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Pediatric Forensic Pathology and Families

Early in this Report, I describe the devastating impact that the sudden unexpected death of a child has on parents, surviving siblings, extended family members, and the community. When these deaths are suspicious, it is imperative that the criminal justice system handles these complex and emotionally charged cases correctly and fairly. Without compromising ongoing criminal investigations, the authorities must proceed sensitively and even compassionately, in recognition of the trauma that families have already endured and the tragic consequences for an individual wrongly accused of fatally abusing a child.

Although my mandate requires me to focus on the role of pediatric forensic pathology in the criminal justice system, the same pathology may also play a decisive role in parallel child protection proceedings. Indeed, the difficulties for child protection workers are, in some respects, more pronounced than for criminal investigators. After all, they are dealing not with the criminal responsibility for a child who has died, but the immediate safety of living children. When a parent is suspected of having fatally abused or neglected a child, pressing decisions must be made about the best interests of the parent's remaining children. Those decisions are necessarily time-sensitive. Weighed against those pressing concerns is the recognition that separating parents from their remaining children – particularly where the parents have done no wrong – only compounds the tragedy for all those affected.

In my view, to fully restore public confidence in pediatric forensic pathology, we need to look at how it can better serve child protection proceedings and the needs of the families affected by a suspicious pediatric death. Most important is the issue of how pediatric forensic pathology can meet the requirements of both criminal justice and child protection proceedings. It is important that, consistent with the needs of the ongoing criminal investigation, pathology findings be accurately provided to those involved in child protection proceedings as promptly as

possible. It is true that this objective can produce tensions between the systems. I recognize the concern that criminal investigations not be jeopardized by the sharing of information that makes its way to those suspected of abuse. But there is also the concern about the severe time lines that face the child protection system in making decisions about the placement of children, and the importance that those decisions be the right ones. There is a significant role for police to play in ensuring that the information provided to those involved in child protection proceedings is accurate and remains current. Up-to-date information, particularly on forensic pathology, may build a stronger case for abuse, or may expose weaknesses in or limitations on earlier expressed opinions. Either way, the information is critical to accurate fact-finding.

First, we need to recognize, but not overemphasize, the concern that the sharing of information may undermine the criminal investigation. At the same time, we need to recognize, but not underestimate, the significance of decisions being made in the child protection forum and how the sharing of information can promote better fact-finding in that forum. My recommendations concerning protocols between the police and children's aid societies are intended to address both objectives.

A second question I discuss in this chapter is how the Office of the Chief Coroner for Ontario (OCCO) can better communicate with families affected by the sudden unexpected death of a child to assist them in understanding what has happened. This role includes explaining the autopsy results and, if it applies, the contemplated retention of the child's organs and tissue samples. As I will explain, I think much more can be done.

Third, I address the issue of how child protection proceedings in which Dr. Charles Smith and flawed pediatric pathology may have played a part should be dealt with.

Finally, I deal with the issue of legal aid funding for child protection proceedings involving pediatric forensic pathology.

Information Sharing

When a child dies under suspicious circumstances, and there are surviving children, there are likely to be parallel criminal and child protection investigations. In these circumstances, it is imperative that relevant information be shared between the police and children's aid societies to the fullest extent possible. A key component of the relevant information to be shared is what the post-mortem examination may yield about the cause of death. The statutory obligation on the police and others to report suspected child abuse reinforces the obligation of the police

to share such information. The obligation is a continuing one. As the police acquire additional relevant information, including new or modified pediatric forensic pathology findings and opinions, it should be shared with children's aid societies as far as possible. The additional information may, as I earlier noted, build a stronger case for abuse, or it may expose weaknesses in or limitations on earlier expressed opinions. Either way, the information is critical to accurate fact-finding in the child protection proceedings. Moreover, it is vital that the information be provided promptly to ensure that it is available when crucial decisions are being made both by children's aid societies and by the court determining whether to bring a surviving sibling into care.

Jenna's case is illustrative of the concern here. Jenna died on January 22, 1997. Her sister, Justine, who was seven years of age, was apprehended by the local children's aid society (CAS) that same day. She remained in foster care or with her aunt and uncle for approximately three-and-a-half months. She was then returned to the care of her mother, Brenda Waudby, and remained there until Ms. Waudby was arrested on September 18, 1997, and charged with murder, approximately eight months after Jenna's death. Justine was reapprehended on that date. The CAS subsequently apprehended a second child, M.W., born to Ms. Waudby in 1999. M.W. was placed in his father's custody.

