

**COMMISSIONER'S STATEMENT ON RELEASE OF THE REPORT, OCTOBER 1, 2008**

Good afternoon.

On April 25, 2007, the Province of Ontario established the Inquiry into Pediatric Forensic Pathology in Ontario, and appointed me as the Commissioner.

The Orders in Council regulating the Inquiry require that I deliver my Report to the Attorney General by September 30, 2008. I did so yesterday.

The Report is being publicly released today. It has four parts:

- an executive summary;
- a volume containing my systemic review and assessment of the practice and oversight of pediatric forensic pathology in Ontario in the years 1981 to 2001, together with my description of the systemic failings that occurred;
- a volume containing the 169 recommendations I have made that, in my view, are necessary to restore and enhance public confidence in pediatric forensic pathology and its future use in the criminal justice system; and
- a volume describing the processes used by the Inquiry that have culminated in the Report that is being released today.

At the same time, we are publishing two volumes of the independent research commissioned by the Inquiry, which I know will make a significant and valuable contribution to the literature in the field.

I am very proud of all that has been accomplished over the last 17 months. It has required the intensive and focused efforts of many talented people, for which I am very grateful.

I begin with the very talented staff of the Inquiry, led by my lead Commission counsel, Linda Rothstein and my special counsel criminal law, Mark Sandler. I simply could not imagine being better or more wisely served.

Beyond our team, I owe thanks to all counsel who appeared at the Inquiry. Their professionalism and cooperation were essential to the expeditious way the Inquiry was able to proceed.

Finally, I want to say a special thanks to the families who were so tragically affected by the events that the Inquiry examined. In private meetings, they shared with me what the loss of a child has meant to them, compounded as it was by the stress and shame of involvement with the criminal law. As many of them made clear, by giving me a background for my recommendations, they wanted to do what they could to avoid these painful experiences ever happening to anyone else. I am grateful for this.

The core reality of this Inquiry is that the sudden unexpected death of a child is a shattering event for parents, for family and for the entire community. If something suggests that a criminal act may have been involved, the devastation takes on a further tragic dimension. It becomes vital for the criminal justice system to determine whether there is truth to the suspicion that the child was killed, and if so, by whom. These are among the most difficult cases the justice system faces, and the role of the pediatric forensic pathologist is often critical.

When the pathology is flawed, or there is a failure of the oversight required to ensure its quality, the consequences are devastating. Sadly, in the years I examined, both occurred in Ontario.

For more than a decade, Dr. Charles Smith was viewed as one of Canada's leading experts in pediatric forensic pathology, and the leading expert in Ontario. Yet he had little forensic

expertise, and his training was, as he himself described, “woefully inadequate.” He achieved the status of a leading expert in the field in large part because there was no one who had the training, experience, and expertise to take him on. He worked all too much in isolation. This situation was prolonged because there was then, as there is now, a severe shortage of forensic pathologists in Ontario and even fewer with the knowledge and experience to do pediatric forensic cases or to provide the culture of peer review on which quality depends. The serious mistakes he made, with the terribly unfortunate consequences that resulted, were on clear display at the Inquiry.

But the tragic story of pediatric forensic pathology in Ontario from 1981 to 2001 is not just the story of Dr. Smith. It is equally the story of failed oversight. The oversight and accountability mechanisms that existed were not only inadequate to the task, but were inadequately employed by those responsible for using them.

The challenge ahead is to correct the failings that permitted these things to happen. We must do all that we can to ensure that, so far as possible, this history is not repeated. That is the objective of the 169 recommendations I have made.

Fundamental to achieving this objective is the creation of a truly professionalized forensic pathology service in Ontario. It must be built on four cornerstones:

1. legislative change that provides both proper recognition of the vital role forensic pathology plays in death investigation and the foundation for proper organization of a forensic pathology system;
2. a commitment to providing forensic pathology education, training, and certification in Canada and strengthening the relationship between service, teaching, and research;
3. a commitment to the recruitment and retention of qualified forensic pathologists; and
4. adequate, sustainable funding to grow the profession.

