Beyond the Goudge Inquiry: Is the Coroner Part of 'The Crown' for Stinchcombe Disclosure Obligations?

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BEYOND THE GOUDGE INQUIRY: IS THE CORONER PART OF "THE CROWN" FOR STINCHCOMBE DISCLOSURE OBLIGATIONS?*

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I  INTRODUCTION

II  PEDIATRIC FORENSIC PATHOLOGY AND THE PERFORMANCE OF QUALITY ASSURANCE

The Nature and Status of Pediatric Forensic Pathology 16
The Imperative to Perform Quality Assurance 18

III  THE APPLICABILITY OF STINCHCOMBE DISCLOSURE OBLIGATIONS TO THE CORONER

The Basics of “First Party” Disclosure under Stinchcombe and “Third Party” Production under O’Connor 20
The Implications of “First Party” Disclosure versus “Third Party” Production for Record Creation and Retention 22
The Disclosure Obligations of the Coroner 30

IV  PEDIATRIC FORENSIC PATHOLOGY AND THE PERFORMANCE OF QUALITY ASSURANCE

The Relevance of Quality Assurance 34
The Privacy Implications of Quality Assurance 40

V  CONCLUSION

45

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Abstract

Pediatric forensic pathology evidence is a critical component of the investigation and prosecution of child and infant death. Several years ago, concerns arose over the work of Dr. Charles Smith, then a renowned expert in the field. The Office of the Chief Coroner for Ontario ("The Coroner") then commissioned an external review of his work on 45 cases. For each case where his findings or conclusions were disputed and the accused had not been acquitted, the defence counsel was given the corresponding reports. In response to the review, the Government of Ontario commissioned a public inquiry led by Justice Stephen Goudge. While the report by Commissioner Gudge strongly endorsed the performance of quality assurance, it did not specifically address whether such quality assurance must, or should, be disclosed to the defence. These events raised three critical questions for criminal cases involving pediatric forensic pathology: (1) Is there an obligation to perform quality assurance, such as external review? (2) Is there a corresponding obligation to disclose the results? (3) Does that obligation include all of the pathologist's work, or only his or her work in that case?

To suggest answers to these questions, this paper examines the jurisprudence governing the disclosure and production of evidence in criminal trials, relating this case law to the particular context of pediatric forensic pathology. While the Supreme Court of Canada’s well-known holding in R. v. Stinchcombe clearly requires "the Crown" to disclose the records that it possesses in a criminal investigation to the defendant for the purpose of his or her trial, there is uncertainty in the literature and the Courts of Appeal over which government actors comprise "the Crown". Specifically, government actors other than the prosecuting Crown attorney's office and the investigating police force may be considered to be "third parties" to the investigation—in which case the acquisition of their records by the defence would be governed by the more restrictive standard established in R. v. O'Connor. This article uses the issue of quality assurance in pediatric forensic pathology to critically re-examine the meaning of "the Crown" for the purpose of disclosure.

First the author discusses the nature of pediatric forensic pathology and the Coroner's obligation to perform quality assurance. The author then outlines the disclosure regime of Stinchcombe and the production regime of O'Connor, and the differing obligations to create and preserve records under those two regimes. On this foundation, the author then provides an overview of the academic literature and case law that consider the question of which government actors comprise "the Crown", and establishes a purposive framework for the meaning of "the Crown". Next, this framework is applied to the Coroner's work in the area of pediatric forensic pathology in order to demonstrate that the more inclusive Stinchcombe standard should apply to the Coroner. Finally, the author discusses what this standard of disclosure would require in practical terms. He argues that historical quality assurance records—that is, records relating to the work of the investigating pediatric forensic pathologist on previous cases, not just the instant case—are disclosable according the standard established in Stinchcombe.
Résumé

L'attention publique était récemment fixée sur le cabinet de pathologie légale de pédiatrie à cause d’une série de condamnations inéquitables du pathologiste Charles Smith, qui était auparavant célèbre. Le juge Stephen Gough a dirigé l’enquête criminelle contre le bureau du coroner de l’Ontario, et il a donné son appui à une politique des examens pour identifier les erreurs des pathologistes; cependant, il n’a pas dit si ces examens doivent, ou devraient, être divulgué au défenseur dans un procès criminel. Ces événements posaient trois questions importantes pour les dossiers criminels avec des problèmes de pathologie légale de pédiatrie, et avec le bureau du coroner de manière générale: 1) Est-ce qu’il y a une obligation d’exécuter un examen d’assurance-qualité? 2) Est-ce qu’il y a une obligation correspondante de révéler les résultats d’un examen d’assurance-qualité? 3) Est-ce que cette obligation inclue tous les travaux d’un pathologiste, ou seulement son travail dans ce dossier-là?

Afin de suggérer des réponses à ces questions, cette dissertation examine la jurisprudence qui gouverne la révélation et production de preuves dans un procès criminel. Le résultat bien connu de la Cour Suprême du Canada dans l’arrêt R. c. Stinchcombe dit qu’une révélation de tous les comptes rendus dans un procès criminel au défenseur par la couronne est nécessaire, mais il reste incertain qui est la couronne dans le gouvernement. Particulièrement, des représentants du gouvernement qui ne sont pas l’accusateur-procureur et police peuvent être considéré comme des “tières” à l’investigation – donc, l’acquisition des comptes rendus par le défenseur pourrait être gouverné par l’étendard plus restrictif établi dans l’arrêt R. c. O’Connor. Cette dissertation utilise le sujet d’assurance-qualité de pathologie légale de pédiatrie afin de réexaminer le sens de “la couronne” dans le contexte de révélation de preuve.

Premièrement, l’auteur explore la nature de la pathologie légale de pédiatrie et l’obligation du coroner de faire de l’assurance-qualité. Ensuite, l’auteur décrit le régime de révélation de Stinchcombe et le régime de production d’O’Connor, et les différentes obligations pour faire des comptes rendus sous ces régimes. L’auteur donne une vue d’ensemble de la littérature académique et des dossiers qui considèrent la question de quels représentants du gouvernement sont “la couronne” et établit une structure pour définir le sens de “la couronne.” Cette structure est utilisée pour examiner le travail du coroner dans le domaine de pathologie légale de pédiatrie pour démontrer que le standard plus libre de Stinchcombe devrait s’appliquer au coroner. Finalement, l’auteur explore les répercussions pratiques de ce standard. Il argumente qu’on peut révéler des comptes rendus historiques d’assurance-qualité – ce qui veut dire des comptes rendus avec une connexion au travail du pathologiste sur ses autres dossiers, et non pas seulement le dossier en question – avec le standard de Stinchcombe.
I INTRODUCTION

Pediatric forensic pathology has been defined as “the study of diseases and injuries of children with subsequent medico-legal interpretation of findings for police and the courts”. It plays a critical role in the investigation and prosecution of child and infant death, especially in differentiating between natural and unnatural causes of death. In April 2007, the Office of the Chief Coroner for Ontario (“the Coroner”) announced the results of an extensive review of the work of Dr. Charles Smith, then a renowned expert in pediatric forensic pathology. In such reviews (which will generally be termed “quality assurance”) another forensic pathologist examines the evidence from the autopsy and related tests to determine if they agree with the reported facts and the interpretations of those facts. Of the 45 cases reviewed, Dr. Smith’s observations or conclusions were disputed in 20 cases, of which 12 had resulted in convictions. In response to the review, the government established a commission under the Public Inquiries Act, led by Justice Stephen Goudge of the Ontario Court of Appeal, with the mandate to “conduct a systemic review... 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.”

Following the review of Smith’s work, the Coroner provided each of the defence and Crown counsel with the quality assurance reports associated with their cases. The errors discovered under review and the Coroner’s eventual disclosure underscores just how important it is that quality assurance reports be disclosed in advance of a trial. The Supreme Court of Canada has clearly expressed

3 Ibid. at 2.
4 Ibid. at 3-4. One case resulted in a “not criminally responsible” designation.
that “[t]he Crown has a public duty to avoid the wrongful conviction of accused individuals.”
9 This duty suggests an obligation to evaluate the accuracy of pediatric forensic pathology evidence through a process of quality assurance. Such a legal obligation suggests three possible components. The first is the performance of quality assurance itself, and the documentation of the results. Next is the disclosure to the accused of such results from his or her individual case. The last possible component is the additional disclosure to the accused of ‘historical’ results—that is, those from all of the cases previously performed by the pathologist in question.

Not all of these component issues were addressed in the Gudge Report, as they were not central to its mandate, and none were evaluated in terms of legal obligation. The Report did emphasize that quality assurance—in particular, peer review—is essential in order to produce pediatric forensic pathology evidence that is worthy of public confidence. 10 Yet, while Commissioner Gudge specifically addressed the issue of disclosure in some circumstances, 11 he did not deal with the disclosure of quality assurance to the accused. Indeed, he did not explicitly state that quality assurance results should be provided to the police or to the Crown. It should be noted, nevertheless, that the Gudge Report addresses many areas beyond these, and I will refer as necessary to its substantive content below. I will do so specifically with respect to quality assurance, the provision of preliminary opinions to the police, the role of errors in an expert’s previous work, and the role of experts in an adversarial system. In accordance with its mandate, the Gudge Report suggested functional solutions to the crisis of public confidence in pediatric forensic pathology. It did not, however, evaluate the legal necessity of those solutions—while the Report recommended legislative reform, its suggestions dealt largely with institutional structure and governance. 12 Furthermore, while the Report carries persuasive weight, just as with other public inquiries it does not constitute law and is hence not binding on the executive.

In light of Commissioner Gudge’s strong endorsement, as well as the practices that the Coroner has already adopted in response its external review, 13 it appears very likely that quality assurance will be routinely performed for the foreseeable future. Nonetheless, the institutional and political impetus to restore public confidence in death investigation could fade over time, particularly as it comes

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10 See Gudge Report, supra note 6, vol. 3 at 285: “[T]here are even fewer forensic pathologists with the knowledge and experience to do pediatric forensic cases, or to provide the culture of peer review on which quality depends” [emphasis added].
11 For example, he was clear that notes from case conferences among the police, coroner, and pathologist should be disclosed: ibid., vol. 3 at 439-40, 442, Recommendation 103. He also specifically considered the disclosure of expert witness evidence that is required by the Criminal Code, R.S.C. 1985, c. C-46, s. 657.3(3). See ibid., vol. 3 at 464-66, Recommendation 125: “The defence is often well served (as is the forensic testimony presented to the criminal justice system) by early, voluntary disclosure of its anticipated forensic evidence. The defence should be encouraged, in its own interest, to provide such early disclosure. It should not be compelled to do so.”
12 See e.g. Gudge Report, ibid., vol. 1 at 56-57, Recommendations 12-14, 17.
13 These will be discussed in more detail below.
up against financial pressures. Moreover, this impetus does not necessarily extend to disclosure to the accused. The Coroner could reasonably argue that quality assurance is for internal oversight purposes only, and that its ongoing effectiveness would be impaired by its release. Even if such a position were not taken with respect to the instant case, both functional and political considerations would promote such an attitude toward the historical quality assurance of the pathologist's work in previous cases. It would be open to the police and Crown to not pursue such records on the basis that they are not relevant to the instant case.

