CITATION NO.: Turner v. Death Investigation Council et al., 2021 ONSC 6625
DIVISIONAL COURT FILE NO.: 175/20
DATE: 20211101

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Penny, Grace and Kurz JJ.

BETWEEN:	)	
DR. JANE TURNER	)	
Applicant	)	Sujit Choudhry and David Baker for the Applicant
– and –	)	
DEATH INVESTIGATION OVERSIGHT COUNCIL and DR. MICHAEL POLLANEN	)	Alexandra Clark and Stephanie Figliomeni, for the Respondent, Death Investigation Oversight Council
Respondents	)	Wayne Cunningham for the Respondent, Dr. Michael Pollanen
	)	Emma Carver for the Hamilton Spectator (a division of Metroland Media Group Ltd.) and Toronto Star Newspapers Ltd.
	)	Iris Fischer and Gregory Sheppard for the Canadian Civil Liberties Association
	)	James Mountford for the parents of AB
	)	Dr. GH in person
	)	**HEARD:** October 5, 2021

Reasons for Decision

[1] This is a motion by the Death Investigation Oversight Council ("DIOC") for an order sealing certain portions of its record of proceedings in this matter. The DIOC also seeks approval of certain redactions to other portions of the record.

[2] This motion arises in the context of an application for judicial review by Dr. Jane Turner. Dr. Turner made a complaint to the DIOC about Dr. Michael Pollanen, who is the Chief Forensic Pathologist for Ontario. The DIOC issued a reporting letter. Dr. Turner challenges the result and seeks an order setting aside the report, remitting her complaint back to the DIOC for reconsideration and for other related relief, including a recommendation that Dr. Pollanen be removed from office as the Chief Forensic Pathologist.

[3] The DIOC's motion is opposed, in varying degrees, by the other parties and by the media intervenors, Hamilton Spectator and Toronto Star and the intervenor, the Canadian Civil Liberties Association. It is supported by certain witnesses who were interviewed as part of the DIOC's investigation into Dr. Turner's complaint. Other witnesses have said they have no difficulty with the disclosure of their names in the record, take no position or actively oppose the order sought.

[4] For the reasons that follow, the motion is granted in part.

Background

Creation and Composition of DIOC

[5] The DIOC is a statutory body that was established in 2010 through amendments to the *Coroners Act*, RSO 1990, c C.37 (the "*Act*"). It acts as an independent oversight body aimed at ensuring that death investigation services are provided in a transparent, effective and accountable manner in Ontario.

[6] The DIOC was created to provide effective oversight of the death investigations regime in Ontario precisely because such oversight was previously lacking. It was created based on recommendations in the Report following the Inquiry into Pediatric Forensic Pathology in Ontario led by The Honourable Stephen T. Goudge.

[7] The Goudge Report was delivered in 2008 in the wake of a number of wrongful convictions arising from the flawed forensic pathology reports of Dr. Charles Smith. The Commission of Inquiry was tasked with determining what went wrong with the practice and oversight of pediatric forensic pathology in Ontario and making recommendations to restore public confidence in death investigations.

[8] One of the issues identified in the Goudge Report was that there was no legislative framework in the *Act* to ensure proper oversight and accountability of forensic pathology. Directors of regional forensic pathology units, such as Dr. Smith, were not subject to any "expressly articulated oversight whatsoever". Further, there was no institutionalized mechanism for receiving complaints from the public and addressing them in an objective way. Part of the proposed solution to remedy these deficiencies was to amend the *Act* to create a governing council to oversee the work of both the Chief Coroner and the Chief Forensic Pathologist and to provide an annual report to the Ministry of Community Safety

and Correctional services, available to the public. The Goudge Report also suggested the establishment of a public complaints process to:

(a) reflect the principles of transparency, responsiveness, timeliness, and fairness;

(b) focus on remedial and rehabilitative responses, rather than punitive ones, except where the public interest is jeopardized; and

(c) provide for appeals by the complainant or the physician to the complaints committee of the governing council where they are not satisfied with the initial resolution of the complaint by the Chief Coroner or the Chief Forensic Pathologist or their designates.

