IN THE MATTER OF an Inquiry pursuant to the *Public Inquiries Act* R.S.O. 1990, c. P.41, as amended, into Pediatric Forensic Pathology in Ontario.

REPLY SUBMISSIONS OF THE PROVINCE OF ONTARIO

ATTORNEY GENERAL FOR ONTARIO

Crown Law Office – Civil
720 Bay Street, 8th Floor
Toronto, ON M5G 2K1

Kim Twohig
LSUC No. 17986O

Tel: (416) 326-4171
Fax: (416) 326-4181

Bill Manuel
LSUC No. 164461F

Tel: (416) 326-9855
Fax: (416) 326-4181

Heather Mackay
LSUC No. 46938A

Tel: (416) 326-3129
Fax: (416) 326-4181

Counsel for the Province of Ontario

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Introduction

1. The submissions below are intended to address some of the issues relating to the Province of Ontario raised in the submissions of the other parties to this Inquiry, which have been grouped under subject headings.

Further Review of Pediatric Forensic Pathology Cases

2. Contrary to Recommendations 1 and 2 of AIDWYC and the Mullins-Johnson Group, it is Ontario's position that it is not necessary to review all shaken baby syndrome cases or head injury cases which resulted in criminal convictions and all pediatric autopsies since 1981 in order to restore confidence in pediatric forensic pathology ("PFP") in Ontario. The evidence before this Inquiry supports this.

3. The problems identified in the PFP cases in which Dr. Smith was involved are either:

    1) Personal to him, i.e. the absence of training in PFP and giving opinions about matters on which he was not qualified to opine; or

    2) Represent differences of opinion in the proper approach to be taken to the interpretation of PFP in shaken baby or head injury cases.

4. With respect to point number one, the OCCO and the Ministry of the Attorney General have already developed a protocol for dealing with cases from the period from 1981-1991 on which Dr. Smith consulted and which resulted in a conviction. This protocol was developed in consultation with the Forensic Services Advisory Committee which includes representatives from AIDWYC. A key feature of this process is a request by the convicted person for a review of the pathology in their case.[1]

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[1] Dr. Michael Pollanen, Transcript Nov 14, p. 111, Feb.21, 2008, pp. 85-86; Dr. Barry McLellan, Transcript, Nov 14, p. 110

5. With respect to point number two, there is at present no consensus in the PFP community regarding the indicia of shaken baby syndrome pursuant to which a review of the pathology in all of these cases could be undertaken.[2] These cases will have to continue to be decided on their particular facts, on a case by case basis. The provisions of the *Criminal Code* dealing with post-conviction review are available to anyone asserting a wrongful conviction based on the facts of their case.

Compensation

6. There was no evidence led at the Inquiry during the evidentiary or Policy Roundtable phases of the Inquiry on which determinations about compensation could be made, i.e. who should or should not be entitled to compensation, for what, from whom and on what basis.

7. The issue of compensation is better left to be resolved through established processes such a civil actions, arbitrations, or mediations. Those processes will allow each case and each person affected to be examined individually to determine entitlement to compensation and the amount, if any.

8. Where there have been demonstrated wrongful convictions, for example, in the case of Mr. Mullins-Johnson, there is a joint federal-provincial protocol dealing with compensation for those found to be wrongfully convicted pursuant to the provisions of the *Criminal Code*.

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[2] Evidence of Dr. Chitra Rao, January 18, 2008, page 21 lines 10-25.

9. Contrary to the recommendation of the Affected Families Group ("AFG") that Ontario establish a compensation process for those affected by the conclusions of Dr. Smith,[3] it is Ontario's position that the mandate of this Inquiry does not permit the Commissioner to make determinations with respect to compensation for those affected by the faulty PFP of Dr. Smith. The Order in Council establishing this Inquiry specifically recognizes that "there are civil and criminal proceedings that have arisen as a result of Dr. Smith's work that are the appropriate forum for the adjudication of those matters".[4] Indeed, several members of the AFG have initiated civil actions with respect to proceedings against them allegedly as a result of Dr. Smith's opinions.[5]

10. Further, the Order in Council states that the review to be conducted by the Honourable Stephen Goudge is to be limited to a systemic review and assessment of:

    a. the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings;

    b. the legislative and regulatory provisions in existence that related to, or had implications for, the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and

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

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[3] Submissions of the Affected Families Group, paragraphs 362 to 364.
[4] Order in Council, Establishing the Inquiry into Pediatric Forensic Pathology in Ontario, Preamble.
[5] Application for Standing, Affected Families Group, page 3.

11. This review is to be conducted "in order to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings". [6]

12. Finally, the Order in Council specifically states that the Commissioner "shall not report on any individual cases that are, have been, or may be subject to a criminal investigation or proceeding".[7] It is Ontario's position that this includes reporting on any entitlement to compensation in a particular case.

