22

Conclusion and Consolidated Recommendations

As we have seen, a number of serious incidents occurred through the 1990s that cast grave doubt on the ability of pediatric forensic pathology, as it was then carried on in Ontario, to properly perform the important role required of it in the criminal justice system. The impact on the individuals involved was often tragic. The systemic review conducted by our Inquiry revealed serious flaws in many aspects of the way forensic pathology was practised. It also revealed serious shortcomings in the mechanisms of accountability and oversight that were responsible for forensic pathology in Ontario. In this volume, I recommend the steps that, in my view, must be taken to address and correct these systemic failings. These changes are necessary if public confidence in pediatric forensic pathology and its future use in the criminal justice system is to be restored and enhanced.

Of primary importance is the creation of a truly professionalized Ontario forensic pathology service. I have described the cornerstones on which such a service must be built. They include legislative recognition of the vital role that forensic pathology plays in death investigation; the provision of proper forensic pathology education, training, and certification in Canada; recruitment and retention of qualified forensic pathologist; and adequate sustainable funding to grow the profession.

Equally important is the need for change in the mechanisms for oversight of forensic pathology in Ontario. Most important, a major institutional change is essential in the governance of the Office of the Chief Coroner for Ontario (OCCO) itself, to ensure the public of effective oversight of both the forensic pathology service and the coronial service. This requires the creation of a Governing Council for the OCCO. In addition, it is important that there be organizational changes to rationalize and clarify the roles and responsibilities of the various parts of the Ontario Forensic Pathology Service and its senior officials.

The work of forensic pathologists in individual cases must be addressed as

well. I have made recommendations designed to build on the significant progress that has occurred in this regard since 2001, to further promote accurate, understandable, and transparent forensic autopsies. In addition, I address the vital need to ensure that forensic pathologists are able to communicate their opinions effectively to the criminal justice system.

At the same time, we must recognize that other participants in the criminal justice system have important roles to play in protecting the public against the introduction of flawed or misunderstood forensic pathology into investigations and criminal proceedings. I make recommendations about how coroners, police, prosecutors, defence counsel, and the courts themselves can help achieve that objective.

Finally, in this volume, I turned to three other issues. The first is what, if anything, can and should be done about the flawed pediatric forensic pathology we examined with regard to potential wrongful convictions. The second addresses the challenges presented by the need to provide for adequate coronial and forensic pathology services to First Nations and other remote communities in Northern Ontario. The third is the changes that should be made if pediatric forensic pathology is to be as sensitive as possible to the devastating impact that the sudden, unexpected death of a child has on the families involved.

I conclude with the consolidated list of my detailed recommendations on each of these important subjects. They arise directly out of the review I was required to conduct for the years from 1981 to 2001. They address the systemic failings in the practice and oversight of pediatric forensic pathology that were identified at the Inquiry. In my opinion, these are the steps that must be taken to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in the criminal justice system.

In the last few years, new leadership has made a significant start in addressing this challenge. But, as they acknowledge, much more must be done. To stop now, risks a return to the troubled years examined at the Inquiry. However, the steps taken so far, together with the sense of hope and enthusiasm for the future they have begun to engender in those who continue in the field, provide a firm foundation on which to build.

My recommendations are intended to build on that foundation. If acted upon, they represent the best way to protect the justice system from flawed pathology, to leave behind the dark times of the recent past, and to create the forensic pathology service that the criminal justice system needs and the people of Ontario deserve.

Consolidated Recommendations

The complete recommendations are found below, numbered sequentially and identified by chapter and page reference in the text.

Chapter 11
Professionalizing and Rebuilding Pediatric Forensic Pathology

1 The Province of Ontario should amend the *Coroners Act* in order to

a) establish the Ontario Forensic Pathology Service as the provider of all forensic pathology services for the province;
b) recognize and define the principal duties and responsibilities of the Chief Forensic Pathologist;
c) recognize one or more Deputy Chief Forensic Pathologists;
d) require that all post-mortem examinations performed under coroner's warrant be performed by "pathologists," a term that should be defined in the *Coroners Act*; and
e) create a Governing Council to oversee the duties and responsibilities of the Office of the Chief Coroner for Ontario. [See page 288.]

2 As expeditiously as possible, the Royal College of Physicians and Surgeons of Canada should

a) approve the accreditation of one-year training programs in forensic pathology offered by Canadian medical schools to candidates with Royal College certification in either anatomical or general pathology;
b) certify forensic pathologists upon successful completion of an accredited training program and a Royal College examination in the subspecialty of forensic pathology; and
c) finalize the process by which pathologists currently practising forensic pathology in Ontario may become certified by the Royal College. [See page 295.]

3 The Ontario Forensic Pathology Service and the Chief Forensic Pathologist should actively encourage

a) faculties of medicine to promote interest in forensic pathology by exposing students in the early years of their programs to forensic pathology; and
b) forensic pathologists to work with the faculties of medicine to educate students about forensic pathology. [See page 296.]

4 The Governing Council and the Chief Forensic Pathologist should ensure that the Ontario Forensic Pathology Service is built upon the three essential and interdependent pillars of service, teaching, and research. [See page 298.]

5 The Province of Ontario, the Governing Council, and the Chief Forensic Pathologist should work with the University of Toronto to establish a Centre for Forensic Medicine and Science, which would

a) educate both practitioners and students in a variety of medical disciplines related to the forensic sciences; and
b) be affiliated directly with the Provincial Forensic Pathology Unit and the Ontario Pediatric Forensic Pathology Unit. [See page 299.]

6 All individuals and institutions that provide or oversee the education of medical students in Ontario should focus on the critical importance of the criminal justice system in medico-legal education. In particular, the Royal College of Physicians and Surgeons of Canada should ensure that any accredited fellowship programs in forensic pathology provide education in relation to expert evidence, the justice system, and the relevant aspects of evidence law and criminal procedure. [See page 301.]

7 All individuals and institutions that provide or oversee the provision of forensic pathology services in Ontario should focus on the critical importance of continuing medical education and, in particular,

a) the Chief Forensic Pathologist or designate should assume primary responsibility for fostering ongoing and interdisciplinary education about the role of the forensic pathologist in the justice system; and
b) the Province of Ontario should adequately fund continuing education for forensic pathologists regarding recent developments in the science of forensic pathology and the role of the forensic pathologist in the justice system. [See page 301.]

8 The Province of Ontario should provide the resources necessary to address the acute shortage of forensic pathologists in Ontario. In particular, the Province of Ontario should

a) provide adequate and sustainable funding for fellowships in forensic pathology in each of the regional forensic pathology units across the province;
b) fund full-time positions within the profession that will support the three pillars of service, teaching, and research, including but not limited to,

Deputy Chief Forensic Pathologist(s), director positions at the regional forensic pathology units, and staff forensic pathologist positions;

c) provide sufficient resourcing to ensure that forensic pathologists' caseloads do not exceed recommended standards;

d) include Ontario Forensic Pathology Service pathologists in the Laboratory Medicine Funding Framework Agreement, to ensure that all pathologists are compensated fairly, whether they work on staff at a hospital or at the Provincial Forensic Pathology Unit, or take steps that will achieve and maintain an equivalent result;

e) increase the number of full-time-equivalent positions in Ontario's regional forensic pathology units;

f) ensure that each unit where post-mortem examinations are performed pursuant to coroner's warrant is fully equipped, up to date, and properly resourced; and

g) fund the construction of a new, modern facility to house the Office of the Chief Coroner for Ontario and related forensic sciences. [See page 305.]

9 The Ontario Forensic Pathology Service should immediately recruit appropriately credentialed forensic pathologists offshore to address the shortage in the province. [See page 306.]

10 The Province of Ontario should provide sufficient resources to permit the recruitment of appropriately credentialed forensic pathologists from other countries. [See page 306.]

11 The Province of Ontario should commit to providing funding sufficient to sustain the changes required to restore public confidence in pediatric forensic pathology. [See page 307.]

Chapter 12
Reorganizing Pediatric Forensic Pathology

12 The *Coroners Act* should be amended to establish and define the Ontario Forensic Pathology Service as follows:

"Ontario Forensic Pathology Service" means the branch of the Office of the Chief Coroner for Ontario which, as directed by the Chief Forensic Pathologist, provides all forensic pathology services performed under or in connection with a coroner's warrant.[1] [See page 309.]