During this period, as Jenna's case proceeded beyond the preliminary hearing and toward the trial, the defence disclosed to the Crown expert medical evidence in its possession that challenged the Crown theory as to the timing of the fatal injuries and cast doubt on the prosecution's case. Ultimately, once this information was fully investigated, and corroborated, at the Crown's request by Dr. Bonita Porter, Deputy Chief Coroner of Inquests, the Crown withdrew the most serious charges against Ms. Waudby. Before the withdrawal, however, she pleaded guilty to a charge of child abuse, in relation to an incident sometime in the one to three weeks before Jenna's death, pursuant to s. 79 of the *Child and Family Services Act,* RSO 1990, c. C.11.[1]

After the criminal charge was withdrawn, Ms. Waudby applied for interim care and custody of both Justine and M.W. The family court judge granted the application in relation to Justine, but ordered that M.W. remain in his father's care with access granted to Ms. Waudby. The CAS opposed Ms. Waudby's applications and later appealed the family court orders. The appeal was dismissed, and the orders were upheld by the reviewing judge.

At the Inquiry, counsel for Ms. Waudby explored whether the police and the

[1] The pathology evidence that formed the basis of the guilty plea could not be confirmed upon review by Dr. Michael Pollanen.

prosecution had kept child protection workers informed of the status of the criminal case, and particularly the progressive disintegration of the theory implicating Ms. Waudby, as new evidence became available. The prosecutor, who testified at the Inquiry, felt that he had complied with his obligations. Moreover, he made it clear that criminal counsel for Ms. Waudby was well placed, indeed better placed, to ensure that the developing evidence was known to those involved in the child protection proceedings. The record is not entirely clear as to precisely what information was communicated by the police or prosecutors to the CAS or when it was communicated. The prosecutor indicated that, in his view, there needs to be a better protocol for determining what parts of the brief should be turned over to the CAS. What the case demonstrates for me, accepting the good faith of all involved, is that there was no clear protocol or practice ensuring that the relevant developments in the criminal case were communicated in a timely and complete way to the child protection workers involved. This problem of course cannot simply be addressed for information arising out of the post-mortem examination. There must be a more general approach.

There are at least two Ontario government documents that are of significance in addressing information sharing between the police and the children's aid societies: Child Protection Standards in Ontario, issued by the Ministry of Child and Youth Services in February 2007, and the Policing Standards Manual, issued by the Ministry of the Solicitor General (now the Ministry of Community Safety and Correctional Services) in 2000.

The Child Protection Standards in Ontario are intended to "promote consistently high quality service delivery to children, youth and their families receiving child protection services from Children's Aid Societies across the province."[2] The document sets

> new standards [that] are the *mandatory* framework within which these services will be delivered. They establish a *minimum level of performance* … and create a norm that reflects a desired level of achievement. The standards will provide the baseline for demonstrating the level of performance within the ministry's overall accountability framework for child welfare. [Emphasis added.][3]

The third standard contained in this document requires that, when the CAS receives information alleging a criminal offence perpetrated against a child, its

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[2] Ministry of Child and Youth Services, Child Protection Standards in Ontario, February 2007, online http://www.gov.on.ca/children/english/resources/child/STEL02_179886.html, p. 2.
[3] *Ibid.*

child protection worker must immediately inform the police and then work with them in accordance with established investigative protocols. Every CAS is directed to have established protocols with the local police departments to cover the investigation of such allegations.[4]

Beyond the basic requirement that local protocols exist, the Child Protection Standards provide little or no direction as to what should be contained within the protocols. In relation to pediatric forensic pathology, these standards do not specifically address the scenario in which a child dies and other siblings remain whose care must be decided on, nor do they articulate the role of the coroner or the forensic pathologist.

The Policing Standards Manual describes itself as stating "the ministry's position in relation to policy matters" and "provid[ing] recommendations for local policies, procedures and programs." Policing agencies and municipalities use the guidelines as primary tools to assist with their understanding and implementation of the *Police Services Act,* RSO 1990, c. P.15, and its regulations.[5]

The Policing Standards Manual sets out a number of guidelines for multidisciplinary coordination in cases of child abuse and neglect, including information sharing. It states:

1. Every Chief of Police *should*, in partnership with local Crown, Children's Aid Societies (CAS), municipalities, school boards and other appropriate service providers, including hospital staff, work to establish a committee to coordinate the development of a local strategy for preventing, and responding to issues and complaints of, child abuse and neglect.
2. The mandate of the committee *should* include:
   a) addressing information sharing among the member organizations, in order to facilitate a coordinated response to child abuse and neglect;
   b) the implementation of local community strategies and education/awareness initiatives/programs for addressing issues related to child abuse and neglect; and
   c) liaising with the local Child Abuse Review Team(s) (CART), where one(s) exists within the community.

…

4. Every Chief of Police *shall* enter into a child abuse protocol with their local Children's Aid Societies (CAS), which should:

[4] *Ibid.,* pp. 2, 4, 25.

[5] Ministry of Community Safety and Correctional Services, Policing Standrds, online http://www.mcscs.jus.gov.on.ca/English/police_serv/pol_stand.html.