The variety of considerations that might affect the decision to create and disclose quality assurance records underscores the necessity of defining a legal basis for doing so—that is, so as to ensure that these records are produced and disclosed to the defence as a matter of law, and not at the discretion of the Coroner or the Crown prosecutor. This would thus be analogous to the change made by R. v. Stinchcombe, the decision in which the Supreme Court established a legal obligation on the prosecuting Crown to disclose to the accused all relevant evidence in its possession. As the Honourable Arthur Martin has observed, Stinchcombe “made it plain that disclosure is not a privilege bestowed upon an accused through the benevolence of Crown counsel. Rather, disclosure is the accused's constitutional right.” The issues of whether quality assurance must be performed in cases of pediatric forensic pathology, and to what extent that quality assurance must be disclosed to the accused in each case, remain to be resolved. Regarding the disclosure of historical quality assurance, however, the issue is more complex. Disclosure is premised on relevance, and the Courts of Appeal of Ontario and of England and Wales have come to opposite conclusions regarding the relevance of the quality of an expert's previous work. Moreover, underlying these issues is a broader unresolved question: the extent to which disclosure obligations apply to government agencies beyond the prosecuting Crown and the investigating police force. The right to full answer and defence recognized under s. 7 of the Charter manifests in two different ways: disclosure under the Stinchcombe regime, which applies to “the Crown”; and production

16 Ibid. at 145.
18 Note that the statutory regime created by ss. 278.1-278.91 of the Criminal Code, supra note 11, and upheld in R. v. Mills, [1993] 3 S.C.R. 668 [Mills], does not apply to pediatric forensic pathology matters, even if one or more of the sexual offences identified in s. 278.2 were involved in one of the cases for which documents were sought. Section 278.2 applies only to records “relating to a complainant or a witness”, and such terms do not encompass victims of suspected homicides. Furthermore, the definition of “record” in s. 278.1 specifically excludes “records made by persons responsible for the investigation or prosecution of the offence”. Given the investigatory role assigned to the Coroner under the Coroners Act, R.S.O. 1990, c. C.37, its records are covered by this exclusion. Thus, production remains governed by the common law regime established in O'Connor.
following R. v. O’Connor,17 which covers third parties.18 The most recent judgment by the Supreme Court dealing with these regimes refers to them as “first party” and “third party”, and I will adopt the same terminology for clarity.19 The “first party” regime of Stinchcombe is premised on the obligation of the Crown to ensure a fair trial, and so is weighted towards making information accessible. In contrast, the “third party” regime of O’Connor explicitly incorporates the privacy and other interests of that other party, performing a balancing exercise that is much less favourable to the accused. Moreover, as will be explained below, the two regimes have different implications for the obligation to preserve records. Currently there is no consensus, either in the literature or among the various Courts of Appeal, regarding which government actors constitute “the Crown”. That is, while Stinchcombe obligations cover the prosecuting Crown attorney’s office and the investigating police force, the critical issue of whether a government agency such as the Coroner should be considered part of the Crown or as a third party still remains unresolved.20 While the Ontario Court of Appeal has commented briefly on some aspects of these matters in two recent decisions,21 in neither case did the Court resolve the issue. On this basis, the Coroner is an excellent case study to re-examine the meaning of “the Crown” for disclosure obligations.

The plan of this paper is as follows. In Part II, I examine pediatric forensic pathology and the performance of quality assurance. I start by briefly assessing the nature and status of pediatric forensic pathology as a discipline, in order to demonstrate why quality assurance is particularly important in that context. I then canvass the practical support and legal obligation for the performance of quality assurance. In Part III, I establish that the Coroner should be considered part of “the Crown” for the purposes of disclosure obligations, and not a “third party”. I begin by briefly summarizing the two regimes that govern an accused’s access to information: the disclosure regime that applies to information held by the “the Crown” as a “first party” and the production regime that applies to information in the possession of a “third party”. I also explain the implications of this choice of regime. I then propose a purposive approach to defining the meaning of “the Crown”, and use that approach to demonstrate why the Coroner should be considered part of “the Crown” and not a third party. In Part IV, I establish that quality assurance records should be disclosed to the defence if the Coroner is so considered; otherwise they should still be produced to the defence if the Coroner is considered separate from the Crown.


20 Indeed, “inadequate disclosure” and “unreliable scientific evidence” have been identified as two of “the principal causes of wrongful convictions”. See Bruce MacFarlane, “Convicting The Innocent: A Triple Failure of the Justice System” (2006) 31 Man. L.J. 403 at 444. The provision of quality assurance to the defence is at the intersection of these causes of wrongful convictions.

II PEDIATRIC FORENSIC PATHOLOGY AND THE PERFORMANCE OF
QUALITY ASSURANCE

This part addresses how the evolving nature of pediatric forensic pathology as a
discipline makes quality assurance particularly important, and establishes the
non-legal and legal bases for its performance. An appreciation of the issues
particular to pediatric forensic pathology is vital to understanding the necessity
of quality assurance. While the Goudge Report has already extensively canvassed
this area,22 it is useful to briefly consider some of the issues here.

The Nature and Status of Pediatric Forensic Pathology

In recent years, the work of once-renowned experts has been questioned. One
source of error that has given rise to this suspicion is that pediatric forensic
pathology is a developing field, one in which the most difficult issues do not
have equivalents in the forensic pathology of adults. The Smith situation in Ontario
is not unique. Similar events have occurred in the UK, where convictions
involving the work of Dr. Roy Meadow have been successfully quashed. In R. v.
Clark,23 Meadow gave statistical evidence, which was later widely criticized, as
to the probability of both of the accused Sally Clark’s children dying of Sudden
Infant Death Syndrome (SIDS).24 He made similar qualitative statements regarding
three such deaths, in addition to medical opinions, at trial in R. v. Cannings;25
indeed, the appeal from the verdict in Cannings was granted partly on the basis
that “the flawed evidence he gave at Sally Clark’s trial serve[d] to undermine
his high reputation and authority as a witness in the forensic process”.26 These
events resulted in serious reflection and introspection within the medico-legal
community.27

Nevertheless, it should not be inferred from the impugned work of Smith or
Meadow either that the entire discipline of pediatric forensic pathology is without
foundation, or that it is a completely reliable and coherent science that was
violated by high-profile practitioners working alone. The truth is more complex.
As the backgrounder to the Coroner’s review of Smith’s work put it, Smith was
one member of a larger death investigation team... in part, relying on
information provided to him by coroners, police, and other forensic
experts.... [He] 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

22 Goudge Report, supra note 6, vol. 2 at 66-79.
24 Ibid. at paras. 94-110; Ray Hill, “Multiple sudden infant deaths—coincidence or beyond
coincidence?” (2004) 18 Paediatric and Perinatal Epidemiology 320; R. G. Carpenter,
“Repeat sudden unexpected and unexplained infant deaths: natural or unnatural?” (2005)
365 Lancet 29.
26 Ibid. at para. 17.
181 Medical Journal of Australia 52; Alec Samuels, “The lessons from the Sally Clark case”
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.28

Moreover, several controversial phenomena are unique to pediatric forensic pathology.29 For example, there is disagreement and uncertainty over how to define and identify Sudden Infant Death Syndrome (SIDS),30 which continues to be difficult to distinguish from suffocation.31 There is more fundamental controversy regarding Shaken Baby Syndrome (SBS), with ongoing debate over whether or not it is a valid, discernible phenomenon.32 These challenges have been publicly recognized by leading experts:

Pediatric forensic pathology is an area of medicine that has only received attention relatively recently.... Unfortunately, the mere naming of an area of medicine does not automatically ensure that there are accepted standards of practice, or that there are specialist training programs for subsequent practitioners. Naming may in fact confer superficial acceptance of an area that may not have an agreed upon content and defining characteristics.33

Similarly, the Chief Forensic Pathologist for Ontario testified in February 2008 that "pediatric forensic pathology...is a fascinating subset of [forensic pathology]

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26 Coroner, "Backgrounder", supra note 2 at 4.
29 Corndler et al., Limits and Controversies, supra note 1 at 152, 160-61.
33 Byard & Krous, "Crisis", supra note 1 at 212.
cases that challenge us”. 34 One implication of these limitations and challenges, therefore, is the need for the performance of quality assurance.

The Imperative to Perform Quality Assurance

In this section, I address the need to perform quality assurance. I start with the support expressed during the Gudge Inquiry and in the Gudge Report, as well as the current practice of the Coroner. I will then examine the role of the Coroner’s credibility. Finally, I explain how the ethical duties of the Crown elevate quality assurance to a legal obligation. For present purposes, quality assurance will be defined as a review of observations and interpretations for reasonableness or correctness by a pediatric forensic pathologist who was not involved in the original investigation.

Support for quality assurance appeared at several stages of the Gudge Inquiry. Indeed, the Coroner’s external review of Dr. Smith’s work was the direct impetus for launching the Inquiry. During his testimony before the Commissioner, Smith himself acknowledged its importance: “I have long been an advocate of quality assurance or quality review mechanisms...because they do [two] things. First of all, they help me avoid mistakes and secondly, they provide educational opportunities.” 35 In his Report, Commissioner Gudge was explicit: “One of the most effective ways to promote oversight and accountability is through the development of quality assurance.” 36 He recommended a continued practice of “full peer review of all reports of post-mortem examination in criminally suspicious deaths”. 37

It is clear that the Coroner is committed to quality assurance at present:

All forensic autopsies on criminally suspicious cases, homicides, and cases going to inquest, now undergo a standardized audit process...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. 38

Unlike the external review that prompted the Gudge Inquiry, the current practice of the Coroner is to use reviewers internal to its office. 39 Nonetheless, it

36 Gudge Report, supra note 6, vol. 4 at 333.
37 Ibid., vol. 3 at 353, Recommendation 51.
38 Coroner, “Backgrounder”, supra note 2 at 5.
39 Gudge Report, supra note 6, vol. 2 at 271. The issue of whether internal or external review is more effective, while interesting, is beyond the scope of this article. See generally Stephen Cordner, Helen McKelvie, Fiona Leahy & David Ranson, A Model Forensic Pathology Service (Toronto: Inquiry into Pediatric Forensic Pathology in Ontario, 2008) at 151-52, online: Gudge Inquiry <http://www.attorneygeneral.jus.gov.on.ca/inquiries/gudge/ policy_research/pdf/Cordner_Model-Forensic-Pathology.pdf> [Cordner et al., A Model Service].
continues to ask the reviewer “whether he or she agrees with the cause of death and other medico-legal opinions”.40 This is a more stringent standard than that of some other agencies (such as the Victorian Institute of Forensic Medicine) which simply ask the reviewer to comment on the reasonableness, not the correctness, of the findings.41

In assessing this commitment to quality assurance, it is useful to emphasize the practical importance of credibility to the work of the Coroner. The Coroner’s motto proclaims, “We speak for the dead to protect the living”; more importantly, its mission statement elaborates that it “serves the living through high quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored”.42 Further support comes from the Shipman Inquiry, a UK commission that chose Ontario as one of five jurisdictions to consider in its review of death investigation and the role of the coroner.43 Its report noted approvingly that the Coroner “seeks, and, is successful in securing for itself, a high public profile...[and] is assisted in achieving its objectives by the high public awareness of the coroner system”.44 The Chair of that inquiry agreed with the philosophy of the Chief Coroner for Ontario—“that it is vital that the public has a high degree of awareness of the coroner service, together with the confidence to approach the service in the event of concern”.45 The Order in Council establishing the Goudge Inquiry imposed a mandate “to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario”.46 Thus, the success of the Coroner in achieving its objectives depends on regaining the public confidence that has now been lost. An ongoing and publicized scheme of quality assurance is a critical component of that process.