It is also vital that major changes be made in the institutional arrangements within which forensic pathology is practiced in Ontario. This is necessary if there are to be proper structures for oversight and accountability. It must be led by the creation of a new Governing Council for the Office of the Chief Coroner of Ontario to ensure more objective and independent governance of the institution, including the work of both the Chief Coroner and the Chief Forensic Pathologist and those they are responsible for in the coronial and forensic pathology services in Ontario.

As well, it is important that there be improvements in the way forensic pathology is practiced in individual cases in Ontario. I have made a series of recommendations about best practices to be followed in the autopsy suite and have put forward the basic principles that should guide them. First among them is that at autopsy, the forensic pathologist should “think truth” rather than “think dirty.” To do so requires an independent and evidence-based approach that emphasizes the importance of thinking objectively. The pathology evidence must be observed accurately and must be followed wherever it leads, even if that it to an undetermined outcome.

Moreover, it must be remembered that serving the criminal justice system is a central function of forensic pathology. It is not enough that autopsies be expertly conducted. The opinions reached by the forensic pathologist must then be communicated to the criminal justice system clearly and in ways that avoid misinterpretation or misunderstanding. I have made a number of recommendations designed to achieve that goal.

It must also be recognized that other participants in the criminal justice system have important roles to play in protecting the public against the introduction of flawed or misunderstood pediatric forensic pathology into the system. Coroners, police, Crown and defence counsel have much to contribute in helping to achieve this objective. My specific recommendations on this subject are designed to ensure that they will be as effective as possible in discharging this responsibility.

I also address the important role the judiciary has to play in screening out unreliable forensic pathology evidence, and in ensuring that it is articulated in language that is not misleading and

that it does not extend beyond its legitimate scope. I hope my recommendations will assist the judiciary in performing this vital gatekeeper function.

As to past cases, I have concluded that there is one set of cases in which a further review is warranted as part of restoring public confidence. The changes in pathology knowledge concerning shaken baby syndrome and pediatric head injuries over the last two decades justify a carefully constructed review of those cases where convictions were registered on the basis of pediatric forensic pathology that today would be seen as unreasonable. My recommendations are designed to ensure that such a review can be conducted practically and efficiently. I have also made recommendations to address the particular challenges faced by those who seek to base their claims of wrongful conviction on flawed forensic pathology.

Importantly, my Report addresses the formidable challenges that exist in delivering adequate coronial and forensic pathology services to First Nations and other remote communities, because the status quo is, in my view, unacceptable.

Finally, I can say that I struggled with the issue of compensation for those involved in the cases that were examined at the Inquiry. While I acknowledge that significant issues would have to be addressed in creating such a scheme, I have urged the Province of Ontario to see if, nonetheless, after the full examination that I was not in a position to conduct, a viable compensation process can be set up.

My mandate has, however, permitted the Inquiry to assist the families affected by flawed pediatric forensic pathology by facilitating counselling services for them. For a number of them, this has been very helpful in helping them to deal with these tragic episodes and move on with their lives. I have recommended that where it would be useful, this be continued for a further three years.

This then is a brief outline of the main issues I have dealt with in the Report. But there are a number of others that also must be addressed if the system of forensic pathology in Ontario is to be fully repaired, and I have made recommendations about them as well.

Taken together, my recommendations are the steps that I have concluded must be taken to restore and enhance public confidence in pediatric forensic pathology in Ontario, and its future use in the criminal justice system.

It is important to underline that in the last few years, new leadership has made a significant start in addressing these challenges. But as they acknowledge, much more must be done. To stop now risks a return to the troubled years examined at the Inquiry. However, the steps taken so far, together with the sense of hope for the future they have begun to engender those who continue to work in this field, provide a firm foundation on which to build.

My recommendations are intended to do just that. If acted upon, they represent the best way to protect the administration of justice from flawed pathology, to leave behind the dark times of the recent past, and to create the forensic pathology service that the criminal justice system needs and the people of Ontario deserve.

Let me close by simply saying that it has been a privilege to serve as the Commissioner of this Inquiry.