consistently applied by pathologists across the forensic pathology service.

[133] *Morin Report, supra* at 87-89, 96-100

RECOMMENDATION 14: OCCO "Guidelines on autopsy practice for forensic pathologists ~ Criminally suspicious cases and homicides" should be amended to require that any changes in opinion must also be communicated in writing, along with the bases for that change.

91. Final opinions and preliminary opinions may vary. New evidence may be discovered, ancillary test results may shed new light on the medical issues, or research or consultation with other experts may lead the scientist to revise his or her view. Not all changes of opinion, as is evident, are suspect.

92. In order to distinguish between these circumstances, it is important that these changes be adequately memorialized and explained, and the reasoning be transparent. A reviewing expert must be able to assess the basis for the alteration.

IV - EXPERT FORENSIC PATHOLOGICAL EVIDENCE AT TRIAL

(A) Defence counsel must be adequately funded and professionally competent to defend criminal cases involving pathological expert evidence.

RECOMMENDATION 15: The Legal Aid tariff needs to be revised to reflect cost of living increases. Legal Aid should offer supplemented rates to those certified, senior counsel appearing on homicide cases. It should also ensure that junior counsel is routinely authorized, and that the hours allotted to defend the cases are adequate.

RECOMMENDATION 16: Legal Aid should ensure that adequate funding is provided to the defence to retain experts. In specialized fields like forensic pathology, Legal Aid must authorize the retainer of out-of-jurisdiction experts. Funding should include an allowance for experts to attend in court to monitor the testimony of other witnesses.

93. AIDWYC and the Mullins-Johnson Group submit that the single most important bulwark against miscarriage of justice is diligent and competent defence counsel. The adversarial system simply will not function properly in the absence of adequately resourced advocates acting for accused persons. Commissioner Kaufman made the same point a decade ago:

> The success of the adversarial system in preventing miscarriages of justice largely rests upon the existence of well-trained, competent prosecutors and defense counsel. This necessarily involves defense 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.[134]

94. Unfortunately, Commissioner Kaufman's comments, and the recommendations of numerous other task forces and study groups have gone largely unheeded by the

[134] Kaufman Inquiry Report, Ch. V.. pp. 1233-1235.

government of Ontario.[135] At present, in Ontario, the Legal Aid Plan has been eroded to the point where most experienced criminal lawyers are reluctant or unwilling to take on legal aid retainers in homicide cases because of the length of the cases and the low rate of pay. Counsel with as little as one year experience are being retained to defend homicide cases. There is now little opportunity for junior counsel to be mentored by senior counsel in the context of legal aid cases.[136] AIDWYC and the Mullins-Johnson Group submit that in the absence of qualified and properly resourced defence counsel it is a certainty that the adversarial system will fail, notwithstanding whatever changes are made as a result of this Commission or other initiatives. AIDWYC and the Mullins-Johnson Group urge the Commissioner to emphasize the importance of this issue in his report to the Attorney General, in the strongest terms.

95. The Commission also heard evidence from Dr. Milroy of the "dramatic effect" that having an opposing expert sitting in court can have in ensuring an expert gives evidence in a responsible manner.[137] Accused persons will generally only have access to such experts if legal aid funds them and does so at a reasonable level.

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[135] *Report of the Fact Finder in the Matter of Ontario Legal Aid Tariff* Mississauga:Graeme McKechnie Consulting 1985; Holden and Kaufman, *Tariff Review Taskforce Report,* Toronto: Legal Aid Ontario, 2000, pp. 183-187; Legal Aid Ontario, *Legal Aid Tariff Reform: Business Case.* Toronto: Legal Aid Ontario, 2001, pp. 2-3, 26-28.
[136] Evidence of John Struthers, *Transcript (8 February 2008),* p.288, II. 8-296, I.1
[137] Evidence of Dr. Milroy, *Transcript (23 November 2007),* p.69, ll. 5-13,

(B) Crown counsel must be adequately supported and professionally competent to prosecute criminal cases involving pathological expert evidence.

RECOMMENDATION 16: Crown counsel prosecuting child homicide cases must have access to the expertise of the Child Homicide Team recently developed at the Ministry of the Attorney General's Criminal Law Division. Consultation with the Team should be mandatory. Plea offers should require approval by the Team. Defence counsel should have access to the Team to prompt further consultation on cases which may be plagued by tunnel vision.

96. AIDWYC and the Mullins-Johnson Group support the new Crown initiative requiring Crown attorneys with carriage of pediatric homicide cases to consult with the Child Homicide Team.[138] In particular, AIDWYC and the Mullins-Johnson Group support the concept of ongoing review of an individual prosecution as it proceeds through the system. What is presently lacking in the initiative, however, is the capacity for defence counsel to access the process. Paul Lindsay, when asked to consider the suggestion that defence be provided access to The Child Homicide Team, stated that he saw no impediment to this taking place. On this basis, AIDWYC and the Mullins-Johnson Group suggest that the Commissioner recommend that access to the Child Homicide Team by defence counsel be formalized. [139]

97. The Child Homicide Team has a further and important role to play in respect of plea agreements in child homicide cases. The Commission heard evidence of plea offers in circumstances where the case against the accused was weak and arguably

[138] Policy Round Table: Crown, defence of the court, *transcript (19 February 2008)* p.15 ll. 19 – p.20 ll. 5
[139] Policy Round Table: Crown, defence of the court, *transcript (19 February 2008)* p.26 ll. 11 – p.27 ll. 22

ought properly to have been withdrawn. In particular, in the case of Joshua's mother, the accused was offer a plea to infanticide in circumstances where she was charged with murder.[140] In the case of Gaurov, the accused, Gaurov's father, was charged with second degree murder but was offered a plea to criminal negligence causing death and a sentence of 90 days to be served intermittently.[141] Although there are circumstances in which a Crown attorney can properly consider difficulties in proving a case as a means to offer a reduced sentence, there are circumstances where the appropriate course is for a charge to be withdrawn. An objective assessment by the Child Homicide Team is essential in determining which cases should proceed.

