INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

In the matter of the Public Inquiries Act, R.S.O. 1990, c. P. 41

And in the matter of the Order in Council 826/2007 and the Commission issued effective April 25, 2007, appointing the Honourable Stephen Goudge as Commissioner

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BRIEF OF AUTHORITIES TO CLOSING ARGUMENT OF DR. CHARLES SMITH

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AUTHORITIES

ROE v. MINISTRY OF HEALTH AND OTHERS. WOOLLEY v. SAME.

[COURT OF APPEAL (Somervell, Denning and Morris, L.JJ.), March 22, 23, 24, 25, April 8, 1954.]

Hospital—Negligence—Liability for negligence of members of staff—Specialist anaesthetist—Spinal anaesthetic administered to patients—Contamination of drug in ampoules—Molecular flaws in ampoules.

On Oct. 13, 1947, each of the plaintiffs underwent a surgical operation at the Chesterfield and North Derbyshire Royal Hospital. Before the operation in each case a spinal anaesthetic consisting of Nupercaine, injected by means of a lumbar puncture, was administered to the patient by the second defendant, a specialist anaesthetist. The Nupercaine was contained in glass ampoules which were, prior to use, immersed in a phenol solution. After the operations the plaintiffs developed spastic paraplegia which resulted in permanent paralysis from the waist downwards. In an action for damages for personal injuries against the Ministry of Health, as successor in title to the trustees of the hospital, and the anaesthetist, the court found that the injuries to the plaintiffs were caused by the Nupercaine becoming contaminated by the phenol which had percolated into the Nupercaine through molecular flaws or invisible cracks in the ampoules, and that at the date of the operations the risk of percolation through molecular flaws in the glass was not appreciated by competent anaesthetists in general.

HELD: having regard to the standard of knowledge to be imputed to competent anaesthetists in 1947, the anaesthetist could not be found to be guilty of negligence in failing to appreciate the risk of the phenol percolating through molecular flaws in the glass ampoules and, a fortiori, there was no evidence of negligence on the part of any member of the nursing staff.

Per curiam: The anaesthetist was the servant or agent of the hospital authorities who were, therefore, responsible for his acts.

Gold v. *Essex County Council* ([1942] 2 All E.R. 237) and *Cassidy* v. *Ministry of Health* ([1951] 1 All E.R. 574), considered.

Since the plaintiffs had been unable to establish negligence on the part of any of the defendants they were precluded from recovering damages.

AS TO LIABILITY OF HOSPITAL FOR NEGLIGENCE OF ITS SERVANTS OR AGENTS, see HALSBURY, Hailsham Edn., Vol. 22, p. 320, para. 605; and FOR CASES, see DIGEST, Vol. 34, p. 550, Nos. *86*, *87*.

Cases referred to:

(1) *Gold* v. *Essex County Council*, [1942] 2 All E.R. 237; [1942] 2 K.B. 293; 112 L.J.K.B. 1; 167 L.T. 166; 106 J.P. 242; 2nd Digest Supp.

(2) *Cassidy* v. *Ministry of Health*, [1951] 1 All E.R. 574; [1951] 2 K.B. 343; 2nd Digest Supp.

(3) *Mahon* v. *Osborne*, [1939] 1 All E.R. 535; [1939] 2 K.B. 14; 108 L.J.K.B. 567; 160 L.T. 329; Digest Supp.

(4) *Barkway* v. *South Wales Transport Co., Ltd.*, [1950] 1 All E.R. 392; [1950] A.C. 185; 114 J.P. 172; 2nd Digest Supp.

(5) *Baker* v. *Market Harborough Industrial Co-operative Society*, (1953), 97 Sol. Jo. 861.

(6) *Re Polemis & Furness, Withy & Co.*, [1921] 3 K.B. 560; sub nom. *Polemis* v. *Furness, Withy & Co.*, 90 L.J.K.B. 1353; 126 L.T. 154; 36 Digest, Replacement, 38, *185*.

(7) *Hay (or Bourhill)* v. *Young*, [1942] 2 All E.R. 396; [1943] A.C. 92; 1942 S.C. (H.L.) 78; 111 L.J.P.C. 97; 167 L.T. 261; 2nd Digest Supp.

(8) *Woods* v. *Duncan, Duncan* v. *Hambrook, Duncan* v. *Cammell Laird & Co., Ltd.*, [1946] 1 All E.R. 420 n.; [1946] A.C. 401; [1947] L.J.R. 120; 174 L.T. 286; 2nd Digest Supp.
(9) *M'Alister (or Donoghue)* v. *Stevenson*, [1932] A.C. 562; 1932 S.C. (H.L.) 31; 101 L.J.P.C. 119; 147 L.T. 281; Digest Supp.
(10) *Stansbie* v. *Troman*, [1948] 1 All E.R. 599; [1948] 2 K.B. 48; [1948] L.J.R. 1206; 2nd Digest Supp.
(11) *Lewis* v. *Carmarthenshire County Council*, [1953] 2 All E.R. 1403; 118 J.P. 51.
(12) *Thorogood* v. *Van Den Berghs & Jurgens, Ltd.*, [1951] 1 All E.R. 682; 115 J.P. 237; sub nom. *Thurogood* v. *Van Den Berghs & Jurgens, Ltd.*, [1951] 2 K.B. 537; 2nd Digest Supp.
(13) *King* v. *Phillips*, [1953] 1 All E.R. 617; [1953] 1 Q.B. 429.
(14) *Stapley* v. *Gypsum Mines, Ltd.*, [1953] 2 All E.R. 478; [1953] A.C. 663.
(15) *Liesbosch, Dredger* v. *Edison S.S.*, [1933] A.C. 449; 102 L.J.P. 73; sub nom. *The Edison*, 149 L.T. 49; Digest Supp.
(16) *Jones* v. *Livox Quarries, Ltd.*, [1952] 2 Q.B. 608; 3rd Digest Supp.
(17) *Bolton* v. *Stone*, [1951] 1 All E.R. 1078; [1951] A.C. 850; 2nd Digest Supp.

APPEAL by the plaintiffs from an order of MCNAIR, J., dated Nov. 12, 1953.

The plaintiffs, Cecil Henry Roe and Albert Woolley, were patients in the Chesterfield and North Derbyshire Royal Hospital. On Oct. 13, 1947, surgical operations were performed on them, in each case a spinal anaesthetic consisting of Nupercaine being administered by injection by lumbar puncture. In each case the Nupercaine was aspirated from a glass ampoule. The glass ampoules containing the Nupercaine had been kept for twelve or more hours in a glass jar containing a one-in-forty solution of phenol, before which they had been immersed for about twenty minutes in a one-in-twenty phenol solution. The anaesthetic was administered by the second defendant, Dr. Graham. After the operations each plaintiff developed spastic paraplegia which resulted in permanent paralysis from the waist downwards.

In an action for damages for personal injuries, the plaintiffs alleged negligence on the part of the Ministry of Health (the successor in title of the trustees of the hospital), and/or Dr. Graham as the anaesthetist, and/or the manufacturers of the Nupercaine, Ciba Laboratories, Ltd. They contended that, as against the first two defendants, the maxim res ipsa loquitur applied inasmuch as paralysis did not ordinarily follow a spinal anaesthetic properly administered; alternatively that, as against the Ministry, on the basis that Dr. Graham was in law the servant or agent of the Ministry, the injuries were caused by the negligent injection of the contents of a glass ampoule of Nupercaine contaminated by phenol; that, on the basis that Dr. Graham was not in law the servant or agent of the Ministry, the contamination occurred through the negligent mishandling of the ampoules by the theatre staff, and, further, that the failure to detect the contamination was due to the failure to employ an effective system of differential colouring in the phenol solution. Further, as against Dr. Graham, it was contended that he negligently injected the contents of an ampoule of Nupercaine contaminated by phenol, that he failed to make any proper examination for cracks in the ampoules, and failed to adopt and maintain an effective system of differential colouring in the phenol solution. During the trial of the action the third defendants were dismissed therefrom on an admission by counsel for all parties that no liability was alleged against them. MCNAIR, J., found that the Ministry had fulfilled its duty by supplying a competent anaesthetist and trained theatre staff, and that the plaintiffs' injuries were caused by the injection of Nupercaine contaminated with phenol which had percolated into the ampoules by means of invisible cracks or molecular flaws in the glass. On those facts he held that neither Dr. Graham, nor, a fortiori, the theatre staff could be guilty of negligence in failing to appreciate the risk of such percolation on the basis of medical

knowledge at the date of the operations; nor could Dr. Graham be guilty of negligence in failing to apply a differential colour test which might have disclosed a risk which, in common with many other anaesthetists, he did not appreciate as a possibility. He held further (i) that the Ministry was not responsible for the acts of Dr. Graham who, as a specialist, was in a position comparable with that of a visiting surgeon or physician for whose acts a hospital does not assume responsibility in law, and (ii) that where an operation was under the control of two persons not in law responsible for the acts of each other, the doctrine of res ipsa loquitur could not apply to either person since the res, if it spoke of negligence, did not speak of negligence against either person individually.

Elwes, Q.C., and *John Hobson* for the plaintiffs.

Berryman, Q.C., *Marven Everett, Q.C.*, and *J. S. L. Macaskie* for the Ministry of Health, the first defendant.

Hylton-Foster, Q.C., and *Cumming-Bruce* for the second defendant, Dr. Graham.

Faulks and *Syrett* for the third defendants, Ciba Laboratories, Ltd.

Cur. adv. vult.

Apr. 8. The following judgments were read.

SOMERVELL, L.J.: The two plaintiffs in these consolidated actions were both anaesthetised by a spinal anaesthetic for minor operations on Oct. 13, 1947, at the Chesterfield and North Derbyshire Royal Hospital, now represented by the first defendant, the Ministry of Health. The results were tragic in that both men were and have since remained paralysed from the waist downwards. Each claims in negligence. The second defendant is the anaesthetist, and one of the issues was whether the principle respondeat superior was applicable as between the hospital and him. The spinal anaesthetic used was Nupercaine, manufactured and supplied by the third defendants, Ciba Laboratories. It was supplied in glass ampoules, one of which was used for each patient. The suggestion that the Nupercaine in the two ampoules in question must have been defective or contaminated before delivery to the hospital was, after investigation, abandoned at the trial. The third defendants were, therefore, not concerned in the substantive appeal. The learned judge found for the defendants and the plaintiffs appeal. He found that the damage had been caused by phenol which had percolated into the ampoules from a solution in which the two ampoules, with others, had been immersed. There was difference of opinion among the experts, but this finding was accepted by all counsel before us as the explanation, and the question, therefore, is whether this percolation was caused by the negligence of the defendants or either of them. The ampoules were about five inches high, one inch in diameter, narrowing towards the top to a neck about $\frac{1}{4}$ inch in diameter, and swelling out slightly above the neck and then tapering. The ampoule was opened by filing and then breaking at the neck. Each contained twenty c.c. of Nupercaine. As delivered by the makers the outside and label were not sterilised. They were to be treated, as a notice on the box stated, as " frankly septic ". The needle of the syringe could be inserted through the neck when the ampoule had been opened without coming in contact with the outside of the ampoule. The ampoule would be held by the sister and the syringe by the anaesthetist and there was a possibility of accidental contact.

It is plain that this possibility exercised a good many anaesthetists round about 1946. There was at the hospital Dr. Pooler, the senior anaesthetist; the second defendant; and a resident anaesthetist who was clearly of a lesser status and who is not concerned in this case. In 1947 Dr. Pooler and Dr. Graham discussed the danger of sepsis as described above, and the importance of sterilising the ampoules. Dr. Pooler in fact started, for his cases, the method which was used by Dr. Graham at the date of the operations on the plaintiffs. That was to immerse the ampoules in a one-in-twenty solution of phenol for twenty minutes and then in a one-in-forty solution for twelve or more hours. On the learned judge's finding a quantity of this phenol solution, sufficient to cause the paralysis,

percolated through a crack in each ampoule, sufficient Nupercaine being left to anaesthetise each patient. There was no precise evidence as to the amount of phenol solution necessary to cause the injuries, but probably about one-fifth of the volume of the Nupercaine. Each plaintiff had an injection of ten c.c. If about one-fifth was phenol solution one would expect anaesthesia and injury.

Dr. Graham appreciated the possibility of cracks and the great danger of phenol solution if injected into the spine. He examined each ampoule for cracks before taking its contents or part of them into the syringe. The learned judge accepted his evidence that he made such an examination carefully in these cases. " I did not believe for one moment that I could have missed a crack " he said. Was he negligent in so believing ? The learned judge deals with this matter in the following paragraph:

> " It is now clear that phenol can find its way into an ampoule of Nupercaine stored in a solution of phenol through cracks which are not detectable by the ordinary visual or tactile examination which takes place in an operating theatre—these cracks were referred to in the evidence as ' invisible cracks '—or through molecular flaws in the glass. The attention of the profession was first drawn to this risk in this country by the publication of Professor MACINTOSH'S book on LUMBAR PUNCTURE AND SPINAL ANAESTHESIA in 1951. In 1947 the general run of competent anaesthetists would not appreciate this risk. (See the evidence of Dr. Macintosh, Day 3, 18, 19, 42-E; of Dr. Organe, Day 8, 61; and of Dr. Cope, Day 9, 25). Dr. Graham certainly did not appreciate this as a risk. I accordingly find that, by the standard of knowledge to be imputed to competent anaesthetists in 1947, Dr. Graham was not negligent in failing to appreciate this risk, and, a fortiori, the theatre staff were not negligent."

