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Enhancing Oversight and Accountability

Introduction

Our systemic review has exposed deep flaws in the oversight and accountability mechanisms, quality control measures, and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001. The litany of problems did not result just because of the people involved. Many were problems of the system. Although there have been significant improvements in the oversight and accountability mechanisms of the Office of the Chief Coroner for Ontario (OCCO) since 2001, more needs to be done to restore and enhance public confidence in pediatric forensic pathology and its future use in the criminal justice system in Ontario.

In Chapters 11, Professionalizing and Rebuilding Pediatric Forensic Pathology; 12, Reorganizing Pediatric Forensic Pathology; and 15, Best Practices, I recommend ways to professionalize and build Ontario's forensic pathology service, and to improve both the organization and the best practices of forensic pathology. These initiatives will improve the quality of the forensic pathology used in death investigations in Ontario. Without proper oversight and corresponding accountability, however, we cannot be sure that, if serious mistakes do in the future arise in forensic pathology or in the way it is used by the criminal justice system, they will not, once again, go undetected. In this chapter, I detail much needed improvements to the important mechanisms for oversight of forensic pathology in Ontario. These mechanisms are centred at the OCCO. In subsequent chapters, I address the contributions required of other participants in the criminal justice system to help protect it from flawed pathology.

As with many aspects of what I discuss in this Report, it is not practical to design oversight and accountability mechanisms targeted only at a small subset of forensic pathology – namely, pediatric forensic pathology. Oversight of pediatric forensic pathology must take place in the broader context of the oversight of

forensic pathology. To be effective, oversight and accountability improvements must address the practice of forensic pathology in Ontario as a whole.

However, in a fundamental way, change must reach beyond forensic pathology. Our systemic review revealed very significant failures of oversight of Dr. Charles Smith by the senior leadership of the OCCO. The failure by the Chief Coroner to oversee effectively a senior colleague of such importance to the work of the OCCO has shaken public confidence in the ability of the current leadership structure to provide proper overall oversight of the work of that institution. In my view, the public's loss of confidence is justified: these serious failures can be seen only as a failure of governance. To provide effective oversight of the work of the OCCO and to restore public confidence, a major institutional change in governance is required.

Hence, the most significant component of my oversight and accountability recommendations is the development of a new governance structure for the OCCO. It requires a Governing Council to ensure more objective and independent governance of the institution, including the work of both the Chief Coroner and the Chief Forensic Pathologist and those they oversee in the coronial and forensic pathology services in Ontario.

Other institutional changes are also needed to improve oversight and accountability of forensic pathology. Principal among these changes are the creation of a registry of pathologists approved to perform coroner's autopsies; and the clarification of the reporting relationships between pathologists and the Chief Forensic Pathologist, between the Chief Forensic Pathologist and the regional units, and between the Chief Forensic Pathologist and the Chief Coroner.

The oversight and accountability mechanisms recommended in this chapter also include a variety of specific tools that can be used to ensure and enhance quality in forensic pathology. As I have said, many improvements have been made since 2001. My recommendations aim to build on these advances.

Oversight, Accountability, and Quality Control / Assurance

Before turning to my recommendations, I will explain what I mean by "accountability," "oversight," and "quality control / assurance." Although these terms appear in the Order in Council establishing the Inquiry and are frequently used by public servants and lay people, their meanings are rarely clearly articulated.

At its simplest, accountability is the obligation to answer for a responsibility conferred. When called on to account, a party on whom responsibility has been conferred must explain and justify – against criteria of some kind – his or her

decisions or actions. Oversight is the other side of this equation. Once a responsibility is conferred, oversight seeks to ensure that the responsibility is properly fulfilled. The overseer must ensure that those who hold the responsibility in fact discharge it and are held accountable for their actions and decisions.

One of the most effective ways to promote oversight and accountability is through the development of quality assurance or quality control measures. Quality assurance can take a variety of forms. An example is the peer review of reports of post-mortem examination.

At the institutional level, oversight is the responsibility of those charged with governing the institution. In that sense, effective oversight is an important component of effective governance. As the OCCO is structured at present, the Chief Coroner holds ultimate responsibility to oversee those who do work for the OCCO. The Chief Coroner must ensure that this work is done properly, whether it is the work of coroners or that of forensic pathologists.

A related institutional issue is accountability. To whom is the OCCO accountable and what is the nature of that accountability? In a democratic system of government, every public institution is, in a broad sense, answerable to the public for its activities. From this perspective, the OCCO is accountable for its work and its oversight of death investigations to the public through its governing ministry, the Ministry of Community Safety and Correctional Services. The public ultimately oversees the OCCO's work through the government of the day. If the OCCO fails to properly oversee the work of coroners or forensic pathologists and is not rigorously held to account, public confidence may well be shaken.

But the public rarely has sufficient information or expertise to exercise this role in an effective way. Nor, in many cases, does the ministry. Moreover, there is another consideration that constrains the ministry. In seeking to hold the OCCO accountable for the delivery of first-class death investigations, the ministry must avoid all political interference. Because the public interest requires that the OCCO be objective and independent from government, the ministry's ability to closely monitor the OCCO and hold it accountable is constrained. Although the OCCO is accountable to the government for the public funds it spends, and for adherence to a range of other governmental policies (for example, policies relating to procurement, budgeting, and financial administration), the Chief Coroner must exercise the duties set out in the *Coroners Act*, RSO 1990, c. C.37, in an independent fashion.

Since the ministry can have no more than this general responsibility, it is vital that effective overall oversight of the work of the institution be central to the day-to-day mandate of the OCCO. Individual actors within the institution must be accountable for the performance of their duties. Those who monitor and supervise

their work must be held accountable for that oversight. Various tools such as policies, protocols, guidelines, audits, and reviews must be available to ensure that all the tasks that comprise a quality death investigation are performed as well as possible. But the crucial level of responsibility is that for the OCCO itself. It must be overseen by a governing body that is objective, has the information and expertise needed to set broad directions, can require that they be pursued and ensure that mistakes are prevented or corrected, and can see that problems are identified and addressed and thus guarantee that the public interest is protected.

Governance of the OCCO: Creation of a Governing Council

Our systemic review revealed significant failures in the OCCO's oversight of pediatric forensic pathology from 1981 to 2001. It had no effective systems in place to ensure meaningful and objective oversight of forensic pathologists working pursuant to coroner's warrant. Rather, senior leaders of the institution, Chief Coroner Dr. James Young and Deputy Chief Coroner Dr. James Cairns, had ad hoc responsibility for the oversight of Dr. Charles Smith. This was part of their overall responsibility for the forensic pathologists doing work for the OCCO. As I describe in Volume 2, they failed in this task.

There were a number of reasons, all of which have systemic implications, for their failure to oversee effectively the forensic pathology being done for the OCCO in Dr. Smith's cases. There were few, if any, tools for effective oversight of Dr. Smith's work. More important, although ultimately responsible as its senior leadership for the oversight of the work of the OCCO, Dr. Young and Dr. Cairns lacked any training or expertise to permit them to oversee forensic pathology. Their objectivity, an essential prerequisite of effective oversight, was compromised by a kind of symbiotic relationship with Dr. Smith – as the leaders of the OCCO, they needed him to continue to do his work for the institution, and he needed them to allow him to do so. Their objectivity was further eroded by their long professional friendships with Dr. Smith. They had worked with him in the close confines of the OCCO and the Ontario Pediatric Forensic Pathology Unit (OPFPU) for years. They liked and admired him. They trusted his work as a senior colleague with a faith that the facts could not shake. Over time, this professional closeness left them increasingly incapable of objectively evaluating his work.

