7

Organization of Pediatric Forensic Pathology

My detailed assessment of the practice and oversight of pediatric forensic pathology in Ontario from 1981 to 2001 must begin with a description of how it, and the forensic pathology of which it was a part, were organized in those decades.

It is important to describe the general institutional arrangements in place at the beginning of this period and the way they evolved over the next two decades. This account will provide some insight into a number of flawed practices that were used by pathologists in those years, along with the limited oversight and accountability mechanisms that were applied to them.

It also provides an essential backdrop to understanding the events set out in several of the following chapters – how these practices could fail so badly and how these oversight and accountability mechanisms could prove so inadequate. These systemic failings are at the heart of the review I am required to conduct. It is a tragic story of flawed practices and failed oversight.

The Era of Dr. John Hillsdon Smith, Provincial Forensic Pathologist

Role and Mandate of the Forensic Pathology Branch

From 1975 to 1994, Dr. John Hillsdon Smith was the Provincial Forensic Pathologist for Ontario. He had trained in England and was certified as a forensic pathologist. He headed the Office of the Provincial Forensic Pathologist, also known as the Forensic Pathology Branch, which provided pathology services to the coronial service in Ontario. The branch was responsible for conducting the more complex coroner's autopsies in the province where the requisite expertise was unavailable locally. It also conducted most adult autopsies in the Toronto area.

The mandate of the Forensic Pathology Branch, as described in 1991, was to

provide advice to hospital pathologists, coroners, and police; to perform forensic autopsies on complex cases; to develop educational programs; to perform ancillary tests such as wound-weapon comparisons, special photographic and X-ray tests, identification tests, and tests for drowning; and to perform autopsies for deaths that occurred in Metropolitan Toronto.

Relationship between the Provincial Forensic Pathologist and the OCCO

During Dr. Hillsdon Smith's tenure, the Forensic Pathology Branch was a separate entity from the Office of the Chief Coroner for Ontario (OCCO). The Provincial Forensic Pathologist did not report to the Chief Coroner. Both offices reported to the assistant deputy minister in the Ministry of the Solicitor General, and both were located in the Coroner's Building on Grenville Street in Toronto. The legal authority for virtually all the work of the Forensic Pathology Branch flowed from coroner's warrants for post-mortem examination.

The Forensic Pathology Branch was initially staffed by the Provincial Forensic Pathologist as well as a Deputy Provincial Forensic Pathologist. The other pathologists who performed autopsies at the Coroner's Building provided services on a fee-for-service basis. In addition, the Forensic Pathology Branch had a core staff of full-time administrative and technical staff.

In his testimony at the Inquiry, Dr. James Cairns, Deputy Chief Coroner for Ontario from 1991 to 2008, stated that, when he arrived at the OCCO in 1991, the pathologists worked in the basement, the coroners worked on the second floor, and the two groups did not interact. The autopsy room was on the first floor. Former Chief Coroner for Ontario Dr. James Young, who worked at the OCCO in the 1980s, also described the pathologists and the coroners as disconnected during this period. Dr. Cairns understood that Dr. Hillsdon Smith and Dr. Beatty Cotnam, who was Chief Coroner from 1962 to 1982, had a falling out shortly after Dr. Hillsdon Smith became Provincial Forensic Pathologist. Initially, both men had intended to have their offices on the second floor of the Coroner's Building, but, because of the acrimonious relationship between them, Dr. Hillsdon Smith moved to the basement. Dr. Hillsdon Smith did not have a significantly better relationship with Dr. Ross Bennett, who succeeded Dr. Cotnam, or with Dr. Young, who became Chief Coroner in 1990.

It was not possible at the Inquiry to hear about the relationship between the offices directly from those who held the positions of Provincial Forensic Pathologist and Chief Coroner in the 1980s (they are all deceased). However, based on the evidence of witnesses who worked within the coronial system, I am

satisfied that, at least up until the early 1990s, the relationship suffered from a lack of communication and collaboration, which contributed to an unhealthy situation where pathologists and coroners operated in separate silos.

Training and Experience of Pathologists Performing Pediatric Coroner's Autopsies

In the 1980s and the early 1990s, almost all the coroner's autopsies in Ontario were performed by fee-for-service pathologists who had neither training nor certification in forensic pathology. Many of them worked in community hospitals. In a small number of cases, physicians without any specialization in pathology completed some post-mortem examinations for the OCCO.

Pediatric cases were not streamed to any particular hospitals or pathologists. Many local hospital pathologists, who had no experience with pediatric cases and no forensic training, performed pediatric autopsies. Whether a pathologist had the necessary skill to perform any given autopsy depended largely on individual work experience. The Provincial Forensic Pathologist had neither a process to determine whether a pathologist had appropriate expertise nor any guidelines about where pediatric cases should be performed.

Some pathologists who were doing fee-for-service work for the Forensic Pathology Branch in the Coroner's Building were considered more senior than others and were called in on an as-needed basis. Other than Dr. Hillsdon Smith, however, none of them had formal training in forensic pathology. By the early 1990s, Dr. Hillsdon Smith was himself performing very few autopsies; he preferred to provide consultation services in cases that interested him.

In the 1980s, most pediatric forensic autopsies in the Toronto area were conducted at the Hospital for Sick Children (SickKids), although some criminally suspicious pediatric cases were performed at the Forensic Pathology Branch. Most staff pathologists at SickKids conducted coroner's autopsies on a fee-for-service basis as a required part of their duties for the pathology department. The nine pathologists performing coroner's autopsies at SickKids in the 1980s had varying levels of training or work experience in forensic pathology. None of them had formal certification in forensic pathology, nor had they completed fellowships in that discipline. Only five to 10 criminally suspicious pediatric autopsies were conducted at SickKids each year, so pathology residents who trained there were unlikely to get any significant exposure to criminally suspicious work. Moreover, some of the SickKids pathologists did not feel comfortable or qualified to perform coroner's autopsies, especially those in criminally suspicious cases. On occasion, they declined to take on cases they felt were beyond their expertise.

When that happened, the cases were either given to a colleague who may have had more forensic experience or returned to the Forensic Pathology Branch.

In short, during Dr. Hillsdon Smith's tenure as Provincial Forensic Pathologist, there was inadequate forensic expertise among the pathologists performing autopsies for the OCCO. Until 1991, there was no formal streaming of cases, such as those involving pediatric deaths or criminally suspicious deaths, to pathologists with training or experience in forensic pathology. There was no coherent forensic pathology service. Some pathologists recognized that particular autopsies were beyond their expertise and declined to conduct them, but others did not.

Oversight by the Provincial Forensic Pathologist

From 1981 to about 1990, Dr. Hillsdon Smith made some effort to establish educational courses in forensic pathology for pathologists and police officers. However, apart from this, in general, the oversight, accountability, and quality assurance mechanisms in place during those years were entirely inadequate. Indeed, virtually no such mechanisms were in place at all.

Educational Programs

In the 1980s, Dr. Hillsdon Smith ran annual courses for senior police officers and pathologists. These courses often brought in leading forensic pathologists from across North America on issues such as gunshot wounds. But by 1990, these courses were no longer being offered.

Pathology residents were also sent to the Forensic Pathology Branch to observe autopsies, which provided some education in forensic work. However, because they did not receive any hands-on training in conducting forensic autopsies, this opportunity was of little practical value.

Lack of Policies and Guidelines Regarding Coroner's Autopsies

It appears that Dr. Hillsdon Smith did not issue policies or guidelines to assist pathologists in conducting post-mortem examinations under coroner's warrant. In the 1980s, Dr. Bennett did issue a few memoranda to coroners and pathologists regarding some autopsy procedures, but that was the only formal source of guidance.

Oversight and Quality Control of Coroner's Cases

In addition, during Dr. Hillsdon Smith's tenure, there was little or no case-by-case oversight of the work of fee-for-service pathologists performing autopsies for the

OCCO. There was essentially nothing that could be called quality assurance of pathology work in the province. In those years, the concept had not yet been developed in, or applied to, forensic pathology.

It was very rare for anyone other than the local coroner to review reports of post-mortem examination. Dr. Hillsdon Smith did not see it as his job to review autopsy reports or otherwise supervise the case work of pathologists performing coroner's autopsies across the province. And, during the latter years of his tenure, he conducted only limited oversight of the work of the pathologists within the Forensic Pathology Branch itself. Indeed, by the early 1990s, he had delegated most of his day-to-day administrative duties to Barry Blenkinsop, a long-time pathology assistant, and to Jack Press, a former police officer who was by then his executive assistant. He no longer scheduled the autopsies to be done at the Forensic Pathology Branch. Rather, the scheduling was being done by the OCCO.

After the establishment of the regional forensic pathology units at SickKids and in Ottawa and Hamilton – which, as we will see, occurred in 1991 and 1992 – there was no formal interaction between the Forensic Pathology Branch and these regional units, even though they performed a significant number of criminally suspicious autopsies. Dr. Hillsdon Smith simply had no involvement with the regional forensic pathology units formed during his tenure, and he did not review or supervise the work of those units.

