WARDLE DALEY BERNSTEIN LLP

JULIE KIRKPATRICK
BARRISTER & SOLICITOR

AFFECTED FAMILIES GROUP

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

FINAL CLOSING SUBMISSIONS

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I - INTRODUCTION

Our case has been a tragedy but let's not have this repeat itself[1].

1. In 1989-91 a family in Timmins, Ontario faced the worst nightmare that can befall an family – their 12 year old daughter, SM, was charged with manslaughter arising out of the death of Amber, a death Dr. Charles Smith, then the most eminent pediatric forensic pathologist in Canada, believed to have resulted from shaking.

2. Following a trial which took place over a period of almost two years, the Honourable Justice Dunn acquitted SM[2]. The reasons for decision of Justice Dunn raised serious issues about Smith's dogmatism, his lack of objectivity, and his competence. They contained what Dr. Pollanen has referred to as a "masterful" analysis of the case[3]. Anyone reading the decision would have been troubled that not just Dr. Smith but all of the Hospital for Sick Children ("HSC") witnesses in support of the prosecution's case had a view of the scientific issues in the case which was contrary to that of all of the experts called by the defence from Canada and various jurisdictions in the United States. In short, this case, and the judicial criticism that

1 PFP148678

2 PFP000118

3 Evidence of Dr. Pollanen, December 6, 2007, page 86, line 21

followed it, offered many lessons on the pitfalls of dogmatic thinking, tunnel vision and confirmation bias.

3. For the Office of the Chief Coroner of Ontario ("OCCO"), this decision should have served as an opportunity to assess and evaluate Dr. Smith's work. All those involved in the coroner's system were well aware of Dr. Smith's increasingly powerful role in the investigation of criminally suspicious child deaths. It should have come as no surprise to them that if Dr. Smith erred the consequences could be enormous.

4. The opportunity presented by Amber's case was ignored. So were many other opportunities in the years that followed.

5. Indeed, if the evidence heard at this Inquiry is to be believed, it appears that nothing could have attracted the attention of those charged with oversight and accountability for pediatric forensic pathology at OCCO in the period 1991 to 2001.

6. OCCO's senior management ignored or minimized:

- Judicial criticism of Dr. Smith in the SM decision itself;
- Dr. Smith's chronically tardy post mortem reports;
- Complaints from other participants in the justice system about his timeliness and responsiveness;
- Misplaced x-rays, a lost cast and mislabelled samples;
- Opinions of other experts critical of Dr. Smith;
- Media reports;

- Complaints from aggrieved families; and
- Cases stayed or dismissed because of deficiencies in Dr. Smith's work or his testimony.

7. Most egregiously, those responsible for oversight and accountability proved unwilling or unable to ensure that Dr. Smith was able to develop and maintain qualities of utmost importance for the criminal justice system: competence, professionalism, objectivity and honesty.

8. As late as April 2002, Dr. Young, the Chief Coroner of Ontario, was prepared to support Dr. Smith's professionalism and competence to the Ontario College of Physicians and Surgeons ("CPSO"), knowing of Dr. Smith's conduct relating to the hair in the Jenna case[4].

9. As Dr. Young said himself to this Inquiry: "I just don't know why we didn't stop him from doing anything at that point"[5].

10. The results of these systemic failures are almost beyond comprehension: wrongful convictions, prosecutions that never should have taken place, children separated from their mothers, a murder charge stayed for delay, and families stigmatized and traumatized.

11. This Inquiry is not the first to hear about tunnel vision and related concepts. Unfortunately, inquiries dealing with such issues have been a regular feature of the Canadian criminal justice system in recent years. What makes this Inquiry different is the scope of transgression.

12. In Ontario, the failures in pediatric forensic pathology are all the more striking in light of the highly-publicized findings and recommendations of the 1997-1998 Kaufman Inquiry into the

4 PFP144923

5 Evidence of Dr. Young, November 30, 2007, page 250, lines 21-23

proceedings involving Guy Paul Morin. Indeed, Dr. Young testified at the Kaufman Inquiry and was charged with implementing certain of its recommendations.

13. Against this backdrop, how could those responsible at OCCO – all dedicated, highly-educated, experienced and informed participants in the death investigation process – get it so wrong? Was there something unique or deeply flawed about the institutional arrangements for pediatric forensic pathology which led to this result?

14. Tunnel vision, confirmation bias and other factors undoubtedly played an important role in the work of Dr. Smith and others in the individual cases the commission has reviewed. Moreover, as the excellent paper submitted by Prof. MacFarlane makes clear, these problems are endemic in human behaviour and reoccur with regularity within the justice system. The practice of forensic pathology may be more susceptible to these psychological forces because of its very nature – it is an interpretive and inexact science, as many testified, one that is as much art as science.

15. However, in our submission the evidence is clear that the central failings involve OCCO itself.

16. From the outset, the institutional arrangements were flawed. No meaningful oversight was provided by OCCO to the Ontario Pediatric Forensic Pathology Unit ("OPFPU"). Quality assurance was minimal and ineffective. ***As the problems began to mount, no one took responsibility for Dr. Smith's errors nor was he held accountable for them.***

17. OCCO's key executives became too closely associated with Dr. Smith and his work. The provision of pediatric pathology services became part of a wider public safety mandate of preventing child abuse.

18. OCCO played a significant role in creating Dr. Smith's iconic status within the small world of pediatric death cases. Having done so, OCCO proved incapable of assessing his work in an objective manner. The lack of an independent complaints process meant that the same people who had promoted Dr. Smith's career and had a vested interest in his work product were responsible for reviewing and assessing complaints.

19. The systemic issues that have given rise to this Inquiry, best illustrated in the lives and experiences of the Affected Families, must be addressed through a critical assessment of what happened to them: how their lives intersected with the coronial system, the criminal justice system, and the child protection system in this Province at a time when they were each mourning the death of a child. The systemic failures and solutions do not begin and end at the doors of the OPFPU, or OCCO, or indeed at the door of Dr. Charles Smith.

20. Because of this, our submissions will follow the Commissioner's mandate to review and assess the institutional arrangements in place during the years of the mandate in order to best make appropriate recommendations for the future. We will do so through an overview of the crucial evidence relating to the institutional failures arising out of the six cases involving our clients. We make a number of recommendations focused on systematic change, with the aim of restoring public confidence.

II – THE INSTITUTIONAL ARRANGEMENTS GOVERNING THE OPFPU BETWEEN 1991 AND 2001

(a) The *Coroners Act*

21. The current *Coroners Act* (the "Act") gives the Chief Coroner of Ontario responsibility for administering the Act and the regulations and supervising, directing and controlling all coroners in Ontario and the performance of their duties. However, the *Coroners Act* is virtually silent about the role of forensic pathology in the death investigation process:

(a) The only reference to the post-mortem examination in the Act is in Section 28(2), which requires the person performing such an examination to report findings in writing to the coroner who issued the warrant, the Crown Attorney, the Regional Coroner and the Chief Coroner;

(b) The role of the Chief Forensic Pathologist of Ontario is not defined in the Act or the regulations;

(c) Regional Pathology Units such as the OPFPU are not defined in the Act;

(d) The role of the Chief Coroner of Ontario in connection with forensic pathology is not explicitly addressed in the *Act*; and

(e) oversight, accountability and quality assurance of forensic pathology are not addressed in the Act.

22. The formal legal arrangements between the HSC and the Province with respect to the establishment of the OPFPU are set out in an Agreement dated September 23, 1991[6]. That Agreement provides for an annual grant from the Ministry of the Solicitor General in the amount of $200,000.00 toward the costs of operating the unit. It contains a schedule outlining the terms

6 PFP057355

of reference for the OPFPU, including its core mandate of performance of coroner's autopsies on bodies of children originating from HSC, from the Metropolitan Toronto Region and in certain instances elsewhere in the Province.

23. The schedule to the Agreement notes in Section 4(c):

> **This Agreement does not alter the relationship between the coroners and the individual pathologist making up the unit, and the method of remuneration for professional activities remains unchanged**

24. According to a letter dated September 17, 1991 from Dr. Phillips to Dr. Young, the purpose of Section 4(c) was to "clarify lines of authority and to underscore the fact that the individual pathologists remains responsible to the coroner (and not to a director of the unit) for their work"[7].

25. This Agreement does not describe the duties of the director of the unit. With respect to oversight and accountability, a paragraph headed "Evaluation" states simply that a quarterly report of the workload and activities of the unit would be forwarded to OCCO and to senior management of HSC.

(b) The Director's Role

26. By letter dated March 10, 1992, Dr. Young recommended to Dr. Phillips that the OPFPU "should have someone supervising it and accountable for its activity".[8] He recommended that Dr. Smith be appointed to this position, which he described as "day-by-day head of this unit".

7 PFP057354

8 PFP044014

27. By letter dated May 29, 1992, Dr. Phillips appointed Dr. Smith as Director of the OPFPU.[9] His letter indicated that the position "includes the responsibilities for all day-to-day operations of the unit and liaison with the Coroner's Office and Police".

28. By letter dated May 20, 1993 to Dr. Philips, Dr. Young recommended that as part of a system of checks and balances to be established in regard to reports with OPFPU, pathologists' reports "be checked and signed off by the Director of the Pediatric Unit in order to ensure that the wording in the conclusion is most appropriate for the forensic setting".

29. ***The 1991 Agreement and the letters described above are the only formal documents which describe the institutional arrangements regarding the OPFPU and more importantly, its accountability and oversight between 1991 and 2001.***

30. A number of important observations flow from these documents.

(c) The Reporting Obligations were Unclear

31. It is completely unclear what reporting obligations Dr. Smith had to HSC or OCCO with respect to the OPFPU.[10] As Dr. Chiasson put it, for practical purposes, if Dr. Smith reported to anyone, it was to Dr. Cairns and Dr. Young.[11] There was no evidence adduced at the Inquiry that Dr. Smith ever provided any formal reports to OCCO about the work of the OPFPU, or that the work of that Unit was ever evaluated by OCCO.

32. Dr. Young was asked specifically at this Inquiry about the lack of documentation outlining oversight of the OPFPU at the time of its creation. He responded as follows:

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9 PFP134457

10 PFP137802, letter dated March 30, 2007 from Dr. Taylor to Dr. Lackser, making this point

11 Evidence of Dr. Chiasson, December 11, 2007, page 69, lines 19-20

> **There wouldn't have been in that period of time in any government document. It wasn't - it wasn't something we were doing at that period of time.[12]**

(d) The Director had a Supervisory Role

33. Although the wording of the 1991 Agreement may have been intended to preserve a direct relationship between the coroner and the individual pathologist doing a coroner's autopsy, it is clear that Dr. Young and Dr. Phillips both came to view Smith as having a supervisory role as Director, which included at a minimum the review of all post-mortem examination reports produced by the OPFPU.

34. In 1999, as part of his attempts to revision the OPFPU, Dr. Chiasson drafted a job description for the Director of the OPFPU. That job description said, in part, as follows:

> **Supervises and provides consultative support for all pathologists at HSC/OCC in matters of pediatric forensic pathology[13]**

35. At the time Dr. Chiasson drafted this document, this was his understanding of what Dr. Smith's responsibilities included at that time.[14] In fact, Dr. Chiasson thought that the title of "Director", referring to all of the regional units, connoted some degree of oversight, and he was surprised that Dr. Young would have thought that the Directors of the units were simply there for administrative reasons.[15]

36. The record also contains a letter dated October 30, 1996 from Dr. Wilson of the Pathology Department at HSC to Dr. Chiasson applying for an appointment as a Regional

12 Evidence of Dr. Young, December 3, 2007, page. 261, lines 11-14

13 PFP056815, page 2

14 Evidence of Dr. Chiasson, December 11, 2007, page 82, line 17

15 Evidence of Dr. Chiasson, December 11, 2007, page 88, lines 11-16

Coroner's Pathologist.[16] That letter states in part "I would be pleased to continue as a staff pathologist in this unit, **under the supervision of Dr. Charles Smith**". (emphasis added)

37. Dr. Smith also suggested in his testimony that he had a supervisory role with respect to the work of other pathologists doing coroner's autopsies.[17] Moreover, the "traffic stop" incident indicates that at least in his mind the position held some authority[18].

38. Dr. Young's evidence that the position of Director was an administrative one only, primarily for purposes of setting schedules, is inconsistent with this evidence and should be given little weight.

(e) Dr. Smith was not an Employee of OCCO

39. Dr. Smith remained an employee of HSC. On criminally suspicious autopsies performed under Coroner's warrant, Dr. Smith continued to collect a fee-for-service from OCCO. At no time was he considered an employee of OCCO and, therefore, the usual range of remedial and disciplinary tools available in an employee/employer relationship were not available in that context. As Dr. Young said: "the sanction is: do you use them or not use them."[19]

40. Although Dr. Smith did approximately 2/3 of his work for OCCO, the only job performance evaluations he received were from his supervisors in the Pathology Department at HSC. For many years, Dr. Becker was the only person with the authority to reprimand Dr. Smith, reduce his salary or take away his privileges.

16 PFP056934, at page 1

17 Evidence of Dr. Smith, January 29, 2008, page 29, line 24

18 PFP056629

19Evidence of Dr. Young, December 4, 2007, page 41, lines 12-13

41. It is clear that HSC only evaluated Dr. Smith's performance in the context of the work he was performing for the Hospital – i.e. surgical pathology and non-coroner's autopsies. There is no evidence that HSC ever attempted to evaluate Dr. Smith's performance of coroner's autopsies, although his role as Director of the unit and his teaching activities in connection with the unit clearly enhanced his job performance evaluations.[20]

42. In addition, concerns about Dr. Smith's surgical pathology in 1997-98 were not passed on to anyone at OCCO, even at meetings called to address concerns OCCO had regarding Dr. Smith's timeliness. It appears that those responsible at HSC simply didn't think the two issues were related, notwithstanding Dr. Thorner's testimony that, at least in his view, there is a relationship between habitual tardiness / lack of organization and quality of work product, including in the context of forensic autopsies.[21] Whatever the reason, the institutional arrangements provided a real barrier for sharing of information between the two organizations.

(f) The OPFPU was not a Unit within OCCO

43. The OPFPU was not an administrative unit within OCCO. It was not a box on any organizational chart.

44. In fact, some witnesses described it as a "virtual unit" which had no administration or offices. As a result, participants in the justice system who had concerns about Dr. Smith were unclear where to address those concerns. Some attempted to deal directly with him at the hospital, either by telephone or in writing. Others dealt through the Regional Coroner. Still, others directed their concerns to OCCO. Interestingly, Dr. Cairns (and to a lesser extent Dr.

20 PFP137698, PFP137686

21 Evidence of Dr. Thorner, January 11, 2008, page 144, line 9

Young) was always able to contact Dr. Smith when he needed him, which perhaps gives some sense of who Dr. Smith thought his real employer was[22].

(g) No Formal Oversight by the Chief Forensic Pathologist

45. There was no formal oversight of the OPFPU by the Chief Forensic Pathologist for the Province. At the time the unit was set up, this may have been understandable, given that the then Chief Forensic Pathologist, Dr. Hillsdon-Smith, reported directly to a Deputy Minister, not to the Chief Coroner, and that there was little cooperation or communication between Dr. Hillsdon-Smith and OCCO.

46. However, after 1994, when Dr. Chiasson was appointed to the position of Chief Forensic Pathologist and began reporting directly to the Chief Coroner, this lack of formal structure became much more problematic. According to Dr. Chiasson, it was unclear what his relationship was with OPFPU. There was nothing in writing documenting any role between him and any of the units, including the OPFPU. Furthermore, he did not sense any degree of oversight, as in a specific oversight role where Dr. Smith was accountable to him for pathology.[23]

(h) Barriers to Informal Oversight

47. At the time he took on the role of Chief Forensic Pathologist, Dr. Chiasson did not feel truly comfortable doing pediatric forensic autopsies. He did not feel that he was an expert in that

22 Evidence of Dr. Cairns, November 26, 2007, page 91, lines 9-24; see also Evidence of , January 30, 2008, page 23, lines 2-7, when explaining his decision to meet with the mother in the Barrie case, he stated that it was his practice to attempt to accommodate OCCO's requests if he could.

