OPENING STATEMENT OF COMMISSION COUNSEL

ON NOVEMBER 12, 2007

1. As you have noted, Commissioner, although this is the first day of evidence at the Inquiry's public hearings, much has gone on behind the scenes.

a) Consultation

2. Commission counsel have engaged in ongoing consultations with all parties with standing and various other persons having an interest in the work of the Inquiry.

3. We have been extremely gratified by the cooperative spirit demonstrated by all counsel for the parties and their obvious commitment to making this public Inquiry as informative, probing and streamlined as possible.

b) Document Production, Collection and Database Creation

4. Commission Counsel issued summonses to all persons or parties thought to be in possession of potentially relevant documents.

5. Working with counsel for those that were the subject of a summons, we have reviewed hundreds of thousands of pages of paper and electronic documentation with a view to identifying those documents which were truly

relevant to the work of the Inquiry. To the extent possible, we have endeavored to collect documents of importance to the Inquiry. To date, we have collected and scanned more than 135,000 pages of documents for the database. Our database has been made accessible electronically to all parties with standing subject to strict and rigorous confidentiality protocols.

6. Our investigation is ongoing. Inevitably, new documentation that is relevant to our work will become available as we proceed but we remain hopeful that the number of new documents that will be added to our database will gradually diminish.

7. A word about privacy issues. Not surprisingly, documents relating to the mandate of this Inquiry raise many serious privacy or confidentiality issues. The Inquiry is examining pediatric forensic pathology in its interface with, for example, child protection agencies, young persons as defendants, families, police, crown counsel and defence counsel.

8. The privacy issues that arise in these contexts are addressed through statutory prohibitions, discretionary and mandatory court orders and have also been addressed through your recent ruling.

9. Following your ruling on November 1, 2007, we distributed to counsel a list of individuals whose identities were the subject of your order together with a list

of pseudonyms by which the commission proposes that they be referred to in the public hearings. All media reporters in the Inquiry have also been asked to familiarize themselves with terms of your non-publication orders.

10. Where necessary webcasting of the hearings may be adjusted to permit inadvertent violations of your non-publication to be addressed.

11. Documents which become part of the record in these hearings, will only be released to members of the public after they have been redacted as necessary to comply with your order and applicable schedules. This may take some time and we appreciate the patience and understanding of those who make requests of the limited time and resources available to address those requests.

c) Witness interviews

12. To date, Commission Counsel and staff lawyers have interviewed a total of 48 witnesses and have documented their interviews in detailed interview summaries. Many of those summaries have been provided to counsel. Some are still in the process of being reviewed by those we have interviewed to ensure their accuracy. They will be distributed to counsel as soon as possible. Although these interview summaries will not be used for cross-examination, we are hopeful that they will assist all counsel in preparing their examinations and in identifying the issues of importance to your work.

13. Not all of the witnesses we have interviewed will testify during our public hearings. In some cases, we have determined that their evidence does not address key issues. In other cases, their evidence duplicates the evidence of others who will be called to testify. In addition, we are hopeful that we can obtain agreement to present important aspects of the evidence in written form such that they will not be required for either examination or cross-examination. Again, our objective is to present the evidence you need to make effective recommendations in as streamlined a fashion as possible.

d) Overview Reports

14. As you have explained, Commissioner, the Chief Coroner's Review was central to the creation of the Inquiry. It was conducted by two Ontario experts and five internationally recognized forensic pathologists. They examined 45 cases of suspicious child deaths where Dr. Charles Smith performed the autopsy or was consulted. In 20 of those cases, they found that some of his conclusions were not reasonably supported by the materials available. All five of the external reviewers will be called to testify in order for us to fully understand and test their conclusions.

15. In 18 of the 20 cases in which Dr.Smith's conclusions were criticized, Commission counsel, together with our wonderful team of staff lawyers, have prepared Overview Reports which summarize the relevant documents in our

database and set out the background and core facts together with their sources. In advance of finalizing these reports, we provided an opportunity to the parties to comment on their accuracy and to suggest modifications.

16. We are hopeful that the Overview Reports, which will be presented this week, will be useful in assisting you in identifying the systemic issues that are relevant to this Inquiry, in making findings of fact on the undisputed terrain and enabling you to make recommendations to restore confidence in pediatric forensic pathology in Ontario.

17. It is important to note that the Overview Reports contain a significant amount of information that has not been tested for its truth. These reports recount the perceptions, information and views of many people. These accounts may or may not be based on accurate facts.

18. In some cases, the Overview reports detail spurious allegations, which were later proven false. In other cases, they contain allegations, which have not yet been proven one way or the other, or which are incapable of proof. In places, the Overview Reports set out the views individuals held at a particular time. These views may not accord with the views those same individuals hold today.

19. Commission counsel believe, however, that it is important that the Overview Reports contain all of this information, because the fact that such views

were held or that such allegations were expressed at the time, may provide insight into the actions or omissions that ultimately occurred.

20. The full record must be placed before you, Mr. Commissioner, so that you may fully appreciate the context in which these cases occurred.

21. We are hopeful that reliance on the Overview Reports will considerably expedite these proceedings and will dramatically reduce the number of witnesses that we would otherwise need to call and documents we would need to prove to establish the factual foundation for your work. They will also help to make clear the complex factual matrix at the heart of any death investigation, and the importance of looking beyond the autopsy procedures and the work of any individual pathologist to appreciate the full nuanced context.

22. Ultimately, it will be for you, Mr. Commissioner, to decide how much or little weight is placed on the information contained within these reports when you make your recommendations.

