IN THE MATTER OF Order in Council, dated April 25, 2007;

AND IN THE MATTER of a Commission of Inquiry pursuant to the *Public Inquiries Act*, R.S.O. 1990, c. P. 41 as amended;

AND IN THE MATTER of an Inquiry into Pediatric Forensic Pathology in Ontario

SUBMISSIONS OF THE OFFICE OF THE CHIEF CORONER OF ONTARIO

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Prologue – Evolution and Vision

Beginning in the early 1990s, the Office of the Chief Coroner for Ontario ("OCCO") under the direction and leadership of Dr. James Young, Dr. Thomas J. Cairns and Dr. David Chiasson put in place systems to monitor and enhance the quality of death investigation in the province. Dr. Young, Dr. Cairns and Dr. Chiasson did so by recognizing gaps and weaknesses in the system as it existed at the time, and particularly as they concerned forensic pathology. Working collaboratively, they instituted a series of innovative measures in an era when "quality assurance" and "oversight" were nascent concepts, both in the field of medicine and in professional fields generally. This demonstrated great foresight on the part of these individuals.

Dr. Young, Dr. Cairns and Dr. Chiasson built a foundation where none previously existed, and from which they hoped to continue to expand their vision for the future. In developing measures to ensure quality and oversight, they reacted appropriately and effectively to anticipate reasonably foreseeable problems. These were accomplished and dedicated physicians who were sincere in their attempts to provide the best quality death investigation system to the people of Ontario.

However, the OCCO faced challenges beyond its control that hampered its ability to implement this vision and these measures to their fullest potential. Ontario's death investigation system faced severe and ongoing human resource shortages in all areas of forensic pathology. It required more seasoned expertise than was available. Indeed, the evidence at this Inquiry has shown that the challenges inherent in effectively monitoring the complex field of pediatric forensic pathology were not unique to Ontario.

It would have been difficult, and perhaps even unreasonable in the circumstances, for the OCCO to anticipate a situation in which a world-renowned pathologist, who was considered to be at the top of his field, and who presented as highly competent would fail the system in the manner that is the subject of this Commission of Inquiry. The system of checks and balances was designed, by Dr. Young, Dr. Chiasson and Dr. Cairns in the first instance, to address problems arising out of the work of those in the system with the least experience. The evidence at this Inquiry has shown that in fact problems arose at a level where competency was assumed.

> "...we built a system to try to build safety into system at -- at the level of the least experienced.
>
> The problem is the system broke down at the top end, not at the bottom end. And we put a lot of thought and a lot of money and a lot of care into trying to improve the quality, and we succeeded, but we -- we failed at one (1) end of the system; the end I wouldn't have expected the failure to be at."
>
> - Evidence of Dr. Young, November 29, 2007, p. 119

> "So what we were trying to do was build a -- build a system that was tiering the work and bringing it up to the level of the people that were trained. We were trying to finance it properly and support it so that, in fact, the forensic pathology would be growing over time. And what we didn't build was -- was enough checks and balances of the person that's in charge of certain areas -- the -- your ultimate expert. And again, I'll address that in my -- in my recommendations.
>
> But the -- the flaw in our system was we were worried about the bottom end, and we were trying to increase the overall quality, but we assumed a level of competence and quality at the top end that -- without checking hard enough at that particular end."
>
> - Evidence of Dr. Young, December 3, 2008, pp. 65-66

The work by those at the helm of the OCCO in the early 1990s, has continued under the direction of Dr. Barry McLellan, Dr. Bonita Porter and Dr. Michael Pollanen. The evidence has shown that these subsequent leaders, together with dedicated teams, have been able to take the lessons learned from the past so to further strengthen the quality of death investigation in the province.

Introduction

1. The fundamental goal of Ontario's death investigation system is the search for the truth. The OCCO, through its dedicated team of professionals, continuously strives to deliver its truth-seeking mandate of serving the living through both high quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored.

    - OCCO Institutional Report, PFP149431, p. 5

2. There are approximately 80,000 deaths in Ontario each year, and of these, the OCCO takes jurisdiction over approximately 20,000. On average, coroners issue warrants for post mortem examination in one-third of those deaths.

    - Evidence of Dr. McLellan, November 12, 2007, pp. 49-52

3. Of the cases subject to a post mortem examination, approximately 400 are classified as either homicide or criminally suspicious. There are approximately 250 pediatric deaths annually.[1] Of the 250 pediatric cases, between five and fifteen per year also fall into the category of homicide or criminally suspicious.

    - Evidence of Dr. McLellan, November 12, 2007, pp. 53-54

4. Recognizing that there are often additional pediatric cases that begin as suspicious or undifferentiated, pediatric homicide or criminally suspicious deaths represent a small portion of the work conducted by the OCCO.

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1 These statistics refer to the deaths of children under five years of age.

5. During Dr. Smith's tenure at the Ontario Pediatric Forensic Pathology Unit ("OPFPU"), the number of deaths investigated by the OCCO was in the order of magnitude of 400,000 to 500,000.

    - Evidence of Dr. Young, November 30, 2007, p. 51, lines 4-8

6. The OCCO recognizes that this Commission of Inquiry is directly concerned with the small but significant subset of the work conducted by the OCCO that involves pediatric forensic pathology.

7. The Order in Council establishing this Commission of Inquiry sets out the following 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;
>
> 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.

8. In her opening comments, Commission Counsel stated the following:

> "...our task is to conduct a systemic examination of the practice of pediatric forensic pathology and its oversight mechanisms as they relate to the criminal justice system in Ontario."
>
> - Commission Counsel, Opening submissions, November 12, 2007, p. 24, lines 4-7

9. The OCCO acknowledges that pediatric forensic pathology is a unique and complex branch of forensic pathology and that the pediatric death investigation brings with it

significant challenges that are not present in adult death investigations. Indeed, as the evidence has shown, the OCCO has paid particular attention to addressing and enhancing pediatric forensic pathology services over the years in recognition of its important role, and has implemented a number of initiatives, including but not limited to the following:

(a) Establishment of the Pediatric Death Review Committee ("PDRC") in 1989;

- Evidence of Dr. Cairns, November 26, 2007, p. 25, lines 22-24

(b) Establishment of the Ontario Pediatric Forensic Pathology Unit at the Hospital for Sick Children ("HSC") in 1991;

- Evidence of Dr. Young, November 30, 2007, p. 23, lines 5-8

(c) Development of the Protocol for the Investigation of Sudden and Unexpected Deaths in Children Under 2 Years of Age in 1995 ("1995 Protocol"), which was updated to include all child deaths under five years of age in 2006;

- Evidence of Dr. Chiasson, November 26, 2007, p. 137, line 25 to p. 138, line 2
- Report of the Pediatric Death Review Committee and Deaths Under Five Committee, PFP057188, pp. 12, 14
- 1995 Protocol, PFP057584, p. 351

(d) Establishment of the SIDS/SUD Review Committee in 2000, which was renamed the Deaths Under Two Review Committee (DU2 Committee), and whose mandate was further expanded when it became the Deaths Under Five Review Committee (DU5 Committee) in 2006;

- OCCO Institutional Report, PFP149431, p. 67

(e) Development of the Investigation Questionnaire for Sudden Unexpected Deaths in Children Under the Age of Two Years in 2001, which was updated to include all child deaths under five years of age in 2006;

- Memorandum, PFP032331
- Investigation Questionnaire, PFP133753
- Investigation Questionnaire, PFP032477
- Evidence of Dr. Lauwers, January 8, 2008, p. 35, lines 2-4

(f) Designation of certain Regional Forensic Pathology Units ("Regional FPUs") and the OPFPU as the only locations in which medicolegal autopsies of children under the age of two years (and now under the age of five) are conducted;

- Memorandum, February 11, 2002, PFP057584 at p. 448

(g) Dissemination of various memoranda and provision of formal educational seminars regarding pediatric death investigation for coroners and pathologists;

- Coroners Investigations Manual, PFP057584
- Evidence of Dr. Lauwers, January 7, 2008, p. 294, line 11; p. 295, line 17
- Evidence of Dr. Edwards, January 7, 2008, p. 295, line 20; p. 296, line 21

(h) Provision of formal and informal educational seminars for other participants in the death investigation system, such as Crown counsel and the police; and

(i) Development of the *Autopsy Guidelines in Sudden Unexpected Deaths of Infants and Children under 5 Years* in 2007.

- Guidelines, PFP137602

10. The OCCO recognizes in this Commission's mandate the ability to make recommendations to enhance quality, oversight and accountability within pediatric forensic pathology. The OCCO further recognizes that this has necessitated a close examination of quality, oversight and accountability within forensic pathology and the death investigation system as a whole.

    - Evidence of Dr. Lauwers, January 8, 2008, p. 59, lines 6-17

11. These submissions are divided into three parts. In Part I, the OCCO examines the evolution of quality, oversight and accountability within the death investigation system over the last 25 years. In Part II, the OCCO analyzes the impediments to its initiatives to provide quality death investigations within an era of limited human and financial resources. The OCCO also considers the shortcomings of the oversight and accountability measures as they pertained to Dr. Charles Smith. In Part III, the OCCO proposes changes to the current structure of the death investigation system to further enhance quality, oversight, and accountability.

12. In these submissions, "accountability" means "the obligation to demonstrate and take responsibility for performance in light of commitments and expected outcomes". "Oversight" is "management by overseeing the performance or operation of a person or group".

    - See Part III

13. This Commission has had the benefit of hindsight in reviewing the events giving rise to this Inquiry. It is easy, with the benefit of what is now known, to judge those on the front-line of death investigations in the 1990s. The OCCO urges this commission to avoid using

hindsight to unfairly judge or lay blame. Instead the OCCO endorses an approach wherein that hindsight is used to assist in the search for the lessons learned. What must be recalled is that the story of oversight of forensic pathology in Ontario is one of evolution – with the OCCO at the forefront.

- The SARS Commission, Final Report, Volume 2, Chapter 1, page 14

PART I

Evolution of Death Investigation System

(i) OCCO and Forensic Pathology Services

14. In order to understand why the OCCO became vested with the responsibility of quality, oversight and accountability for forensic pathology services, and how that oversight and accountability evolved over the last two decades. Essentially, the OCCO filled a vacuum caused by the lack of leadership of Dr. John Hillsdon-Smith in the later stages of his career. At the same time, this enabled the OCCO to rationalize and better coordinate Ontario's death investigation system.