[1] The language of this and other proposed amendments to the *Coroners Act* is recommended language only.

13 The *Coroners Act* should be amended to include the following definitions for pathologist and certified forensic pathologist:

a) "Pathologist" means a legally qualified medical practitioner certified by the Royal College of Physicians and Surgeons of Canada or its equivalent as a specialist in anatomical or general pathology;
b) "Certified forensic pathologist" means a pathologist certified by the Royal College of Physicians and Surgeons of Canada or its equivalent as a specialist in forensic pathology. [See page 310.]

14 The *Coroners Act* should be amended to provide that the Lieutenant Governor in Council appoint a certified forensic pathologist to be the Chief Forensic Pathologist for Ontario to

a) direct the Ontario Forensic Pathology Service and be responsible for the services it provides;
b) supervise, direct, and oversee the work of all pathologists in Ontario under, or in connection with, a coroner's warrant;
c) conduct programs for the instruction of pathologists in their duties;
d) prepare, publish, and distribute a code of ethics for the guidance of pathologists;
e) administer a Registry of pathologists approved to perform post-mortem examinations under coroner's warrant; and
f) perform such other duties as are assigned to him or her by, or under, this or any other Act, or by the regulations, or by the Lieutenant Governor in Council. [See page 311.]

15 The Governing Council should create a document outlining additional duties and responsibilities of the Chief Forensic Pathologist, which would include to

a) ensure that the Ontario Forensic Pathology Service (OFPS) provides a high quality of service;
b) ensure effective oversight of the work performed throughout the OFPS;
c) take responsibility for the service, teaching, and research mission of the OFPS;
d) encourage a collaborative culture of quality within the OFPS;
e) be responsible for the preparation and administration of the annual budget for the OFPS; and
f) be responsible for determining the pathologist who will conduct each post-mortem examination under coroner's warrant in Ontario. [See page 311.]

16 The Chief Coroner for Ontario should direct investigating coroners to issue all warrants for post-mortem examination to the Chief Forensic Pathologist or designate. [See page 312.]

17 The *Coroners Act* should be amended to provide that the Lieutenant Governor in Council may appoint one or more forensic pathologists to be Deputy Chief Forensic Pathologist(s) in Ontario who may act as, and have all the powers and authority of, the Chief Forensic Pathologist during the absence of the Chief Forensic Pathologist, or during his or her inability to act. [See page 312.]

18 The Governing Council, on the recommendation of the Chief Forensic Pathologist, should appoint a regional director for each regional forensic pathology unit who will

a) provide oversight of and be accountable for the work of their regional units;
b) be a member of the Forensic Pathology Advisory Committee; and
c) assist the Chief Forensic Pathologist and the Deputy Chief Forensic Pathologist(s) to create quality assurances processes, peer review processes, and other mechanisms of review. [See page 314.]

19 To ensure quality of service across the province, the Ontario Forensic Pathology Service should utilize and build on the regional forensic pathology units. [See page 315.]

20 The Province of Ontario should fund the actual costs of the regional forensic pathology units. [See page 315.]

21 The Office of the Chief Coroner for Ontario should enter into service agreements regarding each of the regional forensic pathology units. These agreements should, at a minimum, provide that

a) the unit will assume responsibility for a designated geographic area of the Ontario Forensic Pathology Service;
b) each regional director will be accountable to the Chief Forensic Pathologist for the work of his or her unit and will be responsible for the oversight, timeliness, and quality control of all post-mortem examinations performed under coroner's warrant within the unit's designated area;
c) the Chief Forensic Pathologist will be responsible for the general supervision

of the units, for providing direction and guidelines as they relate to acceptable standards of forensic pathology practice in the units, and for ensuring appropriate quality control measures are in place;

d) forensic pathologists performing work for the Ontario Forensic Pathology Service must be included on the Registry of pathologists and will be primarily accountable to their regional director; and

e) each regional director will hold a salaried position with the regional unit, although that may be a full- or part-time position, depending on the local circumstances. [See page 318.]

22 Ontario hospitals should create policies requiring them to report any serious concerns about the work of any hospital pathologist who performs autopsies under coroner's warrant to the Chief Forensic Pathologist, whether or not the concerns arise out of work performed under coroner's warrant. The Office of the Chief Coroner for Ontario should also create policies requiring it to report any serious concerns about the work of a forensic pathologist to the hospital where the pathologist practises. [See page 319.]

23 The Ontario Forensic Pathology Service should ensure that, as a requirement for inclusion on the Registry, pathologists consent to hospitals reporting serious concerns to the Chief Forensic Pathologist and to the Chief Forensic Pathologist reporting serious concerns to the hospitals. [See page 319.]

24 With the support of the Ministry of Health and Long-Term Care and the Ministry of Community Safety and Correctional Services, the Ontario Forensic Pathology Service and each hospital with which a regional unit is associated should create protocols to clearly define the areas and limits of the hospital's responsibilities, to avoid confusion about the oversight roles of the Chief Forensic Pathologist and the hospital. [See page 319.]

25 The Ontario Forensic Pathology Service should increase the number of full-time-equivalent positions in all the units, as well as the proportion of forensic autopsies that are performed within those units. [See page 320.]

26 The Province of Ontario should fund a telemedicine portal in the Provincial Forensic Pathology Unit and at each of the regional forensic pathology units, if not already a part of the particular hospital system. [See page 321.]

27 The Ontario Pediatric Forensic Pathology Unit should continue as a regional forensic pathology unit located at SickKids. Its director must be a certified forensic pathologist. [See page 323.]

28 For pediatric forensic cases that are to be done in Toronto, the Chief Forensic Pathologist or designate should direct that

a) for pediatric forensic cases that do not appear to be criminally suspicious, the post-mortem examination should usually be conducted at the Ontario Pediatric Forensic Pathology Unit;
b) for criminally suspicious pediatric forensic cases, the post-mortem examination should be conducted by an appropriate pathologist at the Ontario Pediatric Forensic Pathology Unit or at the Provincial Forensic Pathology Unit, as determined by the Chief Forensic Pathologist or designate; and
c) particularly in difficult cases, the pathologists at each unit should take advantage of the expertise available at the other unit. [See page 325.]

29 For pediatric deaths outside the area regularly serviced by the Ontario Pediatric Forensic Pathology Unit, the Chief Forensic Pathologist or designate should direct that

a) for pediatric forensic cases within the geographical area of the designated regional units that do not appear to be criminally suspicious, the post-mortem examination should be conducted at the appropriate regional forensic pathology unit or by Dr. Susan Phillips or another approved forensic pathologist in Winnipeg; and
b) for criminally suspicious pediatric forensic cases, the post-mortem examination should be conducted by the pathologist and at the unit designated by the Chief Forensic Pathologist or designate. [See page 326.]

30 Until the Registry of pathologists is created, the provisions of the 2007 Guidelines on Autopsy Practice for Forensic Pathologists: Criminally Suspicious Cases and Homicides should be followed in all criminally suspicious pediatric forensic cases. [See page 327.]

31 Once the Registry is created, the Chief Forensic Pathologist or designate should ensure that, in all criminally suspicious pediatric forensic cases, the post-mortem examination is conducted by an approved pediatric forensic pathologist. [See page 327.]

32 As soon as numbers permit, the Chief Forensic Pathologist should ensure that, in all criminally suspicious pediatric forensic cases, the post-mortem examination is conducted by a certified forensic pathologist with pediatric forensic experience. [See page 327.]

33 For all forensic cases, but particularly for criminally suspicious pediatric cases, the Ontario Forensic Pathology Service should reinforce a policy that encourages collaboration between the forensic pathologist and other relevant professionals.[2] [See page 328.]

34 The Ontario Forensic Pathology Service should establish a protocol for pediatric forensic cases that appear non-criminally suspicious at the outset, but become criminally suspicious during the post-mortem examination. The pathologist must trigger the application of the protocol as soon as a suspicion arises, and the protocol should provide for immediate access to a forensic pathologist and, ultimately, to the Chief Forensic Pathologist. [See page 329.]

35 Until the Registry of pathologists is created, the provisions of the 2007 Guidelines on Autopsy Practice for Forensic Pathologists: Criminally Suspicious Cases and Homicides should be followed in all criminally suspicious adult forensic cases. [See page 330.]

36 Once the Registry is created, the Chief Forensic Pathologist or designate should ensure that in all criminally suspicious adult forensic cases, the post-mortem examination is conducted by an approved forensic pathologist. [See page 330.]

