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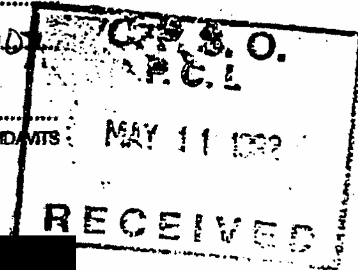
THE HOSPITAL FOR SICK CHILDREN

(1125)

This is Exhibit B referred to in the affidavit of The Honourable Patrick W. Dunn sworn before me, this 19th day of December 20..
A COMMISSIONER FOR TAKING AFFIDAVITS



May 4, 1992

Duncan Newport
Complaints Investigator
College of Physicians and
Surgeons of Ontario
80 College Street
Toronto, Ontario
M5G 2E2

Dear Mr Newport:

Re: [redacted]/Amber [redacted]
Your file 27860

Thank you for the opportunity of responding to the letter from the [redacted] family.

In accordance with your request. I am complying with the Health Disciplines Act and sending you a copy of my records concerning this case. Let me briefly outline for you my involvement in this matter. Then I shall suggest to you a way of investigating this complaint, in keeping with the College's complaints process.

Amber [redacted] was a young girl who died at the Hospital for Sick Children on 30 July 1988. She had been perfectly well, when she suffered a lethal head injury while under the care of a baby-sitter, [redacted] Following the initial management of Amber in Timmins, she was transferred to the Hospital for Sick Children where she later died. While in the Hospital for Sick Children the information given to the responsible physicians was that she suffered this devastating head injury as the result of a fall down several carpeted steps. The responsible ICU physicians did not believe that such a history was able to explain Amber's injuries, and the Hospital's SCAN team was involved. My initial involvement with Amber [redacted] occurred purely by accident, when I happened to see the paperwork in the Health Records Department at HSC on Sunday evening, 31 July 1988. I noted that the Coroner, Dr Ochterlony, did not order a postmortem examination of Amber, and I telephoned him to gently question his decision and suggest that such an examination should be performed. He still decided not to order an examination. The resulting delay in obtaining a postmortem examination significantly diminished the value of such an exam.

In the days that followed, the clinicians involved with Amber's care remained convinced that she had died as a result of non-accidental injury. Therefore, the Chief Coroner's office was informed of these opinions. Because criminal charges against [redacted] were a possibility, the Attorney General of Ontario, Mr Ian Scott, ordered that a disinternment be performed and a postmortem examination undertaken. The Attorney General ordered that I perform such an examination.

As you can see from my autopsy report, I attributed Amber's death to head injury. At no time in the subsequent legal proceedings was the cause of death questioned. In late 1988, I was asked by the Chief Coroner to accompany the Deputy Chief Coroner, Dr James Young, to Timmins Ontario to meet with the [redacted] family and inform them that their baby did not die as a result of an accidental fall down steps, but rather died as a result from head injury which was of abusive nature. On that occasion, we also met with the Crown Attorney for the Timmins area, Mr David Thomas, as well as members of the Timmins Police Force and the [redacted]s lawyer, Mr Ralph Carr. Based on the police investigation, on the statements from physicians and on my postmortem examination, a decision was made by the Timmins Police that there were reasonable and probable grounds to believe that [redacted] did cause the death of Amber [redacted] and therefore, a criminal charge of manslaughter was laid against [redacted]

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May 4/92

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I am one of the physicians who was required to testify in this case. It was my opinion that, in the absence of a credible history, Amber [redacted]s death from head injury was non-accidental in nature; furthermore, it was my opinion that this pattern of injuries could best be explained on the basis of the Shaken Baby Syndrome. In spite of several days of vigorous cross examination by the Defense Counsel for [redacted], Mr Gilles Renault, my opinion did not waver. Furthermore, on two occasions during my week of testimony, the Judge, Patrick Dunn, discussed my evidence with me at length. He repeatedly indicated to me that he believed [redacted] to be guilty, and that he believed the opinions provided by Drs Barker, Driver and me.

