PART II

Limitations of the Death Investigation System

185. The evidence before this Commission has demonstrated that the OCCO, through its dedicated leaders has continually strived to enhance death investigation in the province in an effort to promote public safety and prevent future deaths. Despite this sincere commitment, many of the OCCO's initiatives fell short of ensuring an appropriate level of quality in death investigation. In hindsight, this is particularly evident in relation to the OCCO's oversight of Dr. Smith. While the OCCO acknowledges these shortcomings, they must be assessed in light of the severe limitations facing its leadership, namely:

(a) The absence of a formal role in quality assurance and oversight for the CFP;

(b) The predominance of Dr. Smith in the field of pediatric forensic pathology; and

(c) The lack of resources, both human and financial.

186. In addition, it must be remembered that pathology is an inexact science: though it can be methodologically valid, reasonable, balanced and evidence-based, it cannot offer certainty.

- Evidence of Dr. Pollanen, November 13, 2007, p. 202, line 24 to p. 203, line 4

187. It must also be remembered that the cases that Dr. Smith undertook, particularly those that were criminally suspicious or homicides, were among the most complex in forensic pathology. As Dr. Chiasson remarked, virtually all pediatric cases are inherently complex:

> "...it's my view that the pediatric forensic pathology cases are -- are certainly among the -- the most challenging cases that one can encounter.
>
> And especially all -- virtually anything that is homicide criminally suspicious in -- in the area of pediatrics is -- is wrought with all sorts of complexities;

> whereas, with the adult world, you know -- in fact, most of them cause of death is not an issue, gunshot wound, stab wound.
>
> There may -- there's forensic issues beyond the cause of the death that can be -- cause -- cause difference of opinion and gray areas when you're testifying. But that's -- in pediatrics, it's almost inevitable. So the degree of complexity of the cases, not only of the homicide criminally suspicious, even the natural disease cases is quite remarkable."

- Evidence of Dr. Chiasson, December 10, 2007, p. 179, line 7; p. 180, line 11

188. Many of the most difficult pediatric cases across the province were sent to the OPFPU, and Dr. Smith performed a significant portion of the criminally suspicious and homicide post-mortem examinations.

- Written evidence of Dr. Smith, PFP30334, p. 17

Limitations to Quality Assurance, Accountability and Oversight

A. No Formal Quality Assurance or Oversight Role for the CFP

189. The precise role of the CFP within the death investigation system has never been codified, defined or formally recognized. Both the current CFP and his predecessor, Dr. Chiasson, have had to create their roles as leaders of forensic pathology services in Ontario through consultation, collaboration and buy-in from pathologists across the province.

- Evidence of Dr. Pollanen, November 12, 2007, p. 64, lines 10-25

(i) Legislative Authority

190. There is no reference to the CFP in the *Coroners Act*. As such there are no duties or responsibilities for the CFP prescribed therein.

- Evidence of Dr. Pollanen, November 12, 2007, p. 64, lines 22-25

- *Coroners Act*, R.S.O., c. C. 37

(ii) Lack of Clarity in the Regional FPU Service Agreements

191. Historically, the role of the CFP in relation to the Regional FPUs was unclear, with no definitions of the duties or responsibilities of the CFP contained in the service agreements. According to these agreements, accountability of the Regional FPUs has appeared to flow to the CCO. Currently, the role of the CFP is still not defined in the service agreements.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 130
- PFP033773 (HSC)
- PFP129575 (Ottawa Regional Unit)
- PFP130106 (London Regional Unit)
- PFP130275 (Kingston Regional Unit)
- PFP124556 (Hamilton Regional Unit)

192. The evidence at this Inquiry has shown that this lack of clarity has had significant consequences particularly in relation to the OCCO's relationship with the OPFPU.

193. The HSC and the Ministry of the Solicitor General entered into the first service agreement for the creation of the OPFPU in September 1991, at a time when the Forensic Pathology Branch was separate from the OCCO.

- Agreement, PFP129900

194. As set out above, Dr. Hillsdon-Smith played no role in developing relationships with the OPFPU or any of the Regional FPUs in existence during his tenure.

- Evidence of Dr. Cairns, November 26, 2008, p. 98, line 18 to p. 99, line 2

195. Given the absence of oversight by the PFP, the CCO was given oversight responsibility of the Regional FPUs in the service agreements.

196. With no forensic pathologist at the OCCO to administer the services when the OPFPU was established, Dr. Young saw a need to establish a Director of the OPFPU to provide administrative oversight of the work of the pathologists at the HSC.

- Evidence of Dr. Young, November 30, 2007, p. 25, line 1 to p. 26, line 6

197. Without a clearly defined role for the CFP, it proved difficult for Dr. Chiasson to affect oversight in either the service agreements or the legislation.

198. It also proved difficult for the OCCO to properly oversee Dr. Smith as Director, given that Dr. Smith's role was also not clearly defined.

199. Dr. Young viewed Dr. Smith's role as Director of the OPFPU as a purely administrative role. The OCCO acknowledges that Dr. Young's view was not shared by others within the office. It is clear that both Dr. Chiasson and Dr. Cairns believed that as Director, Dr. Smith had some of the responsibility for the quality and oversight of the pathologists at the HSC. The OCCO recognizes that Dr. Young's understanding of Dr. Smith's role factored into Dr. Young's decision to allow Dr. Smith to continue on as Director of the OPFPU after January 2001.

- Evidence of Dr. Cairns, November 26, p. 97, lines 9-19
- Evidence of Dr. Young, November 30, 2007, p. 25, lines 1-26; pp. 28-29, 220-221
- Evidence of Dr. Chiasson, December 7, 2007, p. 134, lines 3-7
- Letter, PFP134457

200. Despite the fact that the Director of the OPFPU had no official role in quality assurance, Dr. Young expected that if the Director or the Chief of Pathology at HSC had any concerns about a pathologist at the OPFPU, it would be brought to his attention. Similarly, if any of the pathologists working at the OPFPU had any concerns about the Director, Dr. Young would have expected that this would be brought to his attention as well. Since these were pathologists working within the same department in the same field, they would be well placed to recognize potential concerns with another pathologist's work. Dr. Young would not have expected that any of these pathologists would be involved in solving any problems that came to light, or be responsible for quality assurance on a regular basis, but only that if any concerns were noted, that they would be brought to his attention, and he could then address them.

- Evidence of Dr. Young, November 30, 2007, p. 29, lines 3-15

201. The service agreement provided no direction to either the OCCO or the OPFPU as to the respective roles and responsibilities of the Director of the OPFPU and the CFP (when he was appointed). This lack of direction made it difficult for the OCCO to hold Dr. Smith accountable as Director and made it difficult for Dr. Chiasson to assert control over the work of Dr. Smith and others at the OPFPU.

202. As a result, it appears that in some instances Dr. Chiasson was not made aware of forensic pathology issues that may have benefited from his direction. This is best illustrated by the Nicholas and Sharon cases.

Nicholas

203. Nicholas was born in Sudbury on January 2, 1995 and died on November 30, 1995, at 11 months of age. At the time of his death, Nicholas was in his mother's care at their family home.

- Nicholas Overview Report, PFP143263, p. 4

204. No criminal proceedings were ever initiated in this case. However, the local CAS became involved when notified by police that Nicholas' mother was expecting another child, born in 1998. The CAS commenced child protection proceedings at the time of the birth, but eventually withdrew those proceedings on March 25, 1999.

- Nicholas Overview Report, PFP143263, pp. 4, 30-31

205. Dr. Smith and Dr. Cairns were involved in the case approximately twelve months following the death of Nicholas and then again during the CAS proceedings.

- Nicholas Overview Report, PFP143263, p. 13, 30

206. The original autopsy was performed by Dr. Chen on November 30, 1995, and his report is dated August 14, 1996. Dr. Chen found that no anatomical or toxicological cause of death had been established and determined that the cause of death in this case was SIDS, provided that all other aspects of the investigation were negative.

- Nicholas Overview Report, PFP143263, p. 10

207. Dr. James Deacon, the investigating coroner in this case, did not adopt Dr. Chen's findings as to cause of death. In his final Coroner's Investigation Statement, Dr. Deacon certified the manner of death as "undetermined" and the cause of death as "sudden

unexplained death". He felt the OCCO guidelines would place this death in the SUD category, based upon the association of the death with a bump on the head. By definition, as outlined in the 1995 Protocol, "the diagnosis of SIDS can only be considered when all the components of the investigation have been completed and nothing abnormal or suspicious has been discovered. SIDS is really a diagnosis of exclusion." Dr. Deacon felt the diagnosis of SIDS in this case was not supported based on the history with which provided.

- Coroner's Investigation Statement, PFP007626
- Memorandum #631, PFP057584, p. 349

208. In November 1996, the RSC for the Northwest Region, Dr. Elmer Uzans, referred the case to the PDRC for review. In his letter to Dr. Cairns, Dr. Uzans stated that the "death was regarded as suspicious from the beginning." At the time, Dr. Cairns was the Chair of the PDRC and Dr. Smith was the Committee's only pathologist.

- Nicholas Overview Report, PFP143263, p. 13
- Evidence of Dr. Cairns, November 26, 2007, p. 137, lines 18-21; p. 139, line 24; p. 140, line 3

209. Dr. Cairns testified that the Nicholas case was one of the first SIDS/SUD cases to be referred to the PDRC, following the release of Memorandum #631 and the 1995 Protocol for sudden and unexpected deaths of children under two years of age. He stated:

> "We had brought out the protocol in 1995 regarding the investigation of children under two (2). And we had made clear in that protocol what parameters we would accept to call it a SIDS and what parameters we -- we had set out that would call it a SUD, Sudden Unexplained Death. And it explained where one would have to be changed from one to the other.
>
> And obviously, in the early days of that protocol, we would have people phoning us up saying, Okay, can you help me, I'm not sure what category this goes into."

- Dr. Cairns, November 26, 2007, p. 137, lines 22-25; p. 138, lines 1-11

210. As the sole pathologist on the PDRC, Dr. Smith was perceived at the time to be the only appropriately qualified member of the Committee to review the pathology in the case. The Committee decided that the case needed to be investigated further, and not simply re-classified as SUD, because the initial diagnosis of SIDS in a child who had been alert and walking and had sustained a bump on the head was of concern. This was the third or fourth occasion since the introduction of the 1995 Protocol that a case required further investigation by the PDRC. In cases that were potentially criminal, only one member of the Committee would be assigned to conduct an initial review, because the Committee could not testify in court, if required. As such, Dr. Smith was selected to conduct the initial review.

- Evidence of Dr. Cairns, November 26, 2007, p. 139, lines 7-25; p. 140, lines 1-10
- Ombudsman Decision, PFP007831, P. 4

211. In his initial review of the case, Dr. Smith consulted with Dr. Paul Babyn, Acting Chief, Department of Diagnostic Imaging at the HSC. Dr. Babyn reviewed copies of the post mortem radiographs and reported a widening of the skull sutures and the possibility of a left mandibular fracture. He commented on the overall poor quality of the films, however. These preliminary findings were also supported when Dr. Smith reportedly showed the radiographs to Dr. Derek Armstrong, Neuroradiologist, Department of Diagnostic Imaging at the HSC, though Dr. Armstrong also indicated that the original films would be required to rule out any artefact.

- Evidence of Dr. Cairns, November 26, 2007, p. 140, lines 15-25; p. 141

- Nicholas Overview Report, PFP143263, p. 14-15

212. In January 1997, Dr. Smith produced a consultation report, in which the death was attributed to blunt head injury, with cerebral edema, increased head circumference, the splitting of sutures and a left mandibular fracture. Based on these new findings, Dr. Cairns, as Chair of the PDRC, met with police, along with Dr. Smith, and wrote a letter in support of exhuming the body of Nicholas. Both Dr. Smith and Dr. Cairns believed that a disinterment of the body was necessary based on the following facts: the mother's account of events did not coincide with the definition of SIDS or with the new interpretation of the autopsy findings, and Dr. Babyn's review of the radiographs could not rule out a mandibular fracture.[6]

- Report, PFP007656
- Nicholas Overview Report, PFP143263, p. 15-20
- Letter, PFP008299
- Letter, 007831

213. Dr. Cairns did not question Dr. Smith's findings as he was the pathology expert on the PDRC, tasked with providing this very type of expertise, and was known to be a leader in the field of pediatric forensic pathology. Dr. Cairns also felt confident trusting the professional skills of Dr. Babyn in reviewing the radiographs. These were medical professionals providing consultation in their areas of expertise to another medical professional. Given this context, it is not unreasonable, that Dr. Cairns would have relied on their opinions, particularly when their independent findings provided cumulative support for the need for a further evaluation. This context also influenced Dr. Cairns'

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6 The decision of the Ombudsman in response to a complaint by Nicholas' grandfather also stated that it appeared that the OCCO had information before it which required it to investigate further. Ombudsman Decision, PFP007831

continued belief in Dr. Smith's viewpoint in the face of Dr. Halliday's contrary opinions as events unfolded later on during the CAS proceedings.

- Evidence of Dr. Cairns, November 26, 2007, pp. 141-148, 150, 157-160, 171-172

214. On June 25, 1997, the body of Nicholas was disinterred and on June 26, 1997, Dr. Smith conducted the second autopsy of Nicholas. His Report of Post Mortem Examination, dated August 6, 1997, reported the cause of death as cerebral edema consistent with blunt force injury.

- Nicholas Overview Report, PFP143263, pp. 22, 24-26
- Report of Post Mortem Examination, PFP007660

215. Dr. Chiasson, as CFP at the time, was not involved in the decision to disinter the body of Nicholas in 1997. Dr. Chiasson testified that this reflected a bit of a divide between the pediatric and adult forensic pathology work at the OCCO. Dr. Smith had taken the lead, working alongside Dr. Cairns as Chair of the PDRC, in dealing with pediatric forensic pathology issues. Given his deference to and respect for Dr. Smith, Dr. Chiasson did not feel there was a further role for him to play, and certainly there was no formalized role defined at the OCCO, in the legislation or within the OPFPU's service agreement. In hindsight, the OCCO acknowledges that had Dr. Chiasson had a more formal role in the review of Nicholas' death, or at least more formal oversight of Dr. Smith, perhaps the CAS proceedings would not have commenced or would have resolved more quickly.

- Evidence of Dr. Chiasson, December 7, 2007, p. 194, lines 18-24

216. In the CAS proceedings, Dr. Cairns agreed to swear an affidavit on behalf of the CAS, stating his agreement with Dr. Smith's pathological findings that the cerebral edema was

severe and that this was the essential event that led to Nicholas' death. The affidavit was prepared by legal counsel for the CAS, and Dr. Cairns agreed to sign it. At the time Dr. Cairns signed the affidavit, he felt that he was merely stating that the OCCO took the position that it accepted Dr. Smith's opinion on the case. Dr. Cairns recognized at a later stage, however, that this was inappropriate as it gave the impression that he was providing an independent opinion. As soon as Dr. Cairns was made aware of this potential misunderstanding, he took the opportunity to correct it and clarify the limits of his expertise.

