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Improving the Complaints Process

Our systemic review demonstrated that the complaints mechanisms in place to address public concerns about the work of pathologists providing forensic pathology services for use in investigations and criminal proceedings were quite inadequate. In part because of these failures, significant warning signals about the work of Dr. Charles Smith were missed. To address this failing, the Office of the Chief Coroner for Ontario (OCCO) should implement an effective complaints process separate from, and in addition to, the present process administered by the College of Physicians and Surgeons of Ontario (CPSO).

The CPSO is the self-regulating body for the Ontario medical profession. It regulates the practice of medicine to protect and serve the public. All doctors, including pathologists, must be members of the CPSO in order to practise medicine in Ontario. The role and authority of the CPSO is set out in various pieces of legislation including the *Regulated Health Professions Act (RHPA),* SO 1991, c. 18, as amended; the Health Professions Procedural Code, which is Schedule 2 of that Act; and the *Medicine Act, 1991*, SO 1991, c. 30. The CPSO's legislated mandate requires it to investigate complaints against doctors and to discipline doctors who have committed an act of professional misconduct or displayed incompetence. This disciplinary jurisdiction covers physicians and surgeons in traditional and non-traditional roles.

Although the present CPSO process is valuable, an efficient new complaints process at the OCCO will perform several key functions. It will impose a degree of accountability on the medical professionals engaged in the death investigation system and help to ensure that the standards of the profession are upheld. It will also help to uncover flawed pathology practices at an early stage so they can be corrected. Finally, it will help to restore public confidence in the practice and oversight of pediatric forensic pathology in Ontario.

In this chapter, I discuss the broad principles that should guide this new complaints process. It must be transparent, responsive, and timely. It must include a mechanism for appeal through a committee of the Governing Council, giving both the complainant and the forensic pathologist the ability to seek redress if they are not satisfied with the initial outcome. In addition, the complaints process established by the OCCO must benefit from relevant information sharing with other institutions, such as the CPSO. These changes will all enhance the efficiency and breadth of the complaints process.

As with my other systemic recommendations, I focus, by necessity, on forensic pathology as a whole rather than the small subdiscipline of pediatric forensic pathology. The issues that can arise, and which an effective complaints process must address, are not limited to pediatric cases. To be effective, improvements to complaints mechanisms must apply to the entire practice of forensic pathology in Ontario. In addition, it makes sense for the complaints process to handle complaints about both coroners and forensic pathologists.

Although I recommend that the OCCO adopt certain principles as it establishes the new structure, the details of the complaints process are best left to the leaders of the Ontario Forensic Pathology Service (OFPS) and the coronial service to decide.

The Need for a Complaints System at the OCCO

From 1981 to 2001, members of the public who attempted to raise concerns about Dr. Smith faced significant obstacles to the timely, comprehensive, and independent adjudication of their concerns. The OCCO never had a formal independent mechanism in place to address complaints about pathologists, and, after the 1998 disbanding of the Coroners' Council, had no formal mechanism to address complaints about coroners.

When complaints were made to the Chief Coroner or its governing ministry about Dr. Smith's work, the OCCO's reaction was to defend and shield him rather than conduct full, impartial, and timely investigations. Further, the OCCO tried to prevent the CPSO, an independent and objective body, from investigating complaints against Dr. Smith by arguing that it alone had jurisdiction to deal with them. The CPSO agreed to cede jurisdiction to the OCCO. When little action was taken by the OCCO, it then took several years and an appeal to the Health Professions Appeal and Review Board before the CPSO assumed jurisdiction to investigate the complaints about Dr. Smith. In part because these complaints were not investigated and adjudicated in a timely fashion, serious problems with Dr. Smith's work remained undetected.

An effective complaints process can help to prevent the future repetition of serious mistakes by forensic pathologists. It can help to ensure that any problems missed during quality control processes are caught and addressed. Further, it will mean that the OCCO remains responsive and accountable to the public for the performance of its oversight responsibilities.

Jurisdiction of the Complaints Process

All forensic pathologists who are included on the Registry should be subject to the OCCO complaints process where complaints arise about their forensic pathology work – including the performance of autopsies under coroner's warrant as well as forensic pathology consultation opinions provided to Crown or defence counsel – or their conduct when carrying out such work. In this chapter, when I refer to forensic pathologists, I am referring to those forensic pathologists included on the OCCO's Registry of pathologists approved to perform autopsies under coroner's warrant. Where, for example, an individual pathologist not included on the Registry provides a consultation opinion to the defence, complaints arising from his or her work would likely not fall within the OCCO's complaints process.

Coroners should also be subject to the OCCO complaints process. Although my central focus in this chapter is complaints about forensic pathologists, in my view a combined process covering both forensic pathologists and coroners is more cost effective than two separate systems. It also avoids duplication of resources and encourages coordinated approaches to death investigation. The death investigation process can be quite complex, and the roles of the coroner and the forensic pathologist can sometimes overlap – for instance, in the determination of the cause of death. Individual members of the public cannot be expected to distinguish which aspects of the death investigation are the responsibility of the coroner, and which belong to the forensic pathologist. A complaint about a coroner's finding of cause or manner of death could also involve some aspects of a pathologist's responsibility, or vice versa. Allowing the public to access a single complaints process regardless of the medical actor in the death investigation helps to ensure that individuals do not have the onus of determining who does what in a death investigation. Indeed, in some instances, the complaint might relate to both coroner and forensic pathologist. A single, centralized complaints process is therefore preferable.