(C) <u>Judges</u> bear the ultimate responsibility as gatekeepers of expert scientific opinion. They must ensure that experts do not opine beyond the defined limits of their expertise, and that counsel do not invite them to do so.

RECOMMENDATION 17: Trial judges should conduct more demanding expert evidence *voir dires* and insist that the precise area of expertise offered by the witness be precisely delineated. Trial judges must use proactive and interventionist strategies if necessary to ensure that informative *voir dires* are conducted and unreliable evidence is not introduced.

RECOMMENDATION 18: Trial judges must be proactive and interventionist in policing the boundaries of expert witness testimony. The "roaming expert" must be immediately returned to his or her approved territory, with or without an objection from counsel.

98. AIDWYC and the Mullins-Johnson Group endorses the evidence of Professor Beecher-Monas with respect to the gate-keeper function of Judges to keep out

[140] Evidence of Bruce Hillyer *Transcript (23 November 2007),* p.163, ll. 21
[141] Policy Round Table: Crown, defence of the court, testimony of David Gorrell *transcript (19 February 2008)* p.184 ll. 7 – p.12 ll. 18

unreliable evidence. In particular, Professor Beecher-Monas testified as follows:

> "…I think that scientific evidence, like many of these other forms of evidence that you're, talking about, … is an exercise in logic. And I think the same is true with, for example, eye witness experts who would like to testify about the unreliability of eye witness testimony; One needs to look at the empirical basis for what they are saying.
>
> And so I - - I think that there is a great difference between expert testimony and lay testimony, and the scrutiny that the judges need to give to expert testimony is far - - far greater…
>
> I think the Judge has a responsibility to look very carefully at the empirical basis for all of the expert testimony, because experts come in there with a - - come into Court with a special imprimatur: they are experts, right.
>
> Their to assist the jury. They are different from lay witnesses. They don't rely on their personal perceptions of what happened. They rely on their experience, and one needs to know whether that experience is based on empirical data or not. And that is why I think the Judge has an increased responsibility for gate keeping when it comes to expert testimony."[142]

99. Although Judges are generally alive to the requirement to test the reliability of new kinds of scientific evidence, historically established categories of expert evidence have not met with the same level of scrutiny. AIDWYC and the Mullins-Johnson Group submits that the foundational tools for permitting Judges to exercise their gate keeping functions can be found within the Common Law as provided for in *R. V. Mohan* (1994), 89 C.C.C. (3rd) 402 (S.C.C.). However, as Professor Edmond discusses in his paper,[143] our courts have not yet made reliability an explicit requirement for admissibility.[144]

100. In his testimony before the Commission, Professor Code summarized the evidence of a panel of forensic scientists who testified at the Driskell inquiry. He noted that they were frank in admitting that they did not insist upon peer-review,

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[142] Evidence of Dr. Erica Beecher-Monas, *Transcript (22 February 2008),* p.18, ll. 17 - p.19, ll. 25
[143] Edmond, *Pathological Science? Demonsterable Reliability and Expert Forensic Pathology Evidence*
[144] *R. v. Trochym* [2007] 1. S.C.R. 239. and R. v. J. – L. J. [2000] 2 S.C.R. 600.

double blind testing and other indicia of reliability but that forensic sciences were "sort of a cowboy frontier area of science where they're not following the scientific method." Professor Code went on to suggest

> " it's got to be remembered that opinions are an exceptional form of evidence in the Common Law. And so we developed strict admissibility criteria before we allow people to come in and usurp the function of the jury by giving opinion evidence.
>
> So I think there has got to be a rigorous application of - - I wouldn't even call it reliability, I would call it scientific validity. Are - - are these opinions that some expert is proposing to give to usurp the normal function of the trier of fact, do they have scientific validity, and they should be - - they should be held to the burden of establishing the scientific validity of their opinions before they are allowed to make them."[145]

Professor Code went on to state:

> "so I think the - - the proponent - - of the witness, who has got to make it very clear at the admissibility stage what the opinion is that they are seeking and whether that opinion that they are seeking is within the established field of scientific validity that has come to be accepted with this expert.
>
> I mean again, the - - the hair and fibre evidence in Driskoll and Morin is a classic illustration of this, that the - - expert gets on the stand and says, I looked under a microscope and I looked at these two (#2) hairs and they are microscopically similar to me and that was an established body of expertise at that time, that forensic scientists traditionally gave, and there was no vetting of it at the admissibility stage.
>
> But then what they do once they get onto the stand is they give a second opinion…
>
> They are not just giving an opinion about their observations under the microscope, they are giving an opinion about the likelihood of that hair actually coming from that's deceased body based on propositions about the - - the numerical frequency of that hair occurring in the general populous which is something they know nothing about…
>
> It's based on entirely on hunch and guess work, and the rough culture of the office so if - - if the Crown, in - - in Driskoll had been very clear at the admissibility stage, that I am seeking an opinion not just about visual microscopic similarity when I look at these two (#2) hairs, but about the likelihood of - - of that being a match for the deceased, and probabilities of - - of coincidental matches in the general population, the Judge would have been able to put a stop to it at that stage and say, no, you are not eliciting that second opinion unless you can

