IN THE MATTER OF the *Public Inquiries Act*, R.S.O 1990, c. P. 41

AND IN THE MATTER OF

THE INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO
The Honourable Stephen T. Goudge, Commissioner

SUBMISSIONS

OF

DEFENCE FOR CHILDREN INTERNATIONAL - CANADA (DCI-CANADA)

A Party with Standing at the Inquiry

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I N D E X

PART I – OVERVIEW

1. Defence for Children International-Canada (DCI) recommends that the Commission of Inquiry into Pediatric Forensic Pathology make findings of fact and recommendations to restore public confidence in pediatric forensic pathology. DCI suggests recommendations in the following areas:

(a) redesign of the death investigation to promote independence, oversight and accountability;

(b) righting the wrongs relating to surviving children;

(c) development of a model joint protocol for police and children's aid societies;

(d) pediatric death review;

(e) use of opinion evidence relating to allegations of child abuse;

(f) surveillance of parents who have lost children; and

(g) prevention of miscarriages of justice in child welfare proceedings.

2. DCI has focused on the areas in which it believes it can be of most assistance to the Commission. It has not provided an exhaustive review of the evidence but has enhanced a chronology used by the Commission and it is attached as Appendix "A". An overview analysis of the proceedings relating to surviving children is attached as Appendix "B". Our submissions are organized by stating the recommendation proposed followed by the rationale and evidentiary foundation for the recommendation.

3. DCI recognizes that child abuse and neglect is a serious problem in our society. We also recognize that child abuse and neglect is often difficult to detect, either because it takes place within the family and home, or because it is perpetrated by community members in positions of trust. Governments play a vital role in protecting children from abuse and neglect, first by preventing abuse and neglect, and second by responding to instances of abuse and neglect appropriately. This is recognized in Article 19 of the United Nations Convention on the Rights of the Child. Article 19 states:

> 1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
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> 2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.[1]

4. DCI submits that the serious miscarriages of justice before this Inquiry reveal many flaws and failures in the criminal justice system, child protection system, and in pediatric forensic pathology. However, these problems do not take away from the legitimacy or urgency of child abuse and neglect prevention.

5. DCI is grateful for the opportunity to participate in this Inquiry and hopes that its participation was useful to the Commission and that our submissions are of assistance.

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[1] PFP151750, page 5

PART II - REDESIGN OF THE DEATH INVESTIGATION TO PROMOTE INDEPENDENCE, OVERSIGHT AND ACCOUNTABILITY

Recommendation 1:

DCI recommends that the *Coroners Act* be amended to provide for:

- **the codification of the role of the pathologist;**
- **the creation of the role of forensic pathologist and regional deputies;**
- **the creation of the independence of the pathologist from the coroner;**
- **the codification of the roles of deputy chief and regional coroners;**
- **the creation of non-medical death investigators;**
- **the creation of the Governing Council for the Office of the Chief Coroner to whom both the Chief Coroner and the Chief Forensic Pathologist report;**
- **the creation of accountability mechanisms for fee for service providers to the OCCO;**
- **the creation of a complaints system allowing for complaints to be made to a committee of the Governing Council regarding those performing a statutory duty pursuant to the *Coroners Act* and permitting a joint investigation with the appropriate professional regulatory body;**
- **a separation of the investigation and judicial coronial functions with OCCO so as to create separate investigative and judicial coroners;**
- **the use of tissue from post mortem purposes for research with consent; and**
- **standards for terminology describing the cause and manner of death.**

Rationale and Evidentiary Foundation:

6. DCI respectfully submits that both the institution of the Office of the Chief Coroner (OCCO) was an insular and unaccountable organization and the individuals in charge of pediatric death investigations failed personally to prevent miscarriages of justice and a crisis in pediatric forensic pathology. It recommends that the Commission

make findings of fact to that effect as outlined in more detail below. DCI recognizes that it was not directly involved in the events in question, and that our role in the Inquiry is in the nature of a "public interest" party. We appreciate the gravity of recommending this finding and we do not make this recommendation lightly.

7. DCI's past experience with child deaths tells us and the evidence heard in this Inquiry confirms that systems designed to serve and protect children fail for a number of reasons, including systemic causes and the attitudes and actions of individuals, particularly those in charge. An organizational culture that shuns openness and accountability is often a major cause when institutions fail children.

8. A flawed organizational culture is partly the result of systemic or structural factors such as flawed organizational design, poor accountability structures and lack of resources. However, it is not a purely systemic phenomenon. This is because organizational culture is created and reproduced by the members of an organization, and most of all shaped by those in charge. Furthermore, individuals, especially those in charge, can play a more powerful role than systemic and structural factors because: (1) these individuals have the power to shape the organization, and may therefore be responsible for the systemic and structural factors, and (2) through their exercises of authority and discretion, these individuals are able to increase or decrease the effectiveness of whatever accountability structures may be in place.

9. Therefore, in order to understand how OCCO became so insular and in order to prevent this problem in the future, we must identify the contributions of individuals as well as systemic and structural factors. In short, confronting the flawed organizational culture within OCCO requires that the Commission make findings in respect of the role of Dr. Young, Dr. Cairns and Dr. Smith.

10. We believe that addressing their contributions to the failure is the first step in restoring accountability and openness to the coroner's office and pediatric forensic pathology in Ontario. This in turn will help to restore confidence in the coroner's office and pediatric forensic pathology in Ontario.

(a) Institutional Culture

11. DCI submits the Commission should find that Dr. James Young, Dr. Jim Cairns and Dr. Charles Smith contributed to the crisis in pediatric forensic pathology by virtue of the culture of their leadership.

12. Each was committed to either a personal interest or ideology. For Dr. Young, it was the protection of his office. For Dr. Cairns, it was the pursuit of an improved death investigation for children based on his vision of what was right. For Dr. Smith, it was to carve out a niche as the leading pediatric forensic pathologist and protect his position within the Hospital for Sick Children. Each needed each other to fulfill their pursuits. The product was an organizational culture that was so insular, so immune to criticism and so lacking in accountability that someone who was dogmatic, arrogant and ignorant could thrive.

13. Dr. Smith has admitted that he was all those things and more. All things that speak to both his competency and his ethics:

- he was an advocate;
- he was an advocate for the Crown;
- he gave confusing testimony;
- he went beyond his expertise;
- he saw himself as a member of the prosecution team; and
- he was profoundly ignorant.[2]

14. Their shared vision, exposing child abuse by death investigation, was championed by the media and fuelled a moral panic[3] that parents were getting away with murder.[4] The panic appears to have reached its zenith in the Spring and Summer of 1997, which saw:

- the Ontario Child Mortality Task Force released its interim report in March, 1997 and Final report in July, 1997;

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[2] Evidence of Charles Smith, February 1, 2008, page 95, line 13 to page 96, line 12

[3] Cheryl Regehr et al, "Inquiries into Deaths of Children in Care: The Impact on Child Welfare Workers and their Organization" *Children and Youth Services Review* Vol. 24, No. 11, pp641-644 (third page of produced version), PFP175284:

> Inquiries have become prominent and powerful institutions. They are a socio-political phenomenon which has wide ranging effects on public policy and service delivery (Hill, 1990). In part, inquiries help society deal with *moral panic*. The public attention becomes focused on a phenomenon of child deaths, which is not necessarily drive by an increase in incidence but instead a surge in attention. Inquiries are a means for government to demonstrate concern for an issue and to appease the public (Hill, 1990). Inquiries themselves have taken on a tone of the moral righteousness. The motto of the Chief Coroner's Office for Ontario for instance reads "we speaking for the dead." Broad statements recommending sweeping changes on the basis of dramatic cases can therefore not be questioned in this climate of might and right. (emphasis added)

[4] PFP141054, PFP141102, PFP141029, PFP056087, PFP302071 at pages 3 to 4

- *The Toronto Star* ran its "Cry for the Children" series in March, April and May, 1997;
- the inquests into the deaths of Shanay Johnson and Kasandra;
- *The Toronto Star* call for inquests to be mandatory for children who die while under the supervision of the CAS; and
- Jordan Heikamp dies of starvation on June 23, 1997 at the age of 5 weeks.[5]

15. The climate was ripe for absolute trust to be placed in the death investigation system. During this wave of moral panic and absolute trust, investigations were being conducted into the deaths of Joshua, Jenna, Sharon, Nicholas and Jordan, a preliminary inquiry was conducted into the death of Taylor and inquests were conducted into the death of Kasandra and Shanay Johnson who died as a result of violence by her caregiver.

16. In our submission, in this insular culture, together with the unique opportunity afforded by society's increasing awareness and repugnance of child abuse, Dr. Smith flourished.

17. It is important to recognize that the impact of this institutional culture is far-reaching. First, the experiences of those investigated, charged and in some cases convicted as a result of Dr. Smith are well understood. Second, surviving siblings and future born children were also affected. The overview reports provide some detail to their experiences. A chart, summarizing what is known about the child welfare proceedings is attached as Appendix "B" to these submissions. It is fair to say, that as

[5] This progression is laid out in the chronology attached as Appendix "A" to these submissions.

the result of Dr. Smith's opinion at least 17 children were taken into the care of the state and three children were placed for adoption. Those not adopted, appear to have been ultimately returned to their families after the criminal charges were dealt with by the court. Third, the findings in these cases appear to have influenced the academic literature. Dr. Pollanen's article "Fatal Child Abuse Maltreatment Syndrome" appears to draw its conclusions from many of the cases here.[6] Finally, Dr. Smith's inquest work led to 73 recommendations in the Kasandra inquest[7] which formed a platform for the reform of the *Child and Family Service Act* in May, 1999[8].

18. Dr. Cairns and Dr. Young introduced Dr. Smith as the leading authority in either the country or the continent.[9] The only pediatric forensic pathology training in which Dr. Smith participated was training given by himself.[10] He was invited by OCCO throughout the 1980's and 1990's to deliver training and the Coroner's office encouraged him to develop expertise in pediatric forensic pathology.[11] It was advantageous for OCCO to have someone with expertise in Child Abuse and Neglect.[12] They needed Dr. Smith and Dr. Smith needed them.

(b) Institutional Structure

19. DCI submits that the institutional structure also lent itself to being insular and lacked accountability. For example:

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[6] PFP302067, if one look to the descriptive information about the 21 cases in review, many of them could be the cases under review here
[7] PFP000537; PFP000540
[8] Final report of Child Mortality Task Force, PFP057218; Bill 6 PFP303742, page 1
[9] Evidence of Michael Pollanen, December 5, 2007, page 263, lines 11 to 21
[10] Evidence of Charles Smith, page 25, line 25 to page 27, line 9
[11] PFP095493; Cross-Examination of Dr. Cairns, November 28, 2007, page 104, line 12 to page 107, line 9
[12] Cross-examination of Dr. Cairns, November 28, 207, page 109, line 25 to page 110, line 11

- OCCO is housed within the Ministry of Community Safety and Correctional Services which is the Ministry also responsible for policing and corrections;
- the Coroner's Council was eliminated in 1997;
- there was no posting of the position of Director of the OPFPU and Dr. Smith appears to have been chosen by Dr. Phillips and Dr. Young without a competition despite the fact that many pathologists at the HSC were doing forensic work at the time of the creation of the OPFPU[13];
- no member of the Death Under Five Committee is from outside of the Greater Toronto Area;[14]
- the agreement between the CPSO and OCCO regarding the College's jurisdiction over a physician performing a service pursuant to a coroner's warrant[15];
- the Regional Pathologists testified that the attitude of the "Toronto Office" was becoming more collegial and less isolationist"[16] since Dr. Pollanen had become the Chief Forensic Pathologist;
- the Regional pathologists thought it was a step forward for Dr. Pollanen to have actually *visited* their facilities;[17]
- even when Dr. Chiasson was Chief Forensic Pathologist he was made to think, at least for a brief time, that his place was in the autopsy suite;[18]

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[13] Evidence of Ernest Cutz, December 18, 2007, page 17, line 6 to page 19, line 7; PFP134457, Evidence of James Young, November 30, 2007, page 31, line 1 to page 32, line 1
[14] PFP057188, Report of Pediatric Death Review Committee and Death Under Five Committee at page 29
[15] PFP145594, PFP145609
[16] Evidence of Drs. Rao, Skhrum and Dexter, January 18, 2008, page 143, line 21 to page 144, page 24
[17] Evidence of David Dexter, January 18, 2008, page 144, lines 12 to 24
[18] PFP129449

- the CHEO pathologists stated there was a need for more collegiality and cited the manner in which the decision to prohibit CHEO from conducting autopsies in criminally suspicious cases was made[19];
- for 10 years while occupying the position of Assistant Deputy Minister and Chief Coroner, Dr. Young essentially reported to himself[20];
- Dr. Young apparently did not read much (he just scanned things)[21] and he did not write (he wasn't a documenter, he didn't have time to write)[22]; and
- Dr. Cairns never gave consideration to resigning in view of his failure to monitor, supervise and remove Dr. Smith.[23]

20. DCI therefore makes recommendations for the redesign and renewal of the death investigation process which will foster independence, oversight and accountability which reflects and responds to the community that it is intended to serve. To this end, DCI submits that the following statement, taken from *Death Investigation and the Coroner's Inquest*, provides the principles necessary for the redesign and renewal of the death investigation system in Ontario:

> Death investigation in a community needs to be an integrated process that brings together all those who can contribute to the public well-being. This principle should underpin the design of any death investigation system, whether it is based around administrative services, the medical profession, the police, or the legal profession.
>
> The elements that should guide high quality death investigation are:

[19] Evidence of Dr. Michaud, December 20, 2007, page 176, line 15 to page 181, line 3
[20] Evidence of Jim Cairns, November 28, 2007, page 233, lines 10 to 19
[21] Evidence of James Young, December 3, 2007, page 102, line 13 to page 103, line 13
[22] Evidence of James Young, November 30, 2007, page 49, line 21 to page 50, line 3
[23] Evidence of Dr. Cairns, November 28, 2007, page 99, lines 10 to 14

- a therapeutic approach to all dealings with the deceased's family and friends;
- a safe and empathic management of the remains of the deceased;
- acknowledgement of the legal rights of families, friends and practices with a legitimate interest in the death and helping them to exercise those rights;
- comprehensive employment of professionals with relevant expertise for the death investigation;
- integrated application of appropriate technologies in the death investigation;
- clear communication of the results of the death investigation to all those with and interest in the information including:
    - families;
    - friends;
    - government;
    - agencies responsible for public health and safety;
    - the health care staff involved in the prior care of the deceased;
- effective audit and validation of death investigation processes; and
- a mechanism for the continuous review and amendment of death investigations processes.[24]

21. DCI submits that the evidence reflects that independence from Government is an essential characteristic of a death investigation system but that it should not be without oversight. The Victorian Institute provides a model for this type of governance where the council provides the policy direction and operational matters are the responsibility of the Director. The codification of the role of the pathologist will assist in clarifying the obligations of the pathologist. The Chief Forensic Pathologist could report directly to the Governing Council as would a Chief Coroner. This would give the Chief Forensic Pathologist a form of independence recommended by Dr. Butt[25] and found in Victoria State.

[24] Ian Freckleton and David Ranson, *Death Investigation and the Coroner's Inquest* (South Melbourne: Oxford University Press, 2006) at page 722
[25] Evidence of John Butt, November 21, 2007, page 139, lines 2-23

22. A strong case is to be made for trained death investigators who can provide service where physicians are in short supply. DCI anticipates that the ALST-NAN coalition will make recommendations in this regard and will not review the evidence in support of the proposition.

23. A proper complaints system is essential for accountability of those exercising a statutory duty or power under the *Coroners Act* and any law reform should address this. DCI does not propose any particular model except to say that given the existing regulatory framework, it would be practical for there to be a statutory framework for a joint investigation where a health practitioner is performing a statutory duty under the *Coroners Act* and the matters touch upon professional conduct.

24. DCI has recommended that there be a separation of the investigative and judicial coronial functions. While not covered in great detail at this inquiry, inquest coroners preside over inquests. The purpose of an inquest is to answer five questions and to make recommendations to prevent deaths in similar circumstances. Inquest recommendations are kept by the verdict secretary and available to the public on request. DCI submits that consideration be given to the judicial function of coroners being separated from the death investigation side so that the public health and advocacy component does not make its way into the death investigation functions.

25. Research into SIDS has stopped in the Province of Ontario due to a lack of tissue available for review.[26] If statutory reform is undertaken, the Province should examine the use of tissue obtained through an autopsy performed pursuant to a coroner's warrant with the consent of the next of kin.[27]

PART III - RIGHTING THE WRONGS RELATING TO SURVIVING CHILDREN

DCI recommends that:

Recommendation 2:

The Provincial Government, by Order in Council, appoint a Task Force on Child Welfare Matters involving Pediatric Forensic Pathology (the Task Force) to deal with the child welfare issues arising out of this inquiry namely the identification, notification and mediation of problematic child welfare cases involving the opinion of Dr. Smith. The Government of Ontario should provide the Task Force with the necessary resources, powers and expertise to perform its duties with dispatch. The mandate of the task force would include:

- **that the process be carried out in accordance with the *United Nations Convention on the Rights of the Child* including the best interests of the child set out in Article 3 of the Convention and Article 12 which provides that a child has the right to be heard in any judicial or administrative proceeding affecting him or her;**

- **the identification of cases in which the opinion of Charles Smith (either by report, testimony, consultation or otherwise) may have affected a child welfare proceeding in Ontario between 1981 and the present;**

- **upon identification of such cases, review of the pathology work (including court testimony where applicable) by qualified forensic pathologists to determine whether the pathology was flawed (unless this has already taken place in the course of this Inquiry);**

- **identification of cases where there may have been a wrongful separation of parent or guardian from child;**

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[26] Evidence of Ernest Cutz, December 18, 2007, page 116, line 11 to page 117, line 9
[27] PFP176274, pages 4 to 5

- **creation of a process by which individuals, including children, affected by the work of Charles Smith would be notified of the developments relating to the opinions of Dr. Smith;**

- **where a CAS does not have jurisdiction regarding an affected child, to arrange for mediation support for the parents and/or guardians and children affected by the work of Dr. Smith in a child protection proceeding with a view to determining the best interests of the child. Persons identified as supportive by the child may be involved in the process;**

- **where the child is still a ward of a CAS, the issue of disclosure may still fall within the CAS's statutory mandate (as legally, it may continue to be the legal parent);**

- **where the CAS is in an actual or apparent conflict of interest with respect to a particular child for whom it must notify and mediate, the Task Force may recommend that the Task Force take the lead in this process;**

- **the Task Force will assemble an advisory panel with capacity and expertise in these matters;**

- **facilitate the introduction of children (even if they are now adults) to parents or guardians from whom they may have been wrongly separated, if so desired by the child;**

- **make recommendations for the reimbursement of any legal costs incurred by parents in any child protection proceedings that were in any significant measure based upon the erroneous opinion of Dr. Smith;**

- **make recommendations for the removal of names from the Child Abuse Register if there is no longer credible evidence of a history of abuse;**

- **make recommendations regarding information contained in the adoption disclosure register;**

- **identification of the options available to the child including but not limited to contact with a biological parent and their legal rights including the right to seek compensation;**

- **develop a process by which a child can state his or her contact preference on how adoption disclosure should be made (i.e. where, when, how and with whom the disclosure is made and how communication with the biological parent is to be made, if at all);**

- **provision of rights advice;**

- **arrange for the provision of counseling services or financial support for individuals already receiving health care services in respect of the emotional consequences of Dr. Smith's work;**

- **engage the Provincial Advocate for Children and Youth to oversee the identification, notification and mediation of any change to a plan of care or adoption arrangement to ensure that the best interests of the child are respected through the process;**

- **report to the Minister of Children and Youth Services on a monthly basis and to deliver an annual report to the legislature;**

- **make recommendations regarding financial compensation for those victimized by flawed pathology.**

Rationale and Evidentiary Foundation:

26. All of the panelists at the child protection roundtable shared the opinion that we have a moral obligation to the children who may have been wrongly separated from their parents as a result of the opinions of Dr. Smith and Dr. Cairns.[28] To abdicate our responsibilities in respect of those people would be irresponsible and immoral and arguably in breach of the *United Nations Convention on the Rights of the Child* such that "this must be done".[29] DCI accepts this position and submits that in order for confidence to be restored in pediatric forensic pathology, the Government must create a way to right a wrong. Dr. Smith, through this inquiry, agreed to cooperate by identifying circumstances in which he gave evidence.[30] Dr. Smith in his evidence suggested that there may be three to four other cases where he gave evidence that were not the subject of criminal proceedings but were the subject of child protection proceedings. Given the frailties of Dr. Smith's credibility and his history of providing untrue information under

[28] Evidence of Agnes Samler, February 21, 2008, page 258, lines 7 to 16
[29] Evidence of Nick Bala, February 21, 2008, page 258, line 24 to page 259, line 8
[30] Evidence of Dr. Smith, February 1, 2008, page 104, lines 8 to 11

oath[31], DCI submits that there must be a systematic review of his work to identify cases in which his opinion may have affected the outcome of a child protection proceeding.

