Inquiry into Pediatric Forensic Pathology in Ontario

REPORT

Volume 1 Executive Summary

Volume 2 Systemic Review

Volume 3 Policy and Recommendations

Volume 4 Inquiry Process

The Honourable Stephen T. Goudge
Commissioner

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The Report consists of four volumes: 1 (Executive Summary), 2 (Systemic Review), 3 (Policy and Recommendations), and 4 (Inquiry Process). The table of contents in each volume is complete for that volume and abbreviated for the other three volumes.

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Contents

Volume 1: Executive Summary

Volume 2: Systemic Review

Volume 3: Policy and Recommendations

Volume 4: Inquiry Process

Appendices

Inquiry Process

23

The Scope and Approach of the Inquiry

The design and operation of a public inquiry is a significant responsibility. The inquiry must investigate, research, examine issues, and develop public policy in a way that allows the public to understand all this work. Many public inquiries must also hear from witnesses, test the witnesses' recollections and reliability, and find facts.

Although each inquiry's mandate is defined, its process is not. My mandate called on me to conduct a *systemic review* and to decide on my recommendations and complete my Report within a year. These requirements demanded innovation – procedures that deliberately integrated policy making with fact finding, ensured efficiency and cost savings, and adduced evidence in new ways.

The purpose of this chapter is to describe how we went about addressing the challenge. I do not, of course, mean to suggest that every public inquiry should be run in the same way. Each must be responsive to its particular context and mandate. However, I do think all inquiries best approach the task of designing the necessary processes by adopting creative procedures that maximize focus and efficiency without compromising fairness.

The Principles of the Inquiry Process

Public inquiries are not subject to the rules of procedure or evidence that govern criminal or civil trials. So long as they observe the rules of procedural fairness, each one is free to create its own rules and processes – those that will best accomplish its specific mandate. Our approach was guided by the terms of reference laid out in the Order in Council establishing the Commission, which mandated a systemic review and assessment.[1]

[1] See Appendix 1 and Appendix 2.

Commissioners and their counsel often begin their work by reviewing the rules and procedures developed by preceding inquiries: they select those they think are most appropriate for their own purposes. That too is how my counsel and I spent our first weeks. In very little time, we decided on three principles against which we measured a proposed rule or procedure: fairness, efficiency, and transparency. These three principles have all been well described in other reports of public inquiries, and we learned much from them.

Many inquiries have also emphasized "thoroughness" as a guiding principle – the importance of leaving no doubt that all issues relevant to the mandate have been fully explored. While I agree with that approach, it is important not to confuse thoroughness with exhaustiveness.

On the recommendation of my counsel, I was guided by the principle of proportionality as well as the principle of thoroughness. Investigative and hearing times were allocated in proportion to the importance of the issue to my mandate. This approach was necessary to allow me to be responsive to two key features of this Inquiry that were set out in the Order in Council: it was to be systemic in nature, and it had a strict time limit.

Our approach made it essential for Commission counsel, in consultation with me, to determine as early as possible the ground to be covered by becoming familiar with the factual and policy landscape raised by our mandate. Counsel were then able to design a process that enabled us to focus most on the major factual and policy issues and to pay far less attention to minor ones. For example, although the relationship between pediatric forensic pathology and child protection proceedings was explored, it was not a core issue that we examined at length. We conducted our investigation, document collection, witness identification, and hearing timetable with this proportionality in mind. Commission counsel did not follow every conceivable lead, interview everyone with any information that might be relevant, or collect all documents of possible relevance. Rather, we focused on what was significant. This approach was instrumental in allowing the Inquiry to proceed expeditiously.

The principle of proportionality is frequently invoked by those engaged in reform of the civil justice system, but, as I hope our process has demonstrated, it has great utility also in the context of a public inquiry. It requires the commissioner to be engaged in developing the contours of the mandate at an early stage. Preliminary decisions about the relative importance of particular issues cannot await the testimony from the first witness. Nor can the hearing process be allowed to resemble a lengthy multi-party examination for discovery in which questions of limited relevance are patiently tolerated. It is all a fine balance:

investigating the facts and presenting the evidence in a manner that is in proportion to their overall significance to the Inquiry's mandate. I am satisfied we achieved that balance.

Setting Up the Inquiry

Staff

Administrative Staff

The Commission was able to retain David Henderson as its chief administrative officer. Mr. Henderson's experience with other public inquiries and knowledge of government expenditure and administrative guidelines were of great assistance in setting up the Inquiry.

Carole Brosseau was the Commission's manager of finance and operations. Ms. Brosseau was responsible for overseeing all aspects of office management, including administering the budget, reviewing accounts, procuring technological and administrative support, and setting up the hearing room. Ms. Brosseau was assisted in her work by Tiana Pollari, administrative coordinator. Both had valuable prior experience with public consultation processes that was very helpful to us.

Commission Counsel and Staff Lawyers

I was fortunate to retain Linda Rothstein as lead Commission counsel. Ms. Rothstein had recently acted as the City of Toronto's lead counsel at the Toronto Computer Leasing Inquiry. Given that my mandate required that I examine pediatric forensic pathology in the context of the criminal justice system, I was also fortunate to retain Mark Sandler as special counsel, criminal law. Mr. Sandler acted for the Ontario Provincial Police at the Ipperwash Inquiry and served as associate counsel to the Commission on Proceedings Involving Guy Paul Morin, and as counsel to the Review to Make Recommendations to Identify and Prevent Sexual Misconduct in Ontario Schools.

I was also able to retain Robert Centa and Jennifer McAleer, both of whom had previous experience working on public inquiries, as my assistant Commission counsel. Priscilla Platt was our special counsel for privacy law. All made important contributions to the Inquiry.

In addition to Commission counsel, the Commission hired a talented team of seven staff lawyers: Ava Arbuck, Tina Lie, Jill Presser, Jonathan Shime, Robyn Trask, Sara Westreich, and Maryth Yachnin. This team was supported from time

to time by additional lawyers and law clerks, who were retained to assist with individual projects.[2]

I am convinced that a talented legal team of this size was instrumental to my ability to complete my mandate in an expeditious manner. As I describe elsewhere in this Report, the Commission spent a significant amount of time and energy reviewing and summarizing evidence and interviewing witnesses throughout the inquiry process. These tasks could not have been accomplished in such an efficient manner without the skill, size, and dedication of my legal team.

Policy and Research Staff

The Commission was also fortunate to retain Professor Kent Roach as the Commission's director of research. Professor Roach has been involved in many other public inquiries, including the Arar Inquiry and the Air India Inquiry. Professor Lorne Sossin also provided the Inquiry with valuable assistance in fulfilling its policy and research agenda.

Communications and Media Relations Officer

Given that this was a public inquiry which was likely to draw significant media attention, it was important to retain an individual with excellent media contacts and prior experience working with public inquiries. I found both qualifications in Peter Rehak, who was retained as the Commission's communications and media relations officer. Mr. Rehak's duties included drafting press releases, coordinating with the media regarding their attendance during the inquiry process, answering questions from the media about the inquiry process, overseeing the design and operation of the Inquiry's media room, and designing and maintaining the Inquiry's website.

Counselling and Outreach Manager

Ava Arbuck, in addition to her role as a staff lawyer, was the Commission's manager of counselling and outreach. Ms. Arbuck was responsible for contacting all the affected family members, coordinating the private consultations, and attending these meetings with me. She also coordinated provision of the counselling services.

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[2] The Commission would like to acknowledge the hard work provided by Emily Lawrence, Patrice Band, and Debra Newell.

Document Manager and Counselling and Outreach Coordinator

Heather Hogan came to this Inquiry having previously worked on the Toronto Computer Leasing Inquiry. Ms. Hogan ably discharged the task of overseeing the collection and distribution of documents, managing the Inquiry's database, and providing document support for the hearings and roundtables. In addition, Ms. Hogan assisted Ms. Arbuck in coordinating the private consultations and counselling services.

Infrastructure

Offices / Hearing Room

One of the Commission's first tasks was to obtain appropriate facilities. This was challenging. The Commission required both a hearing room and offices. Ultimately, it was able to acquire office space on the 22nd floor at 180 Dundas Street West, in Toronto. This location had been used for prior public inquiries, such as the Walkerton Inquiry and the SARS Commission. We were then able to have a hearing room designed and built on the 20th floor. This work took a few months to complete. We had decided that we would not start oral hearings until the fall of 2007, but it was still a tight schedule. It meant we had to make alternative arrangements for the standing and funding hearings, which were both held in a local hotel in August.

Our hearing room accommodated approximately 27 counsel. Each counsel table had two electronic monitors, which displayed the documents that were before a witness. We retained Christopher Riley as the Commission's registrar. Mr. Riley easily piloted the Inquiry's electronic database to retrieve documents from it quickly and have them available on the hearing room monitors. This allowed us to conduct a largely paperless process.[3] Counsel tables were wired for Internet hook-up, and wireless Internet was also available in the hearing room. A seating plan was prepared for the hearing room.[4]

The hearing room had a public gallery that accommodated approximately 25 people. As described below, our webcasting meant that many members of the public were able to follow the oral hearings from off-site.

Transcription services were provided by Digi-Tran Inc., which produced

[3] For each witness or panel of witnesses, the Commission prepared a binder (or binders) containing the documents that had been identified in the document lists of either my counsel or counsel for the parties. Copies of these binders were then provided to the witness, my counsel, and me for ease of reference. Counsel for the parties, for the most part, relied on the electronic images of the documents that were made available to counsel on their individual monitors.

[4] See Appendix 3.

same-day transcripts that were posted on the Inquiry's website at the end of each day.

The Commission decided that it was not necessary to retain a court deputy. Independent security arrangements were made when appropriate. The Commission also published Hearing Room Rules, which were posted for both counsel and members of the public.

The hearing room had an adjoining media room. It was set up to accommodate the media and was equipped with a large monitor so that members of the press could watch the evidence.

I hope that the facilities at 180 Dundas Street West will be available for the use of public inquiries in the future. This would greatly assist a new commission in completing its work within a limited time frame.

Communications

Paragraph 12 of the Order in Council provides that "[t]he Commission shall establish and maintain a website and use other technologies to promote accessibility and transparency to the public."

Shortly after starting with the Inquiry, Mr. Rehak set up the Inquiry's website, which was continually updated. The resources available on the website included hearing schedules and press releases; transcripts of the proceedings; copies of motion materials, rulings, and submissions; and information on Commission staff.

In addition, the Commission arranged to have the hearings webcast to the public. This process has recently been used at other public inquiries, such as the Cornwall Public Inquiry, the Air India Inquiry, and the Ipperwash Inquiry. Webcasting provided greater access to the public and allowed counsel for parties with standing to monitor the oral hearings without being present if they wanted to do so. It also allowed Commission staff to monitor the hearings from their offices. The webcast was accessed through the Inquiry's website.

Affected Individuals

Private Consultations

One of my first challenges was to determine how I would address the profound personal tragedies at the heart of my systemic review. I wanted to hear from individuals who had been directly affected by the events that precipitated the Inquiry, because of the useful context they would provide for my work. As well, I wanted to offer them an opportunity to be heard in some way.

Commission counsel and I considered a number of options. I rejected the option of calling any affected individuals as witnesses. My systemic mandate was not consistent with a trial of individual cases, and there were three other significant considerations: I wanted to avoid affecting any criminal or civil proceedings; I was concerned not to re-traumatize those who had already suffered much by exposing them to a formal hearing process; and I did not consider it fair to allow testimony or impact statements to be introduced as part of the Inquiry's record without cross-examination.

I found that my concerns were shared by the affected individuals. Some of them had counsel, and they were unanimously of the view that their clients needed privacy and confidentiality in order to feel comfortable telling me about their experiences. In the end, I decided that I would meet privately with individuals or families, with or without their lawyer, as they wished, and that our conversations would be confidential and would not form part of the fact-finding process. Counsel for all the parties endorsed this "off the record" approach.

My staff contacted the individuals, or their counsel, who had received the results of the Chief Coroner's Review.[5] Other individuals contacted us directly after seeing press reports about the Inquiry. My staff did not attempt to persuade anyone to meet with me. They simply explained that the Inquiry's mandate allowed such individuals to meet with me if they wished. The Commission assisted with travel arrangements and costs for those travelling from outside Toronto. Overall, approximately three-quarters of those contacted chose to meet with me. Many indicated to me that they would not have come had I not determined that these discussions would be kept confidential.

The first meetings took place in June 2007. Based on the overwhelming response, more meetings were scheduled for August. I also met with two other families, in January and February 2008, respectively. These meetings were held at a confidential, off-site location. Before discussions with me, each person met with Celia Denov, a social worker with many years of counselling experience, whom I asked to assist. Through Ms. Denov, these individuals were able to learn about the counselling program we could offer, which is described below, and to arrange for counselling services if they chose.

These private consultations did not form part of the Commission's fact-finding process, and no transcripts were made of these meetings.[6] I found it a sad but deeply moving experience. It was a unique opportunity for me to hear

[5] For a description of the Chief Coroner's Review, see Appendix 4.

[6] Our manager of counselling and outreach, Ava Arbuck, attended all the meetings and kept brief notes in order to assist with our subsequent discussions.

directly about every parent's worst nightmare – the loss of a child – and the added stress and shame that follow when that loss is the subject of criminal or child protection proceedings. The central role of pediatric forensic pathology in the criminal justice process was unmistakable.

I am grateful to those who attended for their candour about painful, personal subjects. At the same time, I am heartened and reassured by the response of so many of the individuals with whom I met. They made it clear that it helped to be able to discuss the events with someone who was charged by the government with recommending improvements to the system. They hoped that their input would assist me in accomplishing that work. They all urged me to do what I could to ensure that the criminal justice system never again relies on flawed pediatric forensic pathology. These meetings also made me understand that even an inquiry that is fundamentally systemic in nature can make a helpful contribution to the healing process that is essential following a tragedy.

Counselling

Paragraph 16 of the Order in Council authorizes me to provide for counselling services to anyone, including immediate family members, who has been affected by systemic failings relating to pediatric forensic pathology. It provides: "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." These services were encompassed within the budget provided to the Commission.

Many with whom I met during the private consultations expressed an interest in receiving counselling. With the professional assistance of Ms. Denov, we determined the type of counselling that would best meet their needs and put them together with qualified professionals in their communities. Each psychiatrist, psychologist, or social worker was chosen with the particular person's needs in mind.

I viewed counselling as an important part of our mandate and was encouraged by the number of people who responded positively to the offer of this assistance. We were the second inquiry in Ontario to offer counselling. We learned much from those involved in the creation of the first counselling program – the Cornwall Public Inquiry. Like Cornwall, the process we implemented preserved the privacy of those who used it and maintained client-counsellor confidentiality. In the result, Ms. Denov has informed me that, except in two cases, all the clients believe that the counselling experience has been very helpful to them in grappling with many difficult and long-term issues.

We have also received feedback from the professionals providing the coun-

selling. They are unanimous in their view that counselling was an important and necessary service to be provided by the Inquiry. Indeed, they believe that the government should, in the future, offer counselling assistance in the context of public inquiries, if merited by the circumstances. Each counsellor commented on the complexity of the cases and the fragility of their clients. Most pointed out that their clients continue to lead highly stressed and, in some cases, very chaotic lives. The very fact of the Inquiry itself has caused difficult and painful issues to resurface for many of them and for their children. For the clients who also continue to deal with legal issues, their criminal, employment, and financial circumstances remain challenging.

The counsellors were asked to consider the duration of counselling assistance offered by the Inquiry in relation to their individual clients. Each has acknowledged that it will take considerable work, over time, to assist their clients with current upheavals before work can begin on deeper, long-term issues. Thus, the professionals recommend, and I agree, that up to three years of counselling may be necessary to help individuals and families move on with their lives successfully. I initially authorized funding for counselling for a two-year period. I recommend that funding be provided for up to a further three years if the individual and the counsellor think it would be useful.

Finally, the professionals pointed out that, despite the great needs of their clients, most of them could not have afforded counselling on their own. Most of the counselling options offered through this Inquiry are not available through OHIP.

I am very hopeful that our counselling program will help many individuals and families who were affected by systemic failings relating to pediatric forensic pathology to move forward in a positive way.

Standing and Funding

In every public inquiry, commission counsel have the primary responsibility of representing the public interest, including the responsibility to ensure that all matters that bear on the public interest are brought to the commissioner's attention.

Subsection 5(1) of the *Public Inquiries Act*, RSO 1990, c. P. 41, also provides:

> A commission shall accord to any person who satisfies it that the person has a substantial and direct interest in the subject-matter of its inquiry an opportunity during the inquiry to give evidence and to call and examine or to cross-examine witnesses personally or by counsel on evidence relevant to the person's interest.

Individuals, groups of individuals, institutions, or associations with a "substantial and direct interest" in the subject matter to be reviewed by a public inquiry can apply for standing under this section of the *Public Inquiries Act*. The Act, however, provides no further guidance with respect to the basis on which standing is granted or the rights and responsibilities of those to whom standing is granted. These matters are generally left to the discretion of the commissioner.

In this Inquiry, the Order in Council permitted me to make recommendations to the Attorney General regarding funding to a party to whom I had granted standing where, in my view, the party would not otherwise be able to participate in the Commission.

Applications for Standing

Considerable publicity surrounded the release of the results of the Chief Coroner's Review and the subsequent announcement of this Inquiry. Many of the institutions and organizations with an interest in the subject matter were aware of it from the outset and contacted Commission counsel immediately. As a result, apart from doing so on our website, the Commission decided that it was not necessary to advertise our standing process[7] or to publish a Notice of Hearing.[8]

Rather, in my Opening Statement at our first public hearing on June 18, 2007,[9] I announced the publication of the Commission's Rules of Standing and Funding[10] and invited interested persons to submit applications for standing to the Inquiry. I also advised the public that the Commission's Rules of Standing and Funding, along with information regarding the schedule for applications for standing and funding, were available on the Commission's website.[11]

Applications

Our Rules of Standing and Funding required those seeking standing and funding to apply in writing by July 16, 2007. Given the nature of public inquiries, I was

[7] I understand that the Toronto Computer Leasing Inquiry adopted this practice.

[8] I understand that the Ipperwash Inquiry adopted this practice.

[9] See Appendix 5.

[10] See Appendix 6.

[11] Our media relations officer sent out press releases on May 24, 2007, and June 11, 2007, in advance of my Opening Statement. The press releases are found in Appendix 7. This session was well attended by members of the press, with substantial coverage given to the opening of the Inquiry.

careful to ensure that the rules provided that I could, in my discretion, also consider subsequent applications.

The Rules of Standing and Funding instructed applicants on the basic information to be included in support of their application. Through Commission counsel, the applicants were advised that it was not necessary to prepare formal application records with sworn affidavits. Ultimately, many of the applicants did choose to submit formal application records, while others did not. By July 16, 2007, I had received 11 applications for standing. Of the 11 applicants, seven also sought funding. Once Commission counsel reviewed the applications to ensure that they did not disclose confidential information, they were posted on the Commission's website.

Oral Submissions

At the time that the Rules of Standing and Funding were published, I had not yet determined whether I would also require oral submissions from the applicants. In the Rules of Standing and Funding, I had asked the parties to indicate whether they wished to make oral submissions. Of the 11 applicants, only five expressed a desire to do so; two indicated they were prepared to do so if requested by me; and three others indicated that they were content to rely on their written submissions. One applicant did not take a position on the issue. Ultimately, to increase the transparency of our process, I decided that short oral submissions were in the public interest.

On August 8, 2007, I heard oral submissions from nine of the applicants in support of their applications for standing and funding. The other two applicants were content to rely on their written submissions. Counsel for the applicants were asked to confine their oral submissions to 15 minutes. Counsel were expeditious in their submissions, and we were able to conclude the oral submissions in 90 minutes.

Decision on Standing and Funding

On August 17, 2007, I delivered my ruling.[12] I granted standing to all 11 applicants:

[12] See Appendix 8 for my August 17, 2007, Ruling on Standing and Funding and Appendix 9 for my October 2, 2007, Supplementary Ruling on Funding.

- three institutions – the Office of the Chief Coroner for Ontario (OCCO), Her Majesty the Queen in Right of Ontario,[13] and the Hospital for Sick Children (SickKids);
- two groups of individuals – the Affected Families Group (AFG)[14] and the Mullins-Johnson Group[15] – who were involved in cases examined by the Chief Coroner's Review;
- five organizations involved in various ways in the criminal justice system – the Criminal Lawyers' Association (CLA), the Ontario Crown Attorneys' Association (OCAA), the Association in Defence of the Wrongly Convicted (AIDWYC), the Aboriginal Legal Services of Toronto and Nishnawbe Aski Nation Coalition (ALST/NAN), and Defence for Children International – Canada (DCI–Canada); and
- Dr. Charles Smith.

With respect to the seven parties who sought funding, I granted it to both groups of individuals (the Affected Families Group and the Mullins-Johnson Group) and to the four organizations that sought it (the CLA, AIDWYC, ALST/NAN, and DCI–Canada). I did not grant funding to SickKids.

The hourly rates for counsel who were granted funding were determined by Management Board of Cabinet Directives and Guidelines. My ruling set maximums as to the number of counsel who could be employed to act for a party or undertake various tasks; the maximum hours permitted per day or per week; and the extent to which law clerks could be used to undertake document management and preparation. To eliminate the need for either my counsel or the Ministry of the Attorney General to review the accounts of counsel for the parties, the ministry retained Larry Banack, a senior litigator in private practice, with no connection to our Inquiry, to review every account and to ensure that it was consistent with my ruling.

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[13] "Her Majesty the Queen in Right of Ontario" will be referred to throughout this volume as the Province of Ontario. The Province of Ontario, for the purposes of this Inquiry, sought and was granted standing on behalf of the ministries, agents, and servants of the Crown, with the exception of the OCCO, its employees and agents. The Province of Ontario's standing included representing the Ontario Provincial Police and Crown counsel.

[14] The Affected Families Group is made up of individuals who were subject to criminal investigations but not convicted, and their family members. In some cases, charges were never laid; in other cases, charges were laid but later withdrawn or stayed; in one case, an acquittal was entered.

[15] The Mullins-Johnson Group was made up of nine individuals, two of whom were identified by name and seven others who asked to maintain their confidentiality. All the members of the Mullins-Johnson Group allege they were convicted as a result, in whole or in part, of the opinions of Dr. Charles Smith, of crimes they did not commit.

Subsequent Applications

On August 10, 2007, I received an application for standing from Mrs. Anne Marsden on behalf of a group named Access for All. On August 22, I released my decision dismissing the application. My reasons are contained in my decision.[16]

On October 12, 2007, the College of Physicians and Surgeons of Ontario (CPSO) applied for standing. On October 17, I issued my ruling granting this application.[17]

On November 5, 2007, I granted limited standing and funding to Marco Trotta. The death of Mr. Trotta's eight-month-old son was one of the cases examined by the Chief Coroner's Review. At the time that I granted him limited standing, Mr. Trotta's appeal of his criminal conviction for the murder of his son was on reserve before the Supreme Court of Canada. One of the possible outcomes of the appeal was that a new trial would be ordered. Mr. Trotta sought to have counsel appear, as necessary, to protect his rights should a new trial be ordered. I granted limited standing to Mr. Trotta so that his counsel could attend on days when evidence that might be relevant to his ongoing criminal proceedings was presented to the Commission.[18]

I also received two subsequent applications, each on behalf of two individuals, requesting that they be granted standing as part of the Affected Families Group. I agreed and granted standing in my decisions of November 6, 2007, and January 8, 2008.[19] In the end, I granted standing to 13 parties: four institutions, two groups of individuals with common interests, five organizations, and two individuals.

Rights of Parties with Standing

It was clear from the beginning that some parties would have a more direct and substantial interest in the proceedings than others. That is true of all public inquiries. In recognition of these varying interests, some public inquiries have granted parties standing for only certain phases of an inquiry. In other public inquiries, the decisions granting standing have attempted to limit a party's participation to accord with the party's particular interests.

Section 12 of the Commission's Rules of Standing and Funding provides: "The

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[16] See Appendix 10.

[17] See Appendix 11.

[18] See Appendix 12. Of note, on November 8, 2007, the Supreme Court of Canada released its decision ordering a new trial; see *R. v. Trotta*, [2007] SCR 453.

[19] See Appendix 13 and Appendix 14.

Commissioner may determine those parts of the Inquiry in which a party granted standing may participate and the form of their participation."

With the exception of Mr. Trotta's situation, I decided that I would neither formally create levels or categories of standing nor articulate preliminary limits on any one party's standing. Instead, as is discussed in greater detail below, I would reflect the varying interests of the parties through the time permitted for cross-examination. In my view, this process afforded me a greater degree of flexibility, since I could allocate the time counsel had to cross-examine according to that party's interest in a particular witness.

I was also guided by an appreciation that all the family members of the deceased children had a substantial and direct interest in the subject matter of the Inquiry. However, because of the systemic nature of the Inquiry and the short timeline in which to complete our work, it would not have been appropriate to grant separate standing to each such person.

I am grateful for the efforts and assistance of counsel for the Affected Families Group and the Mullins-Johnson Group, and to the individuals within those groups, who recognized the benefit of organizing themselves into groups with common interests. This cooperation achieved an essential objective for our efficiency and eliminated any need to impose groupings or otherwise limit the number of individuals to whom I granted standing.

Rules of Procedure

The *Public Inquiries Act* provides that, subject to certain provisions in the Act, the conduct of an inquiry and the procedure to be followed are under the control and direction of the commissioner conducting the inquiry.[20]

One of the first tasks I asked Commission counsel to do was to draft Rules of Procedure.[21]

Counsel collected the rules that had been used in many other provincial and federal inquiries. In the interests of time, counsel recommended that we issue our Rules of Standing and Funding first, to be followed by our Rules of Procedure. My counsel wanted to consult with those granted standing about our proposed Rules of Procedure before they released them.

After circulating the draft Rules of Procedure, Commission counsel held a meeting to discuss them with all counsel for parties with standing. Rule 11, which deals with privilege claims, was the only rule that drew some criticism. Instead of

[20] Section 3 of the *Public Inquiries Act*.

[21] See Appendix 15.

revising the rule, my counsel resolved this issue by adopting a flexible approach to the procedures provided for by the rules to meet these concerns.

It can be challenging to draft rules of procedure in the early stages of a public inquiry. The scope of the mandate is often still somewhat unclear, and it can be difficult to predict future problems. Although rules of procedure are an important road map for all involved in a public inquiry, I think a commission must maintain a pragmatic and flexible approach to its rules if it is to adapt to issues as they emerge.

Investigation

Document Production

The Commission's Rules of Procedure provide:

> 10. Copies of all relevant documents are to be produced to the Commission by any party with standing at the earliest opportunity. Production to the Commission will not constitute a waiver of any claim to privilege that a party may wish to assert. Parties are, however, requested to identify to the Commission, within a reasonable time period, any documents over which they intend to assert a claim of privilege.
>
> 11. Where a party objects to the production of any document on the grounds of privilege, a true copy of the document will be produced in an unedited form to Commission counsel who will review and determine the validity of the privilege claim. The party and/or the party's counsel may be present during the review process. In the event the party claiming privilege disagrees with Commission counsel's determination, the Commissioner, on application, may either inspect the impugned document(s) and make a ruling or may direct the issue to be resolved by the Associate Chief Justice of Ontario or his designate.

A significant challenge for any public inquiry is the collection and distribution of relevant documents. Our approach to document production was informed by several aspects of the terms of reference of the Order in Council. First, it required that I complete my work within a strict time limit. Second, it mandated a systemic approach. In light of these considerations, my counsel did not set out to collect every document that could potentially be relevant to our work. If they had done so, it would have been impossible to fulfill the mandate in a timely manner. Instead, my counsel applied a more focused criterion and

collected only those documents that appeared to be relevant and helpful to the systemic nature of the Inquiry. Commission counsel used proportionality as the guiding principle.

Practical Challenges

The Commission did not adopt an identical approach to document production from all the parties. Given the systemic focus of the Inquiry, our tight timeline, and the varying interests and institutional capacities of the parties, we used a more flexible and party-specific approach.

Even before the standing hearings were held or the Rules of Procedure finalized, my counsel consulted with counsel for the institutions and individuals from whom the Commission was seeking production. The purpose of these preliminary discussions was to consider the various issues related to collecting and distributing the relevant documents.

Although the Commission served summonses for document production, my counsel recognized that there was not time simply to wait for the documents to arrive. Many of the parties faced significant challenges assembling documents and had questions regarding the scope of the documents the Commission sought to have produced. If all counsel had not worked together to discuss the practical realities of fulfilling the Commission's mandate, document production would have taken much longer and the Commission would likely have received thousands of documents that it did not require.

Some parties, such as SickKids and Dr. Smith, provided Commission counsel with comprehensive lists of documents, itemizing those in their possession available for disclosure and those over which they claimed privilege. Commission counsel then reviewed the original non-privileged documents and identified those documents the Inquiry required. Although permitted by Rules 10 and 11, Commission counsel did not review the documents over which privilege was claimed by SickKids and Dr. Smith. Instead, after Commission counsel had considered the nature of the privilege claim and discussed the basis of the claim, further production was made. In some cases, Commission counsel also made requests for additional documents or categories of documents that had not been itemized on the original list of documents provided.

The Province of Ontario, rather than compile a comprehensive list of documents, which would have taken months, allowed Commission counsel direct access to its files. As provided in Rule 10, my counsel agreed that this access did not amount to a waiver of privilege. Thus, Commission counsel reviewed the original documents, comprising a total of approximately 100 boxes, and identified those sought to be produced. Lawyers for the Province of Ontario then

reviewed these documents to identify any documents over which privilege was claimed. My counsel and counsel for the Province of Ontario were able to resolve all privilege claims without recourse to the Associate Chief Justice of Ontario, who was charged with adjudicating privilege disputes. Document production from the Province of Ontario also required resolution of issues with respect to the protection of the names of youth under the *Youth Criminal Justice Act*, SC 2002, c. 1 and its predecessor legislation.

The Commission adopted a flexible approach to document production by the OCCO. The OCCO provided Commission counsel with unlimited access to the original files made available to the Review Panel (see below). It also provided my counsel with access to its original files pertaining to the one case in which a coroner's inquest was held. As with the Province of Ontario's files, my counsel reviewed the documents and identified those that counsel wished produced. Privilege claims were resolved through discussion. As the scope of the mandate became clearer, my counsel made additional requests for specific documents that were relevant to our work, and the OCCO brought other documents to my counsel's attention.

On September 17, 2007, the Commission served the CPSO with a summons for document production. The CPSO took the position that it was prohibited from complying with the summons because of the provisions of s. 36 of the *Regulated Health Professions Act, 1991*, SO 1991, c. 18. It moved for directions as to whether it was permitted to comply with the summons. On October 10, 2007, I issued my ruling, in which I concluded that the CPSO was obliged to comply with the summons.[22]

The Commission faced different challenges with respect to the production of files from the individuals who made up the AFG and the Mullins-Johnson Group. First, the AFG was in possession of documents it had obtained as a result of ongoing civil litigation. The deemed-undertaking rule applied to these documents, so they could not be produced without the consent of the party in the litigation that had produced them or by order of the court.

A second challenge arose because individuals in the AFG and the Mullins-Johnson Group had previously been the subject of criminal investigations. Thus, they were in possession of documents they had obtained as a result of the Crown's obligation to make disclosure in criminal proceedings. These documents could not be produced without either the consent of the Crown or a court order commonly referred to as a *Wagg* order.[23] Although the Crown was not

[22] See Appendix 16.

[23] *P.(D.) v. Wagg* (2004), 71 OR (3d) 229 (CA).

prepared to consent to the AFG and the Mullins-Johnson Group allowing my counsel access to the Crown briefs, it was prepared to produce the same documents to my counsel directly. This decision enabled the Commission to access all the documents that formed part of the Crown's disclosure in the cases. However, it was very difficult for counsel for the two groups to identify those documents that were not being provided by the Crown directly but that needed to be disclosed to the Commission. In one of the cases, for example, counsel for the AFG had a database of 10,000 documents that were not demarcated in this way. In hindsight, it might have been faster to obtain *Wagg* orders for the production of these documents.

A third challenge was that some of the documents in the files of defence counsel were protected by solicitor-client and litigation privilege and could not be produced, even under summons. Many relevant documents were originally covered by litigation privilege. Whether they continued to be covered by litigation privilege was complicated, given the potential in these cases for applications to extend the time for appeal and to file fresh evidence, or to apply to the minister of justice under s. 696.1 of the *Criminal Code*, RSC 1985, c. C-46. However, in light of the Commission's mandate, it was important to obtain access to at least some of these documents in order to learn what we could from the briefs of defence counsel who had acted in the original criminal proceedings. With the assistance of counsel for the AFG and the Mullins-Johnson Group, we were eventually able to obtain consent from clients to disclose some of these materials.

In the case of the five organizations involved in the criminal justice system,[24] the Commission neither reviewed their original files nor requested a list of documents. The Commission simply relied on the parties' obligations under Rule 10.

Rule 11 provides a process by which disputes over document production could be quickly resolved. I decided that I would hear any motion with respect to whether a document was relevant to my mandate, and that matters of privilege would be reserved to the Associate Chief Justice. I am grateful to him for agreeing to make himself available to do this. In the end, only one such motion was brought to the Associate Chief Justice,[25] and I did not have to hear any motions on relevance.

Confidentiality Undertakings

Many of the documents we obtained by summons were subject to statutory confidentiality provisions that constrained disclosure to others. As is discussed below,

[24] AIDWYC, ALST/NAN, DCI, CLA, OCAA.

[25] See Appendix 17.

my counsel sought advice from a privacy law expert before disclosing these documents to parties. Counsel for the parties were asked to sign the Confidentiality Undertaking of Counsel (the Undertaking).[26] The Undertaking also required counsel to have any person (including but not limited to clients, law clerks, information technology staff, or secretarial assistants) who needed to access, review, discuss, or handle the documents sign a Third-Party Undertaking, which was tailored to the individual circumstances of that third party. Commission counsel asked the counsel for the parties to provide a list of all the third parties requiring access, as well as a short explanation of the purpose for which access was sought. Commission counsel then provided an appropriately tailored Third Party Confidentiality Agreement.[27]

Distribution of Documents

The task of deciding how best to provide parties with access to the documents we would collect was difficult. Altogether, we collected more than 36,000 documents, comprising almost 180,000 pages of material. We also knew that, throughout the Inquiry, we would be distributing large volumes of material to parties with standing. We hired Platinum Legal Group Inc. (PLG) to provide technical support.

PLG scanned an image of each document into litigation-management software known under the brand name CT Summation iBlaze. PLG coded each document with a unique document number, as well as with its objective characteristics: author, recipient, date, source, and other information. In addition, the images were converted into text files using optical character recognition software, which permitted counsel to search across not only the coded data but the content of documents as well.

The next task was to distribute the data to counsel for the parties with standing. One possibility was to put the data onto CDs or DVDs and courier the disks to the parties. However, this process can be extremely time-consuming and expensive, and can make "rolling disclosure" (releasing small batches of documents as soon as they are ready) extremely difficult. With PLG's help, we were able to avoid these problems.

The Commission chose what it hoped would be a more efficient and effective method of distributing the documents to counsel for the parties. Documents were stored on a secure server that permitted the parties to download them over the Internet via a secure File Transfer Protocol (FTP) site. To protect the security of this highly confidential data, PLG created a multi-layered security system

[26] See Appendix 18.

[27] See Appendix 19 for an example.

involving firewalls, user-IDs, passwords, and RSA-authentication technology. Each party received an RSA security token, which generated a one-time authentication code that changed every 60 seconds. To access the secure FTP document disclosure folder, users had to combine their secret personal identification number with the code generated by the RSA token. Counsel for the parties could then securely download the documents and install them on their network servers or laptop computers.

Commission staff found this process to be a significant improvement over alternative approaches. Moreover, counsel for parties with standing indicated that sharing electronic files through the secure FTP site dramatically increased the efficiency and organization of such a large-scale, document-heavy undertaking.

Conclusion

The approach we took to document production, collection, and distribution succeeded for a number of reasons. It created a large but manageable database that was easily searchable by all parties. (My counsel estimated that an exhaustive approach to document collection would have doubled or tripled the number of documents obtained.) It also enabled Commission counsel and our staff lawyers to master the database quickly, since they had such a direct hand in defining its parameters. And it ensured that counsel did not become so buried in detail that they lost sight of the systemic focus of the Inquiry.

Witness Interviews

Most public inquiries spend much of their investigative time interviewing persons with knowledge or information relevant to the Inquiry's work. Some interviews help to identify those who should be called as witnesses. Many interviews assist with fact finding and document production. Others are simply educational, assisting the Commission staff in understanding the context or identifying issues. Interviews also allow individuals interested in the work of an inquiry to express their views and concerns. I did not personally participate in the interviews that were conducted, but my counsel informed me that our interviews served all these ends.

Commission counsel decided against using non-lawyer investigators to do this work. Although interviewing witnesses is time-consuming, it was extremely important that my counsel develop a high degree of familiarity with the facts and the potential witnesses in order to make careful judgments about which witnesses to call and what questions to ask them.

My counsel interviewed people from across the province. The interviews began almost immediately and continued throughout the Inquiry, even after our public hearings began. Those interviewed included pathologists, coroners, police officers, Crown attorneys, defence counsel, university professors, medical and administrative assistants, administrators, and regulators. Some were interviewed individually; others were interviewed in groups. Some were interviewed on more than one occasion. Many individuals were interviewed in the presence of their counsel; others chose to meet without counsel.

All those interviewed did so voluntarily. The *Public Inquiries Act* does not permit me to compel people to be interviewed. With the exception of Dr. Smith, all those who my counsel sought to interview agreed.

The interviews were neither transcribed nor recorded. My counsel rejected this procedure for at least three reasons: a concern that transcribing the interviews would add a level of formality to the interviews which might make witnesses uncomfortable; a concern that it might even create an adversarial atmosphere; and a concern that generating transcripts would be costly and lead to delay. Instead, one of the Commission lawyers kept notes during the interview and prepared a draft summary for the person interviewed to review. After the person interviewed was satisfied with the summary, it was circulated to all counsel for parties with standing. Once circulated, the summaries remained subject to the Confidentiality Undertaking that counsel had previously executed, so they did not become public unless they were formally tendered as part of our public record. Pursuant to Rule 41 of the Rules of Procedure, neither parties nor Commission counsel were permitted to cross-examine a witness on any interview summary.[28]

My counsel chose to make the interview process and the overall investigation as transparent as possible. We asked counsel for the parties to identify possible persons to be interviewed. Interview summaries for every interview were circulated to the parties, even if the person interviewed was not called as a witness. This process enabled counsel to request that a person who had been interviewed be called as a witness and to ask more informed and focused questions of the witnesses who did testify. In addition, by making our investigation more transparent and by sharing more information with counsel for the parties, I hope we encouraged trust and cooperation from the parties. In total, the Commission interviewed 81 individuals and circulated 71 interview summaries.[29]

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[28] Rule 41 did provide that counsel could seek my leave to cross-examine on interview summaries, but no such request was made.

[29] Because some people were interviewed in groups, there were fewer interview summaries than people actually interviewed.

Unless an interview summary was entered into evidence (as discussed below), I did not review it.

Notices of Alleged Misconduct

Subsection 5(2) of the *Public Inquiries Act* provides:

> No finding of misconduct on the part of any person shall be made against the person in any report of a commission after an inquiry unless that person had reasonable notice of the substance of the alleged misconduct and was allowed full opportunity during the inquiry to be heard in person or by counsel.

"Misconduct" is not defined in the *Public Inquiries Act*. The Commission was guided on this issue by Justice Peter Cory's comments in *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System in Canada)*.[30] In his consideration of a commissioner's power to make findings of misconduct, Justice Cory relied on the *Concise Oxford Dictionary* (8th ed., 1990), which states that "misconduct" is "improper or unprofessional behaviour" or "bad management."[31] Justice Cory also noted that findings of misconduct "should be made only in those circumstances where they are required to carry out the mandate of the inquiry."[32]

I instructed Commission counsel to concentrate primarily on the systemic issues and less on potential misconduct. It was a delicate balance. I wanted to ensure that I was in a position to find the facts of what went wrong. At the same time, I wanted to avoid allowing our hearing to become preoccupied with finger pointing. And most important, I was asked to conduct an inquiry that had a systemic focus.

In the result, some Notices of Alleged Misconduct were served. Recipients were informed that the notice was designed to assist in identifying allegations of misconduct that might arise during the course of the Inquiry and to permit them to respond fairly. They were cautioned that the notices should not be taken as any indication that I intended to make findings against them or that the allegations, if substantiated, necessarily constituted misconduct.[33] Neither the notices nor their existence was disclosed to others.

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[30] [1997] 3 SCR 440.

[31] *Ibid.* at 463.

[32] *Ibid.* at 470.

[33] See Appendix 20 for an example of the Commission's Notice of Alleged Misconduct.

The Review Panel

Paragraph 7 of the Order in Council provides:

> 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.

The "results of the Chief Coroner's Review" were contained in 45 separate two-page documents. The primary reviewer for each of the cases had completed an autopsy report review form, which evaluated the case against a uniform checklist and provided brief explanatory comments. These forms contained little if any narrative.

My counsel determined that the reviewers should be asked to prepare longer reports that set out the explanations for their conclusions.

Thus, in August 2007, the five reviewers returned to Toronto to review their work and prepare fuller reports. The OCCO greatly assisted in facilitating the return of the Review Panel. In addition, the CPSO agreed to defer its intended retainer of members of the Review Panel in order to accommodate the Inquiry's schedule. Commission counsel also solicited input from counsel for the affected parties (the Province of Ontario, Dr. Smith, the Affected Families Group, and the Mullins-Johnson Group) before formulating our instructions for the Review Panel.

The expanded reports were produced to all parties together with the instructions that had been prepared by Commission counsel. These reports then formed the basis of the testimony provided by the individual members of the Review Panel at the Inquiry.

To assist counsel for the parties in preparing for their cross-examinations of the Review Panel, arrangements were made to enable any counsel to meet with each member of the panel to ask questions, test theories, and develop a better understanding of their opinions. Commission counsel encouraged other counsel to meet with the members of the Review Panel to dispel any impression that they were Commission counsel's witnesses and therefore off limits.

Privacy Issues

Public inquiries are, by their nature, public. However, legislation may require that certain kinds of information cannot be made public. In addition, in some of our

cases, pre-existing publication bans arising from previous court proceedings placed limits on the information that could be made public. And s. 4 of the *Public Inquiries Act* itself provides that although hearings are presumptively open to the public, there are exceptional circumstances that permit hearings in the absence of the public.

Given the issues encountered by the Inquiry, these confidentiality requirements were a significant concern. To assist my counsel in addressing them, the Commission retained Priscilla Platt as special counsel, privacy law. Ms. Platt has more than 25 years of expertise in privacy, access to information, and related legal issues. She provided expert advice regarding the *Personal Health Information Protection Act, 2004*, SO 2004, c. 3, Sch. A, the *Child and Family Services Act*, RSO 1990, c. C.11, and the *Youth Criminal Justice Act*. The Commission was guided by the advice it received from Ms. Platt in its collection and distribution of documents.

My counsel were obliged to get two orders from the Ontario Court of Justice – Youth Court on September 25, 2007. These orders were necessary to obtain and produce documents from Ministry of the Attorney General files that related to cases which were subject to the provisions of the *Youth Criminal Justice Act* and its predecessor legislation.[34] In keeping with Regional Senior Justice Robert Bigelow's orders in these two cases, the Commission redacted the names of two young people before disclosing documents to counsel for parties with standing or to members of the press.

On October 19, 2007, I heard two motions to restrict the publication of names of various individuals. In accordance with the dicta of the Supreme Court of Canada in *Dagenais v. Canadian Broadcasting Corp.*,[35] the Commission gave notice of the proposed publication bans to representatives of the media and the parties. Notice was also published on the Inquiry's website. The media were given an opportunity to make submissions with respect to the propriety, scope, or nature of the publication bans that were sought. No representatives of the media chose to participate in these motions.

I issued my ruling granting the motions on November 1, 2007.[36] The ruling did not require my staff to redact the names of those protected by the publication ban in the documents contained in the Commission's database. Redactions were required to protect the identity of individuals investigated and prosecuted under the *Youth Criminal Justice Act*. This process would have been an extremely time-

[34] See Appendix 21.
[35] [1994] 3 SCR 835.
[36] See Appendix 22.

consuming exercise, taking many months. Instead, we restricted access to the unredacted documents to counsel for the parties and the media, all of whom were reminded of their professional obligations to comply with my ruling.

My ruling banned publication of the full names of any of the deceased children whose cases were the subject of the Chief Coroner's Review, as well as the full names of many of their relatives. My ruling also provided the single names or relationships by which individuals could be referred to in the hearing while respecting the privacy of their identities. A chart was prepared by my counsel and provided to counsel for the parties to assist them. Counsel were careful not to refer to these individuals by their full names during the course of the hearings. On the rare occasion when a banned name was mentioned inadvertently, the transcript was corrected. A delay was also built into the webcast, permitting our registrar to cut transmission in such a circumstance. Several of the individuals whose stories had received wide media attention saw no need for this protection and were content to have their full names used throughout.

Education and Consultation

Pathology Seminars

One of the initial challenges for my counsel and me was to familiarize ourselves with the basic concepts and controversies in pediatric forensic pathology. I did not want our learning process to monopolize important Inquiry hearing time. I recognized that there was much we could do apart from the formal hearing process to educate ourselves before the commencement of the hearings. Although we reviewed the leading academic texts in the area, we appreciated that it was a highly technical and complex science and that our self-study would benefit greatly from the assistance of experts. The field of pediatric forensic pathology is very small. We consulted with both domestic and international experts to assist us.

With respect to domestic expertise, I am grateful for the assistance Senator Larry Campbell provided in facilitating the first of our in-house seminars. Dr. Peter Markesteyn, former chief medical examiner for Manitoba, provided my staff and me with a full-day session that covered some of the basic concepts of forensic pathology within the field. I would like to thank Dr. Markesteyn for his assistance.

Within weeks of the Inquiry being called, Dr. Michael Pollanen, the Chief Forensic Pathologist for Ontario, was invited to provide my staff and me with a valuable overview of Ontario's pediatric forensic pathology system and the process employed during the Chief Coroner's Review.

We needed to locate a recognized expert who had no previous involvement in any of the cases before the Inquiry to act as a consultant to the Commission. Our search for an international expert led us to the Victorian Institute of Forensic Medicine in Melbourne, Australia. This institute is widely regarded as one of the pre-eminent forensic pathology facilities in the world, and we were fortunate to be able to retain Dr. Stephen Cordner, the director, as a consultant to the Commission. Dr. Cordner and his colleague Dr. David Ranson were important resources for my counsel throughout the Inquiry. In August 2007, Dr. Cordner travelled to Toronto to conduct a three-day seminar on forensic pathology for my staff.

These educational seminars were of great value to us. They not only assisted staff in their interviews and document review, but also provided us all with a basic understanding of the science at the core of our work.

The seminars were so useful that my counsel suggested we host a one-day seminar for all counsel for parties with standing. Although I have no doubt that counsel would have quickly familiarized themselves with the basics of the science, I did not want to lose valuable hearing time while counsel struggled with difficult concepts or medical terminology. Moreover, the seminar would give us a common knowledge base.

On October 24, 2007, Dr. David Ranson, the deputy director of the Victorian Institute, conducted a one-day education session on forensic pathology for me, my staff, and counsel for the parties. For those unable to attend, the Commission prepared a video/audio tape of the seminar. Many counsel who attended confirmed that they found the seminar very useful, and I am confident that it allowed counsel to ask more informed and focused questions of the witnesses.

Visits

Institutional Visits

On November 5, 2007, counsel for the parties and I visited two forensic pathology units. First, we toured the pathology department at SickKids, including its autopsy facilities. Then we toured the Provincial Forensic Pathology Unit and its autopsy facilities at the OCCO. I am grateful to the leadership of both institutions for arranging these visits. The backdrop they provided assisted in our understanding of the evidence.

Visits to First Nations Communities

On October 29 and 30, 2007, at the invitation of the Aboriginal Legal Services of Toronto and Nishnawbe Aski Nation (ALST/NAN) Coalition, I visited two Aboriginal communities in Northern Ontario – Mishkeegogamang and Muskrat

Dam. It was important to visit these communities in order to get some sense of the particular challenges related to the delivery of pediatric forensic pathology in remote northern communities. I am very grateful to both communities for the warm hospitality they extended to me, Ms. Denov, and Mr. Sandler. In both communities, I had the opportunity to meet with community leaders and with individuals and families who have suffered the tragedy of unexpected infant deaths. These visits, like the ones held in Toronto, were not part of the Commission's fact-finding process but were useful in providing me with important background information. Among other things, they brought home the enormous challenges of making pediatric forensic pathology and coronial services available to remote northern communities in general and, in particular, to First Nations communities.

Systemic Issues List

Well before the public hearings began, we thought it would be useful to compile and circulate to the parties a list of systemic issues that were exemplified by the 20 cases included in the Chief Coroner's Review. We grouped these issues into four areas of concern, recognizing that they were not watertight and that the issues did not necessarily relate to only one area. Our list of 80 systemic issues was also posted on our website on the first day of our oral hearings.[37]

In my view, it was useful to articulate, even before the hearings began, those issues that had been identified by the Commission during its initial investigation and documentary review. We made it clear that the list did not represent my final view of the key issues. It was not intended to be exhaustive or to prejudge the issues, but we hoped it would assist ongoing discussions with the parties about the scope and limits of the Inquiry; provide guidance for the examination of witnesses; and facilitate the ultimate development of recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in the criminal justice system. My counsel also found that the list was particularly useful in explaining the Inquiry's focus to potential witnesses or roundtable panellists.

[37] See Appendix 23.

ALL-COUNSEL MEETINGS AND MOTIONS

All-Counsel Meeting on the Hearing Process

My counsel met regularly with counsel for the parties individually throughout the inquiry process. Each party had different concerns and interests. My counsel tried to respond to these concerns and interests by maintaining an open door and engaging in confidential meetings with counsel as appropriate. In my view, this approach and its successful execution made a vital contribution to the efficiency of our process.

In addition to these one-on-one meetings and discussions, my counsel held an all-counsel meeting early in the process to discuss the proposed Rules of Procedure. My counsel also organized an all-counsel meeting to explain the mechanics of the hearing process.

Held in the Commission's hearing room, it covered a range of administrative and technical topics such as webcasting, document projection, microphones, Internet access, and supervision and security. Commission counsel also described in detail the procedures that would govern the hearing process itself, some of which were novel, including the introduction of documents and Overview Reports (see below), the procedure for objections, the order of cross-examination, the use of interview summaries, the rules regarding speaking to witnesses under cross-examination, and the opportunity to meet with expert witnesses.

Counsel for the parties raised questions and concerns. Commission counsel used the discussion as an opportunity to ensure that their plans for the hearing process addressed all foreseeable problems.

Motions

In addition to the motions regarding standing and funding discussed above, I decided five other motions. On October 4, 2007, I heard a motion for directions by the CPSO related to the summons to its registrar to produce all relevant documents. My ruling on this issue was released on October 10, 2007.[38]

On October 19, 2007, I heard a motion for publication bans brought by Commission counsel and counsel for the Mullins-Johnson Group. On November 1, 2007, I issued my ruling.[39]

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[38] See Appendix 16.

[39] See Appendix 22.

On November 20, 2007, I issued my ruling on the application by Dr. Smith to be examined in chief by his counsel.[40] As discussed below, I later modified my ruling.

On February 8, 2008, ALST/NAN, AIDWYC, the CLA, and the Mullins-Johnson Group brought a motion to recall Dr. James Young, the former Chief Coroner for Ontario, on an issue that arose after he had completed his testimony. They sought to question him about whether the OCCO should permit forensic pathologists to testify on behalf of the prosecution in death penalty cases in the United States. After considering their submissions, I issued my oral ruling later that same day.[41]

Finally, on March 31, 2008, I ruled in response to a request by a member of the public to deliver oral submissions at the Inquiry.[42]

In addition to my rulings, Associate Chief Justice Dennis O'Connor issued a ruling on November 20, 2007, in the matter of certain documents that the Kingston Police Service objected to producing.[43]

Also, as I have already indicated, my counsel were required to obtain two orders from the Ontario Court of Justice – Youth Court in order to obtain and produce documents from Ministry of the Attorney General files that related to cases that were subject to the provisions of the *Youth Criminal Justice Act* and its predecessor legislation.[44]

Overview Reports

Our terms of reference in the Order in Council encouraged the Commission to use procedures that would reduce the need to call witnesses to prove facts. Paragraph 8 enables us to call representative witnesses, and paragraph 7 directs us to rely on "overview reports" wherever possible. It reads:

> 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.

[40] See Appendix 24.
[41] See Appendix 25 for the transcript of my oral ruling.
[42] See Appendix 26.
[43] See Appendix 17.
[44] See Appendix 21.

Commission counsel identified the concept of overview reports as an opportunity to develop an innovative process. My counsel believed that we could drastically reduce the number of witnesses if we prepared a written "overview" of 18 of the cases that formed part of the Chief Coroner's Review. Each report would summarize the relevant documents in the Commission's database and set out the core and background facts in a neutral, non-argumentative way. The goal was to detail carefully all the steps in the death investigation, the criminal proceedings, and the Children's Aid Society proceedings for each case and to document the involvement of the pathologist, coroner, police officer, Crown, defence counsel, and family members to the extent revealed by the documents, many of which had been prepared contemporaneously with the events. In this way, we would be better able to situate the work of Dr. Smith and others within the complex factual matrix that underlies every pediatric death investigation in criminally suspicious circumstances.[45]

Under the direction of Commission counsel, our team of staff lawyers spent four months preparing the Overview Reports. Most reports were more than 100 pages long and summarized thousands of documents. It was essential that there be scrupulous accuracy and no evaluation.

In the interest of fairness, before finalizing the reports, Commission counsel asked the parties to comment on them and suggest modifications, additions, or deletions. Because of the care with which the reports were prepared, there were few suggested revisions. This positive response speaks to the clear and objective approach adopted by the Commission's staff lawyers in preparing the reports, as well as the degree of cooperation consistently demonstrated by counsel for the parties. In the event that an irreconcilable difference arose, the parties had the option of addressing the issue through the evidence of the witnesses.

The Overview Reports were filed on the first day of the public hearings. For the most part, they were used as the primary document source on which witnesses were examined – a process that worked well because it significantly reduced the number of individual documents that had to be shown to any one witness. Commission counsel and counsel for the parties adapted to it with great ease. One of the reasons that witness examinations were so concise and effective was because the Overview Reports anchored every examination. I understand that many of the witnesses found it easy to prepare for their testimony by reviewing these reports.

The Overview Reports contained some information that was never tested for

[45] See Appendix 27 for a sample Overview Report.

its truth, and I was always conscious of this fact. The reports recounted the perceptions, information, and views of many people, which may or may not have been based on accurate facts. In some cases, the reports detailed spurious allegations, which were later proven false. In other cases, they contained allegations that have yet to be proven one way or the other, or that are incapable of proof. They also documented the views individuals held at a particular time; these views may no longer accord with the views those individuals hold today.

My counsel decided, however, that it was important that the Overview Reports contain *all* this information: the fact that such views were held, or that such allegations were expressed at the time, might provide insight into the actions or omissions that ultimately occurred. It was left to me to decide how much or how little weight should be placed on the information contained in the reports. For these reasons, I have included only one sample Overview Report in this volume. However, in order to give readers an understanding of the basic facts of the 20 cases that formed part of the Chief Coroner's Review, brief summaries of each of the cases are included.[46]

Institutional Reports

During the investigative stage of our process, my counsel concluded that many of the policies, procedures, practices, and institutional arrangements, as they related to the practice and use of pediatric forensic pathology between 1981 and 2001, could be summarized in writing. They invited the OCCO, SickKids, and the CPSO to prepare Institutional Reports that described in neutral, non-argumentative language their relevant policies and procedures, as well as the applicable legislation and regulatory provisions. In effect, we asked each of the major institutions to prepare a detailed account of what would otherwise have comprised the evidence-in-chief of their primary institutional witness or witnesses.

Commission counsel concluded that it was better to ask these parties, rather than our staff lawyers, to do this work in order to capitalize on the specialized knowledge within these three institutions.

The Institutional Report prepared by the Office of the Chief Coroner for Ontario was 220 pages in length. It set out the framework for death investigations in Ontario. It described the work of the OCCO and those who work for it. The Institutional Report by SickKids was 162 pages long. It described the history and

[46] See Appendix 28.

work of the Ontario Pediatric Forensic Pathology Unit. The Institutional Report of the College of Physicians and Surgeons of Ontario was 35 pages long. It described the college's regulatory functions and its processes.

The reports were adopted by the representative witnesses from those institutions at the outset of their examinations-in-chief. Commission counsel and counsel for the parties were entitled to cross-examine these witnesses on any aspects of their Institutional Reports. In the end, there was very little cross-examination on the facts described in the Institutional Reports.

This use of these reports dramatically reduced the length of the testimony from these witnesses. It also avoided the need to call a larger number of witnesses to give evidence about matters that were largely uncontentious. Quite apart from these obvious advantages, written evidence about an institution's history, policies, and infrastructure is preferable to oral evidence on these issues because it is generally better organized, it is more likely to be precise, and it summarizes detailed information in easy-to-use graph or chart form.

Hearings

From the beginning, I asked Commission counsel to look for techniques that would allow me to streamline the hearing process. I had a responsibility to the public to be thorough and fair, while at the same time being mindful of efficiency, time, and cost. It was important that we move at a consistent pace. In addition, because this process was publicly funded, the public had the right to expect that we would conduct our work with economy and expedition.

Proceeding expeditiously was also important because recommendations to restore public confidence in pediatric forensic pathology should be brought forward as soon as possible, given the important role it plays in our criminal justice system.

I took the advice of my counsel and did not rush to commence our oral hearings. Oral hearings are costly and have the potential to take on a life of their own if they are not carefully structured. Considerable pressure is often put on a commission to begin public hearings. Although we began with a 12-month mandate, my counsel recommended that we allocate six-and-a-half months to conduct the investigation and to prepare for the hearings. My counsel predicted that this process would allow us to keep the public hearings relatively short and efficient. This proved absolutely correct. Their preparation time was vital in allowing us to identify and understand the important issues on which to focus the hearings. Moreover, the flexibility of the public inquiry process permits commission counsel to employ creative techniques to put evidence before the commission.

Although oral hearings are certainly important and may be more familiar to counsel, the public, and the press, they are not the only tool at a commission's disposal. Our oral hearings were significantly shortened not just by careful preparation but also by the various ways that documents were used in lieu of oral testimony.

Documentary Evidence

As previously discussed, the Commission relied on Overview Reports, the written reports of the Review Panel, and the Institutional Reports – all of which built much of the factual foundation of our work. And, as is discussed below, Dr. Smith also filed evidence in writing.

On three occasions, affidavits were filed instead of calling the witnesses to testify. Commission counsel filed the affidavit of Justice Patrick W. Dunn because Dr. Smith did not seek to cross-examine him. Commission counsel also filed an affidavit from Dr. James Cairns, the then Deputy Chief Coroner for Ontario, on a discrete issue that arose after he had finished testifying. Since no party wished to cross-examine him on the point, we were able to avoid recalling him as a witness. Similarly, Commission counsel filed an affidavit from Sergeant Mark Holden of the Barrie Police Service about a discrete issue arising from one of the 20 cases that continues to be the subject of a police investigation.

I have previously explained how the Commission prepared and circulated interview summaries for each of the individuals or groups of individuals who were interviewed. My counsel decided that although it was not necessary to call several individuals as witnesses, I would benefit by reviewing the interview summaries for these individuals. Commission counsel advised the other counsel that these summaries would be filed as evidence unless there were objections. This process worked well. In the result, I received evidence in this way from four individuals, the Royal College of Physicians and Surgeons of Canada, and the Ontario Association of Pathologists.

My counsel also recommended that we find a way to avoid the time-consuming and often tedious task of requiring counsel to "prove" documents they intended to rely on. Given the large number of documents that make up the database of most public inquiries, it can create significant challenges for the registrar, who must somehow keep track of hundreds if not thousands of exhibits. Commission counsel suggested that documents would be referred to by the PFP number (the unique six-digit document identifier used to catalogue all documents in our database). These documents were then treated as part of the evidentiary record on which I could rely, provided they met simple admissibility conditions specified by

Commission counsel.[47] The decision not to mark and file documents as exhibits further streamlined the hearing process.

Oral Evidence

Informed by the knowledge acquired through the intensive preparation stage, Commission counsel recommended a 60-day hearing schedule, including 15 days of "roundtables" (discussed below). Given the magnitude of the factual and policy issues we confronted, this schedule was very compressed. We were able to focus and therefore shorten the hearing phase because, before we called our first witnesses, my counsel were in a position to make informed judgments about which witnesses should testify, how long each one would require, and what the important aspects of their evidence would be. These assessments proved to be sound.

Time Limits for Examination and Cross-Examination

I imposed firm time limits on my counsel and counsel for the parties in both examination and cross-examination. I adopted the same practice used by my colleague Associate Chief Justice O'Connor in his two public inquiries; namely, that the norm was to allocate no more than the same amount of time to all cross-examinations as was allocated to Commission counsel for evidence-in-chief. After taking requests for cross-examination time, I subdivided the time among requesting counsel according to the interests of their clients in the evidence. Counsel cooperated fully, and the result was focused cross-examination that was very helpful. I am confident that this process assisted the efficiency of the hearing process without compromising its fairness.

Equally, my own counsel never exceeded their time limit of one-half of the witness's total time. This restriction required extensive preparation and a distillation of what often appeared to be volumes of material. Counsel used slides, charts, and other visual aids where it made things simpler and easier to digest. This approach enabled us to fully cover all the significant issues of fact and policy. As with other aspects of our process, we applied the principle of proportionality.

[47] The evidentiary record consisted of the Overview Reports, the Institutional Reports, affidavits, and interview summaries entered into evidence; documents referred to in an Overview Report or one of the Institutional Reports; Dr. Smith's written evidence; documents referred to in a documentary notice; documents referred to by a witness in testimony and then subsequently obtained; documents produced by a party after a witness had testified; documents produced in one of the roundtable compendia; and documents referred to by a participant at the roundtables and subsequently obtained.