The ethical duty of the Crown to ensure the accuracy of the evidence of a pediatric forensic pathology witness, given the recent problems with such evidence in Ontario and elsewhere, elevates the practice to a de facto legal obligation. This ethical imperative is epitomized in the same quote from R. v. Boucher that anchored the recognition of a disclosure obligation in Stinchcombe:

[T]he purpose of a criminal prosecution is not to obtain a conviction, it is to lay before a jury what the Crown considers to be credible evidence relevant to what is alleged to be a crime. Counsel have a duty to see that all

40 Goudge Report, ibid., vol. 2 at 271 [emphasis added].
41 Cordner et al., A Model Service, supra note 39 at 151.
44 Ibid. at paras. 18.40, 18.42.
45 Ibid. at para. 18.66 [emphasis added].
46 O.C. 826/2007, supra note 7 at 3 [emphasis added].
available legal proof of the facts is presented: it should be done firmly and
pressed to its legitimate strength but it must also be done fairly. The role of
prosecutor excludes any notion of winning or losing; his function is a
matter of public duty.47

Given the historical context of the Smith cases, this obligation would lead courts
to put less weight on forensic pediatric pathology evidence where the Coroner
failed to perform, or the Crown failed to obtain, quality assurance assessments.

III THE APPLICABILITY OF STINCHCOMBE DISCLOSURE
OBLIGATIONS TO THE CORONER

In the previous part, I explained why quality assurance should be performed in
pediatric forensic pathology. The purpose of this part is to establish how the
Coroner relates to the prosecuting Crown, in order to address below whether and
how the accused can access quality assurance records held by the Coroner. I start
by summarizing the two different regimes that govern an accused’s access to
information. I also explain a major implication of the determination as to which
regime is applicable, namely the differing obligations to create and retain records.
I then develop an analytic framework to determine which regime applies to a state
agency other than the prosecuting Crown or the police. Finally, I apply that
framework to the Coroner, demonstrating that it should be considered part of
“the Crown”.

The Basics of “First Party” Disclosure under Stinchcombe and “Third Party”
Production under O’Connor

There are two different regimes established by the Supreme Court of Canada
under which an accused in a criminal case can seek information: disclosure and
production. The disclosure regime, established in Stinchcombe, involves
information held by “the Crown”—typically the prosecuting Crown attorney’s
office (“the prosecuting Crown”). The production regime governs information
held by a “third party” to the investigation and prosecution of the offence, and
this regime was established in O’Connor. In this section, I briefly summarize
the main components of the regimes within the context of the cases from which
they originated.

In Stinchcombe, a lawyer faced various charges involving breach of a client’s
trust. His secretary was interviewed twice by police, and the prosecuting Crown
attorney refused to provide the defence with records of her statements.48 The
Supreme Court unanimously held that the Crown has a duty to disclose “all
relevant information” to the accused.49 This holding was premised on the status

para. 11.
48 Stinchcombe, ibid. at paras. 2-6.
49 Ibid. at paras. 11, 21.
of the right to “make full answer and defence” as a principle of fundamental justice under the Canadian Charter of Rights and Freedoms, and “the overriding concern” that without disclosure that right would be impeded.  

50 Exceptions to this obligation were recognized in Stinchcombe and emphasized in R. v. Egger: “to withhold information which is clearly irrelevant or the nondisclosure of which is required by the rules of privilege, or to delay the disclosure of information out of the necessity to protect witnesses or complete an investigation”.  

51 In the same case, the Court elaborated that relevance would apply to “all information reasonably capable of affecting the accused’s ability to make full answer and defence”.

52

The situation in O’Connor was very different from that in Stinchcombe, giving rise to a very different regime. The defendant was charged with sexual assault, and sought access to records of the complainant’s counselling.  

53 Recognizing the importance of the therapeutic relationship and the privacy of the complainant, the Supreme Court explicitly chose a more stringent regime than that of Stinchcombe, one that balanced the rights of the accused against other considerations. The O’Connor test has two stages. The first stage directly assesses “likely relevance”. Unlike Stinchcombe, the O’Connor formulation places the onus to prove relevance on the defence. “Relevance” in this context is defined as “a reasonable possibility that the information is logically probative to an issue at trial or the competence of a witness to testify”.

54 If the first stage of the test is met, the judge evaluates the records to “weigh the salutary and deleterious effects of a production order and determine whether a non-production order would constitute a reasonable limit on the ability of the accused to make full answer and defence”.  

55 Five enumerated factors are involved in this weighing: (1) necessity of the evidence to a “full answer and defence”; (2) the “probative value” of the evidence; (3) the nature and extent of any “reasonable expectation of privacy” vested in the evidence; (4) “whether production...would be premised upon any discriminatory belief or bias”; and (5) any “potential prejudice to...dignity, privacy or security of the person” that production might occasion.  

56 Although Parliament responded to O’Connor by creating a more stringent statutory regime to govern records involving complaints and witnesses in sexual assaults and related offences, the O’Connor system continues to apply to other “third party” records.

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52 Ibid.

53 O’Connor, supra note 17 at para. 1, Lamer C.J.C. and Sopinka J., dissenting on other grounds.

54 Ibid. at paras. 19, 21-22.

55 Ibid. at para. 30.

56 Ibid. at para. 31, Lamer C.J.C. and Sopinka J., dissenting on other grounds, quoting in part L’Heureux-Dubé J. at para. 156.

57 Sections 278.1-278.91 of the Criminal Code, supra note 11, upheld in Mills, supra note 18.
The Implications of “First Party” Disclosure versus “Third Party” Production for Record Creation and Retention

In the previous section, I briefly summarized the origins and purposes of the Stinchcombe “first party” disclosure regime and the O’Connor “third party” production regime. I now identify how the choice of regime shapes the obligation on government agencies to create and retain records. I start by examining the practical importance of such an obligation. I will then consider in turn the case law on the creation, destruction, and loss of records. Finally, I will summarize how the obligations of the Coroner would differ under the two regimes.

An obligation to create and retain records is vital because the right to disclosure or production is effectively meaningless if such records do not exist. In light of the practices adopted by the Coroner in response to its review, and the support for quality assurance contained in the Goudge Report, it seems likely that this should not be a concern in the pediatric forensic pathology context in the near future. Nonetheless, failures in the recent past to document quality assurance sound a cautionary note. Strikingly minimalist documentation of an earlier internal review of Smith’s work, performed by Dr. Cairns (formerly the Acting Chief Coroner), was apparent in the judgment granting a stay in R. v. Kporwodu:

Insofar as Dr. Cairns reviewed the work of Dr. Smith internally, he did not make any notes or memoranda of his review. Where he concluded that Dr. Smith’s work on the case was satisfactory, he may have put a checkmark on the file…. There were no files, notes, memoranda or formal reports relating to the review…. Dr. Cairns testified that he was reasonably sure that he had properly accounted for all of the cases reviewed, internally and externally.58

Similarly, Cairns’ recollection of the review was also minimal: while he was testifying, an adjournment was necessary “to refresh his memory as to the type of review performed”.59 This approach taken by a senior figure in Ontario death investigation suggests that an underlying legal obligation to document quality assurance merits consideration.

The precise scope of the legal obligation to create records is unclear, although the Supreme Court has addressed the legal consequences of the destruction or loss of evidence as it relates to disclosure and production obligations. In Stinchcombe, Sopinka J. for the Court explicitly stated that disclosure obligations persist in the absence of records.60 He mandated “a ‘will say’ statement” for Crown witnesses, summarizing their expected testimony, and for all other persons “the name, address and occupation of the witness, [and] all information in the possession of the prosecution relating to any relevant evidence that the person could give”.61 Indeed, the 1993 Report of the Attorney General’s Advisory Committee on Charge

58 A.K., supra note 21 at paras. 139, 168 [emphasis added].
59 Ibid. at para. 164.
60 Stinchcombe, supra note 14 at paras. 30-33.
61 Ibid. at paras. 30, 33. The Ontario Court of Appeal has further held that where disclosure relating to the credibility of a Crown witness is incomplete, the Crown has a positive
Screening, Disclosure, and Resolution Discussions emphasized that “disclosure requirements after Stinchcombe cannot be thwarted by making less accurate or less comprehensive notes”. Nonetheless, in a later unanimous judgment Sopinka J. wrote that where the police do not create records, there is no Charter breach absent “evidence which would justify the conclusion that the police failed to make a record deliberately to avoid production”. The Supreme Court has not recognized any duty on third parties to create records.

In contrast to creation, however, the destruction of records by both the Crown and third parties has been held to be wrongful:

The entitlement of an accused person to production either from the Crown or third parties is a constitutional right.... If the material which was destroyed meets the threshold test for disclosure or production, the appellant’s Charter rights were breached.

The loss of disclosable evidence constitutes a violation of the Crown’s obligations unless the Crown can establish that the evidence was not lost deliberately or negligently. Negligence in this context will be assessed in light of “the relevance that the evidence was perceived to have” when it was lost, with the proviso that “as the relevance of the evidence increases, so does the degree of care for its preservation that is expected”. There has been no corresponding holding regarding the loss of records by third parties.

As a result, whether the Coroner is considered to be part of “the Crown” or a third party has important ramifications for the creation and retention of quality assurance records. If the Coroner is subject to Stinchcombe disclosure as part of the Crown, a deliberate failure to create records, a deliberate or negligent loss of those records, or any destruction of those records would constitute a breach of the right to full answer and defence. Given the identified importance of quality assurance, it would be difficult for the Coroner to successfully argue that the failure to create those records was merely negligent and not deliberate. In contrast, if the Coroner is instead subject to O’Connor production as a “third party”, only the destruction of those records, not a loss or a failure to create them, would constitute such a breach. Consider, though, that in the absence of a specifically prescribed legal obligation to perform quality assurance or to keep written records of any such processes, the combination of the ethical obligations on the Crown and the abundant evidence of extensive problems with pediatric

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62 Martin Report, supra note 15 at 150.
64 R. v. Carosella, [1997] 1 S.C.R. 80 at paras. 26, 40, Sopinka J. [Carosella] [emphasis added]. Note that the absence of improper reason for the failure to create records in Buric was used to distinguish the facts of that case from Carosella. On this basis, it appears that for destruction of records, motive may be a factor that exacerbates a Charter breach.
forensic pathology means the absence of such records would nonetheless damage the Crown's case. At a minimum, an adverse inference could be drawn as to the credibility of the pediatric forensic pathologist. It would be more likely that an adjournment would be ordered for the Crown to perform quality assurance, or to repeat such processes if they were performed but not documented. Such an adjournment would be attributed to the Crown and contribute to the potential for a stay due to delay.\footnote{Note that in Kporowod, supra note 21 at paras. 78, 138, the Court of Appeal rejected the Crown's submission that "the inquiry into Dr. Smith's competence and the need for an independent review of his work were 'unforeseen events' and that the time associated with this review should be treated as part of the inherent time requirements of the case", because the Crown did not act as soon as it knew about the problems with Smith. Given that the problems around pediatric forensic pathology are now well-publicized, it would be similarly difficult for the Crown to assert that doubt as to the credibility of any pathologist would not warrant documented quality assurance measures.}

In any case, while a failure to create or retain records of quality assurance could have some consequences if the Coroner was considered a "third party", its obligations would still be much greater if it was considered part of the Crown.

