In the matter of the Public Inquiries Act, R.S.O. 1990, c. P.41
And in the matter of Order-in-Council 826/2007 and the Commission issued effective April 25, 2007, appointing the Honourable Stephen Goudge as a Commissioner
And in the matter of a summons to witness issued by the Commission to the Registrar of the College of Physicians and Surgeons of Ontario on September 17, 2007

COMPENDIUM OF COMMISSION COUNSEL
(MOTION FOR DIRECTIONS RETURNABLE OCTOBER 4, 2007)

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO
180 Dundas Street West, 22nd Floor
Toronto, ON M5G 1Z8

Linda Rothstein
Robert A. Centa

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TAB 1

Ontario

Executive Council
Conseil exécutif

Order in Council
Décret

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

WHEREAS on April 19, 2007, the Chief Coroner for Ontario announced the results of a review of certain cases of suspicious child deaths where Dr. Charles Smith performed the autopsy or was consulted ("the Chief Coroner's Review") and found that some of the factual conclusions were not reasonably supported by the materials available;

AND WHEREAS the Ministry of the Attorney General and the Office of the Chief Coroner for Ontario are working together to identify, and the Minister of Community Safety and Correctional Services has requested that the Office of the Chief Coroner review homicide and criminally suspicious cases in which Dr. Smith performed an autopsy or provided an opinion prior to 1991;

AND WHEREAS the Chief Coroner for Ontario has announced that he has made the College of Physicians and Surgeons aware of the concerns identified in the Chief Coroner's Review;

AND WHEREAS the cases that have raised issues with determinations of fact and opinion that were submitted as evidence in criminal proceedings are currently being dealt with through the disclosure of the findings of the Chief Coroner's Review to defendants in related criminal proceedings;

AND WHEREAS there are processes in the Criminal Code of Canada for addressing individual cases of potential wrongful conviction;

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur, sur l'avis et avec le consentement du Conseil exécutif, décrète ce qui suit :

ATTENDU QUE, le 19 avril 2007, le coroner en chef de l'Ontario a rendu publics les résultats de la vérification de certaines affaires de décès suspects d'enfants dans le cadre desquelles le docteur Charles Smith a procédé à une autopsie ou a été consulté («la vérification du coroner en chef»), et qu'il a conclu que certaines des conclusions de faits n'étaient pas raisonnablement étayées par les éléments disponibles;

ATTENDU QUE le ministère du Procureur général et le Bureau du coroner en chef de l'Ontario collaborent afin de rechercher les affaires d'homicides et d'actes criminels dans le cadre desquelles le Dr Smith a procédé à une autopsie ou fourni une opinion avant 1991, et que le ministre de la Sécurité communautaire et des Services correctionnels a demandé que le Bureau du coroner en chef vérifie ces affaires;

ATTENDU QUE le coroner en chef de l'Ontario a annoncé qu'il a informé l'Ordre des médecins et chirurgiens de l'Ontario des questions soulevées par sa vérification;

ATTENDU QUE les affaires où sont mises en question des conclusions de faits et des opinions qui ont été présentées en preuve dans des instances criminelles donnent en ce moment lieu à la divulgation des conclusions de la vérification du coroner en chef aux défendeurs dans les instances criminelles qui les concernent;

ATTENDU QUE le Code criminel du Canada prévoit des recours en cas d'erreur judiciaire;

AND WHEREAS there are civil and criminal proceedings that have arisen as a result of Dr. Smith's work that are the appropriate forum for the adjudication of those matters;

AND WHEREAS the Lieutenant Governor in Council considers it advisable to appoint a person to identify and make recommendations to address systemic failings that may have occurred in connection with the oversight of pediatric forensic pathology in Ontario;

AND WHEREAS the inquiry is not regulated by any special law;

THEREFORE, pursuant to the *Public Inquiries Act*:

Establishment of the Commission

1. A Commission shall be issued effective April 25, 2007, appointing the Honourable Stephen Goudge as a Commissioner.

2. The Commission shall conduct the inquiry to ensure the expeditious delivery of its report and shall deliver its final report and recommendations to the Attorney General no later than April 25, 2008.

3. Senator Larry Campbell shall chair an expert medical and scientific panel, which shall report to the Commissioner, to provide such information and advice as directed by the Commissioner.

