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

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

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

SUBMISSIONS OF THE OFFICE OF THE CHIEF CORONER OF ONTARIO

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Prologue – Evolution and Vision

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

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

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

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

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

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

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

Introduction

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

    - OCCO Institutional Report, PFP149431, p. 5

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

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

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

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

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

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

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

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

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

7. The Order in Council establishing this Commission of Inquiry sets out the following mandate:

> 4. The Commission shall conduct a systemic review and assessment and report on:
>
> a. The policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings;
>
> b. The legislative and regulatory provisions in existence that related to, or had implications for, the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and
>
> c. Any changes to the items referenced in the above two paragraphs, subsequent to 2001
>
> in order to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.

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

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

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

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

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

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

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

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

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

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

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

- OCCO Institutional Report, PFP149431, p. 67

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

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

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

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

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

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

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

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

- Guidelines, PFP137602

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

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

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

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

    - See Part III

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

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

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

PART I

Evolution of Death Investigation System

(i) OCCO and Forensic Pathology Services

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

(ii) Pre-Integration: 1981-1994

Division between Forensic Pathology and the OCCO

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Education, Training and Succession Planning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Establishing the OPFPU at the HSC;

- PFP129900

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) Post-Integration: 1994-Present

A Vision for Quality

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

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

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

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

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

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

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

    (a) Establishment of Death Review Committees;

    (b) Formation of the Regional FPUs;

    (c) Enhancements in forensic pathology services;

    (d) Education and training; and

    (e) Use of case conferences.

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

A. Death Review Committees

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

    - OCCO Institutional Report, PFP149431, p. 64

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

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

(i) Establishment of the Pediatric Death Review Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Memorandum #631, 1995 Protocol and Questionnaire

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

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

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

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

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

- Memorandum #631, PFP057584, p. 349

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Regional Forensic Pathology Units – The Centres of Excellence

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

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

- Proposal, PFP057564

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

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

- Proposal, PFP057564, pp. 2 and 5

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

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

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

- Proposal, PFP057564, p. 5

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

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

- Proposal, PFP057564, pp. 5-6

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

- Proposal, PFP057564, p. 6

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

- Proposal, PFP057564, p. 7

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

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

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

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

- Proposal, PFP057564, p. 7

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

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

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

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

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

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

- Proposal, PFP057564, p. 8

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

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

- Proposal, PFP057564, p. 8

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

- Proposal, PFP057564, p. 8

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

- Proposal, PFP057564, pp. 10-15

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

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

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

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

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

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

(i) Establishment of the OPFPU

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

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

- Memorandum, PFP129900

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Enhancements to Forensic Pathology

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

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

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

(a) Appointing Regional Coroner's Pathologists;

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

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

(d) Promoting education and teamwork.

(i) Regional Coroner's Pathologists

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

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

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

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

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

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

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

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

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

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

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

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

(d) Geographic location.

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

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

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

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

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

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

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

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

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

(ii) Peer Review of Post Mortem Reports

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

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

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

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

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

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

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

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

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

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

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

- Forensic Pathology Corner, PFP129360

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

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

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

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

- Forensic Pathology Corner PFP129360

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) Recruitment of Full-Time Forensic Pathology Staff

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Memorandum, PFP129354

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

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

- Memorandum, PFP129354

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

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

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

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

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

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

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

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

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

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

(iv) Promoting a Dedicated Team Environment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) Dealings with the OPFPU

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

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

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

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

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

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

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

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

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

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

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

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

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

- Memorandum, PFP056292

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

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

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

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

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

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

D. Education and Training of Coroners and Pathologists

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

- Letter, PFP134457
- Memorandum, PFP129355

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

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

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

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

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

(c) The regularization of case conferences;

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

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

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

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

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

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

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

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

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

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

- PFP033007
- PFP032372
- PFP032495
- PFP137627

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

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

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

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

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

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

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

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

E. Case Conferences

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

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

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

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

- Campbell Report, p. 101

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

- Campbell Report, Recommendation #7

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Oversight of Coroners in Death Investigation

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

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

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

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

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

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

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

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

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

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5 See Part III

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

PART III

Future of the Death Investigation System

428. The OCCO sees this Commission as an opportunity to implement further changes to the current system of death investigation to enhance quality and strengthen oversight mechanisms, while at the same time ensuring the independence of all branches of the OCCO, including the forensic pathology services.

429. Shortly after this Commission was called, a working group of pathologists and coroners came together to help formulate the following suggested recommendations. These recommendations coincide with the future vision of the OCCO and in many instances arise from the evidence that was heard by this Commission.[12]

430. The three principles used in making these recommendations are:

(a) The fundamental approach to death investigation in Ontario is based on seeking the truth;

(b) The fundamental goal is to continue to improve the quality of death investigation in the Province of Ontario to further public safety and the administration of justice, and to maintain public confidence in the OCCO; and

(c) This goal can be accomplished by building on the current organizational structure of the OCCO and on many of the unique initiatives first implemented in the 1990s.

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12 See **Appendix A**, "Forensic Pathology Services in Ontario, Report of the Joint Coroner and Pathologist Working Group, January 2008"; See **Appendix B**, "Position Paper, August 29, 2007".

431. There are twelve general areas in which recommendations are made. Each have a number of specific recommendations, which have been set out in the proceeding sections:

(a) A strategic plan for the OCCO;

(b) Development of new and enhanced leadership;

(c) The establishment and growth of a culture of quality;

(d) The creation of the Ontario Forensic Pathology Service ("OFPS");

(e) The future of Pediatric Forensic Pathology;

(f) Accreditation of coroners and pathologists;

(g) Education for death investigation;

(h) Information/communication/technology enhancements;

(i) Regionalization and best practices;

(j) Death investigation team;

(k) Accountability and oversight; and

(l) Suggested changes to the *Coroners Act*.

A. Strategic Plan for the Office of the Chief Coroner

432. The mandate of the OCCO arises out of its jurisdiction as set out in the *Coroners Act*. The OCCO should clearly define its priorities in light of its mandate and restate its vision

in accordance with the changing realities of death investigation in Ontario. This strategic plan should include:

(a) A restatement of mission, vision and values to reflect contemporary death investigation;

(b) An emphasis on a death investigation team consisting of all stakeholders, and centrally, the collaboration of pathologists and coroners;

(c) A culture of quality and performance excellence, which should permeate all activities;

(d) A dedication to peer review of reports including both the coroner's death investigation and the pathologist's post mortem reports, the current products of a death investigation in Ontario;

(e) A re-dedication to seeking the truth, using the scientific method, and developing evidence-based practice, where possible;

(f) The development of a code of conduct for the entire organization;

(g) Adoption of conflict of interest guidelines, which are consistent with those of the Ontario Public Service ("OPS") acknowledged by all staff annually;

(h) Analysis, careful consideration and implementation of the findings of the Commission of Inquiry into Pediatric Forensic Pathology, wherever possible;

(i) Inclusiveness in the strategic planning process engaging all internal and external partners and stakeholders. Effective strategy should be developed for the engagement of those parties who are not employees of the OCCO;

(j) A commitment to education, research and solidifying ties to universities; and

(k) The OCCO should undertake a study to review the provision of death investigation services in the North, for the purposes of ensuring that any changes implemented are data-driven and meaningful.

B. Development of New and Enhanced Leadership

433. Several vacancies exist in senior management positions in the OCCO (Dr. Pollanen, November 12, 2007, page 81, lines 15-22). Major revisions and enhancements to the death investigation system are planned, which will require significant recruitment of coroners, pathologists, senior administrators and support staff currently otherwise employed. These challenges require the following:

(a) The development of sustained, committed and excellent leadership in senior management positions, including coroners, pathologists, senior administrators and support staff;

(b) A commitment by government to adequately resource these positions such that sufficient candidates of the highest calibre will consider death investigation in Ontario as a viable career path and provide guidance of the highest quality to the OCCO. At present, there is a short fall in the resources available for coroners and pathologists at all levels. The staff forensic pathologists are grossly underpaid as compared to their hospital-based counterparts; the transfer funds and fee-for-

service payments to the Regional FPUs do not contribute to the salaries of the forensic pathologists employed therein, in any meaningful way; and coroners are expected to be on-call, with no guaranteed remuneration, at a time when stipends are available in other medical settings for doctors on-call;

- Evidence of Dr. Pollanen, November 12, 2007, p. 70, lines 1-16
- Evidence of Dr. McCallum and Dr. Eden, January 25, 2008, p. 184, lines 8-25; p. 185, lines 1-7
- Evidence of Dr. Shkrum, January 17, 2008, p. 47, lines 7-14
- Evidence of Dr. Chiasson, December 10, 2007, pp. 217-219

(c) The Provincial Government must ultimately understand and acknowledge that the OCCO is competing with other arms of government-funded services such as the Ministry of Health and Long Term Care ("MOHLTC") for the same limited pool of physicians. As long as the current inequities in remuneration persist between these competing interests, death investigation in Ontario will continue to experience challenges with recruitment and retention and therefore, quality death investigation may be jeopardized throughout Ontario; particularly in the North and non-urban centres;

- Evidence of Dr. Lauwers, January 8, 2008, p. 60, lines 23-25; p. 61, lines 1-10
- Evidence of Dr. Eden, January 25, p. 136, lines 4-24

(d) The CCO should occupy no other leadership positions in government so as to maintain objectivity and independence;

(e) The development of a leadership structure for forensic pathology, which mirrors the coroners' leadership structure to assist with the ongoing management of the pathologists' branch of the death investigation system including:

(i) A Chief Forensic Pathologist;

(ii) Two Deputy Chief Forensic Pathologists;

(A) One Deputy Chief Forensic Pathologist (of the two) who should act as Director of the Provincial Forensic Pathology Unit in Toronto;

(B) A second Deputy Chief Forensic Pathologist located at a Regional Forensic Pathology Unit;

(iii) Forensic Pathologists, duly trained to act as Directors of the Regional FPUs, with shared responsibility for quality processes;

(iv) Administrative personnel to support the above;

(f) The creation and funding of leadership positions within the OCCO for a dedicated:

(i) Director of Human Resources;

(ii) Director of Quality;

(iii) Director of Information Technology and supporting team;

(iv) Director of Education;

(v) Director of the Family Liaison Service;

(vi) Data Analyst[13];

(vii) Issues Manager[14];

(viii) Other resources (direct operating expenses, FTE's, etc.) as required to implement the recommendations from the Commission;

(g) The OCCO is currently involved in a number of activities involving quality assurance[15]. External reviewers have recently identified that although the OCCO has a number of processes in place, these require consolidation and regular review. In addition, a number of enhancements with regard to quality are anticipated for forensic pathology. The Director of Quality would enhance these very necessary quality initiatives. In addition, the Director of Quality could provide the **Death Investigation Advisory Council**[16] with a quarterly report of quality for the death investigation system in Ontario;

(h) The development, resourcing and implementation of a comprehensive human resources plan that should include:

(i) Recruitment and retention;

(ii) Training and development;

(iii) Performance management;

(iv) Quality assurance;

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13 The purpose of this position is to collect and analyze data gathered in death investigations to monitor quality benchmarks, collate data for research, and strategic planning, and track all reports for timeliness through central dispatch system.

14 The purpose of this position is to respond to current challenges whether they are from the government or the public.

15 Quality assurance can be defined as a planned systematic activity directed toward providing clients/stakeholders with a service of appropriate quality.

16 See Accountability and Oversight section K,

(v) Development of contracts as a foundation for accountability;

(vi) Remuneration packages (which consider differential fee schedules to address under-serviced areas, including the North, for the recruitment of coroners and pathologists);

(vii) Succession planning and promotion;

(i) Ensuring that there is sufficient depth of leadership in the death investigation system so that it can continue to function normally if a leadership position becomes vacant for a period of time. This should extend to the administrative support of leadership positions as well;

(j) Encouraging and financially supporting physician leaders to partake in leadership courses and organizations to assist with leadership education. These might include, but are not limited to:

(i) Membership in the Canadian Medical Association ("CMA");

(ii) Membership in the Canadian Society of Physician Executives ("CSPE");

(iii) Completion of the Physician Manager Institute Courses;

(iv) Completion of the Harvard Manager Mentor Program through the CMA;

(k) Developing through mentorship, leaders who:

(i) Model by way of aligning actions with shared values;

(ii) Inspire the shared vision through communication and action;

(iii) Challenge the process by searching for innovative ways to improve our death investigation process;

(iv) Enable others by fostering trust, facilitating relationships, developing competence and increasing self-determination;

(v) Create a spirit of community within the OCCO by recognizing and appreciating individual excellence[17], and promoting camaraderie and cooperation;

(l) In the interests of attracting coroners and pathologists to the OCCO and fostering long term commitments, open ended term Orders-in-Council should continue with on-going reviews consistent with Ontario Public Service guidelines to ensure an incumbent is meeting identified goals. This process of appointment should ensure both the appearance of, and actual independence of the investigations conducted and supervised by coroners and pathologists.

C. The Establishment of a Culture of Quality

434. Quality is a fundamental issue before this Commission. This includes quality of post mortem examinations and expert opinions, quality of death investigations, quality of oversight of pediatric forensic pathology, and the quality of the ability of the criminal justice system to encapsulate complex medical evidence into legal process.

435. Improvement in quality requires the following:

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17 Kouzes, JM, Posner BZ, The Leadership Challenge, pg. 26, 2007, Jossey-Bass, San Francisco, CA

(a) Recognition that high quality and performance excellence in death investigation is the core business of the OCCO;

(b) The OCCO must adopt the principals of ***total quality*** which include:

(i) A focus on clients[18] and stakeholders;

(ii) Participation and teamwork by everyone in the organization;

(iii) A process focus supported by continuous improvement and learning[19]

(c) The OCCO's vision statement must recognize that quality death investigation is a service provided to internal and external clients and stakeholders;

(d) The OCCO's mandate must be based upon an unbiased, impartial and transparent process that is uninfluenced by external demands;

(e) At the time of developing the its strategic plan, the OCCO should have a client/stakeholder "needs" focus (information that is of particular interest to a clients/stakeholders group);

(f) The OFPS must strengthen procedural guidelines and peer-review mechanisms of pathologists performing post mortem examinations. The OFPS must:

(i) Develop minimal standards for all post mortem examinations in Ontario;

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18 "Client" is a person, organization or party who receives the findings of a coroner's investigation defined in sections 18, 20 and 28 of the *Coroners Act*

19 Evans JR et al, Managing for Quality and Performance Excellence, p. 19, Thomson, 2008

(ii) The minimal standards must be data-driven by quantifying quality indicators as in the current Ontario Coroners Autopsy Quality Study ("OCAQ Study");

(iii) Standardize operating procedures for post mortem examinations across the province;

(iv) Develop best practice guidelines with regard to writing post mortem reports. These guidelines, developed by the CFP working with a Forensic Pathology Advisory Committee ("FPAC") should include a unified approach to the language of certainty and exclusion;

(g) The OFPS must determine if the current approach to post mortem services meets the needs of the death investigation system based on the interests of ***all*** clients/stakeholders;

(h) The OFPS should continue to perform peer review of all homicides, criminally suspicious cases, and pediatric cases:

(i) These reviews should be performed by the CFP, the Deputies or the Directors of the Regional FPUs, or duly trained designates;

(ii) The reviews should follow the current practices with reference to peer review for post mortem examinations in criminally suspicious cases[20];

(iii) Given the limitations of a second post mortem examination in that tissues are significantly destroyed or altered during the primary post mortem

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20 See **Appendix C**, "Autopsy Report Peer Review Form"

examination, the guidelines for post mortem examinations should ensure that sufficient tissue samples remain to allow the conclusions of the primary pathologist to be reviewed;

(iv) Where a difference in opinion occurs between the primary pathologist and the reviewer, the CFP should review the case and discuss the medical legal issues with the primary pathologist. The goal of the discussion should be a comprehensive exploration of the controversies and/or difference of opinion. Communication arising out of the review process should be disclosed to the Crown: i.e. peer review document, email or other written exchange between reviewer and reviewed pathologist;

(v) An understanding of this commitment on the part of pathologists to resolve differences in opinion in the manner stated above will be a component of allowing pathologists to perform post mortem examinations as members of the Registry (discussed below);

(vi) Consistent with quality assurances processes in like organizations[21] quality assurance processes in the OCCO should not be shared. The exception should be items that need to be disclosed to the criminal justice system;

(i) The OCCO is dedicated to the belief that all Coroners Investigation Statements must be reviewed by the RSC. In addition, a systematic review of all post mortem reports by forensic pathologists must be established for post mortem

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21 See *Quality of Care Information Protection Act* 2004, which exempts hospitals from disclosing the results of quality reviews performed in the interests of improving patient care, and allows care providers a forum for open and free discussion, without the constrictions of fear that their comments will be used against them in some other proceeding

examinations completed under a coroner's warrant. The present peer review system does not yet contemplate a review of all post mortem examinations. Significant enhancements in human and financial resources will be required to achieve these goals;

- Evidence of Dr. Lauwers, January 7, 2008, p. 143

(j) Development of an affiliation with Canada's National Quality Institute ("NQI")[22]. The NQI is a non-profit organization that developed the Canadian Quality Criteria for the Public Sector. The mission statement of the NQI is to "...help organizations to continuously improve performance and results by providing innovative national criteria, progressive implementation programs, services and certification";

(k) Accreditation of the OFPS with the National Association of Medical Examiners should be a long-term goal;

(l) The OCCO must develop a comprehensive Quality Assurance Program that should be benchmarked, revised and studied each year. Each Regional Office and each Regional FPU should be expected to report to the Director of Quality the aggregated results of quality processes so that these can be reviewed collectively by the senior management team;

(m) The Director of Quality should develop a comprehensive Quality Management System that is computer based. This system will allow for computer entry by

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22 www.nqi.ca See **Appendix D**

staff, (anonymously if desired) of all misses and near miss[23] events in the death investigation system. The Director of Quality should review error on a case by case basis and develop with the appropriate personnel, corrective actions. These should be tabulated by the Director and reported in the quarterly reports to the Death Investigation Advisory Council; and

(n) Current and developing quality processes should provide a satisfactory foundation for independent reviewability without resorting to audio and video taping of post mortem examinations. Therefore, the OCCO does not recommend the audio and video taping of post mortem examinations.