37 As soon as numbers permit, the Chief Forensic Pathologist should ensure that, in all criminally suspicious adult forensic cases, the post-mortem examination is conducted by a certified forensic pathologist. [See page 330.]

[2] I have not always distinguished between policies, protocols, guidelines, and practices in my recommendations, although others sometimes do draw distinctions on the basis that some of these documents are intended to be mandatory, others discretionary. From my perspective, they all provide instructions that should be followed.

Chapter 13
Enhancing Oversight and Accountability

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. [See page 338.]

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. [See page 339.]

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. [See page 339.]

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. [See page 339.]

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. [See page 341.]

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. [See page 344.]

44 The Chief Forensic Pathologist should have responsibility for administering the Registry. [See page 344.]

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. [See page 344.]

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. [See page 344.]

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. [See page 346.]

48 The positions of Chief Coroner and Chief Forensic Pathologist should be full-time. [See page 347.]

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. [See page 348.]

50 The Ontario Forensic Pathology Service should appoint dedicated quality assurance staff, including a full-time quality assurance manager, to track quality assurance mechanisms. [See page 349.]

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. [See page 353.]

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. [See page 355.]

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. [See page 356.]

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. [See page 356.]

55 The Paediatric Death Review Committee, the Forensic Services Advisory Committee, and the Deaths under Five Committee should continue. [See page 357.]

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. [See page 358.]

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. [See page 359.]

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. [See page 359.]

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. [See page 360.]

60 The Ontario Forensic Pathology Service should strive to enhance the continuing education of forensic pathologists listed on the Registry. [See page 361.]

Chapter 14
Improving the Complaints Process

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. [See page 366.]

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. [See page 367.]

63 The College of Physicians and Surgeons of Ontario should continue its practice of investigating complaints about forensic pathologists acting under coroner's warrant. [See page 367.]

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. [See page 368.]

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. [See page 369.]

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. [See page 371.]

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. [See page 371.]

Chapter 15
Best Practices

68 The Ontario Forensic Pathology Service should explicitly adopt a set of basic principles that include those set out in this chapter; guidelines for best practices at autopsy should be founded on these principles. [See page 374.]

69 a) Evidence-based forensic pathology is incompatible with an approach of "thinking dirty." It, instead, involves keeping an open mind to the full range of possibilities that the evidence might yield, without preconceptions or presumptions about abuse, and collecting evidence both to support and to negate any possibilities.
b) "Thinking truth," the orientation now adopted by the Office of the Chief Coroner for Ontario, accurately captures the appropriate approach to forensic pathology and helps promote an evidence-based culture. [See page 377.]

70 a) The Ontario Forensic Pathology Service should encourage forensic pathologists throughout the province to attend the scene of death more frequently.
b) The Office of the Chief Coroner for Ontario should develop guidelines

with respect to scene attendance by forensic pathologists throughout the province. The guidelines should draw upon the Toronto memorandum and the experience with scene attendance by forensic pathologists at the Provincial Forensic Pathology Unit and the Hamilton Regional Forensic Pathology Unit. Such guidelines should

i) recognize the strengths and limitations of scene attendance;
ii) identify the circumstances in which scene attendance by the forensic pathologist would be valuable;
iii) emphasize the need for communication between the investigating coroners, police, and forensic pathologists in determining when scene attendance will take place; and
iv) outline a protocol to be followed at the scene when forensic pathologists are in attendance. [See page 379.]

71 Where it is not feasible for the forensic pathologist to attend the scene, the Ontario Forensic Pathology Service (OFPS) should develop and encourage enhanced "real time" communication, including the transmission of digital photographs, and even the use of video and telemedicine technology, so that the forensic pathologist can view the scene, where helpful, prior to the body being removed. The OFPS should be provided with the resources necessary to do so. [See page 380.]

72 Compensation for forensic pathologists should reflect the added work represented by their attendances at the scene. [See page 380.]

73 a) The contents of warrants for post-mortem examination should conform to the current guidelines of the Office of the Chief Coroner for Ontario.
b) In accordance with current guidelines of the Office of the Chief Coroner for Ontario, the investigating coroner should strive to provide full and accurate information to the forensic pathologist. In particular, all relevant hospital and medical records should, if at all possible, be provided to the forensic pathologist prior to the commencement of the post-mortem examination.
c) The coroner should refrain from expressing medical conclusions in any early communications with the forensic pathologist. Although the coroner makes the final determination about cause and manner of death, the coroner is well advised to await the considered opinions of the forensic pathologist before expressing those conclusions.
d) In accordance with existing policy of the Office of the Chief Coroner for Ontario, direct telephone or in-person communication between the

coroner and the forensic pathologist should take place prior to the autopsy for every criminally suspicious case and for autopsies of children under the age of five.

e) Province-wide protocols for police officers should be developed that articulate the types of information that should and should not be provided to the forensic pathologist. Such protocols should also address how police and coroners can coordinate what information is provided to the forensic pathologist and by whom. [See page 384.]

74 a) The police and coroners should be encouraged to provide initial information to the forensic pathologist in writing.

b) Additional information communicated to the forensic pathologist at any time should be provided in writing or, if verbal, should be recorded by both the person communicating the information and the person receiving it.

c) Investigation questionnaires should be utilized by police and coroners to provide information to forensic pathologists in all cases of sudden infant death. The completed questionnaire should be provided to the forensic pathologist before the post-mortem examination begins. [See page 386.]

75 a) As a general rule, police and coroners should not "filter out" relevant information that is to be provided to the forensic pathologist. The forensic pathologist is best situated to determine what is relevant to his or her work.

b) That being said, police and coroners should generally not transmit information that is clearly irrelevant, innuendo, or purely speculative. Coroners and police officers also have discretion as to how relevant information is communicated to the forensic pathologist. This might mean, for example, that information is communicated in ways that reduce its potential misuse or its inflammatory character.

c) The forensic pathologist should remain vigilant against confirmation bias or being affected by extraneous considerations. This is best done through increased professionalism and education, an enhanced awareness of the risks of confirmation bias, the promotion of an evidence-based culture, complete transparency concerning both what is communicated and what parts of it are relied upon by the pathologist, and a cautious approach by the pathologist to the use of circumstantial or non-pathology information. [See page 390.]

76 Any information provided by the coroner or the police to the forensic pathologist should be carefully recorded both by the conveyor of the information and by its recipient. [See page 391.]

77 a) Autopsies should not normally be audiotaped or videotaped. However, what is done at the autopsy should be fully transparent and independently reviewable. Therefore, what is done and by whom at the autopsy should be carefully documented. This documentation includes careful recording through photographs and contemporaneous note-taking by support staff and the forensic pathologist.

b) Best practice also requires the appropriate retention, storage, and transmittal of organs, tissues, samples, and exhibits in accordance with the current autopsy guidelines of the Office of the Chief Coroner for Ontario and policies in place at hospitals where forensic autopsies are performed.

c) In accordance with the current guidelines of the Office of the Chief Coroner for Ontario, materials kept for testing and independent reviewability should be carefully documented. [See page 392.]

78 a) In accordance with the October 2007 Autopsy Guidelines, the Office of the Chief Coroner for Ontario should continue to encourage forensic pathologists to exercise caution in providing preliminary opinions. In particular, a preliminary opinion on the cause of death or other forensic issues, such as timing or mechanism of injury, should not be provided if ancillary investigations have any reasonable chance of altering the preliminary opinion. In such circumstances, the cause of death should be given as "pending further tests."

b) Whether forensic pathologists express a preliminary opinion or indicate that the cause of death is "pending," they should ensure that this is fully understood, including in particular any qualifications or limitations that exist for the preliminary opinion. [See page 395.]

79 a) When a forensic pathologist provides a preliminary opinion at the conclusion of the autopsy, it should be reduced to writing. Either the pathologist should provide the opinion in writing to the police, retaining a copy for his or her records, or the attending police should carefully record the opinion in their notebooks. If this second procedure is followed, the forensic pathologist should review what the police have recorded for accuracy, and indicate in writing that it conforms with her or his opinion, including its limitations. The forensic pathologist should also retain a copy of the relevant entries.

b) If the notification form of the Office of the Chief Coroner for Ontario is used to record the forensic pathologist's preliminary opinion, it should be provided to the police and coroner with a copy retained by the pathologist. [See page 397.]