27. At the child protection roundtable, Professor Bala proposed that legislation be enacted to provide for the identification of children who may have been affected by Dr. Smith's work and the disclosure of that information to them.[32] He also suggested that the Provincial Advocate might be the appropriate party to take on that role.[33]

28. The Provincial Advocate's statutory role is to act as an independent voice for children and youth. The responsibility of the identification of children and disclosure of that information does not fit well with its independence and could jeopardize such independence by taking on the role of providing a non-advocacy service. DCI would not want the Provincial Advocate's independence jeopardized.

29. DCI proposes that a Task Force be set up so that the interests of the children and youth can be quickly advanced under a regulatory framework rather than waiting for legislative reform. The Task Force is naturally housed with the Ministry of Children and Youth Services which funds Ontario's 53 Children's Aid Societies[34]. Furthermore, it is separate from OCCO's overseeing Ministry and has a working relationship with the Provincial Advocate.

30. The identification process will be difficult because there are 53 different children's aid societies. Some of the cases may have been resolved on consent after the

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[31] Evidence of Dr. Smith, January 29, 2008, page 89, lines 12 to 90; page 22
[32] Evidence of Nick Bala, February 21, 2008, page 261, lines 5 to 15 and lines 23 to 24
[33] Evidence of Nick Bala, February 21, 2008, page 261, lines 2 to 4; lines 19 to 22
[34] Evidence of Jane Fitzgerald, February 21, 2008, page 250, line 23 to page 251, line 5; Evidence of Nick Bala, February 21, 2008, page 251, lines 21 to 23

delivery of an opinion as in the case of Sharon's surviving sibling[35] so there will be no judgment. Professor Bala discussed starting with Dr. Smith's files. Unfortunately, Dr. Smith's admitted disorganization may not make this route particularly fruitful. It should be contemplated that it may be necessary to review every child welfare file between 1981 and the present to determine whether Dr. Smith's opinion was utilized and affected the outcome. The Task Force must have the necessary powers to compel the delivery of the documents.

31. Once a case is identified as having been affected by the opinion of Dr. Smith, it will be necessary to have a forensic pathologist review the case to determine whether the opinion was sound. The Task Force must have the necessary resources to retain this expertise.

32. It is conceivable that some children affected by the opinion of Dr. Smith are of the age of majority. They should receive the same support from the Task Force if desired and the same information regarding the legal redress.

33. All the panelists agreed that the best interests of the child should guide the process.[36] That means ensuring that the child's voice is heard and respected in the process. Our advisory panel of young people also agreed. There will be no one solution to these situations. As one of our young people said, "this isn't something you can Xerox

[35] Statement of Claim, PFP116230, page 18, para.63
[36] Evidence of Nick Bala, February 21, 2008, page 265, lines 20 to 23 and page 266, lines 24-25 to page 267, lines 1-2; Evidence of Agnes Samler, February 21, 2008, page 171, lines 15 to 17; Evidence of Jane Fitzgerald, February 21, 2008, page 177, lines 23 to 25; Evidence of Andrew Koster, February 21, 2008, page 221, line 1

and make a soft copy of and email to your friends". Each situation will be different. It will be important for the Task Force to identify skilled mediators who can help the parties navigate the disclosure process and keep the child at the centre.

34. Our child and youth advisory panel, comprised of six young people between the ages of 16 and 18 who had been in the care of the state as children as a result of being found in need of protection, met four times to discuss the issues relating to surviving children and to review the Inquiry's Roundtable on Child Protection. They made the following recommendations regarding the surviving children which, DCI submits, support its recommendation for a Task Force:

- the children have a right to know what had happened to them and what their options are;
- they should not have to wait until they are eighteen;
- the child should be informed by someone who she knows and trusts;
- the child's natural supports (like Big Sister, family, workers) should be mobilized to support the child in this process;
- the adults should respect the fact that the information about the flawed pathology might be traumatic to the child and should not deliver the information around important times (important holidays, birthdays and exam periods);
- the Provincial Advocate for children and Youth should oversee the process;
- the decision of whether the child engages with the parent should be up to the child, not the parent;
- in all circumstances, go slow and introduce the person slowly first with visits and then moving to more extensive contact;
- there be a resource centre for CASs who are managing these situations, for the parents and for the kids that can be accessed individually or collectively;

- while recognizing that the parents may be anxious for some kind of relationship, a child's wish to hold back from a relationship should be respected until the child is ready;

- while a child has a right to be heard, it is not always determinative of their best interests;

- child protection proceedings should move away from all or nothing resolutions. The advisory group was unanimous that contact should continue if the child wants to have it and if it is not harmful to the child.

Recommendation 3:

The Government of Ontario should amend Regulation 464/07 of the *Child and Family Services Act* to permit the disclosure of identifying information for the purpose of assisting the work of the Task Force.

Rationale and Evidentiary Foundation:

35. The Bala/Trocmé paper makes reference to section 168 of the *Child and Family Services Act* which allowed "the Registrar of Adoption Information to disclose identifying information to the adoptive parents, child, and the birth parents if their "health …or welfare requires the disclosure." This provision was repealed and disclosure is now governed by regulation. The regulations provide for an adoption disclosure register where those over the age of 18 may register information about themselves such that if two people apply to be contacted, their contact information will be exchanged. The regulations also provide for the disclosure of adoption information in circumstances relating to health or welfare. All the members of the child welfare panel seemed to agree that:

> [t]his would clearly seem to be a situation where such disclosure is necessary for the health and well-being of both the birth parent and child; failure to disclose this history to a child could be very traumatic to the adoptee if it is only discovered later in life, and with Ontario's new adoption disclosure laws, the adoptee would

> almost certainly be able to discover this information later in life. Disclosure should occur with a view to establishing some form of open adoption that would allow for some contact between the birth parents and children involved, assuming that this is consistent with the best interests of the child and respects the needs of the adults involved.[37]

Recommendation 4:

With respect to the notification to biological parents, adoptive parents and the affected child, the Task Force should operate with the following principles in mind:

- **the bests interests of the child;**
- **the importance of truth in an individual's health and well-being;**
- **the child is not a possession but will have wishes respecting contact which ought to be respected in accordance with his or her best interests;**
- **the financial circumstances of the biological family ought not to be determinative of any issue relating to contact.**

Rationale and Evidentiary Foundation:

36. All of the child welfare roundtable panelists agreed with the principles set above.

Recommendation 5:

The responsibility of the Provincial Advocate for Children and Youth for oversight of the Task Force should be reflected in a regulation promulgated pursuant to paragraph 15(f) of the *Provincial Advocate for Children and Youth Act, 2007,* S.O. 2007, c.9. The Provincial Advocate should be provided with the necessary resources to perform this function effectively.

Rationale and Evidentiary Foundation:

37. Section 15 of the *Provincial Advocate for Children and Youth Act, 2007*, S.O. 2007, c.9 provides that:

> The functions of the Advocate are to,
>
> (a) provide advocacy to children and youth who are seeking or receiving approved services under the *Child and Family Services Act*;

[37] Nick Bala and Nico Trocmé, *Child Protection Issues and Pediatric Forensic Pathology*, PFP303762, at page 63

(b) provide advocacy to young persons who are being dealt with under the *Ministry of Correctional Services Act*;

(c) promote the rights under Part V of the *Child and Family Services Act* of children in care and the rights under Part V of the *Ministry of Correctional Services Act* of young persons in custody;

(d) provide advocacy in accordance with clause 16 (1) (k) to children who are pupils of provincial schools for the deaf, schools for the blind or demonstration schools under section 13 of the *Education Act*;

(e) provide advocacy in accordance with clause 16 (1) (l) to children and youth with respect to matters that arise while held in court holding cells and being transported to and from court holding cells; and

(f) provide any other advocacy that is permitted under the regulations or any other Act.

38. The Government, therefore, through regulations promulgated pursuant to paragraph 15(f), may prescribe other functions of the advocacy office. The Provincial Advocate is well-suited to oversee this process as it is charged with providing "an independent voice for children and youth" and "encouraging communication and understanding between children and families".[38] It is independent from Government which is desirable. It has the necessary experience in advocating for young people to assist with the process and ensure that the rights of the surviving children are respected at each step of the process.

Recommendation 6:

The Government of Ontario amend Regulation 464/07 of the *Child and Family Services Act* to permit the disclosure of identifying information for the purpose of assisting the work of the Task Force on Child Welfare Cases involving Pediatric Forensic Pathology.

[38] *Provincial Advocate for Children and Youth Act, 2007*, S.O. 2007, c.9, section 1

Rationale and Evidentiary Foundation:

39. The Inquiry's research on this topic recommended that disclosure could be made in accordance with section 168 of the Child and Family Service Act.[39] Those provisions have been repealed and adoption disclosure is now governed by Regulation 464/07 which governs the disclosure of identifying information regarding adopted children, adoptive parents and biological relatives. The Task Force will need to access adoption disclosure information in order to effect its mandate. This can be accomplished by Order-in-Council.

PART IV – DEVELOPMENT OF A MODEL JOINT PROTOCOL

Recommendation 7:

The Minister of Children and Youth Services should take the lead on the development of a model protocol for children's aid services for the investigation of and response to cases in which there is a suspicion of child homicide by a parent or guardian. The aim should be for the creation of local joint investigation protocols between the local police, the coroner's office and children's aid societies. Recognizing that the statutory mandate of CASs is to protect children (including the harm that could be caused by wrongful separation), the protocol should reflect:

- **the best interests of the child and the need for the child to be heard in every proceeding that affects them in accordance with Articles 3 and 12 of the *United Nations Convention on the Rights of the Child*;**
- **the need for the CAS to have timely and equal access to information gained through the police investigation.**

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[39] Nick Bala and Nico Trocmé, *Child Protection Issues and Pediatric Forensic Pathology*, PFP303762, at page 63

Rationale and Evidentiary Foundation:

40. There is no principled reason why the criminal investigation should be seen as of greater value than the child welfare proceedings.[40] The inquiry heard from Ed Bradley, Crown Attorney [41], Andrew Koster, Jane Fitzgerald[42] and Dr. Eden[43] about the benefit of a joint protocol. Both Andrew Koster and Jane Fitzgerald spoke to the appropriateness of MCYS taking the lead on this initiative and setting a protocol for the local children's aid societies to follow.

41. It should be noted that the *Protocol for Joint Investigations of Child Physical and Sexual Abuse: Guidelines and Procedures for a Coordinated Response to Child Abuse in the City of Toronto*, Fourth Edition, May 2006, provides at page 13 (Part VI - 4.) that:

> (a) A joint police/CAS investigation will occur in all situations where a child has died under suspicious circumstances, or as a result of abuse and/or neglect, and there may be other children at risk.
>
> (b) Where there appear to be no other children at risk, police will, at a minimum inform a CAS as to the circumstances surrounding the child's death if it is suspected or known that the child died as a result of abuse and/or neglect.
>
> *(c)* The principles of mutual reporting and information sharing are essential and continue to apply in these serious situations. However,

[40] Bala and Tromce, PFP303762, pages 64 to 65; Evidence of Nick Bala and Andrew Koster, February 21, 2008 at page 181, line 20 to 184, line 13
[41] Evidence of Ed Bradley and Brian Gilkinson, January 22, 2008, page 192, line 4 to page 204, line 22
[42] Evidence of Andrew Koster and Jane Fitzgerald, February 21, 2008, page 186, line 23 to page 188, page 18
[43] Evidence of Dr. Eden, January 25, 2008, page 137, line 19 to page 139, line 18

> *in the event of the death of a child, the police may limit the sharing of information so as not to compromise an investigation.* (italicized emphasis added)[44]

42. While this is a concern expressed by some witnesses, there does not appear to be a principled reason for the primacy of the criminal investigation. There was a prevailing undercurrent to the policy that the death investigation process somehow could play a role in preventing child abuse. Dr. Cutz's supplementary statement to the Commission suggests, in support of a division of work between OCCO and the HSC, that "to ensure that infants and children are protected from harm and abuse, the remaining ten per cent of cases that include clear homicides or criminally suspicious deaths are best handled by forensic pathologists"[45]. At its best, a death investigation will exonerate the innocent and recognize a perpetrator of a crime.[46] It is our hope that the death investigation system will identify a perpetrator where there is a crime. But it is a leap to say that quality death investigations will necessarily protect children. This may be so where there are surviving children, however, as Professor Bala points out, there may not be research to support this[47]. The best protection for children is to prevent child abuse before it happens. For the deceased child, the post-mortem has no meaning.

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[44] Protocol for Joint Investigations of Child Physical and Sexual Abuse, PFP304223
[45] PFP176274, page 2, para. (b)
[46] Evidence of David Chiasson, December 11, 2007 page 181, line 14 to 182, line 1
[47] PFP303762, Bala and Tromce, page 67

PART V - PEDIATRIC DEATH REVIEW

Recommendation 8:

The mandate of the Pediatric Death Review Committee be the subject of a comprehensive review to assess its purpose, membership, independence and reporting relationship with a view to creating a viable method of reviewing the deaths of children and making effective and meaningful recommendations to an appropriate body.

Recommendation 9:

The pediatric death review committee and death under five committees should continue in existence and function as expert advisory committees to the regional coroners on medically complex cases. Regional representation on the committees should be encouraged and pathologists or physicians who have been involved in a case going before the committee should be invited to attend to discuss the case with the expert tribunal.

Recommendation 10:

There should be an Ontario Pediatric Death Review Team funded by the Province of Ontario and independent of the Office of the Chief Coroner and Government for the purpose of providing information about child deaths and to prevent or reduce the number of deaths of Ontario children from birth to 18 years. The Death Review Team should have research functions, maintain a register of child deaths, classify the deaths according to demographic criteria and cause of death and other relevant criteria, identify patterns and trends relating to the deaths and make recommendations to government and non-government agencies for the prevention of further child deaths. At a minimum, there should be an independent, transparent and public review of the deaths of children who die in the care of the state including secure and open custody, children's mental health facilities and cases where there may be an open CAS investigation but the child is in the custody of a parent or caregiver.

Rationale and Evidentiary Foundation:

43. Any civilized society will care about how its children die.[48] The PDRC in its current form has not met its full potential in this regard. The problems with the PDRC are as follows:

[48] Evidence of Christopher Milroy, November 23, 2007, page 110, lines 12 to 18

- it operates virtually in secret delivering only two reports in 19 years with only minimal analysis of the data on child deaths in Ontario;[49]
- if the current funding agreement is not renewed, there will be no further reports;[50]
- physicians do not necessarily receive feedback[51];
- it does not provide recommendations to the CAS as a whole;
- it does not create a public body of recommendations available in the manner that inquest verdicts are;[52]
- did not live up to the recommendation in the Ontario Child Mortality Task Force to convene a local interdisciplinary review after a case is reviewed by the PDRC;[53]
- it operates within government;
- its child welfare expertise has come from within the child welfare system[54];
- its recommendations are impractical or do not reflect the experience of the people to whom they are directed[55]
- it has not engaged the voice of children and youth[56].

44. According to Dr. McLellan, the PDRC:

> was created in 1989 in essence to deal with complicated paediatric deaths. This was an area where coroners felt they required the most ongoing assistance with their investigations, with sometimes interpreting complex medical information; so a committee was created at that time to provide expert advice to the Office of the Chief Coroner.[57]

45. The terms of reference of the PDRC outline that the committee, in some cases will determine cause and manner of death:

> On occasion, a coroner will request the assistance of one (1) of the expert committees -- Paediatric Death Review Committee being one (1) of them -- to assist with interpreting the investigation findings and to provide an opinion with respect to cause and manner of death. So, the experts on this Committee are, on occasion, asked to assist with that particular determination. That information goes

[49] Evidence of Jim Cairns, November 28, 2007, page 253, lines 5 to 15
[50] Evidence of Jim Cairns, November 28, 2007, page 253, line 16 to page 254, line 10
[51] Evidence of Drs. Skhrum, Rao and Dexter, January 18, 2008, page 137, line 14 to page 138, line 24
[52] Evidence of Dr. Lucas, January 8, 2008, page 189, line 12 to page 193, line 12
[53] PFP057218, page 36
[54] Evidence of Jim Cairns, November 28, 2008, page 242, line 6 to page 246, line 20
[55] Evidence of Barb Hancock, February 29, 2008, page 98, line 22 to page 103, line 2
[56] Evidence of Barry McLellan, November 15, 2007, page 188, lines 2 to 6; Evidence of Agnes Samler, February 21, 2008, page 267, line 16 to page 268, line 21
[57] Evidence of Barry McLellan, November 12, 2007, page 203, lines, 1 to 5, 13 to 19

> back to the corner[sic], and it's ultimately the coroner who will complete the Coroner's Investigation Statement.[58]

46. The PDRC, however, was not intended to review criminally suspicious deaths.[59]The Death under Five Committee (formerly both the Death under Two and SIDS/SUD Committee) was an offshoot of the PDRC. Its mandate is to retrospectively examine:

> the quality and results of the pediatric death investigations in Ontario. This includes the autopsy and specifically, with this Committee, it's focussing on the classification of deaths. There are a number of pathologists who sit and review the quality of the autopsies conducted and it's one (1) of the important quality assurance committees that exists at the Office.[60]

47. Dr. McLellan suggested in his evidence that the new protocol regarding Deaths under Five, the PDRC and the Death Under Five committee are quality assurance measures as the committees "add value and provide reviews of some of the most complex pediatric deaths."[61]

48. Memo 631 identified the PDRC as a member of the death investigation team thereby requiring that it too should "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.[62]

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[58] Evidence of Barry McLellan, November 12, 2007, page 222, lines 11 to 21; PFP057588, page 4
[59] Evidence of Jim Cairns, November 26, 2007, page 27, lines 12 to 17
[60] Evidence of Barry McLellan, November 12, 2007, page 222, lines 1 to 12
[61] Evidence of Barry McLellan, November 14, 2007, page 117, line 13 to 118, lines 8 to 10
[62] PFP057584 at page 352

49. On the issue which seems to be at the heart of memo 631, that child abuse was going undetected, there is no evidence from the PDRC to support it. At the time that the memo was written, the PDRC produced no reports and kept no statistics about the number of times that a death investigation had failed to detect signs of child abuse. Within OCCO, this would have been the forum from which such a premise would have been propagated but the PDRC produced no public information until its first report in 2004.[63] DCI suggests that it is a fair premise to suggest that abuse goes undetected.[64] However, the committee that would have been in the position to support this proposition in memo 631 offered nothing by way of public report until 2004 and again in 2006.

50. Dr. Cairns indicated that the intention of the "multi-disciplinary committee", the Death Under Five Committee and its predecessors was to be a central committee, focused on ensuring child abuse had not been overlooked with "override" power in determining cause and manner of death:

> it was decided that that determination at that central committee [Death under Two] would override any -- any co -- any decision that may have been made by the local pathologist or the -- or the local or regional coroner, so that's how that came in --into being.[65]

51. As significant development in the PDRC occurred in 1996 or 1997 when the Child Mortality Task Force announced some of its findings and Dr. Cairns, in response to the "temperature in the room", decided arbitrarily that the PDRC would review all cases

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[63] Evidence of Jim Cairns,
[64] Lesa Bethea, M.D. "Primary Prevention of Child Abuse", *American Family Physician*, Vol 59/No. 6, page 2 (Here Dr. Bethea suggests that it is generally accepted that deaths from maltreatment are underreported and that some deaths classified as the result of accident and sudden infant death syndrome might be reclassified as the result of a more thorough investigation) PFP175313
[65] Evidence of Jim Cairns, November 27, 2007, page 27, lines 13 to 20

where a child died with an open CAS file.[66] According to him, the Child Mortality Task Force had recommended it and he had decided to implement it.[67] Around that time, the *Toronto Star* printed a high profile series "Cry for the Children" and it ran an editorial calling for mandatory inquests into all children who die in the care of the CAS which would have effectively doubled the number of inquests in the Province.[68]

52. On his involvement with the PDRC, Detective Mike Davis' interview summary provides:

> One aspect of Mr. Davis' involvement on this Committee was to contact the officers who were involved in the investigations being reviewed by the Committee. Mr. Davis found that many officers were hesitant to speak with him about their case, given that they were not aware of the reason for his call. Mr. Davis thinks this issue may be solved by informing and educating officers about the Committee, its role, who is involved, and why an officer may be calling for information. The Committee members can also serve as valuable resource persons for officers less experienced in these cases. He agrees with the opinions expressed by others that it would be desirable to establish a process to ensure that officers can access such experienced officers for assistance[69]

It is apparent that from his perspective, the PDRC could be an investigative resource for less-experienced officers.