23 Evidence of Dr. Chiasson, December 11, 2007, page 70, lines 2-9

area the way he understood Dr. Smith to be expert, and until 1997 he was content that Dr. Smith take the lead in pediatric forensic cases, working directly with Dr. Cairns.[24]

48. Dr. Chiasson admitted that there were a number of barriers to his ability to exercise oversight, including the following:

(a) Dr. Smith was an acknowledged expert in the field and he was not at the time;

(b) Dr. Smith tended to feel that Dr. Chiasson was junior to him, and was not very open to accepting input;

(c) There was no line reporting between Dr. Smith as Director of the OPFPU and Dr. Chiasson as Chief Forensic Pathologist;

(d) Dr. Smith was used to dealing directly with Dr. Cairns and Dr. Young, who were Dr. Chiasson's superiors.[25]

49. The persons who appear to have exercised informal oversight over the OPFPU, Dr. Cairns and Dr. Young, were not pathologists, let alone forensic or pediatric pathologists. As a result, they were not in a position to effectively critique or review Dr. Smith's work on an ongoing basis.

50. Dr. Cairns in particular admitted that he did not have the expertise to independently verify Dr. Smith's options, for example in Nicholas and Paolo[26].

51. In specific cases examined by the Inquiry, Drs. Cairns and Young failed to appreciate basic pathology errors made by Dr. Smith:

24 Evidence of Dr. Chiasson, December 11, 2007, page 71, lines 6-10

25 Evidence of Dr. Chiasson, December 11, 2007, page 72, lines 24-25

26 Evidence of Dr. Cairns, November 26, 2007, page 179

(a) With respect to the Amber case, Dr. Cairns told the CBC program The Fifth Estate that the medical evidence was confusing and may not have been clearly understood by the trial judge[27]. He admits today that he did not have the expertise to independently and objectively assess the soundness of Justice Dunn's criticisms of Dr. Smith[28];

(b) Dr. Young (putting aside the question of whether and to what extent he read the decision of Justice Dunn) decided that it was a "hard fought case" where reasonable experts could disagree[29];

(c) With respect to the Nicholas case, Dr. Cairns testified that Dr. Mary Case's opinion had no impact on his views of the soundness of Dr. Smith's judgments; [30] and

(d) While Dr. Young had the "hugging the tree" conversation with Dr. Smith as a result of the outcome of the Nicholas case, this was a conversation "about whether Dr. Smith should be at 'the leading edge'".[31] It was <u>not</u> a conversation about competence.

52. In the Nicholas case, Dr. Haliday's opinion did not lead Dr. Cairns to question Dr. Smith's opinion. On the other hand, in the Sharon case, once Dr. Cairns heard about the concerns expressed by prominent forensic scientists at the American Academy of Forensic Sciences Meeting in February, 1999, steps were taken to arrange an exhumation.

53. Why the difference? According to Dr. Cairns, "these were heavy hitters".[32] In other words, Dr. Cairns did not himself have the expertise to assess the forensic pathology issues in each case. Instead, he had to rely on other factors such as the credentials of those disputing the

27 PFP029342, page 361

28 Evidence of Dr. Cairns, November 26, 2007, page 179, line 5

29 Evidence of Dr. Young, November 30, 2007, page 115, lines 18-19

30 Evidence of Dr. Cairns, November 26, 2007, page 200, line 3

31 Evidence of Dr. Young, November 30, 2007, page 147, lines 4-5

32 Evidence of Dr. Cairns, November 26, 2007, page 230, lines 16-22

conclusion. Dr. Haliday was an unknown neuropathologist from another Province[33]; Dr. Baden and Dr. Levine were world-renowned experts.

54. It is hardly surprising that this form of oversight "criteria" applied by Dr. Cairns in respect of Dr. Smith's work led to disastrous consequences, particularly in light of the iconic reputation OCCO had worked hard to create for Dr. Smith.

55. Dr. Young appears to have evaluated Dr. Smith's opinions in Amber, Jenna, Sharon, Nicholas and Tyrell as ones which fell within a reasonable range[34]. Indeed, in his evidence at the Inquiry he attempted to justify Dr. Smith's widening of the timing of injuries "window" in Jenna as conservative and supportable[35].

56. In contrast, the Commission heard evidence from the panel of forensic pathologists that Dr. Smith's findings in each case were flawed or simply unsupportable. This suggests that Dr. Young was not the right person to exercise direct oversight over Dr. Smith's pathology opinions.

(i) Quality Assurance

57. During the years 1991 – 1994 there appears to have been no quality assurance process in existence with respect to the OPFPU, or with respect to forensic pathology generally across the Province.

58. Following his appointment in April, 1994, Dr. Chiasson asked that all completed reports of post-mortem examinations at the Toronto Forensic Pathology Unit be submitted to him for

33 Evidence of Dr. Cairns, November 26, 2007, page 172, lines 19-22

34 PFP144922, Evidence of Dr. Young, November 30, 2007, page 190 (re: Sharon) and page 200 (re: Tyrell)

35 Evidence of Dr. Young, November 30, 2007, page 97, lines 6-19

review before release. This was subsequently confirmed by him in writing by memorandum dated January 30, 1995.[36]

59. By memorandum effective September 1, 1995, Dr. Chiasson extended this review process to all reports of post-mortem examination on cases in which the manner of death was either homicide or undetermined and possibly homicide, for all pathologists across the Province.[37] In effect, this extended his review of reports to the OPFPU in criminally suspicious cases. The purpose of the review was to determine any major forensic pathologic issues that might need to be addressed prior to final release of the report.

60. According to Dr. Chiasson, following the effective date of this memorandum he reviewed well over 1,000 reports per year, and perhaps as many as 1,200 or 1,300[38]. Dr. Chiasson acknowledged on examination the limits of this one person review process[39].

61. From the review forms produced in this proceeding, it is clear that the review carried out by Dr. Chiasson was, in fact, a paper or "tick-mark" review. It did not include review of histology or photographs; Dr. Chiasson simply did not have the time to look at those[40].

62. Dr. Chiasson acknowledged that not all reports in the system came to him. For example, if the case was a consultation, the opinion of the pathologist would not come to him. If the report was very late, for example in the Sharon case, where the report was submitted virtually on the eve of the preliminary Inquiry, it also might not come to him[41].

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36 PFP129354, and See Evidence of Dr. Chiasson, December 11, 2007, page 89, lines 17-21

37 PFP129358

38 Evidence of Dr. Chiasson, December 11, 2007, page 96, lines 3-7

39 Evidence of Dr. Chiasson, December 11, 2007, page 97, line 19

40 PFP057168, 129237, 129239, 129247, 129253, 129267

41 Evidence of Dr. Chiasson, December 11, 2007, page 93, lines 14-18

63. Finally, Dr. Chiasson acknowledged in cross-examination that his lack of expertise at the time with pediatric cases may have played some role in his ability to provide oversight in this way[42].

64. Dr. Chiasson also instituted a quality control audit of cases from the OPFPU in 1997, which identified a number of issues, including turnaround time and problems with the wording of post-mortem reports[43]. The inability of the OPFPU to fix a number of ongoing issues, particularly turnaround time, led Dr. Chiasson to conclude that the OPFPU was not fulfilling its mandate "to provide a high quality forensic pathology service to the Coroner's Office despite our Office's attempts to provide guidance and direction"[44]. As a result, he recommended a "revisioning" which would have seen the OPFPU being physically relocated to OCCO, something Dr. Young was not prepared to support.

65. It is noteworthy that the 1997 audit did not turn up any major concerns about the competence of the work being done by OPFPU, or by Dr. Smith in particular[45].

(j) Lack of any Independent Complaints Process

66. The *Coroners Act* itself does not contain any process by which complaints about the conduct of a coroner or pathologist acting under the *Coroners Act* are to be dealt with.

67. Following the abolishment of the Coroner's Council in 1998, any complaint about the conduct of a coroner or pathologist appears to have been dealt with by Dr. Young, in his capacity as Chief Coroner of Ontario. According to Dr. Young's letter to the CPSO dated April 10, 2002:

42 Evidence of Dr. Chiasson, December 11, 2007, page 98, line 12

43 PFP056839

44 PFP044181, page 1

45 PFP031106

> **I am responsible for bringing the policies and procedures to the attention of all those engaged in coroners' work and, when there has been a breach of these policies and procedures, I communicate directly to the coroners and their agents.[46]**

68. There does not appear to have been any formal complaints process ever set up during Dr. Young's tenure as Chief Coroner. Instead, he appears to have assumed that he had an overriding supervisory authority under the Act to personally review complaints, investigate and respond[47].

69. The inadequacy of this process is amply demonstrated by the Nicholas case. Mr. Gagnon initially complained to the Coroner's Council on February 17, 1999 regarding Dr. Smith. The complaint outlined a number of areas of concern regarding Dr. Smith's conduct in extensive detail, including very specific criticisms about his pathologic findings[48].

70. Dr. Young's reply dated May 6, 1999 acknowledged that many of the issues raised by Mr. Gagnon were "essential to the practice of forensic pathology". In addition, it provided Mr. Gagnon with a copy of the Forensic Pathology Pitfalls Memorandum which had recently been prepared by OCCO. However, on the critical allegations made by Mr. Gagnon regarding Dr. Smith (relating to competence, lack of expertise and bias), Dr. Young's response was as follows:

> **Experts must be allowed their individual opinions as this is what makes them experts. Their opinion is based on training and experiences. The question, is therefore, whether or not their opinion falls within a reasonable range given the facts of the case.[49]**

71. On March 6, 2000, Mr. Gagnon filed a complaint with the Solicitor General regarding Dr. Cairns' conduct in the investigation into Nicholas' death. This complaint is particularly important in that it raised a number of questions about systemic issues. In particular, Mr.

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46 PFP145492, page 2

47 PFP144922, page 2

48 Nicholas Overview Report, PFP143263, paragraph 172

49 PFP007885, page 2

Gagnon alleged that Dr. Cairns' "quest to eradicate child abuse in Ontario had clouded his judgment and impaired the objectivity and credibility of OCCO"[50].

72. The Solicitor General's reply to Mr. Gagnon's letter dated April 13, 2000 was prepared by Dr. Young. That letter also repeated that "the opinion Dr. Smith came to was within a reasonable range given the facts of the case"[51].

73. The Ombudsman of Ontario, in its response to Mr. Gagnon dated September 24, 2001, recommended that the Solicitor General considered establishing an independent complaint handing body with special expertise to review complaints and ensure the accountability of the coroner system[52].

74. No such mechanism has ever been established.

75. In conclusion, during the period under review, the very person who had responsibility for oversight with respect to the activities of OPFPU, and Dr. Smith in particular, was the person responsible for dealing with complaints from the public about both coroners and pathologists. Dr. Young lacked the tools both to exercise effective oversight and to respond appropriately to complaints.

76. In addition, as will be dealt with below, Dr. Young and OCCO became closely identified with Dr. Smith and his work and had a built-in disincentive to provide objective and effective responses to complaints from the public.

50 Nicholas Overview Report, PFP143263, paragraph 188

51 PFP007878, page 1

52 PFP007831; PFP007846

(k) Role of the College of Physicians and Surgeons of Ontario ("CPSO")

77. It is arguable that the CPSO is the only body that ever exerted anything that remotely resembled effective oversight of Dr. Smith.

78. Following the decision of the Health Professions Appeal and Review Board ("HPARB") in February, 2000, which determined that CPSO did have jurisdiction to consider DM's complaint, the Complaints Committee dealt with the merits of complaints by DM, Brenda Waudby, and Maurice Gagnon, and required Dr. Smith to attend before the panel of the Committee to be cautioned in all three cases[53].

79. The CPSO considers a reprimand to be a significant regulatory sanction, according to Dr. Gerace[54].

80. Moreover, the Complaints Committee, assisted by its expert panel, appears to have reached conclusions on Dr. Smith's forensic pathology work in all three cases which parallels evidence heard by this Inquiry:

(a) In the Amber case, the panel concluded that Dr. Smith's work was not as thorough as it should have been and that he was overly dogmatic in stating his conclusions[55];

(b) In the Jenna case, the panel criticized Dr. Smith's failure to review clinical information, as well as his failure to conduct an adequate examination with respect to sexual assault, and, most specifically, concluded that his estimate of the time during which the fatal injuries were received was far too broad[56];

53 Amber Overview Report, PFP143724, paragraph 246; HPARB Decision, PFP056605

54 Evidence of Dr. Gerace, January 16, 2008, page 202, line 1

55 PFP029060, page 13

56 PFP147283, page 8

(c) In the Nicholas case, the deficiencies noted by the panel were similar to many of those outlined by Mr. Gagnon in his initial letter of complaint to OCCO[57].

81. However, there were important deficiencies in the results of the complaints in each case.

82. First, and most important, the Complaint Committee's conclusion in all three cases was that Dr. Smith "met the standards expected of a pathologist assisting the coroner in an investigation". To the contrary, this Inquiry has heard expert evidence in all three cases that Dr. Smith's opinions and testimony were deeply flawed and did not meet forensic pathology standards.[58]

83. This strongly suggests that a body charged with general oversight of the medical profession as a whole may not be ideally suited for oversight of specific issues arising from the role played by forensic pathology in the justice system.

84. Second, the complaint committee clearly did not reach the appropriate conclusion with respect to Dr. Smith's handling of the hair in the Jenna case. HPARB's conclusions on appeal completely contradict the evidence heard before this Inquiry[59]. In retrospect, this appears to be because the expert panel accepted Dr. Smith's explanation in isolation, not being aware of information provided by DC Charmley to the CPSO Investigator, Ms. Doris, or of the explanation provided by Dr. Smith to Dr. Cairns[60].

85. Third, the expert panel appears to have been unaware that at the time of Dr. Cohl's interview with Dr. Smith, he had been suspended by OCCO from doing coroner's autopsies in criminally suspicious death cases. Indeed, the Minutes of that interview suggest that Dr. Smith

57 PFP034523, pages 13-14

58 Evidence of Dr. Young, December 3, 2007, pages 277-283

59 PFP146982

60 PFP147341

was less than candid about his status[61]. Had the College been aware of his suspension, the Complaint Committee might well have determined to take further investigatory steps[62].

(l) Creating Dr. Smith's Icon Status and its Implications

86. Dr. Smith's interest in and involvement with coroner's autopsies appears to date to the early 1980's[63]. Over time, he became the largest frog in the small pond of pediatric forensic pathology – in fact, the only frog.

87. By the mid 1980's he had begun to lecture on forensic pediatric pathology, including giving seminars for pathologists and coroners who were working for OCCO[64]. According to Dr. Cairns, during this time no one else had an interest in forensic pediatric pahtology, and OCCO was encouraging him to develop that expertise[65].

88. By the late 1980's and early 1990's, Dr. Smith was lecturing to Crown Attorneys and police officers and had become a fixture at educational courses for coroners[66]. He began to lecture at international conferences, for example, the first North American conference on Child Abuse and Neglect[67].

89. Dr. Cairns readily admitted that around this time, in the early 1990's, it was very advantageous for OCCO to have someone who had developed this type of expertise. Dr. Cairns

61 PFP147797

62 PFP147797, Evidence of Dr. Gerace, January 16, 2008, page 214, line 21

63 Written Evidence of Dr. Smith, PFP303346, page 11

64 Evidence of Dr. Cairns, November 28, 2007, page 106, lines 5-8

65 Evidence of Dr. Cairns, November 28, 2007, page 107, lines 7-9

66 Evidence of Dr. Cairns, November 28, 2007, page 109, line 2

67 Evidence of Dr. Cairns, November 28, 2007, page 110, lines 3-4

also agreed that being appointed as Director of the OPFPU would have enhanced Dr. Smith's reputation[68].

90. By the mid-1990's, Dr. Smith was giving a forensic pathology course for regional pathologists, seminars for the Canadian Association of Pathologists and a lecture to the Association of Family Court Judges. Furthermore, Dr. Smith was giving a number of presentations to the American Association of Forensic Sciences, including papers where Dr. Young was listed as a co-author[69].

91. Dr. Cairns acknowledged that throughout this period, from 1991 forward, Dr. Young was actively assisting Dr. Smith's career, ***in the sense of promoting him wherever he could***[70]. Dr. Cairns agreed that "Dr. Smith didn't come out of nowhere and become an icon overnight"[71]. Indeed, Dr. Cairns admitted that all of Dr. Smith's career steps from the mid-1980's right forward to the mid to late-1990's were taken with the active encouragement and involvement of OCCO[72].

