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Pediatric Forensic Pathology and Potential Wrongful Convictions

A number of parties made submissions about what should happen to cases dealt with by the criminal justice system in which the forensic pathology is flawed. To discuss these issues, it is necessary to look both backward and forward.

My mandate prevents me from finding that, in any individual case examined at this Inquiry, a wrongful conviction resulted. However, the Chief Coroner's Review concluded that Dr. Charles Smith's work was flawed in a number of cases in which criminal convictions were registered. In one of those cases, the Court of Appeal for Ontario has already determined that errors in pediatric forensic pathology resulted in a wrongful conviction. Others from this group of cases are being pursued in order to establish the same conclusion. All agree that this process should proceed as expeditiously as possible.

However, the flawed pathology in the cases examined in the Chief Coroner's Review also suggests the possibility that there may have been errors of forensic pathology that resulted in wrongful convictions in other past cases involving either Dr. Smith or other pathologists.

Just as important as what has happened in the past is the question of what should be done in future, if, despite the various changes that I propose, flawed pathology should result in convictions that are said to be wrongful.

Finally, I have been urged to address the issue of compensation for those who suffered as a result of the flawed work by Dr. Smith identified in the Chief Coroner's Review. Here, too, both my mandate and the limited evidence I heard present constraints. I have nonetheless been invited to address these questions in some fashion.

For each of these issues, the overarching consideration is restoring and enhancing public confidence in pediatric forensic pathology and its future use in the criminal justice system. What steps should be taken concerning past errors that the criminal justice system may have made because of flawed pediatric foren-

sic pathology, and equally, what should be done to correct such mistakes if they arise in the future? I address these questions in this chapter.

Cases Examined by the Chief Coroner's Review

Criminal convictions were registered in a number of the cases in which the Chief Coroner's Review concluded that Dr. Smith's pathology was flawed. Some of those convicted will undoubtedly seek to put the conclusions of the reviewers before the Court of Appeal as fresh evidence in seeking to have their convictions set aside.

In all these cases, the time limit for appeal will have long passed. Nonetheless, as the evidence before the Inquiry demonstrated, Dr. Smith made a number of errors and, thus, in each case, a substantive issue is raised about whether, in light of that fact, the conviction should be set aside. What is important is to get at this real issue rather than be diverted by skirmishing over, for example, extensions of time. Indeed, the Ministry of the Attorney General acknowledged this priority (and commendably so) during the roundtable we held on this subject.

At that roundtable, Mary Nethery, director and executive lead on justice modernization in the ministry's Criminal Law Division, addressed the approach to be taken to the cases before the Inquiry where extensions will be sought based on the evidence from the Chief Coroner's Review:

> [T]he Ministry wants to expedite those cases where there is this potential fresh evidence; for example, evidence from eminent forensic pathologists presented at this Inquiry, that pathology evidence presented at trial was faulty, or potentially that the science has changed.
>
> So we would be willing to set up an expedited process for dealing with the extension of time to appeal. We would work with the Defence Bar, and the Ontario Court of Appeal to develop that process.
>
> We expect that the process would apply to most of the cases. It may be sort of a group application based on some of the evidence that's been presented here.
>
> So in order to expedite these things … should there be an extension of the process for time to appeal, the real issues would be the merits of the case argued in the Court of Appeal. And [we] would expend our time and energy on that issue, I think both from the defence and the Crown's side.

…

> [A]s Ministers of Justice we do have a role to ensure that justice is done in individual cases and there may be individual cases where we would not agree to that process. I expect that would be rare, if any.

I was advised by James Lockyer, counsel for a number of the convicted parties, that the ministry had followed up on Ms. Nethery's position and "the follow-up … bodes well for the future ... and is in accord with what was said at that roundtable."

I welcome these developments. The question of whether Dr. Smith's work in the cases examined by the Chief Coroner's Review resulted in any other wrongful convictions should be answered as quickly as possible. Such a response will undoubtedly help to restore public confidence.

Recommendation 141

In cases in which it is sought to set aside convictions based on errors in Dr. Charles Smith's work identified by the Chief Coroner's Review, the Crown Law Office – Criminal should assist in expediting the convicted person's access to the Court of Appeal and in facilitating a determination of the real substantive issues in the cases, unencumbered by unnecessary procedural impediments. Such assistance could include

- **consenting to defence applications for extensions of time within which to appeal;**
- **working toward agreement with the defence on evidentiary or procedural protocols for applications to extend time within which to appeal or for introducing fresh evidence on appeal or respecting the appeal itself;**
- **permitting the use of transcripts of the evidence tendered at inquiries (such as this one) by forensic experts or others; or**
- **narrowing the issues that need be resolved by the Court.**

Review of Other Past Cases

A number of the parties, witnesses, and roundtable participants have urged me to recommend that past cases other than the 19 examined at the Inquiry be the subject of one or more reviews. There were varying proposals as to the number,

scope, motivation, and mechanisms of such reviews. The three main proposals were (1) a review of Dr. Smith's cases from 1981 to 1991, (2) a comprehensive review of all Ontario pediatric forensic pathology cases, and (3) a review of all shaken baby syndrome / pediatric head injury cases.

The Chief Coroner's Review initially examined Dr. Smith's criminally suspicious cases from 1991 to 2001. Dr. Michael Pollanen, Chief Forensic Pathologist for Ontario, testified that the Chief Coroner's Review provided a reasonable basis to believe that there might be problems with Dr. Smith's earlier cases. It was therefore decided by the Office of the Chief Coroner for Ontario (OCCO) that his 1981–91 cases should also be reviewed. This review, which is ongoing, is of those cases where Dr. Smith performed the post-mortem examination or was consulted for an opinion, and where the manner of death was recorded by the OCCO as "homicide."

The Mullins-Johnson Group and the Association in Defence of the Wrongly Convicted (AIDWYC) urged me to recommend a comprehensive review of all pediatric forensic cases in Ontario that resulted in convictions from 1981 on. They argued that Dr. Smith's influence and leadership within the province made it likely that others had informally consulted with him or otherwise adopted his flawed approach.

Dr. Pollanen shared with the Inquiry his view that the Chief Coroner's Review also highlighted the need to consider a review of the shaken baby syndrome (SBS) cases – regardless of the pathologist involved – given the scientific uncertainty that has come to characterize that diagnosis. As a result of that uncertainty, he searched the OCCO database for cases between 1986 and 2006 in which the cause of death was coded as SBS or as undetermined head injuries.[1] The search was narrowed to include only deceased children between one month and 12 months. Dr. Pollanen found 142 such cases. He did not know how many of these cases had resulted in convictions.

Dr. Pollanen felt that a review of these cases, such as was undertaken in the United Kingdom under Attorney General Lord Goldsmith, which I discuss later, should be considered in Ontario, and he promoted that position in a presentation he made to Crown counsel in March 2007.

In her testimony, UK forensic pathologist Dr. Helen Whitwell contended that there is a need for a "system where there is the ability to review a case" when research developments or medical advances could affect criminal convictions. She

[1] Dr. Pollanen explained that he included some undetermined head injury cases to account for the fact that the police might have treated those "undetermined" cases as suspicious.

described in some detail the evolution of thinking associated with the SBS cases. Dr. Jack Crane, state pathologist for Northern Ireland, also supported a review of SBS convictions, given the possibility that they may be unsafe or wrongful. He too described the existing controversies in this area, noting that some pathologists remain unconvinced that the syndrome actually exists. Dr. Albert Lauwers, Acting Deputy Chief Coroner, testified that a "moral and ethical and just society" would look at these cases to ensure that no family has been harmed by changing information.

These views from highly qualified and responsible professionals who appeared at the Inquiry are all motivated by the concern that the debate within the global forensic pathology community has evolved and intensified over the last 15 years. As new information has been acquired, the worry expressed by all these doctors is that criminal convictions based on pediatric forensic pathology of former times may be unsustainable in light of the current state of the science. A look at the experience in England and Wales and a brief outline of the current thinking on the subject help to throw light on this concern.

