ONTARIO
COMMISSION OF INQUIRY

THE INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

AFFECTED FAMILIES GROUP
APPLICATION FOR STANDING AND FUNDING

July 13, 2007

Peter C. Wardle, Wardle Daley Bernstein LLP
Julie M. Kirkpatrick, Hauraney & Kirkpatrick

PART I: Introduction

The Affected Families Group (the "Group") is a group of members of four separate families who were directly affected by the systemic failings which occurred in pediatric forensic pathology in Ontario during the period 1981 to 2001.

Each of the families experienced the unexpected death of a child. In each case Dr. Charles Smith performed an autopsy on the dead child's body (or in one case, an exhumation and second autopsy). In each case, Dr. Smith's opinion led directly to criminal and/or child protection proceedings against one or more of the family members. In three of the cases murder charges against one or both parents were either withdrawn by the Crown or the subject of a successful stay application. In the fourth case, a lengthy criminal investigation took place but no charges were laid.

In one case, the true killer was charged and entered a plea of guilty over ten years after the child's death. In another case, it is now accepted that a dog was responsible for the child's injuries.

In each of the four cases, there were contemporaneous child protection proceedings involving surviving siblings, one of whom is now eighteen years of age and is part of the Group seeking standing.

In at least two of the cases, Dr. Smith had significant contact with Children's Aid Societies during the course of child protection proceedings.

What all of these cases have in common is that they involve vulnerable individuals whose lives were torn apart by the impact of the investigations and prosecutions. Even though legal proceedings were concluded in their favour, often after many years, all of these families were left with no effective mechanism to address their complaints about the conduct of both Dr. Smith and the multiple government agencies involved in their cases. Several individuals launched formal complaints with the Office of the Chief Coroner, the College of Physicians and Surgeons, the Ontario Ombudsman, local police forces, local child protection agencies, and many other government agencies. None of those complaints were dealt with satisfactorily. Several individuals have brought civil claims, which are ongoing. In short, the families have been left with an overwhelming sense that the justice system and our public institutions have failed them.

It is the position of the members of the Group that they have a substantial and direct interest in the subject matter of this Inquiry. Each of the four families which are part of the Group directly experienced the systemic failures of pediatric forensic pathology in Ontario during the period covered by the mandate of this Inquiry. Each family was affected directly by the many technical opinions and shortcomings in the specific work undertaken by Dr. Charles Smith. Each family also experienced first-hand the multiple systemic and institutional failures which allowed the individual errors of one medical doctor to engage the entire apparatus of the state, the police and the child protection authorities with inadequate system checks and balances.

Of the cases which have given rise to the establishment of this Public Inquiry, the four cases represented by the "Affected Families Group" are among the most important. The members of the Group have been and continue to be integrally involved in the events underlying the mandate of the Commission. Moreover, the Group anticipates that the facts of each of their cases will become part of the core or background facts underpinning the overview reports to be presented

in the public hearings. The Group believes it is in a unique position to assist in identifying the systemic issues which arise in these cases and which speak to the very mandate of the Public Inquiry. Finally, the Group expects to be in a unique position to make recommendations with respect to institutional responsibility, accountability and oversight for pediatric forensic pathology in the Province of Ontario.

The members of the Group have joined together in an understanding that individual standing at the Public Inquiry is neither necessary or practical, and that their interests can be jointly served, in an efficient, economical manner, given their common focus in the systemic issues which this Inquiry will be examining. It is on this basis that the Group seeks full party status in the Commission's public hearings, with the caveat that the Group may not have expertise or direct interest in the technical, scientific and medical issues which may arise and be the subject of a distinct phase of the Inquiry's work.

