COMMISSION OF INQUIRY
INTO PAEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

MOTION FOR STANDING BY THE OFFICE OF THE CHIEF CORONER FOR ONTARIO

The Office of the Chief Coroner for Ontario ("OCCO") hereby moves for standing to participate fully in all aspects of the Commission of Inquiry into paediatric forensic pathology in Ontario between 1981 and 2001 (the "Commission")

The grounds of said motion are as follows:

1. The OCCO is led by the Chief Coroner for Ontario, together with two Deputy Chief Coroners. The OCCO also includes the Provincial Forensic Pathology Unit, which is run by the Chief Forensic Pathologist for Ontario. In addition, there are Regional Supervising Coroners and local coroners throughout the province.

2. The OCCO investigates approximately 20,000 deaths in Ontario per year. The death investigations are usually led by local coroners, under the supervision of Regional Supervising Coroners.

3. The work of the local coroner in a death investigation is often aided by a variety of professionals, including forensic pathologists, who perform autopsies and prepare reports. The majority of forensic pathology work conducted for the OCCO is conducted by pathologists working on a fee-for-service basis, who are not in the employ of the OCCO.

4. In 2006, the OCCO conducted a review of criminally suspicious and homicide paediatric cases, dating back to 1991, where Dr. Charles Smith had performed an autopsy or provided an opinion in consultation. The results of the review were announced in April 2007.

5. Following the April 2007 announcement, this Commission was established pursuant to the Order in Council, dated April 25th, 2007.

6. If granted standing, the OCCO would be of assistance to the Commission in fulfilling its mandate to conduct a systemic review, assessment and report on:

   (a) the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of paediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings;

   (b) the legislative and regulatory provisions in existence that related to, or had implications for, the practice of paediatric forensic pathology in Ontario between 1981 to 2001; and

   (c) any changes to the items referenced above, subsequent to 2001.

7. The OCCO seeks standing in order to fully participate in presenting evidence and making submissions related to the Commission's mandate.

8. In support of its motion, the OCCO relies on the affidavit of Barry McLellan, Chief Coroner for Ontario, sworn July 11th, 2007.

9. The OCCO makes this motion in writing and reserves its right to seek the opportunity to make oral submissions relating to its request for standing.

Dated at Toronto, Ontario this 16th day of July, 2007

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To:

Commission of Inquiry into Paediatric Forensic Pathology in Ontario

COMMISSION OF INQUIRY
INTO PAEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

AFFIDAVIT OF BARRY MCLELLAN
IN SUPPORT OF THE MOTION FOR STANDING
OF THE OFFICE OF THE CHIEF CORONER FOR ONTARIO

I, Barry McLellan of the Town of Markham, in the Regional Municipality of York, in the Province of Ontario MAKE OATH AND SAY:

1. I am the Chief Coroner for Ontario. I have occupied this position since April 2004.

2. The Office of the Chief Coroner for Ontario ("OCCO") investigates approximately 20,000 deaths per year. The death investigations are usually led by local coroners, under the supervision of Regional Supervising Coroners. In addition, I have two Deputy Chief Coroners, who assist in the overall management of investigations and inquests.

3. The work of the local coroner in a death investigation is often aided by a variety of professionals, including forensic pathologists, who perform autopsies and prepare reports. Currently, the OCCO employs 3 forensic pathologists. However, the vast majority of forensic pathology work conducted for the OCCO is conducted by pathologists working on a fee-for-service basis, who are not in the employ of the OCCO.

4. In June 2005, I announced that the OCCO would be conducting a review of criminally suspicious and homicide paediatric cases, dating back to 1991, where Dr. Charles Smith had performed an autopsy or provided an opinion in consultation (the "OCCO Review"). In November 2005, I announced the scope and format of the review into what was identified to be 44 cases (including one case from 1988). The purpose of this review was to determine whether the conclusions reached by Dr. Smith could be supported by the information and materials available for independent review. Ultimately, 45 cases were the subject of the OCCO Review.