Is it a sufficient remedy that their leadership has been replaced by a new cohort of talented individuals? Quite simply, no. It would be wrong to imagine that the conditions in place during the 1990s were a unique confluence of events and that their recurrence could be avoided simply by installing different individ-

uals in the OCCO's leadership positions. A sound system of oversight and accountability cannot rely on who happens to occupy the OCCO's leadership positions at any given time. Systemic change is necessary. First, there must be a governance structure that ensures that those responsible for governing the OCCO have sufficient expertise to provide institutional oversight of the forensic pathology work done for the OCCO. Second, it is essential that those governing the OCCO not suffer the loss of independent judgment and objectivity that came with the professional closeness of the past. The Chief Coroner, then, should no longer be the ultimate level of responsibility for the OCCO. In my opinion, the creation of a Governing Council is required if the OCCO is to provide effective institutional oversight of forensic pathology in the public interest.

Responsibilities of the Governing Council

What should the responsibility of the Governing Council be? Should it be limited to the forensic pathology service provided by the OCCO? My mandate is directed at the oversight of pediatric forensic pathology, but, of necessity, this recommendation must address oversight and accountability for the OCCO as a whole, including the services provided by coroners as well as forensic pathologists. It would be harmful to have a system that properly oversees forensic pathology but did so by creating a silo for that service separate from the coronial service. Forensic pathology is the core specialized discipline in death investigations, but it must work in partnership with the coronial service. As well, as a practical matter, many of the institutional supports required by the forensic pathology service are also required by, and must be shared with, the coronial service. A single governance structure is cost effective, avoids duplication of resources, and encourages coordinated approaches to death investigation. A Governing Council is essential to provide ultimate oversight of the forensic pathology service provided by the OCCO, and there is no reason to think it will do any less for the coronial service.

A Governing Council with responsibility for all of the OCCO has another advantage. A death investigation system in which the public can have confidence must ensure that deaths are subject to objective, independent, and accountable investigations. At present, the Chief Coroner for Ontario is accountable to, and receives limited oversight from, the deputy minister of emergency planning and management of the Ministry of Community Safety and Correctional Services through the commissioner of community safety. However, in accordance with the institutional independence of the OCCO from government, the oversight provided by the commissioner and the deputy minister is limited to administrative and budgetary matters. As a result, the ministry provides little oversight of the

OCCO's management of the substantive aspects of death investigation in Ontario. Under the current regime, given the limits on oversight by government, the Chief Coroner is, in effect, required to serve in functions akin to both chief executive officer (with ultimate responsibility for managing the OCCO) and chair of the board (with ultimate responsibility for oversight of the management of the OCCO). As Professor Lorne Sossin of the University of Toronto told the Inquiry, these dual responsibilities are incompatible with effective accountability, independent oversight, and good governance. They give the appearance that the OCCO's leadership is not subject to independent scrutiny. Nor is it only an issue of appearance. As I describe above, our systemic review has shown that the closeness of the relationships between Dr. Smith and the Chief Coroner and Deputy Chief Coroner undermined the ability of the latter two to scrutinize Dr. Smith's work objectively.

Thus, in my view, the oversight of the OCCO as a whole, both the coronial service and the forensic pathology service, should be shifted to the Governing Council. The Governing Council would oversee both of the major services provided by the OCCO – the coronial service and the new Ontario Forensic Pathology Service (OFPS). The Governing Council would be independent from government, but would report in much the same limited way to the responsible commissioner and deputy minister as the Chief Coroner does now. Unlike the present situation, however, this structure would serve to create a buffer between government and the operational side of death investigations. It would ensure that the OCCO is operationally independent from government. The Governing Council would also assist in ensuring a collaborative relationship between the Chief Coroner and the Chief Forensic Pathologist and would be available to resolve any issues that might arise between them.

In making this recommendation, it is important to underline that the OCCO, which has given this matter careful thought in light of the traumatic events it has had to grapple with, has come to a very similar conclusion. The OCCO sees the creation of a council to provide oversight for death investigations in Ontario, and to have oversight responsibilities for the Chief Coroner and the Chief Forensic Pathologist, as vital in restoring public confidence in Ontario's death investigation system and in ensuring sound oversight. That is an assessment that I share entirely.

Structure of the Governing Council

In considering a proposed structure for the Governing Council, I was influenced by the governance model in place at the Victorian Institute of Forensic Medicine

(VIFM) in Australia. The VIFM is considered, with justification, to be a world-renowned service provider of forensic medicine. It is created by statute, and is managed by a board that is defined in the legislation and that holds the director of the VIFM accountable for the institute's operations. Likewise, the existence and responsibilities of the Governing Council that will oversee death investigations in Ontario should be set out in the *Coroners Act*. It should be defined as the governing body charged with oversight of the OCCO.

I was also guided by the submissions of the OCCO. The OCCO submitted that the principal functions of the Governing Council should be to provide the Chief Coroner and Chief Forensic Pathologist with strategic planning direction, guidance on performance expectations within the OCCO and on ethical issues, and directions concerning operational priorities and achieving high-quality death investigations. This envisages the Governing Council operating much like a board of directors. In my view, these are sound recommendations. The Governing Council should indeed oversee the strategic direction of the OCCO, including both the coronial service and the OFPS. The Governing Council's responsibilities should include budgetary approval, making senior personnel decisions, running the public complaints process, and ultimate oversight of the work of the OCCO.

The Chief Coroner for Ontario should report to and be accountable to the Governing Council for the professional aspects of the coronial service. The Chief Forensic Pathologist should report to and be accountable to the Governing Council for the professional services of the OFPS. In addition, as I discuss below, an executive director should report to and be accountable to the Governing Council for the administration of both the coronial service and the OFPS.

The Governing Council should report on an annual basis to the Ministry of Community Safety and Correctional Services, and the Governing Council's annual report should be made available to the public. The ministry should also retain the ability, as it does now, to fulfill certain functions in relation to the OCCO, including directing an inquest, in accordance with s. 22 of the *Coroners Act*. The Governing Council would also be required to approve the budget and business plans of the OCCO. The executive director would then present the budget and business plans to the ministry for review and final approval.

The membership of the Governing Council should be set by regulation. Appointments to the Council should be made by the Lieutenant Governor in Council, with a fixed term of office. The Chief Coroner and Chief Forensic Pathologist should sit on the Governing Council as ex officio members. The executive director would serve as secretary to the Governing Council and provide it with appropriate administrative support.

The creation of the Governing Council is fundamentally about good governance.

Its membership should therefore be based on competency, not constituency. The membership should form the basis for an independent, multidisciplinary governance body with the skills to ensure meaningful oversight of the death investigation system, including both the coronial service and the forensic pathology service. Members should therefore be senior decision makers from related public institutions with experience acting in the public interest, or their nominees. In order to ensure an independent perspective on forensic pathology services, its membership should also include a certified forensic pathologist from outside of Ontario.