**The Meaning of “The Crown” for Stinchcombe Disclosure: A Purposive Analysis**

Having summarized the “first party” disclosure regime of *Stinchcombe* and the “third party” production regime of *O'Connor*, and elaborated on the varying implications of those regimes, I will now pull together the existing jurisprudence and literature to propose a purposive approach to determining which one applies to a given government agency. I start by briefly identifying the current absence of an explicit approach. I will then consider the principles governing the interpretation of Charter rights, since disclosure is a manifestation of such a right, before looking at the investigating police force as the paradigm of a state agency that is considered part of “the Crown”. After that, I go through two approaches taken in the case law, which I term the “cautionary” and “reasonableness” approaches, and show how they can be reconciled. Since a given agency can be considered a “first party” with respect to some records and a “third party” for others, I conclude by addressing how this distinction can most appropriately be made.

Many years after the Supreme Court established a disclosure obligation in *Stinchcombe*, it is still unclear today precisely which state actors comprise “the Crown” to which that obligation applies. There is no discernable consensus in the literature or among the various Courts of Appeal, and no definitive statement by the Ontario Court of Appeal or the Supreme Court of Canada.\footnote{Indeed, the Court of Appeal explicitly recognized that it has not yet addressed this issue: Kporowod, ibid. at para. 127.} In order to demonstrate the applicability of *Stinchcombe* to the Coroner, it is first necessary to identify an appropriate underlying theory of its applicability to state agencies. While judgments commonly refer to the “divisibility” of the agency in question from the Crown, the term does not have any clear or consistent content. For example, Belzil J. of the Alberta Court of Queen's Bench has recently described...
divisibility as “at best, problematic and elusive”. 68 Similarly, Prof. David Paciocco has described divisibility as an “unfortunate...indirect and circular approach” that “does not provide analytical criteria”. 69

Crown disclosure under Stinchcombe is rooted in the s. 7 Charter right to full answer and defence, so principles of Charter interpretation are relevant to defining its parameters. It is well established that “Charter rights should be given a generous and purposive interpretation”, 70 as opposed to one that is “narrow” or “legalistic”. 71 A narrow or legalistic approach to the disclosure obligation would thus be contrary to the proper interpretation of the underlying right itself. The unanimous Court in Stinchcombe recognized a disclosure obligation on the Crown because “justice was better served when the element of surprise was eliminated from the trial and the parties were prepared to address issues on the basis of complete information of the case to be met”, particularly in the criminal context. 72 Furthermore, it observed that the absence of “reciprocal disclosure...is not a valid reason for absolving the Crown of its duty...[given] the fundamental difference in the respective roles of the prosecution and the defence”. 73 This reasoning culminated in an oft-cited observation: “the fruits of the investigation which are in the possession of counsel for the Crown are not the property of the Crown for use in securing a conviction but the property of the public to be used to ensure that justice is done”. 74 Subsequent interpretations by judges and scholars alike have placed great emphasis on the first part of this remark, reading “fruits of the investigation” and “in the possession of counsel for the Crown” as a limit on the extent of disclosure. In doing so, too little attention has been focused on the purpose embodied in the second part—the use of public property to advance justice. Indeed, in response to contrary arguments, for example, that disclosure “would impose onerous new obligations on the Crown prosecutors resulting in increased delays”, the Court invoked “the overriding concern that failure to disclose impedes the ability of the accused to make full answer and defence”. 75 In addition to observing that “the search for truth is advanced rather than retarded by disclosure of all relevant material”, the Court specifically noted

68 R. v. Scarr, 2008 ABQB 127, [2008] A.J. No. 203 at para. 46 [Scarr], rev’d 2007 ABPC 201, [2007] A.J. No. 809. Justice Belzil proposes “a principled and pragmatic approach” to disclosure: Scarr, ibid. at paras. 45-57. Note, however, that the issue in the case, and therefore the context for his analysis, was which records held by the investigating police force were disclosable. As a result, he did not address the broader issue of which agencies are included in “the Crown”. Nonetheless, the issues are not completely separate. I will address the Scarr synthesis below.


71 MacDougall, ibid., citing Professor Peter Hogg, Constitutional Law of Canada, 4th ed. (Scarborough: Carswell, 1997) at 820.

72 Stinchcombe, supra note 14 at para. 10.

73 Ibid. at paras. 10-11, citing Boucher, supra note 47 at 23-24.

74 Stinchcombe, ibid. at para. 12.

75 Ibid. at paras. 13, 17 [emphasis added].
that inadequate disclosure was "an important factor" in the notorious wrongful conviction of Donald Marshall Jr. \(^ {76}\) The purpose of Stinchcombe disclosure was to facilitate just outcomes in criminal trials through a meaningful interpretation of the right to full answer and defence.

Based on these principles, the meaning of "the Crown" in reference to disclosure should be appropriate to the purpose of disclosure—while it should not exceed that purpose, neither should it frustrate that purpose. Indeed, the Supreme Court has used broad and general language in referring to "the Crown", such as "the authorities" \(^ {77}\) and "the state". \(^ {78}\) It would be overly formalistic for the scope of disclosure obligations to be limited by the organizational structure of the government, whether that structure is a result of historical development or conscious policy choices. That different functions happen to be performed by different state actors should not affect the content of disclosure:

[T]hese administrative limitations cannot shield the state from legitimate requests by the defence for disclosure of pertinent information. Where investigation into alleged criminal activity has been undertaken by the state, the state must provide disclosure of the results of these investigations.... Stinchcombe disclosure must be made not only of the prosecutor's file, but of the state investigative agencies' files. It is the state that has the obligation of disclosure, not the prosecutor. \(^ {79}\)

Similarly, it has been observed that "the Crown cannot be permitted to use departmental structure to obscure a department's involvement in an investigation". \(^ {80}\) Thus, the proper framework for determining which state agencies constitute "the Crown" must relate to the obligation of the state to facilitate full answer and defence.

It is uncontroversial that "the Crown" includes the police force investigating the offence, as well as the prosecution. \(^ {81}\) Multiple appellate courts have concluded that the prosecuting Crown has an obligation to actively pursue records held by the police that may be subject to disclosure. \(^ {82}\) The Supreme Court has endorsed this duty, and suggested it should go beyond the police: "The necessary corollary to the Crown's disclosure duty under Stinchcombe is the obligation of police

79 R. v. Spurgeon, [1994] A.J. No. 131 at paras. 11, 17 (Q.B.), quoted in Malik Factum, ibid. at para. 99. The context for this statement was the legal inability of a provincial Crown attorney to obtain relevant records from the military police.
(or other investigating state authority) to disclose to the Crown all material pertaining to its investigation of the accused." The Court was not clear, however, on what agencies might constitute an “investigating state authority”. This onerous duty that results from “first-party” status is thus relevant to determining the appropriate meaning of “the Crown”.

Indeed, an over-inclusive interpretation of “the Crown” would be incompatible with the finite capabilities, resources, and knowledge of the prosecuting Crown. As Prof. Paciocco has stated, “the disclosure obligation must be kept within sensible limits”. A good example of this concern arose in R. v. Gingras, in which the defence sought disclosure of a hostile witness’s prison records, based on the premise that the prison regime is part of “the Crown”. The Alberta Court of Appeal rejected this request, holding that such a broad meaning of “the Crown” would be unmanageable:

[In order to meet the tests in Stinchcombe, some months before trial every Crown prosecutor would have to inquire of every department of the provincial government and every department of the federal government. He would have to ask each whether they had in their possession any records touching each prosecution upcoming. It would be impossible to carry out one per cent of that task.]

The Supreme Court has recently cited Gingras in affirming that the inclusion of all government agencies in “the Crown” holds “no support in law” and is “unworkable”. In the remainder of this paper, I will refer back to Gingras as an example of the “cautionary” approach.

The concerns about establishing sensible limits described in Gingras are legitimate and were certainly applicable on the facts of that case. The need for such a limitation was implicitly asserted in the recent judgment of the Ontario Court of Justice in R. v. Unnah, in which the defence sought the investigating police force’s records involving the complainants. Justice Stone held that if “the Crown” were so construed, there would remain no reasonable distinction between occurrence reports held by the police force in question and those held by any other police forces, with the somewhat glib observation that “[s]omewhere there must be a police service that is a genuine third party to the particular Crown office and prosecution.” Nevertheless, it does not follow that the prosecuting Crown’s office and the investigating police force are necessarily the sole components of “the Crown”, or that such concerns require an arbitrary limiting of Stinchcombe relevance to avoid a slippery slope toward the unwieldy outcome predicted in Gingras.

83 McNeil, ibid. at para. 14 [emphasis added].
84 Paciocco, “Filling the Seam”, supra note 69 at 169.
86 Ibid. at 39; partially quoted also in Malik Factum, supra note 77 at para. 98.
87 McNeil, supra note 19 at paras. 13, 22.
89 Ibid. at para. 24.
The reasoning for this “cautionary approach” expressed in Gingras and Unnaib has been further developed by Prof. Paciocco. In his view, in excluding from disclosure “evidence that is beyond the control of the prosecution”, the Supreme Court in R. v. Chaplin affirmed the narrow meaning of “the Crown” as described in Gingras. Thus, information not held by the prosecutor is disclosable only if “the prosecuting Crown officer...has the legal right to control the information for disclosure purposes”. Even information that would have been provided to the Crown “on request” is not disclosable, as “one does not control what has to be asked for”. On this analysis, Stinchcombe obligations would include police information not because the Crown and the police are indivisible, but because of a “special rule” at common law that is particular to the police. This application of Gingras and interpretation of Chaplin is contrary to a purposive interpretation of disclosure as a manifestation as a Charter right, where the meaning of “the Crown” derives not from the structure of government agencies, but the goal of ensuring a fair trial.

A preferable balance between the “cautionary” approach and the purpose of disclosure is struck by the New Brunswick Court of Appeal in R. v. Arsenault, a decision which is often used to temper the position in Gingras. In Arsenault, the Department of Health and Community Services was part of the investigation of charges of sexual interference; its failure to provide two relevant videotapes was found to constitute a violation of the disclosure obligations of the Crown:

Crown counsel have a duty to make reasonable inquiries of other Crown agencies or departments that could reasonably be considered to be in possession of evidence. Counsel cannot be excused for any failure to make reasonable inquiries when, to the knowledge of the prosecutor or the police, there has been another Crown agency involved in the investigation.

Arsenault epitomizes what I will term a “reasonableness” approach. Gingras and Arsenault can be reconciled by recognizing that the “cautionary” approach is also concerned with reasonableness, just not as explicitly as the “reasonableness” approach—it rejects an infinitely broad meaning of “the Crown” because that meaning would require an unreasonably broad obligation to make inquiries.