- PFP139350, Guidelines on Autopsy Practice for Forensic Pathologists, pp. 8-9; 13-14

D. The Creation of the Ontario Forensic Pathology Service

436. As set out in Part I of these submissions, the system of death investigation in Ontario is comprised of two coordinated professional activities:

(a) Death investigations performed by coroners (20,000/year), and

(b) Post mortem examinations performed by pathologists (7,000/year, including approximately 400 cases investigated as criminally suspicious cases or homicides).

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23 Near miss – is a situation where an adverse or sentinel event is narrowly averted by the action of an individual

437. An OFPS should be created and defined in the *Coroners Act* to provide professional oversight and quality assurance for the provision of post mortem examinations performed across the province. The CFP should direct and control the OFPS.

438. Post mortem examinations are performed for the death investigations under the direction of a Coroner's Warrant for Post Mortem Examination. However, the *Coroners Act* does not define a role for pathologists. The OCCO submits that the recognition of the role of the forensic pathologists and the CFP, in particular, is required.

439. The CFP should be defined by the *Coroners Act*[24]. Forensic pathologists are best qualified to direct forensic pathology services in Ontario. In summary, the *Coroners Act* should include the following amendments:

(a) To include the Chief Forensic Pathologist, and Deputy Chief Forensic Pathologists;

(b) The Chief Forensic Pathologist should be appointed by Order-in-Council, accountable to the CCO, to direct forensic pathology services;

(c) Section 28.2 of the *Coroners Act* should specify that the person performing the post mortem examination is a pathologist; and

(d) The term "pathologist" should be defined in the *Coroners Act* (a physician certified by the Royal College of Physicians and Surgeons of Canada or equivalent as a specialist in anatomical or general pathology).

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24 See Section L, for the specific changes the OCCO proposes should be made to the legislation.

440. In addition, a Forensic Pathology Advisory Committee should be developed to encourage participation in decision-making and a collaborative approach to forensic pathology in the OFPS. The FPAC should include Directors of the Regional FPUs. It is not contemplated that the FPAC will provide case-by-case quality assurance and oversight. Instead, the OCCO views this Committee as providing assistance to the CFP in the setting of objectives, protocols and guidelines for the provision of forensic pathology services across the province.

441. The FPAC should have as its mandate, continued improvement of quality processes and continued enhancement of the relationship of the OFPS with the Regional FPUs. In addition, the FPAC should strive to improve post mortem examination services in all areas of the province, considering the OCCO's overall objectives, the best use of resources and Ontario's vast geography.

442. The CFP should develop and maintain a registry of pathologists credentialed to perform post mortem examinations in Ontario ("the Registry"). The OCCO submits that the details with regard to the Registry must be reviewed with the Ontario Association of Pathologists ("OAP"). However, at its most basic, the Registry should have the features as discussed in Section F, "Accreditation of Coroners and Pathologists", herein.

443. The OFPS requires a funding model and budget. The OCCO recognizes that high quality forensic pathology requires adequate budgetary, personnel and other resources. The budget for forensic pathology services should be separate from resources provided for other coroner-related services.

444. With respect to recruitment and retention of forensic pathologists, the OCCO makes the following recommendations:

(a) Given the international shortage of forensic pathologists and the mobility of the speciality, consideration should be given to the development of incentives for recruitment and retention of forensic pathologists from the global marketplace;

- Evidence of Dr. Pollanen, December 6, 2007, p. 18, lines 18-23
- Evidence of Dr. Chiasson, December 10, 2007, p. 211, lines 19-25; p. 212, lines 1-11

(b) The Ministry of Community Safety and Correctional Services should join the Laboratory Medicine Funding Framework Agreement ("LMFFA"). This should ensure competitive compensation for all forensic pathologists in the province;

(c) There should be a blended model of remuneration for forensic pathologists in the Provincial FPU, which should include the LMFFA-based salary and fee-for-service income from coroner post mortem examinations performed on weekends and statutory holidays; and

(d) There should be recruitment of forensic pathologists, duly trained to act as Directors of the Regional FPUs, and whose activities are, in part, compensated to allow for the continuing and ongoing review of post mortem examination reports performed within their geographical jurisdictions and who will support pathologists performing post mortem examinations under coroners' warrants.

445. An important facet of recruitment and retention is the ability to provide forensic pathologists working within the OFPS with opportunities for professional growth and

advancement. The OFPS should have a hierarchical structure that mirrors the Regional Coroners' services and allows pathologists to develop a long-term career path. The hierarchical structure would allow the CFP to concentrate on policy, quality, and educational mandates, while the Deputy Chief Forensic Pathologists provide professional direction and consultation to the Forensic Pathology Units. Such a hierarchical structure should facilitate recruitment and retention of forensic pathologists who want to develop a career in forensic pathology.

446. The OFPS requires modern facilities to ensure quality services and which are maintained in accordance with international standards for the performance of autopsies, infection control and work safety. These facilities should also be properly secured to ensure continuity of evidence and biohazard containment. The current facilities out of which the CFP runs the Provincial FPU are inadequate.

447. The OFPS should be actively involved in the improvement of professional development programs and in the training of pathologists for specialist qualification in forensic pathology.

(a) Professional development programs (i.e. "CME") should promote evidence-based forensic pathology as the preferred basis for the provision of expert opinions;

(b) The Royal College of Physicians and Surgeons of Canada has recently created a specialist qualification in forensic pathology. The Provincial and Regional

Forensic Pathology Units should develop university-partnered fellowship training programs[25]; and

(c) The OCCO recommends on-going and assured funding for forensic pathology fellowship positions. As with other fellowship programs, this funding should come from the MOHLTC.

448. The CFP should have oversight for all of Ontario's forensic pathology services including quality, quality assurance, resource development and allocation ("the budget"), service provision and policy development and implementation.

449. The CFP should have professional autonomy. This recognizes the **independence** of forensic pathology. To ensure appropriate system integration of death investigation, the CFP should be administratively accountable to the CCO. This recognizes the **interdependence** of pathologist and coroner to facilitate high quality death investigation.

- Campbell Report, Chapter 13, p. 300; Chapter 14, Recommendation 1 and 7

450. All pathologists conducting post mortem examinations under a coroner's warrant should be professionally responsible to the CFP for the quality of this work.

451. The CFP, as chair of the FPAC, should:

(a) Provide a collaborative forum for the growth and development of policy and procedures;

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25 At present, both the Hamilton Regional Unit and the Provincial FPU train fellows. (Dr. Rao, January 17th, 2008, page 82, lines 11-20 and Dr. Pollanen, December 6th, 2007, page 36, lines 15-25; p. 37, lines 1-21)

(b) Require post mortem examination reports to be prepared in accordance with protocols and guidelines as developed by the CFP, in consultation with the FPAC. The Reports should be independently reviewable and comprehensible to the various consumers of the Reports;[26]

- PFP139350 Guidelines on Autopsy Practice for Forensic Pathologists

(c) Define the scope and limits in the provision of forensic pathology services to client/stakeholder groups; and

(d) Liaise with other committees integral to the provision of death investigations regarding issues of mutual concern.

452. Revision and improvement of the service agreements with the Regional FPUs should be undertaken, recognizing the centralized role of the CFP as the authority having ultimate oversight and accountability for the delivery of forensic pathology services in Ontario:

- PFP033773 (HSC)
- PFP129575 (Ottawa)
- PFP130106 (London)
- PFP130275 (Kingston)
- PFP129556 (Hamilton)

(a) The service agreements should allow the Regional FPUs to have in their own facilities, computer access to the Coroners Investigation System ("CIS") to assist them in fulfilling their mandate;

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26 This Commission has heard a great deal of evidence with regard to the role of the pathologist in opining on cause and manner of death. The OCCO agrees with the evidence given by Dr. Lauwers and Dr. Lucas on this point (see January 8, 2008, pp. 17-21). In many cases it is appropriate for the pathologist to provide a fulsome discussion of the possible mechanism of death. Often times this will lead to an obvious "manner", however it is the OCCO's submission that the statutory determination of cause and manner should continue to rest with the coroner.

(b) A telemedicine portal should be placed in each Regional FPU to assist in integrating services and providing "real time" review of difficult cases before or during a post mortem examination;

(c) The service agreements should include the provision that the Directors of the Regional FPUs will provide oversight and assistance to pathologists performing post mortem examinations within their geographical areas;

(d) In exchange, the service agreements should earmark a portion of the transfer payment as salary for the Directors. Compensation should appropriately reflect the responsibility and increased workload activities;

(e) Similarly, the transfer payments, which have not been re-visited in several years, should reflect the important role played by the Regional FPUs;

(f) A component of the oversight provided by the Directors should include peer review of all post mortem examinations for criminally suspicious, pediatric and homicide cases within their geographical areas;

(g) Pathologists on the Registry performing post mortem examinations in a geographical area should be accountable to the Director of the Regional FPU for the quality of their work;

(h) The Directors of the Regional FPUs should be expected to be core members of the FPAC and provide guidance to the CFP to ensure that Ontario has a quality forensic pathology service, thereby ensuring high quality death investigation; and

(i) In accordance with the requirements of the Auditor General, the service agreement must include a stipulation that the Directors of the Regional FPUs provide an annual report to the CFP.

453. There should be quantification of the significant backlog of Reports of Post Mortem Examination with development and initiation of a plan to address this issue in Ontario.

454. The job description of the CFP should be revised to reflect the contemporary demands of the position.

E. The Future of Pediatric Forensic Pathology

455. The core mandate of this Commission is pediatric forensic pathology. While the OCCO recognizes that in order to recommend improvements to the provision of pediatric forensic pathology services for the province, this Commission has had to look more broadly at issues relating to forensic pathology in general, as well as address the unique challenges of pediatric forensic pathology.[27]

456. Respectfully, the OCCO makes the following recommendations as they relate specifically to the provision of pediatric forensic pathology:

(a) The OPFPU located at the Hospital for Sick Children should continue as a centre of excellence in the provision of pediatric forensic pathology;

(b) To assure high quality, post mortem examinations performed on children should be done only by pathologists with the requisite expertise and experience. To that end, only those working within the OPFPU, the Provincial FPU, the Hamilton

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27 See Introduction, Part I.

Regional FPU, the Southwestern Regional FPU ("London Regional Unit") and the Ottawa Regional Unit[28], and properly credentialed on the Registry should be allowed to perform pediatric post mortem examinations;

(c) In addition, pediatric cases arising in the Northwest region of the province should continue to be referred to the Office of the Chief Medical Examiner in Manitoba. This relationship should be formalized by a service agreement[29]. The pathologists performing cases under this agreement should be on the Ontario Registry and should submit cases to any review process instituted by the CFP and/or the OCCO;[30]

(d) The scope of practice for pathologists should recognize the need for separate credentialing of forensic pathologists and pediatric pathologists performing post mortem examinations on children;

(e) The OCCO endorses a team approach to the post mortem examination consisting of the co-operative case management of the post mortem examination including, as appropriate: a forensic pathologist, a pediatric pathologist, a pediatric radiologist, a neuropathologist, and clinical specialists as required, as well as pathology assistants skilled in pediatric cases;[31]

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28 At present, there are no criminally suspicious cases (adult of pediatric) performed at the Ottawa Regional Unit or at the Children's Hospital of Eastern Ontario. As this Commission has heard, there will be personnel changes at the Ottawa Regional Unit as of July 2008. At that time, the OCCO anticipates that the Ottawa Unit will commence performing pediatric and criminally suspicious cases again. (Dr. McCallum, January 25th, 2008, pages 213-214)

29 At present, Dr. Susan Philips of the Office of the Chief Medical Examiner in Manitoba performs pediatric cases under Ontario coroners' warrants.

30 See information provided during the policy roundtable on February 28th, 2008, pages 158-160. Currently, while the relationship between Dr. Phillips and the OCCO is an informal one, her reports are subject to review by the DU5 and the PDRC. Between 2000 and 2006, Dr. Phillips has performed approximately 30 post mortem examinations under coroner's warrant. Of those, approximately half are "undetermined"

31 The OCCO prefers this approach to pediatric cases, as opposed to the mandatory "dual doctor" approach proffered by some witnesses at this inquiry. (See Evidence of Dr. Milroy, November 19, 2007, pp. 89-90)

(f) The lead pathologist responsible for the post mortem examination and post mortem report would depend on the nature of the case. Forensic pathologists should perform post mortem examinations on criminally suspicious and/or homicidal deaths of infants and children. Natural deaths in infants and children may benefit from having the post mortem examination performed by pediatric pathologists. The CFP, in consultation with the Director of the OPFPU should develop policies for triaging pediatric post mortem examinations;

(g) In the interests of generating the necessary expertise, funding should be made available through the government to assist with creating opportunities for pediatric pathologists to obtain forensic training and/or forensic pathologists to obtain pediatric training;

(h) In order to adequately meet the needs of residents in Northern Ontario, the OFPS should foster a more formal relationship with the Office of the Chief Medical Examiner in Manitoba and consider strengthening support systems for the Northeastern Regional Forensic Pathology Unit to build expertise and capacity to perform pediatric cases; and

(i) A telemedicine portal should be created at the OPFPU to allow all forensic pathologists and coroners in the province to view appropriate cases for the forensic rounds held at the HSC every 4 – 6 weeks.

457. The Commission has heard evidence regarding the potential for reviewing a number of pediatric head injury/shaken baby syndrome cases that have been the subject of criminal justice proceedings over the last twenty years. Based on the controversies surrounding

shaken baby syndrome, Dr. Pollanen has identified 142 cases within the OCCO's database that could potentially be subject to further review.

458. The OCCO recognizes that there may be a public desire, in the aftermath of this Inquiry to review these cases.

459. Respectfully, the OCCO does not recommend that it be the lead agency for such an endeavour. Aside from the fact that it has neither the human nor financial resources, the OCCO submits that any such review should be undertaken by those more closely tied to the criminal justice system:

(a) The OCCO, and in particular, the OFPS can be available to act as a consultant to assist in identifying potential cases for review and potential experts;

(b) The OCCO is not in a position to determine what, if anything, should flow from a review of these cases;

(c) The OCCO has no role with respect to a review that considers cases where children have survived a supposed shaken baby event; and

(d) Given the current complement of forensic pathologists available in the province, the OCCO believes that if a review is undertaken, external experts are required.[32]

F. Accreditation of Coroners and Pathologists

460. The OCCO recognizes the need for credentialing and accreditation of all physicians involved in death investigation. This requires partnerships with the College of Physicians

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32 Evidence of Dr. Lauwers, January 8, 2008, p. 82, lines 17-25; Evidence of Dr. Pollanen, December 5, 2007, p. 232, lines 11-23

and Surgeons of Ontario, specialty bodies such as the Royal College of Physicians and Surgeons of Canada, and professional associations such as the OAP and the Ontario Coroners Association ("OCA").

Coroners

461. Coroners should be credentialed by the OCCO using a process developed in consultation with the OCA. At minimum, the requirements for credentialing should include:

(a) Satisfactory reports from RSCs of annual audits of Coroners' Investigation Statements (Form 3);

(b) Adherence to guidelines and policies provided by the CCO in the performance of death investigations;

(c) Satisfactory Annual Performance Evaluations completed by RSCs;

(d) Completion of a minimum number of educational credits to be established by the OCCO and the OCA and attendance at educational courses; and

(e) Timely receipt of death investigation reports.

462. Where concerns are identified regarding a coroner's investigation(s), the CCO may convene the Chief Coroner's Review Process to review the matter and provide recommendations.

Pathologists

463. Pathologists should be credentialed by the CFP using a process developed in consultation with the OAP. Credentialing should be based upon assessments of performance,

completeness and timeliness of reports, participation in continuing education, and disposition of any complaints or issues. Pathologists who are appropriately credentialed will be listed on the Registry, as such. While requirements for credentialing and inclusion on the Registry must be considered and discussed with the OAP, at a minimum, the OCCO submits that the requirements should include:

(a) Adherence to protocols and guidelines as initiated by the CFP for the provision of forensic pathology services in the death investigation;

(b) Post mortem reports in criminally suspicious cases will be subject to the peer review process;

(c) Pathologists' post mortem reports and court transcripts will be subject to a regular audit by the CFP, or his/her delegate;

(d) Completion of a minimum number of educational credits to be established by the OFPS and the OAP and attendance at educational courses; and

(e) Adherence to benchmarks established by the FPAC for the timely receipt of post-mortem examination reports.