Experience in England and Wales

In their research study for the Commission, Professors Kathryn Campbell and Clive Walker observed that

> [e]rrors made by pathologists reporting in criminal cases on sudden deaths of infants have resulted in serial miscarriages of justice in the United Kingdom. These types of mistakes are exceptionally grievous for bereaved families, for the credibility of experts, and for the justice system itself. Conclusions presented by experts at trial are often cloaked in dense scientific language which implies that such results and testimony are factually unassailable, but, in reality, these conclusions have been found to be interpretations affected by subjective inferences and shoddy case construction.[2]

The lessons that might be learned from the Goldsmith reviews, and the criminal cases that led to them, speak not only to the review processes but also to how the evolution of scientific knowledge might affect the nature and scope of those reviews.

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[2] Kathryn Campbell and Clive Walker, "Medical Mistakes and Miscarriages of Justice: Perspectives on the Experiences in England and Wales," in *Pediatric Forensic Pathology and the Justice System*, vol. 2 of Inquiry into Pediatric Forensic Pathology in Ontario, Independent Research Studies (Toronto: Ministry of the Attorney General, 2008), 325.

In January 2003, the English Court of Appeal quashed the 1999 conviction of Sally Clark for the murder of her two baby sons.[3] Ms. Clark's first appeal had been dismissed in 2000. She maintained her innocence and asked the Criminal Cases Review Commission (CCRC), the independent body set up to investigate possible miscarriages of justice in England, Wales, and Northern Ireland, to review her convictions as alleged miscarriages of justice. It had come to light that pathologist Dr. Alan Williams had ordered microbiological testing of the second son's blood at autopsy. Test results indicating infection in the child were not included in the autopsy report, nor were they disclosed to the defence or mentioned in testimony. They were therefore not known to the jury.

This non-disclosure was significant because Dr. Williams had testified that there was no indication that the child had died as a result of natural disease or infection. Moreover, the death of Ms. Clark's first child had initially been attributed to sudden infant death syndrome (SIDS). It was only after the second child's death was determined to be non-accidental that the first child's death was revisited and similarly diagnosed. Thus, the non-disclosure could have played a role in both murder convictions.

As well, pediatrician Sir Roy Meadow testified as to the unlikelihood that two SIDS deaths would occur within one family. He calculated the risk of a single SIDS death in a family as 1 in 8,543 and then squared that number to calculate the risk of two SIDS deaths in a single family as one in 73 million. (The fallacy of assuming that deaths in the same family must be explained either by coincidence or homicide rather than, for example, some undetected or yet to be discovered hereditary disease or defect seems obvious.)

The CCRC referred this case to the Court of Appeal. The Court regarded this to be a difficult case, and the pathology to be inconclusive. It quashed the convictions on the basis of the non-disclosure – namely, that there was evidence (the microbiology test results) not before the jury that might have caused it to reach a different verdict.[4] It also held that the figure of one in 73 million very likely "grossly overstates the chance of two sudden deaths within the same family from unexplained but natural causes." That evidence, the Court found, should have been excluded.[5]

Following the release of this decision, Attorney General Lord Goldsmith established an Interdepartmental Group (IDG), consisting of members of the police and Crown Prosecution Service, Home Office, Law Society, and the CCRC. It was

[3] *R. v. Clark*, [2003] EWCA Crim 1020.

[4] *Ibid*. at paras. 134–36.

[5] *Ibid*. at paras. 177–78.

to examine other of Dr. Williams' cases to determine whether similar non-disclosure took place. As well, the Director of Public Prosecutions and the Crown Prosecution Service undertook to disclose Dr. Williams' conduct in the *Clark* case to all defence counsel in his ongoing cases.

This review was eclipsed by the later and larger review announced by Lord Goldsmith on January 19, 2004, in the aftermath of the decision of the Court of Appeal in *R. v. Cannings*.[6] In 2002, Angela Cannings was convicted of murdering two of her four children. A third had also died as a baby. The fourth child, the second youngest, had suffered an acute life-threatening episode as an infant, from which she had fully recovered. The prosecution relied on expert evidence that, in effect, said that where multiple infant deaths occur in a family, unnatural cause of death is established, unless it is possible to establish an alternative natural explanation for the deaths.

In 2003, the Court of Appeal quashed Ms. Cannings' convictions. It held that "it does not necessarily follow that three sudden unexplained infant deaths in the same family leads to the inexorable conclusion that they must have resulted from the deliberate infliction of harm."[7] If, on examination of all the evidence in an infant death case, every possible known cause has been excluded, the cause of death remains unknown. Noting that we are at "the frontiers of knowledge" respecting sudden infant deaths, the Court said:

> All this suggests that, for the time being, where a full investigation into two or more sudden unexplained infant deaths in the same family is followed by a serious disagreement between reputable experts about the cause of death, and a body of such expert opinion concludes that natural causes, whether explained or unexplained, cannot be excluded as a reasonable (and not a fanciful) possibility, the prosecution of a parent or parents for murder should not be started, or continued, unless there is additional cogent evidence, extraneous to the expert evidence ... which tends to support the conclusion that the infant, or where there is more than one death, one of the infants, was deliberately harmed. In cases like the present, if the outcome of the trial depends exclusively or almost exclusively on a serious disagreement between distinguished and reputable experts, it will often be unwise, and therefore unsafe, to proceed.[8]

Subsequently, in *R. v. Kai-Whitewind*, the Court of Appeal refuted the argument that its decision in *Cannings* meant that a prosecution should not proceed or

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[6] *R. v. Cannings*, [2004] EWCA Crim 1.

[7] *Ibid*. at para. 148.

[8] *Ibid*. at para. 178.

should be stopped whenever there is a genuine conflict of opinion between reputable experts.[9] The *Cannings* decision must be understood, the Court said, as applicable to cases where the prosecution relied on inferences based on the coincidence of multiple infant deaths in one family, absent evidence of homicide beyond the competing forensic evidence. There is no general rule that disagreement between medical experts is sufficient on its own to render a conviction unsafe. It is the role of the jury to appraise conflicting expert testimony.[10]

Nonetheless, the *Cannings* decision prompted the Attorney General to ask the Crown Prosecution Service to review all ongoing cases involving an unexplained infant death. That review resulted in a decision not to proceed with the prosecution in three cases. Lord Goldsmith also established a review of past cases in which a parent or caregiver had been convicted in the previous 10 years of killing an infant under two years of age. The purpose behind the review of current and past cases was to identify whether any of them "bore the hallmarks described by the Court of Appeal in the *Cannings* case as making a conviction potentially unsafe."[11]

The Goldsmith review identified a total of 297 cases of relevant past convictions. Twenty-eight of those cases raised concerns about the safety of the convictions. Defence solicitors, and, in some cases, the CCRC and the Court of Appeal, were so notified. Another 89 of the 297 cases were shaken baby syndrome cases. These were not referred to the CCRC pending the Court of Appeal's decision in four such cases that were heard together as *R. v. Harris and others*.[12] On July 21, 2005, the Court of Appeal released its decision.

Lorraine Harris had been convicted of manslaughter in the death of her four-month-old son. Raymond Rock had been convicted of murdering his partner's 13-month-old daughter. Alan Cherry had been convicted of manslaughter in the death of his partner's 21-month-old daughter. Finally, Michael Faulder had been convicted of inflicting grievous bodily harm on his seven-week-old son.

The second Goldsmith review had notified Ms. Harris and Mr. Cherry that it might be appropriate for the safety of their convictions to be considered by the Court of Appeal. Each successfully obtained extensions of time in which to apply for leave to appeal, and the leave was granted. Mr. Rock had already filed a notice of appeal and was granted leave to appeal. The CCRC referred Mr. Faulder's case to the Court.

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[9] *R. v. Kai-Whitewind*, [2005] EWCA Crim 1092.

[10] *Ibid.* at paras. 82–89.

[11] UK, House of Lords, *Parliamentary Debates*, vol. 667, col. 1658 (21 December 2004) (Lord Goldsmith).

