1. Good morning, my name is Stephen Goudge. Thank you very much for attending today.

2. On April 25, 2007, the Province of Ontario established the Inquiry Into Pediatric Forensic Pathology in Ontario. That Order-in-Council appointed me as Commissioner.

3. Today marks the first public session of the Commission. This morning, I want to do five things:

a) introduce some of the members of the Commission's staff;

b) explain the terms of reference for the Commission and describe what the Commission can do, and what it cannot do;

c) share some of what the Commission's staff have done so far;

d) describe the private meetings I am holding with individuals and families affected by practices in Ontario's pediatric forensic pathology system, and explain why these meetings are important to the work of this Commission; and finally,

e) outline the process that the Commission will follow from this point forward.

Introduction of Commission Staff

4. First, I am very fortunate to have Senator Larry Campbell assisting me.

5. Senator Campbell has spent most of his career in law enforcement and death investigation. He was instrumental in establishing Vancouver's District Coroner's office. He became Chief Coroner in 1996. As many of you know, Senator Campbell was elected mayor of Vancouver in 2002.

6. Senator Campbell will provide me with information and advice on scientific and medical issues.

7. One of my first acts as Commissioner was to assemble a team of lawyers, scholars, and administrators to assist me. I am joined by the three senior members of my team at the front of the room:

a) Linda Rothstein is Commission Counsel;

b) Mark Sandler is Special Counsel Criminal law; and

c) Prof. Kent Roach is the Commission's Research Director.

8. With the able assistance of the rest of the team, they were able to start the Commission's investigation process within days after the Order in Council was passed. So far, Commission lawyers have spent a good deal of time meeting with interested

persons and organizations to discuss the Commission's mandate and outlook, and to begin to gather information.

Description of the Commission

9. The Order-in-Council created the Commission and gave it certain powers under the *Public Inquiries Act*. The jurisdiction of this Commission, like all commissions of inquiry, is limited by the Order-in-Council that creates it. I do not function as a Commissioner at large. I can neither expand, nor work outside of the mandate provided to me.

10. Public inquiries are an important component of our Canadian democracy. They play an important role in fact-finding, and in educating and informing concerned members of the public. They also play a role in restoring public confidence in governmental institutions. In the end, they make recommendations designed to ensure, as best we can, that the concerns that gave rise to the Commission are addressed and avoided in the future.

11. I want to emphasize what a commission of inquiry is, and what it is not. It is an investigation into a matter of substantial public interest to a community. It has the power to summons witnesses, to compel the production of documents, and to accept evidence. However, it is not a trial, criminal or civil, and I cannot make findings of criminal or civil liability.

12. My Order-in-Council directs me to “make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.”

13. That is the Commission's primary task: to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings. The Commission's recommendations will, I hope, ensure that no one ever has to endure the horror of being charged criminally, or having a family unit pulled apart, or being wrongfully convicted because of flawed pathology findings or evidence. The Commission's recommendations will also attempt to ensure that pediatric forensic pathology appropriately supports society's interest in protecting children from harm and ensuring that those individuals who do harm children are brought before the courts to be dealt with according to the law.

14. This is a matter of fundamental importance to the administration of justice in Ontario. The death of any young child is an extraordinary tragedy. The enormous grief and trauma experienced by the parents and other family members where a child has died is almost beyond comprehension. Where the death has occurred in circumstances that might be described as criminally suspicious, we must ensure that the death investigation is detailed, thorough, objective, compassionate, and balanced.

15. Pediatric forensic pathology must do its part to ensure that death investigations meet these goals. I am charged with making recommendations to restore and enhance public confidence that pediatric forensic pathology promotes the search for truth and helps to answer as accurately as science permits the question of what caused a child's death.

16. To allow me to make these recommendations, I will conduct a systemic review and assessment of three things:

a) the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings;

b) the legislative and regulatory provisions in existence that related to the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and

c) any changes to these items that have been made subsequent to 2001.

17. I want to underline the words “systemic review” that appear throughout the Order-in-Council. I must take them very seriously. They must inform and guide my decisions as Commissioner.