- Evidence of Dr. Cairns, November 26, 2007, p. 179-186
- Affidavit, PFP007674

217. In hindsight, Dr. Cairns regrets the confusion he may have caused by signing this affidavit with a mistaken understanding of its content, and regrets any delay that may have occurred in properly informing counsel for the CAS about the limits of his expertise.

- Evidence of Dr. Cairns, November 26, 2007, pp. 197-198

218. With the increasing conflicting opinions arising between Dr. Smith and Dr. Halliday in the CAS proceedings, counsel for the CAS suggested that the OCCO seek out another expert opinion. At this point, Dr. Cairns asked Dr. Chiasson to become involved in the case and Dr. Chiasson was tasked with searching for an appropriate expert to provide an independent review. He and Dr. Cairns agreed from the start that whatever the outcome, the OCCO would accept the opinion of this third expert as the definitive opinion in the case. It was felt that it would be necessary to find an expert from outside the country because of Dr. Smith's iconic status in Canada. Dr. Chiasson and Dr. Young proposed Dr. Mary Case, who was Associate Professor of Pathology at St. Louis University Health

Sciences Centre and Chief Medical Examiner for St. Louis, St. Charles, Jefferson and Franklin Counties in the United States.

> "In terms of the expert, since Dr. Smith was known as an eminent pediatric pathologist both in Ontario and across the country, it was felt we would need to go outside Canada."

- Evidence of Dr. Cairns, November 26, 2007, pp. 193-195
- Evidence of Dr. Chiasson, December 7, 2007, pp. 203-204
- Evidence of Dr. Young, November 30, 2007, p. 130, lines 14-15

219. Dr. Case's report was produced for Dr. Chiasson on March 6, 1999. Though Dr. Cairns both accepted and agreed with Dr. Case's opinion, which supported neither Dr. Smith nor Dr. Halliday, this did not impact his views on the soundness of Dr. Smith's judgements at the time. This was because there were two reputable experts in Dr. Smith and Dr. Halliday who had disagreed, and Dr. Cairns understood Dr. Case to have stated that both experts had been wrong. Dr. Cairns, therefore, had no reason to single out Dr. Smith as being the pathologist of particular concern.

- Evidence of Dr. Cairns, November 26, 2007, p. 199, lines 1-10; p. 200, lines 3-16

220. Similarly, Dr. Chiasson recognized that this was a difficult case and that while he agreed with Dr. Case's conclusions and he thought Dr. Smith had gone too far in this opinion, this was not an area Dr. Chiasson felt comfortable with, as it related to pediatric neuropathology.

- Evidence of Dr. Chiasson, December 7, 2007, p. 205, line 2; p. 206, line 9; p. 206, lines 21-25

221. The Nicholas case was the first occasion that concerns about the merits of Dr. Smith's opinions came to Dr. Young's attention. As a result of this case and the subsequent

complaint by Mr. Gagnon to the Coroner's Council, Dr. Young took immediate steps to address concerns with Dr. Smith.

- Evidence of Dr. Young, November 30, 2007, p. 70, lines 4-9

222. Shortly after Dr. Case produced her report in the Nicholas case, Dr. Young had a meeting with Dr. Smith to discuss concerns with his work. Dr. Young did not document this meeting and acknowledges that in hindsight it would have been wise for him to do so. At the meeting, Dr. Young informed Dr. Smith that the official position of the OCCO would be to accept the report of Dr. Case. As well, Dr. Young discussed his concern that Dr. Smith had gone too far in his report and that Dr. Smith had suspected abuse where there was not good evidence that it existed. Dr. Young discussed the importance of maintaining the credibility of the OCCO, the need to stay within the majority opinion in forensic pathology and that the OCCO needed to take a conservative stance in its views.

> "The analogy I gave him, and I remember giving it very -- very clearly was the analogy of a tree. I said I -- you know, I would view right now that -- that your view is out on one (1) -- at -- at the far end of one (1) branch; Dr. Halliday's views were at the other side of the tree in various places on the branch; and Dr. Case was hugging the -- the trunk, and I want you hugging the trunk from now on.
>
> That's the – that's the – that's the direction I want to see the office of the Chief Coroner in regards to these issues as they're evolving."

- Evidence of Dr. Young, November 30, 2007, p. 141-144
- Evidence of Dr. Smith, January 29, 2008, p. 113, lines 15-23; p. 114, lines 1-8

223. Dr. Young also discussed the need for Dr. Smith to improve the timeliness of his post mortem reports and to document all "corridor" consultations. Dr. Young also informed Dr. Smith that these issues would appear in a forthcoming memorandum that would

discuss these pitfalls in forensic pathology. Copies of this memorandum were forwarded to Nicholas' grandfather as well as to the Ombudsman for the province ("Pitfalls Memo").

- Evidence of Dr. Young, November 30, 2007, p. 144, lines 3-20
- Memorandum, PFP007950 ("Pitfalls Memo")
- Letter, PFP007885

224. In retrospect, Dr. Young acknowledges that it would have been beneficial if Dr. Chiasson, or another forensic pathologist, discussed the concerns with Dr. Smith's specific findings in the Nicholas case.

- Evidence of Dr. Young, November 30, 2007, p. 147, lines 15-25; p. 148, lines 1-4

225. Dr. Young testified that he did not appreciate the extent to which Dr. Case was critical of Dr. Smith's work on the case. While he reviewed her report and recognized that she disagreed with the conclusions reached by both Drs. Smith and Halliday, he did not speak to Dr. Case further about the matter.

- Evidence of Dr. Young, December 3, 2007, p. 143, line 15-20

226. With the benefit of hindsight, the OCCO acknowledges that there is much to be learned about the handling of the Nicholas case, particularly, with respect to the appropriate role of the CFP:

(a) Dr. Cairns should have involved Dr. Chiasson in the review of the case at an early stage;

(b) Dr. Cairns should not have agreed to swear an affidavit confirming the forensic pathology evidence of Dr. Smith. As a medically-trained coroner, Dr. Cairns'

affidavit had the unintended consequence of appearing to be an independent opinion confirming Dr. Smith's findings; and

(c) Dr. Young should have more formally involved Dr. Chiasson in dealing with the aftermath of this case, particularly in his discussions with Dr. Smith and his dealings with Nicholas' grandfather.

227. In hindsight, Dr. Young acknowledges that his letter of response to Nicholas' grandfather did not reflect the most appropriate oversight, though at the time dealing with these issues with Dr. Smith in a disciplinary manner seemed to be the correct way to proceed.

- Evidence of Dr. Young, November 30, 2007, p. 162

228. It must also be noted that the OCCO did not have the authority to any way effect Dr. Smith's position as a staff pathologist at the HSC. Under the service agreement and the governing legislation, Dr. Smith was obliged to the coroner only to the extent that he was required to conduct an autopsy and prepare a post mortem examination report. The OCCO had no real mechanism to mandate quality.

- Evidence of Dr. Smith, February 1, 2008, p. 167, lines 8-17

Sharon

229. Sharon was born on December 28th, 1989 and died on June 12, 1997, at the age of seven and a half years. Sharon's mother was charged with second degree murder in her daughter's death.

- Sharon Overview Report, PFP144453, p. 4

230. The OCCO, through Dr. Young, Dr. Cairns and Dr. Chiasson, played an instrumental role in resolving this case ultimately in the favour of the accused, Sharon's mother. They acted quickly to implement effective and timely measures to address concerns that arose in this case. Unfortunately, this did not occur until two years after Sharon's death and original autopsy.

231. Sharon's autopsy was conducted over two days in Toronto on June 13th and 15th, 1997. Dr. Smith conducted the autopsy, with the assistance of Mr. Blenkinsop at the Provincial FPU. Dr. Chiasson had not been contacted or informed that a case of this nature was coming into the Provincial FPU.

- Evidence of Dr. Chiasson, December 10, p. 46, 48
- Evidence of Dr. Young, November 30, 2007, p.176

232. The OCCO acknowledges that the CFP should have been made aware of the fact that Sharon's autopsy was being performed in his morgue, by a visiting pathologist. While it is difficult to know if the outcome in this case would have been different had Dr. Chiasson known about the autopsy ahead of time, it would have at least ensured that a forensic pathologist was aware of the case from the start.

233. While Dr. Smith testified that he believed Dr. Young specifically asked him to attend at the Provincial FPU to conduct the autopsy, there is no evidence from any other witness to support this position. In fact, Dr. Smith admitted that he did not speak to Dr. Young about this apparent request and had had no direct conversation with Dr. Young about Sharon's autopsy.

- Evidence of Dr. Smith, January 30, 2008, p. 160-162, 165
- Evidence of Dr. Young, November 30, 2007, pp. 177-178

- Transcript, PFP076807, p. 28

234. Following Sharon's autopsy, Drs. Young, Cairns and Chiasson had virtually no involvement in the case until early 1999. There is some confusion about the date of a meeting in which a discussion ensued about whether the wounds in this case could be attributed to dog bites. Dr. Cairns recalls that this occurred some months after the original autopsy, but Dr. Chiasson testified that he was quite certain the meeting took place in 1999, following Dr. Young's and Dr. Cairns' return from the American Academy of Forensic Sciences meeting. At this meeting, it appears that Dr. Queen, the least experienced forensic pathologist among those who attended the meeting, was the only one who suggested that the wounds might be dog bites. Dr. Chiasson's recollection is supported by both Dr. Wood's recollection as to the timing of the meeting and by a memorandum Dr. Cairns prepared sometime afterwards, wherein he set out a summary of events. In addition, Dr. Wood testified that he had no memory of any other prior meeting or any recollection of discussing this case with Dr. Smith prior to the preliminary hearing.

- Evidence of Dr. Cairns, November 26, 2007, pp. 214-224
- Evidence of Dr. Wood, January 23, 2008, pp. 120-124, 258-259
- Evidence of Dr. Chiasson, December 10, 2007, pp. 58-61
- Sharon Overview Report, PFP144453, p. 99

235. Whether or not an earlier meeting took place before the preliminary hearing, it is clear from the evidence that after Drs. Young and Cairns attended a meeting at the American Academy of Forensic Sciences in February 1999, the OCCO became aware of the following controversies in the Sharon case:

(a) Experts engaged by the defence were concerned that there would be a miscarriage of justice in this case;

(b) Drs. Bob Dorion, Michael Baden, Rex Ferris and Lowell Levine, some of whom had been retained as experts for the defence, strongly believed that Sharon died as a result of injuries sustained by a dog attack and not as a result of anything her mother did; and

(c) A review (and possible exhumation autopsy) would be required.

- Evidence of Dr. Cairns, November 26, 2007, p. 225-227
- Evidence of Dr. Young, November 30, 2007, p. 169-173
- Evidence of Dr. Wood, January 23, 2008, p. 122

236. As a result of the information learned during the Academy meeting, Dr. Cairns called a case conference with Drs. Chiasson, Smith, Wood, and Mr. Blenkinsop. Dr. Queen also participated in this meeting.

- Evidence of Dr. Chiasson, December 10, 2007, p. 60
- Memorandum, PFP055743

237. Following the meeting, it was determined that exhumation and a second autopsy examination were necessary.

- Evidence of Dr. Wood, January 23, 2008, pp. 120-122

238. Sharon's body was exhumed on July 12, 1999 and the second post-mortem examination took place in Toronto on July 13, 1999.

- Sharon Overview Report, PFP144453, pp. 97-98

239. Dr. Chiasson conducted the second autopsy in the presence of Drs. Smith, Wood, Dorion, Ferris, Constable Barret, D/Sgt. Bird, Mr. Blenkinsop and Bud Davis.

- Sharon Overview Report, PFP144453, pp. 98-101

240. According to Dr. Chiasson, the primary purpose of the second autopsy was to procure bone samples that might have evidence of damage which could assist in assessing whether the injuries were sustained as a result of a dog attack or scissor/knife attack. As Dr. Chiasson testified, they were not expecting that re-examination of the skin and soft tissue wounds would be particularly helpful in this determination.

- Evidence of Dr. Chiasson, December 10, 2007, p. 68

241. Following the second post-mortem examination, Dr. Chiasson wrote a report setting out his findings from the examination. In addition, Dr. Wood and Dr. Smith wrote second reports.

- Report of (Second) Postmortem Examination, PFP011496
- Report, PFP056107
- Report, PFP089567

242. Also following the second post-mortem examination, the OCCO assisted Crown counsel and the Kingston police to make contact with the forensic anthropologist, Dr. Steven Symes.

- Evidence of Dr. Chiasson, December 10, 2007, p. 80

243. Ultimately, the Crown chose to withdraw the charges against Sharon's mother and did so on January 25, 2001.

- Evidence of Mr. Bradley, January 21, 2008, pp. 246-248
- Sharon Overview Report, PFP144453, p. 4

244. As with the Nicholas case, the OCCO recognizes that there are lessons to be learned from the Sharon case. Again, it is clear in hindsight that the CFP must be more formally and directly involved in medicolegal cases, particularly where the circumstances are of such an unusual and potentially suspicious nature as they were in this case as follows:

(a) Dr. Smith did not have the appropriate skill set to conduct Sharon's autopsy. The autopsy should have been conducted by an experienced and, preferably, trained forensic pathologist;

(b) The OCCO, and in particular the CFP, should have had a means of tracking cases, so that if there were problems they could have been brought to light sooner rather than later. In this case it was clear that once Drs. Young and Cairns became aware of the potential problems in early 1999, some two years after Sharon's death steps were taken immediately to address them; and

(c) The CFP must have a method of tracking late reports and of pressing pathologists within the system to produce reports in a timely fashion.

245. In summary, both the Nicholas and Sharon cases clearly illustrate that the CFP must be given the tools to formally provide oversight of the professional activities of forensic pathologists working within the system. While Dr. Cairns, Dr. Young and other coroners attempted to provide some level of oversight, it was insufficient with regard to Dr. Smith. While these leaders were sincere in their attempts, they lacked the necessary expertise to

identify problems with Dr. Smith's work. It is clear that Dr. Chiasson's involvement in both these cases proved instrumental to their resolution.

B. Predominance of Dr. Smith

246. Dr. Smith began his career as a staff pathologist at the HSC in 1981.

- Evidence of Dr. Smith, February 1, 2008, p. 109

247. At the time Dr. Smith joined the HSC staff, there was a well-established practice of staff pathologists taking on pediatric autopsies under coroner's warrant. Dr. Smith began to take on such cases in 1981.

- Written evidence of Dr. Smith, PFP303346, p. 14
- Evidence of Dr. Smith, February 1, 2008, p. 109

248. Through the early stages of Dr. Smith's career, his contact with the OCCO was through investigating coroners on a case-by-case basis. At this stage, Dr. Smith had no expectation that his post mortem reports were being reviewed by a forensic pathologist, or at all.

- Evidence of Dr. Smith, February 1, 2008, p. 113

249. By the time Dr. Smith was appointed the Director of the OPFPU, he was well established as a leading figure in pediatric forensic pathology for the province. This reputation developed, in large part, through Dr. Smith's own interest in autopsy pathology and in forensics, in particular.