Criminal Cases Review Commission

13. There already exists in Ontario's coronial system a multi-disciplinary panel[8] to examine issues arising with respect to pathology, the Forensic Services Advisory Committee. This Committee played an integral role in the Chief Coroner's Review which led to the establishment of this Inquiry. Furthermore, the evidence before the Inquiry is that once a conviction is called into question, the mechanisms in place in the criminal justice system allow for that conviction to be examined by the judiciary in light of all of the available evidence, including fresh evidence, to determine its soundness. Where a conviction is unsound, the Court will so find, as was the case with Mr. Mullins-Johnson.

14. AIDWYC and the Mullins-Johnson Group have recommended that the current mechanisms for post-conviction review should be replaced by a commission similar

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[6] Order in Council, paragraph 4.
[7] Order in Council, paragraph 5.
[8] See Recommendations 7 and 8, AIDWYC and Mullins-Johnson Group.

to the United Kingdom's Criminal Cases Review Commission. [9] It is Ontario's position that such a recommendation would be beyond the mandate of this Inquiry, and further, would not be within the jurisdiction of the Inquiry, which is limited to Ontario. Any procedure relating to post-conviction review is a federal matter, being a matter of criminal law.[10]

15. In any event, no evidence was called at the Inquiry (which could have been subject to cross-examination) to show that such a review commission would be more effective in resolving cases of potential wrongful conviction than the post-conviction mechanisms currently in place. It is therefore submitted there is no evidentiary foundation on which the Inquiry could make such a recommendation.

Prosecution Issues

CHILD HOMICIDE RESOURCE TEAM

16. In its submissions the OCAA recommends (Recommendation 18) a dedicated team of prosecutors who would travel to communities where there is a pediatric homicide prosecution and assume carriage of the prosecution.

17. The Ministry's purpose in establishing the Child Homicide Resource Team is to have an identified group of specially trained prosecutors to act as a resource for experienced local Crown Attorneys in each region who have carriage of child homicide prosecutions. The Team would not conduct the prosecutions, but would

[9] Submissions, AIDWYC and Mullins-Johnson Group, Recommendation 9, page 33 to 43.
[10] Section 91 (27), *Constitution Act, 1867*, 30 &31 Victoria, c. 3 (U.K.).

provide information and advice about pediatric forensic issues to the local Crown attorneys throughout the prosecution.

18. The Ministry of the Attorney General, when developing the Criminal Law Division Initiatives entered into evidence at the Inquiry,[11] considered the OCAA model of establishing a small group of prosecutors that would handle all child homicide prosecutions in Ontario .[12] The small group model was not adopted for two reasons:

    1) It is not necessary to do so, as there are highly experienced Crown Attorneys in all regions who are able prosecute these cases; and

    2) It would place an unreasonable burden on the Crown Attorneys who were part of such a team. First, extensive travel would be required. Secondly, due to the length of murder prosecutions, the members of the team would be required to be away from their homes and families for extended periods of time. [13]

DISCLOSURE OF EXPERT REPORTS

19. In their submissions, the Criminal Lawyers' Association ("CLA") makes detailed recommendations regarding the timelines for disclosure and the content of expert reports (including pathologists' reports) proffered by the Crown. Aside from any issue as to the extent of the detail required, it is not clear why these recommendations should apply only to expert reports for experts called by the Crown and not equally to experts called by the defence. Furthermore, having them apply equally to Crown and defence would encourage the development of requirements that are reasonable and fair to both sides.

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[11] Criminal Law Division Initiatives, PFP304038.
[12] Submissions of the Ontario Crown Attorneys Association, Recommendation 18.
[13] Transcript of Evidence, January 22, 2008, pp. 252-255.

TEST FOR ADMISSIBILITY OF SCIENTIFIC EVIDENCE

20. The CLA has recommended the adoption of a more stringent test for the admission of scientific evidence, which would see the exclusion of such evidence "where there is clear controversy in the scientific community on the issue".[14] The Province submits that this goes too far. One should be mindful of the retreat from such an extreme approach to the admissibility of scientific evidence that occurred in England.