PART II: Application for Party Status

1. Members of the Group

Below we summarize briefly the background of the four families which make up the members of the Group:

(a) Louise Reynolds:

In Kingston, Ontario, on June 12, 1997, the body of Sharon Reynolds, the 7 year old daughter of Louise Reynolds, was discovered by the police in the basement of the family home, several hours after she had been reported missing. She had been savagely attacked. It was known to the police that a pit bull terrier belonging to a neighbour had been in the basement on the day of Sharon's death. Dr. Smith conducted the post-mortem examination on Sharon's body and verbally advised the police that she had died as a result of severe blood loss, secondary to multiple stab wounds. The police asked Dr. Smith about their concerns about certain marks on the girl's body. In response, Dr. Smith advised the police that those marks were "not domestic or wild animal in any way". The Kingston Police Force, relying on Dr. Smith's findings as to the cause of death, quickly

built an elaborate case against Louise Reynolds as the perpetrator of a vicious crime. On June 26, 1997, within weeks of Sharon's death, Louise Reynolds was charged with second degree murder.

The case received huge media attention in the local community, where Louise was vilified as a "baby killer". Louise Reynolds was incarcerated in protective custody for a period of approximately 22 months. Her younger daughter [redacted] was initially placed in foster care. Eventually, Louise had no choice but to agree to give up [redacted] for adoption.

Dr. Smith's written post-mortem report was not completed until March, 1998, some 9 months after the autopsy was completed, and just prior to the commencement of the preliminary inquiry. Dr. Smith testified for the Crown at the preliminary, stating that it was "not a possibility" that a dog could have caused some of the wounds, and that such a conclusion would be "absurd". Eventually, the loss by Dr. Smith of a plaster cast of the girl's skull, and concerns about the reliability of his initial findings, led the Chief Coroner's Office to seek a second autopsy of the child's remains. The conclusion of that autopsy, which took place in July, 1999, was that at least some of the wounds were caused by a dog. The Crown continued to take the position that there was a reasonable prospect of conviction, and the case against Louise Reynolds proceeded. Only in late 2000, following receipt by the Crown of opinions from a number of defence and independent experts, did Dr. Smith resile from his original opinion. The charges against Louise Reynolds were withdrawn by the Crown in January, 2001. The recent review of the case conducted by the Chief Coroner's Office described Dr. Smith's initial opinion as a "serious misdiagnosis". Following the termination of the criminal proceedings Louise Reynolds commenced a civil action against Dr. Smith and a number of other parties; that lawsuit is ongoing.

(b) Brenda Waudby:

In Peterborough, Ontario, on January 22nd, 1997, Brenda's daughter, 18 month old Jenna Mellor was rushed to hospital and pronounced dead at 1:51 a.m. after efforts at resuscitation failed. The attending emergency room physician noted evidence of possible sexual abuse, including a dark hair located in the vaginal area.

Jenna's body was transported by police to the Hospital for Sick Children where Dr. Charles Smith conducted a post-mortem examination and verbally advised the Peterborough Lakefield Community Police Service that the cause of death was blunt abdominal trauma. Dr. Smith did not find possible sexual abuse and made no mention of the hair which had been previously identified by the emergency room physician. Five years later, in February, 2002, the hair was found in Dr. Smith's desk drawer.

As a result of the criminal investigation Brenda's then 8 year old daughter, Justine Traynor was removed from her care on January 23rd, 1997.

Over the next several months, the police were in regular communication with Dr. Charles Smith and the Kawartha Haliburton Children's Aid Society. Dr. Smith verbally advised police that the time of death was prior to the time that Jenna was in the care of a

fourteen-year old babysitter and as a direct result of this opinion the criminal investigation focussed on Brenda Waudby as the prime suspect.

The case received huge local and provincial media attention and Brenda Waudby was publicly vilified, notwithstanding the fact that she had not been charged.

Dr. Smith's written post-mortem report was not completed and delivered to police until September, 1997, over nine months after the autopsy was completed. On September 18th, 1997, Brenda Waudby was charged with second degree murder.