80 a) Using the suggestions contained in this Report, the Office of the Chief Coroner for Ontario (OCCO), and in future the Ontario Forensic Pathology Service (OFPS), should address the important challenge of timely production of forensic pathology reports needed by the criminal justice system.

b) The components of a solution to this difficult problem should include the following:

i) There should be realistic and well-understood timelines for the completion of post-mortem reports. Those set out in the OCCO's July 2004 memorandum would seem to be appropriate.

ii) The OCCO should develop a central tracking system which will permit better knowledge, and therefore better management, of the problem of untimely production of reports.

iii) Growing the profession of forensic pathology will be of great assistance.

iv) The OCCO should be provided with sufficient resources to ensure that there are no administrative impediments to the timely production of reports.

v) The development of better lines of communication between the OCCO and the regional forensic pathology units through their service agreements will assist in minimizing the pressure of clinical pathology work as an impediment to timely forensic pathology reports.

vi) Particularly for difficult, criminally suspicious cases, the OCCO should develop a guideline for prioritizing reports that are urgently needed by the criminal justice system.

vii) Sanctions must be available. Those in positions of responsibility, starting with the regional director, should use their management skills to address the problem. Ultimately, the Chief Forensic Pathologist can utilize the tool of possible removal from the Registry. With increased remuneration for reports provided to the fee-for-service forensic pathologists, this may be enough. At the extreme, actual removal from the Registry may in fact be necessary to preserve the integrity of the OFPS. [See page 401.]

81 a) To shorten delays in producing post-mortem reports, the Office of the Chief Coroner for Ontario should continue to instruct forensic pathologists to submit samples for toxicology testing as soon as possible.
b) The Office of the Chief Coroner for Ontario and the Centre of Forensic Sciences should together quickly create a guideline that prioritizes and expedites toxicology testing in clearly articulated types of cases, such as those that are criminally suspicious.
c) The Office of the Chief Coroner for Ontario and the Centre of Forensic Sciences should continue their discussions on a priority basis to improve the turnaround times for toxicology reports needed by forensic pathologists to complete their reports. [See page 402.]

82 Forensic pathologists should practise teamwork in conducting autopsies. The Ontario Forensic Pathology Service should be charged with creating a culture in which this is expected. [See page 404.]

83 The Office of the Chief Coroner for Ontario should continue to develop guidelines to assist forensic pathologists in adhering to best practices at or surrounding the autopsy. Those guidelines should incorporate, where appropriate, the specific recommendations about best practices made in this Report. Such guidelines should complement the proposed Code of Practice and Performance Standards for forensic pathologists. [See page 405.]

Chapter 16
Effective Communication with the Criminal Justice System

84 Several general principles should inform the way that pathology opinions are communicated:

a) Pathology opinions often depend on technical knowledge and expertise that are not easily understood by lay persons. Particularly in pediatric forensic pathology, opinions may be highly nuanced. However, the criminal justice system in which these opinions are used craves certainty and simplicity. This divergence in the cultures of the two professional areas poses a serious risk of misunderstanding between them, one that is further increased by an adversarial process designed to push and pull these opinions in different directions. To reduce the risk of their being misunderstood, the most important parts of a forensic pathologist's opinion should be expressed in writing at the earliest opportunity.

b) The ability of the various consumers of a forensic pathologist's opinion – including peer reviewers, coroners, and stakeholders in the criminal justice system or child protection proceedings – to understand, evaluate, and potentially challenge the opinion requires that it be fully transparent. It should clearly state not just the opinion but the facts on which the opinion is based, the reasoning used to reach it, the limitations of the opinion, and the strength or degree of confidence the pathologist has in the opinion expressed.

c) Although some of the consumers of a forensic pathologist's opinion are experts, such as peer reviewers, many are lay persons who have little or no understanding of technical language. It is essential that the pathologist's opinion be understood by all the users. It must therefore be communicated in language that is not only accurate but also clear, plain, and unambiguous.

d) In expressing their opinions, forensic pathologists should adopt an evidence-based approach. Such an approach requires that the emphasis be placed on empirical evidence, and its scope and limits, as established in large measure by the peer-reviewed medical literature and other reliable sources. This approach places less emphasis on authoritative claims based on personal experience, which can seldom be quantified or independently validated. [See page 408.]

85 a) The use of the term "asphyxia" should be avoided as an articulated cause of death. If it must be used to describe the mechanism of death, it should be elaborated on to avoid confusion.

b) Forensic pathologists in Ontario should be educated as to the dangers associated with the term "asphyxia" and, under the auspices of the Chief Forensic Pathologist, reach a common understanding as to when it should and should not be used.

c) More generally, forensic pathologists should be careful to express their opinions in terms that are not susceptible to varied meanings, but that do elucidate the issues addressed by the opinions. [See page 410.]

86 a) Forensic pathologists should analyze the level of confidence they have in their opinions and articulate that understanding as clearly as they can. Pending the development of a common language for this purpose, pathologists should use their own formulations to capture, as accurately as possible, their own level of confidence.

b) Under the auspices of the Chief Forensic Pathologist, work should be done, in a multidisciplinary setting, to develop, to the extent possible, some common language to describe what forensic pathologists have to say. That multidisciplinary setting should include leading practitioners and academics from both forensic pathology and the legal profession.
c) One objective should be to build consensus on how levels of confidence should be articulated.
d) The results of this work should be reflected in a proposed Code of Practice and Performance Standards for forensic pathologists. [See page 413.]

87 a) Proof beyond a reasonable doubt is a legal standard applicable to the totality of evidence, and it has no correlation with science or medicine. Forensic pathologists should be educated and trained not to think in terms of "proof beyond a reasonable doubt," and they should not formulate or articulate their opinions in terms of this legal standard.
b) Participants in the justice system should similarly be educated to avoid efforts to compel forensic pathologists to express their opinions in terms of this legal standard. [See page 414.]

88 Forensic pathologists should be educated and trained so that their level of confidence or certainty in their opinions remains essentially the same and not dependent on the forum in which those opinions are expressed. [See page 414.]

89 a) Forensic pathologists should not engage in "default diagnoses." The absence of a credible explanation is not a substitute for sufficient pathology findings to support the existence of abuse or non-accidental injury. In particular, a formulation such as "in the absence of a credible explanation, the post-mortem findings are regarded as resulting from non-accidental injury" should not be used.
b) If the evidence is not sufficient to support a cause of death, it should be characterized as "undetermined." [See page 417.]

90 a) Forensic pathologists should outline in their post-mortem or consultation reports the alternative or potential diagnoses that may arise in a case. They should also evaluate alternative explanations that are raised by the pathology or by the reported history associated with the deceased's death. They should describe precisely what alternative explanations have been

considered and why they can or cannot be ruled out. The same principles should inform all forensic pathologists' communications, including their testimony.

b) More generally, forensic pathologists' opinions, written or verbal, should be responsive to the needs of the justice system. They should address the live or pertinent issues in the case, for instance, and articulate in a transparent way what they have to say about those issues and why. [See page 417.]

91 a) Forensic pathologists should clearly communicate, where applicable, areas of controversy that may be relevant to their opinions and place their opinions in that context.

b) They should also clearly communicate, where applicable, the limits of the science relevant to the particular opinions they express.

c) They should remain mindful of both the limits and the controversies surrounding forensic pathology as they form their opinions and as they analyze the level of confidence they have in those opinions.

d) These obligations extend to the content of post-mortem or consultation reports, to verbal communications, and to testimony. [See page 419.]

92 Forensic pathologists have a positive obligation to recognize and identify for others the limits of their expertise. They should avoid expressing opinions that fall outside that expertise. When invited to provide such opinions, they should make the limits of their expertise clear and decline to do so. [See page 420.]

93 a) Forensic pathologists should never use circumstantial evidence or non-pathology information to bear the entire burden of support for an opinion.

b) Caution in using such evidence or information at all should be particularly pronounced where the circumstantial evidence is potentially unreliable or contentious or comes close to the ultimate issue that the court must decide.

c) Forensic pathologists' opinions must ultimately fall within their particular area of expertise. They should not rely on circumstantial evidence to a point where the opinion no longer meets that requirement.

d) There is some limited scope for forensic pathologists quite properly to use non-pathology or circumstantial evidence in forming their opinions. They need not operate in complete isolation. However, their use or consideration of circumstantial evidence should always be transparent: they

should always disclose both the extent to which they have used or relied on such evidence and the impact such evidence has had on their reasoning and opinions.

e) Forensic pathologists can consider hypothetical questions that involve circumstantial evidence in determining whether, or to what extent, a reported history can be excluded or supported by the pathology findings. [See page 422.]