91 Paciocco, “Filling the Seam”, ibid. at 175.
92 Ibid.
93 Ibid.
95 Ibid. at 117 [emphasis added].
96 While the Supreme Court of Canada has not commented on Arsenault, it has cited Gingras for the proposition that “the obligation upon the Crown to disclose all relevant material does not extend to records which are not within its possession or control”, even though Gingras is also important, and in apparent disagreement with Arsenault, on the particular meanings of “possession” and “control”: see O’Connor, supra note 17 at para. 101. The Ontario Court of Appeal has not commented on Arsenault, and its only mention of Gingras is in Kporovodu, supra note 21 at para. 127, which characterizes the case as providing “some support” for Coroner-Crown divisibility.
Prof. Tim Quigley uses Arsenault to support the proposition that “[i]t is now reasonably clear that the Crown is obliged to disclose evidence...in the hands of other state agents”, and he qualifies this statement by citing Gingras for the limitation that “the government body was a part of the investigation in some way”. Thus, the involvement of the agency in question during the investigation is a major factor in the “reasonableness” of the duty to inquire into whether that agency holds evidence. It should be noted that such involvement could be inferred not only from direct and contemporaneous cooperation in the investigation, but also in situations where information has been provided subsequently to the Crown prosecutor.

Based on the “reasonableness” approach developed in Arsenault, a government agency is part of “the Crown” for the purposes of Stinchcombe disclosure if it was reasonably considered to be involved in the investigation. There is jurisprudence, however, suggesting that such agencies are only part of “the Crown” with regards to records relating to the investigation itself, and remain “third parties” with respect to other records. Such cases tend to adopt, explicitly or implicitly, a narrow interpretation of what constitutes the “fruits of the investigation”, as they were described in Stinchcombe. Notably, the pertinent connection to the investigation comes from the content of the record, and not the stated purpose for its generation. For example, where the charge was assaulting the arresting officer, that officer’s Use of Force Report was held to be disclosable. Similarly, the RCMP’s administrative review of a collision was disclosable to the defendant accused of dangerous driving in the death and injury of two RCMP officers. This limitation of the meaning of “the Crown”, based on the connection of the records to the investigation, changes the relevance threshold established in Stinchcombe. That is, it superimposes a higher relevance threshold on records held by any agency other than the office of the prosecuting Crown attorney. The Stinchcombe relevance threshold is thereby usurped, as no records held by such agencies reach the formal relevance threshold articulated in Stinchcombe unless they already satisfy that higher relevance threshold.

There is support in the jurisprudence for this proposition that the disclosability of records held by a “first party” agency should be dependent only on meeting the low Stinchcombe relevance threshold. This is essentially the approach taken by Belzil J. in R. v. Scurr. He first determined that the “fruits of the investigating”, in the form of “the complete record of the investigation of the charges before the Court”, and any other records “[p]repared for the [p]urpose of the investigation, were clearly disclosable. The heart of

102 Supra note 68 at paras. 45-57.
103 Ibid. at paras. 52-53.
the Scurr synthesis is its approach to records otherwise “[i]nternationally [i]nked to the [i]nvestigation”:

Stinchcombe will apply if there is a factual and evidentiary link between the information sought and the charges before the Court….[T]he additional information sought must have some probative value in the proceedings…. [T]he Supreme Court of Canada in Egger defined relevance for disclosure purposes from the perspective of the accused using Crown disclosure to meet the case for the Crown, advance a defence or otherwise in making a decision which may affect the conduct of the defence. It necessarily follows that in determining whether information sought is intrinsically linked to the investigation, the information sought must be viewed through the prism of Stinchcombe as clarified in Egger. Unless the information sought could be used by the accused for any of the purposes outlined in Egger, it has no probative value and thus is not producible on authority of Stinchcombe.104

Under this approach, the disclosability of particular records is properly addressed at the relevance stage. The purposive analysis in Scurr is consistent with previous decisions such as R. v. Bottineau.105 In that case, the defendants were accused of first degree murder and unlawful confinement. They sought disclosure of occurrence reports involving potential witnesses, generated by the police, which the Crown claimed were third party records. Justice Watt determined that such reports were disclosable under Stinchcombe because they related to the credibility of potential witnesses and because they were created and held by the police; in doing so, he noted that the police had provided the documents to the Crown and such records were “routinely disclosed” in other cases.106 As the “reasonableness” approach provides a balanced determination of which agencies comprise “the Crown”, so too does the Scurr synthesis provide a balanced approach to the records in respect of which agencies should be considered “the Crown”. This approach seems to be supported by a recent judgment of the Supreme Court, which suggests that records will be “first party” records either if they are “related to the investigation, or…could reasonably impact on the case against the accused”.107

The Disclosure Obligations of the Coroner

In the previous section, I developed a formulation whereby “the Crown” includes all agencies that could reasonably be considered to have been involved in an investigation, for the purposes of determining whether records they hold meet the threshold of likely relevance established in Stinchcombe. In this section, I apply

104 Ibid. at paras. 54-57.
106 Bottineau, ibid. at paras. 69, 71, 72.
107 McNeil, supra note 19 at para. 15 [emphasis added].
this formulation to demonstrate that the Coroner is part of “the Crown”. I start by outlining the strong relationships the Coroner has, first with the police, and then with the prosecuting Crown. I will then address how these relationships are reflected in the jurisprudence of the Supreme Court of Canada, affirming that the Coroner should be considered part of “the Crown”.

The Coroner and the police are intimately connected in the investigation of death. Any suspicious or unnatural death must be reported to an individual coroner or the police, and where it is reported to the police they must inform a coroner.108 The involvement of a coroner in the investigation is far from peripheral. Not only may “no person who has reason to believe that a person died [in such circumstances]...interfere with or alter the body or its condition in any way until the coroner so directs by a warrant”, but no exemption is made for police officers.109 In addition, municipal police are obliged to provide “the coroner the assistance of such police officers as are necessary for the purpose of carrying out the coroner’s duties”, and the Chief Coroner can request the same assistance from the Ontario Provincial Police (OPP).110 Most importantly, it is “standard practice” for the pathologist performing the autopsy under the authority of a coroner to provide his or her oral opinion to the police at the conclusion of the examination.111 The Ontario Court of Appeal has recently described this practice as “[c]ontrary to s. 28(2) of the [Coroners] Act”.112 Yet, in a previous Superior Court judgment it had been held to be “reasonable” and “necessary if feasible”,113 and Prof. Lorne Sossin has identified it as a standard part of a “death investigation...where appropriate”.114 Commissioner Goudge observed that “[t]here is nothing necessarily wrong with providing...a preliminary opinion” and it “can be of great assistance” so long as it is sufficiently supported and

108 Coroners Act, supra note 18, s. 10(1). The list of circumstances is remarkably expansive: “(a) as a result of (i) violence, (ii) misadventure, (iii) negligence, (iv) misconduct, or (v) malpractice; (b) by unfair means; (c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto; (d) suddenly and unexpectedly; (e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner; (f) from any cause other than disease; or (g) under such circumstances as may require investigation”.

109 Ibid., s. 11.

110 Ibid., s. 9.

111 Reynolds v. Kingston (City) Police Services Board, 2007 ONCA 166, 84 O.R. (3d) 738 at para. 1 [Reynolds]. Coroners Act, supra note 18, s. 28(2): “The person who performs the post mortem examination shall forthwith report his or her findings in writing only to the coroner who issued the warrant, the Crown Attorney, the regional coroner and the Chief Coroner and the person who performs any other examination or analysis shall forthwith report his or her findings in writing only to the coroner who issued the warrant, the person who performed the post mortem examination, the Crown Attorney, the regional coroner and the Chief Coroner.”

112 Burns II, supra note 111 at paras. 32, 35.

qualified. The Commissioner also emphasized that such an opinion should be documented in writing. It is thus likely that this practice will continue.

The Coroner, through individual coroners, is required to provide extensive information to the Crown’s office. If a coroner orders an autopsy or other testing on a cadaver, the results must be sent not only to that coroner and the Regional and Chief Coroners, but also to the Crown. Where a coroner declines to order an inquest, the investigation must be reported to both to the Chief Coroner and to the Crown. Where a coroner orders an inquest he or she must inform the Crown, as the Crown or designate must act as coroner’s counsel. Out of context, it could be argued that the Coroner’s obligation to communicate with the Crown is relevant only to the Crown’s obligatory function as coroner’s counsel at an inquest. Section 11 of the Crown Attorneys Act, however, states that every Crown Attorney shall,

(a) examine informations, examinations, depositions, recognizances, inquisitions and papers connected with offences against the laws in force in Ontario that the provincial judges, justices of the peace and coroners are required to transmit to him or her, and, where necessary, cause such charges to be further investigated, and additional evidence to be collected, and issue out process to compel the attendance of witnesses and the production of papers, so that prosecutions may not be delayed unnecessarily or fail through want of proof.

Thus, the information the Coroner provides to the Crown is specifically used to prosecute criminal offences, and the Crown is required to act on that information. Given the integral role of the Coroner in the investigation of cases of infant and child death in Ontario, and the close cooperation with the Crown and the police mandated by statute, the Coroner falls squarely within the “reasonableness” approach to disclosure adopted in Arsenault; the Crown attorney’s office is certainly aware of the Coroner’s involvement in an investigation, having received reports of the autopsy and any other testing, and the police have likely received an opinion directly from the pathologist. As the Coroner is the sole agency that

115 Goundge Report, supra note 6, vol. 2 at 174.
116 Goundge Report, ibid., vol. 2 at 175.
117 The proper or ideal relationships between the Coroner and the Crown, and between the Coroner and the police, are important and complex issues well beyond the scope of this discussion. Note, however, that if these relationships were to be changed substantially in both law and practice, such changes could affect the applicability of the Stinchcombe disclosure regime.
118 Coroners Act, supra note 18, s. 28.
119 Ibid., s. 18(1).
120 Ibid., s. 30(1).
121 Crown Attorneys Act, R.S.O. 1990, c. C.49, s. 11 [emphasis added].
122 The Coroner would likely be excluded from “the Crown” based on a strict interpretation of the Paciocco analysis. Nevertheless, a purposive application of that approach would reach a different result. In performing its death investigation functions and communicating the results to the Crown attorney’s office for potential use in criminal prosecutions, the Coroner essentially operates as an investigative agency parallel to the police. Thus, Prof. Paciocco’s “special rule” on disclosure obligations relating to police records should also apply to the Coroner.
exercises oversight over all pediatric forensic pathology in the province, the concern arising in the “cautionary” approach that the prosecuting Crown would have to make inquiries of every government agency is inapplicable. On this basis, the Coroner is clearly subject to Stinchcombe obligations.

While the Supreme Court of Canada appeared to preclude this result in R. v. Colarusso with its comments about the relationship between the investigating coroner and the police, these cases can be distinguished based on the context. The majority clearly differentiated the Coroner from the police, which was “the criminal law enforcement arm of the state”; identified “the potential for improper complicity between the police and the coroner”; and mandated that “[t]he investigation of the coroner must remain separate from any police investigation.” Note, however, that Colarusso was not a case about full answer and defence under s. 7 of the Charter. It was about search and seizure under s. 8. The facts were well summarized by the majority’s characterization of the issue, which was whether a blood or urine sample initially seized and analyzed by a coroner acting pursuant to statutory authority and later appropriated by the state, without obtaining independent authorization, for the purpose of inculminating a defendant in an impaired driving trial violates the privacy rights inherent in s. 8.