Panels

Commission counsel also recommended that we call many of the witnesses in panels. This made good sense. I knew that very few of my recommendations would turn on assessments of witnesses' credibility or their unaided ability to recall specific events. I wanted, wherever possible, to avoid duplication of evidence and to identify efficiently those areas in which there was consensus. When witnesses were particularly important to my task of determining what happened, or where credibility might be an issue, they were called individually. However, the use of panels facilitated our ability to elicit opinions about the important systemic issues from those who also had some fact evidence to give. This provided an important source of information for my ultimate recommendations. It meant that I was able to look to more than our policy roundtables and our research papers.

In total, the Inquiry called 48 witnesses during the oral hearings. Of these, only 11 testified alone. The panels each consisted of two or three witnesses. When questioning a panel of witnesses, Commission counsel typically began by reviewing the background of each witness. After that, the examinations were organized in the way that most logically presented the material, without concern for whether one of the witnesses was being asked all the questions on a particular topic. When two or more witnesses from a particular institution were examined, it was easy to avoid needless repetition of material.

On cross-examination, counsel had the option of directing their questions to a particular witness or to the panel as whole. Again, given the systemic nature of this Inquiry and the fact that credibility was not often an issue, I found that counsel were generally able to target their cross-examinations effectively, even if more than one witness might wish to respond to the question asked.

There was great value in proceeding in this way. It was efficient. For example, after one doctor recounted his practice with respect to a particular procedure, counsel could simply turn to the next doctor and ask whether his or her practice varied. They did not have to summarize the prior witness's evidence or lead up to the question with a lengthy hypothetical question.

Calling witnesses in panels also facilitated discussion about the practical consequences of particular policies. I was able to test policy proposals and generate some very interesting discussions and debates. This outcome would not have been as easy with individual witnesses. Moreover, calling the witnesses in panels assisted in putting them at ease. Commission counsel informed me that many witnesses were less reluctant to testify when they learned that they would be sharing the witness stand with colleagues.

Cross-Examination

I looked to all counsel to make every effort to ensure that their cross-examinations added value to the Commission's mandate. I urged counsel to consult among themselves to avoid duplication and to be conscious of our systemic focus. From very early on in our public hearings, counsel for the parties used much of their time in cross-examination to explore the systemic and policy issues rather than getting bogged down in factual minutiae.

We did not use precious hearing time to debate and adjudicate time allocations. Rather, midway through the examination by Commission counsel, counsel for each of the parties was asked how long they intended to be in cross-examination. These time requests were recorded, and then reviewed by me. Before the conclusion of Commission counsel's examination, the precise times for each cross-examination were posted on the hearing-room monitors for all counsel to see. Only a very few objections to these allocations were ever raised.

All counsel impressed me with their focused questioning – their emphasis on what mattered. Our hearing time was thus both productive and interesting.

Dr. Smith's Evidence

At an early stage in our investigation, my counsel recognized that the fairness of our process would be measured in large part by the way in which we presented Dr. Smith's evidence. My counsel ensured that her examination of him was probing but respectful. Cross-examinations by other counsel also were focused. We set aside a week for his evidence, as sufficient to explore with him what happened without exposing him to endless public vilification.

In order to achieve these objectives, it was necessary to have detailed information about Dr. Smith's anticipated evidence well in advance of his testimony. Because Dr. Smith would not agree to be interviewed in advance, my counsel requested that he prepare a detailed summary of his evidence, which could be circulated to all parties. This issue overlapped with an issue raised by Dr. Smith – that his counsel be permitted to lead his evidence-in-chief. Indeed, Dr. Smith brought a motion to formally request this relief. I initially dismissed this motion but indicated that, if new circumstances arose before Dr. Smith was scheduled to testify, he could renew his request.

After further discussion and negotiation, my counsel recommended that I allow Dr. Smith's counsel to lead his evidence-in-chief for three-quarters of the first day, provided that he prepare a comprehensive written statement that reviewed all of our cases together with a number of systemic issues. It was also agreed that this statement would form part of Dr. Smith's sworn evidence and thus be subject to examination by Commission counsel or any other party.

Dr. Smith and his counsel prepared a thorough 138-page statement and provided it to Commission counsel and the parties approximately a week before he began his testimony. It was very helpful. It significantly reduced the time needed for Dr. Smith to give his evidence-in-chief. It allowed for thoughtful and informed preparation for cross-examination. And it avoided transforming Dr. Smith's oral evidence into an unfair test of his memory.

Questions from the Commissioner

Throughout our hearings, I took my investigatory role seriously. I saw it as my role to ask questions necessary to clarify a point or to further my own understanding of an issue. I hope that my questions also provided counsel with greater insight into the areas in which I was particularly interested and assisted in focusing both their questions and their submissions.

Conclusion

Our oral hearing schedule was possible owing to a combination of procedures we developed to streamline the process: the use of Overview and Institutional Reports to lay out the uncontested facts (in total, 2,055 pages of evidence); the use of witness panels; the dispensing of the requirement to formally prove documents; and enforcement of strict time limits for examination-in-chief and cross-examination. In my view, these procedures facilitated an efficient and fair oral hearing process that thoroughly canvassed all of the main systemic issues.

Roundtables

In order to assist in the development of specific recommendations, the Commission held a series of 18 roundtables in February 2008. Twelve of these roundtables were held in Toronto, and six were held in Thunder Bay. Each roundtable was designed around a particular theme, and many comprised both domestic and international experts. Their purpose was to ensure that the most difficult policy questions could be addressed by leading academics and practitioners.

Commission counsel carefully selected the participants at the roundtables. Some roundtables had as many as six panellists, others as few as two. We wanted input from those who could speak to both the theoretical and the practical aspects of the systemic issues. Participants included academics, pathologists, and lawyers from around the world, in addition to a number of professionals from Ontario's legal, medical, and child-protection communities. Some people had previously testified at the Inquiry; others had prepared research studies for the

Commission; and still others had played no previous role with the Commission. I am grateful to all of those who participated in these roundtables.

For each theme, Commission counsel prepared a series of questions to be discussed and debated by the participants.[48] Participants were informed that the questions were not intended to be exhaustive and that their inclusion did not necessarily mean that they would be addressed in my Final Report. The Commission circulated the themes and proposed questions to the participants and the parties in advance in order to give them the opportunity to consider the issues. We invited comments, including additional questions. The Commission also provided the participants and parties with a compendium of relevant articles and documents for each roundtable.

The roundtables were led by Commission counsel using a question-and-answer format, with the exception of the First Nations roundtables in Thunder Bay. Participants were not required to prepare any submissions in advance or deliver opening statements or positions. Dialogue among the participants was encouraged. Counsel for the parties had a brief opportunity to ask questions at the end of each roundtable. This was not cross-examination, however, and the participants were not sworn. I was also very much involved in the discussions and asked many questions. These roundtables gave me an opportunity to seek out information about the areas I found the most challenging. They were extremely valuable, engaging, dynamic, and full of important insights about the systemic problems.

Submissions

Parties

The parties were required to file written submissions by March 20, 2008. These submissions were circulated to the other parties for download through the Commission's secure FTP site. The parties then had the opportunity to provide written reply submissions by March 27, 2008. In these submissions, I asked the parties to set out any specific findings of fact or systemic recommendations they wished me to make. I imposed no page limits on them.[49] All written submissions were posted on the Inquiry's website.

[48] See Appendix 29 for the list of those who participated at the roundtables and the issues that were discussed.

[49] See Appendix 30, Memorandum from Linda Rothstein to Parties with Standing, dated February 20, 2008.

Oral submissions were heard on March 31 and April 1, 2008. The Commission asked the parties to provide estimates of the time required for their oral submissions before March 21, 2008. I then allocated the time for oral submissions in much the same way I had for cross-examinations. The oral submissions proceeded as scheduled. Both the written and oral submissions were very helpful.

Non-Parties

The Commission also accepted written submissions from non-parties. These were also posted on the Inquiry's website. In total, the Commission received submissions from four non-parties.[50]

The Delivery Date for the Report

The original Order in Council set a date of April 25, 2008, for delivery of the Final Report. I have described the various steps we took immediately, once the Inquiry was established, and how particularly important it was to engage in an intensive investigation and preparation process before beginning the evidence. The time devoted to this permitted us to have a focused and efficient hearing schedule.

We began on November 12, 2007, and concluded on February 29, 2008, after some 60 days of hearings. Counsel for the parties then required a reasonable period of time to prepare their final submissions. As I have said, these submissions concluded on April 1, 2008.

The Order in Council required the Commission to ensure that the Report complied with the *Freedom of Information and Privacy Act* and other applicable legislation. More important for timing purposes, it also assigned to the Commission the responsibility for the translation and printing of the Report in sufficient quantities for public release. These steps, which took some nine or 10 weeks, had to be done within the prescribed timeline.

With the time required for investigation and preparation, hearings, submissions, writing, translation, and production, it was clear by early 2008 that meeting the original delivery date would not be feasible. As a result, on March 27, 2008, I requested and received an extension to September 30, 2008.

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[50] Submissions were received from Dr. Ernest Cutz, who had previously testified as a witness at the Inquiry; Dr. David King, a retired forensic pathologist and former head of the Regional Forensic Pathology Unit at Hamilton General Hospital; the Office of the Provincial Advocate for Children and Youth; and the federal Department of Justice.

Research

Shortly after my appointment as Commissioner, I asked Professor Kent Roach to be the Commission's director of research. Professor Roach holds the Prichard-Wilson Chair of Law and Public Policy at the University of Toronto Faculty of Law, and he has had extensive experience working on public inquiries in Canada.

Over the summer of 2007, Professor Roach retained experts from Australia, Canada, the United Kingdom, and the United States to prepare research studies related to pediatric forensic pathology and its interaction with the justice system. Eleven research studies were prepared for the Commission, and each one was posted on the Inquiry's website.

Establishing the right balance between the research and hearing components of a public inquiry is always challenging. Many public inquiries segregate the policy development / research component from the fact-finding component of their work by creating separate phases. Sometimes these phases take place concurrently and sometimes they follow each other, but they are nonetheless separate. Given the systemic nature of my mandate, I did not believe that separating our work into two distinct phases was appropriate or useful.

The majority of the authors of the studies participated as panellists at the roundtables. Having the researchers as well as other experts at the roundtable panels enabled the Commission to examine carefully the practical implications of conclusions or recommendations made by the researchers.

I read all the research studies carefully as soon as they were available to me. I found them to be thorough and insightful. They assisted me in identifying and addressing issues of importance, comparing alternative approaches, articulating questions for witnesses and panellists, and considering the submissions of the parties during my deliberations.

Conclusion

Designing a process that achieved the objectives of our systemic review was a rewarding challenge for my counsel and me. We spent many weeks developing our approach and refining our procedures. We strove to conduct a fair, efficient, and transparent inquiry. I am confident we succeeded. Hopefully, some of our ideas will be useful to other public inquiries.

Appendices

Appendix 1

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.

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.

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.

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. 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. 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.

Appendix 2

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:

An amendment be made to the Order in Council numbered O.C. 826/2007 and dated April 25, 2007, by substituting "September 30, 2008, or if requested by Commissioner Goudge and approved by the Attorney General, up to a further sixty days, such correspondence to be included in the final report" for "April 25, 2008" in paragraph 2 so the paragraph shall read:

> 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 September 30, 2008, or if requested by Commissioner Goudge and approved by the Attorney General, up to a further sixty days, such correspondence to be included in the final report.

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

Le décret no 826/2007 du 25 avril 2007 est modifié, au paragraphe 2, par substitution de «le 30 septembre 2008 ou, sur demande du commissaire Goudge et avec l'approbation du procureur général, dans les soixante jours qui suivent cette date, la correspondance pertinente étant versée au rapport final» à «le 25 avril 2008», de sorte que le paragraphe se lise comme suit :

> La commission mènera l'enquête avec la célérité voulue et remettra son rapport final et ses recommandations au procureur général au plus tard le 30 septembre 2008 ou, sur demande du commissaire Goudge et avec l'approbation du procureur général, dans les soixante jours qui suivent cette date, la correspondance pertinente étant versée au rapport final.

Recommandé par : Le procureur général,

Recommended _____
Attorney General

Appuyé par : Le président du Conseil des ministres,

Concurred _____
Chair of Cabinet

Approuvé et décrété le

Approved and Ordered MAR 27 2008
Date

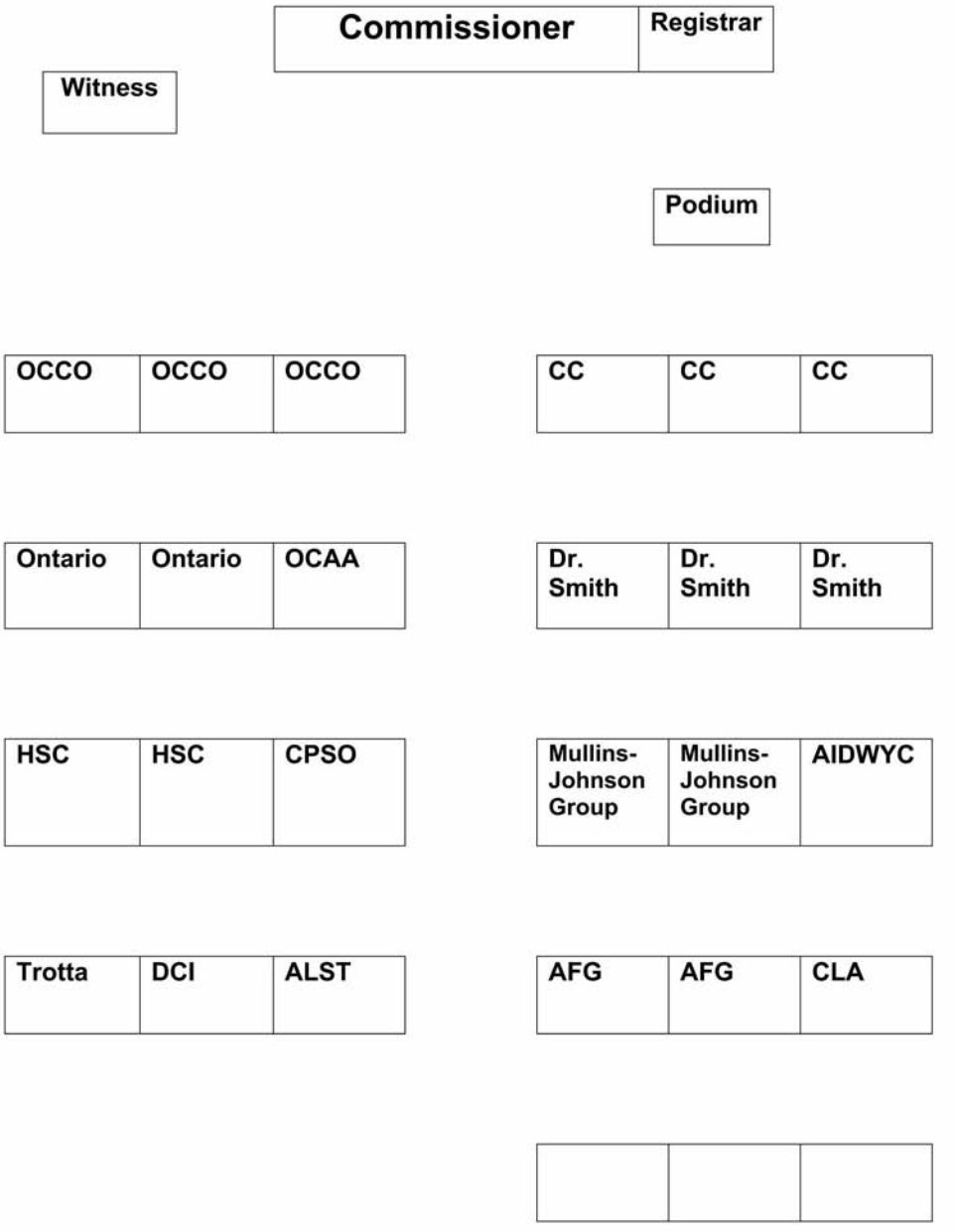
Le lieutenant-gouverneur,

_____
Lieutenant Governor

R.O.C./Décret 366/2008

Appendix 3

Inquiry into Pediatric Forensic Pathology in Ontario
Hearing Room Seating Plan
180 Dundas St. West, 20th Floor



Appendix 4

PFP058378/1

Backgrounder/
Document d'information

Office of the Chief Coroner
26 Grenville Street
Toronto ON M7A 2G9
Telephone: 416 314-4000
Facsimile: 416 314-4030

Bureau du coroner en chef
26, rue Grenville
Toronto ON M7A 2G9
Téléphone : 416 314-4000
Télécopieur : 416 314-4030

April 19, 2007

PUBLIC ANNOUNCEMENT OF
REVIEW OF CRIMINALLY SUSPICIOUS AND HOMICIDE CASES
WHERE DR. CHARLES SMITH CONDUCTED
AUTOPSIES OR PROVIDED OPINIONS

HISTORY:

In November of 2005, Dr. Barry McLellan, Chief Coroner for Ontario, announced the scope and format of a review into 44 criminally suspicious and homicide cases, dating back to 1991, where Dr. Charles Smith had performed an autopsy or provided an opinion in consultation. The purpose of the review was to determine whether the conclusions reached by Dr. Smith in his autopsy or consultation reports, or during his testimony where applicable, could be supported by the information and materials available for independent review.

At the time of the original announcement in November 2005, 44 cases had been identified for review. They included cases where at some point in time, the death had been determined to be a homicide or criminally suspicious and where Dr. Smith was either the primary or a consulting pathologist. Of the 44 cases, 43 dated back to 1991 when the Provincial Paediatric Forensic Pathology Unit first opened, and the other case was a 1988 death that had received significant public attention. Through the process of collecting information and reviewing files, it became evident that there were 45 cases that met the review criteria.

REVIEW PROCESS:

The scope and format for the review were determined with advice from the Forensic Services Advisory Committee of the Office of the Chief Coroner. This Committee was formed to strengthen the independence and objectivity of the Office, as well as to improve communication with key stakeholders. Advice to the Chief Coroner is provided through this multidisciplinary Committee that includes representatives from the Office of the Chief Coroner, the Centre of Forensic Sciences, various police services, the Prosecution Service and the Defence Bar. Committee members share a common interest in advancing the quality and independence of all aspects of post mortem examinations conducted on coroners' cases.

The review was conducted by a panel of internationally respected experts in forensic pathology. The members of the committee included:

Dr. John Butt - Consultant in Forensic Medicine, specializing in expert opinion and evidence, as well as education about investigation and pathology of sudden death and serious injury. Prior to setting up an independent consulting practice, Dr. Butt was the Chief Medical Examiner for the Province of Nova Scotia and before this, he was the Chief Medical Examiner for Alberta.

Professor Christopher Milroy - Professor of Forensic Pathology at the University of Sheffield, England, consultant pathologist to the British Home Office and Honorary Consultant in forensic pathology for the Sheffield Teaching Hospitals National Health Service Foundation Trust.

Professor Helen Whitwell - Professor of Forensic Pathology at the University of Sheffield and a consultant pathologist to the Home Office. She brought special knowledge and expertise to the panel in the area of neuropathology.

Professor Jack Crane - State Pathologist for Northern Ireland, a Professor of Forensic Medicine at The Queen's University of Belfast, and a consultant pathologist of the Northern Ireland Health and Social Services Boards.

Professor Pekka Saukko - Professor and Head of the Department of Forensic Medicine at the University of Turku in Finland.

The cases were prioritized for review based on whether persons who were convicted or found to be Not Criminally Responsible, as a result of any previous court proceedings still had restrictions imposed on their liberty, including those persons who were out of custody, but on parole or on bail. An initial screening review of the investigation materials from the remaining cases by a subcommittee of the Forensic Services Advisory Committee, with forensic pathology, police, and Crown and Defence counsel members, identified 10 cases where there did not appear to be any potential controversial issues with medical evidence. These cases underwent the same structured review, but were reviewed by other senior pathologists in Ontario, in order to ensure best use of the external reviewers' time to deal with the more potentially difficult and complex cases.

All 45 cases were reviewed through a structured process. The reviewers were specifically asked to provide their opinions on the following:

- whether they agreed that the important examinations were conducted;
- whether they agreed with the facts reported as arising from the examinations conducted and;
- whether they agreed with the interpretation of the examinations conducted with respect to the cause and where an opinion was provided, the mechanism of death.

The materials reviewed by the pathologists included:

- autopsy reports or consultation reports completed by Dr. Smith;
- the coroner's warrant;
- any other autopsy or consultation reports arising from the investigation and, where available, second opinion pathology consultation reports;
- photographs from the autopsy and death scene;
- microscopic slides and any other pathology materials;
- police reports;
- reports from the Centre of Forensic Sciences and
- where available, selected relevant court transcripts arising from all pathology and any related medical evidence, for those cases that proceeded through the criminal courts. The review did not include, and was not designed to include, the entire Court record in each individual case.

Wherever possible, families of the 45 children who formed the basis of this review, and counsel who represented parties on matters arising from the coroner's investigations into these deaths, were contacted directly prior to the start of the review. Wherever possible, families of the children, or their counsel, have also now been informed of the results of the review of their child's death. Families of the children are entitled to receive the reports arising from the review of their child's death consistent with the *Coroners Act*, subject to any ongoing Court proceedings, and the Office of the Chief Coroner will now be making these reports available. Families who have not yet been contacted, may call the Office of the Chief Coroner at 1-877-991-9959 at any time in order to inquire about obtaining reports.

RESULTS:

A total of 45 cases were reviewed. The first question dealt with the examinations that were conducted, recognizing that in three cases Dr. Smith was performing a post-exhumation autopsy and in four cases he was providing an opinion in consultation, not having had the opportunity to conduct an autopsy himself. In all but one of the 45 cases, the reviewers agreed that Dr. Smith had conducted the important examinations that were indicated. In one case, there was concern that a complete examination had not taken place and in this same case that a specimen taken at autopsy had not been submitted at the time for potential testing. This concern was made known to appropriate Crown and Defence counsel who had carriage of this case prior to the case coming to conclusion in the Criminal Courts.

The second question was whether the experts agreed with the facts reported as arising from the examinations performed. In nine cases the experts did not agree with significant facts that appeared in either a written report or that came forward during expert testimony in Court. A common theme centred around the timing of certain injuries, including fractures.

The final question was whether the reviewers agreed with the interpretation of the examinations conducted with regard to the cause and where Dr. Smith provided an opinion, the mechanism of death. 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. The concerns raised by the reviewers in these 20 cases ranged from relatively minor to potentially more serious issues. In a number of these cases the reviewers felt that Dr. Smith had provided an opinion regarding the cause of death that was not reasonably supported by the materials available for review.

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. To date the reports of the reviewers have been provided to Crown and Defence counsel in three of these 13 cases. The reports in all of the remaining cases will be provided to the Crown and they will then be appropriately disclosed to Defence counsel.

The Chief Coroner appreciates the public concern that may arise as a result of the reviewers having expressed differing opinions in cases where there were subsequent convictions or a finding of Not Criminally Responsible. As indicated, the opinions of the external reviewers and the concerns leading to this opinion for all of these cases have been, or are in the process of being shared with appropriate Crown and Defence counsel. The significance of the concerns expressed by the reviewers, specifically with respect to the role any medical evidence may have played in a finding of guilt, will therefore be appropriately considered.

It is important to provide a context for the concerns expressed by the reviewers in two cases with respect to Dr. Smith's opinion on the cause of death and mechanism of death. In two cases the reviewers noted that the opinions reached by Dr. Smith were not inconsistent with the body of knowledge available at the time — the early 1990's — with respect to paediatric head injury. In fact, there is still disagreement between medical experts today as to the significance of certain findings in some cases of paediatric head injury. Although the reviewers disagreed with Dr. Smith's opinion, they felt that his conclusions in these two cases were consistent with what other Pathologists and medical experts may well have concluded at the time he provided his opinion.

It is also important to provide a context for the overall results of this review. Dr. Smith was conducting his work as one member of a larger death investigation team. This means that Dr. Smith was, in part, relying on information provided to him by coroners, police, and other forensic experts. Dr. Smith, working as a pathologist within the Coroner's system, frequently presented his findings and opinions at meetings and rounds where other pathologists and coroners would have had an opportunity to provide feedback and, where appropriate, disagree with the opinion being presented. In a number of these cases other pathologists may have reviewed or audited Dr. Smith's work as part of a quality assurance process. In certain cases where expert testimony was given, Defence experts appear not to have recognized concerns that have now been brought forward as a result of this review.

LESSONS LEARNED:

Lessons have been learned in the Ontario Coroner's System through previous cases and as a result of this review. Maintaining public confidence in the Ontario Coroner's System was an underlying reason for conducting this review. Some of the positive changes that have taken place and some of the processes that are now in place to ensure the highest quality of forensic death investigation include:

- In 1995, the Office of the Chief Coroner developed a protocol for coroners, pathologists, police, and other members of the death investigation team to follow when investigating paediatric deaths. This protocol, focusing on deaths of children under the age of two years, has subsequently been presented at a number of educational courses and has become the standard operating procedure for all members of the death investigation team. The protocol has been shared with other jurisdictions and has been used as a template for other death investigation systems. A number of improvements have subsequently been made to the protocol. Late last year, a revised protocol was released through the Office of the Chief Coroner whereby all child deaths under the age of five years are now subjected to this standardized investigation.

- The Office of the Chief Coroner has two review committees focusing exclusively on complex paediatric deaths. The Deaths Under Five Committee reviews the investigation materials and coroners' conclusions on all deaths under the age of five years to ensure consistency in the examinations conducted and the conclusions reached. The Paediatric Death Review Committee reviews complex paediatric deaths, including all cases where Children's Aid was involved prior to the death.

- All autopsies conducted on children under the age of five years are now performed in only one of four centres throughout the province: London, Ottawa, Hamilton and Toronto. This change was introduced in early 2002 to ensure that these complex autopsies are performed at centres where there is the greatest expertise in pathology and paediatric specialties, and where the resources for special tests such as CT or MR imaging are most accessible.

- All forensic autopsies on criminally suspicious cases, homicides, and cases going to inquest, now undergo a standardized audit process. A process of audit began in 1995 and has subsequently undergone a number of improvements. The current audit process, under the direction of the Chief Forensic Pathologist, is intended to ensure that all important examinations have been performed and that the facts arising from these examinations and the conclusions reached are logical and clearly supported by the materials available for any independent review.

- Guidelines have been prepared for autopsies on all criminally suspicious and homicide cases, under the direction of the Chief Forensic Pathologist. These guidelines have recently been updated to include a paediatric module. The guidelines include the important examinations to be completed and the documentation and specimen retention expected, to ensure that the conclusions reached are independently reviewable.

- Guidelines have also been produced for coroners focusing on the important observations to make at scenes, documentation expected in coroners' reports and the essential communication that is expected with pathologists and other members of the death investigation team. It is the coroner, at the conclusion of the investigation, that is responsible for certifying the death, including determining the cause and the manner of death. Arising from this review, an audit was performed of the Coroner's Warrant for Autopsy and the Coroner's Investigation Statements. In 11 of the 45 cases reviewed, the Warrants were completed with less information than what is currently expected based on the guidelines, although in no cases was it felt that the deficiencies identified impacted on the conclusions reached by Dr. Smith. Regardless, there is need for better communication between coroners and pathologists. As a result of this audit, it will soon be policy for direct telephone or in person communication between the coroner and pathologist, prior to the commencement of the autopsy, for every criminally suspicious or homicide case and for all deaths under the age of five years.

- A special course has been developed for pathologists who provide expert testimony in court. With the assistance of Crown counsel, Defence counsel and pathology experts, the importance of balanced and fair testimony are emphasized through a two-day course that includes mock examination and cross-examination. This course will be offered again in June 2007.

- Early case conferences are now held following all homicides and criminally suspicious cases, wherever there are outstanding issues or significant unanswered questions following the autopsy. These case conferences include a senior coroner, the pathologist who conducted the examination, scientists from the Centre of Forensic Sciences, police and any other experts as appropriate. These case conferences are held, in part, to ensure that all members of the death investigation know what has been found at the time of the autopsy and what outstanding examinations or test results are necessary before appropriate conclusions can be reached by the pathologist.

A number of these steps to improve the quality of investigations have been, and will continue to be, shared with other jurisdictions through educational courses and presentations.

FURTHER REVIEW:

This review covered the work of Dr. Smith from 1991 to 2002. Dr. Smith did, however, also conduct autopsies and provide opinions on cases between 1981 and 1991. Given the results of this review, there may well be cases prior to 1991, which raise similar concerns. With this in mind and also being mindful of the fact that the greatest concern surrounds cases with findings of guilt and restrictions of liberty, the Office of the Chief Coroner will work with the Ministry of the Attorney General to try to identify all such cases where Dr. Smith conducted an autopsy, or provided an opinion in consultation, prior to 1991.

As this list of cases is developed, the Prosecution Service will take the lead to disclose the overall results of this review to the person whose liberty was restricted. If any such person asserts their innocence and requests that their case be reviewed, the Office of the Chief Coroner will then assist the Prosecution Service and the Defence to arrange for an independent review of Dr. Smith's forensic pathology work and opinion. The results of the individual review will then be appropriately shared with the person requesting the review through the disclosure process.

As indicated in the original announcement, the start date of 1991 was an arbitrary one that coincided with the opening of the Paediatric Forensic Pathology Unit. This additional step is being taken at this time to ensure that cases of greatest potential concern are reviewed, regardless of when the work was conducted.

Conducting this review has been an essential step for the Office of the Chief Coroner. The Office of the Chief Coroner performs more than 20,000 death investigations and pathologists working for the Office conduct almost 7,000 autopsies every year. Coroners' investigations lead to many important recommendations to advance public safety and information gained through death investigations is essential for the administration of justice. The public must have confidence in the death investigations conducted by this Office. The Office of the Chief Coroner is unaware of any other jurisdiction that has as many processes in place to ensure the highest quality of death investigation, including independently reviewable post mortem examinations.

- 30 -

Contact:
Dr. Barry McLellan
Chief Coroner for Ontario
Ministry of Community Safety and Correctional Services
416-314-4000 or 416-314-4100

Disponible en français

Appendix 5

1. Good morning, my name is Stephen Goudge. Thank you very much for attending today.

2. On April 25, 2007, the Province of Ontario established the Inquiry Into Pediatric Forensic Pathology in Ontario. That Order-in-Council appointed me as Commissioner.

3. Today marks the first public session of the Commission. This morning, I want to do five things:

a) introduce some of the members of the Commission's staff;

b) explain the terms of reference for the Commission and describe what the Commission can do, and what it cannot do;

c) share some of what the Commission's staff have done so far;

d) describe the private meetings I am holding with individuals and families affected by practices in Ontario's pediatric forensic pathology system, and explain why these meetings are important to the work of this Commission; and finally,

e) outline the process that the Commission will follow from this point forward.

Introduction of Commission Staff

4. First, I am very fortunate to have Senator Larry Campbell assisting me.

5. Senator Campbell has spent most of his career in law enforcement and death investigation. He was instrumental in establishing Vancouver's District Coroner's office. He became Chief Coroner in 1996. As many of you know, Senator Campbell was elected mayor of Vancouver in 2002.

6. Senator Campbell will provide me with information and advice on scientific and medical issues.

7. One of my first acts as Commissioner was to assemble a team of lawyers, scholars, and administrators to assist me. I am joined by the three senior members of my team at the front of the room:

a) Linda Rothstein is Commission Counsel;

b) Mark Sandler is Special Counsel Criminal law; and

c) Prof. Kent Roach is the Commission's Research Director.

8. With the able assistance of the rest of the team, they were able to start the Commission's investigation process within days after the Order in Council was passed. So far, Commission lawyers have spent a good deal of time meeting with interested

persons and organizations to discuss the Commission's mandate and outlook, and to begin to gather information.

Description of the Commission

9. The Order-in-Council created the Commission and gave it certain powers under the *Public Inquiries Act*. The jurisdiction of this Commission, like all commissions of inquiry, is limited by the Order-in-Council that creates it. I do not function as a Commissioner at large. I can neither expand, nor work outside of the mandate provided to me.

10. Public inquiries are an important component of our Canadian democracy. They play an important role in fact-finding, and in educating and informing concerned members of the public. They also play a role in restoring public confidence in governmental institutions. In the end, they make recommendations designed to ensure, as best we can, that the concerns that gave rise to the Commission are addressed and avoided in the future.

11. I want to emphasize what a commission of inquiry is, and what it is not. It is an investigation into a matter of substantial public interest to a community. It has the power to summons witnesses, to compel the production of documents, and to accept evidence. However, it is not a trial, criminal or civil, and I cannot make findings of criminal or civil liability.

12. My Order-in-Council directs me to "make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings."

13. That is the Commission's primary task: to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings. The Commission's recommendations will, I hope, ensure that no one ever has to endure the horror of being charged criminally, or having a family unit pulled apart, or being wrongfully convicted because of flawed pathology findings or evidence. The Commission's recommendations will also attempt to ensure that pediatric forensic pathology appropriately supports society's interest in protecting children from harm and ensuring that those individuals who do harm children are brought before the courts to be dealt with according to the law.

14. This is a matter of fundamental importance to the administration of justice in Ontario. The death of any young child is an extraordinary tragedy. The enormous grief and trauma experienced by the parents and other family members where a child has died is almost beyond comprehension. Where the death has occurred in circumstances that might be described as criminally suspicious, we must ensure that the death investigation is detailed, thorough, objective, compassionate, and balanced.

15. Pediatric forensic pathology must do its part to ensure that death investigations meet these goals. I am charged with making recommendations to restore and enhance public confidence that pediatric forensic pathology promotes the search for truth and helps to answer as accurately as science permits the question of what caused a child's death.

16. To allow me to make these recommendations, I will conduct a systemic review and assessment of three things:

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;

b) the legislative and regulatory provisions in existence that related to the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and

c) any changes to these items that have been made subsequent to 2001.

17. I want to underline the words "systemic review" that appear throughout the Order-in-Council. I must take them very seriously. They must inform and guide my decisions as Commissioner.

18. As part of this systemic review, the Commission will wrestle with difficult questions. Among many other matters, the Commission will examine and evaluate:

a) the evolution, limits and inherent frailties of pediatric forensic pathology, and the developing state of that science, including sudden infant death syndrome and shaken baby syndrome;

b) best practices for pediatric forensic pathology, including issues of training, protocols, peer review, oversight, and certification;

c) how key institutions within our justice system work together, and how well they do so. We will examine the interaction between pediatric forensic pathologists, the police, the Coroner's office, Crown Attorneys, and others. We will identify best practices to avoid tunnel vision during investigations and criminal proceedings involving pediatric forensic pathology;

d) the evolution of pediatric death investigation procedures;

e) different models of death investigation and reporting including coroner-based systems and medical examiner-based system, their strengths and weaknesses, and what we can learn from other jurisdictions;

f) how Crown Attorneys and defense counsel obtain and use forensic experts;

g) the role of the legal aid system in ensuring that defence counsel has access to competent expertise in pediatric forensic pathology;

h) the use of scientific experts by courts in other jurisdictions, including how experts are designated by different regulatory bodies, as well as how courts and juries can evaluate an expert's expertise; and

i) how the courts referee forensic disputes both pre-trial and at trial, and how the courts function as gate-keepers by determining who qualifies as an 'expert' and what counts as 'expertise'.

19. As I mentioned earlier, Orders-In-Council tell Commissioners what to do and what not to do. The Order-in-Council creating this Commission is no exception and it clearly states that the Commission:

a) shall not report on any individual cases that are, have been, or may be subject to a criminal investigation or proceeding; and

b) 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.

20. The Commission will not report on individual cases. Without this limitation in the Order-in-Council, the Commission would be required to exhaustively review and call evidence regarding, depending on how one counts, 21, 45, or still more individual cases. I am required to deliver my report in less than one year. It would be impossible to do justice to that many cases and still make timely systemic recommendations.

21. Moreover, the reporting deadline serves an important public purpose: to provide the government with my recommendations as expeditiously as possible in order to restore faith in pediatric forensic pathology and its use in investigations and criminal proceedings.

22. I wish to underline that this Commission does not have the jurisdiction to consider whether or not any criminal conviction should be considered a miscarriage of justice. The *Criminal Code* contains various procedures to do that. The Commission will neither duplicate nor interfere with those procedures. There may be cases where individuals seek to appeal, or to otherwise have reviewed her or his conviction based on new pathology results. As the Attorney General said when he announced this Commission, it is important that such applications be dealt with fairly, and as expeditiously as possible, and I trust that the Ministry will do all it can to ensure that this happens.

23. While the Commission will not be reporting on individual cases, it will be necessary to review individual cases for the purposes of determining what systemic issues they raise. We need to learn enough about the facts of what happened and why to make practical and effective recommendations. I will describe later on how we intend to proceed with this.

Private meetings with individuals and families and counselling

24. This week, and again in August, I will meet privately with individuals and families affected by practices in Ontario's pediatric forensic pathology system between 1981 and 2001. Everyone who will meet with me is doing so voluntarily.

25. In order for me to understand fully the impact that systemic failings have had on people's lives, I believe it is crucial for me to speak with those directly affected.

26. However, in order not to prejudice any ongoing legal proceedings, and in view of the intimate and personal nature of the matters that will undoubtedly be disclosed in these meetings, these meetings must take place in private. They will neither be part of the formal hearing process, nor form a basis for fact-finding. There will be no transcripts of the meetings.

27. What is said to me by the participants will not be disclosed. This confidentiality is essential to permit individuals to feel comfortable discussing these events with me. In fact, many participants agreed to meet with me only on that basis.

28. The Commission is not empowered to correct errors in specific cases nor provide financial compensation but the information from the meetings will be extremely useful background for my work. It will anchor my work in real human experience.

29. In addition, section 16 of the Order-in-Council authorizes me to provide counseling services to victims or families. Anyone, including immediate family members

who has been affected by these systemic failings relating to pediatric forensic pathology is eligible to receive these services.

30. Individuals who qualify for counselling support can choose both the type of counselling and the service provider that is right for them, provided that the Commission agrees that the person is a qualified counsellor. A qualified intake counsellor will assist those who are interested in counselling, but who are unsure what type of counselling can meet their needs and/or how to find a qualified counsellor.

31. Anyone interested in counselling related to matters within the Commission's mandate, should please call the Commission. The process is straightforward, confidential, and supportive. You will be given a private appointment to speak with a qualified intake counsellor, either in person or over the phone and at a time convenient to you. The intake counsellor will answer any questions you may have and will explain the process to you.

32. At this point in time, funding for counselling will be available for a period of up to two years. If necessary, there will eventually be an opportunity for submissions on the need for further counselling.

Process after today

a) Standing

33. Later today, the Commission will publish its Rules of Standing and Funding on the Commission's website: www.goudgeinquiry.ca

34. The Commission invites interested persons to seek standing at the Commission by way of motion in writing with supporting materials, which must be filed in electronic format with the Commission on or before July 16, 2007

35. The Order-in-Council provides that I may make recommendations to the Attorney General regarding funding to a party who has been granted standing where in my view the party would not be otherwise able to participate in the Commission without such funding. Persons may seek funding by way of motion in writing with supporting materials to be filed in electronic format with the Commission on or before July 16, 2007.

36. I anticipate scheduling a public hearing on applications for standing and funding on August 8, 2007, and releasing my decision by August 20. If anyone has questions regarding the process for applying for standing and funding, they should contact Commission Counsel.

b) Rules of Procedure and Practice

37. After the release of my decision on standing and funding, Commission Counsel will invite persons with standing to meet to discuss draft Rules of Procedure and Practice, which I anticipate releasing in final form by the end of August.

c) Further pathological review

38. This Commission was announced about a week after the Chief Coroner for Ontario announced the results of a review of certain criminally suspicious or homicide cases where Dr. Charles Smith was either the primary or consulting pathologist, and found that, in a number of cases some of the factual conclusions were not reasonably supported by the materials available for review.

39. Five eminent forensic pathologists from Canada and around the world conducted the Chief Coroner's Review. The Commission's Order-in-Council directs the Commission to consider the results of the Chief Coroner's Review.

40. As has been publicly reported by the Chief Coroner, the Chief Coroner has advised the College of Physicians and Surgeons of Ontario of the concerns identified in its review of certain cases of suspicious child deaths where Dr. Smith performed the autopsy or was consulted.

41. I have asked the College, and it has agreed, that this inquiry be given priority for access to evidence and experts. I want to be clear that my request may delay any matters that may be before the College, and that I appreciate the College's cooperation in this regard.

d) Overview Reports

42. The Commission began its investigation on April 25, 2007. The goal of the investigation, in part, is to identify the core or background facts that will form the basis of Overview Reports about the systemic issues to be addressed, and to identify representative witnesses. The investigation will consist primarily of document review, consultation with interested persons and witness interviews by Commission staff.

43. The Order-in-Council provides Overview Reports to be prepared, which may contain core or background facts, together with their sources.

44. The Commission will provide an opportunity for parties to comment on the accuracy or completeness of the Overview Reports before they are filed. The Commission may modify the Overview Reports in response. The Overview Reports will be used to assist in identifying the systemic issues that are relevant to the work of the Commission.

e) Public Hearings

45. After the Commission has completed its investigation and the Overview Reports, the Commission will hold public hearings in Toronto.

46. The Overview Reports will be presented in the public hearings. Parties may also propose witnesses to be called to support, challenge, comment upon or supplement the Overview Reports.

47. Our present intention is that from this will emerge the list of systemic concerns that will be the vital basis for our policy work. These systemic concerns will be debated in public roundtable sessions to elicit expert opinion on what solutions are available to solve these systemic concerns.

48. We also anticipate that the public hearings will examine how institutions responded to challenges to the work of pediatric forensic pathologists, and consider recommending strengthened oversight and accountability measures where appropriate.

49. Wherever possible, the Commission will rely on the use of representative witnesses from institutions. Given the systemic focus of the Commission, the Commission does not anticipate hearing from a large number of witnesses whose involvement was limited to one or two cases of interest identified by the Chief Coroner's Review.

50. The Commission will also call experts to assist me to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.

f) Research Project

51. The Commission will also be embarking on an important research project under the leadership of Prof. Kent Roach. The purpose of the research project is to present the Commission with both important background information and various possible policy solutions. Whether or not any of these proposals are accepted is up to me, not the

researchers. The Commission intends to test this research in lively and public roundtables that will bring a diversity of perspectives and experience to the issues.

52. Prof. Roach is in the process of identifying approximately 8 independent researchers, experts from Canada and around the world, to write papers to carry out this project. I hope that in this way the Commission will also create a research legacy that will be of assistance to the administration of justice in many jurisdictions.

Conclusion

53. Thank you all for coming today. Regular updates about the Commission's schedule and events will be posted on our website at www.goudgeinquiry.ca Commission Counsel will now be available to answer questions from the media.

Appendix 6

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULES OF STANDING AND FUNDING

General

1. These Rules of Standing and Funding apply to the Inquiry Into Pediatric Forensic Pathology in Ontario (the "Commission" or "Inquiry"), established pursuant to Order in Council 826/2007 (the "Terms of Reference").

2. Subject to the *Public Inquiries Act*, R.S.O. 1990, c. P.41 (the "Act") and the Terms of Reference, these Rules are issued by The Honourable Stephen T. Goudge (the "Commissioner"), in his discretion to facilitate the efficient disposition of the issues of standing and funding

3. The Commissioner may amend these Rules or dispense with compliance of these Rules as he deems necessary to ensure the Inquiry is thorough, fair and timely.

4. All parties, witnesses and their counsel shall be deemed to undertake to adhere to these Rules, and may raise any issue of non-compliance with the Commissioner.

5. The Commissioner may deal with a breach of these Rules as he deems appropriate.

6. In these Rules, "persons" refers to individuals, groups, governments, agencies, institutions or any other entity.

Standing

7. Commission Counsel, who will assist the Commissioner to ensure the orderly conduct of the Inquiry, have standing throughout the Inquiry. Commission counsel have the primary responsibility of representing the public interest throughout the Inquiry, including the responsibility of ensuring that all matters that bear upon the public interest are brought to the Commissioner's attention.

8. Persons may seek standing at the Inquiry by way of motion in writing with supporting materials, to be filed in electronic format with the Commission on or before **July 16, 2007**, or at the discretion of the Commissioner on any other date.

9. Motions in writing for standing must include the following information:

   a) The person's name, address, telephone number, and fax number and e-mail address, if available;

   b) The name(s) of the lawyer(s), if any, representing the person, together with the lawyer(s)'s address, telephone number, fax number and email address;

c) The nature of the person's interest in the subject matter of the inquiry, why he/she wishes standing, and how he/she proposes to contribute to the Inquiry, having specific regard to the Terms of Reference and the Commissioner's Opening Statement delivered on June 18, 2007; and

d) Whether the person wishes to make oral submissions in support of the motion.

10. A person who wishes to make oral submissions in support of the motion for standing may be given an opportunity to appear in person, or by counsel, and make oral submissions at a hearing at a date and time to be determined by the Commission. The Commissioner will allocate time for oral submissions for each person who is permitted to make oral submissions.

11. Standing will be granted in the discretion of the Commissioner, in accordance with Section 5 of the Act, the Terms of Reference, the systemic nature of this Inquiry and the desirability of a fair and expeditious proceeding.

12. The Commissioner may determine those parts of the Inquiry in which a party granted standing may participate and the form of their participation.

13. All materials filed in support of a party's motion in writing for standing will be available to the public on the Commission's website at www.goudgeinquiry.ca

14. Those granted standing will be designated as Parties before the Inquiry. The Commission will use that designation although this not an adversarial process.

15. Further information with respect to standing may be made available on the Commission's website at www.goudgeinquiry.ca

Funding

16. Further to paragraph 14 of the Terms of Reference, the Commissioner may make recommendations to the Attorney General regarding funding for a party to the extent of the party's interest, where in the Commissioner's view the party would not be otherwise able to participate in the Inquiry without such funding.

17. Persons may seek funding by way of motion in writing with supporting materials to be filed in electronic format with the Commission on or before July 16, 2007, or at the discretion of the Commissioner on any other date. Persons will be expected to seek funding at the same time as they seek standing, and motion materials prepared in support of funding may be combined with motion materials prepared in support of standing.

18. Motions in writing for funding must include the following information:

a) The person's name, address, telephone number, and fax number and e-mail address, if available;

b) The name(s) of the lawyer(s), if any, representing the person, together with the lawyer(s)'s address, telephone number, fax number and email address;

c) The reasons why the person requires funding; and

d) Whether the person wishes to make oral submissions in support of the motion for funding.

19. A person who wishes to make oral submissions in support of the funding motion may be given an opportunity to appear in person, or by counsel, and make oral submissions in support of the motion for funding at a hearing at a date and time to be determined by the Commission. The Commissioner will allocate time for oral submissions for each person who is permitted to make oral submissions.

20. Funding will be recommended at the Commissioner's discretion in accordance with paragraph 14 of the Terms of Reference.

21. Where the Commissioner's funding recommendation is accepted, funding shall be in accordance with approved Treasury Board Guidelines respecting rates of remuneration and reimbursement and the assessment of accounts.

22. All materials filed in support of a party's motion in writing for funding will be available to the public on the Commission's website at www.goudgeinquiry.ca

23. Any updated information with respect to funding may be made available on the Commission's website at www.goudgeinquiry.ca

Appendix 7

Attention News Editors:

Commissioner of Pediatric Forensic Pathology Inquiry to make public statement on June 18, 2007

TORONTO, May 24 /CNW/ - The Honourable Stephen Goudge, Commissioner of the Inquiry into Pediatric Forensic Pathology in Ontario, announced today that he will make an initial public statement to outline his plan for fulfilling his mandate.

The Commissioner will make the statement at 10 a.m. on June 18, 2007, at the Metropolitan Hotel at 108 Chestnut Street in Toronto. His statement will be open to the public and to the media.

The Inquiry's mandate is to conduct a systemic review and an assessment of 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. This review will enable the Commissioner to make recommendations to address systemic failings and restore and enhance public confidence in pediatric forensic pathology in Ontario.

The Commission's mandate does not include reporting on any individual cases that have been or may be subject to a criminal investigation or proceeding. However, between June 18 and 21, 2007, the Commission will meet privately with individuals or families affected by practices in Ontario's pediatric forensic pathology system between 1981 and 2001.

"In order for me to understand the impact that systemic failings have on people's lives, it will be very helpful for me to speak with those directly affected. In order not to prejudice any ongoing legal proceedings and in view of the intimate and personal nature of the matters that may be disclosed in these meetings, these meetings must take place in private. They will not be part of the formal hearing process. The Commission is not empowered to correct errors in specific cases nor provide financial compensation but the information from the meetings will be extremely useful background to me in my work."

"The Commission is dedicated to making sure that no one ever has to

endure the horror of being charged criminally, or having a family unit pulled apart, or being convicted because of flawed pathology findings or evidence."

The Commission invites those who wish to meet with the Commission to contact the Commission in confidence as soon as possible at www.goudgeinquiry.ca or (416) 212-6871. Funding may be available from the Commission, if necessary.

The Inquiry into Pediatric Forensic Pathology in Ontario was established by the Government of Ontario under the Public Inquiries Act on April 25, 2007.

The Commission is to deliver its final Report and recommendations to the Attorney General no later than April 25, 2008.

The Commission started its work immediately after it was established. A team of lawyers is gathering and reviewing relevant documentation, consulting with the key institutions and interviewing experts and witnesses.

The Commission is in the process of establishing an office at 180 Dundas Street West, Toronto, ON.

More information about the inquiry is available on the Commission's web page: www.goudgeinquiry.ca

The Order in Council establishing the Inquiry:

http://www.attorneygeneral.jus.gov.on.ca/english/news/2007/20070425-pi-tr.asp

For further information: or to arrange an interview with Commission Counsel: Peter Rehak, (416) 212-6877

Attention News Editors:

Pediatric Forensic Pathology Inquiry now under way; Commissioner to make public statement on June 18, 2007

TORONTO, June 11 /CNW/ - Commission lawyers and staff of the Inquiry into Pediatric Forensic Pathology in Ontario are interviewing witnesses and examining hundreds of documents in preparation for public hearings later this year and for the Commissioner's initial public statement next week. The Commissioner, the Honourable Stephen Goudge, will outline his plan for fulfilling his mandate at 10 a.m. on June 18, 2007, at the Metropolitan Hotel at 108 Chestnut Street in Toronto.

His statement will be open to the public and to the media.

The Inquiry's mandate is to conduct a systemic review and an assessment of 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. The Commissioner is to make recommendations to address systemic failings and restore and enhance public confidence in pediatric forensic pathology in Ontario.

The Commission's mandate does not include reporting on any individual cases that have been or may be subject to a criminal investigation or proceeding. However, in the days following his statement, members of the Commission will meet privately with individuals or families affected by practices in Ontario's pediatric forensic pathology system between 1981 and 2001.

"It will be very helpful for me to speak with those directly affected in order for me to understand the impact that systemic failings have on people's lives," said Commissioner Goudge. "These meetings must take place in private in order not to prejudice any ongoing legal proceedings and in view of the intimate and personal nature of the matters that may be discussed. These

meetings will not be part of the formal hearing process."

Commissioner Goudge noted that the Commission is not empowered to correct errors in specific cases nor provide financial compensation.

"But the he information from the meetings will be extremely useful background to me in my Work," he said.

"The Commission is dedicated to making sure that no one ever has to endure the horror of being charged criminally, or having a family unit pulled apart, or being convicted because of flawed pathology findings or evidence."

The Commission may be contacted in confidence at (416) 212-6878 or by e-mail at: contact@goudgeinquiry.ca.

The Commission's offices are at 180 Dundas Street West, Toronto, ON., M5G 1Z8

More information about the inquiry is available on the Commission's web page: www.goudgeinquiry.ca

The Order in Council establishing the Inquiry: http://www.attorneygeneral.jus.gov.on.ca/english/news/2007/20070425-pi-tr.asp

The Inquiry into Pediatric Forensic Pathology in Ontario was established by the Government of Ontario under the Public Inquiries Act on April 25, 2007. The Commission is to deliver its final Report and recommendations to the Attorney General no later than April 25, 2008.
For further information: or to arrange an interview with Commission Counsel: Peter Rehak, (416) 212-6877

Appendix 8

DATE: 2007-08-17

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON STANDING AND FUNDING

COMMISSIONER GOUDGE:

I have been appointed by Order in Council 826/2007 to conduct a systemic review of the practice and use of pediatric forensic pathology in the criminal justice system in Ontario, particularly between 1981 and 2001. I am to do so 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.

Paragraph 4 of the Order in Council reads as follows:

> 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;
>
> 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.

Pursuant to this mandate, on June 18, 2007, the Commission published Rules of Standing and Funding and invited those interested in seeking standing and funding to apply in writing by July 16, 2007. The Commission received eleven applications by that date. On August 8, 2007, I heard oral submissions in support of nine of these applications. The other two applicants chose not to appear, but simply relied on their written applications. Of the eleven applicants, four requested standing only, and seven requested both standing and funding.

Subsection 5(1) of the *Public Inquiries Act*, R.S.O. 1990 c. P.41 addresses the issue of standing as follows:

> A commission shall accord to any person who satisfies it that the person has a substantial and direct interest in the subject-matter of its Inquiry an opportunity during the Inquiry to give evidence and to call and examine or to cross-examine witnesses personally or by counsel on evidence relevant to the person's interest.

The Rules of Standing and Funding issued by the Commission make clear that standing will be granted at the discretion of the Commissioner, in accordance with this statutory provision, the Commission's Terms of Reference as contained in the Order in Council,

the Commission's systemic nature, and the desirability of a fair and expeditious proceedings.

In addition to these criteria, I have been guided in the exercise of my discretion as to the nature of standing by several additional considerations: first, whether the applicant may be significantly affected by the Commission's recommendations; second, whether the applicant is uniquely situated to offer information to the Commission that will help it with its work; and third, the need to balance the fundamental importance of a thorough inquiry with the need to avoid duplication so far as possible, so that the Commission can properly discharge its mandate and do so in a timely fashion.

With these factors in mind, I turn to the eleven requests for standing that the Commission has received.

A. Institutions Seeking Standing

Three institutions have sought standing: the Office of the Chief Coroner for Ontario ("OCCO"), Her Majesty the Queen in Right of Ontario ("Ontario") and the Hospital for Sick Children ("HSC"). Because of their involvement in the events that led to the establishment of the Commission, all three have information to offer that will be important to the Commission's work and all three may be affected by my

recommendations. All three should be awarded standing. I will elaborate briefly on my reasons for granting standing to all three.

The OCCO is responsible for investigating deaths in Ontario, including pediatric deaths. Where required, it does so with assistance of pediatric forensic pathology. It utilizes both staff pathologists and pathologists working on a fee for service basis. The OCCO has a vital need for, and a long history with, pediatric forensic pathology in Ontario. On April 19, 2007, the OCCO announced the results of its review of certain cases of suspicious child deaths, which found that some of the factual conclusions of Dr. Charles Smith were not reasonably supported by the materials available. This led directly to the establishment of this Commission. The OCCO's central position to the work of the Commission amply justifies my decision to grant it standing.

Ontario, through the Attorney General, the chief law officer of the Crown, is mandated to superintend all matters connected with the administration of justice in Ontario. It therefore has a vital interest in the role of pediatric forensic pathology in criminal prosecutions in the province. Ontario is also responsible for the Ontario Provincial Police and therefore has a clear interest in the interaction between forensic pathologists and police during criminal investigations into pediatric deaths. As well, Ontario is responsible for the administration of the legal aid system and for the regulatory regimes of health care

professionals. These various responsibilities exemplify why Ontario should be accorded standing.

The HSC is a quaternary pediatric academic health sciences centre in Toronto serving the provincial, national and international community. For a number of years, it has provided pediatric forensic pathology resources to the OCCO through the Ontario Pediatric Forensic Pathology Unit ("OPFPU"). Many of the post mortem examinations that gave rise to the establishment of the Commission were performed at the OPFPU. In light of this direct involvement of HSC and its personnel in pediatric forensic pathology in Ontario, there is no doubt that it should be accorded standing.

B. Individuals Seeking Standing

The Commission also received applications for standing from Dr. Smith and from two groups of individuals who were involved in the cases reviewed for the OCCO, the results of which led to this Commission. The Commission is required to conduct a systemic review of pediatric forensic pathology in Ontario. It does not have a mandate to report on individual cases. Other processes exist to deal with alleged wrongful convictions, and attempts to recover compensation. The Commission must be careful not to interfere with them.

Nonetheless, it will be important to learn enough about facts from the individual cases that gave rise to the Commission to assist in determining the systemic issues that should properly be addressed. The involvement of these applicants in those cases gives them each a unique perspective that can assist the Commission in its work. All three applications for standing are therefore granted. Again a brief elaboration will suffice.

Dr. Smith was the Director of the OPFPU 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.

The first of the two group applications is from seven individuals from four families. Their application refers to them as "the Affected Families Group" ("the AFG") and I will do so as well.

The seven are Louise Reynolds, Brenda Waudby and her daughter Justine Traynor, Lianne Gagnon (Thibeault) and her father Maurice Gagnon, and Anthony Kporwodu and his wife Angela Veno.[1] All four families suffered the death of a child. Each death was the subject of a pediatric forensic pathology examination or consultation by Dr. Smith. In

1. While all seven are prepared to have their names disclosed, a number do not want their contact information made public. That will be respected unless I should subsequently determine that disclosure is necessary.

each case, the events that unfolded for the families following the death were traumatic. These applicants have all experienced the effects of the practice of pediatric forensic pathology in Ontario in a unique and personal way. The common features of those experiences may be of much assistance in bringing the relevant systemic issues into focus and these families will undoubtedly be able to assist with suggestions of how those systemic issues can be best dealt with in future. It is appropriate that these individuals be granted standing as a group to help advance the systemic objectives of the Commission. The AFG should be granted standing.

The second group application is made on behalf of nine individuals. William Mullins-Johnson, Sherry Sherret-Robinson and seven others who request not to be identified publicly. I am prepared to honour their request at this stage. I will refer to this group as the Mullins-Johnson group. Like the AFG, the members of this group all suffered the death of a child in their family, each of which was the subject of a pediatric forensic pathology examination or consultation by Dr. Smith. Unlike the AFG, each individual in this group was charged and convicted of a criminal offence or offences following the death of a loved one. These individuals thus share the added perspective of experiencing the effects of the practice of pediatric forensic pathology in the full context of the criminal justice system. Coupled with the reasons I have given for granting standing to the AFG, this dimension adds to the case for giving standing to the Mullins-Johnson group. It is important to note that counsel for the AFG and the Mullins-Johnson group

made clear their willingness to work together to avoid the repetition of facts that may reflect systemic issues but are common to a number of the cases. I would therefore grant standing to this group.

C. Organizations Seeking Standing

Finally, there are five applications from organizations involved one way or another in the criminal justice system. These are the Ontario Crown Attorneys' Association ("OCAA"), the Criminal Lawyers' Association ("CLA"), the Association in Defence of the Wrongly Convicted ("AIDWYC"), the Aboriginal Legal Services of Toronto and Nishnawbe-Aski Nation ("ALST-NAN Coalition") and Defence for Children International-Canada ("DCI-Canada").

Based on their applications, none of these organizations appear to have any unique information to offer about any of the individual cases that were the subject of the OCCO review. However, given their mandates and histories, all have their own well developed perspectives on the workings of pediatric forensic pathology within the criminal justice system. I am confident that their expertise will be useful to me in crafting my recommendations. I therefore grant standing to each organization because of its particular area of expertise and its unique interest at this Inquiry. I expect each organization to focus its participation on its area of expertise. Again, it is appropriate to give brief elaboration respecting each organization.

The OCCA is made up of non-managerial Crown Attorneys who represent the provincial Crown in the criminal justice system of Ontario. It therefore has significant expertise concerning the duties and responsibilities of Crown counsel in the conduct of criminal matters, including their involvement with pediatric forensic pathology in the criminal process. For example, this may assist in shedding light on the interaction of Crown counsel with forensic pathologists. For this reason, the OCCA should have standing.

The CLA comprises approximately 1000 criminal defence lawyers most of whom practise in Ontario. Its expertise, namely, the interaction between defence counsel and pediatric forensic pathology in the context of the criminal justice system, is the counterpoint to the OCCA. This perspective also warrants standing.

AIDWYC is a national public interest organization dedicated to preventing and rectifying wrongful convictions. It is well recognized for the continuing interest and involvement in criminal justice issues relating to the wrongful conviction of innocent persons. One of the Commission's tasks is to seek to ensure that the use of pediatric forensic pathology in the criminal justice system does not contribute to creating or sustaining wrongful convictions. AIDWYC's expertise will, I think, be helpful to this aspect of my work and it should have standing.

Page: 10

ALST-NAN Coalition is a partnership of ALST, a multi-service legal agency providing services to the Aboriginal community in Ontario, and NAN, a political territorial organization representing 49 First Nation communities in the Treaty 9 and Treaty 5 areas of Ontario. Each of these partners has longstanding expertise in Aboriginal issues, including those involving the interaction between Aboriginal people and the criminal justice system in Ontario. The ALST-NAN Coalition is well placed to assist the Commission with issues raised by the use of and access to pediatric forensic pathology in investigations and criminal proceedings that may be unique to Aboriginal people. This warrants standing.

DCI-Canada is the Canadian section of Defence for Children International, an independent grassroots human rights organization with a mission to promote and protect the rights of the child through concerted international actions. DCI-Canada has experience and expertise in the prevention of violence against children and the prevention of institutional child abuse in particular. This may very well help the Commission to address the issue of how pediatric forensic pathology can best assist child death investigation, and even more, the issue of how surviving children are best dealt with in those circumstances. It should also have standing.

Finally, as the Rules of Standing and Funding provide, it is vital that Commission counsel have standing throughout. Commission counsel have the primary responsibility of

representing the public interest, including ensuring that all matters that bear upon the public interest are brought to the Commissioner's attention.

The Funding Applications

The Commission has received applications for funding from seven of the parties who have been granted standing.

Paragraph 14 of the Order in Council establishing the Commission reads as follows:

> 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.

This and the Commission's Rules of Standing and Funding provide that in making recommendations to the Attorney General regarding funding, I am to be guided by whether those seeking it can provide assistance to me that would not otherwise be available, and by whether, in my view, they would not be able to do so without funding.

The only institution to seek funding is HSC. It does so on the basis that its involvement in the Commission has come about only because it has cooperated with the OCCO over the years to serve the public interest and the needs of Ontario by providing pediatric forensic pathology services to the OCCO. The OCCO has provided it with an annual grant for this purpose, so that HSC has not had to expense significant health care dollars to assist the OCCO. HSC says that without funding from the Attorney General, it will now have to do so, only because of its past support of the mission of the OCCO and that it is, therefore, only fair that it be able to recoup this through funding from the province.