[9] The DIOC is currently comprised of a Chair, a Vice-Chair and several Council Members with broad representation from various disciplines. The Chief Forensic Pathologist and Chief Coroner of Ontario sit as non-voting members of DIOC but are prohibited from participating in DIOC's Complaints Committee.

Functions and Role of DIOC

[10] Section 8.1(1) of the *Act* sets out the various functions of DIOC and establishes that it will oversee the Chief Coroner and the Chief Forensic Pathologist by advising and making recommendations to them on the following matters:

a. financial resource management;

b. strategic planning;

c. quality assurance, performance measures and accountability mechanisms;

d. the appointment and dismissal of senior personnel;

e. the exercise of the power to refuse to review public complaints;

f. compliance with the *Coroners Act* and corresponding regulations; and

g. any other prescribed matter.

[11] Under s. 8.1(2) of the *Act*, the DIOC may request that the Chief Coroner and the Chief Forensic Pathologist report to it on the matters set out in section 8.1(1).

[12] In addition, section 8.1(3) of the *Act* provides that the DIOC will advise and make recommendations to the Solicitor General on the appointment and dismissal of the Chief Coroner and the Chief Forensic Pathologist.

[13] Finally, the DIOC administers a public complaints process through which it reviews complaints regarding death investigations, particularly complaints against a coroner or a forensic pathologist working in Ontario.

The Complaints Committee and the Complaints Process

[14] Section 8.2 of the *Act* provides that there is to be a Complaints Committee of the DIOC that is composed of members of the DIOC as appointed by the Chair.

[15] Under s. 8.4 of the *Act*, any person may make a written complaint to the Complaints Committee about a coroner or a pathologist. As set out in s. 8.4(4), complaints about coroners will be referred to the Chief Coroner and as set out in s. 8.4(5), complaints about pathologists will be referred to the Chief Forensic Pathologist. Under s. 8.4(12), the Chiefs must report on the outcome of their reviews to the Complaints Committee.

[16] Where the complaint is made against the Chief Coroner or the Chief Forensic Pathologist, however, s. 8.4(6) makes clear that the Complaints Committee must review the complaint unless one of the exceptions set out in section 8.4(11) of the *Act* is applicable.

The Powers of the Chief Forensic Pathologist

[17] The Act provides the Chief Forensic Pathologist with broad authority over the work and livelihood of all pathologists practicing within the Province of Ontario. Under s. 7.1 of the *Act*, the Chief Forensic Pathologist is responsible for maintaining a Register of pathologists who are authorized to provide services. Removal from this Register means that a pathologist can no longer perform autopsies in the Province of Ontario.

[18] In addition, under s. 2 of Regulation 273/09 under the *Act*, the Chief Forensic Pathologist must notify the Registrar of the College of Physicians and Surgeons of Ontario in writing if they have any concerns that a pathologist has committed an act of professional misconduct, is incompetent or is incapacitated, or if the pathologist has been removed from the Register of authorized pathologists. Under s. 1 of the same Regulation, the Chief Coroner has the same obligation regarding individual coroners.

The Child Injury Interpretation Committee

[19] Another committee of the DIOC is also relevant to the Complaint and to the judicial review. This is the Child Injury Investigation Committee.

[20] The CIIC was created in 2017 to oversee controversial cases involving children under five years of age. The CIIC was created in direct response to, and very shortly after, the April 12, 2017 decision of the Superior Court of Justice in R. v. France, 2017 ONSC 2040. France had been charged with the second-degree murder of a two-year old child by abdominal trauma. Dr. Pollanen performed the post-mortem and testified both at the preliminary hearing and at trial on the voir dire. Justice Molloy refused to qualify him as an expert at the trial. Among other things, she found that Dr. Pollanen's evidence was either "misleading and a breach of the duty of impartiality to the court" or that he offered his opinions "without doing even the most rudimentary amount of research". She also found that Dr. Pollanen had demonstrated "professional credibility bias" because, "having taken a position ... at the preliminary hearing, Dr. Pollanen was now looking for ways to support it, rather than looking objectively at the research and autopsy findings". For example, he refused "to abandon his bottom-line position ... that this injury in this case was caused by

an assault" and attempted to support his position, even though he "simply does not have the expertise and has not done sufficient research to draw a conclusion".

