November 20, 2007

LIST OF SYSTEMIC ISSUES

Training and Certification of Pediatric Forensic Pathologists

1. What education and training should be required for those doing pediatric forensic pathology in Ontario, and who should provide it?

2. Should formal certification be required, and if so, what kind, and by whom?

3. What continuing education and training should be required, and who should provide it?

4. For each of these, should the focus be on pediatric pathology or forensic pathology or both?

Institutional Considerations

5. Should Ontario have an institutional setting dedicated to pediatric forensic pathology, or should pediatric services be delivered within a forensic pathology institutional setting?

6. What should the relationship be between the chief forensic pathologist of Ontario and forensic pathologists in Ontario? Should forensic pathologists all be located in one or several teaching hospitals?

7. In light of the geographic size of Ontario, how should pediatric forensic pathology services be organized throughout the province, particularly given the need for accessibility, efficiency, competence and quality control?

8. How should pediatric forensic pathology be delivered to Aboriginal communities, given their special circumstances?

9. How should pediatric forensic pathology be delivered to remote communities in Ontario, given their special circumstances?

10. What is the most cost efficient way of delivering quality pediatric forensic pathology services? For example, what are the advantages and disadvantages of using staff doctors or fee-for-service doctors?

11. Does Ontario have a sufficient supply of pediatric forensic pathology services, and how can that be assured in future?

12. Does Ontario have sufficient support services (such as adequate morgues) for pediatric forensic pathology, and how can that be assured in future?

The Post Mortem Examination

13. What is the approach that best balances the objective that no individual be wrongly accused of child abuse with the objective that children be protected from abuse? What are the relative merits of "thinking dirty" or "thinking truth" or other alternatives?

14. How is scientific objectivity best maintained throughout the examination to avoid "tunnel vision" that merely seeks support for an *a priori* conclusion?

15. What subspecialty of pathology should take the lead in pediatric forensic cases? Should a team of pathologists be used rather than a single pathologist?

16. What should the participation of other subspecialties of pathology be in the post mortem examination, and at what stage?

17. What other medical specialties should be available to and accessed by the pathologist, and how is this best achieved in an efficient and timely way?

18. What role, if any, should a "suspected child abuse and neglect" team (a SCAN team) play in assisting the pathologist? Should it serve in an assessment capacity, or in an investigative capacity, or neither, or both?

19. What role, if any, should the deceased child's physician play in providing information to the pathologist?

20. Should the pathologist attend the scene? What guidelines should inform the decision and the attendance?

21. What non-medical information should be provided to the pathologist? Should the pathologist be provided with all or only some of the information in the possession of the police? What guidelines should apply and how can they minimize the risk of "tunnel vision" that may exclude the consideration of possible conclusions, particularly where there is information about past abuse or neglect?

22. How should the information that is provided to the pathologist be memorialized?

23. What should be photographed at the post mortem examination? Should it be videotaped or audiotaped?

24. Should the pathologist communicate preliminary opinions to the police or child protection officials and if so, how should they be memorialized, and who else should receive them?

25. How and where should evidence obtained during or as a result of the examination be kept and preserved?

26. What other steps, if any, should be taken to permit reviewability of the findings?

The Post Mortem Report

27. What guidelines should there be for the content of the post mortem report?

28. What guidelines should there be for the timing of the post mortem report?

29. Who should receive the post mortem report?

30. How should the post mortem report articulate and explain the degree of certainty attached to the opinions it contains? How should this relate to the degree of certainty applicable to the criminal trial?

31. Should the post mortem report offer an opinion on the means, mechanism, or mode of death? Or whether the death was accidental or deliberate?

32. In general, what are the limits of the pathologist's expertise that should be observed in the post mortem report?

33. What language should be used or avoided in the post mortem report to effectively communicate the pathologist's opinions to the criminal justice system? Should there be guidelines about words or phrases to be used or avoided?

34. When, if at all, should the terms "SIDS" and "SUDS" be used in a post mortem report?

35. What is the proper role, if any, for a subsequent report by the pathologist (sometimes called a "final autopsy report"), and what guidelines should there be for it?

The Testimony

36. What should the approach of the pathologist be to giving evidence: advocate for an opinion, scientific truth seeker, officer of the court, all or none of these?

37. Should there be training and/or guidelines for pathologists about giving evidence? Should these address the proper limits of the pathologist's expertise to be observed in giving evidence?

38. In giving evidence, should the pathologist advance alternatives not contained in the post mortem report or respond to invitations to speculate?

39. In giving evidence, what language should be used or avoided to fairly and effectively communicate the pathologist's opinions to the court?

40. Should pathologists testifying for parties adverse in interest meet to focus areas of agreement and disagreement? If so, at what stage, with who else present, and subject to what rules (for example, about issues like confidentiality)?