At the Victorian Institute of Forensic Medicine, membership of the board includes the VIFM director, the state coroner, a nominee of the Chief Justice, two nominees from the Attorney General, nominees from the medical schools, a nominee from the Chief Commissioner of Police, and nominees from the ministries of police and emergency services, health, community services, and women's affairs.

In my view, the membership of the Governing Council of the OCCO should, in significant measure, parallel this structure. One exception is the nominee from the police service. In my view, the inclusion of a police nominee would undermine the appearance of independence of death investigations. Equally, given that members of the Governing Council must act in the public interest and must not be seen to serve a particular constituency, it would not be appropriate, for example, to appoint defence counsel to the Governing Council. In my view, constituency-based appointments would simply be inconsistent with the requirement of independent decision making in the public interest. Constituency interests are better accommodated through advisory committees.

As I describe in Chapter 14, Improving the Complaints Process, the Governing Council should have a public complaints committee to address complaints about coroners or pathologists. The complaints committee should be comprised of members of the council, not including any of the OCCO employees. The complaints committee must develop transparent procedures that are fair to both the coroner or pathologist in question and the complainant. The complaints committee would consider complaints not resolved at the first instance to the satisfaction of both the complainant and the coroner or pathologist.

Recommendation 38

The Province of Ontario, having created the Governing Council by statute, should amend the *Coroners Act* to set out the powers and responsibilities of the Governing Council, including

a) oversight of the strategic direction and planning of the Office of the Chief Coroner for Ontario, including the coronial service and the Ontario Forensic Pathology Service;

b) budgetary approval;

c) senior personnel decisions; and

d) administration of the public complaints process.

Recommendation 39

The Chief Coroner should be accountable to the Governing Council for the operation and management of the coronial service. The Chief Forensic Pathologist should be accountable to the Governing Council for the operation and management of the Ontario Forensic Pathology Service.

Recommendation 40

The Governing Council should report annually to the Ministry of Community Safety and Correctional Services. Its annual report should be available to the public.

Recommendation 41

The Province of Ontario should establish the membership of the Governing Council through a regulation to the *Coroners Act*. The Lieutenant Governor in Council should appoint the following members to a fixed term:

- a nominee of the Chief Justice of Ontario. He or she may act as chair of the council, or the chair may be otherwise designated by the Ministry of Community Safety and Correctional Services;
- the Chief Coroner for Ontario;
- the Chief Forensic Pathologist for Ontario;
- the dean of medicine of an Ontario medical school or his or her delegate;
- a nominee of the Minister of Health and Long-Term Care;
- a nominee of the Attorney General of Ontario;
- a nominee of the Minister of Community Safety and Correctional Services;
- the Director of the Centre of Forensic Sciences or his or her delegate; and

- **three others named by the Ministry of Community Safety and Correctional Services, one of whom should be a certified forensic pathologist from outside Ontario.**

Principles for the Oversight of Forensic Pathology

Through its Governing Council, the OCCO needs to ground its oversight of forensic pathology in Ontario in a set of core building blocks or principles. These building blocks will influence how specific oversight and accountability mechanisms are implemented. In my view, the significant deficits demonstrated by our systemic review provide useful guidance in identifying the most important ones. The crucial building blocks include:

- a professionalized and expanded Ontario Forensic Pathology Service;
- clear lines of responsibility for oversight and accountability;
- an institutional commitment to quality; and
- the proper tools for oversight.

A professionalized OFPS, in addition to creating the foundation for high-quality forensic pathology services, will ensure that those who are in positions of oversight will have the expertise necessary to perform their responsibilities. In addition, the creation of the OFPS will encourage the hiring and retention of the forensic pathologists needed to establish effective systems of peer review of the reports, opinions, and testimony of forensic pathologists in individual cases.

Our systemic review also demonstrated the pitfalls of poorly defined responsibilities for oversight and accountability. The Governing Council must ensure that these responsibilities are clearly articulated within the OCCO as a whole, within the OFPS, and between the coronial service and the forensic pathology service.

The Governing Council must charge the OCCO's leadership with the creation of an institutional commitment to quality with core values that emphasize the pursuit of excellence, the importance of teamwork, and the need for collegiality and knowledge sharing. The OCCO has suggested that it create a strategic plan including "[a] culture of quality and performance excellence," "[a] dedication to peer review," and "[a] re-dedication to seeking the truth, using the scientific method, and developing evidence-based practice." These are the kinds of core values and principles that the coronial system and the OFPS should adopt in order to provide meaningful oversight.

Finally, the Governing Council must ensure that those charged with responsi-

bility for oversight have the necessary tools to allow them to discharge that responsibility. The kinds of tools that can be used are outlined below.

Recommendation 42

The Governing Council should guide the development of quality assurance, oversight, and accountability mechanisms for the work of the Office of the Chief Coroner for Ontario, including both the Ontario Forensic Pathology Service and the coronial service.

Institutional Improvements

The institutional arrangements for the oversight of forensic pathology in the 1980s and 1990s were inadequate. Future arrangements need to include systems such as a registry of pathologists who are permitted to conduct coroner's autopsies. In addition, clarity is needed to define the reporting relationships among the Chief Coroner, Chief Forensic Pathologist, and the Governing Council. Finally, an executive director should assume the burden of administrative responsibilities.

Need for a Registry of Forensic Pathologists

Our systemic review revealed that, in the 1990s, pathologists in Ontario were enlisted to perform coroner's warrant work, including cases that were criminally suspicious, without regard for their training and experience in forensic pathology. The main example, of course, is that criminally suspicious pediatric cases were deliberately triaged to Dr. Smith without any appreciation of his woefully inadequate training in forensic pathology.

During the 2000s, the new leadership of the OCCO has introduced policies to attempt to ensure that pathologists performing criminally suspicious cases have the skills and expertise required. In 2005, the OCCO's Guidelines on Autopsy Practice for Forensic Pathologists: Criminally Suspicious Cases and Homicides introduced a requirement that only a forensic pathologist – defined as a certified anatomical or general pathologist with specific training or certification in forensic pathology and/or recognized experience as a forensic pathologist – may perform autopsies in criminally suspicious cases. The revised October 2007 Guidelines on Autopsy Practice for Forensic Pathologists: Criminally Suspicious Cases and Homicides (the Autopsy Guidelines) added that only forensic pathologists "with pediatric forensic experience" or pediatric pathologists "with significant forensic experience" may perform autopsies in

criminally suspicious deaths of infants or children.

These provisions in the Autopsy Guidelines are good first steps. However, as policy instruments without any meaningful enforcement mechanisms, they are limited in their ability to ensure that forensic pathologists doing coroner's cases meet and maintain specified standards of competence. To build on the improvements already made by the OCCO, some additional mechanisms are needed. As referred to in Chapter 11, Professionalizing and Rebuilding Pediatric Forensic Pathology, a central feature of the proposed OFPS is the creation of a publicly accessible registry of forensic pathologists. The Registry is a vital tool for maintenance of quality control in the forensic pathology used in death investigations. It would help ensure that pathologists involved in death investigations maintain high standards within their profession in relation to their education, skills, and performance. The Chief Forensic Pathologist would be able to use the Registry to institute remedial measures if serious issues arose concerning either the competence of, or any excessive delays in criminal proceedings caused by, forensic pathologists on the Registry. Continued inclusion in the Registry would depend on a willingness to engage in remediation. And, ultimately, if necessary, a competent service could be ensured by the removal of the offending pathologist. Of course, such action would require a corollary process of appeal – for example, to a committee of the Governing Council, in cases of alleged unfair sanctions.