464. The criteria for inclusion onto the Registry should be developed by the FPAC and administered by a board. The board should be made up of the CFP, representatives of the OCCO, pathologists, a member of the judiciary and a Chairperson of a Department of Pathology at an Ontario University.

465. The board will establish different criteria for pathologists performing post-mortem examinations under coroners' warrants for:

(a) Pediatric cases;

(b) Criminally suspicious cases; and

(c) Non-suspicious cases.

466. The Registry should be maintained by the CFP and administered by the board. The framework for administration of the board should include:

(a) A mechanism for appointment upon application to the Registry, based upon inclusion and exclusion criteria;

(b) A mechanism for renewal of inclusion on the Registry based upon audited performance and relevant CME activities;

(c) A mechanism for the removal of pathologists from the Registry; and

(d) An appeals process for those whose applications are denied or appointments are not renewed.

467. Efforts should be made to centralize post mortem examinations to pathologists who perform sufficient numbers of cases in the interests of ensuring quality. This will have the effect of reducing the numbers of pathologists performing post mortem examinations under a coroner's warrant, but increasing the individual numbers of examinations that pathologists will perform.

468. The list of those pathologists on the Registry and their specific credentials should be kept by the CFP and publicly available on the OCCO's website.

469. The OCCO should adhere to the applicable Ontario legislation and CPSO policy where a coroner or pathologist is not satisfactorily re-credentialed to perform death investigations or post mortem examinations.

G. Education for Death Investigation

470. The OCCO recognizes the primary importance of education in providing a framework for high quality death investigation.

471. The OFPS and the OCCO are committed to train forensic pathologists for certification by the Royal College of Physicians and Surgeons of Canada. The Provincial FPU will be the first accredited fellowship training program facility in Canada. The development of fellowship training programs at other Regional FPUs should be encouraged and properly resourced.

472. The government, through the Ministry of Health and Long-Term Care should fund these fellowship positions.

473. Pediatric forensic pathology training should be enhanced as should training in pediatric pathology. This training should become an integral part of the certification program of the Royal College of Physicians and Surgeons of Canada, and should occur at locales such as the HSC, where large numbers of pediatric post mortem examinations are performed each year.

474. The government of Ontario should support the proposal to establish a Centre for Forensic Medicine and Science at the University of Toronto. There are many potential positive outcomes from the creation of such a centre:

(a) The development of evidence-based educational programs in forensic pathology and forensic medicine that would include the inter-professional education for undergraduate students of law and medicine and continuing professional development educational activities for the medical and legal communities;

(b) Knowledge creation in forensic disciplines may prevent adverse outcomes in the criminal justice system;

(c) Fostering an evidence-based culture in forensic pathology will create opportunities to detect and recognize the significance of critical evidence;

(d) The establishment of a focal point and assembly of a critical mass to facilitate research into areas of controversy and debate in forensic medicine and science; and

(e) The provision of a body of scholars and experts that can advise policymakers on critical issues at the interface between medicine/science and that have public policy and social justice implications.[33]

475. The OCCO should seek to establish, through the Centre for Forensic Medicine and Science, post graduate training in Death Investigation for physicians.

476. The OCCO should enhance education on cultural diversity and First Nation issues for coroners and pathologists. This Commission has heard about the specific curriculum focus offered at the Northern Ontario School of Medicine. Health issues unique to Northern Ontario residents and Aboriginal peoples in particular, are interwoven in each year of the

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

medical school's curriculum. The OCCO believes that in partnership with the school, it can expose students to death investigation and the unique challenges of death investigation in the North and in First Nations communities.

- Evidence of Dr. Porter, February 28, 2008, p. 28, lines 16-25

477. The project to develop online education for coroners by the OCCO and OCA should be completed. Consideration should be given to creating a similar educational opportunity for online continuing medical education for pathologists.

478. A telemedicine portal in the OCCO/Provincial FPU for the purposes of providing education to both coroners and pathologists should be created. Given that this technology is now universal in most hospital systems, agreements should be developed to utilize these in hospitals where coroners and pathologists performing duties for the OCCO have privileges.

479. The OCCO should promote the use of its death investigation database ("Coroners Information System") for research into public safety, patient safety, forensic medicine and pathology.

480. The OCCO should promote the repository of data stored at the OPFPU for research and investigation into pediatric deaths.

481. The OCCO should be properly resourced to employ a Director of Education, who can document and tabulate all educational projects and undertakings in the OCCO for each calendar year and provide a summary in the OCCO's Annual Report.

H. Information/Communication/Technology Enhancements

482. The OCCO recognizes the need to utilize information management and effectively harness modern approaches to communication and information technology.

483. The evidence before this Commission has clearly revealed the need for a province-wide coroners' dispatch system, which would allow for the immediate entry and tracking of all coroners' death investigations. In addition, a central dispatch would provide for:

(a) The immediate entry and tracking of all pathologists' post mortem examinations performed under a coroner's warrant;

(b) Streamlining and directing of post mortem examinations to appropriate pathologists and facilities, by the CFP;

(c) RSCs' offices to monitor and track both coroners' death investigations and pathologists' post mortem reports for timeliness of submissions; and

(d) Easy access to a toll free number for the public trying to locate a coroner.

484. Anyone from any area of the province seeking a coroner can call the central dispatch number. The dispatcher would link the caller with the coroner-on-call for the specific geographical area. If the case is accepted for investigation, the coroner would notify the dispatcher. This information would then be entered in the Coroner's Investigation System ("CIS").

485. Upon completion of the post mortem examination, the pathologist will fax an information sheet to the dispatcher recording the cause of death, which organs, if any, have been retained and if toxicology has been ordered. The dispatcher would enter the information in the Coroner's Investigation System. (See paragraphs 502-503, Organ Retention)

486. The OCCO recognizes that in order to implement a central dispatch service, significant resources are required. At present, the OCCO does not have the funding to implement such a service. In order to minimize start-up costs and implementation time, consideration should be given to delivery of the dispatch service by an existing provider with the requisite skills, region-specific knowledge, and accountability, for example, Criticall. This contracted provider would have access to the Coroner's Investigation System for data entry.

487. The OCCO requires adequate funding to institute the following additional advancements:

(a) A telemedicine portal should be situated in the Provincial FPU and all the Regional FPUs for the purposes of exporting education to remote areas of the province and allowing "real-time" review and consultation with forensic pathologists during post mortem examinations;

(b) As set out above, a new physical plant is required to replace the current Provincial FPU and OCCO. The current facilities are no longer adequate for the size or demands of death investigation currently and in the future;[34]

(c) An appropriate investment in new technologies and equipment to ensure that Ontario's system is in stride with contemporary systems in other jurisdictions in the world (e.g. post mortem imaging with CT);

(d) The development of a comprehensive communication plan for communicating new expectations and processes to coroners and pathologists. This will consider

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34 Plans are currently in progress to establish a forensic services complex that will integrate the physical plant of the OCCO and the Centre of Forensic Sciences.

new technologies to improve communication and will become a strategic planning initiative;

(e) Upgrading of the computer system to allow work to proceed at a reasonable rate. In performing its core business, the OCCO relies upon software including proprietary (CIS, Form 3) and government-standard (such as Outlook and IFIS), running on an information technology infrastructure provided by government. The proprietary software addresses current investigative needs well, but will require ongoing maintenance and enhancement. The hardware and network infrastructure is inadequate and unreliable, and creates substantial inefficiencies and delays:

(i) Proprietary software: Funding and resources should be provided for ongoing development of CIS and Form 3. With the introduction of central dispatch, case management functions of the CIS should be substantially enhanced;

(ii) Infrastructure: Computers and related equipment, and particularly network speeds, should reflect contemporary business standards;

(f) The physical plant and technology for both the Regional Supervising Coroners' Offices and Regional FPUs[35] should be upgraded to contemporary standards, as required;

(g) An electronic case management system should be created for all files in the OCCO once central dispatch has been developed. This would include both coroners' and forensic pathologists' reports; and

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35 Cordner, S., A Model Forensic Pathology Service, January 14, 2008, pg. 83

(h) The OCCO should appoint an Information Technology Manager to develop electronic case submission capabilities for investigating coroners.

I. Regionalization and Best Practices

488. Death investigation and forensic pathology services in Ontario are based on regional models with central offices in Toronto. The OCCO recognizes the need to foster best practices in all regional centres that are geographically separated from the central offices.

- Evidence of Dr. Strasser, February 28, 2008, p. 87, lines 9-25; p. 88, lines 1-24

Regionalization

489. The OCCO recommends the amalgamation of Regional Supervising Coroners' Offices, with Forensic Pathology Units in the same physical plant, or at least, the same city (within Regional Administrative Boundary Alignment (RABA) boundaries).

490. Approximately 50% of post mortem examinations are done outside forensic pathology units. For post mortem examinations done in Regional FPUs, the OCCO recommends the adoption of a best practices model of death investigation whereby on a daily basis, pathologists, coroners and Regional Supervising Coroners conduct rounds on all bodies requiring a post mortem examination by reviewing the warrants and externally examining the bodies (modeled after the Provincial FPU). As a result:

(a) Unnecessary post mortem examinations could be substantially reduced or eliminated;

(b) Unnecessary toxicology could be cancelled;

(c) Important, missing information could be obtained before the post mortem examination begins;

(d) Police presence could be requested, where necessary and/or appropriate;

(e) Consultation with the Provincial FPU could be obtained; and

(f) Educational opportunities could be maximized.

491. Given the vast geographical expanse of Northern Ontario, consideration should be given to dividing it into two regions, one managed from Thunder Bay, and the other from Sudbury, each with its own Regional Supervising Coroner.

492. Appropriate funding is required, so that the current Northeastern Regional Forensic Pathology Unit can become a formal Regional FPU. In addition to funding for transfer payments, funding is required for the Director of the unit.

493. The OCCO also requires funding to assistant in enhancing the forensic services currently offered in Thunder Bay.

494. Funding for an aboriginal liaison coordinator is required at the Regional Office in Thunder Bay. This liaison officer will be available to coordinate with Aboriginal communities and Band Councils on individual death investigations and on larger policy issues arising in the North.

- Evidence of Dr. Porter, February 29, 2008, p. 184, lines 19-25; p. 185, lines 1-24

Best Practices

Communication with the Forensic Pathologist

495. For all homicides, criminally suspicious and pediatric deaths, the pathologist and coroner should record a summary of what communication occurred prior to the commencement of the post mortem examination and all such correspondence should be maintained in the coroners' and pathologists' case files.

496. For all homicides, criminally suspicious and pediatric deaths, the pathologist and coroner should record a summary of what communication occurred following completion of the post mortem examination and a summary of that communication should be maintained in the coroners' and pathologists' case files.

497. Following all post mortem examinations, the pathologist should provide the police service with a written statement regarding the cause of death. The pathologist should maintain a copy of this written statement in his/her file.

498. The written communications as described in the preceding paragraphs would be subject to disclosure rules in a criminal prosecution.

Role of Coroner in a Criminal Case

499. The primary role of a coroner in any case, whether criminally suspicious or not, is to fulfill the investigative requirements set out in the governing legislation.

500. The OCCO recognizes that in a criminal or criminally suspicious case, the police investigators and the forensic pathologist will have a more immediate role in the criminal

case. The forensic pathologist will almost always be the primary expert for the police from the OCCO.

501. However, the coroner continues to be involved in every case, to the extent it does not hamper police investigations, so he/she can fulfill his/her investigative responsibilities under the *Coroners Act*.

Organ Retention

502. The OCCO recognizes cultural and personal concern of the public regarding organ retention as a component of the post mortem examination. Until such time as the provincial dispatch system is functioning, the pathologist will fax to both the RSC and the CFP a summary sheet detailing the cause of death, which organs have been retained, if any, and the disposition of toxicology. This would allow for subsequent organ retention and disposition.

503. The OCCO should maintain its current policy of notifying the family when the pathologist requests the retention of organs for further testing. This includes a discussion about the disposition of organs following the completion of the testing.

- Memorandum, PFP057584, p 232

Scene Attendance

504. The OCCO in consultation with the CFP and the FPAC should develop guidelines regarding the attendance of forensic pathologists at death scenes.

- Memorandum re scene attendance, PFP032567

"Specialist" Coroners

505. Given the vast geographical expanse of Ontario, the relatively few pediatric deaths of children less than 5 years of age (250/year), and few homicides of these children (7-10/year), it is the submission of the OCCO that it would be impractical to create "specialist" coroners to investigate pediatric deaths. To ensure quality death investigations, the OCCO should provide educational programs around the issues arising from this Commission of Inquiry, including the pediatric forensic pathology issues, and annually update any controversies that arise in the state of knowledge from the literature. An on-line educational program is currently under development in the OCCO for coroners, and a pediatric program should be developed annually to ensure that all coroners in the province have access to this important information.

J. Death Investigation Team

Police

506. The OCCO should liaise with the Ontario Provincial Police and Aboriginal Peoples to create a model for dedicated police officers with specialized training in death investigation and aboriginal issues regarding death. These police officers should be appointed by the coroner pursuant to section 16(3)(4) of the *Coroners Act*

507. Guidelines should be developed for police officers when attendance by a coroner is not feasible.

508. Consideration should be given to developing policing expertise in pediatric death investigation. An agreement brokered through the Association of the Chiefs of Police could provide that larger police services which have greater human and fiscal resources

could therefore provide training and give assistance to smaller services for these complex cases.

509. The OCCO should facilitate the development of a single memorandum of understanding in the province between all policing services and all Children's Aid Societies for joint investigations of pediatric deaths. This single memorandum would provide a consistent approach to these complex deaths.

510. Greater utilization of available technologies should be explored to provide "real time" virtual attendance at death scenes for coroners and/or pathologists when appropriate.

Centre of Forensic Sciences (Toxicology Section)

511. Toxicology results are required for approximately half of all post mortem cases in Ontario annually, and these cases often involve the criminal justice system. Even more frequently, toxicology is required in the investigation of accidental deaths which impacts on important civil matters such as determination of insurance benefit eligibility.

512. The OCCO should continue to collaborate with the Centre of Forensic Sciences to create guidelines for requesting toxicology and appropriate benchmarks for the completion of analytical testing for toxicology. This should assist in ensuring the timely completion of post mortem reports and coroners' death investigations. Appropriate benchmarks should be based on Society of Forensic Toxicologists or other peer organization benchmarks and should allow for timely completion of death investigations.

- Evidence of Dr. McCallum, January 25, 2008, p. 163, lines 20-25; p. 164, lines 1-19; p. 185, lines 16-25; pp. 186-187
- Evidence of Dr. Lauwers, January 7, 2008, p. 137, lines 19-25, pp. 138-142

Children's Aid Societies

513. The OCCO must comply with the reporting requirements of the *Child and Family Services Act*.

514. The OCCO should commit to early case conferencing in the interests of ensuring that Children Aid Societies are in receipt of the best information available to allow them to fulfill their mandate.

515. Where child protection concerns have arisen with respect to siblings of the decedent and where the CAS has not been involved with a family or child prior to a death, they should be invited to take part in the case conference. Where CAS has been involved, they should be excluded from the case conference as their involvement may be subject to review. The conclusions of the case conference, however, should be shared with the appropriate CAS.

516. The OCCO should convene a meeting with the Ontario Association of Children's Aid Societies to develop a policy around timely release of the cause of death information, following the post mortem examination.

K. Accountability and Oversight[36]

517. The OCCO recognizes that accountability and oversight of death investigation is a key component of its responsibility in discharging death investigation duties[37]. The OCCO acknowledges that public accountability includes transparency and responsiveness to its clients and stakeholders. The OCCO also recognizes that forensic pathology has a unique accountability to the criminal justice system.

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36 In order for this section to be fully understood, it must be read in conjunction with **Appendix F**

37 ***Accountability*** is defined as the obligation to demonstrate and take responsibility for performance in light of commitments and expected outcomes. ***Oversight*** is management by overseeing the performance or operation of a person or group.

518. The following recommendations are made to enhance accountability, oversight and transparency in the OCCO in an effort to help restore the public confidence in the Office:

(a) The creation of a **Death Investigation Advisory Council** to provide oversight for death investigation in Ontario;[38]

(i) The Council should have oversight responsibility for the CCO[39], the CFP and the **Accountability/Complaints Committee**;

(ii) The Council should be ***independent*** of government;

(iii) The Council should provide governance and stewardship to the system of death investigation in Ontario;

(iv) The principal functions of the Council should be to provide the CCO and the CFP with direction regarding strategic planning, setting strategic priorities within each fiscal year, reviewing operational plans for each fiscal year, quality in death investigation, reviews of performance expectations within the OCCO and ethical issues;

(v) Membership on the Council should be governed by Regulation and should include:

(A) A judge of the Ontario Superior Court of Justice, appointed by the Lieutenant Governor-in-Council

(B) The CCO as an ex-officio member;

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38 Sossin, L., *Accountability and Oversight for Death Investigations in Ontario*. January 20, 2008.