On the record before me, HSC has not established that it cannot participate in the Inquiry without funding. As a condition of funding required by the Order in Council is not met, this application is dismissed. That being said, it seems to me that HSC may well have a moral claim on the province, both because of the genesis of its need to participate in the Commission and because it would be unfortunate if its delivery of health care suffered as a result.

Both groups of individuals, the AFG and the Mullins-Johnson group, seek funding. So do four of the organizations: CLA, AIDWYC, ALST-NAN Coalition and DCI-Canada. As I have indicated, in granting them all standing, each has unique assistance to offer the Commission in the discharge of its mandate. I am also satisfied that without funding, none would be able to participate. Therefore, I would grant all six applications for

funding and recommend to the Attorney General that it be provided, in accordance with Management Board of Cabinet Directives and Guidelines.

It remains to provide such guidance as I can concerning the extent of the funding that I have recommended.

The AFG proposes to have three counsel working on the matter, one senior and two junior counsel. It seeks counsel fees (which I take to mean attendance fees at the hearing itself) for one senior counsel and one junior counsel. It also requests up to 500 hours of time for a law clerk. In my view, it is reasonable that three counsel in total might work on preparation concerning the file. However, subject to the exception noted immediately below, it is reasonable that the total hours per day be limited to 10. Where two counsel are required to attend hearings, fees for attendances should be allowed for one senior counsel and one junior counsel and the total hours per day extended to a maximum of 20. That being said, there will be a number of hearing days at which one counsel will suffice. It is also understood that for various parties (including the AFG) it will be necessary that the roles of senior and/or junior counsel be filled at times by alternates to those with primary responsibility for the file. That is simply the reality of life for those with busy practices. This will necessarily entail some overlap in work so that rather more time may be involved in total than if the same lawyer filled the role throughout. Provided that the

substitutions are necessary and the amount of overlap is reasonable, that seems acceptable to me. Finally I would accede to the law clerk request made by the AFG.

The Mullins-Johnson group's request for funding was not framed in precisely the same way as the request made by the AFG. However, it is similarly situated to the AFG. Accordingly, I recommend funding in identical terms to those recommended for the AFG, including the use of substitute counsel where necessary. The hours allocated to a law clerk may also be performed by an articling student.

The CLA seeks funding on the basis that it will require three lawyers to represent its interest but expects only one counsel present at most if not all hearing days. Because of the exigencies of busy practices, it is reasonable that three counsel in total might work on the file, as long as the total hours claimed per day does not exceed ten. The counsel attendance fee should be limited to one counsel (senior, intermediate or junior at the discretion of the CLA). The total allowed hours per day can be used to fund counsel, an articling student or law clerk at the discretion of the CLA. As with all those granted funding, the use of alternate counsel must be necessary, and the overlap in work must be reasonable.

AIDWYC seeks funding for one senior counsel throughout. I took from this submission that it was addressing funding for attending the hearing rather than the total number of

lawyers who might work on the file. I recommend funding on the same basis as recommended for the CLA.

The ALST-NAN Coalition also seeks funding for one counsel. Again, I interpreted this request as addressing the attendance at the hearing itself, rather than the total number of lawyers who might work on the file. I recommend funding on the same basis as recommended for the CLA.

Finally, DCI-Canada seeks funding for one counsel. Again, I interpreted this request in similar fashion as the earlier requests. I recommend funding on the same basis as recommended for the CLA.

These reasons do not preclude any of these six parties from applying for additional funding to deal with exceptional circumstances.

RELEASED: August 17, 2007

Stephen Goudge
Commissioner

Appendix 9

DATE: 2007-10-02

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

SUPPLEMENTARY RULING ON FUNDING

COMMISSIONER GOUDGE:

On August 17, 2007 I issued my ruling on standing and funding. At the end of my reasons I left it open to the parties whom I recommended be granted funding to apply for additional funding to deal with exceptional circumstances. I have received supplementary applications from the Affected Families Group and the Criminal Lawyers Association ("CLA"). In addition, I have received an application from the Ontario Crown Attorneys Association ("OCAA") for funding for hardware and software required to make use of the Inquiry's database.

Affected Families Group

The Affected Families Group is represented by two law firms, one of which is located in Toronto (Wardle Daley) and one of which is located in Peterborough (Hauraney and

Kirkpatrick). Counsel for the Affected Families Group submit that this geographical separation make it very difficult to manage their time to meet the 10 hour daily maximum.

They have requested that I modify my ruling in order to provide that the hours for preparation time be limited to 70 hours a week but that they need not conform to a daily maximum.

I am persuaded that this is reasonable and necessary in order for counsel for the Affected Families Group to manage their time. It conforms to the spirit of my original ruling and does not increase the maximum number of hours per week. I recommend funding on this basis from the date of my pervious ruling.

CLA

The CLA is seeking permission to add a fourth counsel to its roster of counsel. The proposed addition, Mr. Jeffrey Manishen, is a senior and highly experienced counsel, whom the CLA believes would be an invaluable addition to their team. The CLA has agreed that it will abide by my previous funding recommendation, which provides a

maximum of 10 hours remuneration per day for one counsel only and that it will continue to undertake best efforts to minimize duplication of work. I agree. Mr. Manishen may be added to the CLA's roster of counsel.

Second, the CLA requests funding for summation licenses to access the Inquiry's database and has demonstrated that it does not have the financial resources to obtain these itself. I recommend one summation network license, plus three summation mobile licenses for the CLA to be distributed to those on the team best suited to hold those licenses.

OCAA

The OCAA has not previously applied for funding. However, it now says that it will cost $20,000 to $30,000 in order to purchase the hardware and software necessary to review the Inquiry's database and to maintain it. By far the biggest part of this is for software. Given OCAA's financial commitments for the year, it submits that a cost of this size is prohibitive, particularly in a year where it is facing other substantial litigation expenses.

In the circumstances, and to permit its effective participation, I think OCAA's request should be granted in large measure. I therefore recommend that OCAA's request for software, namely for one server license and five mobile licenses at a total cost of $16,160.35 plus taxes be granted.

RELEASED: October 2, 2007

Stephen Goudge
Commissioner

Appendix 10

DATE: 2007-08-22

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON STANDING AND FUNDING

COMMISSIONER GOUDGE:

On August 10, 2007, I received an application for standing from Mrs. Anne Marsden as "Advocate and Auditor" for what appears to be an organization called Access for All. She does not seek funding. For the reasons that follow, I dismiss the application.

On June 18, 2007, I invited interested persons to apply for standing at the Commission. The Rules of Standing and Funding provided that:

> Persons may seek standing at the Inquiry by way of motion in writing with supporting materials, to be filed in electronic format with the Commission on or before July 16, 2007, or at the discretion of the Commissioner on any other date.

This application for standing was filed on August 10, 2007, after the deadline contained in the Rules of Standing and Funding, and after I heard oral submissions from the other applicants. I have nonetheless considered the application on its merits in light of the factors set out in my initial decision on standing and funding.

According to its application materials, Access for All seeks to ensure accountability in the public interest within the health care and justice systems. Mrs. Anne Marsden appears to be a main principal of the organization. Since the 1990s, Mrs. Marsden has headed several volunteer organizations, "which have the public interest as its number one priority". There is a no suggestion in the application that Mrs. Marsden is trained as a health care professional.

Mrs. Marsden requested the opportunity to make oral submissions in support of the application for standing, and to "identify the role she can play in assisting public interest issues being brought to the Commissioner's attention". Having reviewed this application, I have determined that I do not require oral submissions on behalf of Access for All to reach my decision.

I am not persuaded that either Mrs. Marsden or Access for All has a substantial and direct interest in the subject matter of this Commission. Neither:

a) had any involvement in the factual underpinnings that gave rise to the establishment of this Commission;

b) were involved in the provision of pediatric forensic pathology services in Ontario;

c) were involved in the criminal justice system between 1981 and 2001; or

d) will be the subject of, or affected by, any recommendations that may be made by me.

I have also reviewed the application to determine whether, despite the absence of a substantial and direct interest, either Mrs. Marsden or Access for All may have an ascertainable interest on the basis of a particular expertise that will assist the Commission in fulfilling its mandate. On the record before me, I am not persuaded that such an interest exists. Accordingly, I cannot grant this application.

I note that Mrs. Marsden seeks to "assist public interest issues in being brought" to my attention. The responsibility for representing the public interest lies with Commission counsel. No other party need be accorded standing to protect or advance the public interest at large.

The application is dismissed.

RELEASED: August 22, 2007

Stephen Goudge
Commissioner

Appendix 11

DATE: 2007-10-17

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON APPLICATION FOR STANDING BY THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

COMMISSIONER GOUDGE:

By letter of October 12, 2007, the College of Physicians and Surgeons of Ontario ("CPSO") requests standing to participate in this Inquiry.

CPSO is the self-regulating body for the medical profession in Ontario. Among other things, it issues certificates of registration to doctors, monitors and maintains standards of practice, and investigates complaints against doctors. Pathologists involved with pediatric forensic pathology are medical doctors and are therefore subject to this regulation. Thus CPSO is one of the important oversight mechanisms that the Commission is mandated to examine.

In addition, in several of the cases included in the Chief Coroner's Review that led to the establishment of the Commission, complaints were made to CPSO about the pathology done by Dr. Smith. How effectively there complaints were dealt with will very likely be a part of the Commission's work.

Finally recommendations to restore public confidence in pediatric forensic pathology in Ontario may encompass the future oversight role of CPSO.

In summary, because its oversight role comes within the scope of the review that the Commission must undertake, and because it may be affected by the Commission's recommendations, it is appropriate that CPSO be granted standing.

RELEASED: October 17, 2007

Stephen Goudge
Commissioner

Appendix 12

DATE: 2007-11-05

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON THE APPLICATION FOR STANDING BY MARCO TROTTA

COMMISSIONER GOUDGE:

Through his counsel, Marco Trotta seeks standing and funding to enable him to appear at the hearings of the Commission for the limited purpose of protecting his right to a fair trial.

Mr. Trotta's appeal of his criminal conviction for the murder of his eight-month-old son is now on reserve before the Supreme Court of Canada. At his trial, Dr. Charles Smith gave pathology evidence about the cause of the child's death.

The death was one of the cases reviewed by the Chief Coroner's Review, which found that some of Dr. Smith's factual conclusions were not reasonably supported by the

materials available. As is clear from the Order in Council, that Review and the cases it dealt with, played an important role in the establishment of the Commission.

Mr. Trotta's counsel has advised that one of the possible outcomes of the present appeal may be a new criminal trial for his client. Mr. Trotta therefore wishes his counsel to attend as necessary at the hearings of the Commission, simply to protect his fair trial rights in the event that a new criminal trial is directed.

Since the Trotta case may be the subject of evidence at the Commission's hearings, at least to the extent of the pathology involved, this request is reasonable. Mr. Trotta's fair trial rights should be protected, as far as possible. This can be best effected by the presence of his counsel on those limited occasions when evidence is presented to the Commission that could be relevant to his criminal trial.

I therefore order that Mr. Trotta be given standing for this limited purpose, and as long as the possibility of a new criminal trial exists. I direct that his counsel work out with Commission Counsel the details of how this can be effected on a day to day basis. If differences arise, I will rule as necessary.

I also order that counsel for Mr. Trotta be funded for this limited purpose. Mr. Trotta has just recently been released after more than 8 years in custody and would be financially

unable to participate in this Commission without funding. On those days when Mr. Trotta's interest is engaged, either Mr. Lomer or a junior lawyer on his behalf may attend. While some preparation may be necessary, in my view, it will be very limited

RELEASED: November 5, 2007

Stephen Goudge
Commissioner

Appendix 13

DATE: 2007-11-06

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON THE APPLICATION FOR STANDING BY TWO INDIVIDUALS

COMMISSIONER GOUDGE:

The Commission has received an application for standing from two adult individuals who were involved in one of the cases examined by the Chief Coroner's Review. Through their counsel Mr. Wardle, they purpose that they be granted standing as part of the Affected Families Group, which has already received standing.

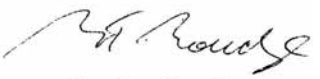
In my view, their application should be granted. For the purposes of standing, they are in exactly the same position as the other individuals who make up the Affected Families Group. Their application for standing is granted.

Mr. Wardle advises that these two individuals are different from the other members of the Affected Families Group in one respect. They are anxious that their full names not be used in the Commission's proceedings particularly because of the potential impact on a surviving child.

For three reasons, I think it is appropriate that these two be treated according to the basic procedure concerning non-publication outlined in my ruling of November 1, 2007. Though these two individuals have standing in a public inquiry, they do not want their full names published. Theirs is not one of the most notorious cases examined by the Chief Coroner's Review. Finally, in my view, they meet the criteria set out in s. 4(b) of the *Public Inquiries Act*.

I therefore order that the full names of these two individuals not be used during the proceedings of the Commission, or published by the media. They will be referred to by first names only or by their relationship to the deceased infant as is presently set out in the Schedule to my ruling of November 1, 2007.

RELEASED: November 6, 2007



Stephen Goudge
Commissioner

Appendix 14

DATE: 2008-01-08

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON THE APPLICATION FOR STANDING BY TWO INDIVIDUALS

COMMISSIONER GOUDGE:

The Commission has received an application for standing from two individuals who were involved in one of the cases examined by the Chief Coroner's Review. The two individuals are already covered by my November 1, 2007, ruling on non-publication orders. In accordance with my ruling of November 1, 2007, the two individuals shall be referred to as S.M., and D.M. or S.M.'s father.

Through their counsel Mr. Wardle, S.M. and D.M. propose that they be granted standing as part of the Affected Families Group, which has already received standing.

In my view, the application of S.M. and D.M. should be granted. For the purposes of standing, S.M. and D.M. are in exactly the same position as the other individuals who make up the Affected Families Group. Their application for standing is granted.

The non-publication order set out in my ruling of November 1, 2007, continues to apply. I order that the full names of S.M. and D.M. are not be used during the proceedings of the Commission, or published by the media.

RELEASED: January 8, 2008

Stephen Goudge
Commissioner

Appendix 15

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULES OF PROCEDURE

General

1. This inquiry (the "Commission" or "Inquiry") will be held in accordance with the *Public Inquiries Act*, R.S.O., c. P.41 (the "Act") and pursuant to Order in Council 826/2007 (the "Terms of Reference").

2. Subject to the Act and the Terms of Reference, the conduct of and procedure to be followed at the Inquiry is under the control and discretion of The Honourable Stephen Goudge (the "Commissioner").

3. The Commissioner may amend these Rules of Procedure ("Rules") or dispense with compliance of these Rules, as he deems necessary to ensure that the Inquiry is thorough, fair and timely.

4. All parties, witnesses and their counsel will be deemed to undertake to adhere to these Rules, and may raise any issue of non-compliance with the Commissioner.

5. The Commissioner may deal with any non-compliance with these Rules as may be appropriate, including by revoking the standing of a party or imposing restrictions on a party or person in attendance at a hearing.

6. In these Rules, "persons" refers to individuals, groups, governments, agencies, institutions or any other entity.

7. In these Rules, the term "documents" is intended to have a broad meaning, and includes the following forms: written, electronic, audiotape, videotape, digital reproductions, photographs, maps, graphs, microfiche and any data and information recorded or stored by means of any device.

Investigation

8. The Inquiry will commence with an investigation by Commission counsel. The goal of the investigation, in part, will be to identify the core or background facts that will form the basis of Overview Reports, as described below, and to identify representative witnesses.

9. The investigation will consist primarily of document review, consultation with interested persons, and witness interviews by Commission counsel.

Document Production

10. Copies of all relevant documents are to be produced to the Commission by any party with standing at the earliest opportunity. Production to the Commission will not constitute a waiver of any claim to privilege that a party may wish to assert. Parties are, however, requested to identify to the Commission, within a reasonable time period, any documents over which they intend to assert a claim of privilege.

11. Where a party objects to the production of any document on the grounds of privilege, a true copy of the document will be produced in an unedited form to Commission counsel who will review and determine the validity of the privilege claim. The party and/or the party's counsel may be present during the review process. In the event the party claiming privilege disagrees with Commission counsel's determination, the Commissioner, on application, may either inspect the impugned document(s) and make a ruling or may direct the issue to be resolved by the Associate Chief Justice of Ontario or his designate.

12. Originals of relevant documents are to be provided to Commission counsel only upon request and where doing so would not interfere with any potential or ongoing investigation or legal proceeding. The parties will otherwise preserve originals of relevant documents until such time as the Commissioner has fulfilled his mandate or has ordered otherwise.

13. Counsel to the parties and witnesses will be provided with documents and information by Commission counsel only upon executing a written undertaking that all such documents and information will be used solely for the purposes of the Inquiry. No such information or documents may be made public until entered as evidence at the Inquiry.

14. Counsel are entitled to provide such documents or information to their respective clients only on terms consistent with the undertakings given, and upon the clients entering into written undertakings to the same effect.

15. These undertakings will be of no force or effect once the documents or information are entered into the public record.

16. The Commission may require that the documents provided, and all copies made, be returned to the Commission if not tendered in evidence.

Overview Reports

17. In accordance with section 7 of the Terms of Reference, Commission counsel will prepare Overview Reports, which may contain core or background facts, together with their source(s).

18. Commission counsel will provide an opportunity to the parties, in advance of the filing of Overview Reports as evidence, to comment on the accuracy of the Overview Reports, and Commission counsel may modify the Overview Reports in response. Parties may also, pursuant to Rule 26 below, propose witnesses to be called to support, challenge, comment upon or supplement the Overview Reports in ways that are likely to

significantly contribute to an understanding of the systemic issues relevant to this Inquiry.

19. The Overview Reports may be used to assist in identifying the systemic issues that are relevant to this Inquiry, to make findings of fact and to enable recommendations to be made, but Overview Reports will not be used in a manner precluded by sections 5 and 6 of the Terms of Reference.

Oral Hearings

20. The Commissioner will conduct hearings as set out in these Rules.

21. The Commissioner will set the dates, hours and place of the hearings.

22. The Commissioner may receive any evidence or information that he considers helpful in fulfilling his mandate whether or not such evidence or information might otherwise be admissible in a court of law. The strict rules of evidence will not apply to determine the admissibility at the Inquiry. However, pursuant to section 11 of the Act, nothing is admissible in evidence at the Inquiry that would be inadmissible in a court by reason of any privilege under the law of evidence.

23. The Commission will rely, wherever possible, on the Overview Reports and may consider such reports in lieu of calling witnesses.

24. The Commission will rely, wherever possible, on representative witnesses on behalf of institutions.

25. Commission counsel may call witnesses or experts, who may, amongst other things, support, challenge, comment upon or supplement the Overview Reports.

26. Parties may propose witnesses to be called as part of the Inquiry. Parties will provide to Commission counsel the names and addresses of all witnesses they believe ought to be heard, and will provide Commission counsel, where applicable, with copies of all relevant documents, including statements of anticipated evidence from witnesses they propose, at the earliest opportunity. In particular, parties may propose witnesses who are likely to contribute to an understanding of the systemic issues relevant to this Inquiry and whose evidence is likely to assist the Commissioner in making recommendations.

27. Commission counsel will have discretion to refuse to call or present evidence proposed by a party. A party may, however, apply to the Commissioner for leave to call a witness whom the party believes has evidence relevant to the Commission's mandate. If the Commissioner is satisfied that the evidence of the witness is required, Commission counsel will call the witness, subject to Rule 33 below.

28. In the normal course, individual witnesses will give their evidence at the hearing under oath or affirmation. Further to section 10 of the Act, however, the Commissioner may admit evidence not given under oath or affirmation.

29. Witnesses who are not represented by counsel for parties with standing are entitled to have their own counsel present while they testify. Counsel for the witness will be permitted to make appropriate objections during the witness's testimony.

30. Witnesses may be called to testify more than once.

31. Subject to the Act, the Commissioner may impose measures to address issues of confidentiality that may arise at the Inquiry.

Rules of Examination

32. In the ordinary course, Commission counsel will call and question witnesses who testify at the Inquiry. Except as otherwise directed by the Commissioner, Commission counsel is entitled to adduce evidence by way of both leading and non-leading questions.

33. Parties will have an opportunity to cross-examine the witness, to the extent of their interest. The Commissioner will determine the order of cross-examinations.

34. 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 the examination of one's own witness.

35. The Commissioner may direct any counsel whose client shares a commonality of interest with the witness only to adduce evidence through non-leading questions.

36. Counsel for a witness, regardless of whether or not counsel is also representing a party, will examine after the other parties have concluded their cross-examinations, unless he or she has adduced the evidence of the witness in chief, in which case there will be a right by that counsel to re-examine the witness. In the event, however, that counsel for the witness intends to adduce evidence in chief not adduced by Commission counsel, counsel for the witness will examine the witness immediately following Commission counsel, and then will have a right to re-examine the witness following the cross-examinations by the other parties.

37. Commission counsel has the right to re-examine any witness at the conclusion of his or her evidence.

38. The Commissioner may set time allocations for the conduct of examinations and cross-examinations.

Use of Documents at Hearing

39. In advance of a witness's testimony, Commission counsel will provide the parties with reasonable notice of a list of the documents associated with the witness's anticipated evidence in chief.

40. In advance of a witness's testimony, counsel, other than Commission counsel, intending to lead a witness's evidence in chief will provide the parties with reasonable notice of the

subject matter of the witness's anticipated evidence in chief and a list of the documents associated with that evidence.

41. Neither parties nor Commission counsel will be entitled to cross-examine a witness on any anticipated evidence statement or witness interview summary that may be provided, except with leave of the Commissioner.

42. Parties who intend to cross-examine a witness will provide reasonable notice of any documents to which they intend to refer during their cross-examination, other than those documents for which notice has previously been provided pursuant to Rules 39 or 40.

43. In the event a party intends to refer to a document during an examination, and the document has not been previously disclosed in the Commission's database, the party must provide Commission counsel and counsel for the witness, if any, with a hard copy and an electronic copy of the document, and must also provide the parties with an electronic copy of the document, at the earliest opportunity.

44. For the purpose of these Rules, the Commissioner will have discretion to determine what constitutes "reasonable notice" or "at the earliest opportunity" in all of the circumstances.

45. The Commissioner may grant Commission counsel or counsel for a party or witness leave to introduce a document to a witness at any point during the hearing upon such terms as are just and fair.

Expert Panels / Research and Policy Papers

46. Due to the systemic nature of the Inquiry, the Commission may utilize a range of research and policy development processes, including:

    (a) research and policy papers (the "Research and Policy Papers") from recognized experts on a broad range of relevant topics. The structure and format of the Research and Policy Papers may vary but will generally include a description of current practices, historical developments, an analysis of relevant issues, and potential options (if applicable). Research and Policy Papers will not necessarily represent the views of the Commissioner or Commission counsel but will be designed to inform the Commissioner's deliberations on systemic issues including comparative experience with pediatric forensic pathology. Research and Policy Papers will be posted on the Commission's website;

    (b) written and/or oral submissions that may be sought from parties and the public about matters relevant to the Terms of Reference, including the Research and Policy Papers;

    (c) meetings or symposia (the format of which may vary) that may be convened to discuss issues raised by the Inquiry at which parties and members of the public may be invited to participate; and

(d) evidence that may be received at any stage of the Inquiry from one or more panels of expert witnesses. The Commissioner may modify these Rules as may be appropriate for the disclosure of documents and the questioning of expert panellists by the parties.

Appendix 16

DATE: 2007-10-10

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON THE CPSO MOTION FOR DIRECTIONS

COMMISSIONER GOUDGE:

On April 25, 2007, Ontario established this Commission pursuant to the *Public Inquiries Act*, R.S.O. 1990, c. P.41 (the *PIA*). Broadly stated, its mandate is to conduct a systemic review of the role pediatric forensic pathology has played in the criminal justice system in Ontario in order to make recommendations to restore and enhance its ability to properly fulfill that role in the future.

Pursuant to that mandate, and s. 7 of the *PIA*, the Commission delivered a summons to the Registrar of the College of Physicians and Surgeons of Ontario (CPSO) on September 17, 2007. It requires the Registrar to attend before the Commission to give evidence and produce the following documents:

1. all documents related to any complaints filed by D.M. regarding Dr. Charles R. Smith (including but not limited to File 27860), and the CPSO's investigation and disposition of that complaint, including but not limited to the Complaints Committee brief;

2. all documents related to any complaints filed by Maurice Gagnon regarding Dr. Charles R. Smith (including but not limited to File 40735) and the CPSO's investigation and disposition of that complaint, including but not limited to the Complaints Committee brief;

3. all documents related to complaints filed by Brenda Waudby regarding Dr. Charles R. Smith (including but not limited to File 46947), and the CPSO's investigation and disposition of that complaint, including but not limited to the Complaints Committee brief;

4. all documents related to any other complaints filed by anyone regarding Dr. Charles R. Smith;

5. all policies, procedures, guidelines or protocols, considered, adopted or used by the CPSO when dealing with complaints made about the conduct of pathologists, forensic pathologists, pediatric forensic pathologists, or coroners; and

6. all documents relevant to policies, procedures, practices, accountability and oversight mechanisms, or quality control measures for pediatric forensic pathology in Ontario from 1981 to 2001.

CPSO takes the position that it and its Registrar are precluded from complying with the summons because of the provisions of s. 36 of the *Regulated Health Professions Act,* 1991, S.O. 1991, c. 18 (the *RHPA*). It has therefore moved for directions regarding whether it is permitted to comply with the summons. If its arguments are successful, the

summons will effectively be set aside or quashed. If CPSO is unsuccessful, it has made clear that it will comply with my direction.

CPSO is joined in this motion by Dr. Smith. He supports CPSO, but also argues that the summons cannot compel the documents sought in paragraphs 1 to 4 because those documents are not relevant to the Commission's mandate and are subject to a privilege that Dr. Smith can and does assert.

Commission counsel argues that none of these arguments have merit and that I should order the Registrar to comply with the summons.

I turn first to the issue of relevance. CPSO does not contest the potential relevance of the documents sought by the summons. However, Dr. Smith says that the documents sought in paragraphs 1 to 4 of the summons fall outside the Commission's mandate, and are, therefore, irrelevant and cannot be summonsed.

To be admissible, the documents must be reasonably relevant to the mandate of the Commission: see *Bortolotti v. Ontario* (*Ministry of Housing*) (1977), 15 O.R. (2d) 617 at 624-625 (C.A.). Paragraph 4 of the Order in Council establishing the Commission

requires it, *inter alia*, to conduct a systemic review of the accountability and oversight mechanisms of pediatric forensic pathology in Ontario from 1981 to today.

Dr. Smith does not dispute that the documents referred to in paragraphs 1 to 3 of the summons relate to complaints to CPSO about his work as a pediatric forensic pathologist in three specific cases in Ontario within the relevant time frame. However, he argues that because the complaints process occurred after his work in these cases was concluded, it had no effect on that work, nor could it provide general guidance for pediatric forensic pathology because it dealt only with three specific cases. Thus he says these documents do not speak to an oversight or accountability mechanism of pediatric forensic pathology.

I disagree. The three cases were included in the Chief Coroner's Review that led to the establishment of the Commission. They will be included in the inquiry that the Commission must make. The complaints in these cases and the way CPSO dealt with them constitute one way in which Dr. Smith was held to account for his work as a pediatric forensic pathologist. A complaints process like this is no less a way of overseeing the work of a professional because it deals with specific cases. Thus, I think that these documents speak directly to an oversight or accountability mechanism that the Commission is required to examine and evaluate. The documents are, therefore, clearly relevant to the Commission's mandate.

Dr. Smith argues that paragraph 4 of the summons seeks documents that may relate to his work as a pathologist in non-forensic cases and that these would be outside the Commission's mandate.

Again, I disagree. How CPSO dealt with complaints that may have been made about Dr. Smith's pathology skills in non-forensic cases is relevant to his work in forensic cases because he was applying many of the same skills. Oversight by CPSO through its complaints process of Dr. Smith's expertise as a pathologist, albeit in non-forensic cases, must therefore be part of the Commission's evaluation of one of the oversight mechanisms of pediatric forensic pathology.

In summary, I would conclude that the documents sought by paragraphs 1 to 4 of the summons are relevant to the Commission's mandate.

CPSO's position turns not on relevance but on s. 36 of the *RHPA*. It says that ss. 36(1) and (3) prevent the Registrar from producing the documents sought by the summons. CPSO relies particularly on s. 36(1) and the confidentiality requirement it contains. While it acknowledges that the exceptions to that requirement were expanded by legislative

amendment in June 2007, it argues that none of them apply to a public inquiry. Section 36(1) (with the recent amendments underlined) and s. 36(3) read as follows:

> **Confidentiality**
>
> 36. (1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* and every member of a Council or committee of a College shall keep confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,
>
> (a) to the extent that the information is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*;
>
> (b) in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;
>
> (c) to a body that governs a profession inside or outside of Ontario;
>
> (d) as may be required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Ontario Drug Benefit Act*, the *Coroners Act*, the *Controlled Drugs and Substances Act (Canada)* and the *Food and Drugs Act* (Canada);

(e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;

(f) to the counsel of the person who is required to keep the information confidential under this section;

(g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;

(h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;

(i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons; or

(j) with the written consent of the person to whom the information relates.

Evidence in civil proceedings

(3) No record of a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act,* no report, document or thing prepared for or statement given at such a proceeding and no order or decision made in such a proceeding is admissible in a civil proceeding other than a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act.* 1991, c. 18, s. 36(3); 1996, c. 1, Sched. G, s. 27(2).

In my view, neither s. 36(1) nor s. 36(3) stand in the way of the Registrar complying with the summons.

Turning first to s. 36(1), whatever the reach of the confidentiality requirement, the recent expansion of the exceptions would seem to signal a general legislative intent that its reach be somewhat diminished. Moreover, it is clear that the provision of a statutory promise of confidentiality does not bar the compelled production of documents by summons unless the documents meet the test for privilege, or the legislature has used language specifically prohibiting their introduction into evidence. See *Transamerica Life Insurance Co. of Canada v Canada Life Assurance Co.* (1995), 27 O.R. (3d) 291 at 301-2.

While s. 36(1) is clearly effective to require documents to be kept confidential in many circumstances, there is no explicit language that puts those documents beyond the reach of a summons. Nor do I think that the listing of exceptions in s. 36(1) can be said to do so by inference. However, even if that were so, and it could be said that the documents sought cannot be summonsed unless an exception applies, the CPSO position cannot prevail.

It is clear that if an exception is required, s. 36(1)(h) applies. Disclosure of the documents summonsed is required by the *PIA*. Sections 7(1) and 11 of that Act read as follows:

> **Power to summon witnesses, papers, etc.**
>
> 7. (1) A commission may require any person by summons,
>
> (a) to give evidence on oath or affirmation at an inquiry; or
>
> (b) to produce in evidence at an inquiry such documents and things as the commission may specify,
>
> relevant to the subject-matter of the inquiry and not inadmissible in evidence at the inquiry under section 11. R.S.O. 1990, c. P.41, s. 7(1).
>
> ...
>
> **Privilege**
>
> 11. Nothing is admissible in evidence at an inquiry that would be inadmissible in a court by reason of any privilege under the law of evidence. R.S.O. 1990, c. P.41, s. 11.

As I have explained, the documents sought are relevant to the Commission's mandate, and CPSO asserts no privilege over all of them. To argue that non-privileged relevant documents that are confidential can only be summonsed if, in addition, the Act authorizing the summons explicitly provides that the summons overrides the confidentiality requirement is to effectively amend s. 7(1) of the *PIA* by adding a third

condition to relevance and privilege. There is no warrant to do so. The plain meaning of s. 36(1)(h) is met by s. 7(1) of the *PIA,* which requires that the Registrar respond to the summons.

Moreover, in my view, it is of no moment that the recent amendment to the exception found in s. 36(1)(d) added the *Coroners Act*, R.S.O. 1990, c. C.37, but not the *PIA*. That exception addresses information required for the administration of the listed Acts. The *Coroners Act* entitles the coroner to obtain information in the investigation of deaths entirely apart from his or her power to summons documents at an inquest. The recent amendment to s. 36(1)(d) has removed the confidentiality impediment to that aspect of the coroner's work. By contrast, the *PIA* gives a commission no entitlement to acquire information except by summons. Thus, s. 36(1)(d) removes an impediment to a method of acquiring information that is unavailable to public inquiries. It is unsurprising, therefore, that the *PIA* is not included in that exception.

CPSO also argues that even if this is so, s. 36(3) prevents the Registrar from complying because a public inquiry is a civil proceeding and, therefore, no document prepared for a proceeding under the *RHPA* is admissible at this inquiry. Dr. Smith supports this position.

Page: 11

In assessing this argument, the recent case of *Winters v. Legal Services Society* [1999] 3 S.C.R. 160 is helpful. The relevant issue there was the meaning of the term "civil proceedings" in the *Legal Services Society Act,* R.S.B.C. 1979, c. 227, s. 3. Although he dissented in the result, Cory J. spoke for the Supreme Court on this issue. He concluded that the term must take its meaning from the particular statute in question. He looked for guidance to Black's Law Dictionary and then concluded that "civil proceedings" in the legislation in issue refers to the enforcement, redress or protection of private rights. At paragraph 62, he said this:

> [62] In *Black's Law Dictionary*, 6th ed. (1990), "civil" is defined as follows: "Of or relating to the state or its citizenry. Relating to private rights and remedies sought by civil actions as contrasted with criminal proceedings." The definition of a "civil action" is an "[a]ction brought to enforce, redress, or protect private rights. In general, all types of actions other than criminal proceedings." This definition essentially accords with that offered by the Legal Services Society: "civil proceedings", as defined in s. 3(2)(*b*), refers to the enforcement, redress or protection of private rights.

In the Ipperwash Public Inquiry, Commissioner Linden was required to consider the meaning of "civil proceeding" in s. 69(9) of the *Police Services Act*, R.S.O. 1990, c. P.15. That subsection precluded certain documents prepared pursuant to that Act from admission in a civil proceeding. Using the same approach as Cory J., he concluded that this prohibition does not apply to a public inquiry because an inquiry is an investigative, not an adjudicative process, and he could make no finding of civil or criminal liability. As he put it at paragraph 44 of his ruling: "... there is no *lis* in a public inquiry."

I would take the same approach in determining whether "civil proceeding" in s. 36(3) extends to a public inquiry. In my view, the purpose of the subsection is to allow the complaints process under the *RHPA* to function without fear that a participant or a third party will use documents prepared for it for the collateral purpose of building or defending a civil case. This protects the integrity of the complaints process by preventing it from being used as a vehicle to assist in vindicating one's rights in another proceeding.

While I agree that the collateral proceeding need not necessarily be a civil action, to be true to that objective, it must be one (in the language of *Winters supra*) that involves the enforcement, redress, or protection of private rights. The subsection is clearly not designed to protect the privacy interest of a participant from exposure in a collateral proceeding since no such protection is offered in the complaints process itself where hearings are presumptively public. This reading of the purpose of s. 36(3) accords with that of Laskin JA speaking on behalf of the Court of Appeal for Ontario in *F.(M.) v. S.(N.)* (2000), 188 D.L.R. (4th) 296.

Given this legislative intent, the prohibition against admissibility in a civil proceeding cannot be read to extend to a public inquiry. A public inquiry does not decide upon private rights. Indeed the Order in Council establishing this Commission expressly

prohibits it from expressing any conclusion regarding the civil or criminal liability of any person or organization. The role of a public inquiry is quite different, as described in *Canada (Attorney General) v. Canada (Commission of the Inquiry on the Blood System)*, [1997] 3 S.C.R. 440 at paragraph 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.

My conclusion that a public inquiry is not a civil proceeding for the purposes of s. 36 of the *RHPA* is also consistent with the way the legislature used the two terms in the *PIA*. In s. 9(1) of that Act, the legislature clearly refers to civil proceedings as those in which liability is established, and explicitly distinguishes such proceedings from an inquiry established under the Act.

I would, therefore conclude that neither s. 36(1) nor s. 36(3) of the *RHPA* prevent the Registrar from complying with the summons issued by the Commission.

The final argument raised to justify non-compliance with the summons is that the documents it seeks in paragraphs 1 to 4 are all protected by a privilege. Only Dr. Smith raises this point. He does not argue that there is an applicable class privilege (such as solicitor-client communications) but rather that all of the documents sought in paragraphs 1 to 4 of the summons meet the four common law criteria that the Supreme Court of Canada has set out to determine whether an individual communication is privileged. In *M. (A.) v. Ryan*, [1997] 1 S.C.R. 157 at para. 20, they are set out as follows:

> The applicable principles are derived from those set forth in *Wigmore on Evidence*, vol. 8 (McNaughton rev., 1961), sec. 2285. First, the communication must originate in confidence. Second, the confidence must be essential to the relationship in which the communication arises. Third, the relationship must be one which should be "sedulously fostered" in the public good. Finally, if all these requirements are met, the court must consider whether the interests served by protecting the communications from disclosure outweigh the interest in getting at the truth and disposing correctly of the litigation.

In my view, this argument must fail. To begin with, it has not been shown that if a privilege exists, Dr. Smith can assert it as one for whose benefit the privilege exists. It is at least possible that only CPSO holds any privilege, and while it reserves the right to assert privilege over specific documents, it claims no privilege over the documents as a whole. In addition, paragraphs 2 and 3 of the summons seek documents related to the Gagnon and Waudby complaints. If these complainants are the holders of any privilege

over any of these documents, such as the complaints themselves, past experience would suggest that the privilege would be waived.

Where privilege is asserted not on a class basis, but on a case by case basis, the presumption is that the communications are not privileged but are admissible unless the common law criteria are met. See *R. v. Gruenke* (1991), 67 C.C.C. (3d) 289 at 303. Dr. Smith has provided no record upon which it could be concluded that the criteria are met for all the documents sought in paragraphs 1 to 4 of the summons. That is especially true for the fourth criterion. Indeed, it would seem unlikely that this criterion could be met for all the documents. The same is true of the other criteria. For example, since the complaints process may culminate in a hearing which is presumptively public, it is hard to imagine that all documents originated in a confidence that they would not be disclosed as is required by the first criterion.

I would, therefore, conclude that Dr. Smith's argument fails. If, as individual documents are produced, a party wishes to advance a claim of privilege, it should proceed as contemplated by the Commission's Rules of Procedure.

In summary, none of the arguments advanced in support of the Registrar declining to comply with the summons issued by the Commissioner succeed. I find that he is obliged to comply, and direct that he do so.

RELEASED: October 10, 2007

Stephen Goudge
Commissioner

Appendix 17

DATE: November 20, 2007

IN THE MATTER OF *THE PUBLIC INQUIRIES ACT*, R.S.O. 1990, c. P.41

AND IN THE MATTER OF THE INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

AND IN THE MATTER OF THE CERTAIN DOCUMENTS WHICH THE KINGSTON POLICE SERVICE OBJECTS TO PRODUCING

Jennifer McAleer and Tina Lee for the Commission

David Migicovsky for the Kingston Police Service

Daniel Bernstein for the Affected Families Group

Heard: November 15, 2007

RULING

[1] To fulfill its mandate, The Commission for the Inquiry into Pediatric Forensic Pathology in Ontario received various documents from the Crown Law Office (Criminal and Civil). The Kingston Police Service brought a motion for a declaration that two documents relating to the prosecution of Louise Reynolds are protected from disclosure by a claim of privilege.

[2] The first document is a memorandum, dated April 18, 2000, from one of the investigating officers to the Crown Attorneys prosecuting the case ("Document Number One"). The second is a note of a meeting, dated July 7, 2000, between the investigating

officers and the Crown Attorneys relating, in general terms, to a number of matters that needed to be addressed in preparation for the then upcoming trial of Ms. Reynolds ("Document Number Two").

[3] The Kingston Police Service bases its claim of privilege on three grounds: solicitor/client privilege, litigation privilege, and the Wigmore case-by-case privilege.

[4] Neither the Attorney General of Ontario nor the Crown Attorneys involved in the communications claim privilege with respect to either of the documents.

Solicitor/Client Privilege

[5] For purposes of this ruling, I accept that in some circumstances communications between a Crown Attorney and police officers can give rise to a claim of solicitor/client privilege. However, solicitor/client privilege only arises when the communication is made for the purposes of obtaining or providing legal advice. As the Supreme Court of Canada stated in *R. v. Campbell*, [1999] 1 S.C.R. 565 at paras. 49 and 50:

> It is of great importance, therefore, that the RCMP be able to obtain professional legal advice in connection with criminal investigations without the chilling effect of potential disclosure of their confidences in subsequent proceedings.... Whether or not solicitor-client privilege attaches...depends on the nature of the relationship, *the subject matter of the advice* and the circumstances in which it is sought and rendered." [Emphasis Added.]

[6] In my view, the record on this motion demonstrates that the communications in issue were not for the purposes of obtaining or providing legal advice. This conclusion is based on three facts. First, on their face, the documents do not support the argument that

legal advice was being sought or delivered. Second, the affiants for the Kingston Police Service do not say that they were seeking or receiving legal advice in either case; rather, the officers merely state, "[w]e seek legal advice and direction regularly from the Crown." Third, Mr. Bradley, the senior Crown Attorney responsible for the Reynolds prosecution, states in his affidavit that legal advice was not sought nor given on either occasion.

[7] Mr. Migicovsky, counsel for the Kingston Police Service, argues that what constitutes legal advice should be given a broad interpretation in the context of a claim for solicitor/client privilege. He relies on several Supreme Court of Canada decisions for this proposition, including *Blank v. Canada*, [2006] 2 S.C.R. 319 at para. 24 and *Descôteaux v. Mierzwinski*, [1982] 1 S.C.R. 860. In his factum, Mr. Migicovsky cites *Descôteaux* as follows:

> Whether communications are made to the lawyer himself or to employees, and whether they deal with matters of an administrative nature such as financial means or with the actual nature of the problem, all information which a person must provide in order to obtain legal advice and which is given in confidence for that purpose enjoys the privileges attached to confidentiality.

[8] I agree with Mr. Migicovsky's submission to the extent that he suggests that a broad range of materials may be privileged; however, *Descôteaux* makes it clear that the materials must be given "in order to obtain legal advice" before the privilege attaches. The communications in issue do not satisfy this requirement.

[9] Thus, I conclude that the claim for solicitor/client privilege must fail.

Litigation Privilege

[10] All the parties accept that the documents in issue were protected by litigation privilege up to the point when the Crown withdrew the charge against Ms. Reynolds. Thus, it is clear that the Crown would not have been required to disclose these documents to the defence as part of its *Stinchcombe* obligations. The question arises, however, whether that litigation privilege survived the termination of the criminal proceedings.

[11] The law of litigation privilege is that the privilege "comes to an end, absent closely related proceedings, upon the determination of the litigation that gave rise to the privilege" (*Blank*, *supra*, at para. 36). In other words, the privilege ends when the litigation ends or when closely related proceedings end, whichever is the latter.

[12] The Kingston Police Service makes two arguments in support of its claim for litigation privilege. First, it argues that the criminal litigation has not ended because the charge against Ms. Reynolds was withdrawn, and that, as a result, it could be re-laid some time in the future. While I suppose this scenario is theoretically possible, it is, to say the least, extremely improbable. The charge was withdrawn almost seven years ago (on January 25, 2001), and the case has been thoroughly investigated. I do not think that the theoretical possibility of a future charge in the circumstances of this case is sufficient to support a claim for the continuation of a litigation privilege.

[13] The Kingston Police Service's second argument is that it is a party to "closely related proceedings". The Kingston Police Service is a defendant by way of cross-claim in a lawsuit brought by Ms. Reynolds relating to her prosecution. The argument is that this civil lawsuit is a "closely related proceeding" to the Reynolds prosecution and, thus, the litigation privilege continues until the civil proceedings against the Police Service have been completed.

[14] I do not accept this argument. For practical purposes, it appears that the cross-claim against the Kingston Police Service will be terminated in the very near future. Ms. Reynolds has dropped her lawsuit against the Kingston Police Service and in doing so has delivered to the Kingston Police Service a full and final release. As the Kingston Police Service's motion for dismissal states:

> The plaintiff [Louise Reynolds] has consented to a dismissal of the action as against these defendants [the Kingston Police Service et al.] and has provided these defendants with a full and final release with respect to all claims that are the subject of these proceedings. The plaintiff has also provided written confirmation that she is restricting her claims against the other defendants [Dr. Charles Smith et al.] to damages for which the other defendants may be directly liable and is not claiming against the other defendants for any portion of her damages which the Court may find to be attributable to fault on the part of these defendants.

[15] While Mr. Migicovsky informed me by letter following the hearing that the Kingston Police Service must participate in the discovery process and testify at trial, there is no indication that the Kingston Police Service will be held liable for any damages

awarded to Ms. Reynolds. In the face of the release, there is no basis for a continued claim against the Kingston Police Service and, thus, no longer a need for the continuation of the litigation privilege in its favour.

[16] In any event, I am satisfied that the outstanding cross-claim against the Kingston Police Service does not constitute "closely related proceedings" for the purposes of the continuation of the litigation privilege arising from the prosecution. In *Blank*, *supra*, at para. 43, the Supreme Court of Canada held, "[t]he Minister's claim of privilege thus concerns documents that were prepared for the dominant purpose of a criminal prosecution relating to environmental matters and reporting requirements. The respondent's action, on the other hand, seeks civil redress for the manner in which the government conducted that prosecution. It springs from a different juridical source and is in that sense unrelated to the litigation of which the privilege claimed was born."

[17] Thus, I do not accept that the documents in issue are subject to a litigation privilege in favour of the Kingston Police Service.

The Wigmore Privilege

[18] The so called Wigmore privilege was adopted in Canadian jurisprudence by the Supreme Court of Canada in *Slavutych v. Baker*, [1976] 1 S.C.R. 254. The onus is upon a party claiming the benefit of this privilege to establish the following four criteria:

(1) The communications must originate in a confidence that they will not be disclosed.

(2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.

(3) The relation must be one which in the opinion of the community ought to be sedulously fostered.

(4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

[19] While I have some concerns with whether the Kingston Police Service has satisfied criteria one to three,[1] I do not find it necessary to decide these issues as I find that the Kingston Police has failed to satisfy criteria four. The Kingston Police Service has not satisfied me that the deleterious effects that disclosure could have on the relationship between the investigating police force and the prosecuting Crown outweigh the benefits of disclosure and the "correct disposal" of the Inquiry's mandate.

[20] The Commission's mandate is to report on, *inter alia*:

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[1] My concerns with the first three criteria are as follows: (1) I question whether Document Number One can be said to have originated in a relationship of confidence since the evidence suggests that only one party had an expectation of confidentiality; (2) I question whether confidentiality is essential to the relationship between the police and Crown counsel because these parties must of necessity work together to prosecute criminal behaviour; and (3) I question whether the community should sedulously foster the relationship given that public officials are held to a higher standard, and that claims of malicious prosecutions should not be curtailed.

> [T]he policies, procedures, practice, 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 ... 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.

[21] There is a strong public interest in having the Commission consider all reasonably relevant information pertaining to the subject matter of the Commission. As Justice Howland stated in *Re Bortolotti et al. and Ministry of Housing et al.* (1977), 15 O.R. (2d) 617, "[a] full and fair inquiry in the public interest is what is sought in order to elicit all relevant information pertaining to the subject-matter of the inquiry."

[22] The contents of these two documents appear to be very relevant to the mandate of this Inquiry.

[23] Pediatric forensic pathology played an essential role in the investigation into and criminal prosecution of Ms. Reynolds. The Commission submits that the documents will assist the Commission in fulfilling its mandate. In particular, the documents will assist in identifying and giving factual context to systemic issues, including:

a) The interaction between the police, Crown counsel and expert forensic pathologists;

b) The use of pediatric forensic pathology in criminal investigations and proceedings;

c) The risk of "tunnel vision" in criminal investigations and prosecutions where pediatric forensic pathology forms a significant part of the criminal prosecution; and

d) Whether police, Crown and/or defence counsel should have specialized training in pediatric forensic death investigations.

[24] Document Number One may help shed light on the dangers of "tunnel vision" in criminal investigations and prosecutions where pediatric forensic pathology plays an integral role in proving the case, particularly where there is disagreement among the experts or the experts are revising their opinions. In my view, the contents of Document Number One are very informative about the interaction of police and prosecutors in this context.

[25] Similarly, Document Number Two is important to the Commission in identifying how the Crown and police were approaching the complex and changing pathology evidence in preparation for trial. It appears, from the notes themselves, that the prosecution team was preparing other forensic evidence to demonstrate the possible role of the dog.

[26] The fact that the government has chosen to call a public inquiry into the matters to which these documents are relevant speaks to the general public interest in their disclosure. Of significance also is the fact that the Kingston Police Service itself has

recognized the public interest in having public disclosure of this type of information. Chief S.J. Closs of the Kingston Police has gone on record and called for a full public inquiry into the investigation and prosecution of Louise Reynolds:

a) On February 20, 2001, Chief Closs wrote to Premier Michael D. Harris requesting a public inquiry into the circumstances of Sharon's death and the resulting criminal investigation and public prosecution. In this letter, Chief Closs stated that a public inquiry was necessary to "restore public confidence in the administration of justice". Copies of this letter were sent to the Solicitor General and Attorney General.

b) Also on February 20, 2001, Chief Closs wrote to the Editor of *The Kingston Whig-Standard*, emphasizing the fact that a full and independent public inquiry into the death of Sharon Reynolds was needed to provide the public with a "full accounting of the circumstances of this investigation and prosecution".

c) On August 14, 2006, Chief Closs wrote to Dr. Barry McLellan, Chief Coroner for Ontario, regarding the Chief Coroner's Review. Chief Closs stated that the Kingston Police Service would co-operate fully with the review. Further, he indicated that the Review should have considered a broader range of materials from the case.

[27] Each of these letters demonstrate that the Chief of Police of the Kingston Police Service was concerned, quite properly and responsibly, about the public's perception of

the administration of justice, and a corresponding concern that any inquiry into Sharon Reynolds' death be given broad powers of investigation.

[28] While the public inquiry presently underway is not as extensive as that called for by Chief Closs, it nonetheless addresses some of the issues he raised relating to public accountability. The point is that there is a strong interest in the disclosure of information relating to the investigation of the Reynolds case, including, in particular, disclosure of information that would further the Inquiry's mandate.

[29] Weighing against disclosure of these documents under the fourth Wigmore criterion are the statements of the two investigating police officers that should the documents be disclosed there will be a chilling effect in future upon the relationships between police officers and Crown Attorneys. Police officers will no longer feel free to communicate openly with Crown Attorneys, which will have a detrimental effect on prosecutions of criminal offences in this country.

[30] With due respect to the officers, I think this concern is overstated. To start, there is nothing in this ruling to suggest that the documents would have had to have been disclosed during the course of the criminal prosecution. On the contrary, it is accepted that the documents in issue would not have formed part of the Crown's obligation of disclosure pursuant to *Stinchcombe*. Moreover, the disclosure that will take place in this case is occurring in rather unusual circumstances. The Government of Ontario has called

a public inquiry because of the significant public interest in determining what went wrong, if anything, with respect to the introduction of forensic pathological evidence in several criminal cases.

[31] Finally, as to the so called chilling effect of disclosure, there is nothing in the documents, with one exception,[2] that is particularly embarrassing or compromising. I do not think that police officers, even if concerned about the possibility of disclosure at future public inquiries (however remote that might be), would be deterred from engaging in these types of communications.

[32] As to the one exception, I am satisfied that the disclosure of the one comment is not sufficiently deleterious to the police-Crown relationship to outweigh the advantages of disclosure. Indeed, one might reasonably say it would be better if these types of comments were not made at all.

[33] In summary, the Kingston Police Service has not persuaded me that the concerns it expresses about disclosure outweigh the public interest in having these documents made public through the process of the inquiry.

Fairness Issues

[34] During the course of his submissions, Mr. Migicovsky raised concerns about the process by which the two documents may be disclosed to the public. These concerns

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[2] Here I refer to the last paragraph of page 1 and the top two paragraphs of page 2 in Document Number One.

centered on questions of fairness to various individuals as a result of Document Number One. Put shortly, his concern was that the release of the documents, without providing the context and explanations relating to their contents, could generate an enormous amount of publicity that could damage unfairly the reputations of two individuals.

[35] In my view, these concerns about the process by which documents may be released by the inquiry are not relevant to the issues that I am called upon to decide on this motion. I indicated to Mr. Migicovsky that, should I not accept his arguments that the documents are privileged, his concerns about fairness in the process by which the documents would be disclosed publicly should be raised with the Commission.

Disposition

[36] In the result, the motion of the Kingston Police Service for a declaration that Documents Number One and Two are subject to privilege is dismissed.

November 20, 2007

A.C.J.O.

Appendix 18

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

The Honourable Stephen Goudge, Commissioner

180 Dundas Street West, 22nd Floor
Toronto Ontario M5G 1Z8

Tel: 416 212-6878
Fax: 416 212-6879
Website: www.goudgeinquiry.ca

Ontario

COMMISSION D'ENQUÊTE SUR LA MÉDECINE LÉGALE PÉDIATRIQUE EN ONTARIO

L'honorable Stephen Goudge, Commissaire

180, rue Dundas Ouest, 22e étage
Toronto (Ontario) M5G 1Z8

Tél. : 416 212-6878
Téléc. : 416 212-6879
Site Web : www.goudgeinquiry.ca

CONFIDENTIALITY UNDERTAKING OF COUNSEL

1. This Confidentiality Undertaking is required to be provided by legal counsel ("Counsel") acting for the Parties to the Commission of Inquiry into Pediatric Forensic Pathology in Ontario (the "Commission") before any Confidential Information is provided to Counsel.

2. "Confidential Information" means any information relevant to the Commission, that is disclosed to the Counsel, by or on behalf of the Commission and any copies, derivatives or summaries (whether electronic or in print form), but does not include: (i) information that the Commissioner, by reason of its use at the Commission hearings, has determined may be made public; or (ii) additional information which the Commissioner has agreed in writing is not confidential or may otherwise be disclosed.

3. I, _____,
as counsel to _____acknowledge and agree as a condition to my receipt of the Confidential Information, to treat the Confidential Information in accordance with the provisions of this Undertaking and to take or refrain from taking certain actions herein set forth. I understand that in light of the sensitivity of the Confidential Information, which includes highly personal information, some of which may be subject to provisions or orders that restrict or prohibit publication or the making of such information public, I am required by this Undertaking to keep the

Confidential Information strictly confidential, must take whatever steps are reasonably necessary to keep this Confidential Information from being disclosed, and may only use the Confidential Information for these proceedings and for no other purpose.

4. Upon providing this Undertaking, the Confidential Information, in electronic format, will be provided to me. Without limiting the generality of the strict duty of confidentiality, I undertake to do the following:

1) Prohibition on Publication or Making Public the Confidential Information

5. I may not in any way publish or make public any of the Confidential Information. I understand this is a broad prohibition that ensures that I do not through my actions, or failure to act, cause the Confidential Information to become available electronically or by any other means to the public or unauthorized persons. For greater certainty, I may not disseminate the Confidential Information by any means where dissemination to the public or unauthorized persons could reasonably result.

2) Prohibition on Sharing the Confidential Information

6. I understand that by obtaining Confidential Information, I am under a strict duty of confidentiality. I am prohibited from sharing the Confidential Information with anyone else, including my client, paralegals, office personnel, experts, without first (i) obtaining the express written authorization of Commission Counsel; and (ii) obtaining, in each case, a confidentiality agreement in the same form as this Undertaking subject to changes necessary to reflect the identity of such party (a "Third Party Confidentiality Agreement"). For greater certainty, I may not provide any of the said third parties with the Confidential Information unless I have obtained the express written authorization of Commission Counsel and an executed Third Party Confidentiality Agreement *before* the Confidential Information is provided.

7. I also recognize that the Third Party Confidentiality Agreement may permit access by third parties to some, but not all, of the Confidential Information, as particularized in the Agreement, based upon the applicable circumstances.

3) Duty to Safeguard Records Provided

8. I understand that I am required to safeguard the Confidential Information provided to me at all times. The Confidential Information kept in my office computer must be password protected with access restricted to only me or authorized third parties. Any printed copies of the Confidential Information must be kept and dealt with in accordance with my obligations under this Agreement. Similarly, any transportation or transmittal of Confidential Information must only be done in accordance with the said obligations.

4) In the Event of a Breach

9. If the Confidential Information is lost or stolen or if there has been unauthorized access, I am required to advise Commission Counsel immediately to ensure that appropriate steps may be taken to address the breach. I am also required to take whatever steps are necessary to mitigate the risks of improper disclosure of the records.

5) Secure Destruction

10. Once the Commission is concluded, the Confidential Information that remains subject to this Undertaking, and any copies of such Confidential Information, that have been provided to me must be securely destroyed, subject to any order of the Commissioner or the courts to the contrary. I undertake to collect for destruction all Confidential Information from those to whom the Commission has authorized me to disclose. Secure destruction requires permanent and irreversible destruction in a manner that ensures that the identity of individuals cannot be discerned. I must do this in relation to the Confidential Information and any copies of them whether paper or electronic. Paper records must be cross-cut or confetti-cut shredded, or put through a process that results in the records being shredded into pieces no larger than the cross-cut or confetti-cut shredding processes. For greater clarity, strip-cut shredding is not sufficient to comply with this undertaking. Confidential Information in electronic format may only be destroyed by either physically damaging the device or through employing wiping utilities that permanently destroy the material. I am required to certify that such has been done to Commission Counsel. As an alternative to destruction, I may return

the said Confidential Information to the Commission at a time and in a manner agreed upon by the Commission.

I have read the above and undertake to comply with these terms as a condition of receiving the Confidential Information.

_____	_____
Signature	Witness
_____	_____
Date	Date

Appendix 19

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

The Honourable Stephen Goudge,
Commissioner

180 Dundas Street West, 22nd Floor
Toronto Ontario M5G 1Z8

Tel: 416 212-6878
Fax: 416 212-6879
Website: www.goudgeinquiry.ca

COMMISSION D'ENQUÊTE SUR LA MÉDECINE LÉGALE PÉDIATRIQUE EN ONTARIO

L'honorable Stephen Goudge,
Commissaire

180, rue Dundas Ouest, 22e étage
Toronto (Ontario) M5G 1Z8

Tél. : 416 212-6878
Téléc. : 416 212-6879
Site Web : www.goudgeinquiry.ca

THIRD PARTY CONFIDENTIALITY AGREEMENT

1. This Confidentiality Undertaking (also referred to herein as a "Third Party Confidentiality Agreement" or "Agreement") is required to be provided by any person (other than Counsel for parties with standing) who is permitted in writing by the Commission to access any Confidential Information (an "Approved Person"). Counsel are required to provide a differently worded Confidentiality Undertaking.

2. "Confidential Information" means any information relevant to the Commission, that is disclosed to Counsel or to Approved Persons, by or on behalf of the Commission and any copies, derivatives or summaries (whether electronic or in print form), but does not include: (i) information that the Commissioner, by reason of its use at the Commission hearings, has determined may be made public; or (ii) additional information which the Commissioner has agreed in writing is not confidential or may otherwise be disclosed.

3. I, _____,
as (describe position and role) _____acknowledge and agree as a condition to my receipt of any Confidential Information, to treat such Confidential Information in accordance with the provisions of this Agreement and to take or refrain from taking certain actions herein set forth. I understand that in light of the sensitivity of such Confidential Information, which includes highly personal information,

some of which may be subject to provisions or orders that restrict or prohibit publication or the making of such information public, I am required by this Agreement to keep any Confidential Information strictly confidential, must take whatever steps are reasonably necessary to keep any Confidential Information from being disclosed, and may only use any Confidential Information for these proceedings and for no other purpose.

4. Upon executing this Agreement, Confidential Information will be provided to me. Without limiting the generality of the strict duty of confidentiality, I undertake and agree to do the following:

1) Prohibition on Publication or Making Public the Confidential Information

5. I may not in any way publish or make public any Confidential Information. I understand this is a broad prohibition that ensures that I do not through my actions, or failure to act, cause any Confidential Information to become available electronically or by any other means to the public or unauthorized persons. For greater certainty, I may not disseminate any Confidential Information by any means where dissemination to the public or unauthorized persons could reasonably result.

2) Prohibition on Sharing the Confidential Information

6. I understand that by obtaining any Confidential Information, I am under a strict duty of confidentiality. I am prohibited from sharing any Confidential Information with anyone other than Counsel or other Approved Persons with whom I am working in connection with this Inquiry, and even then, only in accordance with the terms and conditions both of this Agreement and the Confidential Undertakings of such Counsel or the Third Party Confidentiality Agreements of such other Approved Persons.

7. I also recognize that this Agreement may permit access to some, but not all, of existing Confidential Information, as particularized herein.

3) Duty to Safeguard Records Provided

8. I understand that I am required to safeguard any Confidential Information provided to me at all times. Any Confidential Information kept in my office computer or any other computer in my possession or control must be password protected with access restricted to only me or to Counsel or other Approved Persons. Any printed copies of any Confidential Information must be kept and dealt with in accordance with my obligations under this Agreement. Similarly, any transportation or transmittal of Confidential Information must only be done in accordance with the said obligations.

4) In the Event of a Breach

9. If any Confidential Information is lost or stolen or if there has been unauthorized access, I am required to advise Commission Counsel immediately (directly or through Counsel with whom I am working) to ensure that appropriate steps may be taken to address the breach. I am also required to take whatever steps are necessary to mitigate the risks of improper disclosure of the records.

5) Secure Destruction

10. Once the Commission is concluded, any Confidential Information that remains subject to this Agreement, and any copies of such Confidential Information, that have been provided to me must be securely destroyed, subject to any order of the Commissioner or the courts to the contrary. Secure destruction requires permanent and irreversible destruction in a manner that ensures that the identity of individuals cannot be discerned. I must do this in relation to any Confidential Information and any copies of them whether paper or electronic. Paper records must be cross-cut or confetti-cut shredded, or put through a process that results in the records being shredded into pieces no larger than the cross-cut or confetti-cut shredding processes. For greater clarity, strip-cut shredding is not sufficient to comply with this Agreement. Any Confidential Information in electronic format may only be destroyed by either physically damaging the device or through employing wiping utilities that permanently destroy the material. I and Counsel with whom I am working, are required to certify that such has been done to Commission Counsel. As an alternative to destruction, I may return the

said Confidential Information to the Commission at a time and in a manner agreed upon by the Commission.

11. I understand and accept the following additional restrictions upon my access to, or use of, Confidential Information:

_____

_____

_____

_____

_____

I have read the above and I agree and undertake to comply with these terms as a condition of receiving any Confidential Information.

