

*Hama, Please send this article to Gene Coleman who may be involved in a shaken baby (alleged) case.*

*Thanks, Coleman*

FEATURE

# Civil justice lessons from an inquiry

THE HONOURABLE STEPHEN T. GOUDGE

From April 25, 2007, to October 1, 2008, I was the commissioner of the public Inquiry into Pediatric Forensic Pathology in Ontario. While our task was to make recommendations to restore public confidence in pediatric forensic pathology, particularly its use in the criminal justice system, I think a number of the lessons we learned may well be helpful to the civil justice system.

In a general sense, these lessons concern, first, some of the processes we used, and second, the ways in which expert scientific evidence can best be made to play its proper role in the justice system.

To set the scene, let me give a brief outline of the circumstances surrounding the inquiry.

It hardly needs saying that the tragedy of a child who dies in criminally suspicious circumstances is a devastating event for the parents, the family and the entire community. It is vital for society to deal with the tragedy in a way that is right and just and that allows all those affected to come to terms with it. The criminal justice system is central to this task. It must seek to determine whether there is truth to the suspicion that the child was killed and, if so, by whom.

The role of the forensic pathologist can be vital to this task. The suspected parent or caregiver will often have been the only person in contact with the child in the hours preceding death. There may be little additional evidence. But if the pathologist determines the cause of the child's death, that opinion may be enough to play a decisive role in determining whether someone is charged and convicted. In these circumstances, the criminal justice system must be able to rely confidently on the opinion if it is to deliver a just outcome.

The inquiry I chaired was triggered by the announcement of the results of the review conducted by the Office of the Chief Coroner of Ontario of the work of Dr. Charles Smith in the 45 criminally suspicious pediatric death cases he did between 1991 and 2001, when he agreed to stop doing forensic work.

Although his specialty was pediatric pathology, through the 1990s Dr. Smith had grown to iconic stature in the world of pediatric forensic pathology in Ontario. He had been appointed director of the new Ontario Pediatric Forensic Pathology Unit at the prestigious Hospital for Sick Children. While he had no formal training in forensic pathology, his experience seemed to be unequalled and his manner brooked no

disagreement. He was widely seen as the expert to go to for the most difficult criminally suspicious pediatric deaths. In many of these cases, his view of the cause of death was the critical opinion and figured prominently in the outcome.

During the 1990s, Dr. Smith's reputation grew. There were, however, also significant warning signals – signals that were largely ignored by those charged with the oversight of Dr. Smith and his work, but that began to erode his reputation.

The results of the chief coroner's review were extremely disturbing. They constituted the last and most serious blow to public faith in Dr. Smith, pediatric forensic pathology and the role it must play in the criminal justice system. The five eminent forensic pathologists who did the review, all with impeccable international reputations, found that in a number of cases Dr. Smith's conclusions were not reasonably supported by the materials available. In 20 of the 45 cases, they took issue with Dr. Smith's opinions in either his report or his testimony or both. In all 20, these opinions played a part in involving individuals with the criminal justice system. In 12 of the 20, there were findings of guilt, many of them on very serious charges.

The results were announced on April 19, 2007. Six days later, my inquiry was established.

We were tasked with conducting a systemic review of the way in which pediatric forensic pathology was practised and overseen in Ontario during the Smith years, particularly as it relates to the criminal justice system, in order to make recommendations for the future.

On being appointed, the first and most important decision I made was to appoint Linda Rothstein as my commission counsel. We then assembled an extraordinarily talented legal team. The other leaders were Mark Sandler for criminal law and Rob Centa and Jennifer McAlcer as assistant commission counsel. They worked tirelessly for the next 17 months. I owe them a great deal. And all of us owe our families an equal amount for their patience and support.

Our first task was to devise the process we would use. Several aspects of it are, I think, particularly germane to the civil justice system.

The first relates to the principle of proportionality. Many inquiries have emphasized "thoroughness" as a guiding principle – the importance of ensuring that any issue relevant to the mandate is fully explored. While I agree that this cannot be ignored, it is important not to confuse it with exhaustiveness.