5. In April 2007, I announced the results of the OCCO Review, which found in some instances that factual conclusions reached were not reasonably supported by the materials available. A copy of the Backgrounder, dated April 19, 2007, setting out my announcement is attached hereto as Exhibit "A".

6. Following my announcement with respect to the results of the OCCO Review, the government of Ontario released its Order in Council, dated April 25, 2007 which establishes the Commission of Inquiry ("Commission") with a mandate to conduct a systemic review, assessment and report on the following:

(a) the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of paediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings;

(b) the legislative and regulatory provisions in existence that related to, or had implications for, the practice of paediatric forensic pathology in Ontario between 1981 to 2001; and

(c) any changes to the items referenced above, subsequent to 2001.

A copy of this Order in Council is attached hereto as Exhibit "B"

7. Each issue identified in the mandate of the Commission relates to the management, organization and structure of the OCCO, and in particular to the protocols, accountability and oversight mechanisms in place from 1981 to 2001 as they relate to paediatric forensic pathology.

8. Having carefully reviewed the Order in Council, as well as the Commissioner's Opening Statement delivered June 18, 2007, I believe that the OCCO can contribute to the deliberations of the Commission in a number of ways, including:

(a) making available to the Commission the inside knowledge and experience of the OCCO with particular regard to the relationship between the OCCO and its fee-for-service pathologists today and between 1981 and 2001;

(b) assisting the Commission to properly understand the roles of various professionals in the Coroner's death investigation, including coroners and forensic pathologists and how those professionals fit within the criminal justice system;

(c) informing the Commission with respect to the interplay between the OCCO and the Forensic Pathology Units in place throughout the province;

(d) informing the Commission with respect to the unique aspects of paediatric forensic pathology;

(e) providing the Commission with information with regard to the work of the OCCO in the evolution of the paediatric death investigation systems;

(f) assisting the Commission with regard to its mandate to make recommendations with regard to paediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings;

(g) where appropriate, presenting evidence and making submissions related to the Commission's power to make recommendations; and

(h) assisting the Commission in any other capacity as the Commissioner deems appropriate.

9. As the Commission's mandate is to make recommendations to restore and enhance public confidence in paediatric forensic pathology in Ontario, the OCCO will be directly affected by the Commission's report, particularly as the report relates to the OCCO's over-sight responsibilities over forensic pathologists in the province.

10. Finally, I note that a great many documents central to the Commission's mandate are within the exclusive possession, custody and control of the OCCO.

11. I make this affidavit in support of the OCCO's application for standing and for no other improper purpose.

SWORN BEFORE ME at the City of Toronto, in the Province of Ontario on July//, 2007.

Commissioner for Taking Affidavits

Barry McLellan

This is Exhibit "A" referred to in the affidavit of Barry McLellan sworn before me, this 11th day of July 2007

A COMMISSIONER FOR TAKING AFFIDAVITS

Backgrounder/ Document d'information

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Facsimile: 416 314-4030

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April 19, 2007

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

HISTORY:

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

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

REVIEW PROCESS:

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

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

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

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

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

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

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

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

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

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

The materials reviewed by the pathologists included:

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

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

RESULTS:

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

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

The final question was whether the reviewers agreed with the interpretation of the examinations conducted with regard to the cause and where Dr. Smith provided an opinion, the mechanism of death. In 20 of the 45 cases, the reviewers had some issue with the opinion of Dr. Smith that appeared in a written report, testimony in Court, or both. The concerns raised by the reviewers in these 20 cases ranged from relatively minor to potentially more serious issues. In a number of these cases the reviewers felt that Dr. Smith had provided an opinion regarding the cause of death that was not reasonably supported by the materials available for review.

There were restrictions of liberty arising from findings of guilt, including 12 convictions and one finding of Not Criminally Responsible, in 13 of these cases where the reviewers did not agree with significant facts or with the interpretation of the examinations conducted. To date the reports of the reviewers have been provided to Crown and Defence counsel in three of these 13 cases. The reports in all of the remaining cases will be provided to the Crown and they will then be appropriately disclosed to Defence counsel.