Structure and Establishment of the Registry

The broad concept for the Registry I propose is similar to the model provided by the Home Office Register of Accredited Forensic Pathologists in place in the United Kingdom. It was described by a number of witnesses at the Inquiry. Needless to say, the specifics of the Registry need to reflect the unique characteristics of the practice of forensic pathology in Ontario.

The design of the Registry should be developed and its workings administered by the Chief Forensic Pathologist. As outlined in Chapter 12, Reorganizing Pediatric Forensic Pathology, the new provisions of the *Coroners Act* outlining the responsibilities of the Chief Forensic Pathologist should include his or her responsibility for administering a list of forensic pathologists approved to perform coroner's autopsies. The Governing Council must oversee the Chief Forensic Pathologist's work in establishing the structure and the criteria for the Registry and give final approval to its design.

As its most central function, the Registry would designate the forensic pathologists who, because of their experience and expertise, are approved to conduct autopsies under coroner's warrant. Since different skill sets are required for differ-

ent types of cases, the Registry should be divided into specific tiers with, at a minimum, three categories: forensic pathologists approved to perform criminally suspicious adult cases, those approved to perform criminally suspicious pediatric cases, and those approved to perform routine coroner's cases only.

In the immediate future, during the transition to a professionalized OFPS, some grandparenting will be necessary to allow pathologists with significant experience or training in forensic pathology, but without formal certification in the discipline, to continue to perform criminally suspicious cases. The development of specific grandparenting provisions should be left to the discretion of the Chief Forensic Pathologist. As the profession of forensic pathology in Ontario evolves, the criteria for admission to the Registry, and in particular for inclusion in the tiers for performance of criminally suspicious cases, will undoubtedly become more rigorous. As soon as it is practicable, only certified forensic pathologists should be placed on the Registry to perform criminally suspicious cases. The criteria for performing routine forensic autopsies will undoubtedly be more flexible and may vary based on the skill and experience of the pathologist.

The Registry should include procedures for admission to, renewal on, and removal from the Registry. In guiding the development of these procedures, the Governing Council should emphasize the principles of quality, transparency, and fairness to individual forensic pathologists. The Chief Forensic Pathologist will be charged with establishing the specific criteria for forensic pathologists who seek admission or reappointment to the Registry. Central consideration should be given to their academic training and professional experience. Once the initial criteria for appointment are met, reappointments may consider additional criteria such as continuing medical education, involvement in teaching and/or research activities, peer review of courtroom testimony, and participation in the peer review of others. As a condition of inclusion, members of the Registry will have to comply with the relevant polices, protocols, practice guidelines, and codes of conduct issued by the Chief Forensic Pathologist or the OCCO.

Oversight and assessment of forensic pathologists on the Registry will be aided by the peer review processes outlined below. If the Chief Forensic Pathologist becomes concerned about the work of a forensic pathologist, he or she may take appropriate remedial or corrective measures, up to and including the removal of the pathologist from the Registry. The Governing Council should develop a mechanism for review of the exercise of the Chief Forensic Pathologist's authority in relation to the Registry. This review would allow a form of appeal where a forensic pathologist is dissatisfied with the actions of the Chief Forensic Pathologist.

Recommendation 43

The Ontario Forensic Pathology Service should create a publicly accessible Registry of pathologists who have been approved to perform post-mortem examinations under coroner's warrant.

Recommendation 44

The Chief Forensic Pathologist should have responsibility for administering the Registry.

Recommendation 45

With the approval of the Governing Council, the Chief Forensic Pathologist should design the details of the Registry, including fair and transparent procedures for admission, renewal, and removal. The Registry should have separate categories for those forensic pathologists approved to perform criminally suspicious adult cases, those approved to perform criminally suspicious pediatric cases, and those approved only to perform routine coroner's cases.

Recommendation 46

As the Ontario Forensic Pathology Service grows in size and skill, the criteria for inclusion in the Registry should become more rigorous. As soon as possible, only certified forensic pathologists should be approved to perform criminally suspicious adult cases and only certified forensic pathologists with significant pediatric forensic experience should be approved to perform criminally suspicious pediatric cases.

Clarifying Relationships

Accountability of the Chief Coroner and the Chief Forensic Pathologist

Many difficulties can arise if the Chief Coroner is charged with oversight of forensic pathology. In a number of the cases we examined, the Chief Coroner or Deputy Chief Coroner assumed the major role in overseeing Dr. Smith's pathology work. Their oversight failed in part because of their lack of expertise in the highly specialized science of forensic pathology.

The positions of Chief Coroner and Chief Forensic Pathologist should become parallel positions with separate responsibilities for, respectively, the coronial service and the OFPS. The Chief Forensic Pathologist would therefore be responsible and accountable for the professional work and budget of the OFPS, and would report to the Governing Council and be accountable to it for the operation of the OFPS. As I describe in Chapter 12, Reorganizing Pediatric Forensic Pathology, the fundamental duties and responsibilities of the Chief Forensic Pathologist would be set out in the legislation. The Chief Coroner would be responsible for the professional work of the coronial service, as outlined in the *Coroners Act*, and would report to the Governing Council and be accountable to it for the operation of the coronial service.

As further detailed in Chapter 12, the hierarchy for the new OFPS will clarify oversight and accountability relationships within the forensic pathology service. The Chief Forensic Pathologist will provide overall oversight of the OFPS, including the work of all pathologists performing coroner's cases. The Chief Forensic Pathologist will also supervise the work of the Deputy Chief Forensic Pathologist(s). The directors of the regional units will oversee, and be responsible for, the forensic pathology conducted in their regions, whether at their unit or at another hospital.

In its closing submissions to the Inquiry, the OCCO proposed that the Chief Forensic Pathologist should remain accountable to the Chief Coroner for the provision of forensic pathology services. I recognize the attraction of this argument. The OFPS is essentially a service provider for the coronial service in the death investigation process. Therefore, at first blush, it seems that the Chief Coroner should be able to exercise oversight where, for example, delays in a pathologist's reports are interfering with the work of the coronial service.

In my view, however, a clear definition of this proposed accountability would remain so elusive as to be a constant impediment to sound governance. It is far better to have the clarity that comes with giving the Chief Coroner and the Chief Forensic Pathologist professional responsibility for the oversight of their respective services. The accountability of each is then clear; each would be accountable to the Governing Council. Each is then able to focus on achieving professional excellence for his or her service. Not only does this minimize the risk of disputes between them due to ambiguity of reporting relationships, but it also permits the Governing Council to resolve any disputes that do arise.

Administrative Responsibilities for the Coronial Service and the OFPS

Administrative responsibilities for management of the OCCO are significant. Currently, the Chief Coroner retains a major administrative burden, including indirect oversight of a staff of 84 people. It is important that administrative responsibilities not impede the professional oversight needed from both the Chief Coroner and the Chief Forensic Pathologist.

To allow the Chief Coroner and the Chief Forensic Pathologist to devote their time and attention to the enhancement and development of the professional capacities of the coronial service and the OFPS, an executive director should be appointed with responsibility for the administration required by both the coronial system and the OFPS. The executive director's administrative responsibilities would include, for example, human resources, support services, and physical plant services. The executive director would report directly to the Governing Council. This structure is preferable to that where the Chief Coroner has administrative responsibility for the entire OCCO.