[145] Evidence of Michael Code, *Transcript (19 February 2008)* p.105, ll. 11 – p.109, ll. 15

establish it's scientific validity.[146]

101. The trial judge must ensure that the expert evidence proffered meets not only the familiar standards for admission of expert evidence as outlined above, but also that exclusion is not invited by the balancing of probative value against prejudicial effect[147]. Trial judges should invite argument on this issue, even if counsel do not frame a submission in this manner. As observed in the *Morin Report,* scientific evidence may be capable of providing only "consistent with" answers, a failure to eliminate a suspect or a conclusion, which has extremely limited probative value[148]. In light of the well-known risks of over-emphasis of expert evidence by the trier of fact, exclusion based on the probative-prejudicial balancing standard is appropriate in such cases.

(D) Juries must be given specific instructions to assist them with their task of assessing expert evidence.

RECOMMENDATION 19: Juries should be given sharp, precise instructions about the risks of relying on expert evidence. They should be cautioned against being over-impressed or daunted by these witnesses, and given instructions about how to test the reliability of the science discussed. Juries should be warned that expert evidence has led to wrongful convictions.

102. There are a constellation of factors that have been shown to cause wrongful convictions. Some of them are present in this inquiry. Among the most notable causes that have been highlighted in other inquiries are eye witness identification

[146] Evidence of Michael Code, Transcript (19, February 2008) p. 109 ll. 19 – p.111 ll. 22
[147] This analysis is described in *R. v. Watson* (1996), 108 C.C.C. (3d) 310 (Ont.C.A.), *R. v. Pascoe* (1997), 113 C.C.C. (3d) 126 (Ont.C.A.), and *R. v. Hunter* (2001), 155 C.C.C. (3d) 225 (Ont.C.A.), in various different contexts. It is an element of the initial "legal relevance" stage of the *Mohan* test (*supra*), but its rigorous application to the precise terms of the scientific opinion offered is too often neglected.
[148] *Morin Report, supra* at 31

evidence and confession evidence tendered by unsavoury witnesses.[149] In each of these circumstances juries are required to be cautioned in the strongest possible terms not only with respect to the potential unreliability of such evidence but that "historically such evidence has produced miscarriages of justice." Commissioner Kaufman accepted that cautions of this nature present the best way of communicating to a jury that they need to be cautious, having regard to the fact that this category of evidence has put innocent persons in jail in the past.[150]

103. AIDWYC and the Mullins-Johnson Group submit that the natural tendency of jurors to be over awed by the apparent qualifications and authority of experts needs to be strongly tempered with scrutiny and that such a caution can only help to bring balance to the process.

[149] Sophonow Inquiry Report, Eyewitness Identification Recommendations, Morin Inquiry Report.
[150] *Ibid*

(E) <u>Expert witnesses</u> must only offer appropriately defined, objective, and neutral testimony in a way that advances the comprehension of other participants in the criminal justice system.

RECOMMENDATION 20: Feedback to expert witnesses is critically important. All of Crown counsel, defence counsel, and the judiciary should be invited by OCCO and in turn urged by the Ministry, the Criminal Lawyers' Association and Legal Aid, and the regional senior Justices to communicate with OCCO about the performance of their pathologists as witnesses. Rulings (either on *voir dires* or final judgments) that reflect adversely on OCCO experts must be forwarded to the Chief Forensic Pathologist and the College of Physicians and Surgeons of Ontario, at a bare minimum.

RECOMMENDATION 21: Training of expert witnesses about their appropriate role and the expectations they face in the criminal justice system is necessary.

RECOMMENDATION 22: The performance of OCCO pathologists in giving evidence in Court should be monitored by a peer at least annually.

104. The evidence before the Commission discloses that there were a series of opportunities in which those persons and institutions with oversight responsibilities over Dr. Smith could have intervened to prevent further miscarriages of justice. The earliest, and in many ways, most notable opportunity was presented by the Judgment of Mr. Justice Dunn in 1992. Dr. Pollanen described Justice Dunn's analysis as "masterful." The evidence is equivocal, however, as to whether this judgment was brought to the attention of the OCCO in a timely manner. Had this occurred, and more importantly had it been acted upon, Dr. Smith's competency may have been questioned and steps may have been taken to reign in the excesses of his performance.

105. Feedback to the expert witnesses, and to those to whom the witness answers, is

an essential aspect of accountability that was missing in this case for many years. Indeed, AIDWYC and the Mullins-Johnson Group, submit that this lack of accountability was an essential and defining characteristic that permitted Dr. Smith to obtain the icon status that was undeserved.