(ii) Pre-Integration: 1981-1994

Division between Forensic Pathology and the OCCO

15. Prior to 1994, the OCCO and the Forensic Pathology Branch operated as separate and distinct divisions of the Ministry of the Solicitor General (as it then was known) that ran in parallel to one another. The Chief Coroner of Ontario ("CCO") and the Provincial Forensic Pathologist ("PFP"), as the head of the Forensic Pathology Branch was known at

the time, reported independently to the Assistant Deputy Minister, and occupied the same administrative level within the Ministry's hierarchical structure.

- Evidence of Dr. Cairns, November 26, 2007, p. 21, line 22 to p. 22, line 2, November 29, 2007, p. 29, lines 18-25
- Evidence of Dr. Chiasson, December 7, 2007, p. 41, lines 11-20
- Evidence of Dr. Pollanen, November 12, 2007, p. 100, line 17 to p. 101, line 7

16. Though separate branches, they were housed in the same building at 26 Grenville Street in Toronto, and the offices for both the CCO and the PFP were located on the second floor.

- Evidence of Dr. Cairns, November 26, 2007, p. 22, line to p. 23, line 16

17. Dr. Hillsdon-Smith held the position of PFP for Ontario from 1975 to 1994. During his entire tenure, the Forensic Pathology Branch and the OCCO operated as independent government entities, though the legal authority for virtually all of the work of the Forensic Pathology Branch flowed from the coroners' warrants for post-mortem examination.

- Appendix E of OCCO Institutional Report, PFP149431, p. 107
- Evidence of Dr. Pollanen, November 12, 2007, p. 101, lines 3-7

18. When Dr. Hillsdon-Smith began as PFP in 1975, Dr. Beatty Cotnam was the CCO. According to Dr. Cairns, not long after Dr. Hillsdon-Smith began as PFP, he and Dr. Cotnam experienced a falling out. They were no longer able to work together on the second floor of the Grenville building. Dr. Hillsdon-Smith moved his office to the basement, which became the exclusive domain of the pathologists, while the second floor remained the purview of the coroners. Communication between the two divisions was poor and there was little mixing between pathologists and coroners. The two divisions

operated as separate silos: those who were "upstairs" did not go "downstairs" and *vice versa*.

- Evidence of Dr. Cairns, November 26, 2007, p. 21, lines 13-24; p. 23, lines 10-21; November 29, 2007, p. 30, lines 1-17

19. The divide between pathologists and coroners continued after Dr. Ross Bennett assumed the position of CCO in 1982, and when Dr. Young became CCO in 1990. According to Dr. Cairns, the relationship between Dr. Hillsdon-Smith and both Dr. Bennett and Dr. Young, as had been the case with Dr. Cotnam before them, was not cordial.

- Evidence of Dr. Cairns, November 27, 2007, p. 214, line 25 to p. 215, line 5; p. 216, lines 7-10

20. At no time during Dr. Hillsdon-Smith's tenure from 1975 to 1994 did the PFP report to the CCO.

- Evidence of Dr. Cairns, November 26, 2007, p. 22, lines 19-22
- Evidence of Dr. Chiasson, December 7, 2007, p. 41, lines 11-20

21. The PFP was not accountable to the CCO and *vice versa*. In their organizational structure, and in their personal relationships, the two branches existed as separate silos.

- Evidence of Dr. Cairns, November 29, 2007, p. 30

Education, Training and Succession Planning

22. Other than Dr. Hillsdon-Smith, who had received his training in the British system, there were no board certified, formally trained forensic pathologists in Toronto in the late 1980s, nor were there any formal training programs in Canada.

- Evidence of Dr. Chiasson, December 7, 2007, p. 15, lines 11-16

23. Fee-for-service pathologists working in community hospitals performed virtually all of the autopsy work for the province. Though they may have all had general qualifications in anatomical or general pathology, their qualifications in the forensic aspects of pathology varied greatly, and would have been a function of their experience on the job.

    - Evidence of Dr. Cairns, November 29, 2007, p. 34, lines 10-25
    - Memorandum, PFP129354, p. 2

24. At this time, there were no attempts at recruiting more full-time forensic pathologists. Further, there was no funding for any additional forensic pathologists until the service was integrated with the OCCO and Dr. Chiasson took the role of Chief Forensic Pathologist ("CFP").

    - Evidence of Dr. Cairns, November 26, 2007, p. 24, line 16 to p. 25, line 9
    - Evidence of Dr. Chiasson, December 7, 2007, p. 48, lines 7-20

25. Early in his tenure, Dr. Hillsdon-Smith organized educational sessions for pathologists doing medicolegal autopsy work. According to Dr. Young such sessions had ceased operating by the time he was appointed CCO.

    - Evidence of Dr. Young, December 3, 2007, p. 58, lines 18-24

26. Dr. Hillsdon-Smith offered no formal mentoring in forensic pathology.

    - Evidence of Dr. Cairns, November 27, 2007, p. 214, lines 15-17
    - Evidence of Dr. Smith, February 1, 2008, p. 137, lines 21-24

27. Late in his career, Dr. Hillsdon-Smith appeared to have lost interest in his role. He did not conduct or supervise autopsies. He did not seem interested in educating other pathologists or in enhancing the pathology system in the province. He lost contact with the University

of Toronto, a contact he had made originally which had been important for teaching and continuity purposes.

- Evidence of Dr. Cairns, November 26, 2007, p. 24, lines 22-25; November 27, 2007, p. 214, lines 10-14
- Evidence of Dr. Young, November 30, 2007, p. 86, lines 3-9

28. The quality of oversight during Dr. Hillsdon-Smith's tenure as PFP is illustrated by Dr. Chiasson's experience when working as a fee-for-service pathologist between 1992 and 1994. Although he was working within the Provincial (Central) Forensic Pathology Unit ("Provincial FPU"), Dr. Chiasson did not feel as though he was working for Dr. Hillsdon-Smith. He felt he was simply performing post mortem examinations under coroners' warrants. Dr. Hillsdon-Smith rarely made an appearance in the autopsy room, and the delegation of cases and other day-to-day administrative tasks were undertaken by the Chief Pathologist Assistant, Barry Blenkinsop, and the Executive Assistant, Jack Press.

- Evidence of Dr. Chiasson, December 7, 2007, p. 33, lines 7-21

29. Coordination of function within the death investigation system was complicated by the animosity that had developed between Dr. Hillsdon-Smith and Dr. Cotnam. The working relationship between the PFP and the CCO did not significantly improve when Dr. Bennett, and in turn Dr. Young, became the CCO.

- Evidence of Dr. Cairns, November 27, 2007, p. 214, line 22 to p. 215, line 2; November 29, 2007, p. 30

30. There were no other full-time staff pathologists at the OCCO at the time. Dr. Noel McAuliffe came to work on a full-time fee-for-service basis around this time and there were other pathologists who came in from hospitals on a part-time case-by-case basis.

- Evidence of Dr. Cairns, November 26, 2007, p. 25, lines 4-13
- Evidence of Dr. Chiasson, December 7, 2007, pp. 37-40
- Memorandum, PFP129354

31. There was little, if any, formal or informal interaction between the Provincial FPU and other regional centres where criminally suspicious autopsies were performed in significant numbers.

- Evidence of Dr. Chiasson, December 7, 2007, p. 34, lines 1-10

32. Dr. Hillsdon-Smith was not involved in scheduling autopsies. Rather, the OCCO had taken over the latter responsibility and Dr. Hillsdon-Smith was essentially acting as a consultant for the province if a case interested him. No quality assurance process had been in place under Dr. Hillsdon-Smith's tenure as PFP.

- Evidence of Dr. Young, December 3, 2007, p. 59, lines 11-19
- Evidence of Dr. Chiasson, December 7, 2007, p. 33, lines 22-25

33. The evidence before this Commission clearly establishes that the state of forensic pathology services prior to 1994 was of a variable quality and subject to no oversight. Forensic pathology lacked a leader with a vision for the future.

(iii) Integration of the Forensic Pathology Branch and the OCCO

34. First as Deputy Chief Coroner and then as CCO, Dr. Young recognized this lack of leadership.

35. In particular, Dr. Young recognized that there was an absence of accountability and oversight for forensic pathology services offered in the province when Dr. Hillsdon-Smith was the PFP. In the latter years of Dr. Hillsdon-Smith's tenure, it was clear to Dr. Young

that the forensic pathology service was "drifting". It was isolated and was not administering itself.

- Evidence of Dr. Young, December 3, 2007, p. 106, lines 4-13; p. 109, lines 4-12

36. Dr. Young also realized that better communication and integration between the forensic pathology branch and the OCCO was the key to improving forensic pathology and death investigation in the province.

- Evidence of Dr. Young, December 3, 2007, p. 106, lines 14-23

37. While the forensic pathology service was not formally under the purview of the OCCO, the OCCO was one of the main consumers of its work product. Dr. Young recognized the need to re-build the service and to take steps to increase the quality and oversight of forensic pathology services for the province. Dr. Young took a number of proactive steps, both prior to the departure of Dr. Hillsdon-Smith from the Forensic Pathology Branch and following his retirement, including:

(a) Establishing the OPFPU at the HSC;

- PFP129900

(b) Formally integrating the Forensic Pathology Branch into the OCCO;

- Evidence of Dr. Young, December 3, 2007, p. 106

(c) Recruiting Dr. Chiasson to fill the position of CFP, the new designation for the head of pathology services in the province, following Dr. Hillsdon-Smith's

retirement and securing funding and support from the OCCO for Dr. Chiasson to obtain formal board certification in forensic pathology in the United States; and

(d) Establishing the Regional FPUs (also known as the "Centres of Excellence") to provide high quality forensic pathology services, as well as to train and encourage future pathologists to enter the field of forensic pathology.

- Evidence of Dr. Young, December 3, 2007, p. 59, line 20 to p. 60, line 14
- Evidence of Dr. Chiasson, December 7, 2007, p. 17, line 15 to p. 18, line 2

38. Dr. Young recognized the importance of increasing the complement of trained forensic pathologists providing services to the OCCO. In particular, Dr. Young recognized that looking forward he needed a forensic pathologist at the helm of the forensic pathology branch. To that end, Dr. Young identified Dr. Chiasson as a potential replacement for Dr. Hillsdon-Smith. Dr. Chiasson had already expressed an interest in obtaining his forensic pathology certification. Dr. Young encouraged Dr. Chiasson's interest and facilitated the financial support.

- Evidence of Dr. Young, November 30, 2007, p. 42, lines 7-9
- Evidence of Dr. Chiasson, December 7, 2007, p. 17, line 21 to p. 18, line 2

39. Dr. Chiasson and Dr. Young did not favour the continued tensions between the two divisions and did not wish to work in such an "us and them" environment. They agreed that the OCCO and the Forensic Pathology Branch would combine to form a single office.