Dr. Hillsdon Smith did not introduce any guidelines, recommendations, or requirements for quality assurance of the coroner's autopsies being performed by fee-for-service pathologists at various hospitals. Indeed, in the 1980s and early 1990s, there were few quality control measures in place at all at hospitals regarding coroner's autopsies. SickKids, for example, felt that the OCCO had exclusive responsibility for oversight of autopsies in criminally suspicious cases. It believed that the hospital had no role to play in supervising or reviewing pathology performed under a coroner's warrant. In part because of concerns about the effect on ongoing criminal investigations, criminally suspicious coroner's cases were not discussed during SickKids rounds or even informally among pathologists. Occasionally, SickKids pathologists consulted with each other about non-criminally suspicious coroner's autopsies, and these cases were sometimes presented at SickKids rounds – at least when the coroner gave permission. But SickKids did not vet or review any post-mortem examination reports in criminally suspicious pediatric cases. It did not view peer review as appropriate because the cases were considered a matter between the individual pathologist and the requesting coroner. As a result, pathologists at institutions such as SickKids did not receive the full benefit of their colleagues' advice and experience in coroner's cases, especially those challenging cases engaging criminal suspicions.

The Era of Dr. David Chiasson, Chief Forensic Pathologist

In 1994, when Dr. Hillsdon Smith retired, Dr. David Chiasson was appointed Chief Forensic Pathologist. At about the same time, the province integrated the Office of the Provincial Forensic Pathologist into the OCCO. Dr. Young orchestrated this integration. He had rightly concluded that the Forensic Pathology Branch was not being properly administered. It was isolated from the work of the OCCO and lacked leadership, and he wanted to integrate the expertise of the pathologists more fully into the OCCO. The title "Provincial Forensic Pathologist" was changed to "Chief Forensic Pathologist," and Dr. Chiasson assumed that office.

Responsibilities of and Relationship between the Chief Coroner and the Chief Forensic Pathologist

After the integration, the Chief Forensic Pathologist reported to the Chief Coroner. Only the Chief Coroner maintained a direct reporting relationship with the Ministry of the Solicitor General. The Chief Forensic Pathologist was no longer directly accountable to the ministry.

In conjunction with the change in organizational structure, the human resources and administrative branches of the Office of the Chief Forensic Pathologist were combined with those of the OCCO. Dr. Chiasson was pleased to have Dr. Young handle the high-level administrative aspects of the work because he regarded Dr. Young as a strong administrator who was also successful in obtaining funding. Moreover, Dr. Chiasson wanted to focus on the day-to-day pathology work of the Provincial Forensic Pathology Unit (PFPU) – as the unit within the OCCO that performed autopsies was now called.

According to the OCCO, the Chief Forensic Pathologist remained responsible for the quality assurance of the work of pathologists on a day-by-day basis. The job description for the Chief Forensic Pathologist, written in late 1993, stated that he worked under the administrative direction of the Chief Coroner, but "on professional matters" was the principal authority in the ministry. The Chief Forensic Pathologist was responsible for directing and controlling forensic pathology at the OCCO, including the provision of professional guidance and direction to pathologists who were performing coroner's autopsies, and for assessing the qualities and qualifications of those pathologists.

The evidence at the Inquiry showed that the decision to integrate the Office of the Provincial Forensic Pathologist into the OCCO was well intentioned. The

object of the structural change was to eliminate the division that separated pathologists from coroners and to encourage a team approach to death investigations. However, the change also eliminated the direct accountability of the Chief Forensic Pathologist to the Ministry of the Solicitor General for the provision of forensic pathology services. Moreover, there was no defined process in the legislation, the regulations, or any formal policies of the OCCO whereby the Chief Forensic Pathologist would discharge an ongoing oversight role.

The structural change did not adequately define the respective roles of the Chief Coroner and the Chief Forensic Pathologist. It was unclear who was ultimately accountable for the oversight of pathologists performing coroner's warrant autopsies. In practice, for example, it was not at all clear whether the Chief Forensic Pathologist or the Chief Coroner was to provide the direct oversight of Dr. Charles Smith. In the result, because the Chief Forensic Pathologist was now below him in the organizational structure, the Chief Coroner, who was not a pathologist, became accountable to the ministry for the provision of highly specialized pathology services. The removal of any direct reporting relationship between the Chief Forensic Pathologist and the ministry had eliminated the only existing mechanism for direct accountability for forensic pathology services in the province and had put the ultimate responsibility for those services on the Chief Coroner.

The amalgamation did not improve accountability for the provision of forensic pathology services in Ontario. Rather, the failure to delineate adequately the respective roles of the Chief Coroner and the Chief Forensic Pathologist, and the failure to ensure that the Chief Forensic Pathologist had clear authority to supervise the pathologists, set the stage for a series of oversight failures.

Staffing at the Provincial Forensic Pathology Unit

In 1994, after the integration, Dr. Chiasson was the only full-time salaried pathologist at the PFPU. The other pathologists worked on a fee-for-service basis. Except for Dr. Chiasson, none of them had formal training in forensic pathology.

Dr. Chiasson's top priority was to improve the quality and efficiency of the unit by hiring full-time certified forensic pathologists. He had informed Dr. Young of his concerns during his initial interviews and had even made staffing by full-time certified forensic pathologists a condition of his accepting the position of Chief Forensic Pathologist. Dr. Young supported a move in this direction.

One primary barrier to recruiting full-time qualified forensic pathologists was the scarcity of such professionals. In 1994 and 1995, only a few Ontario pathologists had formal training and certification in forensic pathology, and they all had full-time hospital positions at salaries the PFPU could not match. Outside

Ontario, the situation was not much better. However, Dr. Chiasson overcame these barriers and, over the next five years, retained several full-time, certified forensic pathologists. His expectation at the beginning was that any pathologist working full time at the unit would have certification in forensic pathology.

His plan began well, but, in the spring and summer of 1999, two of the full-time certified forensic pathologists, Dr. Martin Bullock and Dr. Martin Queen, resigned from the PFPU. Following their departures, the PFPU again, by necessity, turned to part-time fee-for-service pathologists to perform forensic autopsies.

Creation of the Ontario Pediatric Forensic Pathology Unit

Before 1991, there was no formal agreement between the OCCO and SickKids, although pathologists at the hospital did perform post-mortem examinations under coroner's warrant. Individual coroners, in consultation with the OCCO, determined the need for forensic pathology services, including those that might be provided by SickKids in pediatric cases. No remuneration agreement existed between the OCCO and SickKids apart from a facility fee that SickKids charged the OCCO pursuant to regulations under the *Coroners Act*, RSO 1990, c. C.37.

In the late 1980s, Dr. M. James Phillips, the pathologist-in-chief at SickKids, wanted to increase the amount of training and academic research work around coroner's autopsies performed at SickKids and requested that coroner's work be conducted within a more coherent organizational unit at the hospital. He was also concerned that fees paid by the OCCO did not match the costs associated with coroner's warrant autopsies. Consequently, in the late 1980s or 1990, Dr. Phillips approached Dr. Bennett, then Chief Coroner, and proposed creating a specialized unit at SickKids. In developing his proposal, Dr. Phillips consulted with Dr. Smith.

The OCCO had three particular goals for the specialized unit as it conducted pediatric forensic cases: to provide quality reports of post-mortem examination, to train residents, and to engage in research. Dr. Young correctly recognized that the pediatric forensic pathology required by the OCCO needed special expertise and more resources. To fulfill these three objectives, the OCCO needed access to SickKids' laboratories and testing equipment, including specialized X-ray equipment that was not available at the OCCO. It also needed SickKids' expertise in radiology, neuropathology, and other areas. In addition, SickKids had the benefit of the Suspected Child Abuse and Neglect (SCAN) Program, a multidisciplinary team at the hospital that could provide guidance to pathologists in assessing injuries. Dr. Young thought that the specialized unit would also assist the OCCO

in building better relationships with both SickKids and the University of Toronto. The educational component of the unit would be achieved through its involvement with teaching residents, pathologists, coroners, the police, and Crown counsel, and the research component through the unit's support for activities in pediatric forensic pathology.

On September 23, 1991, SickKids and the Ministry of the Solicitor General entered into an agreement (the 1991 Agreement) that created the Ontario Pediatric Forensic Pathology Unit (OPFPU). The OPFPU was the first regional forensic pathology unit created in the province, although others followed in the next few years. It performed autopsies on most infants and children who died in Toronto and the surrounding area, and also on pediatric death cases from elsewhere in the province as needed. The OPFPU was an entity formed by contract and composed of the SickKids pathologists who performed work for the OCCO. It was not a discrete physical unit or a separate entity within the hospital's pathology department.

The 1991 Agreement remained in place until 2004, when a new contract was signed. Schedule A to the 1991 Agreement set out limited terms of reference for the unit, including guidance on the types of cases on which the unit would focus and provisions that the unit would remain involved in teaching, research, and, given the growing concern about child abuse (which is discussed later in this chapter), the OCCO's Paediatric Death Review Committee. It set out that the funds advanced would be used as partial compensation for professional involvement in the autopsies – pathology assistants, histopathology technologists, secretarial support, photographic services, supplies, educational expenses, and capital equipment purchases.