21. The English Court of Appeal decided that what is required is not an exclusion of the evidence in these circumstances, but rather a clear exposition of the controversy and the limits of the evidence so that the trier of fact can take that into account in coming to a conclusion on all of the evidence in the case. The English Court of Appeal stated in *R. v. Anthony*[15] that "properly understood *Cannings*[16] is not authority for the bare proposition that a dispute between reputable experts in a specialist field should produce an acquittal". The Court went on to state that "rather, the fundamental issue was whether there are good reasons to believe that unnatural death is the only conclusion that could be drawn from the evidence". [17]

Aboriginal Issues

22. In their submissions, Aboriginal Legal Services of Toronto and Nishnawbe-Aski Nation ("ALST-NAN") state that the Report of the Ipperwash Inquiry notes, at p. 274, "that police services in general have a systemic bias against Aboriginal peoples, and

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[14] Criminal Lawyers Association Submissions, Recommendation 17.
[15] [2005] EWCA Crim. 952.
[16] [2004] EWCA Crim. 1.
[17] See also MacFarlane, Bruce, *Convicting the Innocent: A Triple Failure of the Justice System,* (2006) 31 Man. L.J. 403-487, at para 205.

that the Ontario Provincial Police (OPP) is no exception".[18] This does not accurately reflect the context of the quoted page from the Ipperwash Report.

23. In any event, it is important to note that the Report of the Ipperwash Inquiry sets out, in Chapters 9, 10 and 11.3, the many OPP programs and initiatives undertaken to promote relationship-building with Aboriginal communities, and concludes:

> The police/Aboriginal relations initiatives of the OPP are impressive in their breadth and depth. These programs represent a comprehensive strategy to improve relationships between the OPP and Aboriginal peoples.....To its credit, the OPP has taken positive, significant strides since Ipperwash and I was impressed by all of these efforts.
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> For the most part I believe that the OPP police/Aboriginal relations initiatives conform to the best practices identified in previous inquiries and reports."[19]

24. There is no evidence before the Inquiry to suggest that any of the pediatric death investigations reviewed by the Inquiry involve any systemic bias against Aboriginal peoples by the OPP or any other police service.

25. ALST-NAN has also recommended that the "Attorney General should amend the "Aboriginal Justice" chapter of the Crown policy manual to require pre-charge screening of all proposed charges against Aboriginal people." [20] However, the Crown Policy Manual already expressly acknowledges the disadvantaged position of Aboriginal persons in the justice system and society at large, and directs Crown Attorneys to take the special circumstances of Aboriginal peoples into account with respect to all stages of the prosecution against an Aboriginal accused.[21]

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[18] Submissions ALST-NAN, para. 120.
[19] Report of the Ipperwash Inquiry (2006), Chapter 11 "Bias-Free Policing", p. 280.
[20] Submissions of ALST-NAN, page 74.
[21] Province of Ontario, Ministry of the Attorney General, Crown Policy Manual, March 21, 2005 "Aboriginal Justice", CR116

26. As noted above, there is no evidence before the Inquiry to suggest that racism played a part in any of the charges laid against the two Aboriginal accused involved in the cases before the Inquiry (nor any evidence that more than two of the accused were Aboriginal). Despite this, ALST-NAN state "ALST-NAN query whether racism may also have contributed to the wrongful conviction of Mullins-Johnson".[22] No party to the Inquiry, including counsel for Mr. Mullins-Johnson, led any evidence to suggest racism played a part in the conviction of Mr. Mullins-Johnson.

27. Further, there was no evidence led at the Inquiry to suggest that Crown Attorneys are not properly performing their charge screening functions (as directed by the Crown Policy Manual)[23] when dealing with cases where the accused is Aboriginal. There is, therefore, no evidentiary basis for the recommendation put forward by ALST-NAN.

28. Finally, the recommendation put forward by ALST-NAN does not relate to pediatric forensic pathology, and therefore is not within the mandate of the Inquiry.

Child Protection Proceedings

29. In their submissions, Defence For Children International, Canada ("DCI") recommends that a task force be struck with a broad range of powers relating to child protection matters.[24]

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[22] Submissions of ALST-NAN , para. 166

[23] Province of Ontario, Ministry of the Attorney General, Crown Policy Manual, March 21, 2005 "Charge Screening", CR116.

[24] Submissions of Defence for Children International, Canada, Recommendation 2.

30. Ontario has numerous concerns respecting the powers of the proposed task force as in some areas it would contravene current legislation and existing court orders. Moreover, DCI's submissions oversimplify the complexity of the issues concerning adopted children and Crown wards and potentially puts children at risk of having stable placements interrupted. Where a child has been adopted or made a Crown ward, decisions regarding contact with birth family members are complex and would require careful assessment of the child's best interests including their current mental, emotional and psychological status and needs. It is submitted that these determinations could not and should not be made by the proposed task force. Furthermore, the task force would duplicate the services and functions of a number of other resources such as children's aid societies, the courts, assessors child Advocate and the Children's Lawyer.

31. It is also submitted that DCI's submissions fail to acknowledge existing remedies or avenues for these parents within the child welfare scheme created by the *Child and Family Services Act* ("CFSA") and related regulations. For example:

- Where a child is a Crown ward the society is required to engage in on-going planning that looks at all elements of a child's well-being with the intent of meeting the child's needs. One aspect of the planning process is to review arrangements for contact between the child and their family in the context of that child's best interests.