Although I will refer mainly to complaints made against forensic pathologists, I intend the principles of the complaints process to apply equally to complaints brought about coroners.

Recommendation 61

The Office of the Chief Coroner for Ontario should establish a public complaints process that

a) **is transparent, responsive, and timely; and**

b) **encompasses all the medical practitioners and specialists involved in the death investigation process, including coroners and forensic pathologists.**

The OCCO and the CPSO Must Both Have Jurisdiction Regarding Complaints

The complaints process that I recommend in this chapter is to be adopted in addition to the process currently in place at the CPSO. Although there was once some dispute about which institution – the OCCO or the CPSO – had jurisdiction to investigate and adjudicate complaints brought against pathologists acting under coroner's warrant, that dispute has since been resolved. In recent years, the CPSO has properly asserted its jurisdiction over physicians doing work for the OCCO, whether as coroners or as forensic pathologists, and it should continue to do so.

The evidence at the Inquiry suggested that certain aspects of the CPSO's investigations into the complaints regarding Dr. Smith were unsatisfactory – for example, lengthy delays and the difficulty the CPSO had in obtaining records relevant to the investigation. However, I am satisfied that these failings were either unusual or have since been addressed by changes in practice and policy. I am satisfied that the CPSO continues to have an important role to play in the investigation and adjudication of complaints brought against medical professionals engaged in work for the OCCO.

Nevertheless, the OCCO must also have its own complaints process. In my view, there are four primary reasons why a separate OCCO complaints process is necessary. First and most important, the OCCO can measure the work of forensic pathologists against specific policies, protocols, guidelines, or practices issued by the Chief Forensic Pathologist and the OCCO. The OCCO is best situated to assess if a forensic pathologist has contravened one of its own guidelines or recommended practices, and, if so, to take measures to ensure that it does not happen again. This is the case whether or not the contravention would amount to professional misconduct that would concern the CPSO.

Second, the OCCO is equipped with a unique and comprehensive understanding of the death investigation process, including its various players – coro-

ners, forensic pathologists, police, and Crown counsel, to name but four. Because of its involvement with the entire death investigation, the OCCO can consider not only whether a complaint has merit but also whether it implicates other aspects of the death investigation – and can then decide whether other members of the team ought to be notified or referred for possible discipline.

Third, a separate complaints process will allow members of the public to voice concerns directly to – and be heard by – the institution responsible for a pathologist's forensic work. This access will help restore public confidence in the oversight of forensic pathology in the province.

Finally, the OCCO complaints process can have a flexibility and informality tailored to the institutional needs of the OFPS.

For these reasons, I do not see jurisdiction over complaints as belonging solely to either the CPSO or the OCCO. Both institutions have legitimate and complementary interests in receiving and investigating complaints about medical professionals engaged in death investigations. Both have strengths they can bring to the adjudication of such complaints. I therefore recommend that the CPSO and the OCCO each maintain a jurisdiction over complaints about forensic pathologists . And, as I discuss in more detail below, I anticipate that the CPSO and the OCCO will work together to ensure that future complaints against forensic pathologists will be properly and efficiently adjudicated. This collaboration will ensure that the public benefits from the strengths of both institutional overseers.

Recommendation 62

The complaints process to be established by the Office of the Chief Coroner for Ontario should be separate and apart from the complaints process offered by the College of Physicians and Surgeons of Ontario, and should focus on forensic pathologists' performance of their roles and their compliance with Ontario Forensic Pathology Service requirements.

Recommendation 63

The College of Physicians and Surgeons of Ontario should continue its practice of investigating complaints about forensic pathologists acting under coroner's warrant.

Principles and Design of the Complaints Process

The specific design of the complaints process for coroners and forensic pathologists at the OCCO should be left to the discretion of the Chief Coroner and the

Chief Forensic Pathologist, subject to approval by the Governing Council. In this section, I outline some broad principles that, in my view, should inform the process, as well as several specific features that I think the system must include.

- First, an effective complaints process must be sensitive to the needs of complainants. It must be easy to use, keep the complainant informed, and dispose of complaints in a timely way.
- Second, the complaints process must treat fairly the forensic pathologist who is the subject of a complaint. Forensic pathologists must be afforded an opportunity to be actively involved in the complaints process.
- Third, the OCCO must balance the public's right to know with the legitimate privacy and confidentiality interests of both complainants and forensic pathologists.
- Fourth, where consistent with quality forensic pathology services, the complaints process at the OCCO should emphasize remediation and rehabilitation through continuing medical education rather than punitive sanctions. The complaints process should adopt a remedial/rehabilitative focus allowing for mentorship, supervision, and education of practitioners whose skills and practice are in need of improvement. In cases where the public interest is clearly at risk, sanctions should be imposed that appropriately reflect the gravity of the situation. Since all pathologists performing work for the OFPS will be members of the Registry, other more onerous sanctions, such as suspension or even removal from the Registry, should be available where necessary.
- Fifth, the mechanism for the initial resolution of a complaint should be left to the discretion of the Chief Coroner and the Chief Forensic Pathologist. However, the complaints process must include, at a minimum, the ability for both complainants and forensic pathologists to have recourse to an independent review mechanism when they are dissatisfied with the disposition reached. To achieve this potential for review, the Governing Council should create a complaints committee to which a complainant or a forensic pathologist can appeal. The committee should have the power to review independently the decisions that have been made by the Chief Forensic Pathologist, the Chief Coroner, or their designates.

