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INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

THE HONOURABLE STEPHEN GOUDGE COMMISSIONER

SUBMISSIONS ON BEHALF OF

THE ONTARIO CROWN ATTORNEYS' ASSOCIATION

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Overview

1. The Ontario Crown Attorneys' Association the (OCAA) is a professional association which has been in existence since 1946 and which represents over 800 Assistant Crown Attorneys in Ontario. The OCAA's membership consists of all the non-management trial and appellate counsel who represent the Attorney General for Ontario in the criminal courts of Ontario and before the Supreme Court of Canada.

2. The OCAA's objects relate to the education and training of Crown counsel and the resolution of employment relations issues, including disciplinary matters and professional issues. The OCAA's specific objects include promoting the professional interests of its members; discussing and studying the administration of criminal justice in Ontario and elsewhere; discussing and studying all matters related to the status, roles and duties of Crown Attorneys, Assistant Crown Attorneys, Crown Law Officers and others involved in prosecutorial functions; promoting and encouraging efforts towards the just and efficient enforcement of the law including the public perception of the same; promoting better relations between its members and the employer; and making recommendations or engaging in undertakings or activities consistent with the above purposes.

3. The OCAA provides training and education to Assistant Crown Attorneys on all aspects of practice. The education and training programs are provided through educational conferences for members that the OCAA in partnership with the Ministry of the Attorney General, presents twice each year and through the OCAA's annual Crown "Summer School" comprising week-long courses that every Crown counsel is required to attend.

4. The OCAA members and former members prosecuted the cases that have been an important focus of this Inquiry and continue to prosecute pediatric

death cases in the criminal justice system. Following this overview is a set of recommendations that have been developed by the OCAA with the assistance of the OCAA Goudge Recommendations Committee, a regionally representative group of criminal prosecutors with personal experience in pediatric prosecutions.

5. The fundamental responsibility of each member of the OCAA is to ensure that justice is done in our criminal justice system. The primary function of this system is truth seeking. The objective of the OCAA recommendations is to ensure that the criminal justice system has access to valid, reliable and accurate pediatric pathology evidence from qualified pathologists in aid of seeking the truth.

6. The evidence before the Inquiry demonstrates that over the last few decades, forensic pathologists have been unsupported in the following critical ways. There has/have been no:

a) university-appointed academic forensic pathologists in any Canadian University with research programs;

b) substantive post-graduate training programs in Canadian universities;

c) formal guidelines or codes of practice for forensic pathologists;

d) national attention to the recruitment, workloads or remuneration for pathologists doing forensic work, and only few substantive continuing education programs that were not widespread and not well supported.

Evidence of Dr. Pollanen, 06/12/2007, p. 41, line 24 to p. 44, line 2

7. These significant shortcomings led to an environment in which forensic pathologists were largely self-educated and unsupported institutionally which created a heightened risk of error for pathologists.

Evidence of Dr. Pollanen, 06/12/2007, p. 46, lines 2 – 13

8. The OCAA's submissions and recommendations will focus on the relationship between the pathologist and the criminal justice system in pediatric death cases.

Recommendation: Roster of Pathologists for Suspicious Pediatric Death Cases

(1) The Ontario Chief Coroner's Office (OCCO) must have an oversight mechanism for pathologists who conduct autopsies and consultations pursuant to Coroner's warrants and have ultimate, practical responsibility for the quality of pathological services in Ontario through an appropriate Quality Assurance Program.

(2) The OCCO shall designate a roster of qualified forensic pathologists and pediatric pathologists.

(3) Only pathologists from this roster may conduct autopsies pursuant to a Coroner's warrant in cases of suspicious pediatric death.

(4) The OCCO will create a Forensic Pathology Advisory Committee (FPAC) chaired by the Chief Forensic Pathologist composed of

appropriate stakeholders including the Chief Coroner, the Chief Forensic Pathologist, the Hospital for Sick Children, crown counsel, the defense bar, the judiciary, the police and children's services.

(5) The Forensic Pathology Advisory Committee will develop a process for the selection and de-listing of pathologists on this roster.

(6) A significant factor to be considered by the FPAC in determining its roster of approved pathologists will be information arising from the Quality Assurance Program.

(7) Counsel seeking second autopsies or consultations regarding pediatric death cases shall have free, publicly funded access to the OCCO roster of pathologists.

9. A fundamental systemic problem in Ontario is the paucity of qualified forensic and pediatric pathologists.

10. The OCAA recommends that the Government of Ontario take such steps as are necessary to ensure that the OCCO is adequately resourced to conduct suspicious pediatric death investigations. The OCAA supports the recommendations made by Drs. McLellan and Pollanen regarding the fundamental changes that are required to remedy the serious gaps in service that exist under our coronial system which include: hiring additional full-time pathologists; building suitable facilities; significantly increasing the rates paid to pathologists for fee-for-service autopsies and consultations; intensive and regular in and out of country training; and amendments to the Coroner's Act.

Evidence of Dr. McLellan, 7/11/2007, p. 132 to 136
Evidence of Dr. Pollanen, PFP301189

11. Initially, there may not be enough qualified pathologists in Ontario to compose a designated roster. As a result, the roster will likely include qualified pathologists from outside Ontario and, indeed Canada. However, in order to immediately restore public confidence in pediatric death investigations, the OCAA believes a designated roster is necessary even if there is a present paucity of qualified pathologists in Ontario for the reasons referred to above.

Evidence of Dr. Pollanen, 13/11/2007, p. 119 to 120, p. 203 to 209, 227, line 5 to 229

12. The pathologists on the roster must have appropriate qualifications and experience. Further they must complete certain annual training requirements and be subject to the guidelines and quality assurance system of the OCCO, under the supervision of the Chief Forensic Pathologist, in order to remain on the roster.

Evidence of Dr. Pollanen, 5/12/2007, p. 273, line 3 to p. 278, line 21

13. The OCAA recommends that autopsies in pediatric death cases be conducted by pathologists only from this roster. However, in cases that are most obviously bound for the criminal justice system, the autopsies should be double-doctored by a forensic and a pediatric pathologist from the roster.

14. The Forensic Services Advisory Committee collaborated to determine a list of suitable pathologists which had the confidence of both sides of the bar, the police and the coronial system for the review of Dr. Smith's files. Similar collaboration should occur in the development of the rostered pathologists

recommended above, with an appropriately expanded group of selectors chaired by the Chief Forensic Pathologist.