The Application for Judicial Review and the Present Motion

[21] Dr. Turner is a forensic pathologist who was employed at the Hamilton Regional Forensic Pathology Unit for approximately two years. In December 2017, she performed an autopsy on the infant, AB, and observed abnormalities which could be indicative of child abuse, including abnormal bone lesions. She concluded that the cause of death was bacterial sepsis. As part of her examination, the Applicant sent bone samples to a specialist in bone pathology, who reported that the bone lesions appeared to arise from a bone disease as opposed to injuries.

[22] Dr. Turner and Dr. Pollanen came to different conclusions about whether the infant had been abused. Dr. Pollanen referred the case to the CHC, which held a number of meetings to consider the medical evidence and to discuss the matter. In the end, in December 2018, the CHC concluded that "inflicted trauma was not excluded" as the underlying cause of the bone lesions. Dr. Pollanen prepared his own report concluding the infant had been physically abused.

[23] In a letter dated March 4, 2019, Dr. Turner submitted a complaint to the DIOC regarding Dr. Pollanen. Dr. Turner complained about Dr. Pollanen's conduct in relation to the review of the death of AB. Dr. Turner alleged in her complaint that Dr. Pollanen abused his position of power as head of the Ontario Forensic Pathology Service to enforce his strong bias in pediatric cases in favour of child abuse as the cause of death by trying to impose his judgment on her through the CHC process.

The Complaints Committee's Review and DIOC's Recommendations

[24] During its review, the Complaints Committee collected and consulted a large volume of publicly available or non-confidential written material, including media articles and policy manuals.

[25] In addition, between May 2019 and June 2019, DIOC wrote to 11 individuals to advise them of Dr. Turner's complaint and to request that they attend an interview with the Complaints Committee. In a number of these letters, the interview to be conducted by the Complaints Committee was described as "confidential".

[26] Between May and September of 2019, the Complaints Committee conducted interviews with a total of 17 individuals, including the Applicant and Dr. Pollanen. Of these witnesses, 16 were medical doctors, and of these medical witnesses, 10 were pathologists and 4 were coroners. The remaining witness was a police detective.

[27] At least 4 individuals who were interviewed were provided with an assurance of confidentiality at the time of their interview and at least one individual is said to have expressed a fear of reprisal if Dr. Pollanen were to learn that this individual was the source of certain information. One additional individual expressed a fear of reprisal after that individual's interview was completed.

[28] The Complaints Committee also reviewed a PowerPoint slide presentation regarding the closure of the Hamilton Region Forensic Pathology Unit. Some of the contents of the presentation include sensitive job performance information pertaining to certain forensic pathologists who are not parties to this application or to the initial complaint. It also contains information concerning two infant autopsy cases referenced in Dr. Turner's complaint.

[29] Finally, the Complaints Committee also reviewed voluminous written materials which DIOC requested and received from the Office of the Chief Coroner and from the Ontario Forensic Pathology Service, including the full forensic pathology files relating to two infants (AB and CD) mentioned in Dr. Turner's complaint. These files include the full autopsy reports for these infants, which include a number of autopsy photographs, as well as other medical records of the infants and of their family members, together with photographs relating to police investigations into the deaths of these infants, as well as police notes and correspondence with children's aid organizations.

[30] At the conclusion of the Committee's review, the DIOC produced a report in the form of a letter dated December 9, 2019, containing 14 recommendations aimed at the Ontario Forensic Pathology Service.

[31] In June of 2020, Dr. Turner issued a notice of application for judicial review, asking the Divisional Court to review several aspects of the DIOC decision. This is the first application for judicial review that has ever been initiated against the DIOC.

[32] In response to this application, the DIOC prepared a proposed record of proceedings. The proposed record contains information relating to the review of the complaint, much of which is said to be "sensitive and confidential" in nature. The proposed order governing the record of proceedings would place under seal all of the autopsy files for the deceased infants and redact all identifying information concerning any of the witnesses (other than Dr. Turner or Dr. Pollanen) interviewed by the Committee in the course of its investigation.

[33] There was a dispute among the parties about the scope and application of the sealing and redaction orders. The DIOC brought a motion to settle the form of the record of proceedings.

