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Establishment of the Commission

On April 19, 2007, Dr. Barry McLellan, Chief Coroner for Ontario, announced the results of the Chief Coroner's Review. The public learned that five eminent forensic pathologists, all of whom have impeccable international reputations, had concluded that, in a number of cases of suspicious child deaths where Dr. Charles Smith either performed the autopsy or was consulted, his conclusions were not reasonably supported by the materials available. In 20 of the cases examined, they took issue with Dr. Smith's opinion in either his report or his testimony, or both. Even more troubling was that in 12 of those 20 cases, there were findings of guilt, many on very serious charges.

The results of the Review constituted the last and most serious blow to public faith in pediatric forensic pathology and the central role it must play in criminal proceedings involving child deaths. Six days later, by an Order in Council signed on April 25, 2007, the Province of Ontario established this Commission.

The Commission is required to conduct a systemic review and assessment of the way in which pediatric forensic pathology was practised and overseen in Ontario, particularly as it relates to the criminal justice system from 1981 to 2001, the years in which Dr. Smith was involved. It is also to consider any changes made since 2001. The purpose of the review is to provide the basis for the Commission 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 terms of reference of the Commission provide:

4. The Commission shall conduct a systemic review and assessment and report on:
   a. the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pedi-

atric 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, or had implications for, the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and

c. any changes to the items referenced in the above two paragraphs, subsequent to 2001

in order to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.

5. In fulfilling its mandate, the Commission shall not report on any individual cases that are, have been, or may be subject to a criminal investigation or proceeding.
6. The Commission 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.

Public inquiries, by their very nature, are concerned with how systems worked, or more often, did not work, in a particular setting. Absent this systemic concern, most public inquiries could be replaced by a criminal or civil trial. It is the attention paid to systemic failings and systemic solutions that differentiates a public inquiry from a trial.

The Order in Council directs me in express terms to conduct a systemic review. Does this differentiate my task in any way from that of the usual public inquiry?

The answer is yes, although in the end the difference may be merely a question of emphasis and focus. Unlike many public inquiries, I was not directed to turn over every stone in order to find out all that happened in a particular tragedy. I am not to examine every detail in every case that formed part of the Chief Coroner's Review to determine what happened and why. I am not directed to determine what actually caused the death of any child, or whether the forensic pathology affected the way the police investigated the circumstances of any suspicious child death, or whether the work of Dr. Smith determined the way in which any particular case was decided.

However, I am directed to assess and report on the practice of pediatric forensic pathology in Ontario. It would be impossible for me to do so without making certain factual findings about the practice in specific cases. In saying this, I am mindful of the limitation imposed by the Order in Council. I am not to report on any individual cases that are, have been, or may be subject to a criminal investigation or

proceeding. All of the 20 cases identified by the Chief Coroner's Review fall into this category. All 20 involve a criminal investigation or proceeding. Indeed, in 12, there were criminal convictions, or findings of guilt.

In order to fulfill my mandate, the Order in Council directs me to those very cases. Without facts, I cannot review the practice of pediatric forensic pathology in Ontario in the 1980s and 1990s, much less make coherent and soundly based recommendations on how to improve it in the decades to come. Indeed, Dr. Smith acknowledges that, in order to fulfill my mandate, I must examine and comment on his work, both in the 20 cases and more generally.

Moreover, findings about Dr. Smith's practices, and the practices of other pathologists, as found in these cases are directly relevant to issues of accountability, oversight, and quality control. It is impossible to assess the effectiveness of the oversight mechanisms in those years without first determining whether there were practices in these cases that should have received greater scrutiny. It would be unfair to conclude that an oversight mechanism rightly lost the public's confidence unless there were flawed practices that ought to have been identified and corrected. For me to recommend significant organizational or systemic change, I must conclude that there is good reason to do so, based on what actually happened and why.

I am also satisfied that the mandate to conduct a systemic review must be interpreted in a way that reflects the purpose for which it was called. Like many public inquiries, this Inquiry was called in the aftermath of a loss of public confidence in an essential public service. The public was understandably shocked by the results of the Chief Coroner's Review. In many of the 20 cases, parents or caregivers were charged with criminal offences that bear a significant social stigma. Some of those charged were convicted and incarcerated. In some of the cases, siblings of the deceased children were removed from the care of parents. In Valin's case, the Court of Appeal for Ontario has determined that a miscarriage of justice occurred. An examination of the practices exemplified in these cases is essential if the systemic review is to achieve the purpose intended for it in the Order in Council – namely, to provide the basis for recommendations to restore the public confidence lost as a result of what happened in these cases.