Dr. Smith testified for the Crown at the Preliminary Inquiry in October, 1998, at the conclusion of which Brenda Waudby was committed to trial on the charge of second degree murder in January 1999. Thereafter, defence counsel obtained four independent medical opinions which cast serious doubt on Dr. Smith's findings.

Brenda Waudby gave birth to her youngest child, [redacted] on May 1st, 1999. MacKenzie was apprehended from the hospital at birth and placed in the care of his father. There is clear evidence that Dr. Smith communicated directly with the Children's Aid Society on at least one occasion immediately after [redacted] birth, stating: "I guess I'll be doing his autopsy too".

The charges against Brenda Waudby were withdrawn on June 11th, 1999. Subsequently, Brenda Waudby filed formal complaints with the College of Physicians and Surgeons of Ontario, the Kawartha Haliburton Children's Aid Society and the Peterborough Lakefield Community Police Service. She commenced a civil action in October, 2002, which is ongoing.

Although the charge against Brenda was withdrawn by the Crown, she remained a suspect in the on-going police investigation until December, 2005 when the babysitter was charged with murder. In December, 2006 the accused entered a plea of guilty to a charge of manslaughter. He was sentenced on March 1, 2007 as a young offender to twenty-two months to be served at an adult correctional facility and eleven months house arrest.

(c) Lianne Gagnon (Thibeault):

In Sudbury, Ontario, on November 30th, 1995, 11-month old Nicholas Gagnon struck his head on the bottom of a sewing machine table and died. An autopsy was performed by Dr. Chen, who found the cause of death to be consistent with SIDS. In November, 1996, the Office of the Chief Coroner was asked by the local regional coroner to review the case and prepare an autopsy report. A Consultation Report prepared by Dr. Charles Smith on January 24th, 2007 found the death to be non-accidental. On May 7th, 1997, Dr. Smith and Dr. Cairns met with members of the Sudbury Police force and requested that a homicide investigation be initiated and the body of Nicholas Gagnon be exhumed.

Lianne Gagnon was interrogated by police on June 19th, 1997. The body of her son Nicholas was exhumed on June 25th, 1997. Dr. Charles Smith was present and brought his 11 year old son to the site of the exhumation. On June 26th, 2007 Dr. Smith performed a second autopsy and thereafter produced a written report on August 6th, 1997.

On December 3rd, 1997, after consultation with the Crown Attorney, police advised Lianne Gagnon and her family that no criminal charges would be laid. On the same day, however, the police notified the Children's Aid Society of Nicholas' death two years earlier because they believed Lianne to be pregnant.

The police delivered their investigation file to the Children's Aid Society in February 1998. In March 1998, a Notice of Apprehension was served upon the Sudbury General Hospital in anticipation of the birth of Lianne's child. In April and May of 1998, meetings were held between the Children's Aid Society, the police, Dr. Cairns and Dr. Smith. Lianne Gagnon's daughter [redacted] was apprehended at birth and placed in the care of her parents. Dr. Smith and Dr. Cairns prepared two lengthy Affidavits which were filed in the child protection proceedings in which the Society was seeking Crown Wardship without access. The Children's Aid Society placed Lianne Gagnon's name on the Ontario Child Abuse Register on July 30th, 1998.

Dr. William Halliday was retained by the family to provide an independent opinion and review of Dr. Smith's findings. When these were called into question by Dr. Halliday, both Dr. Smith and Dr. Cairns provided further Affidavits to the Children's Aid Society in response. Ultimately, after Maurice Gagnon had filed a formal complaint with the College of Physicians and Surgeons in October, 1998, the Office of the Chief Coroner requested an independent review by Dr. Mary Case. Dr. Case provided a written report on March 6th, 1999 which stated that Smith's conclusions were unfounded. The Children's Aid Society withdrew their Application on March 24th, 1999.

Subsequently, the family filed an Application for Costs against the Children's Aid Society which was unsuccessful. Maurice Gagnon also filed formal complaints with the now defunct Coroner's Council, the Solicitor General, the Ministry of Community and Social Services, the Ontario Ombudsman and the College of Physicians & Surgeons.