[12] *R. v. Harris and others*, [2005] EWCA Crim 1980.

In all four cases, the appellants submitted that medical research into SBS since their convictions threw into doubt the safety of these convictions. Twenty-one experts gave oral evidence in the Court of Appeal for the various parties; as well, the testimony of four experts was presented in writing.

At the heart of these cases was a challenge to the accepted hypothesis respecting SBS or non-accidental head injury (NAHI). The accepted hypothesis was that the presence of a triad of head injuries consisting of hypoxic-ischemic encephalopathy (disease of the brain affecting the brain's function and often associated with swelling), subdural hemorrhage (bleeding into the space between the brain and the dura, which is adherent to the inner aspect of the skull), and retinal hemorrhages (hemorrhages seen in the retina) in infants is a "hallmark" of NAHI. The Court noted that not all three of the injuries are necessary for NAHI to be diagnosed, but doctors supporting the triad stated that no diagnosis of pure SBS (as opposed to impact injuries or impact and shaking) could be made without both encephalopathy and subdural hemorrhages.[13]

One of the experts testifying was Dr. Jennian Geddes, a neuropathologist. Between 2000 and 2004, a team of doctors led by Dr. Geddes produced three papers setting out their research on the triad. The third paper (Geddes III) put forward a new hypothesis suggesting that there was one unified cause of the triad that was not necessarily trauma. The "unified hypothesis" was that brain swelling combined with raised intracranial pressure could cause both subdural and retinal hemorrhages. Since brain swelling and raised intracranial pressure can be explained by the mere cessation of breathing (absent trauma), the hypothesis, if accurate, would mean that the triad could never be regarded as diagnostic of NAHI. Dr. Geddes was challenged in cross-examination on the validity of the unified hypothesis. She conceded that the hypothesis was advanced to stimulate debate, and not meant to be used as proof in court or as fact (despite having been used as such in various courts). The Court concluded that the unified hypothesis could not be regarded as a credible or alternative cause of the triad. However, this conclusion did not determine the appeals since there remained a body of opinion that cautioned against the use of the triad as a certain diagnosis in the absence of other evidence.[14]

The Court agreed with that body of opinion. Although the Court found that the triad is a "strong pointer" to NAHI on its own, it should not automatically and necessarily lead to a diagnosis of NAHI. All the circumstances, including the clinical picture, must be taken into account.[15] Ultimately, the Court's decision

[13] *Ibid.* at para. 56.
[14] *Ibid.* at para. 69.
[15] *Ibid.* at para. 70.

means that the triers of fact must resolve the diagnostic value of the triad on a case-by-case basis, having regard to all the available evidence.

The Court also considered the first two papers prepared by Dr. Geddes and her team (Geddes I and II). This research was relevant to the degree of force required to cause death. It strongly suggested that severe traumatic axonal damage (damage to the nerve tissues) is a rarity in infant NAHI unless there is considerable impact. It also suggested that the diffuse brain damage that is generally responsible for a loss of consciousness results from oxygen starvation rather than direct trauma to the brain. (As Dr. Whitwell, a member of the Geddes team, explained at our Inquiry, this research meant, among other things, that death might be caused by much less force than previously believed.)

The Court observed that knowledge respecting the growing science of biomechanics (and to an extent Geddes I and II) has moderated the conventional view that strong force is required to cause the triad of injuries.[16] On the issue of how much force is necessary to cause injuries such as the triad, the Court reflected that it is generally agreed that there is no scientific method of correlating the amount of force used and the severity of the damage caused. There is a divide between those who maintain that severe injuries can confidently be attributed to a traumatic cause and those who contend that very little force may cause serious injuries. The Court declined to resolve this issue, referring instead to some general propositions:

- as a matter of common sense, the more serious the injury, the more probable that it was caused by force greater than mere "rough handling";
- if rough play could cause serious injury, then hospitals would be full of such injuries and they are not;
- the cases where serious injuries were caused by minor force would be very rare; and
- the age of the victim is not necessarily a factor in deciding the degree of force or impact. However, the vulnerability of an infant arises from the fact that its head is larger in proportion to its body and its neck muscles are weaker than those of older children. Consequently, injuries at the site of the craniocervical junction are significant.[17]

The Court then evaluated the merits of each appeal. Ultimately, in two of the cases, the Court quashed the convictions as unsafe. In the third, manslaughter

[16] *Ibid.* at para. 148.
[17] *Ibid.* at paras. 76–80.

was substituted for murder. In the fourth, the appeal was dismissed. It is noteworthy that, in Lorraine Harris' appeal, the Court concluded that the Crown's evidence and arguments were powerful. No defence witnesses identified to the Court's satisfaction a specific alternative cause of the child's injuries. But the triad stood alone, and the clinical evidence pointed away from NAHI. Indeed, the finding of the triad itself might be uncertain (given the competing expert testimony on that point). In any event, the Court noted that the mere presence of the triad on its own cannot automatically or necessarily lead to a diagnosis of NAHI. The Court concluded that the fresh evidence as to the reduced capacity of the triad and the reduced amount of force that might be necessary to cause the triad might reasonably have affected the verdict. Accordingly, the conviction was unsafe.[18] The fresh evidence was extensive. It included evidence from the growing science of biomechanics as well as the Geddes I and II findings that might have caused one doctor to have taken a less firm stance in rejecting the explanation that the injuries were caused by shaking to revive the deceased child.

Following the release of the *Harris* decision, Lord Goldsmith announced a review of the shaken baby cases identified earlier. Since one of those 89 cases had already been referred to the Court of Appeal, the number of cases subject to Lord Goldsmith's review was reduced to 88. On February 14, 2006, Lord Goldsmith reported to the House of Lords that this review had been completed. He identified only three convictions as potentially problematic, and notified counsel for those individuals that it might be appropriate for their clients' convictions to be referred to the Court of Appeal or the CCRC. Nine shaken baby cases had previously been referred.[19]

I did not examine the internal workings of the Goldsmith reviews. I am not well positioned to express an opinion on how complete their work was, or whether they drew on the right people to determine which cases were of concern. Dr. Christopher Milroy and Dr. Whitwell did not know whether, or to what extent, forensic pathologists were used during the review process. But the Goldsmith reviews and the English cases that spawned them are nevertheless instructive. They illustrate that a process can be designed to examine criminal convictions involving work of a discredited pathologist (Dr. Williams) or evolving pediatric forensic pathology and related science (SBS). It is appropriate that such reviews, if needed, should be led by government, given their resource implications, the need to access documents in the possession of the authorities, and the implications for the administration of justice. It is also appropriate that their

[18] *Ibid.* at paras. 152–53.

[19] UK, House Lords, *Parliamentary Debates*, vol. 678, col. 1079 (14 February 2006) (Lord Goldsmith).

results be shared with the affected parties in a spirit of cooperation. The Goldsmith reviews were driven by problems identified in individual cases. Thus, there was an evidentiary foundation for revisiting other cases in which similar issues arose.

The Goldsmith reviews and the cases that led to them – most particularly *Harris* – underline both the limits to and the controversies surrounding pediatric forensic pathology. These were discussed in Chapter 6 of this Report, The Science and Culture of Forensic Pathology. But what must be reiterated is that these limits and controversies come up in the head injury cases dealt with by Dr. Smith that were of concern to the Chief Coroner's Review. In Amber's case, controversies surrounding SBS and the possibility of short household falls causing her death figure prominently. In Tyrell's case, the possibility that a fall explains the child's head injuries is, again, central to the case. In Dustin's case, the issue of what inference can safely be drawn from the presence of the triad is raised. In Gaurov's case, the controversial area of re-bleeding is present.[20] In several of these cases, Dr. Whitwell expressed the view that Dr. Smith's opinions represented mainstream or conventional thought at the time, and indeed continue to represent the views of some pathologists. However, in all these cases, the expert reviewers agreed that Dr. Smith expressed opinions that, upon a correct appreciation of pediatric forensic pathology and its limitations, are unreasonable.