53. In respect of the constitution of the PDRC, it was Dr. Cairns' evidence, offered with no trace of irony, that he preferred to have doctors investigating doctors and social workers investigating social workers. It is remarkable that he could maintain this belief given that he acknowledged that the system failed to detect and/or identify the flaws in

[66] Evidence of Dr. Cairns, November 28, 2007, page 238, lines 10 to 22
[67] Evidence of Dr. Cairns, November 28, 2007, page 241, lines 3 to 7
[68] Evidence of Dr. Cairns, November 28, 2007, page 240, lines 1 to page 241, line 21
[69] PFP304376, Interview Summary of Mike Davis, page 3

Dr. Smith's work.[70] When the question of whether the CAS was insulated from review by the constitution of the PDRC, Dr. Cairns replied "I think the results speak for themselves."[71]

54. Dr. Smith was a member of the Death Under Two Committee until July, 2003.[72] For his part, while the PDRC was multi-disciplinary, it was Dr. Smith's evidence that when it came to a CAS matter, the medical professionals deferred to the child welfare people.[73] Practically speaking, it is impossible to analyze the result because of the fashion in which the committee has operated.

55. Dr. Lauwers now chairs both the PDRC and the Death Under Five Committee. He described the committees as follows:

> The Death Under Five Committee has a very limited mandate. Its mandate is just to find a manner and cause of death. The Pediatric Death Review Committee has an extensive mandate. It -- it relates to issues such as assisting -- well -- well, firstly, there are two (2) wings to the Paediatric Death Review Committee. The one wing is the child welfare expert wing, and the other wing is the -- the medical expert wing. For the child welfare expert wing, what happens is in each death in which a child dies and was under the jurisdiction or Children's Aid were involved with them in the preceding year, then generally – not generally -- in each and every case the investigating Children's Aid Society is required to file a report.
>
> Now, just to be clear about that, it's a little -- little bit -- can be a bit ambiguous in the sense that if a child dies, often that initiates a report to CAS. So what happens is there's a mandate that they have to supply a -- they have to issue a serious occurrence report that's followed by, within fourteen(14) days, a report to our office with regard to the circumstances of the death.

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[70] Evidence of Dr. Cairns, November 28, 2007, page 249, lines 6 to page 250, line 2
[71] Evidence of Dr. Cairns, November 28, 2007, page
[72] Statement of Commission Counsel, November 13, 2007, page 60, lines 4 to 20
[73] Evidence of Dr. Smith, February 1, 2008, page 105, line 8 to 106, line 4 and page 107, line 18 to page 108, line 5

> And then it's expected that within ninety (90) days they'll do a mull -- more fulsome review of the involvement of -- of their agency with the death. What can happen though is that our child welfare expert may review the circumstances and say, well, you know, clearly if a child dies in a motor vehicle accident on the Gardner Expressway, it's not necessary for the -- the CAS Society to do a fulsome report of their involvement with the child.
>
> Now, the medical arm of the Pediatric Death Review Committee, many, many child deaths are complicated medical deaths. And it's -- we will receive a package and -- with the understanding of the circumstances of the death aren't really understood. And one (1) of the expert members of the Pediatric Death Review Committee will be asked to review the medical circumstances surrounding the death.
>
> …
>
> I think the committees should remain separate, because respecting the Death Under Five Committee is primarily a committee driven around the pathology issues. It's an iss -- it's a committee that specifically looks at the proper assignation of a cause of death in a pediatric case. So that's the function of that committee. And it should be, in my view, completely isolated from the PDRC.
>
> Having said that, they can sometimes exist in a continuum. For instance, if -- if we look at the pathology report and the circumstances -- if -- if --pardon me -- if the post-mortem report examination and the circumstances are troubling and we can't reconcile them at the Death Under Five Committee, we may well send them on to the PDRC and ask for review of the death at that level.[74]

56. The PDRC's mandate does not include reporting of deaths in young people in secure custody, in open custody or in children's mental health facilities. Deaths in custody will be the subject of a mandatory inquest and deaths in the other two circumstances are reportable. [75] At the present, however, there is no PDRC review, and

[74] Evidence of Albert Lauwers, January 7, 2008, page 98 line 15 to page 101, line 7
[75] Evidence of Barry McLellan, November 15, 2007, page 188, line 9 to page 190, line 3; PFP149431 at page 79

therefore no multi-disciplinary review, of child fatalities occurring in those circumstances.[76]

57. Part of the problem with the PDRC is that it attempts to be too many things to too many people. It is one part death investigation, a second part quality assurance and a third part child advocacy. DCI submits that all three functions are important and that as soon as the committee is doing two out of three of the functions, it has a conflict. While Professor Sossin in his paper "Accountability and Oversight in Death Investigations in Ontario" suggested that the PDRC might provide some level of accountability,[77] he acknowledged in a roundtable that we may be asking the PDRC to do too much.[78]

58. As for the multi-disciplinary side, the PDRC clearly lacks an independent voice for children and youth.[79] Dr. Lauwers, now Deputy Chief Coroner and Chair of the PDRC, was quick to dismiss the suggestion that the Child Advocate be a member of the PDRC without first knowing anything about the statutory role of the Child Advocate. He did, however, acknowledge that the committee had to be alive to the voices of the children and youth who were in the care of the state.[80]

59. DCI respectfully submits that, ultimately, a timely, independent and public child death review system will help to restore public confidence in pediatric forensic pathology

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[76] Evidence of Jim Cairns, November 28, 2007, page 251, line 11 to page 252, line 3
[77] PFP, 175501, pages 47, 56, 60, 66, 68, 70
[78] Evidence of Lorne Sossin, page 175, line 3 to page 177, line 10
[79] Evidence of Barry McLellan, November 15, 2007, page 188, lines 2 to 6; Evidence of Agnes Samler, February 21, 2008, page 267, line 16 to page 268, line 21
[80] Evidence of Albert Lauwers, January 8, 2008, page 198, line 15 to page 200, line 22

and the death investigations system. Victoria State and New South Wales both have child death review teams[81] and other examples exist within Canada.[82]

PART VI - USE OF OPINION EVIDENCE RELATING TO CHILD ABUSE

DCI recommends:

Recommendation 11:

There continue to be physicians connected with children's hospitals who can perform comprehensive examinations of children who are suspected of being victims of child abuse. The court should avoid qualifying clinicians as "child abuse experts: and set the parameters for their evidence. It should be recognized that child abuse is a legal finding, not a medical diagnosis.

The use of the word "team" should be discouraged particularly when only one physician is performing the examination and assessment and rendering an opinion.

The delivery of an opinion on behalf of a "team" should be prohibited. Where members of a team have specialized knowledge such that they can contribute to an opinion, the extent of that knowledge should be the subject of a separate consultation report.

Research should continue into fatal injuries in children.

Rationale and Evidentiary Foundation:

60. Child abuse is a legal finding, not a diagnosis.[83]

61. Doctors are vital in identifying suspected child abuse and neglect because:

(a) they will often be one of the only professionals with access to a child during the pre-school years;

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[81] Evidence of David Ranson, February 13, 2008, page 171, line 16 to page 175, line 3
[82] PFP151748, page 2; PFP151765, PFP300541
[83] Kes Bethea, M.D. "Primary Prevention of Child Abuse", *American Family Physician*, Vol 59/No. 6 page 1 PFP175313

> (b) they will often be one of the only people able to detect injuries in children of all ages, where those injuries are normally concealed by clothing; and
>
> (c) in the case of hospital-based physicians (particularly in emergency departments and children's hospitals), they are uniquely placed to identify child abuse and neglect that is serious enough to require medical treatment.

62. A physician is obliged to contact a Children's Aid Society where a child is in need of protection.[84] Some physicians are reluctant to report abuse[85] and it makes sense for clinicians to be aided by a resource in identifying their obligations. Indeed, this was part of the reason for developing the SCAN team at the HSC.[86] It should be noted, however, that the obligation remains with the clinician to report where they have a *suspicion*.[87] In spite of any reluctance on the part of a physician, the obligation remains.

63. The use of the word "expert" to describe a physician whose practice relate to dealing with suspected child abuse and neglect is problematic in the absence of standards and a recognized medical specialty.[88] Those dangers are seen here. While Dr. Driver's training was "on the job" and she received no child abuse training in her residency[89], her first court experience was within a "year or two, certainly" of her joining the SCAN team. Dr. Huyer was qualified early in his career[90] and Dr. Shouldice was qualified as an expert in child abuse within one or two years of working in child maltreatment.[91] There is

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[84] Section 72(1), *Child and Family Services Act,* R.S.O. 1990, c. C.11, as amended, PFP008187; HSC Policy, PFP153004
[85] Evidence of Dr. Driver, January 9, 2008, page 31, lines 10 to 20
[86] Evidence of Dr. Driver, January 9, 2008, page 31, lines 10 to 20
[87] Section 72(1), *Child and Family Services Act,* R.S.O. 1990, c.C.11, as amended, PFP008187
[88] Gruspier, PFP175420, page 58, 78
[89] Evidence of Dr. Driver, January 9, 2008, page 44, lines 2 to 3
[90] Evidence of Dr. Huyer, January 10, 2008, page 174, line16 to page 175, line 9
[91] Evidence of Dr. Shouldice, page 176, lines 5 to 10

also a danger that the physician functions as an advocate.[92] That being said, physicians should be permitted to give evidence within their experience on their clinical findings with the proper controls.[93]

64. The use of the evidence of physicians in legal proceedings is obviously important. In children who are not yet school age, a physician may be the only adult other than the child's parents who can spot the signs of violence against children. A danger arises, when the physician weighs in on the ultimate issue. As the physician moves from personal observation to the weighing in on the ultimate issue, the constraints on the physician's evidence should tighten. The types of questions that the court needs answering cannot always be answered. There needs to be a principled approach to the introduction of opinion evidence. Fundamentally, however, statements of absolute causation that suggest a discernible uniqueness relating to an injury or finding that is without empirical foundation ought not to be permitted.[94]

65. Over the years, "the SCAN team was no stranger to controversy."[95] In making the statement, Dr. Huyer was referring to the type of opinions that it delivered and that the proceedings are "highly emotional" because children can be taken away and people can be charged criminally. He made reference to the fact that what SCAN does is not an exact science because there are no controlled studies.[96] However, the controversies went beyond those issues to judicial criticism of SCAN for, among other things, being focused

[92] Evidence of Dr. Milroy, November 21, 2007, page 124, lines 3-21
[93] DCI does not make recommendations on the use of opinion evidence but
[94] Cruspier, PFP175420, page 41
[95] Evidence of Dr. Huyer, January 9, 2008, page 223, lines 17 to 20
[96] Evidence of Dr. Huyer, January 9, 2008, page 223, line 23 to page 225, line 3

on one conclusion to the exclusion of other possibilities. These controversies were evidence in Amber's case[97] and in the judgment of Mr. Justice Nasmith.[98]

66. DCI does not believe that a physician will not be emotional about witnessing violence against children. Ethics and training can bring some measure to restraining the emotional component and the rest, DCI submits, should be up to the court and to counsel.

Recommendation 12:

Physicians, including pathologists, should employ the same criteria in making a diagnosis regardless of the court in which the evidence is to be given.

Rationale:

67. Criminal proceedings employ a legal burden of proof beyond reasonable doubt. Child welfare proceedings employ a balance of probabilities standard. As Gruspier notes, however:

> The type of proceedings in which the evidence is presented should make no difference in the level of suspicion. Just because this is a child welfare case does not mean that the level of certainty that is required to make a diagnosis should be lowered. The courts may utilize a different scale, but the forensic pathologist can only make a diagnosis based upon scientific evidence, and the nature of that evidence does not change regardless of its purpose.[99]

[97] PFP124246, pages 48 to 53
[98] PFP148271, Decision of Justice Nasmith, page 2 to 3
[99] K.L. Gruspier, "Pediatric Forensic Pathology As Forensic Science: The Role Of Science And The Justice System", PFP175420, page 39

PART VII - SURVEILLANCE OF PARENTS

Recommendation 13:

Whether under suspicion or not, parents and guardians should be entitled to receive information about the death of their child, including the post-mortem report in a caring and compassionate environment free from police surveillance and judgment. If the opportunity is lost to catch an incriminating statement, so be it. There are some forms of police action that ought not to be countenanced.

Rationale and Evidentiary Foundation:

68. The recommendation is self-explanatory. In the course of Dr. Smith's evidence, we learned that Dr. Smith allowed police surveillance of a conversation between him and a mother of a deceased child in which the post-mortem was discussed. [100]

PART VIII - PREVENTION OF MISCARRIAGES OF JUSTICE IN CHILD WELFARE PROCEEDINGS

DCI recommends that:

Recommendation 14:

Recommendations designed to remedy deficiencies identified in the criminal justice system be replicated with necessary modification where appropriate to apply to child welfare investigations:

- **funding for counsel in child welfare proceedings;**
- **development and support of effective legal advocates[101] for both parent and child in the child welfare proceeding through access to education initiatives;**
- **access to defence pathologists;**
- **funding for expert reports;**
- **the use of opinion evidence; and**
- **guarding against tunnel vision and confirmation bias.**

[100] Evidence of Charles Smith, January 30, 2008, page 6, line 16 to page 17, line 5; PFP303972
[101] PFP303762 at page 67

69. The child welfare system has always been a poor cousin to the criminal justice system with fewer resources and less prestige than the criminal justice system.[102] Challenges exist because of the lack of resources and prestige yet the effects of a miscarriage of justice in a child protection proceeding are unimaginable. Robert Buchanan in his evidence indicated that the total number of hours authorized by Legal Aid Ontario's tariff for all steps of a family law matter prior to trial was 50.[103]

70. DCI submits that the need to guard against tunnel vision is as important in child welfare investigations as in criminal proceedings. Social workers are slow to revise their judgments and:

> social workers need a greater acceptance of their fallibility and a willingness to consider that the judgements and decisions are wrong. To change your mind in the light of new information is a sign of good practice, a sign of strength not weakness.[104]

Recommendation 15:

Where there is a surviving child or child born subsequently, post-mortem report and ancillary testing be prioritized.

Rationale and Evidentiary Foundation:

71. The Inquiry heard evidence that pathology work for living children is given priority over the pathology work for deceased children. In the cases where a child is found to be in need of protection as a result of the death of a sibling, it makes sense to consider the pathology as serving a living child. The Inquiry also heard evidence relating

[102] Evidence of Nick Bala, February 21, 2008, page 137, lines 2 to 22
[103] Evidence of Robert Buchanan, February 19,2008, page 181, lines 12 to 24
[104] Eileen Munro, "Avoidable and Unavoidable Mistakes in Child Protection Work", *Br. J. Social Work* (1996) 26, 793 to 808 at 793(see also pages 799 – 806), PFP175303

to the provisions of *Child and Family Services Act* that provide for a permanent placement to be made within a year of a child coming into care if the child is under six and two years if the child is over six.[105] The statement of claim of Sharon's mother asserts that she felt she had no choice but to consent to an adoption order because her chances of release were so remote.[106]

Recommendation 16:

In making a determination about whether a child is in need of protection, courts, child welfare workers, should recognize that the choice may be between the least damaging alternative.

Rationale and Evidentiary Foundation:

72. Statistics cited by the Provincial Advocate for Children and Youth suggested that from its systemic reviews of three Children's Aid Societies, when asked if they had ever been in a bad placement, 50% of children interviewed said that they had. A bad placement meant abuse, being treated disrespectfully, being treated differently than the biological kids in the home (i.e. in a foster home placement) and for some it meant the use of restraints.[107] It is fairly telling that in child welfare, there is an expression "the least damaging alternative"[108]. It should therefore be recognized, when determining "the best interests" in a child welfare matter, by all parties and the court that a child may not necessarily be safe in CAS care.

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[105] Evidence of Agnes Samler, February 21, 2008, page 175, line 9 to 177, line 10
[106] PFP116230 at page 18
[107] Evidence of Agnes Samler, February 21, 2008, page 174, line 15 to page 175, line 5
[108] Evidence of Andrew Koster, February 21, 2008, page 221, lines 2 to 3

PART IX - CONCLUSION

73. DCI respectfully submits that these recommendations will restore public confidence in pediatric forensic pathology in the Province of Ontario.

All of which is respectfully submitted this 20th day of March, 2008.

Suzan E. Fraser
Counsel for Defence for Children International - Canada

APPENDIX "A": CHRONOLOGY

Date	Event
July 30, 1988	Amber died on July 30, 1988, at the age of 16 months.[109]
August 18, 1988	The Attorney General for Ontario consented to the disinterment of Amber for the purpose of conducting a criminal investigation.[110]
December 13, 1988	Drs. Smith and Young went to Timmins to meet with Crown counsel and the police in respect of Amber.[111]
December 15, 1988	In connection with Amber's death, S.M. was arrested in the presence of her parents and charged with manslaughter, contrary to s. 217 of the *Criminal Code*.[112]

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1989	Event
February 1, 1989	PDRC is formed.
October 15, 1989	Amber's trial commenced.[113]

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1990	Event
March 31, 1990	Dr. Young is appointed Chief Coroner of Ontario.
December 1990	Ministry of the Solicitor General creates the OPFPU at HSC.

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1991	Event
April 11, 1991	Kasandra died at the HSC in Toronto.[114]
July 25, 1991	In Amber case, decision of Justice Dunn acquitting S.M.[115]
September 23, 1991	Agreement between Ministry of the Solicitor General and HSC re: grant for OPFPU: establishment of OPFPU.
October 19,1991	Dr. Cairns becomes Deputy Chief Coroner of Investigations at OCCO.
December 13, 1991	Official Opening of OPFPU.