39 See **Appendix G**

(C) The Chief Forensic Pathologist as an ex-officio member;

(D) The Director of Quality at the OCCO as an ex-officio member;

(E) The president and CEO of a health care corporation;

(F) A Dean of Medicine of an Ontario medical school or delegate;

(G) A nominee of the Minister of Health and Long Term Care;

(H) A nominee of the Attorney General;

(I) The Director of the Centre of Forensic Sciences or delegate;

(J) The President of the Ontario Association of Pathologists;

(K) The President of the Ontario Coroners Association;

(L) Four (4) members of the public[40] nominated by the Chair, and appointed by the Lieutenant Governor-in-Council;

(vi) The Director of Quality of the OCCO should report directly to the Council;

(vii) The CCO and the CFP should provide reports to the Council at its discretion;

(b) A subcommittee of this Council should be the Accountability/Complaints Committee, which should have the ability to hear complaints regarding all participants in the death investigation team, including coroners, pathologists and

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40 Experienced in private industry qualified to provide oversight and governance expertise

forensic consultants. This Committee would ensure that those involved in death investigation meet legislated requirements and regulations. This would be an effective complaints mechanism for the entire death investigation system;[41]

(i) The Committee should be chaired by a senior jurist appointed by the **Death Investigation Advisory Council**;

(ii) The Committee should be comprised of equal numbers of experts in death investigation, members of the lay public and members with legal expertise, not involved with special interest group advocacy

(iii) Committee members should be appointed by the **Death Investigation Advisory Council**;

(iv) The OCCO recommends that the terms of reference of this Committee include the responsibility to:

(A) Provide a window for public accountability;

(B) Serve as a point of contact for members of the public, who might find interaction with the various service providers in death investigation (coroners, pathologists, police, forensic consultants) confusing;

(C) Allow for gate keeping and coordination of complaints from the perspective of the public interest, without duplicating functions performed by regulators (i.e. CPSO);

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41 Sossin, L., *Accountability and Oversight for Death Investigations in Ontario*. January 20, 2008.

(D) Develop and harness multidisciplinary expertise to adjudicate complaints in a complex system;

(E) The OCCO should participate in the development of the final terms of reference;

(v) The Committee should be independent of the OCCO. This removes the possibility that the OCCO, the CCO or the CFP might be investigating complaints about themselves;

(vi) The Committee should triage complaints and direct these to concerned bodies where appropriate. It would be available to hear complaints where the identified bodies have exhausted normal mechanisms for complaint resolution, or where the independent review of a death investigation would be in the public interest;

(vii) The Committee should determine whether regulations and standards have been adhered to and issue reports for remediation to enhance the quality and integration of the members of the death investigation team. Where appropriate, and where issues of professional conduct are in question and found to be supported by the Committee's review, these concerns may be forwarded to the appropriate professional regulatory bodies;

(viii) The Committee should have visibility through the OCCO's newly created website, or could accept referrals from the OCCO's **Family Services Committee**, or other senior managers at the OCCO. Concerned citizens

could send their complaints to the **Death Investigation Advisory Council**, or to the **Accountability/Complaints Committee** directly;

(ix) The Committee should provide an annual report to the **Death Investigation Advisory Council**;

(c) Currently, the CCO receives oversight from, and is accountable to, the Deputy Minister of Emergency Planning and Management of the Ministry of Community Safety and Correctional Services. Following the creation of the Death Investigation Advisory Council, the CCO should receive oversight from, and be accountable to the Council for death investigation. The OCCO should be operationally independent of government for death investigation;

(d) The OCCO should provide an annual report to the Council;

(e) The OCCO should remain in the Ontario Public Service, and as such, the Ministry of Community Safety and Correctional Service should continue to fulfill certain administrative functions in relation to the OCCO, including the following:

(i) Developing financial and resource plans for each fiscal year;

(ii) The Minister should continue to be able to direct that an inquest be held in accordance with section 22 of the *Coroners Act*;

(iii) The sharing and implementation of policy for employees of the Ontario Public Service;

(iv) The Minister should continue to be informed of any high profile deaths, which might evolve to become sensitive for government;

(f) Currently, the CFP receives oversight from, and is accountable to the CCO. Following the creation of the Death Investigation Advisory Council, the CFP should receive oversight from and be accountable to the Council. The CFP should remain accountable to the CCO for the provision of forensic pathology services;

(g) The CFP should be responsible for the operation of the OFPS, including its budget and resource plans. These should be developed annually and jointly presented by the CFP and the CCO to the Death Investigation Advisory Council for consultation and endorsement. The CCO should then present the endorsed business plan to the administrative arm of the Ministry of Community Safety and Correctional Service for its review and final approval;

(h) Further mechanisms of peer review and guidelines for memorializing case conferences and communications between various members of the death investigation team should be developed, such as is currently planned for post mortem reports. This will require recruitment of adequate numbers of fulltime coroners and forensic pathologists;[42]

(i) The OCCO should develop a process of routine review of judicial commentary about the work of coroners and forensic pathologists in the context of criminal justice proceedings;[43]

(j) The OCCO should create a **Family Liaison Service**[44] to provide accessibility to the public for information and guidance when navigating through the complexities

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42 Ibid.

43 Ibid. p. 60

44 Ibid. p. 64

of the death of a family member. This would be most applicable in pediatric death investigations;

(k) The **Family Liaison Service** should produce an annual report regarding contacts, outreach activity and other matters in which it is involved. This report should become a component of the Annual Report of the OCCO;

(l) Terms of reference of the **Family Liaison Service** should be posted on the newly created OCCO website. In addition, a full description of the services that families can expect should be provided, including where complaints should be directed, where applicable;

(m) The OCCO should create its own website[45], which should have appropriate public postings of death investigation guidelines to inform the public. In the same website, an educational password protected area could be created to assist with the educational need of coroners and pathologists. This item should be appropriately resourced, including the hiring of information technology experts; and

(n) Following the development of its strategic plan, the OCCO should set clear objectives for each year and create benchmarks for the evaluation of its performance[46]. A summary of the strategic plan should be placed on the website.

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45 Ibid. p. 65.

46 Ibid. p. 66.

Amendments to the Coroners Act

519. The OCCO recognizes that in order to promote oversight and accountability, and to enhance forensic pathology services in the province, the *Coroners Act* requires amendments. These amendments must recognize the role of the pathologist as part of the death investigation team, and the importance of the Chief Forensic Pathologist in the leadership of the OFPS.

520. Below, the OCCO has prepared tables setting out the current language in the *Coroners Act* alongside the proposed changes:

SECTION 1 – DEFINITIONS

Current Act	Proposed Changes
In this Act, Chief Coroner means the Chief Coroner for Ontario; (coroner en chef) mine means a mine as defined in the *Occupational Health and Safety Act*; (mine) mining plant means a mining plant as defined in the *Occupational Health and Safety Act*; (Installation minière)	Add the following: • "Chief Forensic Pathologist" means the Chief Forensic Pathologist for Ontario. • "Pathologist" means a legally qualified medical practitioner certified by the Royal College of Physicians and Surgeons of Canada or equivalent as a specialist in anatomical or general pathology. • "Ontario Forensic Pathology Service" means the branch of the Office of the Chief Coroner of Ontario, directed by the Chief Forensic Pathologist that provides all forensic pathology services in Ontario, pursuant to completing post mortem examinations under a coroner's warrant. • "Death Investigation Advisory Council" is the governing body, which has oversight for Ontario's death investigation system.
Minister means the Solicitor General; (ministre)	
Same-sex partner means a person of the same sex with whom the deceased was living in a conjugal relationship outside marriage immediately before his or her death, if the deceased and the other person, (a) had cohabited for at least one year, (b) were together the parents of a child, or (c) had together entered into a cohabitation agreement under section 53 of the *Family Law Act*; (partenaire de même sexe)	
Spouse means a person of the opposite sex, (a) to whom the deceased was married immediately before his or her death, (b) with whom the deceased was living in a conjugal relationship outside marriage immediately before his or her death, if the deceased and the other person, (a) had cohabited for at least one year, (b) were together the parents of a child, or (c) had together entered into a cohabitation agreement under section 53 of the *Family Law Act*. (conjoint) R.S.O. 1990, c. C.37, s. 1; 1999, c. 6, s. 15 (1).	

SECTION – DEATH INVESTIGATION ADVISORY COUNCIL

Current Act	Proposed Changes
	(1) The Lieutenant Governor in Council may establish a governing body to have oversight for the death investigation system in Ontario known as the Death Investigation Advisory Council. (2) The Chair of the Death Investigation Advisory Council shall be a judge of the Ontario Superior Court of Justice appointed by the Lieutenant Governor in Council. (3) Membership of the Council shall be determined by Regulation.
	{The Regulation shall list the membership as follows: • Judge of the Superior Court of Justice, to act as Chair of the Council; • *The Chief Coroner and the Chief Forensic Pathologist will be ex officio members of the Council;* • *The Director of Quality of the OCCO will be an ex officio member of the Council;* • *The president and CEO of a health care corporation;* • *The Dean of Medicine of an Ontario medical school or his/her delegate;* • *A* nominee *of the Minister of Health and Long Term Care,* • *A* nominee *of the Attorney General of Ontario;* • *The* Director *of the Centre of Forensic Sciences or his/her delegate,* • *The President of the Ontario Association of Pathologists;*

Current Act	Proposed Changes
	• The *President of the Ontario Coroners Association;* • *Four (4) members of the public as nominated by the Chair and appointed by the Lieutenant Governor-in-Council}*

SECTION – CHIEF FORENSIC PATHOLOGIST AND DUTIES

Current Act	Proposed Changes
	The Lieutenant Governor in Council may appoint a pathologist to be the Chief Forensic Pathologist for Ontario who shall, (a) Direct the Ontario Forensic Pathology Service (b) Supervise and direct all pathologists performing post mortem examinations under a coroner's warrant (c) Conduct programs for the instruction of pathologists in their duties (d) Prepare, publish and distribute a code of ethics for the guidance of pathologists (e) Maintain a registry of all pathologists who perform post mortem examinations under coroner's warrant.

SECTION – DEPUTY CHIEF FORENSIC PATHOLOGISTS

Current Act	Proposed Changes
	The Lieutenant Governor in Council may appoint one or more pathologists to be the Deputy Chief Forensic Pathologists for Ontario, who may act as and have all the powers and authority of the Chief Forensic Pathologist during the absence of the Chief Forensic Pathologist or his or her inability to act.

SECTION 10 – DUTY TO GIVE INFORMATION

Current Act	Proposed Changes
Persons in custody (4) Where a person dies while detained by or in the actual custody of a peace officer or while an inmate on the premises of a correctional institution, lock-up, or place or facility designated as a place of secure custody under section 24.1 of the *Young Offenders Act*(Canada), the peace officer or officer in charge of the institution, lock-up or place or facility, as the case may be, shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (4).	**Persons in custody** (4) Where a person dies while detained by or in the actual custody of a peace officer or while an inmate on the premises of a correctional institution, lock-up or place or facility designated as a place of secure custody under section 24.1 of the *Young Offenders Act* (Canada), the peace officer or officer in charge of the institution, lock-up or place or facility, as the case may be, shall immediately give notice of the death to a coroner. *The coroner shall issue a warrant to hold an inquest upon the body, where the manner of death is not natural. Where the death is natural, the coroner shall investigate the circumstances of the death and, if as a result of the investigation the coroner is of the opinion that an inquest ought to be held, the coroner shall issue his or her warrant and hold an inquest upon the body.*
Notice of death resulting from accident at or in construction project, mining plant or mine. (5) Where a worker dies as a result of an accident occurring in the course of the workers employment at or in a construction project, mining plant or mine, including a pit or quarry, the person in charge of such project, mining plant or mine shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (5).	**Notice of death resulting from accident at or in construction project, mining plant or mine** (5) Where a worker dies as a result of an accident occurring in the course of the worker's employment, the employer shall immediately give notice of the death to a coroner and the coroner shall investigate the circumstances of the death *and, if as a result of the investigation the coroner is of the opinion that an inquest ought to be held, the coroner shall issue his or her warrant and hold an inquest upon the body.*

SECTION 18 – RELEASE OF INFORMATION

Current Act	Proposed Changes
Inquest unnecessary (1) Where the coroner determines that an inquest is unnecessary, the coroner shall forthwith transmit to the Chief Coroner, and a copy to the Crown Attorney, a signed statement setting forth briefly the result of the investigation, and shall also forthwith transmit to the division registrar a notice of the death in the form prescribed by the *Vital Statistics*.	(3) The Chief Coroner or delegate may release relevant findings of the coroner's investigation if the Chief Coroner believes on reasonable grounds that it is necessary to advance public safety.
Record of investigations (2) Every coroner shall keep a record of the cases reported in which an inquest has been determined to be unnecessary, showing for each case the identity of the deceased and the coroner s findings of the facts as to how, when, where and by what means the deceased came by his or her death, including the relevant findings of the *post mortem* examination and of any other examinations or analyses of the body carried out, and such information shall be available to the spouse, same-sex partner, parents, children, brothers and sisters of the deceased and to his or her personal representative, upon request. R.S.O. 1990, c. C.37, s. 18 (2); 1999, c. 6, s. 15 (2).	

SECTION 28 – POST MORTEM EXAMINATION AND ANALYSIS

Current Act	Proposed Changes
(1) A coroner may at any time during an investigation or inquest issue a warrant for a *post mortem* examination of the body, an analysis of the blood, urine or contents of the stomach and intestines, or such other examination or analysis as the circumstances warrant. R.S.O. 1990, c. C.37, s. 28 (1).	(1) A coroner may at any time during an investigation or inquest issue a warrant for a post mortem examination of the body. A coroner and/or pathologist may request analysis of the blood, urine or contents of the stomach and intestines, or such other examination or analysis as the circumstances warrant.
Report (2) The person who performs the *post mortem* examination shall forthwith report his or her findings in writing only to the coroner who issued the warrant, the Crown Attorney, the regional coroner and the Chief Coroner and the person who performs any other examination or analysis shall forthwith report his or her findings in writing only to the coroner who issued the warrant, the person who performed the *post mortem* examination, the Crown Attorney, the regional coroner and the Chief Coroner. R.S.O. 1990, c. C.37, s. 28 (2).	**Report** (2) The pathologist who performs the *post mortem* examination shall forthwith report his or her findings in writing only to the coroner who issued the warrant, the regional coroner, the Chief Coroner and the Chief Forensic Pathologist or his or her delegate. (3) The person who performs any other examination or analysis shall forthwith report his or findings in writing only to the pathologist, the coroner who issued the warrant, the regional coroner the Chief Coroner, and the Chief Forensic Pathologist or his or her delegate. (4) The regional coroner, the Chief Coroner or designate shall forward to the Crown Attorney for all non-natural deaths the results of the post mortem examination and the report of any other examination or analysis.

APPENDICES

A. Report of the: Joint Coroner and Pathologist Working Group on the Provision of Forensic Pathology Services in Ontario, January 2008

B. Position Paper, August 29, 2007

C. Autopsy Report Peer Review Form

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G. Oversight and Accountability Chart

APPENDIX A

FORENSIC PATHOLOGY SERVICES IN ONTARIO

Report of the:

Joint Coroner and Pathologist Working Group
on the Provision of Forensic Pathology Services in Ontario

Office of the Chief Coroner for Ontario

January 2008

Members of the Working Group:

Dr. David Chiasson	Director of the Ontario Pediatric Forensic Pathology Unit Hospital for Sick Children
Dr. John Fernandes	Forensic Pathologist Hamilton Regional Forensic Pathology Unit
Dr. David King	Forensic Pathologist Hamilton Regional Forensic Pathology Unit
Dr. Bert Lauwers	Regional Supervising Coroner Toronto West
Dr. William (Bill) Lucas	Regional Supervising Coroner Central
Dr. Andrew McCallum	Regional Supervising Coroner East
Dr. Jacqueline Parai	Forensic Pathologist Provincial (Central) Forensic Pathology Unit
Dr. Michael Pollanen (Co-Chair)	Chief Forensic Pathologist for Ontario
Dr. Bonita Porter (Co-Chair)	Chief Coroner for Ontario
Dr. Mike Shkrum	Director of the Southwestern Regional Forensic Pathology Unit
Ms. Dorothy Zwolakowski	Executive Officer to the Chief Coroner

Ex-officio Members of the Forensic Pathology Working Group:

Dr. Dimitrios Divaris	Past President Ontario Association of Pathologists
Dr. Dirk Huyer	Ontario Coroners Association

CONTENTS

DEFINITION

The forensic pathology service in Ontario is/ought to be:

- A collaboration of pathologists in Forensic Pathology Units and community hospitals in Ontario who provide medicolegal autopsy services under a coroner's warrant for postmortem examination.
- Administered by the Chief Forensic Pathologist and the Provincial (Central) Forensic Pathology Unit in the Office of the Chief Coroner through the provision of service agreements with Forensic Pathology Units based in University teaching hospitals.
- Mandated to provide independent and unbiased expert opinions
- Part of the death investigation system, but professionally independent.