Considering a Review Process

Before I turn to my precise recommendations, some general observations should be made. First, any review I recommend must be based on the evidence I heard at this Inquiry. That evidence pointed to the need to look to the past, but also the future. It cannot be denied that miscarriages of justice have resulted from flawed pathology in Ontario, elsewhere in Canada, and around the world. In the future, there may be pathologists other than Dr. Smith whose work generates concerns about potential miscarriages of justice. It is equally clear that, as forensic pathology evolves and controversies are resolved or replaced with others, concerns will inevitably arise about the evidence given in earlier proceedings. Thus, in addition to any review of past cases, there is the need to ensure that ongoing processes or mechanisms exist to enable cases that arise in future, whether from flawed pathology or a changing science, to be considered when they arise.

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[20] Re-bleeding refers to the controversy in pediatric forensic pathology about whether a relatively insignificant old or healing subdural hemorrhage can develop into a massive and life-threatening acute subdural hemorrhage as a result of normal handling or minor trauma.

Second, any review I recommend must arise out of this Inquiry's mandate. For example, the Mullins-Johnson Group and AIDWYC urged me to recommend a review of all "Eastern Ontario" forensic pathology cases resulting in criminal convictions, based on some evidence at the Inquiry concerning the quality of the work of a particular pathologist in Ottawa. That evidence was heard because it related to the existence or lack thereof of adequate OCCO oversight of forensic pathology. But the evidence did not demonstrate that the pathologist was conducting autopsies in *pediatric* death cases. The Inquiry did not address – nor could it – the quality of his work respecting non-pediatric cases. Accordingly, I make no such recommendations.

Third, any review should, in my view, be focused on identifying cases in which there were convictions and where flawed pathology opinions raise concerns that the convictions were potentially wrongful. Such a review is thus distinguished from the scope of the Chief Coroner's Review, which examined 45 of Dr. Smith's cases – whether or not they resulted in criminal convictions. That review was designed to assist in restoring public confidence in pediatric forensic pathology. It therefore could not be confined to cases involving criminal convictions, particularly because the concerns about Dr. Smith's work came in part from high-profile cases that had not resulted in convictions. Today it is, hopefully, unnecessary to review historical cases unrelated to potential wrongful convictions in order to restore and enhance public confidence, given the other measures now in place and recommended in this Report.

Fourth, reviews are time consuming and costly. They strain already scarce human and financial resources. There are a limited number of forensic pathologists, and I am proposing that they should be given additional responsibilities to meet ongoing forensic pathology needs. Of course resource considerations alone should not determine whether a review should take place. Indeed, it is arguable that resource considerations cannot predominate in circumstances where a review is likely to expose one or more potential wrongful convictions. Rather, any recommended review should be carefully crafted to recognize the limited resources available and to choose the mechanisms that make best use of those resources.

It is against this background that I have evaluated the need for a review of past cases to identify those in which unreasonable pathology opinions raise significant concerns that the convictions were potentially wrongful. I have carefully considered the three alternatives discussed above. Beyond these three alternatives, there is no reasonable basis, in my view, in the evidence I heard for a review of any other cases because of a concern for possible wrongful convictions due to flawed pediatric forensic pathology. I turn then to the three alternatives proposed.

A Review of Dr. Smith's 1981–1991 Cases

The Chief Coroner's Review examined "criminally suspicious" cases involving Dr. Smith for the period 1991–2001. A review of his cases for the period 1981–91 is ongoing. On June 26, 2008, Chief Coroner Dr. Andrew McCallum tasked Dr. Pollanen with the completion of the review. I endorse this ongoing review and see no need to recommend modifications to a process that appears to me to be working well. It will complete a review of Dr. Smith's cases where wrongful convictions could have resulted.

Recommendation 142

The ongoing review of Dr. Charles Smith's 1981–91 homicide cases should be completed. The results should be made known to the public in a manner consistent with the privacy interests of those concerned, and in a manner that will not interfere with any future legal proceedings.

A Comprehensive Review of Ontario Pediatric Forensic Pathology Cases

As previously indicated, the Mullins-Johnson Group and AIDWYC submitted that Dr. Smith's iconic status in the province, the direction he provided to other pathologists, and the likelihood that he was informally consulted in undocumented cases invite a review of all pediatric death cases which resulted in convictions from 1981 to 2001.

In my view, there was no evidence provided to this Inquiry to permit me to conclude that Dr. Smith's influence on other pathologists was sufficient to compel a review of all pediatric death cases in this province. Indeed, on the evidence I heard, Dr. Smith's influence with other pathologists was not as significant as may have been believed. He tended to work in isolation from other pathologists. I heard of many opinions expressed by other pathologists with much more caution than Dr. Smith often exhibited. I cannot recommend a review of such unwarranted breadth.

A Review of Shaken Baby Syndrome / Pediatric Head Injury Cases

As noted earlier in this report, one of the deepest controversies surrounding pediatric forensic pathology concerns shaken baby syndrome and, more generally, the

cause and mechanism of head injuries. As pathology has evolved, controversies remain and indeed have grown. Forensic pathologists find themselves situated at different places along a spectrum of views on what can and cannot be said with confidence about these issues. The following illustrates both the controversies and the challenges surrounding a review of these cases.

Dr. Pollanen told the Inquiry that, given the views of many doing forensic pathology during Dr. Smith's time, there are undoubtedly instances of pure "triad" cases without other pathology evidence, where expert testimony attributed the death to shaking. Such testimony might have been equally firm in rejecting a caregiver's explanation of a short household fall. The traditional view was that short falls in the home could not cause serious injury or death.

At the time, contrary views (both about the triad and about household falls) were less prevalent and, indeed, might have been regarded as fringe opinions. Today, many forensic pathologists question whether shaking can be diagnosed based on the triad alone. Others continue to hold the opposite view, although it is less commonly held than before. In *Harris,* the English Court of Appeal characterized the triad as "a strong pointer" to non-accidental head injury (NAHI), but cautioned against use of the triad as "automatically and necessarily lead[ing] to a diagnosis of NAHI."[21] The Court's decision raised questions of whether or when the triad alone can be the foundation of proof beyond a reasonable doubt. As for short household falls, there would appear to be much greater acceptance today that they may cause death or serious injury, although many regard such occurrences as extremely unusual.

The evolution in forensic pathology in this area has three components. First, the predominant view is no longer that the triad on its own is diagnostic of SBS. Instead, the issue is fraught with controversy. Some still say it can be. Others say it can never be. The conservative view is to say that one must look not just to the triad but to all the circumstances, acknowledging that a diagnosis of the cause of death may often be difficult, leaving the death as "undetermined."

Second, the predominant view now is that short falls can cause fatal injury, although rarely. Fifteen years ago, the mainstream view was that they never could.

Third, most pathologists agree that this area of their specialty has become much more explicitly controversial than it was in the early or mid-1990s.

Accordingly, the question is validly raised in cases of convictions based on the pure "triad," where no other pathology evidence is identified, and possibly in other SBS cases: Can it be concluded in such cases that a miscarriage of jus-

[21] *R. v. Harris and others*, [2005] EWCA Crim 1980 at para. 70.

tice may have occurred, given the current debate among pathologists? Put another way, does the evolution of pathology compel us to revisit these cases because of both the changing views and the increased controversy among forensic pathologists?

In my view, the answer may depend on factors other than the pathology evidence alone. For example, if the triers of fact were advised only that the triad was completely diagnostic of shaking and not advised of the controversy, then it is certainly arguable that they were deprived of important evidence on whether the case had been proven beyond a reasonable doubt. The same might be said if the triers of fact in a particular case were unequivocally advised that short household falls do not cause death. However, if the controversies were known to the triers of fact and they convicted nonetheless, there may be less compelling reasons for post-conviction intervention.