Quality Control

41. Should there be peer review of the pathology opinion? If so, at what stage? By those with what specialized training and having been provided with what information? Should the review go beyond whether the opinion is reasonable, and address whether it is correct? When should an independent opinion be sought?

42. Should the coroner play a role in the review of the pathologist's opinion? Should this be done through the chief forensic pathologist of Ontario? Should "under 5" or "pediatric review" committees be used in this process?

43. If the pathology is done in a hospital, should the hospital be responsible to review the opinion? Should hospital rounds play a role in this?

44. Should special review mechanisms be used if the pathologist is a leader in the field? If so, what?

45. How should any review be memorialized?

46. Should there be a separate review of the pathologist's testimony and if so by whom and for what purposes?

The Role of the Coroner

47. From the perspective of best pediatric forensic pathology, what are the advantages and disadvantages of the coronial system compared to other models, such as the medical examiner system?

48. What education and training should coroners have respecting pediatric forensic pathology issues?

49. How should the roles of the coroner and the pathologist be best delineated in the investigation of pediatric forensic deaths?

50. What information should be made available to each to best discharge those roles?

51. Should the dichotomy between "cause of death" and "manner of death" be preserved? What roles should the coroner and the pathologist each play in their determination?

52. Should the coroner be able to override the opinion of the pathologist on cause of death and, if so, when?

The Role of the Police

53. Should the police have specialized training in pediatric forensic death investigations?

54. Should there be guidelines concerning the information the police provide to, and receive from, the pediatric forensic pathologist during and following the death investigation?

55. Should there be guidelines concerning the communication by the police of information received from the pathologist to other institutions such as those responsible for child protection?

The Role of the Crown

56. Should Crown counsel have specialized training in order to prosecute pediatric forensic death cases?

57. How should Crown counsel ensure the timely preparation of pediatric forensic pathology reports?

58. Should the Crown have a role in evaluating the accuracy and reliability of pediatric forensic pathology evidence? How and when would that be done?

59. How should the pathology affect the charge selection in pediatric forensic cases?

60. What is the appropriate relationship between the Crown and child protection authorities in pediatric forensic death cases?

The Role of the Defence

61. Should defence counsel have specialized training in order to defend pediatric forensic death cases?

62. When and in what form should the defence receive disclosure of the pediatric forensic pathology report and the information on which it was based?

63. Should there be funding to ensure that the defence can retain pediatric forensic pathology expertise, and how can this be assured?

64. How can a sufficient pool of such expertise be assured?

65. Should a pediatric forensic pathology expert retained by the defence be able to participate in the post mortem examination or conduct his or her own examination?

66. When, if at all, should defence counsel be able to communicate with the pathologists who are Crown witnesses and what guidelines should govern those communications?

The Role of the Child Protection Agency

67. What information should be exchanged between the pathologist and the child protection agency, and at what stage? Should there be guidelines for these communications? How should any communications be memorialized?

68. Should either the coroner or the pathologist play a role in child protection proceedings involving surviving children? If so, what should that be?

69. Should the best interests of the child in such proceedings permit or require the pathologist to advance more speculative opinions than in a criminal proceeding?

The Role of the Family

70. Should there be guidelines for communications between the pathologist or the coroner and the family? How should an ongoing criminal or child protection investigation affect the communication?

71. How, if at all, can the family's need to grieve be reconciled with the work of the pathologist in a pediatric forensic death?

Corrective Measures

72. After the fact of inadequate pediatric forensic pathology, what should the role of the coroner and the Office of the Chief Coroner of Ontario be? How should they deal with complaints about the work of a pediatric forensic pathologist?

73. What should the role of the College of Physicians and Surgeons be? How should it deal with complaints about the work of a pediatric forensic pathologist? Is it able to deal with complaints that relate primarily to the forensic dimension of that work rather than the pathology dimension?

74. What should the role of the hospital be? How should it deal with complaints about the work of a pathologist in a pediatric forensic case? Can it deal with complaints that relate primarily to the forensic dimension of that work rather than the pathology dimension?

75. What role should the Ombudsman's office play after the fact of inadequate pediatric forensic pathology? Are there other institutions that should also play a role?

General

76. If there is a significant change in the science of pediatric forensic pathology, how should the criminal justice system respond?

77. Should the Court of Appeal for Ontario issue guideline judgments on important issues that may be in dispute in pediatric forensic pathology, as has been done by the English Court of Appeal?

78. What does Ontario have to learn from other jurisdictions where similar problems have arisen?

79. What measures, if any, should be undertaken by the bench and bar on the one hand, and the forensic pathology community on the other, to promote the understanding by the former of the scientific assistance offered by the latter in pediatric forensic death cases?

80. For any changes that may be recommended by the Commission, what are the most effective implementation mechanisms? In each case, what is best: legislation, regulation, guidelines or some other mechanism?