- Evidence of Dr. Smith, February 1, 2008, p. 110

250. By contrast, though he had some limited exposure during his training, at no stage in his position as CFP did Dr. Chiasson feel that he had expertise in pediatric forensic pathology.

In fact, in 2001, given his lack of experience in pediatric forensic pathology, Dr. Chiasson began working at the OPFPU in part to expand his forensic pathology practice. He felt it was a weakness that, as CFP, he did not have any particular experience in this area of forensic pathology.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 28-29, 107-108
- Evidence of Dr. Chiasson, December 10, 2007, pp. 190-191

251. Dr. Chiasson held a very high opinion of Dr. Smith during the first half of his tenure as CFP, and had no reason to doubt his competency or abilities as a pediatric pathologist. Dr. Smith was a full-fledged staff pathologist at the HSC, which was, and continues to be, an impressive, world-class institution and a major teaching hospital.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 139-140

252. By the time Dr. Chiasson became CFP, Dr. Smith had already participated in a number of speaking engagements related to both pediatric and forensic pathology, starting in the mid-1980s, and he continued to do so throughout his tenure at the HSC.

- Written evidence of Dr. Charles Smith, PFP303346, pp. 121-136

253. These early speaking engagements included giving lectures on SIDS at the invitation of Dr. Hillsdon-Smith to other autopsy pathologists and a lecture on pediatric forensic pathology at the Canadian Congress of Laboratory Medicine. By the late 1980s, Dr. Smith was invited to give lectures to Crown Attorneys as well.

- Evidence of Dr. Smith, February 1, 2008, pp. 116-118; 122
- Written evidence of Dr. Smith, PFP303346, pp. 130-132

254. Dr. Smith continued to participate in a number of speaking engagements and education programs throughout the 1980s and 1990s. He gave lectures on both pediatric pathology issues and forensic issues. Dr. Smith testified that he felt ethically obliged to share his knowledge and insight with others. In particular, Dr. Smith testified:

> "Yeah, one of the obligations -- I think it's not necessarily a written obligation -- but one of the, certainly one of the - - the moral or ethical obligations of -- of any physician who would be associated with Sick Kids is not simply to do the diagnostic work but to share knowledge and insight, and also because of the very unusual nature of the case material, to appropriately use it to further understandings. So -- so education and research were, I think, an expectation that was part of the fabric of the institution, and so I was doing what I believed to be my responsibility just as my colleagues did the same thing"

- Evidence of Dr. Smith, February 1, 2008 pp. 118-119

255. Dr. Chiasson was aware that Dr. Smith lacked formal training or certification in forensic pathology, but he knew Dr. Smith had been working in this field and had developed a sub-specialty interest in it. Dr. Chiasson was aware that Dr. Smith had been involved in a large proportion of pediatric cases, including the majority of criminally suspicious and homicide cases at the OPFPU. Dr. Chiasson had the sense that Dr. Smith was developing a very good reputation in pediatric forensic pathology.

- Evidence of Dr. Chiasson, December 7, 2007, p. 132, lines 19-25; p. 133, lines 1-6; p. 140, lines 20-25; p. 141, lines 1-6

256. The OCCO submits that it was reasonable for Dr. Chiasson to defer to Dr. Smith based solely on his experience, and not on his training, or lack thereof. As set out above, in the 1990s there was a dearth of formally trained forensic pathologists available. It was not unusual, and in fact was quite common for Dr. Chiasson to rely upon pathologists, who had a great deal of work-related experience, but no forensic pathology qualifications.

257. Dr. Smith had much experience in pediatric forensic pathology, and had contributed to any of the OCCO's efforts in this field, including the establishment of the PDRC and the development of the 1995 Protocol. In addition, Dr. Smith had worked closely with Dr. Cairns. Consequently, Dr. Chiasson was not overly concerned about Dr. Smith taking a lead role in pediatric forensic pathology at the OCCO. Dr. Chiasson felt comfortable concentrating his efforts primarily on adult forensic pathology, where there were numerous issues occupying the bulk of his time.

- Evidence of Dr. Chiasson, December 7, 2007, p. 144, lines 10-24

258. In fact, Dr. Smith's interest in coroner's cases and reputation as an expert in pediatric forensic pathology developed before Dr. Young assumed the position of CCO and well before Dr. Cairns joined the OCCO as Deputy Chief Coroner and Dr. Chiasson as CFP.

- Evidence of Dr. Smith, February 1, 2008, p. 119, lines 15-25

259. Even after Dr. Young became CCO and Dr. Cairns became Deputy Chief Coroner, Dr. Smith participated in a variety of speaking engagements not simply at the behest of the OCCO, but because of his already-established reputation in the area.

- Evidence of Dr. Smith, February 1, 2008, p. 126, lines 1-25; p. 128, lines 6-20; pp 129-131

260. Aside from Dr. Smith's reputation as an expert in the field of pediatric forensic pathology, he was also someone who exuded confidence and self-assuredness, which had a positive impact on those working with him from the OCCO.

> "...he was quite agreeable. He was bright. He came across as somebody that was confident and - - and competent, without being boastful or - - you know, he didn't - - he didn't have strong airs...he was viewed as being very ethical and - - and principled"

- Evidence of Dr. Young, December 3, 2008, p. 142, lines 8-14

261. Dr. Young also testified that he had confidence in Dr. Smith in part because he felt Dr. Smith was being nurtured by a world-renowned pathologist, Dr. Phillips, at the HSC, an institution for which Dr. Young had very high regard.

- Evidence of Dr. Young, November 29, pp. 122, lines 9-25; p. 123, lines 1-2

262. At the time the OPFPU was established, the prevailing wisdom was that the greatest value to be brought to bear on pediatric forensic cases, was the pediatric pathology expertise the OCCO believed resided at the HSC. In particular, this expertise was believed to be embodied in Dr. Smith. Even today, it is acknowledged that the autopsy guidelines authored by Dr. Smith as part of the 1995 Protocol are still applicable today.

- Evidence of Dr. Smith, February 1, 2008, p. 138, lines 13-25
- Evidence of Dr. Pollanen, November 14, 2007, p. 114, lines 1-6
- Memorandum, PFP032588, p. 7

263. Given his renown in the field, the confidence he inspired in all stakeholders in death investigation and his years of valued experience, Dr. Smith was considered "the person to go to" for pediatric forensic pathology, particularly in cases of child abuse and homicides, and was the individual identified within the OCCO with this area of expertise.

- Evidence of Dr. Cairns, November 26, p. 30, lines 10-16
- Evidence of Dr. Chiasson, December 7, 2007, p. 74, lines 8-20

264. The OCCO, and in particular, Dr. Young, Dr. Cairns and Dr. Chiasson relied on Dr. Smith's reputation in the field of pediatric forensic pathology. In retrospect, this reliance was misplaced.

265. It is only with the benefit of hindsight that it is now recognized that Dr. Smith lacked the forensic skill required for many of the cases under review by this Commission.

Case of X

266. In the case of X, Dr. Cairns felt comfortable allowing Dr. Smith to meet with X's mother. Parents of deceased children did contact Dr. Cairns on occasion about findings concerning the death of their children. The practice of the OCCO is not to provide reports of the post mortem examination to family members in written form where there is an ongoing criminal investigation, whether or not the family is implicated in the death. However the results of the post mortem examination can be communicated orally with sensitive information filtered from the conversation. Dr. Cairns felt that, given the length of time it had been since the death of her child, it was not unreasonable for X's mother to make this request. Dr. Cairns' provided the following evidence with respect to the meeting:

(a) X's mother requested that Dr. Smith meet with her at her home to explain the results of the post mortem examination;

(b) Because of the medical complexities involved in the case, Dr. Cairns felt that he was unable to adequately explain the results of the post mortem examination to X's mother. This situation did occur from time to time in medically complicated cases;

(c) Because a considerable amount of time had passed since the death of X and the mother had been given little, if any, information about the results of the post mortem examination, Dr. Cairns agreed, on compassionate grounds, to the mother's request;

(d) Dr. Cairns contacted Dr. Smith and requested that he meet with X's mother for the sole purpose of explaining the results of the autopsy. Dr. Smith agreed to this request and did not express any reluctance to participate in the meeting;

(e) At the time that Dr. Cairns requested that Dr. Smith meet with X's mother, Dr. Cairns was not aware of any interception of her telephone calls by the police, nor was he aware of the existence of a listening device in her home; and

(f) Dr. Cairns only learned sometime after Dr. Smith's initial telephone conversation with X's mother, either from Dr. Smith himself or from the police that the police were intercepting the telephone calls to and from X's mother's home and that there was a listening device in place in the house.

267. Dr. Cairns asserts that at no time in the course of these events was he attempting to assist the police in any way. It was, and continues to be, his understanding that Dr. Smith met with X's mother solely to convey information concerning the results of the post mortem examination. To the best of Dr. Cairns' recollection, Dr. Smith conveyed the same to him at some point after his meeting with X's mother.

268. In hindsight, Dr. Cairns acknowledges that given his eventual knowledge of the listening device in the mother's home, it would have been preferable to have arranged for Dr. Smith to speak with X's mother in an environment that was not known to be under police surveillance. At the time, however, Dr. Cairns did not have the impression that the meeting would interfere with or assist the police investigation in any way.

- Dr. Cairns' Affidavit, PFP177525

D. Lack of Resources

269. Over the last two decades, the OCCO has been plagued by a severe shortage of qualified and experienced pathologists willing to engage in forensic work. This has placed ongoing and undue strain on any attempts by the OCCO to provide high quality forensic pathology services in the province, and has influenced and affected virtually every decision relating to forensic pathology.

270. Throughout Dr. Chiasson's tenure as CFP, a scarcity of human resources presented the primary challenge to recruiting an adequate complement of full-time forensic pathology staff at the OCCO. By all accounts, the pool of physicians from which forensic pathologists draws will continue to be incredibly small and constitutes a challenge that needs to be addressed moving forward.

- Evidence of Dr. Young, November 30, 2007, p. 41, lines 14-18
- Evidence of Dr. Chiasson, December 7, 2007, pp. 61, lines 13-25; p. 69, lines 13-24; p. 111, lines 3-21

271. A key factor underpinning this shortage of human resources is an acute lack of financial resources, which has had a fundamental impact on every aspect of death investigation throughout the period that has been the subject of this Commission of Inquiry. At its most simplistic level, the Commission has heard evidence that little financial incentive exists for pathologists to perform medicolegal autopsies when hospital-based community pathology continues to provide far better compensation. As is submitted in Part III herein, this Commission must address the issue of appropriate financial resources, not only in the fields of adult and pediatric forensic pathology, but also in the death investigation system as a whole.

- Evidence of Dr. Chiasson, December 7, 2007, p. 63, lines 4-10

(i) Lack of Pediatric Forensic Pathology Expertise

272. Pervasive throughout the field of pediatric forensic pathology, is the lack of individuals possessing this expertise. When Dr. Chiasson assumed the position of CFP in 1994, there were no pathologists in the province that were formally trained in both pediatric and forensic pathology. As such, there was no duly trained "pediatric forensic pathologist". Even now, there is a severe shortage of pediatric pathologists in Canada, and a limited number of pediatric forensic pathologists in all of North America.

- Evidence of Dr. Chiasson, December 7, 2007, p. 103, lines 6-20; p. 111, lines 3-21
- Evidence of Dr. Young, November 30, 2007, pp. 39 and 41

273. Pediatrics was seen as a subspecialty in forensic pathology, and Dr. Chiasson had very little experience in this area, whereas Dr. Smith had considerable experience.

- Evidence of Dr. Chiasson, December 7, 2007, p. 208, lines 1-9, 23-25; p. 209, lines 1-9

274. Dr. Chiasson himself did not feel comfortable with pediatric cases. Obviously this made it difficult for him to challenge Dr. Smith's apparent expertise in the area.

275. As a result, Dr. Chiasson did not feel comfortable challenging Dr. Smith for a number of reasons: Dr. Smith was the perceived expert; Dr. Chiasson was junior to Dr. Smith; and ultimately Dr. Chiasson was unable to develop a good collegial relationship with Dr. Smith. Dr. Chiasson testified that he would not have felt comfortable discussing issues with Dr. Smith.

- Evidence of Dr. Chiasson, December 7, 2007, p. 208, lines 10-16

276. Dr. Chiasson felt that Dr. Smith may not have taken kindly to any assertion of control, oversight, quality assurance or any type of discussion with Dr. Chiasson regarding cases with which he had been involved.

- Evidence of Dr. Chiasson, December 7, 2007, p. 209, lines 15-25; p. 210, lines 1-15

277. Indeed, when Dr. Smith testified at the Preliminary Inquiry in the Kporwodu case in November 2001, he testified to the following when asked in cross-examination about his professional relationship with Dr. Chiasson:

> "Ms. Wasser: Q. Now Doctor David Chiasson is the doctor that reviews your work – do you respect his opinions and his work?
>
> A. Yes, in adult stuff. Understand that when it comes to pediatric forensic work such as he will be doing next week at the Hospital for Sick Children *I supervise him.*" [Emphasis added]

- Transcript, PFP020900
- Evidence of Dr. Chiasson, December 10, 2007, pp. 139-141

278. When presented with this testimony at this Commission of Inquiry, Dr. Chiasson stated that he did not have the impression at the time that Dr. Smith was providing any supervisory role for the coroner's autopsies at the OPFPU. Nor did he perceive that Dr. Smith was acting in a supervisory capacity when he attended autopsies that Dr. Chiasson performed at the HSC. On those occasions, Dr. Chiasson understood that Dr. Smith was merely providing assistance, if required, on issues of pediatric pathology, but not with respect to forensic issues. In these circumstances, it was Dr. Chiasson who had carriage of the case, though he understood that these were often suspicious cases.

- Evidence of Dr. Chiasson, December 10, 2007, p. 147, lines 22-25; p. 148, lines 1-25; p. 149, lines 1-8

(ii) Staffing Crisis at the Provincial FPU and its impact on the Re-visioning of the OPFPU

279. Almost ten months after assuming the position of CFP, following sincere efforts to address the shortage of full-time staff at the Provincial FPU, Dr. Chiasson noted that both he and Dr. Deck were the only full-time staff pathologists at the OCCO. Ongoing recruitment was proving a great challenge. In his January 1995 memorandum to Dr. Cairns, Dr. Chiasson noted that this situation was only acceptable insofar as it represented a gradual evolution towards full-time staff:

> "It was evident from the process of selecting a candidate for a full time position, that there were only a very limited number of suitable candidates in Canada and that the process of full time staffing of the unit could not be done overnight and that it would require a co-ordinated planned approach to gradually fill these positions."

- Memorandum, PFP129354
- Evidence of Dr. Chiasson, December 7, 2007, pp. 67-69

280. In August 1999, following the departure of three of the full-time staff forensic pathologists from the Provincial FPU, Dr. Chiasson noted a concerning shortage of suitably trained and/or experienced forensic pathologists in the country. He was doubtful that he would be able to attract even one appropriate candidate.