[109] PFP143724, para. 1, Summation page 3
[110] PFP143724, para. 54, Summation page 21
[111] PFP143724, para. 89, Summation page 31
[112] PFP143724, para. 90, Summation page 32
[113] PFP143724, para. 2, Summation page 1
[114] PFP143173, para 2, Summation page 3
[115] PFP143724, para. 2, Summation page 3

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1992	Event
January 30, 1992	Meeting of SCAN team, Charles Smith, Terri Regimbal, Mary Hall and Sandy Kingston.[116]
March 20, 1992	Gaurov died in Toronto at the age of five weeks.[117]
March 20, 1992	Gaurov's older brother was apprehended by the Children's Aid Society.[118]
May 29, 1992	Dr. Smith is appointed Director of the OPFPU.
June 17, 1992	In the case of Gaurov, Det. Prisor noted that Cst. Line had spoken with Crown counsel Mary Hall and a meeting had been arranged with Dr. Smith for June 22, 1992, at HSC. The meeting was subsequently rescheduled to June 25 and then June 26, 1992.[119]
June 26, 1992	A meeting was held in the Gaurov case involving Dr. Smith, Cst. John Line, Det. Rolf Prisor, and Crown counsel Mary Hall and Sandra Kingston.[120]
June 29, 1992	Gaurov's father was charged with second-degree murder. On the advice of counsel, he did not give a statement to police.[121]
June 30, 1992	In the Gaurov case, Det. Prisor contacted Ms. Graham of the CAS to advise her of Gaurov's father's arrest. He was advised that Gaurov's brother would remain in the care of the Verma family but that there was a family court proceeding scheduled for July 2, 1992.[122]
July 2, 1992	In the Gaurov case, Ms. Graham of CAS advised Det. Prisor that the family court formally ordered that Gaurov's brother should be returned to his mother.[123]
October 22, 1992	Kasandra's stepmother convicted[124]
November 8, 1992	Baby M was born and died in Pickering, Ontario. Criminal proceedings were initiated against Baby M's mother.[125]
November 18, 1992	Dustin died at Hotel Dieu Hospital in Kingston. Dustin was the child of Mary and Richard and was two-months-old at the time of his death.[126]

[116] Handwritten Notes, PFP153138
[117] PFP143828, para. 1, Summation page 3
[118] PFP143828, para. 4, Summation page 3
[119] PFP143828, para. 58, Summation page 32
[120] PFP143828, para. 59, Summation page 32
[121] PFP143828, para. 61, Summation page 33
[122] PFP143828, para. 62, Summation page 33
[123] PFP143828, para. 64, Summation page 34
[124] PFP143175 Kasandra Overview, para 3
[125] PFP142836, paras. 1 and 2, Summation page 3
[126] PFP142940, para. 1, Summation page 4

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1993	Event
May 23, 1993	Delaney was pronounced dead.[127]
June 21, 1993	Kasandra's stepmother paroled[128]
June 26 or 27, 1993	Valin, born in Sault Ste. Marie on February 11, 1989, died at the age of four in Sault Ste. Marie.[129]
June 27, 1993	Autopsy performed on the body of Valin at 1235 by Dr. B. Rasaiah at the Sault Ste. Marie General Hospital.[130]
June 27, 1993	Mr. Mullins-Johnson was arrested at 1830 hours and charged with the first degree murder and aggravated sexual assault of Valin.[131]
July 4, 1993	Tiffani, born in Kingston on March 24, 1993, died in Glen Miller, Ontario. Tiffani was the child of Mary and William and was three and a half months old at the time of her death.[132]
July 23, 1993	Tiffani's parents, Mary and William are arrested and charged with failure to provide necessities of life and thereby endanger the life of Tiffani and with committing an aggravated assault.[133]
November 4, 1993	In the matter of Kasandra, a Ministry of Community and Social Services interoffice memo provided information that an upcoming inquest was related to the death of the 3-year-old in the spring of 1991 and that the stepmother was charged with manslaughter and imprisoned but was currently out on parole, with conditions. The three remaining children lived with their grandparents. Peel CAS was going to court to amend the interim supervision order, to have the stepmother removed from the home and to have supervised access only.[134]

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1994	Event
January 5, 1994	*R. v. Tiffani's case* - a subpoena is issued to Dr. Smith, requesting that he appear in court on January 19, 1994 re Tiffani.[135]
January 24, 1994	Memorandum # 619 (SIDS/SUDS) 057 584

[127] PFP142877, para. 1, Summation page 4
[128] PFP143175, Kasandra Overview para 3
[129] PFP144327, para. 1, Summation page 3
[130] PFP144327, paras. 31 and 32, Summation page 12
[131] PFP144327, paras. 2 and 45, Summation pages 3 and 22
[132] PFP143440, para. 1, Summation page 4
[133] PFP143440, para. 121, Summation page 48
[134] PFP143173, para. 242, Summation pages 82, 83
[135] PFP143440, para. 161, Summation page 63

February 2, 1994	Dr. Meyer signed a Medical Certificate of Death in the death of Dustin. The certificate indicated that the immediate cause of death was: "(1) Massive subdural hematoma (2) respiratory failure secondary to a) bronchopneumonia b) aspiration.[136]
February 25, 1994	In Tiffani's case, meeting was held between Dr. Smith, Dr. Cairns, Dr. Bechard, Crown and OPP.[137]
March 30, 1994	Dr. Smith testified at a preliminary hearing in the criminal prosecution of R.B. That case was unrelated to the prosecution of S.M. in the Amber case. However, in cross-examination, defence counsel asked Dr. Smith about his evidence in the S.M. case.[138]
April 1, 1994	Dr. Chiasson becomes Chief Forensic Pathologist at OCCO.
April 25, 1994	Mother was convicted by a jury of infanticide in the death of Delaney.[139]
May 2, 1994	Decision of Coroners Council re: death of G. Montans 152 228
May 10, 1994	Letter from Dr. Cairns to Dr. Clark, requesting that Dr. Clark re-open the investigation into the death of Paolo because a sibling was in the hospital.
May 30, 1994	Dr. Cairns asks Regional Coroner to reopen investigation re: death of Paolo.
June 1, 1994	Dr. Young is appointed Assistant Deputy Minister, Public Safety Division, Ministry of the Solicitor General.
June 6, 1994	Memorandum #623 (Investigating Potential female Homicides) 032 270.
June 14, 1994	Meeting between Dr. Cairns, Durham Regional Police, Dr. Smith, Dr. Clark, and OCCO counsel re: Paolo.
June 14, 1994	Email from Dr. Smith to Dr. Cairns re: concerns about Paolo's weight and length.
July 15, 1994	Warrant for Post Mortem examination of Paolo by Dr. Smith following exhumation.
September 6, 1994	In the Valin case, the trial of Mr. Mullins-Johnson commenced before the Honourable Mr. Justice Noble sitting with a jury in the Ontario Court of Justice (General Division).[140]
September 21, 1994	In the Valin case, William Mullins-Johnson was convicted by a jury of first degree murder after a two-week trial in the Ontario Court (General Division) in Sault Ste. Marie. He was subsequently sentenced to life in prison with no eligibility for parole for 25 years.[141]

[136] PFP142940, para. 302, Summation page 111
[137] PFP143440, para. 181, Summation page 73
[138] PFP143724, para. 250, Summation page 101
[139] PFP142877, para. 2, Summation page 4
[140] PFP144327, para. 87, Summation page 44
[141] PFP144327, paras. 3 and 92, Summation pages 3 and 53

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1995	Event
April 10, 1995	Protocol for the Investigation of Sudden and Unexpected Deaths in Children Under 2 Years of Age by Dr. Cairns and the PDRC
May 16, 1995	Dr. Driver of SCAN Team examines Katharina with the following findings, "findings do not confirm or deny sexual abuse".[142]
May 19, 1995	Dustin's father was sentenced to six months in custody in the death of Dustin.[143]
September 14, 1995	In Katharina's case, court awards interim custody to father with an order for police to locate, apprehend and deliver the child to his care.[144]
September 14, 1995	In Katharina's case, police attend at Katharina's mother's apartment but conduct no search as no powers pursuant to custody Order.[145]
September 15, 1995	Katharina, born March 20, 1992 in Toronto, was found dead in Toronto at age of three and a half following further order to police to conduct search of apartment.[146]
September 15, 1995	Criminal proceedings initiated against Katharina's mother.[147]
September 16, 1995	Dr. Smith performs autopsy in Katharina's case. He informs police that the cause of death is "Asphyxia in a pattern of neck or chest compression".[148]
September 21, 1995	Dr. James Young advised HSC that the Coroner's office was investigating Katharina's death.[149]
November 30, 1995	Nicholas dies in Sudbury at 11 months of age.[150]
December 30, 1995	Dr. Smith issued his Report of Post Mortem Examination in the Katharina case with the following summary of abnormal findings, "Asphyxia (filicidal)".[151]

[142] PFP143979, para. 73, Summation page 29
[143] PFP142940, para. 1, Summation page 4
[144] PFP143979, paras. 15 and 16, Summation page 7
[145] PFP143979, para. 17, Summation page 7
[146] PFP143979, para. 1, Summation page 3 and paras. 19 and 21, Summation pages 8 and 9
[147] PFP143979, para. 2, Summation page 3
[148] PFP143979, paras. 42 and 43, Summation page 17
[149] PFP143979, para. 51, Summation page 21
[150] PFP143263, para. 1, Summation page 4
[151] PFP143979, para. 45, Summation page 18

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1996	Event
1996	Dr. Chiasson begins a general process for reviewing autopsies, particularly in homicide cases.
January 12, 1996	Katharina's case was listed as one of seven cases for the monthly Ontario Pediatric Forensic Pathology Review Unit.[152]
January 23, 1996	Joshua died at the age of four months in Trenton, Ontario.[153]
February 9, 1996	OPFPU discusses Joshua case at monthly meeting.[154]
March 7, 1996	At approximately 1800, the CAS, in the company of the police apprehended Joshua's brother. He was later placed with an adoptive family in Coburg.[155]
March 12, 1996	A court hearing was held in relation to the CAS's apprehension of Joshua's brother. Interim care and custody were awarded to CAS with weekly, supervised access for Sherry and Peter.[156]
March 27, 1996	Sherry was arrested and charged with first-degree murder in Joshua's death. She did not give a statement at that time and ultimately retained Bruce T. Hillyer to represent her on the charge.[157]
March 28, 1996	A scheduled court appearance was held in relation to the care and custody of Joshua's brother. The order for the CAS to have interim care and custody was continued.[158]
Summer, 1996	Ontario Association of Children's Aid Societies meets with the Deputy Chief Coroner to review the coroner's protocol on the investigation of deaths of children who died as a result of SIDS; identify the classification of deaths of children as Sudden Unexplained Deaths, discuss the issue of death of children in Ontario in the population at large and among those known to a Children's Aid Society and determine to conduct a review of deaths in Ontario.[159] [160]
July 31, 1996	Taylor, born on April 16, 1996, in Thunder Bay, was found dead in his cradle. He was three and a half months old at the time of his death.[161]
August 2, 1996	Police met with three CAS workers and advised them of the circumstances of the investigation and the preliminary results of

[152] PFP143979, para. 52, Summation page 21
[153] PFP143053, para. 2, Summation page 3
[154] PFP143053, para. 93, Summation page 37
[155] PFP143053, para. 112, Summation page 42
[156] PFP143053, para. 117, Summation page 43
[157] PFP143053, para. 142, Summation page 55
[158] PFP143053, para. 143, Summation page 55
[159] *Ontario Child Morality Task Force Interim Report*, PFP039972, Summation page 3

[160] Terms of Reference, PFP057218, Summation page 49
[161] PFP144275, para. 1, Summation page 3

	the post mortem in Taylor's death. Police anticipated the CAS would take legal custody of Taylor's brother, order a full investigation, and allow Laura's parents custody, possibly with conditions that Laura has supervised access only and that Lanny be restricted from any contact with the child.[162]
September 18, 1996	A press conference is held to publicly announce the Ontario Child Morality Project and to publicly announce the inquests into the deaths of seven children including an inquest into the death of Kassandra.[163]
September 18, 1996	OCCO announces changes to the purpose and expansion of the membership on the PDRC. Announces the development of a database of information on deaths of children who are known to the CASs.[164] [dr. cairns evidence]
October 24, 1996	Sheila Walsh, counsel for the Crown in the Tiffani case, wrote memorandum to Jack McKenna, Crown Attorney, regarding a F.O.I. request from Kevin Donovan, a reporter with *The Toronto Star* in which Ms. Walsh states that access to the Crown file may shed unfavourable light on individuals involved with the Tiffani family's care and police investigation of Tiffani's death.[165]
November 15, 1996	Meeting between Dr. Chiasson, Dr. Becker and Dr. Smith re: OPFPU.
November 25, 1996	Letter from Dr. Uzans to Dr. Cairns, requesting that Nicholas case be reviewed by the PDRC (Dr. Smith is subsequently assigned to the case and requests review by Dr. Babyn).
November 28, 1996	Baby F was born and died in City, Ontario.[166]
November 30, 1996	Taylor's parents, Lanny and Laura, were charged with second degree murder, criminal negligence causing death and failure to provide necessaries of life in relation to Taylor's death.[167]
December 19, 1996	In the Valin case, the Court of Appeal for Ontario, Borins J.A. dissenting, dismissed Mr. Mullins-Johnson's appeal of his conviction.[168]

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1997	**Event**
January 20, 1997	Dr. Smith provided a consultation report in the death of Baby F

[162] PFP144275, para. 71, Summation page 23
[163] *Ontario Child Morality Task Force Interim Report*, PFP039972, Summation page 5
[164] Ontario Child Morality Task Force Interim Report, PFP039972, Summation page 18
[165] PFP143440, para. 225, Summation page 100
[166] PFP142804, para. 1, Summation page 3
[167] PFP144275, para. 4, Summation page 3
[168] PFP144327, para. 4, Summation page 3

	in which he gave the following history, "This baby girl was allegedly born to a teenaged woman who had denied being pregnant. She developed postpartum complications and a subsequent search revealed the body of a baby within a plastic garbage bag in her closet. The placenta was also found. A coathanger which had been fashioned into a hooked device was found in her bedroom."[169]
January 22, 1997	Jenna, born April 21, 1995 in Peterborough, died at age of 21 months in Peterborough.[170]
January 22, 1997	Dr. Smith performed the autopsy on Jenna. At the conclusion of the autopsy, Dr. Smith advised police that the cause of death was blunt abdominal trauma.[171]
January 22, 1997	CAS apprehend Jenna's older sister on the day of Jenna's death and place her in temporary foster care.[172]
January 27, 1997	Jenna's older sister moves in with her maternal aunt and uncle.[173]
January 30, 1997	In Jenna's case a case conference is held between Peterborough Police, Dr. Smith, Dr. Cairns and Crown.[174]
February 28, 1997	In Jenna's case a meeting is held between Peterborough Police, Dr. Smith, Dr. Cairns, Dr. Clark and Dr. Young.[175]
March, 1997	Release of Ontario Child Mortality Task Force by the Office of the Chief Coroner and Ontario Association of Children's Aid Societies.[176]
March, 1997	Ontario Child Mortality Task Force Report recommends law reform to better protect children.[177]
March, 1997	*The Toronto Star* calls for inquests to be mandatory into deaths of children in the care of CAS
March 19, 1997	Letter from Dr. Becker to Dr. Chiasson, indicating that he had asked Dr. Smith to formulate a plan to improve the quality of service at OPFPU.
March 26, 1997	In Jenna's case, police assign two undercover officers to assist in the investigation. One of the officers, a female is to develop a friendship with Jenna's mother in an effort to elicit information from her.[178]
March 27, 1997	Jenna's older sister is placed in foster care for a second time.[179]
April 1, 1997	Inquest into the death of Shanay Johnson starts.[180]

[169] PFP142804, para. 34, Summation pages 12-13
[170] PFP144684, para. 1, Summation page 3
[171] PFP144684, para. 39, Summation page 15
[172] PFP144684, para. 3, Summation page 3
[173] PFP144684, para. 3, Summation page 3
[174] PFP144684, para. 54, Summation page 19
[175] PFP144684, para. 56, Summation page 20
[176] *Ontario Child Morality Task Force Interim Report*, PFP039972
[177] *Ontario Child Morality Task Force Interim Report*, PFP039972, Summation page 18
[178] PFP144684, para. 58, Summation page 22
[179] PFP144684, para. 3, Summation page 3

April 5, 1997	Memorandum from Dr. Smith to Dr. Chiasson re: difficulties in developing appropriate triage protocol and seeking assistance.
April 18, 1997	Letter to Charles Smith from Lawrence Becker regarding restrictions on surgical pathology and salary cut[181]
April 19, 1997	"Cry for the Children" series in *The Toronto Star*
April 21, 1997	An Inquest into the death of Kasandra started with Dr. Porter, Deputy Chief Coroner of Inquests, presiding. The jury heard from 56 witnesses over 34 days of evidence.[182]
April 28, 1997	In a memo, Dr. Smith raised with Dr. Cairns issues concerning consultation report practices which arose as a result of Dr. Smith's involvement in the Taylor case. Dr. Smith was uncertain whether, when he reviewed cases and provided consultation reports for other pathologists, he should send his reports to anyone other than the referring doctor, pathologist or coroner. In addition, he asked if he could bill for his time.[183]
May 2, 1997	Jenna's older sister was returned to her mother's care by order of the court.[184]
May 5, 1997	Crown counsel Sheila Walsh wrote to Dr. Smith in anticipation of his preliminary inquiry evidence in Joshua's case, which was then expected to be heard on August 11, 1997.[185]
May 7, 1997	Dr. Cairns and Dr. Smith meet with Sudbury Regional Police to discuss need to re-examine Nicholas's body.[186]
May 9, 1997	Inquest into the death of Shanay Johnson ends.[187]
May 22, 1997	Dr. Cairns authors letter to Dr. Smith in response to questions raised by Dr. Smith regarding his consultation report practices arising of his involvement in the Taylor case. Dr. Cairns responded to the issues raised by Dr. Smith as follows: *"I feel if you are requested by another pathologist to write a consultation report regarding a death that is being investigated by the Coroner then it would be appropriate to forward a copy of your consultation to the referring pathologist, investigating coroner, the Regional Coroner and myself."* [188]
June 13 and 15, 1997	Dr. Smith performs autopsy on Sharon at the Office of the Chief Coroner for Ontario (OCCO) in Toronto.[189]
June 19, 1997	Attorney General orders disinterment of the body of Nicholas.[190]

[180] Verdict of Coroner's Jury, PFP300593, Summation page 1
[181] PFP137850
[182] PFP143173, para. 250, Summation page 85
[183] PFP144275, para. 136, Summation page 51
[184] PFP144684, para. 3, Summation page 3
[185] PFP143053, para. 161, Summation page 64
[186] PFP143263, para. 58, Summation page 20
[187] Verdict of Coroner's Jury, PFP300593, Summation page 1
[188] PFP144275, para. 137, Summation page 51
[189] PFP144453, para. 48, Summation page 16
[190] PFP143263, para. 65, Summation page 22

June 23, 1997	Jordan Heikamp dies[191]
June 25, 1997	Disinterment of Nicholas. Dr. Smith was present.[192]
June 26, 1997	Dr. Smith conducts second autopsy of Nicholas
June 26, 1997	Sharon's mother, Louise Reynolds, is arrested and charged with the second degree murder of Sharon.[193]
June 30, 1997	Taylor's parents, Lanny and Laura, were discharged on all counts following their preliminary inquiry. The Crown brought an application in the nature of certiorari to quash the discharges which was later dismissed.[194]
July, 1997	Final Report of the Ontario Child Mortality Task Force.[195] "The Child Mortality Task Force recommends that upon completion of a case review of the Paediatric Review Committee the regional coroner should convene a local interdisciplinary team to consider the findings of the Paediatric Review Committee where and when local systemic issues need to be addressed." "The Child Mortality Task Force recommends that the Office of the Chief Coroner develop a protocol which will more clearly describe which of those cases where children have died should be referred to the Provincial Paediatric Review Committee."
July 7, 1997	In the Jenna case, meetings are held between Peterborough Police, Dr. Smith and Dr. Cairns.[196]
July 10, 1997	Inquest into the death of Kasandra ends with return of jury verdict delivering 73 recommendations.[197]
July 12, 1997	*Toronto Star* reports death of Jordan Heikamp[198]
July 14, 1997	Email from Dr. Smith to Dr. Cairns re: outcome ***R. v. Taylor's Mother and Father***.
July 15, 1997	In Jenna's case, the police undercover operation is resumed.[199]
July 21-23, 1997	Nicolas's father agrees to sign Consent to Intercept Private Communications between himself and Nicholas's mother. Order to intercept private communication is issued.[200]
July 29, 1997	Police install a recording device in Nicholas' father's vehicle and on his body. Nicholas' father agrees to meet with Nicholas's mother.[201]

[191] PFP141029
[192] PFP143263, paras. 65 and 66, Summation page 22
[193] PFP144453, para. 100, Summation page 44
[194] PFP144275, para. 4, Summation page 3
[195] PFP057218, Summation pages 34-37
[196] PFP144684, para. 60, Summation page 22
[197] PFP143173, para. 250, Summation page 85; Verdict of Coroner's Jury, PFP000537, pages 1-3
[198] PFP141029
[199] PFP144684, para. 61, Summation page 23
[200] PFP143263, para. 70, Summation page 23

August 6, 1997	Dr. Smith produced a Report of Post Mortem Examination in the death of Nicholas. His final opinion on the cause of death was "[c]erebral edema (consistent with blunt force injury)."[202]
August 7, 1997	Meeting between Dr. Cairns, Dr. Smith, Dr. Uzans, Dr. Deacon, Sudbury Regional Police and Crown re: Nicholas
August 10, 1997	Letter from Maurice Gagnon to Dr. Cairns re: death of Nicholas
September 8, 1997	In the Jenna case, Dr. Smith issued his autopsy report. He confirmed the cause of death as blunt abdominal trauma.[203]
September 18, 1997	Jenna's mother is charged with second-degree murder in the death of Jenna.[204]
September 18, 1997	Jenna's sister is re-apprehended by CAS following her mother's arrest and charge. A second child, M.W., born after Jenna's death, was also apprehended and placed with his father.[205]
September 24, 1997	Memo to John Bonn from John Carlisle, cc'd to James Young regarding jurisdiction of CPSO[206]
October 29, 1997	Memo to John Bonn from John Carlise[207]
November 3, 1997	Katharina's mother found not criminally responsible for Katharina's death.[208]

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1998	**Event**
January 12, 1998	Dr. Smith testified at a preliminary inquiry before the Honourable Mr. Justice S. Hunter in Quinte West in the matter of Joshua's death.[209]
January 19, 1998	Tyrell, born in Toronto on February 1, 1994, arrived at the Humber Memorial Hospital Emergency Department.[210]
January 20, 1998	Ms. MacLachlan, a member of the SCAN team involved in Tyrell's case, wrote a note contained in the Progress Notes, which stated the following, "*Jan 20/98 SCAN Note: CAS/Police have been contacted. Maureen (stepmom) is aware + says she*

