*INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO*

***In the matter of the Public Inquires 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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**FACTUM OF DR. CHARLES SMITH**

**(Motion for Leave to be Examined in Chief by his Own Counsel)**

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# PART I—OVERVIEW

1. This motion, brought pursuant to Rule 34 of the Inquiry's Rules of Procedure, seeks an Order granting counsel for Dr. Charles Smith ("Dr. Smith") leave to examine Dr. Smith in chief when he testifies at the Inquiry, commencing January 28, 2008.

2. Dr. Smith submits that the relief sought is appropriate and just for the following reasons which will be more fully elaborated below:

(a) The order sought will grant Dr. Smith the full procedural protection he is entitled due to the very real risk of reputational harm to which he is exposed.

(b) The order sought will enable the Inquiry to obtain the fullest evidentiary foundation from which to make systemic recommendations; and

(c) The order sought is expressly contemplated by Rule 34 of the Inquiry's Rules of Procedure.

# PART II—THE FACTS

3. On or about June 7, 2005, Dr. McLellan, the Chief Coroner of Ontario, announced a Review of 40 criminally suspicious and homicide cases (later increased to 45) dating back to 1988 in which Dr. Smith had either performed the post mortem examination or provided an opinion in consultation.

4. The Review was not a review of all pediatric death investigations; nor was it a Review to determine whether policy and procedures could strengthen the Coroner's system in Ontario. Rather, the Review was expressly to determine "whether the conclusions reached *by Dr. Smith* in his autopsy or consultation reports, or during his testimony could be supported by the information and materials available for independent review." [emphasis added]

**Reference:** Office of the Chief Coroner for Ontario, "Backgrounder: Public Announcement of Review of Criminally Suspicious and Homicide Cases where Dr. Charles Smith conducted Autopsies or Provided Opinions", April 19, 2007, Applicant's Motion Record, Tab 2.

5. Media coverage at the time focused on Dr. Smith's work in particular cases and described Dr. Smith as the subject of "controversy", suggested Dr. Smith was incompetent or negligent, that his handling of autopsies may have led to wrongful convictions and that some argued that "many people have at least been 'wrongly charged', if not wrongly convicted."

**Reference:** "Troubling Evidence", *Toronto Star*, June 9, 2005, A20, Applicant's Motion Record, Tab 3

Natalie Alcoba, "Coroner to review autopsies by pathologist at Sick Kids: Findings in child homicide cases questioned", *National Post*, June 9, 2005, A8, Applicant's Motion Record, Tab 3

Kirk Makin, "Ontario orders pathologist's work reviewed: Experts to look at pediatric investigations done by doctor accused of bungling cases", *Globe and Mail*, June 8, 2005, A8, Applicant's Motion Record, Tab 3.

6. On April 19, 2007, the Office of the Chief Coroner announced the results of its "Review of Criminally Suspicious and Homicide Cases where Dr. Charles Smith Conducted Autopsies or Provided Opinions." The Office of the Chief Coroner revealed that in 20 of the 45 cases, the reviewers "had some issue with the opinion of Dr. Smith that appeared in a written report, testimony in Court or both."

7. Moreover, the Chief Coroner advised that there were "restrictions of liberty arising from findings of guilt, including 12 convictions and one finding of Not Criminally Responsible, in 13 of these cases where the reviewers did not agree with significant facts or with the interpretation of the examinations conducted."

8. The Chief Coroner acknowledged the "public concern" that might exist because of the review results.

**Reference:** Office of the Chief Coroner of Ontario, "Backgrounder: Public Announcement of Review of Criminally Suspicious and Homicide Cases where Dr. Charles Smith Conducted Autopsies or Provided Opinions", *supra.*

9. Despite the absence of any indication in the Backgrounder that Dr. Smith had "erred" in his work, or that he had engaged in any misconduct, subsequent media coverage of the Backgrounder described a "revelation of errors" in Dr. Smith's work. Moreover, because the Office of the Chief Coroner advised that some of the cases in which concerns were identified had resulted in convictions, the public perception created by the media coverage was that Dr. Smith's "errors" had directly resulted in miscarriages of justice.