Recommendation 47

The Governing Council should appoint an executive director with responsibility for the administration of both the coronial service and the Ontario Forensic Pathology Service.

Chief Coroner and Chief Forensic Pathologist as Full-Time Positions

Our systemic review has also demonstrated that oversight suffered under the leadership of a Chief Coroner who was not engaged full-time in that office and who was burdened by other significant and time-consuming positions that he held simultaneously. The problem was compounded by the fact that the Chief Coroner's other positions were senior positions in government, diminishing the appearance of accountability of the OCCO.

In order for the holders of the positions of Chief Coroner and Chief Forensic Pathologist to fulfill their obligations properly, both positions must be full-time. At the same time, the full-time position should allow the Chief Forensic Pathologist to engage in teaching and research because of the importance of both to the development of a professionalized service. I suspect the same is true for the Chief Coroner and the coronial service.

Recommendation 48

The positions of Chief Coroner and Chief Forensic Pathologist should be full-time.

Contractual Relationships with Regional Forensic Pathology Units

As discussed in detail in Chapter 12, Reorganizing Pediatric Forensic Pathology, the service agreements between the OCCO and hospitals regarding the regional forensic pathology units need to be revised to clarify the oversight and accountability relationships.

The agreements should also be amended to create greater accountability through the use of specific quality assurance measures. They should stipulate that every forensic pathologist at a unit that provides services to the OFPS must be included on the Registry. They should explicitly outline each regional director's responsibilities for oversight of, and quality assurance for, forensic pathologists performing coroner's autopsies within the geographical area of the unit. The agreements should also introduce requirements regarding reporting relationships – for example, that the regional director must report to the Chief Forensic Pathologist regarding the unit's practices for peer review and consultation. The service agreements should also incorporate timeliness requirements for the production of reports of post-mortem examination.

Forensic Pathology Advisory Committee

It is vital that the OFPS create a culture of teamwork and collegiality. As we have seen, working in isolation is a route to error. To advance that teamwork goal, the Chief Forensic Pathologist should seek the counsel of other leaders in forensic pathology in the province. The OCCO recommended the creation of a Forensic Pathology Advisory Committee (FPAC). I agree with this recommendation. The FPAC would be created within the OFPS. Its members would include the directors of the regional forensic pathology units. Rather than provide case-specific advice, the FPAC would provide the Chief Forensic Pathologist with assistance in setting objectives, policies, protocols, and guidelines for the provision of forensic pathology services across the province. The FPAC would assist in improving quality processes, and would also enhance the relationship between the Chief Forensic Pathologist and the regional units. It would assist the Chief Forensic Pathologist in addressing issues specific to Ontario's various regions.

In addition, our systemic review demonstrated the danger of concentrating

power and expertise in a single individual. This institutional structure will help guard against that risk.

Recommendation 49

A Forensic Pathology Advisory Committee should be formed to advise the Chief Forensic Pathologist in setting objectives, policies, protocols, and guidelines for the provision of forensic pathology services. Its membership should include the regional directors.

Tools for Oversight and Accountability of Forensic Pathologists' Work

Forensic pathologists act as individual experts when providing forensic pathology opinions and services to the justice system. They do not represent an institution or provide an institutional opinion. The role of the OFPS as overseer of forensic pathology services is to ensure that the appropriate safeguards are in place to ensure the reliability of these individual expert opinions. The OFPS must make certain that appropriately qualified persons are appointed and adequate quality control mechanisms are in place. This is especially true for the most difficult cases, including criminally suspicious pediatric deaths.

Since 2001, the OCCO has greatly improved the tools available for proper oversight of forensic pathology. During the 1980s and 1990s, these tools were limited and, at times, non-existent. The OCCO has, to the best of its abilities in the context of limited financial and professional resources, supported the development of an evidence-based, professionalized forensic pathology service. In this section, I discuss how the OFPS can build on those improvements.

I am aware that additional accountability and oversight mechanisms may place further workload demands on the limited number of forensic pathologists in Ontario. This increased workload is a serious factor to consider. I expect that the Chief Forensic Pathologist will need to weigh carefully workload demands involved in implementing new oversight mechanisms. However, quality of service must remain paramount. That is the lesson to be learned from allowing Dr. Smith to continue in part because there was no one else to do the work.

Quality Assurance Staff

Until recently, the OCCO did not emphasize the quality management of forensic pathology. It still lacks the resources to create a quality assurance unit. In moving

forward, the OCCO must develop a comprehensive quality management philosophy with adequate structures in place to implement that philosophy.

In considering what might be necessary to raise the profile of quality assurance at the OCCO, I am guided by the experiences of other institutions that provide forensic services. Both the Centre of Forensic Sciences (CFS) and the Victorian Institute of Forensic Medicine have formal quality assurance units with dedicated staff. The VIFM has a quality review committee, which accumulates data from the quality management system and provides it to the internal leadership and the VIFM council.

The OFPS must have qualified staff dedicated to quality assurance. There should be a full-time quality assurance manager with a mandate to oversee the quality assurance mechanisms in place at the OFPS. He or she should be responsible for tracking the success of quality management measures so that, through the Chief Forensic Pathologist, this information can be relayed to the Governing Council. Indeed, it may be appropriate for the Governing Council to establish a committee to oversee the work of the quality assurance staff. It would also seem reasonable that the quality assurance manager have responsibility for quality assurance throughout the OCCO. But at a minimum, a dedicated quality assurance manager is necessary for the OFPS.

Recommendation 50

The Ontario Forensic Pathology Service should appoint dedicated quality assurance staff, including a full-time quality assurance manager, to track quality assurance mechanisms.

Policy Guidelines

Policies and standards are a useful means of assuring quality. They clarify expectations for pathologists doing forensic work and encourage consistency of practice and methodology. Our systemic review demonstrated that, before 2001, there were few policy guidelines and standards designed to assist pathologists in performing coroner's autopsies or in their testimony and interaction with the criminal justice system.

The new leadership of the OCCO has developed policies and guidelines reflecting its recognition of the need for an evidence-based, professionalized forensic pathology service. The primary focus of recent policies, such as the province-wide Autopsy Guidelines for criminally suspicious cases, has been on the proper analytical approach or mindset for the forensic pathologist – open-minded, objective, and evidence based.

I endorse the general direction of the OCCO in its recent policies. The Autopsy Guidelines are in line with the best practices for oversight of criminally suspicious cases adopted in other jurisdictions. My main recommendations to improve and build on the current guidelines and policies are set out in my discussion of the best practices in forensic pathology in Chapter 15, Best Practices, and effective communication in Chapter 16, Effective Communication with the Criminal Justice System.

Peer Review – Consultation with Chief Forensic Pathologist

In the 1990s, then Chief Forensic Pathologist Dr. David Chiasson encouraged forensic pathologists to consult him for advice about their difficult cases. He received a mixed response. Some pathologists contacted him frequently about difficult cases, but others, often the more senior pathologists, did not. He had no power to do anything about this unwillingness to seek his advice.