I accept this. Although leading counsel for the plaintiffs did not accept these findings, his main attack on Dr. Graham was based on a different matter. There was evidence that in some hospitals where the immersion system was used the disinfecting liquid, whether a phenol solution or surgical spirit, was stained a deep tint with methylene blue or some other dye. Professor MACINTOSH described the liquids he had seen as the colour of ink. This would make it easier, of course, to detect percolation. It was a method used by Ciba Laboratories and was known to analytical chemists. A certain amount of confusion arose from the fact that the two solutions of phenol in which the ampoules were immersed were coloured, though not deeply. This was not done as a precaution against percolation. The-one-in twenty phenol solution was coloured a light blue and the one-in-forty a light pink for general purposes of identification and not as a precaution against cracked ampoules. As a precaution for this latter purpose the colouring was, as Professor MACINTOSH said, quite inadequate. Dr. Graham gave certain answers which might have meant he was relying on colour to detect cracks. If so, it should have been deeper. I agree with the submission of leading counsel for Dr. Graham that, taking his evidence as a whole, he was not so relying. If, of course, he had seen that the liquid in an ampoule was pink, he would at once have realised there had been substantial percolation. He was, however, relying on his visual inspection. Leading counsel for the plaintiffs submitted that once the plaintiffs had shown that this precaution was taken in some other hospitals the onus passed to Dr. Graham or the hospital to explain why it was not adopted in the present case. If the onus did so pass, I think it was discharged. Leading counsel for Dr. Graham conceded in the course of the trial and before us that if there had been deep tinting it would probably have disclosed any dangerous percolation. The learned judge, who had many difficult matters to deal with, of which he has relieved us, did not, I think, fully appreciate this concession. However, the other reasons which he gives, in my opinion, justify his finding, with which I agree, that Dr. Graham was not negligent. Dr. Graham had never heard of deep tinting as a precaution. There had been

a reference in American publications to colouring, but the only paper traced on " immersion " in this country made no reference to deep tinting as an ingredient of the process. On one occasion Dr. Graham found an ampoule which had been cracked or broken at the top. I do not think this assists either side. Leading counsel for Dr. Graham submitted, I think with force, that, if anything, it confirmed Dr. Graham's view that cracks would be visible. The actual method of immersion without deep tinting was introduced and used in the first instance by his senior, Dr. Pooler. Dr. Graham was entitled to place some reliance on that. It would obviously be wrong to infer negligence from the fact only that it was used in some other hospitals. I felt at one time that as Dr. Pooler had started the system it would have been right that the hospital should have called him. They were, however, submitting that he was not their servant, and on that basis it was, I think, reasonable for them not to call him. If it had been obvious or accepted that he was their " servant " for this purpose, it might well have been a matter for comment if he had not been called.

It is well to consider the nature of the allegation here made with regard to Dr. Graham's interests as well as his duties. If a man driving a motor car is late for an urgent appointment he has, at any rate, a motive for taking a risk. What, however, is the suggested act of negligence here ? It is a failure to instruct a sister to put dye into a solution of phenol. It imposes no burden on the doctor except the speaking of a sentence. He or Dr. Pooler would have every motive for putting this minor burden on the nursing staff if either had any idea that it might prevent injury to his patients. There is, in my opinion, on the evidence no justification for finding that Dr. Graham was negligent in this matter.

The learned judge found that the hospital was not liable in law for Dr. Graham's acts of negligence, if any. I will set out the passage in which the learned judge states the position of Dr. Pooler and Dr. Graham:

> " In October, 1946, he was, with Dr. Pooler who had taken his diploma of anaesthesia some years earlier, appointed as a visiting anaesthetist to the hospital. He and Dr. Pooler between them were under obligation to provide a regular anaesthetic service for the hospital, it being left to them to decide how to divide up the work. In fact, apart from emergencies, they worked at the hospital on alternate days. The hospital set aside a sum of money out of their funds derived from investments, contributions and donations for division among the whole of the medical and surgical staff including visiting and consulting surgeons as the participants might decide. Dr. Graham participated in this fund but otherwise received no remuneration from the hospital. He was at all times allowed to continue his private anaesthetic practice."

The learned judge referred to *Gold* v. *Essex County Council* (1) and *Cassidy* v. *Ministry of Health* (2). He assimilated Dr. Pooler and Dr. Graham to the " consulting physicians or surgeons " referred to by LORD GREENE, M.R., in *Gold's* case (1) ([1942] 2 All E.R. 242). The line suggested in that case and in *Cassidy's* case (2), in the judgments of SINGLETON, L.J., and myself, may not be a very satisfactory one, but I would have regarded Dr. Pooler and Dr. Graham as part of the permanent staff and, therefore, in the same position as the orthopaedic surgeon in *Cassidy's* case (2). Like him they are, of course, qualified skilled men controlling as such their own methods. The positions of surgeons and others under the National Health Service Act will have to be decided when it arises. The position of hospitals under that Act may or may not be different from when they were voluntary or municipal hospitals. Having regard to my conclusion with regard to Dr. Graham, the matter is relevant only on the alleged application of res ipsa loquitur. The learned judge said that principle could not apply to a case where the operation is, as he held here, under the control of two persons not in law responsible for each other. Our attention was drawn to some observations in *Mahon* v. *Osborne* (3) which suggest this is too widely stated. As to the maxim itself, I agree, with respect, with what was said by

LORD RADCLIFFE in *Barkway* v. *South Wales Transport Co., Ltd.* (4) ([1950] 1 All E.R. 403):

> " I find nothing more in that maxim than a rule of evidence, of which the essence is that an event which in the ordinary course of things is more likely than not to have been caused by negligence is by itself evidence of negligence."

In medical cases the fact that something has gone wrong is very often not in itself any evidence of negligence. In surgical operations there are, inevitably, risks. On the other hand, of course, in a case like this, there are points where the onus may shift, where a judge or jury might infer negligence, particularly if available witnesses who could throw light on what happened were not called. Having come to the conclusion that the hospital was responsible for Dr. Graham, the judge's reason (which is applicable in certain cases) for excluding the maxim has not operated on my mind.

I will now turn to the second main submission by leading counsel for the plaintiffs. Invisible cracks are none the less cracks and would not have been there if the ampoules had been carefully handled by the nursing staff. Therefore, there must have been negligent handling. And, of course, if the submission is to succeed, that negligent handling must have caused the injury. A number of experiments were conducted to try to crack ampoules in the way in which they must have been cracked on the findings. It was, of course, possible to break them if handled sufficiently roughly. It was found very difficult to produce an invisible or not easily visible crack except by thermal methods. It would be a very speculative basis on which to find some unidentified nurse negligent. I think, however, making assumptions in the plaintiffs' favour, the submission fails on causation. I will assume that a nurse knocked two ampoules together as she was placing them in the basin and this " rough " handling caused the " invisible " cracks. It would obviously be inadvertent, and, I will assume, negligent. The duty as such not negligently to mishandle equipment would be a duty owed by the hospital. If an ampoule were dropped and broken there would clearly be no breach of any duty to a patient. In the case I am assuming, having knocked the ampoules, the natural inference is that the nurse would look to see if they were cracked. This is what every normal person who has dropped or knocked something does. Is it broken ? As the learned judge has found there was no visible crack and the nursing staff had no reason to foresee invisible cracks, the nurse would reasonably assume no harm had been done and would let the ampoule go forward. The duty which the nursing staff owed to the plaintiffs was to take reasonable care to see that cracked or faulty ampoules did not reach the operating theatre. That duty would not, in my opinion, be broken in the circumstances and on the assumption as set out above. For these reasons I would dismiss the appeal.

DENNING, L.J.: No one can be unmoved by the disaster which has befallen these two unfortunate men. They were both working men before they went into the Chesterfield Hospital in October, 1947. Both were insured contributors to the hospital, paying a small sum each week, in return for which they were entitled to be admitted for treatment when they were ill. Each of them was operated on in the hospital for a minor trouble, one for something wrong with a cartilage in his knee, the other for a hydrocele. The operations were both on the same day, Oct. 13, 1947. Each of them was given a spinal anaesthetic by a visiting anaesthetist, Dr. Graham. Each of them has in consequence been paralysed from the waist down.

The judge has said that those facts do not speak for themselves, but I think they do. They certainly call for an explanation. Each of these plaintiffs is entitled to say to the hospital: " While I was in your hands something has been done to me which has wrecked my life. Please explain how it has come to pass."

The reason why the judge took a different view was because he thought that the hospital authorities could disclaim responsibility for the anaesthetist, Dr. Graham: and, as it might be his fault and not theirs, the hospital authorities were not called on to give an explanation. I think that reasoning is wrong. In the first place, I think that the hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors but also for the anaesthetists and the surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole-time or part-time. The hospital authorities are responsible for all of them. The reason is because, even if they are not servants, they are the agents of the hospital to give the treatment. The only exception is the case of consultants or anaesthetists selected and employed by the patient himself. I went into the matter with some care in *Cassidy's* case (2) and I adhere to all I there said. In the second place, I do not think that the hospital authorities and Dr. Graham can both avoid giving an explanation by the simple expedient of each throwing responsibility on the other. If an injured person shows that one or other or both of two persons injured him, but cannot say which of them it was, then he is not defeated altogether. He can call on each of them for an explanation: see *Baker* v. *Market Harborough Industrial Co-operative Society* (5).

I approach this case, therefore, on the footing that the hospital authorities and Dr. Graham were called on to give an explanation of what has happened. But I think they have done so. They have spared no trouble or expense to seek out the cause of the disaster. The greatest specialists in the land were called to give evidence. [HIS LORDSHIP then stated the facts as found by the learned judge and continued:] That is the explanation of the disaster, and the question is: Were any of the staff negligent? I pause to say that once the accident is explained, no question of res ipsa loquitur arises. The only question is whether on the facts as now ascertained anyone was negligent. Leading counsel for the plaintiffs said that the staff were negligent in two respects: (i) in not colouring the phenol with a deep dye; (ii) in cracking the ampoules.

I will take them in order: (i) The deep tinting. If the anaesthetists had foreseen that the ampoules might get cracked with cracks that could not be detected on inspection they would, no doubt, have dyed the phenol a deep blue; and this would have exposed the contamination. But I do not think their failure to foresee this was negligence. It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness, and then it is put right. That is just what happened here. Dr. Graham sought to escape the danger of infection by disinfecting the ampoule. In escaping that known danger he, unfortunately, ran into another danger. He did not know that there could be undetectable cracks, but it was not negligent for him not to know it at that time. We must not look at the 1947 accident with 1954 spectacles. The judge acquitted Dr. Graham of negligence and we should uphold his decision. (ii) The cracks. In cracking the ampoules, there must, I fear, have been some carelessness by someone in the hospital. The ampoules were quite strong and the sisters said that they should not get cracked if proper care was used in handling them. They must have been jolted in some way by someone. This raises an interesting point of law. This carelessness was, in a sense, one of the causes of the disaster; but the person who jolted the ampoule cannot possibly have foreseen what dire consequences would follow. There were so many intervening opportunities of

inspection that she might reasonably think that, if the jolting caused a crack, it would be discovered long before any harm came of it. As SOMERVELL, L.J., has pointed out, she herself would probably examine the ampoule for a crack, and seeing none, would return it to the jar. The anaesthetist himself did, in fact, examine it for cracks, and, finding none, used it. The trouble was that nobody realised that there might be a crack which you could not detect on ordinary examination. What, then, is the legal position ?

It may be said that, by reason of the decision of this court in *Re Polemis & Furness, Withy & Co.* (6), the hospital authorities are liable for all the consequences of the initial carelessness of the nurse, even though the consequences could not reasonably have been foreseen. But the decision in *Re Polemis* (6) is of very limited application. The reason is because there are two preliminary questions to be answered before it can come into play. The first question in every case is whether there was a duty of care owed to the plaintiff; and the test of duty depends, without doubt, on what you should foresee. There is no duty of care owed to a person when you could not reasonably foresee that he might be injured by your conduct: see *Hay (or Bourhill)* v. *Young* (7) and *Woods* v. *Duncan* (8) ([1946] A.C. 426, per LORD RUSSELL OF KILLOWEN, and ibid., 437 per LORD PORTER). The second question is whether the neglect of duty was a " cause " of the injury in the proper sense of that term; and causation, as well as duty, often depends on what you should foresee. The chain of causation is broken when there is an intervening action which you could not reasonably be expected to foresee: see *Woods* v. *Duncan* (8), ibid., 421, per VISCOUNT SIMON; ibid., 431, per LORD MACMILLAN; ibid., 442, per LORD SIMONDS. It is even broken when there is an intervening omission which you could not reasonably expect. For instance, in cases based on *M'Alister (or Donoghue)* v. *Stevenson* (9), a manufacturer is not liable if he might reasonably contemplate that an intermediate examination would probably be made. It is only when those two preliminary questions—duty and causation—are answered in favour of the plaintiff that the third question, remoteness of damage, comes into play. Even then your ability to foresee the consequences may be vital. It is decisive where there is intervening conduct by other persons: see *Stansbie* v. *Troman* (10); *Lewis* v. *Carmarthenshire County Council* (11). It is only disregarded when the negligence is the immediate or precipitating cause of the damage, as in *Re Polemis* (6) and *Thorogood* v. *Van Den Berghs & Jurgens, Ltd.* (12). In all these cases you will find that the three questions, duty, causation, and remoteness, run continually into one another. It seems to me that they are simply three different ways of looking at one and the same question which is this: Is the consequence fairly to be regarded as within the risk created by the negligence ? If so, the negligent person is liable for it: but otherwise not. Even when the three questions are taken singly, they can only be determined by applying common sense to the facts of each particular case: see as to duty, *King* v. *Phillips* (13) ([1953] 1 All E.R. 620, 624); as to causation, *Stapley* v. *Gypsum Mines, Ltd.* (14), and as to remoteness, *Liesbosch, Dredger* v. *Edison S.S.* (15) ([1933] A.C. 460, per LORD WRIGHT). Instead of asking three questions, I should have thought in many cases it would be simpler and better to ask the one question: Is the consequence within the risk ? and to answer it by applying ordinary plain common sense. That is the way in which SINGLETON and HODSON, L.JJ., approached a difficult problem in *Jones* v. *Livox Quarries, Ltd.* (16) ([1952] 2 Q.B. 613, 618), and I should like to approach this problem in the same way.

Asking myself, therefore, what was the risk involved in careless handling of the ampoules, I answer by saying that there was such a probability of intervening examination as to limit the risk. The only consequence which could reasonably be anticipated was the loss of a quantity of Nupercaine, but not the paralysis of a patient. The hospital authorities are, therefore, not liable for it. When you stop to think of what happened in this case, you will realise that it was a most

extraordinary chapter of accidents. In some way the ampoules must have received a jolt, perhaps while a nurse was putting them into the jar or while a trolley was being moved along. The jolt cannot have been very severe. It was not severe enough to break any of the ampoules or even to crack them so far as anyone could see. But it was just enough to produce an invisible crack. The crack was of a kind which no one in any experiment has been able to reproduce again. It was too fine to be seen, but it was enough to let in sufficient phenol to corrode the nerves, whilst still leaving enough Nupercaine to anaesthetise the patient. And this very exceptional crack occurred, not in one ampoule only, but in two ampoules used on the self-same day in two successive operations; and none of the other ampoules was damaged at all. This has taught the doctors to be on their guard against invisible cracks. Never again, it is to be hoped, will such a thing happen. After this accident a leading text-book, Professor MACINTOSH ON LUMBAR PUNCTURE AND SPINAL ANAESTHESIA, was published in 1951 which contains the significant warning:

> "Never place ampoules of local anaesthetic solution in alcohol or spirit. This common practice is probably responsible for some of the cases of permanent paralysis reported after spinal analgesia."

If the hospitals were to continue the practice after this warning, they could not complain if they were found guilty of negligence. But the warning had not been given at the time of this accident. Indeed, it was the extraordinary accident to these two men which first disclosed the danger. Nowadays it would be negligence not to realise the danger, but it was not then.

One final word. These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure. I agree with my Lord that these appeals should be dismissed.