[34] Justice Corbett was scheduled to hear this motion. Due to the unique character of the matter and the broad-ranging issues of public interest, he ordered that the motion be heard by a full Divisional Court panel. He also ordered that the media be given notice under the Court's protocol. This led to the interventions of the Hamilton Spectator and the Toronto Star and, as well, the CCLA.

Recent Law Governing the Open Court Principle

[35] In *Sherman Estate v. Donovan*, 2021 SCC 25, the Supreme Court of Canada affirmed that it "has been resolute in recognizing that the open court principle is protected by the constitutionally-entrenched right of freedom of expression and, as such, it represents a central feature of a liberal democracy. As a general rule, the public can attend hearings and consult court files and the press — the eyes and ears of the public — is left free to inquire

and comment on the workings of the courts, all of which helps make the justice system fair and accountable": *Sherman Estate* para. 1.

[36] The substance of the approach to the open court principle articulated in cases such as Sierra Club, 2002 SCC 41 was affirmed. The analytical method, however, for the consideration of requests for sealing orders and the like was clarified and restated. In order to succeed, the person asking a court to exercise discretion in a way that limits the open court presumption must establish that:

(1) court openness poses a serious risk to an important public interest;

(2) the order sought is necessary to prevent this serious risk to the identified interest because reasonably alternative measures will not prevent this risk; and,

(3) as a matter of proportionality, the benefits of the order outweigh its negative effects.

[37] Only where all three of these prerequisites have been met can a discretionary limit on openness — for example, a sealing order, a publication ban, an order excluding the public from a hearing, or a redaction order — properly be ordered. This test applies to all discretionary limits on court openness, subject only to valid legislative enactments (*Toronto Star Newspapers Ltd. v. Ontario*, 2005 SCC 41, [2005] 2 S.C.R. 188, at paras. 7 and 22): *Sherman Estate,* para 38.

[38] The discretion is structured and controlled in this way to protect the open court principle, which is constitutionalized under the right to freedom of expression at s. 2(b) of the Charter ((*Canadian Broadcasting Corp. v. New Brunswick (Attorney General)*, 1996 CanLII 184 (SCC), [1996] 3 S.C.R. 480, at para. 23). Sustained by freedom of expression, the open court principle is one of the foundations of a free press given that access to courts is fundamental to newsgathering: Sherman Estate, para. 39.

[39] The strong presumption in favour of open courts allows for public scrutiny which can be the source of inconvenience and even embarrassment to those who feel that their engagement in the justice system brings intrusion into their private lives. But this discomfort is not, as a general matter, enough to overturn the strong presumption that the public can attend hearings and that court files can be consulted and reported upon by the free press: *Sherman Estate*, para. 2.

[40] However, personal information disseminated in open court can be more than a source of discomfort and may result in an affront to a person's dignity. Insofar as privacy serves to protect individuals from this affront, it is an important public interest relevant under *Sierra Club*. Dignity in this sense is a related but narrower concern than privacy generally; it transcends the interests of the individual and, like other important public interests, is a matter that concerns society at large. A court can make an exception to the open court principle, notwithstanding the strong presumption in its favour, if the interest in protecting core aspects of individuals' personal lives that bear on their dignity is at serious risk by reason of the dissemination of sufficiently sensitive information. The question is not whether the information is "personal" to the individual concerned, but whether, because of

its highly sensitive character, its dissemination would occasion an affront to their dignity that society as a whole has a stake in protecting: *Sherman Estate*, para.33.

[41] This public interest in privacy focuses the analysis on the impact of the dissemination of sensitive personal information, rather than the mere fact of distribution, which is frequently risked in court proceedings and is necessary in a system that privileges court openness. It is a high bar. This public interest will only be seriously at risk where the information in question strikes at the core identity of the individual concerned: information so sensitive that its dissemination could be an affront to dignity that the public would not tolerate, even in service of open proceedings: *Sherman Estate*, para. 34.