A recent decision of the Wisconsin Court of Appeals in *State v. Edmunds* – which was decided in the context of a motion for a new trial on the grounds of newly discovered evidence – reflects that this issue is more nuanced than simply whether a controversy was previously known to the court.[22] The Wisconsin Court of Appeals recognized that, in the 10 years since the original trial and post-conviction motion for a new trial, a shift occurred in the medical community with respect to SBS. As a result, views that were on the fringe in 1997 (when the appellant filed her first post-conviction motion) became part of a significant and legitimate debate. At the time of both her trial and her original motion, the debate within the medical community on SBS had not yet matured. Thus, the state was able to easily overcome the appellant's argument by pointing out that the jury would have had to disbelieve the weight of the medical evidence in order to have had a reasonable doubt as to the appellant's guilt. By the time of her second post-conviction motion (brought in 2006), however, the state of the medical evidence was such that a trier of fact would be faced with competing credible medical opinions in determining whether there was a reasonable doubt as to guilt.[23] This situation provided the foundation for the Court of Appeals to order a new trial.

The 2007 *Truscott* reference to the Court of Appeal for Ontario is also instructive.[24] Although it was decided in the context of a reference to the Court of Appeal from the minister pursuant to a s. 696.1 application – which raises its own special issues – it illustrates how earlier knowledge of the scientific controversy,

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[22] 746 NW 2d 590 (Wis. App. 2008).

[23] *Ibid.* at para. 23.

[24] *Reference re: Truscott* (2007), 225 CCC (3d) 321 (Ont. CA).

while an important consideration, is not always determinative. At trial in 1959, the prosecution expert had testified about what inferences could be drawn about the time of death from the deceased's stomach contents, the extent of rigor mortis, and the state of decomposition. His evidence was that there was a definable 45-minute window for the infliction of the fatal injuries and time of death. That evidence, if accepted, meant that Steven Truscott had exclusive opportunity to commit the murder.

On a reference to the Supreme Court of Canada in 1966, fresh expert evidence on the same forensic issues was received by the Court.[25] That evidence included testimony from two leading English forensic pathologists, who took opposing views to each other. Eight members of the Supreme Court concluded that the weight of the new evidence supported the Crown expert's position at trial, but that the decisive point remained the one put to the jury by the trial judge and decided against Mr. Truscott.[26]

More recently, the minister of justice referred the *Truscott* case to the Court of Appeal for Ontario. On the 2007 reference, the Court of Appeal received further fresh expert evidence as to stomach contents, rigor mortis, and decomposition and the significance of that evidence for the time of death. The Court of Appeal determined that, although the fresh evidence related to the same issues canvassed at the trial and on the Supreme Court reference (which would ordinarily tell against the admission of the fresh evidence), the experts here brought significant new considerations to bear on these issues.[27] The Court was satisfied that the state of expert evidence relevant to the time of death in this case was significantly different from how it was at trial and at the first reference. The fresh evidence established that the Crown evidence at trial with respect to the time of death had to be rejected as "scientifically unsupportable."[28] Thus, even where a scientific controversy was previously known to the court, this may not always dispose of the issue where that controversy has evolved significantly. The truth-seeking function of the criminal justice system may sometimes require greater responsiveness to the development of scientific knowledge and opinion.

Another factor that might well be relevant in a review is evidence other than the pathology evidence itself. For example, there may have been significant corroborative evidence, independent of the pathology evidence, that justified the verdict.

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[25] *Reference re R. v. Truscott*, [1967] SCR 309.

[26] *Ibid.* at 342–43.

[27] *Reference re: Truscott* (2007), 225 CCC (3d) 321 (Ont. CA) at para. 201.

[28] *Ibid.* at para. 211.

It follows from the above discussion that, in light of the evolution in this area of forensic pathology, pediatric death cases categorized as SBS or NAHI invite scrutiny. There may or may not ultimately be compelling reasons for post-conviction intervention in individual cases; that would depend on all of the circumstances, including a consideration of the pathology opinion in each case in light of modern views; the extent to which the triers of fact were aware of the now well-known controversies; whether the case relied on categorical evidence, rejecting as impossible explanations such as short household falls; and the nature and extent of corroborative evidence.

In addition, Dr. Pollanen raised the possibility of there being cases within those categorized as SBS or NAHI that were simply misdiagnosed as triad cases, and where, apart from the mischaracterization, other pathology evidence supported the innocent explanation given. This possibility of error in identifying the triad is not a sufficient basis for a review of all cases of SBS or pediatric head injuries, but it would nevertheless be captured by such a review undertaken because of changes in the science and the growing controversy that has resulted.

Simply put, the changes in pathology knowledge concerning SBS and pediatric head injuries provide cogent reasons for a carefully constructed review of these cases. Not all these cases will ultimately make their way to full external pathology review. Triaging these cases is of critical importance to ensure a focused and manageable review. I also recognize that it is very difficult, on the available evidence, to predict the ultimate scope of such a review – in particular, how many cases will ultimately have to undergo the same kind of detailed external review of pathology that was done for Dr. Smith's 45 cases.

Nonetheless, our systemic examination has identified this particular area of forensic pathology as one where change has raised the real possibility of past error. In other words, there may be cases where convictions were registered on the basis of pediatric forensic pathology that today would be seen as unreasonable, either in a substantive sense (for example, by categorically dismissing short falls as a possible cause of fatal injury), or in a procedural sense (by not explaining the controversy to the trier of fact). A similarly motivated examination has taken place in England. And responsible leaders in the field have told me that they think such a review should be carried out.

I agree. In my view, restoring public confidence in pediatric forensic pathology requires that such a review be conducted. Its objective would be to identify those cases in which the pathology opinion can be said to be unreasonable in light of the understandings of today and in which the pathologists' opinions were sufficiently important to the case to raise significant concerns that the convictions were potentially wrongful.

The starting point for a review should be the 142 cases identified by Dr. Pollanen. It is likely that the subset of those cases that resulted in criminal convictions will be significantly smaller. Similarly, the 142 cases likely include a number of cases where the pathology evidence shows clear findings of abuse that put the ultimate outcome beyond a reasonable controversy. For example, the pathology evidence may have revealed a wide array of serious injuries that render any existing medical controversies irrelevant.

It is equally likely that the non-pathology evidence may further reduce the number of cases that raise concerns about miscarriages of justice. For example, if the deceased's caregiver, because of mental illness, undeniably brought about the child's death, the pathology opinion may have been flawed, but the verdict would not have been.

In addition, the convicted person's consent should be a precondition to referring his or her case to an external review. It is possible in some instances that individuals desire only to put such tragic incidents behind them.

That being said, counsel for the Mullins-Johnson Group and AIDWYC made the valid point that some convicted parties may be unresponsive to giving their consent, perceiving that a review provides little or no hope of success. In my view, this point is best addressed by the timing of *when* the individuals are contacted (that is, after their cases have been otherwise triaged), rather than *whether* they are contacted. When contacted, they will therefore be made aware of why their cases have been selected for external review.

Some of the triaging that should take place (such as a preliminary examination of the pathology to determine whether findings of NAHI are self-evident and beyond reasonable controversy) can be based on the files available at the OCCO. The balance of the triaging (such as determining cases that resulted in criminal convictions; cases in which the non-pathology evidence excludes further consideration; and cases in which the convicted parties have no interest in pursuing the matter) can generally take place only after information is collected from other sources, such as police services, prosecution briefs, or defence files. I say "generally" because the OCCO files, in some instances, may also happen to contain non-pathology information of the kind described above.

Although it would be tempting to begin with the cases that resulted in criminal convictions, there was no system in place at the OCCO to track the verdicts in these pediatric death cases. Therefore, it seems most reasonable to commence by determining the cases in which the pathology invites further scrutiny.

A number of the cases examined at this Inquiry involved guilty pleas. Most of the convicted parties now challenge their convictions, arguing that their guilty pleas were induced by various factors, including the serious conse-

quences of potentially being convicted of murder charges and the acknowledged difficulties in challenging Dr. Smith's opinions. Without commenting on the merits of any individual claims, I am satisfied, based on the evidence at this Inquiry, that cases should not be excluded from the review only because an accused pleaded guilty. Nor should a review be confined to cases in which a convicted person remains in custody. Although a review of in-custody cases should be given priority, the fact that other convicted persons may not be in custody does not diminish the importance of addressing their cases if their convictions were wrongful.