[201] PFP143263, para. 71, Summation page 23
[202] PFP143263, para. 72, Summation page 24
[203] PFP144684, para. 62, Summation page 23
[204] PFP144684, para. 2, Summation page 3
[205] PFP144684, para. 2, Summation page 3
[206] PFP145594
[207] PFP145609
[208] PFP143979, para. 2, Summation page 3
[209] PFP143053, para. 160, Summation page 64
[210] PFP144019, para. 19, Summation page 10
[211] PFP144019, para. 62, Summation page 33

	understands need for this. Investigation ongoing."[211]
January 23, 1998	Tyrell died in Toronto. Tyrell was the child of Janette and Garth. Tyrell was almost four years old at the time of his death.[212]
January 26, 1998	In the Tyrell case, Nancy Dale, Executive Assistant of Client Services at the Metro CAS wrote to Regional Coroner Dr. William J. Lucas to alert him of the death of Tyrell and to advise that two other children ages 5 and 7 have been apprehended by CAS.[213]
January 26, 1998	In the Tyrell case, Det. Joseph Kispal of the Royal Canadian Mounted Police and Det. Ken McCulla of the Toronto Police Homicide Squad ("Homicide Squad") went to the family court where they spoke to Jane Anweiler, who advised them that she was counsel for Maureen in the "custody matters" only. Ms. Anweiler advised police that the custody matter would likely be adjourned.[214]
January 27, 1998	In the Tyrell case, a final autopsy report was issued, dated and signed by Dr. Smith. There were two documents labelled "Final Autopsy Report". One signed and dated with the heading "CNS Trauma". A second one was undated and unsigned and included a comment at the top that it may not match the original report format. Dr. Smith was indicated as the author. It indicated that Tyrell's case was a "converted case" and contained the contents of three other documents: (1) the Final Autopsy Report dated January 27, 1998; (2) the Report of Post Mortem Examination; and (3) the report entitled, "Central Nervous System."[215]
February 9, 1998	In the Shanon case, Dr. Smith is issued a subpoena, requiring him to appear on March 10, 1998 and to bring with him his reports.[216]
February 23, 1998	Dr. Neal Haskell returns the scalp to Dr. Smith in the Sharon case.[217]
March 8, 1998	Dr. Smith issues his Report of Post Mortem Examination in Sharon's death.[218]
March 10, 1998	The Crown provided Dr. Smith's Report of Post Mortem Examination and Dr. Wood's Forensic Odontology Examination Report to Mr. Rumble, Louise Reynolds' defence counsel.[219]

[212] PFP144019, para. 1, Summation page 4
[213] PFP144019, para. 88, Summation pages 41 and 42
[214] PFP144019, para. 88, Summation page 42
[215] PFP144019, paras. 101, 102 and 105, Summation pages 50 and 52
[216] PFP144019, para. 146, Summation page 61
[217] PFP144453, para. 150, Summation page 62
[218] PFP 144453, para. 61, Summation page 20
[219] PFP144453, para. 154, Summation page 63

March 24, 1998	In the Tyrell case, Jane Anweiler, counsel for Maureen in the custody proceedings, wrote a letter to the Health Records Department at HSC, where she indicated that she represented Maureen and enclosed a consent signed by Garth and Maureen for the release of the clinical record and autopsy report for Tyrell.[220]
March 27, 1998	In the Tyrell case, HSH replied to request made by Maureen's counsel for Tyrell's autopsy report by sending a form which stated that, "This is a coroner's case. The autopsy will have to be provided to you from them!"[221]
March 31, 1998	Meeting between Dr. Chiasson, Dr. Cairns, Dr. Lucas, Dr. Becker and Dr. Smith re: OPFPU.
April 7, 1998	CAS case conference between Sudbury Regional Police, Dr. Cairns, CAS counsel, and CAS social worker re: Lianne Gagnon.
April 21, 1998	Letter from Dr. Smith to Dr. Chiasson re: March 31, 1998 meeting re: OPFPU.
April 21, 1998	In the Tyrell case, Maureen's counsel Ms. Anweiler wrote a letter to Dr. Dworatzek indicating that she was the solicitor for Maureen and was attempting to obtain a copy of the autopsy report with respect to Tyrell. Her letter indicated that a consent signed by Maureen and Garth was attached.[222]
April 21, 1998	In the Tyrell case, Dr. Lucas wrote to Maureen's counsel Ms. Anweiler that, "*At present time relevant documents have not been received in this office. However, as soon as these documents have been received they will be forwarded promptly.*"[223]
April 27, 1998	Dr. Smith gives evidence at the preliminary inquiry into Sharon's death.[224]
May 1998	Newsletter, "From the Office of the Regional Coroner SGB," asking that all coroners and pathologists who wish to consult with Dr. Smith contact the Regional Coroner first.
May 1998	CPSO Complaints Committee Decision and Reasons re: complaint involving Amber, finding that the CPSO does not have jurisdiction.
May 8, 1998	CAS case conference between Dr. Cairns, Dr. Smith, CAS counsel and CAS social worker re: Lianne Gagnon.[225]
May 26, 1998	In the Valin case, the Supreme Court of Canada unanimously adopted the reasons of the majority of the Court of Appeal for Ontario and dismissed Mr. Mullins-Johnson's appeal.[226]

[220] PFP144019, para. 152, Summation page 71
[221] PFP144019, para. 153, Summation page 71
[222] PFP144019, para. 154, Summation page 71
[223] PFP144019, para. 155, Summation page 71
[224] Transcript, PFP076807, Summation pages 4-24
[225] PFP143263, para. 86, Summation page 30

June 15, 1998	In the Tyrell case, D/Cst. Campbell provides a statement of her anticipated evidence in which she indicates that CAS decided to apprehend both Maureen's daughter and son, "as it was felt the grandmother with whom the children were now residing could not adequately protect the children."[227]
June 16, 1998	Letter from D.M. to HPARB, requesting review of CPSO decision declining jurisdiction to hear complaint involving Amber.
June 16, 1998	In the Nicholas case, Dr. Halliday swears his affidavit in *CAS v. Gagnon*. [228]
June 16, 1998	In the Nicholas case, a telephone conference is held between CAS, Dr. Cairns and Dr. Smith re: Dr. Halliday's affidavit.[229]
June 17, 1998	In the Nicholas case, Réjean Parisé, CAS Senior counsel, faxes to Dr. Cairns the affidavit and C.V. of Dr. Halliday. Mr. Parisé also faxes to Dr. Cairns excerpts from reasons for decision of Dunn, J. in the Amber's case.[230]
June 19, 1998	In the Nicholas case, Dr. Cairns swore an affidavit on behalf of CAS in the CAS proceedings. In his affidavit, Dr. Cairns stated that he agreed with Dr. Smith's findings.[231]
June 23, 1998	In the Nicholas case, Dr. Chen, the pathologist who conducted the initial autopsy swears an affidavit on behalf of Ms. Gagnon in the CAS proceedings.[232]
June 27, 1998	Nicholas's sister was born. The Children's Aid Society of Sudbury and Manitoulin initiated proceedings against Nicholas's sister.[233]
June 29, 1998	In the Nicholas case, Dr. Smith swears a 15-page affidavit in the CAS proceedings. Dr. Smith faxed a draft version of the affidavit to Dr. Cairns and Mr. Al O'Marra on June 22, 1998.[234]
July 6, 1998	Baby F's mother pleaded guilty to infanticide contrary to s. 233 of the *Criminal Code* before Justice Harris of the Ontario Court of Justice. She was sentenced to a two-month conditional sentence, to be served at home, probation for three years, and 150 hours of community service.[235]
July 20, 1998	In the Nicholas case, Dr. Smith swears a second affidavit in the CAS proceedings rejecting Dr. Halliday's theory as implausible.[236]

[226] PFP144327, paras. 5 and 101, Summation pages 3 and 56
[227] PFP144019, para. 131, Summation page 60
[228] PFP143263, para. 91, Summation pages 31 and 32
[229] PFP143263, para. 96, Summation page 34
[230] PFP143263, para. 97, Summation page 34
[231] PFP143263, para. 101, Summation page 36
[232] PFP143263, para. 102, Summation page 37
[233] PFP143263, para. 9, Summation page 5
[234] PFP143263, para. 106, Summation page 38
[235] PFP142804, para. 92, Summation page 31
[236] PFP143263 , para. 136, Summation page 49

July 29, 1998	In the Tyrell case, Maureen's counsel Jane Anweiler wrote to Dr. Lucas indicating she had heard nothing further to his letter of April 21, 1998 and asked to be advised if an inquest had been scheduled. She again requested a copy of the autopsy report of Tyrell as the child welfare proceedings had essentially been put on hold pending receipt of the medical documentation.[237]
July 30, 1998	Letters from defence to Dr. Young and Dr. Smith, requesting further disclosure
August 10, 1998	In the Nicholas's case, a hearing was held in the CAS proceedings, with an attempt to recover over $100,000 in legal costs. Their costs were denied on September 22, 1998.[238]
August 11, 1998	In the Tyrell case, Dr. Lucas responded to Maureen's counsel Jane Anweiler indicating that he was "unable to respond to [her] request for a copy of the post mortem report as this death [was] currently under on-going police investigation." Dr. Lucas also wrote, "No decision has been made regarding whether an inquest will be held."[239]
October 15, 1998	In Joshua's case, Crown counsel Ms. Walsh sent a memorandum to S/Sgt. MacLellan, in which she outlined the Crown's offer to Sherry's defence counsel for a plea of guilty to infanticide.[240]
October 27, 1998	In the Nicholas case, letter sent from CPSO to Maurice Gagnon, declining jurisdiction over Maurice Gagnon's complaint.[241]
November 5, 1998	In the Nicholas case, letter was sent from CPSO to Dr. Young, forwarding Maurice Gagnon's complaint.[242]
December 10, 1998	Memo, "Re-visioning the Pediatric Forensic Pathology Unit," from Dr. Chiasson to Dr. Young.
December 17, 1998	In the Tyrell case, a post-it note of that date was located in a file in the OCCO stating, "Spoke to Det. S. Bronson. Do not release PM to lawyer for family yet."[243]

1999	**Event**
January 4, 1999	A new Indictment charging Sherry with infanticide was placed before the Ontario Court of Justice (General Division) in Joshua's death. Sherry entered a plea of not guilty.[244]

[237] PFP144019, para. 156, Summation page 71
[238] PFP143263, para. 186, Summation page 66
[239] PFP144019, para. 157, Summation page 72
[240] PFP143053, para. 174, Summation page 86
[241] PFP143263, para. 205, Summation page 75
[242] PFP008055, Summation page 1
[243] PFP144019, para. 158, Summation page 72
[244] PFP143053, para. 4, Summation page 3

January 6, 1999	Email from Dr. Smith to Dr. Cairns re: outcome of Joshua case.
January 7, 1999	Memo from Dr. Smith to Dr. Cairns request from counsel for Waudby's.
January 11, 1999	In Nicholas's case, Dr. Chiasson requests an independent review by Dr. Case.[245]
January 16, 1999	In the Tyrell case, the affidavit of Maureen's mother is sworn in connection to the criminal proceedings. It states that when the investigation into Maureen began, the Children's Aid Society took custody of Maureen's two children. The children were later released to Maureen's mother and father. Maureen was allowed to see her children at the C.A.S. office.[246]
January 25, 1999	Dr. Smith provides Dr. Cairns with glass slides, paraffin blocks and tissues obtained at exhumation of Nicholas.[247]
January 28, 1999	In Nicholas's case, a letter was sent from Dr. Cairns to CAS counsel, informing CAS that OCCO had sought the independent opinion of Dr. Case.[248]
February, 1999	Meeting of American Academy of Forensic Sciences, attended by Drs. Young and Cairns.
February 8, 1999	Tamara died in Scarborough. Tamara was one year old at the time of her death.[249]
February 8, 1999	Dr. Taylor issued a warrant to seize CAS's documents regarding Tamara and her family.[250]
February 8, 1999	Tamara's two sisters were apprehended by CAS and placed in foster care.[251]
February 10, 1999	Dr. William J. Lucas, Regional Coroner for Toronto, issued warrants to seize SGH's medical records as well as CAS's documents pertaining to Tamara and her family members or caregivers.[252]
February 11, 1999	The local Children's Aid Society filed a protection application in respect of Tamara's two sisters three days after Tamara's death.[253]
February 17, 1999	Complaint by Maurice Gagnon to Coroner's Council re: Dr. Smith; Maurice Gagnon forwards complaint to Dr. Young.
February 17, 1999	Counsel for Tamara's siblings' father informed CAS that his client Calverton would like to take temporary care of the two children. Calverton is the father of one of Tamara's two siblings.[254]

[245] PFP143263, paras. 153 and 156, Summation page 55
[246] PFP144019, para. 124, Summation page 58 and PFP106482, para. 7, pages 1 and 2
[247] PFP143263, para. 147, Summation page 52
[248]
[249] PFP143345, para. 1, Summation page 4
[250] PFP143345, para. 48, Summation page 19
[251] PFP143345, para. 221, Summation page 92
[252] PFP143345, para. 48, Summation page 19
[253] PFP143345, para. 3, Summation page 4; and para. 221, Summation page 92
[254] PFP143345, para. 223, Summation page 92

March 1, 1999	Meeting between Crown, TPS, Dr. Smith and Dr. Chiasson re: Athena.
March 4, 1999	In Nicholas's case, Dr. Smith sends letter to Dr. Young answering to complaint about his conduct at disinterment of Nicholas.[255]
March 6, 1999	Dr. Case produced her report in the Nicholas case.[256]
March 8, 1999	Letter from CAS counsel to Dr. Cairns and Dr. Smith, expressing concern about Dr. Cairns' role in CAS proceedings.
March 9, 1999	Letter sent from Dr. Young to Maurice Gagnon apologizing for Dr. Smith's conduct at disinterment.[257]
March 24, 1999	William Sullivan, counsel for Tamara's mother in the CAS proceedings, wrote to the OCCO requesting information as to when the Coroner's report would be completed. Dr. Bonita Porter, Deputy Chief Coroner (Inquests), forwarded Mr. Sullivan's request to the Regional Coroner Dr. Lucas.[258]
March 25, 1999	The proceedings against Nicholas's sister concluded when the local CAS withdrew its protection application.[259]
March 29, 1999	Meeting between Kingston Police, Dr. Chiasson, Dr. Cairns, Dr. Bechard and Crown re: disinterment of Sharon and second post mortem examination.[260]
April 1, 1999	Dr. Lucas wrote to Mr. Sullivan, defence counsel in Tamara's case, that he was unable to respond to defence's request for a copy of the Coroner's report because the investigation was not yet complete. Dr. Lucas also stated that Tamara's death was the subject of a police investigation and OCCO was not prepared to disclose any information that may potentially jeopardise the criminal investigation. Dr. Lucas directed Mr. Sullivan to speak to D/Sgt. Davis.[261]
April 12, 1999	Memo #99-02, "Forensic Pathology Pitfalls," from Dr. Young and Dr. Chiasson.
April 23, 1999	Dr. Ein hosted a two hour meeting re: Jenna's case (Crown, Defense, Dr. Smith, D/Cst. Lemay, Sgt. McNevan).
April 26, 1999	First reading of Bill 6, *An Act to Amend the Child and Family Services Act* in order to promote best interests, protection and and well being of children.[262]
April 28, 1999	In Jenna's case, KHCAS noted meeting with Brian Gilkinson requesting the Crown Brief. Gilkinson stated that he was unable to provide the Crown Brief as he was in the middle of a

[255] PFP143263, para. 207, Summation page 76
[256] PFP143263, para. 157, Summation page 56
[257] PFP143263, para. 208, Summation page 76
[258] PFP143345, para. 224, Summation pages 92-93
[259] PFP143263, para. 3, Summation page 4
[260] PFP144453, para. 215, Summation page 98
[261] PFP143345, para. 225, Summation page 93
[262] PFP303742

	preliminary. Note states: "Brian G. stated that he will not be dropping the charges on Thursday - that mom is definitely a child abuse but whether she is a child killer needs to be determined"[263]
April 30, 1999	In Jenna's case, KHCAS noted call from PC Daniel LeMay stating that he didn't have time to copy the Brief but was available the following week if CAS wanted to come to the police station to view it. "Dan states Crown Brief not much different than what Linda received at police station in 1997.[264]
April 30 - August 9, 1999	Dr. Cairns on sick leave.
May 1, 1999	In Jenna's case, M.W., a sibling of Jenna was born.[265]
May 4, 1999	Bill 6 receives Royal Assent.[266]
May 6, 1999	Letter sent from Dr. Young to Maurice Gagnon re: complaint to Coroner's Council.[267]
May 10, 1999	Order of the Attorney General for the exhumation of Sharon.[268]
June 7, 1999	The Medical Certificate of Death was signed in the case of Baby F. It noted that the mother, a teenager, was convicted of infanticide in July, 1998.[269]
June 15, 1999	In Jenna's case, Crown withdraws murder charges as against Jenna's mother.[270]
June 17, 1999	Memo, "Re-visioning Pediatric Forensic Pathology Unit – Progress report," from Dr. Chiasson to Dr. Young.
July 12, 1999	Body of Sharon is exhumed.[271]
July 13, 1999	Dr. Chiasson performs second autopsy on Sharon (attended by Dr. Wood, Dr. Smith, Mr. Blenkinsop, Const. Barrett, D/Sgt Bird, Mr. Paul Davis, Dr. Ferris, Dr. Dorion).[272]
July 23, 1999	In Jenna's case, Jenna's older sister was ordered returned to her mother's care following the withdrawal of charges against her mother. Access was also granted to M.W., a sibling born after Jenna's death.[273]
August 27, 1999	Tamara's mother's two children are returned to her care.[274]
September 13, 1999	Report of Dr. Wood re: Sharon.[275]
September 21, 1999	Dismissal of the application in the nature of certiorari brought

[263] PFP300013, Summation pages 1 and 2
[264] PFP300009, Summation page 1
[265] PFP144684, para. 105, Summation page 64
[266] PFP303742, Summation page 1
[267] PFP143263, para. 154, Summation page 55
[268] PFP144453, para. 219, Summation page 100
[269] PFP142804, para. 53, Summation page 17
[270] PFP144684, para. 198, Summation page 103
[271] PFP144453, para. 220, Summation page 100
[272] PFP144453, para. 223, Summation page 101
[273] PFP144684, para. 3, Summation page 3
[274] PFP143345, para. 226, Summation page 93
[275] PFP144453, para. 225, Summation page 102

	by the Crown to quash the discharges of Taylor' parents Lanny and Laura following the preliminary inquiry.[276]
October, 1999	Crown launches an appeal to the Court of Appeal for Ontario following the dismissal of its application to quash the discharges of Taylor's parents Lanny and Laura.[277]
October 27, 1999	Meeting between Kingston Police, Dr. Chiasson and Dr. Wood re: Sharon.[278]
November 10, 1999	Fifth Estate story airs.
November 22 and 23, 1999	Dr. Smith testified at the preliminary hearing into Tamara's death.[279]
November 30, 1999	In Nicholas case, letter sent from Maurice Gagnon to CPSO, requesting that the CPSO assume jurisdiction over complaint re: Dr. Smith.[280]
December 15, 1999	Letter from counsel for Brenda Waudby to Premier of Ontario, Attorney General, *et al.,* requesting public inquiry into death of Jenna.