- Where a child has been adopted, the CFSA permits post-adoption contact between an adopted child and their birth family where all parties agree and in consideration of the views and preferences of the child where they can be reasonably ascertained.[25]

[25] See *Child and Family Services Act*, R.S.O. 1990, c. C11, ss. 66 and 153.6, and CFSA, Reg. 70, ss. 86 and 110

32. DCI's recommendation regarding the task force also contemplates the disclosure of information to third parties, such as the task force, post-adoption.[26] It should be emphasized that the current legislative regime does not permit the breadth of disclosure suggested and that should such a recommendation be adopted, legislative change would also be required to safeguard confidentiality.[27]

33. DCI also proposes the development of a model protocol for children's aid societies for the investigation of cases where there is a suspicion of child homicide by the person having charge of the child.[28] The submission does acknowledge that there are existing local protocols for joint investigation between certain children's aid societies and police services.[29] It is Ontario's position that the Inquiry should consider this recommendation in light of the reality that communities have varying service capacities. Children's aid societies and local police services are in the best position to develop local protocols for the investigation that best suit their unique circumstances. [30] The Ontario Child Protection Standards, February, 2007, require that every children's aid society have a protocol with the society's local police related to the investigation of allegations that a criminal act has been perpetrated against a child.[31]

34. It is also DCI's recommendation that all child welfare cases since 1981 may need to be reviewed to determine whether Dr. Smith played any role.[32] First, it is Ontario's

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[26] Submissions, Defence for Children International, Canada, Recommendation 2.
[27] CFSA, ss. 161 to 165.
[28] Submissions, Defence for Children International, Canada, Recommendation 7.
[29] For example, see the evidence of Sgt. McLellan, January 24, 2008, pp. 26-29.
[30] Submissions, Defence for Children International, Canada, Recommendation #7.
[31] CFSA, section 15.3 (a); CFSA O. Reg 206/00;
www.children.gov.on.ca/mcys/documents/publication/child-protection-en.pdf
[32] Submissions, Defence for Children International, para. 30.

position that such a review is unnecessary given that Dr. Smith has undertaken to identify the cases in which he has been involved,[33] and as he has co-operated with this Inquiry, there is nothing to suggest he will not fulfill this undertaking.

35. In any event, it is Ontario's position that such a recommendation would be far beyond the mandate of the Inquiry and would be completely unfeasible. Child welfare files are in the possession of the individual children's aid societies that handled the files, and are not in the care and control of the Ministry of Children and Youth Services. Therefore such files, potentially numbering in the tens of thousands, are spread throughout the fifty-three children's aid societies in the Province. To complete the review contemplated by DCI's recommendations, would require each children's aid society to redirect an extensive amount of resources to reviewing their files on the small chance that Dr. Smith played a role in the file. Further, it is not certain that these files would have recorded the involvement of Dr. Smith. It is suggested that these realities make such a review unfeasible. As noted above, existing procedures would allow for a review of any individual cases where birth parents have a concern.

36. Finally, it is Ontario's position that the matters to be addressed by the proposed task force do not involve restoring confidence in pediatric forensic pathology, and therefore are not within the mandate of this Inquiry.

[33] Evidence of Dr. Smith, February 1, 2008, p. 104, lines 8-11.

Specific Cases

AMBER

37. Contrary to the suggestion in the submissions of the AFG,[34] Ms. Regimbal was not unwilling to critically evaluate Justice Dunn's decision. In fact, Ms. Regimbal summarized the deficiencies identified by Justice Dunn in preparation for her meeting with the Hospital for Sick Children's SCAN team and Dr. Smith so that the SCAN team and Dr. Smith could address them.[35] Moreover, Ms. Regimbal fully understood the criticisms of Justice Dunn and expected that Dr. Smith would learn from them, "pull up his socks" and do better in the future.[36]

JENNA

38. The submissions of the AFG with respect to the Jenna case seem to misapprehended the facts of the case and the motivations of Crown Attorney Brain Gilkinson.[37]

39. Mr. Gilkinson met with Dr. Smith and defence expert Dr. Ein on April 23, 1999. When it became clear that Dr. Ein's opinion regarding the time frame for the fatal injuries was significantly narrower than the time frame given by Dr. Smith, and that Dr. Smith deferred to Dr. Ein, Mr. Gilkinson did not continue to "try to implicate" Ms. Waudby. Mr Gilkinson testified that because the Office of the Chief Coroner was responsible for providing Dr. Smith's opinion, it should be provided an opportunity to indicate whether there was any further evidence that would assist the Crown in determining