Mandate

4. The Commission shall conduct a systemic review and assessment and report on:

    a. the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings;

ATTENDU QUE les poursuites civiles et criminelles qui sont survenues à la suite du travail du Dr Smith constituent le moyen adéquat de trancher ces affaires;

ATTENDU QUE le lieutenant-gouverneur en conseil estime souhaitable de nommer une personne chargée de cerner les lacunes systémiques qui peuvent avoir existé relativement à la surveillance de la médecine légale pédiatrique en Ontario et de faire des recommandations à ce propos;

ATTENDU QUE l'enquête n'est régie par aucune loi spéciale;

EN CONSÉQUENCE, conformément à la *Loi sur les enquêtes publiques* :

Constitution de la commission

1. Une commission est constituée à compter du 25 avril 2007, nommant commissaire l'honorable Stephen Goudge.

2. La commission mènera l'enquête avec la célérité voulue et remettra son rapport final et ses recommandations au procureur général au plus tard le 25 avril 2008.

3. Le sénateur Larry Campbell présidera un comité d'experts médicaux et scientifiques qui relève du commissaire et qui est chargé de lui fournir les renseignements et les conseils qu'il lui demande.

Mandat

4. La commission procédera à un examen et à une évaluation systémiques et fera rapport sur ce qui suit :

    a. les politiques, les méthodes, les pratiques, les mécanismes de responsabilisation et de surveillance, les mesures de contrôle de la qualité et les aspects institutionnels de la médecine légale pédiatrique en Ontario de 1981 à 2001 en ce qui concerne son exercice et son rôle dans les enquêtes et dans les instances criminelles;

b. the legislative and regulatory provisions in existence that related to, or had implications for, the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and

c. any changes to the items referenced in the above two paragraphs, subsequent to 2001

in order to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.

5. In fulfilling its mandate, the Commission shall not report on any individual cases that are, have been, or may be subject to a criminal investigation or proceeding.

6. The Commission shall perform its duties without expressing any conclusion or recommendation regarding professional discipline matters involving any person or the civil or criminal liability of any person or organization.

7. The Commission shall review and consider any existing records or reports relevant to its mandate, including the results of the Chief Coroner's Review announced on April 19, 2007, and other medical, professional, and social science reports and records. Further, the Commission shall rely wherever possible on overview reports submitted to the inquiry. The Commission may consider such reports and records in lieu of calling witnesses.

8. The Commission shall rely wherever possible on representative witnesses on behalf of institutions.

b. les dispositions législatives et réglementaires qui portaient sur l'exercice de la médecine légale pédiatrique en Ontario entre 1981 et 2001 ou qui avaient une incidence sur cet exercice;

c. toute modification postérieure à 2001 des éléments visés aux alinéas précédents;

en vue de faire des recommandations visant à rétablir et à rehausser la confiance du public envers la médecine légale pédiatrique en Ontario et son rôle futur dans les enquêtes et dans les instances criminelles.

5. Dans le cadre de son mandat, la commission ne doit pas faire rapport sur des affaires particulières qui font, ont fait ou peuvent faire l'objet d'une enquête ou instance criminelle.

6. La commission s'acquittera de ses fonctions sans formuler de conclusions ou de recommandations quant aux questions de discipline professionnelle mettant en cause une personne ou quant à la responsabilité civile ou criminelle de toute personne ou de tout organisme.

7. La commission examine et étudie les dossiers ou les rapports existants qui se rapportent à son mandat, y compris les résultats de la vérification du coroner en chef rendus publics le 19 avril 2007, et d'autres rapports et dossiers d'ordre médical ou professionnel ou relevant des sciences sociales. En outre, la commission se fonde, dans la mesure du possible, sur les rapports sommaires soumis à l'enquête. La commission peut étudier ces rapports et ces dossiers plutôt que d'entendre des témoins.

8. La commission s'appuie, dans la mesure du possible, sur des personnes représentatives qui témoignent au nom d'institutions.

9. In delivering its report to the Attorney General, the Commission shall ensure that the report is in a form appropriate, pursuant to the *Freedom of Information and Protection of Privacy Act* and other applicable legislation, and in sufficient quantity, for public release and be responsible for translation and printing, and shall ensure that it is available in both English and French at the same time, in electronic and printed versions. The Attorney General shall make the report available to the public.