92. One of the reasons for that encouragement was that it was very useful for OCCO to have someone with this expertise and with this stature[73].

93. Dr. Smith's curriculum vitae also makes it clear that as he gained expertise and prominence, he began to give lectures in areas which were strictly speaking outside his area of

68 Evidence of Dr. Cairns, November 28, 2007, page 111, lines 8-9
69 Evidence of Dr. Cairns, November 28, 2007, page 112, lines 9-12
70 Evidence of Dr. Cairns, November 28, 2007, page 113, line 24
71 Evidence of Dr. Cairns, November 28, 2007, page 114, lines 3-4
72 Evidence of Dr. Cairns, November 28, 2007, page 114, line 10
73 Evidence of Dr. Cairns, November 28, 2007, page 114, line 16

competence, for example on the topic of child abuse. Dr. Cairns agreed that Dr. Smith took on a "public awareness" role in connection with the investigation of child abuse[74].

94. As time went on, Dr. Smith's stature began grew. He went on international exhumations. He went on a well-publicised trip to the Arctic. He went to India. He began to get favourable press treatment. In each case, his association with OCCO would have been very apparent. Dr. Cairns admitted that OCCO assisted Dr. Smith's career throughout and that the Office benefited from his expertise and his pedigree[75].

95. In short, OCCO had a vested interest in Dr. Smith's continuing success. If Dr. Smith turned out to have feet of clay, ***that would have an unfavourable impact for the Office***[76].

96. Dr. Cairns, in his capacity as Deputy Chief Coroner of Ontario, gave opinion evidence in support of Dr. Smith in two specific cases this Inquiry has reviewed (Nicholas and Paolo). The very fact that he would do so would suggests that OCCO as an institution supported Dr. Smith's opinion and testimony in those cases. This has been identified as a problem by Dr. Crane, for example[77].

97. OCCO's role in promoting Dr. Smith's career, its desperate need for his services, and the benefits associated with his icon status go a long way to explain OCCO's failure to take any steps prior to 2001 to respond to Dr. Smith's errors and its glacial reaction in 2001 and following when Dr. Smith's fall from grace began.

74 Evidence of Dr. Cairns, November 28, 2007, page 116, lines 12-13

75 Evidence of Dr. Cairns, November 28, 2007, pages 125-127

76 Evidence of Dr. Cairns, November 28, 2007, page 127

77 PFP135519, page 8

(m) Think Dirty

> **Unfortunately, in this day and age, child abuse is a real issue, and it is extremely important that all members of the investigative team "Think Dirty." They must actively investigate each case as potential child abuse, and not come to a premature conclusion regarding the cause and manner of death until the complete investigation is finished and all members of the team are satisfied with the conclusion.**[78]
>
> **It was sent out as a directive: 'You Shall Use It'**[79]

98. According to Dr. McLellan, the genesis for Memo 631 was a shared concern by the coroners and police that in several cases of pediatric death around the province, autopsies, skeletal surveys, and toxicology were not being done.[80]

99. According to Dr. Smith, the protocol was the culmination of a fifteen year effort on his part to change how pediatric forensic autopsies were done in Ontario. It was specifically designed to respond to mistakes that had been made in investigations and to give guidance to "people who weren't involved in these kinds of death investigations on a frequent basis."[81]

100. For Dr. Young, the protocol was a point of pride because the Memo was "leading edge in trying to document and get consistency in these areas":

> **The philosophy without calling it that, was being adopted worldwide…. If you went to forensic meetings that was the discussion that was going on. The formalization of a protocol and the institutionalizing of trying to get consistency in the approach to these cases, we were leading edge at that point in time.**[82]

78 PFP091216, page 2

79 Evidence of Dr. Cairns, November 27, 2007, page 220

80 Evidence of Dr. McClellan, November 12, 2007, page 205, lines 10-15

81 PFP017346

82 Evidence of Dr. Young, November 30, 2007, page 79, lines 21-25, page 80, lines 1-6

101. For Cairns, the phrase "think dirty" was "like the Nike swoosh" – a brand.[83]

102. In 2003, Dr. Young attended as a witness before the Shipman Inquiry[84] and gave evidence about "the philosophy" that led to findings made by Dame Janet Smith as follows:

> **…the coronial service in Ontario seeks and is successful in securing for itself a high public role. The profile ensures that the public is aware of both the existence of the service and mechanism of investigating deaths about which there is any concern or problem. This acts as a positive encouragement to report deaths about which any concern arises… the investigating coroners are instructed to consider the possibility of "think dirty" and to liaise with the family in investigating the death.[85]**

103. However, in his evidence before the Inquiry, Dr. Young took great pains to distance himself from his former "brand" by saying: "I doubt anyone would want to take ownership for it now, but I can tell you I won't take ownership…. I mean I suppose the person who used it the most often was Dr. Cairns, but I really don't know."[86]

104. The real issue about "Think Dirty" is not the words themselves. Several witnesses have testified that the words were intended only to connote that persons investigating unexpected child deaths should utilize a "high index of suspicion".[87]

105. The phrase "Think Dirty" has now been replaced in the 2007 Autopsy Guidelines with a mandate to "Think Objectively, Think Truth", with an admonition to "keep an open mind to death by child abuse", which we accept as appropriate.[88]

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83 Evidence of Dr. Cairns, November 26, 2007, page 56, line 1-2.

84 The Shipman Inquiry website can be found at www.the-shipman-Inquiry.org.uk. A site search for "James Young" will provide Dr. Young's Witness Statement, an overview of his presentation, and documents provided to the Shipman Inquiry about the Ontario Coronial System.

85 PFP302055

86 Evidence of Dr. Young, November 30, 2007, page 73, lines 10-17

87 see for example, Evidence of Dr. Cairns, November 26, 2007, page 47 line 17 and page 51, lines 9-18

88 PFP137602

106. The real question for this Inquiry is what impact the "Think Dirty" mindset had on child death in investigations during the period under review.

(n) The establishment of a "Default Diagnosis"

107. Dr. Cairns came to the job of Deputy Chief Coroner in 1991 after presiding over a controversial inquest regarding suspected child abuse[89]. Addressing this issue became a central feature in his professional work with OCCO over the next decade.

108. From the perspective of OCCO, of particular concern to Dr. Cairns were those cases where the Children's Aid Society had been involved in monitoring families prior to a child's death:

> **…. the focus of the joint mortality task force was, what was happening to children when they were being monitored by a Children's Aid Society. So the focus when we brought all these extra cases was we felt we needed to have a much closer scrutiny of the role that Children's Aid Societies were playing in deaths of these children. Between 1996 and 1998 we did six systemic inquests all addressing children who had died while they were being supervised by a Children's Aid Society.[90]**

109. In this work, Dr. Cairns found a ready and willing partner in Dr. Smith, who already worked closely with the SCAN team at the Hospital for Sick Children. Dr. Cairns became a friend and supporter of Dr. Smith and defended him in the media[91].

110. As Dr. Milroy stated in his evidence, some of the people who do clinical child protection work "see themselves as advocates for the child".[92] Using the terminology offered to the Inquiry by Dr. Pollanen, the advocacy role in this context appears to have resulted in a "default

89 Evidence of Dr. Cairns, November 26, 2007, page 14, line 19

90 Evidence of Dr. Cairns, November 27, 2007, page 28

91 PFP043012 at page 20; PFP300416 at page 39

92 Evidence of Dr. Milroy, November 21, 2007, page 124, lines 8-21

diagnosis"[93] of child abuse. Indeed, in the Kassandra case, Dr. Marcella Mian stated to the police that "all she deals with is child abuse, so naturally she would assume abuse."[94]

111. The default diagnosis in many of the cases that are before this Inquiry came to be expressed by Dr. Smith in the following terms:

- Valin: "in the absence of a reasonable explanation by history, they indicate non-accidental trauma including sexual abuse" **95**
- Nicholas: "in the absence of a credible explanation, in my opinion, the post-mortem findings are regarded as resulting from non-accidental injury"**96**
- Tiffani: "…of note are the presence of bilateral healing rib fractures which, in the absence of a reasonable explanation, are considered to be non-accidental in nature." **97**
- Amber: "…look for evidence which might prove the babysitter to be innocent"**98**

112. Dr. Cairns did not appear to understand the dangers of such logic. His explanation for the opinion in Nicholas was as follows: "Commissioner I think he was making that reasoning in that there was no satisfactory explanation given as to how it may be accidental"[99].

113. Yet that form of reasoning has no basis in science. As Dr. Pollanen explained:

> **We don't say 'in the absence of evidence to the contrary this is cancer.' What we say is, 'the findings of the histology are not sufficient to come to a diagnosis; re-biopsy. Do more investigations to find out.[100]**

93 Evidence of Dr. Pollanen, December 5, 2007, page 41, lines 1-19

94 PFP068644

95 PFP005027

96 PFP053469

97 PFP005586; PFP005852

98 PFP045338

99 Evidence of Dr. Cairns, November 26, 2007, page 160, lines 11-14

(o) The Use of "Psycho-Social" Risk Factors[101]

114. According to Dr. Huyer, in the hospital and medical setting, "we are the helpers and the healers, and we have a significant power in that." At times, said Dr. Huyer, perhaps "we feel we are very powerful and feel that we are – well, very powerful in that area and – probably the most knowing about that particular problem."[102]

115. According to Dr. Driver, the psycho-social assessment employed by the SCAN team in their child abuse investigations was intended to look at "high-risk factors" which were identified in the literature as including the parents' background, whether it was a family that was isolated, whether there were financial problems, and other "stress factors" at play.[103]

116. Both Dr. Driver and Dr. Huyer testified that this tool was used and considered extensively by the SCAN team throughout this period.[104] Indeed in Dr. Huyer's report in the Kenneth case, he states: "Other concerns suggestive of non-accidental injury are the continued supervision order maintained by the CAS". In his evidence, Dr. Huyer acknowledged that his was written at the time in order to "bolster" his diagnosis of child abuse.[105]

117. There can be no doubt that Dr. Smith was influenced by this philosophy in his conclusions regarding cause of death in pediatric cases. Examples can be found in many of the cases which are before the Inquiry in the "clinico-pathological correlations" found on the HSC generated autopsy form; in comments made to police officers and investigators, in testimony

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100 Evidence of Dr. Pollanen, December 5, 2007, page 42, lines 15-19

101 PFP114437 – See also the presentation given by Dr. Smith to the Toronto Police Service which discusses these factors

102 Evidence of Dr. Huyer, January 9, 2008, page 87, lines 5-9

103 Evidence of Dr. Driver, January 9, 2008, page 82, lines 15-22

104 Evidence of Dr. Huyer, January 9, 2008, page 100, lines 12-18

105 Evidence of Dr. Huyer, January 9, 2008, page 106, lines 5-8

before the court; and in general education provided by Dr. Smith to police officers, Crown Attorneys, coroners, and judges, based on the "experience" of HSC. For example:

- "The mother is married but does not officially live with her husband in order that she collect welfare." [106]
- "[A CAS worker from Durham CAS noted that…] they need evidence to prove this was dirty." [107]
- "…the CAS had been contacted but the family allegedly refused assistance." [108]
- "…the mother initially indicated that the family dog (a pit bull) was covered in ketchup, but later blamed Sharon's death on dog bites." [109]
- "Tyrell's father is the legal guardian but is in jail, having killed a by-stander during a shoot-out." [110]
- "[redacted] (who married Kenneth's mother about three months ago) is not Kenneth's father. He was not present at the time because he was at Scarborough hospital attending to his girlfriend who was giving birth to his baby." [111]
- "the mother, however, denied him access and indicated that she would kill her daughter before allowing him access." [112]

106 PFP152441
107 PFP006903
108 PFP082090
109 PFP011500
110 PFP053921
111 PFP005908
112 PFP007594

- "Sudden death of baby while family was involved in "'cult-like activities'" [113]

- "in what are called the poison hours and you have a situation in where you have a tired or a crying infant who is tired because they haven't gone down for their afternoon nap or they may be irritable for whatever reason, fussy and then you have the care-giver who is usually isolated, so there is no one else around." [114]

- "the real issue in this case is that the mother left home 8-9 hours prior to the child's death…she was to come back within the hour, but came back 8 or 9 hours later." [115]

- "? Hooker"[116]

118. Given the institutional relationship between the OPFPU, the HSC Scan Team, and OCCO, as outlined above, it is no surprise to see "psycho-social" factors figuring prominently in Dr. Smith's approach.

(p) Participation in the Prosecution

119. With the assumption of an advocacy role, there is a danger that medical professionals will "cross the line" into participating in the police investigation.

113 PFP002425
114 PFP143724
115 PFP147797
116 PFP011082

120. Dr. Smith admitted that in the early years he considered himself to be supporting the Crown and that in later years he understood the concept of impartiality but was poor in the execution.[117]

121. But it was not just Dr. Smith who fell into this line of thinking. In the Tyrell case, the Court considered the admissibility of statements made by Tyrell's caregiver to Dr. Mian and Elaine McLaughlin of the SCAN team. The trial judge clearly found that they were "persons in authority" and was scathing in his remarks on this point:

> **I would reject the statement because of the dramatically unsatisfactory nature of the SCAN team evidence, which makes it impossible to know with any degree of certainty what [Tyrell's caregiver] was told about the purpose of the interview and equally impossible to know what was in fact the real purpose of the interview and also the dramatic and startling contradiction between Dr. Mian and Ms. MacLachlan about the so-called protocol averred by Ms. MacLachlan and also because of the apparent lack of any protocol of system or set of standard procedures or organizational guidelines to ensure that the role of the SCAN team is clear and fairly brought home, not only to interviewees, but also that the very members of the SCAN team itself have some consistent understanding of what its true purpose and function is.[118]**

122. Dr. Dirk Huyer candidly advised the Commission that when reflecting on this possibility of assuming an inappropriate investigatory role in a case, he recognized that "theoretically people would be more willing to tell me that because I'm a physician and I'm in a helping environment."[119]

123. In the Tiffani case, police investigators arranged a joint interview of the parents with the investigating coroner present, meeting to "discuss the method of the interview" in advance. According to the notes of the investigating officer, the discussion was as follows:

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117 Evidence of Dr. Smith, January 28, 2008, pages 181-182, lines 19-12

118 PFP012179, pages 17-19

119 Evidence of Dr. Huyer, January 9, 2008, page 87,lines 18-23

> **Coroner will ask medical background of mother in form used for medical history…will mention interview is taped and get consent…. If at any time interview shows criminality, Coroner will stop… Officer will [issue?] caution and continue interview. Same procedure to follow with husband.**[120]

124. Reference to Dr. Smith's stature was used as an investigative tool by the police during the interrogation of Nicholas' mother:

> **you have to understand that there people, they're professional who, the pathologist, the head pathologist for Ontario – I mean, this is a man who's not making idle speculation. This is a man who knows and who has empowered that knowledge to us that his death was not natural. That's the reality of it.**[121]

125. The evidence suggests that OCCO saw itself as "a resource to the system",[122] meaning the prosecution side of the criminal justice system. Nowhere is this more evident that in the Barrie case referred to in the course of this Inquiry. The Affidavit of Staff Sergeant Mark Holden, sworn January 28, 2008, raises significant concerns as set out below:[123]

(a) There were two case conferences with police prior to Dr. Smith meeting with the mother;

(b) There was communication between Inspector McNeill and Dr. Smith about the fact the house was wire-tapped;

(c) There was a meeting between Inspector McNeill and Dr. Smith immediately before the meeting; and

(d) Dr. Smith immediately reported back to Inspector McNeill, describing the mother's demeanour as follows: "it was like talking to her about a load of gravel".

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120 PFP118841

121 PFP008195

122 Evidence of Dr. Young, December 4, 2008, page 152, line 14

123 PFP303972

126. A February 7, 2008 affidavit sworn by Dr. Cairns confirms that he was aware that Dr. Smith's meeting with the mother was going to be wiretapped and that he didn't see a problem with it at the time (although he does now).