MORRIS, L.J., stated the facts and continued: The evidence adduced at the hearing showed that it was only in very rare cases that any untoward consequence followed on spinal anaesthetic injection. In the nature of things the plaintiffs could not know, nor be expected to know, exactly what took place in preparation for and during their operations. When they proved all that they were in a position to prove they then said: "res ipsa loquitur". But this convenient and succinct formula possesses no magic qualities, nor has it any added virtue, other than that of brevity, merely because it is expressed in Latin. When used on behalf of a plaintiff it is generally a short way of saying: "I submit that the facts and circumstances that I have proved establish a prima facie case of negligence against the defendant." It must depend on all the individual facts and the circumstances of the particular case whether this is so. There are certain happenings that do not normally occur in the absence of negligence and on proof of these a court will probably hold that there is a case to answer. (For a valuable discussion of this topic see an article by Dr. ELLIS LEWIS: 1951, 11 CAMBRIDGE LAW JOURNAL, p. 74). Where there are two or more defendants it may be that the facts proved by a plaintiff are such as to establish a prima facie case against each defendant. Thus, in *Mahon* v. *Osborne* (3), MACKINNON, L.J., said ([1939] 1 All E.R. 553):

> "Five persons were concerned in the operation on Mar. 4—Mr. Osborne, the surgeon, the anaesthetist, Nurse Ashburner, as chief or theatre nurse, Nurse Edmunds, and Nurse Callaghan. The plaintiff, having no means of

knowing what happened in the theatre, was in the position of being able to rely on the maxim res ipsa loquitur so as to say that some one or more of these five must have been negligent, since the swab was beyond question left in the abdomen of the deceased. In fact, she sued Mr. Osborne, the surgeon, and Miss Ashburner, the chief nurse. One or other of them, or perhaps both, must have been negligent, but it was for the plaintiff to establish her case against either or both."

Difficulties may arise, however, if a plaintiff only proves facts from which the inference is that there may have been negligence either in defendant A. or in defendant B. So, in the present case it was said that unless Dr. Graham was the servant or agent of the hospital the position at the close of the plaintiffs' cases was that if a prima facie case of negligence was established it was merely a case that pointed uncertainly against either Dr. Graham or the hospital. I do not think that it is necessary to consider whether, if Dr. Graham was not the servant or agent of the hospital and if no evidence at all had been called on behalf of the defendants, it could have been asserted that a prima facie case was made out both against Dr. Graham and against the hospital, for I have come to the conclusion that Dr. Graham was the servant or agent of the hospital.

In *Gold* v. *Essex County Council* (1) LORD GREENE, M.R., pointed out ([1942] 2 All E.R. 242) that in cases of this nature the first task is to discover the extent of the obligation assumed by the person whom it is sought to make liable. He added (ibid.):

> " Once this is discovered, it follows of necessity that the person accused of a breach of the obligation cannot escape liability because he has employed another person, whether a servant or agent, to discharge it on his behalf; and this is equally true whether or not the obligation involves the use of skill."

In the present cases the learned judge held that both plaintiffs were contributors for hospital and surgical treatment under a contributory scheme run by the hospital, so that they made some contributions which were received by the hospital for their treatment. The exact details of the scheme which the hospital had run were not before us and they might not have added materially to the facts proved. While the requisite standard of care does not vary according to whether treatment is gratuitous or on payment the existence of arrangements entitling the plaintiffs to expect certain treatment might be a relevant factor when considering the extent of the obligation assumed by the hospital. In his judgment in *Gold* v. *Essex County Council* (1) LORD GREENE, M.R., analysed the position of the various persons in the " organisation " of the hospital to which the plaintiff in that case resorted for free advice and treatment. He said (ibid.):

> " The position of the nurses again . . . if the nature of their employment, both as to its terms and as to the work performed, is what it usually is in such institutions, I cannot myself see any sufficient ground for saying that the respondents do not undertake towards the patient the obligation of nursing him as distinct from the obligation of providing a skilful nurse."

This passage conveniently demonstrates a contrast. A hospital might assume the obligation of nursing: it might, on the other hand, merely assume the obligation of providing a skilful nurse. But the question as to what obligation a hospital has assumed becomes, as it seems to me, ultimately a question of fact to be decided having regard to the particular circumstances of each particular case: the ascertainment of the fact may require in some cases inference or deduction from proved or known facts. In the present case we are concerned only with the position of Dr. Graham in 1947 in this voluntary hospital.

The general position in regard to nurses would appear to be reasonably uniform and clear. In the case cited above LORD GREENE, M.R., said (ibid., 243):

" Nursing, it appears to me, is just what the patient is entitled to expect

from the institution and the relationship of the nurses to the institution supports the inference that they are engaged to nurse the patients. In the case of a nursing home conducted for profit, a patient would be surprised to be told that the home does not undertake to nurse him. In the case of a voluntary hospital with the usual nursing staff his just expectation would surely be the same. The idea that in the case of a voluntary hospital the only obligation which the hospital undertakes to perform by its nursing staff is, not the essential work of nursing but only so-called administrative work appears to me, with all respect to those who have thought otherwise, not merely unworkable in practice but contrary to the plain sense of the position."

On the principles so clearly enunciated the court in that case held that the hospital had assumed the obligation of treating a patient who sought treatment by Grenz rays and of giving the treatment by the hand of a competent radiographer. That was the natural and reasonable inference to be drawn from the way in which those running the hospital conducted their affairs and from the nature of the engagement of the radiographer.

If a patient in 1947 entered a voluntary hospital for an operation it might be that if the operation was to be performed by a visiting surgeon the hospital would not undertake so far as concerned the actual surgery itself to do more than to make the necessary arrangements to secure the services of a skilled and competent surgeon. The facts and features of each particular case would require investigation. But a hospital might in any event have undertaken to provide all the necessary facilities and equipment for the operation and the obligation of nursing and also the obligation of anaesthetising a patient for his operation. The question in the present case is whether the hospital undertook these obligations. In my judgment, they did. There can be no doubt that they undertook to nurse the plaintiffs and to provide the necessary facilities and equipment for the operations. I think they further undertook to anaesthetise the plaintiffs. The arrangements made between the hospital and Dr. Pooler and Dr. Graham, together with the arrangements by which a resident anaesthetist was employed, had the result that the hospital provided a constantly available anaesthetic service to cover all types of cases. It is true that Dr. Pooler and Dr. Graham could arrange between themselves as to when they would respectively be on duty at the hospital, and each was free to do private work. But these facts do not negative the view, to which all the circumstances point, that the hospital was assuming the obligation of anaesthetising the plaintiffs for their operations. I consider that the anaesthetists were members of the "organisation" of the hospital: they were members of the staff engaged by the hospital to do what the hospital itself was undertaking to do. The work which Dr. Graham was employed by the hospital to do was work of a highly skilled and specialised nature, but this fact does not avoid the application of the rule of "respondeat superior". If Dr. Graham was negligent in doing his work I consider that the hospital would be just as responsible as were the defendants in *Gold* v. *Essex County Council* (1) for the negligence of the radiographer or as were the defendants in *Cassidy* v. *Ministry of Health* (2). I have approached the present case, therefore, on the basis that the defendants would be liable if the plaintiffs' injuries were caused by the negligence either of Dr. Graham or by the negligence of someone on the staff who was concerned with the operation or the preparation for it. On this basis if negligence could be established against one or more of those for whom the hospital was responsible it would not matter if the plaintiffs could not point to the exact person or persons who had been negligent.

It was not suggested that Dr. Graham was negligent in using Nupercaine, nor that there was anything faulty in the manner of his injection. But it was said that the evidence pointed to the fact that the quantity of phenol which must

have found its way into the Nupercaine had passed through cracks of dimensions which would not have eluded a careful examiner. This view depended in part on an estimate as to the percentage of phenol admixture which would be damaging and in part on evidence as to the results of experiments to ascertain the rate at which phenol might percolate through cracks. But it seems unlikely that Dr. Graham in two successive operations would fail to detect cracks which could be observed or felt. The learned judge, having seen and heard Dr. Graham, whose evidence he said was given " in a very careful and forthright manner ", rejected the suggestion that Dr. Graham had failed to detect cracks which could have been seen. I do not think that this finding can be disturbed and, accordingly, the matter must be considered on the footing that phenol had found its way into the ampoules through cracks not ordinarily detectable. On this basis it is clear that if the phenol solution had been tinted with some vivid colouring any escape of the solution into the ampoules would have been readily apparent. This was at all times frankly conceded by leading counsel for Dr. Graham. The question arises whether Dr. Graham was negligent in not arranging for the deep-tinting of the phenol solution. The phenol solution as used in the hospital was in fact coloured although not vividly. This colouring was part of the routine adopted in the hospital to denote and to identify phenol. It was Dr. Pooler who first introduced in the hospital the system of immersing the ampoules in phenol solution. Dr. Graham considered the matter for some time before he followed the lead given him by his senior and more experienced colleague on whose opinion he greatly relied. When Dr. Graham adopted the new method he realised full well, as he unhesitatingly admitted, that if a glass ampoule became cracked there could be resultant percolation of phenol solution which would be a " terribly serious danger ". It was for that reason that he felt it necessary after changing over to the new method to examine carefully for cracks. But Dr. Graham was most emphatic in his evidence that in 1947 he had no knowledge at all that there might be in an ampoule some kind of a crack which was not visible but which yet permitted percolation. He firmly believed that there was no danger provided that there was no crack that could be seen on proper inspection: he never conceived the idea of a crack that he could not see. I read his evidence when taken in its entirety as showing that he was not relying on seeing some discoloration as a warning that there had been percolation, but that he was convinced that danger could only arise if there was a crack that could be seen and that such danger could be fully averted by careful inspection. It is now known that there could be cracks not ordinarily detectable. But care has to be exercised to ensure that conduct in 1947 is only judged in the light of knowledge which then was or ought reasonably to have been possessed. In this connection the then-existing state of medical literature must be had in mind. The question arises whether Dr. Graham was negligent in not adopting some different technique. I cannot think that he was. I think that a consideration of the evidence in the case negatives the view that Dr. Graham was negligent and I see no reason to differ from the conclusions which were reached on this part of the case by the learned judge.

A B C D E F G

But it is further said that there must have been negligent mishandling of the ampoules on the part of some member or members of the staff of the hospital. On behalf of the plaintiffs it was urged that the ampoules must have arrived intact and in good order at the hospital and must have been carelessly handled at a later stage when they were being made ready and available for operative use. There was much evidence which supported the contention that ampoules could only have been damaged if they were mishandled. Even so, it is problematical as to when and where and in what circumstances these two ampoules became damaged. But as the case now stands an acceptance of the finding of fact of the learned judge that Dr. Graham carefully examined the ampoules used and that there were no cracks which would by such examination have

H

been revealed involves that the offending cracks were not d ectable ones. If the view is correct that an anaesthetist in 1947 was not negli nt in not knowing of the risk of seepage through what have been called " invisible cracks " it follows, I think, that members of the theatre staff could not be expected to know of any such risk. In his speech in *Bolton* v. *Stone* (17) LORD PORTER said ([1951] 1 All E.R. 1081):

A " It is not enough that the event should be such as can reasonably be foreseen. The further result that injury is likely to follow must also be such as a reasonable man would contemplate before he can be convicted of actionable negligence."

If some member of the staff had in fact mishandled the ampoules in question, then the position was either that the damage was not seen after an actual inspec-
B tion or that an inspection would have been unavailing: since no detectable damage to them was caused there was no reason to foresee that there was any risk in leaving such ampoules amongst those from which an anaesthetist would select and no reason to contemplate that any injury would be likely to follow. Although there must be abiding sympathy with the two plaintiffs in their grievous and distressing misfortunes, I consider that the judgment of the learned judge was
C correct.

Appeal dismissed.

Solicitors: *Gibson & Weldon*, agents for *John Whittle, Robinson & Bailey*, Manchester (for the plaintiffs); *Berrymans* (for the first defendant, the Ministry of Health); *Hempsons* (for the second defendant, Dr. Graham); *Swepstones* (for the third defendants).

D [*Reported by* MISS PHILIPPA PRICE, *Barrister-at-Law.*]

GALLOWAY *v.* GALLOWAY.

[COURT OF APPEAL (Singleton, Jenkins and Hodson, L.JJ.), March 8, 29, 30, April 13, 1954.]

E *Divorce—Custody—Child born before marriage—Not legitimated per subsequens matrimonium—Matrimonial Causes Act*, 1950 (*c.* 25), *s.* 26 (1).

Infant—Maintenance—Infant born before marriage—Not legitimated per subsequens matrimonium—Matrimonial Causes Act, 1950 (*c.* 25), *s.* 26 (1).

Per JENKINS and HODSON, L.JJ., SINGLETON, L.J., dissentiente: The term " children " in s. 26 (1) of the Matrimonial Causes Act, 1950, does not
F include a child born out of wedlock in circumstances which prevent the child being legitimated by the subsequent marriage of the parents under the provisions of the Legitimacy Act, 1926, and, therefore, on the dissolution of the parents' marriage, no order for the custody or maintenance of the child can be made.

Harrison v. *Harrison* ([1951] 2 All E.R. 346) and decision of MORRIS, L.J.,
G in *Packer* v. *Packer* ([1953] 2 All E.R. 127), approved.

Decision of DENNING, L.J., in *Packer* v. *Packer* (ibid.), not approved.

FOR THE MATRIMONIAL CAUSES ACT, 1950, s. 26 (1), see HALSBURY'S STATUTES, Second Edn., Vol. 29, p. 413.

Cases referred to:

H (1) *Harrison* v. *Harrison*, [1951] 2 All E.R. 346; [1951] P. 476; 115 J.P. 428; 27 Digest, Replacement, 664, *6289*.

(2) *R.* v. *Totley (Inhabitants)*, (184), 7 Q.B. 596; 14 L.J.M.C. 138; 5 L.T.O.S. 196; 9 J.P. 583; 115 E. R. 614; 28 Digest 139, *3*.

(3) *Woolwich Union* v. *Fulham Parish Union*, [1906] 2 K.B. 240; 75 L.J.K.B. 675; 95 L.T. 337; *affd.* H.L., sub nom. *Fulham Parish* v. *Woolwich Union*, [1907] A.C. 255; 76 L.J.K.B. 739; 97 L.T. 117; 71 J.P. 361; 37 Digest 255, *503*.