…

f) require procedures for undertaking and managing joint investigations that:
   i) set out the respective roles and responsibilities;
   ii) address interviewing children, non-offending parents and/or person having charge of the child and alleged offenders, including the use of audio/videotaping and *R. v. K.G.B.* statements where appropriate; and
   iii) set out the procedures for the collection, handling and preservation of evidence taking into consideration the unique circumstances of child physical and sexual abuse investigations, including for arranging for the child to be medically examined;
g) *address information sharing and disclosure at the time of initial notification, during the joint investigation and after the investigation has been completed, including the sharing of information on any legal proceedings arising from the investigation;*

…

j) *address the investigation requirements / procedures following the death of a child, including where foul play is suspected or the death is sudden and unexpected, in accordance with the Ontario Major Case Management Manual and the Chief Coroner's memorandum on the protocol to be used in the investigation of the sudden and unexpected death of any child under 2 years of age;*
k) *address the requirement for an assessment of the risk to other children be completed in any case following the death of a child where foul play is suspected;* … [Emphasis added].

The manual also provides a "Framework for Model Child Abuse Protocol." The Framework identifies the following topics to be addressed within the local protocol:

Planning the Joint Investigation
Collection and Preservation of Evidence
Conducting Joint Investigative Interviews of the Child(ren)
Post-Interview Consultation
Interview with the Non-Offending Parent
Interview of the Alleged Offender
Victims' Assistance
Ongoing Consultation and Case Tracking

The Framework also indicates that the local protocols should address the issue of "Information Sharing and Disclosure," including

- at the time of initial notification;
- dispositions of investigations, including consultation in cases involving a failure to report;
- dispositions of court proceedings and/or orders;
- during joint investigation; and
- ongoing joint investigation.

The Framework also identifies the investigation of child deaths as a separate topic to be covered by the local protocols, including the role of the police and the CAS in such investigations, information sharing, the role of the local coroner, and protocols between the police and the coroner.

As I understand it, the investigation arising out of a child's death is sometimes described in local existing protocols as a "joint" investigation by the police and the CAS, but might sometimes more accurately be described as involving "parallel" investigations conducted by the police and the CAS. For example, homicide investigators will often conduct their own interviews and collect the bulk of the expert and non-expert evidence pertaining to the case without any CAS involvement, whereas the police investigating an alleged sexual assault within the home will often conduct interviews jointly with the assigned child protection worker. It is well beyond the scope of this Report to analyze when and to what extent investigations are or should be joint or parallel. What is important is that, to the extent to which investigations are not conducted jointly – in whole or in part – information sharing becomes all the more vital.

As reflected above, although the Policing Standards Manual is said to contain guidelines only, it does stipulate that the chiefs of police *shall* enter into local protocols with the CAS. In any event, the manual does set out topics to be covered by local protocols, but not their specific content.

In Toronto, Peel, and other jurisdictions across the province, such local protocols do exist. The Toronto protocol is entitled "Protocol for Joint Investigations of Child Physical & Sexual Abuse: Guidelines & Procedures for a Coordinated Response to Child Abuse in the City of Toronto," and provides, in part:

a) A joint police/CAS investigation will occur in all situations where a child has died under suspicious circumstances, or as a result of abuse and/or neglect, and there may be other children at risk.
b) Where there appear to be no other children at risk, police will, at a minimum, inform a CAS as to the circumstances surrounding the child's death if it is suspected or known that the child died as a result of abuse and/or neglect.

c) The principles of mutual reporting and information sharing are essential and continue to apply in these serious situations. However, in the event of the death of a child, the police may limit the sharing of information so as not to compromise an investigation.
d) The Coroner has jurisdiction in all instances involving the death of a child, and involved systems must take direction from the Coroner.

The Toronto protocol also directs that police officers shall keep child protection workers informed of the reasons for criminally charging or not charging, of the outcome of any criminal proceedings, and of dates of future court appearances. Where child protection proceedings are initiated, the CAS worker shall keep the police informed of any order that may have an impact on criminal proceedings and of dates of future court appearances.

The Peel Child Abuse Protocol, which covers the Peel Regional Police, Peel CAS, and Peel Crown Attorney's Office, states the following with respect to information sharing:

a) Effective response requires full co-operation and co-ordination between the police and the Children's Aid Society.
b) To facilitate the joint investigative process, there shall be full disclosure between the police officer and the CAS worker at all times.
c) The police officer has primary responsibility for the criminal investigation of the alleged offender. The CAS worker has primary responsibility for the child welfare investigation / evaluation and for protection of the child. Fullest possible disclosure will be maintained between the police investigators and the CAS workers.

The police officer is also obligated to inform the CAS worker of any conditions of bail, the decision of the criminal court, and the reasons for that decision.