106. AIDWYC and the Mullins-Johnson Group further submit that training and regular monitoring of expert witnesses in respect of expert testimony is essential. Dr. Smith was not alone in crossing the line between witness and advocate. The response of the SCAN Team to the Judgment of Justice Dunn, in this regard, is instructive. During the conference of March 26, 1992, the SCAN Team considered the Judgment of Justice Dunn from the perspective of "why the case was lost."[151] In testimony, members of the team (Dr. Huyer and Dr. Driver) candidly admitted that they reacted defensively, indeed adversarialy, to Justice Dunn's judgment. Dr. Huyer explained that the court system is foreign to physicians and agreed with the suggestion of the Commissioner that enhanced understanding of the justice system may have a benefit.[152]

107. In this regard, AIDWYC and the Mullins-Johnson Group submit that the same rational which prompted Commissioner Kaufman to recommend training Centre for Forensic Science employees in respect of, among other things, "testimonial matters, independence and impartiality, report writing, the use of language, the scope and limitations upon findings and ethics" apply equally to experts working under the auspices of the Chief Corner's office.[153] Moreover, the concerns which gave rise to the following recommendation from the Commissioner Kaufman apply equally in

[151] SCAN Team notes, PFP153135
[152] Evidence of Dr. Huyer and Dr. Driver, *Transcript (10 January 2008)* p.149, ll. 1 – p.160, ll.15
[153] Morin Report, Recommendation 25, p.130.

context of this Inquiry:

> "Recommendation 24: Monitoring of Courtroom Testimony. The Centre of Forensic Sciences should more regularly monitor the courtroom testimony given by it's employees. Monitoring should, where practicable be done through personal attendance by peers or supervisors. Monitoring should exceed the minimum acreditation requirements. All scientists, regardless of seniority, should be monitored. Any concerns should be promptly taken up with the testifying scientist. The monitoring scientist should be instructed that any observed overstatement or misstatement of evidence triggers an immediate obligation to advise the appropriate trial counsel."

V - REGULATORY OVERSIGHT

RECOMMENDATION 23: The College of Physicians and Surgeons of Ontario (CPSO) should issue guidelines for doctors as expert witnesses, and ensure its members understand that professional discipline may be imposed for misconduct in giving evidence.

108. Physicians (including corners and pathologist) who give expert evidence are doing so as physicians and must abide by the ethical and professional obligations of their regulator. The College publishes guidelines and/or policies on a wide variety of issues affecting physicians. The purpose of such guidelines and/or policies is to guide its members in their practice and educate them as to appropriate standards of practice. At present, however, the College of Physicians and Surgeons of Ontario has no articulated policies or guidelines for the giving of expert evidence.[154]

109. There are a variety of American medical associations that have issued guidelines for their members testifying as expert witnesses in courts. Common aspects of these guidelines include requirements that expert witnesses have appropriate expertise, that they testify honestly, fully and impartially, and that they testify in the scope of their expertise and in accordance with the current knowledge in the field.[155]

110. AIDWYC and the Mullins-Johnson Group submit that the College can only be assisted in its role of professional oversight by articulating the expectations of its

[154] Evidence of Dr. Rocco Gerace, *Transcript (16 January 2008)* p.238 II.7 – p.246, II. 6
[155] Guidelines for Expert Witnesses, PFP302733

members in respect of giving expert evidence. Similarly, members of the College, including pathologists and coroners will therefore have the benefit of the educative affect of such guidelines. In the event that members of the College depart from acceptable levels of practice in respect of giving expert evidence, clearly articulated guidelines will provide for a transparent and fair discipline process.[156]

[156] Policy Round Table: Viable Complaints Processes (*20 February 2008)* p.30, II.15 – p.35, II.20, p.38, II.9 – p.39, II.19

VI - MISCELLANEOUS

RECOMMENDATION 24: Ontario pathologists should not give evidence in any case where the death penalty may be imposed.

111. In September of 2000, Dr. Smith gave evidence for the prosecution in the case of *Ohio v. Fuller.* The trial took place well after serious and credible concerns had emerged concerning Dr. Smith's competence, including in a nationally televised report on the Fifth Estate, more than 10 months earlier, and years after complaints to the College of Physicians and Surgeons of Ontario had been made. Dr. Smith's evidence contributed to the successful prosecution of the case which resulted in a recommendation by the jury that the accused be sentenced to death.[157] Ultimately, the Judge did not accept the jury's recommendation and sentenced the accused instead to life imprisonment. Nonetheless, given Dr. Smith's failings it is chilling that his evidence came close to assisting in the execution of an accused person.

112. The Supreme Court of Canada in *United States v. Burns,* [2001] 1 S.C.R. 283 articulated the concerns in this country about the potential for miscarriages of justice, and the broader public and moral ethical concerns about taking of life by the state. It held that the Minister of Justice ought not to assist American authorities in their quest to obtain death sentences by quashing extradition orders that were made without the seeking of assurance by the Ministry of Justice that execution would not be sought. It is grossly inconsistent with these policies and values to permit state

[157] Letter from Assistant Prosecutor Holcomb to Dr. Smith dated September 22, 2000, PFP115000

funded experts in Ontario to assist American authorities in seeking execution. Accordingly, AIDWYC and the Mullins-Johnson Group submit that a clear recommendation to ban such practice is warranted.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

DATED this 20th day of March, 2008.