The broader theme underlying Colarusso is that the relationships among the Coroner, the Crown, and the police should not be allowed to undermine Charter protections. In this respect, the concern in Colarusso is consistent with the purposive interpretation of Stinchcombe that includes the Coroner—the prospect of the Crown and police using the Coroner to avoid their legal obligations of disclosure is analogous to the prospect of the police abusing the powers of a coroner to circumvent their legal obligations regarding search and seizure. Thus,

123 Note, however, that the Coroner does not exercise sole oversight of pediatric forensic pathologists who, as doctors, are regulated by the College of Physicians and Surgeons. The production of records of complaints and disciplinary sanctions by the College is beyond the scope of this discussion. Note that under s. 3(3) of the Coroners Act, supra note 18, the College is mandated to inform the Chief Coroner of a change in the licensing status of a coroner; yet, there is no such provision regarding pathologists that work for a coroner.
125 Ibid at paras. 96-98, La Forest J.
127 Colarusso, supra note 124 at para. 52, La Forest J. See also s. 16 of the Coroners Act, supra note 18. Section 16(2)(c) allows “a coroner who believes on reasonable and probable grounds that to do so is necessary for the purposes of the investigation” to “seize anything that the coroner has reasonable grounds to believe is material to the purposes of the investigation” ; s. 16(4) allows delegation of that power to “a legally qualified medical practitioner or a police officer”; and s. 16(5) mandates that such things be put under “the custody of a police officer for safekeeping”. See also R. v. Rhayson, 2006 ABQB 2, (2006) 137 C.R.R. (2d) 82 at para. 26, where a motion for a stay based on destruction of evidence collected by the Chief Medical Examiner was dismissed because that office had broader powers of search and seizure than the police or the Crown.
the conclusion that the Coroner is subject to disclosure obligations is consistent with the principles underlying *Stinchcombe* and is not inconsistent with the decision of the Supreme Court in *Colarusso*.

**IV ACCESS TO QUALITY ASSURANCE UNDER STINCHCOMBE DISCLOSURE**

Now that I have demonstrated that the Coroner should be considered to be part of “the Crown” for disclosure purposes, in this part I proceed to demonstrate that quality assurance records in pediatric forensic pathology cases—both in the instant case and from the pathologist’s previous cases—should be disclosed to the accused. Recognizing that my approach to determining whether government agencies comprise “the Crown” for disclosure purposes may not be uniformly accepted, I will also explain that quality assurance reports should be produced to the accused even in the event the Coroner is considered a “third party”. First, I demonstrate that quality assurance records meet the relevance thresholds of both the “first party” and “third party” regimes. Then, I will establish that privacy considerations should not prevent the release of the records to the accused.

**The Relevance of Quality Assurance**

I will begin by summarizing the relevance thresholds that apply under the *Stinchcombe* disclosure regime applicable to “the Crown”, and the *O’Connor* regime that governs “third party” production, before applying these relevance tests to quality assurance in pediatric forensic pathology. I will establish the relevance of quality assurance in the instant case as it relates to both regimes. I will then consider historical quality assurance—that is, the work of the pathologist in previous cases. In doing so, I assess the conflicting stances of the Courts of Appeal of England and Wales compared to Ontario. Finally, I will use the Goudge Report, and the external review that prompted it, to argue that historical quality assurance is relevant under both regimes.

The definition of relevance for disclosure established in *Stinchcombe* has been further addressed by the Supreme Court and the Ontario Court of Appeal in subsequent cases. The effective definition of relevant information requires “a reasonable possibility that the withholding of information will impair the right of the accused to make full answer and defence”; both inculpatory and exculpatory information is considered relevant. The sole exceptions to the disclosure obligation have been summarized as follows: the Crown is permitted “to withhold information which is clearly irrelevant or the nondisclosure of which is required by the rules of privilege, or to delay the disclosure of information out of the necessity to protect witnesses or complete an investigation.”

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129 *Stinchcombe, supra* note 14 at paras. 22, 29.

130 *Egger, supra* note 51 at para. 19 [emphasis added]. For the purposes of this article, it is assumed that no privilege attaches to Coroner quality assurance records.
Supreme Court would later observe that “[c]learly the threshold requirement for disclosure is set quite low”. The Ontario Court of Appeal has likewise noted that “the Crown should take a generous view of relevance in making disclosure”. Nonetheless, it has also commented in strong terms against extending relevance “clearly beyond the pale” on “fishing expeditions”.

Both stages of the O’Connor test for “third party” production inquire into relevance. The first stage directly assesses “likely relevance”, and reverses the relevance onus of Stinchcombe from the Crown to the defence. In creating a production regime for third party records in O’Connor, the Supreme Court explicitly adopted a higher initial threshold for relevance than that applicable to “first party” disclosure:

In the “first party” disclosure context, the meaning of ‘relevance’ is expressed in terms of whether the information may be useful to the defence.... In the context of “third party” production, the test of relevance should be higher: the presiding judge must be satisfied that there is a reasonable possibility that the information is logically probative to an issue at trial or the competence of a witness to testify. When we speak of relevance to “an issue at trial”, we are referring not only to evidence that may be probative to the material issues in the case (i.e. the unfolding of events) but also to evidence relating to the credibility of witnesses and to the reliability of other evidence in the case.... A relevance threshold, at this stage, is simply a requirement to prevent the defence from engaging in “speculative, fanciful, disruptive, unmeritorious, obstructive and time-consuming” requests for production.

Thus, while initial relevance for O’Connor “third party” production is more demanding than for Stinchcombe “first party” disclosure, that stringency is partly offset by the broad demarcation of “issue at trial”. One of the factors at the second, balancing, stage of O’Connor is “the probative value of the record in question.” While no specific relevance threshold needs to be satisfied at this stage, relevance counts toward probative value and would affect the outcome of the balancing.

Quality assurance records in pediatric forensic pathology meet both the Stinchcombe “first party” and O’Connor “third party” initial thresholds for relevance. The recent revelations of the fallibility of the discipline in Ontario, as well as in the UK, should be sufficient to establish for the foreseeable future a rebuttable presumption that the competency and objectivity of any pediatric forensic pathologist is an important issue. The strong influence of the work of the discredited pathologists—Smith and Meadow—on others in the field, given their

132  *Daly*, *supra* note 128 at para. 38.
133  *Grimmonte*, *supra* note 128 at paras. 11-12.
134  *O’Connor*, *supra* note 17 at paras. 19, 21.
135  *Ibid.* at paras. 22-24, Lamer C.J.C. and Sopinka J., dissenting on other grounds [emphasis added].
long years as leading experts, should not be underestimated.\textsuperscript{137} As quoted above, the description of relevance in O’Connor specifically contemplated “evidence relating to the credibility of witnesses”.\textsuperscript{138} Quality assurance records of the specific case at trial either strengthen or weaken the reliability of the pathologist’s work in that case and the credibility of his or her testimony. The decision of the Coroner to release the audit of each of the 13 Smith cases to the corresponding defence and Crown counsel is demonstrated admission of this relevance. Nonetheless, to hold that that action was necessary only because the results discredited Smith’s work ignores the basis of both the disclosure and production regimes. Under Stinchcombe, both exculpatory and inculpatory evidence must be disclosed,\textsuperscript{139} while O’Connor requires the material to be “logically probative”.\textsuperscript{140}

Furthermore, quality assurance from all of the pathologist’s previous work is also relevant under both regimes. As recognized by the England and Wales Court of Appeal, a pathologist’s questioned work in a previous case “serves to undermine his high reputation and authority as a witness in the forensic process”.\textsuperscript{141} It is critical to note that the Court took this view even while recognizing that “[s]tate superficially…this appeal is dissimilar, and raises different issues” from the previous case.\textsuperscript{142} In one of the cases involving Dr. Smith’s work, Trafford J. made a similar observation:

The jury’s assessment of the competence and objectivity of Dr. Smith as a forensic pediatric pathologist, \textit{at large and in the autopsy in this case}, is

\textsuperscript{137} Between 1977 and 2002, Meadow published over 20 articles on child abuse in peer-reviewed journals, including 13 on Munchausen syndrome by proxy and a six-part series in BMJ (British Medical Journal) entitled “ABC of Child Abuse”, which covered topics including poisoning, suffocation, medical reports, and courts. Smith has co-authored an article on shaken baby syndrome as recently as August 2006: Tamara Wygnanski-Jaffe, Alex V. Levin, Ayad Shafiq, Charles Smith, Robert W. Enzenauer, James E. Elder, J. Donald Morin, Derek Stephens & Eshetu Atenafu, “Postmortem Orbital Findings in Shaken Baby Syndrome” (2006) 142 American Journal of Ophthalmology 233. In 2002, Smith co-authored Michael S. Pollanen, Charles R. Smith, David A. Chiasson, James T. Cairns & James Young, “Fatal child abuse-maltreatment syndrome: A retrospective study in Ontario, Canada, 1990-1995” (2002) 126 Forensic Science International 101. The other authors were all members of the Forensic Pathology Unit of the Coroner. They include a former Chief Coroner who later became Assistant Deputy Minister for Public Safety and Commissioner of Emergency Management (James Young), a former acting Chief Coroner (James T. Cairns), a former Chief Forensic Pathologist (David A. Chiasson), and the current Chief Forensic Pathologist (Michael S. Pollanen). Dr. Pollanen has been integral in correcting some of Smith’s errors; see e.g. R. v. Mullins-Johnson, 2007 ONCA 720, 87 O.R. (3d) 425 at para. 29; Trotta, supra note 21 at para. 4. While it is likely that his familiarity with Smith’s work aided Dr. Pollanen in correcting these errors, this incidental benefit does not negate the possibility of an adverse long-term impact of Smith’s work on the Coroner.

\textsuperscript{138} O’Connor, supra note 17 at para. 22, Lamer C.J.C. and Sopinka J., dissenting on other grounds [emphasis added].

\textsuperscript{139} Stinchcombe, supra note 14 at para. 29.

\textsuperscript{140} O’Connor, supra note 17 at para. 22, Lamer C.J.C. and Sopinka J., dissenting on other grounds.

\textsuperscript{141} Cannings, supra note 24 at para. 17.

\textsuperscript{142} Ibid, at para. 16. In Cannings, Meadow’s errors in Clark were public knowledge and hence their accessibility to the defence was not dependent on the scope of disclosure. Despite the
central to its determination of whether or not the Crown has proven beyond a reasonable doubt the guilt of either, or both, of the defendants.\textsuperscript{143}

While an error in one matter is not direct evidence supporting an error in a different matter, it nonetheless goes to credibility in every subsequent case. It is also an indicator of technical competence, as the relationship between an expert's asserted competence and his or her actual competence in one matter presumptively reflects that relationship in another matter.

Justice Doherty of the Ontario Court of Appeal has argued otherwise:

I agree with Crown counsel's submission that it is significant that the applicant has offered no evidence to suggest that any of the opinions given by Dr. Smith in this case are open to legitimate debate. Absent such evidence, I do not see how a reasonable trier of fact could possibly find the opinions given by Dr. Smith in this case to be unreliable based on his conduct in other cases. The medical opinions advanced by Dr. Smith in this case are quite limited. It may be that from a medical perspective they are sufficiently elementary to be beyond dispute. Certainly, the applicant has offered nothing to suggest that Dr. Smith's medical opinions in this case are in any way controversial. The manner in which Dr. Smith chose to express those opinions is a subject of controversy on the appeal, but would not be illuminated by evidence of his conduct in other cases.\textsuperscript{144}

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\textsuperscript{143} Kporwodu, supra note 21 at para. 257 [emphasis added].