Pursuant to the 1991 Agreement, the Ministry of the Solicitor General agreed to provide SickKids with a $200,000 grant annually. This grant was intended to defray some of the costs associated with performance of coroner's autopsies at SickKids. SickKids submitted annual requests for funding to the ministry. The annual funding provided by the Ministry of Community Safety and Correctional Services and its predecessor ministry has not increased since 1991. SickKids informed the Inquiry that the $200,000 in funding does not now, and did not in 1991, cover the real costs of conducting forensic autopsies at the hospital. Therefore, the SickKids pathology department has absorbed the additional costs.

In practice, SickKids allocated approximately $125,000 of the grant to pay the OPFPU director's salary. However, the 1991 Agreement did not change the remuneration of individual pathologists at SickKids who performed coroner's autopsies. They continued to receive a fee-for-service payment from the OCCO as set out in the *Coroners Act*.

Appointment of Dr. Smith as Director of the OPFPU

The 1991 Agreement did not specify that there would be a director of the OPFPU, and therefore what the duties and responsibilities of that position would be. Initially, Dr. Phillips assumed responsibility for heading the unit. In 1992, the OCCO and SickKids agreed to appoint Dr. Smith as the first official director of the OPFPU.

The OCCO did not select Dr. Smith because of his forensic pathology training or expertise. Nor did Dr. Phillips, who was himself a renowned clinical pathologist but not a forensic pathologist, appoint him on that basis. Indeed, in 1992, Dr. Smith had no forensic pathology training, and by then had been involved in only 10 to 15 criminally suspicious cases. Rather, Dr. Smith was the only pathologist at SickKids who had the interest and the willingness to take on the role. By 1990, Dr. Smith was already devoting much of his time to coroner's cases and had been named staff pathologist in charge of autopsy services at SickKids because of his dedication to coroner's work. He was willing to fill a void that no one else wanted to fill.

When Dr. Smith became the director of the OPFPU, some of the more senior pathologists at SickKids were not comfortable reporting to a junior colleague about their OCCO work. In addition, some of the SickKids pathologists were rightly concerned that Dr. Smith did not have adequate training to take on the role.

When Dr. Smith was appointed as the OPFPU director, he was not qualified to be the director of a specialized unit dedicated to pediatric forensic pathology. Some of the cases for which this unit was responsible were among the most difficult faced by pediatric forensic pathology and the criminal justice system. However, Dr. Young testified that it was not reasonable to require that the director of the OPFPU be an accredited and trained forensic pathologist. In the 1990s, he stated, the pool of such specialists was limited or non-existent. Although it is true that the number of trained and qualified forensic pathologists was limited at the time, it does not appear that Dr. Young conducted a serious search for other, more qualified or experienced candidates or that he attempted to improve Dr. Smith's skills in forensic pathology after recommending his appointment. The need for forensic pathology expertise was simply not appreciated, and Dr. Smith's appointment was convenient.

Oversight and Accountability of the OPFPU

The 1991 Agreement contained virtually no reference to oversight of the OPFPU and very little discussion about an organizational structure. Rather, it focused on

ensuring the flow of the grant money for the unit. The agreement required the OPFPU to report quarterly on its workload and activities to the OCCO, yet it appears that the OPFPU never produced such reports. The activities of the unit were simply reported briefly in SickKids' annual requests to the ministry for the $200,000 grant for the OPFPU.

During negotiations leading up to the 1991 Agreement, SickKids added a section that, it anticipated, would "clarify lines of authority and … underscore the fact that the individual pathologists remain responsible to the coroner (and not to a director of this Unit) for their work." This section stated: "This agreement does not alter the relationship between the Coroners and the individual pathologists making up the unit …" Indeed, it appears that neither party to the 1991 Agreement intended to create any additional or new oversight relationships. The hospital's motivation was clear: in some coroner's warrant cases, pathologists might be required to determine whether a death was attributable to a medical mistake by a colleague at SickKids. In these circumstances, the hospital wanted to maintain a system whereby the pathologist was accountable only to the requesting coroner. The SickKids pathologists viewed the 1991 Agreement as confirming and continuing the arrangement that was informally in place before the formation of the OPFPU, where their working relationship in each case was with the coroner seeking their services.

At the Inquiry, it became apparent that, although not articulated at the time, there were differences of opinion about the general oversight responsibility for the OPFPU. Dr. Young thought that the Chief Forensic Pathologist was ultimately responsible for day-to-day quality assurance of the work of the OPFPU and its pathologists. However, if the Chief Forensic Pathologist was to oversee the OPFPU, that responsibility was never set out in the agreement regarding the OPFPU or elsewhere. In addition, Dr. Smith testified that he felt he reported to Dr. Young and Dr. Cairns, not the Chief Forensic Pathologist. Moreover, Dr. Chiasson said that, although he was responsible in some general sense for supervision of post-mortem examinations as the OCCO's "liaison" to the OPFPU, he was not responsible for oversight of the OPFPU. In his mind, the responsibility for the OPFPU, and for the regional forensic pathology units that came later, rested with the Chief Coroner, not with the Chief Forensic Pathologist. All agreed, however, that SickKids was not itself responsible for oversight and quality control of the OPFPU.

This ambiguity was a significant problem. Effective oversight requires clearly delineated responsibilities, with no ambiguity over who does what. The fuzziness surrounding the ultimate responsibility for the OPFPU was a major weakness in its organization, and it contributed significantly to the failures of

oversight and accountability. As I describe later, the Chief Forensic Pathologist, who should have the requisite expertise, must play a central role in oversight. That position cannot be marginalized in favour of coroners who, without training in forensic pathology, cannot assume primary responsibility for the oversight of pathologists.

The responsibilities of the director for the OPFPU were also the subject of substantial confusion in evidence given at the Inquiry. Dr. Young testified that he understood the director's role to be strictly administrative in nature. He felt that the director administered the budget and ensured that paperwork such as rotation scheduling was completed as necessary, but was not responsible for quality assurance. However, documents surrounding the appointment of the OPFPU director suggest that Dr. Young at least originally contemplated that the director would play a meaningful oversight role. In a letter to Dr. Phillips on March 10, 1992, Dr. Young commented that it might be appropriate to consider that the director supervise the OPFPU "and [be] accountable for its activity." In his May 29, 1992, letter to Dr. Smith appointing him as director, Dr. Phillips noted that the director position "includes the responsibilities for all day to day operations of the Unit."

Moreover, in 1993, Dr. Young asked Dr. Smith to sign off on all reports of post-mortem examination before they were sent from the unit to the OCCO or the regional coroner. The purpose of the signoff was to ensure that the "wording in the conclusion [was] most appropriate for the forensic setting" and was in line with the OCCO's policies. Evidence at the Inquiry indicated that, from time to time, Dr. Smith did have questions or concerns about a pathologist's opinion on the cause of death. In such cases, he approached the pathologist, and they discussed his suggestions or additional considerations, although he left the decision whether to amend the report with the pathologist. Dr. Smith's review of pathologists' reports within the OPFPU did, then, provide a form of quality assurance. It involved consideration not only of compliance with OCCO policies but also of the accuracy of the cause of death opinion itself.

Individual coroners continued to assign coroner's warrant autopsies to the individual OPFPU pathologists. As director of the unit, Dr. Smith had some say in determining who performed which forensic autopsies at the OPFPU.

Dr. Chiasson understood that the directors of all the regional forensic pathology units, including the OPFPU, had responsibility for quality assurance within their units. In fact, during his first few years as Chief Forensic Pathologist, he tried as best he could to ensure that directors fulfilled their responsibilities for quality assurance.

Dr. Phillips also believed that Dr. Smith had some responsibility for the qual-

ity assurance of the work of the OPFPU, including reports of post-mortem examination. He understood that Dr. Smith was responsible for reviewing his colleagues' reports and for monitoring their turnaround times. He thought that the OCCO would not accept any report from SickKids unless Dr. Smith had signed off on it. However, by contrast, Dr. Smith's own reports were not reviewed by anyone at SickKids before they were sent to the OCCO.

When the OPFPU was established, no provisions were put in place to ensure oversight of the work of the director of the OPFPU. No such mechanisms were ever introduced. This omission was a significant quality assurance failing. It was one of the things that allowed many of Dr. Smith's weaknesses to go unnoticed and uncorrected for years.

The 1991 Agreement regarding the OPFPU therefore failed to clearly allocate the responsibility for supervision and oversight. The lines of accountability and oversight were so unclear that the central witnesses each described a different view of the respective roles and obligations of the Chief Coroner, the Chief Forensic Pathologist, and the OPFPU director. This lack of clarity, combined with the fact that no one stepped forward to take responsibility for oversight, resulted in a vacuum where nobody was held to account for the work of the OPFPU. The idea of a specialized regional unit was laudable, but it failed to change in any significant way the historic relationship of the fee-for-service pathologist with the individual coroner, just as it failed to create any additional oversight or quality control mechanisms. It was a missed opportunity.

Unrealized Research Goals of the OPFPU

SickKids and the OCCO understood that research would be a central function of the OPFPU. The body of existing research into pediatric forensic pathology was thin, and, therefore, ongoing research was important. In 1991, for example, $23,938 of the $200,000 grant to the OPFPU was allocated to research in sudden infant death syndrome (SIDS).