Evidence of Dr. Pollanen, 14/11/2007, p. 28 to 31, line 14

15. It is essential that the defence bar be given full access to the rostered pathologists for second autopsies and other consultation work in order to eliminate any notion of a hierarchy of pathological validity in witnesses. Moreover this access should defy any notion that rostered pathologists are "crown" pathologists or biased in any way.

Evidence of Dr. Pollanen, 6/12/2007, p. 198 to p. 201, line 10

Recommendation: Double-Doctoring

(8) The OCAA recommends that where possible, autopsies in suspicious pediatric death cases should be 'double-doctored' by a forensic and a pediatric pathologist. When the coronial system has access to sufficient forensic and pediatric pathologists, double-doctoring should be mandatory.

16. One of the great challenges in any death investigation of a child is in the selection of the best pathologist for the autopsy conducted under the Coroner's warrant. The proper triaging of pediatric death cases to pathologists best suited for autopsy has been identified as a critical step in a death investigation.

Evidence of Dr. Pollanen, 15/11/2007, p. 217, line 18 to p. 221

17. While there is a preference to have forensic pathologists conduct autopsies in cases that are most obviously bound for the criminal justice system, it has been recognized that the best practice is to have the autopsy double-doctored by a pediatric pathologist and a forensic pathologist. Double-doctoring allows the forensic pathologist trained in evidence-based pathology and the pediatric pathologist trained in pediatric clinical medicine to bring their different, respective expertise to bear on the post mortem examination. Double-doctoring is used in the United Kingdom and is viewed as an effective anti-dote to confirmation bias. It is the best method to obtain valid and accurate results in these complex cases.

Evidence of Dr. Pollanen, 5/12/2007, p. 155 to p. 156, line 4
Evidence of Dr. Pollanen, November 15, 2007, p. 75, line 13 to p. 80, line 23

Recommendation: Crown and Defence Counsel Participation in the Quality Assurance Program in the Judicial Phase

(9) Crown counsel and Defence counsel shall provide information to the OCCO regarding the pathologists performance in much the same way they provide information to the Centre of Forensic Sciences, by a Counsel Monitoring Letter provided to the CFS, at the end of the trial process. (See draft Counsel Monitoring Letter at Appendix "A").

(10) This information must be taken into consideration by the OCCO in remedial training for pathologists and, ultimately, in deciding whether the pathologist should remain on the roster of certified pathologists.

(11) The OCCO will immediately notify the MAG Criminal Law Division if a pathologist is taken off the accredited roster. The ADAG will then immediately inform all Crown Attorneys of the de-listing of the pathologist and will in conjunction with OCCO conduct an immediate review of cases that might be reasonably at risk or cases in which an individual may have been prejudiced as a result of the testimony of the de-listed pathologist.

(12) Absent notification by the OCCO, counsel will rely on the roster in adducing the evidence of rostered pathologists in criminal proceedings.

(13) Crown Attorneys are required, as a performance measure, to ensure that Crown counsel submit a copy of the Counsel Monitoring Letter to the OCCO and to the Chair of the Criminal Law Division Homicide Resource Team in each Child Homicide case.

18. Pathologists are involved in three phases of the criminal justice process – the investigative, the judicial and the post-conviction phases.

Evidence of Dr. Pollanen, 5/12/2007, p. 165, lines 6 – 19

19. The OCCO has made great strides in quality assurance regarding the work of pathologists in the investigative phase. However, the significant systemic improvements to the quality assurance of the work of pathologists conducting autopsies pursuant to a Coroner's warrant - the early central notification system, peer review of the autopsy record, the Autopsy Guidelines, enhanced professional development and continuing medical education activities – are all

aimed at the work of the pathologist before the autopsy report is released to the Crown.

Evidence of Dr. Pollanen, 15/11/2007, p. 105, p. 115, line 19 to p. 116, line 12

20. While the criminal justice system has its own tools to deal with the quality of the pathology evidence in terms of relevance, admissibility, and credibility, the OCCO has not developed a review mechanism for the pathologists performance in the judicial phase of his or her work.

Evidence of Dr. Pollanen, 5/12/2007, p. 166, lines 1 – 22

21. In his testimony, Dr. McLellan, an extraordinarily experienced Chief Coroner, qualified in emergency medicine, indicated that he did not feel that he was qualified to review the pathology of Dr. Smith.

Evidence of Dr. McLellan, 13/11/2007, p.49, line 20 to p. 50, line 10

22. Certainly, Crown counsel and Defence counsel are not qualified to assess the scientific or forensic competency of a pathologist.

Evidence of Brian Gilkinson, 5/12/2007, p. 247, line 18 to p. 248, line 2
Evidence of Paul McDermott, 19/02/2008, p. 122, line 15 to p. 123, line 7

23. However, Crown counsel and Defence counsel are able to provide a qualitative assessment to the OCCO regarding the manner in which a pathologist interacts with the criminal justice process e.g. the timeliness of the Autopsy

Report and supplementary reports, how accessible the pathologist was to counsel for pre-trial meetings, the consistency of the pathologist's opinion throughout the criminal process, the pathologist's communication skills in and out of court regarding his or her findings and evidence.

Evidence of Dr. Pollanen, 5/12/2007, p. 180, line 1 to p. 283, line 21
Evidence of Dr. Pollanen, 6/12/2007, p. 34, line 24 to p. 180, line 1

24. The OCCO should gather important information regarding the performance of pathologists by developing a counsel letter feedback system similar to that used by the Centre of Forensic Sciences. The counsel letter feedback system should reflect the Centre of Forensic Sciences process in which letters are sent out, after the scientist has testified in court (usually after the conclusion of criminal proceedings) for feedback on the performance of the scientist. The letters from counsel are to be returned to the CFS and are used in the quality assurance system.

Evidence of Dr. Prime, 13/02/2008, p. 65, lines 16 to p. 76 line 6

25. The counsel feedback letter should be designed to elicit important, objective information to be used in monitoring the performance of pathologists. Attached as Appendix "A" is a suggested format for the letter which is based on the Centre of Forensic Sciences letter. The letter should cover the following performance issues:

i) whether the pathologist was timely in respect of Autopsy and Supplementary reports and whether or not this impacted on the Crown's ability to provide satisfactory, timely disclosure;

ii) whether the pathologist was available to counsel for pre-trial meetings with counsel, opposing counsel and other pathologists;

iii) whether the pathologist's opinion in testimony was consistent with the opinion contained in his/her Autopsy or Supplementary reports;

iv) whether the pathologist was well prepared;

v) whether the testimony was presented in an objective, professional and clear manner;

vi) whether there were any pertinent comments of the Judge regarding the testimony of the pathologist.