Thus, the overarching purpose of the Inquiry is the restoring of public confidence in the practice of pediatric forensic pathology in Ontario and in the oversight systems that are necessary to support it. The Inquiry must address the legitimate questions about what went wrong with the practice and oversight of pediatric forensic pathology in order to fulfill that purpose and to ensure, so far as possible, that what went wrong does not happen again.

It bears repeating that, because of our systemic focus, the Inquiry did not

investigate any of the 20 cases exhaustively. Commission counsel called evidence only about those aspects of these cases that are relevant to my mandate to conduct a systemic review of the practice of pediatric forensic pathology and its oversight in Dr. Smith's time. Indeed, in one case, which is the subject of an ongoing police investigation, my review was limited to a single discrete issue. I simply did not conduct a full and complete examination of any case. Nor have I attempted to determine, for example, whether any particular individual ought to have been charged with or convicted of a criminal offence, or whether any particular individual was wrongly charged or convicted, or whether child protection proceedings ought to have been instituted, or whether a miscarriage of justice occurred in any case. I make findings in some of the 20 cases to illustrate why and how the system failed in the particular circumstances. However, because of the systemic nature of the Inquiry and the manner in which it proceeded, I am in no position to report on any of the 20 cases and I have not done so.

As a matter of law, I cannot conclude that any individual has breached any legal standard that would entail criminal or civil liability or professional discipline. It is for courts to reach conclusions of civil or criminal liability and for professional regulators to do the same in matters of professional discipline. I have therefore avoided using language that could mistakenly convey the impression that I have made such an impermissible finding. Throughout the report, however, I occasionally use terms such as "fault," "responsible," "failure," "improper," and "lack of professionalism," which could be seen to have a legal connotation. I do not intend by such terms to reach any conclusions in law, or to equate these words with the way they may be used in a professional discipline context or in a civil or criminal proceeding. I intend that readers should attach only the usual, non-legal meaning to these words. For example, by professionalism, I mean no more than those qualities that the public ordinarily expects from a professional.

An additional comment is perhaps useful about the provision in my mandate that requires me to proceed without expressing any conclusion or recommendation regarding matters of professional discipline. Although this provision was not found in our survey of the terms of reference of other commissions, I have interpreted it using the well-known principles on the power of a public inquiry set out by the Supreme Court of Canada, particularly in the case quoted below. The provision does not preclude me from finding misconduct where the facts warrant. That would have made my mandate impossible to fulfill.

The power of a public inquiry to find misconduct is clear from the *Public Inquiries Act*, RSO 1990, c. P.41. It was described by Justice Peter Cory in *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System)*, [1997] 3 SCR 440 at para. 40:

> However, in my view, the power of commissioners to make findings of misconduct must encompass not only finding the facts, but also evaluating and interpreting them. This means that commissioners must be able to weigh the testimony of witnesses appearing before them and to make findings of credibility. This authority flows from the wording of s. 13 of the Act, which refers to a commissioner's jurisdiction to make findings of "misconduct". According to the *Concise Oxford Dictionary* (8th ed. 1990), misconduct is "improper or unprofessional behaviour" or "bad management". Without the power to evaluate and weigh testimony, it would be impossible for a commissioner to determine whether behavior was "improper" as opposed to "proper", or what constituted "bad management" as opposed to "good management". The authority to make these evaluations of the facts established during an inquiry must, by necessary implication, be included in the authorization to make findings of misconduct contained in s. 13 [the counterpart of s. 5 in the Ontario legislation]. Further, it simply would not make sense for the government to appoint a commissioner who necessarily becomes very knowledgeable about all aspects of the events under investigation, and then prevent the commissioner from relying upon this knowledge to make informed evaluations of the evidence presented.

Thus, my use of language like "misconduct," when applied to a professional like a doctor, is not intended as a conclusion regarding a professional discipline matter. That would require not only that I find facts that I determine to be misconduct but that I go further to conclude that the misconduct constitutes a matter of professional discipline. I have not done so and my Report should not be read that way.