Beginning in about 1994, however, Dr. Lawrence Becker, the newly appointed pathologist-in-chief and chief of the Department of Pediatric Laboratory Medicine at SickKids, and Dr. Ernest Cutz, a pathologist at SickKids, expressed concerns to Dr. Young, Dr. Chiasson, and Dr. Cairns about the increasing emphasis on the actual work of forensic autopsies at the OPFPU, and particularly about the adverse effect it was having on their ability to carry out research. Dr. Becker and Dr. Cutz wanted the OPFPU to have a stronger academic focus, particularly in the use of case materials and data for research projects related to SIDS. The investigation of SIDS was a significant area of research within the SickKids pathology department, with Dr. Cutz and Dr. Becker being recognized as eminent

experts in the field. Discussions between Dr. Becker and the OCCO leadership about the issue of research continued sporadically through 1999.

All SIDS autopsies were performed under coroner's warrant. The use of tissue samples from coroner's autopsies for SIDS research became a significant area of dispute within the department at the hospital. According to Dr. Cutz, before the OPFPU was established, Dr. Bennett, as Chief Coroner, had allowed SickKids to use tissue from coroner's autopsies for SIDS research. In February 1994, Dr. Smith drafted a memorandum to Dr. Phillips, informing him that, because of restrictions in the *Coroners Act*, the department could no longer collect or archive tissue from coroner's autopsies for research purposes. The OCCO, through Dr. Smith, ultimately insisted that the SickKids pathologists obtain informed consent from families before taking samples for research purposes, and that they inform the OCCO about the nature and results of all research-based investigations in coroner's cases. Dr. Cutz told the Inquiry that, as a result, their SIDS research projects were terminated.

Whatever caused the ultimate cessation of SIDS research at SickKids, it is obvious that it represented a failure of communication and cooperation between the OCCO and the hospital. It was also a missed opportunity to facilitate important research into a central aspect of pediatric forensic pathology – deaths of children due to SIDS – that SickKids was well placed to continue.

Attempted Re-visioning of the OPFPU

During the mid- to late 1990s, Dr. Chiasson continued to discuss the relationship between the OCCO and the OPFPU with Dr. Becker and Dr. Smith because he had certain concerns about the unit. These concerns focused on three areas: whether or not Dr. Smith and pathologist Dr. Glenn Taylor were doing all of the criminally suspicious and homicide cases at SickKids, as was Dr. Chiasson's preference; the problems with timeliness of post-mortem reports, primarily those of Dr. Smith; and the lack of communication between the OPFPU and the OCCO.

Dr. Chiasson attempted to address at least the timeliness problem directly. He wanted to ensure that Dr. Smith had enough time to concentrate on his coroner's warrant cases and was not diverted by paperwork tasks. Dr. Chiasson understood from Dr. Smith that he had to type or prepare his own reports and that this administrative work created problems for him. Dr. Chiasson therefore suggested to SickKids that Dr. Smith be provided with a dedicated assistant to handle OPFPU communications. It is clear from evidence at the Inquiry, however, that Dr. Smith in fact had adequate administrative support and that this particular aspect of his work did not cause his delays.

When SickKids did not address his concerns about the OPFPU, Dr. Chiasson

proposed a "re-visioning" of the OPFPU in which it would remain a joint venture between the OCCO and SickKids, but would be physically relocated to the OCCO. The director of the OPFPU would report to the Chief Forensic Pathologist. SickKids would continue to provide consultative professional support to the OPFPU, with the OCCO assuming responsibility for administrative and secretarial support. Dr. Chiasson thought that these changes would result in a more responsible unit that maintained a closer collaborative relationship between the OCCO and SickKids. He intended to have all the autopsies in all pediatric forensic cases in Toronto performed at the OCCO, except for non-criminally suspicious cases where the deaths had actually occurred at SickKids.

Despite a series of meetings between senior leaders at SickKids and the OCCO between March and June 1999, the re-visioning proposal did not proceed. Dr. Young testified that he was never in favour of moving the unit from SickKids to the OCCO, although Dr. Chiasson stated that Dr. Young never told him that. Dr. Chiasson believed that the re-visioning failed in large part because of the serious staffing shortages at the PFPU itself. In the spring and summer of 1999, both Dr. Bullock and Dr. Queen resigned from the unit for better-paying positions elsewhere. In mid-July 1999, Dr. John Deck, full-time neuropathologist at the PFPU, went on an extended medical leave of absence. He did not return from leave and retired in 2002. There was simply not the staff at the PFPU to take over the pediatric forensic work. Thus, not only did Dr. Chiasson's hopes for upgrading pediatric forensic pathology come to an end but so did his new vision for the OPFPU.

Regional Forensic Pathology Units

Establishment and Structures

In June 1993, Dr. Young drafted a formal proposal to establish and fund additional regional forensic pathology centres of excellence and to train and recruit new experts in the discipline. He was rightly concerned about the future supply of pathologists to do forensic work in Ontario. He thought that, by moving expertise to various regions, some pressure could be taken off the resources in Toronto. The centres could take advantage of physical facilities in different locations, including a number of newly constructed morgues.

In 1992, the year after the establishment of the OPFPU, the Ministry of the Solicitor General entered into contractual arrangements to establish the Hamilton and the Ottawa regional forensic pathology units. These units were also known as regional centres of excellence. Like the OPFPU, they were each located within teaching hospitals (what are now Hamilton General Hospital and the

Ottawa Hospital), and, consequently, they benefited from resources and infrastructure associated with first-class academic health sciences centres.

In addition to the official regional forensic pathology units, the Children's Hospital of Eastern Ontario (CHEO) handled pediatric forensic cases in eastern Ontario, including Ottawa. The Ottawa Regional Forensic Pathology Unit dealt only with adult forensic cases. However, CHEO was not a regional forensic pathology unit, and there was no contractual agreement between CHEO and the OCCO.

By the mid-1990s, forensic pathology units at four institutions – SickKids, Hamilton, Ottawa, and the PFPU – performed about three-quarters of the criminally suspicious coroner's warrant cases in Ontario. In the 1990s, most criminally suspicious pediatric cases were performed at the OPFPU, the Hamilton unit, or CHEO.

In 2000, the Ministry of the Solicitor General entered into contractual arrangements establishing the London and the Kingston regional forensic pathology units. These units were located, respectively, at London Health Sciences Centre and Kingston General Hospital.

Each regional forensic pathology unit had a director. In every case, the director was also a pathologist who provided fee-for-service forensic autopsies at the unit.

Expertise of Pathologists

There is a good deal of variation in the qualifications of both directors and pathologists working within the regional forensic pathology units and performing criminally suspicious cases. Only one – Dr. Michael Shkrum, the director of the London unit – has formal training and certification in forensic pathology. A few pathologists – such as Dr. Chitra Rao and Dr. John Fernandes in Hamilton and Dr. Edward Tweedie in London – have specialized training through fellowships in forensic pathology, but lack certification. However, a number of pathologists working in the units have no fellowship training or certification in forensic pathology, including the current director of the Kingston unit and former directors of the Ottawa unit and the OPFPU.

Oversight and Accountability Relationships

Unfortunately, the 1991 Agreement establishing the OPFPU appears to have been used as something of a template for the Hamilton and Ottawa agreements in 1992. They, too, neither outlined an oversight structure for the work of the units nor specified the roles and responsibilities of the directors. They did not address the relationship of the units with the OCCO and the Chief Forensic Pathologist, nor did they provide for oversight of the pathology conducted by the directors. The agreements noted only that they did not alter the relationship between coro-

ners and individual pathologists. Therefore, as with the OPFPU, the creation of the specialized regional units in Hamilton and Ottawa failed to change in any significant way the relationship of fee-for-service pathologists with the OCCO or to create any additional mechanisms for meaningful oversight and quality control. In this respect, they did not create oversight structures that were significantly different from what had gone on before. The essential relationship remained that between the pathologist doing the autopsy and the requesting coroner.

In 1997, Schedule A to the Ottawa agreement was amended to clarify the administrative structure of the unit. This represented a significant step forward, at least in Ottawa. The amended agreement provided that the Ottawa unit was one of four forensic pathology units in the province, "under the general supervision of the Chief Forensic Pathologist and ultimately accountable to the Chief Coroner of Ontario." It specified that governance of the unit would be conducted by representatives of the OCCO and the Ottawa Hospital as well as by the administrative head of the unit, who was appointed by the Chief Coroner with the approval of the local hospital administration. Dr. Benoit Béchard, the regional coroner, was named as administrative head of the unit. The 1997 agreement also set out that a professional director would provide oversight of the substantive work of pathologists within the unit – reviewing autopsy reports, for example, and ensuring adequate consultation opportunities among peers. Although not explicitly stated in the agreement, the professional director was in practice a pathologist. Unfortunately, however, this director was given no role in the unit's governance. The agreement set out that the professional director reported to the administrative director on financial matters, and to the regional coroner or Chief Forensic Pathologist on professional matters.

The amended agreement also outlined the roles and responsibilities of the Chief Forensic Pathologist, the professional director, and the administrative director. The Chief Forensic Pathologist was responsible for providing direction and guidelines on standards of forensic pathology practice, ensuring appropriate quality control measures, and reviewing all autopsy reports in criminally suspicious cases. The professional director was responsible for day-to-day management of the unit, ensuring an appropriate early case review system, arranging regular case review of complex forensic issues, and reviewing all autopsy reports before they were released. The administrative director of the unit, who was not a pathologist, was responsible for financial management of the unit, ensuring appropriate staffing schedules, and monitoring turnaround times.