PFP 140213, Letter, CFS Testimony Review Program
Appendix "A".

26. The OCAA agrees that assessing the pathologist's testimony, particularly with respect to the quality of his or her opinion evidence, may require a more 'subtle' assessment than counsel are qualified to provide. For example, an expert's opinion may change because the factual foundation of the original written opinion has changed, or a new alternative opinion may be presented to the witness that required comment.

Evidence of Dr. Pollanen, 15/11/2007, p. 110, line 2 to, p. 114, line 25

27. For this reason, comments of counsel in the feedback letter should be as objective as possible. It should also provide the OCCO with access to the best source of information for assessment by the quality assurance team that is, the

actual transcripts regarding the pathologist's testimony and any comments made by the Judge regarding the testimony.

Evidence of Dr. Pollanen, 15/11/2007, p. 113, line 17 to p. 114, line 25

28. The OCCO and particularly the Chief Forensic Pathologist should be responsible for the quality assurance program for pathologists that conduct autopsies and consultations pursuant to Coroner's warrants. While this type of quality assurance is labour and resource intensive, it is critical to the proper functioning of our coronial system of death investigations.

29. While the OCAA supports the initiatives of the MAG regarding the development of an internal data base of all Child Homicides and the internal dual reporting of adverse judicial comment to the CLDHRD/ CLD Lead and the local Crown Attorney, this initiative has no formal linkage to the OCCO.

PFP 304038, Criminal Law Division Initiatives, initiative 4.

30. The OCAA believes that the Counsel Monitoring Letter feedback system, with its direct linkage to the OCCO and the Ministry's hierarchy would close this important informational gap and greatly assist the OCCO's quality assurance program's ability to detect problems and resolve them with respect to the performance of pathologists in the criminal justice system.

Evidence of Justice McMahon, 6/02/2008, p. 52, line 10 to p. 57, line 24

Disclosure and the Quality Assurance Program

31. There has been some commentary regarding the disclosure obligation on the Crown and the coronial system arising from any quality assurance feedback system that may be developed in the future.

32. The MAG has already acknowledged a potential obligation to provide the Defence with copies of adverse judicial comment regarding the performance of a pathologist in past cases if it is relevant to the credibility of the pathologist. However, it is essential that disclosure not extend to information that is relevant only to the professional development of the pathologist.

> Evidence of Brian Gilkinson, 22/01/2008, p. 138, line 18 – 24
> Evidence of Justice McMahon, 6/02/2008, p.44 line 18 to p. 57, line 7

33. The Centre of Forensic Science experience regarding access to such information is instructive. Dr. Prime testified that specific disclosure requests for quality assurance measures in this program regarding specific scientists have not been a significant problem and one that he would not welcome. The quality assurance measures are designed to rigorously expose weakness so that it can be corrected. In this way the quality of the CFS service is assured. Indeed, errors that are detected by the quality assurance programs are disclosed by way of a revised report if the error has had a meaningful impact on the result of the scientist's work. However, full transparency of these measures would negatively impact on their effectiveness. It is imperative that the disclosure obligation not imperil the vigor of a quality assurance program. Fair and reasonable disclosure should not be inconsistent with vigorous quality assurance, peer reviews or oversight.

Evidence of Dr. Prime, p.80, line 14 to p. 99, line 4

Recommendation: Reciprocal Disclosure

(14) The Superior Court Criminal Rules (particularly Form 17) be amended to:

a. encourage enhanced reciprocal disclosure regarding pathology evidence in circumstances where the Crown has satisfied its disclosure obligations regarding pathology evidence;

b. encourage that Crown and Defence counsel arrange a pre-trial meeting(s), with or without the Judge, with the pathologist(s) to discuss the anticipated evidence of the pathologist(s) and any divergent issues, in circumstances where reciprocal disclosure has been made.

34. The Crown and the Defence have a joint interest in:

1. the presentation by the Crown of only relevant, qualified, valid and accurate expert opinion in pediatric death cases; and

2. timely disclosure and all other fair trial principles.

35. To support and foster these interests we have made recommendations in these submissions including:

1. the joint education of both sides of the criminal bar regarding the gathering and presentation of pathological evidence in pediatric death cases;

2. that Defence counsel have free access to the certified roster of pathologists for independent opinions and autopsies, and

3. that Defence counsel have full access to the quality assurance system of the OCCO.

36. The OCAA supports the concept that scientific evidence is neutral, ". . .it is for the Court and not for the side." We are of the view that the greater and earlier access to defence pathology evidence in a criminal proceeding, the lesser the chance that scientific evidence will be misunderstood in the criminal process.

Evidence of Dr. Milroy, 23/22/2007, p. 85, line 16 to p.86, line 16

37. The OCAA agrees that there may be real Charter concerns regarding a mandatory rule enacted in the Criminal Code to permit Crown reciprocal disclosure rights that even approach the robust and appropriate disclosure obligations on the Crown. Ms. Edwardh and Mr. Code expressed concern that such mandatory disclosure rules may compromise the essential features of defence practice if not violate,". . .the single-most important organizing principle in criminal law."

Evidence of Ms. Edwardh, 19/02/2008, p. 53. line 1 – 24
Evidence of Mr. Code, 19/02/2008, p. p. 61, line 15 to p. 62, line 22

38. However, the OCAA is of the view that creating an expectation, in the form of a practice direction from the Judiciary in the Superior Court Criminal Rules,

regarding early mutual disclosure of pathological expert evidence has the potential of greatly enhancing:

a) the truth-seeking principles and practice in criminal proceedings;

b) early and appropriate resolutions of criminal charges; and,

c) a more efficient use of court and counsel's resources through the agreement on, or narrowing, of pathology issues.

39. The benefits of early reciprocal disclosure are legion and were attested to by virtually every witness and commentator before the Inquiry: the police, Crown counsel, Defence counsel, pathologists, coroners, the judiciary, academics.