- Memorandum, PFP129435
- Evidence of Dr. Chiasson, December 10, 2007, p. 30, lines 9-25

281. The Provincial FPU was placed back into a state of transition at this point. When there had been four full-time staff available to conduct virtually all of the cases coming into the unit, the need for part-time pathologists working on a fee-for-service basis was limited. Dr. Chiasson recalls that there was only one such pathologist that had remained. Following the departure of the three full-time staff forensic pathologists, Dr. Chiasson was

compelled to recruit from the previous pool of part-time hospital-based fee-for-service pathologists, many of whom had been let go over the number of years that the full-time complement of staff had been built up.

- Evidence of Dr. Chiasson, December 7, 2007, p. 242, lines 15-25; p. 243; lines 1-4
- Evidence of Dr. Chiasson, December10, 2007, p. 8, lines 23-25; p. 9, line 1

282. Dr. Chiasson's re-visioning proposal for the OPFPU was also critically dependent on the complement of full-time forensic pathology staff at the Provincial FPU.[7] Dr. Chiasson envisioned a partnership whereby his forensic pathologists would be exposed to pediatric cases and Dr. Smith would similarly have access to the forensic skills of the staff pathologists. The re-visioning of the OPFPU, however, never came to fruition, due to the departure of the majority of his full-time staff. By the end of 1999, Dr. Rose remained the only full-time staff forensic pathologist at the Provincial FPU, apart from Dr. Chiasson.

"...it was my horrible year...we were back to almost square-one."

- Evidence of Dr. Chiasson, December 7, 2007, p. 242, lines 15-20
- Evidence of Dr. Chiasson, December 10, 2007, pp. 7-8, 39, lines 1-19

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7 In March 1998, Dr. Chiasson put forward a proposal for triaging all criminally suspicious and homicide cases at the OPFPU to improve the service provided. All criminally suspicious and homicide cases were to be performed by either Dr. Smith or Dr. Glenn Taylor, Dr. Smith was to participate in daily case rounds at the OCCO, the HSC was to provide Dr. Smith with an administrative assistant and there was to be a significant improvement in turnaround times for the completion of post mortem reports.

- Evidence of Dr. Young, November 30, 2007, p. 80, lines 22-25; p. 81

Dr. Chiasson indicated that he felt that the OPFPU was not fulfilling its mandate of providing a high quality forensic pathology service to the OCCO, despite the attempt to provide guidance and direction. He further indicated that he did not believe the problems of the OPFPU could be remedied, given the current arrangement.

- PFP004181

Dr. Chiasson, therefore, suggested a re-visioning of the OPFPU in which the Unit would remain a joint collaborative venture between the OCCO and the HSC, but be physically relocated to the OCCO, with the Director reporting to the CFP and the HSC continuing to provide consultative and professional support to the Unit.

- PFP004181

SIDS cases would likely have accounted for the greatest proportion of cases redirected to the OCCO. With Dr. Smith undertaking these cases at the OCCO alongside the Provincial FPU staff pathologists, who numbered four by December 1998, Dr. Chiasson hoped that this would be the start of incorporating pediatric cases into the work of the pathologists at the Provincial FPU.

- Memorandum, PFP129428

283. Dr. Chiasson acknowledged that this staffing crisis at the Provincial FPU would also have had an impact on his responsibilities as CFP. Even with the Provincial FPU's fullest complement of four staff pathologists, Dr. Chiasson was managing approximately 100 cases per year, which translated into roughly one-quarter of his time. This was already an impingement on his other responsibilities as CFP, but with only a few years of experience in forensic pathology under his belt, he wanted to maintain his practical skills. With the departure of the majority of his full-time staff, likely the educational aspect and pure administrative pursuits outside of forensic pathology would have suffered.

- Memorandum, PFP129428
- Evidence of Dr. Chiasson, December 10, 2007, pp. 11-13

284. Also in light of this sudden staffing crisis, Dr. Chiasson had concerns about the long-term viability of the Provincial FPU:

> "As troubling as the acute staffing shortage is, I am even more concerned about the long-term future of this forensic pathology unit. Why Drs. Queen and Bullock have resigned after such short periods of employment with the Coroner's Office needs to be very seriously addressed. I have carried out 'exit interviews' with both of them. Certainly, personal issues played a role in their decisions. It is however apparent that both felt that their specialized expertise in forensic pathology and death investigation was not fully appreciated and/or utilized with the Office. Having trained to be medical examiners, I believe that it was frustrating for them to be relegated to being simply an 'autopsy technician' (as one of them termed it).

- Evidence of Dr. Chiasson, December 10, 2007, pp. 11-13
- Memorandum, PFP129428

285. According to Dr. Chiasson, one of the concerns expressed by Dr. Bullock and Dr. Queen was that they wished to be more involved in the death investigation team in cases in which they had performed the autopsy. It is important to note that forensic pathologists were

trained in both cause and manner of death determinations. Another concern that led to Dr. Bullock's and Dr. Queen's departure was the issue of income. Both had accepted hospital positions with significantly greater rates of remuneration. Indeed, one had been guaranteed a minimum salary that was 50 per cent more than that which he had been earning at the OCCO.

- Evidence of Dr. Chiasson, December 10, 2007, pp. 15, lines 7-25; p. 18, lines 9-25; p. 19, lines 8-22; p. 37, lines 6-16
- Memorandum, PFP129435

286. By the end of August 1999, in a memorandum regarding "Forensic Pathology Staffing Crisis", Dr. Chiasson reported that the process of recruiting two forensic pathologists to the Provincial FPU was not going well and that he was becoming increasingly pessimistic about the OCCO's ability to attract even one candidate. He cited a number of reasons for this outlook, namely, a shortage of suitably trained or experienced forensic pathologists, despite the initiation of a forensic pathology fellowship program in Ontario, creation of positions in the field of pathology generally leading to a greater demand than the supply available and to increased competition amongst employers to provide greater remuneration in order to attract qualified pathologists.

- Evidence of Dr. Chiasson, December 10, 2007, pp. 29-36
- Memorandum, PFP129435

287. Between 1994 and 1999, Dr. Chiasson noted a gradual increase in pathologists' hospital salaries. The levels of compensation provided by the OCCO could not compete. One candidate indicated reluctance to leave his current position, though interested in the position at the OCCO, given the low levels of compensation. He indicated that he expected to earn $170,000 annually (including benefits). Dr. Chiasson's salary as CFP

when he began in 1994 was approximately $150,000 to 160,000 and was the upper-most level in terms of salaries for forensic pathologists in the province. At the time, this was the same rate of pay as he had received as hospital staff, though his responsibilities as CFP were greater.

> "...I feel strongly that without a significant improvement in our current salary structure for forensic pathologists, we will be unable to attract any suitable candidates to fill our current vacancies."

- Memorandum, PFP129435
- Evidence of Dr. Chiasson, December 10, 2007, pp. 33-38

288. Salaries within the government were tightly clustered. The most junior forensic pathologists would earn a salary that was approximately $5,000 to $10,000 less than the CFP.

- Evidence of Dr. Chiasson, December 10, 2007, p. 36, lines 13-25, p. 37, lines 1-3

289. The Directors of the Regional FPUs, being hospital employees, were earning higher salaries than their forensic pathologist counterparts at the OCCO, and most were earning incomes over and above their published salaries. As is set out in Part III, this problem persists even today.

- Evidence of Dr. Chiasson, December 10, 2007, p. 39, lines 24-25; p. 40, lines 1-25

290. As this Commission has heard, the lack of forensic pathologists available was not unique to the Provincial FPU. The dire shortage of forensic pathologists in general made it difficult for Dr. Chiasson to fully address concerns regarding quality across the province.

Ottawa Regional Unit

291. As was discussed above, Dr. Chiasson identified concerns regarding Dr. Johnston, through his paper review process. In part because of the human resource issues plaguing Dr. Chiasson, his options with regard to Dr. Johnston were limited. Dr. Chiasson did not feel he could remove Dr. Johnston from providing forensic pathology services altogether because of the severe shortage of forensic pathologists in the province. Dr. Johnston worked full-time in the Ottawa Regional Forensic Unit, and both he and another part-time pathologist conducted the majority of the criminally suspicious cases. There were no appropriately qualified forensic pathologists to fill the gap. To put a complete stop to Dr. Johnston's forensic pathology work would have created major human resource problems. This was an ongoing theme.

- Evidence of Dr. Chiasson, December 11, 2007, pp. 129-130
- Handwritten notes, PFP141283
- Meeting notes, PFP141789

292. Following the initial identification of concerns, Dr. Chiasson continued to review Dr. Johnston's criminally suspicious and homicide post mortem reports with a heightened degree of care. As well, Dr. Chiasson had concerns a number of non-criminally suspicious cases that he reviewed. Dr. Chiasson failed to see much improvement in Dr. Johnston's work product. The ongoing monitoring by Dr. Chiasson consisted of paper reviews, unless a particular problem was detected, in which case a more detailed review would be conducted.

- Evidence of Dr. Chiasson, December 11, 2007, pp. 128-129

293. In comparing the more aggressive steps taken in the case of Dr. Johnston as opposed to those taken with Dr. Smith, the difference in both the quantity and quality of forensic pathology issues with each pathologist must be noted. In Dr. Johnston's case, there were a series of cases which raised a number of forensic pathology concerns, as well as a smaller number of cases (such as the Vanasse case) where the concerns were very significant. Dr. Chiasson clearly found that the conclusions in those cases could not be supported by the evidence, and they had significant forensic implications. The issues with Dr. Johnston were of a more black-and-white nature. With Dr. Smith, on the other hand, even in 1998 and 1999, it appeared that there were only a small number of problematic cases, and the issues of concern entailed grey areas of evolving knowledge in the complex field of pediatric forensic pathology.

- Evidence of Dr. Chiasson, December 10, 2007, p. 171, lines 4-25; p. 172, lines 1-25

294. As was the case with Dr. Johnston, to pull Dr. Smith from case work would have put an impossible strain on the already limited human resources with which Dr. Chiasson was working.

295. As discussed above, without a clearly defined leadership role, ultimately Dr. Chiasson was unable to affect the change he thought was necessary in Ottawa.

296. Prior to January 2001, in keeping with his remedial approach to concerns about pathologists, and given his limited options, Dr. Chiasson did not consider removing Dr. Smith, nor did he consider recommending to Dr. Young that Dr. Smith be removed as Director of the OPFPU. Dr. Chiasson's plans for dealing with concerns surrounding Dr. Smith involved the re-visioning of the unit and bringing him to the OCCO where Dr.

Chiasson could directly supervise his work. Until January 2001, there was no serious consideration of removing Dr. Smith from any cases.

- Evidence of Dr. Chiasson, December 10, 2007, p. 172, lines 14-24

(iii) Timeliness of Reports

297. Another issue affected by limited human resources is the timeliness of delivery of autopsy reports. The evidence before this Commission has established that report timeliness was, and continues to be, a major problem for the OCCO.

- Evidence of Dr. Young, December 4, 2007, p. 171, lines 4-14
- Evidence of Dr. Chiasson, December 7, 2007, p. 162, lines 22-25; p. 163, lines 1-19

298. With limited resources to properly track reports and with little options available in terms of pathologists capable and willing to do the work, the issue of timeliness is difficult for the OCCO. Quite simply, the OCCO does not have the option of removing a pathologist from case work until a backlog of reports is cleared. There are not enough qualified pathologists.

- Evidence of Dr. Lauwers, January 7, 2008, p. 46, lines 22-25; p. 47,lines 1-11; p. 128, lines 15-25, p. 129, lines 1-13
- Evidence of Dr. Rao, January 18, 2008, p. 14, lines 14-25; p. 15, lines 1-25

299. Dr. Chiasson began developing timelines for the completion of post mortem reports when he became CFP. Following discussions with pathologists across the province, he considered that three to four months would be a reasonable timeline for most post mortem reports, barring the need for additional testing that was beyond the control of the pathologist. Because toxicological reports often take a considerable time, if such tests

were pending, the timeline for completion of the post mortem report would be within one month of obtaining test results.

- Evidence of Dr. Cairns, November 26, p. 114, lines 6-20

300. The evidence shows that the problems surrounding the timeliness of Dr. Smith's post mortem reports came to the attention of Dr. Cairns and Dr. Young by 1994.

- Evidence of Dr. Cairns, November 26, p. 61, lines 11-18
- Handwritten notes, PFP134495
- Evidence of Dr. Young, November 30, 2007, p. 46, lines 8-19

301. At the OPFPU, Dr. Smith was the main concern in terms of timeliness of post mortem reports, in part because he was engaged in a significant proportion of the autopsies performed under coroners' warrants.

- Evidence of Dr. Chiasson, December 7, 2007, p. 163, lines 1-10

302. Concerns about Dr. Smith's timeliness were articulated by RSCs at their regular meetings. Dr. Chiasson also became aware of such concerns on an informal basis and recalls receiving memoranda from Dr. Wilson, at the HSC, indicating concerns about major delays in Dr. Smith's reports.

- Evidence of Dr. Chiasson, December 7, 2007, p. 163, lines 11-19

303. The OCCO took steps to address the concerns expressed about Dr. Smith's timeliness. Dr. Cairns and Dr. Chiasson met with both Dr. Smith and Dr. Becker of the HSC to discuss this problem.

- Evidence of Dr. Cairns, November 26, p. 84, lines 11-19

- Letter, PFP056481
- Letter, PFP096530
- Letter, PFP115056

304. On a repeated basis, the OCCO would receive assurances from the HSC that Dr. Becker would monitor and work to improve Dr. Smith's administrative support. Though there would usually be a transient improvement, the situation would deteriorate and the issue would need to be addressed again.

- Evidence of Dr. Young, November 30, 2007, p. 88, lines 6-25; p. 89, lines 1-3

305. In explaining the reasons for the delays in completing his post mortem reports, Dr. Smith informed Dr. Cairns and Dr. Chiasson that he felt he did not have sufficient administrative support at the HSC.

- Evidence of Dr. Cairns, November 26, p. 84, lines 16-25; p. 85, lines 1-20

306. In response, the OCCO, through Dr. Cairns and Dr. Chiasson, indicated to the HSC that some of the grant money that the HSC received for operating the OPFPU should be allocated to providing the proper administrative support for Dr. Smith. Repeated requests were made with the same response each time: "We'll see what we can do." There was little change, however, and Dr. Smith continued to complain of inadequate administrative support, and concerns about the timeliness of his reports continued to be expressed.

- Evidence of Dr. Cairns, November 26, 2007, p. 86, lines 9-22

307. The OCCO canvassed this issue with the RSCs and in order to provide Dr. Smith with an opportunity to deal with his backlog they, in turn, reduced the number of autopsies and consultations that were referred to Dr. Smith in the post-1998 period.