- Evidence of Dr. Cairns, November 27, 2007, p. 216, lines 17-21
- Evidence of Dr. Young, December 3, 2007, p. 106, lines 4-23

40. Overall, Dr. Chiasson was pleased with this plan of action. Dr. Chiasson felt that with his limited administrative experience, he was more comfortable reporting to a CCO who was a medical doctor with a great deal of experience in both death investigation and administration. Dr. Chiasson was content to leave the administrative tasks to someone else so that he could focus on the day-to-day needs of the Provincial FPU.

- Evidence of Dr. Young, December 3, 2007, p. 109, lines 7-12
- Evidence of Dr. Chiasson, December 7, 2007, p. 42, lines 3-21

41. In addition, as a condition to assuming the position of CFP, Dr. Chiasson also expressed his need for dedicated full-time forensic pathology staff at the OCCO. Dr. Young was fully supportive and prepared to work in partnership to further this goal.

- Evidence of Dr. Young, December 3, 2007, p. 105, line 24 to p. 106, line 3
- Evidence of Dr. Chiasson, December 7, 2007, p. 59, lines 5-12

42. At the same time, the Deputy Minister and the Assistant Deputy Minister both expressed dissatisfaction with Dr. Hillsdon-Smith's work product and leadership at the time. They provided their support and approval for the integration of the two divisions.

- Evidence of Dr. Young, December 3, 2007, p.106, line 24 to p. 108, line 7

43. All of these factors led to the integration of the Forensic Pathology Branch and the OCCO in September 1993, which was simply a formal recognition of what in fact was already happening.

- Evidence of Dr. Young, December 3, 2007, p. 109, lines 1-6

44. Integration brought several benefits. A much healthier environment prevailed, and there was a greater sharing of ideas. There was more of a team attitude in the sense that everyone was working together in the best interests of death investigation.

- Evidence of Dr. Cairns, November 27, 2007, p. 216, line 22 to p. 217, line 3

(iv) Post-Integration: 1994-Present

A Vision for Quality

45. When Dr. Hillsdon-Smith was PFP and in charge of overseeing forensic pathology services across the province, there was no system of monitoring or mentoring in place, nor was there much in the form of formal education in the latter part of his career. There was no model to serve as a precedent for building and maintaining quality in the system. When Dr. Young became CCO, he had a vision for building a world-class death investigation system in the province of Ontario. Dr. Young aimed for those working within the system to be "leaders" in the field, "not followers". Similarly, when Dr. Chiasson became CFP he envisioned the provision of the highest quality forensic pathology services. To ensure his plans, he developed a step-wise approach, given the significant gaps in the system that he faced. Dr. Young and Dr. Chiasson, together with Dr. Cairns, implemented a series of measures that built, layer upon layer, a system of checks and balances.

- Evidence of Dr. Young, December 3, 2007, page 104, line 21 to p. 105, line 12
- Evidence of Dr. Chiasson, December 7, 2007, pp. 48-62
- Memorandum, PFP129355

46. When Dr. McLellan became CCO and Dr. Pollanen became CFP, they continued to build upon the solid foundation established by their predecessors.

> "...I feel that what Dr. Chiasson has started has expanded again under Dr. Pollanen. So I think Dr. Chiasson brought it to one (1) new level and then new blood comes in and has brought it to another level in terms, particularly, of the monitoring or the quality control issue as regards to forensic pathology."
>
> - Evidence of Dr. Cairns, November 27, 2007, p. 218, lines 15-21

47. As a fully integrated team, the OCCO was able to implement changes to help advance quality for forensic pathology services and the death investigation system as a whole.

48. The OCCO continues to this day, under the leadership of Dr. Porter and her team, to enhance the services it provides through oversight, training and accountability.

49. The evidence has revealed a number of mechanisms put in place since the early 1990s that have helped shape the quality provided by the OCCO:

    (a) Establishment of Death Review Committees;

    (b) Formation of the Regional FPUs;

    (c) Enhancements in forensic pathology services;

    (d) Education and training; and

    (e) Use of case conferences.

50. While not the primary focus of this Commission, there has also been a great deal of evidence on the quality assurance and oversight mechanisms in place for coroners working within the system.

A. Death Review Committees

51. Recognizing the need for coroners to access expert advice to deal effectively with complex death investigations that involve specialized areas of medicine, the OCCO established a number of expert death review committees in the 1990s. These committees are composed of groups of specialists who conduct objective reviews of the care provided in specific cases, paying particular attention to systemic issues and the findings of the pathologist and the coroner. These committees provide advice and recommendations regarding deficiencies in care, alternatives to treatment, systemic changes, diagnoses and cause of death determinations. Death review committees foster and encourage a team-based approach to death investigation in the most complex cases, drawing upon expertise in the larger clinical and death investigation communities.

    - OCCO Institutional Report, PFP149431, p. 64

52. The establishment of the death review committees demonstrates the OCCO's long-standing ability to recognize the limits of its knowledge-base and of those working in the system by using the appropriate resources in creative and effective ways. The death review committees serve to illustrate the OCCO's ongoing commitment to the notions of teamwork, providing and maintaining high quality death investigations and providing oversight by those with the greatest skill.

53. As has been alluded to, from early on, the OCCO recognized the need for expertise in the investigation of child deaths. This is exemplified in the two death review committees whose mandates are directed exclusively to the oversight of pediatric deaths.

(i) Establishment of the Pediatric Death Review Committee

54. The PDRC was created in 1989 primarily to deal with complicated pediatric deaths, as this was an area in which coroners felt they required considerable ongoing assistance. Many coroners felt they lacked the necessary expertise to interpret some of the complex medical information in these deaths. The PDRC was established to provide expert advice to the OCCO in this area. Its members consisted mainly of medical experts who reviewed the medical care received by children prior to their deaths and assessed whether lack of care was a contributing factor to death, particularly in tertiary care settings.

- Evidence of Dr. Cairns, November 26, 2007, p. 26, line 17 to p. 27, line 11
- Evidence of Dr. McLellan, November 12, 2007, p. 203, lines 11-18

55. At its outset, the PDRC consisted of top-notch medical experts who were highly regarded in their fields. Any recommendations that these physicians made would have been taken very seriously.

- Evidence of Dr. Cairns, November 26, 2007, p. 34, lines 12-17

56. Dr. Cairns played an instrumental role in the work of the PDRC almost from its inception, serving as its Chair from 1992 until late 2007. The PDRC is currently chaired by Dr. Albert Lauwers, Associate Deputy Chief Coroner.

- Evidence of Dr. Cairns, November 26, 2007, p. 28, lines 23-25
- Evidence of Dr. Lauwers, January 7, 2008, p. 8, lines 20-25
- Report of the Pediatric Death Review Committee and Deaths Under Five Committee (June 2007), PFP057188, p. 3

57. As well, Dr. Young was successful in obtaining funding for an Executive Officer to deal with the administration of the Committee.

- Evidence of Dr. Cairns, November 27, p. 25, lines 14-24

58. Over the years, the PDRC's mandate and composition has evolved in response to perceived needs and currently provides a multi-disciplinary approach to the review of child death investigations. In 1991, the PDRC's mandate expanded to include the review of all cases of Sudden Infant Death Syndrome ("SIDS") and Sudden Unexpected Deaths ("SUD"), and in 1996, the PDRC's mandate was further expanded to include the review of child welfare cases. As such, its membership was also broadened to include child welfare specialists, police and Crown Attorneys, in addition to medical experts.

- Evidence of Dr. McLellan, November 12, 2007, p. 223, lines 17-24
- Evidence of Dr. Lauwers, January 7, 2008, p. 97, line 21 to p. 100, line 4
- OCCO Institutional Report, PFP149431, p. 66
- Report, PFP057188, p. 29

59. Importantly, the PDRC was not designed to review criminally suspicious cases, but to assist the OCCO in interpreting medically complex cases. The primary focus is not to determine the cause or manner of death. Instead, the focus is on the appropriateness of the medical care, and systemic issues that flow from the quality of such care. The PDRC also reviews deaths of children who were under the care of a Children's Aid Society ("CAS") (i.e. foster care, supervised parental care, group home).

- Evidence of Dr. Cairns, November 26, 2007, p. 27, lines 6-20; p. 33, lines 7-13
- Evidence of Dr. Lauwers, January 7, 2008, pp. 98-100
- Report, PFP057188, p. 6

60. Each case reviewed by the PDRC becomes the primary responsibility of one member of the Committee, who reviews the overall file, including the coroner's report, the post

mortem report and all medical files. The responsible Committee member then presents the case at the next meeting, with a summary of any concerns or issues, followed by a discussion by the Committee as a whole. A report is subsequently generated reflecting the views of the entire Committee and which is forwarded to the Regional Supervising Coroner ("RSC") and investigating coroner. Any recommendations are also forwarded to the hospital concerned, and the report is made available to the family of the deceased as well.

- Evidence of Dr. Cairns, November 26, 2007, p. 31, line 24 to p. 32, line 25

61. The PDRC offered then, and continues to offer now, a high level of quality and oversight for the medical care and death investigations it reviews, through a multi-disciplinary teamwork approach.

- Evidence of Dr. McLellan, November 12, 2007, p. 223, lines 20-25

Memorandum #631, 1995 Protocol and Questionnaire

62. The OCCO has long amended its policies with respect to death investigation in response to specific incidents that bring new issues to light. Early on in the life of the PDRC it was asked to review various protocols used throughout the world and to formulate new guidelines that would be suitable for investigating pediatric deaths in Ontario. Dr. Cairns led this initiative.

- Evidence of Dr. Cairns, November 27, 2007, p. 220, line 20 to p. 221, line 1
- Memorandum #631, PFP057584, p. 349

63. This request arose out of growing concern that deaths of children were not being fully investigated.

- Evidence of Dr. McLellan, November 12, 2008, p. 204, lines 17-23
- Evidence of Dr. Cairns, November 27, 2007, pp. 220-222
- Written evidence of Dr. Charles Smith, PFP303346, p. 32
- Evidence of Dr. Young, November 30, 2007, p. 74
- OCCO Institutional Report, PFP149431, pp. 60-61

64. On April 10, 1995, the OCCO issued Memorandum #631 and its accompanying Protocol for the Investigation of Sudden and Unexpected Deaths in Children Under 2 Years of Age ("1995 Protocol").

- Memorandum #631, PFP057584, p. 349

65. The 1995 Protocol was the first of its kind and marked a positive first step toward quality assurance for pediatric death investigation.