(d) Angela Veno and Anthony Kporwodu:

In Toronto, Ontario, on March, 1998, Athena, the daughter of Angela Veno and Anthony Kporwodu died at age 3 months. Dr. Smith performed an autopsy on Athena and concluded that Athena had suffered multiple traumatic injuries. He completed his autopsy report in October, 1998 nearly eight months after the post-mortem examination. In May, 1999 the father, Anthony, was charged with manslaughter. In July, 1999 Dr. Smith verbally provided new information to the Crown and police about an injury to Athena's liver. If accurate, this information would have implicated both parents in Athena's death. At this time the police and the Crown were aware of a controversy concerning Dr. Smith's competency and objectivity. As a result the police decided not to lay further charges until they had received written confirmation from Dr. Smith. It took Dr. Smith until April, 2000 to produce a written addendum to his original report. According to the Ontario Court of Appeal in its 2005 decision affirming the stay of the charges, the reasons for the delay "remain a mystery to this day"[1]. Dr. Smith's addendum formed the basis for new charges to be laid against both Angela and Anthony in May, 2000.

---

1 *R. v. Kporwodu* [2005] O.J. No. 1405

By the time the preliminary inquiry of the charges against Angela and Anthony was underway in January, 2001 the Defence became aware of an internal review allegedly being performed by the Chief Coroner's Office into Dr. Smith's work. This ultimately led to the Deputy Chief Coroner being summoned at the preliminary inquiry. Eventually, at the commencement of the trial on the charges in December, 2002, the trial judge ruled that the Coroner's Office had to turn over 17 criminal autopsy files in its possession for disclosure to the Defence, as well as a number of non-criminal autopsy files. Two other members of the Coroner's office, Dr. Chiasson and Dr. McClelland, also testified about the scope and nature of the review during pre-trial motions in the Kporwodu case.

Ultimately, the charges against Angela and Anthony were stayed on the basis of delay. An appeal by the Crown from that decision was dismissed by the Ontario Court of Appeal. A significant amount of the delay (approximately two years) was attributable to the failings of Dr. Smith. The Court of Appeal accepted that "the respondents' lives were devastated and their liberty and security interests adversely affected as a consequence to the delay in the proceedings against them".

A complete list of the names of the group members is set out in Appendix A. A number of the members do not want their contact information (addresses, telephone numbers) shared with the press, and as a result this information will be provided separately on a strictly confidential basis to Commission staff.

2. Nature of the Interests of the Applicants in the Subject Matter of the Inquiry

Each member of the Group has experienced first-hand the systemic failures in pediatric forensic pathology in Ontario in the years between 1981 to 2001 and continue to be integrally involved in the events and issues underlying the mandate of this Inquiry. Each of these four cases raises systemic issues which reach far beyond the competency of Dr. Smith and the reliability of his reports.

There can be no question that each family has a direct and substantial interest in the subject matter of the Inquiry. Their individual experiences are discrete, tragic and poignant examples of systemic failure at various times throughout the period covered by the Inquiry and in various locations throughout the province (Kingston, Peterborough, Toronto and Sudbury).

In Appendix B we provide a chronology of the salient facts in the four cases. From this vantage point, it is clear that the facts of these cases raise many common issues relating to the Commission's mandate - i.e. to the "polices, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001".

During the time period covered by most of these events the individuals who experienced them thought that they were alone. Today we know differently. Collectively, the Group is in a position to offer the Inquiry a broad and unique perspective. That striking commonality of experience and insight, harnessed through informed advocacy and the right of full participation, will assist the Inquiry particularly when viewed alongside the perspectives of institutional parties.

3. Why the Applicants wish to have Standing

Each member of the Group believes that as a result of their experience they have a profound interest in ensuring that the systemic failures they each experienced in connection with pediatric forensic pathology do not reoccur, and that no one else should have to experience what they have lived through.