Ontario

Executive Council
Conseil exécutif

Order in Council
Décret

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

WHEREAS on April 19, 2007, the Chief Coroner for Ontario announced the results of a review of certain cases of suspicious child deaths where Dr. Charles Smith performed the autopsy or was consulted ("the Chief Coroner's Review") and found that some of the factual conclusions were not reasonably supported by the materials available;

AND WHEREAS the Ministry of the Attorney General and the Office of the Chief Coroner for Ontario are working together to identify, and the Minister of Community Safety and Correctional Services has requested that the Office of the Chief Coroner review homicide and criminally suspicious cases in which Dr. Smith performed an autopsy or provided an opinion prior to 1991;

AND WHEREAS the Chief Coroner for Ontario has announced that he has made the College of Physicians and Surgeons aware of the concerns identified in the Chief Coroner's Review;

AND WHEREAS the cases that have raised issues with determinations of fact and opinion that were submitted as evidence in criminal proceedings are currently being dealt with through the disclosure of the findings of the Chief Coroner's Review to defendants in related criminal proceedings;

AND WHEREAS there are processes in the Criminal Code of Canada for addressing individual cases of potential wrongful conviction;

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur, sur l'avis et avec le consentement du Conseil exécutif, décrète ce qui suit :

ATTENDU QUE, le 19 avril 2007, le coroner en chef de l'Ontario a rendu publics les résultats de la vérification de certaines affaires de décès suspects d'enfants dans le cadre desquelles le docteur Charles Smith a procédé à une autopsie ou a été consulté («la vérification du coroner en chef»), et qu'il a conclu que certaines des conclusions de faits n'étaient pas raisonnablement étayées par les éléments disponibles;

ATTENDU QUE le ministère du Procureur général et le Bureau du coroner en chef de l'Ontario collaborent afin de rechercher les affaires d'homicides et d'actes criminels dans le cadre desquelles le Dr Smith a procédé à une autopsie ou fourni une opinion avant 1991, et que le ministre de la Sécurité communautaire et des Services correctionnels a demandé que le Bureau du coroner en chef vérifie ces affaires;

ATTENDU QUE le coroner en chef de l'Ontario a annoncé qu'il a informé l'Ordre des médecins et chirurgiens de l'Ontario des questions soulevées par sa vérification;

ATTENDU QUE les affaires où sont mises en question des conclusions de faits et des opinions qui ont été présentées en preuve dans des instances criminelles donnent en ce moment lieu à la divulgation des conclusions de la vérification du coroner en chef aux défendeurs dans les instances criminelles qui les concernent;

ATTENDU QUE le Code criminel du Canada prévoit des recours en cas d'erreur judiciaire;

AND WHEREAS there are civil and criminal proceedings that have arisen as a result of Dr. Smith's work that are the appropriate forum for the adjudication of those matters;

AND WHEREAS the Lieutenant Governor in Council considers it advisable to appoint a person to identify and make recommendations to address systemic failings that may have occurred in connection with the oversight of pediatric forensic pathology in Ontario;

AND WHEREAS the inquiry is not regulated by any special law;

THEREFORE, pursuant to the *Public Inquiries Act*:

Establishment of the Commission

1. A Commission shall be issued effective April 25, 2007, appointing the Honourable Stephen Goudge as a Commissioner.

2. The Commission shall conduct the inquiry to ensure the expeditious delivery of its report and shall deliver its final report and recommendations to the Attorney General no later than April 25, 2008.

3. Senator Larry Campbell shall chair an expert medical and scientific panel, which shall report to the Commissioner, to provide such information and advice as directed by the Commissioner.

Mandate

4. The Commission shall conduct a systemic review and assessment and report on:

    a. the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings;

ATTENDU QUE les poursuites civiles et criminelles qui sont survenues à la suite du travail du Dr Smith constituent le moyen adéquat de trancher ces affaires;

ATTENDU QUE le lieutenant-gouverneur en conseil estime souhaitable de nommer une personne chargée de cerner les lacunes systémiques qui peuvent avoir existé relativement à la surveillance de la médecine légale pédiatrique en Ontario et de faire des recommandations à ce propos;

ATTENDU QUE l'enquête n'est régie par aucune loi spéciale;

EN CONSÉQUENCE, conformément à la *Loi sur les enquêtes publiques* :

Constitution de la commission

1. Une commission est constituée à compter du 25 avril 2007, nommant commissaire l'honorable Stephen Goudge.

2. La commission mènera l'enquête avec la célérité voulue et remettra son rapport final et ses recommandations au procureur général au plus tard le 25 avril 2008.

3. Le sénateur Larry Campbell présidera un comité d'experts médicaux et scientifiques qui relève du commissaire et qui est chargé de lui fournir les renseignements et les conseils qu'il lui demande.

Mandat

4. La commission procédera à un examen et à une évaluation systémiques et fera rapport sur ce qui suit :

    a. les politiques, les méthodes, les pratiques, les mécanismes de responsabilisation et de surveillance, les mesures de contrôle de la qualité et les aspects institutionnels de la médecine légale pédiatrique en Ontario de 1981 à 2001 en ce qui concerne son exercice et son rôle dans les enquêtes et dans les instances criminelles;

b. the legislative and regulatory provisions in existence that related to, or had implications for, the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and

c. any changes to the items referenced in the above two paragraphs, subsequent to 2001

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

5. In fulfilling its mandate, the Commission shall not report on any individual cases that are, have been, or may be subject to a criminal investigation or proceeding.

6. The Commission shall perform its duties without expressing any conclusion or recommendation regarding professional discipline matters involving any person or the civil or criminal liability of any person or organization.

7. The Commission shall review and consider any existing records or reports relevant to its mandate, including the results of the Chief Coroner's Review announced on April 19, 2007, and other medical, professional, and social science reports and records. Further, the Commission shall rely wherever possible on overview reports submitted to the inquiry. The Commission may consider such reports and records in lieu of calling witnesses.

8. The Commission shall rely wherever possible on representative witnesses on behalf of institutions.

b. les dispositions législatives et réglementaires qui portaient sur l'exercice de la médecine légale pédiatrique en Ontario entre 1981 et 2001 ou qui avaient une incidence sur cet exercice;

c. toute modification postérieure à 2001 des éléments visés aux alinéas précédents;

en vue de faire des recommandations visant à rétablir et à rehausser la confiance du public envers la médecine légale pédiatrique en Ontario et son rôle futur dans les enquêtes et dans les instances criminelles.

5. Dans le cadre de son mandat, la commission ne doit pas faire rapport sur des affaires particulières qui font, ont fait ou peuvent faire l'objet d'une enquête ou instance criminelle.

6. La commission s'acquittera de ses fonctions sans formuler de conclusions ou de recommandations quant aux questions de discipline professionnelle mettant en cause une personne ou quant à la responsabilité civile ou criminelle de toute personne ou de tout organisme.

7. La commission examine et étudie les dossiers ou les rapports existants qui se rapportent à son mandat, y compris les résultats de la vérification du coroner en chef rendus publics le 19 avril 2007, et d'autres rapports et dossiers d'ordre médical ou professionnel ou relevant des sciences sociales. En outre, la commission se fonde, dans la mesure du possible, sur les rapports sommaires soumis à l'enquête. La commission peut étudier ces rapports et ces dossiers plutôt que d'entendre des témoins.

8. La commission s'appuie, dans la mesure du possible, sur des personnes représentatives qui témoignent au nom d'institutions.

9. In delivering its report to the Attorney General, the Commission shall ensure that the report is in a form appropriate, pursuant to the *Freedom of Information and Protection of Privacy Act* and other applicable legislation, and in sufficient quantity, for public release and be responsible for translation and printing, and shall ensure that it is available in both English and French at the same time, in electronic and printed versions. The Attorney General shall make the report available to the public.

10. Part III of the *Public Inquiries Act* applies to the inquiry and the Commissioner may have recourse to the powers contained in Part III as necessary to achieve the mandate of the inquiry

Resources

11. Within an approved budget, the Commission may retain such counsel, staff, or expertise it considers necessary in the performance of its duties at reasonable remuneration approved by the Ministry of the Attorney General. They shall be reimbursed for reasonable expenses incurred in connection with their duties in accordance with Management Board of Cabinet Directives and Guidelines.

12. The Commission shall establish and maintain a website and use other technologies to promote accessibility and transparency to the public.

13. The Commission shall follow Management Board of Cabinet Directives and Guidelines and other applicable government policies in obtaining other services and goods it considers necessary in the performance of its duties unless, in its view, it is not possible to follow them.

9. La commission veillera à remettre son rapport au procureur général sous une forme appropriée, conformément à la *Loi sur l'accès à l'information et la protection de la vie privée* et aux autres lois applicables, et en nombre d'exemplaires suffisant pour sa diffusion publique et devra en assurer la traduction et l'impression. En outre, elle fera en sorte qu'il soit disponible en même temps en version française et anglaise et sur support électronique et papier. Le procureur général mettra le rapport à la disposition du public.

10. La partie III de la *Loi sur les enquêtes publiques* s'applique à l'enquête et le commissaire pourra invoquer les pouvoirs prévus par cette partie, dans la mesure nécessaire à l'exécution de son mandat.

Ressources

11. Dans le cadre d'un budget approuvé, la commission peut retenir les services des avocats, du personnel ou des experts qu'elle juge nécessaires à l'exercice de ses fonctions selon une rémunération raisonnable approuvée par le ministère du Procureur général. Ceux-ci pourront se faire rembourser les frais raisonnables engagés dans l'exercice de leurs fonctions, conformément aux directives et aux lignes directrices du Conseil de gestion du gouvernement.

12. La commission se dotera d'un site Web et utilisera d'autres technologies pour promouvoir l'accessibilité et la transparence.

13. À moins que, à son avis, cela ne soit pas possible, la commission suivra les directives et les lignes directrices du Conseil de gestion du gouvernement ainsi que les autres politiques applicables du gouvernement dans le cadre de l'obtention des autres biens et services qu'elle estime nécessaires à l'exercice de ses fonctions.

14. The Commission may make recommendations to the Attorney General regarding funding for proceedings before the Commission for parties who have been granted standing because they have information relevant to the systemic issues that would otherwise be unavailable and where in the Commission's view the party would not otherwise be able to participate in the inquiry without such funding. Any such funding recommendations shall be in accordance with Management Board of Cabinet Directives and Guidelines.

14. La commission peut faire des recommandations au procureur général en ce qui concerne le financement de la participation à ses travaux des parties qui se sont vues accorder le droit de comparaître parce qu'elles ont des renseignements se rapportant aux questions systémiques qui ne seraient pas disponibles autrement, si elle est d'avis que, à défaut, ces parties ne seraient pas par ailleurs en mesure de participer à l'enquête. Ces recommandations devront être conformes aux directives et aux lignes directrices du Conseil de gestion du gouvernement.

15. All ministries and all agencies, boards and commissions of the Government of Ontario shall, subject to any privilege or other legal restrictions, assist the Commission to the fullest extent so that the Commission may carry out its duties and will respect the independence of the review.

15. Sous réserve de tout privilège ou de toute autre restriction légale, tous les ministères ainsi que tous les organismes, conseils et commissions du gouvernement de l'Ontario prêteront sans réserve leur concours à la commission de façon que celle-ci puisse s'acquitter de ses fonctions et ils respecteront l'indépendance de l'examen.

16. If during the course of the inquiry the Commission receives information, including in writing, from victims or families, the Commission may authorize the provision of counselling assistance.

16. Si, dans le cours de son enquête, la commission reçoit, notamment par écrit, des renseignements des victimes ou des familles, elle peut autoriser la prestation de services de counselling.

Indexed as:

Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System in Canada - Krever Commission)

The Canadian Red Cross Society, George Weber, Dr. Roger A. Perrault, Dr. Martin G. Davey, Dr. Terry Stout, Dr. Joseph Ernest Côme Rousseau, Dr. Noel Adams Buskard, Dr. Raymond M. Guevin, Dr. John Sinclair MacKay, Dr. Max Gorelick, Dr. Roslyn Herst and Dr. Andrew Kaegi and Bayer Inc. and Baxter Corporation, appellants;

v.

The Honourable Horace Krever, Commissioner of the Inquiry on the Blood System in Canada, respondent, and The Canadian Hemophilia Society, the Canadian Aids Society, Canadian Hemophiliacs Infected with HIV, T-COR, the HIV-T Group (Blood Transfused), the Toronto and Central Ontario Regional Hemophilia Society, the Hepatitis C Survivors' Society, the Hepatitis C Group of Transfusion Recipients & Hemophiliacs and Janet Conners (Infected Spouses & Children) Association, interveners.

[1997] 3 S.C.R. 440

[1997] S.C.J. No. 83

File No.: 25810.

Supreme Court of Canada

1997: June 25 / 1997: September 26.

Present: Lamer C.J. and La Forest, L'Heureux-Dubé, Sopinka, Gonthier, Cory, McLachlin, Iacobucci and Major JJ.

ON APPEAL FROM THE FEDERAL COURT OF APPEAL

Administrative law -- Judicial review -- Public inquiry -- Jurisdiction -- Notices of possible findings of misconduct -- Whether Commission had jurisdiction to make findings of misconduct -- Inquiries Act, R.S.C., 1985, c. I-11, ss. 2, 6, 12, 13.

Public inquiries -- Jurisdiction -- Notices of potential findings of misconduct -- Whether notices unfair.

The Commission of Inquiry appointed to examine the blood system after thousands contracted HIV and Hepatitis C from blood and blood products held exhaustive hearings governed by rules of procedure agreed to by all parties. Twenty-five interested parties were granted standing. The Baxter Corporation did not seek standing but subsequently participated in the proceedings by supplying relevant documents and providing witnesses. The

Commission, on the final day of scheduled hearings, sent out confidential notices that the Commission might reach certain conclusions based on the evidence before it, that these conclusions might amount to misconduct with the meaning of s. 13 of the Inquiries Act (setting out jurisdiction to make findings of misconduct), and that the recipients had the right to respond as to whether the Commissioner ought to reach these conclusions. A number of the recipients of notices brought applications for judicial review in the Federal Court, Trial Division. That court declared that no findings of misconduct could be made against 47 of the applicants for judicial review, but otherwise dismissed the applications. Many recipients whose notices were not quashed appealed. The Federal Court of Appeal quashed one notice but dismissed the remaining appeals. At issue here are: (1) whether the Commissioner exceeded his jurisdiction by the nature and extent of the allegations of misconduct set out in the notices; (2) if the Commissioner originally had such jurisdiction, did he lose it by failing to provide adequate procedural protections or by the timing of the release of the notices; (3) whether Commission counsel should be prohibited from taking part in the drafting of the final report because of their receipt of confidential information not disclosed to the Commissioner or the other parties; and, (4) whether the appellant Baxter Corporation should be treated differently from the other appellants.

Held: The appeal should be dismissed.

Several basic principles are applicable to inquiries. A commission of inquiry is not a court or tribunal and has no authority to determine legal liability; it does not necessarily follow the same laws of evidence or procedure that a court or tribunal would observe. A commissioner accordingly should endeavour to avoid setting out conclusions that are couched in the specific language of criminal culpability or civil liability for the public perception may be that specific findings of criminal or civil liability have been made. A commissioner has the power to make all relevant findings of fact necessary to explain or support the recommendations, even if these findings reflect adversely upon individuals. Further, a commissioner may make findings of misconduct based on the factual findings, provided that they are necessary to fulfill the purpose of the inquiry as it is described in the terms of reference. In addition, a commissioner may make a finding that there has been a failure to comply with a certain standard of conduct, so long as it is clear that the standard is not a legally binding one such that the finding amounts to a conclusion of law pertaining to criminal or civil liability. Finally, a commissioner must ensure that there is procedural fairness in the conduct of the inquiry.