66. The impetus for the memorandum and the 1995 Protocol stemmed from a number of concerns:

(a) There was a growing awareness that children's deaths were very different from the deaths of adults. There were many issues to address in children that were not of concern in adults, and the symptoms and signs in children were different from those in adults;

(b) The PDRC was concerned that various members of the death investigation team were inconsistently applying the international definition of SIDS which had been released in 1991. There was concern about the misdiagnosis of SIDS by hospital pathologists. Both investigating coroners and hospital pathologists were looking for guidance on this issue, and this was of concern to the OCCO;

(c) The issue of child abuse had come to the attention of the OCCO in the late 1980s and early 1990s; and

(d) A number of inquests had highlighted the problem of child abuse in the context of pediatric death investigations, yet most physicians at the time had received little or no training in this area.

- Evidence of Dr. Cairns, November 26, 2007, p. 52, lines 5-20; November 27, 2007, p. 221-224
- Evidence of Dr. Young, November 30, 2007, pp. 74 and 80
- Memorandum #631, PFP057584, p. 349

67. The 1995 Protocol encouraged all coroners, pathologists and Chiefs of police in Ontario to maintain a high index of suspicion when investigating sudden and unexpected deaths in children under the age of two to ensure that cases of child abuse were not missed. To convey this message the phrase "think dirty" was used.

- 1995 Protocol, PFP057584, p. 351
- Evidence of Dr. Cairns, November 26, 2007, pp. 53-56
- Written evidence of Dr. Charles Smith, PFP303346, p. 34
- Evidence of Dr. Young, November 30, 2007, pp. 74-76

68. This sentiment was borne out of a number of previous incidents that the OCCO had encountered, in which suspicious deaths had been missed in the first instance.[2]

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2 These include, but were not limited to the following:

(a) A case in which a man reported that his wife had murdered their child, whose death fourteen years earlier had been reported as SIDS, despite the discovery of a healed femoral fracture at the time of the first autopsy. A second autopsy following exhumation of the body revealed multiple rib fractures of different ages. The mother was subsequently charged with second-degree murder and pleaded guilty to manslaughter;

(b) The Montans case, in which a husband killed his wife and staged her death to appear as though it was the result of a motor vehicle accident. Justice Then, who presided over the Coroners' Council that reviewed the complaint against the investigating coroner in this case, confirmed the importance of maintaining a "high index of suspicion, to assume that all deaths are homicides, until they are satisfied that they are not"; and

- Evidence of Dr. Cairns, November 26, 2007, pp. 36-47
- Coroners' Council Report, PFP152228, p. 48
- Evidence of Drs. Cairns, November 26, pp.47-51, November 27, pp. 230-234
- Written evidence of Dr. Charles Smith, PFP303346, p. 32
- Memorandum, PFP032431
- OCCO Institutional Report, PFP149431, p. 62

69. As this Commission has heard, the vast majority of coroners and pathologists who were involved in pediatric deaths did not feel that the phrase "think dirty" implied that cases of sudden unexpected death were to be pre-judged as cases of abuse or homicide, nor did they feel that that the expression influenced their approach to such cases.

- Written evidence of Dr. Charles Smith, PFP303346, p. 34
- Evidence of Dr. Chiasson, December 7, 2007, p. 60, lines 4-22
- Evidence of Dr. Huyer, January 9, 2008, pp. 238-240
- Evidence of Dr. Shkrum, January 17, 2008, p. 175, lines 7 to p. 176, line 21
- Evidence of Dr. Rao, January 17, 2008, p. 176, lines 22 to p. 177, line 6

70. Until this Commission of Inquiry was appointed, no objections to the use of the phrase "think dirty" were ever articulated to the OCCO. The passage of time and the events which are the subject of this Inquiry have come to cast a different light on the expression than was ever attributed to it at the time.

- Evidence of Dr. Young, November 30, 2007, p. 76, lines 5-9
- Evidence of Dr. Chiasson, December 7, 2007, p. 160, lines 15-19

(c) The case of Tammy Homolka, who, prior to her death, had been drugged and sexually assaulted by her sister and Paul Bernardo. The investigating coroner mistakenly determined that her death was natural.

> "...my understanding of "think dirty" is that it was intended to tell the members of the Death Investigation Team and the pathologist to consider child abuse, and in other circumstances, homicide.
>
> I think it has grown to mean something more than it was ever intended to mean."

- Evidence of Dr. Pollanen, December 6, p. 220, line 24 to p. 221, line 5

> "Think dirty. Well I must say that in my view, having read the document over again, the -- nothing changes in the document if that paragraph is removed. That concept does not inform other parts of the con -- conceptual or procedural message that is in the document. And I'll just draw your attention to one (1) aspect. If you look at the evidence-based analysis on the page that's currently on the monitor, where we look at frequency of autopsy, the absence of skeletal x-rays, and the absence of toxicology, the -- the evidence which the protocol is largely based upon, would give as the major advice as due x-rays, not think dirty. And that's the most important point. That the due x-rays provides you the evidence based approach that is necessary to detect the healed fractures which may ultimately be relevant in -- for example, diagnosing child abuse".

- Evidence of Dr. Pollanen, November 14, 2007, p. 108, line 8 to p. 109, line 1

71. The approach advocated by Memorandum #631 was being adopted worldwide. In fact, this particular memorandum was circulated and used in many jurisdictions in the world. Ontario was at the leading edge of both documenting and attempting to achieve consistency in children's death investigations, and other jurisdictions were looking at what Ontario was doing to address these issues.

- Evidence of Dr. Young, November 30, 2007, p. 79, line 21 to p. 80, line 6

72. Indeed, the 1995 Protocol was not the first time that this phrase has been used in OCCO policy. In response to the *Montans* case, the OCCO issued Memorandum #623 on June 6,

1994, encouraging all death investigators to be "thinking dirty" in cases of possible intimate femicide.[3]

- Evidence of Dr. Cairns, November 26, 2007, p. 47, line 21 to p. 48, line 20
- Memorandum #623, PFP032270, p. 5

73. Even Dr. Christopher Milroy acknowledged that the concept of "thinking dirty" was a prevalent message in the United Kingdom in the early 1990s.

- Evidence of Dr. Milroy, February 14, 2008, p. 191, lines 23-25

74. It is believed that following the publication of the 1995 Protocol, the quality of pediatric death investigations, including post mortem examinations, improved throughout the province.

- Written evidence of Dr. Charles Smith, PFP303346, p. 34

75. With the benefit of hindsight, there may have been a better phrase for the OCCO to use to convey the same message of maintaining a high index of suspicion in the sudden and unexpected deaths of children, but it is not believed that this phrase prompted any of the individuals involved in death investigation to pursue the possibility of foul play where no evidence existed to support it.

- Evidence of Dr. Young, November 30, 2007, p. 76, lines 4-9

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3 The concept of maintaining a high index of suspicion in the context of domestic violence was reiterated by the OCCO recently. On May 12, 2004, the OCCO issued Memorandum #04-08, replacing Memorandum #623, and requested that coroners and police remain vigilant for the possibility of foul play in every circumstance in which there is a sudden unexpected death of a female and in which there is also present at the time of death or the finding of the body, a male, particularly a male with whom the deceased woman had or may have had an intimate relationship, recent or remote. The memorandum further encourages vigilance not only in circumstances where there is an obvious violent death, but also in circumstances where violence may not be apparent, or the circumstances give the appearance of a natural cause of death. Memorandum #04-08, PFP032431

76. Indeed, "think dirty" can be seen as simply part of the differential diagnosis to be applied to all sudden and unexpected deaths in children under the age of five. With the discovery that child abuse was not being detected, this issue was simply brought into heightened awareness. The use of differential diagnoses is a bedrock principle in medicine, in which all possibilities for a particular clinical presentation must be considered, but with a weighing of the likelihood of each possibility. Though unlikely, an awareness of remote possibilities is necessary so that important diagnoses are not missed. With the knowledge that child death investigations were found to be deficient and that this was a global phenomenon, the expression "think dirty" was merely used to highlight the importance of thinking about the possibility of foul play as part of the differential diagnosis, since it was routinely being missed.

(ii) DU5 Committee (Formerly DU2 Committee and SIDS/SUD Review Committee)

77. All deaths of children under the age of five years are reviewed by the DU5 Committee. The DU5 Committee has a more limited mandate than that of the PDRC, in that it is solely responsible for reviewing and classifying the cause and manner of death in all deaths of children under five years of age. Its mandate is pathology-driven and its final classification of the cause and manner of death is determinative in all cases. The Committee's findings are provided in a report to the appropriate RSC, whose duty it is to inform the investigating coroner and to ensure that the final Form 3, or Coroner's Investigation Statement, correctly states the cause and manner of death as collectively decided by the Committee.

- Evidence of Dr. Lauwers, January 7, 2008, p. 96, line 2 to p. 97, line 15
- Evidence of Dr. McLellan, November 12, 2007, pp. 226-228

78. The DU5 Committee was created in 2000 at a time when the OCCO became more concerned about ensuring that cases were being consistently classified and focusing more on the quality in the pathology and in death investigation as a whole.

- Evidence of Dr. McLellan, November 12, 2007, p. 227, lines 5-11

79. Members of the DU5 Committee primarily comprise pathologists, senior members of the OCCO and representatives of the police. The function of the policing service representatives is to corroborate the history of the circumstances surrounding the child's death. The pathologists on the Committee are responsible for conducting paper reviews of the autopsy reports, and occasionally view the histological slides whenever a more detailed review is required. Cases are presented by the pathologist with primary responsibility for a particular case and, through a collaborative process, a consensus position is developed with regard to the cause and manner of death.

- Evidence of Dr. Lauwers, January 7, 2008, p. 96, line 14 to p. 97, line 15

80. Though there are cross-appointments between the DU5 Committee and the PDRC, the Committees function distinctly from one another. Occasionally, however, where there are significant medical issues to be addressed, the death might be referred to both the DU5 Committee and the PDRC for review.

- Evidence of Dr. Lauwers, January 7, 2008, p. 100, line 8 to p. 101, line 7

81. Dr. Cairns was the first Chair of the Committee when it was initially established as the SIDS/SUD Committee in June 2000. He remained Chair of the Committee when it was renamed the DU2 Committee in October 2000, and given a mandate for providing the correct classification of cause and manner of death for all deaths under the age of two

years. As the 1995 Protocol for investigating deaths of all children under two years of age was refined over the years, the Committee was renamed the DU5 Committee in December 2006 to reflect the new age range for such investigations. Dr. Cairns remained Chair until late 2007. Currently, Dr. Lauwers is the Chair of this Committee.