Schedule A to the 1997 Ottawa agreement also provided more details about the desired qualifications of pathologists within the unit. It would be staffed by dedicated pathologists acceptable to both the local hospital and the university

and possessing "appropriate training (American Board of Pathology accredited fellowship in forensic pathology or equivalent) and/or concentrated case experience in forensic pathology." It also required that new full-time staff pathologist appointments be made only after an interview process that included representatives from the OCCO, the university, and the Ottawa Hospital. In addition, the agreement usefully set out the role of the unit in providing education in forensic pathology to pathology residents, medical students, unit pathologists, and others, such as police officers and coroners.

The 2000 agreements for the London and Kingston regional forensic pathology units followed the model of the Ottawa unit's 1997 agreement, with detailed provisions for the oversight of, as well as the roles and responsibilities of, the various players within the unit and at the OCCO. The Kingston agreement was essentially identical to the one signed for the Ottawa unit. The London agreement was similar, with a few important differences. It set out that the unit director and the chief/chair of the department of pathology would sit on the executive team governing the unit. This was an improvement because it ensured pathology expertise on the governing body. In addition, the London agreement did not require an administrative director; rather, the unit director was responsible for both substantive and administrative management of the unit.

The arrangements in Ottawa, London, and Kingston were all manifestly superior to the OPFPU and Hamilton agreements. It is unfortunate that the 1997 changes to the Ottawa agreement were not implemented across the province. Since 2001, there have been significant amendments to the agreements regarding the regional forensic pathology units, as I describe in Chapter 9, Oversight of Pediatric Forensic Pathology.

Although the structural arrangements for the regional forensic pathology units lacked clarity for oversight and accountability, the concept of regionalizing the provision of forensic pathology services was a good one. It recognized the need to develop specialized expertise to serve the unique geographical demands of Ontario. Although most of the pathologists at the units did not have formal certification in forensic pathology, they did develop some considerable experience in performing coroner's autopsies. In all five units, they were also working within academic teaching hospitals with extensive resources for testing and consultation. Therefore, they were somewhat better equipped to perform the more complex forensic autopsies, such as criminally suspicious pediatric deaths, than pathologists working in community-based hospitals. Although inadequate oversight and quality control mechanisms within the units failed to detect problems with the work of pathologists such as Dr. Smith, the OCCO was correct in recognizing the need to develop and concentrate the number of professional experts

who were engaged in forensic pathology in centres of excellence across the province. The concept was a sound one, even if the oversight mechanisms for a number of the units were sorely lacking.

The Regional Coroner's Pathologist System

In the 1990s, autopsies in about three-quarters of the criminally suspicious cases were conducted by pathologists affiliated with four of the forensic pathology units – SickKids, Hamilton, Ottawa, and the PFPU. In many parts of the province, however, there was no specialized forensic pathology service, and pathologists in community-based hospitals continued to do the work. Inevitably, therefore, pathologists with very little experience were performing post-mortem examinations in some criminally suspicious deaths. This situation led Dr. Chiasson to become concerned that some pathologists were taking on cases that were beyond their capabilities.

In an attempt to address this problem, Dr. Chiasson introduced the Regional Coroner's Pathologist System in June 1996, by which he invited pathologists to apply for appointments as regional coroner's pathologists. The OCCO asked pathologists who were interested in performing post-mortem examinations in criminally suspicious cases to submit a curriculum vitae and to complete a questionnaire detailing their experience with homicide cases. The stated criteria included previous forensic training and/or experience, previous experience as an expert witness in court, interpersonal skills, and geographical location. Dr. Chiasson did not interview candidates or attempt to assess factors such as interpersonal skills. Based on the applications, the OCCO, through Dr. Chiasson, developed a list of regional coroner's pathologists. In addition, the OCCO named a group of associate regional coroner's pathologists – junior pathologists who were being developed to perform this work in the future. Altogether, some 90 to 95 pathologists were appointed to one or other of these positions.

Dr. Chiasson did not set a very high threshold for the number of homicide autopsies that were required for appointment as a regional coroner's pathologist. In considering applications from remote areas of the province, he considered the reality that pathologists in these areas who had no forensic training or experience were required, as a practical matter, to perform autopsies in criminally suspicious cases.

Dr. Cutz and Dr. Greg Wilson, both of whom worked in the OPFPU in 1996, applied to become regional coroner's pathologists. Dr. Chiasson rejected their applications because he wanted to have Dr. Smith or Dr. Taylor perform the autopsies in all the criminally suspicious pediatric deaths and homicides at the

OPFPU. Dr. Cutz and Dr. Wilson continued to do non-criminally suspicious coroner's warrant cases. On February 17, 1997, Dr. Chiasson wrote to Dr. Smith and outlined the OCCO's position: forensic cases should be triaged among pathologists at SickKids, with Dr. Smith performing the majority of the complex cases, including homicides and criminally suspicious deaths, and Dr. Taylor providing backup when Dr. Smith was not available.

Although well intentioned, the regional coroner's pathologist system was relatively ineffective. Given the very limited number of pathologists with formal training in forensic pathology, the designation was given to pathologists without any training or particular expertise in forensic pathology. It was also given to pathologists like Dr. Smith, whose significant weaknesses in forensic pathology skills and knowledge had gone undetected because of inadequate quality control mechanisms.

The regional coroner's pathologist designation still exists, but, over time, it has fallen into disuse as a way of coping with the challenges of criminally suspicious cases. As of 2008, all adult and pediatric post-mortem examinations in criminally suspicious cases are performed at "centres of excellence" at the regional units.

Lack of an Independent Complaints Mechanism

In the early 1990s, the Coroner's Council dealt with significant complaints about the work of coroners. The council was set up by legislation and provided an independent forum chaired by a judge for this purpose. It was disbanded on December 18, 1998, when the legislature repealed ss. 6 and 7 of the *Coroners Act*. Thereafter, the OCCO did not have any formal or well-understood system in place to investigate and respond to complaints about the work of pathologists or coroners. Instead, it was left to the Chief Coroner to respond on an ad hoc basis to complaints.

Steps Taken by Dr. Chiasson to Increase the Oversight of Pathologists' Work

When Dr. Chiasson was appointed Chief Forensic Pathologist in 1994, he faced a significant challenge to improve the quality of forensic pathology in Ontario. There were essentially no existing structures for oversight of the work of pathologists performing coroner's autopsies. Beyond the institutional changes already referred to, the particular oversight mechanisms that were put in place by Dr. Chiasson were well intentioned and certainly an improvement on the pre-1994

vacuum. However, as I suspect Dr. Chiasson would be the first to admit, they were inadequate in a number of critical ways.

In considering these weaknesses, I recognize that, even if Dr. Chiasson had put forward adequate oversight mechanisms, he had few means by which to enforce compliance with OCCO guidelines or to address concerns with the work of pathologists. He had no direct authority over pathologists at the regional forensic pathology units or over the directors of those units. His supervisory role over the units, if any, was ill defined. In addition, as a relatively junior pathologist, Dr. Chiasson was required to oversee more senior pathologists, such as Dr. Smith, who had existing relationships with the leadership of the OCCO. These factors, which are discussed in greater detail in Chapter 9, Oversight of Pediatric Forensic Pathology, remained significant barriers to effective oversight.

Review of Reports of Post-Mortem Examination within the Provincial Forensic Pathology Unit

One of Dr. Chiasson's first initiatives, beginning in 1994, was to review every report of post-mortem examination at the PFPU before its release to the OCCO and the investigating coroner. Every year, approximately 1,500 autopsies were performed at the unit, some 200 of which initially raised criminal suspicions, with approximately 100 cases ultimately considered homicides.

Dr. Chiasson wanted to ensure the reasonableness of each report's conclusions and assess, so far as he could, the forensic capabilities of the pathologists providing services for the PFPU. He hoped to identify any major forensic pathology issues before the release of the final report. He wanted to ensure that the injuries were properly documented, that there were no inconsistencies in the report, that the summary of abnormal findings was accurate, and that the given cause of death was supported by the findings. This process was, however, no more than a paper review. The numbers alone made impossible anything more substantial.

Review of Reports of Post-Mortem Examination in All Criminally Suspicious Cases

On September 1, 1995, the OCCO announced that, before release by the OCCO to the Crown, all reports of post-mortem examination from anywhere in the province would be reviewed by the Chief Forensic Pathologist in those cases where the manner of death was homicide or undetermined and possibly homicide. Across the province, approximately 400 coroner's autopsies per year raised some criminal suspicions, with 200 to 250 ultimately considered homicides. In May 2000, the OCCO issued a memorandum indicating that the review process for homicide deaths would be expanded to include deaths in custody, deaths

investigated by the police or the Special Investigations Unit, and all deaths categorized as SIDS or sudden unexplained death syndrome (SUDS).

In most cases, the regional coroners forwarded the reports of post-mortem examination to Dr. Chiasson for his review, and he completed his review before the reports were released to the Crown. If Dr. Chiasson identified no concerns, he forwarded a memorandum to the regional coroner stating that the review was completed. If he did have concerns, he expressed them to the pathologist either directly or through the regional coroner. Occasionally, he requested supporting materials before completing his review, but for the most part his examination was a paper review.