Notices warning of potential findings of misconduct, if issued in confidence to the recipient, should not be subject to as strict scrutiny as the formal findings because their purpose is to allow parties to prepare for or respond to any possible findings of misconduct. The more detail included in the notice, the greater the assistance to the party. The only possible harm would be to a party's reputation and this could not be an issue if the notices are released only to the party against whom the finding may be made. Even if the content of the notice appears to amount to a finding that would exceed the jurisdiction of the commissioner, it must be assumed that commissioners will not exceed their jurisdiction. The final report may demonstrate the assumption to be erroneous.

The Commissioner here stated that he would not be making findings of civil or criminal responsibility and, in the interests of fairness to the parties and witnesses, must be bound by these statements. It was not necessary, therefore, to deal with the ultimate scope of the findings that a commissioner might make in a report.

The Commissioner did not exceed his jurisdiction in the notices delivered to the appellants. The inquiry's mandate was extremely broad and the potential findings of misconduct covered areas that were within the Commissioner's mandate to investigate. The appellants' challenge was launched prematurely. As a general rule, such a challenge should not be brought before the publication of the report unless there are reasonable grounds to believe that the Commissioner is likely to exceed his or her jurisdiction. Further consideration of this issue might have been warranted if the Commissioner's report had made findings worded in the same manner as the notices. Even if the challenges were not premature, the notices would not be objectionable. While many of the notices come close to

alleging all the necessary elements of civil liability, none appeared to exceed the Commissioner's jurisdiction. The use of the words "failure" and "responsible" in the notices does not mean, absent something more indicating legal responsibility, that the person breached a criminal or civil standard of conduct. The use of these words was not objectionable.

The procedural protections offered to parties to the Inquiry and to individual witnesses were extensive and eminently fair. The appellants could not have been misled or suffered prejudice as a result of any "misunderstanding" about the type of findings which would be made by the Commissioner.

Although the notices of potential findings of misconduct should be given as soon as it is feasible, it is unreasonable to insist that the notice of misconduct must always be given early. So long as adequate time is given to the recipients of the notices to allow them to call the evidence and make the submissions they deem necessary, the late delivery of notices will not constitute unfair procedure. The timing of notices will always depend upon the circumstances. Here, it was within the discretion of the Commissioner to issue notices when he did because, given the enormous amount of information gathered and the nature and purposes of this Inquiry, it was impossible to give adequate detail in the notices before all the evidence had been heard. The appellants were given an adequate opportunity to respond to the notices, and to adduce additional evidence, if they deemed it necessary.

It was premature to forbid Commission counsel from taking part in the drafting of the report. The Commissioner did not indicate that he intended to rely upon his counsel to draft the final report. In addition, it is not clear from the record what was contained in the confidential submissions reviewed by counsel.

Baxter Corporation should not be treated any differently than the other appellants. Although it must have realized that its conduct would be under scrutiny in the proceedings it took a calculated risk and elected not to seek standing before the Commission. It should not now be allowed to escape the consequences of that decision.

Cases Cited

Distinguished: Re Nelles and Grange (1984), 46 O.R. (2d) 210; Starr v. Houlden, [1990] 1 S.C.R. 1366; considered: O'Hara v. British Columbia, [1987] 2 S.C.R. 591; Phillips v. Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy), [1995] 2 S.C.R. 97; Beno v. Canada (Commissioner and Chairperson,Commission of Inquiry into the Deployment of Canadian Forces to Somalia), [1997] 2 F.C. 527; Attorney General (Que.) and Keable v. Attorney General (Can.), [1979] 1 S.C.R. 218; Rocois Construction Inc. v. Québec Ready Mix Inc., [1990] 2 S.C.R. 440.

Statutes and Regulations Cited

Canada Evidence Act, R.S.C., 1985, c. C-5, s. 5. Canadian Charter of Rights and Freedoms, ss. 7, 13. Inquiries Act, R.S.C., 1985, c. I-11, ss. 2, 6, 12, 13.

Authors Cited

Canada. House of Commons. Third Session of the Thirty-fourth Parliament, 1991-92-93. Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women. Sub-Committee on Health Issues. Report of the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women. Tragedy and Challenge: Canada's Blood System and HIV. (Wilbee Report, May 1993.) Ottawa: 1993.
Concise Oxford Dictionary of Current English, 8th ed. Oxford: Clarendon Press, 1990, "misconduct".

APPEAL from a judgment of the Federal Court of Appeal, [1997] F.C.J. No 17 (QL), dismissing an appeal from a judgment of the Richard J., [1996] 3 F.C. 259, 115 F.T.R. 81, 136 D.L.R. (4th) 449, 37 Admin. L.R. (2d) 260, [1996] F.C.J. No. 864. Appeal dismissed.

Earl A. Cherniak, Q.C., Kirk F. Stevens, Maureen B. Currie and Christopher I. Morrison, for the appellants the Canadian Red Cross Society, George Weber, Dr. Roger A. Perrault, Dr. Martin G. Davey, Dr. Terry Stout, Dr. Joseph Ernest Côme Rousseau, Dr. Noel Adams Buskard, Dr. Raymond M. Guevin, Dr. John Sinclair MacKay, Dr. Max Gorelick, Dr. Roslyn Herst and Dr. Andrew Kaegi.
Randal T. Hughes, Christopher D. Woodbury and Tracey N. Patel, for the appellant Bayer Inc.
Philip Spencer, Q.C., and Tim Farrell, for the appellant Baxter Corporation.
P. S. A. Lamek, Q.C., Angus T. McKinnon and Michele J. Lawford, for the respondent.
Bonnie A. Tough and Kathryn Podrebarac, for the intervener the Canadian Hemophilia Society.
R. Douglas Elliott and Patricia A. LeFebour, for the intervener the Canadian Aids Society.
William A. Selnes, for the intervener Canadian Hemophiliacs Infected with HIV, T-COR.
Allan D. J. Dick, for the intervener the HIV-T Group (Blood Transfused).
David Harvey, for the intervener the Toronto and Central Ontario Regional Hemophilia Society.
Philip S. Tinkler, for the intervener the Hepatitis C Survivors' Society.
Pierre R. Lavigne, for the intervener the Hepatitis C Group of Transfusion Recipients & Hemophiliacs.
Dawna J. Ring, for the intervener Janet Conners (Infected Spouses & Children) Association.

Solicitors for the appellants the Canadian Red Cross Society, George Weber, Dr. Roger A. Perrault, Dr. Martin G. Davey, Dr. Terry Stout, Dr. Joseph Ernest Côme Rousseau, Dr. Noel Adams Buskard, Dr. Raymond M. Guevin, Dr. John Sinclair MacKay, Dr. Max Gorelick, Dr. Roslyn Herst and Dr. Andrew Kaegi: Lerner & Associates, Toronto.
Solicitors for the appellant Bayer Inc.: Fraser & Beatty, Toronto.
Solicitors for the appellant Baxter Corporation: Blaney, McMurtry, Stapells, Friedman, Toronto.
Solicitors for the respondent: Genest, Murray, DesBrisay, Lamek, Toronto.
Solicitors for the intervener the Canadian Hemophilia Society: Blake, Cassels & Graydon, Ottawa.
Solicitors for the intervener the Canadian Aids Society: Elliott, Rodrigues, Toronto.
Solicitors for the intervener Canadian Hemophiliacs Infected with HIV, T-COR: Kapoor, Selnes, Klimm & Brown, Melfort, Saskatchewan.
Solicitors for the intervener the HIV-T Group (Blood Transfused): Goodman and Carr, Toronto.
Solicitor for the Intervener Toronto and Central Ontario Regional Hemophilia Society: David Harvey, Burlington.
Solicitors for the intervener the Hepatitis C Survivors' Society: Tinkler, Morris, Toronto.
Solicitor for the intervener the Hepatitis C Group of Transfusion Recipients & Hemophiliacs: Pierre R. Lavigne, Ottawa.
Solicitors for the intervener Janet Conners (Infected Spouses & Children) Association: Buchan, Derrick & Ring, Halifax.

The judgment of the Court was delivered by

1 **CORY J.**:-- What limits, if any, should be imposed upon the findings of a commission of inquiry? Can a commission make findings which may indicate that there was conduct on the part of corporations or individuals which could amount to criminal culpability or civil liability? Should different limitations apply to notices warning of potential findings of misconduct? It is questions like these which must be considered on this appeal.

Factual Background

2 More than 1,000 Canadians became directly infected with Human Immunodeficiency Virus (HIV) from blood and blood products in the early 1980s. Approximately 12,000 Canadians became infected with Hepatitis C from blood and blood products during the same time period. This tragedy prompted the federal, provincial and territorial ministers of health to agree in September of 1993 to convene an inquiry which would examine the blood system.

3 On October 4, 1993, pursuant to Part I of the Inquiries Act, R.S.C., 1985, c. I-11 (the Act), the Government of Canada appointed Krever J.A. of the Ontario Court of Appeal (the Commissioner) to review and report on the blood system in Canada. Specifically, the Order in Council directed the Commission to:

> . . . review and report on the mandate, organization, management, operations, financing and regulation of all activities of the blood system in Canada, including the events surrounding the contamination of the blood system in Canada in the early 1980s, by examining, without limiting the generality of the inquiry,
>
> . the organization and effectiveness of past and current systems designed to supply blood and blood products in Canada;
>
> . the roles, views, and ideas of relevant interest groups; and
>
> . the structures and experiences of other countries, especially those with comparable federal systems.

On November 3, 1993, an announcement of the Commissioner's appointment and a description of his mandate was published in newspapers across Canada. Subsequently, all those with an interest were provided with an opportunity to apply for standing before the Inquiry and for funding. Twenty-five interested parties were granted standing, including the appellants, The Canadian Red Cross Society and Bayer Inc., the federal government and each of the provincial governments except for Quebec. The appellant Baxter Corporation chose not to seek standing, but subsequently participated in the proceedings by supplying relevant documents and providing witnesses.

4 The Order in Council authorized the Commissioner to "adopt such procedures and methods as he may consider expedient for the proper conduct of the inquiry". In consultation with the parties, the Commissioner adopted rules of procedure and practice. The rules, which were agreed to by all parties, provided that in the ordinary course, Commission counsel would question witnesses first, although other counsel could apply to be the first to question any particular witness. The rules included these procedural protections:

> all parties with standing and all witnesses appearing before the Inquiry had the right to counsel, both at the Inquiry and during their pre-testimony interviews;
>
> each party had the right to have its counsel cross-examine any witness who testified and counsel for a witness who did not have standing was afforded the right to examine that witness;
>
> all parties had the right to apply to the Commissioner to have any witness called whom Commission counsel had elected not to call;
>
> all parties had the right to receive copies of all documents entered into evidence and the right to introduce their own documentary evidence;
>
> all hearings would be held in public unless application was made to preserve the confidentiality of information; and

although evidence could be received by the Commissioner that might not be admissible in a court of law, the Commissioner would be mindful of the dangers of such evidence and, in particular, its possible effect on reputation.

5 The Commission held public hearings throughout Canada between November 1993 and December 1995. In describing his mandate and intention, the Commissioner emphasized that the Inquiry "is not and it will not be a witch hunt. It is not concerned with criminal or civil liability". He said the reason the Inquiry was called was not to advance the interests of those involved with or contemplating litigation of any kind, and that he would not permit the hearings to be used for ulterior purposes. At the same time, he made it clear that he interpreted his mandate as including a fact-finding process focusing upon the events of the early 1980s and that he intended to "get to the bottom" of those events. "For those purposes it is essential to determine what caused or contributed to the contamination of the blood system in Canada in the early 1980's", he warned.

6 On October 26, 1995, Commission counsel delivered a memorandum to all parties inviting them to inform the Commission of the findings of misconduct they felt should be made by the Commission. The memorandum explained that under s. 13 of the Act, the Commissioner is required to give notice to any person against whom he intends to make findings of misconduct. The parties' submissions would help ensure that the notices gave warning of all the possible findings of misconduct which might be made by the Commission. These confidential submissions would be read only by Commission counsel, and would be considered for inclusion in notices issued by the Commissioner. Only those possible findings which were supported by evidence adduced in the public hearings and which were anticipated to be within the scope of the Commissioner's final report were included in the notices.

7 On December 21, 1995, the final day of scheduled hearings, 45 confidential notices naming 95 individuals, corporations and governments, each containing between one and 100 allegations, were delivered pursuant to s. 13 of the Act. The notices advised that the Commission might reach certain conclusions based on the evidence before it, that these conclusions may amount to misconduct within the meaning of s. 13, and that the recipients had the right to respond as to whether the Commissioner ought to reach these conclusions. The recipients were given until January 10, 1996 to announce whether and how they would respond to the notices in their final submissions.

8 A number of the recipients of notices brought applications for judicial review in the Federal Court. On June 27, 1996, Richard J. ([1996] 3 F.C. 259) declared that no findings of misconduct could be made against 47 of the applicants for judicial review, but otherwise dismissed the applications. Many recipients whose notices were not quashed appealed. The Federal Court of Appeal, [1997] F.C.J. No. 17 (QL), quashed the notice against Dr. Craig Anhorn, but dismissed the remaining appeals.

Relevant Statutory Provisions

9 Inquiries Act, R.S.C., 1985, c. I-11

> 2. The Governor in Council may, whenever the Governor in Council deems it expedient, cause inquiry to be made into and concerning any matter connected with the good government of Canada or the conduct of any part of the public business thereof.
>
> . . .
>
> 12. The commissioners may allow any person whose conduct is being investigated under this Act, and shall allow any person against whom any charge is made in the course of an investigation, to be represented by counsel.
>
> 13. No report shall be made against any person until reasonable notice has been given to the person of the charge of misconduct alleged against him and the person has been allowed full

opportunity to be heard in person or by counsel.

Decisions Below

Federal Court, Trial Division, [1996] 3 F.C. 259

10 The appellants made four principal arguments before Richard J. of the Federal Court, Trial Division. They argued that the notices contained conclusions of law in relation to their civil or criminal liability and that the Commissioner did not have the power to make such conclusions. Alternatively, if the Commissioner did have the power to make the conclusions set out in the notices, they submitted that he was precluded from exercising it because he had given assurances that he would not do so, and without these assurances the parties would never have agreed to the procedure for the conduct of the inquiry. Third, they said that delivering the notices at the very end of the proceedings violated the rules of procedural fairness. Finally, the Red Cross contended that Commission counsel should not participate in the preparation of the final report because they had assisted in preparing the notices and had thereby taken a position against the appellants, and because they had seen confidential submissions that were not brought to the attention of all the parties and persons concerned.