**Reference:** Kirk Makin, "Autopsy Review Sparks Wider Probe: All MD's cases that pointed to foul play are now under scrutiny", *Globe and Mail*, April 20, 2007, A1, Applicant's Motion Record, Tab 4

Petti Fong, "B.C. to review pathologist's cases; Concern follows Ontario report on errors in Smith's work", *The Toronto Star*, April 21, 2007, A1, Applicant's Motion Record, Tab 4

April Lindgren, "13 cases of pathologist troubling; Results of investigation; 'Potential miscarriages of justice'", *National Post*, April 20, 2007, A8, Applicant's Motion Record, Tab 4

"A pathologist's trail", *Globe and Mail*, April 21, 2007, A22, Applicant's Motion Record, Tab 4.

10. The prejudicial effect of such coverage was accentuated by public statements by government officials to the effect that "something went terribly wrong", and that miscarriages of justice "may very well" have resulted and that it was an "unspeakable tragedy".

**Reference:** April Lindgren and Shannon Kari, "McGuinty orders inquiry into coroner's cases; Wrongful convictions feared", *National Post*, April 21, 2007, A5, Applicant's Motion Record, Tab 4

Kirk Makin, "Autopsy Review Sparks Wider Probe: All MD's cases that pointed to foul play are now under scrutiny", *supra*

Petti Fong, "B.C. to review pathologist's cases; Concern follows Ontario report on errors in Smith's work", *supra*.

11. Thereafter, on April 25, 2007, the Ministry of the Attorney General announced a Public Inquiry into Pediatric Forensic Pathology in Ontario. The Ministry of the Attorney General's news release announcing the appointment of the Commissioner described the Inquiry as being formed "in the wake of the Chief Coroner's review into the work of Dr. Smith." Moreover, the Attorney General of Ontario was quoted saying "We must get to the bottom of what happened and ensure that *nothing like this* happens again." [emphasis added]

**Reference:** Ministry of the Attorney General, News Release, "McGuinty Government Names Commissioner of Public Inquiry into Oversight of Ontario's Pediatric Forensic Pathology System", April 25, 2007, Applicant's Motion Record, Tab 5.

12. Likewise, the preamble to the Order-in-Council establishing the Inquiry includes repeated statements connecting the work of Dr. Smith to the mandate of the Inquiry:

> 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. Smith* performed the autopsy or was consulted ... 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; ... [emphasis added]

**Reference:** Order-in-Council 826/2007, Applicant's Motion Record, Tab 5.

13. Subsequent media coverage of these announcements was highly prejudicial, referring to "errors" in Dr. Smith's work, to Dr. Smith himself as an "error prone pathologist", and questioning whether his work was "reckless" or "inept".

**Reference:** Kirk Makin et al., "Ontario Judge to Look into Pathologist's Work", *Globe and Mail*, April 26, 2007, A13, Applicant's Motion Record, Tab 6

Kirk Makin, "Pathologist was viewed as star in his field", *Globe and Mail*, April 25, 2007, A7, Applicant's Motion Record, Tab 6

April Lindgren and Shannon Kari, "Judge to head probe into faulty forensics; Dr. Charles Smith", *National Post*, April 26, 2007, A11, Applicant's Motion Record, Tab 6

Robert Benzie, "Judge heads pathologist investigation", *The Toronto Star*, April 26, 2007, A8, Applicant's Motion Record, Tab 6.

14. The Commissioner's Opening Statements at the outset of the Inquiry reiterated several aspects of the Order-in-Council connecting the work of Dr. Smith to the Inquiry. The Commissioner referred to "flawed pathology findings" and "errors in specific cases". He also noted that the Chief Coroner had referred concerns about Dr. Smith to the College of Physicians and Surgeons of Ontario.

**Reference:** Opening Statement by Commissioner Goudge, June 18, 2007, p. 13, Applicant's Motion Record, Tab 7.

15. As in the case of previous public coverage, media reporting of the Commissioner's statement was highly adverse to Dr. Smith, referring to his autopsy work as "botched", and to Dr. Smith as a "discredited" or "disgraced pathologist at the heart of the affair." In one article, families of the deceased children were said to have been "victimized in the Smith cases".