(q) Dr. Smith's Advocacy Role

127. It appears that Dr. Smith was so concerned by the death of children that he too took on a significant advocacy role in the political realm which extended far beyond his work as a pediatric pathologist. For example, in an email sent by Dr. Smith to Dr. Becker in advance of his June 15, 1998 performance review, Dr. Smith described his "National and External Activities" as follows:

> **I have continued to be involved in reshaping the nature of pediatric death investigation in Canada, and have helped to change practices in family law here in Ontario. At their request, I have met with politicians, both federally and provincially, in the hope of effecting legislative changes. this is a spin-off of the effect of heightened media coverage of CAS-related deaths in the past months. I estimate that this is required up to 5% of my time.**[124]

128. In evidence before this Inquiry, Dr. Smith spoke of his interest in speaking to politicians[125] "to see if it was possible to define a Criminal Code that would recognize child abuse or recognize special features of child abuse"[126] because he found it "frustrating that there seemed to be no simple way of dealing with the death of a child that resulted from a violent act that acknowledged that the violent act was not planned and pre-mediated."[127]

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124 PFP137578

125 Evidence of Dr. Smith, January 28, 2008, page 214, lines 7-10, PFP303958

126 Evidence of Dr. Smith, January 28, 2008, page 211, lines 1-6

127 Evidence of Dr. Smith, January 28, 2008, page 212, lines 5-11

129. Many of Dr. Smith's presentations appear to have gone beyond forensic pathology to deal more generally with child abuse.[128]

(r) OCCO's Knowledge regarding Problems with Dr. Smith's Work

130. By the late 1990's, OCCO was aware of serious and continuing problems with turnaround times for Dr. Smith's reports. This was one of a number of issues that led Dr. Chiasson to recommend a revisioning of the OPFPU.

131. The problem was so severe that in several instances the Crown had been forced to issue a summons to Dr. Smith.[129] Regional Coroners were concerned enough about the problem that one of them had encouraged coroners not to use Dr. Smith.[130]

132. Drs. Young and Cairns also knew of a continued problem with access to Dr. Smith experienced by different players in the justice system.[131]

133. Dr. Cairns was aware of concerns that Dr. Smith changed his opinions during the course of a case.[132]

134. Dr. Cairns was aware that in the Simmons case Dr. Smith had made a very serious mistake with respect to DNA evidence which had led to criminal charges not being laid in a timely fashion.[133]

128 PFP114437

129 Sharon Overview Report, PFP144453, paragraph 146; Tiffani Overview Report, 143440, paragraph 161;

130 PFP136211

131 Evidence of Dr. Cairns, November 26, 2007, page 90-92, and November 27, 2007, page 245, lines 13-24

132 Sharon Overview Report, PFP144453, paragraph 319

133 Evidence of Justice John McMahon, February 6, 2008, page 64, lines 4-11

135. In addition, by the late 1990's, OCCO had findings in three specific cases which should have raised concerns about Dr. Smith's competence, objectivity and professionalism:

(a) In the Amber case, both Drs. Cairns and Young were aware of the acquittal. In May, 1998 in the Nicholas case Dr. Cairns was sent an excerpt of Justice Dunn's decision by counsel for the Sudbury CAS[134]. Whether or not Dr. Young read the decision at the time it was released, he certainly had the decision drawn to his attention at the meeting with Ms. Mann on February 14, 1997[135] and in Mr. Gagnon's complaint to the Coroner's Council in February, 1999. Dr. Young was aware of DM's complaint to the CPSO about Dr. Smith;

(b) In the Nicholas case, in March, 1999 OCCO received the opinion of Dr. Mary Case which, concluded "I would not attribute this death to a head injury as there are no findings on which to make such a conclusion"[136]. Dr. Case was shown on the Fifth Estate program in November, 1999 at a pathology conference giving a presentation about the case, and calling Dr. Smith's conclusions "in the area of irresponsible testimony". Dr. Cairns saw the program[137]. Dr. Young received Mr. Gagnon's detailed complaint about Dr. Smith in February, 1999;

(c) In the Sharon case, Drs. Cairns and Young knew in February 1999 that international forensic scientists were concerned that the case might lead to a miscarriage of justice. [138] They knew at around this time that Dr. Smith had lost a cast of Sharon's skull which had been made an exhibit at the preliminary inquiry. In July, 1999, following the exhumation, they were aware that many of the wounds were dog bites, contrary to Dr. Smith's initial opinion.

136. In 1999, OCCO should have been aware of the outcome of criminal charges in the Jenna case. Dr. Smith's original opinion regarding the timing of injuries had been discredited, first by

134 Evidence of Dr. Cairns, November 26, 2007, page 176

135 Evidence of Michele Mann, January 16, 2008, page 49, lines 15-18

136 Nicholas Overview Report, paragraph 157

137 Evidence of Cairns, November 26, 2007, page 258, lines 20-22

138 Sharon Overview Report, PFP044453, paragraph 216

defence expert Dr. Sigmund Ein on April 23rd, 1999 and then by Dr. Bonita Porter, Deputy Chief Coroner and acting Chair of the Pediatric Death Review Committee, on May 26th, 1999. The charges against Brenda Waudby were subsequently withdrawn on June 15th, 1999[139].

(s) Evaluating Dr. Smith's Performances

137. Although Dr. Smith was not its employee, the OCCO could and should have evaluated his performance and that of the OPFPU as a whole. It had a number of tools it could have used to hold him accountable for mistakes:

(a) Written reprimands or warnings;

(b) Re-direction of cases to other pathologists;

(c) Revocation of Dr. Smith's position as member of the PDRC and Death Under 2 Committee; and

(d) Revocation of his appointment as Director of the OPFPU.

138. Although Dr. Cairns testified that he spoke to Dr. Smith many times about tardiness and completion of post-mortem reports, there is not a single document in the record evidencing any written admonishment or reprimand being provided to Dr. Smith by either Dr. Cairns or Dr. Young in the period under review.

139. The only document critical of even the OPFPU was prepared by Dr. Chiasson in December, 1998 as part of his attempt to revision the unit. It states in part as follow:

> **In my view, the Pediatric Forensic Pathology Unit is not fulfilling its mandate to provide a high quality forensic pathology service to the Coroner's Office despite the Office's attempts to provide guidance and direction. Furthermore, I do not believe that the problems with the unit**

139 Jenna Overview Report, PFP144684, paragraph 102

> **can be remedied given the current arrangements we have with the Hospital for Sick Children.**[140]

140. Following the receipt of the opinion of Dr. Mary Case in the Nicholas case, Dr. Young had what he characterized as his "hugging the tree" conversation with Dr. Smith. Dr. Young suggested to this Inquiry that "we had dealt with him in a disciplinary manner".[141] The reality is that no disciplinary measures or sanctions were discussed at this meeting.

(t) The Decision to No Longer Allow Dr. Smith to Perform Coroner's Autopsies in Criminally Suspicious Cases

141. In late January, 2001 OCCO became aware of media coverage relating to Dr. Smith arising out of the stay of charges in Tyrell's case and the withdrawal of charges in Sharon's case. As a result, Dr. Young met with Dr. Smith and asked him to agree to stop performing autopsies in criminally suspicious cases.

142. According to Dr. Young, the reason for this was out of a concern about Dr. Smith's effectiveness, not his competence. Dr. Smith had become an enormous lighting rod and would benefit from time away[142]. "Everything he did from that point forward would attract undue attention. And that was a problem both for the Office and for him"[143].

143. In fact, Dr. Young acknowledged that at this time one of his main concerns was with the impact the controversy could have on OCCO itself[144]. He appears to have given no thought to the impact Dr. Smith's past work might have had on those criminally accused as a result of his opinions.

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140 PFP056292

141 Evidence of Dr. Young, November 30, 2007, page 164, lines 16-17

142 Evidence of Dr. Young, November 30, 2007, page 201, lines 6-11

143 Evidence of Dr. Young, December 4, 2007, page 9, line 14

144 Evidence of Dr. Young, December 4, 2007, page 10, line 18

144. At this time Dr. Cairns still had faith in Dr. Smith and had no concerns about his competence[145]. Dr. Young appears to have been developing such concerns, although he was at pains to assure the Inquiry that they had nothing to do with his decision to take Dr. Smith off the roster[146].

(u) The 2001 Reviews

145. There appear to have been a total of three separate "reviews" of Dr. Smith's work considered or implemented by OCCO in 2001.

146. First, there was the external review initially contemplated by Dr. Young and then quietly cancelled.

147. Dr. Young intended this to be an internal matter. A public press release announcing a review could fatally damage Dr. Smith's reputation "and I would never get him back to work"[147].

148. The purpose of this review is unclear. Dr. Smith's letter of January 25, 2001 sought "an external review" of his post-mortem examinations, presumably to demonstrate that he could return to work. Dr. Young described this as being "whether or not he would come back and do cases"[148].

149. The scope of this review was never determined, according to both Drs. Young and Cairns. Some of the evidence suggests that it would have looked at specific completed cases for purposes of considering whether he had adequate forensic skills:

145 Evidence of Dr. Cairns, November 27, 2007, pages 38, 29, lines 9-13

146 Evidence of Dr. Young, November 30, 2007, pages 202-204

147 Evidence of Dr. Young, November 30, 2007, page 208, lines 12-13

148 Evidence of Dr. Young, December 4, 2007, lines 23-24

(a) The handwritten written notes of January 26, 2001 meeting referring to an external review (U.S./England/Australia) and under the heading "Purpose?" the words "is he a good forensic pathologist"[149];

(b) An email from an Australian pathologist regarding possible starting points for a review;[150]

(c) A media report and a ministry house book note with respect to Sharon's case, suggesting that this case would be the subject of an independent external review[151]; and

(d) Dr. Young's March 30, 2001 letter to James Lockyer describing a "review" with regard to "two specific cases that Dr. Smith was involved in, both of which were abandoned by the Crown", and which commented on standards for reviewing "experts and their opinions"[152].

150. This contemplated external review was quietly cancelled because of the ongoing lawsuits (the Reynolds civil litigation and Dr. Smith's litigation with Maclean's Magazine) and the CPSO complaints. According to Dr. Young, once these matters were underway he decided he was not prepared to reinstate Dr. Smith until they were resolved.[153] He suggested to the Inquiry that he owed Dr. Smith an apology for not informing him of the cancellation of the review[154].

151. Ironically, having taken the position for many years that the CPSO did not have jurisdiction over coroners or pathologists, Dr. Young was now prepared to wait for the outcome of CPSO investigations into the three complaints.

149 PFP139736

150 PFP129226

151 PFP043554; PFP043561

152 PFP115718

153 Evidence of Dr. Young, December 4, 2007, page 21, lines 1-2

154 Evidence of Dr. Young, November 30, 2007, page 217, lines 19-20

152. The way in which the review was cancelled corroborates that Dr. Young's primary concern throughout was OCCO's reputation. With Dr. Smith off the roster and other processes underway where he would have an opportunity to defend himself, the heat was now off OCCO and there was no need to take any decision regarding Dr. Smith's return to work.[155]

153. The second review was the so-called internal review conducted by OCCO of approximately 17 ongoing criminal cases where Dr. Smith was a witness. The cases were identified by Dr. Cairns, with the assistance of the Metropolitan Toronto Police Force. Although various witnesses described these as cases ongoing before the courts, the list included cases where the criminal prosecution had been concluded, such as Amber and Sharon[156].

154. According to Dr. Young, the purpose of this review was to determine whether the cases were being handled correctly and whether there was a need by the Crown for a independent second opinion. It was prospective, rather than retrospective.[157]

155. This internal review was the subject of an extensive analysis by Justice Trafford in *R v. Kporwodu and Veno*. Dr. Cairns has admitted to this Inquiry that Justice Trafford's conclusions are accurate. In addition, he acknowledges that the review was conducted primarily by him; that in cases where the file had previously been the subject of the quality assurance review by Dr. Chiasson, it was not reviewed again; and that the results eventually presented to the Court were misleading, and favourable to Dr. Smith[158].

156. One simple example from this review demonstrates how misleading it was. The Jenna case is listed in the final chart as case 3055/1997. The chart indicates that the case had been

155 Evidence of Dr. Young, December 4, 2007, page 26, lines 16-21

156 PFP031169

157 Evidence of Dr. Young, December 4, 2007, page 17, Bell Affidavit, PFP070836

158 Evidence of Dr. Cairns November 28, 2007, page 179

externally reviewed, that the external reviewer agreed with Dr. Smith, and that the case was "under investigation". In fact several external reviewers by that time, including Dr. Porter, had disagreed with Dr. Smith's conclusions, and the charges against the original accused had been withdrawn as a result.[159]

157. Similar observations can be made about the chart's conclusions regarding Sharon (internal review agrees with Dr. Smith: yes/no, and external review: no) and Amber (internal review agrees with Dr. Smith: yes, and external review agrees with Dr. Smith: yes).[160]

158. Justice McMahon thought that the OCCO internal review dealt with past cases, and "surmised" that it involved Dr. Smith's competence. He was surprised to learn during this Inquiry that it was only a paper review, having assumed it would be far more in depth and that one concern would have been potential wrongful convictions.[161]

159. Aside from the identification of certain cases where a second independent opinion was needed for use by the Crown, the internal review appears to have turned up nothing which caused OCCO to question Dr. Smith's competence. It was, in effect, a whitewash.

160. A third review was conducted by Dr. Carpenter of Dr. Smith's work in a limited number of non-criminally suspicious cases, for the sole purpose of determining whether Dr. Smith could resume work on such cases.

159 PFP031169, page 159

160 PFP031169, page 159

161 Evidence of Justice McMahon, February 8, 2008, page 66

(v) The Maclean's Magazine Article

161. While the reviews were underway information continued to emerge which should have raised red flags for OCCO. On May 14, 2001 Maclean's Magazine published an article entitled "Dead Wrong"[162]. The article described Dr. Smith's errors in the Amber, Nicholas, Sharon and Tyrell cases. It quoted in detail from the decision of Justice Dunn.

162. Dr. Young saw the article but claims not to have closely reviewed the section relating the Justice Dunn's decision. He considered the article to be unfair to Dr. Smith[163]. He subsequently wrote a letter to a member of the public describing the article as "Dead Wrong".[164] At around the same time Dr. Young agreed to attempt to seek reimbursement for Dr. Smith in his costs for suing Macleans.[165]

163. Dr. Young is quoted by Maclean's in the article as stating the following: "Expert opinion is never a matter of right and wrong. A lot of people assume that one person is wrong and one person is right and it just isn't that straightforward. These are opinions."[166]

164. Dr. Young's letter to Mr. Lockyer dated March 30, 2001 raises similar issues. In that letter Dr. Young described the standard of reviewing experts and their opinions as involving four issues, as follows:

(a) Did the expert appear to be unbiased?

(b) Was the expert willing to consider further information and modify his opinion?

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162 PFP125629

163 Evidence of Dr. Young, November 30, 2007, page 8, line 13

164 PFP056581

165 Evidence of Dr. Young, November 30,2007, page 196

166 PFP125629, page 643

(c) Did the expert testify within the area of his expertise?

(d) Did the expert hold opinions that would fall into a broad range of acceptable opinions within a particular field?

165. With respect to issue (d), Dr. Young noted "it is not simply a matter of finding another expert who would agree or disagree with the expert's opinion".

166. Here is one of the real tragedies of the Smith era in pediatric forensic pathology – having identified accurately a number of important principles relating to expert opinion, Dr. Young never seriously considered their application to Dr. Smith, either prior to 2001 or thereafter.

(w) Following the Discovery of the Hair, Dr. Young Continues to Support Dr. Smith

167. In fact, as time went on OCCO learned information about Dr. Smith which should have triggered immediate consequences.

168. In particular, beginning in November, 2001 Dr. Cairns became involved in the Jenna case, where as a result of Det. Charmley's reinvestigation the hair was rediscovered. Following Dr. Cairns meeting with Dr. Smith and his wife[167], he knew that Dr. Smith's explanation about his discovery of the hair made no sense and was likely false[168].

169. Prior to April 10, 2002, Dr. Young was briefed by Dr. Cairns on what he had learned. He acknowledged in his evidence that this issue raised serious questions. Those included Dr. Smith's competence, veracity, and potential obstruction of justice[169].

167 PFP145664 indicates that prior to April 10, 2002 Dr. Cairns called Dr. Carlisle at the CPSO to discuss this meeting with him

168 Evidence of Dr. Cairns, November 27, 2007, pages 88-91

169 Evidence of Dr. Young, December 4, 2007, pages 28-30

170. And yet, OCCO took no steps whatsoever as a result of this information (except that of Dr. Cairns notifying the Registrar of the CPSO of his concerns). Dr. Smith continued to sit on the PDRC and Death Under 2 committees. Furthermore, he continued to be the nominal head of the OPFPU.