> Evidence of Assistant Deputy Minister Paul Lindsay, 19/02/2008, p. 46, line 3 to p. 48, line 11
> Evidence of Assistant Crown Attorney Paul McDermott, 19/02/2008, p.
> Evidence of Dr. Bruce MacFarlane, 19/02/2008, p. 63, line 9 to p. 65, line 5
> Evidence of Justice McMahon, 6/02/2008, p. 76, line 6 tp p. 77, line 7
> Evidence of Dr. Milroy, 20/11/2007, p. 67, line 20 to p. 68, line 12

40. Certain jurisdictions, particularly the United Kingdom, have entrenched the obligation of Defence pathology disclosure in this regard. It is seen as a critical anti-dote to confirmation bias and miscarriages of justice.

41. The justice system can reasonably expect mutual or reciprocal disclosure from Defence counsel in the following circumstances:

1. The expert evidence or the pathologist(s) must be disclosed to the Defence counsel in a timely manner;

2. There must be some level of trust and professionalism between the prosecutor and the Defence counsel;

3. Defence counsel must have had and taken the opportunity to thoroughly prepare its case; have a significant degree of confidence in the case, the credentials and validity of the pathologist who he or she intends to call and his or her opinion, etc.

Evidence of Brian Gilkinson, p. 125, line 7 to p. 127, line 13
Evidence of Mr. Code, 10/02/2008, p. 58, line 15 to p. 61, line 8
Evidence of Justice McMahon, 6/02/2008, p. 72, line 20 to p. 75, line 3

42. Paragraphs 1 and 3 above deal essentially with issues of timely Crown disclosure of the post-mortem examination and the degree of preparation the Defence counsel is willing and able to accomplish well before trial which are two issues that are already, in theory at least, subject to the Superior Court Criminal Rules.

43. An amendment to the Superior Court Criminal Rules to foster defence disclosure of experts' reports would help support a culture of preparation, competence and professionalism which would support appropriate circumstances for early reciprocal disclosure without compromising the fundamental fair trial rights of the accused.

44. Where defence has made disclosure of the anticipated evidence of its pathologist, the Crown and the Defence should consult with each other's experts and raise no impediments to such consultation.

45. 'Hot-tubbing' is a concept used to describe the pre-trial meeting of pathologists to narrow issues or even come to some agreement on divergent opinions. The concept is closely related to reciprocal disclosure and has been embraced and encouraged by the majority of pathologists who testified at the Inquiry. It was described as being an anti-dote to confirmation bias. Moreover, it was viewed to be consistent with evidence-based medicine and peer review concepts. This kind of collegial and collaborative approach is most effective while the case is in the investigative stage, but should be encouraged if there has been no meeting of pathologists by the time the case has entered the criminal justice system.

Evidence of Dr. Butt, 20/11/2007, p. 66 line 6 to p. 67, line 18
Evidence of Dr. Pollanen, 5/12/2007, p. 197 – 199, line 23

46. This kind of pre-trial meeting of pathologists, with or without counsel, should be encouraged at judicial pre-trials.

Voir Dires **and Demonstrable Reliability**

47. During the Inquiry, there was much discussion of changing the rules relating to the admissibility of pathological evidence. The OCAA agrees with Justice Rosenberg that changes should be made incrementally in light of the lack of empirical evidence regarding the practical implications of such changes. However, these changes should be implemented in a coordinated manner across the province and reviewed after a period of time to ensure that the practical experience makes good policy sense.

48. As stated above, the OCAA agrees that changes should be made in respect of reciprocal disclosure and pre-trial meetings of experts. Moreover, we have made practical suggestions concerning a joint education program for the bar. We believe that these suggested changes will go a long way in ensuring the reliability of pathological evidence.

49. However, the OCAA is of the view that Professor Edmond's proposed requirement that the Crown establish "demonstrable reliability" in a pre-trial *voir dire* prior to the admission of pathological evidence is not a sound proposal for the reasons given by Justice Rosenberg before the Inquiry. First, it is very questionable as to whether reliability is an appropriate test. How does one adequately assess "reliability" and who should be doing this assessment? Former Chief Justice Lesage was concerned that this suggested approach may involve the judge in trenching upon the province of the jury as the trier of fact. Perhaps a clearer test would be whether the evidence is of *prima facie* reliability. Such a test is more in keeping with the judge's role as "gatekeeper". Secondly, scarce judicial resources are a serious consideration in implementing another pre-trial process which could prolong criminal proceedings. Finally, a pre-trial process in which the defence is not actively engaged will not lead to more informed decisions on reliability. In the view of the OCAA, these practical problems suggest that more critical analysis is required before such a procedure is implemented.

The Judicial System and Expert Evidence Panel 1, 22/02/08, pp. 37-38

50. The OCAA wants to make clear that despite its view on *voir dires*, it believes that Professor Edmond has made a very important contribution to the field of pathological evidence. He correctly demonstrates that the criminal justice system's treatment of the evidence of pathologists and other experts is wanting.

However, the OCAA believes that there are a number of alternatives that can adequately address his concerns.

51. The OCAA suggests that the following policy alternatives substantially address the systemic problems we face in respect of the interface between the forensic pathologist and the criminal justice system by reasonably ensuring the reliability of pathological evidence:

i) Earlier in these submissions, the OCAA made recommendations concerning a designated roster of qualified pathologists and double-doctoring. We also recommend a comprehensive joint education program on the conduct of criminal cases involving child deaths and pathological evidence. These three recommendations will lead to more reliable pathological evidence.

ii) In the previous part, we discussed the real benefits of reciprocal disclosure. We also discussed the benefits of pre-trial meetings of the experts which should narrow the issues and perhaps lead to a joint report.

iii) The OCAA is not opposed to a pre-trial motion or *voir dire* concerning the admissibility of pathological evidence if it is requested by the defence and there are justifiable reasons for conducting such a proceeding. However, such a proceeding should not be a mandatory feature of the criminal justice system. Such a proceeding would be far more meaningful under our proposed system where there is reciprocal disclosure and a pre-trial meeting of the experts.

iv) Once the pathological evidence is admitted, the judge may comment on any weakness or problems with it to the jury in his/her instructions.

The one qualifier is that in these comments the judge should ensure that he/she stays within their role as "gatekeeper" and not trench upon the jury's role as the trier of fact.

Recommendation: Education and Training of the Criminal Bar

(15) Selected Crown and Defence counsel shall be jointly trained on an annual basis in a Criminal Bar Pediatric Pathology Education Program funded by the Ministry of the Attorney General and the Office of the Chief Coroner.