23. In 2 of the 20 cases identified by the Chief Coroner's Review, we have not prepared Overview Reports. One of those cases, the Trotta case, was the subject of an appeal to the Supreme Court of Canada in the early fall and the Supreme Court's decision was released on Thursday. It has ordered a new trial.

In these circumstances, we are of the view it would be preferable to focus on features of that case as opposed to all of its detailed facts.

24. In the last case, which I am not able to identify by name at this stage, there is an ongoing police investigation. For that reason, we are persuaded that it would not assist the work of the Inquiry to present an Overview Report or engage in a detailed review of all of the facts of that case, at least at this juncture.

e) Dr. Smith

25. A few words about Dr. Smith. It is true that the Coroner's Review was created to examine his work and that the twenty cases in which the review panel identified concerns will be the subject of considerable evidence as this inquiry proceeds.

26. But, as with others, our job is to critically scrutinize Dr. Smith's work, but not to demonize him. Moreover, we cannot allow undue emphasis on his role to distract us from our systemic focus. As will become clear from the Overview Reports, in a number of the cases we will examine, Dr. Smith's opinions were supported by others engaged in the complex and difficult task of pediatric death investigation.

f) Research Papers

27. Our Research Director, Professor Kent Roach, has assembled many internationally renowned experts and scholars to write about many of the systemic issues from an academic perspective. These papers will demonstrate that establishing best practices in forensic pathology and pediatric forensic pathology is an issue of concern throughout the world. Three of these papers have been posted on our website this morning. Commissioner, you have asked me to emphasize that the views expressed in these papers do not necessarily represent your views or the views of your counsel but are the product of independent scholarly work. The issues they raise and the recommendations they propose will be tested in expert roundtables in February and the parties' written submissions.

g) Systemic Issues

28. As you have emphasized, our task is to conduct a systemic examination of the practice of pediatric forensic pathology and its oversight mechanisms as they relate to the criminal justice system in Ontario.

29. While the list of systemic issues cannot be finalized until after our public hearings are completed, the Commission has compiled a list of issues that deserves consideration during the public hearings. They can be usefully grouped into four areas of concern recognizing that they are not watertight and that the issues do not necessarily relate to only one area.

30. The first group is those issues that are most relevant to ensuring that the highest quality of pediatric forensic pathology is available to the criminal justice system.

31. The second group comprises those issues that involve how that pathology is effectively communicated to the criminal justice system.

32. The third group involves issues concerning the roles that can best be played by the main actors who interact with pediatric forensic pathology. These include the coroner, the hospital or other institution in which the pathology may be done, the police, the crown, the defence, the child protection agencies and the families. The broad challenge is to determine how these actors can best assist in ensuring that sound pediatric forensic pathology is supplied to the criminal justice system and how these actors best interface with pediatric forensic pathology to ensure that justice is done.

33. The fourth group concerns those issues that arise after the fact of any inadequate pediatric forensic pathology. The broad challenge is to determine the best corrective measures that ought to be available in these circumstances.

34. The investigation to date raises issues about systemic failings in all of these areas – in the pediatric forensic pathology available to the criminal justice

system, in the communication of it to that system, in the roles played by the other main actors and in the corrective measures available after the fact.

35. Our list of 80 systemic issues has been distributed to the parties for their comments and has been posted on our website.

h) Public Inquiries

36. As you well know, Commissioner, Canadian public inquiries have played an important role in the delivery of justice, broadly defined. There is a spectrum of approaches to a public Inquiry. At one end, there are those that more closely resemble the fact finding processes most often seen in a trial. Witnesses are called to establish every detail, documents are formally entered as exhibits and policy issues are largely secondary. They are primarily designed to determine what happened and what ought to be done about it in a very specific context.

37. At the other end of the spectrum are policy centered inquiries, many of which were carried on largely outside of a public hearing process. Facts are determined by investigators or the Commissioner without *viva voce* evidence. Much of the debate is developed in policy papers, not in examination and cross-examination.

38. The job of your four commission counsel is to chart a course that borrows from each of these approaches and also uses some innovative ones. For

example, our first two and one-half day's evidence will allow you to hear, in tandem if not actually simultaneously, from the former Chief Coroner of Ontario, Dr. Barry McLellan and Ontario's Chief Pathologist, Dr. Michael Pollanen. Together they will describe the statutory regime which frames the work of coroners and pathologists engaged in death investigations and specifically, pediatric criminally suspicious and homicide cases. Together they will address their respective roles in the establishment and design of the Chief Coroner's Review which in turn led to the establishment of this inquiry. By calling their evidence in tandem, we hope to develop the broad themes efficiently and allow for any differences of opinion or perspective to be fairly aired.

39. We are also shortening the time required for their testimony and allowing them to return to their demanding jobs by the end of this week by supplementing their oral evidence with a written report. The Institutional Report prepared by the Office of the Chief Coroner sets out in considerable detail the legal and practical framework for Ontario death investigations. It reviews the work of the Coroner's office and those who work for it. Although the contents of this report cannot be treated as agreed evidence and the parties may choose to cross-examine Drs. McLellan and Pollanen on the report, it will avoid the painstakingly detailed questions and answers that would otherwise be a feature of their days in the witness box.

40. We plan to call many of our witnesses in panels. Whether a witness testifies alone or as part of a panel of two or more, our goal as Commission counsel will be to identify the systemic issues, probe and distill the significant facts, and streamline the evidence. As Justice O'Connor has explained, our role as Commission counsel is to be thorough and evenhanded.