

# **Inquiry into Pediatric Forensic Pathology in Ontario**

## **R E P O R T**

### **Volume 3: Policy and Recommendations**

**The Honourable Stephen T. Goudge**  
*Commissioner*

Published by the Ontario Ministry of the Attorney General  
© Queen's Printer for Ontario 2008

ISBN 978-1-4249-7792-5 (Print) (set)  
ISBN 978-1-4249-7797-0 (Print) (v. 3)  
ISBN 978-1-4249-7798-7 (PDF) (v. 3)

Copies of this and other Ontario Government publications are available from Publications Ontario at ServiceOntario Centre, College Park Building, 777 Bay Street at College, Toronto M5G 2E5. Out-of-town customers may write to Publications Ontario, 50 Grosvenor St., Toronto M7A 1N8. Telephone (416) 326-5300; (416) 325-3408 TTY; or toll-free 1-800-668-9938 or 1-800-268-7095 TTY. Internet: [www.publications.serviceontario.ca](http://www.publications.serviceontario.ca).

This Report is also available at [www.goudgeinquiry.ca](http://www.goudgeinquiry.ca) for one year following publication, and, thereafter, at [www.attorneygeneral.jus.gov.on.ca](http://www.attorneygeneral.jus.gov.on.ca).

Disponible en français

LIBRARY AND ARCHIVES CANADA CATALOGUING IN PUBLICATION DATA

Inquiry into Pediatric Forensic Pathology in Ontario

Inquiry into Pediatric Forensic Pathology in Ontario report  
[electronic resource]

Issued also in French under title: Rapport de la Commission  
d'enquête sur la médecine légale pédiatrique en Ontario.

Includes bibliographical references.

Electronic monograph in PDF format.

Available also in printed form.

ISBN 978-1-4249-7794-9 (v. 1)

978-1-4249-7796-3 (v. 2)

978-1-4249-7798-7 (v. 3)

978-1-4249-7800-7 (v. 4)

1. Forensic pathology—Ontario. 2. Forensic pathology. 3. Pediatric pathology. 4. Medical jurisprudence. 5. Child abuse—Investigation—Ontario. 6. Criminal justice, Administration of—Ontario. 7. Child welfare—Ontario. I. Title. II. Title: Rapport de la Commission d'enquête sur la médecine légale pédiatrique en Ontario.

RA1063.4 I57 2008 614'.108309713 C2008-964036-5

---

# Contents

## Volume 1: Executive Summary

## Volume 2: Systemic Review

*Acknowledgments* xv

*Abbreviations and Acronyms* xvii

*Glossary of Medical Terms* xix

- 1 The Death of a Child and the Criminal Justice System 3
- 2 Growing Concerns 7
- 3 Establishment of the Commission 44
- 4 Investigation of Suspicious Pediatric Deaths 51
- 5 Legislative Context 60
- 6 The Science and Culture of Forensic Pathology 66
- 7 Organization of Pediatric Forensic Pathology 80
- 8 Dr. Smith and the Practice of Pediatric Forensic Pathology 115
- 9 Oversight of Pediatric Forensic Pathology 205

## Volume 3: Policy and Recommendations

*Abbreviations and Acronyms* xiii

*Glossary of Medical Terms* xv

- 10 Restoring Confidence in Pediatric Forensic Pathology 281
- 11 Professionalizing and Rebuilding Pediatric Forensic Pathology 284
  - Overview 284
  - Legislative Recognition of a Professionalized Forensic Pathology Service 285
    - Creation of the Ontario Forensic Pathology Service 286
    - Leadership Structure for the Ontario Forensic Pathology Service 286
    - The Role of Pathologists 287