**Reference:** Kirk Makin, "Inquiry sets sights on root causes of flawed autopsies", *Globe and Mail*, June 19, 2007, A8, Applicant's Motion Record, Tab 8

Canadian Press, "Inquiry head to meet with people affected by pathologist", June 18, 2007, Applicant's Motion Record, Tab 8.

16. On August 17, 2007, the Commissioner granted Dr. Smith standing at the Inquiry. His reasons were brief, implicitly acknowledging the centrality of Dr. Smith's role in pediatric forensic pathology in Ontario during the material time and the fact that the entire Inquiry arose out of concerns about Dr. Smith's work:

> Dr. Smith was the Director of the OPFU at HSC between 1992 and 2001. It was the OCCO review of cases of suspicious child deaths in which Dr. Smith performed the autopsy or was consulted that led directly to this Commission. There can be no doubt that he has a substantial and direct interest that warrants standing.

**Reference:** Inquiry into Pediatric Forensic Pathology in Ontario, Ruling on Standing and Funding, August 17, 2007, p. 6, Applicant's Motion Record, Tab 9.

17. By letter dated October 11, 2007, counsel for Dr. Smith advised Commission counsel that Dr. Smith would attend voluntarily to give evidence at the Inquiry, was available at the proposed time, and that his evidence should be led by his own counsel.

**Reference:** Letter from Niels Ortved to Linda Rothstein, October 11, 2007, Applicant's Motion Record, Tab 10.

18. Dr. Smith subsequently received a Summons to Witness from the Commissioner dated October 22, 2007, requiring him to appear and give evidence before the Inquiry on Monday, January 28, 2008, "and so from day to day until the inquiry is concluded or the Commission otherwise orders."

**Reference:** Inquiry into Pediatric Forensic Pathology in Ontario, Summons to Witness, October 22, 2007, Applicant's Motion Record, Tab 11.

# PART III—LAW & ARGUMENT

## A. DR. SMITH DESERVES PROCEDURAL FAIRNESS

19. In light of the aforementioned sequence of events giving rise to the establishment of this Commission, it is inevitable that, despite its systemic mandate, the Commission will examine subject-matter, hear testimony, review documents, and draw conclusions that will significantly impact on the reputation of Dr. Smith.

20. The harm to Dr. Smith's reputation arises not just from potentially adverse findings that may be drawn by the Inquiry, but from wide public coverage of allegations made in the course of the Inquiry (or inferred from Inquiry evidence or testimony) that impugn Dr. Smith both personally and professionally.

21. To date, it is fair to suggest that Dr. Smith has been the subject of intense media criticism, much of which has prejudged many of the issues that will be examined at the Inquiry.

22. In this context, it is fair and appropriate that Dr. Smith be enabled to offer a comprehensive account of his perspective and involvement in the subject matter of the Inquiry, aided by his own counsel, before facing examination that may further undermine his professional competence and integrity. This is especially so when account is taken of the anticipated breadth and complexity of Dr. Smith's evidence.

23. The Court of Appeal for Ontario has confirmed that examination in chief by one's own counsel is a critical element of a party's right to defend his or her credibility and reputation during an inquiry. In *Re Public Inquiries Act and Shulman*, the Court stated that where an inquiry directed at investigating alleged misconduct in the provincial Coroner's system gave rise to the potential for a party to be "discredited in the eyes of the public", a party should be entitled to be examined in chief by his own counsel:

> [A]ny person affected by allegations made before the learned Commissioner should be accorded the privilege of examination as a witness by his own counsel and should be subject to a right of cross examination, not only by counsel for the Commission but by any person affected by the evidence of that witness.
>
> **Reference:** *Re Public Inquiries Act and Shulman*, [1967] 2 O.R. 375 at 378 [*Shulman*].

24. The principle from *Shulman* is applicable to the proceedings of modern public inquiries regardless of whether those inquiries are specifically oriented to investigating allegations of individual misconduct. Indeed, the *Royal Commission Inquiry into Civil Rights* recommends, without qualification as to type of inquiry, that where allegations of misconduct are raised against a party in an inquiry, the party should be entitled to examination in chief by his or her own counsel:

> Any person against whom allegations of misconduct have been made should have the right to be examined by his own counsel before he is examined by the Commission counsel.