_____	_____
James Lockyer	Louis Sokolov
_____	_____
Philip Campbell	Vanora Simpson
_____	
Alison Craig	

APPENDIX A

Submissions on the Jurisdiction of the Commissioner to Make Recommendations Regarding the Ministerial Review Process and an Independent Review Board

1. There is nothing flowing from the constitutional division of powers between federal and provincial authorities that precludes the Commission from making a recommendation that would address an essential element in the criminal justice system as part of its quest to restore public faith in the pediatric forensic pathology system. Section 92(14) of the *Constitution Act* assigns responsibility for the administration of justice, including criminal justice, to the Provinces. It provides the foundation for this public inquiry, as the Government of Ontario decided that issues arising from the mistakes of Dr. Smith warranted its creation. The administration of criminal justice includes within it the administration of all procedures, rules and remedies necessary, and incidental to, its administration. One remedy incorporated in the criminal justice system is the post-conviction, post-appellate power of review under part XXI.I of the *Criminal Code*, which allows for reviews by the Minister of Justice.

2. It is the Province which administers justice under the *Criminal Code,* and therefore prosecutes individuals for crimes committed under it. It is also the Province which is responsible for the death investigation and pediatric forensic pathology systems. Therefore, it is the actions of the Province that led directly to the wrongful conviction of Mr. Mullins-Johnson, Jenna's mother, and likely several other parties with standing. The Commission has heard considerable evidence regarding the role of Crown attorneys and pathologists employed by the Province in the administration of justice and prosecution of the individuals with standing at the Inquiry, and it is in the

public interest that the Commission make recommendations regarding how people who are victims of the Province's failings can best have those miscarriages remedied. In so far as that proper *provincial* objective may be assisted by *federal* legislation, there is no impediment to the Commissioner saying so – indeed it might properly be considered his duty.

3. In *Di Iorio v. Montreal Jail,* Dickson J., for the majority, pointed out that law enforcement and the administration of justice are primarily the responsibility of the Province and that in all provinces the Attorney General is the chief law enforcement of the Crown. Dickson J. continued:

> Implicit in the grant to the provinces of exclusive legislative authority in respect of the administration of justice and in the grant to the federal government of exclusive legislative authority in respect of criminal law and procedure is *an acceptance of a certain degree of overlapping*. One should not expect to be able to draw a fine line between the two heads of power nor should one attempt to do so. Time and time again the courts have given effect to what was said by Duff C.J. in *Reference re: Validity of the Combines Investigation Act* and of s. 498 of the *Criminal Code:*
>
> Matters, however, which in one aspect and for one purpose fall within the jurisdiction of a province over the subjects designated by one or more of the heads of s. 92 may in another aspect and for another purpose be proper subjects of legislation under s. 91…
>
> Thus, a matter which for some purpose may fall within the scope of the federal power over criminal law and criminal procedure may also fall within the legitimate concern of the provinces as pertaining to the administration of Justice. An argument has been advanced to the effect that if a province can inquire into what is said to be criminal law, it could equally inquire into other fields of exclusive federal jurisdiction such as banking or postal service or penitentiaries. In these proceedings, it is unnecessary to express any concluded view on the right of a provincial government to inquire into some subject of local concern, other than criminal law, touching upon one of the subjects of exclusive federal authority. It should not, however, be overlooked that a provincial inquiry into some aspect of criminal activity, for in the latter inquiry the Province has a special source of exclusive power, administration of justice, upon which it can draw, which may not be available to it in other inquiries [emphasis added].[158]

4. A ruling on the constitutionality of the Commissioner's mandate in the *Keable*

[158] *Di Iorio v. Montreal Jail* (1976), 33 C.C.C. (2d) 289 (S.C.C.) at 327

Commission is dispositive of the issue. Pigeon J. noted:

> …any inquiry into a matter within provincial competence may reveal the desirability of changes in federal laws. The commission might therefore, whatever may be the subject into which it is validly inquiring, submit a report in which it appeared that changes in federal laws would be desirable.[159]

5. The utility ascribed to public inquiries was outlined by Cory. J. in the *Krever Commission* case:

> Commissions of inquiry have a long history in Canada, and have become a significant and useful part of our tradition. They have frequently played a key role in the investigation of tragedies and made a great many helpful recommendations aimed at rectifying dangerous situations.
>
> . . . . .
>
> Undoubtedly, the ability of an inquiry to investigate, educate and inform Canadians benefits our society. A public inquiry before an impartial and independent commissioner which investigates the cause of tragedy and makes recommendations for change can help to prevent a recurrence of such tragedies in the future, and to restore public confidence in the industry or process being reviewed.
>
> The inquiry's role of investigation and education of the public are of great importance. Yet those rules should not be fulfilled at the expense of the denial of the rights of those being investigated. The need for careful balancing was recognized by Decary J.A. when he stated 'the search for truth does not excuse the violation of the rights of the individuals being investigated'. This means that no matter how important the work of an inquiry may be, it cannot be achieved at the expense of the fundamental right of each citizen to be treated fairly.[160]

6. An undeniable consequence of the actions of Dr. Smith that led to this Inquiry is the wrongful conviction of many Ontario citizens. It cannot properly fulfill its mandate of restoring public confidence without recommending a systemic tool that can properly address past miscarriages of justice and one that will emerge in the future. Public confidence cannot be fully restored without a permanent solution. It is not as if any recommendations of this Commission that relate to federal matters will be binding on the Federal Government. As Cory J. said in the *Krever Commission*:

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[159] *Quebec (Attorney General) v. Canada (Attorney General)* [1979] 1 S.C.R. 218 (S.C.C.) at 237.
[160] *Canada (Attorney General) v. The Krever Commission* [1997] 3 S.C.R. 440 at paras 29-31.