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[34] Submissions, Affected Families Group, paragraph 194.
[35] Evidence of Terri Regimbal, January 21, 2008, pp. 159, 172-173, 176-177 and 184; January 22, 2008, p. 45.
[36] Evidence of Terri Regimbal, January 21, 2008, pp. 54-56.
[37] Submissions of the Affected Families Group, paras. 244- 260.

whether the charges against Ms. Waudby should be withdrawn. Mr. Gilkinson was looking for a clear and safe foundation for withdrawing the charges against Ms. Waudby.[38]

40. The comment recorded by the CAS to the effect that Mr. Gilkinson said "mom (Ms. Waudby) is definitely a child abuser, but whether she is a child killer needs to be determined", referred to by the AFG in their submissions,[39] was made during the period of time when Mr. Gilkinson was waiting for a response from the OCCO regarding Dr. Ein's opinion on the timing of Jenna's fatal injuries. [40] At that time, there was uncontradicted medical evidence that Jenna was chronically abused. In addition, Ms. Waudby had admitted to inflicting injuries on Jenna the night before her death and her counsel had informed Mr. Gilkinson that she was prepared to plead guilty to child abuse under the *Child and Family Services Act.* [41]

41. Contrary to paragraph 247 of the AFG submissions, there is no evidence that the CAS asked the Crown Attorney "repeatedly" for the Crown brief. There is one note by a CAS worker to the effect that she met with Mr. Gilkinson on April 28, 1999 and requested the Crown brief, but he was unable to provide it at that time because he was in the middle of a preliminary inquiry.[42]

42. Paragraph 250 of the AFG submissions states that "the relevant information was not before the Hon. Mme. K.E. Johnston on May 7, 1999 when M.W. was removed from

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[38] Brian Gilkinson, Transcript Jan.21, 2008, p.56, line 1 – p.57, line 21; Jan.22, 2008, p.81, lines 21-25.
[39] Submissions of the Affected Families Group, para. 245.
[40] Brian Gilkinson, Transcript Jan.22, 2008, p..81, lines 6-25.
[41] Jenna Overview Report, PFP144684, paras. 20, 67; PFP011011, Homicide Review, pp.7-8; PFP075100, Transcript of Guilty Plea, p.4
[42] PFP300013, Notes of S. Sullivan, Apr. 28, 1999, p.1.

his mother's care", referring to the change in medical opinion regarding the timing of Jenna's fatal injuries. The suggestion seems to be that Mr. Gilkinson should have provided this information to the CAS. At that time, however, Ms. Waudby had the opinion of Dr. Ein, and her counsel Mr. Hauraney had been present at the meeting with Drs. Ein and Smith on April 23, 1999 where they reached consensus. Mr. Gilkinson was waiting for a response to Dr. Ein's opinion from the Chief Coroner's Office. It was not until May 26, 1999 that Mr. Gilkinson received the opinion from Deputy Chief Coroner Bonita Porter which was similar to the opinion of Dr. Ein. [43]

43. Ms. Waudby's counsel was aware of all available evidence on May 7, 1999 and could have provided it to the Court. Mr. Gilkinson had in fact informed the CAS that he would be dropping the murder charge against Ms. Waudby, as he discussed the timing of that with the CAS worker on April 28, 1999.[44] It appears that the CAS would not have been satisfied with information available on May 7, 1999, in any event, as defence counsel Mr. Meneley was informed that the CAS wanted a more detailed explanation from Dr. Ein than was contained in Dr. Ein's previous letter.[45] Dr. Ein provided a more detailed written explanation on July 9, 1999 and on July 23, 1999 the court returned Jenna's sister to the interim custody of Ms. Waudby and ordered that she have access to Jenna's brother.[46] The fact that the CAS appealed this decision indicates that the CAS was still not satisfied that Ms. Waudby's children should be returned to her even though the murder charge had been withdrawn on June 15, 1999 and the evidence in the Crown brief was no different or stronger than

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[43] Jenna Overview Report, PFP144684, par 98, Dr. Porter letter, PFP011121
[44] PFP300013, Notes of S. Sullivan, Apr. 28, 1999, p.1.
[45] Jenna Overview Report, PFP144684, par. 115; Dr. Ein Notes, PFP011151.
[46] Jenna Overview Report, PFP144684, paras. 116-117; Dr. Ein letter PFP011153; Mr. Meneley letter PFP053153, p.4.

the evidence Mr. Meneley presented in the child protection proceedings on July 23, 1999.

44. Paragraph 251 of the AFG's submissions states that Mr. Gilkinson did not disclose the report of Dr. Porter to Ms. Waudby's counsel, despite several attempts by her counsel to obtain the report. The references given by AFG do not support its submissions and there is no evidence that Mr. Meneley ever asked Mr. Gilkinson for Dr. Porter's report.