MISSION

- Our mission is to deliver the highest quality forensic pathology service to the death investigation and the criminal justice system of Ontario.

VALUES

- We are dedicated to **teamwork**.
- We are committed to **quality**.
- We have a progressive **vision for the future**: We are open to change and consideration of new ideas that may challenge current thinking.
- We are dedicated to **ethics**: We have a commitment to uphold the ethical practice of medicine and to provide balanced and reasonable expert opinions and testimony.

GOALS

1. To provide, promote and assist in the provision of forensic pathology services in Ontario.

   1.1. Provide: By performing autopsies in the Provincial Forensic Pathology Unit and overseeing forensic pathology services in the Forensic Pathology Units.

   1.2. Promote: By developing policies and guidelines to facilitate the provision of autopsy services in the Forensic Pathology Units and community hospitals.

   1.3. Assist: By providing an expert consultation service for forensic pathology and administering a review system for autopsy reports.

2. To provide, promote and assist in the provision of education and professional development in forensic pathology.

   2.1. Provide: By offering postgraduate training in forensic pathology through affiliation with the Department of Laboratory Medicine and Pathobiology at the University of Toronto, as well as in other universities/academic health science centres.

   2.2. Promote: By participating in local, regional, national and international activities for the development and application of forensic pathology.

   2.3. Assist: By participating in integrated training of pathologists and coroners and educational programmes for other members of the death investigation team and participants in the criminal justice system.

3. To promote the development of knowledge in forensic pathology and related fields through:

   3.1. Affiliation of the Provincial Forensic Pathology Unit with the University of Toronto.

   3.2. Encouraging scholarly activities and research in forensic pathology in Regional Forensic Pathology Units.

THE FUTURE: DIRECTION, RESOURCES, AND EDUCATION[1]

DIRECTION

Improve the direction and oversight of forensic pathology services: The Chief Forensic Pathologist should be defined in the *Coroners Act* and would be responsible and accountable for the provision of forensic pathology services for the death investigation and criminal justice systems.

Improve policies and guidelines for pathologists: Improve forensic pathology quality by guidelines and quality-based review processes.

Strengthen autopsy services: Improve forensic pathology quality by clarifying the roles of the Forensic Pathology Units and community hospitals and standardizing operating procedures.

RESOURCES

Acquire and effectively manage resources for the forensic pathology service: Enhance the quality of forensic pathology service by providing resources that match expectations and promote the use of Tele-Pathology.

EDUCATION

Strengthen education in forensic pathology: Foster the development of an evidence-based culture in forensic pathology in Ontario and Canada.

Strengthen the relationship of the Provincial Forensic Pathology Unit with the University of Toronto, and its satellite units with their affiliated universities: Establish the Forensic Pathology Units as the premier Canadian centres for postgraduate training in forensic pathology.

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[1] A preliminary version of these future directions was ratified by the senior management of the Office of the Chief Coroner and presented to the Forensic Services Advisory Committee. The preliminary version was provided to the *Commission of Inquiry into Pediatric Forensic Pathology in Ontario.*

DIRECTION

IMPROVE THE DIRECTION AND OVERSIGHT OF FORENSIC PATHOLOGY SERVICES: The Chief Forensic Pathologist should be defined in the Coroners Act *and should be responsible and accountable for the provision of forensic pathology services for the death investigation and criminal justice systems.*

IMPROVE POLICIES AND GUIDELINES FOR PATHOLOGISTS: Improve forensic pathology quality by guidelines and quality-based review processes.

STRENGTHEN AUTOPSY SERVICES: Improve forensic pathology quality by clarifying the roles of the Forensic Pathology Units and community hospitals and standardizing operating procedures.

1. The Chief Forensic Pathologist should be defined in the *Coroners Act*

On an operational level, our system of death investigation is comprised of two coordinated professional activities: death investigations performed by coroners (20,000/year) and autopsies performed by pathologists (7,000/year, including ~400 cases investigated as criminally suspicious cases or homicides). The autopsies are performed for the death investigations under the direction of a coroner's warrant for postmortem examination. However, the *Coroners Act* does not define a role for pathologists.

Forensic pathologists are best qualified to direct forensic pathology services in Ontario.

The plan for the future should be:

- The Ontario *Coroners Act* should be amended:
  - i. To include the Chief Forensic Pathologist, and Deputy Chief Forensic Pathologists[2]
  - ii. The Chief Forensic Pathologist should be appointed by Order in Council, accountable to the Chief Coroner, to direct forensic pathology services.

2. Development of an Ontario Forensic Pathology Service

a. Development of a Forensic Pathology Advisory Committee

To encourage participation in decision-making and a collaborative approach to forensic pathology in the forensic pathology service, a Forensic Pathology Advisory Committee should be developed. The Committee should include Directors of the Forensic Pathology Units and relevant stakeholders.

b. Continued improvement of quality processes

[2] The precise wording can be established later but could be similar to that of Chief Coroner and Deputy Chief Coroners as recognized in the Act). In particular to include sections such as:
sec 4(1)c: conduct programs for the instruction of 'pathologists' in their duties
sec 4(2): The Lieutenant Governor in Council may appoint one or more 'pathologists' to be Deputy Chief 'Forensic Pathologists' for Ontario who may act as and have all the powers and authority of the Chief 'Forensic Pathologist' during the absence of the Chief 'Forensic Pathologist' or his or her inability to act.

c. **Continued enhancement of the relationship with the Regional Forensic Pathology Units**
Details to be developed.

d. **Improvement of autopsy services in communities**
We need to re-assess and improve the provision of autopsies services considering our overall objectives, the best use of resources, and geography.

e. **Registry Development**
The Chief Forensic Pathologist will develop and maintain a registry of pathologists credentialed to do coroners autopsies.

RESOURCES

ACQUIRE AND EFFECTIVELY MANAGE NEW RESOURCES FOR FORENSIC PATHOLOGY SERVICES: Enhance the quality of forensic pathology service by providing resources that match expectation and promote the use of Tele-Pathology.

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3. Create a funding model and budget

- Recognition that there is a direct relationship between the quality of the medicolegal autopsy service and the resources provided to forensic pathology
- The budget for forensic pathology services should be separate from resources provided for other coroner services.

4. Ensure salary parity for forensic pathologists

- The MCSCS should join the LMFFA. This will ensure salary parity for all forensic pathologists in the province.
- A blended model of remuneration for forensic pathologists in the Provincial (Central) FPU which would include the LMFFA-based salary and fee-for-service income from coroner autopsies performed on weekends and statutory holidays.

5. Recruitment and development of a career structure for pathologists

- The Ontario Forensic Pathology Service should have a hierarchical structure that mirrors the regionalized coroner's services and allows pathologists to develop a long-term career path. The hierarchical structure would allow the Chief Forensic Pathologist to concentrate on policy, quality, and educational mandates while the Deputy Chief Forensic Pathologists provide professional direction and consultation to the FPUs.
- Such a hierarchical structure would facilitate recruitment and retention of forensic pathologists who want to develop a career in forensic pathology.

6. Modernization of facilities

Autopsy facilities that support the death investigation system should undergo modernization.

1. Physical plant modernization
2. Secure facilities to ensure continuity of evidence and biohazard containment
3. Safe work environment for staff

EDUCATION

STRENGTHEN EDUCATION IN FORENSIC PATHOLOGY: Foster the development of an evidence-based culture in forensic pathology in Ontario and Canada.

STRENGTHEN THE RELATIONSHIP OF THE PROVINCIAL FORENSIC PATHOLOGY UNIT WITH THE UNIVERSITY OF TORONTO AND ITS SATELLITE UNITS WITH THEIR AFFILIATED UNIVERSITIES: Establish the Forensic Pathology Units as the premier Canadian centres for postgraduate training in forensic pathology.

---

7. **Improvement of professional development programmes**
   Promote evidence-based forensic pathology as the preferred basis for the provision of expert opinions.

8. **Training pathologists for the specialist qualification in forensic pathology**
   The Royal College of Physicians and Surgeons of Canada has recently created a specialist qualification in forensic pathology. The Central and Regional Forensic Pathology Units should develop university partnered fellowship training programmes. We must secure perpetual funding for forensic pathology fellowship positions.

APPENDIX B

Position Paper

August 29, 2007

The Office of the Chief Coroner will be proposing recommendations to the Goudge Inquiry based on two principles.

1. The fundamental goal is to continue to improve the quality of death investigation in the Province of Ontario to further public safety and the administration of justice, and to maintain public confidence in the Office of the Chief Coroner.

2. This goal can be accomplished by building on the current organizational structure of the Office of the Chief Coroner.

Discussion:

The forensic pathology services in the Province of Ontario were integrated into the Office of the Chief Coroner in 1994 as one of a number of initiatives to improve the investigations of complex cases.

Endorsements:

1. The late Mr. Justice Archie Campbell in Chapter 4 of his report: *The Secret Killing of Tammy Homolka:* endorsed this integration.

   "All of these initiatives are relevant in the sense that they strengthen the particular areas- training, interdisciplinary teamwork and the cause of death determination that came into play in the investigation of Tammy Homolka's death"
   Page 101- chapter 4- The Secret Killing of Tammy Homolka.

   "Continuation and support is required for the work of the Chief Coroner's office in developing, for unexplained and suspicious deaths, an inter-disciplinary approach to integrate the work of the police, coroners, forensic scientists and forensic pathologists. "
   The Bernardo Investigation Review - The Report of Mr. Justice Archie Campbell, June 1996. Recommendation #7.

2. In 1998, the Honourable Fred Kaufman released his findings on the inquiry he conducted into the wrongful conviction of Guy Paul Morin. In his report he discusses the Campbell model of case management. He states:

   "I respectfully endorse the Campbell model and urge the continued movement to its earliest implementation in this province"
   The Commission on Proceedings Involving Guy Paul Morin Report Volume 2, Page1121.

3. Recognition and understanding of the unique contributions of each of the members of the team in a particular case is a critical part of achieving a high quality death investigation and ensuring the best result for the stakeholders of this public service. For example, in the case of a homicide where there is a proceeding in the criminal courts, the forensic pathologist has the central role in the performance of autopsy and the provision of expert testimony. The coroner is rarely called to give evidence in these cases. In the case of a natural death at home, the coroner with his/her medical expertise may complete the purpose of the death investigation without requiring a post mortem.

Concluding Principle:

The current Directorate believes that the overall quality of death investigation can be further improved within the existing model and structure of the Office of the Chief Coroner. This can be accomplished by adding resources to the coroner and forensic pathology services, by strengthening educational programs for those who deliver these services in Ontario and clarifying oversight responsibilities.

Directorate:

Dr. Barry McLellan	- Chief Coroner
Dr. Bonita Porter	- Deputy Chief Coroner, Inquests
Dr. James Cairns	- Deputy Chief Coroner, Investigations
Dr. Michael Pollanen	- Chief Forensic Pathologist

APPENDIX C

Ontario Forensic Pathology Service

AUTOPSY REPORT PEER REVIEW FORM

NAME: A #: OCC#:

PATHOLOGIST: REGIONAL CORONER:

ITEMS REVIEWED

	Yes	No	N/A
Autopsy report	✓		
Photographs			
Microscopic slides			
Toxicology report			
Other: specify			

AUTOPSY REPORT FORMAT

	Yes	No	N/A
Injuries described			
Disease described			
Diagnosis list or narrative summary present			

PHOTOGRAPHS

	Yes	No	N/A
Does the description of the injuries reasonably match the photographs?			

ANCILLARY TESTING

	Yes	No	N/A
Histology			
Toxicology			
Radiology			

RELATED DOCUMENTATION

	Yes	No	N/A
Documentation of retained tissue			
Documentation of ancillary reports			
Documentation of samples (e.g., hair, swabs)			

REVIEW OF EXPERT OPINIONS

	Yes	No
Is the cause of death independently reviewable?		
Do you agree with the cause of death?		
Do you agree with the other medicolegal opinions?		

The pathologist who performed the autopsy is responsible for providing testimony on the autopsy report.

Dated on

Michael S. Pollanen, M.D., Ph.D., FRCPath, DMJ (Path), FRCPC
Chief Forensic Pathologist

Jacqueline L. Parai, MD, MSc., FRCPC
Forensic Pathologist

Toby H. Rose, M.D., FRCPC
Forensic Pathologist

APPENDIX D

National Quality Institute / Institut national de la qualité

CANADIAN QUALITY CRITERIA FOR THE PUBLIC SECTOR – OVERVIEW DOCUMENT

Full Criteria including all criteria points and 'Tips for deployment'
are available as part of the Canada Awards for Excellence Application Package available at:
www.nqi.ca/nqistore/product_details.aspx?ID=117

ABOUT THE CRITERIA

The National Quality Institute (NQI) developed the Canadian Quality Criteria for the Public Sector with assistance from professionals from across the public service. The Criteria serves as a framework for effective public service organizations and agencies at all levels, including government departments, schools and school boards, hospitals, police forces, etc. Copyrighted to the Institute, the Canadian Quality Criteria is recognized around the world and used by organizations in all sectors across Canada. As part of our extensive research for the development of the Criteria, we investigated the workings of successful organizations across all sectors.

The Canadian Quality Criteria for the Public Sector is a comprehensive and practical framework for improvement and achieving effective citizen/client-focused service or product delivery. It is founded on the Quality Principles. It also serves as the basis for adjudication of the public sector Quality Awards, under the banner of the *Canada Awards for Excellence* program; the *Canada Awards for Excellence* are Canada's own awards for recognizing outstanding achievement. More and more government, education, health care and other public sector organizations are putting the Criteria into action and discovering the power of continuous improvement.

Organizations everywhere are becoming increasingly aware of the high cost of poor quality. The key to achieving desired results is to use the total "Framework" of Criteria as a roadmap for Quality Improvements, with Section Seven - Organizational Performance in the Criteria identifying outcomes from the efforts made to improve and sustain improvements in citizen/client-focused service delivery. (For ease of use, the generic term "organization" has been used throughout the Criteria; if the term is not commonly used within your structure, simply think of it in the normal way you describe your organization, for example: department or agency.)

We promote awareness and education on the Canadian Quality Criteria for the Public Sector through the provision of products and services. Based on the *Canadian Criteria* we deliver a highly popular seminar (http://www.nqi.ca/Courses/public.aspx) on the intent of the *Canadian Criteria* as well as other workshops to help organization move forward on Excellence.

For more information about the Institute, our services and products, or on the *Canada Awards for Excellence* program, please contact us at: National Quality Institute 2275 Lake Shore Blvd. West, Suite 307, Toronto, ON M8V 3Y3 www.nqi.ca
Questions? Please at info@nqi.ca or call 1-800-263-9648. (local to Toronto please call 416-251-7600)

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THE QUALITY PRINCIPLES

These Principles form the foundation for long-term quality improvement and permeate the Criteria.

LEADERSHIP THROUGH INVOLVEMENT AND BY EXAMPLE

Developing a quality approach involves transforming both thinking and behavior. This can only be achieved if the management is actively involved in facilitating, reinforcing and leading the changes necessary for improvement.

PRIMARY FOCUS ON CLIENT/STAKEHOLDERS

To achieve goals, the primary aim of everyone must be to fully understand, meet and strive to exceed the needs of clients and stakeholders.

COOPERATION, TEAMWORK & PARTNERING

Teamwork is nurtured and recognized. Co-operation, within and between public service organizations and inside and outside sector borders is a cornerstone for the development of win-win relationships.

PROCESS ORIENTED AND PREVENTION-BASED STRATEGY

Any organization, in any sector, is made up of a network of independent processes, that add value. Improvement is achieved through changing these processes to improve the total system. Managing by focusing purely on results alone is fruitless, since results are determined by the system in use. If the system is not changed in a fundamental way, the results will not improve. To facilitate long-term improvements, a mindset of prevention rather than correction must be applied to eliminate the causes of errors and waste.

FACTUAL APPROACH TO DECISION MAKING

Decisions are based upon measured data and an understanding of the cause and effect mechanisms at work. They are not simply based on instinct, authority or anecdotal data.

CONTRIBUTION OF EACH AND EVERY INDIVIDUAL

Everyone must have the opportunity to use his or her creativity and make a positive contribution to the pursuit of excellence.

CONTINUOUS IMPROVEMENTS OF METHODS AND OUTCOMES

No matter how much improvement has been accomplished, there are always practical ways of doing even better, and of providing improved service delivery or products.

OBLIGATIONS TO STAKEHOLDERS, INCLUDING A CONCERN FOR RESPONSIBILITY TO SOCIETY

An organization is seen as part of society, with important responsibilities to satisfy the expectations of its people and all other stakeholders.

RESPECT FOR THE INDIVIDUAL & ENCOURAGEMENT FOR PEOPLE TO DEVELOP THEIR FULL POTENTIAL

Critical for quality improvement are the values that foster mutual respect between people who work together; communication and personal development are directly related to these values.