[42] Applicants for an order making exception to the open court principle cannot content themselves with an unsubstantiated claim that this public interest in dignity is compromised any more than they could by an unsubstantiated claim that their physical integrity is endangered. The applicant must show on the facts of the case that, as an important interest, this dignity dimension of their privacy is at "serious risk". For the purposes of the test for discretionary limits on court openness, this requires the applicant to show that the information in the court file is sufficiently sensitive such that it can be said to strike at the biographical core of the individual and, in the broader circumstances, that there is a serious risk that, without an exceptional order, the affected individual will suffer an affront to their dignity: *Sherman Estate*, para. 35.

Analysis

The DIOC Motion

[43] There are two distinct categories of information proposed to be subject to redaction/sealing orders under the DIOC motion:

(1) a sealing order concerning all information in the autopsy/pathology case files involving two infants, AB and CD, to which reference was made in the Complaint and which were considered during the Committee's review and deliberations; and

(2) redactions of information regarding the identity of 17 witnesses interviewed in the course of the Committee's investigation, the notes from which the Committee reviewed in the course of its deliberations.

Autopsy Files

[44] By the time of oral argument, no party or intervenor was seeking public disclosure of any identifying information of the infants AB or CD or members of their families. Identifying information, for the purposes of these proceedings, has been defined as names, addresses, phone numbers, and health card or other identifying numbers, dates of birth and photographs (including any autopsy photographs).

[45] The DIOC, however, maintains that the entirety of the autopsy files should be sealed and that it is insufficient for only the identifying information to be redacted.

Should Identifying Information Be Redacted?

[46] In this case, the personal information in the autopsy files relating to the infants and their families is of such a sensitive nature that its dissemination would occasion an affront to human dignity that the public would or should not tolerate, even in service of open court proceedings. Among other things, the families involved in these incidents have been drawn into child protection and related inquiries which remain ongoing. There are often legislative prohibitions against publication of identifying information in such circumstances. In addition, the autopsy records contain photographs of the infants who are deceased. The publication of such photographs would, in my view, also constitute an affront to human dignity; if not of the deceased themselves, certainly of their family members and their memories of the infants who are now gone.

[47] I have no hesitation in finding that the identifying information of AB and CD and their families meets the first branch of the test articulated in Sherman Estate – the principle of court openness in this case poses a serious risk to an important public interest, namely protection and preservation of human dignity.

Should The Entirety of the Autopsy Files Be Sealed?

[48] Part two of the *Sherman Estate* test requires that the order sought be necessary to prevent the serious risk to the identified interest because reasonably alternative measures will not prevent the anticipated harm. I would have thought that, prima facie, the redaction of identifying information would serve to protect the personal dignity of the infants and their families. I do not understand the DIOC to be quarreling with this proposition in principle. However, in oral argument, counsel for the DIOC maintained that a sealing order was required "out of an abundance of caution"; that the autopsy files were large and that, to avoid the risk of inadvertent mistakes in catching all of the identifying information, sealing orders for the entire files were still required.

[49] I am unable to accept this argument. Arguments based on an abundance of, or erring on the side of, caution in this context have been consistently rejected by the court. For example, Justice Nordheimer rejected this approach in *R. v. Kossyrine and Vorobiov*, 2011 ONSC 6081, at para. 16, where he said:

> If that were the test, then publication bans would routinely be granted. The test is whether it is necessary to do so. If we were to simply chose the safer route... it would lead to a result where the right of the public to be informed on a timely basis about significant events occurring in the justice system through the freedom of the press enshrined in s. 2(b) of the *Charter* is relegated to secondary status. That result was, of course, expressly rejected in *Dagenais*.

[50] A sealing order over the entire autopsy files is not necessary to prevent a serious risk to personal dignity in this case because reasonably alternative measures, i.e., the redaction of identifying information, will prevent the risk to personal dignity. The DIOC must simply

do the job of redacting the identifying information from the public copy of these records with care.

Witness Identifying Information

[51] In case management endorsements of June 30 and July 13, 2021, I ordered that 15 witnesses (that is, witnesses other than Dr. Turner and Dr. Pollanen) interviewed by Complaints Committee staff be notified of this motion and the potential that an unredacted record would be publicly filed with the Court. Those potentially affected non-parties were invited to make submissions to the Court on the issue.