Dr. Chiasson's review of criminally suspicious cases, although an important advance from the complete lack of quality control in the 1980s and early 1990s, still had a number of significant limitations. Dr. Chiasson did not examine the photographs or the histology underlying a report unless he saw a problem and requested these items. His review would therefore not have identified misinterpretation of an injury or a pathology finding. For example, Dr. Smith's serious errors about the timing of the injuries in Jenna's case were not apparent in a paper assessment of the report of post-mortem examination. Consequently, Dr. Chiasson did not identify any concerns in his review of this case. The fact that the review could not pick up such significant errors demonstrates its limitations.

As Dr. Chiasson recognized during his testimony, he also did not have sufficient information about the circumstances of the deaths to identify a number of errors that occurred in Dr. Smith's reports. During his paper review of these cases, he noted no major concerns and certainly nothing that required a revised report.

At one stage, Dr. Chiasson conducted an audit and determined that, in the majority of criminally suspicious cases, he was receiving reports as part of his review process. However, because the process relied on individual pathologists forwarding reports through the regional coroner, it was not fully inclusive. When reports were very late, they were sometimes sent directly to Crown counsel and bypassed the review process. For example, in Sharon's case, after repeated requests and the issuance of a subpoena for Dr. Smith to attend in court, Dr. Smith provided his report of post-mortem examination to the Crown in March 1998 without sending it through the regional coroner or the OCCO for review. Dr. Chaisson did not have the opportunity to review the report, and he saw it for the first time only in March 1999, before the meeting in Kingston with the Crown and the police. On that occasion, he thought that Dr. Smith had not defined or described the injuries, particularly the internal wound tracks, well. Dr. Chiasson would likely have reached this conclusion much earlier if the report had been sent to him before being forwarded to Crown counsel, as it should have been.

Finally, Dr. Chiasson had no mechanism in place to review consultation reports or second opinions unless they were attached to the report of post-mortem examination. As a result, he did not review Dr. Smith's consultation work in cases such as Taylor's and Baby F's. To this extent as well, the review process was not inclusive enough.[1]

Spot Audit of Work of the OPFPU

In 1997 or thereabouts, Dr. Chiasson conducted a random audit of some 20 pediatric autopsies conducted at the OPFPU to review both the turnaround times for the reports and forensic pathology issues arising in the reports. Dr. Chiasson did not have any major concerns based on his review. In four of the cases, he identified minor concerns involving limited description of injuries and a lack of correlative comment or history, but they were similar to issues he had with pathologists outside the OPFPU. Dr. Chiasson did not conduct similar audits of the work conducted in the other regional forensic pathology units.

Failure to Track Timeliness

The OCCO had the primary obligation to ensure that all pathologists completed their post-mortem reports in a timely fashion, yet Dr. Chiasson's review process for these reports did not specifically track or evaluate the timing of their delivery. Indeed, the OCCO did not have any system or central mechanism to track either consultation or post-mortem reports. It therefore could not track the turnaround times for reports of post-mortem examination in particular cases.

In the 1990s, the OCCO had no policies with clear requirements for turnaround times. In April 1999, in Memorandum 99-02, "Forensic Pathology Pitfalls," sent to all coroners and pathologists, Dr. Chiasson and Dr. Young sought "the continued cooperation of all pathologists in minimizing autopsy report turnaround times" and stated that delays longer than three or four months created problems for coroners. However, this request was not framed as a requirement, and compliance was not specifically monitored.

Despite the lack of a tracking system, Dr. Chiasson heard a number of concerns from regional coroners and others about major delays in Dr. Smith's reports. Dr. Chiasson did try in a limited way to take a more active oversight role with regard to problems with Dr. Smith's significant delays in producing his reports. As noted above, in or around 1997 Dr. Chiasson conducted a random audit of 20 pediatric autopsies. In 1998, he met with Dr. Becker and Dr. Smith and proposed specific turnaround time goals for the unit's cases.

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[1] See Appendix 28 at the end of Volume 4 for summaries of the cases.

SickKids did, however, monitor the timeliness of pathologists' work, including the completion of their reports for coroner's cases. During his tenure as pathologist-in-chief there, Dr. Phillips initiated target turnaround times for all autopsy reports done for the OCCO or for the hospital. When Dr. Becker succeeded him in 1994, he formalized target turnaround times for all pathologists' work. SickKids tracked the times for all surgical pathology, hospital autopsies, and coroner's cases done at the hospital. At the end of each month, Dr. Paul Thorner, director of surgical pathology at SickKids from 1990 to 1996 and associate head of the pathology department at SickKids since 1996, produced a list of every pathologist's incomplete cases, and the results were delivered both to Dr. Becker and to the individual pathologist. However, remedial actions to address problems with timeliness generally focused on the pathologist's hospital work rather than coroner's work. Occasionally, the OCCO called the pathologist-in-chief if it had a concern about delayed coroner's reports, but the OCCO was not specifically informed when SickKids had concerns about delays in a pathologist's reports. SickKids did not share these incomplete case reports with the OCCO. Dr. Cairns, the Deputy Chief Coroner, was not even aware that SickKids had a system that tracked its pathologists' timeliness in completing reports.

Content of Reports of Post-Mortem Examination

In reviewing reports of post-mortem examination, Dr. Chiasson observed that, with regard to incorporating case histories into reports, the practices used varied across the province. He encouraged pathologists to include relevant history in their reports, but to exclude prejudicial or irrelevant information. Some pathologists thought they could not deviate from the form, prescribed by regulations to the *Coroners Act* (the Form 14), which included no space for comments on the history, while others included too much irrelevant information. In Dr. Chiasson's view, the goal was to include only the historical or circumstantial information that was relevant or important to the forensic pathology conclusions, but he was not able to make much progress on this front across the province.

Special Case Reviews

Dr. Chiasson implemented ad hoc reviews for select cases that were particularly complex or that raised a particular forensic pathology issue. In such cases, the post-mortem examination results were discussed in meetings that included coroners, investigating police officers, and Crown counsel. Special case reviews allowed for a "meeting of the minds" among the members of the death investigation team. The special case reviews were a predecessor of the more formalized case conferences later developed within the OCCO.

Consultative Support

Beginning in 1995, Dr. Chiasson contributed a regular column to the OCCO newsletter. In his first "Forensic Pathology Corner" article, he wrote that providing consultation opinions to pathologists, coroners, and police forces was one of his primary roles. He encouraged people to take advantage of his consultative support.

Pathologists did not immediately take up his offer. Eventually, some of them began to consult Dr. Chiasson about difficult cases. Other pathologists, often the more senior among them including Dr. Smith, were less likely to contact him. This represented a lost opportunity, particularly for Dr. Smith, who lacked a basic understanding of many aspects of forensic pathology.

Dr. Chiasson knew that some hospital pathologists were conducting forensic autopsies alone in small hospitals without many resources. In 1995, approximately 200 to 250 pathologists were performing some kind of autopsy work for the OCCO. In his "Forensic Pathology Corner" article in June that year, Dr. Chiasson emphasized the importance of consultation with other pathologists. He commented that, while a system of regular meetings was not practical for most pathologists performing coroner's autopsies, he would "heartily encourage all pathologists to regularly discuss cases with their local colleagues." In difficult cases, he urged pathologists to make use of the expertise of the regional forensic pathology units. Once again, this initiative was well intentioned, but, given the lack of any proper institutional framework for forensic pathology services across the province, it could have only a very modest impact.

Educational Activities

The OCCO's educational programs in forensic pathology had withered by the beginning of the 1990s. In the mid-1990s, Dr. Chiasson reinstituted annual training courses for pathologists which involved some joint education with coroners.

The OCCO also provided funding for pathologists to attend national and international educational conferences and even created a fund for the appointment of a fellow at the OCCO. But it could not attract anyone to accept the position, probably because of the poor levels of compensation received by pathologists doing forensic work.

Review of Participation in Criminal Proceedings

In the 1990s, the OCCO's involvement in criminally suspicious cases usually ended after the completion of the report of post-mortem examination and the coroner's report. In complicated cases, representatives of the OCCO might have participated in case conferences with Crown counsel to ensure that the neces-

sary experts were in place. However, the OCCO did not monitor the participation of pathologists with cases as they progressed through the criminal justice system. The relationship was entirely between the individual pathologist who conducted the autopsy and the Crown counsel who might wish to have the pathologist testify.

In practice, some of the most serious concerns about the work of pathologists in criminal proceedings from 1981 to 2001 arose after the report of postmortem examination was finalized. As described in Chapter 8, Dr. Smith and the Practice of Pediatric Forensic Pathology, in many of the cases examined at the Inquiry, significant problems occurred with Dr. Smith's communications with other participants in the criminal justice system and in his testimony in criminal proceedings.

In these circumstances, it was unfortunate that the OCCO had no system in place to review pathologists' court testimony. The OCCO conducted no review of judicial commentary about the work of its pathologists, nor did it review or monitor any opinions that pathologists expressed informally to police or counsel during the course of criminal proceedings. This breakdown in the monitoring process as complex cases went through the criminal justice system remained a significant oversight failing during Dr. Chiasson's tenure. As is discussed in Chapter 9, Oversight of Pediatric Forensic Pathology, this oversight difficulty continues today and is addressed by my recommendations.