> A commission of inquiry is neither a criminal trial nor a civil action for the determination of liability. It cannot establish either a criminal culpability or civil responsibility for damages. Rather, an inquiry is an investigation into an issue, event, or series of events. The findings of a commissioner relating to that investigation are simply findings of fact and statements of opinion reached by the commissioner at the end of the inquiry. They are unconnected to normal legal criteria. They are based upon and flow from a procedure which is not bound by the evidentiary or procedural rules of a courtroom. There are no legal consequences attached to the determinations of a commissioner. They are not enforceable and do not bind courts considering the same subject matter.[161]

7. These submissions are also consonant with the decision of the Supreme Court of Canada in *MacKeigan v. Hickman,* and with the conduct of previous wrongful conviction inquiries. During the *Marshall Inquiry* into the wrongful conviction of Donald Marshall, two questions were raised which found their way to the Supreme Court of Canada. The second question was as follows:

> The second question is whether the direction to the commission to inquire into a reference by the Minister of Justice is ultra vires the province because it is a matter of criminal law and procedure and reserved exclusively to the federal Parliament under s. 91(7) of the *Constitution Act*.[162]

McLachlin J. commented:

> The question is whether the inquiry is 'into the administration of justice' in which case it falls within the Province's powers under s. 92(14), or into the 'criminal law' or 'criminal procedure' in which case it infringes the federal criminal law power.[163]

Citing the Court's decision in *Di Iorio, supra,* McLachlin J. noted that the phrase 'administration of justice' should be interpreted broadly, and said:

> I am satisfied that the province has constitutional jurisdiction to inquire into the investigation, charging, prosecution, conviction *and subsequent release* of Donald Marshall. These are matters pertaining to the administration of justice within the province, and, subject to the caveat expressed by Pigeon J. in *A.G. Quebec* and *Keable* that no provincially constituted commission of inquiry can inquire into the actual management or operation of the federal activity or entity in question (there the RCMP), they do not constitute an attempt to interfere with the valid federal interest in the enactment of and provision for a uniform system of procedures and rules governing criminal justice in the country [emphasis

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[161] *Canada (Attorney General) v. The Krever Commission* [1997] 3 S.C.R. 440 at para. 34.
[162] (1989) 50 C.C.C. (3d) 449 (S.C.C.) at 476
[163] *Ibid,* at 484.

added].[164]

8. Two months later, the *Marshall Commission* released its report, clearly having understood the Supreme Court of Canada to have authorized them to speak of the need for systemic changes in the review process for wrongful convictions. They observed:

> The Marshall case is not unique, and it would be unrealistic to assume otherwise. "Justice", the British Section of the International Commission of Jurists, for example estimates there are at least 15 cases a year in the United Kingdom in which people are imprisoned for crimes they did not commit. One such incident, of course, is clearly too many, so the question for us is how do we bring these situations to light and provide wrongly convicted people with fair opportunity to establish their innocence.
>
> We believe someone – or some body – has to be appointed to serve as a kind of "court" of last resort, not only for individuals who claim they have been wrongfully convicted but also for others who may have information that someone else has been wrongly convicted.

The Commission continued:

> Although it is important to note that the RCMP's 1982 investigation did lead to Marshall being freed from prison – implying that one cannot always assume that a police force will not be able or willing to conduct a proper investigation into allegations of wrongful conviction – we believe most citizens would feel more comfortable taking this sort of information, at least initially, to a person or body they do not consider to be part of the criminal justice system, or directly or indirectly involved in the original investigation. We believe it makes more sense to expect citizens to provide information to a body that would not seem to have any sort of vested interest.
>
> In order for such an independent body to function effectively, people must not only know about that body's existence and role, but also have confidence that such a body has the power and the resources to conduct a thorough reinvestigation of the conviction. There are two issues here. The first is the constitution of a re-investigative body and the second is the nature of its powers.

The Commissioners made two recommendations:

> Recommendation 1
>
> We recommend that the provincial Attorney General commence discussions with the federal Minister of Justice and the other provincial Attorneys General with a view to constituting an independent review mechanism – an individual or body – to facilitate the reinvestigation of alleged cases of wrongful conviction.

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[164] *Ibid,* at 485.

> Recommendation 2
>
> We recommend that this review body have investigative power so it may have complete and full access to any and all documents and material required in any particular case, and that it have coercive power so witnesses can be compelled to provide information.[165]

9. In its commentary on these recommendations, the Commission commented on the dual, or overlapping, federal and provincial powers that were involved in their recommendations:

> It is our view that this review body would have a jurisdiction and responsibility that includes both the 'administration of justice' (section 92(14) of the *Constitution Act, 1867*) and substantive 'criminal law and procedure' (section 91(27)). It would be a national body, formed on a cooperative basis by the Federal and all the Provincial governments, and would report jointly to both the federal Minister of Justice and the relevant provincial Attorney General.[166]

This is the perfect analogy for what we submit is the Commission's role at this Inquiry. There are overlapping federal considerations in any examination of a post-appellate review mechanism, and the Commission should not abdicate its responsibility for rigid constitutional reasons.