_____	_____
Signature	Witness
_____	_____
Date	Date

Appendix 20

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

The Honourable Stephen Goudge, Commissioner

180 Dundas Street West, 22nd Floor
Toronto Ontario M5G 1Z8

Tel: 416 212-6878
1 866 493-4544
Fax: 416 212-6879
Website: www.goudgeinquiry.ca

COMMISSION D'ENQUÊTE SUR LA MÉDECINE LÉGALE PÉDIATRIQUE EN ONTARIO

L'honorable Stephen Goudge, Commissaire

180, rue Dundas Ouest, 22e étage
Toronto (Ontario) M5G 1Z8

Tél. : 416 212-6878
1 866 493-4544
Téléc. : 416 212-6879
Site Web : www.goudgeinquiry.ca

Notice of Alleged Misconduct

***(Public Inquiries Act,* ss. 5(2))**

Pursuant to subsection 5(2) of the *Public Inquiries Act,* you are notified that in its report(s), the Inquiry Into Pediatric Forensic Pathology in Ontario may make a finding of misconduct by you, the substance of which alleged misconduct is set out in Schedule "A", attached.

This notice is given without prejudice to the ability of the Inquiry Into Pediatric Forensic Pathology in Ontario, through its counsel, to modify the particulars of the substance of the alleged misconduct as circumstances may necessitate.

This notice is designed to assist you in identifying allegations of misconduct that may arise during the course of the inquiry, and should not be taken as any indication that the Commissioner intends to make these findings against you, nor that the allegations, if substantiated, necessarily constitute misconduct.

Receipt of this notice entitles you full opportunity to be heard in person or through counsel with regard to those issues or areas of evidence that affect your interest.

To:

From: Linda R. Rothstein
Lead Commission Counsel
Inquiry Into Pediatric
Forensic Pathology in
Ontario

Date:

Schedule "A"

1.

Appendix 21

ONTARIO COURT OF JUSTICE
(Toronto Region)
Youth Court

IN THE MATTER OF the *Youth Criminal Justice Act* S.C. 2002, c. 1 as amended;

AND IN THE MATTER OF Order in Council 826/2007 establishing the Inquiry into Pediatric Forensic Pathology in Ontario, and appointing the Honourable Stephen T. Goudge as Commissioner;

AND IN THE MATTER OF an application by the Commissioner for an Order pursuant to s. 123(1)(a) and s. 123(5) of the *Youth Criminal Justice Act* for access to records kept pursuant to ss. 114 to 116 and s. 163 of the said *Act*.

ORDER (S.M.)

UPON APPLICATION for an Order pursuant to s. 123(1)(a) and s. 123(5) of the *Youth Criminal Justice Act* concerning records in the possession of the Province of Ontario relating to S.M., a young person;

UPON READING the Affidavit of Robert A. Centa and the exhibits attached thereto, and hearing the submissions of counsel; no one appearing on behalf of although properly served with the material.

THIS COURT ORDERS:

(1) That the Commissioner, his Commission counsel and staff, be granted access to records kept pursuant to ss. 114 to 116 and s. 163 of the *Youth Criminal Justice Act* ("the *Act*") or copies thereof, relating to the investigation and prosecution of S.M., a young person, for manslaughter, contrary to s. 234 of the *Criminal Code*, R.S.C. 1985, c. C-46;

(2) That the said records or copies thereof be used for the purpose of fulfilling the Commissioner's mandate pursuant to Order in Council 826/2007;

(3) That the Commissioner, his Commission counsel and staff be permitted to disclose the said records or copies thereof ("the records") and information contained therein, and use the said records or information at the Inquiry into Pediatric Forensic Pathology in Ontario ("the Inquiry"), provided that the records and information are not disclosed in a form that would reasonably be expected to bring about the identification of the young person, S.M., to whom they relate.

DATED this 25th day of September, 2007.

Ontario Court of Justice

ONTARIO COURT OF JUSTICE
(Toronto Region)
Youth Court

IN THE MATTER OF the *Youth Criminal Justice Act* S.C. 2002, c. 1 as amended;

AND IN THE MATTER OF Order in Council 826/2007 establishing the Inquiry into Pediatric Forensic Pathology in Ontario, and appointing the Honourable Stephen T. Goudge as Commissioner;

AND IN THE MATTER OF an application by the Commissioner for an Order pursuant to s. 119(1)(s)(ii) of the *Youth Criminal Justice Act* for access to records kept pursuant to ss. 114 to 116 of the said *Act*.

ORDER (J.D.)

UPON APPLICATION for an Order pursuant to s. 119(1)(s)(ii) of the *Youth Criminal Justice Act* concerning records in the possession of the Province of Ontario relating to J.D., a young person;

UPON READING the Affidavit of Robert A. Centa and the exhibits attached thereto, and hearing the submissions of counsel;

THIS COURT ORDERS:

(1) That the Commissioner, his Commission counsel and staff, be granted access to all records, dated prior to June 16, 2004, kept pursuant to ss. 114 to 116 of the *Youth Criminal Justice Act* ("the *Act*") or copies thereof, relating to the investigation and prosecution of J.D., a young person, for second degree murder (and then manslaughter), contrary to the *Criminal Code*, R.S.C. 1985, c. C-46;

(2) That, in addition, the Commissioner, his Commission counsel and staff, be granted access to the records listed in Appendix "A", kept pursuant to ss. 114 to 116 of the *Youth Criminal Justice Act* ("the *Act*") or copies thereof, relating to the investigation and prosecution of J.D., a young person, for second degree murder (and then manslaughter), contrary to the *Criminal Code*, R.S.C. 1985, c. C-46;

(3) That, in addition, the Commissioner, his Commission counsel and staff, be granted access to any other records, kept pursuant to ss. 114 to 116 of the *Youth Criminal Justice Act* ("the *Act*") or copies thereof, relating to the investigation and prosecution of J.D., a young person, for second degree murder (and then manslaughter), contrary to the *Criminal Code*, R.S.C. 1985, c. C-46, which relate to the practice of pediatric forensic pathology or its impact on the investigation into Jenna [redacted]s death;

(4) That the said records or copies thereof be used for the purpose of fulfilling the Commissioner's mandate pursuant to Order in Council 826/2007; and

4(a) That the Commissioner, his commission counsel & staff be permitted to disclose said record or copies thereof to counsel for J.D.

(5) That the Commissioner, his Commission counsel and staff be permitted to disclose the said records or copies thereof ("the records") or information contained therein, and use the said records or information at the Inquiry into Pediatric Forensic Pathology in Ontario ("the Inquiry"), provided that the records and information are not disclosed in a form that would reasonably be expected to bring about the identification of the young person, J.D., to whom they relate. ad provided by NW counsel for J.D consents to the said disclosure or a further order is obtained from this Court prior to such disclosure.

DATED this 25th day of September, 2007.

Ontario Court of Justice

Appendix 22

DATE: 2007-11-01

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON THE REQUESTS FOR NON-PUBLICATION ORDERS

COMMISSIONER GOUDGE:

Public hearings, by their very nature, must be conducted in public, so far as possible. That is their raison d'être.

Commission Counsel and Mr. Lockyer have each brought applications asking that I impose certain limited constraints on this principle of openness, by way of non-publication orders. Notice of these applications was provided to all parties granted standing, and to the media. On October 18, the applications were argued by Commission Counsel and Mr. Lockyer in the presence of counsel for the province of Ontario, Dr. Smith, the Affected Families Group and AIDWYC, none of whom opposed the orders being sought. Neither the media, nor the other parties with standing attended.

At the commencement of the hearing of these applications, Commission Counsel requested an order to ensure that names of persons identified during the submissions not

be published or made public. In order to permit full submissions, I granted the order sought.

Both applications propose a ban on identifying certain persons who may be the subject of inquiry by the Commission. Both propose that pseudonyms be used for them so that the Commission can carry out its work as it relates to these individuals, while protecting their identities.

Before turning to the specifics of these applications, several fundamental principles must be emphasized.

First, this Commission, like all public inquiries, must be held in public so far as possible, if it is to fully discharge the mandate expected of it. In *Canada (Attorney General) Canada (Commission of Inquiry on the Blood System in Canada-Krever Commission)*, [1997] 3 S.C.R. 440, Cory J., speaking for the Supreme Court of Canada at para. 30, offered this useful reflection on commissions of inquiry and the purposes served by their open and public nature:

> 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

Page: 4

> 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. [Emphasis added.]

This principle is codified in s. 4 of the *Public Inquiries Act,* R.S.O. 1990, c. P.41 which gives a commissioner discretion to depart from the openness principle in certain limited circumstances. It reads as follows:

> All hearings on an inquiry are open to the public except where the commission conducting the inquiry is of the opinion that,
>
> > (a) matters involving public security may be disclosed at the hearing; or
> >
> > (b) intimate financial or personal matters or other matters may be disclosed at the hearing

> that are of such a nature, having regard to the circumstances, that the desirability of avoiding disclosure thereof in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that hearings be open to the public,
>
> in which case the commission may hold the hearing concerning any such matters in the absence of the public.

Second, it is obviously important that this Commission be able to discharge the mandate given to it by the Lieutenant Governor in Council under the *Public Inquiries Act*. In this context, it is helpful to review the genesis of the Commission and what is expected of it.

The Order in Council makes clear that one of the reasons for establishing the Commission was the review conducted on behalf of the Chief Coroner for Ontario (the "Chief Coroner's Review"). It examined certain cases of suspicious child deaths where Dr. Charles Smith performed the autopsy or was consulted, and found that some of the factual conclusions were not reasonably supported by the materials available. In a number of these cases, the determinations of fact and opinion were submitted as evidence in criminal proceedings.

The Order in Council then tasks the Commission to conduct a systemic review of the role played by pediatric forensic pathology in the criminal justice system since 1981. The purpose of this review is to make recommendations to restore and enhance public confidence in how that role will be played in the future.

It is in the context of these principles that these applications must be considered.

Commission Counsel's application seeks to protect the identities of those young persons who were involved in the infant death cases examined by the Chief Coroner's Review, and who as a result were involved in a proceeding under the *Youth Criminal Justice Act*, S.C. 2002, c. 1 (the "*YCJA*"), or its predecessor, the *Young Offenders Act*, R.S.C. 1985, c. Y-1 (the "*YOA*"), or the *Child and Family Services Act*, R.S.O. 1990, c. C.11 (the "*CFSA*"), or its predecessor, the *Child Welfare Act*, R.S.O. 1980, c. 66 (the "*CWA*"). These pieces of legislation provide that the identities of such young persons be protected, and to that end require that information which would identify them not be published or made public.

Commission Counsel's proposal is aimed at achieving this goal, while at the same time ensuring that the Commission can function efficiently and fulfill its mandate with a transparency that accords with the *Public Inquiries Act*.

The basic procedure proposed is that in those cases triggering the legislated protection, the deceased infant will be referred to by its first name only. Where a child involved in a case attracts the protection of the *CFSA* or the *CWA*, the child and other relatives of the deceased infant will be referred to by first name only, or by their relationship to the deceased infant. Where the young person involved in a case attracts the protection of the *YCJA* or the *YOA*, he or she will be referred to by initials only, as is required under that legislation, and others will be referred to either by their relationship to that young person or by their own initials.

The fundamental premise is that by using the first name only, or initials only, or by only describing the relationship, the identity of the child or young person involved is protected. This achieves the aim of the legislation. At the same time, Commission Counsel is confident that this presents no impediment to the efficient conduct of the Commission's hearings.

Page: 8

Commission Counsel proposes that there be two departures from this procedure. First, in those cases covered by the proposal where standing has been granted to adults, those adults will be referred to by full name. However, the procedure will be fully applicable to all others in those cases, including the child or young person whose identity is being protected.

Second, Commission Council proposes that the same modification should apply in one particular case where the adults have not been granted standing. This case has received wide publicity in the media, and in court proceedings as recently as several weeks ago, none of which spared the names of the adults or the deceased infant, or the participants in the child welfare proceedings that were involved.

Mr. Lockyer's proposal seeks to invoke s. 4(b) of the *Public Inquiries Act*, informed by the common law principles concerning open hearings and publication bans found in cases like *Dagenais v. Canadian Broadcasting Corp.*, [1994] 3 S.C.R. 835 and *R. v. Mentuck*, [2001] 3 S.C.R. 442.

Mr. Lockyer acts for nine adults who have been granted standing. Two of them are involved in cases that come within Commission Counsel's proposal. Since both want

their full names used at the Commission's hearings, both are content with Commission Counsel's proposal as it applies to their cases, and are not included in Mr. Lockyer's application.

In this sense, these two clients of Mr. Lockyer take the same position as Mr. Wardle's clients, known collectively as the Affected Families Group. Mr. Wardle acts for seven adults who have been granted standing. These seven are involved in four cases, all covered by Commission Counsel's proposal. Mr. Wardle made clear that all seven are very willing to have their full names used in the Commission's hearings. They see their cases and the use of their full names as an important part of the public scrutiny that the Commission must apply to pediatric forensic pathology in Ontario.

The other seven for whom Mr. Lockyer acts are extremely anxious to protect their identities. Three of these are involved in cases that are covered by Commission Counsel's proposal, but are not content with it, since it would not protect the use of their full names, given that they have been granted standing. The other four are involved in cases that do not attract the protection of either the *CFSA* or the *YCJA*. They seek to have their identities protected because of personal matters that may be disclosed at the hearing. These personal matters are of such a nature that avoiding disclosure is important and will

not significantly erode the openness principle that is vital to public inquiries, thus directly engaging s. 4(b) of the *Public Inquiries Act*.

Mr. Lockyer therefore proposes that these seven cases be dealt with in a manner similar to the procedure proposed by Commission Counsel. He proposes that the deceased infant be referred to by first name or initial only, and that relatives of the deceased infant be referred to only by their relationship to the infant. In addition, Mr. Lockyer asks that in three of the cases there be no reference to the municipality in which the events took place.

After considering both of these applications, I am of the view that the appropriate order is one that incorporates most, but not all, of these two proposals.

The basic procedure will be as follows:

> a) For those cases covered by Commission Counsel's proposal (which includes three of Mr. Lockyer's clients) and the four additional cases involving Mr. Lockyer's clients, the deceased infant will be referred to by first name only. In the two of these cases where the infant did not have a first name, the first initial of the last name will be used instead.

b) Except for the two departures from this procedure explained below, those related to or closely involved with the deceased infant will be referred to by their first name only, or by their relationship to the infant.

c) For those cases covered by Commission Counsel's proposal that also involve young persons to whom the youth justice legislation applies, the young persons will be referred to by their initials only as is required under the legislation. Those related to them will be described by first name only or by their relationship to the young person.

With one addition to which I will refer, I am satisfied that this basic procedure will protect the identities of the children and young persons entitled to legislative protection of their identities. It will also protect the identities of the seven adults for whom Mr. Lockyer applies, who in my view meet the requirements for this protection found in s. 4(b) of the *Public Inquiries Act*. I am also satisfied that by applying the same protection to similarly situated persons, this procedure will be relatively easy for parties to apply, and therefore will not detract from the efficiency required to meet the time lines that have been given to the Commission.

In three of his cases, Mr. Lockyer requests the additional comfort of a publication ban on referring to the name of the city in which the events occurred. In my view, such an additional non-publication restriction cannot be justified for two of Mr. Lockyer's clients. In one of these, the individual no longer resides in the city concerned, and in the other, the city is sufficiently large that naming it is not a threat to anonymity.

I am, however, prepared to grant the request in the third case. While I think that the basic procedure I have outlined protects identity fully, in this case the city is small, and remains the home of the person's family. In addition, the person has received a pardon. Finally, Commission Counsel advises that as far as can be presently ascertained this limitation will not impede the Commission's work. In these circumstances, I think the person is entitled to the personal comfort that I am advised would come with an order that there be no reference to the name of the city in which the events occurred. Should this subsequently prove to be an impediment to the Commission's work, this restriction can be revisited.

The first of the two departures from the basic procedure that is needed for the Commission to properly fulfill its mandate relates to the two adults for whom Mr.

Lockyer acts who were not included in his application, and the seven adults (involving four cases) for whom Mr. Wardle acts. For several reasons, it is proper that these nine individuals be referred to by their full names.

First, all of these adults have all sought standing and funding to participate in this Commission and cannot be surprised to find themselves involved in a process which must be conducted in public if possible. They are distinguished from the other adults who have been granted standing, because they are not only willing to have their full names used - they want their names to be part of any public scrutiny of their cases undertaken by the Commission.

Second, the cases in which these adults are involved are, in my view, the most notorious among the cases considered by the Chief Coroner's Review. They have received wide coverage in the media and a number of them have been the subject of extensive court proceedings, all without any protection of identities and with use of full names. It is hardly surprising that this late in the day, these adults do not seek protection for their identities.

Third, because the names of these adults and the broad outlines of their cases have so often been referred to in the media, and because their cases were an important part of the genesis of the Commission, the Commission must be able to publicly demonstrate that it has examined their cases. This requires the use of their full names. Only in this way can the Commission show that it is fulfilling this aspect of its mandate.

Finally, I am satisfied that the protection the basic procedure affords to all others in these cases is sufficient to protect the identities of both the deceased infants and the children and young persons involved who are entitled to the legislative protection. This way of proceeding allows the Commission to effectively fulfill the legislature's requirement to protect the identities of certain persons and its requirement to hold public inquiries in public except where s. 4 of the *Public Inquiries Act* may allow otherwise.

The second departure from the basic procedure I would provide for is, like the first, proposed by Commission Counsel, and relates to a case in which the two adults involved have not been granted standing. In my view, it should be treated in the same way as the first exception. The adults' full names should be used. Apart from the first reason, described above, the other reasons supporting the first departure apply here with equal force. In fact, it could be said that the recent media and court coverage of this case has

been the most intense and widespread of all, and with no protection of identities. Thus, I think this case also calls for the full names of the two adults to be used.

In summary, I think the procedure outlined in these reasons best achieves the protection of identities and the principle of openness that the Commission is obliged to observe and I order that it be used in the hearings of the Commission and by all who publish anything about the work of the Commission.

I attach to these reasons a schedule showing the full names of the individuals to whom the procedure applies and the references that are to be used for them in the Commission's hearings. For obvious reasons, this schedule will not be part of the public record, but will be provided to parties with standing and to members of the media who attend the hearings of the Commission and have familiarized themselves with these reasons.

Should a need arise to further address this broad issue, it can be revisited at that time.

RELEASED: November 1, 2007

Stephen Goudge
Commissioner

Appendix 23

November 20, 2007

LIST OF SYSTEMIC ISSUES

Training and Certification of Pediatric Forensic Pathologists

1. What education and training should be required for those doing pediatric forensic pathology in Ontario, and who should provide it?

2. Should formal certification be required, and if so, what kind, and by whom?

3. What continuing education and training should be required, and who should provide it?

4. For each of these, should the focus be on pediatric pathology or forensic pathology or both?

Institutional Considerations

5. Should Ontario have an institutional setting dedicated to pediatric forensic pathology, or should pediatric services be delivered within a forensic pathology institutional setting?

6. What should the relationship be between the chief forensic pathologist of Ontario and forensic pathologists in Ontario? Should forensic pathologists all be located in one or several teaching hospitals?

7. In light of the geographic size of Ontario, how should pediatric forensic pathology services be organized throughout the province, particularly given the need for accessibility, efficiency, competence and quality control?

8. How should pediatric forensic pathology be delivered to Aboriginal communities, given their special circumstances?

9. How should pediatric forensic pathology be delivered to remote communities in Ontario, given their special circumstances?

10. What is the most cost efficient way of delivering quality pediatric forensic pathology services? For example, what are the advantages and disadvantages of using staff doctors or fee-for-service doctors?

11. Does Ontario have a sufficient supply of pediatric forensic pathology services, and how can that be assured in future?

12. Does Ontario have sufficient support services (such as adequate morgues) for pediatric forensic pathology, and how can that be assured in future?

The Post Mortem Examination

13. What is the approach that best balances the objective that no individual be wrongly accused of child abuse with the objective that children be protected from abuse? What are the relative merits of "thinking dirty" or "thinking truth" or other alternatives?

14. How is scientific objectivity best maintained throughout the examination to avoid "tunnel vision" that merely seeks support for an *a priori* conclusion?

15. What subspecialty of pathology should take the lead in pediatric forensic cases? Should a team of pathologists be used rather than a single pathologist?

16. What should the participation of other subspecialties of pathology be in the post mortem examination, and at what stage?

17. What other medical specialties should be available to and accessed by the pathologist, and how is this best achieved in an efficient and timely way?

18. What role, if any, should a "suspected child abuse and neglect" team (a SCAN team) play in assisting the pathologist? Should it serve in an assessment capacity, or in an investigative capacity, or neither, or both?

19. What role, if any, should the deceased child's physician play in providing information to the pathologist?

20. Should the pathologist attend the scene? What guidelines should inform the decision and the attendance?

21. What non-medical information should be provided to the pathologist? Should the pathologist be provided with all or only some of the information in the possession of the police? What guidelines should apply and how can they minimize the risk of "tunnel vision" that may exclude the consideration of possible conclusions, particularly where there is information about past abuse or neglect?

22. How should the information that is provided to the pathologist be memorialized?

23. What should be photographed at the post mortem examination? Should it be videotaped or audiotaped?

24. Should the pathologist communicate preliminary opinions to the police or child protection officials and if so, how should they be memorialized, and who else should receive them?

25. How and where should evidence obtained during or as a result of the examination be kept and preserved?

26. What other steps, if any, should be taken to permit reviewability of the findings?

The Post Mortem Report

27. What guidelines should there be for the content of the post mortem report?

28. What guidelines should there be for the timing of the post mortem report?

29. Who should receive the post mortem report?

30. How should the post mortem report articulate and explain the degree of certainty attached to the opinions it contains? How should this relate to the degree of certainty applicable to the criminal trial?

31. Should the post mortem report offer an opinion on the means, mechanism, or mode of death? Or whether the death was accidental or deliberate?

32. In general, what are the limits of the pathologist's expertise that should be observed in the post mortem report?

33. What language should be used or avoided in the post mortem report to effectively communicate the pathologist's opinions to the criminal justice system? Should there be guidelines about words or phrases to be used or avoided?

34. When, if at all, should the terms "SIDS" and "SUDS" be used in a post mortem report?

35. What is the proper role, if any, for a subsequent report by the pathologist (sometimes called a "final autopsy report"), and what guidelines should there be for it?

The Testimony

36. What should the approach of the pathologist be to giving evidence: advocate for an opinion, scientific truth seeker, officer of the court, all or none of these?

37. Should there be training and/or guidelines for pathologists about giving evidence? Should these address the proper limits of the pathologist's expertise to be observed in giving evidence?

38. In giving evidence, should the pathologist advance alternatives not contained in the post mortem report or respond to invitations to speculate?

39. In giving evidence, what language should be used or avoided to fairly and effectively communicate the pathologist's opinions to the court?

40. Should pathologists testifying for parties adverse in interest meet to focus areas of agreement and disagreement? If so, at what stage, with who else present, and subject to what rules (for example, about issues like confidentiality)?

Quality Control

41. Should there be peer review of the pathology opinion? If so, at what stage? By those with what specialized training and having been provided with what information? Should the review go beyond whether the opinion is reasonable, and address whether it is correct? When should an independent opinion be sought?

42. Should the coroner play a role in the review of the pathologist's opinion? Should this be done through the chief forensic pathologist of Ontario? Should "under 5" or "pediatric review" committees be used in this process?

43. If the pathology is done in a hospital, should the hospital be responsible to review the opinion? Should hospital rounds play a role in this?

44. Should special review mechanisms be used if the pathologist is a leader in the field? If so, what?

45. How should any review be memorialized?

46. Should there be a separate review of the pathologist's testimony and if so by whom and for what purposes?

The Role of the Coroner

47. From the perspective of best pediatric forensic pathology, what are the advantages and disadvantages of the coronial system compared to other models, such as the medical examiner system?

48. What education and training should coroners have respecting pediatric forensic pathology issues?

49. How should the roles of the coroner and the pathologist be best delineated in the investigation of pediatric forensic deaths?

50. What information should be made available to each to best discharge those roles?

51. Should the dichotomy between "cause of death" and "manner of death" be preserved? What roles should the coroner and the pathologist each play in their determination?

52. Should the coroner be able to override the opinion of the pathologist on cause of death and, if so, when?

The Role of the Police

53. Should the police have specialized training in pediatric forensic death investigations?

54. Should there be guidelines concerning the information the police provide to, and receive from, the pediatric forensic pathologist during and following the death investigation?

55. Should there be guidelines concerning the communication by the police of information received from the pathologist to other institutions such as those responsible for child protection?

The Role of the Crown

56. Should Crown counsel have specialized training in order to prosecute pediatric forensic death cases?

57. How should Crown counsel ensure the timely preparation of pediatric forensic pathology reports?

58. Should the Crown have a role in evaluating the accuracy and reliability of pediatric forensic pathology evidence? How and when would that be done?

59. How should the pathology affect the charge selection in pediatric forensic cases?

60. What is the appropriate relationship between the Crown and child protection authorities in pediatric forensic death cases?

The Role of the Defence

61. Should defence counsel have specialized training in order to defend pediatric forensic death cases?

62. When and in what form should the defence receive disclosure of the pediatric forensic pathology report and the information on which it was based?

63. Should there be funding to ensure that the defence can retain pediatric forensic pathology expertise, and how can this be assured?

64. How can a sufficient pool of such expertise be assured?

65. Should a pediatric forensic pathology expert retained by the defence be able to participate in the post mortem examination or conduct his or her own examination?

66. When, if at all, should defence counsel be able to communicate with the pathologists who are Crown witnesses and what guidelines should govern those communications?

The Role of the Child Protection Agency

67. What information should be exchanged between the pathologist and the child protection agency, and at what stage? Should there be guidelines for these communications? How should any communications be memorialized?

68. Should either the coroner or the pathologist play a role in child protection proceedings involving surviving children? If so, what should that be?

69. Should the best interests of the child in such proceedings permit or require the pathologist to advance more speculative opinions than in a criminal proceeding?

The Role of the Family

70. Should there be guidelines for communications between the pathologist or the coroner and the family? How should an ongoing criminal or child protection investigation affect the communication?

71. How, if at all, can the family's need to grieve be reconciled with the work of the pathologist in a pediatric forensic death?

Corrective Measures

72. After the fact of inadequate pediatric forensic pathology, what should the role of the coroner and the Office of the Chief Coroner of Ontario be? How should they deal with complaints about the work of a pediatric forensic pathologist?

73. What should the role of the College of Physicians and Surgeons be? How should it deal with complaints about the work of a pediatric forensic pathologist? Is it able to deal with complaints that relate primarily to the forensic dimension of that work rather than the pathology dimension?

74. What should the role of the hospital be? How should it deal with complaints about the work of a pathologist in a pediatric forensic case? Can it deal with complaints that relate primarily to the forensic dimension of that work rather than the pathology dimension?

75. What role should the Ombudsman's office play after the fact of inadequate pediatric forensic pathology? Are there other institutions that should also play a role?

General

76. If there is a significant change in the science of pediatric forensic pathology, how should the criminal justice system respond?

77. Should the Court of Appeal for Ontario issue guideline judgments on important issues that may be in dispute in pediatric forensic pathology, as has been done by the English Court of Appeal?

78. What does Ontario have to learn from other jurisdictions where similar problems have arisen?

79. What measures, if any, should be undertaken by the bench and bar on the one hand, and the forensic pathology community on the other, to promote the understanding by the former of the scientific assistance offered by the latter in pediatric forensic death cases?

80. For any changes that may be recommended by the Commission, what are the most effective implementation mechanisms? In each case, what is best: legislation, regulation, guidelines or some other mechanism?

Appendix 24

DATE: 2007-11-20

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON THE APPLICATION BY DR. CHARLES SMITH TO BE EXAMINED IN CHIEF BY HIS OWN COUNSEL

COMMISSIONER GOUDGE:

On August 17, 2007 Dr. Smith was granted standing at this Commission. On October 11, his counsel advised that he would attend voluntarily to give evidence. On October 22, to ensure fulfillment of her duty to ensure that the Commission has a full and complete factual record, Commission counsel served a summons on Dr. Smith requiring him to appear to give evidence, commencing on January 28, 2008.

Dr. Smith now applies for an order that he be examined in chief by his counsel before being examined by Commission counsel and cross-examined by other parties. He argues that the risk to his reputation makes this fair and appropriate, and will enable the fullest evidentiary contribution to be made by Dr. Smith to the Commission's work.

The Commission's Rules of Procedure provide that, presumptively, all witnesses will be called and questioned first by Commission counsel. The Rules also allow Dr. Smith to apply for the order he now seeks. The relevant Rules are as follows:

> 32. In the ordinary course, Commission counsel will call and question witnesses who testify at the Inquiry. Except as otherwise directed by the Commissioner, Commission counsel is entitled to adduce evidence by way of both leading and non-leading questions.
>
> ...
>
> 34. 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 the examination of one's own witness.
>
> ...
>
> 36. Counsel for a witness, regardless of whether or not counsel is also representing a party, will examine after the other parties have concluded their cross-examinations, unless he or she has adduced the evidence of the witness in chief, in which case there will be a right by that counsel to re-examine the witness. In the event, however, that counsel for the witness intends to adduce evidence in chief not adduced by Commission counsel, counsel for the witness will examine the witness immediately following Commission counsel, and then will have a right to re-examine the witness following the cross-examinations by the other parties.

There is no doubt that the task of this Commission is fundamentally systemic in nature. Nonetheless there is also no doubt that there will be considerable evidence about the

work of Dr. Smith, particularly in those cases that were the subject of the Chief Coroner's Review. It is clearly important for the work of the Commission and fair to Dr. Smith that he be able to provide his evidence about that work and the oversight mechanisms to which it was or was not subject.

However, at this stage, I cannot conclude that this requires that his evidence in chief be led by his own counsel.

First, it is important to remember Commission counsel's role. It is to act in the public interest to ensure that all the relevant facts are placed before the Commission in a completely impartial way. The Commission requires this to fulfill its mandate. The objective of impartiality is best served by following the usual procedure. As my colleague, Associate Chief Justice O'Connor, wrote in reflecting on his own experience as Commissioner of the Walkerton Inquiry:

> [C]ommission counsel's role is not to advance any particular point of view, but rather to investigate and lead evidence in a thorough, but also completely impartial and balanced, manner. In this way, the Commissioner will have the benefit of hearing all of the relevant facts or evidence unvarnished by the perspective of someone with an interest in a particular outcome.

Second, I do not think that this way of proceeding adds any risk to Dr. Smith's reputation. I know Commission counsel will lead his evidence fairly. Moreover, as Rule 36 provides, Dr. Smith's own counsel then has the right to adduce any evidence in chief not adduced by Commission counsel. This will allow Dr. Smith to give his own full account of events before cross-examination commences.

Third, I am confident that this way of proceeding will provide a complete evidentiary picture of Dr. Smith's work and its oversight. It is Commission counsel's role to be thorough. I am also confident that with the cooperation of Dr. Smith and his counsel beforehand, this can be done most expeditiously.

Dr. Smith's application is therefore dismissed. Should new circumstances relevant to this issue arise between now and the end of January, Dr. Smith is free to renew his request.

RELEASED: November 20, 2007

Stephen Goudge
Commissioner

Appendix 25

ORAL RULING ON MOTION TO RECALL DR. JAMES YOUNG

00001

THE INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

****

BEFORE: THE HONOURABLE JUSTICE STEPHEN GOUDGE, COMMISSIONER

Held at:
Offices of the Inquiry
180 Dundas Street West, 22nd Floor
Toronto, Ontario

****

February 8th, 2008

…

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…

RULING:

COMMISSIONER STEPHEN GOUDGE: Well, thank you very much for your submissions. I have considered them, and put this together as my decision.

Let me begin as a preliminary matter by commending counsel for the expeditious and efficient way this motion was put together and argued.

Let me start by recognizing the deep, and

00026

legitimate interest, and concern of the applicants in death penalty issues.

However, in my view, it is important to remember that the focus of this Inquiry must be on pediatric forensic pathology, and the systemic issues central to its use in the criminal justice system in Ontario.

The systemic issue that the applicants seek to pursue with Dr. Young this morning is the oversight of pathologists who work under a coroner's warrant when they consult on cases not done under warrant; that is, indeed, an important issue for the Commission. However, it is one about which we have all ready heard much evidence.

The challenges presented, given that most of these pathologists are not direct employees of the Office of the Chief Coroner of Ontario are real.

I look forward to hearing more abut those issues at the round tables, and to the thoughts of all participants in their final submissions.

Moreover, the letter at the heart of this application demonstrates that Dr. Smith did, in fact, testify outside of Canada, and in a case where the death penalty could have been imposed.

In addition, the evidence indicates that

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Dr. Pollanen, the current Chief Forensic Pathologist, is active in international death investigations.

The parties should feel free to urge me to make whatever recommendations they feel are appropriate to ensure that the necessary oversight, and accountability mechanisms, in their view, are in place to deal with the international dimensions of the work of Ontario forensic pathologists.

Ultimately, however, it must be remembered that Dr. Young is being recalled today for a very narrow purpose. In my view, it would not be fair to him to permit a canvas of an entirely different matter based on a letter that could have been put to him when he was here before, and which raises a systemic issue that was clearly on the table at that time.

In addition, and even more important than this, is the reality that there is very considerable evidence about the OCCO oversight of forensic pathologists and, in addition, the round tables and final submissions which I hope both will deal with this systemic problem lie ahead of us.

I conclude, therefore, that it is unnecessary for the effective work of the Commission to pursue this letter with Dr. Young.

For these reasons, the motion is

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dismissed.

Appendix 26

DATE: 2008-03-31

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

RULING ON MOTION TO MAKE ORAL SUBMISSIONS

COMMISSIONER GOUDGE:

On March 25, 2008, I received a Notice of Motion from Mrs. Anne Marsden requesting permission to make oral submissions. For the reasons that follow, I dismiss the motion.

I previously dismissed an application for standing brought by Mrs. Marsden in the name of an organization called Access for All. She does not have standing to make oral submissions or to bring a motion for leave to make oral submissions. Clearly only those with standing are entitled to do so.

I can also say that the draft of Mrs. Marsden's oral submissions, which she provided to Commission counsel and others last night, deals with matters outside of my mandate. They deal with allegations that have not been the subject of evidence at the Inquiry and cannot be part of the work of the Commission.

As Commission counsel previously advised Mrs. Marsden, if she wishes to make written submissions about matters within my mandate, she is free to do so. I will review them. If she wishes to make written submissions, she should deliver them by April 20, 2008.

The motion is dismissed.

RELEASED: March 31, 2008

Stephen Goudge
Commissioner

Appendix 27

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

The Honourable Stephen Goudge,
Commissioner

180 Dundas Street West, 22nd Floor
Toronto Ontario M5G 1Z8

Tel: 416 212-6878
1 866 493-4544
Fax: 416 212-6879
Website: www.goudgeinquiry.ca

COMMISSION D'ENQUÊTE SUR LA MÉDECINE LÉGALE PÉDIATRIQUE EN ONTARIO

L'honorable Stephen Goudge,
Commissaire

180, rue Dundas Ouest, 22e étage
Toronto (Ontario) M5G 1Z8

Tél. : 416 212-6878
1 866 493-4544
Téléc. : 416 212-6879
Site Web : www.goudgeinquiry.ca

VALIN
OVERVIEW REPORT
PREPARED BY COMMISSION COUNSEL

Table of Contents

Part I. Overview

1. Valin was born in Sault Ste. Marie on February 11, 1989, to Paul Johnson and Kim Lariviere. She died at the age of four, on June 26 or 27, 1993, in Sault Ste. Marie. Valin had an older sister and a younger brother, who were six and three, respectively at the time of her death. The family lived together in Sault Ste. Marie, Ontario. William Mullins-Johnson was Mr. Johnson's brother and Valin's uncle. At the time of Valin's death, he resided with the family.

2. On June 27, 1993, Mr. Mullins-Johnson was arrested and charged with the first degree murder and aggravated sexual assault of Valin.[1]

3. On September 21, 1994, after a two-week trial in the Ontario Court (General Division) in Sault Ste. Marie, a jury convicted him of first degree murder. He was subsequently sentenced to life in prison.[2]

4. Mr. Mullins-Johnson appealed his conviction to the Court of Appeal for Ontario. On December 19, 1996, the Court of Appeal, Borins J.A. dissenting, dismissed his appeal.[3]

5. Mr. Mullins-Johnson then appealed as of right to the Supreme Court of Canada. On May 26, 1998, the Supreme Court unanimously adopted the reasons of the majority of the Court of Appeal for Ontario, and dismissed the appeal.[4]

6. On September 7, 2005, Mr. Mullins-Johnson filed an application for ministerial review pursuant to Part XXI.1 of the *Criminal Code*.[5]

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[1] Arrest Details, June 27, 1993, PFP110916; Supplementary Report, June 30, 1993, PFP110894.

[2] Indictment, December 2, 1993, PFP110387, p. 4; Warrant of Committal, September 21, 1994, PFP036161.

[3] *R. v. Mullins-Johnson* (1996), 112 C.C.C. (3d) 117 (Ont. C.A.), PFP003581. Justices Catzman and Labrosse agreed the appeal should be dismissed. Justice Borins dissented and was of the opinion that a new trial should be ordered.

[4] *R. v. Mullins-Johnson* (1998), 124 C.C.C. (3d) 381 (S.C.C.).

[5] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 9.

7. On September 21, 2005, Mr. Justice Watt of the Superior Court of Justice released Mr. Mullins-Johnson on bail pending his application for ministerial review.[6]

8. On July 17, 2007, the Minister of Justice, the Honourable Ron Nicholson, granted the application for ministerial review and referred the case to the Court of Appeal for Ontario on the following terms:

> AND WHEREAS, new information has arisen concerning whether William Mullins-Johnson was guilty or not guilty of the murder of [Valin], which information was not presented as evidence at trial, or on the appeal to this Honourable Court, or on the appeal to the Supreme Court of Canada;
>
> AND WHEREAS, an application for ministerial review (miscarriages of justice) was made to the Minister of Justice by counsel on behalf of William Mullins-Johnson pursuant to Part XXI.1 of the *Criminal Code*, for an order directing a new trial or, in the alternative, for an order referring the matter to the Court of Appeal for hearing and determination as if it were an appeal by William Mullins-Johnson;
>
> AND WHEREAS, I am satisfied that there is a reasonable basis to conclude that a miscarriage of justice likely occurred in this case;
>
> I HEREBY respectfully refer this matter to this Honourable Court pursuant to section 696.3(3)(a)(ii) of the *Criminal Code*, based on a consideration of the existing record herein, the evidence already heard, and such further evidence as this Honourable Court in its discretion may receive and consider, to determine the case as if it were an appeal by William Mullins-Johnson on the issue of fresh evidence.[7]

9. That same day, the Court of Appeal for Ontario released Mr. Mullins-Johnson on bail pending the hearing of his appeal, which was scheduled for October 15, 2007.[8]

10. On October 15, 2007, the Court of Appeal, after hearing *viva voce* evidence from Mr. Mullins-Johnson and Dr. Michael Pollanen, and the submissions of counsel, acquitted Mr. Mullins-Johnson. The Court reserved on the issue of whether a declaration of factual innocence should be made.

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[6] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 17.
[7] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 19.
[8] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 19.

11. On October 19, 2007, the Court of Appeal delivered its written judgment. The Court confirmed that Mr. Mullins-Johnson was wrongly convicted, that the "fresh evidence shows that the appellant's conviction was the result of a rush to judgment based on flawed scientific opinion", and that he was "the subject of a terrible miscarriage of justice", but did not make a declaration of factual innocence.[9]

12. In 2005, the Chief Coroner for Ontario commenced a review of certain cases of suspicious child deaths where Dr. Charles Smith performed the autopsy or was consulted ("the Chief Coroner's Review"). All of the parties involved in the Mullins-Johnson case (the Office of the Chief Coroner, the Ministry of the Attorney General and counsel for Mr. Mullins-Johnson) agreed that three of the pathologists who had been asked to assist in the global review of Dr. Smith's work be requested to independently provide opinions on the cause of Valin's death. Professor Christopher Milroy, Dr. John Butt and Professor Jack Crane were selected.[10]

13. Professor Milroy issued his report on May 1, 2006[11], Dr. Butt on June 1, 2006[12] and Professor Crane on September 22, 2006. [13]

14. As part of the global review of Dr. Smith's work, Professor Milroy was also assigned to be the primary reviewer for Valin's case. The results or conclusions of Professor Milroy's work were memorialized in a brief document, which contained a checklist and some commentary on the file.[14]

15. The structure of the Chief Coroner's Review, including its scope and the role played by the various reviewers in each of the cases under consideration, will be the subject of evidence at the Inquiry.

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[9] *R. v. Mullins-Johnson*, October 19, 2007, 2007 ONCA 720.
[10] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 158.
[11] Report of Professor Milroy, May 1, 2006, PFP004096.
[12] Report of Dr. Butt, June 1, 2006, PFP004065.
[13] Report of Professor Crane, September 22, 2006, PFP004089.
[14] Autopsy Report Review Form, December 12, 2006, PFP058511.

PART II. The Circumstances Surrounding Valin's Death

16. On Saturday, June 26, 1993, Mr. Mullins-Johnson, who had been living in the Johnson family home for approximately two months, was asked to babysit Valin and her brother, as Mr. Johnson and Ms. Lariviere were going to a baseball tournament that evening. Valin's sister was spending the night at her Aunt Helen's house.[15]

17. Mr. Johnson and Ms. Lariviere were present for dinner, which took place at approximately 1830. Before dinner, Ms. Lariviere bathed the two children and noted no injuries or bruises to either child. At approximately 1900, Mr. Johnson and Ms. Lariviere left the family home to attend the baseball tournament, leaving Valin and her brother in the care of Mr. Mullins-Johnson.[16]

18. According to Mr. Mullins-Johnson, Valin was falling asleep on the couch at approximately 1930, so he told her to go to bed. She came over, kissed him, and then went to her room to go to sleep. At approximately 2000, he put Valin's brother to bed. While upstairs, he noticed that Valin was asleep and closed her door. He then came downstairs, cleaned up the dishes from dinner and watched television.[17]

19. Ms. Lariviere returned home at approximately 2130 that evening. Mr. Mullins-Johnson, who was watching the Blue Jays' game on television when she arrived home, advised her that both children were asleep in their beds. Ms. Lariviere did some laundry, watched part of the

[15] Typed statement of Paul Johnson, June 27, 1993, PFP110032; Written statement of Paul Johnson, June 27, 1993, PFP110633; Typed statement of Paul Johnson and Kim Lariviere, July 8, 1993, PFP110035; Will say of Paul Johnson, PFP110030; Typed statement of Kim Lariviere, June 27, 1993, PFP110047; Will say of Kim Lariviere, undated, PFP110044; Written statement of Kim Lariviere, June 27, 1993, PFP110643; Typed statement of William Mullins-Johnson, June 27, 1993, PFP109980; Written statement of William Mullins-Johnson, June 27, 1993, PFP110613.

[16] Typed statement of Paul Johnson, June 27, 1993, PFP110032; Written statement of Paul Johnson, June 27, 1993, PFP110633; Typed statement of Paul Johnson and Kim Lariviere, July 8, 1993, PFP110035; Will say of Paul Johnson, PFP110030; Typed statement of Kim Lariviere, June 27, 1993, PFP110047; Will say of Kim Lariviere, undated, PFP110044; Written statement of Kim Lariviere, June 27, 1993, PFP110643; Typed statement of William Mullins-Johnson, June 27, 1993, PFP109980; Written statement of William Mullins-Johnson, June 27, 1993, PFP110613.

[17] Typed statement of William Mullins-Johnson, June 27, 1993, PFP109980; Written statement of William Mullins-Johnson, June 27, 1993, PFP110613.

baseball game with Mr. Mullins-Johnson, had a shower, and went to bed at approximately 2320. When she went to bed, Valin's door was closed and she did not look in on her.[18]

20. Around 2400, three of Mr. Mullins-Johnson's friends, Ken Boyer, Kelly Boyer and Steve Nadjiwon, came by the house.[19] They all watched a boxing match on television and then left at approximately 0130 to look for a party. Mr. Mullins-Johnson returned home at approximately 0300.[20]

21. Mr. Johnson, who went out with friends after the tournament, returned home at approximately 0200. He went straight to bed and did not check in on Valin or her brother.[21]

22. At approximately 0700 the next morning, June 27, 1993, Mr. Johnson and Ms. Lariviere were awoken by a loud noise. Their son [Valin's brother] had fallen down. Mr. Johnson went to tend to his son. Ms. Lariviere went to the washroom, then opened Valin's door to check on her. She noticed that there was vomit on the bed and floor. Ms. Lariviere returned to bed, where Mr. Johnson told her that he had taken Valin's brother back to his bedroom. They shared a cigarette and Ms. Lariviere told Mr. Johnson that Valin had thrown up. The two remained in bed for a period of time and then Ms. Lariviere went to wake up Valin. She described Valin as being face down, on her knees, her arms bent and her bum in the air. When she rolled Valin over, she noticed that Valin's face was purple so she screamed for help. Mr. Johnson ran into the bedroom and saw Valin lying on her back all blue, stiff and ice cold. He undid Valin's pyjamas to

[18] Written statement of Kim Lariviere, June 27, 1993, PFP110643.

[19] The police later collected information from a witness, Ronald Masse, which conflicted with the Boyers' statements as to timing of their visit to the Mullins-Johnson home, see Statement of Ronald Masse, undated, PFP110086. In that same statement, Masse stated that Mullins-Johnson did not mention to him that Steve Nadjiwon was not present. The police warned the Boyers that if they were lying about the timing of their visit, they might be charged as being accessories to the murder, see memo-book notes of Sgt. Welton, July 8, 1993, PFP059401. Mr. Masse later accused Ken Boyer of being involved in Valin's death, see Memo from Special Constable Bourgeois to Sgt. Welton, October 14, 193, PFP059363.

[20] Typed statement of William Mullins-Johnson, June 27, 1993, PFP109980; Written statement of William Mullins-Johnson, June 27, 1993, PFP110613; Statement of Kelly and Ken Boyer, June 28, 1993, PFP110002; Statement of Kelly Boyer, July 8, 1993, PFP110003; Statement of Ken Boyer, July 8, 1993, PFP110006; Statement of Stephen Nadjiwon, June 28, 1993, PFP110097.

[21] Typed statement of Paul Johnson, June 27, 1993, PFP110032; Written statement of Paul Johnson, June 27, 1993, PFP110633.

give her CPR and noticed that her chest was blue. Ms. Lariviere then ran downstairs to call 911.[22]

23. While on the phone with the 911 dispatcher, Ms. Lariviere yelled instructions to Mr. Johnson on how to give Valin mouth to mouth resuscitation. However, Mr. Johnson had difficulty getting Valin's mouth open. He tried pounding on her chest. He then brought Valin downstairs and laid her on a rug to wait for the ambulance. He unzipped her pyjamas while downstairs. Ms. Lariviere placed her hand on Valin's heart and felt it was still warm.[23]

24. The ambulance arrived at 0725. Mr. Johnson met the attendants, Nancie Scott and Robert Weir, and brought them inside the home. Nancie Scott observed Valin lying on her back with significant discolouration to her face and arms. Her chest was a dark, purple colour. Her legs were up in the air in a stiffened position. She found no pulse. Her opinion was that Valin was dead. She called the police and awaited their arrival.[24]

25. Mr. Weir entered the residence, and noted that Valin was on a brown blanket, supine, with her hands and arms elevated and her knees bent. Rigor mortis had set in, and she had blue spots all over her face and body. There was pooling of the blood in her face and arms. He assessed her neck and radial pulse and determined that she was dead.[25]

26. Cst. Brad Clarida and Cst. Romano Carlucci of the Sault Ste. Marie Police Force arrived at the residence at 0748.[26] The ambulance attendants brought them inside. Cst. Clarida

[22] Typed statement of Paul Johnson, June 27, 1993, PFP110032; Written statement of Paul Johnson, June 27, 1993, PFP110633; Will say of Paul Johnson, PFP110030; Typed statement of Kim Lariviere, June 27, 1993, PFP110047; Will say of Kim Lariviere, undated, PFP110044; Written statement of Kim Lariviere, June 27, 1993, PFP110643; Typed statement of William Mullins-Johnson, June 27, 1993, PFP109980; Written statement of William Mullins-Johnson, June 27, 1993, PFP110613; Transcript of 911 call, June 27, 1993, PFP110362.

[23] Typed statement of Paul Johnson, June 27, 1993, PFP110032; Written statement of Paul Johnson, June 27, 1993, PFP110633; Will say of Paul Johnson, PFP110030; Typed statement of Kim Lariviere, June 27, 1993, PFP110047; Will say of Kim Lariviere, undated, PFP110044; Written statement of Kim Lariviere, June 27, 1993, PFP110643; Typed statement of William Mullins-Johnson, June 27, 1993, PFP109980; Written statement of William Mullins-Johnson, June 27, 1993, PFP110613.

[24] Call Report of Nancie Scott, June 27, 1993, PFP110131; Call Report of Nancie Scott, June 27, 1993, PFP110588.

[25] Call Report of Robert Weir, June 27, 1993, PFP110149; Call Report of Robert Weir, June 27, 1993, PFP110663.

[26] Supplementary Report, September 3, 1993, PFP110898, p. 1.

observed Valin lying on the living room floor, wrapped in a blanket. He observed redness in her face. Mr. Johnson advised Cst. Clarida that Valin had been found in her bed in a kneeling position with her head on the bed and her hands beside her head. At trial, Cst. Clarida testified that he "pulled back the yellow blanket to observe the child fully. The child was fully clothed in pyjamas, I noticed her being very stiff. Her knees pulled up and her arms like this, like she had been kneeling on ... on her knees and elbows." Cst. Carlucci observed that there was discolouration and redness to Valin's face.[27]

27. Cst. Clarida then called the coroner, Dr. Crookston, and asked him to come to the scene. He also telephoned Cst. Martynuck and Sgt. Welton, who arrived within minutes and took over the investigation.[28]

28. Dr. Crookston arrived shortly after 0800. He looked at Valin and could see that she was obviously dead. At approximately 0815, he took her rectal temperature, which was 82 degrees Fahrenheit.[29] He took no reading of the room temperature, but later testified at trial that it appeared to be normal room temperature, which was 70 degrees Fahrenheit. Sgt. Welton noted in his memo-book that the room temperature was approximately 70 degrees Fahrenheit.[30]

29. Cst. Biocchi, an identification officer, arrived at 0805. He made observations and took photographs of Valin. He then attended upstairs where he seized samples of the vomit from Valin's bedroom and took additional photographs.[31] Cst. Biocchi did not take a temperature reading in the living room, but estimated, at trial, that it was around 72 degrees Fahrenheit.

30. At 0900, Sgt. Welton interviewed Mr. Mullins-Johnson. He stated:

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[27] Will say of Cst. Clarida, June 28, 1993, PFP110918; Memo book notes of Cst. Clarida, June 27, 1993, PFP110872; Evidence of Cst. Clarida, Case on Appeal, PFP036566, p. 66; Will say of Cst. Carlucci, June 28, 1993, PFP110918.

[28] Will say of Cst. Clarida, June 28, 1993, PFP110918; Memo book notes of Cst. Clarida, June 27, 1993, PFP110872.

[29] Evidence of Dr. Crookston, Case on Appeal, PFP036566, pp. 218-224; Will say of Cst. Martynuck, undated, PFP110055, p. 2; Memo book notes of Sgt. Welton, June 27, 1993, PFP059401, p. 2.

[30] Memo book notes of Sgt. Welton, June 27, 1993, PFP059401, p. 2.

[31] Evidence of Cst. Biocchi, Case on Appeal, PFP036812, p. 188.

The family, Paul, Kim, [Valin's brother] and Valin where gone most of Saturday. Paul had a ball tournament at Strathclair. They got home about 6:00 P.M. I was making supper and had it ready when they got home. I made steak, Kraft dinner and salad. After Kim gave [Valin's brother] and Valin a quick bath we sat down for supper. The kids watched T.V. while eating and after eating Valin lay on the couch and said she was tired. At about 7:30 P.M. I told her to go to bed because she was falling asleep on the couch. She came over and gave me a kiss good night and went up to bed. At about 8:00 P.M. I took [Valin's brother] up to bed and saw Valin sleeping so I closed her door. The kids usually go to bed at 8:00 P.M. After [Valin's brother] went to bed I came downstairs and was watching the Toronto Blue Jays game and cleaned the dishes. Kim came home at about 9:30 or 10:00. Her and Paul had gone back to the ball field after supper as Paul had another game to play at 7:30 P.M. Paul did not come home with her. Kim went to bed at about 11:00 P.M. Around 11:30 or 12:00 midnight three of my friends, Ken Boyer, Kelly Boyer and Steve Nadjiwon came over. We sat around until about 1:30 A.M. and we decided to go for a walk in the Rankin Reserve. At 2:50 A.M. Ken told me the time and I headed home. It took me about five minutes to get home. When I got home everything was fine, all the lights where out. I went to sleep on the couch in the living room where I normally sleep.

A little after 7:00 A.M. I was awakened by Kim who was upset and said Valin was dead. I went upstairs and met Paul coming down. We went back to Valin's room and I saw her on her back with her legs pulled up and arms up by her face. Her body was blue. Kim had called 9-1-I and yelled to Paul and I to do C.P.R. We could not open her mouth. Kim spread a blanket on the floor in the living room and Paul carried Valin downstairs.

I asked [Valin's brother] what Valin got into and he said she took two pink pills with water.

The ambulance attended and then the police arrived.

Q: Was Valin complaining about being sick to you?

A: No.

Q: What was Valin's normal bedtime?

A: Usually 8:00 P.M.

Q: Did any of your friends go upstairs while they where visiting?

A: No, nobody.[32]

[32] Typed statement of William Mullins-Johnson, June 27, 1993, PFP109980; Written statement of William Mullins-Johnson, June 27, 1993, PFP110613.

PART III. The Death Investigation

31. Valin's body was taken to the Sault Ste. Marie General Hospital ("Hospital") for an autopsy at the direction of Dr. Crookston.[33] His Warrant for Post Mortem Examination was directed to the attention of Dr. Rasaiah or Dr. Chawla. Dr. Crookston also directed that a blood culture be done on Valin. He listed the date and time of death as, "93/6/27 0400 (est.)". Under the heading 'Case History', he wrote:

> Fever x 2 days.
>
> Went to bed 1930h on 93/6/26.
>
> Found dead in bed 0700 on 93/6/27, sitting cross-legged and slumped forward, having vomited partially digested food.
>
> Father carried child to living room and attempted CPR.
>
> At scene, cyanosis of face & chest, rigor mortis of arms, rectal temperature 82F.[34]

A. The Post Mortem Examination

32. Dr. B. Rasaiah, the Hospital pathologist, performed the autopsy on June 27, 1993, starting at 1235. Jim Corelli (pathology assistant), Tammy Weir (pathology assistant), Cst. Terry Biocchi, Sgt. Welton and Cst. Martynuck attended the autopsy.[35] Dr. Crookston attended for about 10-15 minutes.[36] A diagram representing the distribution of rigor mortis was completed.[37] Cst. Biocchi took photographs.[38]

33. Sgt. Welton's notes of the autopsy are as follows:

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[33] Evidence of Dr. Crookston, Case on Appeal, PFP036566, pp. 222-223.
[34] Warrant for Post Mortem Examination, June 27, 1993, PFP003842.
[35] Supplementary Report, July 2, 1993, PFP110933
[36] Evidence of Dr. Crookston, Case on Appeal, PFP036566, p. 223.
[37] Diagram, June 28, 1993, PFP110110.
[38] Supplementary Report, July 2, 1993, PFP110933.

12:30 10-7 General Hosp. for P.M.

Tammy WIER assistant to Dr. Rasaiah present.

12:35 Jim Corelli and P.C. Biocchi attend

death within 24 hours

hemorages area of left eye and upper chest below neck

bruise in area of vagina

small bruise on left thigh, lips of vagina and right inner area of vagina & rt thigh

sexual assault kit #02419

13:08 Dr. Rasaiah point out large opening of rectum

1312 Kinghorn advised at home

13:18 advised of hair in area of vagina

13:28 Crosby notified

13:32 Kinghorn arrived

13:35 Pozzo advised

13:37 Lalouette arrived

13:38 Dr. examined deceased

13:44 Lalouette left

13:45 Crookston arrived

13:55 Dr. Lalouette arrived

13:56 Martynuck left

13:57 Dr. Crookston attended and assisted Dr. Lalouette

14:10 Dr. Lalouette left

14:15 Dr. Crookston left

14:15 C.A.S. Lisa Stroyan attended at hosp.

-called by Dr. Crookston

14:36 S/Sgt. Pozzo attended at scene

14:50 Jim Corelli advised that Dr. Rasaiah had called an expert at Sick Children and was told this looks like chronic abuse. [Commission Counsel note: That expert is now thought to be Dr. Mian]

15:00 Dr. Zehr and P.C. Toni from I.D. arrived

Dr. Zehr says size of vaginal opening consistent with penetration

Annual penetration gross. Worst she has ever seen.

Damage indicates ongoing abuse.

...

15:25 did an annus wash

did vaginal wash

15:50 Dr. Zehr left pathology

16:30 Dr. Rasaiah began P.M.

16:50 started to open body

Dr. showed bruising in area of upper chest & neck area

Petical hemorage on lungs & heart

Bruising under scalp area of left side and right side

Bruising in area of pubic area is deep and within 24 hours

Dr. suspects death between 8-10 p.m.

Death is a result of suffocation

Force applied to upper chest area

Small amount of aspirant in tracia

Bruising of tracia

17:30 addressed Kinghorn and Pozzo cause of death.

Hold on bod for 24 hours to be reviewed again

17:45 Toni seized sexual assault kit.[39]

34. Cst. Martynuck's notes of the autopsy were as follows:

1230 At General Hospital for Post Mortem of [Valin] to be done by Dr. Rasiah Rasaiah

Tammy Wier also in attendance

...

-appears as if dead within last 24 hours.

-very suspicious-not natural.

-Large hemorrhages by left eye, & on upper chest just below the neck. (hemorrhages are under the skin)

-going to ask Dr. Hutton to examine in case of physical abuse

-bruising in vagina

[39] Memo book notes of Sgt. Welton, June 27, 1993, PFP059401, pp. 3-7.

-below on left thigh about 1" from anus, bruising near lips of vagina

-bruising on right inner area by vagina and right inner thigh

[diagram drawn by officer]

1308 Rectal opening (when cleaned of feces) is obvious opening blk/purple in colour

1312 hrs Kinghorn notified at home, sexual assault

[Cst. Martynuck left the autopsy between 1:12 and 1:20 p.m. to pick up a sexual assault kit]

advised appears that there is a hair in the vaginal area-to be seized when kit is completed (advised by Welton on return)

1328 hrs Sgt. Crosby notified

1332 hrs Kinghorn arrived

1335 Kinghorn contacted S/Sgt Pozzo to advise

1337 Dr. Lalouette arrived

1338 Dr. Lalouette examined victim- also took swab

1344 hrs Lalouette left

1345 Crookston arrived

warrants for bedding and the bed

check out boys room

want bed and bedding

-want to check the other kids beds

-living room, sexual activity (couch)

1353 Dr. Lalouette returned

1356 Clear from morgue to meet Blair at station Welton to remain at morgue.[40]

35. The hair that was observed in Valin's vaginal area was photographed and seized by Cst. Biocchi.[41]

36. Due to concerns about possible sexual abuse, Dr. Rasaiah asked Dr. Patricia Zehr, a gynaecologist with a specialty in child sexual abuse, to examine Valin.[42] Dr. Zehr arrived at the autopsy at approximately 1455, as did Cst. Toni.[43] Cst. Toni's memo book notes of Dr. Zehr's examination stated:

14:55- attended General Hospital morgue re: autopsy on 4 year old girl [Valin].

Present-

Biocchi

Tammy Weir

Jim Corelli

Dr. Rasaih

Dr. Zehr

In other room-

Welton

Kinghorn

B. Pozzo

[40] Memo book notes of Officer Martynuck, June 27, 1993, PFP110956, pp. 6-9.
[41] Supplementary Report, July 2, 1993, PFP110933.
[42] Consultation Record of Dr. P. Zehr, June 27, 1993, PFP004872.
[43] Supplementary Report, July 2, 1993, PFP110933.

Advised to stay with body-exam done by Dr. Zehr- anal sphincter totally open- no resistance

Vagina larger than normal

Hymen almost all gone-worn smooth

Bruising around vagina and legs right beside

Bruises right hip side and back of hip below knee, inside area below knee, petechiae on left side of face and top chest and down to pelvic and in fleshy area front of vagina

Photos taken of injuries on outside

Inside- bruising heart-petechiae throat, head, chest area

Bruising to trachea[44]

37. Cst. Toni's will say stated:

THAT On the 27th of June 1993, at approximately 1415hrs, I was called at home by Cst. Biocchi regarding a death that was suspicious, and he needed some assistance

THAT I attended at the General Hospital at approximately 1455hrs, and spoke to Inspector Kinghorn, S/Sgt Pozzo and Sgt. Welton in the lunchroom of the lab area

THAT I was instructed to stay at the hospital to maintain continuity of the body, and to photograph and attend the autopsy

THAT Present in the morgue were Cst. Biocchi, pathology technicians Tammy Weir and Jim Corelli, Dr. Rasaiah and Dr. Zehr.

THAT Dr. Zehr examined the childs rectum and vagina, and did washings on both

THAT These two samples were turned over to myself

[44] Memo book notes of Cst. Toni, June 27, 1993, PFP110492, p. 1.

THAT Bruising was noted on the body of the child

THAT These included the front area of the vagina, on the thighs just beside the vagina on both sides, the right hip area side and back (3), just below the right knee on the inside, petichiae bruising on the entire left side of face, chest and down abdomen to pelvic are, bruise under chin left side and bruises on left temple area

THAT All of these were photographed

THAT During the autopsy, I also photographed bruising on the inside which included petichiae bruising on the heart, bruising in the throat, head, chest and trachea areas

THAT At 1745hrs, I received all exhibits that had been seized from Jim Corelli which included sexual assault kit #02419, clothing, and bedding from the hospital

THAT At 1754hrs, I left the hospital and attended at the station.[45]

38. Dr. Zehr's consultation record, authored that same day, stated:

[Valin] is a 4-year-old female child who was found in her home unresponsive this morning at 0700 hours. Ambulance was sent for, but when they arrived the child was dead. Apparently she was found in her bed wearing underpants and a full-length zippered sleeper lying in the knee-chest position with her bum in the air on her haunches and her face down. The coroner was called and the body was then removed by the Arthur Funeral Home and then brought to the hospital. I was asked to see the child by Dr. Rasaiah because of some suspicious findings of query sexual abuse.