Despite the existence of local protocols such as these, several experts at the Inquiry described deficiencies in the existing interplay between those involved in the investigation or prosecution of pediatric forensic cases (whether they are coroners, police, forensic pathologists, or Crown attorneys) and children's aid societies.

Jane Fitzgerald, executive director of the CAS of London and Middlesex and member of the board of directors of the Ontario Association of Children's Aid Societies (OACAS), confirmed that local protocols do exist. However, in her view, information is shared in most cases because of the personal relationships of those involved in the investigation and not as a result of the protocols. She also

explained that current protocols are generally entered into between police and children's aid societies, and do not include coroners and forensic pathologists. She characterized the investigation of suspicious children's deaths as a "three-legged stool," which requires all three "legs."

Andrew Koster, executive director of the Brant CAS, stated that, because child protection workers have to make very fast decisions about remaining children in the home of a deceased sibling, they need as much information as possible as quickly as possible from police and forensic pathologists. He noted that, in practice, the sharing of information by police with the CAS is intermittent across the province. In some jurisdictions, the police will not share such information out of concern that they will thereby jeopardize the ongoing criminal investigation.

Nicholas Bala, a well-recognized expert in child protection issues and a law professor at Queen's University, advised the Inquiry that children's aid societies sometimes have had to litigate against the police to obtain information from ongoing criminal investigations in order to carry out the appropriate child protection investigations. The CAS has to make rapid decisions about the placement of surviving siblings, bringing the placement issues to court, and providing disclosure to the parents, but the police or the coroner's office may not have completed their investigations and may therefore be unwilling to release information. He indicated that courts tend to order disclosure to the CAS when the issue is litigated, but that litigation is not the best way to resolve these issues. He agreed that the child welfare system would benefit from better protocols between police forces and children's aid societies on information sharing so that litigation would not be necessary.

There was some discussion at the Inquiry as to whether such protocols should be province wide or negotiated locally. Both Professor Bala and Mr. Koster advocated for a system in which there were provincial standards, implemented locally to allow for regional differences.

The OCCO has also recognized the need for standardization of joint investigative protocols. In June 2007, the OCCO released the second report of the Paediatric Death Review Committee (PDRC). The PDRC reported that, in its review of deaths in 2005 and 2006, it found as a repeated theme inconsistencies in whether investigative protocols between police and the CAS were followed and used; it also found poor communication and sharing of information with co-investigators and other professionals involved with the families. As a result, the PDRC recommended enhanced sharing of information and mandatory police and CAS protocols for joint investigations and reporting of all child deaths.

The Inquiry revealed that province-wide standardization still does not exist. There are local protocols, but they are often poorly understood and

compliance varies. In other instances, they fail to address the sharing or exchange of information in a timely way. The extent to which information can be shared, and indeed must be reported, remains the subject of misunderstanding or confusion.

I agree with Professor Bala and Mr. Koster that there is a need both for province-wide standards, supplementing those that already exist, and for local protocols to facilitate their implementation. The provincial standards should specifically address the expectations surrounding the sharing of information relating to joint or parallel investigations arising out of child deaths where other children may be at risk. They should emphasize the importance of timely and accurate communication of such information, and of its being updated as circumstances change; in particular, the police need to keep child protection workers updated to ensure that decisions regarding surviving children are accurate. The standards should remove any misconceptions that inhibit the appropriate sharing of information, and they should reinforce the point made earlier that, although it is important to protect the integrity of an ongoing criminal investigation, the need to withhold information from the child protection system in order to do so should not be overstated. Similarly, the significance of decisions being made in the child protection forum, and how the sharing of information can promote better fact-finding in that forum, should not be underestimated. The standards should also articulate the roles to be played by coroners, forensic pathologists, and Crown counsel in the sharing of information in investigations arising out of the suspicious death of a child. It would be helpful if the standards were accompanied by a template for local protocols to facilitate their timely adoption across the province.

As I have said, the provincial standards should be sufficiently flexible to permit local jurisdictions to implement them in a manner that best suits their particular communities. However, that flexibility must not be so broad that it defeats their fundamental purpose – standardization across Ontario. This is a delicate balance that will need to be addressed by those who will be responsible for developing these standards and local protocols. Of course, once such a protocol is developed, local agencies will need to be trained in order to ensure its effective implementation.