[52] Four witnesses provided consents to the disclosure of their names. Five witnesses did not respond to the notice. Six witnesses objected to the disclosure of their names or any identifying information about them. Four of the latter group retained counsel, who assisted them in filing submissions with the Court. The other two filed their own submissions by email.

[53] The six witnesses objecting to the disclosure of their names and content of their interviews all make essentially the same points:

- they were given assurances by Complaints Committee staff that the information they provided would be kept confidential
- the Committee appeared to be serious in its assurances of confidentiality
- they had a reasonable expectation that the assurances of confidentiality would be honoured
- Dr. Pollanen, as Chief Forensic Pathologist, controls access to the Registry of pathologists who are authorized to perform autopsies. There is a concern that they could potentially face reprisals from their "effective superiors"
- had they been advised that their identity and information would not be kept confidential, they would have either declined to be interviewed or their answers to questions would have been more cautious and less frank
- they are not parties to and want nothing to do with Dr. Turner's complaints or the application for judicial review
- it would be unfair in the circumstances if their participation in the Committee's investigation were now publicly disclosed and
- they "believe" that future potential witnesses would be deterred from coming forward, or withhold pertinent information, if there is no guarantee of confidentiality in DIOC's complaints proceedings

[54] The DIOC argues:

(a) there is an important public interest in protecting the privacy of non-parties who are drawn into legal proceedings, particularly where there is a public interest in encouraging candour by offering protection to the witnesses who provide information to public oversight bodies;

(b) for DIOC to effectively supervise the death investigation system in Ontario, it is important that it be able to receive certain information in confidence. Subject to specified exceptions noted in subsection 8.3(2) of the Act, the members and employees of DIOC's Complaints Committee are required to "keep confidential all information" that comes to their knowledge in the course of performing their complaint review duties;

(c) there are a limited number of pathologists and in particular, forensic pathologists, licensed to practice in Ontario. The public disclosure of small details, such as a forensic pathologist's gender coupled with the location of his or her practice, could therefore identify him or her; and

(d) in the circumstances of a complaint to DIOC regarding the Chief Forensic Pathologist, unique considerations arise. Nearly all of the witnesses interviewed by DIOC were employed either as a coroner or as a pathologist at the time of their interview. For witnesses in these roles, there may be concerns regarding qualifications, employment and career advancement when answering questions about the Chief Forensic Pathologist. These concerns result from the authority, including control of the authorized Register for pathologists, that is granted to the Chief Forensic Pathologist by the relevant provisions of the *Act*. In this very case, as noted earlier, several of the witnesses have expressed this concern and requested that the information they provided be held in confidence.

[55] I am, again, unable to accept these arguments.

[56] I am prepared to accept, as a theoretical proposition, that witness candour in regulatory investigations, especially in the context of a complaint about the conduct of the Chief Forensic Pathologist in the province of Ontario, is an important matter of public interest. However, in *Desjardins v. Canada (Attorney General)*, 2020 FCA 123, the Federal Court of Appeal cautioned against "confus[ing] an important interest (i.e., protecting persons who make a disclosure and witnesses) with a serious risk of harm that could result from disclosing their identity". As the first branch of the test in *Sherman Estate* makes crystal clear, the requirement is not only that there be an important interest but that the open court principle must pose a serious risk to that interest.

[57] I am not satisfied, in this case, that the open court principle poses a serious risk to the public interest in fostering witness candour. I come to this conclusion for several reasons.

[58] First, as noted above, the open court principle is protected by the constitutionally-entrenched right of freedom of expression and, as such, it represents a central feature of a liberal democracy. Sustained by freedom of expression, the open court principle is also one of the foundations of a free press given that access to courts and their

processes is fundamental to news gathering. I have a great deal of sympathy for a witness who may have been given assurances of confidentiality by an investigator working for the Committee and it may well be that there will be some unfairness if the Committee is now not in a position to make good on that assurance. But undertakings of this kind are simply incapable of displacing constitutional imperatives, repeatedly endorsed by the Supreme Court of Canada, which demand the courts to operate within, and to enforce, the concept of openness.

[59] Thus, the claims of individuals to reasonable reliance on assurances of confidentiality do not, standing alone, constitute an important public interest. The argument under the first branch of the *Sherman Estate* test must turn on whether the effective exercise of the DIOC's oversight and investigative functions requires a guarantee of confidentiality to all potential witnesses. As I will explain below, I would find that it does not.