The child had already been examined several times before I got there and had had a skeletal series done to look for any evidence of fractures. She had dry swabs taken from the vagina and the rectum for semen as well as Chlamydia and GC studies done by Dr. Crookston. Apparently one adult pubic hair was found in her genital area and that was taken for forensic evidence.

When I saw the child she was lying in the dorsal supine position. I do not have her height and weight present, but that has been documented. Her face showed evidence of petechiae primarily around the left side of the face and around her neck and a lot on her trunk going down into the abdominal area. There were red and white markings on her body and arms, but whether that was an indication, of trauma or lividity, that is pooling of the blood once dead depending on the

[45] Will say of Cst. Toni, June 29, 1993, PFP110352.

position that they are in, is unclear. Her legs also showed evidence of some bruising and petechiae around the knees and there were some areas that looked a bit like abrasions on the tops of the knees. There is petechiae along the mons with bruising in the vulvar area on the inner thighs and around the labia majora.

I was asked particularly for my opinion regarding the genital area of this prepubertal female and I examined her in the dorsal frog-leg position. With the police photographer I documented the hymen in this position. It was somewhat attenuated with very little hymenal tissue. The orifice was larger than one would expect for a 4-year-old being approximately 8mm. There was a small nubbin of hymenal tissue at eight o'clock. Using a nasal speculum I did look up into the vagina, but did not see any obvious hemorrhage or bruising. As swabs have already been done, I proceeded to do vaginal washings for forensic purposes.

I then examined the child in the knee-chest position similar to the way that she was found and was immediately struck by the gross gaping of the anus. It measured 1cm horizontally and 12mm vertically. There was no tone to the anal sphincter. The edges were attenuated and rolled which to me is pathognomonic of chronic anal intercourse. I can think of no other reason that the anal tone would be so destroyed and the edges of the sphincter so attenuated other than repetitive penetration, most likely penile although other instruments could have been used. The hymen in the knee-chest position showed that there was a small amount of hymenal tissue going along the left edge of the hymen. Again the hymenal orifice was enlarged at about 7mm. Washings were attempted to be taken from the rectum, but it was a bit difficult to get all the returns, but a small sample was obtained.

In summary, this is a 4-year-old female child who was found dead in her home this morning. Forensic evidence is being collected and the police are investigating. My opinion is that this child shows evidence of chronic sexual abuse. The anal findings are pathognomonic of sexual abuse and it looks to me like it has been ongoing for some time. The vagina also shows evidence of penetration of some sort. There is no obvious laceration or scar tissue along the posterior fourchette or around the perineal body, but the hymenal orifice is larger than you would expect in a 4-year-old. The hymen is almost completely worn away as well which would support my premise that penetration has occurred vaginally as well. It is difficult to assess this little girl's mouth as her jaws were closed, but we did do a dry swab for forensic purposes to look for any semen.

I understand that the cause of death has not yet been determined. I do not know if she was sexually assaulted recently, but I have no question in my mind that she has been abused sexually for some time.[46]

[46] Consultation Record of Dr. P. Zehr, June 27, 1993, PFP004872.

39. Blood was taken from Valin's heart and submitted for blood culture screening. A Ministry of Health laboratory in Sault Ste. Marie issued two reports on the blood culture growth, after seven and fourteen days, respectively. There was no culture growth.[47]

40. Lung tissue was also taken and submitted for screening. The forensic laboratory subsequently concluded that:

> Rare bucocyte seen
>
> No organisms seen
>
> No acid alcohol fast
>
> Bacteria seen
>
> Few colonies micrococcus species which may be contaminants.[48]

41. A sexual assault kit was also done on Valin.[49] Subsequent testing revealed that no DNA was found on Valin's body, nor did she have any sexually transmitted diseases.[50]

42. That same say, Dr. Duffin, a radiologist at the Hospital, issued his Diagnostic Imaging Report on the post mortem skeletal survey done on Valin. He found no fractures or abnormalities.[51]

[47] Laboratory Reports, June 28, 1993, PFP110115, PFP110118.

[48] Laboratory Report, June 30, 1993, PFP110124.

[49] Memo book notes of Cst. Toni, June 27, 1993, PFP110492, p. 2.

[50] Report of Sandra Lindel, October 5, 1993, PFP036071, pp. 1-3; Laboratory Reports, various dates, PFP110120, PFP110121, PFP110122, PFP110123.

[51] Diagnostic Imaging Report, June 27, 1993, PFP004915.

Part IV. The Arrest of Mr. Mullins-Johnson and the Ongoing Investigation

43. At 1800, Officers Martynuck, Welton, Blair, Kinghorn, Clarida, Biocchi, Toni, Kates, and Pozzo met to discuss the autopsy findings. In her memo book notes, Cst. Martynuck wrote, "death between 8-10 p.m. Arrest to be made by Welton and myself."[52]

44. Officers Martynuck and Welton arrived at Valin's house at 1830 to arrest Mr. Mullins-Johnson and also to execute a search warrant for the seizure of a number of household items. Cst. Martynuck met with Ms. Lariviere in the living room and explained "what the investigation had revealed i.e. sexual assault over a period of time and death by asphyxiation."[53]

45. Sgt. Welton arrested Mr. Mullins-Johnson at approximately 1830. He was charged with first degree murder and aggravated sexual assault.[54]

46. While Mr. Mullins-Johnson was being arrested, the police were also executing search warrants at the Johnson residence and seized, *inter alia*, the bedding from Valin's room, her mattress, her clothing, her teddy bear, the couch from the living room, hair samples, Kleenex, fecal matter, track pants and other clothing of Mr. Mullins-Johnson, garbage from the upstairs washroom, and fingernail clippings from Valin.[55] Cst. Toni also reattended at the home for further forensic investigation and made a video of the scene.[56] Cst. Biocchi accompanied her, took additional photographs and collected further evidence, including swabs from Valin's bedroom.[57] While Cst. Toni was at the Johnson residence, she received information from

[52] Memo book notes of Officer Martynuck, June 27, 1993, PFP110956, p. 12.

[53] Memo book notes of Officer Martynuck, June 27, 1993, PFP110956, p. 12.

[54] Arrest Details, June 27, 1993, PFP110916; Supplementary Report, June 30, 1993, PFP110894.

[55] Warrants and records of seized items, June 27, 1993, PFP110185, PFP110186, PFP110189, PFP110190, PFP110326, PFP110400.

[56] [56] Memo book notes of Cst. Toni, June 27, 1993, PFP110492, pp. 2-4; Will say of Cst. Toni, June 29, 1993, PFP110352, pp. 1-2.

[57] Supplementary Report, July 2, 1993, PFP110933.

pathology assistant Corelli that the "sperm tests were negative at the hospital." She later reattended at the Hospital to take additional photographs of Valin.[58]

A. Post- Arrest Statements of Mr. Mullins-Johnson

47. Officers Martynuck and Welton drove Mr. Mullins-Johnson to the police station. According to the memo book notes of Cst. Martynuck, on the way, Mr. Mullins-Johnson was, "crying, sobbing, hysterical." According to Officer Martynuck's notes, he told the officers:

> I didn't do it. I wouldn't hurt that little girl. You got nothing, you got fuck all, what have you got on me, man, nothing, you got fuck all. I didn't touch her, she went to bed & that's that.[59]

48. They arrived at the station at 1840. Upon arrival, Sgt. Welton explained the time and cause of death to Mr. Mullins-Johnson. According to Cst. Martynuck, Mr. Mullins-Johnson replied:

> I was doing dishes, watching T.V. I put [Valin's brother] to bed at 8. Valin went to bed by herself. I was the only other person in the house.[60]

49. While at the station that evening and the following morning, Mr. Mullins-Johnson was interviewed on several occasions by Officers Martynuck and Welton. He repeatedly denied any involvement in Valin's death.[61]

B. Post-arrest Statements of Paul Johnson and Kim Lariviere

50. Subsequent to Mr. Mullins-Johnson's arrest, Valin's parents were each interviewed a second time. Mr. Johnson's interview took place at 1855. He stated:

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[58] Memo book notes of Cst. Toni, June 27, 1993, PFP110492, pp. 2-4; Will say of Cst. Toni, June 29, 1993, PFP110352, pp. 1-2.

[59] Memo book notes of Officer Martynuck, June 27, 1993, PFP110956, p. 13; Memo book notes of Sgt. Welton, June 27, 1993, PFP059401, pp. 8-9.

[60] Memo book notes of Officer Martynuck, June 27, 1993, PFP110956, p. 13.

[61] Memo book notes of Officer Martynuck, June 27, 1993, PFP110956, pp. 14-36, 46-48.

> My brother Bill has babysat my children pretty well from the time that they were born. My kids have always liked him. About three months ago, tops, Bill moved in with us. He has babysat for us a few times since then. Last night Bill was babysitting for us. My wife and I left at 7:00 P.M. and I didn't see the kids again until this morning. Bill was there alone with the kids when we left. I saw my daughter on the bed this morning. She was on the side of the bed nearest the door about six inches from the edge of the bed.
>
> There was vomit beside her, up toward the pillow. She was curled up and was face down on the bed with her bum in the air. She has had other babysitters too and has never complained about any of them.[62]

51. Ms. Lariviere was re-interviewed at 1900. She told police:

> Billy started babysitting for me when [Valin's sister] my oldest, was about 1 1/2 to 2. [Valin's sister] is 7 in November. He never did live with us until the last 2 1/2 months. He did stay with us once for two weeks but I didn't have any children at the time. He would babysit twice a month before he moved in. Billy moved in about 2 months ago, 2 1/2 at the most. It was the middle of the month when he moved in. He wouldn't babysit too often because ball season hadn't started. He babysat once a week or twice a week at the most. I played ball in Garden; I wouldn't bring the kids because of the flies. I usually brought them when I played in Rankin unless it was a late game. Last night the kids had a bath at 6:00. I washed their hair and they played in there. They came down and started eating supper at about 6:20 or 6:30 P.M. We left about 5 to 7:00, within that 5 minute span we left. Billy was there by himself. I came home between 9:30 and quarter to 10. I got a tea and I sat down and watched the ball game. Billy was laying on the couch. I put a load of wash in. I went downstairs. I sat down I watched the rest of the ball game. I watched some of TSN Sports. I went upstairs, went to the washroom, Valin's door was closed. I went to bed. Billy was downstairs. I heard him leave about 11:30 or quarter to 12. I didn't hear anyone knock on the door. He left the light and T.V. on. I never heard anyone else. At 7:00 right on the dot I got up. [Valin's brother] fell. Paul went downstairs. I got up and went to the washroom. Valin's door was closed. I opened it. There was barf over the bed. She was bent over. When I first looked at her her feet were this far apart (showing approximately 1 foot) from her headboard. She was on her knees facing the foot of the bed. Her bum was on her feet. Her head was either on her hands on the bed or on the bed with her hands beside her face. She was on her covers. Her covers were folded on an angle. I pulled her over on her back. She was cold. Her pyjamas were done up. I just backed up and started to scream and Paul came in the room. I ran downstairs and I called 911. Billy woke up and was asking "what's wrong". I told him something was wrong with Valin. He ran upstairs, pulled ?????? downstairs, and I spread a blanket.

[62] Written statement of Paul Johnson, June 27, 1993, PFP110635.

> The children loved staying with Billy. There was no problem leaving them with Billy. Valin complained about a sore "frog", meaning vagina. I said "let me see" and I checked her and her vagina wasn't red or anything.
>
> Her underwear was always soiled on her backside. I just thought it was because she wasn't wiping her bum.[63]

52. At 2000 on June 27, 1993, the Sault Ste. Marie Police Force issued a press release, which stated:

> At approximately 7:34 am on June 27,1993 Police Officers responded to a call for assistance to an east end residence. On arrival officers found that a four year old female had died overnight under what the officers considered suspicious circumstances.
>
> Dr. Crookston, Coroner attended the scene and ordered an autopsy to be conducted.
>
> Investigation has resulted in the arrest of William David Mullins-Johnson, age 22. Mullins-Johnson has been charged with first degree murder and aggravated sexual assault. The accused will be remanded in custody to appear in bail court on Monday, June 28th, 1993 at 1:30 p.m.[64]

C. June 28, 1993

53. Between 1155 and 1235 on June 28, 1993, Dr. Rasaiah, Cst. Martynuck, Cst. Toni and Jim Corelli took a second view of Valin's body at the morgue. Cst. Martynuck made the following note in her memo book:

> 1210 bruising on right side of face-cheek area
>
> -bruise on upper right outside of thigh/ hip area
>
> ...

[63] Typed Statement of Kim Lariviere, June 28, 1993, PFP110882.
[64] Press release, June 27, 1993, PFP110535.

1235 Rasaiah finished. Took some biopsy's[65]

54. Cst. Toni's will say statement regarding this event stated:

> THAT At 1200hrs, I attended at the General Hospital morgue where I met with Dets. Welton and Martynuck and Dr. Rasaiah and Jim Corelli
>
> THAT The body was examined again, and photographs were taken of the bruising that had become more prominent
>
> THAT More samples were taken from bruising areas of the deceased by Dr. Rasaiah.[66]

55. Sgt. Welton noted, "Dr. points out bruising on right side of face much more visible."[67]

56. That same day, the police prepared a 'Homicide/Sudden Death Report,' which stated:

> Between 1900 hours on the 26th of June 1993 to 0000 hours the 27th of June 1993, the accused, Bill Mullins-Johnson sexually assaulted the deceased, [Valin], age 4 years old in the residence at [address]. The accused also inflicted injuries resulting in Valin being suffocated. On the 27th of June 1993 at 1830 hours, the accused was arrested … for first degree murder and aggravated sexual assault.[68]

57. Also on June 28, 1993, Dr. Crookston issued his Coroner's Investigation Statement. He classified Valin's death as a "homicide," with the medical cause of death being "asphyxia." He wrote:

> Autopsy revealed gross anal dilation and scarring, ecchymoses and subcutaneous hemorrhage of thighs, dependent lividity, and signs of asphyxiation. Hymen crescentic, attenuated. Pathologist estimates time of death to be approximately 21:00 on 93/6/26. Examined also by Dr. P. Zehr, a gynaecologist with expertise in child sexual abuse. Photographs taken by police, copies to be sent to Dr. M. Mian, Director of the Suspected Child Abuse and

[65] Memo book notes of Officer Martynuck, June 28, 1993, PFP110956, pp. 53-54.

[66] Willsay of Cst. Toni, June 29, 193, PFP110352, p. 2.

[67] Memo book notes of Sgt. Welton, June 27, 1993, PFP059401, p. 17.

[68] Homicide/Sudden Death Report, June 28, 1993, PFP03668.

> Neglect Team, Hospital for Sick Children, Toronto. Drug screen negative. … Police have charged William Mullins-Johnson with sexual abuse and murder. [69]

58. That same day, the police submitted the items seized under warrant from the Johnson home, to the Northern Regional Forensic laboratory for analysis. Under the heading 'Case History' was written:

> 4 year old [Valin] was found in her bed by a parent at approximately 0730hrs on the 27 Jun 93, deceased. She had vomited on her bed. She was wearing underpants and one-piece pyjamas. At the autopsy, it was revealed that she had been repeatedly sexually abused vaginally and anally. She died as a result of asphyxiation.
>
> The accused is the uncle who lives at this address and was babysitting at the estimated time of death.[70]

59. On June 28, the police interviewed Ms. Kathy Labrecque, who stated that Valin would often come to her home to ask for food as she was hungry. She also reported seeing Valin and her brother outside of the home naked. She was concerned that the children were not getting sufficient supervision.[71]

60. On June 30, 1993, the Sault Ste Marie Police Force, prepared a Supplementary Report. It stated, *inter alia*:

> Dr. Crookston ordered a Post Mortem on the deceased which took place at the General Hospital on June 27, 1993. The Pathologist, Dr. Rasaiah, advises that the deceased died as a result of suffocation, and estimates time of death between 20:00 hours and 22:00 hours, June 26, 1993. Dr. Rasaiah requested Dr. Lalouette and Dr. Zehr examine the deceased, and it was determined that Valin had been sexually assaulted, and had been sexually assaulted on an on-going basis for an extended period of time.

[69] Coroner's Investigation Statement, June 28, 1993, PFP003664.
[70] Case Submission, June 28, 1993, PFP005016.
[71] Statement of Kathy Labrecque, June 28, 1993, PFP110038.

> On June 27, 1993, at approximately 18:30 hours, the accused, William Mullins-Johnson, was arrested at 66 Robin Street for Murder and Aggravated Sexual Assault.[72]

61. On July 2, 1993, Det. Welton met with Dr. Rasaiah and showed him the vomit that was seized from Valin's bed. According to Det. Welton, Dr. Rasaiah advised him that, "In my opinion it is not consistent with what I found examining the stomach contents." His opinion was that the vomit was from someone else.[73]

62. On July 9, 1993, the police interviewed Jeff Lariviere, Kim's brother, who reported, *inter alia*, that on June 27, 1993, Mr. Mullins-Johnson would not look at him when they spoke, which was unusual because he always made eye contact before. According to Jeff, Mr Mullins-Johnson "was acting weird as if he was worried about something."[74]

D. The Report of Post Mortem Examination

63. On July 13, 1993, Dr. Rasaiah issued his Report of Post Mortem Examination. He noted the following abnormal findings:

(a) Petechiae of face, neck and upper chest.

(b) Haemorrhagic mucosa upper and lower lips

(c) Cutaneous injuries

(d) Petechiae visceral pericardium, visceral pleura, thymus, brain and laryngeal mucosa

(e) Oedema and congestion of lungs

(f) Dilated vaginal opening

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[72] Supplementary Report, June 30, 1993, PFP110891, p. 2.
[73] Memo book notes of Det. Welton, July 2, 1993, PFP059401, p. 22.
[74] Statement of Jeff Lariviere, July 9, 1993, PFP110043.

(g) Markedly dilated rectal opening.[75]

64. He determined the cause of death to be "cardiorespiratory arrest due to asphyxia."[76]

65. On July 14, 1993, the Northern Regional Forensic Laboratory issued its toxicology report on the blood samples taken from Valin at autopsy. There were no positive findings.[77]

66. On July 16, 1993, a warrant was issued permitting the police to search Mr. Mullins-Johnson's cell at the Sault Ste. Marie District Jail and seize his bed sheets, blankets and bedding, hair care utensils, toothbrush, razor blades, clothing, paper cups, reading material, urine and eating utensils.[78] In support of the issuance of the warrant, Sgt. Welton set out his grounds for belief as follows:

> At the early stages of the investigation it appeared that the victim had become ill and regurgitated on the bed.
>
> Prior to leaving the scene, police seized a number of exhibits including the vomitus on the bed; and, subsequently, Valin's pyjamas were seized at the post mortem examination.
>
> At a post-mortem examination conducted by Dr. Rasiah at the General Hospital at approximately 12:30 p.m. on June 27th 1993 it was discovered that Valin had been the subject of extended sexual abuse over an extended period of time. During the course of the autopsy, Dr. Rasiah examined the contents of Valin's stomach.
>
> The time of death was determined to be between 7:00 p.m. and 10:00 p.m. on June 26, 1993 and the cause of death was asphyxiation caused by pressure being applied to the chest area.
>
> As a result of post-mortem examination and statements taken from all persons present in the residence during the evening and night of June 26, 1993, William David Mullins-Johnson was arrested by myself for the murder of [Valin] and I firmly believe that William David Mullins-Johnson had exclusive opportunity based on the time of death and that according to his statement he was alone with the children during this time period.

[75] Report of Post Mortem Examination, July 13, 1993, PFP003199

[76] Report of Post Mortem Examination, July 13, 1993, PFP003199.

[77] Report of Susan Rimek, July 14, 1993, PFP036075.

[78] Information to Obtain Search Warrant, July 16, 1993, PFP110205, p. 2.

Since that time, Dr. Rasiah has examined the vomitus seized from Valin's bed and states that this vomitus was not regurgitated by the victim.

Sandra Lindell, Pathologist, Northern Centre of Forensic Sciences advises me that they are able to do DEOXYRIBONUCLEIC ACID (also known as D.N.A.) analysis of the vomitus located on the bed. It is my belief that the accused person regurgitated on the bed while he was placing the victim on the bed.

In order to complete a D.N.A match, the Centre of Forensic Science must have a control sample to match the subject samples.

William Mullins-Johnson has been incarcerated in the Sault Ste. Marie District Jail since his appearance before the Justice of the Peace on June, 28th, 1993 and continues to be an inmate at the facility.

I have consulted with the Superintendent of the District Jail who has agreed to assist us in our investigation. He has advised me that the accused Mullins-Johnson has been confined to a solitary cell since his incarceration.

At my direction, the cell of the accused (cell Q-5 at the District Jail) was given a thorough cleaning on Tuesday, July 13th 1993 while he was at court. I am advised by the District Jail Superintendent and do believe that the accused was issued brand new clothing, bedding and toiletry items upon his return from the Court House. I am also advised by the District Jail Supervisory personnel and do believe that the accused was locked in his cell (cell Q-5) continually since his return from the Court appearance and no one else has entered the cell since his return. I am further advised by the District Jail Supervisory personnel and do believe that the toilet in the accused's cell was prevented from being flushed since the late evening on Thursday, July 15th, 1993.

I am advised by the District Jail Supervisory personnel and verily believe that William Mullins-Johnson has been supplied with "clean" newly purchased reading material in cell Q-5.

I am further advised by District Jail Supervisory personnel and verily believe that William Mullins-Johnson is being fed by the use of disposable paper plates and cups and plastic eating utensils which are, after use by William Mullins-Johnson, being retained and held by Tony Hocking, Security Lieutenant at the District Jail, either in an area adjacent to cell Q-5 in the main jail building or in Mr. Hocking's office located in a portable building on the grounds of the District Jail adjacent to the main jail building.

From my training, experience and from my discussions with the forensic biologist from the Centre of Forensic Science, I believe that the cell, toilet, toiletry items, bedding and clothing that was issued to and/or used by William Mullins-Johnson

> will contain samples of hair, saliva and secreted body fluids or substances of William Mullins-Johnson that will enable a D.N.A analysis to be completed and matched with the subject material, namely the vomitus.
>
> A positive D.N.A. match of any such hair, saliva and/or secreted body fluids or substance will afford evidence to place William Mullins-Johnson in direct contact with the area where the victim was located at a point in time subsequent to her going to bed and proximate to the time of death.[79]

67. The items were seized on July 16, 1993, pursuant to the warrant.[80] The seized items were then submitted to the Northern Regional Forensic Laboratory for analysis.[81] On July 22, 1993, a further submission was made to the Northern Regional Forensic Laboratory.[82]

68. On August 5, 1993, James Corelli, a laboratory technician at the Sault Ste. Marie General Hospital, wrote to Glen Wasyliniuk, Crown Attorney, North Region. He wrote:

> I am forwarding to you copies of the warrant for Post-Mortem as well as Dr. Zehr's report. The reason for this is that we are not sure if you have already received these copies.
>
> Also, I am submitting to you copies of the reports we received pertaining to bacterial, viral, and GC studies we requested. As you will notice, all came back negative. I sent swabs, blood, lung tissue and brain tissue, all areas which would predominantly show infections.[83]

E. The Consultation with Dr. Mian and Dr. Smith

69. Dr. Rasaiah initially consulted Dr. Mian, Director of the Suspected Child Abuse and Neglect Team ("SCAN Team"), Hospital for Sick Children ("HSC"), for her opinion. Dr. Mian, in turn, consulted Dr. Charles Smith for his assistance. They reviewed the autopsy photographs and co-authored a report, dated August 6, 1993. The cover letter to the report stated:

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[79] Information to Obtain Search Warrant, July 16, 1993, PFP110205, pp. 4-6.

[80] Supplementary Report, August 1, 1993, PFP110897; Memo book notes of Sgt. Welton, July 16, 1993, PFP059401, pp. 28-30.

[81] Case submission, July 16, 1993, PFP110481.

[82] Case submission, July 22, 1993, PFP110431.

[83] Letter from Mr. Corelli to Mr. Wasyliniuk, August 5, 1993, PFP110013.

Thank you for asking us to provide you with our opinion in this case. Enclosed please find our joint report regarding this unfortunate child.

With regards to the issue of the management of future cases, there is some merit in considering transfer of the body to a specialized forensic pathology center for these cases which are medico-legally complex. There is, in fact, work being done by the Chief Coroner's office on developing guidelines for the management of such cases province-wide.[84]

70. The report stated:

... Dr. Rasaiah requested a second opinion because of bruising in the genital area, the large vaginal and anal openings with the appearance of abnormal contours, suggestive of sexual abuse.

The child's face and upper chest show evidence of petechiae and small bruises. If these are confirmed by histologic examination, their pattern is consistent with an asphyxial mode of death, resulting from chest or abdominal compression.

The bleeding on the calvarium is consistent with direct trauma or blows to the head.

The anus is gaping with a large opening. The size in and of itself is difficult to judge in a post-mortem examination. The limited number of views and the low magnification, do not allow for any definitive findings. However, the views available are suspicious for the presence of fissures at the 1, 4, 6 and 8 o'clock positions (given that this is based on an assumption of orientation, these positions may not be accurate). The one at 6 o'clock seems freshest, the others appear to have evidence of more healing. The histologic examination would assist in clarifying these observations, since the finding of tearing, hemorrhage or inflammation would confirm the presence of acute and/or healing fissures. In the absence of a history of severe constipation, these findings would be suggestive of anal penetration, likely forceful, by a round, blunt object. The position in which the child was found is suggestive of sodomy.

The inner thighs and perineum show evidence of bruising. If these are confirmed histologically they are very suspicious of non-accidental trauma or a sexual nature, by their position alone. The external genetalia appear otherwise normal.

The hymen itself is seen at low magnification; the close up is of poor quality and does not allow for a more detailed examination. The hymenal configuration is difficult to determine, it may be annular or crescentic. The rim which is visible appears to be adequate with smooth edges. In the absence of multiple views and

[84] Cover letter, August 6, 1993, PFP132681.

> magnification it is not possible to comment with any further accuracy. It should be noted that a normal examination of the hymen, neither confirms nor denies the possibility of sexual abuse.
>
> CONCLUSION:
>
> This child's photographs show findings, which if confirmed by the post-mortem examination, indicate death by asphyxiation, trauma to the head and injury to the perineum and anus. In the absence of a reasonable explanation by history, they indicate non-accidental trauma, including sexual abuse. [85]

71. The Commission has no written record of any communication between the police or coroner and Drs. Mian and Smith following receipt of their report.

F. Subsequent Investigation

72. On September 10, 1993, the Medical Certificate of Death was issued. It classified the death as a homicide and stated, "Presumed to have been asphyxiated during sexual assault." [86]

73. On September 27, 1993, the Centre of Forensic Sciences ("CFS") issued its report on the DNA comparison between the vomit found on Valin's bed and Mr. Mullins-Johnson's DNA. The report stated, "The vomit on the pillow (B1) did NOT come from William MULLINS-JOHNSON (B50 x 1). [Valin] (B35) cannot be excluded as a source of the vomit (B1)."[87]

74. Mr. Terry O'Hara (as he then was) and Ms. Jennifer Reid, both from Kingston, Ontario, represented Mr. Mullins-Johnson. They, in turn, retained Dr. Frederick Jaffe of Mississauga, and Dr. James Ferris of Vancouver.

75. On September 29, 1993, Dr. Jaffe wrote to Ms. Reid. In his letter, he stated:

> I have read the material you sent me concerning the above matter. The assessment of the forensic aspects of this case is made difficult by the lack of photographs taken at the scene and, particularly, at autopsy. There are also

[85] Report on [Valin] by Dr. Mian and Dr. Smith, August 6, 1993, PFP003220.
[86] Medical Certificate of Death, September 10, 1993, PFP003673.
[87] Report of Pamela Newall, September 27, 1993, PFP036063.

some unresolved questions. Was the vomit retained and analysed ? What were the results of the examinations of the vaginal, anal and oral swabs ? You mention in your letter "blood on the front of the body". What was the source of the bleeding ? Whose blood was it ?

The forensic evaluation of the case resolves itself into the following areas :

1. What was the medical history of the deceased?

The autopsy showed extensive haemorrhaging in the form of petechiae and larger bruises of the skin and some internal organs. These were not associated with any deep injuries or any external lacerations of the skin. Did this child have a bleeding tendency? Vomiting is not usually associated with asphyxial states. Whose vomit was it? Dr. Rasaiah reports yellow mucoid material in the nose, bronchi and stomach. Was this vomit?

2. Signs of remote sexual abuse. This seems fairly clear. There is old damage to the hymen, rectum and anus. (The dilation of the anus must be interpreted with some caution as this may be due to post mortem flaccidity but there is microscopic evidence of old trauma and the body was in rigor when examined).

3. Signs of recent sexual abuse. This resolves itself into two questions:

Did sexual abuse occur a) before death

b) after death.

There is little in the pathological findings to indicate recent sexual activity in the anus and rectum apart from some deep areas of haemorrhage, and nothing in the vagina. In this connection, the results of the examination of the swabs will be important.

In the absence of relevant pathological findings and the results of laboratory tests the question of pre- or post mortem sexual penetration cannot be resolved.

4. The cause of death. The post mortem examination did not reveal any natural cause of death nor a traumatic cause. If the findings in the nose and bronchi indicated aspiration of vomitus, this might account for death. However, normal individuals do not aspirate vomitus. Was this child unconscious? The edema of the brain might suggest this.

The many petechiae which Dr. Rasaiah found might well be post mortem in origin but this could only be confirmed on the basis of photographs.

> This is as far as I am able to assess the pathological findings at this time. If you should receive any further material, I'd be glad to look at it. It might possibly help if I could have a look at Dr. Rasaiah's microscopic slides. I am sorry that I seem to have raised more questions than I have answered.[88]

76. On October 5, 1993, the Northern Regional Forensic Laboratory issued its report on all of the materials that had been sampled for blood and/ or semen, including swabs and washings from Valin's body, Valin's pyjamas, Valin's bed, the bed coverings, the hospital sheets, the couch where Mr. Mullins-Johnson slept, the clothing of Mr. Mullins-Johnson, the materials seized from his cell and various hairs. No semen was found on any part of Valin's body, clothing or bed. The hair found in her vagina at autopsy was non-human. No hairs or semen were found as a result of a "pubic hair combing" of Valin. Semen was found on the couch cushions, the inside front of Mr. Mullins-Johnson's track pants, and the undershorts and one sheet from his cell.[89]

77. On January 29, 1994, Dr. Jaffe wrote to Ms. Reid, as follows:

> I have read the additional material you sent me concerning the above matter. I shall briefly discuss some of the pathological points which arise.
>
> Position of the Child
>
> Dr. Zehr attributes great significance to the fact that the child was found "lying in the knee-chest position with her bum in the air" (Consultation Report p.1), and that "it is a very common position that children can assume who have been sodomised" (p.9).
>
> Actually, there is some uncertainty in the records concerning the child's original position.
>
> "Mother stated ... found her in a sitting position in bed with her head over to her legs" (Unusual Circumstances and/or Sudden Death Report). Also "..sitting cross-legged and slumped forward" (Dr. Crookston, p.39).
>
> Dr. Rasaiah stated that the distribution of the lividity showed that the child had been in the knee-chest position (p.56) but he had stated earlier that the lividity does not become "fixed" for 12 hours (p.55). If the body had been moved before

[88] Letter from Dr. Jaffe to Ms. Reid, September 29, 1993, PFP003232.
[89] Report of Sandra Lindel, October 5, 1993, PFP036071, pp. 1-3.

that time the lividity would have shifted and one could not draw any conclusions from it.

Time of Death

Postmortem lividity and rigor mortis have long been discredited as indicators of the time of death. The Moritz formula which Dr. Rasaiah uses to determine the time of death on the basis of the body temperature was popular in the days of the surrey with the fringe on top, the Keystone cops and the 5 [cent] cigar. It is now known that the internal body temperature describes a sigmoid curve as it falls and requires a much more complex mathematical treatment. In any event, the internal body temperature is useless without an accurate determination of the environmental temperature. The precision with which Dr. Rasaiah fixed the time of death lacks a scientific basis.

Anus

The anus is a muscular sphincter which contracts during rigor mortis and relaxes in the subsequent vascular flaccidity. Dr. Zehr and Dr. Rasaiah do not appear to have taken this into account, even though Dr. Rasaiah in his Autopsy Report (p. 6c) indicated that rigor was in the process of passing off.

Drs. Smith and Mian from the Hospital for Sick Children are more circumspect. "The anus is gaping with a large opening. The size in and of itself is difficult to judge in a post-mortem examination". However, they also find 4 fissures in the anus (on the basis of photographs!) which no one had noticed before.

In this connection it is interesting that Dr. Rasaiah examined the vagina and anus and TOOK TISSUE SPECIMENS from these areas before Dr. Zehr did her examination (p.63).

Age of Bruises

Dr. Rasaiah is again very dogmatic but I agree that most of the bruises seem recent (within the final 48 hours). He mentions that, as the bruises age, haemosiderin appears but he does not appear to have made any stains for iron which would have detected early haemosiderin formation.

Sexual Abuse

There appears to be general agreement that there had been "chronic sexual abuse" (p.4) but that there was "no indication of recent sexual abuse" (Dr. Rasaiah, p. 77) and "I do not know whether she was sexually assaulted recently"

(Dr. Zehr, Consultation Record, June 27, 1993). All laboratory reports were negative.

Cause of Death

The body showed many recent bruises of the head, lips, neck, chest and genital areas. These were not associated with deep injuries but were undoubtedly traumatic in origin. They lacked specific characteristics (finger marks, fingernail scratches etc.) and seem to have been caused by blunt trauma, insufficient to have caused death.

There were many petechial haemorrhages, the significance of which is notoriously difficult to assess, especially as petechial haemorrhages can arise after death. The term "asphyxia" (i.e. lack of oxygen) is not helpful as everyone who dies, irrespective of cause, dies of lack of oxygen. The body showed no indication how such an asphyxia might have been brought about.

The most abnormal organs were the lungs which were edematous and haemorrhagic. This may represent an early acute pneumonia. Bacterial and viral cultures were negative but aspiration of stomach acid (Mendelson's Syndrome) remains a possibility.

The various experts seem to ignore the two days' fever before death (Warrant for Post Mortem Examination. Dr. David Crookston, Coroner).

In summary then, we have a 4 year old girl who seems to have been sexually abused in the past and to have been recently subjected to repeated minor blunt trauma. She died after a mild illness of two days' duration. The cause of death remains conjectural.[90]

78. On May 18, 1994, Dr. Rasaiah wrote to Dr. Ferris. He stated:

The enclosed autopsy slides from above case are being sent to you at the request of Kingston Ontario lawyer, Jennifer Reid. Please notify us, if you also require the paraffin blocks,

Please return slides after completion of your review.[91]

79. On June 22, 1994, Dr. Rasaiah sent the slides and blocks from Valin's autopsy, as well as his autopsy report, to Dr. Smith for his expert opinion. This was done at the request of Mr.

[90] Letter from Dr. Jaffe to Ms. Reid, January 29, 1994, PFP036128.
[91] Letter from Dr. Rasaiah to Dr. Ferris, May 18, 1994, PFP003932.

Wasyliniuk.[92] The Commission does not have any documentation that the police or Crown requested a written consultation report from Dr. Smith.

80. On June 31, 1994, Dr. Ferris wrote to Mr. O'Hara. He stated:

> The opinions expressed on the interpretation of petechial haemorrhages by Dr. Rasaiah are not entirely correct. It is very significant, in this case, to recognise that almost all of the petechial haemorrhages are seen in areas of lividity and as such must be interpreted as a postmortem phenomenon occurring after death and in no way related to the cause of death.
>
> Microscopic examination confirms that the bruising of the cheeks, face and the pubic area, described by Dr. Rasaiah, are not in fact antemortem injuries but are as a result of postmortem leakage of blood into the tissues caused by postmortem lividity. This is a frequent finding in bodies which have lain face down for several hours after death and must also be considered the explanation of the alleged 'bruises' on the centre of the upper chest. This explanation also accounts for most of the sub-scalp 'bruising' seen on the photographs. In my opinion Dr. Zehr was wrong to describe the petechiae over the mons pubis and top part of the external genitalia as bruising.
>
> However, I believe that there is evidence of one area of bruising on the under-surface of the left side of the scalp and that there is a distinct bruise on the left side of the neck just below the jaw margin. These are within areas of petechial haemorrhage but can be identified as distinct from the petechiae related lesions.
>
> The opinions expressed on the interpretation of petechial haemorrhages by Dr. Rasaiah are not entirely correct. It is very significant, in this case, to recognise that almost all of the petechial haemorrhages are seen in areas of lividity and as such must be interpreted as a postmortem phenomenon occurring after death and in no way related to the cause of death.
>
> Microscopic examination confirms that the bruising of the cheeks, face and the pubic area, described by Dr. Rasaiah, are not in fact antemortem injuries but are as a result of postmortem leakage of blood into the tissues caused by postmortem lividity. This is a frequent finding in bodies which have lain face down for several hours after death and must also be considered the explanation of the alleged 'bruises' on the centre of the upper chest. This explanation also accounts for most of the sub-scalp

[92] Letter from Dr. Rasaiah to Dr. Smith, June 2, 1994, PFP003934.

'bruising' seen on the photographs. In my opinion Dr. Zehr was wrong to describe the petechiae over the mons pubis and top part of the external genitalia as bruising.

However, I believe that there is evidence of one area of bruising on the under-surface of the left side of the scalp and that there is a distinct bruise on the left side of the neck just below the jaw margin. These are within areas of petechial haemorrhage but can be identified as distinct from the petechiae related lesions.

There are pathologically significant petechial haemorrhages on the face. These are tiny diffuse and uniformly distributed on the face, and eyelids and are of a type characteristically associated with asphyxial deaths caused by compression of the neck structures, the significance of these petechae will be discussed under a separate heading below, dealing with the cause of death.

Cause of Death:

There appears to some doubt as to the precise mechanism of death. Dr. Rasaiah appears to attribute death to airway obstruction as a result of suffocation and smothering and although I am unclear as to the definitive basis for this interpretation, it seems to be based in part on the presence of bruising of the face and lips. In my opinion the discoloration of the lips is not due to bruising but is a direct consequence of postmortem change. I have also concluded that the 'bruises' to the cheeks are not true antemortem injuries and therefore there is no definitive evidence of the degree of facial compression necessary to indicate a smothering death.

The external bruising on the left side of the neck is consistent with the application of blunt force to the neck. There is fresh bruising in the deep structures of the neck adjacent to the thyroid gland caused by compression of the neck structures. These injuries were sustained at or around the time of death and when taken in conjunction with the facial petechial haemorrhages can be reasonably interpreted as evidence of manual strangulation. The nature and extent of these injuries is consistent with the application of a relatively minor force and it is entirely possible that death occurred rapidly and possibly unexpectedly as a result of vagal inhibition. This is a mechanism of death which occurs when the vagus nerve in the neck, which is located immediately adjacent to the thyroid gland, is stimulated and leads to reflex slowing or stopping of the heart.

Sexual Assault Injuries:

The interpretation of the changes in the vagina and rectum are difficult. Dilatation of the vaginal and anal orifices at postmortem must be done with extreme caution since the sphincter muscles around theses openings often dilate after death. Nevertheless, there does appear to be evidence to suggest repeated penetration of the anus and probably the vagina before death. There is however no evidence, in the material available to me, of fresh injury to the vagina sustained immediately prior to death. I believe that the rectal laceration seen on microscope examination can be interpreted as evidence of anal penetration several hours before death.

Other bruises to the limbs may be supportive evidence of the nature of such sexual assaults although none of these bruises have been sustained at the time of death.

Dr. Rasaiah has based his determination of the time of death on the presence of postmortem lividity, rigor mortis and rectal temperature. He is mistaken in his use of the term 'fixation' as applied to postmortem lividity. Fixation of lividity has nothing to do with the absence of skin blanching upon the application of external pressure but is used to describe the fixation of blood in the tissues, after approximately 10-15 hours, when the position of the body is changed. Lividity is the discolouration of the skin produced when after death blood drains by gravity to the under surfaces of the body. If the position of the body is changed shortly after lividity develops the blood will re-position itself to the new under surfaces of the body. If the position of the body is not changed for 10 to 15 hours then the blood will have become 'fixed' in the tissues and will not be seen to drain to the new under surface. There is no valid evidence in this case as to the extent of fixation, if any, of the lividity.

The extent and speed of onset of rigor mortis (postmortem stiffening) in any individual is very variable and this is particularly true of infants and children. Assessment of postmortem stiffening is very subjective and can be significantly modified by moving of the body. As a consequence, assessment of rigor mortis by a pathologist who sees the body for the first time in the mortuary should be discounted as a means of determining the time of death.

Determination of the time of death based on rectal temperature is very inaccurate and while it may be of investigative value to the police it is of no real evidential value. In fact such calculations can be very misleading. I have enclosed a copy of a section of a textbook 'The Essentials of Forensic Medicine' by Polson, Gee and Knight for your information and this current textbook describes the dangers of relying on such calculations better than I can recount.

> In this particular case there is no evidence of the room temperature except the subjective impression of the Coroner that the room temperature seemed normal and he guessed that it was about 70 degrees F. I have included below a table of time of death based upon rectal and environmental temperature developed for investigative use by the Department of forensic medicine at Charing Cross and Westminister Medical Schools. We have found this table helpful but of no real evidential value.
>
> ...
>
> If for example we use this table and assume that the rectal temperature was 82 degrees F. (Approx. 27 degrees C.) at 0800 hours and that the environmental temperature was 70 degrees F. (21 degrees C.) then the above table gives an approximate time since death range of 8 - 16 hours. If we allow for a possible variation of 2 degrees each way in the environmental temperature, the time since death range would be 6 - 18 hours prior to 08.00 hours. On this basis alone the precise estimation of time of death given by Dr. Rasaiah is not only misleading but also quite wrong.[93]

81. he then summarized his conclusion as follows:

(a) The child appears to have died as a direct result of neck compression.

(b) The compression force was not great and death may be sudden and unexpected and may be due in part to vagal inhibition.

(c) The petechial haemorrhages on the chest, pubic area and some of the sub-scalp petechiae are due to post-mortem lividity.

(d) There is evidence of chronic repetitive anal and vaginal penetration.

(e) There is no evidence of injuries to the anus or vagina which might have occurred during the course of the final assault recent laceration of the anal mucosa.

(f) Most of the areas of bruising are not associated with the fatal episode.

[93] Letter from Dr. Ferris to Mr. O'Hara, June 31, 1994, PFP036150, pp. 4-7.

(g) Accurate determination of the time of death based on the evidence available is not possible. The best estimation of the time of death would be between 6 and 18 hours before the time of the Coroner's examination at the scene. [94]

[94] Letter from Dr. Ferris to Mr. O'Hara, June 31, 1994, PFP036150, p. 8.

PART V. The Trial

82. The Commission does not have a copy of the transcripts of Mr. Mullins-Johnson's preliminary hearing.

83. The trial of Mr. Mullins-Johnson commenced on September 6, 1994, before the Honourable Mr. Justice Noble sitting with a jury in the Ontario Court of Justice (General Division).[95] In preparation for the trial, the police and Crown compiled a Crown brief, which included details about Mr. Mullins-Johnson, including his criminal record and prior involvement with mental health professionals. His criminal record included a conviction for break and enter in January, 1989, for which he was sentenced to two years less a day. He served his sentence at the Thunder Bay Correctional Centre and in Brampton at the Ontario Correctional Institute. While in custody, and after being released on parole, Mr. Mullins-Johnson was seen by several mental health professionals and/or parole officers. Their impressions and assessments of Mr. Mullins-Johnson were included in the Crown brief.[96]

84. The key pathological issues at trial were:

(a) the time of death;

(b) the cause of death; and

(c) the injuries on Valin's body and their significance, specifically as they pertained to the issue of sexual abuse.

85. The Crown theory was that Valin was the victim of chronic, sexual abuse, and died during the course of a sexual assault at a time when only Mr. Mullins-Johnson was present. Drs.

[95] Case on Appeal, PFP036566, p. 18. The Crown sought to lead the evidence of two young girls as similar fact evidence. The trial judge rejected the Crown's application. A non-publication order was issued preventing the publication of the girls' identities or any information that would identify them. Accordingly, they are not named in this report.

[96] Address History of Accused, undated, PFP110432; History of Accused, undated, PFP110433; Probation & Parole points of Interest, undated, PFP110436; Information from Counsellors in 1986, undated, PFP110442

Rasaiah, Smith and Zehr were called as expert witnesses by the Crown in support of that position.[97]

86. The defence called Drs. Jaffe and Ferris.[98]

87. The evidence of each of the experts on the three key trial issues is set out in detail in the facta filed in relation to Mr. Mullins-Johnson's appeals at the Court of Appeal for Ontario and the Supreme Court of Canada.[99] This overview report contains a brief summary of each of the expert's evidence on the key, pathology issues in chart form below.

A. Time of death

Dr. Rasaiah	Dr. Smith	Dr. Jaffe	Dr. Ferris
Dr. Rasaiah testified that there was no accurate or precise manner to determine the time of death based on the scientific evidence at that time, but that there were a number of approaches that pathologists could use to determine the time of death. The first is the temperature of the body. For every hour, there is a drop in body temperature of 1.5	Dr. Smith testified that pathology is not an exact science and that there is considerable variation in what can affect changes or the rate of change that a body undergoes after death. In addition, all of the studies and experiments available at the time dealt with adults and not children, therefore the science with respect to children was even	Dr. Jaffe testified that no good method had been established to determine the time of death.[105] Body temperature has the advantage of being capable of measurement, but there are so many variables that it is not sufficiently accurate to come to a conclusion. Children cool more quickly than adults. Because there are so many variables, body	Dr. Ferris testified that the determination of the time of death by any method, although of investigative value, is of very limited evidentiary value. He did not believe that one could accurately determine the time of death from almost any method in an unobserved death.[107]

[97] The *curriculum vitaes* of Drs. Rasaiah and Smith, filed as exhibits at the trial, can be found, respectively at PFP036048 and PFP036088. This Commission does not have a copy of Dr. Zehr's *curriculum vitae*.

[98] The *curriculum vitaes* of Drs. Jaffe and Ferris, filed as exhibits at the trial, can be found, respectively at PFP036125 and PFP036134.

[99] Appellant's Factum at the Ontario Court of Appeal, March 8, 1996, PFP036484; Respondent's Factum at the Ontario Court of Appeal, October 15, 1996, PFP036533; Appellant's Factum at the Supreme Court of Canada, January 7, 1998, PFP136042; Respondent's Factum at the Supreme Court of Canada, May 8, 1998, PFP059606.

degrees Fahrenheit. The environmental temperature is taken into account as well as whether the child has some underlying natural disease. Using Dr. Crookston's reading of the deceased's temperature, which measured 82 Fahrenheit shortly after 0800, the time of death was calculated to be 2100.[100]	more imprecise.[101] He stated, "I don't pretend for a moment that I can help you establish a time of death within the precision of an hour or several hours."[102] He testified that the time of death could be more or less than Dr. Rasaiah's estimate of 15-17 hours prior to autopsy. He testified he was very reluctant to make a statement as to the time of death based on the body temperature as recorded by Dr. Crookston.[103] He further testified that caution was warranted in the area of a determination of time of death and that it is easier to mislead than to be accurate in this area.[104]	temperature had become discredited as an accurate way of determining time of death.[106]	
The second method of estimating time of death is to look at post mortem staining.		Dr. Jaffe testified that while lividity becomes fixed after a period of time, it is not an	With respect to post mortem lividity, Dr. Ferris testified that he did not believe that

[100] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 60-62.
[101] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 99-100.
[102] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, p. 100.
[103] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 107-109.
[104] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 115-116.
[105] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 164-165.
[106] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 165-166.
[107] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, pp. 40-41.

Post mortem staining begins around two hours after death and is fixed around 12 hours. Given the fixed post mortem staining on the front of the body at the time of autopsy, Dr. Rasaiah concluded that the body had been in that position (face down, kneeling in excess of 12 hours.[108]		instantaneous event. It happens over a number of hours. Therefore, it is not a reliable method of estimating time of death.[109]	method had any validity at all.[110]
The third method of estimating time is the extent of the rigor mortis. At the time of autopsy, 1255 on June 27, there was no rigor mortis in the face or neck but it was present in the upper limbs and lower limbs and based on that, he estimated time of death as having occurred 15-17 hours before that time (i.e. 2000 to 2200 on June 26, 1993).[111]		Dr. Jaffe testified that the degree of rigor mortis present is a subjective evaluation and therefore cannot be used as a reliable tool to estimate time of death.[112]	
Dr. Rasaiah opined that the time of death was between 2000-2200 on June 26, 1993. He acknowledged that the level of accuracy		Dr. Jaffe was not prepared to draw a conclusion as to time of death.[114]	Dr. Ferris did not draw a conclusion as to time of death during his evidence.

[108] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 62-67.
[109] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, p.165.
[110] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, pp. 41-42.
[111] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 67-69.
[112] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, p. 165.

in giving such an estimate was low and did not claim that his estimate was an accurate and precise method.[113]			

B. Cause of death

Dr. Rasaiah	Dr. Smith	Dr. Jaffe	Dr. Ferris
Dr. Rasaiah testified that the cause of death was a lack of oxygen, causing the heart to stop (cardio-respiratory arrest due to asphyxia).[115] He categorized this as an unnatural cause of death and testified that he found no evidence of a natural cause.[116] Dr. Rasaiah concluded that there was a mechanical obstruction either to the nose and mouth, neck or upper chest.[117]	Dr. Smith testified that Valin did not die a natural death. She died of asphyxia.[119] He agreed with Dr. Ferris' report that death was possibly due to manual strangulation.[120] He testified that there was no evidence that Valin died from aspirating her stomach contents.[121] Dr. Smith testified that he could not tell the mechanism, which stopped the oxygen flow to the body.[122]	Dr. Jaffe testified that Dr. Rasaiah's diagnosis of asphyxia rested upon shaky grounds. He saw no clear cause of death, only a number of possibilities.[123] He could not exclude manual strangulation.[124] He suggested that the possible cause of death was inhalation of acid from the stomach.[125]	In his report, Dr. Ferris stated that Valin appeared to have died as a direct result of neck compression.[126] At trial, Dr. Ferris testified that the cause of death in this case was a problem. He felt it was reasonable to say that there was no definitive cause of death that had been established.[127] He found no evidence of natural disease.[128] There was no definitive, easily

[113] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 79, 105-106.
[114] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, p.166.
[115] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, p. 70.
[116] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 70-71.
[117] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 50-53.
[118] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 142-143.
[119] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 71-72.
[120] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 72-75.
[121] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 75-77.
[122] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, p. 116.

He acknowledged that it was possible that Valin got stomach acid in her lungs after extreme vomiting and that caused a build up of fluids in her lungs, which led to her death. However, no vomit was found in the lower air passages or lungs and, therefore, he concluded that the vomit was not the problem.[118]			identifiable cause of death. All he could say was that the mechanism of death was not a severe force.[129] His view was that the cause of death was undetermined.[130] However, he agreed that the external and internal bruising to the neck, sustained at or around the time of death, taken in conjunction with facial hemorrhages "can be reasonably interpreted as evidence of manual strangulation."[131]

C. Injuries on Valin's body and their significance, particularly as they pertained to sexual abuse

Dr. Rasaiah	Dr. Smith	Dr. Zehr	Dr. Jaffe	Dr. Ferris
Dr. Rasaiah examined Valin's genitals at autopsy. The vaginal opening appeared to him	Dr. Smith did not see any abnormalities with respect to the vaginal area (he and Dr. Mian	Dr. Zehr testified that there was evidence of sexual assault on Valin. Her conclusion was	Dr. Jaffe testified that the petechial hemorrhages seen in the photos clearly occurred post	

[123] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 168-169.
[124] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 200-201.
[125] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 177-178.
[126] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, p. 32.
[127] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, p. 31.
[128] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, p. 21.
[129] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, p. 34.
[130] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, pp. 46-47.
[131] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, pp. 53-55.

to be markedly dilated.[132] The anal opening was, in his view, excessively dilated notwithstanding that there may have been some dilation of the anal muscles post mortem.[133]	viewed photos taken at autopsy). He described the hymen as appropriate in size shape and thickness. Dr. Smith concluded that the vagina appeared normal.[134]	based on the gross abnormalities of the anal-rectal area with changes and gaping; changes which looked as though there had been penetration of some kind; trauma around the monds, the labia, the inner thighs and the anus.[135] Dr. Zehr testified that the size of the anal gaping was abnormal. The normal folds around the anus were missing and it appeared very smooth and attenuated, which was characteristic in children that had been sexually assaulted or sodomized. She stated that repeated penetration with a penis or object	mortem. The chest revealed a textbook picture of post mortem hemorrhages.[138] The large hemorrhages, which appeared to be bluish in colour, were caused by some form of blunt impact and were sustained before death, possibly at the time of death. His opinion was that the bruises were 36 hours or less in age.[139] The gaping in the anus was perhaps a bit more than one would expect simply by post mortem relaxation.[140]	

[132] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 71-72.
[133] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 71-72.
[134] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 88-89.
[135] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 21-22.
[136] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 24-25.
[137] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, pp. 29-30.
[138] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 171-172.
[139] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 172-173.
[140] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 175-176.

		would create these symptoms.[136] Dr. Zehr testified there may have been penetration of the vaginal area, but not to the degree of the anal area, if there was.[137]		
Dr. Rasaiah testified that there was nothing about any of the injuries to the sexual organs that suggested that they were recent.[141]	Dr. Smith testified that there was evidence of recent sexual abuse. He stated that he found fresh bruises in the anal area and, microscopically, one laceration in the cells, which line the rectum-anal region. He described this as evidence of a fresh laceration and evidence of at least recent, if not fresh, bleeding or bruising into the area. With respect to the laceration, there was no healing associated with it and therefore it occurred at the	Dr. Zehr was unable to provide a timeframe for when the sexual abuse took place, but stated "there have been multiple episodes or it's been fairly long-standing to get this degree of change in the tissues." It was her view that Valin had been sexually assaulted chronically over a period of time but there was nothing to indicate that it had happened recently.[143]	Dr. Jaffe saw no recent injuries to the anal opening, but did see some old damage. He saw no fissure. With respect to the area that Dr. Smith described as having fecal matter, Dr. Jaffe regarded it as a post mortem artefact and not a recent injury. It could have occurred after death or by the coroner taking Valin's temperature rectally.[144] Dr. Jaffe agreed in cross-examination that in his report, he thought the bruises were pre mortem but at	Dr. Ferris testified that the hemorrhage around the neck structures might have occurred within 30 minutes of death.[146] The bruising around the pubic and vaginal areas were clearly sustained several hours prior to death, either 8-18 hours or even 6-24 hours before death.[147] He found no evidence of fresh injury to the vagina.[148] With respect to the anus, he testified that he noted injury to

[141] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, p. 144.
[142] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 82-87.
[143] Case on Appeal at the Supreme Court of Canada, Vol. II, PFP036812, p. 25.
[144] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 176-177.

	time of death or shortly before. There was also a hemorrhage associated with it, which suggested that the deceased was alive when the injury occurred. Based on the bruising and the laceration, it was his opinion that sodomy did occur. Based on the perimortem bruising and fissuring as well as the position of the body, it was his conclusion that this was typical of the type of injury that one would expect in a child who had been subjected to anal intercourse.[142]		trial he believed they were classical post mortem bruises.[145]	that area and was of the opinion that it was probably sustained some hours prior to death. The rectal laceration seen microscopically can be interpreted as evidence of anal penetration 8-18 hours prior to death.[149] There was nothing to indicate that there was a very fresh injury occurring in and around the time of death. The inside of the anus revealed an area of chronic ulceration, consistent with an injury or infection happening days or weeks before the death, but not an acute episode occurring at the time of death.[150] He saw no acute

[145] Case on Appeal at the Supreme Court of Canada, Vol. III, PFP037014, pp. 190-195, 204-205.
[146] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, p. 22.
[147] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, p. 22-23.
[148] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, p. 55.
[149] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, p. 55.
[150] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, pp. 26-27.
[151] Case on Appeal at the Supreme Court of Canada, Vol. IV, PFP037225, p. 46.

				fissure. He saw no evidence of any sex related activity that could be described as occurring at or around the time of death.[151]

88. On September 21, 1994, Mr. Mullins-Johnson was convicted of first degree murder and sentenced to life in prison with no eligibility for parole for 25 years.[152]

[152] Indictment, December 2, 1993, PFP110387, p. 4; Warrant of Committal, September 21, 1994, PFP036161.

Part VI. The Appeals

A. Appeal to the Court of Appeal for Ontario

89. Mr. Mullins-Johnson appealed his conviction to the Court of Appeal for Ontario. On December 19, 1996, the majority (Catzman and Labrosse, JJ.A.) dismissed the appeal. Justice Borins dissented. He would have granted the appeal, quashed the conviction, and ordered a new trial.[153]

B. Appeal to the Supreme Court of Canada

90. Mr. Mullins-Johnson then appealed to the Supreme Court of Canada.[154]

91. On October 8, 1997, in advance of the hearing at the Supreme Court of Canada, Michael Lomer, appellate counsel for Mr. Mullins-Johnson, wrote to Crown counsel, Scott Hutchinson. He stated:

> As you may recall, DNA typing was done on some samples during the above-noted trial. Specifically, stains were prepared from the vomit found on the victim's sheets and pillow. The pillow stain results indicated that [Valin] could not be excluded as the source of the vomit and that William Mullins-Johnson was not the source of the vomit. The stain prepared from the sheets was not examined. The relevant report from the Centre for Forensic Sciences can be found at p. 846 of the Case on Appeal.
>
> We have retained the services of Dr. John Waye from IDENT in Hamilton. He advises that there are a number of far more discriminating tests that can be done on these samples. Specifically, the CFS now routinely types the following additional loci: LDLR, GYPA, HBGG, D7S8, GC, FES, vWA, THO1, F13.
>
> I am writing to request that you instruct CFS to perform the above-noted typing on the sheets and the pillow stains and that Dr. Waye be permitted to observe the procedure. With respect to the stain from the sheets, since it was not examined at all, DQA1 will of course have to be typed as well. I would appreciate

[153] *R. v. Mullins-Johnson* (1996), 112 C.C.C. (3d) 117 (Ont. C.A.), PFP003581.
[154] Letter from Mr. Lomer to Mr. Hutchinson, January 2,1997, PFP059594.

> it if this matter was treated on an urgent basis, given the time required to perform the tests and the fact that this appeal will be inscribed for the winter session.[155]

92. Mr. Hutchinson replied on October 15, 1997. He stated:

> While you ask that this matter be "treated on an urgent basis" I do not propose to drop everything and deal with your present request. Firstly, this form of testing has been available for many, many months: secondly, I am not certain where these exhibits are or whether they remain under the jurisdiction of the court (in which case an application under section 605 of the Criminal Code would be necessary): and thirdly, (without meaning to be more dense than usual) I am not sure how additional testing would be relevant.
>
> Please contact me by telephone so that we can discuss this and other matters.[156]

93. On January 7, 1998, Mr. Lomer sent his factum to Mr. Hutchinson. In his cover letter, he asked, "Would kindly advise as to the status of the DNA testing at your earliest convenience."[157]

94. On February 16, 1998, Mr. Hutchinson wrote to Mr. Ray Prime, Acting Director, CFS. He said:

> William Mullins-Johnson was convicted of first degree murder on September 21, 1994. On December 19, 1996 the Ontario Court of Appeal (Mr. Justice Borins, dissenting) dismissed his appeal. Mr. Mullins-Johnson's appeal to the Supreme Court of Canada will likely be heard in June of this year.
>
> At Mr. Mullins-Johnson's trial a fair bit of scientific evidence was adduced on behalf of the Crown.
>
> Most of this scientific evidence related to the cause and time of death. However, there was some trace evidence which was examined and which formed part of the case for the Crown. This included vomitus found near the victim's body and semen stains found elsewhere in the house. DNA analysis was conducted in respect of these samples and an opinion provided based on the DQA1 system. (For your reference I have enclosed copies of the report prepared by the Centre of Forensic Sciences together with the report prepared by the Northern Regional Forensic Laboratory.)

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[155] Letter from Mr. Lomer to Mr. Hutchinson, October 8, 1997, PFP059580; *R. v. Mullins-Johnson* (1998), 124 C.C.C. (3d) 381 (S.C.C.), PFP004199; Order, May 26, 1998, PFP110382.

[156] Letter from Mr. Hutchinson to Mr. Lomer, October 15, 1997, PFP059577.

[157] Letter from Mr. Lomer to Mr. Hutchinson, January 7, 1998, PFP059575.

> As this appeal sits awaiting argument in the Supreme Court of Canada I have been asked by defence counsel to seek further testing with respect to the items previously tested by the Centre of Forensic Science. In particular I would ask that the vomitus stain and the blood stain from the victim ([Valin]) be re-tested in additional profiling systems. As I understand defence counsel's concern, the DQA1 system, while successfully excluding his client as a source of the vomitus, is of limited discriminating value in ensuring that the vomitus is not the product of some other person besides the victim (the only other realistic suspect in this case is the victim's biological father).
>
> Based on my own understanding (however limited) of this form of testing I am inclined to agree with defence counsel and therefore I would ask that these samples be further tested in the manner I have suggested. I leave it to the Centre and the scientific experts assigned to this matter to determine what profiling systems and what form of testing are the most useful in the circumstances.
>
> With this all in mind I would, therefore, ask that you assign this matter to a scientist at your earliest convenience and ask them to contact me so that we might discuss how best to proceed. As I note above, this matter is to be heard in the Supreme Court of Canada in June, 1998 and it would be unfortunate if this testing could not be completed prior to that time.[158]

95. Dr. Prime responded on February 26, 1998. He advised that Pamela Newall had been assigned to conduct the requested re-testing.[159] On April 24, 1998, Ms. Newall reported her findings. She concluded that, "The DNA STR profile of the vomitus on the pillow comes from a female and matches the DNA profile from V. JOHNSON at 9 STR loci."[160]

96. Ms. Newall's report was faxed to Mr. Hutchinson that same day.[161] Mr. Hutchinson forwarded the report to Mr. Lomer on April 28, 1998.[162]

97. Mr. Mullins-Johnson's appeal to the Supreme Court of Canada was heard and dismissed on May 26, 1998.[163]

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[158] Letter from Mr. Hutchinson to Dr. Prime, February 16, 1998, PFP059568.