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CRITERIA OVERVIEW

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SECTION ONE - LEADERSHIP

This section focuses on those who have primary responsibility and accountability for the organization's performance, usually referred to as senior management. Good leadership is based on a foundation of ethics and values that reflect quality principles.

SECTION TWO - PLANNING

This section examines business planning (which incorporates improvement plans), the linkage of planning to strategic direction/intent, the implementation and the measurement of performance to assess progress.

SECTION THREE – CITIZEN/CLIENT FOCUS

This section examines the organization's focus on client-centered service and/or product delivery, to achieve client/stakeholder satisfaction.

SECTION FOUR – PEOPLE FOCUS

This section examines the development of a human resource plan for meeting the goals of the organization, and achieving excellence through people. Also examined are the organization's efforts to foster and support an environment that encourages people to reach their full potential. People are the prime resource of any organization and success is directly related to how the organization develops its human resources. Treating people in the organization with respect and trust, and providing them with the opportunity to contribute ideas or speak out on issues of concern, without fear of retribution, are of paramount importance.

SECTION FIVE - PROCESS MANAGEMENT

This section examines how work is organized to support the organization's strategic direction, with a focus on the management of key processes as well as continuous improvement. Process management applies to all activities within the organization, in particular to "key" processes; those that are critical for success and normally have a major impact on meeting citizen/client needs. Process improvement priorities are derived from goals established within the improvement plan. Processes are value-adding transformations involving people and other resources such as materials and information. Processes may be of two basic types: service related or product related. Service processes include data and information, and the expertise to transform them into value for the client. Product related processes include the raw materials and expertise from various functions to manufacture the product. Other factors include customer requirements, measurement data, team effectiveness, levels of individual knowledge and skills,

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leadership, training and development etc. It is important to focus on the key processes and to simplify and prioritize these processes as they relate to the primary mission of the organization. It is these key processes that need to be continually analyzed and improved.

Section Six – Supplier/Partner Focus

This section examines the organization's external relationships with other organizations, institutions and/or alliances that are critical to its meeting its strategic objectives.

Section Seven – Organizational Performance

This section examines the outcomes from the overall efforts for quality improvement, and their impact on organizational accomplishments.

About NQI

Vision

To be a global leader in promoting and building organizational excellence

Mission Statements

Canada Awards for Excellence Mission Statement

To inspire organizations by promoting excellence and showcasing their success as role models in an interdependent global economy that benefits all Canadians

National Quality Institute (NQI) Mission Statement

Helping organizations to continuously improve performance and results by providing innovative national criteria, progressive implementation programs, services and certification

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APPENDIX E

Proposal to Establish a Centre for Forensic Medicine and Science at the University of Toronto[1]

Contact:

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Office of the Chief Coroner
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Toronto, ON
M7A 2G9

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Telephone: 416 314 4040

[1] A preliminary version of the document was presented to the Dean of Medicine on January 9, 2008.

Steering Committee to establish a Centre for Forensic Medicine and Science at the University of Toronto

Michael Pollanen MD PhD
Associate Professor of Laboratory Medicine & Pathobiology
Chief Forensic Pathologist for Ontario

Avrum Gotlieb MD CM
Professor and Chair of Laboratory Medicine & Pathobiology

Peter Collins MD
Associate Professor of Psychiatry
Law and Mental Health Program

Martin Evison PhD
Associate Professor of Anthropology
Director, Forensic Science Program

Kathy Gruspier JD PhD
Adjunct Professor Forensic Science

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SUMMARY

'Forensic medicine and science' refers to a heterogeneous set of disciplines that have the common goal of providing evidence to assist in the administration of justice. The forensic disciplines occur when the traditional branches of science and medicine intersect with the Law. In the last 10 years, there has been an explosion of theoretical and applied research leading to astounding new developments in the forensic arena. Although forensic medicine and science are established disciplines within the University of Toronto, there is at present no University-wide policy for cohesive and coordinated advancement of education and research activities in these disciplines.

We propose to establish an extra-departmental unit – the Centre for Forensic Medicine and Science at the University of Toronto. The Centre will unify the currently disparate forensic community, coordinate knowledge-based initiatives, and create an environment that fosters interdisciplinary scholarly activity and research. The Centre will develop and coordinate forensic educational programs across the entire training spectrum and through inter-professional education in allied Faculties.

The vision of the Centre will be to create the leading collaborative organization for forensic research and education in the North America. The mission of the Centre will be to contribute to the development of a rigorous empirical basis for forensic medicine and science.

We propose to construct the Centre using a 'hub and spoke'-model. The 'hub' will be an advisory group and the Director. We propose that the 'hub' should also be characterized by physical space on campus to facilitate educational activities, seminar participation and collaborative meetings in a discrete location. The Director and advisory group will provide the basis for initiating and facilitating collaborative activities between the 'spokes' – that form the principle branches of forensic disciplines – for the Centre. The five main disciplinary branches will be:

(1) Forensic pathology
(2) Forensic psychiatry and psychology
(3) Forensic science
(4) Forensic pediatrics
(5) Allied Hospital and Faculty partners

The first goal of the Centre will be to provide an institutional infrastructure to *unify the forensic community*. The main strategies include the development a seminar series for the wider University of Toronto community to promote cohesion and interest in forensic medicine and science. In addition, the Centre will promote evidence-based forensic medicine and science to advance justice, domestically and internationally.

The second goal of the Centre will be to *create and deliver diverse education programs*. The main strategy will include the delivery of inter-professional and cross-faculty education in forensic medicine and science. This will include creating and delivering continuing education for physicians and lawyers. The Centre will also play a major role in developing a post-graduate medical education curriculum and fellowships in forensic medicine for specialty programs.

The third goal of the Centre will be to *create and foster research collaborations*. Strategies will include development of a strategic network to promote investigation of 'leading-edge' forensic issues that are capable of extramural funding.

We believe that the Centre for Forensic Medicine and Science at the University of Toronto will be the focal point for forensic medicine and science in Ontario and Canada.

FORENSIC MEDICINE AND SCIENCE: THE LEADING EDGE

The rise of forensic disciplines

'Forensic medicine and science' refers to a heterogeneous set of applied disciplines that have the common goal of providing evidence to assist in the administration of justice. Indeed, forensic means *of the public legal forum* and reminds us that forensic disciplines occupy a strange and unique hybrid status in science – forensic disciplines are the subject areas that occur in the overlap or boundary zones between traditional branches of science and the Law. On this basis, forensic disciplines are by definition inter-disciplinary. Each forensic discipline is an applied science of a root discipline and represents a sub-specialization of that discipline, e.g., forensic pathology is part of the medical discipline of pathology.

In the last 10 years, great developments have occurred in the forensic community that has led to the rise of forensic disciplines. Consequently, the various branches of forensic medicine and science are currently at a key stage in their evolution as independent disciplines of science. There have been three exciting large-scale developments.

First, the forensic disciplines are now more defined by their *forensic* prefix, rather than their root discipline. For example, many of the modern approaches in the sub-disciplines such as *forensic anthropology* and *forensic pathology* have more in common now with each other the than the root disciplines from which they derive, i.e., an increasing emphasis on the *forensic* rather than the *pathology* or the *anthropology*.

Second, there are astounding new developments in various forensic areas including the development of new models and new ideas. The latter includes the development of new experimental models, new approaches to forensic genetics, and the creation of new paradigms for forensic evidence. Classical controversies and problems have become re-invigorated by new research.

Third, there has been exponential growth in the peer-reviewed literature[2] over the last ten years. The rate of growth has mirrored other developing areas in bioscience including the new neurosciences. Table 1 shows the rate of publication in the peer-reviewed literature since the 1970s.

Table 1. Forensic Publications per 5-year interval.

Years	Number
1970-1975	1724
1976-1980	1831
1981-1985	1923
1986-1990	2441
1991-1995	3507
1996-2000	5105
2001-2005	8098

Although the rise in the peer-reviewed literature goes across forensic sub-disciplines, the greatest growth has been seen with forensic pathology and science. Forensic pathology and science constitutes about 70% of the publications is in any given year. Table 2 shows the forensic subcategories in the peer-reviewed literature.

[2] Data from PUBMED, November 2007.

Table 2. Article Classification by Discipline (one-year).

Classification	Number of Articles
Forensic Science	423
Forensic Pathology	259
Forensic Toxicology	105
Forensic Medicine	88
Forensic Anthropology	58
Forensic Odontology	35
Forensic Entomology	13
Historical	9
Total	**990**

Forensic Science

In a courtroom in Toronto in 1993, a tremor occurred which has set off a seismic wave in Canadian forensic science and criminal law. The tremor was the first case in which DNA evidence was used in Canada to identify the perpetrator of a rape-homicide of a child[3]. Since then, DNA analysis has become a standard tool in any major criminal investigation where biological material is available.

The inherently scientific nature of DNA typing makes it a highly reliable form of forensic evidence, compared with many other traditional analytic approaches to forensic evidence. Thus, the higher empirical standard of DNA evidence has produced the need for all other forensic disciplines to move towards a new scientific paradigm. The law was quick to respond to this new forensic tool by setting a higher legal standard for the admission of new evidence into a courtroom. The standards include determining if the methods had been: (i) tested (and if error rates and/or standards exist); (ii) published and peer-reviewed; (iii) generally accepted in the relevant scientific community. Recently, the Supreme Court of Canada has determined that the legal test for new or novel evidence can be applied to evidence that has traditionally been accepted by courts in Canada[4].

Therefore, it is now gaining general acceptance that the traditional forensic sciences can no longer rely upon the long-held assumption of reliability and utility. On this basis, there is a coming paradigm shift, based in part on the empirical nature of DNA and the numerous wrongful convictions, which it has disclosed.[5] The shift will be towards *scientific validation* of reliability, rather than the *assumption* of reliability.

Currently there is no branch of forensic science, which has an empirical-scientific foundation, as strong and reliable as DNA analysis. Thus, the main unsolved fundamental problem emerges: to establish a satisfactory empirical-scientific basis for all branches of forensic medicine and science.

[3] *R. v. Terceira (J.)* (1998) O.A.C. LEXIS 171, 107 O.A.C. 15.
[4] *R. v. Trochym* [2007] 1 S.C.R. 239, 2007 SCC 6.
[5] M.J. Saks and J.J. Koehler, "The Coming Paradigm Shift in Forensic Identification Science" (2005) 309 Science 892.

Forensic Medicine

The single most important leading-edge issue in forensic medicine is defining a firm empirical-scientific basis for forensic pathology and forensic pediatrics. In general, there have been two general approaches that have been used contribute to progress in this area. First, there is increased commitment to developing an evidence-based framework. Second, there are increasing efforts to develop research in forensic pathology, rather than solely concentrating on case reports and other anecdotal sources of knowledge. For example, there is increased use of advanced investigative techniques to address in forensic pathology research questions. Also, experimental models are being used, more than ever before, to study fundamental issues in forensic pathology.

Another 'leading edge'-issue in forensic medicine is how forensic medicine can protect and promote human rights and sustain international justice. From a forensic perspective, the 20th century has defined a new role for forensic medicine. First, we have seen the use of forensic methods to identify people killed in natural disasters, such as the Tsunami, and also civilians that have been killed in armed conflicts. Second, we all know that forensic medicine has been used to investigate crimes against humanity such as in Kosovo and Bosnia. These two applications have created a new subspecialty of forensic medicine[6]: the forensic analysis of genocide and mass killing.

As we move through the 21st century, it is apparent now more than ever before, that the forensic approach to investigating international violence is a very effective tool in the struggle for Human Rights and supporting the Rule of Law. By its very nature, forensic medicine is a search for the truth, often in circumstances that are emotionally charged or controversial. This truth-seeking approach accords well with the need for objectivity when dealing with suspicious deaths in police custody, extra-judicial executions, and deaths caused by government persecution of its citizens.

VISION AND MISSION

The vision of EDU will be to *create the leading collaborative centre for forensic research and education in North America*.

The mission of the Centre will be to *contribute to the development of a rigorous empirical basis for forensic medicine and science*.

SCOPE

The scope of the Centre will be broad and multi-disciplinary. The Centre will unify the forensic community, coordinate knowledge-based initiatives, and create an environment that fosters interdisciplinary research. The Centre will develop forensic educational programs across the entire training spectrum and through inter-professional education in allied Faculties. The forensic disciplines in the scope of the Centre will include:

(1) Forensic pathology
(2) Pediatric forensic pathology
(3) Forensic neuropathology
(4) Forensic psychiatry and psychology
(5) Forensic archeology
(6) Forensic anthropology
(7) Forensic dentistry
(8) Forensic radiology

[6] This new sub-specialty is an amalgamation of forensic pathology, archeology, anthropology, and other human identification sciences.

(9) Forensic pediatrics
(10)Forensic nursing
(11)Forensic science
(12)Clinical forensic medicine
(13)Forensic aspects of mass killing
(14)Military medicine

NEED FOR THE CENTRE

There are five main reasons why the proposed Centre will benefit the University of Toronto and beyond:

(1) Creation of a unified forensic community at the University of Toronto.
(2) To fill a vacuum in forensic research, since no research collaborations or independently funded research programs currently exist.
(3) To organize educational programs including continuing professional development programs in forensic disciplines where none exist at present.
(4) To explore why forensic evidence has contributed to miscarriages of justice in Ontario and beyond and offer solutions to these problems.
(5) To educate academic and lay communities about the scope and limits of forensic evidence (the 'CSI effect').

The way forward in the development of forensic disciplines at the University of Toronto is to create an environment that will foster excellence in forensic medicine and science. The Centre will provide the basis for that fostering and development by filling a void in education and research. External stakeholder groups will incur benefits including the strengthening of the criminal justice system. The Centre will be a model for forensic inter-disciplinarity for other universities.

The Centre will unify the forensic community

The forensic community at the University of Toronto is disparate and geographically scattered amongst various institutions and hospitals. This has resulted in a community, which is not unified and has little communication across disciplinary lines. Thus, while forensic pediatricians and forensic pathologists might testify in criminal court on the same cases, there are no substantive educational or research linkages between the disciplines at the University-level. Similarly, although all physicians in forensic practice confront the same issues with expert witness testimony, there are no common educational programs for physician expert witnesses.

There are many issues common to all forensic disciplines. These include requirement for a solid basis in research and scientific rigor, proper training and recognition of the scientific expert, understanding of quality assurance issues, and the ability to present evidence coherently to the Court. The Centre will help codify good practices across the disciplines and facilitate communication between different types of forensic experts.

The lack of a common institutional base has greatly limited communication and professional collaboration. This has been to the detriment of forensic efficacy. The Centre will bring the forensic community together, thereby unlocking opportunities and providing new challenges to members of the forensic community.

The Centre will spark forensic research

Surprisingly, there is a major forensic research vacuum in Canada. There are only a few scattered and isolated investigators and there are no large-scale research collaborations. At the University of Toronto, there are no ongoing forensic research collaborations or are there any are independently funded forensic research projects or programs. There have been three major impediments to developing research projects and programs at the University of Toronto. First, there has traditionally been a strict dedication to clinical service commitments and a lack of emphasis on scholarly activities (e.g., pathologists focusing on performing autopsies, rather than balancing service duties with scholarly activities). Second, the lack of cohesion in the forensic community resulting in lost opportunities to develop collaborative research or identify research problems. Finally, it is a fact that forensic research does not easily fit into the predetermined categories of national research funding portfolios. For example, it is not clear which of the tri-council agencies has a mandate for forensic pathology. However, this has changed in recent years with an increased emphasis on interdisciplinary research.

The vacuum in forensic research has been recently emphasized by the complete absence of any forensic genomic research at the University of Toronto. This is remarkable since the University of Toronto is one the most important sites for genomic research in the world. In the past, there was a recognized sudden infant death syndrome (SIDS) research group at the University of Toronto (Hospital for Sick Children), but this research program has long since been dormant. The Centre will spark new research initiatives at the University of Toronto.

The Centre will co-ordinate and develop educational programs

One of the main mandates of the Center will be the development of educational programs across the University campus. Although there is already a well-developed degree program in the forensic sciences, there is no regular and coordinated forensic education in the professional faculties (Medicine, Nursing, and Law). Postgraduate training exists in forensic pathology and forensic psychiatry and to a limited extent in forensic pediatrics. There is great room for expansion and coordination of educational effort among pathology, pediatric and psychiatry. In addition, the Royal College of Physicians and Surgeons has just ratified a subspecialty certification in forensic pathology. This is a huge advancement in forensic medicine in Canada – the Centre is well situated to be the leader in developing a training site for this subspecialty certification. Similar efforts can be developed along similar lines in forensic pediatric and clinical forensic medicine in the pediatrics and emergency medicine specialties, respectively.

The Centre can also be instrumental in outreach education to the: public; police; crown attorneys; defense lawyers; Office of the Chief Coroner, Centre of Forensic Science; and the general medical community

The Centre will help prevent miscarriages of justices

Several public inquiries into wrongful convictions including *Report of the Kaufman Commission on Proceedings Involving Guy Paul Morin* have recommended research and knowledge discovery as a preventative measure for miscarriages of justice. Unfortunately, Canadian universities have not been responsive to these recommendations.