45. Mr. Gilkinson decided to withdraw the criminal charge against Ms. Waudby after he received Dr. Porter's report, so there was no need to disclose it to the defence pursuant to *Stinchcombe*. Mr. Meneley wrote to Dr. Porter on June 22, 1999, but did not mention that he has asked Mr. Gilkinson for the Crown brief[47] and although "Angie" in Mr. Meneley's office appears to have informed someone in Dr. Porter's office that "the Crown" had not been cooperative in giving information,[48] it is not clear whether this reference was to Mr. Gilkinson, the police or staff in the Crown Attorney's office. There is evidence as to why Mr. Gilkinson did not provide the Crown brief to the CAS on April 28, 1999,[49] but there is no evidence that Mr. Gilkinson was aware of, or had refused, a request by Mr. Meneley for the brief.

46. Contrary to paragraph 252 of AFG's submissions, the Crown does not have an obligation to provide information or evidence from a criminal investigation to the CAS for purposes of child welfare proceedings absent a court order. In fact, the Crown is subject to a deemed undertaking not to disclose information obtained for the purpose

[47] Jenna Overview Report, PFP144684, par. 106; Mr. Meneley letter PFP053153
[48] Jenna Overview Report, PFP144684, par. 108; Fax cover PFP053165.
[49] Notes of S. Sullivan Apr. 28, 1999, PFP300013

of a criminal proceeding to any other party for a purpose other than the resolution of the criminal proceedings, except in accordance with the protocol established by the courts.[50] Mr. Gilkinson complied with all his legal obligations regarding disclosure of the Crown brief. There was some evidence of a court order for "full disclosure of police records,"[51] but it is not clear what this means. The order was apparently not directed to the Crown, as it was never provided to the Crown.

47. Furthermore, in respect of paragraph 252 of the AFG submissions, there was never an absence of evidence of child abuse. The notes of Dr. Ein, the defence expert, state "it's pretty obvious she was a CHR [chronically] battered child."[52] Neither Dr. Ein nor either of the pathologists who reviewed this case disputed Dr. Smith's findings that Jenna had older injuries that were indicative of abuse.[53] Ms. Waudby admitted after arrest and under caution that she had injured Jenna on the evening of January 20, 1997 badly enough that she should have taken Jenna to the hospital.[54] She subsequently pled guilty to an offence of child abuse in relation to the older injuries.

48. With respect to paragraph 253 of AFG's submissions, the Crown does not agree that there were any disclosure issues, or that disclosure issues had any impact on the child welfare proceedings. The inference in the quote in paragraph 253 is that Ms. Waudby pled guilty to the *Child and Family Services Act* (*CFSA*) offence at the Crown's insistence. The reference given by AFG does not support this submission. In

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[50] *P.(D) v. Wagg* [2004] 71 O.R. (3d) 229, *Goodman v. Rossi* [1995] 24 O.R. (3d) 359

[51] Notes of S. Sullivan Apr. 28, 1999, PFP300013, p.2.
[52] PFP011149, p.2
[53] Medico-Legal Report Death of Jenna Mellor, PFP135465, p. 7, Dr. Christopher Milroy, Transcript Nov. 19, 2007, p. 118, lines 3 – 7; p. 124 lines 16 - p. 125, line 13; p. 127, line 13 – p. 128, line 22; p. 135, lines 5 – 13; Nov. 21, 2008, p. 186, line 19 – p. 187, line 13; Dr. Michael Pollanen, Transcript Dec. 5, 2007, p. 112
[54] Jenna Overview Report, PFP144684, paras. 20, 67; PFP011011, Homicide Review, pp.7-8

fact, Mr. Gilkinson made it clear on the record, before Ms. Waudby entered her plea, that the *CFSA* plea did not relate to the matter before the other court (i.e. the murder charge), but rather to older injuries. He informed the court before the plea was entered that the Crown would be withdrawing the more serious charges.[55] Mr. Gilkinson testified that he believed he had a reasonable prospect of conviction with on a criminal charge or a *CFSA* charge in respect of the previous injuries and that it was in the public interest to proceed with a charge. He was willing to accept a plea under the *CFSA* rather than the *Criminal Code* as Ms. Waudby had "been put through enough in terms of the homicide." [56]

49. With respect to paragraph 254 of the AFG submissions, there is a procedure under section 76 of the *CFSA* for having one's name removed from the Child Abuse Register. There is no evidence that Ms. Waudby's name has been unlawfully placed or kept on the Register.