(16) Completion of this program shall be required for any Crown counsel prosecuting, and a pre-requisite for Counsel receiving funding from the Ontario Legal Aid Plan in, criminal matters than involve a pediatric death.

52. One of the fundamental tensions examined in the Inquiry is the potential conflict between the justice system's need for certainty and the uncertainty of scientific knowledge because of lack of consensus among scientists and the evolving nature of scientific knowledge.

53. Education of the criminal bar regarding this tension is essential, particularly in pediatric pathology. The criminal bar requires regular, diligent training regarding the nature and use of expert evidence in criminal proceedings, and in particular pediatric pathology. The criminal bar needs particular training to give counsel the rudimentary scientific skills to objectively assess forensic reports and opinions and to keep abreast of the law in this area relating to the extent of properly admissible expert opinion evidence and to provide counsel with an understanding of recent developments in science and the law relating to opinion evidence and pathology.

54. Currently, there is no education program available to the criminal bar that provides this type of particular and rigorous training in pediatric pathology. Such training would assist those lawyers who conduct pediatric death cases and, as a result, ensure system-wide competency.

> Evidence of Paul McDermott, 19/02/2008, p. 20, line 1 to p. 22, line 16
> Evidence of Professor Code. 19/02/2008, p. 34, line 15 to p. 36, line 21

55. Given the small number of pediatric death cases in the criminal justice system annually, the OCAA recommends that the Ministry of the Attorney General and the OCCO fund a two day training session for counsel who conduct or may conduct pediatric death cases (up to 70 participants).

56. This joint education program is proposed as an initiative that would assist systemically in leveling the playing field regarding particular, critical knowledge germane to criminal cases involving pediatric death.

57. The quality assurance branch of Legal Aid Ontario has undertaken to record the presentation and make either attendance at the Educational Program or review of the DVD a mandatory requirement for funding of a legal aid certificate for a criminal case involving a pediatric death.

> Evidence of Marlys Edwardh, 19/02/2008, p. 23, line 1 to p.40, line 13
> Evidence of Professor Code, 19/02/2008, p. 34 to 36, line 19

58. The joint education program would also have a salutary effect on civility and professionalism in the criminal bar. In other jurisdictions, such joint educational programs have proved to be a durable tool in developing mutual professionalism and competence at the bar and the practical elevation of the interests of justice.

Evidence of Dr. Bruce McFarlane, 19/02/2008, p. 31, line 20 to p. 32, line 8

59. The OCAA has asked two prominent Crown counsel with extensive experience in forensic sciences and forensic pathology, to develop a curriculum for the joint education of the criminal bar.

60. Shawn Porter and Robert Wadden have developed a curriculum for an audience of up to 70 counsel, Defence and Crown, which would focus specifically on the educational issues that have been raised at this Inquiry. The curriculum has been reviewed and approved by the OCAA Goudge Recommendation Committee, the OCAA Expert Summer School Directors. This draft curriculum is attached as Appendix "B" to our submissions.

Appendix "B", Pathological Education Proposal
Appendix "C", Curriculum Vitae, Robert Wadden, Shawn Porter

Recommendation: Prosecutions in the Transition Period

(17) An Advisory Panel, composed of a Group Lead and at least one Crown Attorney per region will receive annual specific training in addition to the program outlined above, including:

a. **Interaction with pathologists pre-charge and pre-court appearances;**

b. **The uniform use of appropriate medical terms for use in meetings and in presentation in court;**

c. **The uniform use of language regarding certainty in the presentation of opinions and alternative opinions in the course of testimony;**

d. **The body of opinion literature regarding pediatric death which is generally accepted as reliable;**

e. **The presentation of the evidence of the pathologist in court**.

(18) For a transition period of not less than 2 years, these senior, specifically trained Crowns from the Advisory Panel should conduct pediatric death prosecutions as lead counsel with the assistance of a Crown from the local office. This proposal will ensure best practices in these medically complicated prosecutions and contribute to the critical mass of competency in pediatric death prosecutions. During the transition period the Advisory Panel will meet to determine next steps in achieving the medium and long term goals of building consistent competency in these prosecutions. Although this proposal is resource intensive and will require at least 7 additional FTE's, it is the best way to build expertise and competency in this critical area of prosecutions.

61. The OCAA submits that it is essential that pediatric death cases, among the most complex and difficult of criminal cases, be prosecuted by experienced and specially trained Crown prosecutors. Like many institutions in the justice system, the operational mantra for the prosecutorial system has been to do more with less even as our most serious prosecutions have become longer and more complex.

62. As in the case of triaging pediatric death cases to pathologists for autopsy, we recommend a kind of double-lawyering regarding the prosecution of these large and complex files.

Evidence of Dr. Pollanen, p. 218 -221

63. In the short term, the best case scenario for a just result in our adversarial system is to have the most expert prosecutor conducting a prosecution in his or her area of expertise against an equally expert defence counsel. Public confidence in the system must be quickly restored.

64. It is arguably more important to match Crown expertise to the complex pediatric death case given the quasi-judicial obligations of the Crown and his or her role in continuously assessing the case for reasonable prospect for conviction.

Evidence of Dr. MacFarlane, p. 31, lines 10 – 19
Evidence of Paul Lindsay, p. 45 to 46, line 8

65. In the medium and long term, the best case scenario is for this expertise to be shared and fostered across our prosecutorial system in every region of the Province. While the OCAA supports the MAG initiative to create the Criminal Law Division Child Homicide Resource Team (hereafter CLDCHRT), the OCAA is of

the view that in the transitional period described above, this team should have expanded responsibilities.

66. Having members of the CLDCHRT conduct these prosecutions with local Crowns will provide greater safeguards in these complex prosecutions by:

a) increasing the CLDCHRT's experience in these specialized prosecutions;

b) increasing the validity of the Team's expertise through practical application of their specialized education in these trials;

c) allowing the CLDCHRT to troubleshoot weaknesses in Crown expertise and education by conducting case studies after completion of these prosecutions;

d) increasing the critical mass of expertise in prosecutors across the Province through collaboration on the case with the local assigned prosecutor;

e) promoting the most robust, on the scene, support for these prosecutions in the short term.

67. In the medium and long term, as this theoretical and practical expertise is adequately expanded across the Crown system, the CLDCHRT's role will become more advisory to Crowns across the Province.