[159] Letter from Dr. Ray Prime to Mr. Hutchinson, February 28, 1998, PFP059567.

[160] Report of Pamela Newall, April 24, 1998, PFP003717, p. 2.

[161] Fax cover page, April 24, 1998, PFP059561.

[162] Letter from Mr. Hutchinson to Mr. Lomer, April 28, 1998, PFP059562.

[163] *R. v. Mullins-Johnson* (1998), 124 C.C.C. (3d) 381 (S.C.C.), PFP004199; Order, May 26, 1998, PFP110382.

98. On April 3, 2001, Mr. Lomer, in his capacity as a private citizen, wrote to Dr. James Cairns, then the Chief Coroner for Ontario, as follows:

> I am writing to you with respect to Mr. Mullins-Johnson who was convicted of first degree murder some time ago. I was counsel with respect to his appeal to the Court of Appeal for Ontario and his subsequent appeal to the Supreme Court of Canada. I did not do his trial. Dr. Charles Smith was the pathologist. I am no longer Mr. Mullins-Johnson's lawyer and have not been since the hearing of the case in the Supreme Court of Canada a couple of years ago. However, it is a case that has always caused me a nagging doubt with respect to his guilt.
>
> I am writing this letter by memory but there were three main issues of interest to pathology at the trial and they were:
>
> 1. Cause of death.
>
> 2. Time of death.
>
> 3. Whether the deceased child had been sexually assaulted at or about the time of death.
>
> There were four pathologists involved in the case and it was only Dr. Smith who testified that the child was sexually assaulted at or around the time of death. Dr. Smith was the only one of the four who saw the microscopic artifact that was the basis for his conclusion that the child died during the course of a sexual assault. As you are no doubt aware the law is that a jury can accept or reject the evidence given by any expert witness. The jury clearly accepted the evidence of Dr. Smith and rejected the evidence of the two pathologists called by the defence. Otherwise the jury could not have convicted Mr. Mullins-Johnson of first degree murder. One of the defence pathologists was Dr. Ferris. I am concerned that this is another of those cases where Dr. Smith's opinion is at odds with what is generally accepted by pathologists practicing in this area. If that is so, then a miscarriage of justice of the most serious sort may well have occurred. As well, if Dr. Smith's opinion was overreaching then the potential number of suspects would increase to include the child's mother.
>
> I read in the Star that there is going to be a review of the professional conduct of Dr. Smith by your office. If that is to be the case, and I have no reason to disbelieve what I read in the newspaper, I am alerting you to this case. It is my view that this is another case of Dr. Smith's that ought to be looked at in the interests of justice.
>
> I have no instructions to request anything on behalf of Mr. Mullins-Johnson and I do not purport to act for him. Simply put, I am writing as a private citizen

> concerned about a case that I was extremely familiar with. Any materials I have I would be happy to turn over to you.[164]

99. On December 28, 2001, Mr. David Bayliss, on behalf of the Association in Defence of the Wrongly Convicted ("AIDWYC"), wrote to Dr. Cairns. In his letter, he stated:

> It is now well known in the legal community that the Office of the Chief Coroner is undertaking a review of Homicide cases in which Dr. Charles Smith has been involved as an expert witness.
>
> AIDWYC is presently investigating the case of William Mullins-Johnson as a potential wrongful conviction. Mr. Mullins-Johnson was convicted of 1st degree murder in the death of his four year old niece in 1994. His appeals to the Ontario Court of Appeal and the Supreme Court of Canada were dismissed. I have attached these reported decisions with this letter.
>
> There were four pathologists involved in the case including Charles Smith. Dr. Smith was the only one of the four who was of the opinion that the child died during the course of a sexual assault. He was not the pathologist who conducted the autopsy. Since the jury convicted of 1st degree murder, they must have accepted the evidence of Dr. Smith.
>
> Time of death and cause of death, that is, whether or not the child was killed or died as a result of a non-inflicted death, were also issues in the case. Clearly, therefore, Dr. Smith's opinion may also have motivated the jury's finding of homicide.
>
> On behalf of Mr. Mullins-Johnson, AIDWYC requests that the coroner's office review Dr. Smith's work in the Mullins-Johnson case. Although the case is no longer before the courts, it is certainly ongoing in the sense that an innocent man may be imprisoned because of an opinion by a doctor whose reliability in other cases is under scrutiny by his own colleagues. As such we suggest fairness dictates that Mr. Mullins-Johnson receive the same consideration being extended to accused persons who are presently before the courts.[165]

100. On January 7, 2002, the sections of Valin's pillow, top sheet, white sheet and yellow bedspread that had been tested before trial at CFS were returned to Cst. Biocchi. [166]

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[164] Letter from Mr. Lomer to Dr. Cairns, April 3, 2001, PFP003936.

[165] Letter from Mr. Bayliss to Dr. Cairns, December 28, 2001, PFP115660.

[166] Letter from Ms. Hagerman to Cst. Biocchi, January 7, 2002, PFP059698.

101. On February 27, 2003, James Lockyer, on behalf of AIDWYC wrote to Sean Porter of the Ministry of the Attorney General, Crown Law Office Criminal. He stated:

> Further to our telephone call two weeks ago, I am formalizing my request, on behalf of AIDWYC, for your assistance in this case. You seem to be the appropriate Ministry contact in this case given the nature of the request and that you are a member of the CFS Advisory Board.
>
> AIDWYC is involved in a preliminary investigation of the conviction of Mr. Mullins-Johnson and has enlisted the help of Dr. Bernard Knight, a pathologist of international repute, to assess the pathological aspects of the case. As part of his examination, Dr Knight has requested that the microscopic material examined by the Crown pathologists be made available to him. Dr. Knight would like to view the original slides examined by Drs. Rasaiah and Smith or, if the originals are not still available, re-cuts from the same paraffin blocks.
>
> The deceased in the case was [Valin], a four year old girl. The autopsy was conducted at the Sault St. Marie General Hospital and specimens in the case were submitted to the Northern Regional Forensic Laboratory. NRFS reference numbers associated with the file are:
>
> O.F.N. 184433-2, Lab. File No. 3167-93[167]

102. Mr. Lockyer also requested copies of a number of the involved officers' notes.[168]

103. On March 4, 2003, Carol Brewer, Deputy Director, Crown Law Office Criminal, replied to Mr. Lockyer. She advised that Mr. Porter was away from the office, and that Mr. Phillip Downes, who had worked on the appeal, would be assigned to assist AIDWYC.[169]

104. On March 13, 2003, Mr. Downes wrote to Mr. Lockyer and advised him he was assigned to the file and would, "be taking steps to secure the material you have requested without undue delay."[170]

105. On March 28, 2003, Mr. Downes wrote to the trial Crown, Mr. Wasyliniuk. He stated:

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[167] Letter from Mr. Lockyer to Mr. Porter, February 27, 2003, PFP059544.
[168] Letter from Mr. Lockyer to Mr. Porter, February 27, 2003, PFP059544.
[169] Letter from Ms. Brewer to Mr. Lockyer, March 4, 2003, PFP059559.
[170] Letter from Mr. Downes to Mr. Lockyer, March 13, 2003, PFP059556.

> A couple of weeks ago I told you about the inquiry from Mr. James Lockyer in relation to the above matter. Mr. Lockyer is conducting a preliminary investigation of the conviction of Mr. Mullins-Johnson on behalf of the Association Defence of the Wrongly Convicted (AIDWYC). A copy of his letter to Shawn Porter of this office is attached. I have been asked to assume responsibility for responding to Mr. Lockyer's request.
>
> You will recall that on September 21st, 1994 William Mullins-Johnson was found guilty of the first degree murder of his 4 year old niece, [Valin]. On December 19th, 1996 the Court of Appeal dismissed the appeal against conviction, and on May 26th, 1998 the Supreme Court of Canada dismissed his further appeal.
>
> The Sault Ste. Marie Police investigated this case and while it is not absolutely clear from the material I have, it would appear that Detectives Martinyuk and Welton were involved in the investigation.
>
> As you can see from Mr. Lockyer's letter, he is requesting at this stage some police notes and some material from the autopsy performed on [Valin]. While I have retrieved all of the materials relating to the appeals, the kind of material requested by Mr. Lockyer is, I presume, still the in the possession of the police and the Northern Regional Forensic Laboratory.
>
> I understand that it is the general practice to provide the material requested, subject to any ongoing privacy concerns. I would greatly appreciate your assistance in locating the requested materials. There is no suggestion at this time of any wrongdoing by either the Crown or the police and as a result it would seem appropriate to seek the assistance of the Sault Ste. Marie Police in obtaining the requested materials. If there is an individual assigned to assist I am happy to speak to him or her directly.[171]

106. That same day, a letter was sent on behalf of Mr. Wasyliniuk to Insp. Toni. Enclosed was the letter from Mr. Downes. He asked that Insp. Toni retrieve the requested items.[172]

107. On April 3, 2003, (now) D/Sgt. Martynuck sent an email to fellow officers Ault, Biocchi, Carlucci, Dubas, Gioia and Toni. It stated:

> A letter has just been rec'd from the Crown Law Office via Glen Wasyliniuk regarding the Mullins-Johnson murder conviction in the death of [Valin] from 1993. The request is from a Mr. Lockyer who acts on for of Mullins-Johnson on behalf of the Association Defence of the Wrongly Convicted.

[171] Letter from Mr. Downes to Mr. Wasyliniuk, March 28, 2003, PFP059542.
[172] Letter from Mr. Wasyliniuk to Inspector Toni, March 28, 2003, PFP059548.

> The Ontario Court and the Supreme Court of Canada have upheld the murder convictions and there is no suggestion at this time of wrongdoing by our Service or the Crown. The request has been made to obtain the notes from the above officers in the matter. The offence occurred on June 27th 1993.
>
> Glen is requesting your notes to be forwarded to me ASAP. I am attaching what your role was and the information that is believed to be in your notes. If you have any questions please do not hesitate to contact me.
>
> 1) Randy Ault- your notes related to your escort of Mullins-Johnson-no date provided
>
> 2) Terry Biocchi-your notes on your investigation
>
> 3) Romano Carlucci-notes of the investigation
>
> 4) Mark Dubas-notes when you escorted Mullins-Johnson-no dates provided
>
> 5) Rob Gioia-notes from securing the crime scene
>
> 6) Cathy Toni-notes related to taking phone of body and crime scene, assistance in investigation.[173]

108. Officers Ault, Toni, Gioia and Carlucci all replied to the request.[174]

109. On May 21, 2003, Mr. Lockyer wrote to Mr. Porter. He sought an update on the requests of February 27, 2003.[175]

110. On June 4, 2003, Dr. Rasaiah sent a letter to S/Sgt. Carlucci. He stated:

> On the 15th of May 2003 at 1200 hours, I received a fax from you requesting the slides and blocks on [Valin].
>
> This is notify you that the microscopic slides were first sent to Dr. Frederick Jaffe of Mississauga, Ontario, who returned the slides on 20 December 1993.

---

[173] Email from D/Cst. Martynuck, April 3, 2003, PFP059538.

[174] Email from Officer Ault, April 6, 2003, PFP059537; Fax from Officer Gioia, April 7, 2003, PFP059466; Fax from Officer Toni, April 15, 2003, PFP059516; Fax from Officer Carlucci, May 7, 2003, PFP059454.

[175] Letter from Mr. Lockyer to Mr. Porter, May 21, 2003, PFP059534.

> The microscopic slides were then sent to Dr. Rex Ferris of the Vancouver Hospital and Health Sciences at the request of Kingston, Ontario lawyer, Jennifer Reid.
>
> On the 22nd of June 1994, the microscopic slides and tissue blocks were sent to Dr. Charles R Smith of the Hospital for Sick Children, Toronto, at the request of Crown Attorney, Mr. Glen Wasyliniuk. Our records show that the microscopic slides and tissue blocks were not returned.
>
> On the 3rd of June 2003, I telephoned Dr, Charles Smith who indicated to me that he would look for the slides and blocks.[176]

111. On July 15, 2003, Mr. Wasyliniuk wrote to Mr. Downes, as follows:

> Enclosed is some of the material requested by AIDWYC.
>
> I am advised that the police notes enclosed are all the notes available. Sgt. Jane Martynuck of the Sault Police Service advises that she has checked with the officer's and police personnel named in the request and obtained all the notes in existence.
>
> The pathological evidence requested are the slides examined by Dr. Rasaiah and Smith for the prosecution. Please note Dr. Rasaiah's enclosed correspondence indicating that the slides and tissue blocks were sent to Dr. Charles Smith and not returned. The correspondence also indicates that Dr. Frederick Jaffe and Dr. Rex Ferris, who both testified for the defence, had received the slides earlier than Dr. Smith.
>
> I enclose my entire file. If there are further questions that I can be of assistance with please call.[177]

112. On October 14, 2003, Mr. Downes wrote to Dr. Rasaiah. He stated:

> I am Crown counsel responsible for responding to the request by defence counsel for the slides and blocks on [Valin].
>
> On June 4, 2003 you wrote to Staff Sgt. Carlucci of the Sault Ste. Marie Police Service indicating that you had asked Dr. Smith if he had that material. A copy of your letter is attached for your convenience. May I inquire as to whether you have you heard from Dr. Smith on this issue? If not, would you be kind enough to

[176] Letter from Dr. Rasaiah to S/Sgt. Carlucci, June 4, 2003, PFP003997.

[177] Letter from Mr. Wasyliniuk to Mr. Downes, July 15, 2003, PFP059533.

> either contact him again or provide me with contact information so I can do so myself.[178]

113. Dr. Rasaiah responded the next day. He wrote:

> Thank you for your faxed letter dated 14th October 2003.
>
> As I had indicated in my letter dated June 4, 2003, I had telephoned Dr. Charles Smith to return the tissue slides and blocks on [Valin] (Autopsy number A-93-51), but I did not receive any response.
>
> I called Dr. Charles Smith's office on the 14th of October at 10:00 a.m. and left a message with his secretary but Dr. Charles Smith did not return my call.
>
> [Dr. Rasaiah provided contact information for Dr. Smith.][179]

114. On October 31, 2003, Mr. Downes wrote to Dr. Smith. He stated:

> I understand that in June, 2003 Dr. Rasaiah contacted you about these slides. The Crown has been asked to provide them to defence counsel who are looking into Mr. Mullins-Johnson's conviction for the murder of [Valin].
>
> I would be very grateful if you could advise me of your knowledge as to the whereabouts of this material or could provide them to me so that they can be given to defence counsel.[180]

115. On December 29, 2003, Mr. Downes drafted a memorandum to file regarding a telephone call he had with Dr. Smith that day. The memo stated:

> Spoke by telephone to Dr. Smith @ 9:45 a.m. today.
>
> He had requested his assistant to search the archive for the material. Their first search had proved fruitless. He thinks the samples may not be there. He will take another look when his assistant returns next week.
>
> I asked Dr. Smith to let me know by way of letter what his final position was on the whereabouts of the material. He agreed to do so.[181]

---

[178] Letter from Mr. Downes to Dr. Rasaiah, October 14, 2003, PFP059529.

[179] Letter from Dr. Rasaiah to Mr. Downes, October 15, 2003, PFP059527.

[180] Letter from Mr. Downes to Dr. Smith, October 31, 2003, PFP059524.

116. On January 6, 2004, Mr. Bayliss, on behalf of AIDWYC, wrote to Mr. Downes. He stated:

> I write on behalf of Mr. Mullins-Johnson and the Association in Defence of The Wrongfully Convicted.
>
> As you know, this file sat for almost a year in your office with our letters unresponded before you took it over. You explained that the delay was due to the fact that Sean Porter, who had carriage of the file, was in Ireland and no one at your office attended to this file when he left. You were very apologetic when you contacted me and assured me that immediate action would be taken to provide the materials we were requesting. The required materials, detailed in out letter of February 27, 2003, included slides from the autopsy which we wish to send to another pathologist who is assisting AIDWYC in reviewing Mr. Mullins-Johnson's case.
>
> You have now had carriage of the file for almost a year. You have asked us to be patient and have undertaken to provide the materials to us without unnecessary delay. We have been patient but your undertaking has not been kept. Mr. Mullins-Johnson continues to reside in the penitentiary with little progress on AIDWYC's investigation of his case over the last two years. This delay has been due to the failure of your office to provide the materials we have requested.
>
> Please keep in mind that AIDWYC is investigating Mr. Mullins-Johnson's case because of the possibility that he was wrongly convicted of first degree murder of a child. It seems to me that this possibility should be sufficient to motivate you act expeditiously without letters and phone calls from me.
>
> Would you please advise me of the status of the missing materials at your earliest convenience.
>
> Thank-you for your anticipated cooperation.[182]

117. Mr. Downes replied on January 12, 2004. He wrote:

> Thank you for your letter of January 6, 2004.
>
> I understand your frustration over the delay in receiving the materials you have requested. When I had to be away from the office for personal reasons in the late fall I had hoped that I would have a favourable response from Dr. Smith to my repeated requests for the forensic material. He informed me on December 29, 2003 that he has been unable to located the slides. I have asked him to conduct

[181] Memorandum, December 29, 2003, PFP059523.

[182] Letter from Mr. Bayliss to Mr. Downes, January 6, 2004, PFP059521.

> a further search and he has agreed to do so and provide me with a written response to my requests. I will be in contact with him again this week if I have not heard from him.
>
> In the mean time, I enclose copies of the police notes I have received from the Sault Ste. Marie Police. A summary chart of your request and our response is attached.
>
> Where you asked for "any further notes" I cannot say at this time whether the notes I am providing now were or were not provided originally. I am simply providing you with the notes forwarded to me from the Sault police in response to your letter.
>
> I do appreciate the important efforts that AIDWYC is undertaking in reviewing Mr. Mullins-Johnson's conviction and I apologize for the delay so far. I should point out that while you suggest that there is correspondence relating to your request dating back some two years, the earliest request we have is February 27, 2003 to Mr. Porter. If you are aware of earlier letters please let me know so that we can complete our records.[183]

118. Mr. Downes also provided a chart listing the officers involved in the case and the status of the disclosure of their respective memo-book notes to AIDWYC.[184]

119. Mr. Bayliss wrote again to Mr. Downes on January 20, 2004. He stated:

> Thank you for your letter of January 12, 2004. You are in fact correct that our first correspondence to Mr. Porter was on February 27, 2003, so that the delay is eleven months not two years as I stated in my letter…
>
> …
>
> With respect to the microscopic slides which are required by our expert to assess the physical evidence that we have in furtherance of AIDWYC's investigation of this matter, it is disconcerting to hear that Dr. Smith has been "unable to locate" the slides. As you have indicated that you will be asking Dr. Smith to look for the slides again and provide written report with respect to his efforts, I wonder if you might also ask him if there are blocks of tissue from the autopsy from which new slides can be made if the originals have been lost.

[183] Letter from Mr. Downes to Mr. Bayliss, January 12, 2004, PFP059397.
[184] Letter from Mr. Downes to Mr. Bayliss, January 12, 2004, PFP059397.

> You have also included in a subsequent telephone call that you will have an officer investigate the whereabouts of the slides. I would also ask that you have this officer look into the availability of tissue blocks from which new slides can be taken.
>
> Given that we have been delayed for a year now waiting for these materials, we are hopeful that they can be provided in the near future.[185]

120. On January 28, 2004, Mr. Downes wrote to Dr. Smith, as follows:

> I understand from our recent telephone conversation that you have so far been unable to locate any of the microscopic slides examined by you in this case.
>
> I would greatly appreciate it if you could confirm, in writing, whether this continues to be the case and whether, if the slides are not available, you have any knowledge of whether the tissue block from the autopsy is nevertheless available from which new slides could be generated.
>
> I would appreciate hearing from you at your earliest convenience.[186]

121. That same day, Mr. Downes wrote to D/Sgt. Martynuck. He requested an update on several specific officers' notebooks. He then stated:

> Dr. Charles Smith has been unable to locate the microscopic material examined in the course of this ease. It is obviously of some concern to everyone if this material cannot be located. Consequently, I would like to have this issue investigated to determine what happened to the forensic material after the trial to try and determine, as quickly and as thoroughly as possible, where this material is. If the original slides are not available, can new slides be generated from tissue blocks from the autopsy?
>
> It is of some importance that we get to the bottom of this as quickly as possible. I would be grateful if you could let me know at your earliest possible convenience whether you are in a position to undertake this investigation.[187]

122. Mr. Downes also wrote to Mr. Bayliss on January 28, 2004. He stated:

> Thank you for your letter of January 20, 2004 (received January 26, 2004).

[185] Letter from Mr. Bayliss to Mr. Downes, January 20, 2004, PFP059395.

[186] Letter from Mr. Downes to Dr. Smith, January 28, 2004, PFP004000.

[187] Letter from Mr. Downes to D/Sgt. Martynuck, January 28, 2004, PFP059361.

> With respect to the notes, the table attached to my letter of January 12, 2004 provides the position of the Sault Ste. Marie Police in response to your request. My understanding is that where no notes have been provided, there were none made. I have, however, asked them to clarify or provide more information on those officers where it is indicated that notes are not available.
>
> With respect to the forensic material, I have written both to Dr. Smith and the investigating officer with a view to determining both the whereabouts of the original slides and the availability of the tissue block from which new slides might be generated. I have urged on them both the need for prompt attention to these requests and will advise you of any response.[188]

123. On January 30, 2004, (now) Sgt. Toni drafted a memorandum to S/Sgt. Carlucci, which stated:

> On the 29th of January 2004 you asked me to check with the hospital to see if any samples were available from the [Valin] homicide in 1993. On the 30th of January 2004 at 1130am I spoke with Jim Corelli who was the pathology assistant on the case. He advised me that three or four months ago Sgt. Martynuck had asked him the same question and they had researched their files. He had found items from every file around that case number, except that one. IE: if it was case number 110, they found 109 and 111, but not 110. They determined that they had sent everything to Dr. Charles Smith, including slides and block tissues. They had received a letter back from him acknowledging receipt of the items and still have this letter. They have never received any of the samples back. They keep these items for approximately 20 years, and also make records of when items are received back. There are no notations in this file that anything was received back. He advised me that Dr. Rasaiah was not working today, but he would ask him about it again on Monday.[189]

124. On February 2, 2004, Sgt. Toni drafted a second memorandum to S/Sgt. Carlucci. She wrote:

> Further to my report from the 29th of January 2004, I spoke to Dr. Rasaiah today about this case. He advises that there is not a letter in the file from Dr. Smith acknowledging receipt of the samples, but rather his letter to Dr. Smith when he sent the items, which includes an indication that he was sending them all (slides and blocks) on the advise of the Crown Attorney Glen Wasyliniuk. He was reluctant at the time, knowing that if he sent everything and they got lost, that he would lose everything. He advises they do regularly send slides and/or blocks of tissue to different doctors such as this. The common practice is that the

[188] Letter from Mr. Downes to Mr. Bayliss, January 28, 2004, PFP059388.

[189] Memorandum from Sgt. Toni to S/Sgt. Carlucci, January 30, 2004, PFP059381.

> reviewing pathologist prepares a report on his findings, sends a report to the Crown Attorney, or whoever requests the review, as well as a copy to the original pathologist (Dr. Rasaiah in this case). This is usually accompanied by a notation thanking them for loaning the items, and that they are being returned. When the items are received back at the lab, there is a notation made in the file, and the tissues are replaced in storage. These items were never returned, nor was he ever given a copy of Dr. Smith's report. He has no idea to this date as to what Dr. Smith concluded.
>
> Dr. Rasaiah advises that if the Crown Attorney reviewing this case wishes to call him, he would be happy to talk to him about it. [Emphasis in original.][190]

125. On February 4, 2004, Sgt. Toni drafted another memorandum to S/Sgt. Carlucci. It stated:

> On the 04th of February 2004, Louise O'Neill from Superior Court advised me that she had recalled the file of William Mullins-Johnson and there are no document exhibits with the courts.
>
> Also, I reviewed the two boxes of document evidence and two boxes of physical evidence and did not find any of the items such as a report from Dr. Smith or any biological samples.[191]

126. On February 27, 2004, Mr. Downes wrote to Mr. Bayliss, as follows:

> Please find enclosed some follow-up material. I trust that the covering letter to me from S/Sgt. Carlucci is self-explanatory.
>
> I have also enclosed a copy of my letter to Dr. Smith dated January 28, 2004. I have not received a reply. It appears from S/Sgt. Carlucci's letter and the attached documents that Dr. Smith is best placed to provide information about the whereabouts of this material. I am considering what other options are available to us to obtain the material or further information about it from Dr. Smith and will keep you advised.[192]

127. On March 16, 2004, Mr. Downes again wrote to Dr. Smith, as follows:

> Please find enclosed a copy of my letter to you of January 28, 2004.

[190] Memorandum from Sgt. Toni to S/Sgt. Carlucci, February 2, 2004, PFP059382.
[191] Memorandum from Sgt. Toni to S/Sgt. Carlucci, February 4, 2004, PFP059383.
[192] Letter from Mr. Downes to Mr. Bayliss, February 27, 2004, PFP059354.

I would be very grateful if I could receive a reply at your earliest convenience.[193]

128. On April 7, 2004, Mr. Downes sent an email to D/Sgt. Martynuck. It stated:

> Would you be able to look into my request below. You might pass on this email to Staff Sgt. Romani Carlucci who was kind enough to undertake some follow-up work on the Mullins-Johnson request and provided further material which was greatly appreciated.
>
> There is one further area in which I would appreciate some assistance and which I feel, given the situation involving the whereabouts of the forensic material, requires that this be done by the police and not by Crown counsel.
>
> We have so far been unsuccessful in locating the forensic material that seems to have last been in the custody of Dr. Charles Smith in Toronto. I have written and spoken to him repeatedly and have given consideration to what means are available to compel information or material from him. I think at thus stage, however, it would be prudent to contact the coroner's office, either locally or the chief Coroner's office in Toronto and see if they can shed any light on this issue. The autopsy was conducted at the Sault Ste Marie General Hospital and is number A-93-51. Specimens were apparently also sent to the Northern Regional Forensic Laboratory under reference number OFN 184455-2, Lab File No. 3167-93.
>
> We are looking for the slides taken from the original tissue block or the block itself from which new slides might be taken.[194]

129. On April 8, 2004, D/Sgt. Martynuck forwarded the email to S/Sgt. Carlucci.[195]

130. On April 13, 2004, Mr. Downes wrote to Mr. Bayliss. He stated:

> On March 16, 2004 I sent Dr. Smith a registered letter asking for a response to my earlier letter requesting his written response to my questions about the possible whereabouts of the forensic material in this case. I have not heard back from him. I have asked the police to conduct inquiries with the office of the Coroner in the event that they might be of any assistance.
>
> If you see fit to pursue any particular procedure or course of action I would be pleased to co-operate.[196]

---

[193] Letter from Mr. Downes to Dr. Smith, March 16, 2004, PFP059349.

[194] Email from Mr. Downes to Officer Martynuck, April 7, 2004, PFP110452.

[195] Email from Officer Martynuck to S/Sgt. Carlucci, April 8, 2004, PFP110452.

131. Mr. Bayliss replied on November 15, 2004. He wrote:

> I enclose a copy of your letter to us dated April 13, 2004. With respect to this letter could you please advise:
>
> -Has Dr. Smith responded to your registered letter dated March 16, 2004;
>
> -Has the coroner's office been of any assistance in locating the slides or tissue;
>
> -Has there been any other development of significance since April, 2004.
>
> Obviously, our office and AIDWYC, which is investigating this case, are concerned that Dr. Smith's negligence appears to have brought any investigation of this aspect of the case to a standstill.
>
> Could you please contact me at your earliest convenience to discuss the matter.
>
> Thank you for your anticipated co-operation.[197]

132. On November 17, 2004, Mr. Downes wrote to Dr. Barry McLellan, Chief Coroner. He stated:

> We have received a request from Mr. James Lockyer and Mr. David Bayliss in relation to the above individual. They are conducting a preliminary investigation on behalf of the Association Defence of the Wrongly Convicted (AIDWYC) into the conviction of Mr. Mullins-Johnson.
>
> On September 21, 1994 William Mullins-Johnson was found guilty of the first degree murder of his 4 year old niece, [Valin]. On December 19th, 1996, the Court of Appeal dismissed the appeal against conviction, and on May 26th, 1998, the Supreme Court of Canada dismissed his further appeal.
>
> The Sault Ste. Marie Police investigated this case and have provided assistance over the last eighteen months or so in locating material requested by Mr. Lockyer and Mr. Bayliss.
>
> AIDWYC has enlisted the help of Dr. Bernard Knight to assess the pathological evidence in the case. As a result, we have been asked if Dr. Knight could view

[196] Letter from Mr. Downes to Mr. Bayliss, April 13, 2004, PFP059346.

[197] Letter from Mr. Bayliss to Mr. Downes, November 15, 2004, PFP059345.

> the original slides examined by Dr. Rasaiah and Dr. Charles Smith in this case or, if the originals are not available, "re-cuts from the same paraffin blocks".
>
> I understand that the autopsy was conducted at the Sault Ste. Marie General Hospital and specimens in the case were submitted to the Northern Regional Forensic Laboratory under reference number O.F.N.184433-2, Lab File No, 3167-93.
>
> I and Sgt. Romano Carlucci of the Sault Police have made requests to various parties, including the Regional Coroner, Dr. Legge, Dr. Smith, and Dr. Rasaiah but have been unable to locate any of the forensic material. Dr. Legge suggested that we seek your assistance in determining the whereabouts of this material from Dr. Smith. I would be grateful if you could provide any assistance you can at your earliest convenience.[198]

133. On November 24, 2004, a post-it note was written and attached to the June 22, 1994, letter from Dr. Rasaiah to Dr. Smith, in which Dr. Rasaiah indicated he was sending the [Valin] slides and blocks to Dr. Smith, at the request of Mr. Wasyliniuk, for Dr. Smith's expert opinion. The post-it note read:

> DZ spoke to Dr. Rasaiah
>
> -once materials were sent, no response from CRS
>
> -no report was issued to Dr. Rasaiah
>
> -he was not allowed to hear CRS' testimony so does not know what was said[199]

134. That same day, James Corelli sent a fax cover page to Sgt. Toni, which stated, "[H]ere is copy of our cover letter to as to when we sent slides and blocks. [A]pparently if needed we have a letter stating he did receive-however I believe [illegible] may have a copy of ltrs as well."[200]

135. On November 26, 2004, Dr. Cairns and Dorothy Zwolakowski met with Dr. Smith to discuss the missing slides. On November 29, 2004, 20 slides were located in Dr. Smith's office.

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[198] Letter from Mr. Downes to Dr. McLellan, November 17, 2004, PFP003995.
[199] Post-it note, November 24, 2004, PFP003935.
[200] Fax cover page, November 24, 2004, PFP110453.

The OCCO took possession of the slides on November 30, 2004, at which time the Crown was notified.[201]

136. On December 1, 2004, Mr. Downes sent a fax to Mr. Bayliss, which stated, "I would like to update you on the status of my inquiries but I have been unable to reach you by telephone. Please give me a call so that we can talk."[202]

137. On December 10, 2004, Mr. Downes wrote to Mr. Bayliss to advise him that the slides had been found:

> I am writing to tell you that Dr. McLellan's office has been successful in locating some of the original autopsy slides from Mr. Mullins-Johnson's trial. It appears, however, that there are still some slides outstanding, which may be relevant for your purposes.
>
> Dr. McLellan's office is in the process of reviewing the slides and searching for the remaining ones. They will also be taking steps to ensure that a proper record of the slides is created prior to releasing them to you. I understand that they hope to be in a position to have them sent to you in early January. I will advise you as soon as possible.[203]

138. On December 14, 2004, Mr. Wasyliniuk sent the complete set of photographs taken by the Sault Ste. Marie Police Service to Mr. Downes.[204]

139. On January 10, 2005, Mr. Bayliss wrote again to Mr. Downes. He stated, "Can you please advise with respect to the availability of the slides and/or tissue blocks now that you have met with the coroner?"[205]

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[201] Case contact log, undated, PFP003662.
[202] Fax cover page, December 1, 2004, PFP059337.
[203] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 112.
[204] Letter from Mr. Wasyliniuk to Mr. Downes, December 14, 2004, PFP003962.
[205] Letter from Mr. Bayliss to Mr. Downes, January 10, 2005, PFP059327.

C. The January 19, 2005 Report of Dr. Michael Pollanen

140. On December 7, 2004, Dr. Barry McLellan, the Chief Coroner for the Province of Ontario contacted Dr. Michael Pollanen. At that time, Dr. Pollanen was provided with 20 microscopic slides prepared by Dr. Rasaiah from the post mortem. He subsequently was also provided with the autopsy photographs. On the basis of those materials, as well as the autopsy report of Dr. Rasaiah and the consultation report of Dr. Ferris, Dr. Pollanen was asked to address the following questions:

(a) Is there evidence of acute penetrating anal trauma?

(b) Is the cause of death mechanical asphyxia?

(c) What is the time of death?[206]

141. On January 19, 2005, Dr. Pollanen issued his report. With respect to the first question, whether there is evidence of acute penetrating anal trauma, Dr. Pollanen wrote:

> The central issue in this case, in my view, is that there is no evidence of acute anogenital injury and that this diagnosis was mistakenly advanced at trial. In addition, the diagnosis rests on a shaky foundation that does not stand up to scrutiny by review.
>
> ...
>
> My review of the post-mortem photographs does not disclose evidence of acute anal trauma. Furthermore, the study of McCann et al is informative, reconciling observations of Drs. R, M and S. The post-mortem appearance of the anus in children is notoriously difficult to interpret. Most of the pitfalls involve overinterpretation of post-mortem changes and normal anatomical structures.
>
> ...
>
> As is discussed in detail below, Dr. S's diagnosis of sodomy is based on his histologic observation of a laceration in the anorectal tissues.
>
> ...

[206] Report of Dr. Michael Pollanen, January 19, 2005, PFP004202, pp. 2-6.

> My review of the relevant histologic slides is described in table below. There is no histopathologic evidence of injury to the anus, anorectal junction, or vagina in the microscopic slides available for my examination. The observations of "ulceration", "laceration," and "hemorrhage" made by other pathologists are, in my view, attributable to autolysis or artefacts related to dissection or tissue preparation for microscopy. Similarly, the observations of "fibrosis", "capillary proliferation" and "chronic inflammation" are normal histology or minimal deviation from normal histology that have no forensic importance.
>
> ...
>
> In conclusion, based on the reviewable evidence available to me I find no evidence of acute penetrating anal trauma in [Valin]. I find no evidence of old trauma, but this cannot be excluded, since anal mucosal trauma may heal without apparent residual lesions such as scarring.[207]

142. With respect to the cause of death, Dr. Pollanen stated:

> Much of what Dr. R. describes as trauma in his autopsy report are post-mortem artefacts related to lividity. These lividity artefacts range from petechial hemorrhages and Tardieu spots to larger pools of hypostatic hemorrhage in the subcutaneous fat and dermal-subcutis interface. This is from prone positioning of the body and the development of intense rigor mortis (gravitational pooling of the blood after death). This phenomenon is well known and is described in standard textbooks. It is commonly observed in forensic autopsies, but can be quite alarming to those who have not become acquainted with it. It is most problematic in the ventral neck and scalp, where it simulates the hemorrhagic lesions of strangulation and subcalpular bruising, respectively.
>
> In my view, Dr. R and Dr. S have misinterpreted many of the Tardieu spots and larger hypostatic hemorrhages as bruising. This misinterpretation has had the effect of overemphasizing the forensic importance of these findings i.e. artefacts have become evidence of injury.
>
> ...
>
> Mechanical asphyxia by external compression of the nose and mouth, or chest compression cannot be excluded as a cause of death. However, the main support for this conclusion seems to be an essentially negative autopsy i.e. the differential diagnosis includes asphyxia not because there are positive findings that allow one to make that conclusion, but rather because the possibility cannot be negated.

[207] Report of Dr. Michael Pollanen, January 19, 2005, PFP004202, pp. 7-15.

...

In my view, given the essentially negative autopsy, it is reasonable to consider mechanical asphyxia, as a cause of death. On the basis of the same line of reasoning, it is also prudent to consider natural causes...

...

Therefore the essentially negative autopsy supports death by mechanical asphyxia or an undiscovered natural cause. If the pathologist offers a conclusion of mechanical asphyxia, then it is largely based on circumstantial evidence and the belief that most of the expected natural causes of death have been excluded by the post-mortem (i.e. diagnosis by exclusion). The circumstantial evidence might include consideration of situational factors and background information that are, in my view, outside of the proper consideration of the pathologist. Interpretation of situational factors, in my view, are more properly interpreted by the trier of fact than the pathologist.

...

In conclusion, based on the reviewable evidence available to me, I give as a cause of death *unascertained* which means that both natural and un-natural causes of death are objectively possible. In general, the pathologist's decision on the cause of death can be powerful evidence in a trial. If the determination of the cause of death falls short of reasonable certainty, then the court benefits from an unambiguous explanation of the uncertainty. This is not tantamount to an expression of ignorance, but it is in accordance with the importance the courts place on the independent and objective evidence of a pathologist in criminal proceedings. [Emphasis in original.][208]

143. With respect to the time of death, Dr. Pollanen stated:

Like the other issues in this case, determination of the time of death is a recurrent challenge in forensic pathology...

...

Suffice it to say that the prevailing view now is that the determination of the time of death by the pathologist is seldom useful as strong evidence in criminal proceedings for three main reasons:

-The non-predictability of the rate of post-mortem changes

[208] Report of Dr. Michael Pollanen, January 19, 2005, PFP004202, pp. 15-20.

> -The lack of reproducible standards that allow correspondence between a postmortem interval and a postmortem change
>
> -The wide variation in opinions among similarly qualified and reasonable pathologists even when confronted with the same facts in a case
>
> Thus, the pathologist's determination of the time of death is usually subjective and little weight should be placed on it. Any significant reliance on postmortem observations and temperature-based methods of determining time of death, particularly if it is used to narrow a 'window of opportunity' for the commission of a crime, is fraught with hazard.
>
> ...
>
> In summary, the prevailing view now is that the determination of the time of death by pathologic evidence must be treated with the utmost caution.[209]

144. Dr. Pollanen concluded by stating:

(a) I disagree with the medical argument that was used at the trial to conclude that [Valin] was sodomized.

(b) Hypostatic artefacts have been over interpreted as bruises and petechial hemorrhages.

(c) The cause of death has not been ascertained by the postmortem examination.

(d) If the cause of death is mechanical asphyxia, then the major support of that determination is an essentially negative autopsy, rather than positive anatomical evidence.

(e) The medical argument that was used at the trial to conclude that [Valin] died between 8:00 and 10:00 p.m. on Saturday, June 26, 1993 must be interpreted with the utmost caution.

(f) Based on the materials that have been made available there is little that can now, retrospectively, be done to clarify some of the outstanding issues (i.e., it is my

[209] Report of Dr. Michael Pollanen, January 19, 2005, PFP004202, pp. 20-21.

> understanding that post-mortem blood samples, formalin-fixed tissues and the wax blocks are no longer available). Theoretically, the tissue on the existing microscope slides is a DNA source for [Valin].[210]

145. On January 24, 2005, Dr. McLellan left Mr. Downes a voicemail message advising that Dr. Pollanen had completed his report. The message was subsequently passed on to Mr. Ken Campbell, Deputy Director, Crown Law Office Criminal.[211]

146. On February 3, 2005, Mr. Bayliss left a message for Mr. Downes, which stated:

> Ms. Vanderlaan, my name is David Bayliss. I'm counsel for someone named, William, his first name, and Mullins-Johnson is the last name. Phil Downes is working on it. It's an AIDWYC potential wrongful conviction case.
>
> We are trying to locate slides that Dr. Smith apparently lost.
>
> Phil was having a meeting with the Coroner who had found something that might be what we are looking for. I think that took place just prior to Christmas. And I have sent Phil a letter and sent him a voice-mail today asking him what came of that and whether the slides and/or tissue blocks are now available.
>
> And I'm now just leaving this message with you to make sure that Phil gets it because I know he is involved in a long trial. So if he's not checking his messages, hopefully, you will call him.
>
> My number is: 416-788-5250.
>
> Again, we are, you know, very anxious to find out the result of Phil's meeting.[212]

147. The message was passed along to Mr. Campbell.[213]

148. On February 4, 2005, Mr. Bayliss wrote to Mr. Campbell. He wrote:

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[210] Report of Dr. Pollanen, January 10, 2005, PFP004202, p. 22.
[211] Transcript of voicemail message, January 24, 2005, PFP059326.
[212] Transcript of voicemail message, February 3, 2005, PFP059325.
[213] Transcript of voicemail message, February 3, 2005, PFP059325.

> I understand this file has now been assigned to you as a result of Mr. Downes involvement in [another matter].
>
> As you will see from the correspondence history of the file, we have been attempting for some time to obtain possession of the slides from the autopsy of [Valin], for examination by an expert. These were apparently "misplaced" by doctor Charles Smith who last had them, according to police information.
>
> As a result of our attempts and media interest in this situation, some slides in relation to the matter were obtained by the chief coroner, Dr. McLellan. Mr. Downes wrote to me on December tenth, 2004, advising of this information. The letter also stated that the slides that were available would be provided to us sometime in early January. Mr. Downs undertook to advise me as soon as the slides were indeed available.
>
> It is now February 4. By letter dated January 10, 2005, I wrote to Mr. Downes requesting information arising out of his meeting with the coroner. As a result of a voice mail message left on February 3, I was advised that you are now assigned to the file. It is unfortunate that Mr. Downes, who I understand actually met with Dr. McClellan, could not have advised me of the results of that meeting.
>
> Be that as it may, could you please advise at your earliest convenience what, if any, slides or tissue blocks are now available.[214]

149. On February 8, 2005, Mr. Campbell left a message for Dr. McLellan asking that he call him about the Mullins-Johnson case.[215]

150. On February 11, 2005, Mr. Campbell wrote to Mr. Wasyliniuk. He stated:

> I met with Dr. James Cairns, the Deputy Chief Coroner of Ontario, this morning. He provided me with a ***Report*** that has been prepared by Dr. Michael Sven Pollanen in connection with this case. He also briefed me about the contents of the ***Report***. I have enclosed a copy of that ***Report*** for your consideration.
>
> I have also enclosed, for your assistance, a thick, red-bound, tabbed volume of materials that, I think, contains a copy of ***all*** of the expert evidence that was adduced by the parties at the trial of this matter (i.e. all of the Reports, CV's and Transcripts of *viva voce* evidence). Hopefully, this volume of materials will help you in recalling this case, and in understanding and assessing the potential significance of the new ***Report*** by Dr. Pollanen.

[214] Letter from Mr. Bayliss to Mr. Campbell, February 4, 2005, PFP059324.
[215] Action Memo, February 8, 2005, PFP003955.

> Further, for your information, after my meeting with Dr. Cairns this morning, I quickly briefed Paul Lindsay, the Acting Assistant Deputy Attorney General of the Criminal Law Division, and Carol Brewer, the Acting Director of the Crown Law Office - Criminal, and provided them both with a copy of this new ***Report***. Given the potential significance of this new ***Report*** on this case, I thought that they needed to be advised of this information as soon as it was available.
>
> I anticipate that very early next week I will provide defence counsel in this case with a copy of this ***Report***, and advise them that the Crown has no objection to the defence obtaining the original tissue slides from the Coroner's Office in the event that they still want to have their own expert examine this case. While the defence will, no doubt, be pleased with the content of the new ***Report***, my guess is that they will still want to have their own expert conduct another examination of the available slides.
>
> I trust that, for the time being at least, this is satisfactory. If it is at all possible, I would like to discuss this case (and the significance of this new ***Report***) further with you early next week, in order to best assess our next steps in this case. [Emphasis in original.][216]

151. On February 14, 2005, Dr. McLellan wrote to Michal Fairburn of the Crown Law Office Criminal, who had been assigned to the file. He stated:

> I enclose a copy of my letter of February 14, 2006, sent to Dr. Butt and Professors Milroy and Crane, with respect to the review of materials arising from the autopsy performed on [Valin]. I also enclose, for your information, the Revised Inventory List of Attachments.
>
> Thank you for meeting with me on January 27, 2006 to discuss the appropriate materials to be included for this review. I will forward a copy of the reports arising from this review to your and Mr. Lockyer's attention when received.[217]

152. A duplicate letter was sent to Mr. Lockyer that same day.[218]

153. On February 16, 2005, Mr. Campbell wrote to Mr. Bayliss and enclosed a copy of Dr. Pollanen's report. His letter stated:

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[216] Letter from Mr. Campbell to Mr. Wasyliniuk, February 11, 2005, PFP059322.
[217] Letter from Dr. McLellan to Michal Fairburn, February 14, 2005, PFP058614.
[218] Letter from Dr. McLellan to Mr. Lockyer, February 14, 2005, PFP116544.

> On Friday, February 11, 2005 I was provided with a ***Report*** prepared by Dr. Michael Sven Pollanen of the Office of the Chief Coroner in connection with this matter.
>
> It seems that your request for production of the microscopic slides in this case set in motion a series of events that led to something of a review being conducted by Dr. Pollanen of at least some of the available materials in this case, and the preparation of this ***Report***.
>
> Pursuant to my continuing obligation to make full and complete disclosure to the defence, I have enclosed, for your consideration, a copy of this ***Report*** by Dr. Pollanen.
>
> Please understand that you are being provided with this ***Report*** on the condition that it will be used only for the purposes of advancing the position of your client on an application to the federal Minister of Justice in proceedings launched pursuant to Part XXI.1 of the Criminal Code, and it will not be distributed or otherwise disseminated to the media or any members of the public. As summarized in the ***Martin Report***, these conditions are part of the normal, implied duties of defence counsel with respect to Crown disclosure materials. If you disagree, however, with my understanding of these duties, I would greatly appreciate it if you would please return the enclosed ***Report*** to me so that we can take steps to arrive at a common understanding as to your obligations in this regard. [Emphasis in original.][219]

154. On February 17, 2005, Dr. Pollanen sent a memorandum to Dr. Barry McLellan in which he provided a list of other forensic pathologists who might be appropriate for reviewing the death of Valin. He recommended:

> Professor Stephen Cordner- Australia
>
> Professor Jack Crane- Northern Ireland
>
> Dr. Peter Ellis- Australia
>
> Dr. Stephen Leadbeatter- United Kingdom
>
> Professor Christopher Milroy- United Kingdom

[219] Letter from Mr. Campbell to Mr. Bayliss, February 16, 2005, PFP059281.

Professor Derrick Pounder- United Kingdom[220]

155. He also noted that he would have recommended Professor Bernard Knight but for the fact that Dr. Knight may have already been retained by a party in the proceeding.[221]

156. On March 10, 2005, Mr. Bayliss replied to Mr. Campbell's letter of February 16, 2005. He wrote:

> Given the report of Dr. Pollanen, we feel that Mr. Mullins-Johnson is now in a position to bring an application under section 696 of the Criminal Code of Canada. I am in the process of providing an opinion to Legal Aid Ontario requesting a funding for this procedure.
>
> While I will, as you have requested in your covering letter, keep the report confidential at this point, I feel it is at least my duty to remind you of obligations the Crown has to other persons affected by the actions of Dr. Charles Smith. I know that two persons in particular, Mr. Kporwodu and Ms. Veno, have their appeals on reserve with the Ontario Court of Appeal. It seems to me that the report of Dr. Pollanen in Mr. Mullins-Johnson's case would be admissible as fresh evidence on that appeal. I ask you to consider your obligation to disclose the report to those defendants and any others whose lives have been and continue to be affected by of Dr. Smith's opinions.[222]

157. On March 17, 2005, Mr. Campbell received a letter from Ms. Marlys Edwardh, counsel for Anthony Kporwodu. She was seeking, for the purposes of the Kporwodu appeal at the Court of Appeal for Ontario, a copy of Dr. Pollanen's report in the Mullins-Johnson case.[223]

158. Mr. Campbell responded to Ms. Edwardh the following day. He wrote:

> I am sorry that I missed your call yesterday afternoon. However, I did receive your letter in connection with the above-noted matter which, I take it, outlines the nature of your inquiry in writing. Permit me to respond.
>
> As you know, I am not Crown counsel assigned to this case. Crown counsel on this appeal are, of course, Michal Fairburn and Jennifer Woollcombe. They are the counsel from this Office who prepared and argued the appeal on behalf of the

[220] Internal Memorandum from Dr. Pollanen to Dr. McLellan, February 17, 2005, PFP003957.
[221] Internal Memorandum from Dr. Pollanen to Dr. McLellan, February 17, 2005, PFP003957.
[222] Letter from Mr. Bayliss to Mr. Campbell, March 10, 2005, PFP085003.
[223] Letter from Ms. Edwardh to Mr. Campbell, March 17, 2005, PFP059279.

Crown in this case. Indeed, I know only very little of the factual circumstances of this case, or the legal issues it raises. Accordingly, I am, as I am sure you can appreciate, extremely reluctant to interfere in it, especially given that Ms. Fairburn is currently away from the office (and out of the country) on vacation, and is unavailable for consultation.

But perhaps I may be of some assistance to you, pending Ms, Fairburn's return, by providing you with some details with respect to the *R. v. Mullins-Johnson* matter. You are quite right that Dr. Pollanen has, quite recently, prepared a *Report* in connection with the *R. v. Mullins-Johnson* case. It is entitled "*Report and Opinion on the Death of [Valin]*" and it is dated January 19, 2005. [Valin] is, of course the name of the young child who Mr. Mullins-Johnson stands convicted of murdering.

As its title would suggest, this *Report* by Dr. Pollanen is not, at least as I understand it, a "review of the post-mortem examination of Dr. Charles Smith" in this case (as your letter suggests). Indeed, I understand that it was Dr. Bob Rasihah who performed the autopsy on the deceased in this case. Rather it is a *Report* in which Dr. Pollanen offers his own views and opinions on a number of the important forensic pathology issues in this case (based primarily on a review of the microscopic slides from the post-mortem examination), and comments upon the nature of the evidence of all of the expert evidence that was adduced by both parties (Crown and Defence) at trial. While it would certainly be fair to observe that, in this *Report*, Dr. Pollanen disagrees with important aspects of the expert opinion of Dr. Charles Smith, it would be equally fair to observe that Dr. Pollanen also expressed views that differed in material respects with key aspects of the other expert opinion evidence in this case.

Having said that, I feel obliged to also tell you that, even with respect to the *R. v. Mullins-Johnson* case, I am presently at something of a disadvantage. This was an appeal that I had no involvement in, and which was argued, both in the Court of Appeal and the Supreme Court of Canada, by Mr. Scott Hutchison of our office. I have only relatively recently taken over the matter in anticipation of an eventual application by the accused under s. 696.1 of the Criminal Code to the federal Minister of Justice. I have not yet had an opportunity to familiarize myself with the trial evidence in the case, or the details of the expert evidence that was adduced on the forensic pathology issues in the case. It was only very shortly after taking over carriage of the case, that I received the *Report* by Dr. Pollanen and quickly disclosed it to Mr. David Bayliss who, I am sure you are aware, is counsel for the accused in *R. v. Mullins-Johnson*.

I should also tell you that I received some advance notice of your disclosure request, and have been contemplating my disclosure obligations in this regard. More specifically, on the afternoon of March 11, 2005 I received a letter from Mr. Bayliss suggesting that I might have a disclosure obligation to provide copies of the Report by Dr. Pollanen to "other persons affected by the actions of Dr. Charles Smith", and specifically suggesting that this *Report* might be "admissible

as fresh evidence" in connection with the appeal in *R. v. Kporwodu and Veno*. I take it that you and Mr. Bayliss have been speaking.

Early this week I spoke to Ms. Woollcombe in an effort to understand how this *Report* by Dr. Pollanen in *R. v. Mullins-Johnson* might be relevant to the issues in *R. v. Kporwodu and Veno*. I must confess that its relevance was not immediately apparent to me. While I profess no detailed knowledge of the circumstances of the *R. v. Kporwodu and Veno* case, I thought that the Crown appeal related to whether the trial Judge had erred in staying the proceedings as a result of a perceived violation of s. 11(b) of the Charter of Rights. Unfortunately, my conversation with Ms. Woolcombe did not greatly assist me in understanding the potential relevance of the *Report* of Dr. Pollanen. I say this meaning no disrespect to Ms. Woollcombe. It is just that, notwithstanding her involvement in the R. v. *Kporwodu and Veno* appeal, she also had considerable difficulty understanding how this *Report* by Dr. Pollanen might be relevant to your case. However, she did mention that it was Ms. Fairburn who argued the points that seemed to relate most closely to Dr. Smith.

Accordingly, even after my discussion with Ms. Woollcombe I failed to understand the relevance of the *Report* by Dr. Pollanen to your case. While Dr. Smith was clearly an expert witness who was involved in both *R. v. Kporwodu and Veno* and *R. v. Mullins-Johnson*, I remain quite unclear as to how the mere existence of a subsequent expert opinion (that of Dr. Pollanen), which conflicts with the expert opinion expressed at trial by Dr. Smith (amongst others) in *R. v. Mullins-Johnson* is relevant to your appeal, let alone admissible as "fresh evidence".

Nevertheless, after speaking with Ms. Woolcombe, I resolved to speak to Ms. Fairburn about the matter upon her return to the office from her vacation next week before reaching any final conclusion about my disclosure obligations. Having now received your letter dated March 17, 2005 requesting disclosure of the *Report* by Dr. Pollanen (and understanding the urgency of your request), I will certainly speak to Ms. Fairburn at the first available opportunity. You will then be contacted as soon as a final decision has been reached with respect to whether or not the *Report* of Dr. Pollanen will be forthcoming to you by way of disclosure.

In the meantime, however, I would greatly appreciate it if you would kindly try to articulate precisely the relevance of the *Report* of Dr. Pollanen in your outstanding appeal. That is the issue that I am presently labouring with, and will need to speak to Ms. Fairburn about. In your letter yesterday you say that, on your appeal, "the competence of Dr. Smith is very much in issue" and that this is tied to the appropriateness of the stay of proceedings imposed by the trial Judge. If it is any assistance to you, I can tell you now that the *Report* by Dr. Pollanen, while certainly offering an opinion that differs in important aspects from much of the expert opinion evidence adduced at trial (including that of Dr. Smith), the *Report* does not, at least as I read it, directly challenge the competence of Dr. Smith.

> I trust that, for the time being at least, this is satisfactory. I hope that you understand that, at this point in time, knowing so little about the issues in *R. v. Kporwodu and Veno*, and not that much more about *R. v. Mullins-Johnson*, I am simply not in a position to immediately disclose the *Report* by Dr. Pollanen to you, especially in the absence of Ms. Fairburn. I think that her perspective on this issue is absolutely vital to a fair and proper resolution of this disclosure issue. Given that she will be available sometime next week, I hope that you will be content to wait until then for a final answer to your disclosure request. [Emphasis in original.][224]

159. On March 24, 2005, Ms. Edwardh wrote to Ms. Fairburn and again requested a copy of Dr. Pollanen's report.[225] On March 30, 2005, Ms. Fairburn responded to Ms. Edwardh. She wrote:

> I have carefully considered your disclosure request made in correspondence dated March 24, 2005. As it was received late in the afternoon on the day before a four day weekend, I was unable to follow up until everyone returned to work on March 29, 2005. Please consider this my response.
>
> I have discussed this request with Kenneth Campbell (Senior Crown counsel with current carriage of the *Mullins-Johnson* matter), Scott Hutchison (Crown counsel on the *Mullins-Johnson* appeal in the Court of Appeal and Supreme Court of Canada), Glen Wasyliniuk (the trial Crown), Philip Downes (Crown counsel on the appeals and Crown counsel responding to disclosure requests until January 2005), and Dr. James Cairns of the Office of the Chief Coroner. Jennifer Woollcombe and I have also reviewed the *Mullins-Johnson* appeal file. I have also reviewed Dr. Michael Pollanen's report dated January 19, 2005. Notwithstanding your careful and detailed letter, I am of the view that the report and related information you have requested are irrelevant to the *Kporwodu and Veno* appeal. To the extent that the other information you have requested, like when the "controversy" in the *Mullins-Johnson* case arose and when the Crown became aware of the "controversy", assists in demonstrating why the Dr. Pollanen report is not relevant to the appeal, I have decided to disclose it in this letter. I will not be disclosing the report.
>
> While I agree with most of the factual assertions in your letter, I cannot agree with a few critical facts. The suggestion that during the course of the trial John McMahon instructed Rita Zaied to "... obtain and disclose to the defence files in the possession of the Crown Attorney's office wherein Dr. Smith had prepared post-mortem reports and/or offered opinions related to cause of death" is not an accurate characterization of the evidence. You have the copy of the e-mail that Mr. McMahon sent out to the Crown Attorney's system dated November 26,

[224] Letter from Mr. Campbell to Ms. Edwardh, March 18, 2005, PFP059270.

[225] Letter from Ms. Edwardh to Ms. Fairburn, March 24, 2005, PFP059263.

2002. For your ease of reference, it is contained at Volume 11, Tab "M1" of the Appeal Book. In that e-mail, Mr. McMahon focused on "... information relevant to the ***competence or credibility*** of Dr. Charles Smith". You indicate that the defence did not receive information regarding the *Mullins-Johnson* case. This was because the Crown did not have concerns about the competence or credibility of Dr. Smith in the case. I have taken the liberty of speaking with both Glen Wasyliniuk who prosecuted Mr. Mullins-Johnson and Scott Hutchison who appeared for the Attorney General during both appeals. Neither Crown counsel had any concerns, at all, about the competence or credibility of Dr. Smith in the *Muffins-Johnson* prosecution or on appeal.

You also suggest that I argued that the defence did not "need" the OCCO files that related to the cases on the 17 case-list chart because, with the "chart", there was sufficient evidence to attack the reliability and credibility of Dr. Smith at trial. My argument was not that the chart could be used to attack credibility and reliability, but, rather, that the chart gave an opportunity to focus the disclosure/production request. My position was also that the material contained in the OCCO files of each of the cases reflected on the chart was irrelevant to the trial issues in *Kporwodu and Veno*. Finally, it was my position that, at a minimum, the Crown position at trial, as it related to the content of the underlying files, was arguable. The *Mullins-Johnson* case is not reflected on the chart because it was not reviewed, at all, until very recently. As you know, Dr. Pollanen's report is dated January 19, 2005.

You also indicate in your letter that you understand that "... the controversy surrounding this case came to light in 2001 and has been under investigation ever since." Allow me to convey the information I have learned regarding how and when the "controversy" in the *Mullins-Johnson* case came to light. As indicated above, while I feel under no obligation to disclose this information (for lack of relevance to the *Kporwodu and Veno* appeal) I believe it will assist you in concluding that the Dr. Pollanen report of January 19, 2005 has no relevance to the appeal. For this reason I am prepared to disclose the following information.

As indicated above, neither Mr. Wasyliniuk nor Mr. Hutchison had any concerns, at any time, regarding the opinion expressed by Dr. Smith in the *Mullins-Johnson* case. As indicated in Mr. Campbell's March 18, 2005 letter to you and supported by the material filed in the *Mullins-Johnson* appeal (facta, appeal books and transcript), Dr. Smith was one of many experts in the case. While Dr. Smith's opinion was challenged in some respects at trial, it was not challenged on the basis of competence or malice, but, rather, in the classic way: Crown expert says X and defence expert says Y.

I have learned from Dr. James Cairns that a letter was sent by Michael Lomer to the Office of the Chief Coroner on April 3, 2001. Mr. Lomer had been counsel to Mr. Mullins-Johnson at both the Court of Appeal for Ontario and the Supreme Court of Canada. (The Supreme Court of Canada dismissed his appeal on May 26, 1998.) I have reviewed this correspondence. Mr. Lomer specifically indicates

that he is writing as a "private citizen", as he was not retained by Mr. Mullins-Johnson and had no instructions to write *on his behalf. This letter questioned whether Dr. Smith's work in the Mullins*-Johnson case should be reviewed. Dr. Cairns satisfied himself that Dr. Smith did not conduct the autopsy. We understand from Dr. Cairns that based on his understanding of Dr. Smith's role in the case and given the content of Mr. Lomer's letter, no action was taken by the Office of the Chief Coroner.

While there may have been a "controversy" about Dr. Smith's testimony in the *Mullins-Johnson* case in 2001, as you suggest in your letter, as I understand it from Dr. Calms and Crown counsel with carriage of the prosecution and appeals, that "controversy" was not shared with the Crown or, according to Dr. Cairns, the Office of the Chief Coroner. To the best of my knowledge, based on my discussions and a review of the *Mullins-Johnson* file in this office, there were no issues about Dr. Smith's evidence until fairly recently. I have not heard or seen anything in my many inquiries that would suggest that the case has been "under investigation" since 2001.

I note that by correspondence to Shawn Porter, Crown counsel in the Crown Law Office - Criminal, dated February 27, 2003, James Lockyer indicated that AIDWYC was involved in a preliminary investigation of the conviction of Mr. Mullins-Johnson. To this end, Dr. Bernard Knight had been enlisted to assess the pathological aspects of the case. A request was made for the original slides, or the re-cuts from the same paraffin blocks. Note that in the letter there is no concern expressed about the competence or credibility of Dr. Smith. There was also a request for a number of police officers' notes. Philip Downes, Crown counsel with the Crown Law Office - Criminal, took carriage of the *Mullins-Johnson* file and pursued fulfilling AIDWYC's request. David Bayliss eventually took the matter over for AIDWYC. Philip Downes took steps to locate the material originally requested by Mr. Lockyer. Mr. Downes had difficulty in locating the material. On November 17, 2004, Mr. Downes sent a letter to the Office of the Chief Coroner, Dr. Barry McLellan, asking for his assistance in locating the material requested.

On December 10, 2004, Mr. Downes wrote to Mr. Bayliss and informed him that Dr. McLellan's office had been successful in locating some of the original slides and were in the process of reviewing the slides and searching for the remaining ones. As you know, Dr. Pollanen, the Medical Director of the Toronto Forensic Pathology Unit in the Office of the Chief Coroner, authored his report in relation to the review on January 19, 2005.

I believe that this sets out an accurate chronology as it relates to what you characterize as the *Mullins-Johnson* "controversy". I can assure you that there is nothing in the report of Dr. Pollanen that, in any way, undermines the above-history of the case.