- Evidence of Dr. Cairns, November 26, 2007, p. 87, lines 9-23

308. Referrals were instead sent to other fee-for-service pathologists, but options were limited for pediatric forensic pathology in Ontario, as there were very few pathologists capable of doing this work. Cases were sent primarily to pathologists in Hamilton and London, but soon there was a backlog in Hamilton as well. There was limited capability for these centres to take on all of the new cases arising.

- Evidence of Dr. Cairns, November 26, p. 88, lines 4-22

309. At no time did Dr. Smith ever indicate that his workload needed to be reduced or temporarily halted in order to address his backlog of cases. At no time did Dr. Smith inform the OCCO that he felt overwhelmed, or was too busy or behind in his work.

- Evidence of Dr. Cairns, November 26, p. 88, lines 14-22
- Evidence of Dr. Chiasson, December 10, 2007, p. 179, lines 1-6
- Evidence of Dr. Smith, February 1, 2008, p. 161, lines 10-20

310. Dr. Smith now acknowledges that throughout his tenure at the HSC, there were persistent problems with the timely completion of his post mortem reports, that the problems were drawn to his attention on several occasions, but that often any improvements he made were of a temporary nature. Dr. Smith acknowledges that frequent delays in the completion of his reports adversely affected the work of his colleagues and may have led to complications in the criminal justice system.

- Written evidence of Dr. Smith, PFP303346, p.20

311. Dr. Cairns agreed that the OCCO does have a primary role in ensuring the timely completion of post mortem reports by fee-for-service pathologists. While it is feasible that

one method of achieving this objective is for the OCCO to cease referring cases to a particular pathologist where a backlog has occurred, this would require a sufficient pool of pathologists. In the face of a shortage of expertise, such a tool would effectively backfire, as it would lead to the backlog of cases for one or more other pathologists. This is precisely what occurred when efforts were made to reduce Dr. Smith's workload.

- Evidence of Dr. Cairns, November 26, p. 94, lines 6-25, p. 95, lines 1-9

(iv) Workload and Staffing Issues at the OPFPU

312. Dr. Smith was the expert in pediatric forensic pathology, and was considered by everyone to be an invaluable resource. Though some problems with his work were recognized, such as delays in completing his post mortem reports, the OCCO was faced with a dilemma: if the OCCO ceased using him as a resource, because of these administrative concerns, the perception at the time was that there was no alternative pathologist with the equivalent level of expertise. The OCCO faced having to either accept some delay, while pushing Dr. Smith on critical delays that had a potential to impact the criminal justice system, or cease using him altogether. It was considered inappropriate or wrong to cease referring cases to Dr. Smith.

> "So it could've been that we said to Dr. Smith, right, you're not doing anymore. But given the short supply of pathologists, in general, he would not be the only pathologist that would be behind and yet the tool of taking them off was going to create equally a problem because it was putting all the work on someone else who, very shortly, may have been in the same boat.
>
> So if there had been an abundance of the proper experts, it certainly would have been, Okay, you're off the rota, and we'll put somebody else on. There's four (4) more people more than willing to pick up your work. We weren't in that fortunate position."

- Evidence of Dr. Cairns, November 26, 2007, p. 94, lines 22-25; p. 95, lines 1-9

313. Indeed, when Dr. Smith removed himself from conducting medicolegal autopsies in 2001, this resulted in workload problems for the remaining pathologists performing these autopsies and a backlog of cases at the HSC, as only a few other pathologists were able and willing to do the pediatric medicolegal work. The return of Dr. Smith to non-criminally suspicious, non-homicide medicolegal autopsies at the HSC was both requested and sanctioned by the HSC and thought to be necessary by the OCCO[8].

- Evidence of Dr. Cairns, November 27, p. 71, lines 5-13; p. 239, lines 2-23

314. There simply were not enough pathologists with experience in pediatric forensic pathology to do the work.

315. With his recent experience as Director of the OPFPU, Dr. Chiasson believes that a medicolegal workload at the HSC of approximately 50 to 60 cases per year would be considered a full caseload, given that these cases tend to be the more difficult pediatric forensic cases and are, therefore, often more time consuming. In addition, much derivative work results, such as presentations, meetings and case conferences. This additional work can be considerable within both the academic and OCCO environment.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 136-137

316. Given his additional duties as Director, it is not unreasonable to suggest that Dr. Smith was likely carrying a workload from the OCCO that could, in itself, have constituted a full-time job. Yet, in addition to his work for the OCCO, Dr. Smith was contributing to

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8 By the middle of 2001, the OCCO recognized that Dr. Smith's removal from all medicolegal work created a significant gap in the system. In order to address this gap, the OCCO asked Dr. Smith to return to the roster to perform non-criminally suspicious cases. The OCCO was comfortable allowing Dr. Smith to return to cases on this limited basis, because it had engaged Dr. Blair Carpenter to perform a paper review of a sample of Dr. Smith's non-criminal cases. Dr. Carpenter found that based on his review, "there is no ground for concern at the moment for the quality, completeness and accuracy of the pediatric medicolegal postmortems performed by Dr. Smith. On this basis, Dr. Smith was allowed to return to non-criminally suspicious cases. (PFP026940; PFP028789)

the pathology work at the HSC. It is quite conceivable that Dr. Smith's workload during the relevant period was far greater than that of a full-time position.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 136-138, lines 3-18
- Evidence of Dr. Taylor, December 18, 2007, p.238, lines 16-24

317. Yet Dr. Smith never complained that his workload was too onerous, or that he could not keep up with it.

- Evidence of Dr. Chiasson, December 10, 2007, p. 178, line 25; p. 179, lines 1-6
- Evidence of Dr. Smith, February 1, 2008, p. 161

(v) Structural Limits: Tracking

318. The OCCO had no method of keeping track of Dr. Smith's backlog. Even at present, the OCCO does not have the necessary resources to track cases in the system. The OCCO was not aware of whether the HSC was tracking the backlog in Dr. Smith's cases.

- Evidence of Dr. Cairns, November 26, p. 89, lines 1-20, p. 90, lines 6-13

(vi) Criminally Suspicious Cases

319. There was, and continues to be, no formalized system within the OCCO which allows the effective monitoring of cases proceeding through the criminal justice system. Once the coroner has issued a final report, including any post mortem report provided by the pathologist retained in the case, the OCCO does not, and did not in the past, further track the outcome of criminally suspicious cases potentially headed for trial. At this stage, the case becomes a matter between those involved in the criminal investigation and the Crown Attorney's office. Indeed, tracking of all such cases proceeding at different times across

the province would be a monumental feat. Although the evidence at this Commission of Inquiry illustrates the need to track cases that go to trial, as well as the adequacy of the testimony provided, it is extremely difficult to accomplish this from a practical point of view.

- Evidence of Dr. Young, November 29, 2007, p. 138, lines 19-25; p. 139, lines 1-23; p. 161, lines 13-25; p. 163, lines 1-17

(vii) Transcripts and Court Decisions

320. In retrospect, it was important for the OCCO to have been informed about major criticisms of those working in the death investigation system. Specifically, it would have been very helpful for the OCCO to have been made aware of Justice Dunn in the SM (Amber) case, and in particular his criticisms of Dr. Smith. ("Dunn Decision")

- Dunn Decision, PFP051538

321. The Dunn decision was not brought to the attention of the OCCO by any source that would have had resonance. Ideally, this information would have been forwarded to the OCCO by professional colleagues in the death investigation system, such as Dr. Smith himself, members of the SCAN team, others at the HSC who might have been aware of the decision or from counsel for the Crown or defence.

- Evidence of Dr. Young, November 29, 2007, p. 160, lines 18-25; p. 161, lines 1-11

Amber

322. Amber was born in Timmins on March 13, 1987 and died on July 30, 1988 at the HSC. Dr. Smith carried out a post mortem examination of Amber's body on August 19, 1988, following exhumation.

323. Criminal proceedings were initiated against Amber's twelve year-old babysitter, SM. SM was acquitted by Justice Dunn on July 25, 1991.

- Amber Overview Report, PFP143724, p. 3
- Dunn Decision, PFP051538

324. At the time of Amber's death, Dr. Young was the Deputy Chief Coroner and Dr. Smith was actively engaged in coroners' cases and had spoken on a number of occasions about pediatric forensic pathology.

- Evidence of Dr. Smith, February 1, 2008, p. 131, lines 1-18

325. Dr. Young became involved in the case shortly after Amber's death as a result of a call he received from Dr. Katy Driver, a pediatrician working with the SCAN team at the HSC. There was concern in this case that the local coroner had not ordered an autopsy and some of Amber's treating physicians doubted that Amber's injuries were representative of an accidental death.

- Evidence of Dr. Young, November 29, 2007, p. 126, lines 13-24

326. As Deputy Chief Coroner, Dr. Young remained engaged and concerned about this matter in early discussions with the Timmins police, the Crown and Amber's parents.

- Amber Overview Report, PFP143724, p. 18, 29

- Evidence of Dr. Young, November 29, 2007, p. 130, lines 18-25; pp. 131-132

327. On the basis of Dr. Smith's post mortem examination report and the opinions of Dr. Driver and Dr. Barker, Dr. Young understood that Amber had died as a result of a head injury caused by severe shaking.

328. Dr. Young had no reason to dispute Dr. Smith's unequivocal opinion as to what had occurred in this case. By the time Dr. Smith became involved in the Amber case, he had already conducted a number of autopsies in the field and had spoken on a number of occasions about pediatric forensic pathology.

- Evidence of Dr. Young, November 29, 2007, p. 131-132
- Evidence of Dr. Smith, February 1, 2008, p. 131, lines 1-18

329. Dr. Young had no further involvement in the Amber case or the proceeding criminal case against her babysitter, SM. As Dr. Young testified, at present there is no formal mechanism within the OCCO to track a case through the criminal justice system. The coroner may never know whether there has been a disposition in a criminal trial.

- Evidence of Dr. Young, November 29, 2007, p. 139, lines 4-23

330. Justice Dunn acquitted SM on July 25, 1991. In doing so, Justice Dunn wrote lengthy reasons in which he was critical of Dr. Smith and the SCAN team from the HSC. While Dr. Young became aware of the acquittal sometime after July 1991, he was not provided with the reasons for the decision, nor was he aware of the extent of Justice Dunn's criticism, until shortly prior to testifying at this Inquiry:

(a) The OCCO was never formally apprised of the acquittal or the reasons for the decision;

(b) The OCCO was not provided with a copy of the decision upon its release or at anytime thereafter by Dr. Smith, the HSC, or the Crown Attorneys office involved in the case;

(c) Similarly, Dr. Young was not provided with a copy of the decision by the College of Physicians and Surgeons ("CPSO"), during its investigation of Dr. Smith, following a complaint made by SM's father, DM;

(d) At the time of DM's complaint to the CPSO and during the College's investigation, Dr. Young continued to hold the belief that Dr. Smith had had conversations with Justice Dunn suggesting that he believed SM was responsible for Amber's death; and

- Evidence of Dr. Young, November 30, 2007, p. 18, lines 7-24

(e) Dr. Young has no recollection of discussing the Dunn decision with CPSO investigator, Michelle Mann. It was his testimony, as supported by the half page note produced by Ms. Mann, that this meeting with the investigator dealt with the background events immediately following Amber's death, including the signing of the death certificate, and the decision to exhume the body. Ms. Mann even required information from Dr. Young with regard to the difference between a coroner and pathologist.

- Evidence of Dr. Young, February 8, 2008, pp. 35-40; 59-64
- Ms. Mann's Note, PFP152788

(f) Dr. Smith admitted to having told Drs. Young, Cairns and others that he had on more than one occasion conversed with Justice Dunn during the course of the trial, who indicated that he (Justice Dunn) believed SM was responsible for shaking Amber. Further, Dr. Smith admitted to having told members of the OCCO and others that he had a conversation with Justice Dunn several years after the trial, wherein Justice Dunn indicated that had he understood the science regarding shaken baby syndrome in the early 1990s as he did in later years, he likely would have accepted the evidence of the HSC witnesses; and

- Written evidence of Dr. Smith, PFP303346, pp. 41-42
- Evidence of Dr. Dr. Chiasson, December 10, 2008, p. 43, lines 18-25; p. 44, lines 1-21

(g) While Dr. Cairns was provided a copy of a portion of the decision by Mr. Parise, a lawyer involved in the child protection proceedings in the Nicholas case in 1998 he did not place great weight on it as he had spoken with Dr. Marcellina Mian who indicated that the SCAN team at the HSC, had supported Dr. Smith's conclusions. This coupled with the fact that Dr. Smith had told him about his apparent conversations with Justice Dunn, gave Dr. Cairns no reason to be concerned about the portions of the decision he had read.

- Evidence of Dr. Cairns, November 26, 2007, pp. 173-177

331. In the complaint filed by Maurice Gagnon, there is reference to Justice Dunn's decision and his criticism of Dr. Smith. Dr. Young received this complaint on February 17, 1999 and responded to it on May 6, 1999.

- Nicholas Overview Report, PFP14326, pp. 61-64

- Complaint, PFP008359
- Pitfalls Memo, PFP007885

332. As Dr. Young testified, the reference to Justice Dunn's decision in Mr. Gagnon's complaint letter did not register for him, as his focus was on the specific complaints being raised by Mr. Gagnon about how his grandson's case had been dealt with by both the OCCO and Dr. Smith.

- Evidence of Dr. Young, November 29, 2007, p. 175, lines 9-25; p. 176, lines 1-15

333. With the benefit of hindsight, Dr. Young acknowledges that he should have taken steps to inform himself of the Dunn decision and in particular, should have recognized it as a concern, particularly in light of Mr. Gagnon's complaint letter.

334. As set out above, Dr. Young's primary source of information regarding the acquittal and Justice Dunn's decision was Dr. Smith. Dr. Young did not receive a copy of the Dunn decision from anyone directly involved in the case or in any other direct manner. Given the circumstances he believed to be true at the time, it was reasonable for Dr. Young to react to the acquittal in the manner that he did and to take no further steps to better inform himself of the particulars or to take further action in relation to Dr. Smith.

335. The evidence shows that, as a general practice, the HSC received copies of all court cases that involved the hospital. The OCCO believes that the tracking of cases through to their completeness in the criminal justice system and the ability to access decisions and/or rulings relevant to evidence given by professionals working within the death investigation system represents a good systemic practice that requires resources not currently available to the OCCO.

- Evidence of Dr. Young, November 30, 2007, p. 112, lines 16-25; p. 113, lines 1-7
- CPSO letter, PFP146277, p. 2

336. Financial considerations also played a role in Dr. Chiasson's difficulties with recruitment and retention.

Dialogue/Discussions with OPFPU

337. Throughout his tenure, Dr. Chiasson made it a priority to keep the lines of communication open between the HSC and the OCCO. As the evidence has shown, Dr. Chiasson did so even with the limited resources available to him.