Pediatric Forensic Hospital Rounds

When Dr. Chiasson was appointed Chief Forensic Pathologist in 1994, he expressed an interest in having a greater degree of interaction with the OPFPU than had his predecessor. At Dr. Chiasson's suggestion, commencing in January 1995, Dr. Smith arranged monthly pediatric forensic rounds at the OPFPU. Dr. Chiasson attended these rounds at SickKids so he could provide his experience in forensic matters and also learn more about pediatric pathology cases. In his forensic pathology training in Baltimore, he had observed the importance of hospital rounds in ensuring quality practice.

In the 1980s and early 1990s, coroner's cases were sometimes discussed at SickKids rounds, but criminally suspicious cases were not. In 1994, the OCCO expressly indicated that all coroner's autopsies, aside from those related to medical malpractice, could be presented at SickKids rounds. It appears that at least some criminally suspicious autopsies were discussed during these pediatric forensic rounds at the hospital, and, although they proved to be a helpful quality control device, they tapered off around 1997. They were discontinued for a variety of reasons, but primarily because of sporadic attendance by the pathology staff and

Dr. Smith's own pressured schedule and general lack of interest in keeping them up. The termination of these hospital rounds represented yet another lost opportunity to improve the quality of pediatric forensic pathology in Ontario.

In 1997, Dr. Chiasson tried to involve Dr. Smith in the work of the PFPU through participation in weekly and daily rounds at the unit. He recognized that Dr. Smith's cases were extremely challenging and thought Dr. Smith would benefit from discussions with colleagues with forensic experience. Although Dr. Smith initially came to some of these rounds, his attendance there soon dwindled, and that opportunity was lost as well.

Around 1999, Dr. Chiasson instituted a series of pediatric pathology rounds at the OCCO so that PFPU staff could gain exposure to pediatric cases. Dr. Smith presented the cases during these Wednesday afternoon rounds. He was usually the only pathologist from SickKids who attended. The pediatric pathology rounds at the PFPU focused more on criminally suspicious cases than did the SickKids rounds. These rounds continued at least through 2000, and possibly after 2001.

Resignation of Dr. Chiasson

In 1999, 2000, and 2001, Dr. Chiasson experienced a growing series of frustrations in his position as Chief Forensic Pathologist.

First came the resignations, in the spring and summer of 1999, of two of the full-time certified forensic pathologists at the PFPU, Dr. Bullock and Dr. Queen. This was followed, in mid-July 1999, by the departure of Dr. Deck on an extended medical leave of absence. Dr. Deck did not return and retired in 2002. When Dr. Chiasson conducted exit interviews with Dr. Queen and Dr. Bullock, they told him that they had wanted to be more involved in the death investigation team. They did not feel that their specialized expertise in forensic pathology and death investigation, gained through training in medical examiner's offices where pathologists determined both the cause and the manner of death, had been fully appreciated or used within the unit.

Before these departures, full-time staff pathologists had, for some years, conducted a large majority of the autopsies at the PFPU. Now, Dr. Chiasson once again had to recruit fee-for-service pathologists. He also had to conduct more autopsies himself, thereby reducing the amount of time he could devote to his managerial and educational functions. By the end of 1999, the only staff pathologists at the unit were Dr. Chiasson and Dr. Toby Rose.

In a June 16, 1999, memorandum to Dr. Young, Dr. Chiasson indicated his increasing frustration with the staffing situation at the PFPU and with his

dealings with the other regional forensic pathology units. The two doctors met to discuss Dr. Chiasson's concerns. Dr. Young was willing to support the appointment of Dr. Chiasson and the unit's other staff pathologists as coroners if that would keep them in their positions. He also agreed to have Dr. Chiasson assume a greater hands-on role in the administration of and budget relating to coroner's autopsy services. Dr. Young said he was committed to increasing significantly the salaries of both the Chief Forensic Pathologist and the staff forensic pathologists.

However, Dr. Chiasson was not successful in recruiting new staff forensic pathologists in 1999. He told Dr. Young that without a significant improvement in the salary structure at the unit, he would be unable to attract any suitable candidates. The job market was becoming even more difficult as many older pathologists retired and fewer residents entered training programs in pathology. Hospital pathologists were paid significantly more than the PFPU pathologists. Salaries for hospital pathologists at this time were increasing significantly, reaching $205,000 on average. In addition to their base hospital salaries, some pathologists received additional remuneration for their fee-for-service work for the OCCO. In contrast, as Chief Forensic Pathologist, Dr. Chiasson's starting salary was $156,000, and the other staff pathologists at the unit earned between $150,000 and $160,000 per year. The two forensic pathologists who left the unit took positions at hospitals for significantly more money, one being guaranteed at least a 50 per cent salary increase.

The compensation problem was not just about an inability to attract and keep properly trained and certified forensic pathologists. It also forced the OCCO back to a greater reliance on fee-for-service pathologists. Because these pathologists were not employed by the OCCO, the senior people there – Dr. Young, Dr. Cairns, and Dr. Chiasson – always felt it would be difficult for the OCCO to impose administrative or disciplinary sanctions on pathologists when they were warranted. They felt they had essentially only one very blunt tool – to stop sending cases to that pathologist. Given the shortage of pathologists capable of doing high-quality forensic work and the perceived need to get the work done at all costs, the OCCO considered that it had very little ability to hold a fee-for-service pathologist accountable.

In March 2000, Dr. Chiasson was dealing with the imminent retirement of Mr. Blenkinsop, the Chief Pathologist Assistant at the OCCO, and the loss of the three staff pathologists. He contemplated resigning because he no longer felt he could effectively carry out the responsibilities of his position. Issues with Dr. Smith were also a problem, although, from Dr. Chiasson's point of view, they were a minor part of the management issues he was facing.

In October 2000, Dr. Chiasson was appointed Deputy Chief Coroner, Pathology, at the OCCO, but neither his job responsibilities nor his salary changed. When these same frustrations continued in 2001, he expressed his concerns to Dr. Young, saying that he had expected to play a greater role in the management of issues related to death investigation. Still the job frustrations, mainly related to recruiting, continued. Dr. Chiasson did manage to hire another pathologist, but that person soon resigned to take a position for significantly more money. And, when hospital-based pathologists engaged in a strike over the remuneration for fee-for-service autopsies, even more referrals were made to the PFPU. In this environment, Dr. Chiasson concluded that he could not carry out his responsibilities as Chief Forensic Pathologist as they ought to be conducted. On June 29, 2001, he resigned. For reasons not of his own making, he had been unable to deliver on his hopes for the improvement of forensic pathology in Ontario.

Following his resignation, Dr. Chiasson continued to perform fee-for-service autopsy work for the OCCO. He also reviewed reports of post-mortem examination in criminally suspicious cases on a contract basis. After he resigned, there was no Chief Forensic Pathologist in Ontario for five years – until 2006 – when Dr. Michael Pollanen was appointed.

OCCO Response to Increasing Concerns about Child Abuse

In the late 1980s and early 1990s, the OCCO became increasingly concerned about child abuse. Similar concerns were growing around the world. In this context, the OCCO began to develop policies addressing pediatric death investigations. In addition, it created committees charged with the review of certain kinds of pediatric deaths.

Paediatric Death Review Committee

In 1989, the OCCO created the Paediatric Death Review Committee (PDRC) to assist the OCCO by reviewing the deaths of children, paying special attention to the pre-mortem medical care received by those children in medically complex cases. The PDRC's central concern was whether the medical care was reasonable and whether its quality raised any systemic issues. The committee did not focus on determining the cause of death. The early members of the PDRC included both Dr. Smith and Dr. Cairns, who became the chair of the PDRC in 1992.

In cases where local coroners could not answer some of the questions in diffi-

cult investigations of pediatric deaths, they referred them to their regional coroner. The regional coroner could then choose to refer the case to the PDRC. This referral did not occur until the report of post-mortem examination was finalized. One member of the PDRC was then assigned to review and summarize the file, which included the coroner's report, the final post-mortem report, and all the medical files. When the PDRC met, that member would present the case and the issues, and the committee as a whole would discuss the case and reach a consensus about it. If the case raised medical practice issues, the PDRC would make recommendations. The PDRC produced a report in each case reflecting the views and opinions of the entire committee.

In the 1990s, the OCCO expanded the scope of the PDRC's work. On January 24, 1994, the OCCO announced that the PDRC would review all SIDS and SUDS deaths with the intention of producing an annual report on these deaths to assist coroners and pathologists.

Nicholas' case was one of the first SIDS or SUDS cases referred to the PDRC, and Dr. Smith was assigned to review it. The committee discussed the case and agreed that it did not fit the SIDS category because Nicholas was awake and standing when he collapsed. The PDRC concluded that the case should be investigated further and be classified as SUDS pending that investigation. When Dr. Smith's consultation report concluded, "In the absence of an alternative explanation, the death of this young boy is attributed to blunt head injury," the case was not returned to the committee for further consideration. The PDRC was not designed to review criminally suspicious cases, although it did, at least initially, consider a number of them. That being said, in 1993 or 1994, because of its case reviews, the PDRC became concerned about undetected child abuse. As a result, subsequently it became involved in drafting a new protocol that, in part, addressed criminally suspicious pediatric deaths.