Recommendation 163

a) The Province of Ontario, with the assistance of the Ontario Association of Children's Aid Societies and others, should develop province-wide standards, supplementing those that already exist, on the sharing of information arising

out of the investigations of suspicious child deaths by the police and children's aid societies.

b) The provincial standards should:

- Specifically address the expectations surrounding the sharing of information relating to joint or parallel investigations arising out of child deaths where other children may be at risk.
- Emphasize the importance of the timely and accurate communication of such information, and its updating as circumstances change, particularly by the police to child protection workers to ensure that decisions regarding surviving children are accurate.
- Remove any misconceptions that inhibit the appropriate sharing of information, and reinforce the point that, although it is important to protect the integrity of an ongoing criminal investigation, the need to withhold information from the child protection system in order to do so should not be overstated. The significance of decisions being made in the child protection forum, and how the sharing of information can promote better fact-finding in that forum, should also not be underestimated.
- Articulate the roles to be played by coroners, forensic pathologists, and Crown counsel in the sharing of information in investigations arising out of the suspicious death of a child.

c) Local protocols should also be created across the province to permit local jurisdictions to implement the provincial standards in a manner that best suits their particular communities.

d) The timely development of these local protocols should be facilitated through the creation of a template for such protocols to accompany the provincial standards.

e) Local children's aid societies, police, coroners, forensic pathologists, and Crown counsel should receive joint training on the provincial standards and their local implementation to ensure that all parties have common understandings and interpretations of the standards and protocols and their application locally.

Communicating with Affected Families

There was no dispute among the parties at the Inquiry that the families of a deceased child are entitled to receive timely information about the death investigation and its results in a caring and compassionate manner. In particular, the forensic pathology concerning the cause of the child's death can be vitally important to the family. As stated by the Baroness Helena Kennedy in *Sudden Unexpected Death in Infancy* (Kennedy Report), the 2004 report of the inquiry set up after the acquittal of Sally Clark in England:

> Parents suffering a terrible tragedy need sensitive support to help deal with their loss. It is every family's right to have their baby's death properly investigated. Families desperately want to know what happened, how the event could have occurred, what the cause of death was and whether it could have been prevented. This is important in terms of grieving, but is also relevant to a family's high anxiety about future pregnancies and may identify some underlying cause, such as a genetic problem. And if there happens to be another sudden infant death in the family, carefully conducted investigations of an earlier death also help prevent miscarriages of justice.[6]

It is vital that the family of the deceased child be kept informed as much as possible. The reality, however, is that coroners and forensic pathologists are already overburdened.

In its written submissions, the OCCO proposed the creation of a Family Liaison Service to provide information and guidance to the public when navigating through the complexities of the death of a family member, particularly in pediatric death cases. The terms of reference of the Family Liaison Service would be posted on the newly created OCCO website. In addition, a full description of the services that families can expect would be provided, including information on where complaints should be directed, where applicable.

I endorse the OCCO's proposal. The development of such a service would, I hope, go a long way toward ensuring that the families of deceased children are properly, and compassionately, informed and updated about the status and results of the death investigation. Of course, the development of such an office will require appropriate funding from the province.

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[6] *Sudden Unexpected Death in Infancy: A Multi-Agency Protocol for Care and Investigation* (London: Royal College of Pathologists and Royal College of Paediatrics and Child Health, September 2004) (Chair Baroness Helena Kennedy), 1, online http://www.rcpath.org and http://www.rcpch.ac.uk.

Recommendation 164

The Office of the Chief Coroner for Ontario (OCCO) should develop a Family Liaison Service dedicated to communicating with families, particularly those that have suffered the loss of a child. The service should ensure that it communicates with the affected families in an effective, timely, caring, and compassionate manner. The Province of Ontario should provide additional funding to the OCCO to enable this service to be developed.

Releasing Post-Mortem Reports to Families

One of the proposals made at the Inquiry to resolve the issue of inadequate communication was that the family of the deceased child be given immediate access to the post-mortem report on its completion. Concerns were raised, however, that criminal investigations might be jeopardized by the early release of the post-mortem report in every case.

The Kennedy Report recommended that the results of post-mortem examination be discussed with the parents at the earliest opportunity. It was anticipated that a pediatrician specializing in sudden unexpected deaths in infants would discuss the autopsy results with the parents. The Kennedy Report also recommended that the pediatrician "write a detailed letter to the parents, giving information concerning the cause of the infant's death and make arrangements to meet them to explain the contents of the letter, answer questions and offer future care and support."[7]

I am hopeful that the OCCO's hiring of dedicated personnel to deal with families of a deceased child will go a long way toward resolving concerns about inadequate communication. I also propose that guidelines be established to assist those personnel in communicating with the families. Those guidelines should, in my view, include a provision that disclosure of the autopsy results should be made to the family, both verbally and in writing, in a timely and sensitive manner.

Where there is an ongoing criminal investigation, the issue of what information should be released to the affected families, including the post-mortem report, is a contentious one that needs to be addressed. The OCCO encouraged me to recommend that it convene a meeting with the OACAS to develop a policy respecting the timely release of the cause of death information where there is an ongoing criminal investigation. I agree that such a meeting would be appropriate to allow the parties to find the appropriate balance between keeping the family

[7] *Ibid.*, 20.

informed on the one hand, and, on the other, protecting any possible criminal investigation. That meeting should also involve leading police forces to ensure that their position(s) are understood and incorporated into the policy.