11 Richard J. noted that s. 13 of the Act clearly contemplates that an inquiry's investigation may lead to a finding of misconduct against a person. This, he stated, covers any conduct, regardless of whether or not it exposes that person to civil or criminal liability. In his view, the finding of facts, and in particular facts that reveal what went wrong or why a disaster occurred, can be an essential precondition to the making of useful, reliable recommendations as to how to avoid a repetition of the events under review. He noted that the Supreme Court of Canada has upheld many inquiries where the focus of the investigation was to uncover facts related to misconduct, including inquiries focused specifically on whether there was misconduct on the part of particular individuals. In none of these cases, he continued, did the Court question the jurisdiction of the inquiry to make findings of fact showing misconduct.

12 Richard J. found that the Inquiry had both an investigatory and an advisory role. In order to fulfil this role, the Commissioner had a wide discretion to determine the Inquiry's agenda and the procedures under which it would operate. He rejected the appellants' argument that they had a legitimate expectation, based on assurances given by the Commissioner during the hearings, that he would not make factual findings that could be interpreted as amounting to findings of legal liability. He held that the legitimate expectation doctrine was limited to procedural rights. In his view, it could not be used to alter the substantive jurisdiction of the Commission.

13 Richard J. found that the appellants had failed to show that they would be prejudiced by future criminal or civil trials. They were protected, in his view, by the limits on the use of their testimony in criminal proceedings provided by ss. 7 and 13 of the Canadian Charter of Rights and Freedoms and by s. 5 of the Canada Evidence Act, R.S.C., 1985, c. C-5. He further noted that he had not been referred to any legal authority for the proposition that the findings of the Commissioner, much less the contents of the notices, would be admissible in evidence in subsequent civil proceedings. In any case, he said, the trial judge will be better placed to determine whether the evidence in the report should be admitted into evidence and if so, what weight should be accorded to it.

14 Richard J. held that the challenges to potential findings of misconduct were, at this stage, purely speculative. The Commissioner had undertaken not to make any findings of civil or criminal liability, and all persons receiving notices are allowed full opportunity to argue against adoption of the allegations. He held that the Commissioner had not exceeded his mandate by conducting an investigation of the commission of particular crimes. He concluded that when released, the findings of the Commissioner might be set aside on the basis that they exceeded the mandate of the Commission. Here, he stated, all that was before him was the administrative decision to give statutory notice to affected parties.

15 With respect to the procedure adopted by the Commissioner, Richard J. found that s. 7 of the Charter did not apply to protect reputation, and even if it did, the issuance of the notices accorded with the principles of

fundamental justice. The procedural safeguards recommended under the Act had been provided to the appellants. He rejected the appellants' complaints regarding the evidence accepted by the Commission, the confidential submissions, the timing of the notices, the fairness of the hearings and the conduct of Commission counsel.

16 Richard J. declared that no explicit findings of misconduct could be made against 47 of the persons who received notices. Counsel for the Commissioner had confirmed that these persons would not be named in any adverse findings of fact resulting from the notices. He dismissed the remaining applications for judicial review. He further declared that all of the appellants were to be allowed to respond to the notices.

Federal Court of Appeal, [1997] F.C.J. No. 17 (QL)

17 Décary J.A., writing for the court, found that the challenge to the Commissioner's jurisdiction was not premature. In his view, the fact that the Commissioner had not yet prepared his final report was not significant. If the Commissioner did not have jurisdiction to make the findings in his final report which were being suggested in the notices, he would also be without jurisdiction to give notice that such findings might be made. Décary J.A. emphasized, however, that courts must show extreme restraint before intervening at this stage in order to avoid disrupting the work of inquiries. The courts should only intervene, he concluded, when it is clear that the Commissioner is about to exceed his jurisdiction.

18 Décary J.A. went on to examine whether the Commissioner had the authority to make the findings contained within the notices. He noted that public inquiries into tragedies inevitably tarnish reputations and raise questions about the responsibility borne by certain individuals. Consequently, Parliament and the courts have imposed strict limits on the use of these findings in civil and criminal trials. The findings made by a commissioner, moreover, are merely statements of the commissioner's opinion with respect to the conduct of a person. Such an opinion does not have the weight, force or effect of a judgment.

19 Décary J.A. noted that s. 13 of the Act expressly permits a commissioner to make findings of "misconduct". He concluded that this encompasses the power of a commissioner to find that an individual breached a standard of conduct. Since that standard may be moral, legal, scientific, social or political, a conclusion that someone breached a duty does not necessarily mean that the individual in question broke the law. It simply means that the individual failed to meet a standard proposed by the commissioner. To hold otherwise would completely muzzle public inquiries and would be inconsistent with s. 13.

20 Décary J.A. left open the question of whether a Commissioner could ever make a finding of civil or criminal liability, but found that in this particular case the Commissioner was precluded from doing so both by his own assurances that he would not and because of an absence of authority within the terms of the Order in Council appointing the Inquiry. The question, therefore, became whether the notices sent to the appellants contained findings or threatened findings of civil or criminal liability.

21 In Re Nelles and Grange (1984), 46 O.R. (2d) 210 (C.A.), the test adopted for this question was whether the findings would have the weight of a decision or determination of civil or criminal liability in the eyes of the public. This case was cited with approval by this Court in Starr v. Houlden, [1990] 1 S.C.R. 1366, at p. 1398. However, Décary J.A. said that approach should be restricted to inquiries into the commission of particular crimes. First, he said, the strict test would paralyse the work of most broad inquiries such as this one. In addition, he observed that the test is inconsistent with the approach taken by this Court in other cases, such as O'Hara v. British Columbia, [1987] 2 S.C.R. 591, at p. 596, and Phillips v. Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy), [1995] 2 S.C.R. 97. Although none of these decisions examined the actual findings made by a commissioner, he concluded that the Supreme Court would not have authorized inquiries leading inevitably to findings of fact that would determine responsibility in the eyes of the public if those findings were prohibited.

22 Décary J.A. noted that the Commissioner cannot make findings of civil or criminal liability, and he cannot escape this prohibition simply by using language that is less precise but essentially suggests the same thing. The

more a commissioner uses terms with "hallowed legal meaning" (at para. 55), the more likely it is that a court will find the conclusions to be determinations of legal responsibility.

23 Décary J.A. then applied this approach to the notices in this case. He acknowledged that the choice of certain expressions, such as "responsible for" and "despite knowing" indicated potential findings of legal liability, but he was not prepared to quash the notices on that basis alone. However, he went on to state at para. 69:

> I am certain that the Commissioner will understand that he would be venturing onto dangerous ground if, in his final report, he were to persist in using some of the terms he used in the notices and in adopting turns of phrase that bear too close a resemblance to the expression of a conclusion of law.

Subject to this caveat, he held that the Commissioner had the power to issue the notices and rejected the appellants' first argument.

24 Décary J.A. rejected the claim that the late delivery of the notices had violated rules of procedural fairness. He noted that the Commissioner had broad latitude and discretion in determining the Inquiry's procedures, and that those adopted were in accordance with procedural fairness. He said he could see no objection to a commissioner's waiting until the end of the hearings to give notices. The appellants were given the opportunity to respond to the notices and to adduce additional evidence in a short but flexible time period, which they chose to ignore.

25 Décary J.A. then reviewed the situation of two appellants who were not parties to the inquiry, and were, therefore, unrepresented there; Baxter Corporation, and Craig A. Anhorn, a former employee of the Red Cross. They both claimed that since they were not parties they should have received their notices earlier, and the notices should have set out the evidence which was relied upon for the allegations of misconduct. Décary J.A. rejected Baxter Corporation's claim, holding that the company knew that it would be a likely subject of investigation and had deliberately chosen not to seek standing at the inquiry. Having taken this calculated risk, he stated, it must now bear the consequences. On the other hand, in light of the unique position of Craig Anhorn, he found that it was appropriate to quash the notices issued to him.

26 Finally, Décary J.A. turned to the submission that Commission counsel should be prohibited from participating in the final report because they had reviewed confidential documents which had not been disclosed to the other parties or the respondent. He seemed sympathetic to the appellants' claim, but held that it was premature, since the Commissioner had not stated any intention to rely on Commission counsel in the drafting of the final report. Décary J.A. cautioned that he did not think the Commissioner should seek advice from those of his counsel who knew of matters which he and the appellants did not.

27 Accordingly, he allowed the cross-appeal by Craig Anhorn, but dismissed all other appeals.

Issues

28

1. Did the Commissioner exceed his jurisdiction by the nature and extent of the allegations of misconduct set out in the notices?
2. If the Commissioner originally had such jurisdiction, did he lose it by failing to provide adequate procedural protections or by the timing of the release of the notices?
3. Should Commission counsel be prohibited from taking part in the drafting of the final report because of their receipt of confidential information not disclosed to the Commissioner or the other parties?
4. Should the appellant Baxter Corporation be treated differently from the other appellants?

Analysis

Did the Commissioner Exceed his Jurisdiction by the Nature and Extent of the Allegations of Misconduct Set Out in the Notices?

A. Introduction -- Commissions of Inquiry

29 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.

30 It may be of assistance to set out what was said regarding the history and role of commissions of inquiry in Phillips, supra, at pp. 137-38:

> As ad hoc bodies, commissions of inquiry are free of many of the institutional impediments which at times constrain the operation of the various branches of government. They are created as needed, although it is an unfortunate reality that their establishment is often prompted by tragedies such as industrial disasters, plane crashes, unexplained infant deaths, allegations of widespread child sexual abuse, or grave miscarriages of justice.
>
> At least three major studies on the topic have stressed the utility of public inquiries and recommended their retention: Law Reform Commission of Canada, Working Paper 17, Administrative Law: Commissions of Inquiry (1977); Ontario Law Reform Commission, Report on Public Inquiries (1992); and Alberta Law Reform Institute, Report No. 62, Proposals for the Reform of the Public Inquiries Act (1992). They have identified many benefits flowing from commissions of inquiry. Although the particular advantages of any given inquiry will depend upon the circumstances in which it is created and the powers it is given, it may be helpful to review some of the most common functions of commissions of inquiry.
>
> One of the primary functions of public inquiries is fact-finding. They are often convened, in the wake of public shock, horror, disillusionment, or scepticism, in order to uncover "the truth". Inquiries are, like the judiciary, independent; unlike the judiciary, they are often endowed with wide-ranging investigative powers. In following their mandates, commissions of inquiry are, ideally, free from partisan loyalties and better able than Parliament or the legislatures to take a long-term view of the problem presented. Cynics decry public inquiries as a means used by the government to postpone acting in circumstances which often call for speedy action. Yet, these inquiries can and do fulfil an important function in Canadian society. In times of public questioning, stress and concern they provide the means for Canadians to be apprised of the conditions pertaining to a worrisome community problem and to be a part of the recommendations that are aimed at resolving the problem. Both the status and high public respect for the commissioner and the open and public nature of the hearing help to restore public confidence not only in the institution or situation investigated but also in the process of government as a whole. They are an excellent means of informing and educating concerned members of the public.

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.

31 The inquiry's roles of investigation and education of the public are of great importance. Yet those roles should not be fulfilled at the expense of the denial of the rights of those being investigated. The need for the careful balancing was recognized by Décary J.A. when he stated at para. 32 "[t]he 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.

The Background of This Inquiry

32 The circumstances which gave rise to this Inquiry cannot be forgotten. The factual background underlines the importance of the Commission and places the hearings in their proper context. More than 1,000 Canadians became directly infected with HIV from blood and blood products in the early 1980s, and approximately 12,000 more were infected with and exposed to the dangers of Hepatitis C. These infections were caused by the very system Canadians rely upon to restore their health in times of illness or accident. It is a system which operates throughout the country. The Wilbee Report (Report of the Sub-Committee on Health Issues of the Standing Committee of the House of Commons on Health and Welfare, Social Affairs, Seniors and Status of Women, Tragedy and Challenge: Canada's Blood System and HIV (May 13, 1993)), a 1993 parliamentary study of the blood system, observed that every 20 seconds of every single day someone in Canada requires a blood transfusion. A great many Canadian families are touched in some way by the urgent and continuous need for blood and blood products. Clearly, the blood system is an essential part of Canada's health care system. The answers to questions as to how and why this vitally important system failed Canadians are crucial both to ensuring that this terrible tragedy never recurs and to restoring public confidence in our system of health care.

33 It is against that background that the assessment must be made of the jurisdiction of the Commissioner to issue notices indicating potential findings of misconduct against the appellants.

B. The Scope of a Commissioner's Power to Make Findings of Misconduct

34 A commission of inquiry is neither a criminal trial nor a civil action for the determination of liability. It cannot establish either 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. The nature of an inquiry and its limited consequences were correctly set out in Beno v. Canada (Commissioner and Chairperson,Commission of Inquiry into the Deployment of Canadian Forces to Somalia), [1997] 2 F.C. 527, at para. 23:

> A public inquiry is not equivalent to a civil or criminal trial. . . . In a trial, the judge sits as an adjudicator, and it is the responsibility of the parties alone to present the evidence. In an inquiry, the commissioners are endowed with wide-ranging investigative powers to fulfil their investigative mandate. . . . The rules of evidence and procedure are therefore considerably less strict for an inquiry than for a court. Judges determine rights as between parties; the Commission can only "inquire" and "report". . . . Judges may impose monetary or penal sanctions; the only potential consequence of an adverse finding . . . is that reputations could be tarnished.

Thus, although the findings of a commissioner may affect public opinion, they cannot have either penal or civil consequences. To put it another way, even if a commissioner's findings could possibly be seen as determinations of

responsibility by members of the public, they are not and cannot be findings of civil or criminal responsibility.

35 What then should be the result of the appellants' submission that a commissioner conducting a public inquiry does not have the jurisdiction to make findings that would be considered by reasonably informed members of the public to be a determination of criminal or civil liability? Since it is clear that a commissioner's findings cannot constitute findings of legal liability, it would appear that the appellants are asserting that in light of the potential harm to the reputations of parties or witnesses, a commissioner should not be permitted to allocate blame or assign responsibility for the events under scrutiny. While they acknowledge that a commissioner does have the authority to make findings of fact, they appear to challenge his ability to assess those facts or to evaluate what happened according to a standard of conduct. In order to demonstrate why this argument must be rejected it will be necessary to first look at the Inquiries Act, and then at decisions which have reviewed the jurisdiction and authority of other commissions of inquiry.

The Inquiries Act

36 The Inquiries Act provides for two types of investigations. The first is described in s. 2 of the Act. It provides that when the Governor in Council deems it appropriate, an inquiry may be held "concerning any matter connected with the good government of Canada or the conduct of any part of the public business" of the government. The second is described in s. 6 of the Act. It provides for the appointment of "a commissioner or commissioners to investigate and report on the state and management of the business . . . of [a] department" of government or "the conduct of any person in that service". It is this second type of inquiry that is more often specifically concerned with the conduct of individuals.