In a recent Ontario case, a man called William Mullins-Johnson[7] was wrongly convicted of raping and murdering his 4-year old niece, Valin Johnson. However, upon review of the case it became apparent that the forensic experts misinterpreted the autopsy findings. After an appeal hearing, it

[7] This is one of the cases that precipitated the *Inquiry into Pediatric Forensic Pathology in Ontario*, established under the Public Inquiries Act on April 25, 2007. The mandate is a systemic review of provincial pediatric forensic pathology services and to recommended improvements.

was clear that the flawed evidence used to convict the man could not sustain his conviction. The conviction was quashed. In their reasons for judgment, the three-member panel of the Ontario Court of Appeal wrote:

> It is now clear that there is not and never was any reliable pathological evidence that Valin was sexually assaulted or otherwise abused during her short life and certainly not on the evening of her death. It is also now clear that there is no evidence to support a finding of homicidal asphyxia, the cause of death proffered at trial. While the cause of Valin Johnson's death remains undetermined, there is now no evidence to suggest it was the result of any crime. That Mr. Mullins-Johnson was arrested, and convicted of first degree murder and spent twelve years in prison because of flawed pathology evidence is a terrible miscarriage of justice.

The misinterpretation of the autopsy findings was corrected by the growth of knowledge in the ensuing years after the conviction of William Mullins-Johnson[8]. Specifically, research in forensic pathology in the post-conviction time period cast scientific doubt on the reliability of the medical evidence presented at trial. This case illustrates a fundamental principle in forensic medicine and science: the development of new knowledge through research is the best way to prevent and correct miscarriages of justice based on flawed forensic medical or scientific evidence. The more frequent example is exculpatory DNA fingerprinting in post-conviction DNA testing in rape-homicide cases e.g., David Milgaard[9] case.

On this basis, the Centre can foster meaningful research projects and programs that test the foundation of central ideas, beliefs and dogma in forensic medicine and science. This can be achieved by developing new analytical methods and techniques, providing an environment to facilitate novel discoveries, and developing new ideas. In this way, the Centre will help prevent miscarriages of justices.

The Centre will help educate the public and address the CSI effect

Some investigators have attributed the apparent rise in acquittals in criminal trials to the 'CSI effect'. The CSI effect is named after a popular television program, which chronicles the use of forensic evidence to "get the bad guy". It is said that this television show (and others similar to it) have raised the public's expectations in regards to forensic science. Jurors are said to be acquitting more people because the forensic evidence as presented to them in a trial in no way approaches the level that they are accustomed to 'experiencing' on these television shows. Others have argued that the CSI effect has served to educate the public and that perhaps these acquittals were warranted, given that the public is generally more educated about the limits of forensic science than in the past. To date, there has been no empirical or scientific research on whether the CSI effect exists or not. All of the rhetoric as to its existence has been anecdotal.

The Centre with its many constituents will be well placed to conduct research into whether the CSI effect exists or not. Regardless of the existence of the CSI effect, it is certain that the public has received much of its education about forensic science from the popular media. The Centre will have as one of its roles a mandate to educate the public about all aspects of forensic science. The many specialists who will comprise the Centre can easily offer public lectures, seminars, and continuing education.

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[8] *R. v. Mullins-Johnson* (2007) ON C.A. 720

[9] Reference re Milgaard (Can.), [1992] 1 S.C.R. 866

GOALS

Goal #1: Unify the forensic community and promote the evidence-based framework

Objectives

(1) Develop a regular general educational seminar series for the wider University of Toronto community to promote cohesion and interest in forensic medicine and science.

(2) Promote evidence-based forensic medicine to advance domestic, social and international justice.

(3) Develop outreach professional initiatives in the law enforcement community.

Strategies

There are two fundamental principles that will foster the unification of the forensic community at the University of Toronto and beyond. First, is the concept of inter-disciplinarity. Since forensic fields are essentially inter-disciplinary, most forensic professionals and scholars are favorably predisposed to collaborative and cross-disciplinary perspectives. This will facilitate developing a cohesive community, unified by the Centre and its core staff. We simply need to tap into this innate inter-disciplinary view. Second, all initiatives must be cast within the evidence-based theoretical framework, since this represents the modern paradigm for forensic investigation and research. The main mechanism for publicly developing the university forensic community and promoting the evidence-based framework is a weekly seminar series. This seminar series would be for the entire university community and deal with three types of issues: (i) foundational forensic issues; (ii) leading edge issues and controversies; and (iii) results of research and scholarly work by the Centre.

Furthermore, it is important that any large-scale initiative in forensic medicine and science include a mechanism to advance international and social justice. In the 21st century, we now know that forensic medicine and science has a pivotal role to play in international criminal justice and Human rights missions. For example, forensic methods have been increasingly applied in the disaster victim identification (DVI) efforts (e.g., Indian Ocean Tsunami). In addition, forensic pathology and anthropology have been instrumental in international criminal prosecutions in *ad hoc* war crime tribunals. Members of the steering committee have been involved in several UN-sponsored international missions and have collaborative ties with the International Criminal Court in The Hague. Therefore, one important strategy is to develop the forensic community and promote an evidence-based focus that will include developing ties with international organizations that use forensic professionals such as the International Criminal Court, the United Nations and non-governmental organizations. This will allow key professionals and scholars affiliated with the Centre to contribute to the greater landscape of forensic medicine and science to promote international justice. The Centre can host national and international working groups and hold symposia on 'leading-edge' issues thereby fostering the productive use of the forensic disciplines (e.g., recent initiatives with The Missing by the International Committee of the Red Cross [ICRC]).

Establishing professional outreach initiatives with the law enforcement community is vital in order to establish extra-mural relevance of the activities of the Centre. This can be accomplished by developing liaisons with regional, provincial and international policing agencies. For example, the steering committee associated with this proposal has substantive contacts with the Ontario Provincial Police and INTERPOL. One important initiative that has yet to be developed in Ontario is the systematic approach to Cold Cases. The Centre could contribute to the development of strategies and provide expertise for Cold Case initiatives.

Goal #2: Create and deliver diverse educational programs in forensic medicine and science.

Objectives

(4) Create and deliver inter-professional and cross-faculty undergraduate forensic education.

(5) Create and deliver continuing medical and legal education for physicians and lawyers in forensic medicine and science.

(6) Develop a post-graduate medical education curriculum and fellowships in forensic medicine for specialty programs at the University of Toronto.

(7) Create a website for the Centre with the ability to webcast educational events and research seminars to other institutions.

Strategies

There are currently no educational programs for forensic medicine and science in the Faculty of Medicine, Faculty of Law, or the Faculty of Art and Science at the St. George or Scarborough Campuses. There is an undergraduate forensic science program at the University of Toronto at Mississauga. The latter program is an important partner to the Centre and will form the main platform to co-ordinate forensic science initiatives. However, at present, the Forensic Science Program lacks dedicated faculty, physical space, graduate students and post-doctoral fellows. It is likely that the synergy between the Centre and the Forensic Science Program will greatly benefit both, including providing collaborations to strengthen the latter.

The Centrecational activities of the Centre can be divided along the Centrecational spectrum and across the relevant Faculties.

Faculty	***Degree, program***	***Main educational strategies***
UTM	BSc, forensic science	Delivery of core lectures in introductory courses; redevelopment of FSC401; expansion of course offerings
Law	JD	Create forensic curricula targeted to relevant issue (e.g., expert witnesses, forensic evidence, miscarriages of justice)
Arts & Science (St. George)	BSc, pathobiology	Create a 4th year course on *Pathobiology of trauma and injury*
Medicine	MD	Create a one-week duration *legal medicine* curriculum for the 2nd year of the PBL curriculum
Medicine	Allied health professional programs (e.g., physiotherapy)	Create forensic curricula targeted to the relevant professional groups
Nursing	BSc, nursing	Create forensic curricula targeted to forensic nursing and legal issues in nursing
Medicine	Royal College Residency training programs	Create forensic curricula targeted to the relevant specialties (e.g., Pathology, Pediatrics, Emergency Medicine etc)
Medicine	Royal College Fellowship in forensic pathology	Develop and implement (first programs to be accredited in July 2008)

Medicine & other faculties	MSc and PhD	Develop graduate research in forensic areas
Medicine	Continuing medical education for pathologists and other physicians	Create regular symposia and workshops
Law	Continuing legal education for prosecutors, defense lawyers and jurists	Create regular symposia and workshops

In addition, we need to create a website for the Centre with the ability to webcast educational events and research seminars to other institutions. This will be a major educational vehicle and will promote digital collaboration with people beyond the University of Toronto campus environment.

The Centre can also be a 'resource hub' to provide speakers and experts for the extra-mural education efforts of other organizations such as the Criminal Lawyers Association, Crown Attorney groups, and other professional development programs.

In Forensic Psychiatry, the last 10-15 years have seen a profusion of good clinical research into risk assessment and management of violent and sexual offenders; now the focus is more on a developmental/basic science understanding of the principal risk-enhancing diagnoses, e.g., psychopathy and the paraphilias. However, what is urgently needed is better knowledge transfer to other players in the extendedmental health-criminal justice system. This specifically applies to, professionals working in 'general mental health' as our increasing knowledge base, in a risk-sensitive or even risk-averse society, has led to others eschewing or abandoning patients that seem to present with forensic issues. This has led to tremendous expansion of the forensic system, and increasing partition of this system from the general mental health system.

Goal #3: Create and foster forensic research collaborations.

Objectives

(8) Create a strategic network of research collaborations on 'leading-edge' issues in forensic medicine and science that are capable of extramural funding.

(9) Recruit, foster, and fund graduate students and post-doctoral fellows in forensically-relevant research areas.

(10) Create funded undergraduate and summer research opportunities in forensically-relevant research areas.

Strategies

The main strategy will be to identify research areas that can benefit from the expertise in the Centre and then to facilitate research collaborations with an emphasis on an inter-disciplinary approach. For example, the forensic psychiatry and forensic pathology groups are well developed as clinical services but have comparatively little translational research activity. Furthermore, basic science-type research initiatives can be based on identified forensic or legal problems that have been identified by clinical and courtroom experience.

One important operational strategy is to form collaborative groups that are focused on well-defined problems that are amenable to scientific analysis or hypothesis-driven research (e.g., experimental approaches). Defining such groups and research agendas should focus on developing pilot data that makes the projects (or research programs) viable for extra-mural grant funding application. This implies the need to have some pool of funds to generate pilot research data.

In addition to the three main federal granting agencies, there are other organizations that may provide funding for forensically-based research. Such agencies include: scientific funding agencies, international organizations that have mandate for Human rights and social justice; and domestic justice organizations. Such agencies include: NIH, NIJ, WHO, UNESCO, Institute of Peace Studies, and government ministries.

Although forensic genetics is probably the best example, every forensic discipline—anthropology, ballistics, botany, chemistry, computer science, entomology, fluidics, toxicology—has seen and will continue to enjoy rapid advancement in recent years. Even within forensic genetics there remains huge untapped potential for further curiosity driven and applied research in such fields as microfluidics, nanotechnology, and the genetics of common characteristics.

Some major research themes that can be developed by the Centre include:

(1) Collaborative/translational studies in forensic medicine
(2) Clinicopathological studies (e.g., retrospective and prospective case series)
(3) Forensic genomics
(4) Cellular and molecular pathology of injury
(5) Ethics and philosophy of forensic medicine
(6) Translational legal-medical issues (e.g., causation, expert witnesses, miscarriage of justice)
(7) Forensic aspects of injury (clinical and pathological)
(8) Epidemiology of injury and violence
(9) Basic mechanism of physical injury and healing
(10) SIDS
(11) Genetic susceptibility to injury
(12) Interprofessional forensic services (forensic nursing)
(13) Forensic aspects of skeletal biology and pathology
(14) Medical jurisprudence
(15) Miscarriages of justice and forensic evidence
(16) Human identification
(17) Genocide studies
(18) Postmortem medical imaging (virtual autopsy)

OPERATIONAL MODEL

The Centre will be constructed using a 'hub and spoke' structure[10] (Appendix 1). The 'hub' will consist of an advisory group and a Director/Coordinator. We propose that the 'hub' should also be characterized by physical space on campus to facilitate educational activities, seminar participation and collaborative meetings in a central location. The Director/Coordinator and advisory group will provide the basis for initiating and facilitating collaborative activities between the 'spokes', which form the principle branches of forensic disciplines for the Centre. The five main forensic disciplinary branches will be:

(1) Forensic pathology
(2) Forensic psychiatry and psychology
(3) Forensic science
(4) Forensic pediatrics
(5) Allied Hospital and Faculty partners

Many of these radial braches or 'spokes' of the Centre are housed in traditional departments or institutions in which the *forensic* portion is a sub-specialty of a larger discipline (e.g., forensic

[10] This model has been highly effective for interdisciplinary ventures at the University of Toronto. The best example is the Joint Centre for Bioethics.

pediatrics and forensic psychology are subspecialties of pediatrics and psychology, respectively). However, in many cases the *forensic* component is not nurtured or well-developed in the home department. The Centre will provide the scholarly foundation for the forensic components that are lacking in the traditional departments or institutions. The five main forensic disciplinary branches of the Centre will be defined as follows:

Forensic Pathology

The primary branch will be the Provincial Forensic Pathology Unit. The Ontario Pediatric Forensic Pathology Unit, Hospital for Sick Children will also be closely aligned with the forensic pathology branch. Both of these Forensic Pathology Units are part of the Department of Pathobiology and Laboratory Medicine in the Faculty of Medicine. The Provincial Forensic Pathology Unit, which is housed in the Office of the Chief Coroner, will be the lead organization since it is the main centre for forensic autopsies in the Province of Ontario. In addition, the Provincial Forensic Pathology Unit is the leading centre for postgraduate medical education in forensic pathology with an established international fellowship program in forensic pathology. The Provincial Forensic Pathology Unit will be the first accredited training site for the new sub-specialty certification in forensic pathology offered by the Royal College of Physicians and Surgeons of Canada. The first trainees will start in July 2008. In addition, there are research activities including one MSc student involved in experimental forensic pathology, and well-established teaching commitments with the University of Toronto.

Forensic pathology is well-developed over Ontario. Each Department of Pathology in the Faculties of Medicine have Forensic Pathology Units. These Forensic Pathology Units represent important extra-mural partners that will participate in research ad educational efforts.

Forensic Psychiatry and Psychology

The primary branch will be the Law and Mental Health Program at the Centre for Addiction and Mental Health and is based in the Department of Psychiatry. The mission of the Law & Mental Health is to establish the University of Toronto as an international leader in research on the causes and prevention of violence and crime among the mentally ill by conducting and encouraging research and scholarship through local, national and international collaborations; to comprehensive care to mentally disordered offenders; to supporting training in forensic in psychiatry; and to promote public safety through assessment and treatment of mentally disordered offenders in Ontario.

The program faculty is active in various other clinical and administrative settings, including: the Oak Ridge Division of the Mental Health Centre Penetanguishene; the Mental Health Court at Old City Hall, Toronto and other court settings in Toronto; the Forensic Program at the Whitby Mental Health Centre; the Department of Psychiatry at the North York General Hospital; and the Ontario Review Board. Program faculty members also provide consultations for a variety of external agencies including: the National Parole Board; the Correctional Service of Canada at various sites and various Canadian corporations. Program faculty members also consult for law enforcement and criminal justice agencies nationally and internationally. Law and Mental Health Program is well situated to provide leadership in forensic psychiatry through the Centre.

Forensic Science

The primary branch will be the Forensic Science Program, University of Toronto at Mississauga (UTM). The Forensic Science Program is the leading undergraduate educational program in Ontario and offers an honours specialist degree in forensic science. At present, there is an extensive undergraduate research program. A graduate program is currently planned. The Forensic Science Program has strong historic links with the Centre of Forensic Science. It is anticipated that the Forensic Science Program will be a major academic linkage with the non-medical and non-clinical forensic disciplines in the Faculty of Arts and Science.

Forensic Pediatrics

The primary branch will be the Suspected Child Abuse and Neglect Team (SCAN) at the Hospital for Sick Children. The SCAN team will be the lead organization for medical and inter-professional education concerning child abuse. The SCAN team will also form a core of academic pediatricians that can participate in translation and observational research to clarify controversies in forensic pediatrics. The Centre could be instrumental in developing a new sub-specialty certification in forensic pediatrics, as has recently been developed for forensic pathology.

Institutional, Faculty and Hospital partners

These partners will include the: Faculty of Law, Faculty of Nursing, Centre of Criminology, Joint Centre for Bioethics, and University Teaching Hospitals involved in Trauma Medicine.

The Faculty of Law will provide a focal point for inter-professional education, including joint undergraduate teaching initiatives between the Faculties of Medicine and Law. The Faculties of Law and Medicine can jointly provide a legal-perspective to certain issues in the undergraduate medical curriculum and a medical-perspective to certain issues in the undergraduate legal curriculum. Joint seminars between medical and law students can be facilitated. The faculty members in the Faculty of Law can also provide key foci for inter-disciplinary research at the leading edge of medicolegal issues such as miscarriages of justice, international Human Rights and forensic genomics.