> I remain unable to determine any relevance to the *Kporwodu and Veno* appeal. The indictment in this matter is stayed. The credibility and competence of Dr. Charles Smith's findings in relation to another murder case, from 1994, is irrelevant to the appeal from a s. 11 (b) stay of proceedings. The review of Dr. Smith's (and other experts work) was triggered as a result of AIDWYC's request for the slides in the *Mullins-Johnson* matter. This request, made February 27, 2003, did not mention any concern regarding Dr. Smith's opinions in the case. The slides were not located until late 2004. I remind you that the indictment in the *Kporwodu and Veno* case was stayed on June 23, 2003. (It is also worthy of note that despite the fact that Dr. Pollanen's report is dated January 19, 2005, the Crown was not contacted by Dr. McLellan until January 24, 2005. While a message was left that the report had been prepared, the Crown did not learn the contents of the report until, at the earliest, February 10, 2005 and Mr. Campbell did not come into possession of the report until February 11, 2005.)
>
> I hope that this information will shed some light on the evolution of the "controversy" in the *Mullins-Johnson* case. Having regard to this information, I am sure you will agree that it bears no relevance to the outstanding appeal.
>
> As a practical matter, I note that you wrote to Mr. John Kromkamp on March 18, 2005 and asked that he advise the Court of your disclosure request and the fact that a fresh evidence application may be brought or an application for some other form of relief. I know that you are keenly aware of the fact that this is a murder appeal from a stay of proceedings for unreasonable delay. The Crown is most anxious that the appeal not be placed in a holding pattern for long. In light of this fact, I expect that you will either communicate with Mr. Kromkamp and let him know that you are satisfied that the Crown has no disclosure obligation or that an application will be brought immediately. I look forward to hearing from you. [Emphasis in original.][226]

160. The commission has been advised by the Ministry of the Attorney-General that Ms. Edwardh did not pursue the matter after receiving Ms. Fairburn's letter.

161. On March 30, 2005, the Toronto Star published an article about Dr. Smith in which it indicated, *inter alia*, that he had lost tissue samples in the Mullins-Johnson case.[227]

162. On April 7, 2005, Dr. McLellan prepared a memorandum for Assistant Deputy Minister Glen Murray. It stated:

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[226] Letter from Ms. Fairburn to Ms. Edwardh, March 30, 2005, PFP059257.

[227] Article, Toronto Star, March 30, 2005, PFP084981, pp. 2-3.

On July 27, 1993, [Valin], a 4-year-old girl was found dead in her bed. A medical-legal autopsy was performed by Dr. Rasaiah from Sault Ste. Marie and he gave the cause of death as "cardiorespiratory arrest due to asphyxia".

Dr. Charles Smith, a consulting Crown pathologist, opined that there was evidence of perimortem sodomy. Dr. Smith was a pathologist at the Hospital for Sick Children and the Medical Director of the Paediatric Forensic Pathology Unit (at HSC) at the time.

On September 21, 1994, William Mullins-Johnson was found guilty of the first-degree murder of his 4-year-old niece ([Valin]).

On December 19, 1996, the Court of Appeal dismissed the appeal against conviction.

On May 26, 1998, the Supreme Court of Canada dismissed a further appeal.

The Association in Defence of the Wrongfully Convicted enlisted the help of another pathologist (Dr. Bernard Knight from England) to assess the pathologic evidence in this case. Dr. Knight requested access to the autopsy tissues in order to review the microscopic findings.

Dr. Barry McLellan, Chief Coroner, was contacted by Philip Downes (Crown counsel), on November 17, 2004 requesting assistance in locating the slides and paraffin blocks arising from this case. Up until this time, Mr. Downes had been unsuccessful in locating the slides and tissues through Dr. Smith.

In early December 2004, Dr. McLellan did locate the original slides at HSC (not all slides) but could not locate the tissue blocks. It appears that these tissue blocks (and the missing slides) went missing some time after being sent to Dr. Smith at the time he provided his consultation.

In order to ensure that the slides that would be of greatest value to a consultant pathologist (such as Dr. Knight) were available, Dr. McLellan requested the assistance of Dr. Michael Pollanen, Medical Director of the Toronto Forensic Pathology Unit, to catalogue the slides. Dr. Pollanen expressed concern on reviewing the slides that there was no evidence of anal trauma. A meeting was therefore arranged with Mr. Downes to provide this information as well as to recommend that Dr. Pollanen prepare a report detailing his findings.

Mr. Downes agreed that such a report should be prepared. Dr. Pollanen authored his report in relation to the review on January 19, 2005. Dr. Pollanen disagreed with the medical argument that was used at trial to conclude that [Valin] was sodomized. He also provided his opinion that the cause of death had not been ascertained by the postmortem examination.

This information is now in the hands of Kenneth Campbell (Senior Crown counsel) who has assumed carnage of this matter, as Mr. Downes is involved in another long case.

The Office of the Chief Coroner has provided a list of other consulting Forensic Pathologists who may be positioned to provide another opinion on this matter should Crown counsel wish to pursue this option.

The report of Dr. Michael Pollanen has been disclosed to Defence counsel (by Crown counsel).

Recent media attention has focused on the fact that tissue blocks went missing after being sent from the original pathologist to Dr. Charles Smith. The contents of Dr. Pollanen's report have not been made public and would at this time be considered as confidential disclosure.

The Office of the Chief Coroner has announced (through an article published in the Toronto Star on March 31, 2005) that an audit will be performed of all tissue samples arising from autopsies on all homicides and criminally suspicious cases conducted at the Hospital for Sick Children since 1991 (when the HSC Forensic Pathology Unit opened). The audit will include cases where it is known that tissues were sent to HSC for pathological consultation on homicide and criminally suspicious cases, where the primary autopsy was done elsewhere. This audit is in part based on the concern of the OCC about the missing tissue arising from the autopsy of [Valin].

It is likely that Dr. Pollanen's report will be used in order to argue that Mr. Mullins-Johnson has been wrongfully convicted.

If it is determined that Mr. Mullins-Johnson has been wrongfully convicted, the potential exists that there will be a request for some form of public inquiry into:

1. Dr. Smith's involvement in this case; or

2.Dr. Smith's involvement in all homicide and criminally suspicious cases; or

3. All paediatric homicide/criminally suspicious cases where autopsies were conducted at the Hospital for Sick Children (over some defined period of time).

Dr. Smith is not conducting any autopsies for the Office of the Chief Coroner but remains a staff pathologist at the Hospital for Sick Children.[228]

[228] Memorandum from Dr. McLellan to Glenn Murray, April 7, 2005, PFP116014.

163. On May 6, 2005, an additional ten glass slides and 28 paraffin blocks were located in Dr. Smith's office at the HSC. A message was left for Mr. Campbell on May 9, 2005, advising him of this discovery. The slides were to be turned over to Dr. Pollanen.[229]

164. On May 9, 2005, Mr. Campbell wrote to Mr. Bayliss. He stated:

> I was just contacted by the Coroner's Office and advised that, just this past Friday (May 6, 2005), the review being conducted by the Coroner's Office in conjunction with the Hospital for Sick Children, turned up some 28 Paraffin tissue blocks and 10 microscopic slides in relation to this case. They were discovered, I understand, in Dr. Charles Smith's Office. These are the materials that, initially, were thought to be missing or lost. These materials have now been provided to Dr. Michael Sven Pollanen for his review and consideration.
>
> I thought that I should disclose this important development to you as soon as I became aware of it.
>
> Of course, I am providing you with this information pursuant to my continuing disclosure duties, and on the condition that it will be used only for the purposes of advancing the position of your client on an application to the federal Minister of Justice in proceedings launched pursuant to Part XXI. 1 of the Criminal Code, and on the understanding that it will not be distributed or otherwise disseminated to the media or any members of the public. I thank you for your continuing kind co-operation in this regard.[230]

D. The May 24, 2005 Report of Dr. Michael Pollanen

165. On May 9, 2005, Dr. Pollanen received the newly found set of paraffin blocks and microscopic slides from the Office of the Chief Coroner. He examined those items and on May 24, 2005, issued a supplementary report. In his report, Dr. Pollanen concluded that:

(a) The cause of death is unascertained. But, there are unexplained recent contusions of the lower limbs including the upper inner thighs and buttocks.

[229] Case Contact Log, May 9, 2005, PFP003661.
[230] Letter from Mr. Ken Campbell to Mr. Bayliss, May 9, 2005, PFP0059254.

(b) The histologic findings in the neck, thought to represent evidence of strangulation are Pinsloo-Gordon hemorrhages. Therefore, the findings have no medicolegal importance and cannot be used as evidence for strangulation.

(c) The histologic findings in recut histologic preparations of the anorectal tissues are indicative of post-mortem artefacts. Therefore, the findings have no medicolegal importance and cannot be used as evidence for sexual assault.

(d) The tissue in the paraffin blocks is a DNA source for Valin.[231]

166. On May 31, 2005, Mr. Campbell sent a copy of Dr. Pollanen's Supplementary Report to Mr. Bayliss. In the covering letter, he wrote:

> Further to my letter of May 9, 2005, please find enclosed a copy of the ***Supplementary Report and Opinion on the Death of [Valin]*** that has recently been prepared by Dr. Pollanen of the Coroner's Office. While the Report is dated May 24, 2005, I was first notified of the existence of this Report (and able to obtain a copy) just yesterday afternoon.
>
> ...
>
> In light of the contents of the original ***Report*** by Dr. Pollanen, and the contents of his recent ***Supplementary Report***, I have reached the conclusion that it is appropriate for the Crown to now take steps to have this entire case (and, more specifically, the expert opinion evidence adduced at the trial of this matter) carefully reviewed by another, independent forensic pathologist. I am sure you will agree that the opinions that have been expressed by Dr. Pollanen are cause for concern about this matter. Nevertheless, there are still aspects of the case that remain unconsidered and unexplained. I think that the time has come for the Crown to take steps to have a more fulsome and comprehensive review undertaken with respect to this entire case. As I mentioned to you in my letter of March 15, 2005, I have spoken with Dr. Jim Cairns in this regard, and he too thinks that this is a wise course of action.
>
> I will, of course, endeavour to keep you advised of my progress on this important issue, and will alert you to any further developments. However, I trust that, for the time being at least, this is satisfactory. [Emphasis in original.][232]

[231] Supplementary Report and Opinion on the Death of [Valin], May 24, 2005, PFP003610, p. 2.
[232] Letter from Mr. Campbell to Mr. Bayliss, May 31, 2005, PFP059251.

167. That same day, the Toronto Star reported that missing evidence in the Mullins-Johnson case had been found in Dr. Smith's office.[233]

168. Mr. Campbell also sent a copy of the report to Mr. Wasyliniuk on June 6, 2005.[234]

169. On June 7, 2005, CBC News reported that the Chief Coroner for Ontario had ordered a review into 40 cases involving Dr. Smith.[235] That was followed by a similar report from CTV News on June 8, 2005.[236]

170. On June 28, 2005, Mr. Bayliss sent an email to Dr. Pollanen, which stated:

> We are dealing with Dr. Bernard Knight on this case. In fact, our original request made 3 years ago for the slides and tissue blocks were for the purpose of allowing Dr. Knight to provide us with an opinion. He has reviewed your report and agrees with your analysis, but feels he should look at the slides himself in order to base his opinion on complete materials. He originally thought that the photos in your report would be sufficient but is now concerned that his opinion could be undermined if he has not reviewed the original materials.
>
> Dr. Knight is in Cardiff Wales. While he could look at the slides quickly, they would need to be transferred there and back. If there is a concern about transporting the precise re cuts you looked at could fresh cuts be made for Dr. Knight's purposes?
>
> We are pressed for time so could you respond at your earliest convenience.[237]

171. Dr. Pollanen replied via email that same day. He wrote:

> Thank you for your email. I anticipate that there will be no issue with providing the materials that you wish to have reviewed. The Chief Coroner is the best person to organize the transfer of the slides which are currently in my evidence

[233] Article, Toronto Star, May 31, 2005, PFP034601.
[234] Letter from Mr. Campbell to Mr. Wasyliniuk, June 6, 2005, PFP059250.
[235] Article, CBC News, June 7, 2005, PFP058644.
[236] Article, CTV News, June 8, 2005, PFP058650.
[237] Email from Mr. Bayliss to Dr. Pollanen, June 28, 2005, PFP003660.

locker. I have sent him this email and he will follow up with you directly or via the Crown.[238]

172. On June 29, 2005, Dr. Pollanen wrote to Dr. McLellan. He stated:

> This letter should read in conjunction with my report and supplementary report on the death of [Valin]. Please provide the Crown with a copy of this letter. In this letter I address: (1) further discussion of an issue raised in my first report (sudden natural death); and (2) logistic issues related to review of microscopic slides by other pathologists.
>
> **Sudden natural death from channelopathy?**
>
> In my report I indicate the following:
>
> > In my view, given the essentially negative autopsy, it is reasonable to consider mechanical asphyxia, as a cause of death. On the basis of the same line of reasoning, it is also prudent to consider natural causes. Based on the scene photographs, one possible occurrence is sudden natural death during sleep.
> >
> > Sudden natural death could have been due to a primary arrhythmic disorder. It is beyond the scope of this report to discuss the full range of recently discovered mutations that can cause sudden cardiac death in children. These defects range from mutations in genes that encode ion channel proteins ('channelopathies') and the contractile proteins of the sarcomere. The current state-of-the-art in forensic pathology practice in North America is that we do not search for these mutations in cases of sudden unexplained death.
>
> Thus, in my view, sudden natural cardiac death related to an arrhythmia is at least as possible as homicidal death by mechanical asphyxiation, based on autopsy appearances. The main difficulty with the sudden cardiac death hypothesis is that this possibility is as speculative as the diagnosis of mechanical asphyxia. But, unlike the mechanical asphyxia diagnosis, there have been recent advances that make the sudden cardiac death hypothesis at least partially testable on scientific grounds. The testability is related to the recent discovery of ion channel mutations ('channelopathies') that cause sudden cardiac death in young individuals. These genetic syndromes are incompletely characterized, but many of the mutations that cause the long QT syndrome (LQTS) and the related disorder known as the Brugada syndrome have been recently discovered.

[238] Email from Dr. Pollanen to Mr. Bayliss, June 28, 2005, PFP003660.

> The genetic basis (DNA testing) for sudden natural death by arrhythmia due to LQTS was first published in March 1995. Prior to March 1995, it was not possible to test for LQTS mutations. In addition, the genetic testing for LQTS and Brugada syndrome is still not a routine procedure in forensic medicine, but would be considered to be in the transitional stage between 'research' and 'routine practice'. Undoubtedly, 10 years from now postmortem mutational analysis (molecular forensic pathology) will become commonplace and more mutations will become known.
>
> ...
>
> On this basis, I would advise that the paraffin block of liver from the postmortem of [Valin] be used for DNA testing to determine if a LQTS mutation is present. This would, at least partially, allow the sudden cardiac death hypothesis to be tested using an objective scientific method. There are various laboratories that can provide the testing and I will supply the details upon request.
>
> **Review of slides**
>
> It is my understanding that (an) other pathologist(s) may wish to review the slides from the postmortem of [Valin]. I will fully facilitate this process.
>
> Essentially, the slides from the postmortem can be divided into three groups: (1) the original critical slides from the anogential tissues; (2) the original routine slides of other tissues and organs; (3) recut slides from all blocks, i.e., these recuts encompass all slides including the anogenital tissues. The review pathologists should have access to the recut slides, including the slides of the anogenital tissues. In addition, it might be necessary for the reviewing pathologists to examine the original critical slides from the anogential tissues, since many of the key issues are based on these slides. These slides are unique and irreplaceable. On this basis, the security of these slides must be assured. I suggest the recut slides be transported to the reviewing pathologist(s) first. If the reviewing pathologist(s) need to examine the original critical slides from the anogential tissues, we can then make provisions to ensure these slides are not lost in transit.[239]

173. That same day, Mr. Bayliss wrote to Mr. Campbell. He stated:

> As you know we, on behalf of Mr. Mullins Johnson and the Association in Defence of the Wrongly Convicted, have been attempting to secure slides from the autopsy of [Valin] for review by our own expert witness, Dr. Bernard Knight. Our first letter to your office requesting the slides was sent on February 27, 2003,

[239] Letter from Dr. Pollanen to Dr. McLellan, June 29, 2005, PFP004242.

> some 28 months ago. Our request eventually precipitated the location of the slides and the report of Dr. Pollanen.
>
> All of the biological materials collected at the autopsy have now been located. I have spoken to Dr. McLellan and he has advised me that fresh cuts have been taken from the tissue blocks and they are ready to be shipped immediately. Dr. McLellan feels that your consent is required for this so I write formally requesting that you provide it so that the materials can be shipped forthwith to Dr. Knight in Wales.
>
> Time is now of the essence and we respectfully request that you address this matter without delay. I can provide the sipping details for Dr. Knight as soon as your consent is provided.[240]

174. The next day, Mr. Bayliss left a phone message and emailed Mr. Campbell requesting that he give his permission for the slides and blocks to be released by the OCCO to Dr. Knight for his review.[241]

175. On July 6, 2005, Dr. McLellan wrote to Dr. Knight and sent him the slides and blocks. In his letter, he wrote:

> I have been advised that you have been retained by Mr. David Bayliss to review materials arising from the autopsy of [Valin] and that you have requested the microscopic slides arising from this case.
>
> Enclosed with this letter are recut slides from all original tissue blocks. Original slides from the anogenital tissues, as well as original slides from all other tissues and organs, are currently being held in secure storage in the Forensic Pathology Unit at the Office of the Chief Coroner. In order to ensure ongoing security of the original slides, these recut slides have been prepared.
>
> Please return the slides to my attention once you have had the opportunity to review them. If you feel the need to review any of the original slides, special arrangements will need to be made to ensure that these slides are not damaged or misplaced.[242]

176. That same day, Dr. McLellan wrote to Mr. Campbell. He wrote:

---

[240] Letter from Mr. Bayliss to Mr. Campbell, June 29, 2005, PFP116755.

[241] Transcript of voicemail message of Mr. David Bayliss to Mr. Ken Campbell, June 30, 2005, PFP059248; Email from Mr. David Bayliss to Mr. Ken Campbell, June 30, 2005, PFP059247.

[242] Letter from Dr. McLellan to Dr. Knight, July 6, 2005, PFP003954.

> I enclose a copy of a letter dated June 29, 2005 addressed to my attention from Dr. Michael Pollanen.
>
> Dr. Pollanen raises two issues in his letter. The first is his recommendation that post mortem tissue from [Valin] be used for DNA testing to determine if the death may be the result of a channelopathy. The second matter is that of the specific slides to be sent to Dr. Bernard Knight. I am in the process of arranging for recut slides from all original tissue blocks to be sent from our office to Dr. Knight in the next few days. If there is a request made by Dr. Knight, or any other pathologist, to examine the original slides from the anogenital tissues (or any other tissue), special arrangements will need to be made to ensure that these original slides are not damaged or misplaced. I will inform you if I am made aware that Dr. Knight has requested the original slides.
>
> Please advise me as to whether you would like to have the DNA testing performed as per Dr. Pollanen's suggestion.[243]

177. On July 13, 2005, Dr. Knight received the blocks and slides.[244]

178. That same day, Dr. Knight wrote an email to Mr. Bayliss seeking some guidance concerning the material he had received. He wrote:

> In fact, I have this evening started to look at the slides. I already have encountered a snag, in that the 28 slides (numbered 1 to 29, as there seems to be no 27) only have these sequential serial numbers, but without any key to their origin, it is very difficult to know what I am looking at, especially as the object of the exercise is to compare Dr Pollanen's opinion with the slides he commented upon in his report.
>
> The major organs, like spleen and brain, present no difficulty, but some anonymous bits of muscle and subcutaneous tissue cannot be firmly matched with samples from the neck and anal region, etc.
>
> Is there no list indicating where each numbered slide came from at the autopsy?
>
> In Dr Pollanen's first report there is a list giving numbers from 1 to 9, plus two B5s, (e.g. 5 & 6 were anorectal junction) but I do not know if these nine numbers correspond to the re-cuts which I have received…and 9-29 are not so listed.

[243] Letter from Dr. McLellan to Mr. Campbell, July 6, 2005, PFP003772.

[244] Email from Mr. David Bayliss to Dr. Pollanen, July 13, 2005, PFP116745.

I think it essential that I can be confident that I am looking at the same slides as the other pathologists and wonder if the Coroner's Laboratory has an index list giving the tissue origins which correspond to these numbers.

Some of the slides, even though they are new re-cuts, are slightly difficult to examine, as the mounting medium has shrunk due to air under the cover-slips, as Dr Pollanen mentioned in his study of the originals - but his were old stored slides, not new recuts. However, this is a minor problem compared to my ignorance of the site of sampling.

Sorry to raise a problem, but I have to be sure what I am looking at, vis-à-vis the opinion of other pathologists.[245]

179. Dr. Knight's questions were passed on to Dr. McLellan and Dr. Pollanen.[246]

180. On July 14, Dr. Pollanen wrote to Dr. Knight. He stated:

In my review, I had to reconstruct the sampling of the histologic slides, since there is no master list of blocks/slides in the autopsy report. Here are my suggestions to clarify:

1. The label B5 refers to the fact that the specimen (in this case a section of lymph node) was fixed in B5 fixative solution, rather than formalin. Thus, the label of B5 does not relate to a block or tissue site.

2. The original blocks were labeled with sequential numbers of two types. First, labeling with 1, 2, 3, 4, etc., and then other blocks labeled with 1, 2, 3, 4, etc, but the latter series had the numbers circled. The circled numbers referred to series of 9 slides that have the most medicolegal relevance. It is possible that the recut slides do not reflect this block labeling, i.e., I believe the slides are labeled sequentially by block number, but the slide numbers are not circled in the recut set. However, it should be possible to reconstruct the origin of the slides, as I did. I have not specifically described the sections of the galae, etc. (as I indicated in my report), as I was concentrating on the anogential tissues.

3. The original slides in the series of 9 slides have three labels in addition to the numbers listed above. The labels are handwritten and read: 2 = margin of vagina; 5 = anorectum and 6 = anorectum as indicated in table on page 4 in my report. In the original autopsy report the 'anorectum' is further expanded as indicated also in my report starting on pg 7. Also, I describe the exact number of tissue pieces and histologic composition of each slide in my report starting on page 7. Thus, it

[245] Email from Dr. Knight to Mr. David Bayliss, July 13, 2005, PFP116739.

[246] Email from Mr. Bayliss to Dr. McLellan, July 14, 2005, PFP116739.

should be fairly easy to determine the origin of the slides, i.e., slide 2 that is "margin of the vagina" has two pieces of tissue: skin with hair, and non-keratinizing stratified squamous epithelium (i.e., vaginal mucosa). Even without my direct attribution of slides the squamocolumnar junction of the rectum etc., can be readily found.

4. The 'hemorrahge' in the neck tissues is visible in the sections of the neck viscera, which should present no problem for location.

5.The reconstruction of slides etc, sounds daunting but once the information from all sources is considered, the logical sequence of the slides is readily apparent and unmistakable. This requires correlation of all documents.

6. If my explanations have made the situation more difficult to understand (i.e., as email sometimes does) I will be happy to speak with Professor Knight on the telephone and we can go through each of the slides one by one. It took me some hours to consolidate the histologic record the first time I attempted it.

Please note that I did not explicitly label the slides for Professor Knight, as I thought that part of the review process would include an independent reconstruction of the pathological materials, as I had done. Please let me know if I can be of any further assistance. If the problem is intractable I have a solution: the entire lot of material (blocks, original slides with labeling etc., can be photographed (gross) with digital photography and emailed so that Professor Knight can piece together the record by visual inspection of the composition of the original slides and blocks (i.e., exactly the way I did it). This issue sometimes arises in review cases and this case is no exception; it is a good that the slides are not too numerous![247]

181. On July 15, 2005, Dr. Knight replied to Dr. Pollanen via email. He wrote:

Many thanks for your prompt and helpful reply to my query about the slide labelling.

I rather suspected this would be the case, but on the off-chance that there was a key list, I thought I would enquire.

I will go though them carefully and hopefully will be able to match slides with descriptions. The shrinkage of the mountant is a little odd, in new re-cut preparations, as it is marked in some of them, obscuring the edges of the sections, but the central parts are mostly clear.

[247] Email from Dr. Pollanen to Dr. Knight, July 14, 2005, PFP116741.

Many thanks, I will get back to you if I have real problems.[248]

182. On July 20, 2005, Dr. Prime sent Mr. Campbell a complete list of the materials in the possession of the CFS in relation to the Mullins-Johnson case.[249]

E. The August 11, 2005 Report of Professor Bernard Knight

183. On August 11, 2005, Dr. Knight[250] wrote to Mr. Bayliss.[251] With respect to the time of Valin's death, he stated, *inter alia*:

> The pathologist who conducted the autopsy of [Valin] was Dr. Rasaiah, who appears from the documents to have been a hospital pathologist with no professional qualifications in forensic pathology. This may well explain his outdated appreciation of the methodology and quality assurance aspects of estimating the time since death.
>
> However, the defects in attempting to determine the time of death began with the coroner, Dr. Crookston, who made the elementary error of failing to measure the ambient temperature at the scene of death, thus frustrating any hope of scientifically assessing the time of death from body temperature.
>
> ...
>
> [R]igor is now discarded by all experienced pathologists as anything more than the most approximate of pointers to the time of death.
>
> ...
>
> [I]t is patently obvious that rigor is next to useless for determining the time since death.
>
> ...
>
> In the context of [Valin], Dr. Rasaiah's contention that on the basis of rigor mortis, death must have occurred from 15 to 17 hours prior to the autopsy, is frankly ludicrous.

[248] Email from Dr. Knight to Dr. Pollanen, July 15, 2005, PFP116734.

[249] Letter from Dr. Prime to Mr. Campbell, July 20, 2005, PFP059676.

[250] Dr. Knight's *curriculum vitae* can be found at PFP058555.

[251] Report of Professor Bernard Knight, August 11, 2005, PFP003620.

> In relation to postmortem hypostasis…the settling of the blood in the tissues due to gravity is an even worse indicator of time since death than rigor mortis.
>
> …
>
> It is in the use of *body temperature* that Dr. Rasaiah's opinion is most flawed.
>
> The failure of Dr. Cookston to measure the ambient temperature at the scene (which modern knowledge has shown must be taken close to the body because of the variable micro-environments at a scene) invalidates any hope of even the most modest accuracy attainable through temperature calculations.
>
> …
>
> [I]t is patently obvious that [Valin] died less than 36 hours before Dr. Crookston's examination, but the point along the 0-36 hour scale is extremely uncertain. [Emphasis in original.]
>
> …
>
> Overall, I feel the child died later than other pathologists suggested, though the times of both Dr. Smith and Professor Ferris partially overlap this period – and Dr. Jaffe overlaps everyone.[252]

184. On the issue of the cause of death, Dr. Knight wrote:

> [I]n my opinion, the majority, if not all, of the skin haemorrhages, both small petechiae and larger ecchymoses, are undoubtedly post-mortem in origin.
>
> …
>
> I am unable to offer a definitive cause of death, having read all the autopsy findings. The presence of petechial hemorrhages in the skin of the face and trunk, given the deep frontal hypostatis, is not diagnostic. Dr. Rasaiah describes petechial haemorrhages on the upper eyelids, but given the marked facial hypostatis, these cannot safely be ascribed to compression of the neck. He fails to mention the very important observation that there were no petechiae in the whites of the eyes or inside the eyelids, which, if they exist in a case, are more useful as indicators of compression of the neck.

[252] Report of Professor Bernard Knight, August 11, 2005, PFP003620, pp. 2-9.

> There appears to be a bruise on the outside of the neck, under the left side of the jaw which cold be due to hypostatis, as discussed above. There is also a deep haemorrhage in the tissues of the neck on the left side of the larynx, which has to be interpreted with extreme caution, as this area is prone to post-mortem artefactual haemorrhages (the Pinsloo-Gordon artefact). These findings can occur from natural pressure on the neck, but are certainly not diagnostic of it, especially in the absence of petechiae or other haemorrhages in the interior of the larynx, root of the tongue and whites of the eyes.
>
> The possibility of 'suffocation' (obstruction of nose and mouth) cannot be either confirmed or excluded.
>
> ...
>
> In relation to the major organs of the body, I agree with the other pathologists and am satisfied that no natural disease process is observable in the materials supplied. This is not to say that natural diseases did not cause or contribute to death, but none was seen. Specifically, multiple sections of the heart muscle revealed no disease process such as myocarditis, which can cause sudden death. [253]

185. Dr. Knight also reviewed Dr. Pollanen's reports of January 19 and May 24, 2005. He concluded that:

> [I]t is my opinion that his conclusions are entirely valid. His detailed tabulated descriptions of the microscopic sections that he reviewed and the photographs incorporated in his report, give me no reason to dispute his interpretation that there was no evidence of recent trauma to be seen in the ano-rectal area of the deceased. They are at variance with the interpretation of Dr. Rasaiah and in such a difference of fact and opinion, I strongly favour the views of Dr. Pollanen.[254]

186. Dr. Knight reviewed the autopsy slides from the anal and vaginal region of Valin. It was his opinion that:

(a) I saw nothing that could be accepted as evidence of an ano-rectal tear.

(b) There was no extra-vascular extravasation of blood (haemorrhage) in any of the sections to indicate or suggest recent acute trauma…

[253] Report of Professor Bernard Knight, August 11, 2005, PFP003620, p. 10 & 13
[254] Report of Professor Bernard Knight, August 11, 2005, PFP003620, pp. 12-13.

(c) There was patchy advanced post-mortem autolysis, especially damaging the lower rectal lining.

(d) There was some patchy mild chronic inflammatory changes, unrelated to acute trauma and within normal limits for the perineal/rectal area.

(e) The vaginal area showed no abnormalities.

187. Dr. Knight concluded:

> [T]here is nothing in the histological material made available to me, that supports the infliction of either a tear in the anal margin or acute trauma of any sort to the anal region.[255]

188. Dr. Knight's report was forwarded to Dr. Pollanen on August 31, 2005.[256]

189. On September 2, 2005, Dr. Pollanen called a meeting at the Coroner's office so he could brief counsel on the case. Present were Dr. Pollanen, AIDWYC counsel and Al O'Marra, counsel to the Chief Coroner. For 150 minutes Dr. Pollanen expressed his opinions on the case, accompanied by a photograph and Power Point presentation, and answered questions from counsel.[257]

190. On September 7, 2005, Mr. Mullins-Johnson filed an application for Ministerial review pursuant to Part XXI.1 of the *Criminal Code*.[258] The Minister subsequently appointed Professor David Paciocco of the University of Ottawa to assist him in his determination of the application.[259]

191. On September 14, 2005, Dr. Pollanen wrote to Professor Jack Crane, State Pathologist for Northern Ireland, Professor Christopher Milroy, Department of Forensic Pathology, Sheffield

[255] Report of Professor Bernard Knight, August 11, 2005, PFP003620, p. 14.
[256] Letter from Mr. Lockyer to Dr. Pollanen, August 31, 2005, PFP003896.
[257] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 16.
[258] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 9.
[259] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 17.

University, England and Dr. John Butt, Consulting Forensic Pathologist, Vancouver, British Columbia. He stated:

> Thank you for agreeing to review the autopsy of this 4-year-old girl who died in her residence in Sault Ste. Marie, Ontario in 1993. To facilitate the review process, I will provide a brief chronological summary of the case.
>
> In 1993, [Valin], a 4-year-old girl was found dead in bed in her residence. An autopsy was performed by a local hospital pathologist and the cause of death was given as 'asphyxia'. Anal abuse was raised as an issue. Dr. Charles R. Smith was the consulting pathologist on the case and opined that the child was sodomized just prior to death. The uncle, William MULLINS-JOHNSON, was arrested and convicted of 1st degree murder. The verdict was upheld in the Court of Appeal and the Supreme Court and he is currently serving a life-sentence. The Association in Defense of the Wrongly Convicted (AIDWYC) launched a post-conviction investigation of the case and has subsequently sought a post-conviction remedy, i.e., application to the Federal Justice Minister under s.696. AIDWYC made a request of the Chief Coroner that pathological materials from the autopsy be made available for review by an independent forensic pathologist retained by AIDWYC. Prior to release of the materials, the Chief Coroner asked me to review the case. I gave the opinion that the pathological evidence presented at trial was flawed (see my report for the details). AIDWYC then had Sir Bernard Knight review my reports and the original autopsy and consultation reports (see his report for details).
>
> On this basis, the Attorney General wishes to have an independent review of my opinion and has requested that this occur under the auspices of the larger review process that is currently underway on the work of Dr. Smith.
>
> Accompanying this letter is an inventory list and a set of review materials needed to review this case. The items do not include the original set of histologic slides, but a set of recut slides has been prepared and can be circulated among the reviewing experts.
>
> We will make appropriate arrangements for you to review the original slides if you deem it necessary, but representative photomicrographs are given in my report. Although Dr. Smith was the main crown pathologist, another pathologist actually performed the postmortem and some of the review issues relate to the autopsy and opinions of the original pathologist. Furthermore, Dr. Rex Ferris was a defense pathologist involved with the case and forms an integral part of the pathological evidence as I have described in my reports.[260]

[260] Letters from Dr. Pollanen to Professors Crane and Milroy, and Dr. Butt, September 19, 2005, PFP003835; PFP003840; PFP003838.

192. On September 15 and 16, 2005, the *Toronto Star* and *The National Post*, respectively, reported on the Mullins-Johnson case and his application to be granted bail pending the ministerial review.[261]

193. On September 16, 2005, Dr. Rasaiah wrote to Dr. Pollanen and requested two unstained sections from the tissue blocks of Valin's autopsy and a copy of the autopsy photographs.[262]

194. On September 19, 2005, Dr. Rasaiah, in a letter to Mr. Kenneth Campbell, Director, Crown Law Office Criminal, responded to Dr. Pollanen's report. In his cover letter, he stated:

> As you know, I have requested copies of the slides and photographs for review. In my practice in the United States, I deal with Dr. Werner Spitz, who is the recognized authority in North America and not Dr. Bernard Knight, who is an expert from Wales. Dr. Spitz's assistance could be sought, if indicated or necessary.
>
> I would also like to inform you that I am prepared to rebut Dr. Pollanen's report in court.[263]

195. In the attached report, Dr. Rasaiah set out his qualifications, then stated the following:

(a) a pathologist who is both a forensic pathologist and a clinical pathologist has a distinct advantage over a forensic pathologist only;

(b) the investigation into Valin's death was a thorough one and not a quick diagnosis;

(c) the autopsy was undertaken with the utmost care and he, as the pathologist conducting the autopsy, was best able to distinguish between a bruise and post-mortem staining (as opposed to a determination based on photographs);

(d) Drs. Ferris, Jaffe, Smith, Rasaiah, Pollanen and Knight found no evidence of a natural cause of death;

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[261] Article, Toronto Star, September 15, 2005, PFP059245; Article, The National Post, September 16, 2005, PFP059243.

[262] Letter from Dr. Rasaiah to Dr. Pollanen, September 16, 2005, PFP116642.

[263] Letter from Dr. Rasaiah to Mr. Campbell, September 19, 2005, PFP004836.

(e) with respect to determining the time of death, it is known in the pathology field that this is an estimate. The most reliable indicator is body temperature. The criteria of temperature, rigor mortis and post-mortem lividity are used internationally and are in all the leading text books;

(f) the article on which Dr. Pollanen relied (Post-Mortem Findings in Children by Dr. John McCann et. al.) to question Dr. Rasaiah's conclusions with respect to the anus has significant shortcomings;

(g) there are inconsistencies between Professor Knight's report and textbook with respect to the value of petechial hemorrhages as indicators of asphyxia; and

(h) the findings of Dr. Rasaiah were supported by Dr. Zehr and even, on some key issues, by the defence experts, Drs. Jaffe and Ferris.[264]

196. On September 21, 2005, Dr. Rasaiah again wrote to Mr. Campbell. This letter was written to rebut the conclusions drawn by Dr. Knight in his report of August 11, 2005. In his letter, Dr. Rasaiah noted that:

(a) while Dr. Knight stated that the time of death was between 0-36 hours, it was known what time the parents had left the home [i.e. less than 36 hours];

(b) the neck of Valin was carefully examined and dissected only at the end of the autopsy. Therefore, there would be no Prinsloo-Gordon artefact;

(c) the possibility of suffocation could not be either confirmed or excluded by Professor Knight;

(d) petechiae are not always due to obstruction of the large veins in the neck, there are other causes including cardiac failure;

(e) he queried who prepared the slides for Professor Knight as Professor Knight, in his report, indicated that the slides were improperly mounted;

[264] Report of Dr. Rasaiah, September 19, 2005, PFP004838.

(f) whether Professor Knight was reviewing the appropriate slides and not those from another case;

(g) that there is no evidence, contrary to media reports, that the death was due to natural causes;

(h) the absence of literature references in support of Professor Knight's conclusion that bruises on Valin's thigh could be from riding and falling from a bike; and

(i) the absence of any comment by either Dr. Pollanen or Dr Knight on the presence of hemorrhages in the lungs, thymus gland, peritracheal tissue and brain. [265]

197. That same day, Mr. Mullins-Johnson was granted bail by Justice Watt of the Superior Court of Justice.[266] CBC News reported his release.[267]

198. On September 26, 2005, Dr. Rasaiah wrote a third letter to Mr. Campbell. He stated:

(a) some of the photographs clearly showed bluish and reddish bruising in the upper high and vulvar area;

(b) the histological examination of the anorectal area showed traumatic injuries and Dr. Pollanen was mistaken;

(c) Dr. Pollanen was mistaken in concluding that there is no evidence of neck trauma;

(d) the methodology of the autopsy precluded a finding of Prinsloo-Gordon hemorrhages;

(e) neither Dr. Pollanen nor Professor Knight commented on the sections of the brain, which was a major omission;

[265] Letter from Dr. Rasaiah to Mr. Campbell, September 21, 2005, PFP003637.
[266] Recognizance of Bail, September 21, 2005, PFP058970.
[267] Article, CBC News, September 21, 2005, PFP116665.

(f) no histological interpretation was given by either Dr. Pollanen or Professor Knight with respect to the thymus;

(g) neither Dr. Pollanen nor Professor Knight commented on the six hematoma which are clearly visible and due to blunt force trauma; and

(h) he is disappointed that the expert reports were released to the public before input by him, particularly "when the accuracy and validity of the consultation reports are in question." [268]

199. On September 28, 2005, Dr. Pollanen wrote to Dr. Rasaiah. He stated:

> As you may know, a comprehensive set of materials has been prepared for this case to facilitate external review. Therefore, an additional set has been prepared for you, based on your request of September 16, 2005. The materials are provided with this letter.
>
> However, a set of unstained slides has not been included. One set of duplicate slides has been prepared and is currently circulating among the international reviewers. The original set of slides are in the Toronto Forensic Pathology Unit. You are welcome to attend my office at any time to review the slides.[269]

200. On October 7, 2005, Dr. Rasaiah responded to Dr. Pollanen. He wrote:

> Thank you for your telephone call this morning. You indicated that you are unable to send me either the unstained or stained recut slides because of decisions made by others.
>
> On the 28th of September 2005, you sent me a comprehensive set of material made to facilitate external review and included photographs but not the microscopic slides.
>
> I would like to know who the "others who had made a decision not to send me the recut slides" are and the reasons for not doing so.[270]

201. On October 11, 2005, Dr. Pollanen wrote back to Dr. Rasaiah. He stated:

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[268] Letter from Dr. Rasaiah to Mr. Campbell, September 26, 2005, PFP003640.
[269] Letter from Dr. Pollanen to Dr. Rasaiah, September 28, 2005, PFP116641.
[270] Letter from Dr. Rasaiah to Dr. Pollanen, October 7, 2005, PFP116630.

> Thank you for your letters of October 5 and 7, 2005. This response summarizes our telephone conversation on October 7, 2005.
>
> I have no objection to providing access to histologic preparations from the postmortem of [Valin]. As I indicated in my previous letter, you may attend this office at any time to examine the original slides. Alternatively, a set of recut slides is circulating with international reviewers and can be made available for your examination, once the slides have been returned to Canada.
>
> Therefore, there is no immediate plan to prepare a new set of recut slides. I have discussed this matter with the Chief Coroner and he concurs.
>
> It is important for you to know that no one is attempting to limit your access to the slides and it would be a mistake to think that was the case. In addition, it should also be clear that every effort has been made to share with you the results of the review process that has taken place to date, including my reports and the report of Sir Bernard Knight.[271]

202. On October 20, 2005, Dr. Rasaiah wrote again to Mr. Campbell. He stated:

> I have read the Inventory List of Attachments which was sent by Dr. Michael S. Pollanen to external reviewers to facilitate their review on the death of [Valin]. This list was provided to me by Dr. M. Pollanen on September 28, 2005.
>
> I am surprised and concerned to see that my court testimony and the report and trial evidence of Dr. Pat Zehr, Obstetrician and Gynecologist, were not included in the list.
>
> As all the information was not provided to the external reviewers, they will be unable to provide an informed opinion.[272]

203. On October 24, 2005, Dr. Pollanen wrote to Mr. Campbell. He advised that he would not make any additional written comment on the Valin case unless his views were requested. That was because it was "the only reasonable position to take given that the case is now under ministerial review and review by an external panel of pathologists." He then set out some

[271] Letter from Dr. Pollanen to Dr. Rasaiah, October 11, 2005, PFP116629.
[272] Letter from Dr. Rasaiah to Mr. Campbell, October 20, 2005, PFP058605.

information with respect to the location of the slides of the autopsy and the procedure in place to maintain their continuity.[273]

F. The December 6, 2006 Report of Dr. James Ferris

204. On December 6, 2005, Dr. Ferris, [274] who had testified on behalf of Mr. Mullins-Johnson at his trial, wrote to Mr. Lockyer. He stated:

> Following my involvement in this case in 1994, I was so concerned about the outcome of the trial and a possible miscarriage of justice that I retained all of my original file including all of my hand-written and typed notes and these are available if required.
>
> At that time, I was instructed by Mr. Terry O'Hara. Mr. O'Hara was unwell before and during the trial and much of my pre-trial briefing and consultations were with his relatively inexperienced junior, Ms. Jennifer Reed. My information from Mr. O'Hara was that it could be assumed that the child [Valin] had been the victim of chronic sexual abuse and had apparently been murdered. However, he was also of the strongly held opinion that Mr. Mullins-Johnson was not guilty of this murder, and I was asked to deal specifically with the issues relating to the timing of death and any injuries that might have been present on the body of [Valin]. Issues relating to the cause of death did not form a major part of my instructions.
>
> It was my understanding that the evidence of sexual abuse was based on examinations by Dr. P. Zehr and supported by Dr. Marcellina Mian and Dr. Charles Smith from the Toronto Hospital for Sick Children. The main purpose of my review of the microscope sections, taken from the areas of the vagina, anus and adjacent tissues at postmortem examination, was to attempt to confirm these opinions alleging sexual abuse.
>
> I was also unable to support the criteria used by Dr. Rasaiah to establish the cause of Valin's death as due to suffocation and smothering. It was my opinion that there was doubt as to the precise mechanism of death, however based on the criteria which I will discuss below, it was my opinion that if this was a case of murder, then a possible mechanism would be the application of relatively minor compressing force to the neck resulting in vagal inhibition and reflex cardiac arrest.

[273] Letter from Dr. Pollanen to Mr. Campbell, October 24, 2005, PFP003928.

[274] Dr. Ferris' updated *curriculum vitae* can be found at PFP058529.

> It was my opinion at the time of writing my 1994 Report that the accurate determination of the time of death based on the observations recorded at the time was very difficult if not impossible and that the opinion on time of death expressed by Dr. Rasaiah was "*not only misleading but quite wrong*".
>
> …I welcome this opportunity to review and clarify some of the opinions given by me at the time of the trial of William Mullins-Johnson.
>
> There is no doubt that at that time, my opinions were unduly influenced by the apparent authoritative opinions given by Drs. Smith and Mian who strongly supported the observations and opinions of Dr. Zehr. I was concerned at that time with the opinions expressed by Dr. Smith in the Mullins-Johnson case and since that time I have found myself disagreeing with his forensic pathology opinions expressed in several cases and this experience including his work on the Louise Reynolds case has made me extremely cautious about the quality of his forensic pathology work.
>
> I am now aware that Dr. Smith's professionalism has been questioned by others, and I was clearly in error to accept so readily his opinions in the Mullins-Johnson case. Similarly, in retrospect I was wrong to have accepted Mr. O'Hara's assumption that [Valin] had been the victim of sexual abuse and murder.[275]

205. Dr. Ferris later concluded:

> Having reviewed all of the evidence and materials referred to above, it is clear that my opinions were unduly influenced by my instructions from Mr. O'Hara and my ready acceptance of the opinions of Drs. Zehr, Mian and Smith. It is now clear to me that those influences reduced the level of objectivity of my opinions that would normally be expected from a Forensic Pathologist of my experience.
>
> Further, when I was attempting to clarify and explain the limitations of such evidence, my difficulties and caution in reaching my conclusions as expressed in court were interpreted as inconsistency and contradiction.
>
> **It is now my opinion that there is no reasonable evidential foundation on which to determine the cause of [Valin's] death.**
>
> **It is now my opinion that there is no reasonable evidential foundation on which to conclude that [Valin] had been the victim of either chronic or recent sexual abuse.**

[275] Letter from Dr. Ferris to Mr. Lockyer, December 6, 2005, PFP003648.

> **It is now my opinion that there is no reasonable evidential foundation on which to base the time of [Valin's] death.** [Emphasis in original.][276]

206. On December 8, 2005, Dr. Pollanen gave his power point presentation on Mr. Mullins-Johnson's case to Mr. Campbell, Ms. Fairburn and Det. S/Sgt. Dickinson of the Sault Ste. Marie Police Service.[277]

207. On December 9, 2005, Dr. Rasaiah examined the blocks and slides on Valin at the OCCO. On December 12, 2005, he wrote to Mr. Ken Campbell. He concluded that:

> Re-examination of the slides confirmed histological findings reported in my post-mortem report A-93-51 reported on July 13, 1993. [278]

208. On December 12, 2005, Michal Fairburn wrote to Det. S/Sgt. Dickenson. She stated:

> Thank you for coming to Toronto to attend the meetings with Dr. Pollanen and Dr. Rasaiah. We look forward to receiving your notes so that we can make disclosure. Please send them as soon as they are typed. In addition, as a result of the meetings, Mr. Campbell and I are of the view that it is very important that the international reviewers have available to them most of the photos in the case. Could you please have a full set of photos reproduced and sent to us as soon as possible? We don't need the ones of the outside or inside of the house. What's relevant for the purposes of the review is photos of the bed and all photos of Valin (including those taken while she was still at home and those taken at autopsy).
>
> In addition, would you mind following up on the two CFS issues we discussed:
>
> a) confirming that the hair found at autopsy was in fact of non-human origin; and
>
> b) where Mr. Mullins-Johnson's control sample came from and where it has been stored over the last 12 years.[279]

209. On December 15, 2005, Dr. McLellan requested that genetic testing be done on a sample of Valin's tissue for the presence of Long QT Syndrome.[280]

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[276] Letter from Dr. Ferris to Mr. Lockyer, December 6, 2005, PFP003648.

[277] Letter of Ms. Fairburn to Prof. Paciocco, December 19, 2005, PFP110288.

[278] Letter of Dr. Rasaiah to Mr. Campbell, December 12, 2005, PFP003643.

[279] Letter from Ms. Fairburn to Det. S/Sgt. Dickenson, December 12, 2005, PFP110287.

210. On December 19, 2005, Ms. Fairburn wrote to Prof. Paciocco, who had been asked by the Minister of Justice to provide an opinion on the Mullins-Johnson s. 696 application. She stated:

> I acknowledge receipt of your letter dated November 30, 2005. Your comments are very helpful. In the event that "new" evidence comes to light, whatever that may be, we will bear your comments in mind and address the questions you raise.
>
> On Thursday December 8, 2005, Ken Campbell and I met with Dr. Michael Pollanen, Medical Director of the Toronto Forensic Pathology Unit in the Office of the Chief Coroner for Ontario. Also present at the meeting was a police officer from the Sault Ste. Marie Police Service, Detective Staff Sergeant Scott Dickinson. Dr. Pollanen gave a powerpoint presentation, which elucidated upon his Report and Opinion on the Death of [Valin] and his Supplementary Report and Opinion on the Death of [Valin]. Both these reports are contained within the record provided by AIDWYC at volume 5, tabs C1 and C2. Detective Staff Sergeant Scott Dickinson took notes of the meeting. I will forward a copy of his notes once I have received them, but understand he is off work until the new year. I understand from the officer that he wishes to type out his notes before providing a copy.[281]
>
> During the meeting, Dr. Pollanen provided us with a number of articles and documents:
>
> Michael S. Pollanen: *Subtle Fatal Neck Compression*, 136 Med. Sci. Law (2001) vol. 41, No. 2 (enclosed)
>
> Michael S. Pollanen: *A Triad of Laryngeal Hemorrhages in Strangulation: A Report of Eight Cases*, Journal of Forensic Sciences 614 (copy of article does not contain full citation) (enclosed)
>
> Michael S. Pollanen, D. Noel McAuliffe: *Intra-cartilaginous laryngeal haemorrhages and strangulation*, Forensic Science International 93 (1998) 13 (enclosed)
>
> CD Rom with Powerpoint Presentation
>
> Guidelines on Autopsy Practice for Forensic Pathologists, 2005

[280] Requisition Form, December 15, 2005, PFP003732; Informed Consent, December 15, 2005, PFP003730;

[281] Officer Dickinson's typed notes can be found at PFP110333, pp. 5-7.

Other than the Guidelines on Autopsy Practice for Forensic Pathologists (which are contained at volume 5, Tab D of the AIDWYC record) the Crown was not previously in possession of any of these materials. I note that the CD Rom contains very sensitive and graphic images, not only of [Valin], but other deceased individuals and their body parts. I have not enclosed a copy of the powerpoint presentation, which was provided to us at the end of the meeting. To have real meaning and context, I believe the presentation needs explanation by Dr. Pollanen. Nonetheless, I would be happy to forward a copy if you wish.

On December 9, 2005, Ken Campbell and I met with Dr. Bihubendra Rasaiah.[282] As you know, he was the pathologist who conducted the original autopsy on [Valin]. His post-mortem report is located at pp. 126-136 of volume 1, tab A of the AIDWYC record. Dr. Rasaiah provided the following materials:

Examination of Modern Legal Medicine, Psychiatry and Forensic Science, pp. 81-2 (copy does not contain full citation) (enclosed)

Handbook of Forensic Pathology, Craniocerebral Trauma, Subscapular Hemorrhages (copy does not contain full citation) (enclosed)

David Ellison, Seth Love, *Neuropathology*, 11:14 (copy does not contain full citation) (enclosed)

J. Thomas Stocker, Louis P. Dehner, *Pediatric Pathology*, pp. 438, 441-2 (copy does not contain full citation) (enclosed)

Dr. Rasaiah also provided a copy of the Consultation Record of Dr. Patricia Zehr (which is found in the AIDWYC materials at volume 1, tab 1, pp. 194-6).

Following our meeting with Dr. Rasaiah, he attended at the Office of the Chief Coroner for Ontario to view the original slides and blocks. On December 15, 2005, we received a report from Dr. Rasaiah, dated December 12, 2005. It is also enclosed with this letter.

While meeting with Dr. Pollanen on December 8, 2005, he advised that a group of three experts will be considering the forensic results in this case. He indicated that the experts are Professor Jack Crane, State Pathologist for Northern Ireland and Professor of Forensic Medicine at Queen's University, Belfast, Dr. John Butt, a consulting forensic pathologist and former Chief Medical Examiner for Nova Scotia, and Dr. Chris Milroy, Home Office Pathologist and Professor of Forensic Pathology, University of Sheffield. While we understand that the review has not

[282] Officer Dickinson's typed notes of the December 9 meeting can be found at PFP110333, pp. 7-10.

yet begun, we are hopeful that we will have a result before the end of February.[283]

211. On January 17, 2006, Dr. McLellan wrote to Mr. Lockyer. He stated:

> I write to acknowledge receipt of your letters of January 12 and 13, 2006, regarding the review of materials arising from the case of [Valin].
>
> As discussed with you on the telephone yesterday, I will be asking my assistant, Katherine Stephen, to arrange a meeting with yourself and Ms. Fairburn to review which materials have been sent to the external reviewers and to discuss the additional materials that are appropriate to forward at this time.[284]

212. A duplicate letter was sent to Ms. Fairburn that same day.[285]

213. On January 18, 2006, Ms. Fairburn wrote to Det. S/Sgt. Dickinson, as follows:

> There are two things that I need and I am hoping you can assist.
>
> (a) Could you please provide me with an inventory of the contents of the garbage pail seized from the upstairs washroom
>
> (b) Could you please provide a continuity chart as it relates to the following items:
>
> (i) Mr. Mullins-Johnson's trackpants that he was wearing at the time he was arrested…;
>
> (ii) [Valin's] fingernail cuttings taken at the time of autopsy (…never submitted to CFS);
>
> (iii) Two pairs of male underwear (one white and one blue) seized from laundry pile (…never submitted to CFS); and
>
> (iv) Garbage pail and its contents seized from upstairs washroom.[286]

[283] Later from Ms. Fairburn to Prof. Paciocco, December 19, 2005, PFP110288.
[284] Letter from Dr. McLellan to Mr. Lockyer, January 17, 2005, PFP116567.
[285] Letter from Dr. McLellan to Ms. Fairburn, January 17, 2006, PFP116574.

214. On January 27, 2006, counsel for Mr. Mullins-Johnson and the Crown Law Office Criminal met with Dr. McLellan. It was agreed by all parties that three of the pathologists who had been asked to assist in the global review of Dr. Smith's work be requested to separately provide opinions on the cause of Valin's death. Professor Milroy, Professor Crane and Dr. Butt were chosen.[287]

215. On January 30, 2006, Ms. Fairburn wrote again to Det. S/Sgt. Dickinson. She stated:

> Pursuant to my letter dated January 18, 2006, I wonder if you have had a chance to check on the contents of the garbage pail seized from the upstairs washroom? In addition, could you please let me know when you will have a chance to complete the continuity chart as it relates to the items listed in that correspondence? We can't submit any of those items to the CFS for testing until the continuity chain is completed…[288]

216. On February 7, 2006, Ms. Fairburn again wrote to Det. S/Sgt. Dickinson. She stated:

> Pursuant to my letters of January 18 and 30, 2006 (of which I attach a copy for your reference), I wonder if you could contact me? Time is moving on and the CFS cannot conduct any testing until the continuity issues have been addressed…[289]

217. On February 14, 2006, Dr. Barry McLellan wrote to Drs. Butt, Milroy and Crane.[290] He stated:

> I write in follow-up to my letter of January 16, 2006 with respect to the review of materials arising from the autopsy performed on [Valin]. I indicated to you at that time, that there would be additional materials sent to you for the purposes of this review. I now enclose these additional materials, as well as a Revised Inventory List of Attachments.
>
> As you are aware, a set of recut slides was prepared in this case and has been, or will soon be made available, for your review. In Dr. Pollanen's covering letter of September 28, 2005, he indicated that you may be provided with an

[286] Letter from Ms. Fairburn to Det. S/Sgt. Dickinson, January 18, 206, PFP110324.

[287] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 158.

[288] Letter from Ms. Fairburn to Det. S/Sgt. Dickenson, January 30, 2006, PFP110323.

[289] Letter from Ms. Fairburn to Det. S/Sgt. Dickinson, February 7, 2006, PFP110322.

[290] The *curriculum vitaes* of Professor Milroy, Dr. Butt and Professor Crane can be found, respectively, at PFP058454, PFP058425, and PFP058513.

> opportunity to review the original slides if you deemed this was necessary for your review. In this particular case, we will be asking each of you to review the original slides. In order to facilitate this process, the original slides will be brought to you in the secure custody of a police officer. You will be contacted in the near future to determine the best date and time for these slides to be made available for your individual review.
>
> I included a Backgrounder document (arising from a Press Conference held November 1, 2005) with my previous letter of January 16, 2006. The external review of the case of [Valin] commenced prior this announcement. You will note on page 3 of the Backgrounder document that for those cases requiring external review in future, each case will initially be reviewed by one external pathologist. If concerns are raised by this reviewing pathologist, the materials will also be reviewed by two further external pathologists. It also indicates that if the review requires the involvement of three pathologists, these pathologists will then meet and discuss their findings to reach consensus opinions.
>
> In the case of the review of materials arising from the autopsy performed on [Valin], I will require each of you to prepare individual reports. I will not be arranging for the three of you to meet to discuss your findings, in order to reach consensus opinions. You may, however, at any time during the review of materials, and prior to completing your report, communicate with one or both of the other two reviewers, if you feel this would assist you in reaching your conclusions.
>
> In reviewing this case (and in reviewing future cases), I require your opinions on three specific areas:
>
> (a) Do you feel that the important forensic pathology examinations were conducted?
>
> (b) Do you agree with the facts reported as arising from the examinations performed?
>
> (c) Do you feel that the conclusions reached with respect to the cause of death are supported by the materials that were provided for your review? [291]

218. On February 24, 2006, Christine Fontanella, from the lab that was testing Valin's DNA for the Long QT Syndrome, sent an email to Katherine Stephen and Dorothy Zwolakowski advising that:

[291] Letter from Dr. McLellan to Drs. Butt, Milroy and Crane, February 14, 2006, PFP003100.

> Unfortunately, we were unable to extract enough usable DNA from [Valin's] sample. We have exhausted all possibilities at this point and will not be able to proceed any further unless you have additional blood or tissue samples for us to work with. Please let me know if you do and we can make arrangements to try and extract usable DNA for our test.[292]

219. On March 6, 2006, Dr. McLellan wrote to Ms. Fairburn. He stated:

> I write in response to your letter of February 23, 2006 in which you requested an estimate as to the timeline for the three forensic pathology experts to complete their reports with respect to the death of [Valin].
>
> I am currently making arrangements for the original microscopic slides to be delivered to Dr. Butt and Professors Milroy and Crane, in keeping with my letter of February 14, 2006. The slides will be transported in the secure custody of Det. Sgt. Tom Girling. Once I am aware of Det. Sgt. Girling's travel arrangements, I will correspond with you and Mr. Lockyer.
>
> As you are aware, the three forensic pathology experts cannot complete their report until they have had the opportunity to review the original microscopic slides. The three experts are all aware of the urgency of this review. Once they have had an opportunity to review the microscopic slides, I will contact them individually to determine when their reports will be complete. I will correspond with you and Mr. Lockyer once I have this information.
>
> I appreciate the fact that there is time pressure to completing these reviews and I will continue to take steps to ensure the review process is completed as soon as possible.[293]

220. On March 21, 2006, Dr. McLellan wrote to Mr. Lockyer. He stated:

> In follow-up to my letter of March 6, 2006, I write to inform you that Det. Staff Sgt. Tom Girling departed for the United Kingdom on March 18, 2006, carrying with him the original microscopic slides arising from the autopsy conducted on [Valin]. These original microscopic slides will be made available to Professors Milroy and Crane for their review.
>
> I understand that Dr. Butt will likely be in Toronto sometime during the first two weeks of April for other purposes. He has been contacted and will review the original microscopic slides when he is in Toronto.

---

[292] Email from Ms. Christine Fontanella, February 24, 2006, PFP116476, p. 1; Letter from Dr. Pollanen to Dr. McLellan, July 4, 2006, PFP058627.

[293] Letter from Dr. McLellan to Ms. Fairburn, March 6, 2006, PFP058622.

> Once I am aware that the three forensic pathology experts have reviewed the original microscopic slides, I will be contacting them to determine when their reports will be complete.[294]

G. The Reports of Professor Milroy, Professor Crane and Dr. Butt

221. Professor Milroy issued his report on May 1, 2006[295]. Dr. Butt issued his report on June 1, 2006.[296] Professor Crane replied on September 22, 2006. [297]

H. DNA Retesting

222. Meanwhile, continued efforts were being made to have further DNA testing done on some of the items originally seized as part of the investigation. On August 1, 2006, the OCCO published a specific protocol for additional DNA testing to be done in the Mullins-Johnson case.[298]

223. On September 26, 2006, Mr. Lockyer wrote to Ms. Fairburn regarding the August 1, 2006 protocol. He stated:

> I have now reviewed the draft Centre of Forensic Sciences' protocol. I have no problem with its contents but for one matter. In my opinion the work should be done in Toronto and not Sault Ste. Marie for three reasons:
>
> 1. The results need to be, as far as possible, beyond reproach. In this regard Mr. Newman himself should be asked to do the work, something I first suggested in my letter of April 3, 2006.
>
> 2. The impetus for this testing was begun by Inspector Pluss of the Sault Ste. Marie Police Service. The testing being conducted is so 'remote' that it would likely be rejected by the Centre of Forensic Sciences in normal circumstances. Bearing in mind as well Dr. Rasaiah's unsolicited second, third and fourth opinions on his views of the pathology of the case, Mr. Mullins-Johnson has cause for concern that the authorities in Sault Ste. Marie perceive themselves to

[294] Letter from Dr. McLellan to Mr. Lockyer, March 21, 2006, PFP058625.
[295] Report of Professor Milroy, May 1, 2006, PFP004096.
[296] Report of Dr. Butt, June 1, 2006, PFP004065.
[297] Report of Professor Crane, September 22, 2006, PFP004089.
[298] Protocol for Additional Testing, August 1, 2006, PFP058702.

have a lot at stake in this case. He, and I, would feel a lot ' safer' if the work was done in- a place far removed from Sault Ste. Marie by a person who has had no previous association with it.

3.Last and not least I will be designating an expert for Mr. Mullins-Johnson pursuant to the protocol. He/she will be from Toronto and consequently if the work is done in Sault Ste. Marie it will significantly increase the time and cost for that expert. On the other hand, to ship the items to be examined to Toronto seems a minimal inconvenience.[299]

224. On October 19, 2006, Ms. Fairburn wrote to Det. S/Sgt. Dickinson. She stated:

As a follow-up to my e-mail message to you and Inspector Pluss yesterday, I am requesting that the following exhibits be forwarded to the Centre of Forensic Sciences in Toronto for testing:

a. Mr. Mullins-Johnson's trackpants that he was wearing at the time he was arrested (CFS # B37, SSMP #38)

b. Two pairs of male underwear (one white and one blue) seized from laundry pile (SSMP #60 - never before submitted to CFS)

c. Garbage pail and its contents seized from upstairs washroom (SSMP #57)

d. [Valin's] fingernail clippings taken at the time of autopsy (SSMP #3A (left hand) and 2B (right hand) - never before submitted to CFS).