[60] In the absence of that finding, the DIOC does not have the right to withhold information from its record of proceedings to be filed with this Court on this application for judicial review merely because assurances of confidentiality were offered by Committee staff to some interviewees. Were it otherwise, any public body could avoid the open court principle merely through the mechanism of offering its own assurances. The reference to keeping all information confidential in s. 8.3(1) of the *Act* does not mean that the DIOC is permitted to seal or redact information filed with the Court in the context of a legal proceeding. *Au contraire*, s. 8.3(2) specifically states that confidential information may be disclosed for the purposes of: a) administering the *Act;* and, b) as required by law. "As required by law" includes the requirement to comply with the constitutional principle of open courts.

[61] Second, the alleged "harm" (i.e., that the Chief Forensic Pathologist may retaliate against individuals who provided information to DIOC by removing pathologists from the Register, making complaints to the College of Physicians and Surgeons of Ontario or otherwise interfering with their ability to earn a livelihood) is, in the circumstances, unsupported and speculative. Further, given the small size of this specialized professional community and the specificity of Dr. Turner's Complaint, it is a dubious proposition, at best, that Dr. Pollanen has no idea who the sources of information given to the Committee are likely to have been.

[62] In *Canada (Commissioner of Competition) v Parrish & Heimbecker Limited*, 2021 CanLII 82 (CT), the Competition Tribunal rejected a similar argument put forth by the Commissioner of Competition. In that case, the Commissioner proposed that farmers who provided signed witness statements, but who feared economic retaliation from the grain elevator owner for their participation in the investigation, should have their identities redacted. The Tribunal held that this proposal bordered on allegations of witness tampering and witness intimidation. Compelling evidence would be required to support such an approach. However, the Commissioner's evidence fell well short of the mark in that case. See also: *Adult Entertainment Association of Canada the Nuden v. Ottawa (City)*, 2005 CanLII 16571 where Hackland J. rejected a request for anonymity on behalf of female adult entertainment performers seeking to challenge a bylaw.

[63] Further, retaliatory action by Dr. Pollanen against a pathologist simply because they gave an interview to the Committee in the course of a DIOC regulatory investigation specifically addressing a complaint against the Chief Forensic Pathologist would, on its face, be unlawful and a violation of professional rules of conduct. If such reprisals were to occur, the individuals involved would have access to various preventive and remedial processes, including legal proceedings, complaints to the College of Physicians and Surgeons of Ontario and DIOC's own complaint process (under s. 8.4(6) of the *Act*, the Committee is under a duty to review every complaint made about the Chief Forensic Pathologist). Accordingly, there are existing legal mechanisms that protect witnesses and deter the Chief Forensic Pathologist from retaliating against a pathologist who co-operated in the Committee's investigation that do not interfere with the open court principle.

[64] In this regard, reference should also be made to the DIOC's May 21, 2019 letter to Dr. Pollanen, which specifically raised the possibility that "this file could invoke hesitation on the part of potential witnesses" and expressed the "hope" that as a leader of the organization, he would "encourage their honest participation if called upon" to do so. If the DIOC were concerned that the spirit and intent of this request was not being followed, it could take action against Dr. Pollanen in accordance with its mandate.

[65] I agree with the media intervenors when they say that the better answer to concerns about reprisals is to instill a culture where such reprisals are not tolerated, not to endorse a culture of secrecy, anonymity, speculation and distrust. It cannot be forgotten that transparency and public disclosure is of particular importance in light of recent problems with oversight and accountability of Ontario's system of forensic pathology.

[66] It was, in part, the media's investigation that resulted in uncovering systemic problems associated with Charles Smith and the Motherisk scandal. This was noted by the Court of Appeal in its decision in *R. v. Hayman*, 2021 ONCA 242 at para. 37. Problems with oversight and accountability in the forensic pathology realm lead to the Goudge Report's recommendation to establish a governing council to oversee Ontario's forensic pathology system. The public's need for transparency and accountability was cited as the very purpose for creating the DIOC and establishing its mandate, structure, powers and responsibilities.