94 a) When forensic pathologists base their opinions, in whole or in part, on consultation with other experts, they should identify those experts as well as the content of the opinions those experts expressed.

b) When informal "corridor" consultations influence formal opinions, the same identification and acknowledgment procedures should be followed. In addition, the consulted experts should express in writing, where feasible, any significant findings or opinions they contributed. [See page 423.]

95 a) The articulation of the basis for the forensic pathologist's opinion in a completely transparent way is at the cornerstone of evidence-based pathology.

b) Forensic pathology opinions, whether given in writing or in oral communication, should articulate both the pathology facts found and the reasoning process followed, leading to the opinions expressed. [See page 427.]

96 Forensic pathologists, in order to communicate their opinions in plain language to their lay readers, should consider including a glossary of medical terms, and, in some cases, relevant secondary literature, in their post-mortem or consultation reports. [See page 427.]

97 The Office of the Chief Coroner for Ontario should develop a Code of Practice and Performance Standards for forensic pathologists in Ontario which describes, among other things, the principles that should guide them as they write their reports and the information that should be contained in them. It should draw on existing sources, including the *Code of Practice and Performance Standards for Forensic Pathologists* in England and Wales. It should include at least the following:

a) the principles set out in Recommendation 84;

b) guidance on the content of their autopsy and consultation reports (particularly where they may be used by the justice system), including

i) the subjects mandated by the *Code of Practice and Performance Standards for Forensic Pathologists* in England and Wales;
ii) details of each expert's academic and professional qualifications, experience, and accreditation relevant to the opinions expressed in the report, as well as the range and extent of this expertise and any limitations on it;
iii) the levels of confidence or certainty with which the opinions are expressed;
iv) any alternative explanations that are raised by the pathology or by the reported history associated with the deceased's death, with an analysis of why these alternative explanations can or cannot be ruled out;
v) what the pathologist has to say that is relevant to the live or pertinent issues in the case and why;
vi) any area of controversy that may be relevant to their opinions, placing their opinions in that context;
vii) any limits of the science relevant to the particular opinions;
viii) the extent to which circumstantial or non-pathology information has been used or relied on, and its impact on the reasoning and opinions;
ix) any other expert opinions relied upon;
x) the pathology facts found and the reasoning process that was followed, leading to the opinions expressed; and
xi) a glossary of medical terms, if helpful, to assist in communicating opinions in plain language to lay readers.

c) guidance on

i) language to be used or avoided, and the dangers associated with the use of particular terms;
ii) how best to think about and articulate levels of confidence or certainty;
iii) the need to avoid the formulation or articulation of opinions in terms of proof beyond a reasonable doubt;
iv) the need to avoid default diagnoses;
v) the importance of recognizing and identifying for others the limits of their own expertise and of avoiding the expression of opinions that fall outside that expertise; and
vi) the cautions that should surround the use of circumstantial evidence or non-pathology evidence. [See page 429.]

98 The Code of Practice and Performance Standards for forensic pathologists in Ontario should also address giving evidence, again drawing on existing sources for its content, particularly the *Code of Practice and Performance Standards for Forensic Pathologists* developed in England and Wales. It should also include specific guidance on how forensic pathologists should deal with hypothetical questions and the differing views of colleagues. [See page 433.]

99 a) Forensic pathologists should avoid potentially misleading language, such as the phrase "consistent with," and adopt neutral language that clearly reflects the limitations of the opinion expressed.
b) Work should be done in a multidisciplinary setting to build consensus on words and phrases that forensic pathologists should utilize or avoid as potentially misleading. The results of this work should be reflected in the Code of Practice and Performance Standards for forensic pathologists. [See page 435.]

100 Forensic pathologists should be regularly reminded of the dangers of being misinterpreted or misunderstood by the criminal justice system. To that end, those engaged in forensic pathology should be provided with regular continuing education and training to enhance their effective communication with the criminal justice system. [See page 436.]

Chapter 17
The Roles of Coroners, Police, Crown, and Defence

101 The coroner and forensic pathologist should work in close cooperation where there is a post-mortem examination. In doing so, the coroner should respect the forensic pathologist's expertise and independent professional judgment. [See page 438.]

102 The Office of the Chief Coroner for Ontario should continue to facilitate early and ongoing case conferencing, particularly for criminally suspicious pediatric death investigations. Such case conferencing promotes the exchange of relevant information among the participants, an objective and informed investigation, and forensic pathology opinions that are accurate and address the real issues in the case. [See page 442.]

103 Case conferences should be recorded in notes that ultimately form part of disclosure in criminal cases. [See page 442.]

104 Case conferences are excellent opportunities for members of the death investigation team to communicate among themselves. However, they do not provide the only opportunity for communication. The members of the death investigation team should engage in regular and ongoing communication, particularly when the death investigation uncovers new evidence. That evidence should be presented to the forensic pathologists to allow them to reconsider their opinion in light of the new information. Any such communications should be documented by the parties involved in those communications. [See page 443.]

105 Participants at case conferences should understand the respective roles of coroners and forensic pathologists, and how those roles affect the scope and nature of the opinions that they are able to render. A proper understanding of those roles may assist in preventing pressure from being exerted on forensic pathologists to change their opinions in order to conform to a coroner's determination of cause or manner of death. It may also assist in preventing police and Crown counsel from placing unwarranted reliance on non-expert opinions rendered by coroners for purposes other than the criminal justice system. [See page 443.]

106 Coroners should avoid offering opinions in court proceedings that do not fall within their expertise. The danger is not only that the opinions may be wrong but also that they may be accorded undue weight because they emanate from the coroner's office. [See page 444.]

107 The Ministry of Community Safety and Correctional Services, police colleges, and the Ontario Forensic Pathology Service should work together to provide specialized training on pediatric forensic death investigations for select officers, and more basic training for other officers on forensic pathology and the issues identified at this Inquiry. [See page 446.]

108 Criminally suspicious pediatric death investigations should be conducted, where possible, by officers having specialized training and expertise in such cases. [See page 447.]

109 a) The Ministry of Community Safety and Correctional Services should create and maintain a roster of officers with specialized training and expertise in pediatric death investigations.
b) Those officers should be available, when needed, to provide advice to any police service in Ontario respecting the investigation of these cases.
c) This roster, together with 24-hour contact information for the on-call officer(s), should be disseminated to all police services in Ontario. [See page 447.]

110 The police should be trained to be vigilant against confirmation bias in their investigative work generally, and for pediatric forensic cases in particular. This training is best accomplished through increased professionalism, an enhanced awareness of the risks of confirmation bias, the promotion of an evidence-based culture, and complete transparency regarding what is communicated between the police and the forensic pathologist. [See page 447.]

111 The Ministry of the Attorney General (Criminal Law Division) should implement its initiatives on the prosecution of child homicide cases and the use of a Child Homicide Team as soon as possible. [See page 450.]

112 Members of the Child Homicide Team should be experienced in homicide prosecutions and knowledgeable about the scientific method generally and pediatric forensic pathology in particular. Their education should be ongoing. [See page 450.]

113 Defence counsel should be entitled to approach the Child Homicide Team when significant disagreements between the defence counsel and the prosecutor arise in individual child homicide cases. That right should be formalized in ministry policies and made known to Crown counsel and the defence bar. [See page 450.]

114 The Child Homicide Team should, as an important component of its role, review cases in which plea offers have been made to the defence. This role will arise either as part of the mandated consultation by the prosecuting Crown with the team at every stage of the prosecution, or at the initiative of the defence. [See page 452.]

115 a) In accordance with Ministry of the Attorney General initiatives, a prosecuting Crown should report to his or her supervisor and to the division

lead for child homicide cases adverse judicial comments or his or her own concerns about the participation of a pediatric forensic pathology expert witness in the criminal justice system.

b) To enhance the oversight and accountability of such witnesses, the division lead for child homicide cases should report such comments or concerns to the Chief Forensic Pathologist. [See page 454.]