The end result of the review I propose will be to identify cases in which the pathology opinion offered at trial is now said to be unreasonable, and was sufficiently important to the case to raise a significant concern that the conviction was potentially wrongful. The convicted person can then determine whether to access the processes available to address individual cases of wrongful conviction.

Such a review, unless carefully managed, could clearly burden the Ontario Forensic Pathology Service (OFPS) and affect its ability to conduct its ongoing work to the standards that will be required in future. This straining of resources cannot be permitted to happen. Because the review is directly related to the administration of justice, the Ministry of the Attorney General should be responsible for it. That ministry should ensure that, where pathology resources are needed for this review, they be obtained from outside the OFPS, whose resources, at least in the immediate term, will have to be totally focused on ongoing service of the highest quality.

In summary, I think the review I have recommended is necessary in the interests of justice. I am also confident that a review of the kind I have recommended will make an important contribution to the restoring of confidence in pediatric forensic pathology and its vital role in the criminal justice system.

Recommendation 143

The significant evolution in pediatric forensic pathology relating to shaken baby syndrome and pediatric head injuries warrants a review of certain past cases because of the concern that, in light of the change in knowledge, there may have been convictions that should now be seen as miscarriages of justice.

a) **The objective of that review should be to identify those cases in which there was a conviction and in which the pathology opinion, if now viewed as unreasonable, was sufficiently important to raise significant concern that the conviction was potentially wrongful.**

b) Guided by the example provided by the Chief Coroner's Review, the review should utilize a small volunteer subcommittee of the Forensic Services Advisory Committee representing the Crown, the defence, the Office of the Chief Coroner for Ontario (OCCO), and the Chief Forensic Pathologist.

c) Human and financial resources to support the subcommittee's work should be provided by the Ministry of the Attorney General, not the OCCO, because the objective concerns the administration of justice. As well, the ministry should be responsible for compensating any external reviewers retained in connection with this review.

d) The review should include convictions after either plea or trial.

e) The review should not be limited to cases where the convicted person is still in custody.

f) The review should be completed only in those cases where the convicted person consents.

g) Although the procedure used should be up to the subcommittee, the following approach is recommended for its consideration:

   i) the subcommittee should begin with the 142 cases identified by Dr. Michael Pollanen;

   ii) the subcommittee should review the cases with the help of the OCCO records to eliminate those cases in which the available pathology or non-pathology information makes it clear that there would be no significant concern about a potential wrongful conviction;

   iii) the subcommittee should then obtain the information necessary to determine those cases in which there was a conviction and eliminate the remainder;

   iv) the subcommittee should then obtain the requisite records (such as police files) for the identified cases and use that additional information to further eliminate cases using the criterion in paragraph (ii) above;

   v) the subcommittee should proceed further with the cases that remain only if the consent of the convicted person is obtained;

   vi) the subcommittee should, where the convicted person gives consent to the review, obtain transcripts of relevant court proceedings, if possible;

   vii) the subcommittee should refer the cases that remain for external review by

forensic pathologists, where the subcommittee is of the view that the pathology was sufficiently important that, if it is unreasonable procedurally or substantively in light of current knowledge, there is a significant concern that the conviction was potentially wrongful. The external review cannot be permitted to have an adverse impact on the ability of the Ontario Forensic Pathology Service to perform its regular duties;

viii) **the external reviewers should report on the reasonableness of the pathology opinions expressed in these cases, in light of current knowledge, including whether the court was fairly advised of the extent of the controversy relating to shaken baby syndrome / pediatric head injury, as it is now understood; and**

ix) **the convicted persons should be advised of the results of the external review so that they can determine whether to utilize the existing processes available to address individual cases of potential wrongful conviction.**

h) **The public should be advised of the results of the review, in a manner consistent with the privacy interests of those involved, and in a manner that will not interfere with any future legal proceedings.**

Future Role of the Forensic Services Advisory Committee

Using a subcommittee of the Forensic Services Advisory Committee (FSAC) was invaluable in expediting the Chief Coroner's Review. I also recommend that a subcommittee of the FSAC play a central role in the review I have proposed. In my view, such a subcommittee could also address individual cases brought to it in future by a convicted person in which it is alleged that flawed forensic pathology contributed to a wrongful conviction. It could examine larger concerns brought about by the work of a particular pathologist in the criminal justice system. It could address concerns about past criminal cases brought about by further evolution in medical knowledge. The subcommittee's role could have the incidental effect of helping to educate both forensic pathologists and participants in the justice system about practices to be avoided with respect to forensic pathology. In other words, it could perform a useful institutional role.

Recommendation 144

The Forensic Services Advisory Committee through a subcommittee should be available to consider other cases in which it is alleged that flawed pediatric

forensic pathology may have contributed to wrongful convictions and to recommend to the Office of the Chief Coroner for Ontario what further steps, if any, should be taken.

a) **Depending on the workload created by such referrals, the subcommittee should either be made a standing committee or be constituted as needed.**

b) **The Ministry of the Attorney General should provide the subcommittee with adequate human and financial resources to staff its work. The Office of the Chief Coroner for Ontario should also not be required to compensate any external reviewers retained in connection with its work.**

c) **Where the subcommittee has referred a case for external review, and where that review results in findings that the pathology opinion earlier expressed was unreasonable and sufficiently important to raise significant concern that the conviction was potentially wrongful, the Crown Law Office – Criminal should assist in expediting the convicted person's access to the Court of Appeal and in facilitating a determination of the real substantive issues in the cases, unencumbered by unnecessary procedural impediments. Such assistance should be similar to that provided where the Chief Coroner's Review identified errors in Dr. Charles Smith's work.**

d) **The Crown Law Office – Criminal should also provide similar assistance, to the extent to which it is applicable, to a convicted person seeking ministerial review pursuant to s. 696.1 of the *Criminal Code*, if that is the appropriate forum to address the issue of a potential wrongful conviction.**

Application for Review to the Minister of Justice

The *Criminal Code*, RSC 1985, c. C-46, provides that an application for review on the grounds of a miscarriage of justice may be made to the federal minister of justice by or on behalf of a person who has been convicted of an offence under the Code or other federal acts or regulations and whose rights of judicial review or appeal have been exhausted. In investigating the merits of such an application, the minister has wide statutory powers. As well, the minister's power to take evidence, issue subpoenas, enforce the attendance of witnesses, compel them to give evidence, and otherwise conduct an investigation may be delegated. The ultimate decision on the application is made by the minister who, if satisfied that there is a reasonable basis to conclude that a miscarriage of justice likely occurred, may direct a new trial or refer the matter to the court of appeal for hearing and determination as if it were an appeal. The minister may also, at any time, refer any

question, in relation to an application on which the minister desires assistance, to the appropriate court of appeal for its opinion.

In making a decision, the minister is required to consider, among other things, whether the application is supported by new matters of significance that were not previously considered; the relevance and reliability of information presented; and the fact that any remedy available is an extraordinary one because the application is not intended to serve as a further appeal.

In practice, there are four stages in the review process: the preliminary assessment by the Criminal Convictions Review Group (CCRG) of the Department of Justice; the investigation; the report on the investigation (which the applicant is entitled to comment on); and the minister's decision. In reaching that decision, the minister considers the applicant's submissions, the investigation report, and a memorandum of legal advice prepared by the CCRG or outside counsel who conducted the investigation.

The process is application-based, meaning that, among other things, the applicant is expected to present the evidence relied on to support the minister's determination that there is a reasonable basis to conclude that a miscarriage of justice likely occurred. That does not mean that the minister, or those investigating on the minister's behalf, cannot, for example, retain an expert forensic pathologist to inform the minister's determination. They can. But it is clear that the applicant must first present new and significant information as part of the initial application. Practically speaking, if applicants seek to allege that changing science explains their wrongful convictions, they will have to present some scientific evidence to support this position at first instance.