4. How They Propose to Contribute

As outlined above, the members of the Group believe that collectively they can contribute in a positive, substantial, and constructive way to the work of this Commission. Specifically, they can assist:

(a) by sharing information and documentation with Commission staff in an organized and focused manner;

(b) by identifying systemic issues which arose from their experiences which should be examined by the Commission;

(c) by providing an important perspective which would otherwise not be present at the Inquiry, that being the perspective of those most acutely affected by these tragic events, and by doing so through informed advocacy and full participation in the proceedings.

(d) by proposing recommendations to ensure that these events do not recur.

Below is a brief preliminary list of the systemic issues which we believe are triggered by the specific factual context of the Group seeking standing before this Inquiry:

1. Procedures for "first contact" by emergency responders where a child has died in suspicious circumstances;
2. Nature and extent of legal authority exercised by public officials carrying out duties under the *Coroners Act*;
3. Procedures for transporting a child's body, preserving evidence during transport, and conducting an autopsy where a warrant is issued under the *Coroners Act*;
4. Contemporaneous documentation, record-keeping and preservation of evidence by "first contact" emergency responders;
5. Immediate consultation, review and oversight of autopsy results in complex pediatric cases;
6. Procedures for specific consultation in cases where there is any suspicion of sexual assault;
7. Storage and preservation of samples and other evidence by persons working under the authority of the *Coroners Act*;

8. Oversight and supervision of pediatric pathologists by the Office of the Chief Coroner;

9. Policies for communication between Police, Crown Attorneys and the Children's Aid Society relating to forensic pathology issues, including written and verbal communications at the investigatory stage and during and after court proceedings;

10. Nature and extent of immunity for officials conducting investigations under the *Coroners Act*;

11. Effective review and complaint process for those persons affected by investigations carried out under the authority of the *Coroners Act*;

12. Separation of the advocacy and public awareness functions of the Office of the Chief Coroner from investigatory functions;

13. Disclosure to the defence of material originating with the Office of the Chief Coroner relating to the competency and experience of pediatric pathologists;

14. Guidelines for those giving expert medical evidence in criminal and child protection proceedings;

15. Early investigation of alternate theories of cause of death and timing of injuries raised by the defence; and

16. The ability of legally aided litigants to challenge forensic evidence.

5. The Group Satisfies the Criteria for Standing

The Criteria

Section 11 of the Inquiry's Rules of Standing and Funding provides that standing will be granted in the discretion of the Commissioner, in accordance with Section 5 of the *Public Inquiries Act*, the Terms of Reference, the systemic nature of the Inquiry and the desirability of a fair and expeditious proceeding.

Section 5(1) of the *Public Inquires Act* states as follows:

> 5.(1) A commission shall accord to any person who satisfies it that the person has a substantial and direct interest in the subject-

> matter of its inquiry an opportunity during the Inquiry to give evidence and to call and examine or to cross-examine witnesses personally or by counsel on evidence relevant to the person's interest.

Section 4 of the Terms of Reference provides as follows:

> 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;
>
> 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.

Substantial and Direct Interest

The "substantial and direct interest" under Section 5(1) of the *Act* was reviewed by Commissioner O'Conner in his ruling on standing and funding in the Arar Commission[2] . Commissioner O'Conner commented that it was neither possible nor desirable to set out a comprehensive list of the types of interest that would come within this test. He noted that obliging applicants to prove that their "legal interests" would be "affected" by the outcome of the inquiry might be an overly restrictive view of the test.