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

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

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

LESSONS LEARNED:

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

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

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

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

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

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

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

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

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

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

FURTHER REVIEW:

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

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

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

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

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

Disponible en français

This is Exhibit "B" referred to in the affidavit of Barry McLaughlin sworn before me, this 11th day of July 2007

A COMMISSIONER FOR TAKING AFFIDAVITS

Ontario

Executive Council
Conseil exécutif

Order in Council
Décret

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

WHEREAS on April 19, 2007, the Chief Coroner for Ontario announced the results of a review of certain cases of suspicious child deaths where Dr. Charles Smith performed the autopsy or was consulted ("the Chief Coroner's Review") and found that some of the factual conclusions were not reasonably supported by the materials available;

AND WHEREAS the Ministry of the Attorney General and the Office of the Chief Coroner for Ontario are working together to identify, and the Minister of Community Safety and Correctional Services has requested that the Office of the Chief Coroner review homicide and criminally suspicious cases in which Dr. Smith performed an autopsy or provided an opinion prior to 1991;

AND WHEREAS the Chief Coroner for Ontario has announced that he has made the College of Physicians and Surgeons aware of the concerns identified in the Chief Coroner's Review;

AND WHEREAS the cases that have raised issues with determinations of fact and opinion that were submitted as evidence in criminal proceedings are currently being dealt with through the disclosure of the findings of the Chief Coroner's Review to defendants in related criminal proceedings;

AND WHEREAS there are processes in the Criminal Code of Canada for addressing individual cases of potential wrongful conviction;

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

ATTENDU QUE, le 19 avril 2007, le coroner en chef de l'Ontario a rendu publics les résultats de la vérification de certaines affaires de décès suspects d'enfants dans le cadre desquelles le docteur Charles Smith a procédé à une autopsie ou a été consulté («la vérification du coroner en chef»), et qu'il a conclu que certaines des conclusions de faits n'étaient pas raisonnablement étayées par les éléments disponibles;

ATTENDU QUE le ministère du Procureur général et le Bureau du coroner en chef de l'Ontario collaborent afin de rechercher les affaires d'homicides et d'actes criminels dans le cadre desquelles le Dr Smith a procédé à une autopsie ou fourni une opinion avant 1991, et que le ministre de la Sécurité communautaire et des Services correctionnels a demandé que le Bureau du coroner en chef vérifie ces affaires;

ATTENDU QUE le coroner en chef de l'Ontario a annoncé qu'il a informé l'Ordre des médecins et chirurgiens de l'Ontario des questions soulevées par sa vérification;

ATTENDU QUE les affaires où sont mises en question des conclusions de faits et des opinions qui ont été présentées en preuve dans des instances criminelles donnent en ce moment lieu à la divulgation des conclusions de la vérification du coroner en chef aux défendeurs dans les instances criminelles qui les concernent;

ATTENDU QUE le Code criminel du Canada prévoit des recours en cas d'erreur judiciaire;

AND WHEREAS there are civil and criminal proceedings that have arisen as a result of Dr. Smith's work that are the appropriate forum for the adjudication of those matters;

AND WHEREAS the Lieutenant Governor in Council considers it advisable to appoint a person to identify and make recommendations to address systemic failings that may have occurred in connection with the oversight of pediatric forensic pathology in Ontario;

AND WHEREAS the inquiry is not regulated by any special law;

THEREFORE, pursuant to the *Public Inquiries Act*:

Establishment of the Commission

1. A Commission shall be issued effective April 25, 2007, appointing the Honourable Stephen Goudge as a Commissioner.

2. The Commission shall conduct the inquiry to ensure the expeditious delivery of its report and shall deliver its final report and recommendations to the Attorney General no later than April 25, 2008.

3. Senator Larry Campbell shall chair an expert medical and scientific panel, which shall report to the Commissioner, to provide such information and advice as directed by the Commissioner.