171. As a result, for a lengthy period Dr. Smith continued, at least in theory, to be responsible for the review of autopsy reports of other HSC pathologists in criminally suspicious child death cases, while at the same time being prevented from doing such autopsies himself!

172. Further, inexplicably, on April 10, 2002, knowing of the information which had emerged in the Jenna case, Dr. Young wrote a letter of support for Dr. Smith to the CPSO.[170]

173. That letter is carefully crafted (by Dr. Smith's counsel!), and does not actually defend the correctness of Dr. Smith's findings in the three cases under review by the CPSO Complaints Committee. However, it signals in unambiguous terms that the Chief Coroner of Ontario was supporting his pathologist. According to the letter:

(a) Dr. Smith was "qualified" to undertake the work requested in each case;

(b) At no time did Dr. Smith act in bad faith or with the intent of obstructing or hindering the coroner's investigation in each case;

(c) For Nicholas and Amber the conclusions he reached fell within the "range of reasonable expectations";

(d) With respect to Amber, in which Dr. Young was directly involved, he was "completely satisfied" that Dr. Smith's conclusions met the standard expected;

170 PFP145664

(e) Dr. Young had investigated Mr. Gagnon's allegations and had not found any professional misconduct, and Dr. Smith's opinion "fell within a range of acceptable opinions"; and

(f) Dr. Young was not willing to comment on Dr. Smith's involvement in Jenna, because of the ongoing criminal investigation.

174. Dr. Young was unable to explain why he wrote this letter, given the circumstances at the time. He acknowledged with the benefit of hindsight that OCCO should have stopped Dr. Smith from doing anything after it found out about his conduct in regard to the hair[171].

175. Dr. Young's failure to act may have had collateral consequences. As outlined earlier, a few months later Dr. Smith was interviewed by the chair of the panel of assessors appointed by the Complaints Committee. He gave arguably misleading information about his ongoing work in connection with the OPFPU, which he still at least theoretically headed. Arguably, had Dr. Smith's position been taken away in April 2002 the CPSO would have investigated those cases further[172].

176. As late as November, 2002 Dr. Young was still supporting Dr. Smith; he wrote a letter on his behalf to the Northumberland OPP after the traffic stop incident.[173]

177. When Dr. McLellan became acting chief coroner in July 2002 he did not agree that Dr. Smith should continue as Director of the OPFPU. Dr. Young refused to take the position away

171 Evidence of Dr. Young, November 30, 2007, page 250, lines 4-6

172 Evidence of Michele Mann and Dr. Gerace, January 16, 2008, page 126, lines 6-18

173 PFP056635

from him, but on Dr. McLellan's insistence, agreed to assume responsibility for all matters relating to Dr. Smith.[174]

178. It was only in October 2003, in the context of ongoing concerns about cases which were continuing to receive media attention, and in the context of the decision of Justice Trafford in the Kporwodu case, that OCCO demonstrated any real concerns about Dr. Smith continuing to conduct coroner's autopsies[175](although Dr. McLellan had continued to express his concern since his appointment as acting Chief Coroner). At that time, Dr. Smith was forced to resign from his committee work. Finally, in April 2004 he was forced to resign as head of the OPFPU after Dr. McLellan became Chief Coroner[176].

(x) Conclusions on OCCO's Failure to Hold Dr. Smith Accountable

179. During the period from the early 1990's through to 2004 there can be no little doubt that Drs. Young and Cairns, and Dr. Young in particular, sheltered and protected Dr. Smith. Why did this take place?

180. The key barriers to effective oversight and accountability by OCCO appear to have been:

(a) Neither Dr. Young or Dr. Cairns were forensic pathologists, and Dr. Chiasson did not have the authority or experience to supervise Dr. Smith. As a result, no one was in a position to effectively evaluate his work;

(b) There were no clear lines of authority or reporting;

(c) Accountability for the work of the OPFPU was nowhere defined;

174 Evidence of Dr. McLellan, November 15, 2007, pages 99-100, lines 8-15

175 Evidence of Dr. McLellan, November 13, 2007, lines 18-24

176 Evidence of Dr. McLellan, November 13, 2007, page 68, lines 1-4

(d) OCCO was so invested in Dr. Smith's work that it was incapable of objective and critical oversight;

(e) Dr. Cairns in particular was enamoured of Dr. Smith's icon status;

(f) The consequences of critical oversight would have had a highly negative impact for OCCO's reputation and for Dr. Young in particular;

(g) At various times, Dr. Smith was treated as a friend and colleague who was under attack.

181. Of these, (d) through (g) are most troubling. Failing to create an effective organizational structure to allow for oversight and supervision by those who have the skills to do it is one thing; fostering an environment where such oversight cannot meaningfully occur is another.

182. It is incomprehensible that the 2001 review never contemplated a retrospective examination of past cases for purposes of determining whether there were errors which may have led to miscarriages of justice. Clearly, both Drs. Young and Cairns were more focussed on public perception and on the need to protect the reputation of the office than on the underlying issues involving Dr. Smith and the devastating consequences for the individuals and families involved.

183. Consequently, AFG submits that there needs to be a major overhaul of the governance structure at OCCO. AFG's recommendations in this regard are set out in Part IV below.

III – SYSTEMIC ISSUES RAISED BY THE CASES OF THE AFFECTED FAMILIES GROUP

(a) Amber

184. The key systemic issues raised by the case involve confirmation bias, tunnel vision, misleading testimony, lack of objectivity in approaching scientific controversy, and failure to appreciate the lessons of the case after the fact.

185. There are several striking examples of confirmation bias in the case.

186. Dr. Smith's testimony that the autopsy was a "fishing expedition" about which all of the experts were pessimistic is one obvious example[177]. It suggests that he approached the autopsy with a conclusion already formed. This obviously troubled Justice Dunn.

187. Another example is the forehead or subgaleal bruise.

188. According to the overview report, on August 12, 1988, following the decision to exhume Amber's body, the police had a meeting with Dr. Young. Police notes indicate that Dr. Young told them that "the autopsy should reveal evidence of bruising between the scalp and skull which would tend to support the babysitter's story or the absence of bruising which would strongly suggest infant shaking syndrome"[178].

177 Amber Overview Report, paragraph 79

178 Amber Overview Report, paragraph 53, PFP143724, page 20

189. On exhumation and autopsy Dr. Smith did in fact note a "reddish-brown "forehead bruise and "reddish-brown bruise on the frontal scalp" corresponding to the forehead bruise[179], which Justice Dunn later referred to as "bruise 1".

190. This bruise was discounted by Dr. Smith as being a trivial injury of little significance. He appears to have assumed (and so advised one of the defence experts) that it predated the collapse, although this does not appear to have been the case.[180]

191. At least four of the defence experts, on the other hand, opined that from autopsy photographs they saw bruising in the subgaleal skin (the deeper layers of skin underneath the scalp) consistent with SM's explanation of a fall[181].

192. In other words, confirmation bias led Dr. Smith to discount findings which did not fit with his *a priori* conclusion that the case was a shaking death.

193. Tunnel vision helps explain some obvious questions about the case, such as: how could a 12 year old girl shake an 18 month old infant to death? And why would she do so?

194. Having reached a conclusion that it must be a shaking death, the prosecution experts made the evidence fit that conclusion (the "bolt out of the blue") and ignored or discounted other evidence pointing towards the explanation of a fall (the bruise, unilateral subdural hematoma, lack of any signs of prior abuse, the explanation provided by SM). Ms. Reginbal's unwillingness

179 Amber Overview Report, paragraph 61

180 Amber Overview Report, PFP143724, paragraphs 69, 125

181 Amber Overview Report, PFP143724, paragraphs 169, 177, 190, 201

to critically evaluate the decision of Justice Dunn at the SCAN team meeting is further evidence of tunnel vision[182].

195. As seen later in Tyrell's case, once the fall was excluded early on in the investigation the facts were arranged to fit an alternate hypothesis, which was made to appear compelling.

196. Dr. Smith's misleading evidence is well documented in the decision of Justice Dunn and the Overview Report. His use of anecdotes, his references to sociological factors in shaking deaths, and his evidence regarding the minimum height for a lethal death stand out.

197. However, Dr. Smith's comments on the academic literature are one of the most striking feature in Amber's case.

198. At the time, Dr. Duhaime had just published what became a seminal article on the biomechanical forces at play in shaking injuries. That article suggested that death from pure shaking was unlikely without the evidence of other blunt trauma[183].

199. It may well have been the view of many clinicians and pathologists working in the field of infant head trauma at the time that short falls could not kill, but there was certainly opinion to the contrary[184].

200. As time went on, opinions in this area began to change. Dr. Huyer testified that by the mid to late 1990's he was aware that short falls could kill in extraordinary circumstances[185]. Dr. Whitwell testified that increasingly there has been literature to suggest that occasionally a low

182 PFP153142

183 PFP124653

184 Aoki and Masuzawa article, referred to in paragraph 97 of Amber Overview Report

185 Evidence of Dr. Huyer, January 9, 2008, page 199, lines 24-25, page 200, lines 1-2

level fall can kill[186]. Her 2002 paper cites a number of articles published in the period 1984-2002[187].

201. Over the next 10 years after his testimony in the Amber case, however, Dr. Smith clung to the illusion that the literature was moving in his direction:

- May 4, 1992: In his letter to the CPSO he stated "...in the months that have followed since her death, the increasing body of medical literature in the area of child abuse serves to underscore my opinion" [188]

- March, 1994: While testifying in Dustin's case, he described the medical literature "which was very controversial five years ago, in fact has become less so..." [189]

- March 9, 1998: In his letter to the CPSO he stated "In my view, the medical literature does not support the hypothesis that Amber's death is attributable to a fall down several carpeted steps. At the time I testified in this trial, the literature was strong on this point and, in the intervening years, the literature is even more definitive" . [190]

- January, 2000: During the preliminary in Tyrell's case, he stated "the literature is very clear that this type of head injury cannot occur as a result of an accidental fall that occurs about the home. The only exception to that rule is the [epi] dural

186 Evidence of Dr. Whitewell, December 12, 2007, page 53, lines 8-12

187 PFP301288 "Infant Head Injury Changing Perspective"

188 PFP147101

189 PFP048194, page 57

190 PFP146291, page 10

haemorrhage" , and "These are some good studies published in the last ten years that I think are helping to clarify that..." [191]

- March 2, 2001: In his letter to the CPSO he stated "...the literature now is more complete and serves to reinforce my earlier and honestly held opinion..." [192]

202. One can usefully contrast Dr. Smith's approach to being an expert witness to the Guidelines from the American College of Emergency Medicine:

> **The expert witness should not provide expert medical testimony that is false, misleading, or without medical foundation. The key to this process is thorough review of available and appropriate medical records and contemporaneous literature concerning the case being examined. [Emphasis Added]**

203. On January 30th, 1992 a meeting took place involving members of the SCAN team, Crown Attorneys, and Dr. Smith to discuss the implications of Justice Dunn's decision. This should have been an important "lessons learned" meeting for all involved.

204. Instead, it appears to have been an exercise in "damage control". The case itself had no value as a precedent because the "family court judge" was "at the bottom of the heap" and it would be acceptable to indicate that the team simply disagreed with the decision if it came up at a later date.[193]

205. Judging from contemporaneous notes, it appears that Dr. Smith took away no lessons from this meeting, nor did others.[194]

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191 PFP105484, page 503

192 PFP146344, page 3

193 PFP153142, Evidence of Dr. Huyer, January 9, 2008, page 203, lines 8-13

194 PFP153134; PFP153138

(b) Nicholas

206. The key systemic issues in the Nicholas case are confirmation bias, noble cause corruption, the role of forensic pathology in child protection proceedings, and lack of an effective and independent complaints process.

207. In particular, the Nicholas case provides an excellent example to the Commission of the type of case impacted by Memo #631, and the potential consequences of "thinking dirty" and assuming a non-accidental death "in the absence of evidence to the contrary".

208. The initial conclusion in the Nicholas case was "Sudden Unexplained Death". Upon review by the Regional Coroner in November, 1996, this conclusion was determined to be unsatisfactory and the case was referred to the Pediatric Death Review Committee, chaired by Dr. Cairns.[195]

209. The case was assigned to Dr. Smith for review,[196] the rationale being that if it became necessary to give evidence in court proceedings, the "committee" could not give evidence.[197] Dr. Smith's consultation report stated that "in the absence of an alternate explanation, the cause of death of this young boy is attributed to blunt head injury."[198]

210. After a meeting held between Dr. Smith, Dr. Cairns, the Regional Coroner, and police investigators, the circumstances of the death were considered to be "highly suspicious" and it was determined that an exhumation would be of assistance.[199] Approaching the case from a

195 PFP008325
196 PFP051704
197 PFP007831
198 PFP007660
199 PFP099366

"think dirty" perspective suggested that the death was non-accidental unless the results of the autopsy proved otherwise.

211. Dr. Smith's initial consultation report was based on what Inspector Keetch has called "the five pillars" of the case:

1. cerebral edema;
2. increased head circumference;
3. splitting of the skull sutures;
4. suspected mandibular fracture; and
5. scalp injury.[200]

212. Following the exhumation of Nicholas it was apparent that most, if not all, of these pillars had collapsed. There was no mandibular fracture. Dr. Smith was given information which explained the increased head circumference. The splitting of the sutures was described as "mild." At that point, Dr. Smith's focus shifted, as he attempted to use what was clearly a post-mortem artefact[201] to bolster his opinion. This is a clear example of what Dr. Pollanen has referred to an additional aspect of confirmation basis – the tendency to refuse to acknowledge contradictory facts which might push the death investigation process toward the correct answer.[202]

213. In this case Dr. Smith later was described by Dr. Mary Case, the CPSO Complaints Committee, and Dr. Crane as exaggerating or over-stating the opinions of others in order to lend support to his own erroneous conclusion. For example, the various statements regarding possible

200 Evidence of Inspector Keetch, January 14,2008, page 69, lines 15-21; Nicholas Overview Report, PFP143263, page 17, paragraph 52

201 Evidence of Dr. Crane, November 27, 2007, pages 11-12, lines 12-3

202 Evidence of Dr. Pollanen, November 15, 2007, page 69, lines 9-14

skull and mandibular factures throughout the criminal investigation and the child protection proceedings are as follows:

- Dr. Babyn [letter to Dr. Cairns, Jan. 13, 1997]:

> **mild diastasis of the coronal and sagittal sutures with an area in the occiput which may be an accessory suture…. There is a region of apparent disruption of the neck of the left mandibular condyle suspicious for an angulated fracture…** [203]

- Dr. Smith [Consulation Report, Jan 24, 1997]:

> **A preliminary evaluation of the post-mortem radiographs was given by Drs. Paul Babyn and Derek Armstrong … there was a splitting of the skull sutures. A left-sided mandibular fracture was present.**[204]

- Dr. Babyn [findings in Report of Post-Mortem, June 26,1997]:

> **…latrogenic changes including prior opening of the calvarium are noted, with disruption of the metallit suture evident. No definite fracture of the skull, mandible, ribs or visualized skeleton otherwise seen.**[205]

- Dr. Smith [Notanda – Report of Post-Mortem, June 26, 1997]:

> **…this second postmortem examination revealed no fracture of bone, although the presence of soft tissue injury could not be excluded. Hemorrhagic discolouration was seen along the skull sutures, in keeping with the initial radiographic observation of split sutures.**[206]

- Dr. Smith [CAS Affidavit, June 29, 1988]:

> **marked widening of skull sutures" and "changes to the left side of the mandible which could be interpreted as mandibular fracture"**[207]

- Dr. Smith [CAS Affidavit, June 29, 1998]:

> **widely split skull sutures**[208]

203 PFP008310

204 PFP007656

205 PFP007660

206 PFP007660

207 PFP008407

208 PFP008407

214. In his evidence, Inspector Keetch stated that he was not aware of the conflicting language used to describe the skull sutures and, further, was not aware of the differences that may exist between them.[209]

215. It may be argued that child protection proceedings provided the forum which was most ready to accept the erroneous conclusions of Dr. Smith and Dr. Cairns. Indeed, we have seen that language such as 'in the absence of evidence to the contrary' may well be sufficient to secure a child's removal from a parent's care.