---

2 Arar Commission, Ruling on Standing and Funding, May 4, 2004 at 6 - 7

Commissioner O'Connor noted that where an individual such as Mr. Arar was integrally involved in the events underlying the mandate of the factual inquiry (indeed he was specifically named in the terms of reference), he would have a substantial and direct interest. At the same time, merely being a witness, did not, in itself, constitute a substantial and direct interest, nor was having a genuine concern about the issues raised in the subject matter of the Inquiry. Commissioner O'Conner concluded his analysis of Section 5(1) of the *Act* by stating as follows:

> As I said above, it is not possible to set out a definitive list of the factors that will control the determination of when an interest is sufficiently linked to the mandate to be considered "substantial and direct". There will necessarily be a degree of judgment involved. That judgment should have regard to the subject matter of the Inquiry, the potential importance of the findings or recommendations to the individual or organizations including whether their rights, privileges or legal interest may be affected, and the strength of the factual connection between the individual or group in the subject matter involved.[3]

In his earlier decision on standing in the Walkerton Inquiry[4], Commissioner O'Conner concluded that "the residents of Walkerton were seriously affected by the water contamination and have a significant interest in the subject matter of Part I of the Inquiry. Given the tragedy that the residents have suffered, their interests must be represented". Commissioner O'Conner went on to grant standing to two citizens groups representing local residents and business and community interests.

Finally, in Commissioner Glaude's ruling on standing and funding in the Cornwall Public Inquiry[5], the Commissioner granted full standing to a group of individuals who claimed to be victims of sexual abuse, and sought standing at the Inquiry under the name The Victims Group.

---

3 *supra* , at 8

4 Report of the Walkerton Inquiry, dated January 14, 2002 App E (II), at 69

5 Decision of Glaude J. on Standing and Funding, Cornwall Public Inquiry, dated November 17, 2005

It was their position that the traumatic and life altering experiences they had faced when children constituted the very subject matter of the Inquiry and therefore that they had a direct and substantial interest in the Inquiry and the recommendations flowing from it. Commissioner Glaude accepted these submissions.

The Group Satisfies the Criteria

In this case, it is submitted that the members of the Group have a strong factual connection with the subject matter of this Commission's work - i.e. they were integrally involved in the events underlying the mandate of the Inquiry and they have directly experienced the horrific consequences of a failed system. Moreover, it would be fundamentally unfair to exclude the people who have lived through these events from a process directly seeking to prevent their recurrence.

The members of the Group also have first-hand experience with the "policies, procedures and practices" that governed pediatric forensic pathology in the years covered by the mandate. They were directly affected by the lack of appropriate "accountability and oversight mechanisms". Their perspective on these issues cannot be duplicated by any other party with standing at the Inquiry.

This Inquiry is focussed on systemic issues, not on individual cases. The members of the Group understand that the Commission's work will not proceed on a case-by-case basis, and will not make findings about what took place in any individual case, except insofar as it informs the systemic issues to be addressed. The members of the Group also understand that the Commissioner has no jurisdiction to make conclusions or recommendations regarding professional discipline or civil liability. The purpose of the Group in seeking standing is not to

pursue those issues, which some may choose to pursue individually elsewhere. Rather, their interest is as expressed above, in the systemic issues which underlie the failures in their cases.

Finally, with respect to the "desirability of a fair and expeditious proceeding", the Applicants believe that by joining together in a group and asking for party status on that basis, they will be able to substantially contribute to the efficiency of the Commission's process.

Unique Perspective

While the primary basis for seeking standing is that of "substantial and direct interest", the Group also relies upon the recent practice of public inquiries to grant standing to those representing "distinct ascertainable interests", and whose experience or perspective is essential to the fulfilment of the mandate of the Commission[6]. The members of the Group represent a distinct interest – that of persons who are victims of the systemic failures of pediatric forensic pathology in the time period covered by the Commission's mandate. They have a unique perspective that cannot be duplicated by other interests. Only victims can address the subtle human dimensions of issues like the timing of the release of autopsy findings, the impact of public disclosure of apparently incriminating findings, and the daily exigencies of being the object of investigations and prosecutions arising from the death of one's own child.

The Group is prepared to make oral submissions with respect to standing on August 8, 2007, if required.