18. As part of this systemic review, the Commission will wrestle with difficult questions. Among many other matters, the Commission will examine and evaluate:

a) the evolution, limits and inherent frailties of pediatric forensic pathology, and the developing state of that science, including sudden infant death syndrome and shaken baby syndrome;

b) best practices for pediatric forensic pathology, including issues of training, protocols, peer review, oversight, and certification;

c) how key institutions within our justice system work together, and how well they do so. We will examine the interaction between pediatric forensic pathologists, the police, the Coroner's office, Crown Attorneys, and others. We will identify best practices to avoid tunnel vision during investigations and criminal proceedings involving pediatric forensic pathology;

d) the evolution of pediatric death investigation procedures;

e) different models of death investigation and reporting including coroner-based systems and medical examiner-based system, their strengths and weaknesses, and what we can learn from other jurisdictions;

f) how Crown Attorneys and defense counsel obtain and use forensic experts;

g) the role of the legal aid system in ensuring that defence counsel has access to competent expertise in pediatric forensic pathology;

h) the use of scientific experts by courts in other jurisdictions, including how experts are designated by different regulatory bodies, as well as how courts and juries can evaluate an expert's expertise; and

i) how the courts referee forensic disputes both pre-trial and at trial, and how the courts function as gate-keepers by determining who qualifies as an 'expert' and what counts as 'expertise'.

19. As I mentioned earlier, Orders-In-Council tell Commissioners what to do and what not to do. The Order-in-Council creating this Commission is no exception and it clearly states that the Commission:

a) shall not report on any individual cases that are, have been, or may be subject to a criminal investigation or proceeding; and

b) shall perform its duties without expressing any conclusion or recommendation regarding professional discipline matters involving any person or the civil or criminal liability of any person or organization.

20. The Commission will not report on individual cases. Without this limitation in the Order-in-Council, the Commission would be required to exhaustively review and call evidence regarding, depending on how one counts, 21, 45, or still more individual cases. I am required to deliver my report in less than one year. It would be impossible to do justice to that many cases and still make timely systemic recommendations.

21. Moreover, the reporting deadline serves an important public purpose: to provide the government with my recommendations as expeditiously as possible in order to restore faith in pediatric forensic pathology and its use in investigations and criminal proceedings.

22. I wish to underline that this Commission does not have the jurisdiction to consider whether or not any criminal conviction should be considered a miscarriage of justice. The *Criminal Code* contains various procedures to do that. The Commission will neither duplicate nor interfere with those procedures. There may be cases where individuals seek to appeal, or to otherwise have reviewed her or his conviction based on new pathology results. As the Attorney General said when he announced this Commission, it is important that such applications be dealt with fairly, and as expeditiously as possible, and I trust that the Ministry will do all it can to ensure that this happens.

23. While the Commission will not be reporting on individual cases, it will be necessary to review individual cases for the purposes of determining what systemic issues they raise. We need to learn enough about the facts of what happened and why to make practical and effective recommendations. I will describe later on how we intend to proceed with this.

Private meetings with individuals and families and counselling

24. This week, and again in August, I will meet privately with individuals and families affected by practices in Ontario's pediatric forensic pathology system between 1981 and 2001. Everyone who will meet with me is doing so voluntarily.

25. In order for me to understand fully the impact that systemic failings have had on people's lives, I believe it is crucial for me to speak with those directly affected.

26. However, in order not to prejudice any ongoing legal proceedings, and in view of the intimate and personal nature of the matters that will undoubtedly be disclosed in these meetings, these meetings must take place in private. They will neither be part of the formal hearing process, nor form a basis for fact-finding. There will be no transcripts of the meetings.

27. What is said to me by the participants will not be disclosed. This confidentiality is essential to permit individuals to feel comfortable discussing these events with me. In fact, many participants agreed to meet with me only on that basis.

28. The Commission is not empowered to correct errors in specific cases nor provide financial compensation but the information from the meetings will be extremely useful background for my work. It will anchor my work in real human experience.

29. In addition, section 16 of the Order-in-Council authorizes me to provide counseling services to victims or families. Anyone, including immediate family members

who has been affected by these systemic failings relating to pediatric forensic pathology is eligible to receive these services.

30. Individuals who qualify for counselling support can choose both the type of counselling and the service provider that is right for them, provided that the Commission agrees that the person is a qualified counsellor. A qualified intake counsellor will assist those who are interested in counselling, but who are unsure what type of counselling can meet their needs and/or how to find a qualified counsellor.

31. Anyone interested in counselling related to matters within the Commission's mandate, should please call the Commission. The process is straightforward, confidential, and supportive. You will be given a private appointment to speak with a qualified intake counsellor, either in person or over the phone and at a time convenient to you. The intake counsellor will answer any questions you may have and will explain the process to you.