Following the presentation of the case for the Crown, the defense provided nine expert witnesses who disagreed with our opinion. Judge Dunn subsequently acquitted [redacted] of manslaughter, and accepted the explanation that she died as the result of falling down four carpeted steps. Because of the legal costs involved with this case, the [redacted] family allegedly attempted to recover their expenses from the Ministry of the Attorney General. I am advised that the Attorney General has recently refused to pay for such costs.

I remain as convinced as ever, that Amber [redacted]s head injury resulted from a non-accidental injury. Furthermore, in the months which have passed since her death, the increasing body of medical literature in the area of child abuse serves to underscore my opinion.

Part of the difficulty in dealing with a case such as this, is the very nature of the legal process. The witnesses for the defense, as would be expected of them, presented areas of question or concern. However, as you realize, the legal process does not allow Crown witnesses to return to the stand to provide reasonable explanation for those questions or matters of differing opinion. Simply put, this is one of the frustrations that physicians encounter when dealing with the criminal process.

The College of Physicians and Surgeons is caught in a difficult situation because of the complaint launched by the [redacted] family. Obviously, I believe that there can be no resolution of this problem. However, as the College is required to consider the nature of the complaint, may I suggest to you that you seek the wise counsel of the Chief Coroner, Dr James Young. He became aware of Amber's death in August 1988 and has an excellent knowledge of the issues and problems of this case. Furthermore, I believe his opinion should be sought as my involvement in the postmortem examination was based upon my role as a coroner's pathologist for the Ministry of the Solicitor General and the Chief Coroner's Office through the *Coroner's Act of Ontario*, and my involvement at no time was based upon my position as a member of the medical staff at the Hospital for Sick Children.

This case draws attention to a more general problem, for which I would appreciate learning of the College's position. Let me explain...

Because of the fundamental difference between medical and legal decision making, there will always be occasions wherein a medical diagnosis does not stand up in a court of law. It is easy to understand this discrepancy.

In medicine, diagnostic decision-making is based on a balance of probability. Therefore, it is reasonable for a physician to make a diagnosis of child abuse based upon the weight of evidence. It is also reasonable for a police officer to lay a criminal charge, for the laying of charges is based upon reasonable and probable grounds. However, within the criminal court system, the burden of proof goes beyond the balance of probability, and instead a verdict is based upon evidence which is "beyond reasonable doubt". Therefore, a physician can make a diagnosis of child abuse, and that diagnosis may be correct, but the burden of proof is insufficient for criminal charges to be upheld. Furthermore, the physician may have relevant diagnostic information which is correct, but which is not admissible in court. This has the potential to create a problem for the physician. It is reasonable for a defendant from such a legal action to believe that the physician was wrong, and to harbour much anger towards him or her. Furthermore, the Supreme

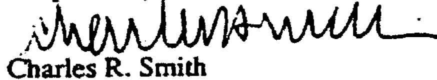
Court of Canada's *Nelles* decision may cause defendants to believe that they should be compensated for criminal charges having been wrongfully laid.

Another fundamental difference that I have alluded to is the order by which evidence is presented in a Supreme Court, and the related regulations under the *Canada Evidence Act*. It is very upsetting to provide testimony for the prosecution, and later to be prevented by the legal process from correcting or refuting obvious errors of medical fact that are made by defense witnesses.

This creates a problem for the College. Clearly the College is obligated to investigate complaints against a physician, and that complaint may be based upon a diagnosis which is reasonable but which is not upheld in court. However, the spin-off of the complaints investigation process may be to the detriment of the citizens of this province. At the best of time, physicians are reluctant to testify in court. Should it become commonplace for physicians to be investigated by the College when their medical opinion is not upheld in a court of law, there will be an even greater disincentive for physicians to participate in important medico-legal matters.

I am sorry for the hurt which has been suffered both by the ██████ family and the ██████ family. However, my autopsy diagnosis attributing Amber's death to head injury remains unchanged, as does my opinion that Amber did not die from falling down several carpeted steps but died as the result of a non-accidental injury.

Respectfully submitted,



Charles R. Smith