OCCO Policies and Pediatric Deaths

Memorandum 551(B)

Reflecting the growing concern about undetected child abuse, on December 19, 1990, Dr. Young circulated Memorandum 551(B) to all coroners, pathologists, and police forces. It set out that, in some recent cases, coroners and pathologists had found injuries highly suspicious for child abuse but had not immediately notified the police – a response that delayed the criminal investigation. The memorandum counselled that "[a]ll coroners investigating deaths of infants and small children, should entertain a very high level of suspicion. Deaths in this age group are relatively uncommon, and other than SIDS, the circumstances are usually

obvious. Police should be notified immediately when anything suspicious is encountered."

Memorandum 616

On July 23, 1993, Dr. Young issued Memorandum 616, regarding SIDS, to all coroners, pathologists, and police. The memorandum set out the universally accepted definition of SIDS.[2] It reminded its readers that a proper investigation of SIDS included a thorough police investigation, autopsy, and coroner's investigation. The memorandum also underscored that SIDS was a diagnosis of exclusion, one that could be made only where the police investigation, the coroner's investigation, and the autopsy were all negative. If there were any concerns, the death should be classified as SUDS.

The 1995 Infant Death Investigation Protocol

Through 1993 and 1994, the OCCO became increasingly concerned that members of the death investigation team were not sufficiently vigilant and were too quick to conclude that deaths were not criminally suspicious. In 1993, two such flawed death investigations came to the attention of the OCCO and contributed to the OCCO's emphasis on having a high level of suspicion in death investigations.

One of these cases was a pediatric death where unexplained fractures were initially missed. The other was a domestic homicide staged to look like a car accident. The death was initially treated as a motor vehicle accident, and a second autopsy was required. In 1994, the Coroner's Council issued a ruling in the case, making a number of systemic recommendations, including that new coroners "should be trained to have a high index of suspicion, to assume that all deaths are homicides until they are satisfied that they are not." The first OCCO policy to use the expression "thinking dirty" was drafted shortly after the Coroner's Council Report. It addressed the investigation of homicides committed by intimate partners.

In 1993 and 1994, the members of the PDRC determined that many death investigations were not following the existing guidelines for SIDS deaths. The police were often minimally involved, and many of the hospital pathologists performing autopsies had no pediatric pathology training. The PDRC encountered a number of cases of misdiagnosis by hospital pathologists and remained con-

[2] SIDS was defined in the memorandum as the "sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy (with X-rays), examination of the death scene and review of the clinical history."

cerned that child abuse was going undetected. As a result, the members of the PDRC investigated how these deaths were being handled in other parts of the world. They determined that the OCCO should issue a comprehensive new protocol for the investigation of the deaths of children under two years of age.

On April 10, 1995, the OCCO circulated Memorandum 631, attaching the Protocol for the Investigation of Sudden and Unexpected Deaths in Children under 2 Years of Age (the 1995 Infant Death Investigation Protocol), to all coroners, pathologists, and chiefs of police. Dr. Cairns drafted it in consultation with the PDRC, and Dr. Smith contributed to Appendix D, which described the steps to take when conducting pediatric forensic autopsies.

The 1995 Infant Death Investigation Protocol was one of the earliest efforts in any jurisdiction to deal with pediatric deaths in such an organized fashion. In many ways, it represented a significant advance in pediatric death investigations in Ontario. It emphasized the importance of teamwork, and reflected an early attempt to articulate an evidence-based approach. It required a complete autopsy, including X-rays and toxicology in all cases, and it also underlined the importance of radiology. It outlined the unique features of the autopsy in sudden and unexpected deaths of children under two. In fact, the foundations of a number of the current procedures in pediatric autopsies are found in this memorandum. However, as I discuss in Chapter 8, Dr. Smith and the Practice of Pediatric Forensic Pathology, the 1995 Infant Death Investigation Protocol and its appendices were in some ways underinclusive.

Regrettably, the Protocol also introduced the concept of "thinking dirty" into the investigation of infant deaths. The 1995 Infant Death Investigation Protocol was intended to ensure that children's deaths were investigated thoroughly and that deaths due to child abuse were not prematurely and incorrectly designated as SIDS. However, in attempting to accomplish this objective, it urged all members of the death investigation team – including coroners and pathologists – to "think dirty":

> Unfortunately, in this day and age CHILD ABUSE IS A REAL ISSUE and it is extremely important that all members of the investigative team "THINK DIRTY". They must actively investigate each case as potential child abuse and not come to a premature conclusion regarding the cause and manner of death until the complete investigation is finished and all members of the team are satisfied with the conclusion. [Emphasis in original.]

In the mid- to late 1990s, the OCCO met with chiefs of police, coroners, and pathologists to educate them about the 1995 Infant Death Investigation Protocol.

The "think dirty" message was a central part of this education campaign. Dr. Young adopted the expression and used it frequently in presentations.

At the Inquiry, a number of Ontario pathologists testified about their interpretation of the concept of "thinking dirty." Dr. Cutz believed that the use of the term was inappropriate. Dr. Chiasson interpreted the 1995 Infant Death Investigation Protocol as conveying the important reminder that homicide is always one of the diagnostic possibilities. To him, it did not mean that pathologists should continue to think dirty in the absence of evidence to support criminal suspicions. Dr. Taylor saw the phrase as a reminder to the pathologist to look for evidence of injury, along with all the other causes of sudden unexpected death in a child. Dr. Shkrum, Dr. Rao and Dr. David Dexter, the director of the Kingston Regional Forensic Pathology Unit, did not believe that the "think dirty" language influenced their approach or practice in pediatric deaths. They understood that the proper approach was to keep an objective and open mind.

In many ways, the 1995 Infant Death Investigation Protocol was a significant advance in the treatment of pediatric death investigations and in pediatric autopsies. However, its embrace of the "think dirty" philosophy was problematic. Dr. Cairns first heard the expression "thinking dirty" from Mr. Press, the former Toronto police officer who became Dr. Hillsdon Smith's executive assistant. Dr. Cairns testified that he took the expression to mean that one should not accept things at face value and should consider more sinister explanations. He did not believe that the expression "thinking dirty" suggested a lack of objectivity or indicated a presumption of guilt. However, in testimony, Dr. Cairns analogized the "think dirty" message to his experience in emergency medicine, in which physicians must assume that the presenting symptoms in their patients indicate the most critical health risk and act on that basis until it is proven otherwise. He used the example of a patient presenting with chest pain who is assumed to be suffering from a heart attack until that explanation could be ruled out. For him, the most critical health risk in this context was undetected child abuse.

Apart from the point raised by some witnesses that a wrongful conviction is also an unacceptable scenario, this analogy demonstrates a major flaw in the "think dirty" approach. Whereas clinical medicine properly approaches treatment by considering the worst possible explanation, forensic pathologists fulfill a very different role. They are providing information that may influence criminal proceedings. In this context, it is dangerous and inappropriate to leave any impression that forensic pathologists begin with a premise of foul play that must be disproved. Their objectivity requires that any such impression be avoided. They must "think truth," not "think dirty." They must also be seen to do so.

In circulating the 1995 Infant Death Investigation Protocol, Dr. Cairns and Dr. Young were motivated by legitimate concern about child abuse, backed up by their professional experience with pediatric death investigations. However, injecting a "think dirty" approach into pediatric death investigations was a serious error that created both an unfortunate perception and a risk of skewing outcomes.

SIDS/SUDS Committee

Once the 1995 Infant Death Investigation Protocol was established, additional cases were referred to the Paediatric Death Review Committee. The OCCO determined that a separate committee should be established to handle cases arising from this memorandum and to identify any controversial or problematic cases at an early stage. The committee would triage such cases and determine whether they required further investigation or review. This new committee was initially called the SIDS/SUDS Committee. It was composed of pathologists, coroners, and police officers, and it first met on June 27, 2000.

The committee reviewed every death of a child under two years of age to determine if members agreed with the coroner's determination of the cause and manner of death. The committee's decision overrode that of the pathologist, coroner, or regional coroner. The committee did not focus on issues of medical care; rather, it ensured that cases were investigated as directed by the 1995 Infant Death Investigation Protocol and that causes and manner of death classifications were consistent. On October 10, 2000, the SIDS/SUDS Committee was renamed the Deaths under Two Committee, but the mandate did not change. The committee is still in operation today, although its jurisdiction has since been extended to deaths of children under the age of five.

Summary

In this chapter, I have attempted to describe the institutional arrangements and organizational structures for forensic pathology as they existed and evolved through the 1980s and 1990s. I have considered the critical weaknesses of Dr. Chiasson's well-intentioned attempts to implement increased oversight and quality control of forensic pathology in the 1990s. Although gaps remained in the ability to oversee and ensure quality forensic pathology, the new structural arrangements for forensic pathology, including the regional forensic pathology units, were an improvement over previous arrangements. The OCCO's important recognition of the dangers of child abuse was, unfortunately, accompanied by the

"think dirty" approach advocated by its leadership. This is the background against which the flawed practices demonstrated by Dr. Smith's work and the failed oversight of that work must be assessed.