37 Justice Krever recognized from the outset that his inquiry was not to be directed at investigating misconduct of individuals, but rather was to be focused upon ensuring that there would be a safe, efficient and effective blood system in Canada. On November 22, 1993, he stated that:

> As I interpret the terms of reference, the focus of the inquiry is to determine whether Canada's blood supply is as safe as it could be and whether the blood system is sound enough that no future tragedy will occur. For those purposes it is essential to determine what caused or contributed to the contamination of the blood system in Canada in the early 1980's.

38 Section 13 of the Act makes it clear that commissioners have the power to make findings of misconduct. In order to do so, commissioners must also have the necessary authority to set out the facts upon which the findings of misconduct are based, even if those facts reflect adversely on some parties. If this were not so, the inquiry process would be essentially pointless. Inquiries would produce reports composed solely of recommendations for change, but there could be no factual findings to demonstrate why the changes were necessary. If an inquiry is to be useful in its roles of investigation, education and the making of recommendations, it must make findings of fact. It is these findings which will eventually lead to the recommendations which will seek to prevent the recurrence of future tragedies.

39 These findings of fact may well indicate those individuals and organizations which were at fault. Obviously, reputations will be affected. But damaged reputations may be the price which must be paid to ensure that if a tragedy such as that presented to the Commission in this case can be prevented, it will be. As Richard J. stated in the Federal Court Trial Division, at para. 71:

> The finding of facts, and in particular facts that reveal what went wrong or why a disaster occurred, can be an essential precondition to the making of useful, reliable recommendations to the government as to how to avoid a repetition of the events under review.

And as Décary J.A. put it in the Federal Court of Appeal, at para. 35:

> . . . a public inquiry into a tragedy would be quite pointless if it did not lead to identification of the causes and players for fear of harming reputations and because of the danger that certain findings of fact might be invoked in civil or criminal proceedings. It is almost inevitable that somewhere along the way, or in a final report, such an inquiry will tarnish reputations and raise questions in the public's mind concerning the responsibility borne by certain individuals. I doubt that it would be possible to meet the need for public inquiries whose aim is to shed light on a particular incident without in some way interfering with the reputations of the individuals involved.

I am in agreement with these observations. In my view, it is clear that commissioners must have the authority to make those findings of fact which are relevant to explain and support their recommendations even though they reflect adversely upon individuals.

40 The appellants do not appear to challenge the power of a commissioner to make findings of fact; their objection is to the commissioner's assessment of those facts. However, in my view, the power of commissioners to make findings of misconduct must encompass not only finding the facts, but also evaluating and interpreting them. This means that commissioners must be able to weigh the testimony of witnesses appearing before them and to make findings of credibility. This authority flows from the wording of s. 13 of the Act, which refers to a commissioner's jurisdiction to make findings of "misconduct". According to the Concise Oxford Dictionary (8th ed. 1990), misconduct is "improper or unprofessional behaviour" or "bad management". Without the power to evaluate and weigh testimony, it would be impossible for a commissioner to determine whether behaviour was "improper" as opposed to "proper", or what constituted "bad management" as opposed to "good management". The authority to make these evaluations of the facts established during an inquiry must, by necessary implication, be included in the authorization to make findings of misconduct contained in s. 13. Further, it simply would not make sense for the government to appoint a commissioner who necessarily becomes very knowledgeable about all aspects of the events under investigation, and then prevent the commissioner from relying upon this knowledge to make informed evaluations of the evidence presented.

41 The principal argument presented to prohibit commissioners from making findings which include evaluations of the conduct of individuals is that those findings may harm the reputations of the named parties. However, I am not convinced that a commissioner's evaluation of facts found to be unfavourable to a party will necessarily aggravate the damage caused to the reputation of the party by the unfavourable findings of fact standing by themselves. For example, suppose an inquiry made the following unfavourable factual findings:

> Company X learned by late summer or early fall 1984 that its manufacturing process for producing untreated factor concentrates was ineffective in destroying the causative agent of AIDS. A safer, viable process for producing heat-treated factor concentrates was available and in use. Company X did not withdraw its products produced by the ineffective and unsafe process.

Is the damage to the reputation of the party caused by these findings increased if the commissioner's evaluation of them is included, as in the following example?

> Company X learned by late summer or early fall 1984 that its manufacturing process for producing untreated factor concentrates was ineffective in destroying the causative agent of AIDS, and that a safer, viable process for producing heat-treated factor concentrates was available and in use. Despite its knowledge of the grave dangers to the public, Company X failed to withdraw those products produced by what it knew to be an ineffective and unsafe process. This was unacceptable conduct.

It cannot be said that there would be any real difference between the public's impression of Company X's conduct

if the findings were phrased in the second manner rather than the first. The harm to the company's reputation must result from setting out the factual findings. Since this is clearly within the commissioner's jurisdiction, I see no reason why the commissioner should be prevented from drawing the appropriate evaluations or conclusions which flow from those facts.

42 In addition, to limit a commissioner solely to findings of fact would require first the commissioner and, subsequently, the courts to wrestle with the difficult issue of distinguishing between fact and opinion. On my interpretation of the statute it is not necessary to consider that question. The wording of s. 13 by necessary inference authorizes a commissioner to make findings of fact and to reach conclusions based upon those facts, even if the findings and conclusions may adversely affect the reputation of individuals or corporations.

The Jurisprudence

43 The appellants contend that even if findings of misconduct are authorized by the Act, this power has been restricted by decisions of the courts. They argue that the judicial restriction is such that the authority cannot be exercised if the findings would appear in the eyes of the public to be determinations of liability. In support of their position, they rely on comments made by the Ontario Court of Appeal in Nelles, supra, which were favourably referred to by this Court in Starr v. Houlden, supra, at p. 1398. In Nelles, the court prohibited a provincially appointed commissioner from expressing his opinion as to whether the death of any child was the result of the action, accidental or otherwise, of any named persons. This restriction, the court held, flowed from the terms of the inquiry's authorizing order, which forbade the commissioner from expressing "any conclusion of law regarding civil or criminal responsibility" (p. 215). That provision stemmed from the concern that, in its absence, the inquiry would intrude upon the federal criminal law power. The Court of Appeal described this concern in these words at p. 220:

> . . . the fact that the findings or conclusions made by the commissioner are not binding or final in future proceedings is not determinative of what he will decide. What is important is that a finding or conclusion stated by the commissioner would be considered by the public as a determination and might well be seriously prejudicial if a person named by the commissioner as responsible for the deaths in the circumstances were to face such accusations in further proceedings. Of equal importance, if no charge is subsequently laid, a person found responsible by the commissioner would have no recourse to clear his or her name.

The appellants rely upon this statement to support their position that a commissioner cannot make findings which would appear in the eyes of the public to be determinations of legal liability.

44 I cannot accept this position. The test set out above is appropriate when dealing with commissions investigating a particular crime. However, it should not be applied to inquiries which are engaged in a wider investigation, such as that of the tragedy presented in this case. I agree with the Federal Court of Appeal that if the comments made in Nelles were taken as a legal principle of law applicable to every inquiry, the task of many if not most commissions of inquiry would be rendered impossible.

45 The decisions in Nelles and Starr are distinguishable from the case at bar. In Nelles, the court found that the purpose of the inquiry was to discover who had committed the specific crime of killing several babies at the Hospital for Sick Children in Toronto. By the time the case reached the Court of Appeal, one criminal prosecution for the deaths had failed and an extensive police investigation into the deaths was still continuing. When it established the commission, the government described it as an inquiry into deaths thought to have been the result of deliberate criminal acts. Further, the Attorney General had stated that if further evidence became available which would warrant the laying of additional charges, they would be laid and the parties vigorously prosecuted. The court clearly viewed the proceedings as tantamount to a preliminary inquiry into a specific crime. For the commissioner to have named the persons he considered responsible would, in those circumstances, have amounted to a clear attribution of criminal responsibility.

46 Starr can be similarly distinguished. The public inquiry in that case arose out of widely publicized allegations of conflict of interest and possible criminal activity by Patricia Starr and Tridel Corporation. The Order in Council establishing the inquiry named both Starr and Tridel and, without providing any requirement for making recommendations, mandated an investigation into their conduct in language virtually indistinguishable from the pertinent Criminal Code provisions. This Court concluded that the purpose of the inquiry was to conduct an investigation solely for the purpose of obtaining evidence, determining its sufficiency and deciding whether a prima facie criminal case had been established against either of the named parties. In the reasons, this observation was made at p. 1403:

> . . . there seems to be a complete absence of any broad, policy basis for the inquiry. This is not, for example, a commission of inquiry into the relationship of charities and public officials. There is no express mandate for the Commissioner to inquire into anything other than the specific allegations of the relationship between dealings by public officials with the two named individuals and any benefits that may have been conferred to the officials.

At page 1405, this conclusion was reached regarding the aim of the commission:

> There is nothing on the surface of the terms of reference or in the background facts leading up to the inquiry to convince me that it is designed to restore confidence in the integrity and institutions of government or to review the regime governing the conduct of public officials. Any such objectives are clearly incidental to the central feature of the inquiry, which is the investigation and the making of findings of fact in respect of named individuals in relation to a specific criminal offence.

The Court concluded that the inquiry was ultra vires the province.

47 Clearly, those two inquiries were unique. They dealt with specific incidents and specific individuals, during the course of criminal investigations. Their findings would inevitably reflect adversely on individuals or parties and could well be interpreted as findings of liability by some members of the public. In those circumstances, it was appropriate to adopt a strict test to protect those who might be the subject of criminal investigations. However, those commissions were very different from broad inquiries such as an investigation into the contamination of Canada's blood system, as presented in this case.

48 The strict test set out in Nelles has not been followed in other cases dealing with commissions of inquiry. In Phillips, supra, the Court refused, at para. 19, to suspend an inquiry which had the stated purpose of investigating the explosion at the Westray mine, including "(b) whether the occurrence was or was not preventable; (c) whether any neglect caused or contributed to the occurrence; . . . (f) whether there was compliance with applicable statutes, regulations, orders, rules, or directions. . . ."

49 In O'Hara, supra, an inquiry was upheld in circumstances where the commissioner was to report on whether a prisoner sustained injuries while detained in police custody, and if so, the extent of the injuries, the person or persons who inflicted them, and the reason they were inflicted. The Court made a distinction between inquiries aimed at answering broad policy questions and those with a predominantly criminal law purpose. The inquiry was upheld, despite the fact that it would inevitably lead to findings of misconduct against particular individuals, because it was not aimed at investigating a specific crime, but rather at the broad goal of ensuring the proper treatment by police officers of persons in custody.

50 Nor was a strict approach taken in the earlier case of Attorney General (Que.) and Keable v. Attorney General (Can.), [1979] 1 S.C.R. 218, at pp. 226-27, where this Court upheld an inquiry into "the conduct of all persons involved in . . . [an] illegal entry made during January 1973 . . . setting fire to a farm . . .[and] theft of dynamite".

51 Clearly, the findings that may be made in Phillips and that were made in O'Hara and Keable would fail the strict test set out in Nelles and referred to in Starr. Yet each of these commissioners has made or may make findings of misconduct, as authorized by the Act. This they could not and cannot do without stating findings of fact that are likely to have an adverse effect on the reputation of individuals. Nonetheless, the inquiries were upheld by this Court. It follows that the strict test advanced by the appellants cannot be of general application. A more flexible approach must be taken in cases where inquiries are general in nature, and are established for a valid public purpose and not as a means of furthering a criminal investigation.

What Can be Included in a Commissioner's Report?

52 What then can commissioners include in their reports? The primary role, indeed the raison d'être, of an inquiry investigating a matter is to make findings of fact. In order to do so, the commissioner may have to assess and make findings as to the credibility of witnesses. From the findings of fact the commissioner may draw appropriate conclusions as to whether there has been misconduct and who appears to be responsible for it. However, the conclusions of a commissioner should not duplicate the wording of the Code defining a specific offence. If this were done it could be taken that a commissioner was finding a person guilty of a crime. This might well indicate that the commission was, in reality, a criminal investigation carried out under the guise of a commission of inquiry. Similarly, commissioners should endeavour to avoid making evaluations of their findings of fact in terms that are the same as those used by courts to express findings of civil liability. As well, efforts should be made to avoid language that is so equivocal that it appears to be a finding of civil or criminal liability. Despite these words of caution, however, commissioners should not be expected to perform linguistic contortions to avoid language that might conceivably be interpreted as importing a legal finding.

53 Findings of misconduct should not be the principal focus of this kind of public inquiry. Rather, they should be made only in those circumstances where they are required to carry out the mandate of the inquiry. A public inquiry was never intended to be used as a means of finding criminal or civil liability. No matter how carefully the inquiry hearings are conducted they cannot provide the evidentiary or procedural safeguards which prevail at a trial. Indeed, the very relaxation of the evidentiary rules which is so common to inquiries makes it readily apparent that findings of criminal or civil liability not only should not be made, they cannot be made.

54 Perhaps commissions of inquiry should preface their reports with the notice that the findings of fact and conclusions they contain cannot be taken as findings of criminal or civil liability. A commissioner could emphasize that the rules of evidence and the procedure adopted at the inquiry are very different from those of the courts. Therefore, findings of fact reached in an inquiry may not necessarily be the same as those which would be reached in a court. This may help ensure that the public understands what the findings of a commissioner are -- and what they are not.

The Need for Procedural Fairness

55 The findings of fact and the conclusions of the commissioner may well have an adverse effect upon a witness or a party to the inquiry. Yet they must be made in order to define the nature of and responsibility for the tragedy under investigation and to make the helpful suggestions needed to rectify the problem. It is true that the findings of a commissioner cannot result in either penal or civil consequences for a witness. Further, every witness enjoys the protection of the Canada Evidence Act and the Charter which ensures that the evidence given cannot be used in other proceedings against the witness. Nonetheless, procedural fairness is essential for the findings of commissions may damage the reputation of a witness. For most, a good reputation is their most highly prized attribute. It follows that it is essential that procedural fairness be demonstrated in the hearings of the commission.