- Evidence of Dr. Lauwers, January 7, 2008, p. 95, line 24 to p. 96, line 1
- Report, PFP057188, p. 12
- OCCO Institutional Report, PFP149431, p. 67

82. The DU5 Committee serves as a quality assurance mechanism, providing a definitive assessment of both cause and manner of death through a multi-disciplinary, team-oriented approach.

B. Regional Forensic Pathology Units – The Centres of Excellence

83. In the early 1990s, Dr. Young recognized that the future supply of forensic pathology in the province was in jeopardy. He realized there was a shortage of forensic pathologists, and was also concerned about ensuring the quality of work across the province. Dr. Young envisioned a system in which cases would be moved to various regional units within a certain geographical range. It was hoped this would ensure that some of the more difficult medicolegal cases would be handled by a unit with a focus on forensic pathology. This was also a recognition that given the vast size of the province, it was not always optimal to move complex cases to the Provincial FPU in Toronto. In June 1993, Dr. Young proposed the establishment of the Regional Forensic Centres of Excellence.

- Evidence of Dr. Young, December 3, 2007, p. 137, line 22; to p. 138, line 18; p. 139, lines 13-15
- Memorandum, PFP057563

- Proposal, PFP057564

84. In his proposal document, Dr. Young noted that forensic pathology, as a sub-specialty of pathology, was still in its infancy, and that the OCCO had a vested interest in ensuring that both the calibre of and access to forensic pathology services were consistent with provincial demands. He also opined that over the following ten years it was expected that a great many forensic pathologists would retire from the profession. He wrote:

> "This is particularly problematic because many new pathologists do not want to enter the field of forensics due to the complexity of medico-legal cases and associated court proceedings. In addition, the monetary rewards of forensic pathology are not sufficiently attractive. For example, the remuneration for conducting an autopsy is $478. In order to attend court or an inquest, the remuneration is $200 per day. Greater financial gains can be realized through private practice. New pathologists do not want to get involved with court proceedings, which are often lengthy and require a lot of detail."

- Proposal, PFP057564, pp. 2 and 5

85. It was great foresight on the part of Dr. Young to recognize the greying of forensic pathology and the need to look beyond Toronto in order to ensure quality throughout the province. He acquired this vision for forensic pathology at a time when the Forensic Pathology Branch was not even formally integrated within the OCCO.

86. Dr. Young also recognized that it was becoming increasingly difficult for the Provincial FPU to accept cases outside of Toronto without creating a backlog of cases. The increased volume of cases was attributed to the rising number of violent and complicated deaths combined with the increased complexity of court cases across the province. In addition, there were increased costs in the human and financial resources necessary for completing such work.

- Evidence of Dr. Young, December 3, 2007, p. 139, lines 1-5

- Proposal, PFP057564, p. 5

87. In his proposal, Dr. Young further noted:

(a) The increased expectation placed on forensic pathologists by the criminal justice system to provide greater detail in forensic pathology examinations and reporting, which made each case more complex and time-consuming. Dr. Young felt that some pathologists lacked the necessary experience to undertake the more difficult cases, and that some expressed reluctance to participate in cases that would likely proceed to trial or litigation.

- Proposal, PFP057564, pp. 5-6

(b) That no accreditation program in forensic pathology existed in Canada, and that to receive formal training and accreditation, pathologists were forced to go to the United States. He noted the need to establish Canadian standards to maintain quality control in forensic pathology and to avoid court challenges;

- Proposal, PFP057564, p. 6

88. The Regional FPUs were proposed to address regional needs and to support the training and development of forensic pathologists across the province. Dr. Young noted that this proposal was consistent with government policy to decentralize and to service northern regions where medical services were lacking.

- Proposal, PFP057564, p. 7

89. The unique characteristic of the Regional FPUs was that they exemplified a joint effort between area teaching hospitals, local universities and the government. Such units would

facilitate the professional development of current forensic pathologists, serve to attract future pathology residents, create an environment for better quality teaching and improve the quality of research.

- Evidence of Dr. Young, December 3, 2007, p. 140, lines 16-19
- Proposal, PFP057564, p. 7

90. By developing appropriate expertise on a regional level, it was hoped that less reliance would be placed on the facilities in Toronto, which would assist in reducing the costs associated with transporting bodies and travel for forensic pathologists.

- Proposal, PFP057564, p. 7

91. Dr. Young listed the objectives of the proposal for the Regional FPUs as follows:

(a) To address the shortage of trained forensic pathologists;

(c) To balance the increasing workload on forensic pathologists and pathology units;

(d) To encourage and improve the level of training of forensic pathologists in Ontario;

(e) To achieve greater consistency of quality in the forensic work undertaken; and

(f) To engage in advanced research through linkages with the associated university teaching hospitals.

- Proposal, PFP057564, p. 8

92. It was anticipated that the affiliation between the local university, teaching hospital and the OCCO would make forensic pathology attractive to pathologists in training, and that a

scholarship fund could assist with the high costs of receiving training and accreditation in the United States. The ultimate goal would be to establish provincial standards and ensure a high level of quality control for forensic pathologists.

- Proposal, PFP057564, p. 8

93. The concept for the Regional FPUs was noted by Dr. Young to be "...a proactive approach to skill shortages and developing regional expertise. Addressing the issue today, through the allocation of modest funding, will alleviate current problems associated with the quality of autopsy reports provided, the prevention of lost court cases, the reduction in travel and transportation costs as well as the heavy caseloads at major teaching hospitals."

- Proposal, PFP057564, p. 8

94. Dr. Young noted the successes of the OPFPU that had been established at the HSC (discussed below) and the informal arrangements that were already in place with regard to Hamilton and Ottawa. He proposed more formalized financial arrangements for both, as well as the establishment of similar centres in Kingston and London. As a long range plan, he also proposed a northern "Centre" in either Sault Ste. Marie or Thunder Bay.

- Proposal, PFP057564, pp. 10-15

95. As this Commission has heard, the need for a forensic pathology unit in the North is very real. This is discussed further in Part III of these submissions.

96. Dr. Randy Hanzlick, Chief Medical Examiner, Fulton County, Georgia, endorsed the provincial model for Centres of Excellence, given the geographic area to be covered by the OCCO, including remote areas that are often difficult to access, and the advantage of having death investigations available locally. He commented that Centres of Excellence

assist in maintaining contact with local coroners by providing needed autopsy and investigative services. He advised continuing to build upon the current framework of existing Centres of Excellence and noted that the qualifications of forensic pathologists servicing the centres were a critical factor.

- "Options for Modernizing the Ontario Coroner System", Dr. R. Hanzlick, January 2008, p. 23

97. Dr. Hanzlick recommended developing the concept of Centres of Excellence further to become formal "regional offices" with fully qualified forensic pathologists. In order to achieve this objective, the funding that has remained static since 2000 would need to be increased.

- "Options for Modernizing the Ontario Coroner System", Dr. R. Hanzlick, January 2008, p. 52

(i) Establishment of the OPFPU

98. Standing apart from the other Regional FPUs, is the OPFPU. It is the only Regional Unit located in the same city as the Provincial FPU and it is the only unit dedicated to the provision of pediatric autopsy services.

99. As the evidence has shown, the OPFPU was the first Regional FPU created in the Province.

- Memorandum, PFP129900

100. The creation of the OPFPU was a recognition of the difficult nature of pediatric forensic pathology, of the need to harness pediatric expertise at the HSC and of the well-established

role the HSC had in providing quality autopsy services to the OCCO. Further, its establishment recognized that:

(a) Pediatric forensic pathology requires special expertise and special testing;

(b) The HSC is a world-renowned institution with expertise and technical services not available elsewhere in the province;

(c) The HSC was already doing a substantial amount of work for the OCCO;

(d) The HSC was not adequately funded for the work it was doing for the OCCO; and

(e) Dr. Smith was on staff at the HSC and highly motivated to do medicolegal cases.

- Evidence of Dr. Young, December 3, 2007, p. 132, line 7 to p. 134, line 3
- Evidence of Dr. Smith, February 1, 2008, p. 158, lines 3-19

101. In the circumstances, it was fair for the OCCO to expect that the OPFPU would provide the death investigation system with quality service, equivalent to the quality that is expected from the HSC.

- Evidence of Dr. Smith, February 1, 2008, p. 159, lines 2-20

102. Currently under the direction of Dr. Chiasson, the OPFPU continues to provide the OCCO with quality pediatric forensic autopsy services, consultative advice and a forum for education and guidance in matters relating to pediatric forensic pathology, including:

(a) Access to weekly autopsy rounds, with rounds dedicated to forensic cases every 4 to 6 weeks;

(b) Consultation services from pediatric neuropathologists, other pediatric pathology sub specialists and clinical pediatric specialists;

(c) Access to ancillary testing and technical assistance (such as microbiology and biochemistry laboratories); and

(d) The development of important linkages between the OPFPU and the OCCO so both institutions can benefit from one another's expertise.

- Evidence of Dr. Taylor, February 11, 2008, pp. 144-145
- Evidence of Dr. Pollanen, February 11, 2008, p. 148, line 14 to p. 149, line 3
- Evidence of Dr. Lauwers, January 7, 2008, p. 274, line 20 to p. 275, line 21; pp. 278-280
- Evidence of Dr. Edwards, January 7, 2008, pp. 275-277

C. Enhancements to Forensic Pathology

103. From the start of his tenure, Dr. Chiasson, with support from Dr. Young and Dr. Cairns, took active steps to increase quality and oversight of forensic pathology services for the province.

104. For the first time in the province, the OCCO, and in particular the Forensic Pathology Branch was making efforts to guarantee a certain level of quality in the service being provided.

105. Dr. Chiasson's efforts were multi-faceted and included:

(a) Appointing Regional Coroner's Pathologists;

(b) Implementing a Peer Review Process for homicide and criminally suspicious cases;

(c) Recruitment of full-time forensic pathologists; and

(d) Promoting education and teamwork.

(i) Regional Coroner's Pathologists

106. Dr. Chiasson recognized that homicide investigations and prosecutions were becoming increasingly complex, and that the expectations placed on pathologists performing autopsies in criminally suspicious deaths and homicides had significantly increased. The vast majority of the province did not have a Regional FPU nearby and the financial cost of transporting bodies over large distances could be prohibitive. As a result, community pathologists often took on cases that were beyond their forensic capabilities. Dr. Chiasson wanted to ensure that the OCCO continued to provide medicolegal death investigations of the highest quality.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 96-98
- Evidence of Dr. Lucas, January 8, 2008, p. 42, line 6 to p. 43, line 19
- Memorandum, PFP115898

107. To address this situation, Dr. Chiasson created the Regional Coroner's Pathologist system, a list of OCCO-sanctioned community pathologists who were both willing and capable of providing autopsy services in homicides and criminally suspicious cases.