10. In 1997, the *Morin Commission* was given a mandate to "make such recommendations as it considers advisable relating to the administration of criminal justice in Ontario". In his final report, Justice Kaufman recognized the important systemic need for the creation of an independent criminal case review board to replace or supplement the ministerial powers exercised under then s. 690[167]. He stated:

> Based upon my ruling and the limited evidence I have heard, I am not able to make recommendations as to the existing or any proposed review mechanisms for cases involving potential wrongful convictions. However, the availability of an

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[165] *Royal Commission on the Donald Marshall Jr. Prosecution* (1989), Commissioners Report at pp. 143-145.
[166] *The Royal Commission on the Donald Marshall Jr. Prosecution* at 145.
[167] The Honourable Fred Kaufman: *The Commission on Proceedings Involving Guy Paul Morin*, Executive Summary and Recommendations, p. 1 and Recommendation #117. (1998: Queen's Printer for Ontario).

> adequate mechanism is an issue of great importance. I am able to recommend that the Government of Canada study the adequacies of the present regime and the desirability of a criminal case review board, drawing upon the representations of all interested parties.[168]

11. Commissioner Kaufman made a number of other recommendations that on a strict constitutional interpretation seem to trespass into federal jurisdiction, including amendments to the *Criminal Code* and *Canada Evidence Act* allowing for reciprocal disclosure, jury research, the admissibility of exculpatory statements, and Crown appeal privileges.[169]

12. In 2001, Justice Cory issued his Report on the *Sophonow Inquiry*. The Commission was tasked with making recommendations relating to the administration of justice in Manitoba. Even though no application was made to Commissioner Cory to review post-appellate mechanisms, in his final report, Justice Cory felt obliged to make a recommendation to address his concern that there may be other cases of wrongful convictions needing reconsideration:

> I recommend that, in the future, there should be a completely independent entity established which can effectively, efficiently and quickly review cases in which wrongful conviction is alleged. In the United Kingdom, an excellent model exists for such an institution. I hope that steps are taken to consider the establishment of a similar institution in Canada.[170]

13. At the provincial Inquiry into the wrongful conviction of David Milgaard, part of the Commission's mandate was to explore the Ministerial review that was conducted in the case. In a judgment on the issue, Laing J. ruled that while the Ministerial review process properly fell within the Commission's mandate to investigate the administration of justice, constitutional limitation precluded questioning of the Department of Justice

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[168] *The Commission on Proceedings Involving Guy Paul Morin*, Vol. 2., pp. 1237 – 1241.
[169] *The Commission on Proceedings Involving Guy Paul Morin*, Executive Summary and Recommendations, Recommendations 17, 77, 80, and 88.
[170] The Honourable Peter deC. Cory: *The Inquiry Regarding Thomas Sophonow*, pp. 101 & 137 (2001).

lawyers with regard to reasons behind their actions and advice given or received.[171] That issue, however, is quite different from the systemic question that has faced this and several other Commissions of Inquiry in the past. No issue was taken with the Commission exploring the investigative and systemic aspects of the Ministerial review process; rather, the only objection was with respect to the internal advice and consultations within the Department of Justice.

14. Finally, in his Report on the trial and conviction of James Driskell, Justice LeSage endorsed the recommendation of Justice Cory in the *Sophonow Inquiry*, and emphasized the difficulties with the current conviction review process. In particular, he stated:

> I am concerned about the adversarial nature of the present process. Driskell could not launch an application until he had sufficient disclosure to satisfy the Department of Justice standard for launching a section 696.2 review. However, the [Winnipeg Police Service] would not make disclosure for purposes of a section 696.2 review until Driskell's application was made. This is a classic 'catch 22' situation. If there was an independent inquisitorial body, as in the U.K., it could, after being satisfied that a threshold, not necessarily a high threshold, has been met, commence the section 696.2 process of its own initiative. In this way, information that is unavailable to the application because of their inability to compel disclosure, would be available to the independent agency to allow them to make a better determination of whether a miscarriage of justice occurred.

15. While each of these inquiries into miscarriages of justice in Canada resulted in a recommendation that an independent body such as the CCRC be instituted, this Commission is in perhaps the best position to make such a recommendation. The Inquiry was called to address a broad systemic failure that has led to not just one, but likely numerous wrongful convictions including many that have yet to be remedied. Its mandate uniquely extends to the restoration of *public confidence* in the system – an objective inseparable from the legal mechanisms by which judicial error in the forensic

[171] [2006] S.J. No. 523.

sphere is redressed. Satisfaction of the Commission's mandate requires not only an examination of what led to so many wrongful convictions, but a critical assessment of the review process available to those who have exhausted their legal appeals. As was noted by McLachlin J. in *Hickman,* "the term 'criminal procedure', reserved exclusively to the federal government, should not be confused with the larger concept of 'criminal justice'", which is wholly within this Commission's mandate.[172] Constitutional parameters did not deter four previous inquiries from making recommendations into the mechanism for reviewing wrongful convictions; it would be most unfortunate if the one best suited to undertake this examination declined a similar opportunity. Just because, practically speaking, a recommendation necessarily would have to apply across the country does not mean its consideration should be excluded.

[172] [1989] 2 S.C.R. 796 (S.C.C.) at para. 76.