116 In furtherance of the ministry initiatives, the ministry should develop, in consultation with others, guidelines or protocols modelled on the protocols for the Crown and the Centre of Forensic Sciences that followed the Commission on Proceedings Involving Guy Paul Morin. These would address:

a) what adverse judicial comments or other identified concerns about pediatric forensic pathology expert witnesses should be reported;
b) how these comments or concerns should be reported;
c) what transcripts, if any, should be obtained, and by whom; and
d) under what circumstances this information is disclosable, and in relation to what categories of cases. [See page 455.]

117 Crown counsel should properly prepare forensic pathologists for giving evidence. This preparation involves, among other things, meeting with the pathologist in advance of the court proceedings. Such meetings will assist the Crown in understanding the limitations on the expert's expertise and opinions. The preparation of the expert should also focus on presenting the evidence in a way that is clear, unambiguous, understandable, and grounded in the witness's expertise. [See page 456.]

118 The following principles should inform the approach of both parties to the evidence of forensic pathologists:

a) Both parties should ensure that they understand the scope and limitations of the forensic pathologists' expertise and opinions. They should exercise care not to ask questions that invite forensic pathologists to speculate, or to stray outside of their expertise or the outer boundaries of the science.
b) Both parties should be vigilant not to introduce, through their questions, terminology that breeds misunderstanding or misinterpretation.
c) Subject to the court's discretion, both Crown and defence counsel should also allow forensic pathology experts reasonable time to consider their responses to new information that may be relevant to their opinions or any limitation on them. [See page 457.]

119 In accordance with a lawyer's ethical duty of competence, no lawyer should defend a criminal pediatric homicide or similar case that is beyond his or her competence or skills. [See page 460.]

120 The Province of Ontario, together with Legal Aid Ontario, should ensure that serious criminal cases involving pediatric forensic pathology are defended by lawyers who possess the necessary skill and experience to do so. This means, among other things, that the compensation for defending these cases should be significantly increased, and that the eligibility criteria for defending these cases should be appropriately defined.

The following represent ways in which these objectives may be achieved:

a) The Extremely Serious Criminal Cases Panel should be extended to cover all criminal pediatric homicide cases, including charges of manslaughter and criminal negligence causing death, as well as similar cases which involve forensic pathology or other complex medical evidence that must be critically evaluated and potentially challenged.
b) At least for pediatric homicides or similar cases, the eligibility criteria for Extremely Serious Criminal Cases should be tightened to ensure that these cases are defended by highly skilled lawyers. Although the experience and skills of some lawyers will be sufficient to meet heightened eligibility criteria without specific education and training in pediatric forensic pathology, such education and training should also inform the eligibility criteria.
c) Legal Aid Ontario should consider the criminal specialty designation by the Law Society of Upper Canada as a factor in determining whether counsel fulfill heightened eligibility criteria.
d) Legal Aid Ontario should regularly authorize junior or associate counsel for these cases, also to be paid at correspondingly increased rates. These counsel should not have to meet all of the eligibility criteria applicable to the lead or senior counsel. [See page 460.]

121 For criminal pediatric homicides and similar cases, Legal Aid Ontario normally should, if requested, fund the attendance of forensic pathologists in court when pathologists retained by the Crown or other significant experts relevant to the pathology issues present testimony in the case. [See page 462.]

122 Legal Aid Ontario's hourly tariff rates for forensic pathologists and similar experts should be increased to ensure defence access to their expertise and provide relative equivalence to the fees paid by the Crown. As well, in determining the number of hours to be authorized, whether an out-of-province

forensic pathologist should be authorized, or whether more than one forensic pathologist or expert should be authorized, Legal Aid Ontario's discretion should be informed by the lessons learned at this Inquiry – including the complexity of criminal pediatric homicide cases and the potential for miscarriages of justice where forensic pathology evidence cannot be skilfully evaluated and, if necessary, challenged. [See page 462.]

123 The total funding available to Legal Aid Ontario should be sufficient to enable the recommendations in this chapter to be implemented. [See page 463.]

124 Expert witnesses to be called by the prosecution should make themselves available to meet with defence counsel in advance of the court proceedings to explain their opinions and any limitations on them. As part of their trial preparation, defence counsel should seriously consider meeting with such experts. This is particularly appropriate in forensic pathology cases. [See page 463.]

125 The defence is often well served (as is the forensic testimony presented to the criminal justice system) by early, voluntary disclosure of its anticipated forensic evidence. The defence should be encouraged, in its own interest, to provide such early disclosure. It should not be compelled to do so. [See page 466.]

126 A court-monitoring program for forensic pathologists should be established by the Office of the Chief Coroner for Ontario, in consultation with the Ministry of the Attorney General and the Criminal Lawyers' Association. [See page 467.]

127 a) The Ministry of the Attorney General and the Ministry of Community Safety and Correctional Services should fund regular joint courses for defence counsel and the Crown dealing with forensic pathology generally and pediatric forensic pathology in particular.

b) This education should assist lawyers in developing the specialized knowledge necessary to act as counsel in pediatric forensic pathology cases. Educational programs could be live or online, but there should also be web-based materials so that lawyers in pediatric forensic pathology cases may access them as a resource when the course is not being offered. [See page 468.]

128 Law schools should be encouraged to offer courses in basic scientific literacy and the interaction of science and the law. [See page 469.]

Chapter 18
The Role of the Court

129 When a witness is put forward to give expert scientific evidence, the court should clearly define the subject area of the witness's expertise and vigorously confine the witness's testimony to it. [See page 475.]

130 A concern about the reliability of evidence is a fundamental component of the law of evidence. Threshold reliability plays an important role in determining whether proposed expert evidence is admissible under the *Mohan* test. Reliability can be an important consideration in determining whether the proposed expert evidence is relevant and necessary; whether it is excluded under any exclusionary rule, including the rule that requires evidence to be excluded if its prejudicial effect exceeds its probative value; and whether the expert is properly qualified. Trial judges should be vigilant in exercising their gatekeeping role with respect to the admissibility of such evidence. In particular, they should ensure that expert scientific evidence that does not satisfy standards of threshold reliability be excluded, whether or not the science is classified as novel. [See page 487.]

131 In determining the threshold reliability of expert scientific evidence, the trial judge should assess the reliability of the proposed witness, the field of science, and the opinion offered in the particular case. In doing so, the trial judge should have regard to the tools and questions that are most germane to the task in the particular case. [See page 496.]

132 The trial judge's gatekeeping function may be facilitated, in some cases, by written descriptions in the expert reports of the nature of the relevant discipline and how it engages with the various criteria of reliability. In forensic pathology, these descriptions could include areas of controversy relevant to the case and a reading list of scientific literature on the subject. [See page 498.]

133 Judges should consider whether there are parts of the proposed expert evidence that are sufficiently reliable to be admitted and others that are not or which must be modified to be admitted. [See page 500.]

134 The National Judicial Institute should consider developing additional programs for judges on threshold reliability and the scientific method in the context of determining the admissibility of expert scientific evidence. [See page 502.]

135 It would be useful if the Canadian Judicial Council, in conjunction with the National Judicial Institute, could examine the feasibility of preparing a Canadian equivalent to the *Reference Manual on Scientific Evidence* prepared by the Federal Judicial Center in the United States. [See page 502.]

136 a) A code of conduct for experts giving evidence in criminal proceedings should be created.
b) It should be incorporated into the criminal justice system. This may best be done through the introduction of practice directions and amendments to pretrial conference forms.
c) The code should provide that experts have a duty to assist the court on matters within their expertise and that this duty overrides any obligation to the person from whom they received instructions or payment.
d) Experts should be required to certify that they understand this duty as part of their reports and agree to be bound by the obligations contained in the code of conduct before giving evidence. [See page 505.]

137 Court-appointed or joint experts are not recommended for cases involving pediatric forensic pathology. Rather, effective use of the adversarial system, which allows each party to call its own evidence and to cross-examine the other party's witnesses, is particularly appropriate in areas of dispute or controversy in these cases. [See page 506.]

138 a) Trial judges can play an important role in enforcing compliance with the existing *Criminal Code* provisions respecting disclosure of anticipated expert testimony and in taking steps, even where there has been full compliance, to ensure that all parties are fully prepared and informed and, as a result, can effectively test the expert testimony presented.
b) Pretrial judges have an equally important role to play in cases in which pediatric forensic pathology or other complex expert evidence may figure prominently. They can facilitate the narrowing of the issues between the parties. They can facilitate the production of further particulars of the proposed expert's opinion or the grounds on which it is based. Finally, they can explore with the defence the voluntary early disclosure of the report by its proposed witness or a summary of the anticipated opinion of that witness, as well as how and when that disclosure might take place. [See page 509.]