68. Unquestionably, this proposal will likely require additional resources. For the duration of the 5 to 15 Child Homicide trials annually, the Criminal Law Division will require additional crowns to backfill the duties of the team members.

However, in our view, the benefits of this recommendation clearly outweigh its costs.

Recommendations: Pre-Charge Screening

(19) Crown Attorneys should not take an active part in the independent death investigative process of the Coroner.

a. The Coroner's office has access to its own staff counsel for any advice that it requires.

b. The Office of the Crown Attorney, subject to legal advice sought from police investigators, should play no part in multi-disciplinary committees at the death investigation stage of a pediatric death file.

(20) Crown Attorneys should not take an active part in the independent investigation of criminal charges by the police except pursuant to the Crown's role to provide legal advice regarding charges available. When this advice is requested in the circumstances of a pediatric death the OCAA recommends that:

a. Advice should be provided to the police on discrete, complete and accurate written information. Advice on charges should not be given until the Autopsy Report has been completed.

b. Advice given will be recorded but such advice will, of course, be privileged until the completion of the criminal matter.

69. The criminal justice system in Ontario is an adversarial system that contains a number of checks and balances. One of these checks and balances is the independence of the investigative apparatus, including death investigations undertaken by the coronial system, from the prosecution service. This independence is reflected in a number of MAG policy documents and inferred in some coronial policy documents.

> Evidence of Dr. Pollanen, 15/11/2007, p. 43, line 1 to p. 44, line 20
> PFP032438, Memorandum: Physical Scientific Evidence, Dr. McLellan, July 12, 2004
> PFP171206, Practice Memorandum, Police: Relationship with Crown

70. Likewise, death investigations conducted by the Coroner's office are independent of criminal investigations performed by the police. Independence of death investigators, in this case pathologists, from police investigators and prosecutors and vice versa is a critical systemic design aimed at fostering independent critical analysis and the avoidance of confirmation bias.

> Evidence of Dr. Pollanen, 15/11/2007, p. 58, line 6 to p. 64, line 1
> Evidence of Michael Code, 19/02/2008, p. 81, line 7 to p. 83, line 14

71. It is apparent from a number of witnesses at the Inquiry that they had misapprehended the independent function and role of a pathologist working under a Coroner's warrant as an independent scientist. In some cases the pathologist felt that he was the 'Crown' pathologist. Dr. Smith apparently felt at times that he was an advocate for the victim or the Crown.

Evidence of Dr. Chiasson, 178/11/2007, p. 164, line 3 to p. 165, line 18

Evidence of Dr. Smith, 3/01/2008, p. 185, line 15 to p. 186, line 23

72. It is critical that the independence of death investigations conducted by coroners and pathologists be fostered. While there should be cooperation between death investigators, police and the prosecution service, the principle of independence of each service is critical to the overall effectiveness of the criminal justice system.

73. The MAG has set out a policy regarding Crown interaction with the police which provides best practice guidelines aimed at ensuring Crowns and police maintain their mutual independence when Crowns provide advice to the police. Crowns should not participate in pre-charge screening unless they are providing advice at the request of the police. Except in very rare circumstances, the Crown should not provide advice in a pediatric homicide case unless there is a written autopsy report.

PFP171206, Practice Memorandum, Police: Relationship with Crown

74. The OCAA submits that, while it is important that the Crown participate in pre-charge screening with the police when the assistance of the crown is requested, it is critical that this participation occur, as far as possible, after the death investigation has been completed by the Coroner's office to the point of completion of the post mortem report by the pathologist.

75. Crowns should not take part in early case conferences, conducted by the death investigation team which occur shortly after the death. Crown counsel have no value to add to such conferencing and anything that they may add would be

second-hand, circumstantial non-pathological evidence. Except in rare circumstances, it is too early in the evolution of the case in the criminal justice system for crown participation.

Evidence of Dr. McLellan, , 12/11/2007, p. 217, line 11 to p. 222, line 1
Evidence of Dr. Pollanen, 12/11/2007, p. 224, line 1 to p.225, line10

76. Generally, Crowns should only begin to take part in case conferencing after a post mortem report has been completed in which the pathologist's rationale and opinion regarding cause and manner of death have been recorded.

Evidence of Brian Gilkinson, 22/01/2007, p. 239 to p. 240, line 17

Conclusion

77. In conclusion, the OCAA submits that its recommendations are intended to address the main systemic issue facing the Inquiry - the need for reliable and accurate pathological evidence. From the perspective of the criminal justice system, the reliability of such evidence is crucial in fulfilling the truth seeking function of the process. From the perspective of the Crown Attorney, the reliability of such evidence is crucial in that it goes to ensure that justice is done.

Finally, from the perspective of the accused, the reliability of such evidence is fundamental in that it ensures a fair trial.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

Paul J.J. Cavalluzzo
Veena Verma
Counsel to the OCAA

Appendix "A"

Office of the Chief Coroner of Ontario

To: Crown Counsel
Defence Counsel

From: Chief Forensic Pathologist

Re: Quality Assurance Program – Judicial Phase

R v. **File Number:** **Date of Testimony:**

Court Jurisdiction, Court Room and Location:

Pathologist:

Judge:

Date of Ruling/Judgment with comment regarding Pathologist:

Pre-trial

Did the Pathologist provide the Autopsy Report in a timely fashion?

Did the Pathologist provide supplementary reports in a timely fashion?

Was the Pathologist available for meetings with counsel and/or other pathologists prior to the preliminary inquiry and/or trial?

Was the Pathologist able to explain with sufficient clarity the foundation of the opinion regarding cause, method and manner of death?

Trial

Was the pathologist well prepared?

Was the testimony presented in an objective, fair, professional and understandable manner?

Was the Pathologist's testimony in court consistent with the content of his written opinion or report? If not, please attach transcript order form with date(s), witness, courtroom and jurist to the OCCO.

Did the judge make any findings regarding the validity of the Pathologist's opinion? If yes please confirm the dates of testimony for the Pathologist, that of any other experts testifying on point, and the judgment related to the pathologists evidence. (Please attach the transcript order form used in your jurisdiction)

Appendix "B"

Crown and Defence Program on the Conduct of a Criminal Case Involving a Child Death

Synopsis:

This two-day course would focus on providing leading criminal prosecutors and defence counsel with training in the relevant medical and legal issues involved in the prosecution or defence of a homicide in which the deceased is a child. One purpose of the course is to teach the forensic science in this field (sub-specialty of pediatric pathology) to give lawyers the skills to objectively assess forensic reports and opinions. A second purpose will be to focus on the law in this area relating to the extent of properly admissible expert opinion evidence and to provide lawyers with an understanding of recent developments in the law relating to opinion evidence and pathology.