Alastair MacGregor, deputy chairman of the CCRC for England, Wales, and Northern Ireland, described the post-conviction process there. The Criminal Cases Review Commission is an independent body with responsibility for investigating alleged miscarriages of justice. It was created in 1997 to replace an earlier review process by the home secretary or secretary of state. Convictions and sentences are assessed by the CCRC and, when it determines that there is a "real possibility" that the conviction or sentence would not be upheld, it is referred to the appropriate court – the Court of Appeal in cases dealt with on indictment.[29]

The CCRC proactively investigates all claims of wrongful convictions that are, in Mr. MacGregor's words, "not obviously frivolous." Mr. MacGregor indicated that there is no legally articulated threshold for investigation by the CCRC. Each case is screened to determine whether it merits investigation based on common

[29] *Criminal Appeal Act 1995* (UK), 1995, c. 35, ss. 9(1), 10(1), 13(1)(a).

sense that is exercised on "a very generous basis to the applicant." The CCRC, according to Mr. MacGregor, does not rely on the applicants to know what is relevant to post-conviction review or to know what information may be available to assist them in their application. He explained that, if there was reason to believe there was a problem with the pathology evidence, the CCRC would almost certainly seek its own report.

Dr. Crane confirmed, based on his own experience, that the CCRC will retain forensic pathologists to review the evidence in a case. The retainer is with the CCRC, not the parties. Applicants need not have counsel or pay for forensic testing.

AIDWYC and the Mullins-Johnson Group urged me to recommend that the current model for post-conviction review be replaced by an effective and independent mechanism modelled on the CCRC and that the Province of Ontario advocate for that change with the federal minister of justice. They also urged me to recommend that there be an adequate funding structure for the post-conviction review process. This structure would include access to post-conviction consultation and review by pathologists and funding for it by the OCCO, akin to post-conviction forensic testing at the defence's request by the Centre of Forensic Sciences.

In support of this position, the two groups made a number of submissions. One is of particular relevance to the evidence I heard. They submitted that the current ministerial review process, constrained by the legislative framework, is not sufficiently proactive. The onus of properly preparing an application, conducting an investigation, searching for fresh evidence, seeking out helpful experts, compiling the required documentation, and retaining counsel rests on the applicant. The steps in preparing a s. 696.1 application are costly and time-consuming. Applicants often do not have the necessary resources or information to put an application together, particularly in cases involving expert evidence. This problem, I am told, is even more acute when forensic pathologists are required because of the shortage of these experts.

I was also pointed to four Inquiry reports that recommended change in this area:

The 1989 Nova Scotia *Royal Commission on the Donald Marshall, Jr., Prosecution* recommended that the provincial Attorney General commence discussions with the federal minister of justice and the other provincial attorneys general with a view to creating an independent body to facilitate the reinvestigation of cases of alleged wrongful conviction.[30]

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[30] Nova Scotia, *Royal Commission on the Donald Marshall, Jr., Prosecution: Findings and Recommendations*, vol. 1 (Halifax: The Commission, 1989), 145 (Chair T. Alexander Hickman).

In the 1998 *Report of the Commission on Proceedings Involving Guy Paul Morin*, the Honourable Fred Kaufman recommended that the Government of Canada study the advisability of creating, by statute, a criminal case review board to replace or supplement the current process of review of conviction by the federal minister of justice.[31]

In the 2001 report of the Inquiry Regarding Thomas Sophonow, the Honourable Peter Cory said:

> [I]n the future, there should be a completely independent entity established which can effectively, efficiently and quickly review cases in which wrongful conviction is alleged. In the United Kingdom, an excellent model exists for such an institution. I hope that steps are taken to consider the establishment of a similar institution in Canada.[32]

Similarly, in the 2007 report of the Driskell Inquiry, the Honourable Patrick LeSage echoed and supported the recommendation of the Sophonow Inquiry that an independent body be created for post-conviction review. Commissioner LeSage expressed his concern about the adversarial nature of the present process:

> Driskell could not launch an application until he had sufficient disclosure to satisfy the Department of Justice standard for launching a section 696.2 review. However, the WPS [Winnipeg Police Service] would not make disclosure for purposes of a section 696.2 review until Driskell's application was made. This is a classic "catch 22" situation. If there was an independent inquisitorial body, as in the U.K., it could, after having been satisfied that a threshold, not necessarily a high threshold, has been met, commence the section 696.2 process of its own initiative. In this way, information that is unavailable to the applicant because of their inability to compel disclosure, would be available to the independent agency to allow them to make a better determination of whether a miscarriage of justice occurred.[33]

I found these reports, all prepared by distinguished judicial colleagues, worthy of serious consideration and, indeed, persuasive. My recommendations, however,

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[31] Ontario, *The Commission on Proceedings Involving Guy Paul Morin: Report*, vol. 2 (Toronto: Ministry of the Attorney General, 1998), 1237.

[32] Manitoba, *The Inquiry Regarding Thomas Sophonow: The Investigation, Prosecution and Consideration of Entitlement to Compensation* (Winnipeg: Manitoba Justice, 2001), 101.

[33] Manitoba, *Report of the Commission of Inquiry into Certain Aspects of the Trial and Conviction of James Driskell* (Winnipeg: Manitoba Justice, 2007), 121–22 (Commissioner Patrick J. LeSage).

must be based on the evidence I heard and my own mandate. As was pointed out by counsel for both the federal and the provincial governments, in only one case included in my review (Mr. Mullins-Johnson) was s. 696.1 engaged, and there it worked very well. I have no evidence of the s. 696.1 process working poorly in cases involving pediatric forensic pathology. As well, such cases form only a subset of the cases presented to the minister for review. Neither my mandate nor the individual cases I examined enable me to address how the s. 696.1 process operates generally for all other kinds of cases. Nor can it be said that a complete overhaul of the current process is necessary to restore confidence in pediatric forensic pathology.

However, it is clear from what I have heard about the science of forensic pathology and the challenge of presenting it to the criminal justice system, that advancing an application to the minister under s. 696.1, in a case where pediatric forensic pathology was important in the conviction and is now attacked, will undoubtedly be challenging. The science is complex. Finding and retaining experts may well be difficult and expensive. For the minister, passing judgment on pediatric forensic pathology opinions may require a scientific context that may not be easy to acquire.

As well, for indigent convicted persons, engaging the s. 696.1 process in a case involving pediatric forensic pathology poses additional challenges. As I understand it, as one precondition to funding a s. 696.1 application, Legal Aid Ontario must be provided with a legal opinion as to the merits of the appeal. The opinion need not demonstrate that the application will ultimately succeed. This precondition is like that required for Legal Aid Ontario to fund appeals of convictions.

Where post-conviction relief is dependent on fresh pathology evidence, the convicted person may be in a Catch-22 situation. If legal aid funding is dependent on some showing that the application has merit, and a demonstration of merit is dependent on fresh pathology evidence, the convicted person may be unable to obtain funding to retain a forensic pathologist. This concern has been addressed in part through an earlier recommendation that contemplates an enhanced role for the FSAC subcommittee in referring appropriate cases for external review. But that earlier recommendation does not address the capacity of individual applicants to retain their own forensic pathologists when needed.

Given these challenges, two aspects of a process like the CCRC are attractive in cases like these:

1. A structure like the CCRC may make it easier to find the necessary expertise because the institution, not the individual, is retaining the requisite expertise; and

2 The independence of a process like the CCRC may tend to secure for difficult decisions a greater degree of public confidence, because the complex science at the core of these decisions means that the usual basis for public confidence – namely, lay understanding and assessment of their validity – is not as available. Adding the element of independence may help.

In my view, a CCRC model cannot be justified simply as something necessary to restore confidence in pediatric forensic pathology and its use in the criminal justice system. The attributes of the CCRC system I referred to could, however, assist in enhancing public confidence. If there should be a conviction in future based on flawed pathology, and the appellate process is no longer available, such a system would have the two advantages described above in addressing an alleged wrongful conviction.