Recommendation 64

With the approval of the Governing Council, the Chief Coroner for Ontario and the Chief Forensic Pathologist should design the specific procedures for the complaints process to

a) **reflect the principles of transparency, responsiveness, timeliness, and fairness;**

b) **focus on remedial and rehabilitative responses, rather than punitive ones, except where the public interest is jeopardized; and**

c) **provide for appeals by the complainant or the physician to the complaints committee of the Governing Council where they are not satisfied with the initial resolution of the complaint by the Chief Coroner or the Chief Forensic Pathologist or their designates.**

Mechanisms to Address Complaints about the OCCO/OFPS Leadership

From 1981 to 2001, neither the OCCO nor its governing ministry had an adequate process in place to address complaints made about its senior leadership. For example, Nicholas' grandfather filed a complaint with the Solicitor General about Deputy Chief Coroner Dr. James Cairns' conduct in the investigation into Nicholas' death. Chief Coroner Dr. James Young, who was not in a position to assess the complaint independently, nevertheless personally prepared the Solicitor General's reply to that complaint.

In 2002, subsequent to the Ombudsman's recommendation arising from Nicholas' case that the Solicitor General consider establishing an independent complaints-handling body, a formal mechanism was instituted for complaints regarding the Chief Coroner or the Deputy Chief Coroner: any such complaints would be sent directly to the deputy minister's office and be investigated independently of the OCCO.

Although this process for handling complaints about the senior leadership was definitely a step forward, it should now be superseded by the creation of the complaints committee of the Governing Council to deal in the final instance with complaints concerning the work of the Chief Coroner, the Chief Forensic Pathologist, and their respective deputies. In cases where there is need for a further review of the initial disposition, it should be conducted by the deputy minister in the Ministry of Community Safety and Correctional Services.

Recommendation 65

The complaints committee of the Governing Council should deal with complaints concerning the work of the senior leadership of the Office of the Chief Coroner for Ontario, with a further review by the deputy minister if necessary.

Information Sharing during Complaints Process

Our systemic review showed that a lack of coordination and exchange of information among various institutions frustrated complainants' attempts to have their concerns heard in a full and timely manner.

The complaints processes of the OCCO and the CPSO will serve the public interest best if there is cooperation between the two institutions. Both institutions have a responsibility for the work of forensic pathologists. Each should know when the other has cause for serious concern about a forensic pathologist. This dual process will allow the two institutions to respond to complaints in a manner that uses their unique strengths. In addition, cooperation and exchange of information should reduce any duplication of effort and resources.

The OCCO should inform the CPSO when it has any serious concerns about the work or conduct of a forensic pathologist. It should be prepared to disclose the relevant information it has gathered during its investigation processes as well as the outcome of such processes. Likewise, the CPSO should inform the OCCO when it has any serious concerns about the work or conduct of a forensic pathologist and be prepared to disclose any relevant information it has gathered throughout its investigation, whether or not the case proceeds to a formal discipline process.

In sharing information, the OCCO and the CPSO should consider the privacy and confidentiality interests of the various parties involved, including the complainants, the families, and any other third parties. The two institutions must then balance these interests with the need for sufficient information sharing between them to ensure the quality of forensic pathology in the province.

I am mindful that the CPSO, like all colleges regulating health professions in Ontario, is subject to statutory duties to maintain the confidentiality of information obtained during the course of its work. Disclosure of information is permissible in a number of situations, including, first, where written consent has been given by the person to whom the information relates and, second, as may be required for the administration of the *Coroners Act,* RSO 1990, c. C.37. In most cases, the CPSO will likely be able to obtain consent from the forensic pathologist and the complainant to enable disclosure to the OCCO. Indeed, all forensic pathologists will be required to consent to such information sharing as a condition of their inclusion on the Registry.

Recommendation 66

The Office of the Chief Coroner for Ontario and the College of Physicians and Surgeons of Ontario should each be prepared to inform the other of

a) **the fact that it has a serious concern about the work or conduct of a forensic pathologist or coroner;**

b) **relevant information it has gathered during the investigation process; and**

c) **the outcome of its investigation.**

Recommendation 67

The Chief Forensic Pathologist should ensure that all forensic pathologists are required, as a condition of their inclusion on the Registry, to consent to the Office of the Chief Coroner for Ontario and the College of Physicians and Surgeons of Ontario sharing information relating to serious concerns about their work or conduct.