---

6 *supra*, 1, 3, & 4

PART III: Application for Funding

Paragraph 14 of the Terms of Reference provides that the Commission may make recommendations to the Attorney General regarding funding, 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 parties would not otherwise be able to participate in the Inquiry without such funding.

None of the Applicants have substantial financial means. None of them would be able to participate in the work of the Inquiry if they had to pay for legal fees and disbursements themselves. Accordingly, none of them would be able to participate in the work of the Inquiry without funding.

As outlined above, we expect that many of the core or background facts that will form the basis of overview reports and evidence before the Commission will flow from the four cases with which the Applicants were involved. The members of the Group have a huge amount of information, insight and experience with respect to these events which they intend to share with the Commission. As a result, the Group believes that it meets the requirements of paragraph 14 of the Terms of Reference.

Legal Representation

The Group will be represented by Wardle Daley Bernstein LLP (Toronto) and Hauraney & Kirkpatrick (Peterborough & Millbrook).

Due to the complexity of the Inquiry, and what we anticipate will be a large amount of documentary production, we propose to have three counsel working on the file, consisting of one senior counsel and two junior counsel. However, counsel fees for only one senior counsel and

one junior counsel are being requested (i.e. at all times there will be a maximum of two counsel in the hearing room). We also request that the Commissioner recommend up to 500 hours of time for a law clerk to help organize documents in connection with the Inquiry, again at standard government rates.

The counsel who would have primary carriage of this matter would be as follows:

(a) Peter Wardle;

(b) Julie Kirkpatrick; and

(c) Daniel Bernstein

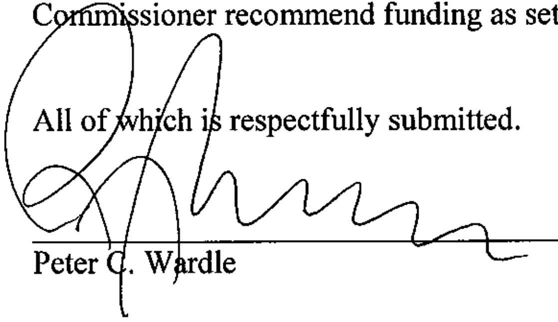
Peter Wardle is an experienced civil litigation practitioner with over 20 years experience, including experience with commissions of inquiry. He is presently lead counsel for Citizens for Community Renewal, a community group with full standing at the Cornwall Public Inquiry. Julie Kirkpatrick is a civil litigation practitioner from Millbrook, Ontario. Ms. Kirkpatrick practises in association with James Hauraney, a criminal and civil litigator with over thirty years experience, who has represented Brenda Waudby in both criminal and civil proceedings for many years. Daniel Bernstein is a partner at Wardle Daley Bernstein LLP. Curriculum vitae for all four individuals are attached.

As has been done in the Cornwall Public Inquiry, we request that the Commissioner recommend Mr. Hauraney as alternate senior counsel to take Mr. Wardle's place from time to time as necessary and appropriate. In addition, there may be occasions where both Peter Wardle and James Hauraney are unable to participate in the Inquiry because of other commitments and we therefore request that the Commissioner recommend Helen Daley as the second alternate counsel. A copy of Ms. Daley's curriculum vitae is included.

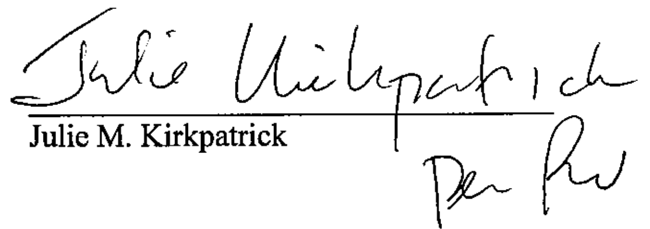
Conclusion

The Affected Families Group respectfully seeks full standing for the Inquiry and asks that the Commissioner recommend funding as set out in Part III above.

All of which is respectfully submitted.



Peter C. Wardle



Julie M. Kirkpatrick