

ACTING ON THE GOUDGE REPORT INTO CHILD PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

December 2, 2008

Ontario is acting on the recommendations made by Justice Stephen Goudge in his inquiry into Pediatric Forensic Pathology in Ontario by establishing a review team for “shaken baby” death cases and a committee to consider issues of compensation related to Dr. Charles Smith’s work.

DR. SMITH COMPENSATION FRAMEWORK ADVICE COMMITTEE

The Attorney General has established a committee to provide him with legal advice on a compensation framework for those who have suffered injustice as a result of flawed pediatric forensic pathology conducted by Dr. Charles Smith in Ontario.

Leading the Dr. Smith Compensation Framework Advice Team is the Honourable Coulter Osborne. After his call to the Bar in 1959, Mr. Osborne practised in Kitchener, Ontario until his appointment to the Supreme Court of Ontario in 1978. During his tenure on the Supreme Court of Ontario, he was appointed the Commissioner of the Inquiry into Motor Vehicle Accident Compensation in Ontario in 1987. Mr. Osborne subsequently served on the Court of Appeal from 1990 and, in June 1999, was appointed the Associate Chief Justice of Ontario. On September 17, 2001, he was appointed Integrity Commissioner.

SHAKEN BABY DEATH REVIEW TEAM

The Attorney General has also struck a medical/legal review of criminal convictions from deaths involving “shaken baby syndrome.” Justice Goudge recommends a review that determines which cases involving “shaken baby syndrome” resulted in a conviction or a finding of not criminally responsible. The medical/legal review would look at those cases resulting in a conviction to determine whether the pathology evidence was inconsistent with current scientific knowledge. The review would consider trial decisions and supporting evidence to determine if a change in scientific opinion would be sufficiently important to the outcome of the case to raise concerns about the validity of the conviction.

A similar review of 88 cases in the United Kingdom resulted in three cases that were overturned.

Leading the Shaken Baby Death Review Team is the Honourable Justice Donald A. Ebbs of the Ontario Court of Justice. Justice Ebbs articulated with the Ministry of the Attorney General before being called to the Bar with Honours in 1969. Following that, he practiced law in Peterborough, was a member of the Canadian Bar Association and served as a part-time Assistant Crown Attorney. In 1983, Justice Ebbs was appointed to the bench and presided in both Windsor and London. He then served as a Regional Senior Judge for the west region before assuming the role of Associate Chief Justice and Coordinator of Justices of the Peace in 2001. Justice Ebbs retired from this position in 2007.

STRENGTHENING ONTARIO'S DEATH INVESTIGATION SYSTEM

On October 23, 2008, Community Safety and Correctional Services Minister Rick Bartolucci introduced legislation that would, if passed, establish a framework to strengthen the death investigation system, provide for greater oversight and accountability, and improve coroner and pathology services in Ontario. Guided by Justice Goudge's recommendations, the legislation would build on the progress Ontario has made in the past five years to improve the province's coronial system.

The Ministry of the Attorney General has since implemented a number of initiatives to improve the way it handles child homicide cases, including:

- Appointing a nine-person Child Homicide Resource Team to provide advice to Crowns at all stages of a child homicide prosecution
- Developing a database to better track child homicide cases and the pathologists involved in those cases
- Enhancing Crown training and education on pediatric forensic pathology issues and assessing expert evidence.

THE GOUDGE INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

In April 2007, several days after the chief coroner announced the results of a review into the work of pediatric pathologist Dr. Charles Smith, the McGuinty government called a public inquiry into Ontario's pediatric forensic pathology system.

On October 1, 2008, Justice Stephen Goudge released the inquiry's report and recommendations.

The inquiry cost approximately \$9.4 million, not including any special government grants or inquiry-related expenses of independent public bodies, such as the Hospital for Sick Children or the College of Physicians and Surgeons.

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