10. Part III of the *Public Inquiries Act* applies to the inquiry and the Commissioner may have recourse to the powers contained in Part III as necessary to achieve the mandate of the inquiry

Resources

11. Within an approved budget, the Commission may retain such counsel, staff, or expertise it considers necessary in the performance of its duties at reasonable remuneration approved by the Ministry of the Attorney General. They shall be reimbursed for reasonable expenses incurred in connection with their duties in accordance with Management Board of Cabinet Directives and Guidelines.

12. The Commission shall establish and maintain a website and use other technologies to promote accessibility and transparency to the public.

13. The Commission shall follow Management Board of Cabinet Directives and Guidelines and other applicable government policies in obtaining other services and goods it considers necessary in the performance of its duties unless, in its view, it is not possible to follow them.

9. La commission veillera à remettre son rapport au procureur général sous une forme appropriée, conformément à la *Loi sur l'accès à l'information et la protection de la vie privée* et aux autres lois applicables, et en nombre d'exemplaires suffisant pour sa diffusion publique et devra en assurer la traduction et l'impression. En outre, elle fera en sorte qu'il soit disponible en même temps en version française et anglaise et sur support électronique et papier. Le procureur général mettra le rapport à la disposition du public.

10. La partie III de la *Loi sur les enquêtes publiques* s'applique à l'enquête et le commissaire pourra invoquer les pouvoirs prévus par cette partie, dans la mesure nécessaire à l'exécution de son mandat.

Ressources

11. Dans le cadre d'un budget approuvé, la commission peut retenir les services des avocats, du personnel ou des experts qu'elle juge nécessaires à l'exercice de ses fonctions selon une rémunération raisonnable approuvée par le ministère du Procureur général. Ceux-ci pourront se faire rembourser les frais raisonnables engagés dans l'exercice de leurs fonctions, conformément aux directives et aux lignes directrices du Conseil de gestion du gouvernement.

12. La commission se dotera d'un site Web et utilisera d'autres technologies pour promouvoir l'accessibilité et la transparence.

13. À moins que, à son avis, cela ne soit pas possible, la commission suivra les directives et les lignes directrices du Conseil de gestion du gouvernement ainsi que les autres politiques applicables du gouvernement dans le cadre de l'obtention des autres biens et services qu'elle estime nécessaires à l'exercice de ses fonctions.

14. The Commission may make recommendations to the Attorney General regarding funding for proceedings before the Commission for parties who have been granted standing because they have information relevant to the systemic issues that would otherwise be unavailable and where in the Commission's view the party would not otherwise be able to participate in the inquiry without such funding. Any such funding recommendations shall be in accordance with Management Board of Cabinet Directives and Guidelines.

14. La commission peut faire des recommandations au procureur général en ce qui concerne le financement de la participation à ses travaux des parties qui se sont vues accorder le droit de comparaître parce qu'elles ont des renseignements se rapportant aux questions systémiques qui ne seraient pas disponibles autrement, si elle est d'avis que, à défaut, ces parties ne seraient pas par ailleurs en mesure de participer à l'enquête. Ces recommandations devront être conformes aux directives et aux lignes directrices du Conseil de gestion du gouvernement.

15. All ministries and all agencies, boards and commissions of the Government of Ontario shall, subject to any privilege or other legal restrictions, assist the Commission to the fullest extent so that the Commission may carry out its duties and will respect the independence of the review.

15. Sous réserve de tout privilège ou de toute autre restriction légale, tous les ministères ainsi que tous les organismes, conseils et commissions du gouvernement de l'Ontario prêteront sans réserve leur concours à la commission de façon que celle-ci puisse s'acquitter de ses fonctions et ils respecteront l'indépendance de l'examen.

16. If during the course of the inquiry the Commission receives information, including in writing, from victims or families, the Commission may authorize the provision of counselling assistance.

16. Si, dans le cours de son enquête, la commission reçoit, notamment par écrit, des renseignements des victimes ou des familles, elle peut autoriser la prestation de services de counselling.