50. With respect to paragraph 256 of AFG's submissions, Mr. Gilkinson did not rely solely on Dr. Smith's opinion about the age of rib-head fractures when he agreed to the guilty plea to the *CFSA* offence. He also relied on Dr. Ein's agreement with Dr. Smith's opinion that there were older injuries, Mr. Hauraney's acceptance of the medical consensus[57] and on Ms. Waudby's statements to the police.[58]

51. With respect to paragraphs 258-260 of AFG's submissions, the inference appears to be that because there is now uncertainty among pathologists about the age of the

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[55] PFP075100, Transcript of Guilty Plea, pp.2 –4.
[56] Brian Gilkinson, Transcript Jan.21, 2008, pp.60-61.
[57] Brian Gilkinson, Transcript Jan.22, 2008, pp.83, line 17-p.84, line 5.
[58] Jenna Overview Report, PFP144684, paras. 20, 67; PFP011011, Homicide Review, pp.7-8

rib-head fractures upon which Ms. Waudby's guilty plea was based, there is no evidence to support the guilty plea. That is not the case. There are now opinions that Jenna had a liver injury that was healing at the time of her death.[59] All physicians who examined Jenna were of the definite opinion that she was a chronically abused child. In addition, Ms. Waudby gave a statement to the police that she had abused Jenna two days before Jenna's death.[60] While the evidence to support the guilty plea may have changed in some respects, there is still ample evidence to support the plea.

52. In paragraph 309 of Dr. Smith's submissions, he states that he informed the Crown in the Jenna case that a clinical opinion should be obtained, but "inexplicably", the Crown waited until after the preliminary inquiry to seek a clinical opinion. In fact, Dr. Smith suggested to the police identification officer that it might be worthwhile consulting a clinician, but this suggestion never appeared in Dr. Smith's written report, and there is no evidence that he communicated this suggestion to the investigating officer or to the Crown Attorney David Thompson. After this suggestion was made by Dr. Smith to the identification officer, Dr. Smith continued to opine about the timing of the fatal injuries, including giving evidence at the preliminary inquiry. He did not consult a clinician, nor did he indicate at any time prior to the meeting arranged by the Crown with Dr. Ein that the timing of death in this case was outside his area of expertise or that the issue of timing should be addressed by a clinician.

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[59] Brian Gilkinson, Transcript Jan.22, 2008, p. 87, line 5 – p. 88, line 16.
[60] Jenna Overview Report, PFP144684, paras. 20, 67; PFP011011, Homicide Review, pp.7-8

SHARON

53. Dr. Smith, in paragraph 308 of his closing argument, expresses surprise that the Crown relied on him as a witness at the preliminary inquiry rather than on Dr. Wood, as Dr. Wood "was clearly more qualified than a pediatric pathologist to opine on potential bite marks." It was Dr. Smith, however, who initially gave the unequivocal opinion that the cause of Sharon's death was multiple stab wounds.[61] Dr. Smith did not refer the Crown to Dr. Wood; rather Dr. Bechard suggested that Dr. Wood be consulted.[62] As long as Dr. Smith's opinion was supported by Dr. Wood, Dr. Smith never objected to being the lead medical witness in the case.

JOSHUA

54. Dr. Smith suggests in his closing arguments that Sgt. MacLellan unfairly criticized Dr. Smith for not allowing Sgt. MacLellan to take notes during the autopsy of Joshua's body. [63] Dr. Smith further suggests that his views are supported by other pathologists. However, other pathologists expressed concerns about the police taking detailed notes of discussions about medical issues at autopsies, as some comments might be misinterpreted by police officers. Sgt. MacLellan did not disagree with that concern. His evidence was that Dr. Smith told him not to take any notes, which was contrary to Sgt. MacLellan's duty as a police officer. Sgt. MacLellan testified that he intended to (and did in fact) take general notes about who was present at the autopsy and what occurred.[64]

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[61] Sharon Overview Report PFP144453, par. 62; Autopsy Report PFP011623.
[62] Sharon Overview Report PFP144453, par. 65; Ferguson Memo, PFP087957.
[63] Closing Argument, Dr. Smith, paras. 224-226.
[64] Sgt. Greg MacLellan, Transcript Jan. 24, 2008, pp.20 – 22.

55. It is Ontario's position that it is important that police officers be permitted to take general notes at autopsies that might pertain to the collection of evidence and that may relate to subsequent disclosure issues, such as the photographs taken by one of Dr. Smith's assistants in the Joshua case.[65]

TIFFANI

56. In his closing arguments, Dr. Smith suggests that the Tiffani case was an example of where a Crown Attorney failed to understand his opinion and its limitations.[66] In support of this position, Dr. Smith points to sections of police notes regarding the Tiffani case which record that he variously indicated orally the difficulty in differentiating between, on the one hand, natural and accidental causes of death, and on the other hand, non-accidental causes of asphyxia.[67] However, what Dr. Smith ignores are the repeated requests by the prosecuting Crown Attorney for Dr. Smith to put his opinion and its limitations in writing and his initial refusal to do so.[68]

57. What the Tiffani case exemplifies is not a failing on the part of the prosecuting Crown Attorney, but rather a failing on the part of Dr. Smith to ensure that his opinion was sufficiently concrete and properly conveyed. In fact, but for the Crown Attorney's persistence in seeking written confirmation of his opinion, this situation would have persisted until Dr. Smith finally gave evidence in Court.