In recent years, policies and guidelines issued by the OCCO have highlighted the Chief Forensic Pathologist's role in quality control. The Autopsy Guidelines mandate notification of the Chief Forensic Pathologist in all criminally suspicious cases, and encourage consultation with the Chief Forensic Pathologist in difficult or contentious cases. This system is preferable to relying on forensic pathologists' individual judgments about when to consult with the Chief Forensic Pathologist.

Peer Review of Reports of Post-Mortem Examination

Peer review of autopsy reports is central to an effective quality assurance system in criminally suspicious cases. It is, quite simply, the best way to assess a pathologist's work in a difficult case before the work enters the criminal justice system. Reports of post-mortem examination in criminally suspicious deaths, particularly pediatric deaths, must receive the highest level of scrutiny.

In the 1980s and early 1990s, there was no real quality control of the work of pathologists in these cases. In the mid-1990s, Dr. Chiasson began to review, personally, all reports of post-mortem examination in criminally suspicious cases. However, Dr. Chiasson's paper review was only that. It was inadequate to catch many of the most serious problems.

The OCCO's new leadership has greatly improved the procedures for peer review of reports of post-mortem examination in criminally suspicious cases. As of August 2004, the directors of the regional units assumed responsibility for

review of autopsy reports in their units. As set out in the Autopsy Guidelines, all autopsy reports in criminally suspicious cases are now peer reviewed by the Chief Forensic Pathologist, a regional director, or a staff forensic pathologist at the Provincial Forensic Pathology Unit (PFPU) before they are released to the coroner and the criminal justice system. The regional directors review the reports of other pathologists within their units, while the Chief Forensic Pathologist reviews the reports of the regional directors. The Chief Forensic Pathologist's reports are reviewed by his colleagues at the PFPU or by a regional director; and, within the PFPU, staff forensic pathologists provide peer review of their colleagues' reports. In the unusual instance of criminally suspicious cases performed outside of a forensic pathology unit, such as at the Winnipeg Health Sciences Centre, the Chief Forensic Pathologist generally reviews the reports.

The extent of the current peer review of reports of post-mortem examination in criminally suspicious cases is more comprehensive than Dr. Chiasson's paper review in the 1990s. The originating forensic pathologist is asked to submit all necessary materials to the reviewing forensic pathologist, including the report, background information, images from the gross examination, ancillary reports, and, in some cases, histology slides. If necessary, as in most pediatric homicides, the histology is examined. The peer review form provided in the Autopsy Guidelines requires the reviewing forensic pathologist to indicate whether he or she agrees with the cause of death and the other forensic opinions. Agreement is an appropriately high standard. This requirement is more rigorous than peer review processes at the CFS and VIFM, which require only that the reviewing scientist find the conclusions reasonable.

The Autopsy Guidelines also incorporate a process for further examination where there is a difference of opinion between the originating and the reviewing forensic pathologists. If there is a significant difference of opinion about the cause of death or other major forensic issues between the originating and reviewing forensic pathologists, the Chief Forensic Pathologist is notified. The Chief Forensic Pathologist undertakes a comprehensive review and prepares a written report.

The OCCO's model for peer review of criminally suspicious cases has provided a template for other jurisdictions in developing their peer review structures. The VIFM developed its peer review process in or around 2006 based on the OCCO's advances. I commend the OCCO on its current peer review system for criminally suspicious cases and recommend that this system continue.

In Ontario, the process for review of reports of post-mortem examination applies only to reports in cases giving rise to criminal suspicions. Within the forensic pathology units, peer review in non-criminally suspicious cases is undertaken

at the discretion of the directors and, as a result, reviews vary in their frequency, scope, and procedures. Some of the regional directors review all coroner's cases, while others conduct only random or sporadic reviews. To ensure that forensic pathologists at the forensic pathology units receive continuing feedback about their work, I recommend that the OFPS require some peer review of all reports of post-mortem examination in coroner's cases where the autopsy is conducted at one of the regional forensic pathology units or the PFPU. This review can be undertaken by a colleague (rather than the regional director or Chief Forensic Pathologist) and does not need to mirror the complete review undertaken in criminally suspicious cases.

Given limited human resources, I do not think it is feasible at present to expect the formal peer review process to extend to non-criminally suspicious autopsies conducted outside of the forensic pathology units.

Peer Review of Supplementary and Consultation Reports

A very significant failure in the peer review system in the 1990s was the lack of review of supplementary and consultation reports. 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. In addition, there were no mechanisms in place to examine supplementary reports. As a result, he did not review Dr. Smith's consultation work or supplementary opinions. These failures allowed significant errors to go undetected.

The current procedures for peer review as set out in the Autopsy Guidelines do not provide for peer review of supplementary or consultation opinions in criminally suspicious deaths. Unless the supplementary opinion is the result of the peer review process itself, there is no process in place allowing the Chief Forensic Pathologist or directors of the regional forensic pathology units to review supplementary reports provided by pathologists after the initial report of post-mortem examination. Dr. Michael Pollanen, the Chief Forensic Pathologist, indicated that such a process would be desirable. I agree.

I recommend that a peer review process be developed for supplementary and consultation opinions in criminally suspicious cases in order to ensure their quality. The peer review process should be set out in the Autopsy Guidelines.

Quality Control during Rounds

Peer review through consultation during rounds is an important aspect of sound medical practice – it may ensure that significant findings are not missed. In the

1990s, there were some opportunities for review of forensic pathology work through rounds at hospitals housing regional forensic pathology units. However, in part because of concerns about the effect on ongoing criminal investigations, the rounds often did not include discussion of criminally suspicious cases. That has changed for the better, and, currently, rounds at the regional forensic pathology units include discussion of criminally suspicious cases.

Although the current system of rounds provides some quality assurance, more can be done to ensure the comprehensiveness of consultations at the regional forensic pathology units. As opposed to the VIFM, which is able to ensure frequent consultations between pathologists who work within one centralized unit, the forensic pathology services in Ontario face the burden of having forensic pathologists – of necessity – located in regional centres that are far apart. In order to enable peer review among colleagues at the various regional forensic pathology units, telemedicine technology should be utilized.

The Chief Forensic Pathologist should endeavour to enhance the telecommunication facilities between the PFPU and the regional forensic pathology units. By linking the regional units using telemedicine technology, consultation between forensic pathologists, as well as with other experts, can occur in real time or at daily conferences. Telemedicine portals should be situated in the PFPU and the regional forensic pathology units. Adequate funding is required for these facilities.

In addition, best practices should be developed at the regional forensic pathology units – as are currently in place at the PFPU – for daily morning rounds for review of cases. Directors of the regional forensic pathology units should be required to report to the Chief Forensic Pathologist regarding the consultation opportunities within their units.

Recommendation 51

In order to enhance quality assurance of the work of pathologists, the Ontario Forensic Pathology Service should

a) **in accordance with the October 2007 Autopsy Guidelines, continue to require direct notification of the Chief Forensic Pathologist of preliminary autopsy results in all criminally suspicious deaths;**

b) **in accordance with the October 2007 Autopsy Guidelines, continue to require full peer review of all reports of post-mortem examination in criminally suspicious cases by either a regional director, a staff pathologist at the Provincial Forensic Pathology Unit, or the Chief Forensic Pathologist or designate;**

c) develop a system for peer review of reports of post-mortem examination in non-criminally suspicious cases where the autopsy was conducted at a regional forensic pathology unit or the Provincial Forensic Pathology Unit. The review system may be less comprehensive than the peer review system for criminally suspicious cases;

d) develop a system for peer review of opinions made supplementary to the report of post-mortem examination in criminally suspicious cases;

e) develop a system for peer review of consultation opinions in criminally suspicious cases; and

f) develop best practices for daily morning rounds at the regional forensic pathology units. The regional directors should report to the Chief Forensic Pathologist regarding implementation of these best practices.