32. At this point in time, funding for counselling will be available for a period of up to two years. If necessary, there will eventually be an opportunity for submissions on the need for further counselling.

Process after today

a) Standing

33. Later today, the Commission will publish its Rules of Standing and Funding on the Commission's website: www.goudgeinquiry.ca

34. The Commission invites interested persons to seek standing at the Commission by way of motion in writing with supporting materials, which must be filed in electronic format with the Commission on or before July 16, 2007

35. The Order-in-Council provides that I may make recommendations to the Attorney General regarding funding to a party who has been granted standing where in my view the party would not be otherwise able to participate in the Commission without such funding. Persons may seek funding by way of motion in writing with supporting materials to be filed in electronic format with the Commission on or before July 16, 2007.

36. I anticipate scheduling a public hearing on applications for standing and funding on August 8, 2007, and releasing my decision by August 20. If anyone has questions regarding the process for applying for standing and funding, they should contact Commission Counsel.

b) Rules of Procedure and Practice

37. After the release of my decision on standing and funding, Commission Counsel will invite persons with standing to meet to discuss draft Rules of Procedure and Practice, which I anticipate releasing in final form by the end of August.

c) Further pathological review

38. This Commission was announced about a week after the Chief Coroner for Ontario announced the results of a review of certain criminally suspicious or homicide cases where Dr. Charles Smith was either the primary or consulting pathologist, and found that, in a number of cases some of the factual conclusions were not reasonably supported by the materials available for review.

39. Five eminent forensic pathologists from Canada and around the world conducted the Chief Coroner's Review. The Commission's Order-in-Council directs the Commission to consider the results of the Chief Coroner's Review.

40. As has been publicly reported by the Chief Coroner, the Chief Coroner has advised the College of Physicians and Surgeons of Ontario of the concerns identified in its review of certain cases of suspicious child deaths where Dr. Smith performed the autopsy or was consulted.

41. I have asked the College, and it has agreed, that this inquiry be given priority for access to evidence and experts. I want to be clear that my request may delay any matters that may be before the College, and that I appreciate the College's cooperation in this regard.

d) Overview Reports

42. The Commission began its investigation on April 25, 2007. The goal of the investigation, in part, is to identify the core or background facts that will form the basis of Overview Reports about the systemic issues to be addressed, and to identify representative witnesses. The investigation will consist primarily of document review, consultation with interested persons and witness interviews by Commission staff.

43. The Order-in-Council provides Overview Reports to be prepared, which may contain core or background facts, together with their sources.

44. The Commission will provide an opportunity for parties to comment on the accuracy or completeness of the Overview Reports before they are filed. The Commission may modify the Overview Reports in response. The Overview Reports will be used to assist in identifying the systemic issues that are relevant to the work of the Commission.

e) Public Hearings

45. After the Commission has completed its investigation and the Overview Reports, the Commission will hold public hearings in Toronto.

46. The Overview Reports will be presented in the public hearings. Parties may also propose witnesses to be called to support, challenge, comment upon or supplement the Overview Reports.

47. Our present intention is that from this will emerge the list of systemic concerns that will be the vital basis for our policy work. These systemic concerns will be debated in public roundtable sessions to elicit expert opinion on what solutions are available to solve these systemic concerns.

48. We also anticipate that the public hearings will examine how institutions responded to challenges to the work of pediatric forensic pathologists, and consider recommending strengthened oversight and accountability measures where appropriate.

49. Wherever possible, the Commission will rely on the use of representative witnesses from institutions. Given the systemic focus of the Commission, the Commission does not anticipate hearing from a large number of witnesses whose involvement was limited to one or two cases of interest identified by the Chief Coroner's Review.

50. The Commission will also call experts to assist me to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.

f) Research Project

51. The Commission will also be embarking on an important research project under the leadership of Prof. Kent Roach. The purpose of the research project is to present the Commission with both important background information and various possible policy solutions. Whether or not any of these proposals are accepted is up to me, not the

researchers. The Commission intends to test this research in lively and public roundtables that will bring a diversity of perspectives and experience to the issues.

52. Prof. Roach is in the process of identifying approximately 8 independent researchers, experts from Canada and around the world, to write papers to carry out this project. I hope that in this way the Commission will also create a research legacy that will be of assistance to the administration of justice in many jurisdictions.

Conclusion

53. Thank you all for coming today. Regular updates about the Commission's schedule and events will be posted on our website at www.goudgeinquiry.ca Commission Counsel will now be available to answer questions from the media.