216. The child protection proceedings in the Nicholas case were initiated at the termination of the criminal investigation for two reasons: Lianne Thibeault was pregnant, and she was in school with the intention of becoming a teacher.[210]

217. It is respectfully suggested that Dr. Smith and Dr. Cairns remained adamant that Ms. Thibeault had killed Nicholas and more than willing participants in trying to hold her accountable in any way possible. As Insp. Keetch indicated, the last meeting regarding the criminal investigation was very emotional, with the Chief of Police visibly upset that she was going to "get away with" it.[211]

218. It is noteworthy that at the first meeting Dr. Smith attended with the CAS on May 7, 1998, he told them that he was 99% sure that it was a non-accidental death. The Crown had not been satisfied that "in the absence of an alternate explanation" met the criminal standard; Dr. Smith was determined to ensure that the same issue did not arise again in the child protection context.

209 Evidence of Inspector Keetch, January 15, 2008, page 61, lines 16-24

210 Evidence of Inspector Keetch, January 14, 2008, page 120, lines 24-25, page 121, lines 1-3

211 Evidence of Inspector Keetch, January 14, 2008, page 127, line 9-20

219. What is of equal concern, for the purposes of this Inquiry, is the participation of Dr. Cairns as Deputy Chief Coroner. Dr. Cairns swore an Affidavit for these proceedings which stated:

> **I am aware of the contents of Dr. Smith's Affidavit. I share the opinions stated in the Affidavit, having had the opportunity to review, consider and discuss the opinions of Dr. Smith.**[212]

220. In his evidence, Dr. Cairns acknowledge that it was inappropriate for him to file an Affidavit in support of Dr. Smith's opinion when he was clearly not qualified to opine on the pathological findings in the case, and that he knew or ought to have known that in doing so his position as Deputy Chief Coroner would carry significant weight. The goal of preventing child abuse – a noble cause – appears to have blinded Dr. Cairns to the appropriateness of the means.

221. Mr. Gagnon's complaints and their resolution have already been discussed. However, one aspect should be highlighted here – the attitude of Dr. Young in dealing with complaints of this nature.

222. Throughout Dr. Young's evidence before this Inquiry, it was made abundantly clear that he remains dismissive of those "pen pals" like Mr. Gagnon who for years remained engaged in a "never-ending debate" without resolution.[213]

223. It was also clear that any discussion by Dr. Young of a complaints process had, at its core, the maintenance of professional reputations at all costs:

> **…. what happens is that people go from complaint mechanism to complaint mechanism to complaint mechanism. And we deal literally these days with complaints in - into the Coroners Office, a complaint to the College, a**

212 PFP007674; Nicholas Overview Report, PFP143263, paragraph 101

213 Evidence of Dr. Young, November 30, 2007, page 165, lines 24-25

> **complaint to the Ombudsman, a complaint to the Minister, a complaint to the press and it – it literally can go on for extended periods of time. And – at several points there's considerable jeopardy that people are in in terms of their profession.**[214]

224. The above-mentioned "complaint mechanisms" were all of the avenues that Mr. Gagnon pursued in his quest for accountability and redress. Ironically, were it not for the strength and the tenacity of individuals like S.M.'s father, Nicholas' grandfather, and Jenna's mother in going from "complaint mechanism to complaint mechanism to complaint mechanism", Dr. Charles Smith would have remained firmly entrenched in place in his position as Director of the OPFPU.

(c) Jenna

225. The key systemic issues raised by this case involve confirmation bias, the sharing and recording of information during the death investigation process, misleading testimony, "corridor consultations", Crown disclosure, plea bargaining, and the impact on child protection proceedings.

226. Dr. Smith's autopsy notes indicate that he received information before the autopsy, likely from the Investigating Coroner, suggesting that Jenna's parents used cocaine, that a babysitter had charge of Jenna the evening of her death, that Brenda had gone out for coffee and been away 6-7 hours, and that she might be a prostitute.[215]

227. Five years later, one of the things which Dr. Smith remembered clearly about the case was that the "real issue" was that the mother had gone out for an extended period of time the night of Jenna's death. He told Dr. Cohl during the CPSO investigation: "the real issue is that

214 Evidence of Dr. Young, December 4, 2007, page 121, lines 24-25, page 212, lines 1-7

215 PFP303644

the mother left home 8-9 hrs, prior to the child's death...she was to come back within the hour, but came back 8 or 9 hours later."[216]

228. In short, completely collateral information, prejudicial to Ms. Waudby, was provided to Dr. Smith at the outset, thought important enough by him to be written down, and then remembered years later as the most important issue in the case. The evidence regarding timing of the injuries suggests this collateral information influenced Dr. Smith's analysis of the case.

229. From the initial notes of Cst. Kirkland, it appears that Dr. Smith initially concluded that the fatal injuries occurred within a few hours prior to death.[217]

230. Dr. Milroy told the Inquiry that this opinion "was a perfectly reasonable opinion to give to police" and that he, in effect, had "gotten it right" at this stage.[218] Sgt. Charmley and Crown Attorney Brian Gilkinson both agreed that had this remained the case, there would have been no basis to charge Ms. Waudby.[219]

231. However, almost immediately that time interval began to widen. Officer Lemay's notes indicate that he was told by the investigating coroner after the autopsy that the injuries occurred "prior to 1700 on January 21, 1997".[220] Several days later, the police were told that "the intrabdominal trauma was caused within a twenty-four hour period".[221]

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216 PFP147797, page 8

217 Jenna Overview Report, PFP144684, paragraph 39; PFP079210

218 Evidence of Dr. Milroy, November 19, 2007, page 125, lines 10-13

219 Evidence of Sgt. Larry Charmley, January 15, 2008, page 207, line 6; Evidence of Brian Gilkinson, January 21, 2008, page 26, lines 8-10

220 Jenna Overview Report, PFP144684, paragraph 40

221 PFP072968, page 3

232. At the preliminary Inquiry, Dr. Smith's opinion was that the timing of injuries, if they all occurred at the same time, was "consistent with" 24 to 48 hours before death.[222]

233. Dr. Milroy stated that "there's nothing in the pathology that accounts for why the time was expanded" to "include consideration of the mother when she should clearly have been excluded."[223]

234. Subsequently, all experts who have reviewed this case have confirmed that Jenna died within six hours of the fatal injuries having been inflicted.[224] Indeed, in evidence before this Inquiry, Crown Attorney Brian Gilkinson confirmed that during the April 29, 1999 meeting, without any debate Dr. Smith agreed with Dr. Ein's opinion.[225]

235. Once again, the evidence strongly suggests that confirmation bias played a role in Dr. Smith's initial approach to the case. When confronted with clear medical evidence contradicting his opinion, he immediately retreated.

236. Furthermore, none of Dr. Smith's opinions on timing are formally documented. The Report of Post-Mortem Examination, completed by Dr. Smith eight months after Jenna's death, does not deal directly with his opinion on timing of injuries, nor does it outline his analysis of that issue.[226]

237. The evidence regarding the hair found on Jenna's body also makes it clear that the issue is not simply filling in "gaps" in written documentation, it is also one of the transfer of this

222 Jenna Overview Report, PFP144684, paragraph 74

223 Evidence of Dr. Milroy, November 19, 2007, page 125, lines 18-25

224 Jenna Overview Report, PFP144684, paragraphs 82, 84, 96, 98 and 110

225 Evidence of Brian Gilkinson, January 21, 2008, page 27, lines 17-18, page 62, lines 21-25

226 PFP011066, Report of Post-Mortem Examination dated September 18th, 1997.

documentation to those who need to see it – whether it be the pathologist, the Crown, defence counsel, or those involved in child protection proceedings.

238. The evidence is clear that the hair was seen by several individuals at the Peterborough Civic Hospital upon Jenna's arrival, including the investigating coroner, Dr. Thompson.[227]

239. It is unclear whether Dr. Smith had access to all of the hospital records at the time of performing the autopsy. What is clear is that Dr. Thompson did not include any information about the hair or the possibility of sexual assault on his Coroner's Warrant.[228] No one appears to have ensured that Dr. Smith had all the relevant records and that he was aware of the concerns of hospital staff regarding the possibility of sexual assault.

240. In many cases before this Inquiry, Dr. Smith has referred to "corridor consultations" that support his own findings. The Jenna case offers a poignant illustration of why all such consultations must be recorded in detail by the individual providing the consultation.

241. Dr. Milroy testified that the photographs show a reddening area on the vagina that raised suspicion of an injury. In his view, an appropriate sexual assault investigation was not done. There were no swabs and samples taken from the vaginal area. Histology of the area was not completed.[229] A dark curly hair, although seized by Dr. Smith, was not specifically photographed, documented, or provided to police.[230]

227 Jenna Overview Report, PFP144684, paragraphs 34-35

228 Jenna Overview Report, PFP144684, paragraph 37; PFP011007

229 Evidence of Dr. Milroy, November 19, 2007, page 169, lines 4-13

230 Evidence of Dr. Milroy, November 19, 2007, page 148, lines 4-11

242. Dr. Smith advised Dr. Thompson on the day of Jenna's autopsy that there was "no evidence of sexual assault".[231] He stated to police that Dr. Dirk Huyer was present and they together agreed that there was no evidence of abuse.[232] Dr. Dirk Huyer did not prepare a written report and has repeatedly indicated that he has no specific recollection of attending the autopsy, although he does remember discussing the case with the police.[233] Dr. Smith's post-mortem examination report makes no mention of a sexual assault examination having been completed, or of the involvement of Dr. Huyer.

243. Dr. Smith's autopsy notes, belatedly produced in 2004, indeed make reference to the presence of Dr. Huyer at the autopsy.[234]

244. Following the April 23, 1999 meeting, it is apparent that Crown Attorney Gilkinson was not completely satisfied with the opinion of Dr. Ein, notwithstanding the fact that Dr. Smith had ultimately agreed with the six hour time frame.[235] Mr. Gilkinson and investigating officers then met with Dr. Porter and sought an opinion from her. According to Mr. Gilkinson, he felt that OCCO should have an opportunity to respond to the issues raised by Dr. Ein.[236]

245. As outlined in CAS notes, Mr. Gilkinson continued to look for an "angle to implicate mom"[237] because in his view "mom is definitely a child abuser, but whether she is a child killer needs to be determined."[238]

231 Jenna Overview Report, PFP144684, paragraph 40

232 Jenna Overview Report, PFP144684, paragraph 40

233 Evidence of Dr. Huyer, January 6, 2008, page 245; PFP139633; PFP053105

234 Jenna Overview Report, PFP144684, paragraph 86

235 Evidence of Brian Gilkinson, January 21, 2007, page 56, lines 13-19

236 Evidence of Brian Gilkinson, January 21, 2007, page 57, lines 1-8

237 Jenna Overview Report, PFP144684, paragraph 92

238 PFP300013

246. Unfortunately for Ms. Waudby, these events took place at a time when Justine had already been in foster care for almost 24 months,[239] and Ms. Waudby was due to give birth to her youngest child.[240]

247. There is evidence before this Inquiry that the Kawartha Haliburton CAS repeatedly asked the investigating officer and the Crown Attorney for information regarding the status of the criminal proceedings, and requested access to the Crown Brief.[241]

248. At no point was the KHCAS advised of the fact that as of April 23rd, 1999, Dr. Smith had agreed with the opinion of Dr. Ein that the fatal injuries were inflicted within 6 hours of death. In fact, there is evidence to suggest that the KHCAS were specifically told by the investigating officer that the Crown Brief was "not much different" than in 1997.[242]

249. Dr. Smith became involved in the child protection proceedings as well, offering an opinion on May 6th,1999 to the worker that 'I guess I'll be doing his autopsy too" [referring to M.W.].[243] Again this gratuitous and inflammatory comment was provided to the KHCAS despite the fact that Dr. Smith had agreed with the conclusions of Dr. Ein on April 23rd, 1999 with respect to timing of injuries, and was not a participant in the CAS decision-making process.

250. The result was that relevant and necessary information was not before the Honourable Mme. Justice K.E. Johnston on May 7th, 1999 when M.W. was removed from his mother's care.[244]

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239 The implication of the 24-month rule is discussed in the Bala, Nicholas & Trocma, Nico: "Child Protection Issues and Pediatric Pathology" at page 40

240 PFP300012

241 PFP300012, PFP300013, PFP300009

242 PFP000009

243 PFP300011

244 PFP303267, Evidence of Brian Gilkinson, January 22, 2008, page 78, lines 5-13

251. Dr. Porter released a report to Crown Attorney Gilkinson on May 26th, 1999 which, again, confirmed that the timing of the injuries to Jenna were less than six hours from her death.[245] This report was not disclosed by the Crown to the defence, or to the CAS. Laird Meneley, counsel for Ms. Waudby in the CAS proceedings, made several attempts to obtain this report from both Dr. Porter and Mr. Gilkinson without success.[246]

252. It is our respectful submission that the Crown Attorney has a positive duty, not only to report child abuse to the CAS,[247] but to immediately report the finding that there is an absence of evidence of same. There should never be reliance on defence counsel to simply "pass the information along".[248]

253. There can be no doubt that the above disclosure issues had a serious impact on the child protection proceedings involving Justine and M.W.:

> **The Crown Attorney did not withdraw the charge against Brenda until June 15th, 1999. The Crown Attorney insisted that no withdrawal of the criminal charges would be made unless Brenda plead guilty to an offence under section 79(2)(a)…. Brenda's daughter spent more than one and a half years in foster care while Brenda's criminal charges were outstanding. Brenda has never spent a single overnight with her infant son. Brenda, Brenda's children and her extended family have been completely devastated as a result of her being arrested for a crime she did not commit.** [249]

254. Brenda Waudby's name remains on the Child Abuse Registry.

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245 Jenna Overview Report, PFP144684, paragraph 98

246 PFP160829; PFP161453

247 Evidence of Brian Gilkinson, January 21, 2008, page 38, lines 16-21

248 Evidence of Brian Gilkinson, January 22, 2008, page 79, lines 19-23

249 PFP053153

255. The potential for members of a death investigation team to approach a case using a common set of shared (and therefore unchallenged) assumptions is a fact which runs through the cases before this Inquiry, and is something that is important to guard against.

256. As noted earlier, the Crown appears to have been of the view that Ms. Waudby was a "child abuser". In his evidence before this Inquiry, Mr. Gilkinson very candidly agreed that this was based on the pathological findings of Dr. Smith regarding old rib injuries.[250]

257. The same conclusions appear to have been relied upon, both by the Crown and by the defence, when Ms. Waudby entered a plea of guilty to a charge under section 79(2)(a) of the *Child and Family Services Act*[251]. As of that time Dr. Smith's opinion regarding the timing of the rib injuries had not, in fact, been challenged.[252]

258. As a consequence of the CFSA conviction, Ms. Waudby was placed on probation requiring her to take direction from her Probation Officer in conjuction with the KHCAS "for the care and management of her children". [253] The fact of the plea of guilty to child abuse was used in subsequent child protection proceedings involving Justine and M.W.[254]

259. The pathological evidence before this Inquiry regarding the age of Jenna's rib injuries is important to note:

(i) Dr. Smith noted broken ribs at the time of autopsy;[255]

250 Evidence of Brian Gilkinson, January 22, 2008, page 84, lines 3-5

251 PFP075100

252 Evidence of Brian Gilkinson, January 22, 2008, page 83, lines 22-24

253 PFP075100

254 PFP053153

255 PFP101617

(ii) The x-rays which accompanied the body from the Peterborough Civic Hospital were unremarkable;[256]

(iii) The x-ray report of Dr. Paul Babyn showed "questionable posterior rib fractures";[257]

(iv) The CT scan reported by Dr. Paul Babyn showed "findings in keeping with acute, non-accidental injury given lack of defined healing, multiplicity of fractures and fracture location;[258]

(v) In his interview with the CPSO, Dr. Smith stated that there was "no good histology of rib healing (in radiological information) and further stated: "I don't know when the rib injuries occurred – 6 hrs., 24 hrs. or more"; [259]

(vi) In his 2005 review, Dr. Pollanen stated: "none of the fractures show definite evidence of a healing reaction…. the rib fractures occurred by a chest compression mechanism in the perimortem period Historical details about how the compressive force was applied are lacking";[260] and

(vii) The only reference to 7-10 day old rib injuries is the police officer's notes at the third case conference on July 7th, 1997, when Dr. Smith apparently reported that the "only thing new was old rib injuries had been discovered." [261]

260. When asked specifically to consider this issue in retrospect, Mr. Gilkinson very candidly stated the following:

> **I agree that that's the import of what his opinion is. That wasn't the opinion we had or we relied on at the time the plea was entered.... so I'm sitting here wondering whether or not we took a plea -- well, we took a plea on the basis of rib head fractures that were considered old at the time…you**

256 PFP101617

257 PFP011115

258 PFP011116

259 PFP147797, page 8.

260 PFP072613, page 8 and page 13.

261 PFP072650

> **just do the best you can to make the decisions that appear to be appropriate with the information you have at the time.** [262]

(d) Sharon

261. The Sharon case serves as an alarming example of misleading and Crown-biased testimony, confirmation bias, and tunnel vision. It also raises issues about forensic training, due diligence in preparing forensic opinions, post-mortem report writing, pathologist scene visits, allocation of cases amongst pathologists, and recording of material communications within OCCO and between OCCO and the police and Crown.