Establishment of the Governing Council	287
An Educational Foundation for a Professionalized Forensic Pathology Service	288
Education, Training, and Credentialing in Other Jurisdictions	289
United Kingdom	289
United States	291
Australia	292
Accreditation and Certification in Forensic Pathology in Canada	293
Increasing the Interest in Forensic Pathology	295
The Three Pillars: Service, Teaching, and Research	296
Funding Forensic Pathology Fellowships	298
A Centre for Forensic Medicine and Science at the University of Toronto	298
Educating the Medical Profession about the Criminal Justice System	299
Continuing Medical Education	301
Recruitment and Retention of Forensic Pathologists	302
Creation of a New Facility	304
Immediate Steps	306
Adequate and Sustainable Funding	307
<b>12 Reorganizing Pediatric Forensic Pathology</b>	<b>308</b>
Effective Organization of the Work of Forensic Pathology in Ontario	309
The Ontario Forensic Pathology Service	309
The Role of the Chief Forensic Pathologist	309
The Role of the Deputy Chief Forensic Pathologist	312
The Role of Regional Directors	312
Building on the Regional Units	314
The Northeastern Regional Forensic Pathology Unit	315
The Service Agreements	316
Future Growth of the Units	320
The Use of Technology	320
Effective Organization of Pediatric Forensic Pathology in Ontario	321
The OPFPU	321
Relationship between the PFPU and the OPFPU	323
Information Sharing between SickKids and the OCCO	325
Pediatric Forensic Pathology across Ontario	325
Protocol for Criminally Suspicious Pediatric Cases	326
Double Doctoring	327
Protocol for Pediatric Cases That Become Criminally Suspicious during Autopsy	328
Protocol for Criminally Suspicious Adult Cases	329

<b>13 Enhancing Oversight and Accountability</b>	<b>331</b>
Introduction	331
Oversight, Accountability, and Quality Control / Assurance	332
Governance of the OCCO: Creation of a Governing Council	334
Responsibilities of the Governing Council	335
Structure of the Governing Council	336
Principles for the Oversight of Forensic Pathology	340
Institutional Improvements	341
Need for a Registry of Forensic Pathologists	341
Structure and Establishment of the Registry	342
Clarifying Relationships	344
Accountability of the Chief Coroner and the Chief Forensic Pathologist	344
Administrative Responsibilities for the Coronial Service and the OFPS	346
Chief Coroner and Chief Forensic Pathologist as Full-Time Positions	346
Contractual Relationships with Regional Forensic Pathology Units	347
Forensic Pathology Advisory Committee	347
Tools for Oversight and Accountability of Forensic Pathologists' Work	348
Quality Assurance Staff	348
Policy Guidelines	349
Peer Review – Consultation with Chief Forensic Pathologist	350
Peer Review of Reports of Post-Mortem Examination	350
Peer Review of Supplementary and Consultation Reports	352
Quality Control during Rounds	352
Annual Performance Reviews	354
Oversight of the Chief Forensic Pathologist	355
Committee Development	356
A Central Tracking System for Forensic Cases	357
Evaluation of Pathologists' Testimony	358
Accountability to External Standards and Review Mechanisms	360
Continuing Medical Education	361
<b>14 Improving the Complaints Process</b>	<b>363</b>
The Need for a Complaints System at the OCCO	364
Jurisdiction of the Complaints Process	365
The OCCO and the CPSO Must Both Have Jurisdiction Regarding Complaints	366
Principles and Design of the Complaints Process	367
Mechanisms to Address Complaints about the OCCO/OFPS Leadership	369
Information Sharing during Complaints Process	370

<b>15 Best Practices</b>	<b>372</b>
Basic Principles	373
The Pathologist's Basic Orientation: Thinking Dirty vs. Thinking Truth	374
Specific Best Practices	377
Scene Attendance	377
Providing On-Scene Information to the Pathologist	379
Information Provided to the Pathologist	380
Information Relayed by Coroner or Police about the Circumstances Surrounding the Death	381
Recording the Pre-autopsy Communications	384
Filtering the Information Provided to the Pathologist	387
Recording and Preserving the Autopsy's Work Product	391
Providing Preliminary Opinions	392
Recording the Preliminary Opinion	396
Timeliness of Reports	398
Toxicology Testing	402
Teamwork	403
Implementation of Best Practices for the Conduct of Autopsies	404
<b>16 Effective Communication with the Criminal Justice System</b>	<b>406</b>
General Principles	407
Sources of Misinterpretation or Misunderstanding	408
The Substance and Language of the Opinion	408
The Level of Confidence or Certainty in the Opinion	410
Failure to Address Other Explanations for the Pathology Findings	414
Opinions in Areas of Controversy within Forensic Pathology	417
The Limits of the Pathologist's Expertise	419
Misplaced Reliance on Non-pathology Information	420
Failure to Indicate Reliance on Other Expert Views	423
The Omission of the Facts and Reasoning Process Underlying the Opinion	424
Implementing More Effective Communication	427
Report Writing	427
Testimony	430
Building Consensus on Language	433
Additional Steps	435