Finally, I have also kept in mind the difference between an inquiry and a civil or criminal trial in determining the facts required for my report. The systemic review called for by my mandate clearly necessitates that I find the facts of what happened during the years under review. I have been careful to avoid expressing those facts in language that would either constitute or suggest findings of civil or criminal liability. I have been fortunate that, in very many instances, the facts were not disputed.

Where it was necessary to make factual findings from conflicting evidence, I have made them only where the evidence made those findings more likely than not. Indeed, where there could be significant adverse consequences to the reputation of an individual, I have required clear, cogent, and convincing evidence.

The processes and procedures that the Commission has used are fully outlined in Volume 4. At this point a brief description will suffice.

Immediately upon the establishment of the Commission, I appointed Linda

Rothstein as lead Commission counsel, Mark Sandler as special counsel, criminal law, and Robert Centa and Jennifer McAleer as assistant Commission counsel. I asked Professor Kent Roach to be the Commission's research director, assisted by Professor Lorne Sossin. Commission counsel quickly put together a small but very talented group of young lawyers and administrative staff. This team has simply been invaluable to me throughout. They have been superb.

The Commission began its work by establishing its Rules of Standing and Funding and setting up its research program.

Professor Roach put together a roster of highly qualified scholars whose independent research was of substantial assistance to the Commission and will add significantly to the body of knowledge of forensic pathology and related topics.

The legal team proceeded to gather and organize the large quantity of relevant information and documentation. An easily searchable electronic database was created. Standing was granted to the Office of the Chief Coroner for Ontario, Her Majesty the Queen in Right of the Province of Ontario, the Hospital for Sick Children, the College of Physicians and Surgeons of Ontario, two groups of affected individuals, five organizations involved in various ways in the criminal justice system, and of course Dr. Smith. Limited standing was granted to one individual. Funding was also granted to a number of these parties.

Beginning in June 2007, I held separate private meetings with a number of individuals and families who have been affected by the practice and oversight of pediatric forensic pathology in Ontario. Although these meetings were not part of the Commission's fact-finding process, the insights they gave me have assisted in anchoring the work of the Commission in real human experience. In addition, the Commission has been able to provide counselling services for those individuals who wished it, to assist them in moving forward with their lives.

In order to better understand the specific pathology errors made in the cases, the Commission invited the five forensic pathology experts from the Chief Coroner's Review – Dr. John Butt, Dr. Jack Crane, Dr. Christopher Milroy, Dr. Pekka Saukko, and Dr. Helen Whitwell – to return to Toronto, in order to produce more detailed reports on their assigned cases. The expert reviewers graciously accepted, and their expanded forensic reports were vital to the work of the Commission.

After ruling on a number of motions for directions and publication bans, the Commission began its public hearings in early November 2007. With the cooperation and hard work of all, the Commission was able to sit long hours and full weeks, allowing it to conclude its fact gathering by the beginning of February 2008. The Commission then conducted a series of intensive policy roundtables over three weeks in February. The Commission heard from experts from around

the world and from a variety of disciplines on topics ranging from the organization of pediatric forensic pathology to the effective communication of expert scientific evidence in the justice system. The roundtables focused entirely on the policy aspects of my mandate, and were of great assistance in determining what recommendations to make and why.

The final two days of these roundtables were held in Thunder Bay. These two sessions, together with visits I made in October 2007 to two First Nations communities in Northern Ontario, helped the Commission address the special challenges of making available pediatric forensic pathology to distant communities in general and to Aboriginal communities in particular.

The public part of the Commission's work was concluded with the receipt of written submissions and then two days of oral submissions on March 31 and April 1, 2008. These have been of great assistance as I moved to the last phase of my task, the writing of this report.

Before I turn to my detailed assessment of the practice and oversight of pediatric forensic pathology in Ontario from 1981 to 2001, I think some additional context is helpful. The next chapter, Chapter 4, describes in general terms how the investigation of a suspicious pediatric death takes place and the roles that the various participants, including the pathologist, play in it. Chapter 5 sets out the legislative context in which such an investigation is done, and Chapter 6 provides an overview of the science of forensic pathology.