Fairness in Notices

56 That same principle of fairness must be extended to the notices pertaining to misconduct required by s. 13 of

the Inquiries Act. A commission is required to give parties a notice warning of potential findings of misconduct which may be made against them in the final report. As long as the notices are issued in confidence to the party receiving them, they should not be subject to as strict a degree of scrutiny as the formal findings. This is because the purpose of issuing notices is to allow parties to prepare for or respond to any possible findings of misconduct which may be made against them. The more detail included in the notice, the greater the assistance it will be to the party. In addition, the only harm which could be caused by the issuing of detailed notices would be to a party's reputation. But so long as notices are released only to the party against whom the finding may be made, this cannot be an issue. The only way the public could find out about the alleged misconduct is if the party receiving the notice chose to make it public, and thus any harm to reputation would be of its own doing. Therefore, in fairness to witnesses or parties who may be the subject of findings of misconduct, the notices should be as detailed as possible. Even if the content of the notice appears to amount to a finding that would exceed the jurisdiction of the commissioner, that does not mean that the final, publicized findings will do so. It must be assumed, unless the final report demonstrates otherwise, that commissioners will not exceed their jurisdiction.

Summary

57 Perhaps the basic principles applicable to inquiries held pursuant to Part I of the Act may be summarized in an overly simplified manner in this way:

(a) (i) a commission of inquiry is not a court or tribunal, and has no authority to determine legal liability;

(ii) a commission of inquiry does not necessarily follow the same laws of evidence or procedure that a court or tribunal would observe.

(iii) It follows from (i) and (ii) above that a commissioner should endeavour to avoid setting out conclusions that are couched in the specific language of criminal culpability or civil liability. Otherwise the public perception may be that specific findings of criminal or civil liability have been made.

(b) a commissioner has the power to make all relevant findings of fact necessary to explain or support the recommendations, even if these findings reflect adversely upon individuals;

(c) a commissioner may make findings of misconduct based on the factual findings, provided that they are necessary to fulfill the purpose of the inquiry as it is described in the terms of reference;

(d) a commissioner may make a finding that there has been a failure to comply with a certain standard of conduct, so long as it is clear that the standard is not a legally binding one such that the finding amounts to a conclusion of law pertaining to criminal or civil liability;

(e) a commissioner must ensure that there is procedural fairness in the conduct of the inquiry.

C. Application of the Principles to the Case at Bar

58 It must be remembered that in this case, the challenge brought by the appellants was triggered not by any findings of the Commission but by the s. 13 notices. Therefore, these reasons are not concerned with any challenge to the contents of the commission report or any specific findings. It will also be remembered that the Commissioner very properly stated that he would not be making findings of civil or criminal responsibility. In the interests of fairness to the parties and witnesses, the Commissioner must be bound by these statements and I am certain he will honour them. It follows that it is not appropriate in these reasons to deal with the ultimate scope of the findings that a commissioner might make in a report. The resolution of this issue will so often be governed by

the nature and wording of the mandate of the commissioner and will have to be decided on that basis in each case.

59 The question then is whether the Commissioner exceeded his jurisdiction in the notices delivered to the appellants; I think not. The potential findings of misconduct cover areas that were within the Commissioner's responsibility to investigate. The mandate of the Inquiry was extremely broad, requiring the Commissioner to review and report on "the events surrounding the contamination of the blood system in Canada in the early 1980s, by examining . . . the organization and effectiveness of past and current systems designed to supply blood and blood products in Canada". This must encompass a review of the conduct and practices of the institutions and persons responsible for the blood system. The content of the notices does not indicate that the Commissioner investigated or contemplated reporting on areas that were outside his mandate.

60 If the Commissioner's report had made findings worded in the same manner as the notices, then further consideration might have been warranted. However, the appellants launched this application before the Commissioner's findings had been released. Therefore, it is impossible to say what findings he will make or how they will be framed. Quite simply the appellants have launched their challenge prematurely. As a general rule, a challenge such as this should not be brought before the publication of the report, unless there are reasonable grounds to believe that the Commissioner is likely to exceed his or her jurisdiction.

61 Even if it could be said that the challenge was not premature, the notices are not objectionable. They indicated that there was a possibility that the Commissioner would make certain findings of fact which might amount to misconduct. While they are not all worded in the same manner, the reproduction of some of them may help illustrate the basis for this conclusion. Many of the doctors and the Red Cross received notice of a general allegation that they:

> . . . failed adequately to oversee, direct and provide resources for the operation of the Blood Transfusion Service (BTS) and Blood Donor Recruitment (BDR) at both the national and local level, and as a result contributed to and are responsible for the failures set out below. . . .

This was followed by a series of specific allegations, such as the following:

> Red Cross
>
> 5. The CRC failed to implement in a timely manner, during January 13 - March 10, 1983, any national donor-screening measures to reduce the risk of transfusion-associated AIDS, this failure causing unnecessary cases of transfusion-associated HIV infection and AIDS to occur.

The notice served on the appellant Baxter contained only one allegation:

> 1. After becoming aware in 1982 and thereafter of the possibility or likelihood that its factor concentrates transmitted the causative agent of AIDS, Baxter failed to take adequate steps to notify consumers and physicians of the risks associated with the use of its products and to advise that they consider alternative therapies.

It will be remembered that the Commissioner, from the outset of the Inquiry, wisely emphasized that he did not have the intention or the authority to make any legal determinations. Rather, his stated goal was to examine what went wrong with the blood system in the 1980s and to assess ways of resolving the problems in order to protect the blood system in the future. Thus, it was clear from the beginning that his findings would have nothing to do with criminal or civil liability.

62 Further, while many of the notices come close to alleging all the necessary elements of civil liability, none of them appears to exceed the Commissioner's jurisdiction. For example, if his factual findings led him to conclude

that the Red Cross and its doctors failed to supervise adequately the Blood Transfusion Service and Blood Donor Recruitment, it would be appropriate and within his mandate to reach that conclusion. Some of the appellants object to the use of the word "failure" in the notices; I do not share their concern. As the Court of Appeal pointed out, there are many different types of normative standards, including moral, scientific and professional-ethical. To state that a person "failed" to do something that should have been done does not necessarily mean that the person breached a criminal or civil standard of conduct. The same is true of the word "responsible". Unless there is something more to indicate that the recipient of the notice is legally responsible, there is no reason why this should be presumed. It was noted in Rocois Construction Inc. v. Québec Ready Mix Inc., [1990] 2 S.C.R. 440, at p. 455:

> A fact taken by itself apart from any notion of legal obligations has no meaning in itself and cannot be a cause; it only becomes a legal fact when it is characterized in accordance with some rule of law. The same body of facts may well be characterized in a number of ways and give rise to completely separate causes. . . .
>
> [I]t is by the intellectual exercise of characterization, of the linking of the fact and the law, that the cause is revealed.

While the Court in Rocois was concerned only with facts, I believe the same principle can be applied to conclusions of fault based on standards of conduct. Unless there is something to show that the standard applied is a legal one, no conclusion of law can be said to have been reached.

63 There are phrases which, if used, might indicate a legal standard had been applied, such as a finding that someone "breached a duty of care", engaged in a "conspiracy", or was guilty of "criminal negligence". None of these words has been used by the Commissioner. The potential findings as set out in the notices may imply civil liability, but the Commissioner has stated that he will not make a finding of legal liability, and I am sure he will not. In my view, no error was made by the Commissioner in sending out these notices.

> If the Commissioner Originally had such Jurisdiction, did he Lose it by Failing to Provide Adequate Procedural Protections or by the Timing of the Release of the Notices?
>
> a. Procedural Protections

64 The appellants argue that they did not have the benefit of adequate procedural protections. As a result, they contend that the Commissioner has lost the authority to make the type of findings which are referred to in the notices. They submit that they interpreted comments made by the Commissioner during the Inquiry as assurances that he had no intention of making the type of findings suggested by the notices. If these assurances had not been given the appellants say that they would have insisted upon tighter evidentiary procedures, greater ability to cross-examine, and other procedural protections.

65 Yet the three corporate appellants were not uninformed bystanders. Rather, they had detailed and intimate knowledge of the blood system, of the terrible tragedy resulting from its contamination with HIV, and of the public outcry and investigation which followed. The Canadian Red Cross Society and Bayer Inc. participated in the proceedings of the Inquiry. As a result it is difficult to accept that they could have been surprised by the fact that the notices were critical. In fact, the prospect of the Commissioner's ultimately making findings adverse to a witness was specifically raised by counsel for the Red Cross during discussions among counsel in November 1993 concerning the procedural rules. In response, counsel for the Commission referred to s. 13 of the Act and indicated that a notice would have to be provided to any party who might face an adverse finding. No concern about the procedure was raised at that time. The third corporate appellant, Baxter Corporation, was not involved in the meeting and was not a party at the Inquiry. However, it knew about the Inquiry and its goals, and participated by offering witnesses and entering documentary evidence.

66 The position of the intervener the Canadian Hemophilia Society is both illuminating and helpful on this point. Like the appellants, the Society received a notice of a potential finding of misconduct. The Society was a party to the Inquiry, and accepted and adapted to the same procedures as the appellants. However, unlike the appellants, it continues to support the Commissioner's right to make findings of misconduct. The Society submitted and confirmed that the practices and procedures adopted at the Inquiry were, in light of its mandate, fair and appropriate. As well, it emphasized that it knew from the outset of the Inquiry that there was a risk that the Commissioner would make findings of misconduct against the group as a result of its involvement in the Canadian blood system.

67 Significantly, the procedural protections offered to parties to the Inquiry and to individual witnesses were extensive and exemplary. The Commission, with the full consent of the parties, offered a commendably wide range of protections. For example;

> all parties with standing and all witness appearing before the Inquiry had the right to counsel, both at the Inquiry and during their pre-testimony interviews;
>
> each party had the right to have its counsel cross-examine any witness who testified, and counsel for a witness who did not have standing was afforded the right to examine that witness;
>
> all parties had the right to apply to the Commissioner to have any witness called whom Commission counsel had elected not to call;
>
> all parties had the right to receive copies of all documents entered into evidence and the right to introduce their own documentary evidence;
>
> all hearings would be held in public unless application was made to preserve the confidentiality of information; and
>
> although evidence could be received by the Commissioner that might not be admissible in a court of law, the Commissioner would be mindful of the dangers of such evidence and, in particular, its possible effect on reputation.

These procedures were adopted on a consensual basis, after a meeting with all parties to determine which protections would be required. I am not sure what further protections the appellants could have realistically expected. The procedure adopted was eminently fair and any objections to it must be rejected. Nor can I accept that the appellants could have been misled or that they suffered prejudice as a result of any "misunderstanding" about the type of findings which would be made by the Commissioner. That submission as well must be rejected.

b. Timing of the Notices

68 The appellants submit that because the Commissioner waited until the last day of hearings to issue notices identifying potential findings of misconduct which might be made against them, their ability to cross-examine witnesses effectively and present evidence was compromised. They submit that there is no longer any opportunity to cure the prejudice caused by the late delivery of the notices, and that they must therefore be quashed. For the following reasons, I must disagree.

69 There is no statutory requirement that the commissioner give notice as soon as he or she foresees the possibility of an allegation of misconduct. While I appreciate that it might be helpful for parties to know in advance the findings of misconduct which may be made against them, the nature of an inquiry will often make this impossible. Broad inquiries are not focussed on individuals or whether they committed a crime; rather they are

concerned with institutions and systems and how to improve them. It follows that in such inquiries there is no need to present individuals taking part in the inquiry with the particulars of a "case to meet" or notice of the charges against them, as there would be in criminal proceedings. Although the notices should be given as soon as it is feasible, it is unreasonable to insist that the notice of misconduct must always be given early. There will be some inquiries, such as this one, where the Commissioner cannot know what the findings may be until the end or very late in the process. So long as adequate time is given to the recipients of the notices to allow them to call the evidence and make the submissions they deem necessary, the late delivery of notices will not constitute unfair procedure.

70 The timing of notices will always depend upon the circumstances. Where the evidence is extensive and complex, it may be impossible to give the notices before the end of the hearings. In other situations, where the issue is more straightforward, it may be possible to give notice of potential findings of misconduct early in the process. In this case, where there was an enormous amount of information gathered over the course of the hearings, it was within the discretion of the Commissioner to issue notices when he did. As Décary J.A. put it at para. 79:

> . . . the Commissioner enjoys considerable latitude, and is thereby permitted to use the method best suited to the needs of his inquiry. I see no objection in principle to a commissioner waiting until the end of the hearings, when he or she has all the information that is required, to give notices, rather than taking a day to day approach to it, with the uncertainty and inconvenience that this might involve.

In light of the nature and purposes of this Inquiry, it was impossible to give adequate detail in the notices before all the evidence had been heard. In the context of this Inquiry the timing of the notices was not unfair.

71 Further, the appellants were given an adequate opportunity to respond to the notices, and to adduce additional evidence, if they deemed it necessary. The notices were delivered on December 21, 1995, and parties were initially given until January 10, 1996 to decide whether and how they would respond. This period was then extended following requests from the parties. The time permitted for the response was adequate. It cannot be said that the timing of the delivery of the notices amounted to a violation of procedural fairness.

> Should Commission Counsel be Prohibited from Taking Part in the Drafting of the Final Report Because of their Receipt of Confidential Information not Disclosed to the Commissioner or the Other Parties?

72 The appellant Red Cross Society argues that because Commission counsel received confidential documents concerning allegations against the appellants, they should be forbidden from taking part in the drafting of the report. This argument too is premature, because there is no indication that the Commissioner intends to rely upon his counsel to draft the final report. In addition, it is not clear from the record what was contained in the confidential submissions reviewed by counsel. If the submissions were composed merely of suggested allegations, then I do not believe that there is any merit to this complaint. However, in the unlikely event that the submissions also included material that was not disclosed to the parties, there could well be valid cause for concern. As Décary J.A. put it at para. 103:

> The method adopted at the very end of the hearings for inviting submissions from the parties was particularly dangerous in that it opened the door to the possibility that a person in respect of whom unfavourable findings of fact would be made in the final report might not have had knowledge of all of the evidence relating to that person.

If the submissions did contain new, undisclosed and untested evidence, the Commissioner should not seek advice regarding the report from counsel who received the confidential submissions.

Should the Appellant Baxter Corporation be Treated Differently From the Other Appellants?

73 The appellant Baxter Corporation argued that it should be treated differently from the other appellants because it was not a party before the Inquiry and was therefore unrepresented during the hearings. It submits that its position is analogous to that of Craig Anhorn, whose notice was quashed by the Court of Appeal because he took part in the Inquiry without realizing that he was a potential target of the investigation.

74 The Court of Appeal dismissed this argument, holding that Baxter Corporation's name had appeared in the Wilbee Report which preceded and prompted this Inquiry, and that it must therefore have realized that its conduct would be under scrutiny in the proceedings. Baxter Corporation, it held, took a calculated risk and elected not to seek standing before the Commission. It should not now be allowed to escape the consequences of that decision.

75 I agree with this conclusion. I believe that a private individual such as Craig Anhorn is in a very different situation from that of a large corporation which must have known from the outset what was at stake in the Inquiry, and made a calculated decision not to participate. I do not believe that Baxter Corporation should be treated any differently than the other appellants and would dismiss this ground of appeal.

Disposition

76 I would dismiss this appeal.

cp/d/hbb/DRS/DRS