Recommendation 165

a) Disclosure of autopsy results to parents should be made verbally and in writing in a timely manner that is sensitive to the parents' loss and bereavement.

b) The Office of the Chief Coroner for Ontario should meet with the Ontario Association of Children's Aid Societies and leading police forces to develop a policy respecting the timely release of the post-mortem information where there is an ongoing criminal investigation.

Organ and Tissue Retention and Disposition

Another area that highlights communication concerns is the retention and disposition of organs and tissues taken at autopsy.[8] Some families may have cultural or religious objections, while others may wish to be informed by the OCCO of what is being done in this regard.

The current OCCO memorandum on the issue recognizes that, "[t]he importance of communication with families at all stages of the Coroner's investigation cannot be overemphasized." It provides that the investigating coroner is to make reasonable efforts to advise the family, before the autopsy, that there may be a need to retain tissue specimens. When the forensic pathologist communicates the initial autopsy findings to the coroner, both the pathologist and the coroner must decide together whether it would be beneficial to retain whole organs and en bloc tissue specimens. The purpose of such organ and tissue retention is to advance the death investigation in homicides, and in undetermined or suspicious deaths. The forensic pathologist will record all organ and tissue retentions and convey this information to the investigating coroner and the regional coroner.

The investigating coroner must make reasonable efforts to let the family know about the results of the post-mortem examination as soon as possible following the autopsy. This notification is supposed to include information about any whole organs or en bloc specimens retained and about how they can be returned to the family for burial or cremation. The investigating coroner is to inform the

[8] This is to be distinguished from organ *donation*, for which there is a separate OCCO policy. I endorse the OCCO's policy with respect to organ *donation*.

family that it is common practice for the retained organs and en bloc specimens to be cremated by the hospital or forensic pathology unit once they are no longer required for the death investigation. However, the coroner should advise the family that, if they wish to have the organs or tissues returned, a funeral home should be contacted to assist.

In its written submissions, the OCCO recognized the cultural and personal concerns that can arise regarding organ retention as a component of the post-mortem examination. The OCCO suggested the continuation of its current policy of notifying families when pathologists request the retention of organs for further testing. This includes discussion with the family about the disposition of organs following the completion of the testing. I agree with the OCCO's submissions and endorse its current policy on organ and tissue retention. I wish to add only one comment. Should there be a conflict between the OCCO and the family as to whether organs and tissues should be retained, I am of the view that, if the death investigation truly needs to retain tissues and organs, that need must prevail over the cultural and religious beliefs of the families. But retention must be for the shortest time possible and with a full and sensitive explanation to the family.

Recommendation 166

The Office of the Chief Coroner for Ontario's current policy for organ and tissue retention and disposition should be continued. Coroners should be encouraged to communicate with families about the need for organ and tissue retention in a timely manner that is respectful of these families and their cultural or religious beliefs.

Reviews of Child Protection Cases Involving Dr. Smith

Defence for Children International – Canada (DCI–Canada) submitted that child protection cases where Dr. Smith was involved should be reviewed. The goal would be to identify whether faulty pediatric forensic pathology played a part in separating children from their parents or guardians, and, if so, to address how best to remedy that wrongful separation. The Affected Families Group supported DCI–Canada's recommendation that appropriate steps should be taken to notify children adopted or subject to Crown wardship as a result of the errors made by Dr. Smith.

In my opinion, there is no basis for me to make such a recommendation. The

Chief Coroner's Review has already identified all the cases involving Dr. Smith between 1991 and 2001 in which the child's death was criminally suspicious. The cases from that group in which there were other siblings constitute the cases in which Dr. Smith may have given a pathology opinion that mattered in child protection proceedings. The universe of cases between 1991 and 2001 involving Dr. Smith is known.

The ongoing review for 1981 to 1991 will achieve the same for that period. Although it will identify only those cases in which there was a conviction, it is unlikely that there would be any other cases that were criminally suspicious in which there were surviving siblings who are still in care and in which Dr. Smith gave pathology evidence in child protection proceedings. Dr. Smith was involved in few forensic cases during those years, and, given the length of time that has elapsed, any children affected are likely to be grown.

Finally, nothing in the record suggests that the testimony of any other pediatric forensic pathologist requires a review.

While no further review is warranted, our mandate permits us to assist families in the cases already identified. The Inquiry has already facilitated counselling for those families affected by flawed pediatric forensic pathology. For a number of the individuals, the counselling has been very helpful in assisting them to deal with these tragic episodes and move on with their lives. The Inquiry was initially able to commit to funding counselling for a two-year period – the duration of the Inquiry. Where the counselling began during the life of the Inquiry, I recommend that funding be provided for up to a further three years if the individual and the counsellor think it would be useful.