On the recommendation of my counsel, I was guided as well by the principle of proportionality. Investigative and hearing time was allocated in proportion to the importance of the issue

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to the inquiry's mandate. That could be done only because we invested time at the beginning in determining the factual and policy mandate raised by our order-in-council. We were thus able to focus most on the major issues and pay far less attention to the minor ones.

For example, although the relationship between pediatric forensic pathology and child protection proceedings was explored, it was not a core issue that needed to be examined at length. With the confidence that can only come by knowing the case well, commission counsel did not follow every conceivable lead or interview everyone with any information that might be relevant or collect all documents of any conceivable relevance. Rather, we focused on what was significant. More than anything else, this allowed us to proceed expeditiously.

I know that the principle of proportionality has increasingly come to inform civil justice reform. If our inquiry can be seen as a test drive of that principle, its benefits are enormous. It does not just apply to the choice of procedures or the expenditure of funds, but at least as importantly to the allocation of time, based on a determination of which issues really matter in a trial and which are secondary. A clear-eyed and determined approach to civil justice on this basis would pay huge efficiency dividends.

A second aspect of our process that I would like to describe flows directly from this approach. It relates to our time management of the testimony of each witness. Our early understanding of the real issues that we had to address became the prism through which we viewed the evidence each witness could offer.

Take Dr. Smith as an example. By mid-September 2007, we were able to determine just what issues he could help us with. That allowed us to determine not only when he would be called

but, more importantly, that a week would be sufficient to elicit what he could give us. All parties knew both of these things several months before our hearings began, and they could prepare accordingly.

I also adopted the practice of my colleague Associate Chief Justice Dennis O'Connor in the Walkerton Inquiry, namely to allocate no more time for all cross-examinations of a witness than was allocated to commission counsel for the evidence-in-chief. And after taking requests from counsel for shares of that cross-examination time, I then subdivided it according to the interests of the parties in the particular witness. The result, I think, was an efficient process that did not compromise fairness. Indeed, I now feel about evidence as I have always felt about argument – that time limits, determined reasonably and in advance, significantly improve the quality of the evidence process. A focused cross-examination is far superior to an unfocused one.

I am convinced that this approach can be applied to the civil justice system. It requires, before timelines are imposed, that there be a good understanding of the key issues to be determined and what the particular witness can contribute to them, that this knowledge be developed with the assistance of counsel and that all this be done in advance and on a transparently reasoned basis. It also requires firm implementation, with exceptions being made only when truly unanticipated matters of significant relevance arise unexpectedly. If all this is done, the benefits can be dramatic.

The third aspect of our process that might be useful relates to the cases in which the chief coroner's review had expressed serious concerns about Dr. Smith's work. Because these cases triggered the inquiry, they had to be central to our factual investigation.

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Although we were not to report on every aspect of these cases, it was vital that we examine what failed with the practice and oversight of pediatric forensic pathology in them, since they exemplified ways in which the system could, and indeed did, go badly wrong.

To determine the systemic failings they demonstrated, it was essential to first determine what actually happened. Only then could we evaluate what failed and how the failures arose, and then recommend measures to ensure that these mistakes would not be repeated.

We quickly concluded that the timeline we were given made it impossible for us to call evidence about what happened in each case, one after the other. Most inquiries have their hands full dealing with just one case – witness those concerning Donald Marshall, David Milgaard and Guy Paul Morin.

Courtesy of the creative thinking of Linda and her team, our solution was something we called overview reports. During our first four months, we turned our young staff lawyers loose on the challenge of creating an overview report for each of the cases that was important to our mandate.

We produced 18 overview reports, most of them well over 100 pages in length. Using the relevant documents in our database and the occasional interview, these reports set out the core facts and the background of each case in neutral and non-argumentative language.

The goal was to detail what happened with scrupulous accuracy but with no evaluation. This detail included the steps taken in the death investigation, the criminal proceedings and any related child protection proceedings. The actions of the patholo-

gist, the coroner, the key police officers, Crown and defence counsel and family members were all covered. In this way, Dr. Smith's work was situated within the complex factual matrix that underlies every pediatric death investigation in criminally suspicious circumstances.

Before we finalized these reports, they were circulated and commission counsel invited the parties with standing to give us proposed modifications, additions or deletions. Because of the care taken in their preparation, almost no alterations were suggested, and all that were suggested were accommodated. Had any irreconcilable differences arisen, the parties knew they had the option of addressing the issue through evidence they might call at the inquiry. That option was never taken.