338. At these meetings, Dr. Chiasson discussed administrative and communication concerns.

- Evidence of Dr. Chiasson, December 7, 2007, pp. 145-147, 161, lines 18-25; p. 162, lines 1-4

339. From the perspective of the OCCO, there were three main concerns:

(a) Triaging of the majority of criminally suspicious and homicide cases in the first instance to Dr. Smith, with Dr. Taylor as the alternate

(b) Timeliness of post mortem reports from the OPFPU, primarily concerning Dr. Smith

(c) Strengthening the links between the OCCO and the OPFPU

- Evidence of Dr. Chiasson, December 7, 2007, pp. 161-164, lines 1-21
- Letter, PFP117913

340. As was eventually articulated in his re-visioning plan, Dr. Chiasson felt it was important that Dr. Smith was more closely aligned with the work of the OCCO in adult forensic

cases in order to provide greater exposure to issues in forensic pathology. Dr. Chiasson felt that Dr. Smith already had a great deal of support available to him on the pediatric pathology side through the HSC.

- Evidence of Dr. Chiasson, December 7, 2007, p. 164, lines 7-9

341. In a letter to Dr. Smith dated February 17, 1997, Dr. Chiasson emphasized the value to the OCCO of greater linkages with the HSC as follows, particularly with Dr. Smith attending the OCCO's morning and weekly rounds:

> "...I heartily agree with you that your regular attendance at the Coroner's Office morning rounds would be very valuable, providing you with the opportunity to discuss pediatric case-related issues with other forensic pathologists and the Regional Coroner on an immediate, rather than delayed, basis. At the same time, the broader case spectrum would be of benefit to our adult-oriented staff.

- Letter, PFP117913
- Evidence of Dr. Chiasson, December 7, 2007, p. 190, lines 4-13

342. Dr. Smith did attend morning pathology rounds at the OCCO, but his attendance dwindled after a while. Dr. Chiasson did not insist on Dr. Smith's presence when he stopped attending. As Dr. Smith was not an employee, it was difficult for Dr. Chiasson to enforce compliance.

- Evidence of Dr. Chiasson, December 7, 2007, p. 190, lines 11-13; p. 209, lines 15-21, p. 214, lines 7-20

343. The letter also outlined Dr. Chiasson's preferences for triaging cases at the HSC and conveyed the expectation that Dr. Smith would allow adequate time for the completion of all duties related to work derived from the OCCO. He wanted to ensure that if Dr. Smith was going to concentrate in this area that he would have the time available to do it. Dr. Chiasson stated:

> "This implies that your work schedule allows you the time to perform forensic autopsies in a comprehensive manner, generate the necessary documentation and testify in court as required and also permits you to be actively involved in pediatric forensic pathologic consultative work."

- Letter, PFP117913
- Evidence of Dr. Chiasson, December 7, 2007, p. 165, lines 2-16; p. 166, lines 1-2

344. On March 31, 1998, Dr. Chiasson, Dr. Cairns and Dr. William Lucas met with Dr. Becker and Dr. Smith to discuss the OCCO's ongoing concerns. Again, problems with triaging cases, communication and complaints about delayed reports were discussed. As explained previously, it was proposed that all autopsies in suspicious and non-natural cases be performed by Dr. Smith or Dr. Taylor, that a dedicated administrative liaison person for OCCO cases be provided, that turnaround times be improved with the objective of 90 percent of cases reported in 90 days and that all pediatric Coroner's cases be presented at morning rounds at the OCCO on the day following the autopsy. It was agreed that all OPFPU reports would be reviewed as part of an ongoing audit and that a meeting would be reconvened in six months to assess progress on the issues identified.

- Evidence of Dr. Chiasson, December 7, 2007, p. 191, lines 5-18
- Typewritten notes, PFP096526

345. Dr. Smith claimed that increased secretarial support was required. Dr. Chiasson testified that though Dr. Smith argued this position, he understood that Dr. Smith often completed his own reports.

- Evidence of Dr. Chiasson, December 7, 2007, p. 192, lines 12-18

346. The OCCO now understands that in fact there was secretarial support available to Dr. Smith during this period. The OCCO was not aware of the available support for Dr. Smith at the time.

- Written evidence of Dr. Smith, PFP303346, pp. 19-20

347. By the end of 1998, Dr. Chiasson did not feel that the situation at the OPFPU had improved in any satisfactory way.

- Evidence of Dr. Chiasson, December 7, 2007, p. 193, lines 4-7

348. Ultimately, as is set out in earlier sections, Dr. Chiasson was not able to effectively deal with the issue he identified at the OPFPU. His own unit was woefully underfunded and understaffed (by 1999 at least). There were no alternatives to the status quo from Dr. Chiasson's perspective.

HSC: Failure to Share Concerns about Dr. Smith

349. Dr. Chiasson does not recall any formal communication from Dr. Becker about concerns respecting Dr. Smith's timeliness of reporting on surgical cases. However, Dr. Becker did not seem surprised that the OCCO was experiencing difficulties, and there was a sense that perhaps he was having problems as well, though this was only an impression that Dr. Chiasson formed.

- Evidence of Dr. Chiasson, December 7, 2007, p. 166, lines 9-25

350. At no time was Dr. Chiasson informed of any concerns that Dr. Becker may have had with respect to the quality of Dr. Smith's surgical pathology.

- Evidence of Dr. Chiasson, December 7, 2007, p. 166, lines 21-25

351. Dr. Chiasson acknowledged that awareness of such concerns may not have been relevant to the OCCO's perception of Dr. Smith's diagnostic abilities in medicolegal cases, as ability in one subspecialty does not necessarily reflect ability in another. However, awareness of these concerns may have been relevant with respect to general concerns about Dr. Smith's professional functioning, such as work overload and diminished attention and care, which may have equally affected Dr. Smith's functioning in forensic pathology.

- Evidence of Dr. Chiasson, December 7, 2007, p. 167, lines 5-25; p. 168, lines 6-22

352. Indeed, awareness of the grave concerns expressed by Dr. Becker regarding Dr. Smith's delayed reports and diagnostic inconsistencies over a two year period, with little noted improvement, would have been of great interest to the OCCO and to Dr. Chiasson in particular, especially in the context of the concerns that the OCCO shared about Dr. Smith on an ongoing basis with Dr. Becker.

- Evidence of Dr. Chiasson, December 7, 2007, p. 169, lines 14-25; p. 170, lines 1-15
- Letter, PFP137850

Dr. Smith's Lack of Responsiveness

353. The OCCO attempted on a number of occasions to persuade the HSC to increase the amount of clerical support for Dr. Smith. This arose primarily out of a concern for the timeliness of his reports, and also because of the difficulties experienced by those in the death investigation system in successfully contacting Dr. Smith. In communications with the OCCO, Dr. Smith attributed these failings to a lack of sufficient administrative support.

- Evidence of Dr. Cairns, November 26, p. 101, lines 13-23

354. After their calls were not returned by Dr. Smith, Dr. Cairns often fielded calls from police officers, RSCs and others involved in the administration of justice whose calls were not returned by Dr. Smith. Dr. Cairns, for his part, took proactive steps to address this problem, and would attempt to call Dr. Smith on their behalf. Dr. Smith usually returned his calls in a timely manner. When Dr. Cairns advised Dr. Smith about the importance of promptly responding to queries from others, Dr. Smith promised to try his best to improve, but the pattern kept repeating itself. As the OCCO was not Dr. Smith's employer, Dr. Cairns felt he was doing what was within his power to exert pressure on Dr. Smith to improve his responsiveness to others in the death investigation system. He did not feel it was necessary to put his request in writing since he had made his concerns explicit orally.

- Evidence of Dr. Cairns, November 26, p. 90, lines 20-25; p. 91, lines 1-25; p. 92, lines 1-25
- Evidence of Dr. Young, November 30, 2007, p. 47, lines 4-15

355. To a lesser agree, Dr. Young was also aware of Dr. Smith's unresponsiveness to queries by those working in the criminal justice system. Though Dr. Young spoke with Dr. Smith about this issue, he also did not document this concern in writing.

- Evidence of Dr. Smith, November 30, 2007, p. 49, lines 1-9

356. While there is value in documenting concerns of this nature, it would have been difficult for the OCCO to put many of these issues in writing, owing to the great volume of work that required attention at the OCCO. The OCCO has a limited number of professional resources and such documentation would be demanding in the face of all of the other work

the OCCO needs to address. If such documentation is required in the future, then adequate resources need to be allocated to the OCCO.

- Evidence of Dr. Young, November 30, 2007, p. 51, lines 11-25; p. 52, lines 1-21; p. 53, lines 1-12

357. This issue and that of the timeliness of reports were issues that were taken seriously by the OCCO. However, the dilemma was that Dr. Smith was the pediatric pathology expert ("guru" or "go-to person"). Dr. Smith was the only pathologist with this expertise and it was considered inappropriate or wrong to cease referring cases to him altogether at the time.

- Evidence of Dr. Cairns, November 26, p. 93, lines 15-25, p. 94, lines 1-5

358. In addition, the OCCO was limited in its ability to exert control over Dr. Smith in the absence of an employer-employee relationship. Dr. Chiasson had no formal oversight role in the OCCO's relationship with Dr. Smith. To the extent that Dr. Cairns may have been able to exert more influence over Dr. Smith given their closer working relationship it was limited to administrative matters. Dr. Cairns was not in a position to identify or comment on matters that were of a strictly forensic pathology nature.

359. This external relationship continues to be the case today in the OCCO's relationship with the Regional FPUs, which the OCCO submits is a problem that can be remedied by revising the service agreements and clarifying the primary role of the CFP in the oversight of the professional activities of pathologists.

- Evidence of Dr. Young, November 30, 2007, p. 51, lines 16-25; p. 52, lines 1-9
- See Part III

Absence of CFP

360. From 2001 to 2006, the OCCO did not have a designated CFP. Dr. Chiasson resigned from the position of CFP in 2001, and the position remained unfilled due to challenges in recruiting a suitable replacement. There were very few qualified pathologists in Ontario and, of those qualified, there was little interest in the position of CFP. To fill the void in the interim, Dr. McLellan was appointed Deputy Chief Coroner of Forensic Services, and he assumed responsibility for the administrative duties normally undertaken by the CFP. This included organizing daily rounds and educational courses and setting policy with respect to forensic pathology services. Dr. Chiasson continued to provide professional consultation, including review of complex cases and attendance at selected case conferences, on a contractual basis. In 2004, Dr. Pollanen was appointed Medical Director of the Provincial FPU, shortly after joining the OCCO as a full-time forensic pathologist.

- OCCO Institutional Report, PFP149431, pp. 15-16

361. This five-year gap in which there was no expert leadership for forensic pathology services meant that there was little opportunity to improve and build upon oversight initiatives across the province. It also proved a challenge to the OCCO in terms of dealing with novel issues that arose.

<u>Paolo</u>

362. An example is the situation that arose in the case of Paolo. In October 2001, Dr. Cairns received a request from Ms. Lucy Cecchetto, Senior Crown Counsel, Crown Law Office (Criminal), to undertake a review of Dr. Smith's opinion of the Paolo case. She had received a request from Mr. Michael Lomer and Mr. Howard Bornstein, defence counsel,

to conduct an independent external review of the Paolo case. This was a case with which Dr. Cairns was already very familiar, as he had been involved when the case had been re-opened when a sibling had sustained a fractured femur in 1994.

- Evidence of Dr. Cairns, November 26, 2007, p. 125, lines 10-25; p. 126, lines 1-25
- Evidence of Dr. Cairns, November 27, 2007, p. 123, lines 21-25; p. 124, lines 1-19
- Letter, PFP014558
- Letter, PFP014583

363. In completing his review, Dr. Cairns looked at all autopsy and medical evidence, including autopsy findings and exhibits. According to a letter written by Ms. Cecchetto, Dr. Cairns believed there had been complete consistency between Dr. Smith's opinion and that of other medical experts, he did not detect any contradictions and did not have any concerns with the autopsy report or any of the medical evidence. Ms. Cecchetto wrote that in Dr. Cairns' opinion, no further opinion was required.

- Letter, PFP014583

364. Dr. Cairns was not concerned about providing an opinion regarding pediatric pathology opinion evidence in this case, as he had understood that no cause of death had been determined by Dr. Smith; a fact the trial judge made clear during the trial. As well, Dr. Cairns was comfortable providing this opinion to Ms. Cecchetto, a very senior Crown Counsel, who should have been familiar with the limits of Dr. Cairns' expertise in this area.

- Evidence of Dr. Cairns, November 27, 2007, p. 141, lines 5-25; p. 142, lines 5-8; pp. 143-144; p. 148, lines 1-21

365. In addition, Dr. Cairns gave this opinion at a time when there was no CFP within the OCCO. There was no forensic pathologist responsible for oversight who could have been available to undertake this review. As well, Dr. Cairns, as Chair of the PDRC, and because of his familiarity with the case, was in a good position to undertake this very limited review.

366. In hindsight, Dr. Cairns believes that those without expertise in pathology should not review the work of pathologists, no matter how simple the conclusion may seem. He accepts that this conclusion in this case has been refuted by the forensic pathologists who have now reviewed the exhumed skull.

- Evidence of Dr. Cairns, November 27, p. 142, lines 15-23

Limitations of the Complaints Process Available

367. The OCCO has always recognized the importance of accountability as a means of ensuring public confidence.

368. During the 1990s, the OCCO acknowledges that there were limited mechanisms in place for physicians working within they system to be held accountable.

369. In large measure this was due to the limited financial resources afforded these mechanisms and because of the ongoing concern over recruiting and retaining professionals. As Dr. Young noted, he was not going to recruit the professionals required if they would be vulnerable to too many oversight processes.

- Evidence of Dr. Young, November 30, 2007, p. 17, lines 2-22

370. The OCCO also notes that even the mechanisms available (principally complaint to the CCO and the CPSO) at the time failed to fully identify or address the issues related to Dr. Smith which have now been brought to light by the evidence presented at this Commission

371. The OCCO believes there are two principal reasons to explain this failing:

(a) Dr. Smith the apparent pre-eminent expert in the field, misled both the OCCO and the CPSO with regard to some of the cases under review; and

(b) Neither the OCCO nor the CPSO engaged the appropriate experts to assess Dr. Smith's conduct and competency. In part because, as discussed, the field of pediatric forensic pathology is so complex and there are relatively few experts available.

(i) Coroners' Council – Abolished

372. The Coroners' Council was established to deal with complaints from families or others respecting the work of coroners in the death investigation process. Any significant complaint about a coroner would be referred to the Coroners' Council, which would decide the appropriate action to be taken. This could range from an interview to a full hearing, which would be presided over by a Judge, with witnesses and legal counsel representing various parties. The Coroners' Council conducted very few such full hearings.

- Evidence of Dr. Cairns, November 26, 2007, p. 38, lines 4-25; p. 39, lines 1-4

373. The Coroners' Council derived its authority from s. 7 of the *Coroners Act*, but the Council was disbanded on December 18, 1998, when ss. 6 and 7 of the *Coroners Act* were repealed.