Recommendation 167

The Province of Ontario should provide funding to permit counselling for individuals from families affected by flawed pediatric forensic pathology in cases examined at this Inquiry for up to a further three years, for a total of five years from the time of commencement, if the individual and the counsellor think it would be useful.

Those whose names have been placed on the Child Abuse Register as a result of Dr. Smith's flawed pathology should be assisted. The Child Abuse Register is a database that contains the names of individuals who have been found to have abused or neglected a child in their care. The *Child and Family Services Act* (*CFSA*) and regulations govern the Child Abuse Register. The register is made up of information of child abuse or neglect received and verified by a CAS. Once information is verified by a CAS, it must be reported to the director of the regis-

ter within 14 days. When an individual is entered into the register, the *CFSA* requires that the director give written notice to the registered person.

The threshold for determining whether an individual's name should be entered into the register is lower than the standard of proof in civil and criminal matters. Such a decision can be made simply on the basis that there exists credible evidence to support the registration. In *Ridley v. Children's Aid Society for the County of Hastings*, Justice Sydney Robins held that, for the register to achieve its purposes, entries should not be limited to cases in which abuse was established on a criminal or civil standard of proof. Instead, credible evidence supporting the information in the register is adequate: "[I]f credible evidence is adduced it remains for the Director to determine in light of the circumstances of the request before him whether the information should remain in the register. In the absence of credible evidence the name must be expunged."[9]

If a request is made for the removal or amendment of information in the register, the director may either grant the request or hold a hearing under ss. 76(4) – (12) of the *CFSA*. If, after a hearing, the director decides that the information in the register is in error or should not be there, the director must remove it or otherwise amend the register. The director may also order that the CAS amend their records to reflect this decision.

In their study, Professors Nicholas Bala and Nico Trocmé suggested that I recommend the "removal of names from the Child Abuse Register if there is no longer credible evidence of a history of abuse."[10] In its written submissions, DCI–Canada adopted Professors Bala and Trocmé's recommendation and similarly urged me to recommend the removal of names from the Child Abuse Register.

In my view, people whose names have been placed on the Child Abuse Register as a result of faulty pediatric forensic pathology should no longer bear the stigma associated with that registration. The director of the register should be encouraged to grant the request of such persons to have their names removed.

Recommendation 168

In the discharge of his or her mandate, the director of the Child Abuse Register in Ontario should be encouraged to grant the request of persons wrongly listed on

[9] [1981] OJ No. 174 (HCJ) at para. 20.

[10] Nicholas Bala and Nico Trocmé, "Child Protection Issues and Pediatric Forensic Pathology," 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), 87.

the register as a result of faulty pediatric forensic pathology to have their names removed from the register if there is no longer credible evidence of abuse.

Legal Aid Funding in Child Protection Proceedings Involving Pediatric Forensic Pathology

Elsewhere in this Report, I make recommendations relating to increased funding of counsel and pathology experts for pediatric homicide prosecutions and for applications for ministerial review of wrongful convictions. Here, I would like to address funding by Legal Aid of counsel and experts in child protection proceedings involving pediatric forensic pathology.

At the roundtable on pediatric forensic pathology and potential child abuse, Ms. Fitzgerald indicated that when there is a homicide in a family, child protection workers have to make very complex decisions about whether to bring surviving siblings into care. Child protection workers have to consider the best interests of the siblings and their safety. To do so, Ms. Fitzgerald explained, CAS workers necessarily rely on information they receive from other professionals. She said that CAS workers are not in a position to question medical evidence or act as a check against potentially flawed expert opinions on pediatric forensic pathology. Ms. Fitzgerald noted, however, that, in child protection proceedings, counsel for the parents or experts retained on behalf of the parents can perform this check on expert medical opinions. Ms. Fitzgerald's experience in child welfare court was, however, that parents unfortunately often did not have access to the Legal Aid support that would have enabled them to obtain the legal advice or expert opinion they needed to question the forensic pathologist's evidence. Professor Bala advised the Inquiry that it can be very difficult for parents to obtain counsel for child protection proceedings:

> Our Legal Aid system is often woefully inadequate in the child protection context, in particular. And parents are often having great difficulty getting adequate counsel. Issues about Legal Aid are certainly true in the criminal system. They're even worse in a child protection system. In many parts of Ontario now, it's not possible to find lawyers who will take certificates to do child protection work because of the nature of the fee schedule and the difficulty of the work.

Rob Buchanan, vice-president of Legal Aid Ontario (LAO), said that in some parts of Ontario it is difficult, for economic reasons, to find a capable lawyer to assist with a child protection matter. Mr. Buchanan also explained that there is no big case management process available for family law matters. He said that a

lawyer preparing for a child protection hearing would have a maximum of 50 hours of preparation. Additionally, Mr. Buchanan told me that eligibility cut-offs for LAO funding are very low. For example, for a single person to be eligible for a Legal Aid certificate, he or she must have an annual income of no more than $13,000 per year.