TAB 2

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

The Honourable Stephen Goudge, Commissioner

180 Dundas Street West, 22nd Floor
Toronto Ontario M5G 1Z8

Tel: 416 212-6878
1 866 493-4544
Fax: 416 212-6879
Website: www.goudgeinquiry.ca

Ontario

COMMISSION D'ENQUÊTE SUR LA MÉDECINE LÉGALE PÉDIATRIQUE EN ONTARIO

L'honorable Stephen Goudge, Commissaire

180, rue Dundas Ouest, 22e étage
Toronto (Ontario) M5G 1Z8

Tél. : 416 212-6878
1 866 493-4544
Téléc. : 416 212-6879
Site Web : www.goudgeinquiry.ca

SUMMONS TO WITNESS

(Section 7)

Re: INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO (the "Commission")

To: The Registrar, the College of Physicians and Surgeons of Ontario ("CPSO")

You are hereby summoned and required to attend before the Commission at an inquiry conducted by the Commission to be held at 180 Dundas Street West, 22nd Floor, in the City of Toronto on Monday, the 4th day of October, 2007 at 12:00 noon and so from day to day until the inquiry is concluded or the Commission otherwise orders, to give evidence under oath touching the matters in question in the inquiry and to bring with you and produce at such time and place:

1. all documents related to any complaints filed by D.M. regarding Dr. Charles R. Smith (including but not limited to File 27860), and the CPSO's investigation and disposition of that complaint, including but not limited to the Complaints Committee brief;

2. all documents related to any complaints filed by Maurice Gagnon regarding Dr. Charles R. Smith (including but not limited to File 40735), and the CPSO's investigation and disposition of that complaint, including but not limited to the Complaints Committee brief;

3. all documents related to complaints filed by Brenda Waudby regarding Dr. Charles R. Smith (including but not limited to File 46947), and the CPSO's investigation and disposition of that complaint, including but not limited to the Complaints Committee brief;

4. all documents related to any other complaints filed by anyone regarding Dr. Charles R. Smith;

5. all policies, procedures, guidelines or protocols, considered, adopted or used by the CPSO when dealing with complaints made about the conduct of pathologists, forensic pathologists, pediatric forensic pathologists, or coroners; and

6. all documents relevant to policies, procedures, practices, accountability and oversight mechanisms, or quality control measures for pediatric forensic pathology in Ontario from 1981 to 2001.

For the purpose of this Summons, the term "document" includes a sound recording, videotape, film, photograph, chart, graph, map, plan, survey, book of account, and data and information in electronic form.

Dated this 19th day of September 2007,

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

.....

Honourable Stephen T. Goudge
Commissioner

Note:

You are entitled to be paid the same personal allowances for your attendance at the hearing as are paid for the attendance of a witness summoned to attend before the Superior Court of Justice.

If you fail to attend and give evidence at the inquiry, or to produce the documents or things specified, at the time and place specified, without lawful excuse, you are liable to punishment by the Superior Court of Justice in the same manner as if for contempt of that Court for disobedience to a summons.

TAB 3

80 COLLEGE STREET, TORONTO, CANADA M5G 2E2

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Carolyn Silver
Legal Office
Telephone: (416) 967-2600, Ext. 239
Direct Fax: (416) 967-2647
E-Mail: csilver@cpso.on.ca

FAX: (416) 961-3330
TOLL FREE: (800) 268-7096
TEL: (416) 967-2600

September 20, 2007

By Fax to 416 282-6879

Rob Centa
Inquiry into Pediatric Forensic Pathology
in Ontario
180 Dundas Street West, 22nd Floor
Toronto ON M5G 1Z8

Dear Mr. Centa:

Re: Inquiry into Pediatric Forensic Pathology in Ontario (the "Commission")

We have received a copy of the Commissioner's Summons to Witness to the College Registrar dated September 19, 2007, summonsing his attendance before the Commission on October 4, 2007 to produce the information set out in the summons.

As you are aware, section 36(1) of the *Regulated Health Professions Act* imposes confidentiality requirements on all College employees, requiring them to keep confidential all information that comes to their knowledge in the course of their duties, and prohibiting them from communicating any such information to any other person, subject to certain exceptions enumerated in the Act. In our view, none of the exceptions permit the Registrar to produce the documents you have requested.