139 It will often be in the best interests of all concerned for expert witnesses to meet before trial to discuss and clarify their differences. In appropriate cases, judges, particularly pretrial judges, can encourage and facilitate such meetings between willing experts, without requiring that they take place. [See page 511.]

140 a) In cases in which expert evidence is important, trial judges should make use of the model charge language provided by the Canadian Judicial Council model instructions.
b) Judges should remind jurors that they should apply their common sense to expert testimony and that it is up to them to decide whether to accept all, part, or none of the expert's opinion.
c) In addition, judges should, in appropriate cases, provide structured questions to assist the jury in determining the ultimate reliability of the expert's opinion. These questions may resemble the ones available to judges to assess threshold reliability as discussed in this Report. [See page 513.]

Chapter 19
Pediatric Forensic Pathology and Potential Wrongful Convictions

141 In cases in which it is sought to set aside convictions based on errors in Dr. Charles Smith's work identified by the Chief Coroner's Review, the Crown Law Office – Criminal should assist in expediting the convicted person's access to the Court of Appeal and in facilitating a determination of the real substantive issues in the cases, unencumbered by unnecessary procedural impediments. Such assistance could include

- consenting to defence applications for extensions of time within which to appeal;
- working toward agreement with the defence on evidentiary or procedural protocols for applications to extend time within which to appeal or for introducing fresh evidence on appeal or respecting the appeal itself;
- permitting the use of transcripts of the evidence tendered at inquiries (such as this one) by forensic experts or others; or
- narrowing the issues that need be resolved by the Court. [See page 516.]

142 The ongoing review of Dr. Charles Smith's 1981–91 homicide cases should be completed. The results should be made known to the public in a manner consistent with the privacy interests of those concerned, and in a manner that will not interfere with any future legal proceedings. [See page 527.]

143 The significant evolution in pediatric forensic pathology relating to shaken baby syndrome and pediatric head injuries warrants a review of certain past cases because of the concern that, in light of the change in knowledge, there may have been convictions that should now be seen as miscarriages of justice.

a) The objective of that review should be to identify those cases in which there was a conviction and in which the pathology opinion, if now viewed as unreasonable, was sufficiently important to raise significant concern that the conviction was potentially wrongful.
b) Guided by the example provided by the Chief Coroner's Review, the review should utilize a small volunteer subcommittee of the Forensic Services Advisory Committee representing the Crown, the defence, the Office of the Chief Coroner for Ontario (OCCO), and the Chief Forensic Pathologist.
c) Human and financial resources to support the subcommittee's work should be provided by the Ministry of the Attorney General, not the OCCO, because the objective concerns the administration of justice. As well, the ministry should be responsible for compensating any external reviewers retained in connection with this review.
d) The review should include convictions after either plea or trial.
e) The review should not be limited to cases where the convicted person is still in custody.
f) The review should be completed only in those cases where the convicted person consents.
g) Although the procedure used should be up to the subcommittee, the following approach is recommended for its consideration:

    i) the subcommittee should begin with the 142 cases identified by Dr. Michael Pollanen;
    ii) the subcommittee should review the cases with the help of the OCCO records to eliminate those cases in which the available pathology or non-pathology information makes it clear that there would be no significant concern about a potential wrongful conviction;

iii) the subcommittee should then obtain the information necessary to determine those cases in which there was a conviction and eliminate the remainder;
iv) the subcommittee should then obtain the requisite records (such as police files) for the identified cases and use that additional information to further eliminate cases using the criterion in paragraph (ii) above;
v) the subcommittee should proceed further with the cases that remain only if the consent of the convicted person is obtained;
vi) the subcommittee should, where the convicted person gives consent to the review, obtain transcripts of relevant court proceedings, if possible;
vii) the subcommittee should refer the cases that remain for external review by forensic pathologists, where the subcommittee is of the view that the pathology was sufficiently important that, if it is unreasonable procedurally or substantively in light of current knowledge, there is a significant concern that the conviction was potentially wrongful. The external review cannot be permitted to have an adverse impact on the ability of the Ontario Forensic Pathology Service to perform its regular duties;
viii) the external reviewers should report on the reasonableness of the pathology opinions expressed in these cases, in light of current knowledge, including whether the court was fairly advised of the extent of the controversy relating to shaken baby syndrome / pediatric head injury, as it is now understood; and
ix) the convicted persons should be advised of the results of the external review so that they can determine whether to utilize the existing processes available to address individual cases of potential wrongful conviction.

h) The public should be advised of the results of the review, in a manner consistent with the privacy interests of those involved, and in a manner that will not interfere with any future legal proceedings. [See page 533.]

144 The Forensic Services Advisory Committee through a subcommittee should be available to consider other cases in which it is alleged that flawed pediatric forensic pathology may have contributed to wrongful convictions and to recommend to the Office of the Chief Coroner for Ontario what further steps, if any, should be taken.

a) Depending on the workload created by such referrals, the subcommittee should either be made a standing committee or be constituted as needed.
b) The Ministry of the Attorney General should provide the subcommittee with adequate human and financial resources to staff its work. The Office of the Chief Coroner for Ontario should also not be required to compensate any external reviewers retained in connection with its work.
c) Where the subcommittee has referred a case for external review, and where that review results in findings that the pathology opinion earlier expressed was unreasonable and sufficiently important to raise significant concern that the conviction was potentially wrongful, the Crown Law Office – Criminal should assist in expediting the convicted person's access to the Court of Appeal and in facilitating a determination of the real substantive issues in the cases, unencumbered by unnecessary procedural impediments. Such assistance should be similar to that provided where the Chief Coroner's Review identified errors in Dr. Charles Smith's work.
d) The Crown Law Office – Criminal should also provide similar assistance, to the extent to which it is applicable, to a convicted person seeking ministerial review pursuant to s. 696.1 of the *Criminal Code*, if that is the appropriate forum to address the issue of a potential wrongful conviction. [See page 535.]

145 The Province of Ontario should bring to the attention of the federal government the two advantages identified in this Report of the model of the Criminal Cases Review Commission (CCRC) – a structure that may make it easier to find the necessary expertise, and an independence that may secure a greater degree of public confidence in its decisions – for cases involving pediatric forensic pathology. These points should inform any future discussion about adopting a CCRC model in Canada. [See page 541.]

146 The Province of Ontario should address the difficulties faced by those seeking to access the s. 696.1 *Criminal Code* process on the basis of flawed pediatric forensic pathology by

a) ensuring, together with Legal Aid Ontario, that they can obtain legal aid funding for the necessary pathology expertise to support their applications. Legal Aid Ontario should adequately fund s. 696.1 applications. As well, consideration should be given to having Legal Aid Ontario fund, under appropriate circumstances, the retention of defence forensic pathologists as a basis for determining whether an application to the minister of justice has sufficient merit to be filed; and

b) urging the federal government to enhance the investigative role of the Criminal Convictions Review Group (CCRG) of the Department of Justice to address allegations that flawed forensic pathology contributed to wrongful convictions. This could include enhanced use of forensic experts retained by the CCRG to investigate and evaluate an application for ministerial relief. [See page 541.]

147 The Province of Ontario, together with Legal Aid Ontario, should consider enabling legal aid funding, under appropriate circumstances, of forensic pathologists prior to a determination that the appeal has sufficient merit to be funded and as a basis for determining whether an appeal based on fresh evidence has merit. [See page 542.]

148 The Province of Ontario should address the identified challenges to see if it is possible to set up a viable compensation process. The objective is to provide expeditious and fair redress for those who, through no fault of their own, have suffered harm as a result of these failures of pediatric forensic pathology, thereby helping to fully restore public confidence. [See page 545.]

Chapter 20
First Nations and Remote Communities

149 a) Northern Ontario should be divided into two coronial regions – the Northwest Region, to be based in Thunder Bay; and the Northeast Region, to be based in Sudbury.

b) Each of these two regions should be headed by its own regional coroner and properly resourced to fulfill its duties under the *Coroners Act*.

c) More generally, the Province of Ontario should provide adequate resources to ensure coronial and forensic pathology services in Northern Ontario that are reasonably equivalent to those services provided elsewhere in the province, even though doing so will cost more in the North. [See page 549.]