- Evidence of Dr. Cairns, November 26, 2007, p. 38, lines 4-25; p. 39, lines 1-4
- Coroners' Council Report, March 1994, PFP152230

374. During an era of fiscal restraint, the Ontario government abolished the Coroners' Council. This left only the CCO available to address complaints.[9]

- Evidence of Dr. Young, November 30, 2007, p. 151, lines 23-25; p. 152, lines 1-25; p. 153, lines 1-13

(ii) CPSO

375. In November 1991, DM, SM's father launched a complaint against Dr. Smith and others at the HSC following the acquittal of his daughter.

- Letter, PFP148678

376. Dr. Smith responded to this initial complaint in a letter dated May 4, 1992. In his response, Dr. Smith suggested that the CPSO speak to Dr. Young, then CCO, given his knowledge as to the circumstances following Amber's death and because Dr. Smith's involvement in the case arose under a coroner's warrant.

- Letter, PFP145968

377. Dr. Young held the position that oversight of medical doctors conducting coroner's work, was more appropriately dealt with by the Coroners' Council, and not the CPSO:

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9 The evidence has shown that Nicholas' grandfather also involved the Ombudsman in his complaint about how Nicholas' case was handled. (PFP143263, p. 63)

(a) A medical doctor working as a coroner, is not providing a medical act;

(b) The CPSO did have an overarching jurisdiction to deal with issues relating to professional misconduct (i.e. ethics or criminal matters); and

(c) Dr. Young's position vis-à-vis pathologists was admittedly weaker.

- Evidence of Dr. Young, November 30, 2007, p. 13, lines 4-25; pp. 14-17
- Evidence of Ms. Mann, January 16, 2008, p. 21
- Letter, PFP000047

378. The CPSO received legal advice that, for the most part, agreed with this position with respect to coroners. Although the CPSO was thought to have jurisdiction over the conduct of coroners, it was felt that:

> "...most complaints against Coroners acting in their capacity as Coroners would probably be more sensibly processed through the Coroners complaint system."

- Letter, PFP152519

379. As well, in a meeting of the Executive Committee of the CPSO that Dr. Young and Dr. Cairns attended in October 1997 with Dr. John R. Carlisle, the CPSO's Deputy Registrar, the CPSO was reportedly in agreement with this position.

- Memorandum, PFP148172

380. Dr. Young also expressed concerns about excessive oversight and its impact on recruitment and retention issues for both coroners and pathologists. He believed every step of discipline and review has the potential of dissuading people from doing coroner's work or autopsy work under coroner's warrant.

- Evidence of Dr. Young, November 30, 2007, p. 17, lines 1-22
- Evidence of Professor Lorne Sossin, February 20, 2008, p. 62, lines 4-25; p. 63, lines 1-2

381. On March 4, 1998, Dr. Young wrote a letter to the CPSO outlining his belief that the CPSO did not have jurisdiction to deal with complaints against pathologists performing work for the OCCO under the *Coroners Act*. Dr. Carlisle recommended that the CPSO adopt this position in a memorandum dated March 13, 1998.

- Letter, PFP000047
- Memorandum, PFP145631

382. Ultimately, in its decision regarding the complaint launched by DM, the Complaints Committee provided, on May 13, 1998, that the Committee had no jurisdiction over this matter, since Dr. Smith's involvement in the matter was undertaken as an agent of the OCCO.

- Decision, PFP148207

383. On October 5, 1998, Nicholas' grandfather registered a complaint with the CPSO against Dr. Smith regarding a number of concerns surrounding the disinterment of Nicholas. He was advised by the CPSO to seek redress through the Coroner's Council at the OCCO. Upon discovering that the Coroner's Council had been abolished, Nicholas' grandfather contacted the CPSO again in 1999 and 2000, urging the College to take carriage of his complaint. On January 17, 2000, he was advised by the Registrar that any matters in which a physician acts as an agent of the OCCO must be referred to the OCCO for disposition, and elimination of the Coroner's Council did not absolve the OCCO of that responsibility.

- Letter, PFP144835
- Letter, PFP144831
- Letter, PFP144824
- Letter, PFP145296
- Letter, PFP144806

384. DM appealed the decision of the Complaints Committee to the Health Professions and Appeal and Review Board ("HPARB"), which decided the Committee's decision to be unreasonable. The Board returned the matter to the Committee to address the original complaint made by DM.

- Decision, PFP145923

385. On May 29, 2001, Jenna's mother also sent a letter of complaint to the CPSO regarding Dr. Smith's performance of the post mortem examination in that case.

- PFP146246

386. A panel of three assessors was ultimately appointed to assist the Complaints Committee with the investigation into Dr. Smith. The panel was asked to provide an opinion as to:

(a) Whether Dr. Smith's care met the standard of practice of the profession;

(b) Whether Dr. Smith's care revealed a lack of knowledge, skill or judgement or disregard for the welfare of his patients; and

(c) Whether Dr. Smith's clinical practice, behaviour or conduct exposed, or was likely to expose, his patients to harm or injury.

- Evidence of Ms. Doris, January 16, 2008, p. 111, lines 2-6; p. 114, lines 1-25; p. 115, lines 1-15

- Letter, PFP148421

387. The Commission heard evidence that when the Complaints Committee feels that it lacks the specific expertise to dispose of a complaint, it will seek an independent opinion. In this case, the Committee decided to hire a panel of experts. The panel consisted of a forensic pathologist from the United States, the Deputy Chief Medical Examiner for the province of Alberta and a pathologist at the Alberta Children's Hospital.

- Evidence of Ms. Doris, January 16, 2008, p. 99, lines 16-25; p. 100, lines 1-4; pp. 111-112

388. In the fall of 2002, the Complaints Committee reached its decisions in all three cases. A final common disposition was reached in all three cases:

> "The Committee acknowledges the expert panel's opinion that ***Dr. Smith's overall approach was acceptable.*** Nevertheless, the Committee is extremely disturbed by the deficiencies in his approach in this case as set out above.
>
> Accordingly, the Committee will require Dr. Smith to attend before a panel of the Complaints Committee, to be cautioned with respect to those points. A caution in person is a serious outcome for members of the medical profession. It is a tangible symbol of the disapproval of one's peers and a sharp reminder about the need for improvement in future practice." (emphasis added)

- Decision, PFP034523

389. Jenna's mother, Nicholas' grandfather and DM all launched appeals of their respective decisions. HPARB dismissed the appeals in all three decisions, and the decision of the Complaints Committee stood.

- Evidence of Ms. Doris, January 16, 2007, pp. 146-151
- Letter, PFP148103
- Letter, PFP152371
- Letter, PFP152374
- Decision, PFP146982

- Decision, PFP146400

390. It is the position of the OCCO that once the CPSO assumed jurisdiction over the complaints launched against Dr. Smith for the medicolegal work he performed for the OCCO, the College failed to provide an adequate remedy for Dr. Smith's deficiencies. Whereas the CPSO cautioned Dr. Smith, once the OCCO had all of the relevant facts before them, it removed him completely from medicolegal work when it became cognizant of the potential extent of Dr. Smith's failings. That said, the OCCO believes that the CPSO is the appropriate regulator and has overriding responsibility for the actions of physicians in the course of their medical work.

391. In fairness, the CPSO was limited by the fact that Dr. Smith was not entirely truthful during the investigation (i.e. conversation with Justice Dunn).

- Written evidence of Dr. Smith, PFP303346, p. 42

(iii) 2001 Proposed External Review of Dr. Smith

392. Eventually it became clear to the OCCO that more drastic measures had to be taken with regard to Dr. Smith immediately, this view came about because of the events surrounding two criminal cases in which Dr. Smith was involved.

393. In January 2001, within the span of a week, the OCCO learned of the Crown's decision to withdraw charges in two cases in which Dr. Smith had performed the post mortem examination. On January 22, the charges against the caregiver in the case of Tyrell were withdrawn, and on January 25, the charges against Sharon's mother were withdrawn. Although well aware of Sharon's case, neither Dr. Young nor Dr. Cairns had known of Tyrell's case prior to the withdrawal of charges, and this came as a surprise to the OCCO.

In both cases, there was significant contrary expert opinion regarding Dr. Smith's pathological findings that led the Crown to conclude that there was no reasonable prospect of conviction.

- Evidence of Dr. Young, November 30, 2007, p. 198, lines 6-25; pp. 199-201, lines 1-11
- Evidence of Dr. Cairns, November 27, 2007, p. 34, lines 7-25; pp. 35-36; p. 236, lines 5-25; p. 237, lines 1-18

394. The OCCO took immediate and drastic action, given the unusual and concerning circumstances of the withdrawal of charges in two cases in such quick succession. Dr. Young felt that Dr. Smith should be removed from performing medicolegal work for the OCCO and conveyed this sentiment in a meeting with Dr. Smith on January 25, 2001.

- Evidence of Dr. Young, November 30, 2007, p. 200, lines 18-25; p. 201, lines 1-11, 15-25; p. 202, lines 1-2
- Evidence of Dr. Cairns, November 27, 2007, p. 39, lines 4-9

> "...I discussed with him that he had become a lightening rod and, in my view, everything right now that he did or touched would attract an undue amount of attention.
>
> And that I felt that was both a problem to the Office of the Chief Coroner but also a problem to him, professionally and personally. And that it would be a good idea if he was not doing cases in the immediate future for the Office of the Chief Coroner."

- Evidence of Dr. Young, November 30, 2007, p. 204, lines 15-25; p. 205, lines 1-11

395. By this time, the OCCO was aware of some of the concerns surrounding some of Dr. Smith's work, given the issues that had arisen in the cases of Nicholas, Amber, Sharon and Jenna.[10] The OCCO was also aware that there had been concerns about Dr. Smith's delayed post mortem reports, documentation of consults and storage of autopsy specimens,

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10 In January 2001, the OCCO was not aware of the issue of the missing hair evidence in the Jenna case. It was only aware that charges had been withdrawn against Jenna's mother previously. The OCCO did not become aware of the missing hair until later in 2001.

as had been outlined in the Pitfalls Memo, whose message had largely been aimed at Dr. Smith. Given the growing amount of controversy surrounding Dr. Smith and the history of concerning cases, the OCCO felt that the removal of Dr. Smith from medicolegal work was warranted at this time.

- Memorandum, PFP007950

396. Yet it must be remembered that Dr. Smith had a long history with the OCCO in which he had taken responsibility for a large body of very good work in the preceding decades, and for which he had been highly regarded. He was viewed both in Canada and internationally as a leading expert in pediatric forensic pathology. The OCCO was well aware that pediatric cases were the most complex and challenging within the field of forensic pathology and that many of the issues that had arisen in Dr. Smith's problematic cases involved emerging areas of controversy.

397. In this context, neither Dr. Young nor Dr. Cairns had lost complete faith in Dr. Smith's ability to conduct medicolegal work, but recognized the need for a review of his work to satisfy the OCCO that Dr. Smith was indeed competent to be reinstated under its auspices.

- Evidence of Dr. Young, November 30, 2007, p202, lines 4-20; p. 203, lines 1-9; p. 204, lines 15-25
- Evidence of Dr. Cairns, November 27, 2007, p. 38, lines 9-25; p. 39, lines 4-9
- Memorandum, PFP007950

398. Until the results of any such review were available, Dr. Young wanted to avoid any undue and premature damage to Dr. Smith's reputation. He, therefore, suggested that Dr. Smith voluntarily withdraw his services from all medicolegal autopsies, including

criminally suspicious cases, pending a review of some of his cases before any potential reinstatement.

> "But I, then, gave him the option with the discussion as to whether he wished to withdraw from doing cases. I suggested to him that that was, perhaps, the best thing to do in terms of -- of his long term reputation. And -- and if we were ever to -- for him to do cases again, that -- that it would be best if he had made the decision. And before we would make that decision there would be -- it would be done on the basis of a -- review satisfying me that it was okay for him to go back and do cases."

- Evidence of Dr. Young, November 30, 2007, p. 208, lines 2-11
- Evidence of Dr. Cairns, November 27, 2007, p. 40, lines 1-6

399. According to Dr. Young, Dr. Smith reluctantly, but without argument, agreed that resigning from cases in these circumstances was the best course of action, and promptly faxed a letter to that effect to Dr. Young, dated January 25, 2001. The letter also requested an external review of his post mortem examinations.

- Evidence of Dr. Young, November 30, 2007, p. 205, lines 14-19
- Evidence of Dr. Cairns, November 27, 2007, p. 37, lines 20-25
- Letter, PFP127457

400. Dr. Young testified that the sole purpose of the proposed external review was to satisfy himself that Dr. Smith could be reinstated to the performance of post mortem examinations for the OCCO. However, Dr. Young did not have the precise form of the review in his mind when he discussed this with Dr. Smith. Dr. Young was merely trying to provide an appropriate solution to a situation that required immediate action.

- Evidence of Dr. Young, November 30, 2007, p. 205, lines 20-25; p. 206, lines 1-8, 10-21; p. 215, lines 5-11

401. On January 26, 2001, a day after Dr. Young received Dr. Smith's letter, a meeting was held among senior members of the OCCO to discuss the recent events surrounding Dr. Smith and how to address these issues going forward. Notes taken during this meeting indicate that there was some discussion about the possible external review of Dr. Smith's cases. In Dr. Cairns' recollection, there was discussion about the need to retain experts from outside Canada, given that Dr. Smith was held in very high repute and that there were likely no pathologists within Canada who were prepared to objectively review his work.

- Evidence of Dr. Cairns, November 27, 2007, p. 43, lines 2-24; p. 47, lines 11-25; p. 48, lines 1-7
- Handwritten Notes, PFP139736

402. The OCCO was to select the cases for review and to seek out pathologists who would be prepared to complete the review. The exact nature and scope of the review was never clearly defined, however, just as the preparations for the review began, it was called to a halt. Though neither Dr. Young nor Dr. Cairns could recall the exact date on which the proposed external review was cancelled, the evidence shows that this would have occurred at the latest by February 12, 2001, less than three weeks from the time Dr. Young had initially made the request. In effect, while some form of external review had been contemplated, it was never fully formulated, nor did it ever materialize. Save for the notes of the meeting on January 26, 2001 and correspondence with police and the Crown in an attempt to identify relevant cases, there is no record or paper trail with further details of the proposed review process.

- Evidence of Dr. Cairns, November 27, 2007, p. 63, lines 2-24; p. 68, lines 3-20
- Evidence of Dr. Young, November 30, 2007, p. 222, lines 8-25; p. 223
- Handwritten Notes, PFP139736

- Email, PFP129226
- Fax Cover Page, PFP115195
- Report, PFP115196
- Fax Cover Page, PFP115194
- Letter, PFP044076
- Report, PFP044077

403. The proposed external review did not go forward for a number of reasons: the OCCO learned that a lawsuit had commenced against Dr. Smith as a result of the withdrawal of charges in Sharon's case, and that the CPSO was proceeding with its own investigation regarding complaints against Dr. Smith. Dr. Young was concerned about the inevitable conflicts surrounding the sharing of information whenever multiple investigations were carried out simultaneously. Given that reviews of Dr. Smith's work would occur through the lawsuit and the CPSO investigation, Dr. Young after discussion with counsel decided to await the results, particularly of the CPSO investigation, before launching his own review. Dr. Young was comfortable proceeding in this manner as Dr. Smith had already been removed from medicolegal cases and Dr. Young was not planning to reinstate him prior to the resolution of all of these matters. Dr. Young felt that the results of the CPSO investigation would provide an external review of at least some of the relevant cases, and that these results could eventually be used as part of the OCCO's own review. Dr. Young decided not to proceed with the OCCO's external review and he believes that this information was passed on to the Crown Attorneys, who, in his view, would have informed the defence bar.