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2000	**Event**
January, 2000	Crown's appeal to Court of Appeal for Ontario from the dismissal of Crown's application to quash the discharges of Taylor's parents Lanny and Laura is abandoned.[281]
January 5 and 6, 2000	The preliminary hearing in the Tyrell case took place before Justice L. Feldman of the Ontario Court of Justice in Toronto.[282]
February 8, 2000	Dr. Cairns meets with defence counsel for Louise Reynolds.[283]
February 14, 2000	Dr. Smith prepares a Supplementary Report on the Post Mortem Examination. This Supplementary Report is disclosed to the defence on February 16, 2000.[284]
March 6, 2000	In the Nicholas case, Maurice Gagnon files complaint re: Dr. Cairns with the Solicitor General.[285]
April 3, 2000	*R. v. Kporwodu* – Dr. Smith is served with a subpoena, requiring him to appear on April 10, 2000 Addendum to Report of Post Mortem Examination of Dr. Smith

[276] PFP144275, para. 4, Summation page 3
[277] PFP144275, para. 4, Summation page 3
[278] PFP144453, para. 239, Summation page 107
[279] PFP143345, para. 117, Summation page 43
[280] PFP143263, para. 211, Summation page 77
[281] PFP144275, para. 4, Summation page 3
[282] PFP144019, para. 165, Summation page 75
[283] PFP144453, para. 257, Summation page 113
[284] PFP144453, para. 259, Summation page 114
[285] PFP143263, para. 188, Summation page 67

	re: Athena
April 13, 2000	In the Nicholas case, Solicitor General responds by letter to Maurice Gagnon re: complaint of Dr. Cairns.[286]
May 19, 2000	Memo #00-02, "Protocol when conducting Sudden Death Investigations" Memo #00-03, "Protocol for Review of Reports of Post mortem Examination by the Chief Forensic Pathologist"
June 26, 2000	In the Nicholas case, Maurice Gagnon files complaint with Ombudsman.[287]
June 27, 2000	First meeting of Death Under Two (SIDS/SUDS) Committee (precursor of Death Under Two Committee)
September 1, 2000	HPARB determines that CPSO has jurisdiction and refers complaint involving Amber to CPSO
September 11, 2000	Dr. Cairns retains Dr. Synces
October 2000	Dr. Chiasson is appointed Deputy Chief Coroner of Forensic Services
October, 2000	Death Under Two Committee is established.
October 23, 2000	Letter from Ombudsman to Dr. Young re: Maurice Gagnon's complaint.[288]
November 10, 2000	Letter from Dr. Young to Ombudsman re: Maurice Gagnon's complaint.[289]
November 23, 2000	Letter from Deputy Solicitor General to Ombudsman re: Dr. Cairns' and Dr. Smith[290]
December 7, 2000	Dr. Symes provides his report in the case of Sharon. It is provided to defence counsel on December 8, 2000.[291]
December 19, 2000	In e-mail to Crown counsel Edward Bradley, Crown counsel Sheila Walsh provides comments regarding her involvement with Dr. Smith in the Tiffani case. She advises she met with Dr. Smith, the Chief Coroner, Dr. Bechard and the investigators in Toronto. She was present when Dr. Smith gave his verbal opinion that the death was a homicide and Tiffani's parents were charged on that basis. Everyone present knew that this was the basis of the charges. Ms. Walsh states how she later tried for months to get Dr. Smith's opinion and how she found him very unco-operative. She also states the following, "*Sometime later, I was at a Crown's conference where Jim Young gave a presentation concerning the Coroner's Office investigation into past baby deaths, and the creation of a 'team'*

[286] PFP143263, para. 190, Summation page 68
[287] PFP143263, para. 193, Summation page 69
[288] PFP143263, para. 194, Summation page 70
[289] PFP 143263, para. 195, Summation page 70
[290] PFP 143263, para. 195, Summation page 70
[291] PFP144453, para. 312, Summation page 137 and para.313, Summation page 138

	to review those cases as well as new cases. Dr. Smith's name was on the team. I spoke privately to Dr. Young, expressing my concerns about Dr. Smith's conduct in the [Tiffani's] case. He said that he was planning to have a meeting about [Tiffani's] case. I never head another thing about it."[292]

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2001	Event
January 12, 2001	Meeting between Crown and Kingston Police re: withdrawal of charges against Louise Reynolds
January 15, 2001	*R. v. Kporwodu and Veno* – preliminary hearing commences
January 16, 2001	In the Tyrell case, Justice A. Campbell of the Superior Court of Justice delivered oral reasons ruling the statements of the SCAN team inadmissible.[293]
January 22, 2001	*R. v. Mother of Tyrell* – charges withdrawn/stayed
January 23, 2001	*Globe and Mail* article "Murder charge withdrawn" re: end of criminal proceedings against Mother of Tyrell
January 25, 2001	Letter from Dr. Smith to Dr. Young requesting that he be excused from coroners' autopsies.[294]
January 25, 2001	*R. v. Reynolds* - Crown withdraws charges against Louise Reynolds.[295]
January 26, 2001	Dr. Young announces external review of Dr. Smith's work.[296]
January 26, 2001	OCCO meeting re: Dr. Smith (Dr. Young, Dr. Cairns, Dr. Uzans, Dr. Porter, Jeff Mainland, Barry Blenkinsop, Al O'Marra)
January 31, 2001	Meeting between Regional Director of Crown Operations, TPS, Dr. Chiasson and Dr. Cairns
February 2, 2001	List of 15 cases for Dr. Smith review is sent to Regional Director of Crown Operations
February 2, 2001	Dr. Chiasson emails Dr. Alan Goldbloom re: agreement re: post mortem examinations following February 1, 2001 meeting
February 19, 2001	Letter from Crown to Dr. Cairns, confirming independent review by OCCO of Dr. Smith's work re: Tamara
February 20, 2001	Letter from Chief of Kingston Police to Premier of Ontario, requesting public inquiry into death of Sharon [redacted].[297]
April 3, 2001	In the Valin case, Mr. Lomer who was counsel for Mr. Mullins-Johnson at the time of his appeals to the Court of Appeal and the Supreme Court of Canada, wrote to Dr. James Cairns, Chief

[292] PFP143440, para. 228, Summation pages 102 and 103
[293] PFP144019, para. 234, Summation page 105
[294] PFP127457, para. 1, Summation page 1
[295] PFP144453, para. 327, Summation page 147
[296] PFP055831, Summation page 2
[297] PFP115724, para.1, Summation page 1

	Coroner for Ontario, in his capacity as a private citizen, to state that it "*was a case that has always caused me a nagging doubt with respect to his guilt*." Mr. Lomer also wrote as follows, "*I read in the Star that there is going to be a review of the professional conduct of Dr. Smith by your office. If that is to be the case, and I have no reason to disbelieve what I read in the newspaper, I am alerting you to this case. It is my view that this is another case of Dr. Smith's that ought to be looked at in the interests of justice.*"[298]
April 30, 2001	Dr. Cairns interviewed by Jane O'Hara
May - August, 2009	Dr. Cairns takes sick leave
May 8, 2001	The Ministry of the Solicitor General prepared a briefing note regarding the *Maclean's* article on Dr. Smith's work (including the Sharon case) the author of which is unknown. The contact stated along the bottom of the briefing note is Dr. Young.[299]
May 14, 2001	*Maclean's* published the article, "*Dead Wrong: How the Faulty Findings of an Eminent Pathologist Led to Erroneous Murder Charges and Ruined Live"* by Jane O'Hara. The article detailed, among other cases, Dr. Smith's involvement in the Amber case. O'Hara wrote: "Smith's involvement in the case of the Timmins girl brought harsh commentary from the bench as long ago as 1991 .... Ontario Provincial Court Judge Patrick Dunn criticized him for not even following his own prescribed autopsy procedures in accusing the Grade 6 student of shaking a 16-month-old baby to death. Cairns, the deputy chief coroner and a close colleague of Smith, dismisses Dunn's criticism. "The judge,' says Cairns, 'didn't understand the medical evidence."[300]
May 31, 2001	Letter of regret from Dr. Young to Maurice Gagnon
	Letter from Dr. Young to Ombudsman, setting out undertakings.
Late May, 2001	Dr. Young announces decision to delay the independent review of Dr. Smith's work
Late May, 2001	Dr. Cairns subsequently asks Dr. McLellan to conduct paper review of two or three non-criminal cases of Dr. Smith
June 1, 2001	Letter from Dr. Chiasson to Dr. Carpenter, requesting that Dr. Carpenter perform a quality control review of six of Dr. Smith's non-criminally suspicious cases

[298] PFP144327, para. 102, Summation page 57
[299] PFP144453, para. 347, Summation page 164
[300] PFP143724, para. 255, Summation pages 103-104

June 4, 2001	*The Toronto Star* article, "Lawsuit Delays Review of MD's Work"
June 13, 2001	Reports of Dr. Carpenter re: quality control review
June, 2001	Dr. Smith is subsequently reinstated to the list of pathologists available for non-criminally suspicious medical legal autopsies
July, 2001	Dr. Chiasson resigns as Deputy Chief Coroner of Forensic Services and begins working as a consultant forensic and cardiovascular pathologist for the OCCO
July, 2001	Police Chief McLaren assigns D/Const Charmley to review the prior investigation re Jenna's death.
July, 2001	Brenda Waudby files a complaint against Dr. Smith with the CPSO
September 24, 2001	Letter from Ombudsman to Maurice Gagnon after completion of investigation
October 5, 2001	Peterborough Police speaks with Dr. Smith re: hair found in Jenna
October 10, 2001	Letter from Crown to defence, stating that Dr. Cairns had advised that there was no review of every case involving Dr. Smith
November 6, 2001	Email from Dr. Smith to Jeff Mainland stating that he has the missing fibre
November 13, 19 and 20, 2001	*R. v. Kporwodu and Veno* – preliminary hearing resumes
November 13, 19 and 20, 2001	Dr. Cairns testifies on *voir dire*
November 19, 2001	Meeting between Dr. Cairns, all counsel of record and TPS re: review of Dr. Smith's work
November 19, 2001	Dr. Cairns provides a copy of the 17-case chart to Crown
November 16, 2001	Peterborough Police retrieves hair from Dr. Smith's office
December 17 to 18, 2001	*R. v. Kporwodu and Veno* – preliminary hearing resumes
December 17, 2001	Dr. Smith testifies
December 13, 2001	Katharina's mother receives an absolute discharge from the Ontario Review Board.[301]
December 21, 2001	Letter from Dr. Smith to CPSO, responding to Brenda Waudby's complaint
December 28, 2001	In the Valin case, Mr. David Bayliss, on behalf of the Association in Defence of the Wrongly Convicted (AIDWYC), wrote to Dr. Cairns and stated, "*It is now well known in the legal community that the Office of the Chief Coroner is undertaking a review of Homicide cases in which Dr. Charles Smith has been involved as an expert witness. …On behalf of*

[301] PFP143979, para. 2, Summation page 3

	Mr. Mullins-Johnson, AIDWYC requests that the coroner's office review Dr. Smith's work in the Mullins-Johnson case."[302]

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2002	**Event**
February 15, 2002	Dr. Smith sends Dr. Cairns a copy of his report to CPSO re: complaint of Brenda Waudby
February 15, 2002 (?) – April 15, 2002	Dr. Cairns meets with Dr. Charles Smith, and his wife re: Jenna's case
February 18, 2002	Letter from Crown to counsel in Paolo's case stating that Dr. Cairns had advised that there was a review of 20 cases
July 1, 2002	Dr. McLellan becomes Acting Chief Coroner of Ontario
September 13, 2002	Letter from Crown to Dr. Cairns, requesting report re: review of Dr. Smith's opinion in Paolo's case
September 27, 2002	Report of Dr. Cairns re: review of Dr. Smith's findings re: Paolo's case
October 15, 2002	CPSO Complaints Committee Decision and Reasons re: Dr. Smith – Dr. Smith Cautioned
October 23, 2002	*R. v. Kporwodu and Veno* - Affidavit of Dr. Cairns. Dr. Cairns swore an affidavit in the application for third party records in the case of *R. v. Kporwodu and Veno*. In it, Dr. Cairns stated that a review of Dr. Smith's work was pending following the negative media coverage Dr. Smith had received.[303]
November 20, 2002	*R. v. Kporwodu and Veno* – Supplementary Affidavit of Dr. Cairns
November 26, 2002	E-mail from Mr. McMahon, Director of Crown Operations to all Crowns requesting information that might be relevant to Dr. Smith's competence or credibility related to *R. v. Kporwodu and Veno*.[304]
November 27, 2002	Mr. Kotanen, Assistant Crown Attorney, replied to Director of Crown Operations, writing: "As a mentioned to Rita a while back, Dr. Smith was my expert in *R. v. [Tamara's father]*, a baby death. Defence obtained an opinion from an expert to the effect that Smith's cause of death was wrong. We obtained a second opinion that Smith was right. The accused plead guilty on my facts, choosing to accept Smith's findings (as confirmed) rather than their own expert's. Reluctantly.[305]
November 28, 2002	Ms. Walsh wrote an e-mail to John McMahon and Jon McGrath in response to a request for information about Dr. Smith for *R.*

[302] PFP144327, para. 103, Summation page 58
[303] PFP144453, para. 348, Summation page 165
[304] PFP143345, para. 230, Summation page 94
[305] PFP143345, para. 231, Summation page 95

	v. Kporwodu and *Veno* in which she discussed Dr. Smith's opinion in the Dustin case.[306]
November 27 to 29, December 2, 4, 10, 13, 16, 19 and 20 2002	*R. v. Kporwodu and Veno* –trial resumes Justice Trafford rules on Phase I of application re: CPSO files on November 27, 2002, finding that application would proceed to Phase II, with the court reviewing the records Dr. Cairns testifies on November 28 and 29, 2002

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2003	**Event**
January 13, 2003 (and March 3, 2003)	Sheila Walsh authored two identical memoranda to Assistant Crown Attorney Julie Battersby on these dates summarizing her involvement with Dr. Smith in the Dustin and the Tiffani cases. In the Dustin case she writes that, *"[Richard] was charged with manslaughter and failure to provide necessaries of life in connection with his infant son Dustin. Dustin died as a result of a severe shaking.*"[307] In the Tiffani case, she writes that Mary and William were both charged with manslaughter "*as a result of a verbal opinion expressed by Dr. Charles Smith*" and that her "*experience with Dr. Smith has been problematic in the sense that he did not testify in accordance with opinions he had expressed verbally in [Tiffani's case]*."[308]
February 12, 2003	Letter from Maurice Gagnon to Deputy Solicitor General, indicating intention to initiate civil action against Dr. Smith, OCCO and Ministry of Public Safety and Security
February 17, 2003	Letter from Dr. Young to CPSO re: Complaints Committee decision re: Dr. Smith
April 15, 2003	Dr. Smith attends his last PDRC meeting
August, 2003	Brenda Waudby, Dr. Smith and CPSO testify before HPARB panel re: Brenda Waudby's appeal of the CPSO's decision.

[306] PFP142940, para. 305, Summation page 112
[307] PFP142940, para. 306, Summation page 112
[308] PFP143440, para. 230, Summation pages 104-106

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2004	Event
April, 2004	Dr. McLellan becomes Chief Coroner of Ontario
June 16, 2004	Forensic Pathology Consultation report of Dr. Pollanen re: Jenna
July 1, 2004	Dr. Smith resigns from his position as Director of the OPFPU
July 29, 2004	Dr. Taylor assumes position of Director of the OPFPU at the request of Dr. McLellan
September, 2004	Dr. Chiasson assumes position as staff pathologist at the Department of Pediatric Laboratory at HSC
November 26, 2004	Meeting between Dr. Cairns, OCCO staff and Dr. Smith re: missing slides for Valin
November 29, 2004	20 slides re: Valin are located in Dr. Smith's office

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2005	Event
January, 2005	Dr. Young is appointed Special Advisor to the Deputy Minister, Public Safety and emergency Preparedness for the Government of Canada
February 9, 2005	Dr. Michael Pollanen, Chief Forensic Pathologist, OCCO, wrote to Dr. McLellan indicating that, during an inventory of retained specimens at the Toronto Forensic Pathology Unit, skeletal material from Sharon's autopsy was found in a labelled plastic container.[309]
Winter and Spring 2005	Dr. McLellan orders tissue audit of all of Dr. Smith's cases at HSC
April 18, 2005	Dr. Smith takes leave of absence from HSC.
May 6, 2005	Additional 10 slides and 28 paraffin blocks for Valin are located in Dr. Smith's office.
June 7, 2005	Announcement by Dr. McLellan of formal review into Dr. Smith's work since 1991 and Results of Audit into Tissue Samples Arising from Homicide and Criminally suspicious Autopsies Performed at the Hospital for Sick Children
July 18, 2005	Dr. Smith resigns from HSC medical staff
September 7, 2005	In the Valin case, Mr. Mullins-Johnson filed an application for ministerial review pursuant to Part XXI. 1 of the *Criminal Code*.[310]
September 21, 2005	In the Valin case, Mr. Mullins-Johnson was granted bail by Justice Watt of the Superior Court of Justice.[311]

[309] PFP144453, para 352, Summation page 166
[310] PFP144327, para. 6, Summation page 3

November 1, 2005	Dr. Taylor turns over the position of Director of the OPFPU to Dr. Chiasson
December 28, 2005	In Jenna's case, J.D., the youth who was babysitting Jenna the night she died, was arrested and charged with second degree murder.[312]

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2006	Event
April 24, 2006	Dr. Pollanen is appointed Chief Forensic Pathologist at OCCO.
December 14, 2006	J.D. pleads guilty to manslaughter in the death of Jenna.[313]

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2007	Event
February, 2007	Dr. McLellan requests review of coroner's involvement in 45 cases by Dr. Lauwers and Dr. Edwards.
March 1, 2007	In the case of Jenna, J.D. was sentenced, as a youth, to 22 months incarceration followed by 11 months of community supervision.[314]
March 8, 2007	Dr. Lauwers and Dr. Edwards provide results of review of coroner's involvement in the 45 cases.
April 11, 2007	The CAS Supervising Order was terminated in respect of Joshua's brother.[315]
April 17, 2007	Announcement by Dr. McLellan of results of review of criminally suspicious and homicide cases where Dr. Smith conducted autopsies or provided opinions.
September, 2007	Dr. McLellan steps down as Chief Coroner.
October 15, 2007	In the Valin case, the Court of Appeal, after hearing *viva voce* evidence from Mr. Mullins-Johnson and Dr. Michael Pollanen, and the submissions of counsel, acquitted Mr. Mullins-Johnson. The Court reserved on the issue of whether a declaration of factual innocence should be made.

[311] PFP144327, para. 201, Summation page 106
[312] PFP144684, para. 4, Summation page 3
[313] PFP144684, para. 199, Summation page 103
[314] PFP144684, para. 200, Summation page 103
[315] PFP143053, para. 231, Summation page 117

APPENDIX "B": ANALYSIS OF CHILD WELFARE PROCEEDINGS

SURVIVING SIBLINGS OUTLINE	CHILD PROTECTION PROCEEDINGS TIMELINE	OUTCOME
DUSTIN **PFP142940** September 9, 1992 - November 18, 1992		
Dustin was the natural child of Mary and Richard. Mary's daughter from a previous relationship resided with them.[316]	On November 17, 1992, the emergency physician at the Belleville General Hospital contacted the Belleville Children's Aid Society (at 2:10 p.m.)[317] regarding Dustin's condition because there was "retinal hemorrhaging present … behind both eyes."[318] Dr. Patel thought that this was a case of shaken baby syndrome.[319] On November 25, 1992, Mary indicated to police that the CAS had apprehended her daughter and Det. Malihot stated that there was going to be a hearing on November 26, 1992.[320] Mary's daughter was placed in the care of her maternal grandmother with a few hours of supervised access per week by Mary and no access by Richard. Richard was denied access.[321] On February 15, 1993, the CAS referred Richard for a psychological assessment and an assessment of his alcohol	**Unknown**.