- Evidence of Dr. Chiasson, December 7, 2007, p. 97, lines 7-13
- Memorandum, PFP115898

108. Dr. Chiasson felt that formal identification of such pathologists would assist in the initial coroner/police management of cases and allow for the concentration of educational efforts for pathologists working in advanced medicolegal death investigation. It also addressed the need to have designated pathologists in areas of the province that lacked easy access to the Regional FPUs.

- Evidence of Dr. Chiasson, December 7, 2007, p. 100, lines 4-8
- Memorandum, PFP115898

109. The Regional Coroner's Pathologist designation was a first attempt by the OCCO to differentiate pathologists with the necessary experience and skill level to take on complex, criminally suspicious cases.

- Evidence of Dr. Lucas, January 8, 2008, p. 43, lines 14-19

110. Dr. Chiasson initiated an application process specifying certain qualifying criteria, including the following:

(a) Prior forensic pathology training and/or experience;

(b) Prior experience as an expert witness in court;

(c) The willingness and interpersonal skills for working as part of a team; and

(d) Geographic location.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 101-102
- Memorandum, PFP115898

111. As this was an initial attempt to address a perceived need in the province, the criteria were not set at prohibitively high levels. Dr. Chiasson did not wish to discourage capable

pathologists who were interested in this work, and he recognized that there were very few pathologists in the province with formal training in forensic pathology, that the work was not well compensated, and that there were scarce human resources in certain areas of the province.

- Evidence of Dr. Chiasson, December 7, 2007, p. 102, line 25 to p. 103, line 2

112. Of the 200 to 250 pathologists performing medicolegal autopsies throughout the province, ultimately about 90 to 95 were rostered in the Regional and Associate Regional Coroner's Pathologist system.

- Evidence of Dr. Chiasson, December 7, 2007, p. 98, lines 8-12

113. At the OPFPU, Dr. Smith and Dr. Glenn Taylor were appointed as Regional Coroner's Pathologists.

- Evidence of Dr. Chiasson, December 7, 2007, p. 127, lines 4-10

114. The OCCO now recognizes the importance of keeping track of the pathologists performing autopsy services under coroner's warrant and in particular their forensic education, experience and their case load volume. As is set out in Part III of these submissions, the OCCO endorses the creation of a Registry system, whereby only pathologists who are on the Registry can perform autopsies under coroner's warrants.

(ii) Peer Review of Post Mortem Reports

115. Shortly after he began as CFP, Dr. Chiasson began reviewing individual post mortem reports[4] generated by the pathologists working out of his unit in Toronto. This consisted of approximately 1,500 reports per year. Dr. Chiasson initiated this peer review process to ensure that reports leaving the OCCO were reasonable in terms of the conclusions reached.

- Evidence of Dr. Chiasson, December 7, 2007, p. 56, line 24 to p. 57, line 2; p. 82, line 21-22

116. Starting in 1995, Dr. Chiasson undertook a similar initiative to review all post mortem reports in homicides and criminally suspicious cases from across the province, prior to their release to the Crown Attorney's office. The purpose of such a review was to identify any major forensic pathology issues that may need to be addressed prior to the final release of the report.

- Evidence of Dr. Chiasson, December 7, 2007, p. 81, lines 21-23
- Memorandum, PFP129358

117. This review, together with the review of all cases from the Provincial FPU was part of a new process for exerting quality control over forensic pathology in the province. Dr. Chiasson was unaware of any such quality control process in place prior to the initiation of these reviews.

- Evidence of Dr. Chiasson, December 7, 2007, p. 81, line 25 to p. 82, line 2

118. In initiating these reviews, careful consideration was given to the best approach for quality control, given that between six and eight thousand medicolegal autopsies were

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4 "Post Mortem Report" has been used interchangeably throughout these submissions with "autopsy report" and "Report of Post Mortem Examination"

generally performed on an annual basis in Ontario. With neither the personnel nor the resources to allow for every generated autopsy report to be reviewed by a forensic pathologist, a more pragmatic approach was sought.

- Evidence of Dr. Chiasson, December 7, 2007, p. 82, lines 10-20
- Forensic Pathology Corner, PFP129360

119. As it stood, post mortem reports were submitted to the investigating coroner who could then correlate the pathologist's findings with the known circumstances in the case. Any concerns could be discussed with the pathologist prior to releasing the report to the family.

- Forensic Pathology Corner, PFP129360

120. Dr. Chiasson considered that this level of quality control would suffice in the majority of uncomplicated cases. Homicides and criminally suspicious cases were the exceptions. With respect to this issue, Dr. Chiasson reported the following in the "Forensic Pathology Corner", a regular article that he created to contribute to the ongoing education of pathologists and coroners in the OCCO's official newsletter, the Mortem Post, starting in 1995:

> "Although many are relatively straightforward from a pathology point of view, the amount of resources that are entailed in the investigation and prosecution of such cases clearly dictates that an increased level of scrutiny of the medicolegal autopsy report is required. Annually, there are only about 200-250 homicides in this province. In Maryland, all of the homicide autopsy reports (annual average 500-600) are co-signed by the Chief Medical Examiner. In the Toronto Forensic Pathology Unit, all homicide autopsy reports are personally reviewed by myself prior to being released for distribution. At a recent Regional Coroners meeting, it was agreed to extend this review process province-wide."

- Evidence of Dr. Chiasson, December 7, 2007, p. 75, lines 11 to 19
- Forensic Pathology Corner, PFP129360

121. It was decided, therefore, that with limited resources, the best method of implementing quality control by forensic pathologists was to focus on homicide and criminally suspicious cases, which would be reviewed by the CFP prior to their release.

- Forensic Pathology Corner PFP129360

122. In addition to the 1,500 cases at the Provincial FPU that Dr. Chiasson reviewed, which included some homicide and criminally suspicious cases, the review of such cases from around the province resulted in an additional 150 to 200 cases.

- Evidence of Dr. Chiasson, December 7, 2007, p. 82, line 24; p. 95, lines 9-12

123. These reviews were primarily paper reviews. Photographs or histological slides would not normally be reviewed, unless there was an issue and Dr. Chiasson specifically requested them.

- Evidence of Dr. Chiasson, December 7, 2007, p. 86, lines 7-16

124. Dr. Chiasson fairly conceded that if the post mortem report included a misinterpretation of an injury or a pathological finding, this peer review process would most likely not detect such an error.

- Evidence of Dr. Chiasson, December 7, 2007, p. 86, lines 17-24

125. Further, the review process did not capture or include consultation reports or second opinions, unless these accompanied the post mortem report itself.

- Evidence of Dr. Chiasson, December 7, 2007, p. 88, lines 11-20

126. On occasion, reports bypassed this peer review process. In an audit conducted by Dr. Chiasson early in the implementation of this initiative, he was relieved to find that the majority, though not all, of the required reports were received for review by the CFP.

- Evidence of Dr. Chiasson, December 7, 2007, p. 87, lines 14-16

127. Thus, in response to a question from Commission Counsel, Dr. Chiasson agreed that if post mortem reports were completed very late in the death investigation process, it was possible that they would arrive in the hands of the Crown Attorney or the court without having ever been reviewed by the CFP.

- Evidence of Dr. Chiasson, December 7, 2007, p. 87, lines 1-13

128. Dr. Chiasson blamed the shortfall on the fact that there was such a large cohort of pathologists across the province involved in this process. Because of this factor, Dr. Chiasson was, in fact, pleased with the overall positive results of the initial audit.

- Evidence of Dr. Chiasson, December 7, 2007, p. 87, lines 9-13

129. Despite its limitations, Dr. Chiasson's paper review of homicide and criminally suspicious cases represented an important recognition by the OCCO of the need to provide oversight of those working within the system on a case-by-case basis. It was also recognition of the primacy of the CFP over the professional activities of pathologist's conducting medicolegal autopsies.

Eastern Ontario Forensic Pathology Unit ("Ottawa Regional Unit")

130. The situation that presented itself within the Ottawa Regional Unit is a prime example of the benefit of Dr. Chiasson's paper reviews. Problems were identified in the course of Dr.

Chiasson's paper peer review process that enabled Dr. Chiasson to act quickly in the Vanasse case, where an individual's freedom was at stake. However, the OCCO faced significant limitations, particularly in the form of an ongoing human resource crisis that prevented a more timely resolution of some of the issues.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 177-179
- Judgement, PFP141947

131. During the period 1995 to 1997, Dr. Chiasson identified significant concerns with the work being produced by the Ottawa Regional Unit and, specifically, the work of Dr. Brian Johnston as well as another pathologist, Dr. Wenckeback.

- Evidence of Dr. Chiasson, December 7, 2007, p. 177, lines 7-10; December 11, 2007, p. 122, line 24 to p. 123, line 5
- Handwritten notes, PFP141787
- Memorandum, PFP141852

132. In particular, Dr. Chiasson found that Dr. Johnston occasionally arrived at forensic pathology conclusions that could not be supported by the documented evidence. Though not every case of Dr. Johnston's was problematic, Dr. Chiasson felt that his conclusions could not be substantiated in a number of post mortem reports.

- Evidence of Dr. Chiasson, December 11, 2007, p. 121, lines 8-11
- Handwritten notes, PFP141787

133. This raised the concern that his findings in the post mortem reports could adversely impact the criminal justice system by wrongly inculpating or exculpating individuals.

- Evidence of Dr. Chiasson, December 11, 2007, p. 122, lines 2-6

134. These concerns were the subject of ongoing discussions primarily with the RSC, Dr. Ben Bechard. In addition, both Dr. Young and Dr. Cairns were kept apprised of the matter.

- Evidence of Dr. Chiasson, December 11, 2007, pp. 122-124

135. Dr. Chiasson held a number of meetings with Dr. Bechard, and together they met with Dr. Johnston and suggested certain remedial activities, including working within the Provincial FPU for a number of months. Dr. Johnston was not receptive to these suggestions, and Dr. Chiasson wrote a memorandum to Dr. Young summarizing the events and suggesting that Dr. Johnston be removed as Director of the Ottawa Regional Unit. Dr. Johnston would continue to work for the unit under the new Director.

- Evidence of Dr. Chiasson, December 7, 2007, p. 185, line 13 to p. 186, line 9
- Memorandum, PFP130640

136. The OCCO subsequently searched for a new Director, but this proved challenging.

- Evidence of Dr. Chiasson, December 7, 2007, p. 187, lines 11-18; p. 187, line 24 to p. 186, line 1

137. The OCCO recognizes that Dr. Chiasson's ability to effect significant change in Ottawa was hampered by the fact that he had no formalized oversight of Dr. Johnston. This is discussed further in Part II herein.