- Evidence of Dr. Young, November 30, 2007, pp. 211-219, 223-224

404. In assessing the appropriateness of Dr. Young's decision to not proceed with his own review, it is important to recall the state of Dr. Young's knowledge as of January 2001, as well as the circumstances that existed at the time. Dr. Young was not faced with the same sense of urgency that Dr. McLellan was presented with in June 2005, when a formal review of all of Dr. Smith's work was announced:

(a) At no time as of January 2001 was Dr. Young been made aware of any complaint to the OCCO from other stakeholders in the death investigation system, including from the police, counsel for the Crown or counsel for the defence, regarding either Dr. Smith's testimony or his conduct in the course of criminal proceedings;

(b) In addition, in every case in which concerns had been raised about Dr. Smith's work, including that of Amber, Nicholas, Jenna, Tyrell and Sharon, the final outcome of criminal proceedings, if any, had resolved in favour of the accused and their families;

(c) At this point, the manner and circumstances in which Dr. Smith had retained the hair that was the subject of the Jenna case was not known to the OCCO; and

(d) As well, Dr. Young was unaware that Dr. Smith had been untruthful about his conversation with Justice Dunn, specifically respecting Justice Dunn's alleged admission that he had "got it wrong".

405. Unlike the situation that presented itself to Dr. McLellan in 2005, when it became acutely apparent that the accused in Valin's case had likely been convicted and was currently incarcerated based on what proved to be faulty pathological findings on the part of Dr. Smith, there was no circumstance known to Dr. Young by January 2001 that involved the

loss of freedom of any individual as a result of Dr. Smith's work, or the fact that children had been removed or separated from their families.

406. As far as Dr. Young was concerned, he had taken immediate steps to remove Dr. Smith from medicolegal cases as soon as he learned of the withdrawal of charges in the two cases, and indeed, this took place on the very same day that the charges were withdrawn in the case of Sharon. Dr. Young was not contemplating Dr. Smith's return to work on criminally suspicious/homicide cases until and unless an eventual review confirmed his competence in this area. Having completely removed Dr. Smith from any work that could cause potential harm in the immediate future, with no knowledge or suspicion of any wrongful convictions in the past, Dr. Young believed he had taken all of the appropriate measures to address the concerns surrounding Dr. Smith.

407. Given the upcoming lawsuit and CPSO investigation, Dr. Young felt there would be sufficient investigation of Dr. Smith's work in the interim, and contemplated a more fulsome review if necessary, pending the completion of these other proceedings. It is in light of all of these factors that Dr. Young's decision to call off the external review should be viewed.

408. It is also not reasonable to expect, when gazing retrospectively through a 2008 lens, that the OCCO should have, and could have, on its own accord, contemplated reviewing transcripts in order to monitor the testimony of forensic pathologists across Ontario. Although observance of live testimony had occurred sporadically in some educational settings, as was the case for Dr. Rao during her training in Hamilton, this was certainly not an established practice for pathologists working on criminally suspicious and homicide cases.

409. It is reasonable for the OCCO to have expected that those experienced in the criminal justice system, who were exposed on a regular basis to the conduct of expert witnesses in criminal proceedings, such as judges and counsel for the Crown and defence, would have contacted the OCCO if there had been any concerns with the testimony provided by forensic pathologists. Until 2001, this had not occurred.[11]

- Evidence of Dr. Cairns, November 27, 2007, p. 245, lines 13-24; p. 246, lines 1-6
- Evidence of Dr. Young, December 3, 2007, p. 146, lines 13-24; lines 4-7

410. During the few weeks that the OCCO had operated under the impression that an external review would be undertaken, an *ad hoc* process was initiated to search for and identify relevant cases, with an emphasis on the most pressing cases, namely, those that were criminally suspicious or homicides. This initiative was led primarily by Dr. Cairns, who faced a number of challenges in his attempts to gather the information. One of the first tasks undertaken was a search of the OCCO's electronic database, which was capable of identifying those cases in which Dr. Smith had performed the post mortem examination from 1986 onward. While the files contained the autopsy and police reports, they did not contain information to indicate whether the case had gone to trial, or any final outcome from that process.

- Evidence of Dr. Cairns, November 27, 2007, p. 55, lines 8-25; pp. 56-57

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11 During the early stages of planning the 2005 Review, Dr. Pollanen did not immediately recognize the need to review transcripts as part of the review process. It is unreasonable to expect the OCCO to have considered reviewing transcripts in the 1990s; when no one in the criminal justice process advised them of concerns.

- Evidence of Dr. Pollanen, November 13, 2007, p. 223, lines 4-13

411. To assist with his search for cases, and in particular, to identify those cases that were currently before the courts and would require more urgent attention, Dr. Cairns met with Detective Tony Smith and Mr. John McMahon, the Toronto Regional Director of Crown Operations, as he then was, on January 31, 2001. Both Detective Smith and Mr. McMahon agreed to assist the OCCO and both subsequently forwarded a number of relevant cases that had been identified as a result of this request.

- Evidence of Mr. McMahon, February 6, 2007, pp. 24-28
- Evidence of Dr. Cairns, November 27, 2007, pp. 55-62
- Letter, PFP115202
- Chart, PFP115203
- Fax cover page, PFP115195
- Chart, PFP115196

412. In the meantime, criminally suspicious and homicide cases that could be identified through the file system at the OCCO were reviewed by one of Dr. Cairns, Dr. Chiasson or Dr. McLellan, only in the event that they had not been previously subject to Dr. Chiasson's paper review. Any notations as part of this process were placed in the individual files. No separate record was kept regarding the files that were thus pulled and viewed.

- Evidence of Dr. Cairns, November 27, 2007, p. 62, lines 5-25; p. 63, lines 2-24

413. While there was no method of locating the cases in which Dr. Smith provided a consultation, it is not clear whether such cases were ever contemplated as forming any part of the proposed external review. As discussed, the review was cancelled before it got off the ground.

- Evidence of Dr. Cairns, November 27, 2007, p. 56, lines 2-21

414. Though there has been nomenclature throughout this Commission of Inquiry and in the written and oral testimony given by Dr. Cairns during the Kporwodu proceedings that refers to an "internal review" by the OCCO as distinct from an "external review", it must be emphasized that these various processes were simply part and parcel of the very same initiative that flowed from Dr. Young's direction to conduct an external review of Dr. Smith's cases. These processes were merely the OCCO's attempt to begin to address Dr. Young's call for an external review, which never came to fruition.

- Evidence of Dr. Cairns, November 27, 2007, pp. 62-24

415. In the end, seventeen cases were identified through these processes and were detailed in a chart that Dr. Cairns prepared solely as a result of a subpoena *duces tenems* received from the defence at the preliminary hearing stage. The subpoena made the following request:

> "Any and all records, files, notes, charts, medical reports and similar documentation in your possession relating to or concerning the investigation of Dr. Charles Randall Smith, the review of his credentials and competence, the review of his work in any manner including all post mortem examinations & all reports generated by him that have been or are now subject matter of any such investigation or review"

- Appendix C of Affidavit, PFP031169, p. 45

416. As mentioned previously, no records had been kept by the OCCO with respect to the efforts expended as a result of the request for an external review of Dr. Smith's cases in 2001. In fact, Dr. Cairns requested the court's indulgence of a week's time to gather the necessary information, precisely because there was no ready record of the cases that had been identified in that brief process. Dr. Cairns' preparation of this chart was merely an effort to be helpful to the court, but had the unintended effect of giving the appearance that a thorough, methodical review had been completed.

- Evidence of Dr. Cairns, November 27, 2007, p. 63, lines 1-11
- Affidavit, PFP031169, pp. 5-7, Exhibit C
- Transcript, PFP020996, pp. 67-70

417. Dr. Cairns admits that in his earnest attempts to assist the court during the preliminary hearings and at the trial in understanding the nature and scope of the OCCO's work that took place in 2001 in relation to Dr. Smith, he inadvertently provided information that led the court to believe that the external review was a much broader review than it actually was. He was asked to provide information to the court about the review that took place and he attempted to do so in as thorough a manner as possible. In doing so, he gave the unintended impression that the external review was a more formally defined process than was, in fact, the case. Despite Dr. Cairns' attempts to clarify the parameters within which the cases identified were reviewed, confusion resigned at the hearings, in part because the prosecution and defence disagreed about the admissibility of this evidence. Dr. Cairns felt this stifled his ability to provide an accurate account of the limited nature of the response to the request for an external review.

> "But the way that the evidence came out, I did not clearly -- there were -- there were some difficulties in -- in both the preliminary hearing, Mr. Commissioner, in that they were trying to bring in an O'Connor application during the preliminary hearing.
>
> So the Crown was wanting me to say nothing and the defence were wanting me to say everything, and the Judge was trying to -- to say, just keep it there. The same was happening in the trial.
>
> So therefore, the evidence of the witness was continuously being confused as to what you couldn't say. So therefore, I agree having read both transcripts that my evidence, although not done deliberately, was confusing and I can see why there was this talk of a review.
>
> And I think that with -- with justification, that the defence thought this was a -- a high power review with minutes and all the rest were taken. *And while I was saying it wasn't*, I think because of the way the evidence came out, they felt that I was trying to conceal that there had been a substantive review which I was not forthcoming.

> And I think a lot of that was as a result of the words reviewed, and the way the evidence comes out."
>
> [Emphasis added]

- Evidence of Dr. Cairns, November 27, 2007, p. 52-53, lines 12 to 13; p. 54, lines 1 to 25

418. Testimony is a product of the questions put to witnesses. It is a feature of the defence position in Kporwodu that the review that took place in 2001 was elevated to an unwarranted status.

- Transcript, vol. 3, tab 5, PFP021218, pp. 4, 10-13, 20-22, 55-61, 92

419. The prospect of an external review was never formally announced in a press release, as Dr. Young felt that Dr. Smith's decision to withdraw from medicolegal work was an internal matter for the OCCO. He was also concerned that an announcement might prematurely and irreversibly damage Dr. Smith's reputation, should the review confirm that Dr. Smith was competent to return to medicolegal work, as Dr. Young anticipated would be the case. By the same token, the OCCO did not conceal this information from the public. On the contrary, when questioned shortly thereafter by the Kingston Whig Standard about whether Dr. Smith was still involved in cases for the OCCO, Dr. Young explained that Dr. Smith was no longer conducting post mortem examinations and that an external review was planned.

- Evidence of Dr. Young, November 30, 2007, pp. 207-209
- Evidence of Dr. Cairns, November 27, 2007, pp. 40-41
- Article, PFP055831

420. However, information about the proposed external review was disseminated very quickly to those in the death investigation system. Dr. Cairns contacted the Attorney General's

Office to enquire about cases that were currently before the courts. This was to be part of a secondary review, to assess the need for additional expert opinion for those cases that were still in the criminal justice system. Dr. Young expected that the Attorney General's office would take on the responsibility of notifying the defence bar, as this was the normal flow of information. The OCCO did not normally contact the Defence Bar directly.

- Evidence of Dr. Young, November 30, 2007, pp. 210-211
- Evidence of Dr. Cairns, November 27, 2007, p. 242, lines 10-25; pp. 243-245

2006 Chief Coroner's Review

421. In contrast to the arrested review of 2001, a comprehensive review of Dr. Smith's work in criminally suspicious and homicide cases, which came to be known as the Chief Coroner's Review, was initiated, developed and fully implemented between June 2005 and April 2007.

422. The gravity of the situation that Dr. McLellan faced in late 2004, however, must be distinguished from the circumstances which Dr. Young dealt with in 2001. Indeed, Dr. McLellan, who had assumed the position of CCO in April 2004, who had been a participant in the events that took place in 2001, who had knowledge of the ongoing concerns with Dr. Smith's work over a number of years as a senior member of the OCCO, who had personally expressed concerns about Dr. Smith's involvement with committees and conducting autopsies, and one of whose first order of business as CCO was to remove Dr. Smith from the directorship of the OPFPU, did not contemplate any such review of his work until significant concerns were specifically brought to his attention for the first time in the case of Valin.

423. Prior to this, no review, and certainly nothing in the order of magnitude of what eventually became the Chief Coroner's Review, had ever been considered. In truth, the Chief Coroner's Review was the culmination of an evolving set of increasingly troubling events that came to light in Valin's case. As a result of slides and tissue blocks that had been misplaced by Dr. Smith, it was inadvertently discovered by Dr. Pollanen that Dr. Smith's interpretation of the pathological findings could not be supported, but had likely played a critical role in convicting the accused who was continuing to serve a sentence. The urgency of the liberty interests at stake in the face of a gross misdiagnosis of the pathological findings in Dr. Smith's consultation report, prompted the call for a comprehensive review of all of Dr. Smith's criminally suspicious and homicide cases.

424. In 2001, on the other hand, Dr. Young was not faced with any concrete loss of individual liberty interests as a consequence of Dr. Smith's work. His removal of Dr. Smith from medicolegal work at the time seemed to be a sufficient solution, even as the proposed external review was called to a halt for other reasons.

- Evidence of Dr. Young, December 3, 2007, p. 9, lines 12-19

425. In fact, at the time that Dr. McLellan publicly announced that a formal review would take place, the process was yet to be worked out. Though it was recognized from the outset that the review would be a major undertaking, given that 40 cases were initially identified, Dr. McLellan's announcement advised that the FSAC would be consulted prior to establishing the exact review and reporting process. The deliberative process through which the parameters and objectives of the review were ultimately developed by the FSAC's subcommittee was itself somewhat protracted as unforeseen issues arose and had to be dealt with. It is conceivable that none of the individuals who were involved in

developing and defining the Chief Coroner's Review were cognizant of the full extent of the review that would eventually take place.

- Evidence of Dr. McLellan, November 13, 2007, p. 136, lines 1-4
- Backgrounder, PFP033962, p. 2

426. The purpose of the review was to determine whether the conclusions reached by Dr. Smith in his autopsy or consultation reports could be supported by the information and materials available. Since the review in this case was being conducted to maintain public confidence in the work of the OCCO, it was important to make a formal public announcement and to continue to inform the public about its development and progress.

- Evidence of Dr. McLellan, November 13, 2007, p. 135
- Evidence of Dr. McLellan, November 14, 2007, p. 34
- Backgrounder, PFP033969

427. The results of the Chief Coroner's Review were announced April 19, 2007. In summary, 20 cases where identified where experts retained had some issue with Dr. Smith's opinion in his written report, testimony in Court or both.

- Backgrounder, PFP058378, p. 4