Mandate

4. The Commission shall conduct a systemic review and assessment and report on:

    a. the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings;

ATTENDU QUE les poursuites civiles et criminelles qui sont survenues à la suite du travail du Dr Smith constituent le moyen adéquat de trancher ces affaires;

ATTENDU QUE le lieutenant-gouverneur en conseil estime souhaitable de nommer une personne chargée de cerner les lacunes systémiques qui peuvent avoir existé relativement à la surveillance de la médecine légale pédiatrique en Ontario et de faire des recommandations à ce propos;

ATTENDU QUE l'enquête n'est régie par aucune loi spéciale;

EN CONSÉQUENCE, conformément à la *Loi sur les enquêtes publiques* :

Constitution de la commission

1. Une commission est constituée à compter du 25 avril 2007, nommant commissaire l'honorable Stephen Goudge.

2. La commission mènera l'enquête avec la célérité voulue et remettra son rapport final et ses recommandations au procureur général au plus tard le 25 avril 2008.

3. Le sénateur Larry Campbell présidera un comité d'experts médicaux et scientifiques qui relève du commissaire et qui est chargé de lui fournir les renseignements et les conseils qu'il lui demande.

Mandat

4. La commission procédera à un examen et à une évaluation systémiques et fera rapport sur ce qui suit :

    a. les politiques, les méthodes, les pratiques, les mécanismes de responsabilisation et de surveillance, les mesures de contrôle de la qualité et les aspects institutionnels de la médecine légale pédiatrique en Ontario de 1981 à 2001 en ce qui concerne son exercice et son rôle dans les enquêtes et dans les instances criminelles;

b. the legislative and regulatory provisions in existence that related to, or had implications for, the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and

c. any changes to the items referenced in the above two paragraphs, subsequent to 2001

in order to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.

5. In fulfilling its mandate, the Commission shall not report on any individual cases that are, have been, or may be subject to a criminal investigation or proceeding.

6. The Commission shall perform its duties without expressing any conclusion or recommendation regarding professional discipline matters involving any person or the civil or criminal liability of any person or organization.

7. The Commission shall review and consider any existing records or reports relevant to its mandate, including the results of the Chief Coroner's Review announced on April 19, 2007, and other medical, professional, and social science reports and records. Further, the Commission shall rely wherever possible on overview reports submitted to the inquiry. The Commission may consider such reports and records in lieu of calling witnesses.

8. The Commission shall rely wherever possible on representative witnesses on behalf of institutions.

b. les dispositions législatives et réglementaires qui portaient sur l'exercice de la médecine légale pédiatrique en Ontario entre 1981 et 2001 ou qui avaient une incidence sur cet exercice;

c. toute modification postérieure à 2001 des éléments visés aux alinéas précédents;

en vue de faire des recommandations visant à rétablir et à rehausser la confiance du public envers la médecine légale pédiatrique en Ontario et son rôle futur dans les enquêtes et dans les instances criminelles.

5. Dans le cadre de son mandat, la commission ne doit pas faire rapport sur des affaires particulières qui font, ont fait ou peuvent faire l'objet d'une enquête ou instance criminelle.

6. La commission s'acquittera de ses fonctions sans formuler de conclusions ou de recommandations quant aux questions de discipline professionnelle mettant en cause une personne ou quant à la responsabilité civile ou criminelle de toute personne ou de tout organisme.

7. La commission examine et étudie les dossiers ou les rapports existants qui se rapportent à son mandat, y compris les résultats de la vérification du coroner en chef rendus publics le 19 avril 2007, et d'autres rapports et dossiers d'ordre médical ou professionnel ou relevant des sciences sociales. En outre, la commission se fonde, dans la mesure du possible, sur les rapports sommaires soumis à l'enquête. La commission peut étudier ces rapports et ces dossiers plutôt que d'entendre des témoins.

8. La commission s'appuie, dans la mesure du possible, sur des personnes représentatives qui témoignent au nom d'institutions.

9. In delivering its report to the Attorney General, the Commission shall ensure that the report is in a form appropriate, pursuant to the *Freedom of Information and Protection of Privacy Act* and other applicable legislation, and in sufficient quantity, for public release and be responsible for translation and printing, and shall ensure that it is available in both English and French at the same time, in electronic and printed versions. The Attorney General shall make the report available to the public.