Yours very truly,

Carolyn Silver

CS/es
cc: Vicki White

TAB 4

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

File #5421

PRESENT:

Taivi Lobu, Designated Vice-Chair
William M. Avery, Q.C.
Ann M. Nunnez

Thursday, the
3rd day of
February, 2000

[redacted] Complainant
Stacey A. Taraniuk, Student at Law, Representative for Complainant
Charles R. Smith, M.D., Member Complained Against
Elizabeth Stewart, Legal Counsel for Member Complained Against
Michele Mann & Lisa Brownstone, Representatives, College of Physicians & Surgeons of Ontario

DECISION AND REASONS

IN THE MATTER OF A COMPLAINT REVIEW UNDER SECTION 29(2) of Schedule 2 to the *Regulated Health Professions Act, 1991*, the *Health Professions Procedural Code*, Statutes of Ontario, 1991, c.18, as amended.

BETWEEN:

[redacted]

Complainant -

and -

CHARLES RANDAL SMITH, M.D.

Member Complained Against

Introduction

This decision arises from a request by Mr. [redacted] (the Complainant) to the Health Professions Board, now the Health Professions Appeal and Review Board (the Board), to review a decision of the Complaints Committee (the Committee) of the College of Physician and Surgeons of Ontario (the College). The decision concerned the conduct and actions of Charles Randal Smith, M.D., in relation to an autopsy which Dr. Smith conducted as an agent of the Chief Coroner's office.

Background

On July 28, 1988, a 16-month-old child, Amber [redacted], suffered head injuries when the Complainant's daughter, [redacted] who was 12 years old at the time, was babysitting her. Miss [redacted] was taken to a hospital in Timmins where she was diagnosed with a left subdural haematoma and a cerebral contusion. She was transferred to the Hospital for Sick Children's Intensive Care Unit where she died on July 30, 1988.

Dr. Smith first became involved on July 31, 1988, as the Director of Autopsy Services, when the Health Records department of the Hospital for Sick Children consulted him about the certificate of death which erroneously indicated that Ms. [redacted]'s parents had consented to an autopsy. Because the parents had not in fact consented to an autopsy, Dr. Smith contacted the Coroner who then indicated that an autopsy was not to be conducted. At the request of the Coroner, Dr. Smith amended the certificate accordingly.

Subsequent discussions which Dr. Smith had with other medical personnel at the Hospital for Sick children resulted in the Chief Coroner's office being approached. An application for an order exhuming the body was then made and granted. The Chief Coroner retained Dr. Smith to conduct the autopsy on behalf of the Coroner. In his autopsy report, Dr. Smith concluded that the neurotrauma suffered by Miss [redacted] was consistent with "Shaken Baby Syndrome." Dr. Smith and the Chief Coroner discussed the matter with the Crown Attorney's office, and manslaughter charges were laid against Ms. [redacted] After a lengthy trial, Ms. [redacted] was found not guilty of the charges against her. The presiding judge expressed concern about the diagnosis of "Shaken Baby Syndrome," and concluded that death by falling was a reasonable explanation for the infant's injuries.

The Complaint and the Committee's Decision

Mr. [redacted] complained to the College about the conduct and actions of Dr. Smith. In addition to the allegation that Dr. Smith made an incorrect diagnosis of "Shaken Baby Syndrome," Mr. [redacted] presented a number of other issues in relation to Dr. Smith, including a failure to obtain a Coroner's warrant for a *post mortem* examination; the alteration of the Medical Certificate of Death; the request for exhumation; late request for an autopsy; the absence of a *post mortem* radiographic survey; matters concerning communication with police; and an alleged misrepresentation by Dr. Smith of his role in the exhumation. After conducting an investigation, the Complaints Committee took no action with regard to Dr. Smith as it determined that it had no jurisdiction:

> The Committee concludes that Dr. Smith's involvement in this matter was undertaken as an agent of the Chief Coroner's office. Under the *Coroner's Act*, jurisdiction to deal with complaints against physicians acting as Coroners or otherwise as agents of the Chief Coroner, in the performance of those

functions, is conferred upon the Chief Coroner. As such, this Committee has no jurisdiction to take any action in this matter.