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[65] Sgt. Greg MacLellan, Transcript Jan. 24, 2008, pp.75, line 1 – p. 76, line 3.
[66] Closing Argument of Dr. Smith, para. 231.
[67] Closing Argument of Dr. Smith, paras. 232-237.
[68] See Tiffani Overview Report, para. 199-207.

DUSTIN

58. In his closing argument, Dr. Smith suggests that the Dustin case is a further example of where the Crown failed to understand his opinion and its limitations.[69] Once again, in support of this position, Dr. Smith points out where police notes record that he indicated orally the difficulty in coming to an opinion because of the limitations of the initial autopsy.[70] However, the concern of the Crown Attorney in this case was not merely the limitations of his opinions, but the manner in which he chose to present them by way of an emotional criticism of the initial autopsy. [71]

59. In fact, the notes of the Crown Attorney taken at a meeting with Dr. Smith prior to the preliminary inquiry indicate that the limitations of the autopsy were reviewed and Dr. Smith nevertheless confirmed his opinion on the cause of death.[72] As the limitations of the initial autopsy did not prevent Dr. Smith from providing a written opinion on the cause of death prior to his testimony,[73] it is not surprising that the Crown Attorney would not have expected them to be an impediment to his testifying to that opinion in court.

VALIN

60. In his closing argument, Dr. Smith suggests that the Crown should have had a system for "categorizing and filing evidentiary material" which would have meant

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[69] Closing Argument of Dr. Smith, para. 238.
[70] Closing Argument of Dr. Smith, para. 239.
[71] Closing Argument of Dr. Smith, para. 305.
[72] See Dustin Overview Report, para. 146.
[73] See Dustin Overview Report, para. 113-118.

there would be no need to "rely on the individual pathologist to maintain custody of such significant materials". [74]

61. There is no need for the Crown to develop a system for "categorizing and filing evidentiary material", because, as Dr. Smith admits, the materials would have been 'categorized and filed' had he simply accessioned the Valin case, as provided for in the procedures of the Hospital for Sick Children.[75] The difficulties that arose with respect to the missing evidence for the Valin case were caused by Dr. Smith's failure to take advantage of this readily available procedure and choosing instead to maintain personal possession of the samples, and not any failing of the Crown.

Office of the Chief Coroner

62. The submissions of the Office of the Chief Coroner are not a reflection of any policy of the Government of Ontario.

63. OCCO has made many recommendations for improvements to the Coronial system with consequent funding and legislative implications. While the Coroner's system has come under examination in this Inquiry, the focus of the Inquiry is and should remain pediatric forensic pathology. Reforms to the coroner's system in Ontario will be determined after the government has had the benefit of reviewing the Commissioner's report regarding this Inquiry.

64. Decisions regarding proposed funding or legislative solutions must be made by the government in the larger context of overall public policy and competing demands.

[74] Closing Argument, Dr. Smith, para. 748.
[75] Closing Argument, Dr. Smith, para. 754.

OCCO did not lead evidence about funding levels over the relevant time period, and had the level of funding been as significant an issue as portrayed in OCCO's submissions, evidence could have been led that there have been significant funding increases in recent years.

65. It should also be noted that funding of OCCO was not an issue that factored into the result in any of the cases considered by this Inquiry.

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ATTORNEY GENERAL FOR ONTARIO

Crown Law Office – Civil

Counsel for the Province of Ontario

Kim Twohig, General Counsel

Bill Manuel, Counsel

Heather Mackay, Counsel

IN THE MATTER OF an Inquiry pursuant to the *Public Inquiries Act,* R.S.O. 1990, c P.41, as amended into Pediatric Forensic Pathology in Ontario

REPLY SUBMISSIONS FROM
THE PROVINCE OF ONTARIO

Ministry of the Attorney General
Crown Law Office - Civil
8th Floor, 720 Bay Street
Toronto ON M5G 2K1

Kim Twohig
LSUC 17986O
Tel: (416) 326-4171

William J. Manuel
LSUC 164461F
Tel: (416) 326-9855

Heather MacKay
LSUC 46938A
Tel: (416) 326-3129

Of Counsel for the Province of Ontario