Recommendation 145

The Province of Ontario should bring to the attention of the federal government the two advantages identified in this Report of the model of the Criminal Cases Review Commission (CCRC) – a structure that may make it easier to find the necessary expertise, and an independence that may secure a greater degree of public confidence in its decisions – for cases involving pediatric forensic pathology. These points should inform any future discussion about adopting a CCRC model in Canada.

Recommendation 146

The Province of Ontario should address the difficulties faced by those seeking to access the s. 696.1 *Criminal Code* process on the basis of flawed pediatric forensic pathology by

a) ensuring, together with Legal Aid Ontario, that they can obtain legal aid funding for the necessary pathology expertise to support their applications. Legal Aid Ontario should adequately fund s. 696.1 applications. As well, consideration should be given to having Legal Aid Ontario fund, under appropriate circumstances, the retention of defence forensic pathologists as a basis for determining whether an application to the minister of justice has sufficient merit to be filed; and

b) urging the federal government to enhance the investigative role of the Criminal Convictions Review Group (CCRG) of the Department of Justice to address

allegations that flawed forensic pathology contributed to wrongful convictions. This could include enhanced use of forensic experts retained by the CCRG to investigate and evaluate an application for ministerial relief.

Legal Aid

In Chapter 17, The Roles of Coroners, Police, Crown, and Defence, I address some of the issues surrounding the defence of pediatric death cases on legal aid. Immediately above, I also address the challenges of obtaining legal aid funding for s. 696.1 applications.

It need only be added here that the same challenges exist for appeals of conviction based on flawed pediatric forensic pathology. Where appellate relief is entirely dependent on fresh pathology evidence, the convicted person may be in the same Catch-22 situation discussed in connection with s. 696.1 applications. If legal aid funding is dependent on some demonstration that the appeal has merit, and a demonstration of merit is dependent on fresh pathology evidence that by its nature is difficult to assemble, the convicted person may be unable to obtain funding to retain a forensic pathologist.

Recommendation 147

The Province of Ontario, together with Legal Aid Ontario, should consider enabling legal aid funding, under appropriate circumstances, of forensic pathologists prior to a determination that the appeal has sufficient merit to be funded and as a basis for determining whether an appeal based on fresh evidence has merit.

Compensation

Several parties urged me to make a recommendation concerning compensation for those harmed by flawed pediatric forensic pathology. The submissions suggested that compensation be extended to those wrongly charged or convicted, and to those families affected as a result of criminal allegations against the parent. The Affected Families Group suggested that not only is compensation within my mandate, but that it is essential to the fulfillment of my mandate. They submitted that compensation of those who have suffered as a result of faulty pediatric forensic pathology is necessary to restore public confidence in the system. Accordingly, they asked that I recommend a process to effect compensation.

Similarly, the Mullins-Johnson Group and AIDWYC maintained that the

injustices visited on innocent families and individuals by bad pathology evidence warrant some form of compensation. They suggested that, because civil litigation of each individual claim is inefficient and ineffective, this Inquiry should recommend the development of an alternative mechanism to consider claims for compensation. They recognized that it is beyond my mandate to recommend compensation for any named individual or family affected by the testimony or opinions of Dr. Smith. Defence for Children International – Canada also urged me to make recommendations regarding financial compensation for those victimized by flawed pathology.

The Province of Ontario maintained that my mandate does not permit me to make determinations with respect to compensation because I am prohibited from reporting on individual cases and because the Order in Council implicitly, if not explicitly, assumes that existing civil mechanisms are to be used. Additionally, the province suggested that it would be inappropriate for me to recommend compensation because the Inquiry received no evidence on which to base determinations about that complex issue (including who should be entitled, and for what, from whom, and on what basis). I was urged to leave the issue of compensation to established processes: civil actions, arbitrations, mediations, and the joint federal-provincial protocol for compensation of the wrongfully convicted.

I have struggled with this issue.

On the one hand, my mandate prevents me from reporting on individual cases. It also focused me on a systemic examination of pediatric forensic pathology, and particularly its use in the criminal justice system. Thus, I did not examine all aspects of the identified cases in which Dr. Smith's work was flawed. Nor did I hear anything about systems of compensation, either through civil courts or otherwise, that might be used for any of those involved.

On the other hand, it appears from what I did hear that some individuals involved in these cases – some well publicized – were tragically harmed by becoming involved in the criminal justice system because of this flawed pathology and through no fault of their own. Whether they were intensively investigated, charged, or convicted, or where there were surviving children seized for no other reason, there is no doubt that they have suffered tragic and devastating consequences. In my view, it would assist the restoration of public confidence if a way could be found, within or outside any civil litigation, to compensate them expeditiously and appropriately.

I should be clear that I can address only the 19 cases about which I heard and in which Dr. Smith made errors. Moreover, it would appear that, in some of them, the individuals may well have become involved in the criminal justice system regardless of flawed pathology.

Thus, there are significant challenges that would have to be addressed in creating a compensation scheme for those who were involved in the 19 cases and who tragically became involved in the criminal justice system simply because of flawed pediatric forensic pathology and through no fault of their own. Some important questions include

- Who should be considered for compensation – only those wrongly investigated, wrongly charged, or wrongly convicted, or family members as well, particularly those wrongly separated from each other as a result of flawed pediatric forensic pathology?
- How is "wrongly" to be defined? For example, does it relate to those who would not have become involved in the criminal justice system without the flawed pathology? Or does it refer to the factually innocent?
- Who should pay, and how should that be determined? Who beyond the government should be responsible to pay, in what proportions, and how? At what stage is that determined?
- Is the flawed pathology identified by the Chief Coroner's Review sufficient failure or must more be established?
- How should compensation be quantified?

These should not be regarded as reasons for taking no action, but instead as some of the challenges to be overcome in the interest of full restoration of public confidence.

The 2006 *Report of the Events Relating to Maher Arar: Analysis and Recommendations*, by Associate Chief Justice Dennis O'Connor, recommended that "[t]he Government of Canada should assess Mr. Arar's claim for compensation in the light of the findings in this report and respond accordingly."[34] The terms of reference for that inquiry specifically prohibited Commissioner O'Connor from expressing any conclusion or recommendation regarding the civil or criminal liability of any person or organization. Commissioner O'Connor acknowledged this limitation and commented in Recommendation 23:

> I wish to make two comments about Mr. Arar's claim for compensation. First, in addressing the issue of compensation, the Government of Canada should avoid applying a strictly legal assessment to its potential liability. It should recognize the suffering that Mr. Arar has experienced, even since his return to Canada. ... In

[34] Canada, *Report of the Events Relating to Maher Arar: Analysis and Recommendations* (Ottawa: Public Works and Government Services Canada, 2006), 362.

> addition, as the Inquiry has proceeded, some of the mental suffering that Mr. Arar experienced in Syria has re-surfaced. Based on the assumption that holding a public inquiry has served the public interest, Mr. Arar's role in it and the additional suffering he has experienced because of it should be recognized as a relevant factor in deciding whether compensation is warranted.
>
> The only other observation that I wish to make is that, if the Government of Canada chooses to negotiate with Mr. Arar, negotiated arrangements can be more creative than a mere damage award. A compensation agreement could involve anything from an apology to an offer of employment or assistance in obtaining employment.[35]

I would echo Commissioner O'Connor by encouraging the government, in addressing the challenge of compensation, to avoid applying a strictly legal assessment to its own potential liability. Any compensation should recognize the suffering that innocent individuals have experienced and continue to experience as a result of flawed pediatric forensic pathology.

Recommendation 148

The Province of Ontario should address the identified challenges to see if it is possible to set up a viable compensation process. The objective is to provide expeditious and fair redress for those who, through no fault of their own, have suffered harm as a result of these failures of pediatric forensic pathology, thereby helping to fully restore public confidence.

[35] *Ibid.*, 363.