**INQUIRY INTO
PEDIATRIC FORENSIC
PATHOLOGY IN ONTARIO**

The Honourable Stephen Goudge,
Commissioner

180 Dundas Street West, 22nd Floor
Toronto, Ontario M5G 1Z8

Tel: 416 212-6878
1 866 493-4544
Fax: 416 212-6879
Website: www.goudgeinquiry.ca

**COMMISSION D'ENQUÊTE
SUR LA MÉDECINE LÉGALE
PÉDIATRIQUE EN ONTARIO**

L'honorable Stephen Goudge,
Commissaire

180, rue Dundas Ouest, 22e étage
Toronto (Ontario) M5G 1Z8

Tél.: 416 212-6878
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INTERVIEW SUMMARY
MICHAEL DAVIS

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Background

Mr. Davis is a former police officer who served on the Toronto Police Service from 1973 to 2005. After completing 32 years of service, Mr. Davis retired from the Toronto Police Service.

Mr. Davis has been involved in many roles during his tenure as an officer, but the majority of his experience was in the investigative field. He was promoted to the rank of detective in 1987. In 1988, he transferred to the Homicide Squad, where he remained for 16.5 years, until his retirement.

In April, 2005, Mr. Davis and Mr. Mark Mendelson formed Mendelson Davis Consulting Partners. They are licensed private investigators who conduct private investigations and other consultative work in Ontario.

Pediatric Death Investigations

While a member of the Homicide Squad, Mr. Davis was either the lead investigator or the immediate supervisor in a number of pediatric death cases in Toronto. His involvement in the majority of these cases arose as a result of being "on call" at the time the call came in. He sees the desirability of triaging these cases given the investigative difficulties associated with them, so that they are assigned to officers with particular experience in them.

Mr. Davis explained that typically, once police receive a report of a baby or child death, uniformed officers, followed by investigative personnel from the local division, would attend the scene. Once there has been a determination of suspicious circumstances surrounding the death, or a conclusion that a homicide has occurred, detectives from the Homicide Squad would be dispatched to the scene.

Often, the coroner would have already been to the scene, pronounced death, and ordered a post mortem examination, prior to the arrival of the homicide detectives. He thinks it desirable that coroners receive additional training in dealing with death scenes.

The post mortem examinations conducted on babies and children were done at the HSC. Mr. Davis has had direct involvement with Dr. Smith, Dr. Taylor, and Dr. Wilson from the OPFPU.

Typically, prior to the commencement of the post mortem examination, the detectives would meet with the pathologist assigned to perform the examination. They would pass on the information they had by that stage, including date, time, location, circumstances surrounding the death, information from witnesses, scene observations, any weapon(s) located at the scene, and any medical history known about the deceased.

Mr. Davis now sees the desirability that much of the information acquired in the investigation be filtered out, and not provided to the pathologist prior to the post mortem examination. He believes that this information may colour the pathologist's opinion. Indeed, he sees the benefit of involving highly trained coroners more extensively in serving as the filters in communicating information to the pathologist. He also doubts the necessity of the investigators attending the autopsy itself (as opposed to the forensic identification officers). He feels that the investigators can meet with the pathologist after the post mortem examination has been completed, to learn what the pathologist has found.

In practice, upon completion of the post mortem examination, if the pathologist was able to provide a cause of death, s/he would inform the detectives verbally. The detectives would record that information in their memorandum book. It is best practice for the detectives to confirm with the pathologists that they have accurately recorded what the pathologist is prepared to say.

Mr. Davis noted that typically in pediatric death investigations in Toronto, a close relationship would develop between the homicide detectives involved, the Chief Coroner's Office, physicians in the pathology department, and the SCAN unit from HSC.

Pediatric Death Review Committee

Mr. Davis was a member of the Pediatric Death Review Committee chaired by Deputy Chief Coroner Dr. James Cairns, from 2000 to 2005.

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.

Educational Initiatives

While with the Toronto Police Service, Mr. Davis lectured and presented on a wide variety of topics. He was not aware of any continuing education for officers in relation to investigating pediatric death cases.

Drawing on his experiences, Mr. Davis created a power-point presentation to provide training and education for officers of all levels who may become involved in pediatric death investigations. He continuously updated his presentation between 1999 and 2003. He presented it at the Ontario Police College in Aylmer, Ontario, and at their own police college. In addition, he traveled with Dr. Cairns and Dr. Huyer and presented it to other social agencies, modified to suit their needs. He was also a panel member, on the subject of baby and child death investigations, at Crown schools for child abuse prosecutions.

Mr. Davis does not know whether this presentation continues to be used as an educational tool today. He has provided the Commission with his most recent power point presentation. The Commission has omitted the photographs that form part of the presentation, as well as the names of the cases referred to in the presentation.

Mr. Davis thinks it is important that these kinds of presentations be modified to reflect ongoing medical knowledge and developments, including controversies over shaken baby cases etc., and delivered to officers and other participants in the justice system.

"Think Dirty" and Other Concerns

Mr. Davis has never liked the term "think dirty". He believes that an investigator should remain open minded throughout the investigation. He made sure, in his power-point presentation, to convey this idea clearly. The presentation refers to the need to remain open minded and to consider the various defences that typically arise in pediatric death cases.

Mr. Davis would like to see a Crown involved in investigations as early as possible to provide assistance to the police.

Finally, Mr. Davis had an unsatisfactory experience in sharing information with a children's aid society. He learned after the fact that the information he had communicated had been reduced to an affidavit and presented in the child protection proceedings. He was concerned about its impact upon an ongoing investigation. He recognizes the difficult challenges in reconciling the criminal investigator's needs and the need to protect siblings in a child protection setting. He feels, at a minimum, that the children's aid society should inform the investigator prior to the use of shared information, so that the investigator can provide input as to the form and content of the information to be used.