262. Notwithstanding that Dr. Smith had little experience with penetrating wounds,[263] he performed Sharon's autopsy because he was asked to by Dr. Young.[264] He did not visit the scene.[265] He did not request that the autopsy be done by a forensic pathologist, nor did he seek the assistance of Dr. Chiasson, whom Dr. Smith knew to be one.[266]

263. Dr. Smith was told by the police at the time of autopsy of their working theory that Sharon's death was a homicide and that she was stabbed possibly by scissors.[267] Rather than shave the scalp to examine the wound edges microscopically (which Dr. Smith acknowledged he should have), he sent the scalp to be examined for head lice, which was indicated as a possible motive for the scalping.[268] The scalp was no longer in a condition to be examined by the time it returned from the entomologist.[269]

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262 Evidence of Brian Gilkinson, January 22, 2008, page 87, lines 12-25, page 88, lines 1-7

263 Dr. Smith, February 1, 2008, page 9, lines 7-11

264 PFP303346/82

265 PFP303346/87

266 Dr. Smith, January 30, 2008, pages 164-165, lines 19-4

267 Dr. Smith, February 1, 2008, page 10, lines 21-25

268 Dr. Smith, February 1, 2008, pages 12-13, lines 24-16

269 Dr. Smith, February 1, 2008, page 13, lines 17-20

264. Dr. Smith acknowledged at the Inquiry that he made a number of other basic errors in his post-mortem examination, including inadequate description of wounds and wound tracks, failure to measure the depth of one of the key penetrating wounds, insufficient tissue excisions around the wounds, failure to ensure sufficient photographs were taken, and failure to take swabs.[270]

265. While at the time of the autopsy Dr. Smith knew of the possible presence of a dog in Sharon's home when she died,[271] there is little documentation of any communications between the police and OCCO / Dr. Smith regarding the "alarming" information the police were gathering about the pitbull Hat Trick in the week following Sharon's death.[272]

266. Two days after the post-mortem examination, Dr. Smith unequivocally told Cst. Goodfellow in response to concerns raised about some of the wounds that they were "not domestic or wild animal in any way".[273] This was then passed on to the investigation team.

267. It does not appear that Dr. Smith asked any questions during this conversation, and it is unclear whether the police volunteered any information. The information emerging about Hat Trick should have made its way to Dr. Smith and formed part of his initial opinion. Today, ten years later, it is still unclear what Dr. Smith knew about the dog and when he knew it.

268. Although Dr. Smith testified that he believed Mr. Blenkinsop would be consulting with Dr. Wood about the wounds,[274] this is inconsistent with (a) Dr. Wood's testimony that he was not consulted until many months later, likely as a result of the dog theory having been raised by

270 PFP303346/83; Dr. Smith, February 1/08, page 18, lines 10-17

271 PFP303346/82; also see the evidence of Dr. Queen from his interview statement (which Commission Counsel indicated would be filed as evidence) in which he states that dog bites were discussed at the autopsy.

272 Inspector Begbie, January 24, 2008, pages 208-209, lines 24-16

273 Sharon Overview Report, PFP144453, para.74

274 PFP303346/83

the defence,[275] and (b) Dr. Smith's willingness to release Sharon's body for burial three days after the autopsy even though Dr. Wood had not examined it.[276]

269. A December 19, 1997 memo from Jennifer Ferguson to Jack McKenna suggests that Dr. Wood was being consulted to "*nip [the defence's dog attack] theory in the bud*."[277] Dr. Wood acknowledges that this phrasing was "particularly unfortunate", as it suggests that he was being retained to give a specific opinion from the outset.

270. Like Dr. Smith's initial oral opinion, Dr. Wood's February 22, 1998 opinion regarding the wounds was unequivocal in rejecting the possibility of a dog attack.[278] It left no room for doubt,[279] notwithstanding that it was based only on a review of some (not all) of the photographs, rather than an examination of the body, which Dr. Wood testified would have been "very important" in order to analyze the wounds.[280]

271. When asked about whether his opinion ought to have been expressed in less certain terms, Dr. Wood's response was to imply that it was up to the defence to cross-examine him about it at trial.[281]

272. This answer suggests that Dr. Wood, like Dr. Smith, may indeed have viewed it as his role to nip the defence theory in the bud and support the Crown's theory.

275 Dr. Wood, January 23, 2008, pages 66-67, lines 23-9; page 78, lines 7-12

276 Dr. Smith, February 1, 2008, pages 25-26, lines 14-23

277 Sharon Overview Report, PFP144453, para.109

278 Sharon Overview Report, PFP144453, para.114

279 Dr. Wood, January 23, 2008, page 211, lines 6-9

280 Dr. Wood, January 23, 2008, pages 50-52

281 Dr. Wood, January 23, 2008, page 213, lines 4-18

273. Equally telling is Dr. Wood's email in 2000 to a colleague asking, "in extreme confidence", for any information about Dr. Dorion to assist Dr. Wood in doing a "hatchet job" on him.[282]

274. The research on dog attacks available at the time (which formed part of Dr. Wood's own file in the Sharon matter[283]) referred to patterns of wounding in young children similar to those on Sharon's body, including scalp lacerations and scalp avulsion (separation).[284] Apparently, neither Dr. Smith nor Dr. Wood took the time to review this literature before they rendered their initial opinions.

275. Dr. Smith acknowledged that when testifying at the preliminary Inquiry he assumed the role of supporting the Crown's position and dismissing the dog attack theory, notwithstanding that he knew by that time that he was supposed to be neutral and objective.[285]

276. He did so by resisting a justified challenge to his relevant forensic experience by defence counsel and by expressing unjustified confidence in his opinion to assist with what he perceived to be the Crown's strategy for undermining the defence's dog attack theory.

277. Even though by Dr. Smith's own admission to Jane O'Hara he recognized that he didn't know anything about dog bites,[286] under cross-examination at the preliminary inquiry he vigorously refuted these suggestions by defence counsel, even remarking that "as absurd as it is

282 PFP081005

283 PFP170446

284 PFP170446; Dr. Wood, January 23, 2008, pages 237-238, lines 22-10; Dr. Pollanen, December 5/07, pages 1201-21, lines 18-11

285 PFP303346/84; Dr. Smith January 30, 2008, pages 185-186, lines 15-3

286 PFP303004/23

to think that a polar bear attacked Sharon, so it is equally absurd that it's a dog wound."[287] Dr. Smith admitted at the Inquiry that he was in reality not as confident as he sounded.[288]

278. In his evidence at the preliminary inquiry, Dr. Smith even went so far as to suggest, wrongly, that he was *uniquely qualified* to render an opinion about the penetrating wounds in this case because there were differences in wounding patterns between children and adults.[289]

279. When questioned at the preliminary inquiry about the basis for his opinion that the scalp was deliberately cut out by scissors, he testified that microscopic examination revealed the wound edge to be remarkably smooth,[290] even though the scalp was no longer in a condition to be examined when it was returned to him.

280. In sum, through misleading and emotive testimony Dr. Smith managed to annihilate the defence's theory that the wounds were caused by a dog attack. This is reflected in the Court's comment to defence counsel: "....lots of luck convincing a jury that this death was caused by a dog attack.... Based on the evidence that I've heard."[291]

281. After the American Academy of Forensic Sciences meeting in February 1999, Dr. Young and Dr. Cairns clearly acted responsibly in raising concerns about the case.

282. No one at OCCO appears to have recorded the internal case conference between Dr. Cairns, Dr. Dr. Smith, Dr. Wood, Mr. Blenkinsop, and Dr. Queen at which the possibility of a dog attack was raised, and regrettably, dismissed. The evidence as a whole suggests that the

287 Sharon Overview Report, PFP144453/81, para.184

288 Dr. Smith January 30, 2008, page 184, lines 11-15

289 Sharon Overview Report, PFP144453/85, paras.193; Dr. Milroy, November 19/07, pages 88-89, lines 17-1

290 Sharon Overview Report, PFP144453/78, para.181

291 Sharon Overview Report, PFP144453/92, para.198

meeting was called by Dr. Cairns after he and Dr. Young returned from the AAFS meeting.[292] It is still a mystery, however, why so many present (with the exception of Dr. Queen) managed to miss what Drs. Pollanen and Milroy described as a straightforward diagnosis.[293]

283. Dr. Chiasson was the pathologist who conducted and was in charge of the second post-mortem examination, notwithstanding that he felt his experience with dog-bites was limited and he did not have a high level of comfort.[294]

284. With hindsight, Dr. Chiasson acknowledged that this may have been the reason he was unable to reach a definitive opinion regarding the nature of many of the wounds.[295]

285. Dr. Chiasson also acknowledged, with hindsight, that the second autopsy presented a missed opportunity to engage and involve an independent forensic pathologist in the case.[296]

286. It is not only Dr. Smith (and others at OCCO) who exhibited tunnel vision in this case. The Kingston police persisted in their view that Sharon's mother killed her, despite the results of the second exhumation showing that a dog caused almost all of the wounds.

287. As indicated by Sgt. Bird in his April 2000 memo, "Make no mistake, the right person, Louise, is on trial. If we want justice to be served and her found guilty, it's an absolute must that we get back on track and work towards this common goal."[297]

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292 For example, see PFP055743

293 Dr. Pollanen, December 5/07, page 120, lines 2-3, page 123, lines 9-11; Dr. Milroy November 19/07, page 53, lines 18-19

294 Dr. Chiasson, December 11, 2007, page 106, lines 16-18, page 112, lines 5-18

295 Dr. Chiasson, December 11, 2007, page 112, lines 5-18

296 Dr. Chiasson, December 11, 2007, page 115, line 91-15

297 PFP287924

288. Also reflective of the police's state of mind is Sgt. Begbie's characterization of the mood as "doom and gloom"[298] after Mr. Bradley became involved in early 2000, presumably because he began questioning whether the case could survive scrutiny.

289. Surprisingly, the views of the Kingston police about Sharon's mother's guilt persisted ***even after receiving Dr. Symes' opinion which definitively dismissed the scalping theory*** – a key part of the police's theory on motive.

290. This is evident from Chief Closs's letter writing campaign following the withdrawal of the charges against Sharon's mother, in particular his February 20, 2001 letter to The Kingston Whig-Standard calling for an independent inquiry into Sharon's death.[299]

291. The magnitude of the tunnel vision is perhaps best illustrated by Inspector Begbie's inability at the Inquiry to even express a coherent theory of Sharon's mother's involvement following the changed medical evidence:

> **Basically, whether the – the mother was involved and the dog joined in, or whether the dog came down and foraged later, that's – we – we weren't able to tell that.**
>
> **…**
>
> **That was – that was the initial – from the onset of the case there was a scalping. The scalp come off somehow. Maybe the – maybe the dog is what's responsible, and that's – some of the defence experts have said with the – the injuries to the head is what's removed the – the scalp but the mother still could have inflicted injuries before.[300]**

(e) Tyrell

292. Tyrell's case is a striking example of the deficiencies with written post-mortem reports in Dr. Smith's era. Other systemic issues arising from the case include confirmation bias,

298 Inspector Begbie, Jan. 24, 2008, page 144-145, lines 24-3

299 Sharon Overview Report, PFP144453, paras.330 - 336

300 Inspector Begbie, Jan. 24, 2008, page 235, lines 18-23, page 237 lines 10-16.

misleading testimony, inappropriate reference to controversy in the literature and communications between Crown and defence.

293. The post-mortem report of Dr. Smith describes the cause of death as "CNS trauma". It contains no history. It contains no information explaining how the cause of death was determined. It says nothing one way or another about Maureen's explanation about Tyrell's fall.[301]

294. Although Dr. Becker obviously was consulted regarding the neuropathology issues raised by the post-mortem and authored a report on the central nervous system which was incorporated into the report, this is not apparent from the report itself.[302]

295. The HSC Final Autopsy Report, a document not released to the police, Crown or defence, contains a history which accurately describes Maureen's summary of Tyrell's fall ("he was jumping on couch and jumped backward off the couch, lost his footing, and fell backward, hitting his head on a marble table or a tile floor. He immediately got up and tried to run forward but fell and struck his forehead")[303].

296. However, this report contains highly prejudicial information about Tyrell's father. It is impossible to say whether this information might have played a role in Dr. Smith's thinking about the case.[304]

297. In conclusion, there are a number of problems with the report itself –with what it contains and what is left out. Dr. Smith's reasoning and opinions are not contained in the report but in

301 PFP012442

302 Tyrell Overview Report, paragraph 100

303 PFP012348

304 Tyrell Overview Report, paragraph 104

verbal sidebars with the police at various stages of the investigation[305]. No attempt appears to have been given to serious consideration of the explanation in light of the pathological findings of bruising in two different areas of the skull.

298. As outlined in the Overview Report, and in Dr. Crane's evidence before the Inquiry, Dr. Smith's evidence at the preliminary Inquiry was inflammatory and misleading. He was drawn into testifying outside his expertise.[306] He repeated his opinions on whether short falls could kill in words that could have been taken from a transcript in Amber, even using the same article. Instead of acknowledging any continuing debate in the literature, he attempted to suggest that Dr. Duhaime now supported his position. According to Dr. Smith, "...with the newer studies, the literature is on my side".

299. One can usefully contrast Dr. Smith's approach to that of Dr. Robin Humphrey, Neurosurgeon in Chief at HSC, who was retained by the Crown shortly before trial. Dr. Humphreys took the explanation provided by the caregiver as something to be considered seriously ("If the description of what happened to Tyrell...is in any way accurate..."). He reviewed the pathology findings with the explanation in mind ("Those scalp contusions...could thus be in keeping with the two separate blows to the head created first by striking it on the table and floor, and then secondly after again falling to the floor"). He concluded that the pathology could provide confirmation for this history ("There is pathological confirmation of these blows"). He ended his report by concluding that there is considerable uncertainty as to the mechanism of the head injury.

305 Tyrell Overview Report paragraphs 98, 135, 136, 148

306 Tyrell Overview Report, paragraph 191 and following

300. Contrast this to Dr. Smith's verbal advice to the police: "children do not die from accidental falls of this nature."[307]

301. It is clear in retrospect that in this case defence counsel laid traps for Dr. Smith, encouraging him to talk at the preliminary to get his evidence tied down, and preparing to demolish him at trial. There was sharing of defence opinions just before trial, presumably to ensure that the Crown would not be in a position to seek further opinions.

302. OCCO appears to have been unaware of any issues raised by this case until the time when the charges were stayed, when the media reported that the Crown had done so to avoid a miscarriage of justice.[308]

303. At that time Dr. Cairns spoke to the Crown, Frank Armstrong, and was advised that there were no concerns about Dr. Smith's conduct in the case.[309]

304. Arguably, given the controversy swirling about Dr. Smith at the time, Dr. Cairns should have gone further. Had he spoken to defence counsel, for instance, he may have learned of the misleading evidence given by Dr. Smith earlier in the case.[310]

(f) Athena

305. The primary systemic issues raised by the Athena case obviously relate to OCCO's control over the timing and delivery of post-mortem reports and consultation opinions.