Mr. [redacted] requested that the Board review the decision of the College's Complaints Committee.

The Review - Request for Standing

Prior to the review, Ms. Mamie Corbold, counsel for the Ministry of the Solicitor General and the Office of the Chief Coroner, applied on behalf of her clients for standing in the proceedings. Ms. Corbold submitted that the Ministry and Coroner's Office had an interest in the review in that the complaint was related to the conduct and actions of Dr. Smith in relation to a post mortem ordered under the *Coroner's Act*, that Dr. Smith's *post mortem* findings were the subject of his testimony in court proceedings; that written submissions from the Chief Coroner's Office were relied upon by the Committee in arriving at its decision; and that the Board's decision could have implications with respect to the Coroner's jurisdiction to deal with complaints against physicians performing work pursuant to the *Coroner's Act*. An opinion from the Board's legal counsel, Mr. David Jacobs, as to the Board's authority to grant intervener status in this matter, was received with regard to the request made on behalf of the Ministry and the Office of the Chief Coroner, and circulated to the parties and Ms. Corbold. Submissions regarding such opinion were received from all parties.

Procedure before the Board in complaint reviews is governed by Schedule 2 to the *Regulated Health Professions Act, 1991*, the *Health Professions Procedural Code* (the *Code*). The *Code* has no provision allowing for the participation of non-parties at complaint reviews. In contrast, there is provision for non-party participation in disciplinary hearings.

The Board's role in a complaint review is to review the record of investigation before the Committee, and to consider the adequacy of the Committee's investigation of the complaint and the reasonableness of its decision. According to the information before the Board, neither the Ministry of the Solicitor General or the Office of the Chief Coroner intervened or made submissions concerning jurisdiction at the Complaints Committee level. With regard to Ms. Corbold's submission that "written submissions made by my client were a key factor in the Committee reaching the decision that it did.....," the information before the Board on this point indicates that legal submissions from Ms. Corbold's client(s) were not before the Committee and were not therefore provided to the Board by the College. Subsection 32 (1) of the *Code* requires that where a review is requested, the College shall provide the Board with "a record of the investigation and the documents and things upon which the decision was based."

By letter of March 18, 1998, the College investigator advised Mr. [redacted] that on March 10, 1998, the College received correspondence from the Chief Coroner stating his position that the College had no jurisdiction to investigate the conduct of a physician who was fulfilling a function as a representative of the Coroner, and the Committee directed that the issue be raised with the College's Executive Committee for clarification of the College's policy on this issue. The letter from the Chief Coroner was not included in the Committee's record of investigation which was forwarded to the Board for the complaint review. The Health Boards Secretariat, the administrative arm of the Board, requested that the College produce this letter to the Board in order to ensure that the record of investigation from the College was complete. The College responded by stating that "The Complaints Committee did not review this material during its deliberation of [the Smith/[redacted] complaint]."

Given the Committee's decision in this matter, the threshold issue for this Board is whether or not the College's jurisdiction over its members is ousted when they are acting on a Coroner's warrant under subsection 28(1) of the *Coroner's Act*. In a complaint review, parties are entitled to comment on the adequacy of the College's investigation and the reasonableness of its decision. Other than such comment, there is no provision for new information to be provided. The information from the College indicates that neither the Ministry of the Solicitor General or the Office of the Chief Coroner were parties or accepted as interveners in the proceedings before the Complaints Committee. The Board is to review the Complaint Committee proceedings, and not to hold a hearing *de novo*.

Even if the Board did have the authority to grant intervener status to non-parties, the Board was not of the view that this was an appropriate case for so doing. The Board was not persuaded that Ms. Corbold's clients could provide submissions relevant to the issue at hand which may not be available via Dr. Smith, who was not serving as a coroner, but as a pathologist acting under a Coroner's warrant. Accordingly, the Board denied the request for standing made by Ms. Corbold on behalf of her clients for standing.