316 PFP142940 Dustin Overview Report, para. 6

317 PFP142940 Dustin Overview Report, para. 29
PFP002286 Emergency Record

318 PFP142940 Dustin Overview Report, para. 39
PFP048736 Will Say Statement of Det. Al Portt, page 1

319 PFP142940 Dustin Overview Report, para. 48
PFP080056 Case Summary, November 18, 1992, page 2

320 PFP142940 Dustin Overview Report, para. 81
PFP048669 Statement of Mary [redacted], page 23

321 PFP142940 Dustin Overview Report, para. 124

322 PFP142940 Dustin Overview Report, para. 125

323 PFP002260 Letter from Patrick Hurley to Dr. Bechard, March 19, 1993

	and drug use. During a meeting with Mary and Richard on that date, the CAS worker advised that long-term plans for Mary's daughter were "dependent upon the coroner's report."[322] On March 19, 1993, counsel for Mary and Richard sent a letter to Dr. Bechard requesting information on the status of the coroner's investigation. The CAS had taken the position that, until Dr. Bechard's report had been "completed and distributed", it would restrict Mary's access to her daughter and would deny Richard access.[323]	
KATHARINA **PFP 143979** March 20, 1992 - September 15, 1995		
None	CAS involved prior to Katharina's death.[324]	N/A
NICHOLAS **PFP143263** January 2, 1995 - November 30, 1995		
Nicholas had no surviving siblings at the time of his death. Nicholas's sister was born on June 27, 1998.[325]	A day prior to the birth of Nicholas's sister, the CAS reached a settlement with Nicholas's parents and maternal grandparents for a temporary, without prejudice, supervision order. The settlement provided that, upon birth and during the hospital stay, the child not be left unattended or unsupervised with Nicholas's mother. Following discharge from the hospital, the child was to be in the custody of the maternal grandparents, subject to the supervision of the CAS. The mother was to have supervised access to her child, with daily three-hour	After the OCCO received the expert report of Dr. Case and provided to the parties on March 23, 1999, the CAS decided to seek to vacate all temporary orders, withdraw the child protection application and

[324] PFP143173 Katharina Overview Report, paras. 56 to 68
[325] PFP143263 Nicholas Overview Report, para. 104
[326] PFP143263 Nicholas Overview Report, para. 104, pages 37 and 38
[327] PFP143263 Nicholas Overview Report, para. 105, page 38 and para. 140, page 51

	visits.[326] On June 29, 1998, the CAS filed a child protection application regarding Nicholas's sister. The CAS sought an order that Nicholas's sister become a ward of the Crown and placed under the care of the CAS with no access by the mother. The child protection application set out the background of the case, stating that the Coroner's Office is of the opinion, at a high level, that the child, Nicholas, died due to a non-accidental injury and that the non-accidental injury was caused by the mother. On July 30, 1998, Nicholas' mother was informed her name had been placed on the Child Abuse Register.[327]	withdraw the registration of Nicholas' mother on the Child Abuse Register. The child protection proceedings concluded on March 25, 1999. Application withdrawn by CAS. No further CAS involvement.[328]
SHARON **PFP144453** December 28, 1989 - June 12, 1997		
Sharon's mother had five children: (a) her eldest daughter was born in February, 1986 and was adopted by relatives; (b) Sharon was born in December, 1989; (c) her son was born in June, 1991; (d) her second youngest daughter was born in November, 1993; and (e) the youngest daughter was born in March, 1995 and lived with her grandparents.[329]	Ms. Reynolds had previous involvement with the Kingston Children's Aid Society. She herself had been a Crown Ward.[330]	Ms. Reynolds' second youngest daughter was made a Crown Ward for the purposes of adoption. Statement of Claim of Ms. Reynolds suggests that while in custody she had no choice but to consent to an adoption order.[331] CAS involvement with siblings not in mother's custody at the time of Sharon's death - **unknown**[332]
TAMARA **PFP143345** January 18, 1998 - February 8, 1999		

328 PFP143263 Nicholas Overview Report, para. 162, page 58
329 PFP144453 Sharon Overview Report, paras. 7 and 8
330 PFP144453 Sharon Overview Report, para. 11
331 PFP116230 Reynolds' Statement of Claim, para. 5, page 3 and para. 63, page 18
332 PFP083101 CAS Notes to Worker, February 5, 1986 - June 17, 1997

Tamara had two older surviving sisters.[333]	Child protection proceedings were commenced on February 11, 1999.[334] On January 20, 1999, Tamara was brought by ambulance to hospital with a fractured right femur. The CAS was notified and the family was placed under review.[335] According to a CAS worker who gave evidence at the preliminary inquiry, the policy for the Children's Aid Society of Metropolitan Toronto was to involve the SCAN Team.[336] When Tamara's mother refused to consent to the SCAN team reviewing Tamara's records, she was advised by the CAS that they might take legal action if she refused to cooperate.[337] On February 8, 1999, the coroner issued a warrant to seize CAS documents.[338] On February 9 and February 10, 1999, information was shared between CAS and police.[339] On February 10, 1999, Tamara's other siblings were brought to the SCAN clinic for physical exams and x-rays.[340] On March 24, 1999, counsel for Tamara's mother in the CAS proceedings wrote to OCCO requesting information about when the coroner's report would be released. Dr. Bonita Porter forwarded the request to the Regional Coroner, Dr. Lucas. Dr. Lucas wrote to counsel on April 1, 1999: "… as you are well aware, this death is the subject of a police investigation and our office is not prepared to disclose any information that may potentially jeopardize that criminal investigation." [341] The CAS provided the investigating office with case notes of their interview with Tamara's sister on February 15, 1999.[342] By August 17, 1999, both children had been returned into the care of Tamara's mother.[343]	On August 27, 1999, CAS confirmed that the two children had been returned to her care.[344] Overview report is inconclusive as to end of proceedings.

[333] PFP143345 Tamara Overview Report, para. 7

[334] PFP143345 Tamara Overview Report, para. 3

[335] PFP143345 Tamara Overview Report, para 13

[336] PFP143345 Tamara Overview Report, para 13
PFP071709 Preliminary Hearing Transcript, page 49, lines 18-21

[337] PFP052592 Letter from Ms. Waisberg and Mr. Standish to V. Thomas, February 1, 1999

[338] PFP052291 Coroner's Warrant for Seizure

[339] PFP052483 CAS Case Note, February 9, 1999
PFP052439 CAS Case Note, February 10, 1999

TAYLOR **PFP144275** April 16, 1996 - July 31, 1996		
Taylor had an older brother from a previous relationship of Taylor's mother who lived in the home and was 20 months-old when Taylor died. The CAS was involved with respect to Taylor's brother following Taylor's death.[345]	Taylor resided with his parents, Lanny & Laura. Laura's 20 month old son from a previous relationship also lived in the home.[346] On July 31, 1996, while the parents were at the hospital with Taylor, the investigating officer called the CAS, having decided that the CAS should take Taylor's brother from the residence of a neighbour.[347] It was Det. Boote's opinion that the child possibly would be better off in the hands of the CAS overnight, so the CAS agreed to pick up the child.[348] On August 2, 1996, police met with three CAS workers and advised them of the circumstances of the investigation and the preliminary results of the post-mortem. Police anticipated the CAS would take legal custody of Taylor's brother, order a full investigation, and allow Laura's parents custody, possibly with conditions that Laura have supervised access only and that Larry be restricted from any contact with the child.[349] On August 3, 1996, CAS workers and police met with Laura's parents to advise them that Taylor's brother would	Parents discharged, Crown appeals dismissed.[356] Outcome of child protection proceedings for Taylor's brother is unreported in overview report. **Commission reports that no further CAS involvement. Child is with mother.

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340 PFP052439 CAS Case Note, February 11, 1999
PFP052551 CAS Case Investigation Summary, February 24, 1999

341 PFP143345 Tamara Overview Report, para. 225
PFP052207 Letter from Dr. Lucas to Mr. Sullivan, April 1, 1999

342 PFP082105 Letter from T. Standish to Det. Bell, April 8, 1999
PFP082108 CAS Case Notes, February 15, 1999

343 PFP143345 Tamara Overview Report, para. 226

344 PFP143345 Tamara Overview Report, para. 226

345 PFP144275 Taylor Overview Report, para. 71

346 PFP144275 Taylor Overview Report, para. 2

347 PFP144275 Taylor Overview Report, para. 43

348 PFP144275 Taylor Overview Report, Footnote 93
PFP136485 Det. Boote's Supplementary Occurrence Report

349 PFP144275 Taylor Overview Report, para. 71
PFP136746 D/C Hay's Supplementary Occurrence Report

	be removed from their home until the CAS could complete its investigation. The child was apprehended and a hearing date was scheduled for August 6, 1996.[350] On September 23, 1996, Dr. Smith sent a fax to Dr. Cairns: " … The male figure in the home previously injured another child from a former liaison. I'm working on the rest of Mark's autopsy, as well. It's a tough case. In your absence, I advised the Coroner Dr. Perales, how to testify in Family Court for a CAS hearing. You may want to give him a call, as he doesn't have a Regional to help him…" [351] On December 4, 1996, police provided CAS workers with a copy of the preliminary results from the post-mortem examination.[352] On January 15, 1997, CAS documents were seized by police pursuant to a warrant.[353] On June 30, 1997, both parents were discharged after a preliminary inquiry. On July 14, 1997, Dr. Smith sent an email to Dr. Cairns about a conversation he had with the defence lawyer. In the email, he stated: "The defence lawyer thought that the Crown Attorney might try to appeal the acquittal and get a preferred indictment on a lesser charge than the original charge of second degree murder. He was also aware of the concern by the local CAS, but agreed with me that there was previous evidence of child abuse which should help them. I have to think that the task of the CAS would have been made much easier if the crown attorney had considered accepting a guilty plea.	

350	PFP144275	Taylor Overview Report, para. 47
	PFP136495	Det. Boote's Supplementary Occurrence Report
351	PFP144275	Taylor Overview Report, para. 26
	PFP009823	Fax from Dr. Smith to Dr. Cairns, September 23, 1996
352	PFP144275	Taylor Overview Report, para. 52
353	PFP144275	Taylor Overview Report, para. 52
	PFP136965	Information to Obtain Search Warrant, January, 1997
354	PFP144275	Taylor Overview Report, para. 135
	PFP09821	Email from Dr. Smith to Louise Cater, July 14, 1997
355	PFP144275	Taylor Overview Report, para. 122
	PFP136431	Det. Boote's Supplementary Occurrence Report
356	PFP144275	Taylor Overview Report, para. 133

	I have obviously thought of this case a great deal, discussed it with others and pondered about any mistakes I might have made, but I don't know what more I could do. I have to think that on pediatric cases, it's best not to risk the whole case by demanding that the case go through the courts, and instead take a guilty plea to a lesser charge." [354] On October 3, 1997, Laura's mother called Det. Boote and informed him that Laura had left Lanny and had told the CAS about recent abuse. Laura's mother felt that she may be willing to speak with police. [355]	
TIFFANI **PFP143440** March 24, 1993 - July 4, 1993		
Tiffani was born in March, 1993. Her father had two children with a previous spouse, a brother born October 1987, and a sister born in October, 1990. In a statement obtained during the investigation into Tiffani's death, the older siblings' mother told police that the father had previously mistreated the older siblings.[357]	CAS involvement prior to Tiffani's birth regarding children of previous spouse.[358]	The file was closed to the Kawartha-Haliburton CAS in January, 1992, after the termination of the supervision order.[359]
ATHENA **No Overview Report** Date of Death: March 6th, 1998		
Athena had an older brother.	At the end of an interview with police on March 7, 1998, Athena's 16-month-old brother was apprehended by the CAS because of the information received from the	

357 PFP143440 Tiffani Overview Report, para. 6
358 PFP143440 Tiffani Overview Report, paras. 6 to 9
359 PFP143440 Tiffani Overview Report, paras. 6 to 9
360 PFP014374 Decision of Trafford, J., June 23, 2003

	Homicide Squad.[360]	
BABY F **PFP142804** Born and died on November 28, 1996[361]		
No.	N/A	N/A
JENNA **PFP144684** April 21, 1995 - January 22, 1997		
Older sister Justine and younger brother M. born on May 1, 1999.	Justine was apprehended on January 22, 1997. She resided in a family placement until March, 1997 at which time she went into foster care. Justine was returned to the care of her mother by court order on April 30, 1997.[362] Justine then moved to her mother's care where she remained until the date of arrest on September 18th, 1997.[363] Brenda became pregnant with her third child after the preliminary hearing and was due at the end of April, 1999.[364] M. was born May 1, 1999. Following a hearing on May 5, M. was placed in the temporary care of Brenda at her mother's residence subject to 24 hour supervision. On May 7, 1999, the family court ordered that M.W. would be in the temporary care of his father, subject to daily supervised access by mother each day from 9:00 a.m. to 5:00 p.m. at home of the father. Justine was ordered returned July 23, 1999.[365] On August 13, 1999, the CAS appeal was dismissed.[366] M. was returned home in March, 2000.	A Family Court Assessment was completed in the winter of 2000 and, ultimately, M. was returned to Brenda's care under terms of supervision.[367] All CAS orders were terminated in 2001. Brenda remains on the Child Abuse Register.[368]
GAUROV **PFP143828** February 11, 1992		

361 PFP142804 Baby F Overview Report, para. 1
362 PFP144684 Jenna Overview report, para. 3
PFP072650 Supplementary Occurrence Report of Daniel LeMay, at page 19
363 PFP072650 Supplementary Occurrence Report of Daniel LeMay
PFP144684 Jenna Overview Report, para. 2
364 PFP300012 CAS note
365 PFP144684 Jenna Overview Report, para. 3
366 PFP144684 Jenna Overview Report, para. 3
367 Information from counsel for Brenda
368 Information from counsel for Brenda

- March 20, 1992		
Gaurov had an older brother.	On March 20, 1992, Gaurov's older brother was apprehended by the Children's Aid Society. For approximately one year, Gaurov's father was only permitted to visit with Gaurov's brother in the presence of a CAS supervisor. [369]	No further CAS involvement.
TYRELL **PFP144019** February 1, 1994 - January 23, 1998		
Tyrell was born in Toronto on February 1, 1994. Tyrell was the child of Janette and Garth. Tyrell was almost four years old at the time of his death. Tyrell was living in the care of [Maureen] a former partner of biological father,[Garth]; [Maureen] reported that she had been caring for Tyrell since he had been left by his biological mother in Jamaica with relatives and his father had arranged for Tyrell to travel to Canada to live with her; she reported the whereabouts of biological mother was unknown; father, [Garth] is incarcerated in Hamilton-Wentworth Detention Centre; she and Garth had lived together for a period of time.[370]	Maureen (Tyrell's caregiver at the time of his death) has two of her own children, [a son] age 5 years and [a daughter] age 7 years. She was supported financially through Social Assistance benefits. Following Tyrell's death, the two surviving children were taken into custody by CAS.[371] According to the anticipated evidence of D/Cst. Craddock and D/Cst. Lynda Campbell of the Toronto Police, on January 21, 1998, at 1330, they attended Maple Leaf Public School to transport Maureen's seven year old daughter and five- year-old son to the police station. Ms. Healey was to meet them at the station. Maureen's daughter was at the school, but her son was not, since he attended junior kindergarten during the morning hours. Since Maureen's daughter appeared uncomfortable, Principal Elizabeth St. Clair took her to the police station in her automobile.[372] According to the anticipated evidence of D/Cst. Craddock, after Maureen's interview was completed at 1629, Ms. Healey "apprehended the children as being in need of protection under the Child and Family Services Act because it is at this time known [sic] how Tyrell was injured."[373] Dr. Mian wrote on January 23, 1998, "In summary, this 3 year old suffered head injury that led to his death. It was the opinion of the SCAN Team that this injury was NOT consistent with the history available and most consistent with a severe shaking episode. In the absence of a clear explanation of accidental trauma, non-accidental injury	Children returned to mother after charges stayed.[378]

[369] PFP143828 Gaurov Overview Report, paras 3, 4, 24

[370] PFP144019 Tyrell Overview Report, paras. 1 and 6

[371] PFP144019 Tyrell Overview Report, paras. 88 and 89

	must be suspected."[374] This child died in the CCU. [Maureen's] other two children were apprehended by the CAS. CAS and Homicide Police continue to investigate. Case closed to SCAN.[375] According to affidavit material later filed in connection with the criminal proceedings, when the investigation into Maureen began, the CAS took custody of her son and daughter. The children were later released to Maureen's mother and her mother's husband.[376] According to the notes of Det. Bronson, on January 6, 1999, he was advised by Ms. LeRoy that "children are in care of the grandparents" and that there was a "strict crt order that the children are not to be with mother."[377]	
VALIN **PFP144327** February 11, 1989- June 26 or June 27, 1993		
Valin was born in Sault Ste. Marie on February 11, 1989, to Paul Johnson and Kim Lariviere. She died at the age of four, on June 26 or 27, 1993, in Sault Ste. Marie. Valin had an older sister and a younger brother who were six and three, respectively at the time of her death. The family lived together in Sault Ste. Marie, Ontario. William	Valin had an older sister and a younger brother who were six and three, respectively at the time of her death. On June 27th, 1993, a worker from the Children's Aid Society of Algoma interviewed Valin's sister and brother.[380]	No further CAS involvement.

372 PFP144019 Tyrell Overview Report, para. 69
373 PFP144019 Tyrell Overview Report, para. 72
374 PFP144019 Tyrell Overview Report, para. 82
375 PFP144019 Tyrell Overview Report, para. 92
376 PFP144019 Tyrell Overview Report, para. 124
377 PFP144019 Tyrell Overview Report, para. 134
378 Information from counsel for Maureen

Mullins-Johnson was Mr. Johnson's brother and Valin's uncle. At the time of Valin's death, he resided with the family.[379]		
KASSANDRA PFP143173 December 15, 1987 - April 11, 1991		
Kasandra was born in Mississauga on December 15, 1987. Kasandra's parents lived together in a common law relationship at the time of her birth. They separated in June 1988, when Kasandra was six months old. Kasandra died on April 11, 1991, at the Hospital for Sick Children in Toronto. Kasandra was three and a half years old, and was living with her father and stepmother, Maria, in Brampton, Ontario, at the time of her death.[381] Maria had three other children.[382]	The children were placed in the care of their maternal grandmother. Maria's bail terms stated that her mother had to be present when she was with the children.[383] On March 12th, 1992, police interviewed Dr. Mian who was then director of the SCAN team: "Doctor Mian went on to say that all she deals with is child abuse so naturally she would assume abuse… Dr. Mian further stated that as far as she was concerned, the doctors and the child care people may as well have held Kassandra down while her step-mother beat her to death. It was further stated that the doctors and the CAS dropped the ball on this one and that the hospital wanted an inquest because of that."[384] In June, 1992, Maria applied to amend her bail terms to allow the children to return to her care. A bail variation was granted on June 25, 1992 providing that the children would continue to live with their grandmother but Maria would have access in the company of several named individuals.[385] On October 2, 1992, the last condition of bail was amended to require that under no Circumstances would Maria administer physical or corporal discipline to the children.[386]	***According to counsel for Kasandra's stepmother, she finally regained custody between 2 and 3 years after her release from custody.
BABY M		

379 PFP144327 Valin Overview Report, para. 1
380 PFP144327 Valin Overview Report, para. 52
381 PFP143173 Kassandra Overview Report, paras. 1 and 2
382 PFP143173 Kassandra Overview Report, paras. 241 and 242
383 PFP143173 Kassandra Overview Report, para. 242
384 PFP143173 Kassandra Overview Report, para. 169
385 PFP143173 Kassandra Overview Report, paras. 178 and 181
386 PFP143173 Kassandra Overview Report, para. 182

PFP142836 Born and died in Pickering on November 8, 1992.		
No	No	N/A
DELANEY **PFP142877** December 20, 1992 - May 23, 1993		
No	N/A	N/A
KENNETH **PFP144159** May 18, 1991 – October 12, 1993		
While Kenneth's mother was on bail, she gave birth to a son born August 17, 1994.[387]	Newborn son was immediately apprehended and placed in foster care.[388] She was granted weekly visitation, but lost complete custody in 1996. He has since been adopted.[389]	Kenneth's brother adopted.
PAOLO **No Overview Report** September 14, 1992 - May 29, 1993		
Younger siblings born after his death.	CAS involved after injuries to second child.	Unknown.
"X" **No Overview Report**		
Not at time of death.	Unknown	Unknown

387 PFP144159 Kenneth Overview Report, para. 3
388 PFP144159 Kenneth Overview Report, paras. 3 and 342
389 PFP144159 Kenneth Overview Report, paras. 344 and 346

DEATH INVESTIGATION AND THE CORONER'S INQUEST

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they engage in clinical audit, root cause analysis, professional development including extensive postgraduate medical education, and health care policy review. However, any administrative system that places its complete trust in just one individual will inevitably be disappointed from time to time. The medical profession has long recognised this and today health care is usually delivered in a team environment to help reduce these risks.

We are of the view that society's dominant death investigation process, the issuing of a death certificate, should also occur in a team setting.

Characteristics of a sophisticated death investigation system

Death investigation in a community needs to be an integrated process that brings together all those who can contribute to the public well-being. This principle should underpin the design of any death investigation system, whether it is based around administrative services, the medical profession, the police, or the legal profession.

The elements that should guide high-quality death investigation are:

- a therapeutic approach to all dealings with the deceased's family and friends;
- safe and empathic management of the remains of the deceased;
- acknowledgment of the legal rights of families, friends, and parties with a legitimate interest in the death and helping them to exercise those rights;
- comprehensive employment of professionals with relevant expertise for the death investigation;
- integrated application of appropriate technologies in the death investigation;
- clear communication of the results of the death investigation to all those with an interest in the information, including:
  - families;
  - friends;
  - government;
  - agencies responsible for public health and safety;
  - public health and safety practitioners and policy-makers; and
  - the health care staff involved in the prior care of the deceased;
- effective audit and validation of death investigation processes; and
- a mechanism for the continuous review and amendment of death investigation processes.