**Reference:** Ontario, *Royal Commission Inquiry into Civil Rights*, Report No. 1, vol. 1, (Toronto: Queen's Printer, 1968) at 452.

25. Similarly, in *Gosselin v. Ontario (Royal Commission of Inquiry into Certain Deaths at the Hospital for Sick Children)*, the Divisional Court treated the entitlement to examination in chief by one's own counsel as an "aspect" of standing before an inquiry:

> The *Shulman* case was one in which the person who was held to be entitled to the privilege of examination in chief by his own counsel in giving evidence, *which is one of the aspects of "standing"*, was a person who was in jeopardy of being discredited in the eyes of the public if certain findings were made by the commissioner. [emphasis added]

**Reference:** *Gosselin v. Ontario (Royal Commission of Inquiry into Certain Deaths at the Hospital for Sick Children)* (1984), 4 O.A.C. 242 at 248.

26. The Federal Court in *Canada (A.G.) v. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission)* held that inquiries convened to examine possible wrongdoing or misconduct have been required to observe a common law duty of procedural fairness encompassing the right to examination in chief by one's own counsel.

**Reference:** *Canada (A.G.) v. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission)*, [1996] F.C.J. No. 864 (F.C.T.D.) at para. 133 (QL), aff'd [1997] F.C.J. No. 17 (F.C.A.), [1997] S.C.J. No. 83 (S.C.C.).

27. Significantly, the same right was granted by the Commission in the Krever Inquiry. As that Inquiry was not directed to investigating specific allegations of misconduct, but to more systemic issues, its recognition of the right to examination in chief by one's own counsel demonstrates that the right is applicable to systemic inquiries which may nevertheless adversely affect individual

reputation. This accords with the Supreme Court's reasoning that "procedural fairness is essential for the findings of commissions may damage the reputation of a witness."

**Reference:** *Canada (A.G.) v. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission)*, [1997] S.C.J. No. 83 at para. 55 (QL).

28. That the right to address allegations of misconduct is a fundamental aspect of procedural fairness is underscored by the Court of Appeal in *Re the Ontario Crime Commission*:

> In the present inquiry, allegations of a very grave character have been made against the applicants, imputing to them the commission of very serious crimes. *It is true that they are not being tried by the Commissioner, but their alleged misconduct has come under the full glare of publicity, and it is only fair that they should be afforded an opportunity to call evidence, to elicit facts by examination and cross-examination of witnesses and thus be enabled to place before the commission of inquiry a complete picture rather than incur the risk of its obtaining only a partial or distorted one.* This is a right to which they are, in my view, fairly and reasonably entitled and it should not be denied them. [emphasis added]

**Reference:** *Re the Ontario Crime Commission, Ex parte Feeley and McDermott*, [1962] O.R. 873 at 896.

## B. THE ORDER REQUESTED WILL ENABLE THE FULLEST EVIDENTIARY FOUNDATION

29. There is no dispute that Dr. Smith was at the centre of the Coroner's system of pediatric death investigations in Ontario between 1991-2000. Obviously, Dr. Smith will have critical insight into the death investigations in the cases that have formed the impetus of this Inquiry.

30. However, Dr. Smith's evidence will not be limited to case-specific insight. Dr. Smith:

(a) conducted or was consulted in the majority of all Ontario pediatric post mortems in criminally suspicious circumstances between 1991 and 2001 and a significant number between 1981 and 1991;

(b) was the Director of the Ontario Pediatric Forensic Pathology Unit ("OPFU") at the Hospital for Sick Children from the date it was established by the Minister of the Solicitor General in 1991 until 2001;

(c) was a member of the Coroner's Pediatric Death Review Committee from 1987 until 2001 and both the Death under Two and Death under Five Committees; and

(d) was involved in the development of various protocols related to pediatric forensic pathology during the material time.