138. The events relating to Dr. Johnston in Ottawa serves as a valuable illustration of Dr. Chiasson's oversight at work.

(iii) Recruitment of Full-Time Forensic Pathology Staff

139. Dr. Chiasson's vision for improving the quality of forensic pathology services centred on strengthening the Provincial FPU. Dr. Chiasson viewed the unit as critically important to the entire system and felt that it needed to be run more efficiently and effectively as a first priority. He stated the following:

> "I've always felt...the Unit...was, if you will, the trunk of the tree, and -- and if that wasn't functioning, your tree wasn't going to grow very well."
>
> - Evidence of Dr. Chiasson, December 7, 2007, p. 48, line 21-25 to p. 49, line 1

140. Improving forensic pathology services in Ontario meant recruiting full-time forensic pathology staff. In a memorandum to Dr. Cairns, dated January 30, 1995, Dr. Chiasson stated:

> "One of the major factors that was part of my decision to take on the position of Chief Forensic Pathologist was that the Coroner's office agreed, in principle, that the unit should be staffed by full time pathologists with training in and/or experience in forensic pathology."
>
> - Memorandum, PFP120354, p. 2
> - Evidence of Dr. Chiasson, December 7, 2007, p. 59, lines 5-12

141. Accordingly, a significant effort was made by Dr. Chiasson to secure full-time forensic pathologists at the Provincial FPU, but the task proved extremely challenging. Dr. Chiasson noted that in the process of selecting full-time candidates for the OCCO, it was evident that there were only a limited number of suitable candidates in Canada, and that staffing the Provincial FPU would require a coordinated and planned approach to gradually fill the required positions.

- Evidence of Dr. Chiasson, December 7, 2007, p. 62, lines 15-18
- Memorandum, PFP129354

142. At the time that Dr. Chiasson assumed the position of CFP, there were very few formally trained forensic pathologists in Ontario. Dr. Michael Shkrum was board certified by the American Board of Pathology and was practising in London, Ontario. In Hamilton, Dr. David King was working full-time; he had formally trained in Britain and obtained the Diploma of Medical Jurisprudence ("DMJ").

- Evidence of Dr. Chiasson, December 7, 2007, p. 62, lines 19-21; p. 63, lines 1-3

143. It is possible that there were one or two other hospital pathologists working in the communities who may have also held board certification in forensic pathology.

- Evidence of Dr. Chiasson, December 7, 2007, p. 63, lines 8-10

144. The situation outside Ontario was not much better. Apart from a number of forensic pathologists working in Alberta in a medical examiner's system, there were not many pathologists with formal training and certification in forensic pathology in other Canadian jurisdictions.

- Evidence of Dr. Chiasson, December 7, 2007, p. 63, lines 11-23

145. By January 30, 1995, the first full-time forensic pathology staff position was filled by Dr. John Deck, a neuropathologist with extensive previous experience in forensic pathology.

- Evidence of Dr. Chiasson, December 7, 2007, p. 61, line 1; to p. 62, line 7
- Memorandum, PFP129354, p. 2

146. Dr. Deck accepted this position following his retirement as a hospital neuropathologist in Toronto. Dr. Chiasson did not expect that Dr. Deck would remain at the OCCO in the long term, but was relieved that he was able to find someone with forensic pathology experience to fill at least one full-time position at the time, as "there were no obvious candidates around". Dr. Deck's academic background and expertise in neuropathology also promised to bring added value to the OCCO.

- Evidence of Dr. Chiasson, December 7, 2007, p. 61, lines 10-25; p. 62, lines 3-7

147. At the time Dr. Deck came on board as full-time staff at the Provincial FPU, the OCCO also had five part-time fee-for-service pathologists, in addition to Dr. McAuliffe, who carried a full-time load on a fee-for-service basis.

- Memorandum, PFP129354

148. Dr. Chiasson felt this was an unacceptable situation going forward. In his January 30, 1995, memorandum he stated the following:

> "I strongly feel that the current situation is only acceptable as part of a gradual evolution towards a full time staff. This change over should be carried out as soon as practically possible, given the recognized shortage of trained forensic pathologists in this country."

- Memorandum, PFP129354

149. In 1996, Dr. Martin Queen, who had just completed his American Board certification in forensic pathology, was recruited to work full-time at the OCCO. In 1997, Dr. Martin Bullock was also recruited following his American Board certification in forensic pathology. Both Dr. Queen and Dr. Bullock formally trained in the United States before writing their American Board exams.

- Evidence of Dr. Chiasson, December 7, 2007, p. 65, line 11; p. 66, line 6

150. In 1998, Dr. Toby Rose transitioned from a part-time fee-for-service pathologist to a salaried full-time forensic pathologist at the OCCO. She also received her American Board certification in forensic pathology, though unlike Dr. Queen and Dr. Bullock, she had not completed any formal training. At the time, the American Board granted permission to those with sufficient practical experience to sit the certification exams.

- Evidence of Dr. Chiasson, December 7, 2007, p. 66, lines 4-20

151. The OCCO encouraged Dr. Queen, Dr. Bullock and Dr. Rose to obtain their Board certification in forensic pathology. Board certification became a pre-requisite for any pathologist to be hired at the Provincial FPU in a full-time, salaried position.

- Evidence of Dr. Chiasson, December 7, 2007, p. 66, line 21; p. 67, line 3

152. By 1998, there were five full-time forensic pathologists on staff at the OCCO.

- Evidence of Dr. Chiasson, December 7, 2007, p. 66, lines 18-20

153. Funding for these additional full-time forensic pathologists was obtained by Dr. Young.

- Evidence of Dr. Young, December 3, 2007, p. 61, lines 13-15

(iv) Promoting a Dedicated Team Environment

154. Improving forensic pathology services in Ontario also meant improving the level of collaboration within the Provincial FPU. Dr. Chiasson wished to promote a greater sense of commitment and connection to the OCCO and its work. Instead of pathologists functioning essentially as "independent contractors", coming to the unit only when needed to conduct a post mortem examination under coroner's warrant, Dr. Chiasson wanted to

promote a sense that the pathologists working at the Provincial FPU were an integral part of the unit team.

- Evidence of Dr. Chiasson, December 7, 2007, p. 49, lines 4-13

155. As such, Dr. Chiasson initiated a number of changes, one of which was the development of an on-call schedule, or roster, for pathologists performing coroner's autopsies at the Provincial FPU. The schedule specified the particular pathologist that would be responsible for performing all the autopsies that came into the Provincial FPU on a given day. For most pathologists, this involved a commitment of one full day every two weeks for the performance of autopsies at the OCCO. It was made clear to the part-time pathologists participating on the roster that in no way were their other hospital pathology commitments to interfere with the provision of these services on the day they were responsible for autopsies at the OCCO.

- Evidence of Dr. Chiasson, December 7, 2007, p. 51, line 19; p. 52, line 18; p. 67, line 19, p. 68, line 7
- Memorandum, PFP129354, p. 2

156. The promotion of teamwork naturally helped encourage continuity and consistency in the pathology work performed at the Provincial FPU, and to inject some rigour into the forensic pathology process.

157. Dr. Chiasson also initiated morning pathology rounds, which were attended by the pathologist on call for the day, the CFP, the pathologist assistants and representatives of the OCCO. Often Dr. Cairns attended these rounds, as would the RSCs, and on occasion, the CCO.

- Evidence of Dr. Chiasson, December 7, 2007, p. 50, lines 9-19

158. Morning pathology rounds consisted of reviewing cases both before and after the completion of the post mortem examination. For new cases, the coroner's warrant and the history would be reviewed. If there was additional information in the possession of either the RSC or the police, this information was shared. Decisions would be made as to whether any special investigative procedures or tests were indicated, and whether any follow-up was necessary.

- Evidence of Dr. Chiasson, December 7, 2007, p. 50, line 20; p. 51, line 4; p. 53, lines 10-22
- Memorandum, PFP129354

159. In addition to morning pathology rounds, Dr. Chiasson initiated weekly pathology rounds that took place on Wednesday afternoons. Every alternate week, these rounds focussed on cases with a significant toxicological component, and members of the Centre of Forensic Sciences, Toxicology Unit, would participate. These rounds included a discussion of pending cases, any preliminary toxicology results and next steps. On "non-toxicological" weeks, the cases reviewed would be those that were of special interest, either from a medical or forensic perspective, involving any manner of death.

- Evidence of Dr. Chiasson, December 7, 2007, p. 54, line 23; p. 55, line 13
- Memorandum, PFP129354

160. All pathologists affiliated with the OCCO were expected to attend the weekly pathology rounds.

- Evidence of Dr. Chiasson, December 7, 2007, p. 55, lines 23-25
- Memorandum PFP129354, p. 2

161. Dr. Chiasson also developed "Special Case Reviews" for particularly complex forensic pathology cases. Special Case Reviews were ad hoc multidisciplinary meetings convened upon the request of those working in the death investigation system. Meetings were arranged so that the results of the post mortem examination could be discussed with coroners, investigating police officers, crown attorneys and others as deemed necessary. Representatives of the OCCO, most often Dr. Cairns, were also involved in these meetings.

- Evidence of Dr. Chiasson, December 7, 2007, p.58
- Memorandum, PFP129354, p. 1

(v) Dealings with the OPFPU

162. Early on, Dr. Chiasson recognized the need to foster a close working relationship with the OPFPU.

163. Throughout his tenure, Dr. Chiasson made significant efforts to strengthen ties and address any concerns between the Provincial FPU and the OPFPU. This was accomplished through the following measures:

(a) Participation in monthly forensic pathology rounds at the OPFPU;

- Evidence of Dr. Chiasson, December 7, 2007, pp. 151-153

(b) Ongoing meetings and correspondence with Dr. Lawrence Becker and Dr. Smith;

- Evidence of Dr. Chiasson, December 7, 2007, p. 161, line 18; p. 162, line 4

(c) Inviting Dr. Smith to attend rounds at the OCCO;

- Evidence of Dr. Chiasson, December 7, 2007, pp. 190, lines 4-13; p. 209, lines 15-18

(d) A quality audit of the OPFU in 1997;

- Evidence of Dr. Chiasson, December 7, 2007, pp. 170-174
- PFP134371

(e) Proposing a re-visioning of the OPFPU in 1998, when Dr. Chiasson noted very little improvement in the service provided by the OPFPU to the OCCO. In particular, no administrative assistant had been hired for Dr. Smith, as the OCCO had repeatedly requested, and the turnaround times for post mortem reports had increased. The latter was particularly distressing to the RSCs who were often the ones trying to appease those awaiting the reports;

- Evidence of Dr. Chiasson, December 7, 2007, pp. 212-219
- PFP056292

(i) Under Dr. Chiasson's proposal, the OPFPU was to be physically relocated to the OCCO, with the OPFPU Director providing a minimum 50 per cent time commitment to the Unit. The HSC was to continue to provide consultative professional and technical support and the OCCO was to assume responsibility for administrative and secretarial support;

- Memorandum, PFP056292

(ii) In essence, Dr. Chiasson proposed a redistribution of cases such that all deaths outside the HSC, as well as all homicides and criminally suspicious cases, would be performed at the OCCO; and

- Evidence of Dr. Chiasson, December 7, 2007, pp. 215-216

(iii) While Dr. Smith was to remain Director of the OPFPU, he would report directly to Dr. Chiasson.