Professors Bala and Trocmé urged me to recommend that Legal Aid provide better support for parents involved in child protection proceedings:

> One way to promote fairness to parents and the best informed judicial decision making is to ensure that parents have access to effective advocates, and, in appropriate cases, to independent experts who can credibly challenge the opinions of government-retained or -employed experts. While Legal Aid does provide funding for the most indigent parents involved in the child protection process, the amount of funding per case is often inadequate, making it very difficult for parents and their counsel to effectively challenge agency decisions and experts. Further, many parents of limited means have incomes just above the very low Legal Aid ceilings but are unable to afford the often enormous costs of child protection litigation.[11]

While I appreciate the comments of Professors Bala and Trocmé and others, I am not in a position, by virtue of my limited mandate, to address Legal Aid funding for family counsel and experts in all child protection proceedings. My mandate is confined to restoring confidence in pediatric forensic pathology in the province. Thus, any recommendations I make with respect to funding from LAO are confined to cases in which pediatric forensic pathology plays an important role in the child protection proceeding.

As the evidence at the Inquiry has demonstrated, pediatric forensic pathology is a complex science. Counsel must have a heightened degree of knowledge and skill to be able to comprehend and, if appropriate, challenge pediatric forensic pathology evidence. It is for that reason that in Chapter 17, The Roles of Coroners, Police, Crown, and Defence, I recommend that only knowledgeable, skilled, and experienced counsel take on these cases in the criminal context. As discussed in that chapter, Legal Aid Ontario needs to increase the compensation in cases involving pediatric forensic pathology to ensure that qualified counsel will take on these complex cases.

The same principles apply in child protection proceedings in which pediatric forensic pathology plays an important role. I accept that counsel and experts

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[11] *Ibid.*, 88.

available to parents are a necessary protection against miscarriages of justice caused by flawed pediatric forensic pathology not only in criminal cases but also in child protection proceedings. Accordingly, in child protection cases where pediatric forensic pathology plays an important role, necessitating the involvement of counsel with heightened experience, knowledge, and skill, LAO should fund those counsel at an increased rate. I note that Professor Michael Trebilcock's recent *Report of the Legal Aid Review 2008* also highlights the need for the legal aid tariff to be increased, particularly for criminal and family lawyers, to help ensure that qualified counsel take on legal aid cases.[12] He, too, recommended that the tariff be significantly raised in the immediate future. Additional hours may also need to be funded because of the complex nature of these cases. In addition, these cases typically require the involvement of a forensic pathologist to assist counsel and the family. LAO should also provide funding for the retention of a forensic pathologist at a rate commensurate with that of the expert being relied on by the Crown. Again, LAO may need to authorize additional hours, as required, for the expert.

Recommendation 169

a) Legal Aid Ontario should work with the family law bar to ensure that family lawyers are funded for child protection proceedings in which pediatric forensic pathology plays an important role. The tariff for counsel who litigate these cases should be increased to create incentives for experienced and specially trained lawyers to take on legally aided cases and to reflect their added expertise. Legal Aid Ontario should fund an adequate number of hours to ensure that family counsel can properly fulfill their duties.

b) In appropriate cases, Legal Aid Ontario should authorize funding for one or more forensic pathologists and, where necessary, out-of-jurisdiction pathologists, including their travel expenses.

c) Legal Aid Ontario should raise the hourly rate for forensic pathology experts to a level that is commensurate with funding of experts retained by the Crown. This is necessary to ensure that experts of comparable skill to that of experts retained by the Crown are prepared to assist the family lawyer. This increase should occur expeditiously in pediatric forensic pathology cases.

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[12] Michael Trebilcock, *Report of the Legal Aid Review 2008*, http://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/trebilcock/legal_aid_report_2008_EN.pdf (accessed August 14, 2008).

d) Legal Aid Ontario should increase the number of hours of funding authorized for forensic pathologists.

I end this Report where I began. The sudden, unexpected death of a child is a terrible tragedy. For the parents, the loss is shattering. It is all the more devastating when flawed pathology focuses suspicion on a grieving parent and invites legal proceedings to separate that parent from surviving children. It is of course no less troubling when flawed pathology imperils the search for the truth – wherever it may lead.

Public confidence in pediatric forensic pathology requires that it serve the child protection proceedings and the needs of affected families. Those dual needs demand that the child protection system has the facts necessary to make timely informed decisions. Suspected family members and their counsel must be able to evaluate and, if need be, challenge the existing pathology evidence. Most important, families must be treated fairly and compassionately both in assisting them to understand what has happened, when they do not know, and in providing them with counselling when they have been adversely affected by flawed pediatric forensic pathology. My recommendations in this chapter are intended to assist in restoring public confidence in pediatric forensic pathology by addressing these issues.