[67] Indeed, it seems to me entirely possible that the concern over reprisals, for example, is more likely to be heightened in the absence of disclosure than because of it. This is because, without full disclosure, any "reprisal" would be more difficult to connect to the witness' participation in the regulatory investigation. With full disclosure, the witness's role is out in the open, with the full knowledge of the DIOC and the Committee, which would also tend to discourage retaliatory-type behaviour on the Chief Forensic Pathologist's part.

[68] Third, there is no actual evidence of a significant risk of harm. In *Canada (Commissioner of Competition) v. Parrish & Heimbecker Limited, supra* the Competition Tribunal did not have direct evidence from the farmer witnesses that allegedly feared retaliation if their identities were not redacted. The request for anonymity failed because the claim was not supported by "clear, convincing and cogent evidence" and the evidence submitted to

underscore the farmers' refusal to testify absent confidentiality protections constituted hearsay.

[69] Here, there are submissions made by several witnesses who do assert a "concern" about possible reprisals on their own behalf. Even overlooking the fact that these concerns are not presented in the form of evidence but, rather, as submissions, there is simply no foundation for the bald assertions made. In other words, while these doctors say there is a "concern" about possible reprisal-type action, there is no evidence put forward to support or prove the risk or likelihood of such harm. Their expressed "belief" that without a guarantee of anonymity, other witnesses will be less likely to co-operate in future investigations is similarly unsupported by any evidence, rendering these assertions mere speculation.

[70] In *Desjardins*, the Federal Court of Appeal held that the lack of "well grounded" and "convincing" evidence was fatal to the Public Sector Integrity Commissioner's request that the witnesses who participated in the workplace investigation be granted anonymity. Indirect evidence – namely, a sworn statement from personnel in the Commissioner's office about the implications of removing witnesses' confidentiality for future investigations – was not sufficient.

[71] Finally, licensed coroners and pathologists are not, in my view, merely "vulnerable witnesses" as characterized by the DIOC in its factum. Nor, in the circumstances of the investigation of a formal complaint made against the Chief Forensic Pathologist, can they be regarded as akin to "whistleblowers" or confidential informants. These people are highly trained, highly specialized public servants and regulated health professionals subject to professional standards, who are required to provide information in their professional capacities. They operate in an important and highly regulated environment. Virtually every aspect of their work is of a public nature, conducted on behalf of the public. As part of their work, they are often expected to testify in court and are, therefore, aware of legal process. By virtue of their office and professional status, they have an enhanced duty to the public to report wrongdoing by their peers and participate in regulatory investigations, especially in their own bailiwick of forensic pathology. In this context, the suggestion that without a guarantee of anonymity, they would not have consented to be interviewed or would not have been as forthcoming is extremely troubling. Further, the fact that they have these obligations to the public, and their status as physicians licensed to report on causes of death, both serve to reduce their expectation of confidentiality in any event.

[72] Having concluded that, in the circumstances, the open court principle does not pose a serious risk to the public interest in witness candour, it is unnecessary to consider the various and complex questions associated with whether the order sought is necessary or whether, as a matter of proportionality, the benefits of the order outweigh its negative effects.

Conclusion

[73] For these reasons, I would order that:

(a) the autopsy files shall not be sealed. However, all identifying information, as defined above, shall be redacted from them; and

(b) the information regarding witness identities in the DIOC's proceedings shall not be redacted from the record of proceedings.

Costs

[74] Only Dr. Turner sought costs as against the DIOC. In my view, the DIOC acted appropriately in seeking the court's guidance concerning the content of the record of proceedings. It did not proceed in an adversarial manner. The motion was akin to one seeking directions. No party can claim "success". I would make no order as to costs.

Penny J.

I agree

Grace J.

I agree

Kurz J.

Released: November 1, 2021

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DIVISIONAL COURT FILE NO.: 175/20
DATE: 20211101

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Penny J., Grace J. and Kurz J.

BETWEEN:

DR. JANE TURNER

Plaintiff/Appellant

– and –

DEATH INVESTIGATION OVERSIGHT COUNCIL and DR. MICHAEL POLLANEN

Defendant/Respondents

REASONS FOR JUDGMENT

Released: November 1, 2021