Annual Performance Reviews

The evidence revealed that there are currently no formal systems in place – other than some review of individual autopsy reports – to review the overall performance of pathologists conducting criminally suspicious autopsies within the regional units or to review the performance of the regional directors. Even though the OCCO does not have a direct employment relationship with forensic pathologists performing coroner's work on a fee-for-service basis, it must exercise some oversight of performance.

I recommend that the Chief Forensic Pathologist immediately institute a program of annual performance reviews. He or she should review the work of the directors of each of the forensic pathology units. The directors should, in turn, conduct annual performance reviews of the forensic pathologists doing work for the OCCO within their units. I recognize that this does not provide for performance assessments of pathologists performing coroner's autopsies outside of the forensic pathology units. However, since these pathologists will not be conducting either criminally suspicious adult cases or pediatric cases, particularly criminally suspicious pediatric cases, review of their performance is less urgent. The Chief Forensic Pathologist, at his or her discretion, may in future decide to implement a more complete system of performance reviews.

Recommendation 52

The Chief Forensic Pathologist should institute a program of annual performance reviews. He or she should conduct annual performance reviews of the work of the regional directors. The regional directors should conduct annual performance reviews of the work of forensic pathologists within their units.

Oversight of the Chief Forensic Pathologist

In the 1990s, as the director of the OPFPU at the Hospital for Sick Children, Dr. Smith was widely perceived as the "go-to" pathologist for child abuse and homicide cases in Ontario, and as the leading expert in pediatric forensic pathology. Dr. Smith's reputation in the field clearly left some Ontario pathologists unwilling to challenge and review his opinions. This situation demonstrates a problem for effective oversight of the casework of those perceived to be at the top of the profession.

Two steps must be taken to address this issue. First, as the many internationally renowned experts from whom we heard emphasized, it is very important that the OFPS create a culture in which colleagues feel comfortable critiquing the work of senior members of their institutions. It is crucial that the Chief Forensic Pathologist and the senior leadership of the OFPS lead the way in creating this institutional culture, by encouraging challenges to their own work and being open to accepting constructive criticism from juniors.

Second, the Autopsy Guidelines provide that the Chief Forensic Pathologist's reports are reviewed either by a colleague at the PFPU or by a director of a regional forensic pathology unit. This system for peer review of the Chief Forensic Pathologist's work is in line with practices at other institutions. However, some additional measures are required to ensure that the experience with Dr. Smith is not repeated. Forensic pathologists external to the province are more likely to be immune to hidden pressures that may accompany the review of the work of a senior colleague with an excellent reputation. Therefore, I recommend that out-of-province expertise be employed from time to time to review the casework of the Chief Forensic Pathologist on a random basis. The Forensic Pathology Advisory Committee should consider whether this technique should be extended to other senior leaders of the OFPS.

Recommendation 53

The Chief Forensic Pathologist and the senior leadership of the Ontario Forensic Pathology Service should lead the creation of a culture in which constructive criticism of a forensic pathologist's work is encouraged regardless of position and reputation.

Recommendation 54

In order to ensure adequate oversight of the casework of the Chief Forensic Pathologist, beyond that provided for in the October 2007 Autopsy Guidelines, out-of-province expertise should be used on a random basis to assess the casework of the Chief Forensic Pathologist.

Committee Development

When Dr. Barry McLellan became Chief Coroner in 2004, the OCCO had a well-developed system of committees for review of pediatric cases – namely the Paediatric Death Review Committee (PDRC) and the Deaths under Two Committee. The main change under the new leadership has been the expansion of the mandate of the Deaths under Two Committee (renamed the Deaths under Five Committee as of October 2006) to include review of all death investigations relating to children under the age of five years. The Deaths under Five Committee, whose membership includes a number of forensic pathologists, reviews all deaths of children under five years to assess the accuracy of the cause and manner of death determinations.

In addition, in 2004, under Dr. McLellan's leadership, the Forensic Services Advisory Committee (FSAC) was created. It is a multidisciplinary committee designed to provide independent and external advice to the Chief Coroner in order to ensure the quality and independence of post-mortem examinations in coroner's cases. The FSAC was created in part to respond to the concerns raised by criminal defence lawyers about the OCCO's perceived lack of objectivity. The FSAC generated a list of forensic pathologists willing to provide opinions to the defence. It addressed the education of forensic pathologists. It also played a central role in determining the scope and process of the Chief Coroner's Review.

I recommend that the work of the PDRC, the Deaths under Five Committee, and the FSAC continue. They provide valuable mechanisms for enhancing quality and bringing a multidisciplinary perspective and insight to the OCCO's death investigations.

Recommendation 55

The Paediatric Death Review Committee, the Forensic Services Advisory Committee, and the Deaths under Five Committee should continue.

A Central Tracking System for Forensic Cases

The OCCO's inability to track criminally suspicious pediatric cases through the criminal justice system was one factor in its failure to properly oversee the delivery of forensic pathology services. For example, in 2001, defence counsel asked the OCCO to review Dr. Smith's work in Valin's case. Since the OCCO had no good system for tracking events in the case, it was completely unaware that Dr. Smith had provided an expert opinion and had testified at the trial. That made oversight difficult, to say the least.

The OCCO's inability to track cases makes it more difficult to monitor the timely production of autopsy reports. As discussed in more detail in Chapter 15, Best Practices, the OCCO had, and currently has, no mechanism to track delays by forensic pathologists in producing reports.

The OCCO and the OFPS should develop a system to track cases in the criminal justice system in which their professionals continue to be involved. The system can be loosely modelled on the current dispatch system for Toronto, which tracks coroner's cases through a centralized computer system. When someone in Toronto requires a coroner, he or she calls a central number for the dispatching of a coroner. Information about the case, including the post-mortem examination, is entered into the centralized computer system.

From the perspective of my mandate, such a tracking system need only include the approximately 7,000 annual coroner's cases involving forensic pathology work. However, it may be practical and cost-effective to track all 20,000 of the OCCO's annual cases.

As outlined in the OCCO's final submissions to the Inquiry, a province-wide coroner's dispatch and tracking system would allow for immediate entry and tracking of all coroner's death investigations. It would assist the Chief Forensic Pathologist in directing post-mortem examinations to appropriate forensic pathologists and facilities. It would also allow the Chief Forensic Pathologist to track which forensic pathologist is involved in a case, as well as the progress of the case after completion of the report of post-mortem examination and, subsequently, through the judicial process. In addition, and importantly, it would allow the Chief Forensic Pathologist – who will be responsible for the timely production of reports – to monitor the timeliness of reports of post-mortem examina-

tion. Finally, the tracking system could be used by the regional directors, regional coroners, and the Chief Coroner in fulfilling their responsibilities for individual death investigations.

The tracking system must include as well mechanisms for tracking consultation opinions, supplementary opinions after the initial report of post-mortem examination, and the giving of evidence in criminal proceedings.