150 The Office of the Chief Coroner for Ontario should seek to enter into a service agreement with the Winnipeg Health Sciences Centre to ensure that the same or analogous protocols and procedures as recommended in this Report with respect to peer review, accountability, and quality assurance are in place in Winnipeg for Ontario cases autopsied there. [See page 550.]

151 The Northeastern regional forensic pathology unit should become a formal forensic pathology unit with a director and funding for transfer payments. As such, it should perform pediatric forensic autopsies as determined by the Chief Forensic Pathologist. [See page 552.]

152 Steps should be taken to enhance the likelihood that investigating coroners will attend the death scene in accordance with the Office of the Chief Coroner for Ontario's existing guidelines. Such attendances improve the quality of many death investigations and provide an opportunity for coroners to communicate with affected families and build relationships with affected communities. [See page 554.]

153 The attendance or non-attendance of investigating coroners at death scenes should be tracked as part of the quality assurance processes of the Office of the Chief Coroner for Ontario (OCCO). Similarly, compliance with the OCCO guideline indicating that coroners must document their reasons for not attending the scene and discuss them with the regional coroner should also be tracked. [See page 554.]

154 The Office of the Chief Coroner for Ontario should consider, in consultation with remote communities and First Nations, the development of specific guidelines that better address those circumstances in which investigating coroners will be expected to attend death scenes in remote communities. [See page 554.]

155 The medical profession and medical schools, such as the Northern Ontario School of Medicine, together with the Province of Ontario, the Nishnawbe Aski Nation, the Office of the Chief Coroner for Ontario, and others, should work in partnership to increase the numbers of physicians working in remote areas. Even more specific to the mandate of this Inquiry, the fee provided to coroners to attend death scenes, particularly in remote communities, should be increased so that it is not a disincentive to attendance. [See page 555.]

156 a) Where it is not feasible for investigating coroners to attend the scene, all available technology, such as digital photography, should be used to provide timely information to the coroners and enable them, in turn, to provide direction or guidance, as may be needed, to the police or the forensic pathologist.

b) The Office of the Chief Coroner for Ontario should develop, in partnership with remote communities and First Nations, enhanced technology, such as remote teleconferencing, which is ultimately designed to provide "real-time" information to the coroner and the forensic pathologist. Resources should be made available to enable this technology to be developed and used. [See page 556.]

157 a) The use of police officers as coronial surrogates was evidently intended for emergency situations only. It should not be the norm or the default position for all deaths within the coroner's jurisdiction.

b) The Office of the Chief Coroner for Ontario should engage in a consultative process with those communities most affected to evaluate various models for delegating coronial investigative powers to others, including health care professionals or community-based individuals with specialized training. [See page 559.]

158 The Office of the Chief Coroner for Ontario should consult with Aboriginal leaders in developing policies for accommodating, to the extent possible, diverse Aboriginal practices concerning the treatment of the body after death. [See page 561.]

159 Coroners should receive training on cultural issues, particularly surrounding death, to facilitate the performance of their responsibilities. [See page 561.]

160 Coroners play an important role in communicating with affected families about the death investigation. Such communication should include information about where the body is being transported, whether and why a post-mortem examination is being conducted, what that involves, when it is expected to take place, what if any issues arise in connection with organ or tissue removal, when the body or any organs or other body parts will be returned, and, if requested, what the results of the post-mortem examination or other relevant reviews reveal. In the absence of compelling reasons in the public interest, it is unacceptable for a family already suffering the loss of a child to be left uninformed and unaware of this and other information relating to the death investigation. [See page 563.]

161 In remote communities, community leaders play a vital role in providing support for families and community members affected by a death, particularly that of a child. They can also help to identify systemic issues that are

raised by individual deaths, including the pediatric forensic pathology work associated with those deaths. Community leaders can work with the OCCO and, where applicable, First Nations governments and political organizations toward needed change. It is therefore important that regional coroners and investigating coroners meet with community leaders to build relationships and facilitate partnerships. [See page 564.]

162 a) The Office of the Chief Coroner for Ontario should work in partnership with First Nations governments and political organizations to develop communication protocols. Priority should be given to the development of such protocols for the North, where the need is particularly acute.

b) Whatever model is developed to enhance communications, it should involve people within the coroner's system who understand and are familiar with the relevant Aboriginal cultures, languages, and spiritual or religious beliefs and practices. [See page 565.]

Chapter 21
Pediatric Forensic Pathology and Families

163 a) The Province of Ontario, with the assistance of the Ontario Association of Children's Aid Societies and others, should develop province-wide standards, supplementing those that already exist, on the sharing of information arising out of the investigations of suspicious child deaths by the police and children's aid societies.

b) The provincial standards should:

- Specifically address the expectations surrounding the sharing of information relating to joint or parallel investigations arising out of child deaths where other children may be at risk.
- Emphasize the importance of the timely and accurate communication of such information, and its updating as circumstances change, particularly by the police to child protection workers to ensure that decisions regarding surviving children are accurate.
- Remove any misconceptions that inhibit the appropriate sharing of information, and reinforce the point that, although it is important to protect the integrity of an ongoing criminal investigation, the need to withhold information from the child protection system in order to do so should not be overstated. The significance of decisions being

made in the child protection forum, and how the sharing of information can promote better fact-finding in that forum, should also not be underestimated.

- Articulate the roles to be played by coroners, forensic pathologists, and Crown counsel in the sharing of information in investigations arising out of the suspicious death of a child.

c) Local protocols should also be created across the province to permit local jurisdictions to implement the provincial standards in a manner that best suits their particular communities.

d) The timely development of these local protocols should be facilitated through the creation of a template for such protocols to accompany the provincial standards.

e) Local children's aid societies, police, coroners, forensic pathologists, and Crown counsel should receive joint training on the provincial standards and their local implementation to ensure that all parties have common understandings and interpretations of the standards and protocols and their application locally. [See page 576.]

164 The Office of the Chief Coroner for Ontario (OCCO) should develop a Family Liaison Service dedicated to communicating with families, particularly those that have suffered the loss of a child. The service should ensure that it communicates with the affected families in an effective, timely, caring, and compassionate manner. The Province of Ontario should provide additional funding to the OCCO to enable this service to be developed. [See page 579.]

165 a) Disclosure of autopsy results to parents should be made verbally and in writing in a timely manner that is sensitive to the parents' loss and bereavement.

b) The Office of the Chief Coroner for Ontario should meet with the Ontario Association of Children's Aid Societies and leading police forces to develop a policy respecting the timely release of the post-mortem information where there is an ongoing criminal investigation. [See page 580.]

166 The Office of the Chief Coroner for Ontario's current policy for organ and tissue retention and disposition should be continued. Coroners should be encouraged to communicate with families about the need for organ and tissue retention in a timely manner that is respectful of these families and their cultural or religious beliefs. [See page 581.]

167 The Province of Ontario should provide funding to permit counselling for individuals from families affected by flawed pediatric forensic pathology in cases examined at this Inquiry for up to a further three years, for a total of five years from the time of commencement, if the individual and the counsellor think it would be useful. [See page 582.]

168 In the discharge of his or her mandate, the director of the Child Abuse Register in Ontario should be encouraged to grant the request of persons wrongly listed on the register as a result of faulty pediatric forensic pathology to have their names removed from the register if there is no longer credible evidence of abuse. [See page 583.]

169 a) Legal Aid Ontario should work with the family law bar to ensure that family lawyers are funded for child protection proceedings in which pediatric forensic pathology plays an important role. The tariff for counsel who litigate these cases should be increased to create incentives for experienced and specially trained lawyers to take on legally aided cases and to reflect their added expertise. Legal Aid Ontario should fund an adequate number of hours to ensure that family counsel can properly fulfill their duties.

b) In appropriate cases, Legal Aid Ontario should authorize funding for one or more forensic pathologists and, where necessary, out-of-jurisdiction pathologists, including their travel expenses.

c) Legal Aid Ontario should raise the hourly rate for forensic pathology experts to a level that is commensurate with funding of experts retained by the Crown. This is necessary to ensure that experts of comparable skill to that of experts retained by the Crown are prepared to assist the family lawyer. This increase should occur expeditiously in pediatric forensic pathology cases.

d) Legal Aid Ontario should increase the number of hours of funding authorized for forensic pathologists. [See page 586.]