The Review

At the review, submissions were made on behalf of Mr. [redacted] and Dr. Smith. The Committee did not make a decision about the substance of the complaint, but restricted itself to a finding that it had no jurisdiction. Accordingly, the Board focused its review on the reasonableness of the Committee's decision regarding its jurisdiction.

a) Information in Possession of the Board

Through the ordinary course of its business, the Board was in possession of a 1997 memorandum of the College outlining policy discussions concerning the Coroner's and College's respective complaints systems. The memorandum was from the Deputy

Registrar of the College to the College's Registrar, and copied to the College President, the College's Executive Committee, the Chief Coroner of Ontario and Deputy Chief Coroner of Ontario. As this memorandum was in possession of the Board but was not a part of the record of investigation or in correspondence otherwise made available to the parties, it was circulated to the parties for comment. Ms. Elizabeth Stewart, legal counsel for Dr. Smith, submitted that as this material was not among the materials reviewed and considered by the Complaints Committee, neither the document or its contents would be the proper subject of review by the Board. Mr. Stacey A. Taraniuk, representative for Mr. [redacted] commented that the memorandum did not relate to the instant proceedings as it pertained to complaints proceedings for physicians who were appointed as coroners - not pathologists acting under a Coroner's warrant. Given the comments of the parties and the fact that policy discussions could not supercede statutory jurisdiction, the Board will disregard the 1997 memorandum of the College.

b) Jurisdiction of the Committee

Pursuant to subsection 25(1) of the *Code*, the Complaints Committee shall investigate a complaint "regarding the conduct or actions of a member." After such an investigation, and upon considering submissions of the member and relevant records and documents, pursuant to subsection 26(2), the Committee may:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint.

2. Refer the member to the Executive Committee for incapacity proceedings.

3. Require the member to appear before the panel or another panel of the Complaints Committee to be cautioned.

4. Take action it considers appropriate that is not inconsistent with the health profession Act, the Code, the regulations or by-laws.

Acts of professional misconduct under subsection 1(1) of Ontario Regulation 856/93 of the *Medicine Act, 1991*, include: failing to maintain the standard of practice of the profession; having a conflict of interest; failing to fulfil the terms of an agreement for professional services; signing or issuing, in the member's professional capacity, a document that the member knows or ought to know is false or misleading; contravening the *Medicine Act, 1991*, the *Regulated Health Professions Act, 1991*; an act or omission relevant to the practice of medicine that having regard to all the circumstances, would

reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and, conduct unbecoming a physician.

Dr. Smith is a pediatric pathologist who perforins autopsies ordered by a coroner. The College is his professional governing body. Membership in the College is a prerequisite for his responsibilities with the Coroner's office. As indicated by the aforementioned provisions made under the *Medicine Act, 1991*, and the *Regulated Health Professions Act*, the College has authority over its members with regard to complaints in connection with matters of professional conduct. There is no provision in the *Medicine Act, 1991*, the *Regulated Health Professions Act, 1991*, or the *Coroner's Act*, which ousts the authority of the College when a member is acting as an agent for the Coroner's office. While there may be overlap with regard to Dr. Smith's accountability to both the Coroner's office and the College, the involvement of the Coroner's office does not displace the College's responsibility to govern its members. The Committee must in some manner determine if any action is warranted by the College as a result of the conduct and actions of the member complained against. As the Committee declined jurisdiction to make such a determination, the Board finds the Committee's decision to be unreasonable.

c) Additional Recommendations

The Board further observes that Dr. Smith may not have been acting as an agent of the Coroner in relation to all of the acts complained of, and the complaint appears to extend beyond Dr. Smith's diagnosis of "Shaken Baby Syndrome" as set out in the "Areas of Concern" in the College's decision. If the College has not already done so, the Board would recommend that it confirm the scope of the complaint.

In the review proceedings, Mr. [redacted] made further submissions in response to the disclosure of the record of investigation which included a letter of March 9, 1999, from Dr. Smith which Mr. [redacted] had not previously received. In addition to any further investigative steps which the Committee may take, the Board recommends that the College consider such submissions in its consideration of the complaint.

Disposition

For all of the reasons given, and pursuant to sections 35(l) and 26(2) of the Code, the Board returns this matter to the Committee and requires it to address the complaint filed by Mr. [redacted] In doing so, the Board makes no finding or comment as to the merits of the complaint, and nothing in this decision should be taken to indicate any such finding.

DATED at TORONTO
this 1st day of September, 2000.

Taivi Lõbu, Designated Vice-Chair