\textsuperscript{144} Trotta, supra note 21 at para. 37. While the assessment of Doherty J.A. could be distinguished from other cases given the minimal involvement of Smith in the investigation in Trotta, it would be unadvisable to underestimate the impact of a renowned expert on the trier of fact. Indeed, in its decision ordering a new trial on fresh evidence, the Supreme Court rejected the Crown's submission that the impact of Smith's evidence was sufficiently minimal to forgo a new trial in favour of substituting manslaughter for murder (2007 SCC 49, [2007] 3 S.C.R.)
In contrast to Doherty J.A.’s conclusions, the Goudge Report highlights a list of “indicia of reliability” for scientific evidence, one of which asks, “Has the expert made serious mistakes in other investigations or prosecutions?”145 Proof of errors made in other cases is evidence, albeit indirect, that the opinions in the current case are unreliable. The weight given to expert evidence is a function of the credibility of the expert witness. That credibility derives substantially from past experience. If the past work is demonstrably flawed, less weight should be given by the trier of fact to the current evidence. That is, while the most direct route to decrease the weight given to an expert’s evidence would be to present conflicting evidence of another expert, attacking the expert’s overall credibility is nonetheless a viable alternative. It is also striking that Doherty J.A. would later note, writing the judgment on the appeal of the verdict for the same panel, that at trial the doctor who performed the original autopsy “changed his opinion [partly] in deference to Dr. Smith’s greater expertise”.146 That is, initial disagreement with Smith’s evidence was given little weight, both by the party expressing disagreement and by the Court, precisely because it was inconsistent with Smith’s findings.

Justice Doherty’s statement suggests a second argument against the relevance of the quality assurance: that the defence should find its own expert to assess the work of the Coroner’s pathologist. Under this traditional view, given the nature of the adversarial system, the failure of the defence to find such an expert is an indicator of the veracity of the Crown witness. Indeed, Commissioner Goudge held that “effective use of the adversarial system, which allows each party to call its own evidence and to cross-examine the other party’s witnesses, is particularly appropriate in areas of dispute or controversy in these cases”.147 Yet, the Commissioner also recognized that such a process is resource-intensive.148 The dearth of experts in pediatric forensic pathology is readily demonstrated on both the facts of Kporwodu and the nature of the Coroner’s review of Smith’s criminal cases.149 In Kporwodu, the expert chosen to review Smith’s work was in New Mexico, and it took over five months for the Crown to receive the report.150 Of the five experts selected for the review, one practiced in Canada, two in England, one

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146 R. v. Trott (2004), supra note 144 at para. 9 (Ont. C.A.) [emphasis added].
147 Goudge Report, supra note 6, vol. 3 at 506-07, Recommendation 137.
148 Ibid., vol. 3 at 506.
150 A.K., supra note 21 at paras. 130, 150.
in Northern Ireland, and one in Finland.\textsuperscript{151} It is unreasonable to assume the defence is capable of undertaking the expense to retain such experts. Commissioner Goudge recognized these expenses in his recommendation for further spending by Legal Aid Ontario for “forensic pathologists and similar experts”.\textsuperscript{152} Furthermore, while it is not the responsibility of the Crown or the Coroner to do research for the defence, the situation is very different when that research has already been done. This latter situation should describe pediatric forensic pathology cases since, as demonstrated above, there is an obligation to perform quality assurance.

Instant and historical quality assurance meet both the Stinchcombe requirement of “not clearly irrelevant” and the O’Connor requirement of “probative value”. Quality assurance of the instant case is clearly admissible relevant evidence. Quality assurance on past cases would arguably be inadmissible due to the collateral facts bar, such that it could not be independently established if the pathologist denied it.\textsuperscript{153} This consideration may have underlain the concerns expressed by Doherty J.A. quoted above. Past quality assurance, however, is pertinent to reliability, which, according to the Supreme Court in \textit{R. v. Mohan}, “has special significance in assessing the admissibility of expert evidence”.\textsuperscript{154} \textit{Mohan} is widely recognized as setting out the test for the admissibility of expert evidence.\textsuperscript{155} Reliability is an aspect of all parts of the \textit{Mohan} test, one part of which is whether or not the expert is properly qualified.\textsuperscript{156} For this reason, quality assurance from past cases and the instant case would be admissible to challenge the admissibility of the pathologist’s evidence.\textsuperscript{157} Commissioner Goudge noted moreover that the trial judge should consider “the reliability of the witness” in the determination of admissibility.\textsuperscript{158} Past quality assurance records would also be relevant in the trial itself. If the pathologist were allowed to testify, there would certainly be the “good faith basis” necessary for cross-examination on the quality assurance records.\textsuperscript{159} Thus, both current and historical quality assurance records have sufficient relevance to be producible under O’Connor, as well as disclosable under Stinchcombe.

\begin{itemize}
\item \textsuperscript{151} Coroner, “Backgrounder”, \textit{supra} note 2 at 2.
\item \textsuperscript{152} Goudge Report, \textit{supra} note 6, vol. 3 at 461-63, Recommendations 121-23.
\item \textsuperscript{155} See e.g. Goudge Report, \textit{supra} note 6, vol.3 at 475.
\item \textsuperscript{156} \textit{Ibid.} at 475, 478.
\item \textsuperscript{157} This determination is often made on a \textit{voir dire}. See e.g. \textit{ibid.} at 497-98.
\item \textsuperscript{158} \textit{Ibid.} at 495.
\end{itemize}
The Privacy Implications of Quality Assurance

Since quality assurance records meet the relevance thresholds for both “first party” disclosure and “third party” production, the remaining critical consideration is privacy. In particular, the families of the deceased infants and children who are subject to autopsies may assert a privacy interest in the content of quality assurance of those autopsies. Like relevance, the role of privacy is most straightforward for quality assurance in the instant case, but more complex for quality assurance from previous cases. In this part, I begin by reviewing the explicit role of privacy in “third party” production under O’Connor and explaining its implicit role in “first party” disclosure under Stinchcombe. I will then assess the Supreme Court jurisprudence on the nature of privacy interests. On this basis, I establish that there is at most a minimal privacy interest in quality assurance reports. I then demonstrate that the risk that releasing quality assurance records to the accused would violate any such interest is negligible.

While privacy interests are explicitly considered under the O’Connor “third party” production regime, their role under Stinchcombe disclosure is not straightforward. Recall from above that in O’Connor, one of the enumerated factors is “reasonable expectation of privacy.”\(^{160}\) The Ontario Court of Appeal has found that production of quality assurance from past cases raises “very difficult and important privacy issues.”\(^{161}\) As for disclosure, that court in a case regarding Dr. Smith described as “proper” the assertion by the Coroner and the Crown at trial that

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\text{[e]ven if Stinchcombe applied, there were third-party privacy interests that had to be considered...based on R. v. Mills ... in which the Supreme Court of Canada at paras. 108-9 observed that it was wrong to equate “Crown possession or control with a total loss of any reasonable expectation of privacy” and that “Stinchcombe and O’Connor...did not address the situation...[of] records in the Crown’s possession in which a complainant or witness has a reasonable, and non-waived, expectation of privacy.”}\(^{162}\)
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It is unclear if the court in using the term “proper” was commenting on the correctness of the argument or merely its reasonableness.\(^{163}\) The Supreme Court has more recently explained that while there may be a “residual privacy interest” in records held by the Crown and thereby subject to the Stinchcombe regime, such privacy interests will “as a general rule” be outweighed by the underlying right to full answer and defence.\(^{164}\) In this context, it is prudent to assess the privacy interest in the pertinent records for the purposes of both Stinchcombe disclosure and O’Connor production.

160 O’Connor, supra note 17 at para. 31, Lamer C.J.C. and Sopinka J., dissenting on other grounds.
161 Trotta, supra note 21 at para. 18.
162 Kporvodu, supra note 21 at paras. 133-34, quoting Mills, supra note 18.
163 The Ontario Court of Appeal declared soon after the release of Stinchcombe that “[i]n holding that the Crown should take a generous view of relevance in making disclosure, we also acknowledge that, in some cases, other factors (e.g., privacy interests of witnesses) will also have to be considered where the material appears to the Crown to be irrelevant”. See Daly, supra note 128 at para. 38.
164 McNeil, supra note 19 at para. 20.
The Supreme Court has canvassed the nature of privacy interests extensively. In *Mills*, it was reiterated that a production order for third party records invoked the “reasonable expectation of privacy” included in s. 8 of the *Charter* as determined in *Hunter v. Southam Inc.* 165 *Mills*, like *O’Conn*, was a sexual assault case in which the accused sought the therapeutic records of the complainant. 166 There is no bright-line test for such an expectation; instead, “the determination of when a reasonable expectation of privacy actually exists in a particular record (and, if so, to what extent it exists) is inherently fact- and context-sensitive”. 167 The judgment in *Mills*, however, also stated that “the values protected by privacy rights will be most directly at stake where the confidential information contained in a record concerns aspects of one’s individual identity or where the maintenance of confidentiality is crucial to a therapeutic, or other trust-like, relationship.” 168 In *O’Conn*, L’Heureux-Dubé J. quoted approvingly from the majority in *R. v. Plant* as follows:

In fostering the underlying values of dignity, integrity and autonomy, it is fitting that s. 8 of the *Charter* should seek to protect a biographical core of personal information which individuals in a free and democratic society would wish to maintain and control from dissemination to the state. This would include information which tends to reveal intimate details of the lifestyle and personal choices of the individual. 169

Similar language invoking “intimate aspects of the life of the complainant” were used by Lamer C.J.C. and Sopinka J. in their judgment. 170 A unanimous Supreme Court has more recently emphasized that “*Plant* clearly establishes that not all information an individual may wish to keep confidential necessarily enjoys s. 8 protection”. 171 The majority in *Edwards* held that the context-specific inquiry included both “the existence of a subjective expectation of privacy [and] the objective reasonableness of the expectation”. 172 While a privacy interest can relate both to the nature of the relationship and the type of information involved, the mere desire for confidentiality does not determine the reasonableness of the expectation.

There is at most a minimal “reasonable expectation of privacy” in quality assurance reports held by the Coroner, such that privacy interests would be insufficient to prevent either disclosure or production. The authority to conduct criminal autopsies under the *Coroners Act*, and the obligation to provide the results to the Crown, is independent of consent from the family of the deceased. 173

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165 *Mills*, supra note 18 at para. 77; *Hunter v. Southam*, supra note 70.
166 *Mills*, ibid. at paras. 23-26.
167 *O’Conn*, supra note 17 at para. 99, Lamer C.J.C. and Sopinka J., dissenting on other grounds. See also *Edwards*, supra note 126 at para. 45, Cory J.: “A reasonable expectation of privacy is to be determined on the basis of the totality of the circumstances.”
168 *Supra* note 18 at para. 89.
170 *O’Conn*, ibid. at para. 7.
172 *Edwards*, supra note 126 at para. 45, Cory J.
Such power is relatively uncontroversial, as society’s interest in investigating suspicious deaths outweighs the family’s privacy interest. There is thus no therapeutic or trust relationship between the pathologist, or coroner, and the family of the deceased, despite the fact that the pathologist and the coroner are physicians. Indeed, the ‘relationship’ is typically one of suspicion, as the caregiver is usually a suspect in pediatric death.\(^{174}\) There can be no relationship between the pathologist, or coroner, and the subject of the record, as the subject is deceased.\(^{175}\) It is true that autopsy records may include extensive information about the life of the deceased, which may implicitly reveal attributes of that life. For example, past

173 coroners act, supra note 18. Note that since the autopsy is compelled and the family has no ability to withhold the results from the Crown, part of the reasoning in O’Connor—the general rule that releasing the records to the Crown connotes a waiver of privacy interests—is inapplicable.