10. Part III of the *Public Inquiries Act* applies to the inquiry and the Commissioner may have recourse to the powers contained in Part III as necessary to achieve the mandate of the inquiry

Resources

11. Within an approved budget, the Commission may retain such counsel, staff, or expertise it considers necessary in the performance of its duties at reasonable remuneration approved by the Ministry of the Attorney General. They shall be reimbursed for reasonable expenses incurred in connection with their duties in accordance with Management Board of Cabinet Directives and Guidelines.

12. The Commission shall establish and maintain a website and use other technologies to promote accessibility and transparency to the public.

13. The Commission shall follow Management Board of Cabinet Directives and Guidelines and other applicable government policies in obtaining other services and goods it considers necessary in the performance of its duties unless, in its view, it is not possible to follow them.

9. La commission veillera à remettre son rapport au procureur général sous une forme appropriée, conformément à la *Loi sur l'accès à l'information et la protection de la vie privée* et aux autres lois applicables, et en nombre d'exemplaires suffisant pour sa diffusion publique et devra en assurer la traduction et l'impression. En outre, elle fera en sorte qu'il soit disponible en même temps en version française et anglaise et sur support électronique et papier. Le procureur général mettra le rapport à la disposition du public.

10. La partie III de la *Loi sur les enquêtes publiques* s'applique à l'enquête et le commissaire pourra invoquer les pouvoirs prévus par cette partie, dans la mesure nécessaire à l'exécution de son mandat.

Ressources

11. Dans le cadre d'un budget approuvé, la commission peut retenir les services des avocats, du personnel ou des experts qu'elle juge nécessaires à l'exercice de ses fonctions selon une rémunération raisonnable approuvée par le ministère du Procureur général. Ceux-ci pourront se faire rembourser les frais raisonnables engagés dans l'exercice de leurs fonctions, conformément aux directives et aux lignes directrices du Conseil de gestion du gouvernement.

12. La commission se dotera d'un site Web et utilisera d'autres technologies pour promouvoir l'accessibilité et la transparence.

13. À moins que, à son avis, cela ne soit pas possible, la commission suivra les directives et les lignes directrices du Conseil de gestion du gouvernement ainsi que les autres politiques applicables du gouvernement dans le cadre de l'obtention des autres biens et services qu'elle estime nécessaires à l'exercice de ses fonctions.

14. The Commission may make recommendations to the Attorney General regarding funding for proceedings before the Commission for parties who have been granted standing because they have information relevant to the systemic issues that would otherwise be unavailable and where in the Commission's view the party would not otherwise be able to participate in the inquiry without such funding. Any such funding recommendations shall be in accordance with Management Board of Cabinet Directives and Guidelines.

15. All ministries and all agencies, boards and commissions of the Government of Ontario shall, subject to any privilege or other legal restrictions, assist the Commission to the fullest extent so that the Commission may carry out its duties and will respect the independence of the review.

16. If during the course of the inquiry the Commission receives information, including in writing, from victims or families, the Commission may authorize the provision of counselling assistance.

14. La commission peut faire des recommandations au procureur général en ce qui concerne le financement de la participation à ses travaux des parties qui se sont vues accorder le droit de comparaître parce qu'elles ont des renseignements se rapportant aux questions systémiques qui ne seraient pas disponibles autrement, si elle est d'avis que, à défaut, ces parties ne seraient pas par ailleurs en mesure de participer à l'enquête. Ces recommandations devront être conformes aux directives et aux lignes directrices du Conseil de gestion du gouvernement.

15. Sous réserve de tout privilège ou de toute autre restriction légale, tous les ministères ainsi que tous les organismes, conseils et commissions du gouvernement de l'Ontario prêteront sans réserve leur concours à la commission de façon que celle-ci puisse s'acquitter de ses fonctions et ils respecteront l'indépendance de l'examen.

16. Si, dans le cours de son enquête, la commission reçoit, notamment par écrit, des renseignements des victimes ou des familles, elle peut autoriser la prestation de services de counselling.