Medical

The medical lecture will be provided by one or more leading forensic pathologists with appropriate pediatric experience. The topics to be addressed will include:

The Lexicon of the Pathologist

Glossary and definitions relating to cause of death, manner of death, and the certainty of opinions.

The Practice of the Pathologist

The role of the forensic pathologist in relation to the coroner;
The conduct of an autopsy, including the proper role of technicians;
The legal requirements and the protocols informing the conduct of a proper autopsy and their significance in the preparation of an opinion;
A description of how the autopsy is conducted and how a pathologist makes observations relying on histology, toxicology, radiology and dissection;
Application of the Scientific method (and the limits of its application) relating to transparency and reproducibility.
Pathological Pitfalls

Anatomy of human body

Focusing on issues unique to pediatrics (for example, incomplete brain development) including a description of Post mortem changes;
The relevance of pre-existent medical conditions;
Proper basis of forming a forensic pathologist's opinion;

Evidence based medicine;
"off the table" considerations including: pre-existent medical conditions; historical events; competing potential causes of death

Communication

Formulation of an opinion
Peer Review and Preparation of Report
Use of Photographs and Diagrams
Consultation with Other Experts
Testifying in Court

Legal

The legal component of this program is intended to provide crown and defence lawyers with the current law on the relevant issues of opinion evidence and pathology in particular. The specific focus of this program will be on the legal implications of the current changes taking place in forensic pathology. This component would be taught by leading practitioners from the crown and defence bar. The topics will include:

Admissibility and Limits of Opinion Evidence

A refresher on *R. v. Mohan* and *R. v. J. (J-L)* and how the principles established in these cases have been developed to the present;
A refresher on the distinction between expert given opinion and an observation of fact (for example, *R. v. Marquard*) and the limitations of lay opinion (for example, *R. v. Graat);*
Who qualifies as an expert? The differences between an expert (as defined by the law) and an expert (as accepted by the alleged expert's peer group);
Novel issues on old science and the retrospective application of the Mohan criteria (for example, *R. v. Trochym*);

Legal issues from recent cases in pathology (focusing on reliability)

Evidence – based medicine;
Term of art – what it means and entails;
How the courts have defined "evidence-based medicine" and what they have said about it (for example, *Truscott* and *Mullins- Johnson*);
The J.(J-L) criteria and the trial judge's gatekeeper role considered in the context of pathological evidence;
Reliability of the Science regarding pathological issues;

Truscott and *Mullins- Johnson* and the impact of the Inquiry into Pediatric Forensic Pathology (the Goudge Inquiry);
Evidence-based medicine in court including consideration of hearsay, photographs, the use of *voir dires* and other issues.

Case Studies

Lessons learned from *Mullins-Johnson, Reynolds, Waudby* and *Speyer*

Best Practices

The third component of this course is intended to bring practitioners up to date on best practices in this field. This would be a panel composed of a leading pathologist, a senior crown and a senior defence counsel experienced in this field. The issues discussed will be:

Recommendations from the Gouge Inquiry
-What changes are recommended in how lawyers practice in the context of these cases;

Reciprocal Disclosure
-A discussion of current law and practice and its future within the context of pediatric pathology cases;

Forensic Pre-Trials
-When they should be used and how they are conducted.
-When should the defence provide a copy of an expert's report in advance of the times set by the Criminal Code?
-When should the expert's meet to discuss their differences and identify common issues?
-Hot-tubbing

Appendix "C1"

ROBERT W. WADDEN, B.A., LL.B.

Crown Attorney's Office, Suite 3045, 161 Elgin Street · Ottawa, Ontario · K2P 2K1
Telephone: (613) 239-1188 · Fax: (613) 239-1214 · Email: Robert.Wadden@ontario.ca

Assistant Crown Attorney, Ottawa, Ontario

Adjunct Professor, University of Ottawa Law School

Co-Director, Trial Advocacy Course, Ontario Ministry of the Attorney General

PROFESSIONAL EXPERIENCE

November, 1993 to Present

Assistant Crown Attorney, Attorney General of Ontario
Crown Attorney's Office, Ottawa, Canada

Prosecution of criminal offences under the *Criminal Code*

Responsibilities include representing the Attorney General before all levels of trial courts and the Court of Appeal, as well as before administrative tribunals such as Coroner's inquests and the Ontario Review Board.

January, 2001 to Present

Adjunct Professor, University of Ottawa Law School
Faculty of Common Law, Ottawa, Canada

Teaching of full semester course in Forensic Science and its application to criminal law.

February, 1992 to November, 1993

Associate Lawyer, Fasken Campbell Godfrey
Toronto, Ontario

Associate counsel on commercial and administrative litigation, insolvency and civil law matters for large corporate clients.

PROFESSIONAL ASSOCIATIONS

Canadian Association of Law Teachers

Ontario Crown Attorney's Association
Director 2003-2005; Treasurer 2005-2007

Law Society of Upper Canada
Called to the Bar in 1992

EDUCATION

University of Toronto Law School, Toronto, Ontario, Canada
May, 1990 *Bachelor of Laws (LL.B.)*

Memorial University of Newfoundland, St. John's, Nfld., Canada
May, 1986 *Bachelor of Arts (B.A.) in English Literature & Philosophy*

LEGAL TEACHING & LECTURING

Canadian Conference on Counter-Terrorism and Public Health
Panelist on Coordination of Joint Investigations, October 2003

Canadian Police College
Guest Lecturer at course for bloodstain pattern analysis forensic experts

University of Ottawa,
Carleton University and
Algonquin College, Ottawa
Guest Lecturer at Undergraduate Courses in Law and Law Enforcement

Law Society of Upper Canada, Bar Admission Course
Lecturer and Instructor in Criminal Law, 2000 - 2005

COMMUNITY INVOLVEMENT

School Council, Ottawa Public School
Executive Member, 2006-07, Representative to Ottawa Association of School Councils

Ottawa Internationals Soccer Club
Volunteer

Runner at Charitable Events
10 km and ½ Marathon races

Robert Wadden

Robert W. Wadden

Appendix “C2"

Shawn Porter received his BA from the University of Toronto in 1985 and his LL.B. from Osgoode Hall Law School in 1988. He as called to the Ontario Bar in 1990. Mr. Porter articled at the law firm of Greenspan, Rosenberg and then, after remaining at Greenspan, Rosenberg for a brief period, joined the Scarborough Crown Attorney’s Office as an Assistant Crown Attorney in September 1990. Mr. Porter is currently counsel with the Ministry of the Attorney General, Crown Law Office – Criminal. He is a member of the Centre of Forensic Sciences Advisory Committee and the Forensic Services Advisory Committee (the Advisory Body to the Chief Coroner for the Province of Ontario). Mr. Porter lectures regularly on issues related to DNA and expert evidence.