Law reform options

Three important options for coronial law reform were identified in the United Kingdom and then in Victoria by the parliamentary inquiry into that state's coronial legislation in 2005:

1 The system recommended by Dame Janet's Smith's Shipman Inquiry in 2003:

> All deaths should be reported to a coroner so that the coroner makes the decision about which deaths require further investigation. The coroner should be responsible for certifying all deaths, whereas doctors should only provide a medical opinion on the cause of death. The coroner should also consult with the family of the person who has died regarding the cause of death.

2 The system recommended in the Luce Report in 2003:

> The coroner should continue to be informed only of notifiable deaths, but all death certificates would be scrutinised by a medical assessor at the coroner's office. For deaths not reportable to the coroner, two professional medical opinions should be required to certify the cause of death.

Français

Provincial Advocate for Children and Youth Act, 2007

S.O. 2007, CHAPTER 9

Consolidation Period: From October 5, 2007 to the e-Laws currency date.

Last amendment: 2007, c. 9, s. 24.

INTERPRETATION

Purpose

1. The purpose of this Act is to provide for the Provincial Advocate for Children and Youth as an independent officer of the Legislature to,

(a) provide an independent voice for children and youth, including First Nations children and youth and children with special needs, by partnering with them to bring issues forward;

(b) encourage communication and understanding between children and families and those who provide them with services; and

(c) educate children, youth and their caregivers regarding the rights of children and youth. 2007, c. 9, s. 1.

Interpretation

2. (1) In this Act,

"advocacy" means promoting the views and preferences of children and youth as provided for in this Act, and exercising the functions and powers outlined in sections 15 and 16, but does not include conducting investigations or providing legal advice or legal representation; ("intervenir", "intervention")

"Advocate" means the Provincial Advocate for Children and Youth appointed under section 3; ("intervenant")

"Board of Internal Economy" means the Board of Internal Economy established by section 87 of the *Legislative Assembly Act*; ("Commission de régie interne")

"capable" has the same meaning as in section 2 of the *Personal Health Information Protection Act, 2004*; ("capable")

"child" has the same meaning as in subsection 3 (1) of the *Child and Family Services Act*; ("enfant")

"investigative authority" means a person, body or organization that has the authority under an Act of Ontario or Canada to conduct investigations into allegations of offences, abuse, wrongdoing or other matters, and includes, but is not limited to, a police service, Children's Aid Society or coroner, and the Ombudsman; ("autorité chargée des enquêtes")

"law enforcement" has the same meaning as in subsection 2 (1) of the *Freedom of Information and Protection of Privacy Act*; ("exécution de la loi")

"Minister", except in sections 17 and 21, means the Minister of Children and Youth Services, or, if the administration of this Act has been assigned to another Minister under the *Executive Council Act*, that Minister; ("ministre")

"personal information" means personal information within the meaning of the *Freedom of Information and Protection of Privacy Act*; ("renseignements personnels")

"regulations" means regulations under this Act; ("règlements")

"review" means gathering and assessing information for the purpose of advocacy; ("examen")

"systemic review" means providing advocacy to a group of children or youth who are in similar circumstances, either in response to a complaint or request by one child or youth, or on the Advocate's own initiative and includes the review of facilities, systems, agencies, service providers and processes as permitted under this or any other Act; ("examen systémique")

"young person in custody" has the same meaning as in subsection 54 (1) of the *Ministry of Correctional Services Act*; ("adolescent sous garde")

"youth" means one or more young persons within the meaning of the *Child and Family Services Act* or the *Ministry of Correctional Services Act*. ("jeune") 2007, c. 9, s. 2 (1).

Same

(2) Words and expressions used in this Act that are defined in the *Child and Family Services Act*, other than the word "court", have the same meaning as in that Act, unless this Act provides otherwise, either expressly or by necessary implication. 2007, c. 9, s. 2 (2).

Principles to be applied

(3) In interpreting and applying this Act, regard shall be had to the following principles:

1. The principles expressed in the United Nations Convention on the Rights of the Child.
2. The desirability of the office of the Provincial Advocate for Children and Youth being an exemplar for meaningful participation of children and youth through all aspects of its advocacy services. 2007, c. 9, s. 2 (3).

THE ADVOCATE

Advocate to be appointed

3. (1) The Lieutenant Governor in Council shall, on the address of the Legislative Assembly, appoint a person to be the Provincial Advocate for Children and Youth. 2007, c. 9, s. 3 (1).

Qualifications

(2) The Advocate must be a person with significant experience in areas such as children's mental health, child welfare, developmental services, youth justice, education or pediatric health services. 2007, c. 9, s. 3 (2).

Transitional

(3) The person who, immediately before the coming into force of this subsection, held the title of "Chief Advocate" in the Office of Child and Family Service Advocacy continued under section 102 of the *Child and Family Services Act* shall be deemed to have been appointed as the Advocate until an Advocate is appointed under subsection (1). 2007, c. 9, s. 3 (3).

Deputies

4. The Advocate may appoint deputies, including, without being limited to, deputies for youth justice, aboriginal youth and youth in the various geographic regions of Ontario, including youth in northern or remote communities. 2007, c. 9, s. 4.

Officer of the Assembly

5. The Advocate is an officer of the Assembly. 2007, c. 9, s. 5.

Term of office

6. (1) Subject to subsection (2), the Advocate holds office for a term of five years, and may be reappointed for one further term of five years. 2007, c. 9, s. 6 (1).

Removal from office

(2) The Lieutenant Governor in Council may at any time remove the Advocate from office for cause, on the address of the Legislative Assembly. 2007, c. 9, s. 6 (2).

Temporary appointment

(3) If the office of Advocate becomes vacant, or if for any reason the Advocate is unable or unwilling to fulfil the duties of the office, the Lieutenant Governor in Council may appoint a temporary Advocate to act as Advocate for a term of not more than six months. 2007, c. 9, s. 6 (3).

Not a public servant

7. The Advocate is not a public servant within the meaning of the *Public Service of Ontario Act, 2006*. 2007, c. 9, s. 24 (3).

Full-time Advocate

8. The Advocate shall work exclusively as Advocate and shall not hold any other office under the Crown or engage in any other employment. 2007, c. 9, s. 8.

Remuneration of Advocate

9. (1) The Advocate shall be paid a salary fixed by the Lieutenant Governor in Council. 2007, c. 9, s. 9 (1).

Salary not to be reduced

(2) The Advocate's salary shall not be reduced unless the Lieutenant Governor in Council has received an address from the Assembly recommending a reduction. 2007, c. 9, s. 9 (2).

Pension

(3) Despite section 7, the Advocate shall be a member of the Public Service Pension Plan. 2007, c. 9, s. 9 (3).

Expenses

(4) The Advocate is entitled to be paid reasonable travelling and living expenses, as approved by the Board of Internal Economy, while absent from his or her ordinary place of residence in the exercise of the Advocate's functions under this Act. 2007, c. 9, s. 9 (4).

ADMINISTRATION

Budget

10. (1) The money required for the carrying out of the functions of the Advocate shall be paid out of funds appropriated by the Legislature for the purpose. 2007, c. 9, s. 10 (1).

Directives

(2) The Board of Internal Economy may from time to time issue directives to the Advocate with respect to the expenditure of funds, and the Advocate shall comply with those directives. 2007, c. 9, s. 10 (2).

Estimates

(3) The Advocate shall present annually to the Board of Internal Economy estimates of the sums of money that will be required for the performance of all the functions of the Advocate. 2007, c. 9, s. 10 (3).

Same

(4) The Board shall review and may alter the estimates as it considers proper. 2007, c. 9, s. 10 (4).

Audits

(5) The accounts and financial statements of the Advocate shall be audited annually by the Auditor General and the results of those audits shall be presented to the Speaker of the Legislative Assembly. 2007, c. 9, s. 10 (5).

Premises and supplies

11. The Advocate may lease any premises and acquire any equipment and supplies that are necessary for the carrying out of the functions of the Advocate. 2007, c. 9, s. 11.

Services of experts

12. The Advocate may enter into contracts to retain the services of specialists and consultants. 2007, c. 9, s. 12.

Staff

13. (1) Subject to the approval of the Board of Internal Economy, the Advocate may retain the staff that the Advocate considers necessary for the carrying out of the functions of the Advocate, and may determine their remuneration and their terms and conditions of employment. 2007, c. 9, s. 13 (1).

Benefits

(2) The benefits determined under Part III of the *Public Service of Ontario Act, 2006* with respect to the following matters for public servants employed under that Part to work in a ministry, other than in a minister's office, who are not within a bargaining unit apply to the Advocate's staff:

1. Cumulative vacation and sick leave credits for regular attendance and payments in respect of such credits.
2. Plans for group life insurance, medical-surgical insurance or long-term income protection.
3. The granting of leaves of absence. 2007, c. 9, s. 24 (4).

Same

(3) For the purposes of subsection (2), if a benefit applicable to a member of the Advocate's staff is contingent on the exercise of a discretionary power or the performance of a discretionary function, the power may be exercised or the function may be performed by the Advocate or any person authorized in writing by the Advocate. 2007, c. 9, s. 24 (4).

Pension

(4) The Advocate's staff are members of the Public Service Pension Plan. 2007, c. 9, s. 13 (4).

Delegation to staff

14. (1) The Advocate may delegate in writing to any member of the Advocate's staff the authority to perform any of the Advocate's functions or to carry out any of the Advocate's powers, subject to any terms provided for in the delegation. 2007, c. 9, s. 14 (1).

Restriction

(2) The Advocate may not delegate the power to make a delegation or to make a report under section 21. 2007, c. 9, s. 14 (2).

FUNCTIONS AND POWERS

Functions

15. The functions of the Advocate are to,

(a) provide advocacy to children and youth who are seeking or receiving approved services under the *Child and Family Services Act*;

(b) provide advocacy to young persons who are being dealt with under the *Ministry of Correctional Services Act*;

(c) promote the rights under Part V of the *Child and Family Services Act* of children in care and the rights under Part V of the *Ministry of Correctional Services Act* of young persons in custody;

(d) provide advocacy in accordance with clause 16 (1) (k) to children who are pupils of provincial schools for the deaf, schools for the blind or demonstration schools under section 13 of the *Education Act*;

(e) provide advocacy in accordance with clause 16 (1) (l) to children and youth with respect to matters that arise while held in court holding cells and being transported to and from court holding cells; and

(f) provide any other advocacy that is permitted under the regulations or any other Act. 2007, c. 9, s. 15.

Powers

16. (1) In carrying out the functions of the Advocate, the Advocate may,

(a) receive and respond to complaints;

(b) conduct reviews, whether in response to a complaint or on the Advocate's own initiative;

(c) represent the views and preferences of children and youth to agencies and to service providers;

(d) use informal methods to resolve disputes between children or youth and agencies and service providers;

(e) make reports as to the result of the Advocate's review to the complainant, subject to section 20;

(f) provide advice and make recommendations to entities including governments, ministers, agencies and service providers responsible for services,

(i) under the *Child and Family Services Act*,

(ii) provided to young persons under the *Ministry of Correctional Services Act*, or

(iii) that are provided for in the regulations;

(g) educate children in care, young persons in custody, their families and staff of agencies and service providers about the rights of the children under Part V of the *Child and Family Services Act* and the rights of young persons in custody under Part V of the *Ministry of Correctional Services Act*;

(h) communicate with children in care and young persons in custody regarding complaints;

(i) provide advocacy to, but not represent as legal counsel or agent, children in care and young persons in custody who are appearing before a court or tribunal, or who are appearing before a body or person that is reviewing their care, custody or detention disposition;

(j) provide advocacy to children in care and young persons in custody regarding complaints made with respect to rights under Part V of the *Child and Family Services Act* or Part V of the *Ministry of Correctional Services Act*;

(k) receive and respond to complaints from children who are pupils of provincial schools for the deaf, schools for the blind or demonstration schools under section 13 of the *Education Act* and use informal methods to resolve those complaints;

(l) receive and respond to complaints from children and youth with respect to matters that arise while held in court holding cells and transported to and from court holding cells;

(m) meet with children who have undergone emergency admission to a secure treatment program under the *Child and Family Services Act* to explain, in language suitable to their understanding, the children's right to a review of the admission;

(n) where an investigative authority is conducting an investigation that involves a child in care or a young person in custody, provide advocacy to the child or youth that does not interfere with the investigation;

(o) provide information to children and youth and their families on how to access approved services;

(p) engage in systemic reviews on behalf of children and youth;

(q) provide public education about this Act and the role of the Advocate; and

(r) perform other powers and duties provided for in the regulations. 2007, c. 9, s. 16 (1).

Restriction on acting as counsel

(2) The Advocate shall not represent a child or youth before a court or tribunal. 2007, c. 9, s. 16 (2).

Restriction on advocacy

(3) Nothing in this Act permits the Advocate to summon and enforce the attendance of witnesses, to compel testimony under oath or to compel witnesses to produce records or things. 2007, c. 9, s. 16 (3).

Power not to act on complaint

(4) The Advocate may, in his or her discretion, decide not to take any action based on a complaint if the Advocate is of the opinion that,

(a) the subject matter of the complaint is trivial;

(b) the complaint is frivolous or vexatious; or

(c) the complaint is not made in good faith. 2007, c. 9, s. 16 (4).

Reasons to be given

(5) Where the Advocate decides not to act on a complaint, or to take no further action with regard to a complaint, the Advocate shall give the complainant notice in writing of the Advocate's decision, and of the reasons for the decision. 2007, c. 9, s. 16 (5).

Special requirements or needs

(6) In the course of carrying out his or her functions, the Advocate shall provide advocacy that is sensitive to any special requirements or needs of the child or youth. 2007, c. 9, s. 16 (6).

Notice of review

17. Where the Advocate intends to undertake a systemic review, the Advocate shall advise the Minister or the administrative head of the Ministry, agency, service provider or other entity that is to be affected of the intention to conduct the review. 2007, c. 9, s. 17.

OBLIGATIONS ON OTHERS

Obligations of service providers

18. (1) An agency or service provider, as the case may be, shall inform a child in care or a young person in custody, in language suitable to his or her understanding, of the existence and role of the Advocate, and of how the Advocate may be contacted. 2007, c. 9, s. 18 (1).

Same

(2) An agency or service provider, as the case may be, shall afford a child or youth who wishes to contact the Advocate with the means to do so privately and without delay. 2007, c. 9, s. 18 (2).

Same

(3) Every agency or service provider, as the case may be, shall, without unreasonable delay, provide the Advocate with private access to children in care or reasonable private access to young persons in custody who wish to meet with the Advocate. 2007, c. 9, s. 18 (3).

CONFIDENTIALITY AND PRIVACY

Confidentiality

19. The Advocate, and all of the Advocate's staff, shall take an oath not to disclose any personal information obtained in the course of acting under this Act, except as permitted under this Act. 2007, c. 9, s. 19.

Protection of privacy and access to information

20. The following rules apply to the collection, use or disclosure of personal information by the Advocate:

1. The Advocate may directly collect personal information from an individual for the purposes of carrying out the functions of the Advocate.
2. When collecting personal information directly, the Advocate shall explain to the individual from whom it is being collected how the information may be used or disclosed, and any limitations on confidentiality that may apply.
3. The Advocate may collect personal information about an individual indirectly either with the individual's consent, or, if it is not reasonably possible to obtain the individual's consent, with the consent of a person who is authorized to consent on behalf of the individual in accordance with paragraph 12.

4. The Advocate may only use personal information about an individual that has been collected indirectly with the consent of the individual, or, if it is not reasonably possible to obtain the individual's consent, with the consent of a person who is authorized to consent on behalf of the individual in accordance with paragraph 12.
5. With the consent of an individual, or, if it is not reasonably possible to obtain the individual's consent, with the consent of a person who is authorized to consent on behalf of the individual in accordance with paragraph 12, the Advocate may collect personal information in the possession of an agency, service provider or other entity about the individual, if that information would normally be available to the individual, either through law or policy.
6. The Advocate may use personal information about an individual,
   i. for the specific purpose for which it was collected, or
   ii. for the purpose of seeking the individual's consent to use or disclose the information, where the personal information was collected indirectly.
7. The Advocate may only disclose personal information,
   i. with the consent of the individual to whom the information pertains, or, if it is not reasonably possible to obtain the individual's consent, with the consent of a person who is authorized to consent on behalf of the individual in accordance with paragraph 12, and
   ii. in accordance with this Act and any other laws of Ontario and Canada.
8. Despite paragraph 7, the Advocate may disclose personal information without consent,
   i. if the Advocate reasonably believes that the disclosure is necessary to eliminate or reduce a significant risk of death or serious bodily harm to a person or group,
   ii. if the disclosure is authorized or required by law, or
   iii. if the disclosure is necessary for the purposes of law enforcement.
9. The Advocate may only disclose under subparagraph 8 iii information that was received from a child or youth without the consent of the child or youth if the interest of the continued proper administration of justice in having the information disclosed outweighs the privacy interests of the child or youth in not having the information disclosed.
10. The Advocate may not disclose in a public report or public communication the name or identifying information of any individual who has not consented to the disclosure unless a person who is authorized to consent on behalf of the individual in accordance with paragraph 12 has consented to the disclosure.
11. Any consent required by this section must be knowledgeable as described in subsection 18 (5) of the *Personal Health Information Protection Act, 2004*, relate to the specific information, and be given freely.
12. Where an individual is not capable of consenting to the collection, use or disclosure of personal information, a person who would be capable of consenting to the collection, use or disclosure, as the case may be, of personal health information on the individual's behalf under the *Personal Health Information Protection Act, 2004* may consent on the individual's behalf.
13. An individual or a person who is authorized to consent on behalf of an individual in accordance with paragraph 12 may withdraw consent to the collection, use or disclosure of personal information at any time.
14. All of the rules in this section that apply to the Advocate apply equally to the Advocate's staff and to any specialists or consultants retained by the Advocate. 2007, c. 9, s. 20.

REPORTING REQUIREMENTS

Report to the Legislative Assembly

21. (1) The Advocate shall, after April 30 in every year, make a report in writing and shall deliver the report to the Speaker of the Legislative Assembly no later than December 31 in that year. 2007, c. 9, s. 21 (1).

Contents

(2) The report mentioned in subsection (1) shall contain whatever information the Advocate considers appropriate, but shall contain, at a minimum, a report on the activities and finances of the Advocate's office, the outcomes expected in the fiscal year of the Government of Ontario in which the report is made, and the results achieved in the previous fiscal year. 2007, c. 9, s. 21 (2).

Laying before Assembly

(3) The Speaker shall lay the report before the Assembly at the earliest reasonable opportunity. 2007, c. 9, s. 21 (3).

Minister's copy

(4) The Advocate shall deliver a copy of the report to the Minister of any Ministry to which it is relevant before delivering it to the Speaker. 2007, c. 9, s. 21 (4).

Other reports

(5) The Advocate may make any other public reports as he or she considers appropriate, and may present such a report to the public or any other person he or she considers appropriate, but shall deliver a copy of the report to the Minister of any Ministry to which it is relevant before the presentation. 2007, c. 9, s. 21 (5).

MISCELLANEOUS AND REGULATIONS

Limitation of liability

22. No proceeding shall be commenced against the Advocate or any person acting on behalf of or under the authority of the Advocate for anything done, reported or said in good faith in the course of the exercise or performance or intended exercise or performance of a power, duty or function under this or any other Act. 2007, c. 9, s. 22.

Regulations

23. The Lieutenant Governor in Council may make regulations,

(a) permitting the Advocate to provide any advocacy not otherwise provided for in this Act, subject to any conditions that may be provided for in the regulations;

(b) providing for anything that under this Act may be provided for in the regulations. 2007, c. 9, s. 23.

24. OMITTED (PROVIDES FOR AMENDMENTS TO THIS ACT). 2007, c. 9, s. 24.

25. OMITTED (AMENDS OR REPEALS OTHER ACTS). 2007, c. 9, s. 25.

26. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS ACT). 2007, c. 9, s. 26.

27. OMITTED (ENACTS SHORT TITLE OF THIS ACT). 2007, c. 9, s. 27.

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IN THE MATTER OF the *Public Inquiries Act*, R.S.O 1990, c. P. 41

AND IN THE MATTER OF

THE INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO
The Honourable Stephen T. Goudge, Commissioner

Proceedings at Toronto

SUBMISSIONS
OF
DEFENCE FOR CHILDREN INTERNATIONAL-CANADA
(DCI-CANADA)
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