APPENDIX B

LIST OF RECOMMENDATIONS

RECOMMENDATION 1: Review of all Previous “Shaken Baby” and Head Injury Cases which Resulted in Criminal Convictions in the Province of Ontario

RECOMMENDATION 2: Review of All Pediatric Autopsies in the Province of Ontario Since 1981

RECOMMENDATION 3: A Speedy and Just Resolution of the Cases Examined at this Inquiry

RECOMMENDATION 4: Eligible cases for review can be identified and screened by a panel of scientists internal to Office of the Chief Coroner for Ontario (OCCO).

RECOMMENDATION 5: Independent, external experts should review the science in cases identified as potentially problematic during the preliminary, internal screening process.

RECOMMENDATION 6: A scientific advisory committee should be convened at OCCO to continually review important changes in the science applied by pathologists and its potential effects on criminal prosecutions.

RECOMMENDATION 7: If "bad pathology" is identified in the scientific reviews, a multi-disciplinary panel should review the implications of the new scientific conclusion in the context of the case as a whole, to determine whether it calls into question the soundness of the conviction.

RECOMMENDATION 8: The experience that Ontario develops with the reviews of pediatric forensic pathology necessary in these cases should not go to waste. The external panel established to review the cases identified based on the current evidence should be institutionalized, and made available to initiate reviews based not only on changing science but on any issue which raises the spectre of wrongful convictions.

RECOMMENDATION 9: The Commissioner should recommend that the current Department of Justice "Criminal Conviction Review Group" (CCRG) / Ministerial Review application-based model for post-conviction review be replaced by an effective, independent conviction review mechanism modeled on the British Criminal Cases Review Commission (CCRC). The Province of Ontario should advocate for this change in dealings with the federal Minister of Justice.

RECOMMENDATION 10: The Commissioner should recommend that adequate funding structure for the post conviction review process.

RECOMMENDATION 11: The Commission should recommend that a mechanism be

developed by the Government of Ontario to investigate and settle claims for compensation.

RECOMMENDATION 12: OCCO's "Guidelines on autopsy practice for forensic pathologists ~ Criminally suspicious cases and homicides" should be amended to require that all information made available to the pathologist by investigators, coroners, clinicians, or any other source must be carefully recorded and provided to Crown Counsel for disclosure to defence counsel.

RECOMMENDATION 13: OCCO "Guidelines on autopsy practice for forensic pathologists ~ Criminally suspicious cases and homicides" should be amended to require that all expressions of pathology opinion, from the very initial and preliminary stages of an investigation onward, must be provided to investigators or other interested justice system participants in writing. OCCO Guidelines should include guidance for pathologists on the use of standardized language to promote effective and accurate communication of their opinions.

RECOMMENDATION 14: OCCO "Guidelines on autopsy practice for forensic pathologists ~ Criminally suspicious cases and homicides" should be amended to require that any changes in opinion must also be communicated in writing, along with the bases for that change.

RECOMMENDATION 15: The Legal Aid tariff needs to be revised to reflect cost of living increases. Legal Aid should offer supplemented rates to those certified, senior counsel appearing on homicide cases. It should also ensure that junior counsel is routinely authorized, and that the hours allotted to defend the cases are adequate.

RECOMMENDATION 16: Legal Aid should ensure that adequate funding is provided to the defence to retain experts. In specialized fields like forensic pathology, Legal Aid must authorize the retainer of out-of-jurisdiction experts. Funding should include an allowance for experts to attend in court to monitor the testimony of other witnesses.

RECOMMENDATION 17: Trial judges should conduct more demanding expert evidence *voir dires* and insist that the precise area of expertise offered by the witness be precisely delineated. Trial judges must use proactive and interventionist strategies if necessary to ensure that informative *voir dires* are conducted and unreliable evidence is not introduced.

RECOMMENDATION 18: Trial judges must be proactive and interventionist in policing the boundaries of expert witness testimony. The "roaming expert" must be immediately returned to his or her approved territory, with or without an objection from counsel.

RECOMMENDATION 19: Juries should be given sharp, precise instructions about the risks of relying on expert evidence. They should be cautioned against being over-impressed or daunted by these witnesses, and given instructions about how to test the reliability of the science discussed. Juries should be warned that expert evidence has led to wrongful convictions.

RECOMMENDATION 20: Feedback to expert witnesses is critically important. All of Crown counsel, defence counsel, and the judiciary should be invited by OCCO and in turn urged by the Ministry, the Criminal Lawyers' Association and Legal Aid, and the regional senior Justices to communicate with OCCO about the performance of their pathologists as witnesses. Rulings (either on *voir dires* or final judgments) that reflect adversely on OCCO experts must be forwarded to the Chief Forensic Pathologist and the College of Physicians and Surgeons of Ontario, at a bare minimum.

RECOMMENDATION 21: Training of expert witnesses about their appropriate role and the expectations they face in the criminal justice system is necessary.

RECOMMENDATION 22: The performance of OCCO pathologists in giving evidence in Court should be monitored by a peer at least annually.

RECOMMENDATION 23: The College of Physicians and Surgeons of Ontario (CPSO) should issue guidelines for doctors as expert witnesses, and ensure its members understand that professional discipline may be imposed for misconduct in giving evidence.

RECOMMENDATION 24: Ontario pathologists should not give evidence in any case where the death penalty may be imposed.