The OCCO and OFPS will require adequate resources in order to implement a central tracking system.

Recommendation 56

The Office of the Chief Coroner for Ontario should implement a central tracking system for, at a minimum, coroner's cases in which post-mortem examinations are conducted. The Province of Ontario should provide the resources necessary to create, implement, and administer the central tracking system.

Evaluation of Pathologists' Testimony

Some of the most serious concerns about the work of forensic pathologists in criminal proceedings from 1981 to 2001 concerned communications with other participants in the criminal justice system and testimony in court. One basic failing was that the OCCO was, in some cases, unaware of the problems. At present, the OCCO has no mechanisms in place to review the courtroom testimony of forensic pathologists or the opinions a forensic pathologist provides to Crown counsel or police, or to discover and review adverse judicial comment.

What is the best way to review a pathologist's work after the final report of post-mortem examination is produced? There are a number of possible models used by other institutions and jurisdictions. The Centre of Forensic Science's accreditation system requires a review of the testimony of each scientist once a year. CFS managers attend court to observe CFS scientists giving evidence. If it is not possible to conduct an in-person review while a scientist is testifying, a CFS manager reviews the transcript. The CFS also has a system in place whereby, after a CFS scientist testifies, the CFS requests that Crown and defence counsel complete a questionnaire reporting on the scientist's work.

The VIFM requires that, at least once a year, each forensic pathologist be accompanied to court by another forensic pathologist. The reviewing forensic pathologist completes an evaluation form addressing issues such as appearance and conduct, as well as technical issues regarding use of appropriate language and ability to present scientific evidence. Dr. Jack Crane, the state pathologist for

Northern Ireland, also often attends court to observe his junior staff.

In my view, the OFPS should implement a system of annual peer review of testimony by OFPS pathologists in criminal cases. The review should be documented and encompass a process of discussion and feedback.

At the PFPU, a process for peer review of testimony can be put in place directly through the Chief Forensic Pathologist. In order to entrench the practice at the regional forensic pathology units, the directors of the units should be required to document and report on such peer review of testimony on a regular basis. It is not necessary or practical to also review the transcripts of forensic pathologists' evidence on a regular basis, although that may be necessary if significant concerns arise.

There should also be some form of oversight of forensic pathologists' more informal consultations with Crown and defence counsel. The OFPS should develop a program to obtain feedback from defence and Crown counsel regarding the work of forensic pathologists in criminal proceedings. This could mirror the CFS's court-monitoring program, and could be administered by the OFPS's quality management staff.

In Chapter 17, The Roles of Coroners, Police, Crown, and Defence, I outline the need for Crown counsel to bring adverse judicial comments to the attention of his or her supervisor and to the division lead for child homicide cases, who should report such comments or concerns to the Chief Forensic Pathologist. The Chief Forensic Pathologist should review any adverse comments by judges brought to his or her attention and take whatever steps are appropriate as a result.

Recommendation 57

In order to enhance quality assurance of the work of forensic pathologists during criminal proceedings, the Ontario Forensic Pathology Service should develop

a) a system of peer review of testimony given by forensic pathologists in criminal proceedings; and

b) a program to obtain feedback from defence and Crown counsel regarding the work of forensic pathologists in criminal proceedings.

Recommendation 58

Where brought to his or her attention, the Chief Forensic Pathologist should review any adverse comments made by judges about the work of forensic pathologists in criminal proceedings, and take whatever steps are appropriate as a result.

Accountability to External Standards and Review Mechanisms

Our systemic review demonstrated that objective oversight may be hindered by close professional relationships. When people work together in small groups, they may have difficulty challenging the work of their colleagues. In order to maintain quality, external and impartial review mechanisms are required.

Experts who appeared at the Inquiry emphasized the importance of external quality assurance programs in addition to internal peer review. I heard evidence about the various external review processes in place at other institutions. In Australia, the VIFM engages in external proficiency testing programs that assess the performance of the pathologists as a group. In Northern Ireland, external audits are conducted of the work done at the State Pathologist Office. In the United Kingdom, all Home Office pathologists must submit a number of their cases for review by the Scientific Standards Committee.

In Ontario, there is no external review mechanism in place to review the collective work of the PFPU or the regional forensic pathology units. Neither the PFPU nor any of the regional forensic pathology units are accredited by an external agency. In addition, no external reviews are conducted of autopsy reports produced in the units.

I recommend that random external audits be implemented on a regular – perhaps annual – basis of sample reports of post-mortem examination generated within each regional forensic pathology unit and the PFPU. The reviewer must be a forensic pathologist external to the forensic pathology unit, and should be external to the OFPS if possible. This will ensure an independent perspective of the work of Ontario forensic pathologists conducting criminally suspicious cases.

In addition, the OFPS should make itself accountable to the best external organization(s) that benchmark such services, such as the National Association of Medical Examiners (NAME), a U.S. organization dedicated to the improvement of death investigations. NAME conducts an inspection and accreditation program for forensic death investigation offices, including an inspection checklist and a set of policies and procedures. Although accreditation by an organization such as NAME is likely not yet feasible, given the OFPS's current facilities, accreditation by such an external assessor should be a long-term goal of the OFPS. The OFPS should invite review of its quality assurance work by external organizations.

Recommendation 59

In order to ensure quality through impartial review mechanisms, the Ontario Forensic Pathology Service should

a) **develop a system of random external audits of a sample of autopsy reports from the regional units and the Provincial Forensic Pathology Unit; and**

b) **strive to make itself accountable to external organizations that benchmark services.**

Continuing Medical Education

In the 1990s, Dr. Smith's lack of knowledge about advances in forensic pathology and about the proper role of an expert witness was detrimental to the quality of pediatric forensic pathology in the province. In a number of cases examined during the Chief Coroner's Review, Dr. Smith was not conversant with the most recent and important medical literature. Because of this lack of knowledge, he was unable to communicate accurate information to actors in the criminal justice system. And, at least early on, Dr. Smith failed to understand that his role as an expert witness was not that of advocate for the Crown's case.

The new leadership team at the OCCO has developed expert witness workshops for forensic pathologists and bimonthly seminars on difficult forensic pathology issues. These are useful additions to the continuing medical education of forensic pathologists. However, more can be done. The Registry provides a powerful tool for the OFPS to ensure that its forensic pathologists receive continuing education, provided that programs are available.

In order to ensure that pathologists performing coroner's autopsies have an adequate knowledge base, the Chief Forensic Pathologist should enhance the continuing education of forensic pathologists listed on the Registry. As discussed in Chapter 11, Professionalizing and Rebuilding Pediatric Forensic Pathology, this education should address the role of an expert witness within the justice system as well as recent developments in the practice and science of forensic pathology.

Recommendation 60

The Ontario Forensic Pathology Service should strive to enhance the continuing education of forensic pathologists listed on the Registry.

In this chapter, I have set out important ways in which oversight and accountability of forensic pathology must be enhanced. Most important is the creation of a Governing Council to be responsible for both the OFPS and the coronial service provided by the OCCO. The creation of a Registry is also very important, and so

is the clarifying of relationships within the OCCO and the OFPS. Finally, there is a need for enhanced tools of oversight of the work of forensic pathologists. None of these steps alone can guarantee that the past will not be repeated. However, together they provide, in my view, our best hope of achieving that objective.