307 Tyrell Overview Report, PFP144019, paragraph 148

308 Tyrell Overview Report, PFP144019, paragraphs 280-281

309 Evidence of Dr. Cairns, November 27, 2007, page 237, lines 1-2

310 Evidence of John Struthers, February 8, 2008, page 223, lines 20-22

306. As found by the trial judge, and affirmed by the Court of Appeal, Dr. Smith's delays in this case were unexplained, and had a significant impact on the time it took for the case to reach trial, with highly prejudicial effects for the family.[311]

307. There are however several other issues raised by the case which deserve the Commissioner's attention. As outlined in the trial judge's reasons, there were a series of misunderstandings which led to Athena's body being cremated at a time when the family were still considering whether to obtain a second opinion.[312]

308. It is also important to note that there was evidence before Justice Trafford that the family, when inquiring about a second (defence) autopsy, was told by the Regional Coroner Dr. Bennett that the cost would be prohibitive.[313]

309. Finally, the use made by the police of the post-mortem report in their investigation – it was not released to the family until the police had wiretapped their hotel room, so as to gauge their reaction – again raises issues about the active involvement of OCCO in ongoing police investigations.[314]

IV - RECOMMENDATIONS

(a) Training and Certification

310. Formal accreditation in forensic pathology should be required for all those who engage in forensic pathology in the Province, and in particular for all those pathologists conducting post mortem examinations under coroner's warrant in cases involving criminally suspicious deaths.

311 Court of Appeal Decision, PFP018971, paragraphs 14, 55

312 Decision of Trafford J., PFP034420, pages 113-114

313 Decision of Trafford J., PFP034420, pages 113-114

314 Decision of Trafford J., PFP034420, pages 121-124

The parameters of any accreditation process, the extent of the formal training and experience required, and whether for example pathologists currently doing fee for service work with significant practical forensic skills could be grandfathered are matters which an accreditation body should determine and control.

311. OCCO should establish a roster of all those approved by the Chief Forensic Pathologist to conduct coroner's autopsies in the Province. Criteria for approval should include certification and agreement to comply with all OCCO policies and to meet applicable forensic pathology standards.

(b) Institutional Considerations

312. OCCO should have a Governing Council with representatives of all stakeholders in the justice system, including the Crown, the defence, and non-governmental organizations. Membership on the Council should be at the instance of the Ministry responsible for OCCO. The Governing Council should have ultimate responsibility for oversight of OCCO and should be responsible through a Chairperson to provide annual reports to the Ministry.

313. The Chief Coroner should continue to have responsibility for OCCO's day to day organizations, but should report to the Governing Council on a regular basis, with particular emphasis on oversight and quality assurance. The Council should also have responsibility for review and approval of all OCCO major policies and initiatives. The Council should have a subcommittee responsible for forensic pathology.

314. The position of Chief Forensic Pathologist, the responsibilities of that office, and the duties of individual pathologists should be defined in the *Coroners Act*. The Act should provide that:

(a) The Chief Forensic Pathologist has overall responsibility for oversight, quality assurance and accountability for the work of all staff and fee for service pathologists conducting post mortem examinations or other services under Coroner's Warrant.

(b) The authority of the Chief Forensic Pathologist extend to determining, either by guideline or otherwise, where autopsies take place, and by whom.

(c) The Chief Forensic Pathologist should be responsible by statute for setting guidelines governing the conduct of autopsies and post mortem examination reports.

(d) The pathologist conducting a post-mortem examination is responsible for providing an independent, objective and reviewable opinion to OCCO on the cause and mechanism of death and on other issues relevant to the death investigation.

(e) A staff forensic pathologist within the Toronto FPU be designated as having primary responsibility for quality assurance, under the authority of the Chief Forensic Pathologist.

(f) The Chief Forensic Pathologist report annually to the Governing Council on efforts made within the office to ensure quality assurance.

(g) The Chief Forensic Pathologist continue to report as a Deputy Chief Coroner to the Chief Coroner for Ontario, who should continue to have ultimate accountability for the quality of all death investigations carried out in Ontario.

315. The OPFPU should be disbanded. All coroner's autopsies in criminally suspicious child deaths should be conducted at the Toronto FPU or at other Regional Pathology Units. Pathologists at HSC should continue to conduct coroner's autopsies in non-criminally suspicious child death cases under guidelines established by the Chief Forensic Pathologist. Those guidelines should include written procedures to be followed in the event the categorization of a death becomes criminally suspicious while the autopsy is underway. The Chief Forensic Pathologist should ensure that pediatric pathologists from HSC (and elsewhere in the province,

from the appropriate hospital) are available to consult in specific criminally suspicious death cases at the Toronto FPU and the Regional Units.

(c) The Post Mortem Examination

316. The existing 2007 Autopsy Guidelines outline a balanced approach to the objective of "Thinking Truth" while maintaining a high index of suspicion in certain specific circumstances, and this approach should be endorsed.

317. The Autopsy Guidelines should specifically acknowledge that forensic pathology is an interpretative science which can be susceptible to psychological factors such as confirmation bias and tunnel vision. Forensic pathologists conducting an autopsy should be cautioned that such dangers do exist and must be guarded against at all times. The forensic pathologist should be encouraged to seek feedback and constructive criticism from colleagues in every case.

318. All information provided to the forensic pathologist in the process of obtaining a history, whether from the family physician of the deceased, treating physicians, police, coroner, CAS or other professionals, should be documented, either in the post mortem examination report or in accompanying notes contained in the file.

319. The Autopsy Guidelines should explicitly outline that while it is important for forensic pathologists to get an accurate and complete history, this information can be highly prejudicial and can subtly influence the outcome of the death investigation. Forensic pathologist should be cautioned to carefully review and consider the use of such information, whether received from the police, through medical records, the Coroner, or some other fashion.

320. At the time of the autopsy the forensic pathologist should be provided with a written investigation synopsis by the police. It should be the forensic pathologist's obligation to ensure that any additional information required from the police is documented at the time of autopsy. Following the autopsy proper, but before the completion of the post mortem report, OCCO should ensure that the investigation synopsis provided by the police is updated so that the forensic pathologist has an accurate synopsis of the police investigation at the time the report is completed.

321. In addition to the Coroner's current obligations to attend the death scene, the Autopsy Guidelines should provide that the forensic pathologist visit the death scene where practicable in any case which is criminally suspicious and where the mechanism of death is not immediately apparent.

322. The Chief Forensic Pathologist should develop written guidelines outlining the circumstances in which a pediatric pathologist should participate in the post mortem examination (for example, when there is suggestion of an unusual physical disease process or a SIDS like death).

(d) The Post Mortem Report

323. The post mortem report should contain a complete history, including the source of any information provided. In addition, the report should contain a summary of the analysis of the forensic pathologist leading to any conclusions expressed. Where the forensic pathologist's opinion touches on a controversy in the academic literature that controversy should be outlined and the reasons for the pathologist's view set out. Pathologists should be encouraged to outline

reservations and qualifications to their opinions. The report should identify all documents received by the pathologist, and should record all samples taken.

324. The report should include conclusions regarding cause and mechanism of death. If the pathologist has been asked or will be asked to express any other opinion relevant to the death investigation (for example, timing of injuries) that opinion should be outlined. The pathologist should never comment on means of death or on whether the death was accidental or deliberate, or suggest a perpetrator.

325. The forensic pathologist should limit the opinion to areas within his/her expertise. Where consultations have been made with other physicians the scope of those consultations and the reliance of the forensic pathologist on the information obtained should be set out in writing.

326. The forensic pathologist should avoid vague or unclear terminology about the certainty with which an opinion is held. As far as possible, the pathologist should use everyday language to signal the degree of certainty: possible, likely, more likely than not, highly likely, certain. If an explanation for a death provided by the family of the deceased or a caregiver cannot be excluded by the forensic pathologist as a possible cause of death, that should be specifically outlined in the report.

327. There should be clear guidelines on when post mortem examination reports are to be finalized. Breach of those guidelines should result in notification to the person responsible for quality assurance and, if repeated, to the Chief Forensic Pathologist.

(e) The Testimony

328. There should be guidelines for all forensic pathologists giving evidence in court in Ontario. These guidelines could be promulgated by the accreditation agency or by the CPSO as part of a broader initiative dealing with physicians giving expert evidence.

329. The guidelines should cover the overriding obligation of the pathologist as an expert witness to the court, the need to avoid speculation or testifying outside one's area of expertise, the obligations of the pathologist with respect to disclosure of opinions and the basis for those opinions, the obligation to fairly and accurately describe the scientific literature, and the need to avoid becoming an advocate for any particular party.[315]

330. As a best practice, the Crown and the defence should be encouraged to allow communication between pathologists in advance of testimony, including if possible a meeting to narrow issues and seek consensus. Such a meeting should be held on a without prejudice basis, in the absence of counsel for the parties.

331. OCCO should, as part of its quality assurance program, institute a questionnaire along the lines of that employed by CFS to canvass Crown and Defence after the fact of testimony in a particular case. In addition, staff pathologists should have opportunities to watch other pathologists testify.

(f) Quality Assurance

332. The existing peer review process described in the 2007 Autopsy Guidelines should be adopted, with the modifications described below.

315 Useful guidelines to consider are those submitted by AIDWYCC on January 16, 2008 (PFP302733)

333. Responsibility for quality assurance should not be solely that of the Chief Forensic Pathologist. There should be a staff position at OCCO dealing specifically with quality assurance.

334. Random audits of a percentage of completed post-mortem reports should take place on a regular basis to monitor compliance of all reports with the Autopsy Guidelines.

335. In child death cases where the coroner is likely to conclude that the cause of death is homicide, the post mortem report should be the subject of a more detailed technical review by another forensic pathologist, if possible outside the unit, whose mandate should include a thorough review of the report to determine whether the conclusions are reasonable and transparent.

336. In any case where it appears that the forensic pathologist's opinion will be the primary basis on which charges are laid or child protection proceedings will be brought (i.e. where there is an absence of any circumstantial evidence suggesting homicide), the Chief Forensic Pathologist must obtain an independent opinion of the cause of death from a respected pathologist outside the Province.

337. Where possible, the coroner or regional coroner should be assigned to death investigations based on medical expertise. For example, a case involving a deceased with penetrating wounds should be assigned to a coroner or regional coroner with emergency medicine expertise. This should provide an additional potential quality assurance check on the opinions reached by the pathologist.

(g) The Role of the Police

338. Police forces should develop expertise in pediatric death cases which can be accessed quickly when necessary. (In practice, such expertise could only be developed by the OPP or Metropolitan Toronto Police Force but should be accessible by local police forces.)

339. There should be a section devoted to child homicide deaths in the Major Case Management Manual in use across the Province. That section should cover information to be provided by the police to forensic pathologists during the course of the death investigation, as outlined above. It should also recommend direct contact between the officer in charge of the investigation and the pathologist.

340. Police officers should be required to take notes during post-mortem examinations and of any communications with the forensic pathologists or coroners.

341. Any opinions received from forensic pathologists must be in writing and be documented clearly.

(h) The Role of the Crown

342. The recommendations of the Attorney General's committee should be adopted, with the following modifications.

343. The Child Homicide Committee should have an explicit role in precharge screening.

344. The Committee should be accessible to the defence.

345. In a case where parallel criminal and child protection proceedings are underway, the Crown should ensure that all information relevant to pathology opinions, especially any

uncertainties about those opinions, or any changes in those opinions, are communicated in a timely fashion to the CAS.

346. There should be joint Crown and defence education sessions focussed on current issues in pediatric forensic pathology.

(i) The Defence

347. In a case where a suspect is identified by the police prior to the post mortem examination, if that person engages a pathologist, that pathologist should be entitled to participate in the initial autopsy.

348. The Ontario Legal Aid Plan should be encouraged to develop guidelines for the prompt approval of funding requests related to this issue.

349. In criminally suspicious cases, guidelines for disposal of a child's body should ensure that disposal does not happen until the family has been advised in writing of their right to a second autopsy and has confirmed in writing that they do not wish such an autopsy to take place.

350. The list of pathologists on the roster described above should be available to the defence.

(j) Role of The Child Protection Agency

351. Neither the coroner nor the pathologist should play any direct role in the decision-making leading to child protection proceedings, nor should they play an advocacy or public awareness role relating to child abuse.

352. CAS agencies should be advised by OCCO through a guideline that the differing standard of proof between criminal and child protection proceedings should not serve as a lowered barrier to allow pathology opinions or conclusions to unduly influence child protection proceedings.

353. CAS agencies, local police forces, and local Crown Attorney offices should be encouraged to develop protocols to govern sharing of information during the investigation and prosecution of a suspicious child death. Such protocols should encourage the full exchange of all scientific evidence and opinion, including that exculpatory to any potential suspect.

(k) The Role of the Family

354. OCCO should be charged with creating, subject to the approval of the Governing Council, an explicit charter of bereaved persons governing relations between those involved in the death investigation process and bereaved families.[316]

355. The *Coroners Act* should explicitly provide that in all circumstances the family is to have immediate access to the post-mortem report on completion, regardless of whether a criminal or child protection investigation is underway, or whether a decision regarding an inquest has been made.

356. The *Coroners Act* should be amended to provide that an application for an exhumation should be made to a judge on notice to the family members concerned.

316 Useful guidelines are provided in the Report of the Sudden unexpected Death in Infancy Working Group in the United Kingdom (the "Kennedy report")

(l) Corrective Measures

357. There should be an independent complaint process established under the *Coroners Act* for members of the public or others affected by findings made by a coroner or forensic pathologist during the death investigation. That process should have three components.

358. First, in the case of a complaint about a coroner, there should be an informal complaints investigation process which allows the affected person to complain in writing to the Chief Coroner of Ontario, and, in the case of a complaint about a pathologist, to the Chief Forensic Pathologist of Ontario. Those receiving the complaint should have an obligation to investigate the complaint and determine what action, if any, should be taken in response within a defined time period. For forensic pathologists, the authority of the Chief Forensic Pathologist in response to a complaint should include: (a) requiring that a pathologist undergo remedial measures as a condition of continuing to conduct coroner's autopsies, (b) a written reprimand, (c) suspension, and (d) removal from the roster. Any decision should be communicated in writing to the person initiating the complaint.

359. Second, a person making a complaint should have the right, if not satisfied with the outcome of the informal complaints process, to have the complaint independently reviewed by a Complaints Committee established as a subcommittee of the Governing Council established above. That committee should have the capacity to hold hearings to determine the validity of a complaint.

360. Third, the Chief Coroner and/or Chief Forensic Pathologist should be obliged to commence an investigation into the conduct of a specific coroner or pathologist whenever

OCCO learns of information suggesting that such person has failed to comply with appropriate standards, regardless of whether a complaint is received from the public.

361. There should be a protocol established as part of the Coroners Manual to determine how and when complaints made about forensic pathology should raise systemic issues which go beyond the specifics of the particular complaint. That protocol should establish a mechanism by which cases could be reviewed retrospectively to determine whether a miscarriage of justice may have occurred. It should outline warning signs that might demonstrate when a problem goes beyond one of reasonable differences between experts.

(m) General

362. The Commissioner should recommend that the Government of Ontario establish a compensation process for those affected by the conclusions of Dr. Smith during the mandate of this Inquiry.

363. Those included in such a process should include anyone charged criminally or made the subject of child protection proceedings as a result of errors identified during this Inquiry, or which have arisen out of Dr. Smith's work, provided that such proceedings have terminated in the person's favour or have been overturned by the courts. The families of those affected should also be entitled to participate in such a process.

364. The Government should appoint an Assessment Officer charged with making recommendations to the Province regarding compensation in any particular case. The Assessment Officer should be entitled to rely upon evidence adduced at this Inquiry in making such recommendations. The authority of the Assessment Officer should extend to

recommendations regarding monetary compensation, counselling and other measures as he or she deems fit. The compensation process should be informal and expeditious. Any family not prepared to participate should be entitled to pursue civil remedies in the courts.

365. AFG adopts the recommendations of Children's International regarding the appropriate steps to be taken to notify children adopted or subject to Crown wardship as a result of errors made by Dr. Smith.

366. AFG supports the recommendations of other parties with standing regarding the necessity for a further review of shaken baby cases in Ontario in the years covered by the mandate, given the uncertainties of the science.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

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Peter C. Wardle
Wardle Daley Bernstein LLP

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Daniel Bernstein
Wardle Daley Bernstein LLP

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Julie Kirkpatrick
Barrister & Solicitor