174 see e.g. kporowodu, supra note 21, and Trotta, ibid. While s. 278(1) of the criminal code is formally inapplicable, it remains an illuminating demarcation of privacy interests in a similar situation; in that context, a criminal autopsy record would be exempted from the privacy regime as one “made by persons responsible for the investigation or prosecution of the offence”: criminal code, supra note 11, s. 278(1).

175 counsel for the coroner asserted that it “had a statutory duty to maintain privacy in its files”: A.K., supra note 21 at para. 193. Neither the quality of care information protection act, S.O. 2004, c. 3 Sch. B nor the personal health information protection act, S.O. 2004, c. 3 Sch. A would apply, as the definitions of “health care” in those acts (at s. 1 and s. 2, respectively) should not cover the work of coroners or forensic pathologists. Nonetheless, as part of the Ministry of Community Safety and Correctional Services, the Coroner is covered by the freedom of information and protection of privacy act, R.S.O. 1990, c. F-31 [FIPPA]. Even if anonymized, the quality assurance records would nonetheless constitute “personal information” as defined in FIPPA, s. 2. Given the relatively small number of pediatric forensic pathology cases in Ontario, these cases will generally meet the requisite “reasonable expectation that, when the information in it is combined with information from sources otherwise available, the individual can be identified...[or] he or she could be identified by those familiar with the particular circumstances or events contained in the record”: Ontario (Attorney General) v. Pascoe (2001), 154 O.A.C. 97 at paras. 14-15 (Div. Ct.), aff’d (2002), 166 O.A.C. 88 (C.A.), citing IPC Orders P-230/May 6, 1991, P-316/June 16, 1992, & P-651/April 6, 1994 (Information and Privacy Commissioner/Ontario), cited in Barbara Mcsac, Rick Shields & Kris Klein, The Law of Privacy in Canada, looseleaf, vol. 1 (Toronto: Thomson Canada, 2000) at para. 3.7.2.3. Thus, quality assurance records of work by pediatric forensic pathologists for the Coroner would be facially nondisclosable under FIPPA, s. 21(1)(f) as a presumptive “unjustified invasion of personal privacy”, following FIPPA, ss. 21(3)(a) & (b). Under s. 21(3)(b), records of criminal investigations are also a presumptive invasion, “except to the extent that disclosure is necessary to prosecute the violation or to continue the investigation”; thus, records of past investigations would not be exempted. Nevertheless, s. 23 provides for disclosure “where a compelling public interest in the disclosure of the record clearly outweighs the purpose of the exemption”. The public interest would include the principle of fundamental justice of full answer and defence; see Dersch v. Canada (Attorney General), [1990] 2 S.C.R. 1505 at 1514, cited in Stinchcombe, supra note 14 at para. 17. Given the major role of pediatric forensic pathology evidence in criminal trials, that public interest would undoubtedly outweigh the concern for privacy. Note also that under s. 21(2)(a), a “relevant circumstance” for determining whether the invasion is unjustified is whether “(a) the disclosure is desirable for the purpose of subjecting the activities of the Government of Ontario and its agencies to public scrutiny”. This consideration, although overtaken by the presumption in ss. 21(3)(a) & (b), would also inform the application of the public interest exception in s. 23.
injuries noted in *R. v. Trotta* were the foundation for conclusions about the abusive nature of the relationships among the deceased and his family members. Nevertheless, such information does not expose “intimate details of the lifestyle and personal choices of the individual”, as invoked in *O’Connor*, to any extent comparable to that of a counselling or psychiatric relationship. Moreover, as a death—especially the death of a child—is a sensitive event in the life of a family, it would certainly be subjectively and objectively reasonable to expect the Coroner to keep the records confidential from the general public. Nonetheless, redaction and anonymity measures would respect this general confidentiality, even if the records formed part of the public record of a criminal trial.  

The risk that disclosure or production would violate any such minimal privacy interest is negligible. A formalistic transplantation of the reasoning of *O’Connor* or *Mills* is misleading if it is done without regard to the difference in context. Where the complainant or a witness has a privacy interest in records that involve them, there is no way to use the records without compromising that interest. The privacy infringement relates to both the public record and the trial process itself. Withholding the identity of the complainant or witness may reduce the violation of their privacy with respect to the general public, but they are still subject to the potentially profound indignity of cross-examination based on such records. The introduction and use of the records is intrinsically dependent upon the demonstrable connection between the person identified in the records and the person on the stand. In stark contrast, anonymizing quality assurance records in pediatric forensic pathology would have no impact on their utility or fairness, because the identity of the pathologist, and not the identity of the deceased, is at issue. Redacting by the Court, and undertakings by defence counsel such as those explicitly approved by the Court of Appeal in *Trotta*, should provide sufficient protection against general publicity. Furthermore, the integrity of the deceased is not an issue. The trial process does not confront the family of the deceased in the same way it does a complainant in the context contemplated by *O’Connor* or *Mills*. In *Mills*, the Supreme Court repeatedly emphasized that “full answer and defence does not include the right to evidence that would distort the search for

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176 Note that Commissioner Goudge ruled on very similar privacy interests in the context of a public inquiry. The Commissioner decided that first names or initials would provide sufficient protection of privacy interests: Goudge Inquiry, “Ruling on the requests for non-publication orders” (1 November 2007) at 14, online: Inquiry into Pediatric Forensic Pathology in Ontario <http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/file/pdf/Ruling_Non-Publication-Orders.pdf>. In doing so, he emphasized the importance of not unduly restricting information, in the context of both the general need for public inquiries to be public and the specific mandate of the Inquiry to restore public confidence: *ibid.* at 1-6.

177 *Supra* note 21 at para. 16: “Counsel for Kporwodu and Veno...are in possession of copies of the material that the applicant wants. They properly take the position that they hold the material subject to an undertaking that they will use it only in the defence of their own clients. They cannot produce it to counsel for the applicant without a court order.”

178 Conceivably, it could arise indirectly from reference to the records of a particular deceased child that the death was potentially preventable despite the lack of criminal culpability. It is human nature to feel guilt over accidents one could have prevented with perfect knowledge.
truth inherent in the trial process". An attempt to challenge the objectivity and technical capacity of the critical Crown witness, based upon a factual assessment of his or her or her previous work, would not distort that search for truth; indeed, it would epitomize it.

Under either "first party" disclosure following Stinchcombe—if that regime is held to incorporate a privacy consideration—or "third party" production following O'Connor, privacy concerns would be insufficient to prevent quality assurance records held by the Coroner from being provided to the defence. If Stinchcombe disclosure obligations can outweigh recognized grounds of privilege, it would be illogical to find that they are not more important than a privacy interest that does not amount to privilege. Such a relationship between privacy and full answer and defence under both Stinchcombe and O'Connor was clearly described in Mills:

[T]he accused's right must prevail where the lack of disclosure or production of the record would render him unable to make full answer and defence. This is because our justice system has always held that the threat of convicting an innocent individual strikes at the heart of the principles of fundamental justice. However, between these extremes lies a spectrum of possibilities regarding where to strike a balance between these competing rights in any particular context.

Given the often critically decisive role of the pathologist's evidence in establishing guilt in cases of infant death, the tension between the two rights would strongly favour those of the accused. Similarly, under the five-factor O'Connor second stage analysis, the combination of the substantial probative value and need to ensure full answer and defence, the minimal reasonable expectation of privacy or potential prejudice to the family of the deceased, and the absence of a discriminatory basis for seeking the record should compel production of the records to the defence. While quality assurance records from previous cases are less directly relevant than those from the pathologist's previous cases, the

For example, Louise Reynolds would likely have suffered severe distress over the death of her daughter even if the correct cause of a dog attack had been initially identified: see Reynolds, supra note 112. In that respect, discussion of the circumstances of that death at an unrelated trial could cause her additional suffering. No such accusations, however, would be generated by the trial process itself; assuming anonymity was maintained, it would merely be an unwanted reminder of terrible circumstances. Even if the family could be identified from public records, any indignity would be far outweighed by the potential impediment to the accused's ability to defend himself or herself against criminal charges.

179 Supra note 18 at para. 76. See also paras. 74, 89, 90, 94.
180 Note that the disclosure obligations of the prosecutors in England and Wales with regard to expert witness error in previous cases give absolutely no weight, much less mention, to the privacy interests of the victims in those previous cases: Crown Prosecution Service, Disclosure Manual, supra note 142 at paras. 3.6.1-3.6.50.
181 See Stinchcombe, supra note 14 at para. 22: "The trial judge might also, in certain circumstances, conclude that the recognition of an existing privilege does not constitute a reasonable limit on the constitutional right to make full answer and defence and thus require disclosure in spite of the law of privilege."
182 Supra note 18 at para. 89 [emphasis added].
importance to full answer and defence remains sufficient to outweigh the privacy interest just as it does for the instant case. Thus, under either Stinchcombe “first party” disclosure or O’Connor “third party” production, neither privacy issues nor relevance necessitate the withholding of quality assurance records in pediatric forensic pathology from the instant case or the pathologist’s previous cases.

V CONCLUSION

The Goudge Report was a comprehensive and conscientious analysis of the steps that will best restore public confidence in a discipline and a system that have been severely shaken. It emphasized the importance of the performance of quality assurance in criminal cases involving pediatric forensic pathology. The disclosure of records of that quality assurance is certainly reflective of the spirit of the Report. As my analysis has demonstrated, such disclosure is also a legal requirement.

There is a demonstrable obligation on the Crown and the Coroner to perform quality assurance in pediatric forensic pathology investigations. Nonetheless, obligations to create and preserve records of that quality assurance depend largely on the applicability of Stinchcombe disclosure to the Coroner as opposed to O’Connor production. Based on a purposive analysis of the literature and jurisprudence, for the purposes of Stinchcombe, “the Crown” includes agencies reasonably expected to hold evidence, including those involved in the investigation directly or that provided information to the prosecutor after the fact. Which records held by such agencies will be specifically disclosable should be determined solely on the basis of the relevance criteria outlined in Stinchcombe, and not by a more stringent analysis of the relationship of the records to the investigation itself. Under this framework, the central role of the Coroner in death investigation and prosecution, and its close relationships with the police and the Crown bring the Coroner within the meaning of “the Crown”. Given the particular relevance of quality assurance in the context of pediatric forensic pathology, records of such quality assurance from the instant case must be disclosed. Moreover, the accuracy and reliability of a pathologist’s work in previous cases are relevant to his or her work in the instant case. Thus, quality assurance records from all of the pathologist’s previous work in cases involving pediatric forensic pathology are also disclosable.