Appendix "D"

Recommendation: Roster of Pathologists for Suspicious Pediatric Death Cases

(1) The Ontario Chief Coroner's Office (OCCO) must have an oversight mechanism for pathologists who conduct autopsies and consultations pursuant to Coroner's warrants and have ultimate, practical responsibility for the quality of pathological services in Ontario through an appropriate Quality Assurance Program.

(2) The OCCO shall designate a roster of qualified forensic pathologists and pediatric pathologists.

(3) Only pathologists from this roster may conduct autopsies pursuant to a Coroner's warrant in cases of suspicious pediatric death.

(4) The OCCO will create a Forensic Pathology Advisory Committee (FPAC) chaired by the Chief Forensic Pathologist composed of appropriate stakeholders including the Chief Coroner, the Chief Forensic Pathologist, the Hospital for Sick Children, crown counsel, the defense bar, the judiciary, the police and children's services.

(5) The Forensic Pathology Advisory Committee will develop a process for the selection and de-listing of pathologists on this roster.

(6) A significant factor to be considered by the FPAC in determining its roster of approved pathologists will be information arising from the Quality Assurance Program.

(7) Counsel seeking second autopsies or consultations regarding pediatric death cases shall have free, publicly funded access to the OCCO roster of pathologists

Recommendation: Double-Doctoring

(8) The OCAA recommends that where possible, autopsies in suspicious pediatric death cases should be 'double-doctored' by a forensic and a

pediatric pathologist. When the coronial system has access to sufficient forensic and pediatric pathologists, double-doctoring should be mandatory.

Recommendation: Crown and Defence Counsel Participation in the Quality Assurance Program in the Judicial Phase

(9) Crown counsel and Defence counsel shall provide information to the OCCO regarding the pathologists performance in much the same way they provide information to the Centre of Forensic Sciences, by a Counsel Monitoring Letter provided to the CFS, at the end of the trial process. (See draft Counsel Monitoring Letter at Appendix "A").

(10) This information must be taken into consideration by the OCCO in remedial training for pathologists and, ultimately, in deciding whether the pathologist should remain on the roster of certified pathologists.

(11) The OCCO will immediately notify the MAG Crown Law Division if a pathologist is taken off the accredited roster. The ADAG will then immediately inform all Crown Attorneys of the de-listing of the pathologist and will in conjunction with OCCO conduct an immediate review of cases that might be reasonably at risk or cases in which an individual may have been prejudiced as a result of the testimony of the de-listed pathologist.

(12) Absent notification by the OCCO, counsel will rely on the roster in adducing the evidence of rostered pathologists in criminal proceedings.

(13) Crown Attorneys are required, as a performance measure, to ensure that Crown counsel submit a copy of the Counsel Monitoring Letter to the OCCO and to the Chair of the Criminal Law Division Homicide Resource Team in each Child Homicide case.

(14) The Superior Court Criminal Rules (particularly Form 17) be amended to:

a. encourage enhanced reciprocal disclosure regarding pathology evidence in circumstances where the Crown has satisfied its disclosure obligations regarding pathology evidence;

b. encourage that Crown and Defence counsel arrange a pre-trial meeting(s), with or without the Judge, with the pathologist(s) to discuss the anticipated evidence of the pathologist(s) and any divergent issues, in circumstances where reciprocal disclosure has been made.

Recommendation: Education and Training of the Criminal Bar

(15) Selected Crown and Defence counsel shall be jointly trained on an annual basis in a Criminal Bar Pediatric Pathology Education Program funded by the Ministry of the Attorney General and the Office of the Chief Coroner.*

(16) Completion of this program shall be required for any Crown counsel prosecuting, and a pre-requisite for Counsel receiving funding from the Ontario Legal Aid Plan in, criminal matters than involve a pediatric death.*

Recommendation: Prosecutions in the Transition Period

(17) An Advisory Panel, composed of a Group Lead and at least one Crown attorney per region will receive annual specific training in addition to the program outlined above, including:

a. Interaction with pathologists pre-charge and pre-court appearances;

b. The uniform use of appropriate medical terms for use in meetings and in presentation in court;

c. The uniform use of language regarding certainty in the presentation of opinions and alternative opinions in the course of testimony

d. The body of opinion literature regarding pediatric death which is generally accepted as reliable;

e. The presentation of the evidence of the pathologist in court.

(18) For a transition period of not less than 2 years, these senior, specifically trained Crowns from the Advisory Panel should conduct pediatric death prosecutions as lead counsel with the assistance of a Crown from the local office. This proposal will ensure best practices in these medically complicated

prosecutions and contribute to the critical mass of competency in pediatric death prosecutions. During the transition period the Advisory Panel will meet to determine next steps in achieving the medium and long term goals of building consistent competency in these prosecutions. Although this proposal is resource intensive and will require at least 7 additional FTE's, it is the best way to build expertise and competency in this critical area of prosecutions.

Recommendations: Pre-Charge Screening

(19) Crown Attorneys should not take an active part in the independent death investigative process of the Coroner.

a. The Coroner's office has access to its own staff counsel for any advice that it requires.

b. The Office of the Crown Attorney, subject to legal advice sought from police investigators, should play no part in multi-disciplinary committees at the death investigation stage of a pediatric death file.

(20) Crown Attorneys should not take an active part in the independent investigation of criminal charges by the police except pursuant to the Crown's role to provide legal advice regarding charges available. When this advice is requested in the circumstances of a pediatric death the OCAA recommends that:

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b. Advice given will be recorded but such advice will, of course, be privileged until the completion of the criminal matter.