31. Given the centrality of his role to pediatric forensic pathology in Ontario, it is anticipated that Dr. Smith will have evidence related to:

(a) the evolution and limitation of pediatric forensic pathology as a science;

(b) the training and education available in pediatric forensic pathology;

(c) interactions between the key institutions and individuals involved in all pediatric death investigations: other medical professionals, the police, the local and regional Coroners, the Office of the Chief Coroner, Crown Attorneys, Defence counsel and regional Children's Aid Societies;

(d) the evolution of pediatric death investigation procedures and protocols in Ontario;

(e) the interaction between the OPFU and the Office of the Chief Coroner; and

(f) quality control measures in place within the OPFU and the Office of the Chief Coroner.

32. Unlike any other witness who will give evidence during the Inquiry, Dr. Smith has direct evidence on most systemic issues, as well as direct involvement in each of the cases forming the basis of the Inquiry. The breadth and complexity of his evidence is such that counsel for Dr. Smith is in the best position to assist Dr. Smith in providing the Inquiry with the most relevant evidence arising from his experience and knowledge.

33. Moreover, permitting Dr. Smith the right be examined in chief by his own counsel will not limit Commission counsel's ability to seek evidence from Dr. Smith in fulfillment of the public interest. It will not diminish Commission counsel's ability to examine Dr. Smith thoroughly and

independently since Commission counsel will have the right to full examination upon completion of Dr. Smith's examination in chief.

**Reference:** Inquiry into Pediatric Forensic Pathology in Ontario, Rules of Procedure, Rule 32.

34. Counsel for Dr. Smith proposes that Commission counsel be afforded each of the following opportunities consistent with the Rules of Procedure:

(a) provision of a "will say" statement in advance of Dr. Smith's testimony, outlining thoroughly the anticipated evidence to be given by Dr. Smith in chief;

(b) the opportunity to respond to the "will say" statement and suggest further issues and questions to be covered during Dr. Smith's examination;

(c) provision of a list of documents associated with Dr. Smith's anticipated evidence;

(d) the right to conduct an independent examination of Dr. Smith following examination in chief by his own counsel;

(e) the right to re-examine Dr. Smith at the conclusion of his evidence; and

(f) the right to direct the order of Dr. Smith's cross-examination by other parties.

35. Finally, Dr. Smith's examination in chief by his own counsel poses no restriction on the inherent ability of the Commissioner to rule as to appropriate and inappropriate questioning, to intervene and to question Dr. Smith directly, and to generally direct the conduct of examinations at the Inquiry.

## C. COMMISSIONER HAS JURISDICTION TO GRANT LEAVE

36. The Rules of Procedure for the Inquiry include procedures for the examination of witnesses. These procedures expressly state that "in the ordinary course", Commission counsel will call and question witnesses.

**Reference:** Inquiry into Pediatric Forensic Pathology in Ontario, Rules of Procedure, Rule 32.

37. However, Rule 34 provides as follows:

> Counsel for a party may apply to the Commissioner to examine a particular witness in chief. If counsel is granted the right to do so, examination will be confined to the normal rules governing one's own witness.
>
> **Reference:** Inquiry into Pediatric Forensic Pathology in Ontario, Rules of Procedure, Rule 34.

38. The very inclusion of the right to seek to be led in examination in chief by one's own counsel in the Inquiry's Rules of Procedure not only confirms that the Commissioner can grant such relief but, more significantly, acknowledges that there are circumstances in which such an right ought to be granted.

39. The Commission must be assumed to have drafted this rule conscientiously with both the rights of participants in the Inquiry and the Inquiry's systemic mandate in mind. The position of the Commission in drafting the rule may be analogized to that of the legislature in drafting a statute, in which case:

> It is presumed that every feature of a legislative text has been deliberately chosen and has a particular role to play in the legislative design. The legislature does not include unnecessary or meaningless language in its statutes[.] ... This is what is meant when it is said that the legislature "does not speak in vain."
>
> **Reference:** Ruth Sullivan, *Statutory Interpretation*, (Concord: Irwin Law, 1997) at 56.

40. Moreover, the Commissioner is expressly limited from "report[ing] on individual cases" that may be before the courts, or "expressing any conclusion or recommendation regarding professional discipline matters involving any person or the civil or criminal liability of any person." Thus, the recognition that a party might want to be led in chief by his or her own counsel embodied in rule 34 must be assumed to have been included to protect the general character, credibility and dignity of individual parties during the course of the Inquiry.