- Evidence of Dr. Chiasson, December 7, 2007, p. 218, lines 3-6

164. Dr. Chiasson's efforts were meant to improve collaboration between the two units, but were also meant to allow him greater insight into the operation of the OPFPU. Unfortunately, as is discussed below, such insight was not easily obtained in light of Dr. Smith's perceived dominance of the field of pediatric forensic pathology.

165. As discussed in Part II, with hindsight the OCCO recognizes that many of Dr. Chiasson's initiatives fell short of ensuring quality autopsy services, certainly with regard to Dr. Smith. That said, it must be clearly understood that Dr. Chiasson created a provincial forensic pathology service, complete with peer review and teamwork where there had been nothing in place prior.

D. Education and Training of Coroners and Pathologists

166. Dr. Young, Dr. Cairns and Dr. Chiasson recognized that training, education and ongoing support were valuable tools for quality death investigations for both coroners and pathologists.

- Letter, PFP134457
- Memorandum, PFP129355

167. The OCCO has taken a number of initiatives to enhance training and education for the members of the death investigation team:

(a) The creation of the Education Course for New Coroners in 1992;

- Evidence of Dr. Cairns, November 26, 2007, p. 15, line 22; p. 16, line 16

(b) The creation of education programs for pathologists and coroners;

- Evidence of Dr. Young, December 3, 2007, p. 61, line 16; p. 62, line 4
- Evidence of Dr. Chiasson, December 7, 2007, p. 71, lines 3-11
- Regional Coroner's Pathologist Course, PFP129374

(c) The regularization of case conferences;

(d) The regular contribution, by Dr. Chiasson of an article entitled the "Forensic Pathology Corner" to the Mortem Post, the OCCO's official newsletter; and

- Evidence of Dr. Chiasson, December 7, 2007, p. 75, lines 11-16
- Forensic Pathology Corner, PFP129356

(e) Encouraging attendance at the American Academy of Forensic Sciences meetings.

- Evidence of Dr. Cairns, November 26, 2007, p. 20, lines 9-14

168. The education and training initiatives of the OCCO continue to this day:

(a) Development of the Expert Witness Course for forensic pathologists;

- Evidence of Dr. Pollanen, November 12, 2007, p. 240, lines 14-22

(b) Continuation of the Joint Annual Forensic Pathologist and Coroners Course;

- Evidence of Dr. Pollanen, November 12, 2007, p. 239, lines 2-13

(c) Development of updated Guidelines for Death Investigation and on Autopsy practice for forensic pathologists; and

- PFP033007
- PFP032372
- PFP032495
- PFP137627

(d) Development though the Quality Assurance Committee of the Guidelines for Death Investigation in 2003.

169. In addition to these educational initiatives targeting fully qualified pathologists and coroners, the OCCO and other Regional FPUs recognize the growing need to train future members of the death investigation team.

- Evidence of Dr. Pollanen, December 6, 2007, p. 36, line 15, p. 38, line 14
- Evidence of Dr. Rao, January 17, 2008, p. 82, lines 15-20
- Evidence of Dr. Shkrum, January 17, 2008, p. 36, lines 11-17

170. As set out in Part III of these submissions, more training and education are required to address both the disparity of experience among current pathologists in the system and the dire need for new forensic pathologists to replace the aging profession.

- Appendix E, Dr. M.S. Pollanen, Proposal to establish a Centre for Forensic Medicine and Science at the University of Toronto, January 22, 2008

171. Further, the OCCO fully supports the Royal College of Physicians and Surgeons' recognition of forensic pathology as a sub-specialty following certification in either anatomical or general pathology. This too, is more fully discussed in Part III.

- Evidence of Dr. Pollanen, November 12, 2007, p. 45, lines 20-23

- Evidence of Dr. Shkrum, January 17, 2008, p. 213, line 13; p. 215, line 17

E. Case Conferences

172. The team concept is at the heart of the OCCO's death investigations. Coroners, pathologists and other professionals bring unique expertise to the work.

173. Case conferences developed based on recommendations from the *Bernardo Investigation Review, the Report of Justice Archie Campbell, 1996* ("Campbell Report") which endorsed the collaboration between the various disciplines that participate in death investigations in criminally suspicious and homicide cases. Such cases are among the most complex.

- OCCO Institutional Report, PFP149431, pp. 56-59

> "All of these initiatives are relevant in the sense that they strengthen the particular areas- training, interdisciplinary teamwork and the cause of death determination that came into play in the investigation of Tammy Homolka's death"

- Campbell Report, p. 101

> "Continuation and support is required for the work of the Chief coroner's office in developing, for unexplained and suspicious deaths, an inter-disciplinary approach to integrate the work of the police, coroners, forensic scientists and forensic pathologists."

- Campbell Report, Recommendation #7

174. In 1998, the Honourable Fred Kaufman released his findings on the inquiry he conducted into the wrongful conviction of Guy Paul Morin. In his report he discussed the Campbell model of case management and stated:

> "I respectfully endorse the Campbell model and urge the continued movement to its earliest implementation in this province."

- The Commission on Proceedings involving Guy Paul Morin Report, Volume 2, p. 1121

175. Case conferences provide a forum for forensic pathologists to render opinions beyond simply the post mortem findings. They provide forensic pathologists with the opportunity to participate in the larger death investigation process. Through case conferences, forensic pathologists obtain further information and can provide opinions as to both cause and manner of death.

- Evidence of Dr. Chiasson, December 10, 2007, p. 165, line 13; p. 166, line 10

176. Typically, case conferences must take place within a reasonable time frame after the post mortem examination, usually within two weeks, wherever possible. The RSC has a critical role to play as the coordinator of these conferences.

- Evidence of Dr. Lucas, January 7, 2008, p. 89, lines 6-14
- OCCO Institutional Report, PFP149431, p. 58

177. In the majority of case conferences, the cause of death is quite apparent. In such cases, there is often little for the pathologist to contribute in terms of how the case or police investigation ought to proceed. Such case conferences usually focus instead on prioritizing exhibits submitted to the Centre of Forensic Sciences, with a discussion of the strengths of the available science to assist the police with their investigative objectives. In practice, the pathologist may not need to attend case conferences where the cause of death is straightforward and there are no controversial issues related to the medical evidence.

- Evidence of Dr. Lucas, January 7, 2008, p. 90, line 20; p. 91, line 14
- OCCO Institutional Report, PFP149431, p. 59

178. In cases conferences where the cause of death is not clear, the pathologist has often had difficulty establishing definitive findings at the time of the gross post mortem examination.

Case conferences can also assist in determining whether any further testing is necessary. Early case conferences are critical in complex cases to provide police investigators with an idea of the strengths or deficiencies in the forensic pathology, which can then assist in the direction of their investigation. In such case conferences, the pathologist is the key participant.

- Evidence of Dr. Lucas, January 7, 2008, p. 89, line 15; p. 90, line 18
- Evidence of Dr. Edwards, January 7, 2008, p. 92, line 10; p. 94, line 7

179. In most instances, preliminary findings from the pathologist are sufficient for holding a case conference. A post mortem report is not required in order for a case conference to be conducted.

- Evidence of Dr. Lucas, January 7, 2008, p. 89, line 24; p. 90, line 4

180. In his first article of the "Forensic Pathology Corner", Dr. Chiasson highlighted a number of issues of systemic importance which bear on the value of teamwork as found at the OCCO and as illustrated by the case conference:

(a) The death investigation system in Ontario requires dedicated professionals and good communication between the agencies involved;

(e) The pathologist's role does not begin and end with the performance of a competent medicolegal autopsy. Equally important is the ability to communicate this information to coroners, the police and others in the death investigation process;

(f) The importance of consultation in forensic pathology was emphasized, given the often unusual and unique situations;

(g) While many pathologists across the province would not be able to participate in the daily and weekly rounds taking place at the Provincial FPU, all pathologists were encouraged to regularly discuss cases with local colleagues;

(h) In particularly perplexing cases, pathologists were encouraged to enlist the services of the Provincial FPU and the Regional FPUs located in Hamilton, Ottawa and at the HSC;

(i) Potentially controversial forensic issues were best tackled as early as possible; and

(j) One of the CFP's primary responsibilities was to provide consultative support to pathologists, coroners and the police. Dr. Chiasson encouraged all to take advantage of this support.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 75-80
- Forensic Pathology Corner, PFP129356

181. Dr. Chiasson emphasized the importance of communication and collaboration in the provision of forensic pathology services and within the overall death investigation system.

- Evidence of Dr. Chiasson, December 7, 2007, p. 78, line 21; p. 80, line 18
- Forensic Pathology Corner, PFP129356

F. Oversight of Coroners in Death Investigation

182. The focus of this Commission has been on forensic pathology and pediatric forensic pathology in particular. However, this Commission has heard evidence about the role of the coroner as leader of the death investigation team.

183. The OCCO is dedicated to ensuring quality and providing oversight of the work of its coroners. The evidence has shown, for example, that coroners are guided through difficult cases by RSCs. The evidence has also shown that:

(a) The OCCO has recently formed the Chief Coroners Review, in part as a replacement of the Coroner's Council.

- Evidence of Dr. Lauwers, January 8, 2008, pp. 48, 62-63
- PFP032462
- PFP032463
- PFP032464
- PFP032468

(b) The Coroners' Investigation Statement, (also known as Form 3) are reviewed by RSCs;

- Evidence of Dr. Lauwers, January 7, 2008, p. 101, line 23; p. 102, line 1

(c) The RSCs now have an audit tool available for evaluating the performance of coroners in the completion of their warrants and the Form 3.

- Evidence of Dr. Lauwers, January 7, 2008, pp. 143-147
- PFP032488

184. In formulating suggested recommendations, the OCCO has recognized these initiatives and the need to further enhance continued oversight of its coroners.[5]

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5 See Part III