The items should be directed to the attention of Jonathan Newman, the head of the biology section in Toronto. As indicated in my e-mail message to you yesterday, there is a premium on getting these items to the lab as quickly as possible. Provided they are received at the CFS soon, the biology work can be completed by the end of November to middle of December. We have provided this date to Professor Paciocco as the date when he will receive the Crown's position with respect to the case. Anything you can do to get the samples to Toronto as soon as possible would be most appreciated.[300]

225. That same day, Ms. Fairburn wrote to Mr. Lockyer. She stated:

We take no objection to the testing being done in Toronto, as you requested in your letter dated September 26, 2006. I have consulted with Mr. Jonathan

[299] Letter from Mr. Lockyer to Ms. Fairburn, September 26, 2006, PFP058689.

[300] Letter from Ms. Fairburn to Det. S/Sgt. Dickinson, October 19, 2006, PFP058691.

> Newman on this issue, and we agree that the convenience of your expert is a valid consideration. Mr. Jonathan Newman has very kindly agreed to do the required forensic work. As I indicated in my call to you on October 13, 2006, provided Mr. Newman receives the items soon, subject to the availability of your expert, he believes that he can have the testing completed by the end of November to mid-December. The Sault Ste. Marie Police Service has agreed to transport the items to Toronto. I am informed that this can be done probably by mid-next week. I expect to have confirmation of that fact soon and will let you know the exact date once I hear from Inspector Art Pluss. The items will be directed to the specific attention of Mr. Newman.
>
> As per your request of me during our conversation last week, Mr. Newman informs me that your expert is welcome to be present when the items are unpackaged. Once Mr. Newman is in possession of the sealed items, we will coordinate a mutually convenient date for all.[301]

226. It would appear that the DNA re-testing was conducted on November 8, 2006. [302]

227. On November 22, 2006, Dr. Jonathan Newman, Biology Section Head, CFS, issued his Preliminary Report.[303]

228. On March 23, 2007, Ms. Fairburn sent an email to Dr. Knight, which stated:

> As I indicated in the message I left for you earlier today, I am a Crown Counsel working on the above case. In a letter to Mr. David Bayliss dated August 11, 2005, you provided your opinion with respect to a number of forensic pathology issues in this case.
>
> In the letter, you make reference to having reviewed twenty-seven re-cut slides provided to you by the Office of the Chief Coroner for Ontario. On page 13 of the report, you indicate that the slides carried "serial number A-53-91" and were individually numbered 1 to 28, although there was no slide number 27. Would you be kind enough to consult your notes and confirm the slide numbers you were dealing with? The reason I ask is that the serial number for the slides in this case was actually A-93-51. While having spoken with Dr. Michael Pollanen, it appears that this is likely a transposition error in the report, it would be very helpful if you could confirm the slide numbers you viewed. To this end, could you please send me a communication by letter or e-mail to confirm? My e-mail address is…

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[301] Letter from Ms. Fairburn to Mr. Lockyer, October 19, 2006, PFP058694.

[302] Letter from Mr. Lockyer to Ms. Fairburn, November 1, 2006, PFP058700.

[303] Preliminary Report of Dr. Newman, November 22, 2006, PFP058739.

> While I appreciate how very busy you are, your prompt attention to this inquiry would be most appreciated. We are endeavouring to have submissions done in this case in the very near future and this is one of the few issues that remains outstanding. Thank you for your assistance.[304]

229. Dr. Knight replied to Mrs. Fairburn the next day. He wrote:

> Thanks for your phone call and Email.
>
> I am afraid that I cannot help you at all in this matter, as I have absolutely nothing left in the way of documentation about the Mullins-Johnson case. I have been retired for eleven years and have no office or secretarial facilities. I gave up offering forensic expertise years ago and became involved in Mullins-Johnson as a personal favour, as with the Truscott case, though I can't remember the circumstances.
>
> I have no hard copy of any reports now and the electronic version on my home computer was lost when it fatally crashed a considerable time ago. There were never any 'notes' about the slides, as I always write directly into a final report.
>
> As to the slide numbers, I would be surprised if the numbers I quoted in my report were incorrect, unless it was an undetected typing error.
>
> Whatever the numbers, I recall that I agreed in every respect with Dr Pollanen's interpretation of the slides.[305]

230. On April 2, 2007, Mr. Newman released his final report on the DNA testing. He concluded:

> 1. A single source male DNA profile suitable for comparison was obtained at up to 9 STR loci from the following items:
>
> 5-2 Acid phosphatase positive area C from trackpants
>
> 5-3 Acid phosphatase positive area D from trackpants
>
> 5-4 Acid phosphatase positive area E from trackpants
>
> 5-5 Acid phosphatase positive area (original testing) from trackpants

[304] Email from Ms. Fairburn to Dr. Knight, March 23, 2007, PFP058631.
[305] Email from Dr. Knight to Ms. Fairburn, March 24, 2007, PFP058631.

7-2 Bloodstain on outside, front of white underwear (epithelial fraction only)

7-3 Cut-out of fabric from inside, front of white underwear (epithelial fraction only)

2. No DNA other than that attributable to [Valin] (B35) was obtained from the right (item 4-2) hand fingernail clippings from her.

3. In addition to DNA attributable to [Valin] (B35) a trace amount of DNA (one allele) was detected on the left hand fingernail clippings (item 4-1) at one locus only. This allele cannot be attributed to the donor of the male DNA profile determined from items 5-2 to 5-5, 7-2 and 7-3, described above.

4. The DNA profile from the amylase positive area A from the trackpants (5-7) is a mixture, a major source of DNA and a trace amount of DNA comprising the minor source. The major DNA profile can be accounted for by the same male DNA profile observed in samples 5-2 to 5-5, 7-2 and 7-3.[306]

231. On April 4, 2007, Ms. Fairburn sent an email to Dr. McLellan in which she wrote:

I understand that Dr. Rasaiah is no longer on the roster of pathologists used by OCCO. Is this correct and since when? Prior to that occurring (if I am correct) what would be the correct way to characterize his relationship with OCCO? i.e. Contract, on a roster, employed by ... Thank you for your ongoing assistance.[307]

232. Dr. McLellan responded to Ms. Fairburn that same day. He stated:

Dr. Rasaiah is still conducting coroner's autopsies at the Sault Area Hospital. Criminally suspicious cases and homicides are no longer autopsied in Sault Ste. Marie.

Dr. Rasaiah conducts these autopsies under Coroner's Warrant on a fee for service basis (as do all other pathologists who conduct coroner's autopsies at Ontario hospitals).

I hope that this is the information you were looking for.[308]

[306] Report of Dr. Newman, April 2, 2007, PFP058754.

[307] Email from Ms. Michal Fairburn to Dr. McLellan, April 4, 2007, PFP058634.

[308] Email from Dr. McLellan to Ms. Fairburn, April 4, 2007, PFP058634.

Part VII. Mr. Mullins-Johnson's Section 696 Application Granted

233. In April, 2007, Ms. Fairburn and Mr. Campbell of the Ministry of the Attorney-General filed their submissions to the Minister on Mr. Mullins-Johnson's s. 696 application. They stated:

> In the unusual circumstances of this case, and bearing in mind Dr. Ferris' recantation of critical aspects of his evidence, Dr. Smith's credibility and reliability difficulties, and the sheer weight of the new expert opinion evidence, the Minister of Justice should order an appeal. At that appeal, Mr. Mullins-Johnson should be acquitted.[309]

234. On Friday, April 27, 2007, Attorney-General Michael Bryant called publicly for an acquittal in Mr. Mullins-Johnson's case.[310]

235. On July 17, 2007, the Minister of Justice, the Honourable Ron Nicholson, granted the application for ministerial review and referred the case to the Court of Appeal for Ontario on the following terms:

> AND WHEREAS, new information has arisen concerning whether William Mullins-Johnson was guilty or not guilty of the murder of [Valin], which information was not presented as evidence at trial, or on the appeal to this Honourable Court, or on the appeal to the Supreme Court of Canada;
>
> AND WHEREAS, an application for ministerial review (miscarriages of justice) was made to the Minister of Justice by counsel on behalf of William Mullins-Johnson pursuant to Part XXI.1 of the *Criminal Code*, for an order directing a new trial or, in the alternative, for an order referring the matter to the Court of Appeal for hearing and determination as if it were an appeal by William Mullins-Johnson;
>
> AND WHEREAS, I am satisfied that there is a reasonable basis to conclude that a miscarriage of justice likely occurred in this case;
>
> I HEREBY respectfully refer this matter to this Honourable Court pursuant to section 696.3(3)(a)(ii) of the *Criminal Code*, based on a consideration of the existing record herein, the evidence already heard, and such further evidence as this Honourable Court in its discretion may receive and consider, to determine

[309] Submissions of the Ministry of the Attorney-General, April 2007, PFP135700, p. 93, para. 211.
[310] Article, CBC News, April 27, 2007, PFP116325.

> the case as if it were an appeal by William Mullins-Johnson on the issue of fresh evidence.[311]

236. That same day, Mr. Mullins-Johnson was re-released by the Court of Appeal for Ontario on bail pending the hearing of his appeal.[312]

237. On September 6, 2007, counsel for Mr. Mullins-Johnson filed their factum in the Court of Appeal for Ontario. Counsel for Mr. Mullins-Johnson sought an acquittal and a declaration of factual innocence from the Court.

238. The Respondent, the Crown Law Office Criminal, filed its factum on October 3, 2007. The Crown supported an acquittal for Mr. Mullins-Johnson, but submitted that the Court of Appeal should not make a declaration of factual innocence.

239. The appeal was heard on October 15, 2007. After hearing *viva voce* evidence from Mr. Mullins-Johnson and Dr. Michael Pollanen, and the submissions of counsel, the Court of Appeal acquitted Mr. Mullins-Johnson. The Court reserved on the issue of whether a declaration of factual innocence should be made.

240. On October 19, 2007, the Court of Appeal delivered its written judgment. The Court confirmed that Mr. Mullins-Johnson was wrongly convicted and that he was "the subject of a terrible miscarriage of justice", but did not make a declaration of factual innocence.[313] The Court stated:

> [20] We agree with the submissions of Crown counsel about the fresh evidence as expressed in para. 12 of their factum:
>
> > There is no doubt that the new expert opinions in this case are credible and highly cogent. They go to the very core of whether there was an offence committed in this case. The opinions have been provided by some of the leading Canadian and international experts in forensic pathology and pathology. The opinions not only have a profound impact

[311] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 19.
[312] Appellant's Factum at the Ontario Court of Appeal, September 6, 2007, PFP135543, para. 19.
[313] *R. v. Mullins-Johnson*, October 19, 2007, 2007 ONCA 720.

> on the reliability of the jury verdict reached at trial, it is submitted that they are dispositive of the result.

[21] Finally, in their excellent factums the parties have fully reviewed for us the entire body of evidence aside from the expert evidence. In short, without the expert evidence there is no case against the appellant and no evidence of a crime. The non-expert evidence, if anything, is inconsistent with guilt and, again, is not indicative of a crime. Now that the trial expert evidence has been completely discredited, there is no case against the appellant and he is clearly entitled to an acquittal.

THE DECLARATION OF INNOCENCE

[22] The fresh evidence shows that the appellant's conviction was the result of a rush to judgment based on flawed scientific opinion. With the entering of an acquittal, the appellant's legal innocence has been re-established. The fresh evidence is compelling in demonstrating that no crime was committed against [Valin] and that the appellant did not commit any crime. For that reason an acquittal is the proper result.

[23] There are not in Canadian law two kinds of acquittals: those based on the Crown having failed to prove its case beyond a reasonable doubt and those where the accused has been shown to be factually innocent. We adopt the comments of the former Chief Justice of Canada in *The Lamer Commission of Inquiry Pertaining to the Cases of: Ronald Dalton, Gregory Parsons, Randy Druken*, Annex 3, pp. 342:

> [A] criminal trial does not address "factual innocence". The criminal trial is to determine whether the Crown has proven its case beyond a reasonable doubt. If so, the accused is guilty. If not, the accused is found not guilty. There is no finding of factual innocence since it would not fall within the ambit or purpose of criminal law.

[24] Just as the criminal trial is not a vehicle for declarations of factual innocence, so an appeal court, which obtains its jurisdiction from statute, has no jurisdiction to make a formal legal declaration of factual innocence. The fact that we are hearing this case as a Reference under s. 696.3(3)(a)(ii) of the *Criminal Code* does not expand that jurisdiction. The terms of the Reference to this court are clear: we are hearing this case "as if it were an appeal". While we are entitled to express our reasons for the result in clear and strong terms, as we have done, we cannot make a formal legal declaration of the appellant's factual innocence.

[25] In addition to the jurisdictional issue, there are important policy reasons for not, in effect, recognizing a third verdict, other than "guilty" or "not guilty", of "factually innocent". The most compelling, and, in our view, conclusive reason is the impact it would have on other persons found not guilty by criminal courts. As

Professor Kent Roach observed in a report he prepared for the *Commission of Inquiry into Certain Aspects of the Trial and Conviction of James Driskell*, "there is a genuine concern that determinations and declarations of wrongful convictions could degrade the meaning of the not guilty verdict" (p. 39). To recognize a third verdict in the criminal trial process would, in effect, create two classes of people: those found to be factually innocent and those who benefited from the presumption of innocence and the high standard of proof beyond a reasonable doubt.

[26] Nothing we have said in these reasons should be taken as somehow qualifying the impact of the fresh evidence. That evidence, together with the other evidence, shows beyond question that the appellant's conviction was wrong and that he was the subject of a terrible miscarriage of justice. We conclude these reasons by paraphrasing what the president of the panel said to Mr. Mullins-Johnson at the conclusion of the oral argument after entering the verdict of acquittal: it is profoundly regrettable that as a result of what has been shown to be flawed pathological evidence Mr. Mullins-Johnson was wrongly convicted and has spent such a very long time in jail.

[27] We can only hope that these words, these reasons for judgment and the deep apology expressed by Ms. Fairburn on behalf of the Ministry of the Attorney General will provide solace to Mr. Mullins-Johnson, to his mother and to everyone who has been so terribly injured by these events.

DISPOSITION

[28] Accordingly, in accordance with the terms of the Reference and s. 696.3(3)(a)(ii) of the *Criminal Code,* we admit the fresh expert evidence, allow the appeal, quash the conviction for first degree murder and enter an acquittal.

[29] We wish to thank all counsel, defence and Crown, for their assistance not only in preparing the materials for this court and for their oral submissions but in assisting Mr. Mullins-Johnson in his pursuit of the acquittal that he so justly deserves. And, while all the experts deserve thanks, we wish to express special appreciation to Dr. Pollanen whose diligence set in motion the chain of events that led to this acquittal.[314]

[314] *R. v. Mullins-Johnson*, October 19, 2007, 2007 ONCA 720.

Appendix 28
Overview of the 20 Cases

The 20 cases that follow were examined as part of the Chief Coroner's Review.

1 Amber

Amber was born in Timmins, Ontario. She died on July 30, 1988, at the age of 16 months. On July 28, 1988, she was taken to the local hospital. Her 12-year-old babysitter, S.M., reported that Amber had fallen down the stairs. Amber was transferred to the Hospital for Sick Children (SickKids), where she later died. The investigating coroner did not order an autopsy and concluded that Amber had died from an accidental fall. SickKids physicians later discussed the case and concluded that the history of a short fall did not account for her injuries. On August 19, 1988, Amber's body was disinterred, and Dr. Charles Smith performed the autopsy. Dr. Smith concluded that Amber had died of a head injury caused by a severe shaking. On December 15, 1988, the police charged S.M. with manslaughter. S.M.'s trial lasted some 30 days over a 13-month period from October 1989 to November 1990. On July 25, 1991, the trial judge, Justice Patrick Dunn, acquitted S.M. of the manslaughter charge.

2 Baby F

Baby F was born and died on November 28, 1996. On November 30, 1996, police officers discovered Baby F's body wrapped in several plastic bags in her mother's bedroom closet. She had been dead for two days. On December 1, 1996, a pathologist at the local hospital conducted an autopsy. The pathologist requested a second opinion from Dr. Smith, who produced a consultation report, concluding that the cause of death was asphyxia. On March 19, 1998, Baby F's mother was charged with infanticide, and on July 6, 1998, she pleaded guilty to the charge. She received a two-month conditional sentence to be served at home, was placed on

probation for three years, and was ordered to perform 150 hours of community service. On October 24, 2006, Baby F's mother received a pardon arising out of the conviction.

3 Baby M

Baby M was born and died in Pickering, Ontario, on November 8, 1992. Early that morning, Baby M's grandparents found Baby M's mother in the bathroom of their home, covered in blood. Ambulance attendants discovered Baby M's body in the toilet. Dr. Smith performed the autopsy on the morning of November 8, 1992, and concluded that the cause of death was asphyxia. That evening, the police charged Baby M's mother with second-degree murder. In July 1994, Baby M's mother pleaded guilty to manslaughter. She received a suspended sentence, probation for three years, and was ordered to perform 300 hours of community service.

4 Baby X

Baby X died in 1996, at the age of two. The history was that Baby X suffered a fall while at a daycare facility. Dr. Smith performed the post-mortem examination. Subsequently, Baby X's mother contacted Deputy Chief Coroner Dr. James Cairns about the results of the autopsy. Dr. Cairns requested that Dr. Smith meet Baby X's mother at her home in the Barrie area to discuss his findings. On September 4, 1996, Dr. Smith telephoned Baby X's mother and arranged to meet with her the next day at her home. The police intercepted the conversation and contacted Dr. Smith to advise him that listening devices installed in the home would likely intercept his conversation with Baby X's mother. On September 5, 1996, Dr. Smith met with Baby X's mother to discuss the post-mortem results. He met with the police before and after his meeting with Baby X's mother. The police investigation into Baby X's death is ongoing, and the Inquiry did not examine the forensic pathology in this case. The Inquiry only examined a discrete issue.

5 Delaney

Delaney was born in Woodstock, Ontario. He was pronounced dead on May 23, 1993, at the age of five months. On the evening of May 22, 1993, Delaney was left alone with his mother and cousin at a family member's home. The next day, family members discovered Delaney's body. His mother was in the same room. Physicians admitted Delaney's mother to a psychiatric hospital, where she later

confessed to putting her hand in Delaney's mouth three times. On May 24, 1993, Dr. Smith performed the autopsy. He concluded that the cause of death was asphyxia. On June 2, 1993, the police charged Delaney's mother with second-degree murder. They later added a charge of infanticide. On April 26, 1994, a jury acquitted Delaney's mother of second-degree murder but convicted her of infanticide. She received a suspended sentence and three years' probation.

6 Dustin

Dustin was born in Belleville, Ontario. He died on November 18, 1992, at the age of two months. On the morning of November 17, 1992, Dustin's father realized that Dustin was no longer breathing. He was taken to a local hospital, where he later died. On November 18, 1992, a local pathologist performed the autopsy. The pathologist concluded that the cause of death was (1) respiratory failure, secondary to bronchopneumonia and aspiration, and (2) massive subdural hematoma. In February 1993, the regional coroner consulted Dr. Smith for a second opinion. Dr. Smith reviewed the autopsy materials and concluded that the cause of death was blunt trauma. On April 22, 1993, the police charged Dustin's father with manslaughter and failure to provide the necessaries of life. On May 25, 1994, following a preliminary hearing, the court discharged Dustin's father of the charge of failure to provide the necessaries of life, but committed him to stand trial for manslaughter. On April 21, 1995, Dustin's father pleaded not guilty to manslaughter but guilty to the offence of aggravated assault. He was sentenced to six months in custody.

7 Gaurov

Gaurov was born in Toronto, Ontario. He died on March 20, 1992, at the age of five weeks. Gaurov's father reported that, on March 18, 1992, he heard his son cry, and, when he went to pick him up, Gaurov gasped and went limp. Gaurov was taken to a local hospital and then transferred to SickKids, where he later died. On March 21, 1992, Dr. Smith performed the autopsy and concluded that Gaurov had died of shaken baby syndrome. On June 26, 1992, Gaurov's father was charged with second-degree murder. On December 3, 1992, he pleaded guilty to a new charge of criminal negligence causing death. He was sentenced to 90 days in custody, to be served intermittently, and two years' probation.

8 Jenna

Jenna was born in Peterborough, Ontario. She died on January 22, 1997, at the age of 21 months. On January 21, 1997, at approximately 5 p.m., Jenna's mother, Brenda Waudby, left Jenna in the care of a babysitter, J.D., who was 14 years old at the time. That night, Jenna was taken to a local hospital, where she died. Dr. Smith performed the autopsy and concluded that Jenna had died of blunt abdominal trauma. On September 18, 1997, the police charged Ms. Waudby with second-degree murder. In October 1998, following a preliminary hearing, the court committed Ms. Waudby to stand trial on the charge. On June 15, 1999, after receiving the opinions of several experts suggesting that Jenna had suffered her fatal injuries at a time when Ms. Waudby did not have care of Jenna, the Crown withdrew the charge. Two years later, in July 2001, the police began a reinvestigation of Jenna's death. Ultimately, in December 2006, J.D. pleaded guilty to manslaughter. He was sentenced as a youth to 22 months in custody, followed by 11 months of community supervision.

9 Joshua

Joshua was born in Belleville, Ontario. He died on January 23, 1996, at the age of four months. On the morning of January 23, 1996, Joshua was taken to a local hospital, where he died. Joshua's mother, Sherry Sherret, reported that when she went to Joshua's bed that morning, she discovered that he was blue and not moving. Dr. Smith performed the autopsy on January 24, 1996, and concluded that the cause of death was asphyxia. On March 27, 1996, the police charged Ms. Sherret with first-degree murder. The preliminary hearing took place over a 12-month period, from January 1997 to January 1998. On January 13, 1998, the judge committed Ms. Sherret to stand trial for first-degree murder. On May 26, 1998, the defence brought an application by way of certiorari to quash the committal, which the court granted. Ms. Sherret was ordered to stand trial on the charge of second-degree murder. On January 4, 1999, a new indictment was put before the court charging Ms. Sherret with infanticide. She pleaded not guilty to the charge but elected to call no evidence. She was convicted of infanticide and sentenced to one year in custody, followed by probation for two years.

10 Kasandra

Kasandra was born in Mississauga, Ontario. She died on April 11, 1991, at the age of three-and-a-half years. On April 9, 1991, ambulance attendants found

Kasandra unconscious. They took her to a local hospital, which transferred her to SickKids, where she later died. Kasandra's stepmother later admitted to hitting Kasandra on the head. On April 12, 1991, Dr. Smith performed the autopsy. He concluded that the cause of death was cranio-cerebral trauma. On April 24, 1991, the police charged Kasandra's stepmother with manslaughter. On July 3, 1991, following a preliminary hearing, the court committed her to stand trial on the charge. On August 2, 1991, Kasandra's stepmother filed an application for certiorari to quash the committal, which she later abandoned. Kasandra's stepmother's trial commenced in the fall of 1992. After several days of testimony at the trial, she changed her plea to guilty. On October 22, 1992, Kasandra's stepmother was convicted of manslaughter. She was sentenced to two years less one day in custody. In 1997, a coroner's inquest was held into Kasandra's death.

11 Katharina

Katharina was born in Toronto, Ontario. She was found dead on September 15, 1995, at the age of three-and-a-half years. That afternoon, the police found Katharina's body in her mother's apartment. Her mother admitted to smothering her daughter with a pillow. The police charged her with first-degree murder. Dr. Smith performed the autopsy on September 16, 1995, and determined the cause of death to be asphyxia. In February 1996, following a preliminary hearing, the court committed Katharina's mother to stand trial on the first-degree murder charge. After the preliminary hearing, her fitness to stand trial became an issue. However, on October 6, 1997, she was found fit to stand trial and pleaded not guilty to the charge. On November 3, 1997, a court found her not criminally responsible for the death of Katharina due to the fact that she suffered from a mental disorder.

12 Kenneth

Kenneth was born in Scarborough, Ontario. He died on October 12, 1993, at the age of two years and five months. On the afternoon of October 9, 1993, Kenneth's mother telephoned 911 because her son was not breathing. According to her, Kenneth had been tangled in his bedsheets. Kenneth was taken to the local hospital and then transferred to SickKids, where he later died. Dr. Smith performed the autopsy on October 13, 1993, and concluded that the cause of death was asphyxia. On November 23, 1993, the police charged Kenneth's mother with second-degree murder. On October 24, 1995, a jury convicted Kenneth's mother of the offence. She was sentenced to life imprisonment with parole ineligibility

for 10 years. She appealed. On January 22, 1998, the Court of Appeal for Ontario dismissed her appeal.

13 Nicholas

Nicholas was born in Sudbury, Ontario. He died on November 30, 1995, at the age of 11 months. That day, Nicholas was taken to a local hospital, where he was pronounced dead. His mother, Lianne Gagnon, reported that Nicholas had crawled under a sewing table and had fallen from a standing to a sitting position before losing consciousness. She assumed that he had hit his head on the underside of the sewing machine. On December 1, 1995, a pathologist at the local hospital performed the autopsy. The pathologist concluded that the cause of death was undetermined and that the findings were consistent with sudden infant death syndrome, provided all other aspects of the investigation were negative. In November 1996, the regional coroner referred the case to the Paediatric Death Review Committee, which assigned the initial review of the case to Dr. Smith. On January 24, 1997, Dr. Smith produced a consultation report, attributing Nicholas' death to blunt head injury. On June 25, 1997, Nicholas' body was exhumed, and Dr. Smith performed a second autopsy. He concluded that the cause of death was cerebral edema. Ultimately, the Crown and the police did not pursue any criminal charges in relation to Nicholas' death. However, in 1998, the local children's aid society initiated proceedings in respect of Ms. Gagnon's second child. The proceedings concluded on March 25, 1999, when the children's aid society withdrew its application after it was provided with an independent expert report by Dr. Mary Case.

14 Paolo

Paolo died on May 29, 1993, at the age of eight-and-a-half months. On May 30, 1993, a local pathologist performed the post-mortem examination, and concluded that Paolo's death was attributable to sudden infant death syndrome. Almost one year later, on May 6, 1994, Paolo's parents, Marco and Anisa Trotta, brought a second child, who was one month old at the time, to the hospital with a fractured femur. This led to the reopening of the investigation into Paolo's death. In July 1994, Paolo's body was exhumed, and Dr. Smith performed a second autopsy. He found multiple fractures but opined that the cause of death was undetermined. The police charged Mr. Trotta with second-degree murder, aggravated assault, and assault causing bodily harm. They charged Ms. Trotta with manslaughter, criminal negligence causing death, and failing to provide the nec-

essaries of life. On June 12, 1998, a jury convicted Mr. Trotta of all charges. He was sentenced to life imprisonment with no eligibility for parole for 15 years. Ms. Trotta was acquitted of manslaughter but was convicted of criminal negligence causing death and failing to provide the necessaries of life. She was sentenced to five years in custody. Both Mr. and Ms. Trotta appealed their convictions. In 2004, the Court of Appeal for Ontario dismissed their appeals. They appealed to the Supreme Court of Canada. On November 8, 2007, the Supreme Court of Canada allowed their appeals, set aside their convictions, and ordered a new trial which is pending. For this reason, the Inquiry did not examine this case in detail.

15 Sharon

Sharon was born in Kingston, Ontario. She died on June 12, 1997, at the age of seven-and-a-half years. That evening, the police found Sharon's body in the basement of her home. On June 13 and 15, 1997, Dr. Smith performed the autopsy. The police later discovered that there was a pit bull dog in Sharon's home on the night of her death. Dr. Smith concluded that the cause of death was exsanguination, secondary to multiple stab wounds. On June 26, 1997, the police charged Sharon's mother, Louise Reynolds, with second-degree murder. Ms. Reynolds' preliminary hearing took place over 15 days between April and November 1998. On November 19, 1998, the preliminary hearing judge committed her to stand trial for second-degree murder. In July 1999, after Dr. Cairns and Chief Coroner Dr. James Young learned that other experts believed that Sharon had died from a dog attack, Sharon's body was exhumed. Dr. David Chiasson performed the second autopsy on July 13, 1999. He concluded that a dog caused at least some of Sharon's injuries, but that it was possible that a weapon caused some others. On January 25, 2001, after receiving the reports of several experts suggesting that Sharon had died as a result of a dog attack, the Crown withdrew the second-degree murder charge against Ms. Reynolds.

16 Tamara

Tamara was born in Scarborough, Ontario. She died on February 8, 1999, at the age of one year. That afternoon, Tamara was taken to a local hospital, where she was pronounced dead. Tamara's mother reported that, when she got home early that afternoon, she found that Tamara was cold and not breathing. On February 9, 1999, Dr. Smith performed the post-mortem examination. He later concluded that the cause of death was asphyxia associated with multiple traumatic injuries. On February 10, 1999, the police charged Tamara's father with second-degree

murder. On May 18, 2000, following a preliminary hearing, the court ordered him to stand trial on the charge. On August 30, 2001, Tamara's father pleaded guilty to manslaughter. He was sentenced to three-and-a-half years in custody, in addition to 15 months of time served.

17 Taylor

Taylor was born in Thunder Bay, Ontario. He died on July 31, 1996, at the age of three-and-a-half months. That night, the police were called to Taylor's home, where they found his body. On August 1, 1996, a pathologist at a local hospital performed the autopsy. Following the autopsy, the pathologist consulted with Dr. Smith. Both pathologists concluded that the cause of death was head injury. Taylor's parents were charged with second-degree murder, criminal negligence causing death, and failure to provide the necessaries of life. On June 30, 1997, following a preliminary hearing, the court discharged Taylor's parents on all charges. On September 7, 1999, the Crown brought an application to quash the discharges, which the court dismissed on September 21, 1999. On October 19, 1999, the Crown filed a notice to appeal the court's dismissal of its application. Ultimately, the Crown abandoned that appeal.

18 Tiffani

Tiffani was born in Kingston, Ontario. She died on July 4, 1993, at the age of three-and-a-half months. That morning, ambulance attendants found Tiffani's body in her bed. A pathologist at a local hospital performed the autopsy on July 5, 1993. The pathologist found nothing suspicious and initially reported that the cause of death was undetermined. After Tiffani was buried, the police and regional coroner learned that a radiologist had overlooked several rib fractures on Tiffani's X-ray. On July 13, 1993, Tiffani's body was exhumed, and Dr. Smith performed a second autopsy. Dr. Smith found multiple rib fractures and diagnosed the cause of death as asphyxia. On July 23, 1993, the police charged Tiffani's parents with failing to provide the necessaries of life and aggravated assault. On March 25, 1994, the police added a further charge of manslaughter. On May 12, 1995, following a preliminary hearing, the court discharged Tiffani's parents of the manslaughter and aggravated assault charges, and Tiffani's parents pleaded guilty to failing to provide the necessaries of life. Tiffani's mother received a suspended sentence and probation for two years, and her father was sentenced to five months in custody.

19 Tyrell

Tyrell was born in Toronto, Ontario. He died on January 23, 1998, at the age of four years. On the morning of January 19, 1998, Tyrell's caregiver brought him to a local hospital. He was later transferred to SickKids, where he died. Tyrell's caregiver reported that, the previous night, Tyrell had been jumping on the couch at home when he fell and hit his head. Dr. Smith performed the autopsy on January 24, 1998. He concluded that Tyrell had died of a head injury. On January 6, 1999, the police charged Tyrell's caregiver with second-degree murder. In January 2000, following a preliminary hearing, the judge committed Tyrell's caregiver to stand trial on the second-degree murder charge. On January 22, 2001, after receiving conflicting reports from several experts, the Crown requested a stay of the proceedings against Tyrell's caregiver.

20 Valin

Valin was born in Sault Ste. Marie. She died on June 26 or 27, 1993, at the age of four. On the morning of June 27, 1993, Valin's mother found Valin in bed, face down and on her knees. Ambulance attendants concluded that she was already dead. The evening before, Valin and her brother were left in the care of their uncle, William Mullins-Johnson. On June 27, 1993, a pathologist at a local hospital performed the autopsy, concluded that Valin had died of cardio-respiratory arrest due to asphyxia, and found evidence of sexual abuse. That day, the police charged Mr. Mullins-Johnson with first-degree murder and aggravated sexual assault. The pathologist consulted a physician at SickKids, who later authored a joint consultation report with Dr. Smith. The SickKids physicians opined that Valin had likely died of asphyxia and that she had suffered anal penetration. The defence experts agreed, to various degrees, with those opinions. On September 21, 1994, a jury convicted Mr. Mullins-Johnson of first-degree murder. He was sentenced to life in prison with no eligibility of parole for 25 years. Mr. Mullins-Johnson appealed to the Court of Appeal for Ontario. On December 19, 1996, the majority of the Court dismissed the appeal. Mr. Mullins-Johnson then appealed to the Supreme Court of Canada, which heard and dismissed his appeal on May 26, 1998. In 2001, the Association in Defence of the Wrongly Convicted began investigating Mr. Mullins-Johnson's case. Several experts reviewed Valin's autopsy materials. On September 7, 2005, Mr. Mullins-Johnson filed an application for ministerial review pursuant to the *Criminal Code*, ss. 696.1 to 696.6. On July 17, 2007, the minister of justice granted the application and referred the case to the Court of Appeal for

Ontario. On October 19, 2007, the Court allowed the appeal and acquitted Mr. Mullins-Johnson of first-degree murder.

Appendix 29

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

The Honourable Stephen Goudge, Commissioner

180 Dundas Street West, 22nd Floor
Toronto Ontario M5G 1Z8

Tel: 416 212-6878
1 866 493-4544
Fax: 416 212-6879
Website: www.goudgeinquiry.ca

Ontario

COMMISSION D'ENQUÊTE SUR LA MÉDECINE LÉGALE PÉDIATRIQUE EN ONTARIO

L'honorable Stephen Goudge, Commissaire

180, rue Dundas Ouest, 22e étage
Toronto (Ontario) M5G 1Z8

Tél. : 416 212-6878
1 866 493-4544
Téléc. : 416 212-6879
Site Web : www.goudgeinquiry.ca

Policy Roundtables: Participants and Issues

Roundtable on February 11, 2008 (morning): Credentialing and Growing the Pediatric Forensic Pathology Service in Ontario.

Panellists: Drs. Stephen Cordner (Australia)*, Randy Hanzlick (United States)*, Christopher Milroy (England) and Michael Pollanen will participate.

Questions may include:

1) What educational enhancement is necessary, at the undergraduate and graduate level?
2) What research enhancement is needed?
3) What are the roles of universities and the forensic pathology community in contributing to these objectives?
4) What role can universities play in developing evidence based forensic medicine?
5) What are the resource implications of these objectives?
6) What additional professional certifications are needed and which organizations should provide them?
7) What is the role of the medical professional organizations (particularly of pathologists) in upgrading quality?
8) Should there be a government approved roster of qualified forensic pathologists? Who should run it? What would its duties be beyond credentialing?
9) In addition to addressing quality, will these steps enhance supply? What else is needed? More resources? More use of technology to access global supply?

Roundtable on February 11 (afternoon): Organizing Pediatric Forensic Pathology in Ontario.

Panellists: Drs. David Ranson (Australia)*, Randy Hanzlick* (United States), Michael Pollanen, David Chiasson and Glenn Taylor will participate.

Questions may include:

1) How do we describe those pediatric deaths that require enhanced investigation? All except those that are certain not to be the subject of charges? Or, those that are criminally suspicious or unexplained? Or, those that are criminally suspicious from the beginning? Or become criminally suspicious during the investigation? (The identified group of cases may be called pediatric forensic cases.)

2) Should there be a lead subspecialty in these investigations? Or is double doctoring better? What are the cost and human resource implications of each?

3) How should the forensic pathology service be set up or maintained in Ontario? Should it be regionalized? Should forensic pathology investigations be concentrated in specified centres in Ontario? What is the optimal mix of salaried and fee for service forensic pathologists? Within the forensic pathology service, how should pediatric forensic pathology be organized? Should pediatric forensic pathology be connected to teaching hospitals? If so, how?

Roundtable on February 12 (morning): Enhancing the Relationship Between the Coronial Service and the Pediatric Forensic Pathology Service.

Panellists: Drs. Stephen Cordner (Australia)*, Albert Lauwers, Michael Pollanen and the Chief Coroner, Dr. Bonita Porter, will participate.

Questions may include:

1) Questions may include: What is the optimal relationship between the Chief Coroner and the Chief Forensic Pathologist?

2) To whom should each report?

3) Who should be ultimately responsible for quality assurance?

4) Who should select the forensic pathologist in an individual case?

5) What education and training should coroners have respecting pediatric forensic pathology issues?

6) How should the roles of the coroner and the forensic pathologist be best delineated in the investigation of pediatric forensic cases?

7) What information should be made available to each to best discharge their roles?

8) What roles should the coroner and the forensic pathologist play in determining "cause" and "manner" of death? "Mechanism" of death?

Roundtable on February 12 (afternoon): The Death Investigation Team in Pediatric Forensic Cases.

Panellists: Dr. David Ranson (Australia)*, Det. Sgts. Chris Buck and Gary Giroux, Crown counsel John Ayres, and Dr. Albert Lauwers will participate.

Questions may include:

1) Do those involved in pediatric forensic cases require specialized training? If so, what? Delivered by whom?

2) What is the role of the pathologist's level of certainty as to cause of death in investigation or charge selection?

3) Should the police have guidelines about the kind of information given or kept from the forensic pathologist? What about ongoing information acquisition?

4) Should there be guidelines about the police acting on early and incomplete forensic pathology opinions?

5) What tools should the police and Crowns have to ensure timeliness by forensic pathologists?

6) Should the police and Crowns have guidelines about communicating forensic pathology opinions to child protection officials?

7) What is the role of case conferencing in death investigation?

8) How can tunnel vision be best prevented particularly in highly charged baby death cases?

9) What role, if any, should prior bad conduct by caregivers play in baby death cases?

10) What role, if any, should a SCAN Team play in pediatric death investigations?

Roundtable on February 13 (3/4 day): Oversight and Accountability

Panellists: Professor Lorne Sossin*, Drs. Stephen Cordner and David Ranson (Australia)* and Dr. Ray Prime will participate.

Questions may include:

1) What are the relative responsibilities of the Chief Forensic Pathologist and the Chief Coroner in quality assurance?

2) Should spot audits be used? Who should do them? How often? Using what information?

3) Should the quality assurance process encompass the pathologist's work following the post-mortem report? If so, how can the necessary information be obtained? Should counsel give evaluations of court performance?

4) Are special mechanisms are needed for the perceived leaders of the discipline?

5) What sanctions should be available where concerns are uncovered?

6) What role can hospitals play in quality assurance for forensic pathologists?

7) What communications should there be between hospitals and the OCCO about a pathologist's competence?

8) When quality assurance processes yield adverse results, should there be disclosure to the Crown or the defence?

9) How will quality assurance processes affect the supply of pathologists?

10) What can other jurisdictions teach us?

11) What can oversight and accountability employed for other forensic disciplines teach us?

Roundtable on February 14 (3/4 day): The Best Practices of Pediatric Forensic Pathology in a Particular Case.

Panellists: Drs. Stephen Cordner (Australia)*, Christopher Milroy (England), David Chiasson, and Michael Pollanen will participate.

Questions may include:

1) What is the proper attitude with which to approach a case? Think dirty? Think heightened index of suspicion? Think truth?
    a. What is evidence based forensic pathology? How does one encourage the development of evidence based pathology? How does it apply in any particular case? What scope remains for experience based considerations?
    b. Should there be guidelines or protocols for steps up to and including the autopsy?

2) Intake information

3) Site visits

4) Autopsy communications

5) Accompanying histology, toxicology, radiology tests etc.

6) The propriety of seeking clinical assistance

7) Memorialising activity and information exchange
    a. How and when should peer review occur? At the autopsy? After? After release of the post mortem report? How much information should be peer reviewed? Should review be external or internal? How can technology help? How can the "icon" risk be addressed? What disclosure obligations follow from peer review?
    b. Should there be guidelines or protocols for post mortem reports?

8) Requiring full elaboration of the facts and the reasoning used to reach the opinion

9) Considering the appropriate scope of the opinion

10) Concerning the use of circumstantial information to form the opinion

11) Requiring full transparency about others relied on

12) Concerning the degree of certainty underpinning the opinion

13) Concerning respect for the limits of expertise

14) Concerning timeliness
    a. Should there be guidelines, protocols, or codes of conduct for the pathologist's role in trial preparation and as an expert witness re:

15) Consistency with reports

16) Timeliness of response

17) Memorialising communications with police, Crowns and coroners

18) Ethical obligations to the court and the justice system

19) Obligations when testifying
    a. Who should be responsible for preparing these various guidelines?
    b. Who should be responsible for "policing" them? The Chief Forensic Pathologist? The Chief Coroner? What enforcement tools do they need for salaried pathologists? For fee for service pathologists?
    c. What are the cost implications of an enhanced level of scrutiny?
    d. How are particularly controversial issues like "shaken baby syndrome" best dealt with in a particular case?

Roundtable on February 15 (morning): Effective Communication between Pediatric Forensic Pathology and the Criminal Justice System.

Panellists: Professor Gary Edmond (Australia)*, Dr. David Ranson (Australia)*, Professor Kent Roach and Professor Erica Beecher-Monas (United States) will participate.

Questions may include:

1) How does the pathologist determine the level of certainty of his/her opinions?

2) How is that best articulated in reports? To the police? To the Court?

3) What language choices are best or should be avoided?

4) How are changing or supplementary opinions to be dealt with? If based on new information? If not, but simply not addressed in the post mortem report?

5) Should forensic pathologists have professional obligations regulating their testimony, to address issues such as speculation, unscientific language and exceeding their expertise? Who should prepare and enforce them?

Roundtable on February 19: Crown, Defence and the Court.

Panellists: Professor Michael Code, Marlys Edwardh, Nye Thomas, Rob Buchanan and Paul McDermott will participate.

Questions may include:

1) Should there be specialized training to do pediatric forensic cases?

2) How can forensic pathology expertise be made available to the defence?

3) Should Crown and defence experts exchange views and discuss them pre-trial? Under what terms of privilege or confidence? How can this be effected?

4) Should the court appoint its own expert? In what circumstances?

5) How can proper scepticism by defence counsel of Crown expertise be assured? By Crowns of defence expertise?

6) Should there be ethical constraints on plea-bargaining in cases of doubtful pathology?

7) What peer review documents should be disclosed to defence?

Roundtable on February 20 (morning): Viable Complaints Processes.

Panellists: Professor Joan Gilmour, Professor Lorne Sossin*, Dr. Rocco Gerace, and Dr. Catherine Yarrow will participate.

Questions may include:

1) What is the appropriate forum or forums to deal with complaints? CPSO? OCCO? CFP? Some hybrid? Other?

2) What is the threshold for full investigation of such a complaint?

3) What sanctions should be available?

4) If sanctions are applied, what effect should that have on past and present cases in the criminal justice system?

Roundtable on February 21 (morning): Pediatric Forensic Pathology and Potential Wrongful Convictions.

Panellists: Alastair MacGregor, Q.C. (England), Dr. Michael Pollanen, Bruce MacFarlane (Manitoba)*, Kerry Scullion and Mary Nethery will participate.

Questions may include:

1) Should there be a review of all pediatric forensic pathology convictions 1981 to date? By whom? In what depth? If not, should a subset be reviewed, e.g. shaken baby cases?

2) What should happen to conviction cases identified as having bad pathology by such a review?

3) When bad forensic pathology is discovered in a particular case, what is the responsibility of the OCCO to the criminal justice system? Similarly for the CPSO and the Crown?

4) What level of concern about a forensic pathologist is required to generate a complete review of all his/her pediatric forensic cases?

5) How can the s. 696 process be best utilized to address pediatric forensic pathology cases?

6) What lessons can be learned from the Criminal Cases Review Commission in addressing pediatric forensic pathology cases?

Roundtable on February 21 (afternoon): Pediatric Forensic Pathology and Potential Child Abuse.

Panellists: Professor Nicholas Bala*, Agnes Samler, Jane Fitzgerald and Andrew Koster will participate.

Questions may include:

1) What role does forensic pathology play in child protection cases?

2) What role do different burdens of proof and different liability rules play in child protection as opposed to criminal cases?

3) Does "think dirty" encourage increased awareness about child abuse? How can vigilance about child abuse be maintained?

4) How should CAS actions be co-ordinated with police and forensic pathology in cases of suspicious deaths where there are surviving children?

5) What, if any, can be done to minimize the harms to a family that has lost a baby in unknown or suspicious circumstances? Is close supervision of the family a viable alternative to apprehension of surviving children?

Roundtable on February 22 (morning): The Judicial System and Expert Scientific Evidence, Panel 1.

Panellists: The Honourable Patrick LeSage Q.C., The Honourable Mr. Justice Marc Rosenberg, Professor Gary Edmond (Australia)*, Professor Erica Beecher-Monas (United States), will participate.

Questions may include:

1) Is the legal system too vulnerable to inaccurate or unreliable or unrepresentative expert opinions and in particular to such forensic pathology opinions? Are reputations and style too important?

2) If so, what should be done to guard against these dangers? How do courts and counsel obtain the necessary knowledge content for healthy scepticism?

3) How should a judge ensure that experts do not give testimony beyond their range of expertise? Are there special challenges when the investigation was conducted by a multi-disciplinary team, many of whom may not testify?

4) How should expert opinion be challenged at the preliminary inquiry stage? In child protection proceedings?

5) Should judges be more cautious about admitting expert forensic pathology evidence even if it is not characterized as novel science?

6) What, if any, role should concerns about reliability and quality assurance play in the decision to admit expert testimony? Or the weight that is accorded to expert testimony?

7) Should judges be able to require competing experts to meet? To appoint their own experts?

8) What should be the role of continuing judicial education with respect to expert opinions?

9) What should be the role of guideline judgments such as those given by the Court of Appeal in England and Wales?

10) Should rules of courts address the form of expert reports and testimony?

Roundtable on February 22 (afternoon): The Judicial System and Expert Scientific Evidence, Panel 2.

Panellists: Andrew Robertson, Q.C. (England) and Alastair MacGregor, Q.C. (England).

Questions will be specific to possible lessons to be learned from the English experience in dealing with pediatric forensic pathology cases.

Six Policy Roundtables in Thunder Bay: Enhancing the Capacity of Pediatric Forensic Death Investigation in Remote or Northern Communities.

February 28, Roundtable 1: The Delivery of Pediatric Forensic Pathology Services in Northern Ontario

Panellists: Dr. Roger Strasser, Founding Dean of the Northern Ontario School of Medicine, a joint venture of Lakehead University (Thunder Bay) and Laurentian University (Sudbury); Dr. William McCready, Associate Dean of Clinical Affairs at the Northern Ontario School of Medicine; Dr. Martin Queen, Forensic Pathologist, Chief of Laboratory Medicine and Pathology, Sudbury Regional Hospital; Dr. David Eden, Regional Supervising Coroner, Northern Ontario; Dr. David Chiasson, Director of the Ontario Pediatric Forensic Pathology Unit, Hospital for Sick Kids; Dr. Bonnie Porter, Chief Coroner of Ontario

Questions may include:

(1) What initiatives have been/can be taken to increase the supply of family physicians in Northern Ontario who can serve as coroners? What role should the OCCO play in any recruitment initiatives?

(2) What inducements can be offered to encourage the existing population of practitioners to accept coronial duties? (e.g., guaranteed monthly stipends rather than the existing fee-for-service arrangement.)

(3) To what extent are Northern Ontario School of Medicine (NOSM) students exposed to pathology/forensic pathology in their undergraduate training? To what extent does NOSM interact with the Northeastern Regional Pathology Unit?

(4) How does/should NOSM's curriculum address the unique needs of Aboriginal communities?

(5) How many placements are/should be reserved for Northern and/or Aboriginal students?

(6) How does/should NOSM ensure that its medical students are, in fact, committed to practice in remote communities?

(7) How many Family Medicine post-graduate positions are offered by NOSM? Are NOSM Family Medicine residents exposed to coronial practice during their training?

(8) With respect to NOSM medical students who accept Family Medicine residencies in central or southern Ontario, how successful has NOSM been in attracting those students to return to Northern Ontario to establish practices?

(9) What role should the OCCO play in attracting NOSM students, undergraduate and post-graduate, to coronial practice? What resources would be required?

(10) What are the geographic boundaries for the new Northern Region? What determines those boundaries? What are the implications for oversight by the OCCO?

(11) Are the regional coroner's facilities and resources (staffing, equipment, access to/communication with head office and access to/communication with local coroners) adequate?

(12) Should a centralized dispatch service be introduced to the Northern Region?

(13) What should the catchment areas be for pediatric forensic pathology services for the Northern Region?

(14) How can technological solutions (such as tele-health) assist the coroner in meeting the challenges presented by the North's relatively sparse and dispersed population in dealing with pediatric forensic death cases?

February 28, Roundtable 2: The Organization of Pediatric Forensic Death Investigations

Panellists: Dr. Shelagh McCrae, Investigating Coroner; Det. Insp. Dennis Olinyk, Ontario Provincial Police; Dr. David Eden, Regional Supervising Coroner, Northern Ontario; Dr. Martin Queen, Forensic Pathologist, Chief of Laboratory Medicine and Pathology, Sudbury Regional Hospital; Dr. David Chiasson, Director of the Ontario Pediatric Forensic Pathology Unit, Hospital for Sick Kids; Mr. James Sargent, Funeral Director

Questions may include:

(1) What is the caseload on a yearly basis for a coroner in a northern community? How many of those cases are pediatric? How many of those cases are criminally suspicious? How does the caseload impact on expertise in death investigation? What training is required to ensure that those with small caseloads can still effectively investigate? In small communities, how can an investigating coroner maintain the necessary degree of objectivity and impartiality?

(2) How are the pediatric forensic death cases distributed to pathologists?

(3) How should the challenges associated with pediatric forensic death investigations in the Northern Region be addressed: Consider, in this regard, body transportation, access to OCCO representatives (local coroner, regional supervising coroner), access to paediatric pathology expertise (as well as paediatric radiology, etc), access to expertise/human resources at OCCO "head office" (Deputies, Chief Coroner, Chief Forensic Pathologist).

(4) Should/can coroners more frequently attend the scenes in pediatric forensic death cases? Who should serve as surrogates for the coroners, when required?

(5) What are the unique issues for police services in pediatric forensic death investigations in Northern/remote communities? How are OCCO policies communicated to local police? What training do/should police receive?

(6) In small communities where coroners, police or coronial surrogates may be known to one another in other capacities, what protections should be built into the investigative process to ensure that conflict of interest concerns are avoided?

(7) Should local police services be linked to a team of specialist police officers (i.e. OPP or Toronto Police Service) to assist with criminally suspicious pediatric death investigations?

(8) In complex cases, should provision be made to fly in a forensic pathologist to attend the scene?

February 29, Roundtable 1: Barriers to Pediatric Forensic Death Investigations in Remote Aboriginal Communities

Panellists: Deputy Chief John Domm, Nishnawbe Aski Police Service; Chief Connie Gray-Mckay, Mishkeegogamang First Nation; Vernon Morris, Pikangikum First Nation; Dr. David Eden, Regional Supervising Coroner; Elder Elizabeth Mawakeesick, Sandy Lake First Nation

Co-Facilitator: Wally McKay, Former Grand Chief of Nishnawbe Aski Nation

Topic: This roundtable will discuss what specific barriers exist to conducting pediatric forensic death investigations in criminally suspicious cases in remote Aboriginal communities and consider recommendations to remove these barriers.

Questions may include:

1) On an annual basis, how many criminally suspicious pediatric deaths occur in Northern Aboriginal communities? How many of these ultimately become the subject of forensic pathology?

2) Generally, how and when are police and coroners initially informed of these cases? What are the barriers to timely notification, scene preservation or collection of evidence that exist with respect to these cases?

3) Do current protocols or guidelines regarding death investigation in criminally suspicious pediatric deaths respond appropriately to the realities of investigating these cases in Northern Aboriginal communities?

4) What barriers impact an investigating coroner, police officer or forensic pathologist's ability to attend the scene of a criminally suspicious pediatric death in Northern Aboriginal communities?

5) When and under what circumstances should coroners delegate their responsibilities? To whom should these responsibilities be delegated? What are the consequences of delegating these responsibilities?

6) What are the unique issues for police services in pediatric forensic death investigations in Northern/remote communities? How are OCCO policies communicated to local police? What training do/should police receive?

7) What type of training should be provided to investigating coroners and police officers about traditional practices regarding the death of an Aboriginal child?

8) What type of accommodation, if any, should death scene investigators offer to families who wish to conduct traditional practices regarding the death of an Aboriginal child?

9) In small communities where coroners, police or coronial surrogates may be known to one another in other capacities, what protections should be built into the investigative process to ensure that conflict of interest concerns are avoided?

10) Should local police services be linked to a team of specialist police officers (i.e. OPP or Toronto Police Service) to assist with criminally suspicious pediatric death investigations?

February 29, Roundtable 2: Limitations and Impact of Criminally Suspicious Investigations in Pediatric Death Cases

Panellists: Mary Jean Robinson, Area Director, NAN-Legal Corp.; Barbara Hancock, Tikinagan Child and Family Services

Co-Facilitator: Wally McKay, Former Grand Chief of Nishnawbe Aski Nation

Topic: This roundtable will discuss what impact criminal investigations in pediatric forensic death cases have in remote Aboriginal communities and how communication, access to the deceased, reporting results and other issues can best be addressed

Questions may include:

1) What impact do investigations into criminally suspicious pediatric deaths have in remote Aboriginal communities?

2) What are the consequences for families and communities impacted by the delivery of pediatric forensic pathology?

3) What role do child and family services play in cases giving rise to pediatric forensic pathology?

4) In the case of a criminally suspicious pediatric death in a Northern Aboriginal community, what steps do child and family services take with respect to surviving children? How are these processes impacted by the delivery of pediatric forensic pathology services?

5) How should issues regarding communication, including the reporting of pediatric post mortem examination results, and access to the deceased's body be addressed?

6) What are the challenges that arise from the need to remove a deceased child from the community for post mortem examinations in these cases? Is there on-site counseling provided to families to ease the trauma of their deceased child's removal? Who provides the counseling? If counseling is not currently provided, who should provide the counseling service?

7) How should contact between the family and the coroner's office be enhanced during the period of time that the deceased child's body is removed for post mortem examination?

February 29, Roundtable 3: Community Involvement with Pediatric Death Investigations

Panellists: Jim Morris, Sioux Lookout Health Authority; Dr. David Eden, Regional Supervising Coroner

Co-Facilitator: Wally McKay, Former Grand Chief of Nishawbe Aski Nation

Topic: This roundtable will discuss the use of community resources/members to assist in coronial (particularly pediatric forensic) death investigations. Pros and cons of the community health representative model will be explained, and will assist with exploring the community investigator model for use in the coronial system.

Questions may include:

1) What community resources/members are available to assist in coronial (particularly pediatric forensic) death investigations?

2) What are the pros and cons of the community health representative model?

3) What is the community investigator model and what is its use in the coronial system?

4) How can community services assist in death investigation and the delivery of pediatric forensic pathology?

February 29, Roundtable 4: Improving Communication Between Aboriginal Communities and the OCCO

Panellists: Deputy Grand Chief Alvin Fiddler; Nathan Wright, Chiefs of Ontario; Dr. Bonnie Porter, Chief Coroner; Dr. David Eden, Regional Supervising Coroner

Co-Facilitator: Wally McKay, Former Grand Chief of Nishawbe Aski Nation

Topic: This roundtable will discuss how to improve and enhance in a constructive way ongoing communications between Aboriginal communities and the OCCO on the issues discussed earlier.

Questions may include:

1) How can communication between Northern Aboriginal communities and the OCCO be improved in these cases?

Appendix 30

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

The Honourable Stephen Goudge, Commissioner

180 Dundas Street West, 22nd Floor
Toronto Ontario M5G 1Z8

Tel: 416 212-6878
1 866 493-4544
Fax: 416 212-6879
Website: www.goudgeinquiry.ca

COMMISSION D'ENQUÊTE SUR LA MÉDECINE LÉGALE PÉDIATRIQUE EN ONTARIO

L'honorable Stephen Goudge, Commissaire

180, rue Dundas Ouest, 22e étage
Toronto (Ontario) M5G 1Z8

Tél. : 416 212-6878
1 866 493-4544
Téléc. : 416 212-6879
Site Web : www.goudgeinquiry.ca

MEMORANDUM

To	Parties with Standing
From	Linda Rothstein, Commission Counsel
Date	February 20, 2008
Re	Submissions

There has been a small change in the schedule for submissions. The original due date was March 21, 2008, which is a statutory holiday. Therefore, the new schedule for submissions is as follows:

- March 20, 2008, 12:00 noon – Written submissions due
- March 27, 2008, 12:00 noon – Reply submissions, if any, due
- March 31 and April 1 – Oral submissions

Parties should provide an estimate of the time required for their oral submissions on or before March 21, 2008 at noon. The Commissioner will then allocate times for oral submissions.

Please direct your written submissions to what findings of fact and, more importantly, what systemic recommendations the Commissioner should make, and the basis advanced for each, including why the evidence supports the need for the systemic recommendations.

If any party wishes to submit that the Commissioner should make a recommendation in relation to the introduction of a Criminal Case Review Commission or changes to Part XX1.1 of the Criminal Code to address alleged miscarriages of justice, that party should make submissions regarding the

Commissioner's jurisdiction to do so. The Federal Government will be permitted to make submissions on that issue, should it arise.

If parties wish to urge the Commissioner to make systemic recommendations, please be as specific and detailed as possible and provide, if possible, the language that you would like to see adopted. It would also be helpful if you set out why the evidence supports the need for such recommendations.

The Commissioner has established the following rules respecting submissions:

1. Submissions are to be double-spaced, and with numbered paragraphs and page numbers, with one-inch margins.

2. Submissions must comply with the Commissioner's non-publication order issued November 1, 2007.

3. Submissions must be delivered in the following formats:

    a. Three bound copies; and

    b. A single .PDF file containing the complete document (eg. a single file should contain the front cover, the index, the text of the submissions, and all schedules or appendices). Do not submit separate electronic files for the different sections of the submission.

4. The .PDF security settings must permit users to print, save, copy and paste text from within the document, and modify the document.

5. Citations for documents and transcripts must be contained in footnotes, rather than endnotes, and

a. Documents should be cited by PFP number and should contain references to the specific page of the document. For example, the first page of Appendix D to Memo #631, located in the Coroner's Investigation Manual, would be cited as: "PFP057584 at p. 371."

b. Transcript references should identify the person testifying, and identify the passage relied on, for example: "Evidence of Dr. Pollanen, 11/12/2007, p. 43, lines 3 to 6."

6. Parties are not required to provide copies of the documents or transcripts cited in their submissions.

Appendix 31

List of Appearances for Parties with Standing

Office of the Chief Coroner for Ontario	**Stockwoods LLP** Brian Gover Luisa Ritacca Teja Rachamalla
Ministry of the Attorney General for Ontario	William Manuel Kim Twohig Heather C. Mackay
Hospital for Sick Children	**Borden Ladner Gervais LLP** William Carter Barbara Walker-Renshaw Kate A. Crawford
Dr. Charles Smith	**McCarthy Tétrault LLP** Niels Ortved Jane Langford Erica Baron Grant Hoole
Affected Families Group & Two Individuals	**Wardle Daley Bernstein LLP** Peter Wardle Daniel Bernstein **Hauraney & Kirkpatrick** James Hauraney Julie Kirkpatrick
Mullins-Johnson Group	**Lockyer Campbell Posner** James Lockyer Philip Campbell Alison Craig
Ontario Crown Attorney's Association	**Cavalluzzo Hayes Shilton McIntyre & Cornish LLP** Paul Cavalluzzo Veena Verma
Criminal Lawyers' Association	**Ross & McBride LLP** Jeffrey Manishen **Schreck & Greene** Mara Greene **Di Luca Copeland Davies LLP** Joseph Di Luca Breese Davies

Association in Defence of the Wrongly Convicted	**Sack Goldblatt Mitchell LLP** Louis Sokolov Vanora Simpson **Falconer Charney LLP** Elisabeth Widner
The Aboriginal Legal Services of Toronto and Nishnawbe Aski Nation Coalition	**Falconer Charney LLP** Julian Falconer Jackie Esmonde **Aboriginal Legal Services of Toronto** Kimberly Murray
Defence for Children International – Canada	Suzan E. Fraser Barrister & Solicitor
College of Physicians and Surgeons of Ontario	Carolyn Silver Natasha Egan
Marco Trotta	Michael Lomer Barrister & Solicitor

Appendix 32

List of Witnesses

Dr. Katy Driver, SickKids SCAN Program **Dr. Dirk Huyer**, SickKids SCAN Program **Dr. Michelle Shouldice**, SickKids SCAN Program	January 9 & 10, 2008
Dr. Paul Thorner, SickKids Division of Pathology	January 11, 2008
Acting Inspector Robert Keetch, Greater Sudbury Police Service	January 14, 2008
Sergeant Larry Charmley, Peterborough Lakefield Community Police Service **Constable Scott Kirkland**, Peterborough Lakefield Community Police Service	January 15, 2008
Dr. Rocco Gerace, College of Physicians and Surgeons of Ontario (CPSO) **C. Michéle Mann**, CPSO **Elizabeth Doris**, CPSO	January 16, 2008
Dr. David Dexter, director, regional forensic pathology unit **Dr. Chitra Rao**, director, regional forensic pathology unit **Dr. Michael Shkrum**, director, regional forensic pathology unit	January 17 & 18, 2008
Ed Bradley, Crown counsel **Brian Gilkinson**, Crown counsel **Terri Regimbal**, Crown counsel	January 21 & 22, 2008
Dr. Robert Wood, odontologist	January 23, 2008
Sergeant Greg MacLellan, Ontario Provincial Police **Inspector Brian Begbie**, Kingston Police	January 24, 2008
Dr. David Legge, regional coroner **Dr. David Eden**, regional coroner **Dr. Andrew McCallum**, regional coroner	January 25, 2008
Dr. Charles Smith	January 28, 29, 30 & 31, 2008 February 1, 2008
Mr. Justice John McMahon	February 6, 2008
David Gorrell, defence counsel **John Struthers**, defence counsel **Bruce Hillyer**, defence counsel	February 8, 2008

Dr. Katy Driver, SickKids SCAN Program **Dr. Dirk Huyer**, SickKids SCAN Program **Dr. Michelle Shouldice**, SickKids SCAN Program	January 9 & 10, 2008
Dr. Paul Thorner, SickKids Division of Pathology	January 11, 2008
Acting Inspector Robert Keetch, Greater Sudbury Police Service	January 14, 2008
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Commissioner and Inquiry Staff

Commissioner
The Honourable Stephen T. Goudge

Lead Commission Counsel
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Special Counsel, Criminal Law
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