The overview reports were filed on the first day of public hearings, on November 12, 2007. They proved to be invaluable sources of information that allowed us to move directly to an evaluation of whether what had happened constituted systemic failings in the practice and oversight of pediatric forensic pathology. In effect, we began our hearings with over 1,600 pages of necessary evidence taken at no cost in hearing time.

There are many civil trials in which a similar process might be used. It could consist of the filing of agreed evidence about what happened where the real contest is not that, but rather the evaluation of what happened against a factual or legal standard. Even if the filed evidence was not agreed to, but simply constituted evidence-in-chief, hearing time would be saved. Many administrative tribunals proceed in this way. We did this at the inquiry without Dr. Smith's evidence-in-chief, which obviously was going to be contested. Indeed, I remember doing a civil trial with Dennis O'Connor before Associate Chief Justice Frank Callaghan (as he then was) in which we proceeded in this way, and I am sure that trial was far from unique.

Let me turn now from issues of process to several of the substantive questions we dealt with that also may be of relevance to the civil justice system.

While my report necessarily has a good deal to say about how to improve the actual practice and oversight of forensic pathology, the interface of the science with the criminal justice system was also of vital importance. My report addresses the roles that the expert witness, counsel and the court each must play if the justice system is to be protected against flawed scientific evidence. Although the report is mostly targeted at forensic pathology, I think it also has general application.

The evidence at our inquiry clearly demonstrated a number of ways in which an expert scientific opinion (whether given in writing or evidence) can lead to misunderstanding or misinterpretation by the lay audiences in the justice system. Here are a few examples.

To begin with, the use of clear, plain and unambiguous language is essential. For example, like Justice Fred Kaufman in the Morin Inquiry, we found the phrase "consistent with" to have infected many opinions. Forensic pathologists who were unable to narrow their opinions to a single cause or a mechanism of death would often indicate that the pathology is "consistent with" a particular cause or mechanism of death such as smothering. The risk of ambiguity here is obvious. Even if used by the expert to mean no more than that it is not impossible that the cause of death is smothering, it may be heard by a legal audience as being reasonably likely that the cause of death is smothering. Counsel who vet their experts' opinions for this sort of language are



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The level of certainty with which the expert holds an opinion can also be a source of difficulty. Particularly if the science is an interpretive one – as forensic pathology is – opinions that appear on paper to be held with unqualified certainty may be advanced by the expert with far less confidence. Here, too, transparency and clarity of language ought to be the goal of counsel preparing the witness.

My final example is one that was of particular importance in our inquiry. Pediatric forensic pathology is a science in which there are a number of areas of significant controversy. These are areas in which respected members of the specialty hold significantly different views. The best known of these areas is shaken baby syndrome. There are different schools of thought about the diagnostic criteria that must be found in order to support such a conclusion, or even whether it is possible to exert enough force on an infant through shaking alone to cause fatal injury.

In a number of the cases we examined, the expert opinion of "shaken baby" was offered with no reference at all to the existence of the controversy, let alone any attempt to locate the opinion within the controversy. Such an approach leaves the justice system without a vital part of the context for the opinion and impedes both proper testing by opposing counsel and fully informed evaluation by the trier. If the expert is to optimize his or her utility to the justice system in such a case, this must be corrected. Once again, counsel calling the expert has an important role to play in ensuring that this is done.

In addition to ensuring that the expert opinions they intend to call communicate as effectively as possible, counsel have an

important role in protecting the justice system against flawed scientific evidence by helping to ensure that expert evidence always meets a basic standard of reliability.