41. This is consistent with the inclusion of equivalent provisions in the rules of previous public inquiries the mandates of which were not directed at investigating allegations of misconduct against individuals, but to systemic issues.

**Reference:** Order-in-Council 826/2007

Ontario, *Report of the Walkerton Commission of Inquiry*, (Toronto: Queen's Printer for Ontario, 2002), Appendix 1, Rules of Procedure and Practice, Rule 9

*Commission of Inquiry on the Blood System in Canada: Final Report*, vol. 3, (Ottawa: Public Works and Government Services Canada), Appendix C, Rules of Procedure and Practice, Rule 1.

42. Counsel for Dr. Smith are aware of no cases in which a party with standing sought and was denied the right to be led in examination in chief by his own counsel, where provision for such a procedure is included in the rules of the Inquiry.

43. Indeed, in the *Toronto Computer Leasing Inquiry*, a party subject to widely publicized allegations of impropriety was found to be entitled to have his own counsel lead him in chief.

**Reference:** *Toronto Computer Leasing Inquiry* and *Toronto External Contracts Inquiry*, Volume 3: Inquiry Process, (Toronto: City of Toronto, 2005), Appendix G: Commissioner's Rulings, Ruling on Application by Counsel for Tom Jakobek, p. 310.

## PART IV—RELIEF SOUGHT

44. Dr. Smith respectfully requests that the Commissioner grant him the right to be examined in chief at the Inquiry by his own counsel, on the following basis:

(a) provision of a "will say" statement in advance of Dr. Smith's testimony, outlining thoroughly the anticipated evidence to be given by Dr. Smith in chief;

(b) the opportunity to respond to the "will say" statement and suggest further issues and questions to be covered during Dr. Smith's examination;

(c) provision of a list of documents associated with Dr. Smith's anticipated evidence;

(d) the right to conduct an independent examination of Dr. Smith following examination in chief by his own counsel;

(e) the right to re-examine Dr. Smith at the conclusion of his evidence; and

(f) the right to direct the order of Dr. Smith's cross-examination by other parties.

**ALL OF WHICH IS RESPECTFULLY SUBMITTED**

November 2, 2007

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## LIST OF AUTHORITIES

### CASES

1. *Re Public Inquiries Act and Shulman*, [1967] 2 O.R. 375 (C.A.)

2. *Gosselin v. Ontario (Royal Commission of Inquiry into Certain Deaths at the Hospital for Sick Children)* (1984), 4 O.A.C. 242 (Div. Ct.)

3. *Canada (A.G.) v. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission)*, [1996] F.C.J. No. 864 (F.C.T.D.)

4. *Canada (A.G.) v. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission)*, [1997] S.C.J. No. 83 (S.C.C.)

5. *Re the Ontario Crime Commission, Ex parte Feeley and McDermott*, [1962] O.R. 873 (C.A.)

### LEGISLATION

6. Order-in-Council 826/2007

### OTHER AUTHORITIES

7. Ontario, *Royal Commission Inquiry into Civil Rights*, Report No. 1, vol. 1, (Toronto: Queen's Printer, 1968)

8. Inquiry into Pediatric Forensic Pathology in Ontario, Rules of Procedure

9. Ruth Sullivan, *Statutory Interpretation*, (Concord: Irwin Law, 1997)

10. Ontario, *Report of the Walkerton Commission of Inquiry*, the Hon. Dennis O'Connor, Commissioner, Appendix 1, Rules of Procedure and Practice, Rule 9

11. *Commission of Inquiry on the Blood System in Canada: Final Report*, vol. 3, (Ottawa: Public Works and Government Services Canada), Appendix C, Rules of Procedure and Practice, Rule 1

12. *Toronto Computer Leasing Inquiry* and *Toronto External Contracts Inquiry*, Volume 3: Inquiry Process, (Toronto: City of Toronto, 2005), Appendix G: Commissioner's Rulings, Ruling on Application by Counsel for Tom Jakobek, p. 310