<b>17 The Roles of Coroners, Police, Crown, and Defence</b>	<b>437</b>
Coroners	437
Case Conferences	439
The Coroner's Expertise	443
Police	445
Crown	448
Disclosure Issues Arising from the Ministry Initiatives	452
The Crown's Obligations in Preparing for and Tendering Forensic Pathology Evidence	455
Defence	457
Defence Counsel Meeting with Experts	463
Disclosure of Expert Reports and Meetings between Experts	464
Counsel Evaluations of Expert Witnesses	466
Education in Forensic Pathology	467
<b>18 The Role of the Court</b>	<b>470</b>
The Admissibility of Expert Evidence	471
Defining the Limits of the Expertise	471
The Test for Admissibility of Expert Evidence	475
<i>Mohan</i>	475
Addressing Threshold Reliability	477
<i>Daubert</i>	480
<i>J.-L.J.</i>	482
<i>Trochym</i>	483
<i>Re Truscott</i>	485
Tools for Judges to Use in Determining Threshold Reliability	487
The Process to Determine the Admissibility and Scope of Expert Evidence	496
When There Is No Objection	496
The Form of the <i>Voir Dire</i>	497
The Range of Outcomes from the Admissibility Hearing	499
Judicial Education to Enhance the Gatekeeping Function	500
The Interaction of the Justice System with Expert Witnesses	503
A Code of Conduct for Expert Witnesses	503
Court-Appointed or Joint Experts	506
Case Management, Disclosure of Expert Reports, and Meetings between Experts	507
Pretrial Meetings or "Hot Tubs" between Experts	509
Charges to the Jury with Respect to Expert Evidence	511

<b>19 Pediatric Forensic Pathology and Potential Wrongful Convictions</b>	<b>514</b>
Cases Examined by the Chief Coroner's Review	515
Review of Other Past Cases	516
Experience in England and Wales	518
Considering a Review Process	525
A Review of Dr. Smith's 1981–1991 Cases	527
A Comprehensive Review of Ontario Pediatric Forensic Pathology Cases	527
A Review of Shaken Baby Syndrome / Pediatric Head Injury Cases	527
Future Role of the Forensic Services Advisory Committee	535
Application for Review to the Minister of Justice	536
Legal Aid	542
Compensation	542
<b>20 First Nations and Remote Communities</b>	<b>546</b>
Guiding Principles	546
The Current Structure of Forensic Services in the North	549
Coroners	549
Forensic Pathologists in Pediatric Cases	550
The Coroner's Attendance at the Death Scene	552
When the Coroner Cannot Attend the Death Scene	555
The Technology	555
Delegation of the Coroner's Investigative Powers	556
Cultural Issues	560
Communication between the OCCO and First Nations	561
Informing Affected Families	561
Communication between Coroners and Community Leaders	563
Communication with First Nations Governments and Political Organizations	564
<b>21 Pediatric Forensic Pathology and Families</b>	<b>567</b>
Information Sharing	568
Communicating with Affected Families	578
Releasing Post-Mortem Reports to Families	579
Organ and Tissue Retention and Disposition	580
Reviews of Child Protection Cases Involving Dr. Smith	581
Legal Aid Funding in Child Protection Proceedings Involving Pediatric Forensic Pathology	584



22 **Conclusion and Consolidated Recommendations** 588  
Consolidated Recommendations 590

**Volume 4: Inquiry Process**

23 The Scope and Approach of the Inquiry 635  
Appendices 675

Commissioner and Inquiry Staff 985