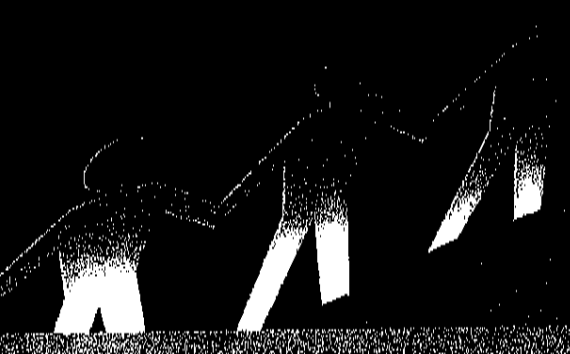
My report addresses this issue by focusing largely on the role of the court as gatekeeper, with its obligation to ensure that expert evidence has a threshold reliability. Counsel, however, also have an obligation to vet expert scientific evidence against this standard, both beforehand, for expert evidence they intend to call, and in cross-examination for expert evidence they challenge. For both counsel and the court, the substantive questions are whether the jurisprudence is clear that threshold reliability is an available tool of admissibility and, if so, how it can be applied in practice.

The Supreme Court of Canada, in *R. v. Mohan*,<sup>1</sup> established a four-part test for the admissibility of expert evidence.<sup>1</sup> It must be relevant and necessary in assisting the trier of fact, not otherwise subject to an exclusionary rule, and given by a properly qualified expert. The post-*Mohan* jurisprudence makes clear, I think, that reliability plays a central role in a number of these criteria, particularly relevance and necessity. As my former colleague Charron J.A. (as she then was) said in *R. v. K. (A.)*:

The evidence must meet a certain threshold of reliability in order to have sufficient probative value to meet the criterion of relevance. The reliability of the evidence must also be considered with respect to the second criterion of necessity, after all, it could hardly be said that the admission of unreliable evidence is necessary for a proper adjudication to be made by the trier of fact.<sup>2</sup>

Indeed, I would say that reliability has always been a fundamental organizing principle of the law of evidence. Often applied


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to novel science, it is by no means limited to that; *R. v. J. - L. J.*<sup>3</sup> and *R. v. Trochym*<sup>4</sup> put this beyond doubt.

Where the court is performing its gatekeeper function, the reliability of expert evidence must be determined to be sufficient to permit it to be considered by the trier of fact, the jury. If the court is that trier, reliability is applied as part of the determination of whether the expert evidence is to be relied upon. For counsel, the concept is important in evaluating whether one's own expert can properly be called, or whether the other side's expert evidence can properly be admitted and considered.

How then is the concept unpacked in practice? In *R. v. J. - L. J.*, the Supreme Court affirmed the utility of the criteria for reliability established in the famous 1993 American case of *Daubert v. Merrell Dow Pharmaceuticals Inc.*<sup>5</sup> whether the theory or technique employed by the expert has been tested; whether it has been subjected to peer review on publication; its known or potential error rate; and whether the theory or technique has general acceptance in the field.

In the chapter on this subject in my report, I set out a number of additional specific criteria that may be helpful in particular cases. Let me leave you, however, with one general thought.

Expert scientific evidence is becoming increasingly common, and increasingly important, in the civil justice system, just as it is in the criminal justice system. It is vital that all of us be increasingly vigilant in ensuring its reliability, if the system is to deliver just outcomes. We cannot and should not be daunted by the challenge, even though much of the science seems esoteric and difficult to understand. The task can be accomplished if a vigilant attitude is coupled with an application of the specialized skill we have been trained in – the ability to think logically.

At its simplest, that means examining the expert scientific opinion to see if the underlying data on which the opinion is based has been accurately observed and recorded. It means then seeing if the expert's reasoning process from that data to the ultimate opinion is set out clearly and comprehensibly. Most importantly, it means seeing if this explains how the opinion follows from the data. Simply put, is the reasoning process logical? This approach is obviously not failsafe. It is, however, an important way of approaching the reliability of expert evidence that draws on what we are good at. In effect, it uses our own expertise.

To conclude then, these are some of the lessons – lessons of process and lessons of substance – that I learned from our inquiry and that I think can be of use to the civil justice system. There are undoubtedly others, and in the interest of sales of our book, I urge each of you to rush out and purchase your own copy and read it in detail.

Suffice it to say that if there are any civil justice lessons to be learned from the Inquiry into Pediatric Forensic Pathology in Ontario, it will simply enhance the privilege it has been for me to serve as its commissioner.

#### Notes

1. [1994] 2 S.C.R. 9.
2. (1999), 137 C.C.C. (3d) 225 (Ont. C.A.).
3. [2002] 2 S.C.R. 600.
4. [2007] 1 S.C.R. 239.
5. 509 U.S. 579 (1993).