The Faculty of Nursing will provide a base to explore and develop forensic nursing in Canada. The Centre of Criminology and the Joint Centre for Bioethics will provide bases to explore the psychosocial and ethical dimensions of issues at the leading edge of forensic science.

Clinical trauma services and trauma research groups at Sunnybrook Health Sciences Centre and St. Michael's Hospital represent fruitful areas for collaboration. These organizations are largely involved in healthcare and injury prevention, rather than forensic work. However, these partnerships can provide a solid base to explore and develop clinical forensic medicine (e.g., Emergency and Critical Care Research Program, Sunnybrook Health Sciences). In addition, developing a neurotrauma registry can for example, facilitate major research areas such as clinico-pathological studies of neurotrauma. Developing a partnership with the Emergency Medicine residency training program can also help develop clinical forensic medicine as a sub-specialty area at the University of Toronto.

GOVERNANCE

The provisional governance model of the Centre includes an advisory committee and day-to-day management by a director. The advisory group will consist of five members, one member from each of the main disciplinary branches of the Centre. The advisory group will foster the goals and objectives of the Centre. The Director/Coordinator will be responsible for coordinating the education and research efforts of the Centre. This can be achieved by liaising between the five main disciplinary branches, established cross-curricular teaching opportunities between the Faculties, fostering research collaborations, and developing educational programs. The Director/Coordinator should also be actively practicing in a primary forensic service area and be involved in research and education.

The Director/Coordinator will have a key and difficult task at the Centre – to co-ordinate and unify a rather disparate group of professionals and academics that are geographically separated across the campus and allied institutions. In addition, forensic professionals and academics have traditionally identified with their home departments and organizations, despite the lack of traditional support of their work. For example, forensic pathologists have traditionally more closely identified themselves with other *pathologists* rather than other *forensic* specialists, such

as forensic psychiatrists. To some extent identification with the root discipline (pathology for forensic pathologists) is a way to stay connected to the mainstream of the field. However, this carries the price of not developing a cohesive *forensic* community that is unified around *forensic* concepts. The Director/Coordinator will need to develop an environment within the forensic community and the physical space of the Centre that emphasizes unification of a diverse group along the common forensic component of their work. The Director/Coordinator will need to be a leader and a builder. The advisory group will play an important role in providing strategic direction for the Centre, to ensure success in research collaborations and extra-mural grant funding.

Faculty associated with the Centre would be by cross-appointment (type C EDU). A home department that is associated with the supervisor will officially supervise graduate students. It is anticipated that the Centre could develop a collaborative graduate degree program within a few years of initial development.

The Centre would have many external stakeholders that will benefit from educational and research initiatives. The main stakeholders include: the police (local, regional and provincial police forces); crown attorneys; defense lawyers; Office of the Chief Coroner, Centre of Forensic Science; and the general medical community. The Centre can provide a summary of activities in an annual report.

RESOURCES AND INFRASTRUCTURE

Budget

One model is a type C EDU. This would define the *Centre for Forensic Medicine and Science* with substantial budgetary support to meet the goals. The putative budget can be divided into seven general areas:

(1) Salary support for core staff
(2) Salary support for the Director
(3) Funds to support daily operations
(4) Funds to support the seminar series
(5) Funds to support visiting scholars
(6) Funds to support pilot projects
(7) Stipendiary support for trainees

A preliminary assessment of the resources (per year and excluding research funds) required for the putative Centre are:

Program leadership and trainee support

Director[11]	0.5 FTE	75,000
Program Director (Education)	0.20 FTE	30,000
Program Director (Research)	0.20 FTE	30,000
Administrative assistant and benefits	1.0 FTE	40,000
Casual Administrative support	0.25 FTE	10,000
Summer student stipends	5 @ $4,800 pa	24,000
Graduate student stipends	3 @ 23,900 pa	71,700

Program delivery

Weekly seminar series (honoraria, expenses for visiting lectures)	10 speakers ($1000 each)	10,000
Supplies		20,000
Presentations at national and international meetings		30,000
Interdisciplinary Pilot Research Projects funds		100,000

One-time expenses

Computers and communication equipment		Estimated 50,000
Website development, and maintenance with webcasting capabilities		Estimated 20,000
Furnishings	Highly dependent on location	Not yet determined
Refurbishment or development of space	Highly dependent on location	Not yet determined

Thus, the preliminary estimated start up cost is $ 510,700 per annum. The budget will require support from funding mechanisms outside of the University of Toronto.

In the future, one model for the Director would be to establish a Canada Research Chair for the Centre. Another possibility includes an endowed/academic or interdisciplinary Chair.

The Centre-model would require the funds to support daily operations including consumable expenditures (e.g., computer expenses, photocopies, etc). A dedicated travel budget to facilitate extra-mural collaborations and participation in international advisory committees and working groups is also required. Many international organizations are usually non-governmental and are 'not-for-profit' and rely on host institutions to provide travels funds (e.g., International Criminal Court).

Funds to support the seminar series and special symposia are essential. This would include infrastructure to support the regular seminar series. In addition, the Centre-model approach would need funds to support special symposia such as continuing professional development. Funds to support guest speakers will provide a mechanism to bring new knowledge from the forensic 'leading-edge' to the University of Toronto community. This will be a mechanism to disseminate important ideas and research results in the pre-publication phase.

[11] Further consultation will be required to develop the budget, including contributions toward salaries.

Funds to support visiting scholars will provide a mechanism to encourage collaboration with outside organizations. This will be a major mechanism to promote the development of new knowledge. This is important because it emphasizes an important mechanism to generate new ideas stemming from productive dialogue.

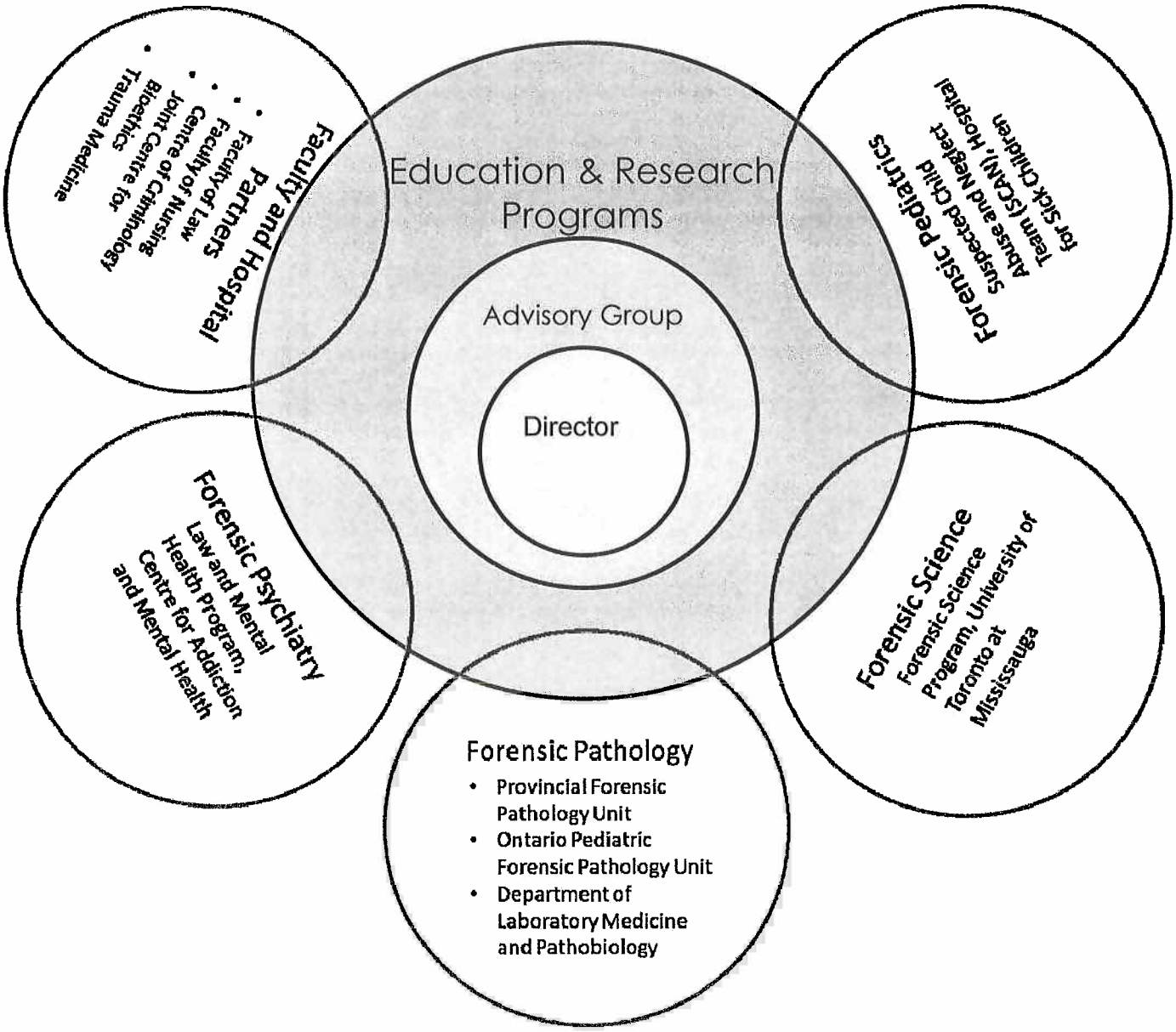
The Centre-model for the Centre would require dedicated physical space on the St. George campus or in the Discovery District. The basic facilities required include basic office space, presentation/seminar space, and communal meeting space to encourage collaboration. The basic office facilities would need to include space for the Director, administrative staff, visitors and trainees. In addition, the initial capital outlay will require furnishings, computers, audiovisual equipment, and website development.

Timeline

Key events in the upcoming development of this proposal include:

(1) Testimony on the concept of the Centre at the Inquiry into Pediatric Forensic Pathology in Ontario (February 2008)
(2) Submission of abbreviated proposal to Faculty of Medicine faculty council and other faculty participants including UTM, Faculty of Law (February 2008)
(3) Retreat of key participants in the development of the Centre with facilitator Helena Axler (May 2008)
(4) Exploration of funding sources and physical space locations

Appendix 1: Operational model for the Centre for Forensic Medicine and Science



Appendix 2: List of people consulted on the Centre concept

Dr. Avrum Gotlieb	Chair, Department of Laboratory Medicine and Pathobiology
Dr. Martin Evison	Forensic Science, UTM
Dr. Kathy Gruspier	Forensic Science, UTM
Dr. Michael Pollanen	Chief Forensic Pathologist for Ontario
Dr. Peter Collins	Law and Mental Health Program
Dr. Kent Roach	Law
Dr. Colleen Flood	CRC in Health Law and Policy, Law
Dr. Mike Shkrum	Forensic Pathology, UWO
Dr. Chitra Rao	Forensic Pathology, McMaster U
Dr. John Fernandes	Forensic Pathology, McMaster U
Dr. David Dexter	Forensic Pathology, Queen's U
Dr. Christopher Milroy	Forensic Pathology, Ottawa U (designate)
Dr. Jacqueline Parai	Forensic Pathology, Ottawa U (designate)
Dr. Toby Rose	Office of Chief Coroner
Dr. Bonita Porter	Office of Chief Coroner (Chief Coroner)
Dr. Noel McAuliffe	Office of Chief Coroner
Dr. Bert Lauwers	Office of Chief Coroner
Dr. Peter Singer	Centre for Global Health
Dr. Michelle Shouldice	SCAN, Hospital for Sick Children
Dr. David Chiasson	Pathology, Hospital for Sick Children
Dr. Glenn Taylor	Pathology, Hospital for Sick Children
Dr. Ernst Cutz	Pathology, Hospital for Sick Children
Ms. Ann Morgan	Ministry of the Attorney General
Mr. Shawn Porter	Ministry of the Attorney General
Dr. Mariana Valverde	Director, Centre of Criminology
Dr. Phil Klassen	Deputy Director, Law and Mental Health Program
Dr. Barry McLellan	President, Sunnybrook Health Science Centre
Dr. Catherine Whiteside	Dean, Faculty of Medicine
Dr. Gordon Rubenfeld	Trauma, Emergency and Critical Care, Sunnybrook Health Science Centre
Dr. Sioban Nelson	Dean, Faculty of Nursing
Dr. Ian Orchard	Vice-President and Principal, UTM
Dr. Ulli Krull	Vice-President (Research) and Vice-Dean (Graduate Affairs), UTM
Dr. Averill Gage	Vice-Principal (Academic) and Dean, UTM
Dr. Ray Prime*	Director, Centre of Forensic Science
Dr. Ross Upshur*	Director, Joint Centre for Bioethics

* Discussions planned

Appendix 3: Putative participating institutions at the University of Toronto and beyond

(1) Provincial Forensic Pathology Unit, Office of the Chief Coroner

(2) Department of Pathobiology and Laboratory Medicine

(3) Ontario Pediatric Forensic Pathology Unit, Hospital for Sick Children

(4) Suspected Child Abuse and Neglect team, Hospital for Sick Children

(5) Sexual Assault and Domestic Violence Care Centre, Women's College Hospital

(6) Joint Centre for Bioethics

(7) Faculty of Law

(8) Forensic Science Program, University of Toronto (Mississauga)

(9) Trauma, Emergency and Critical Care Research Program, Sunnybrook Health Sciences Centre

(10) Centre of Criminology, University of Toronto

(11) Law and Mental Health Program, Department of Psychiatry

(12) Behavioral Sciences Section, Ontario Provincial Police

(13) Hamilton regional forensic pathology unit, McMaster University

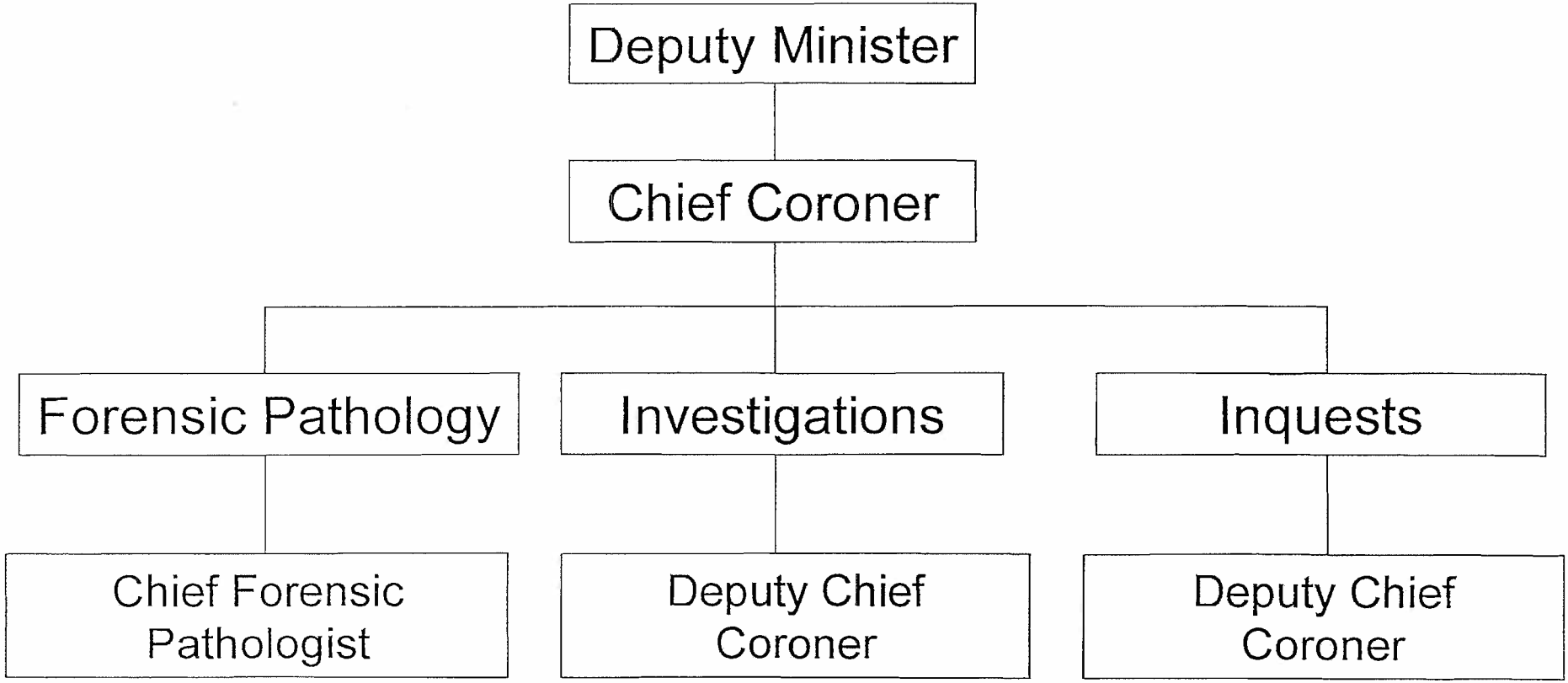
(14) Southwestern regional forensic pathology unit, University of Western Ontario

(15) Eastern regional forensic pathology unit, University of Ottawa

(16) Kingston regional forensic pathology unit, Queen's University

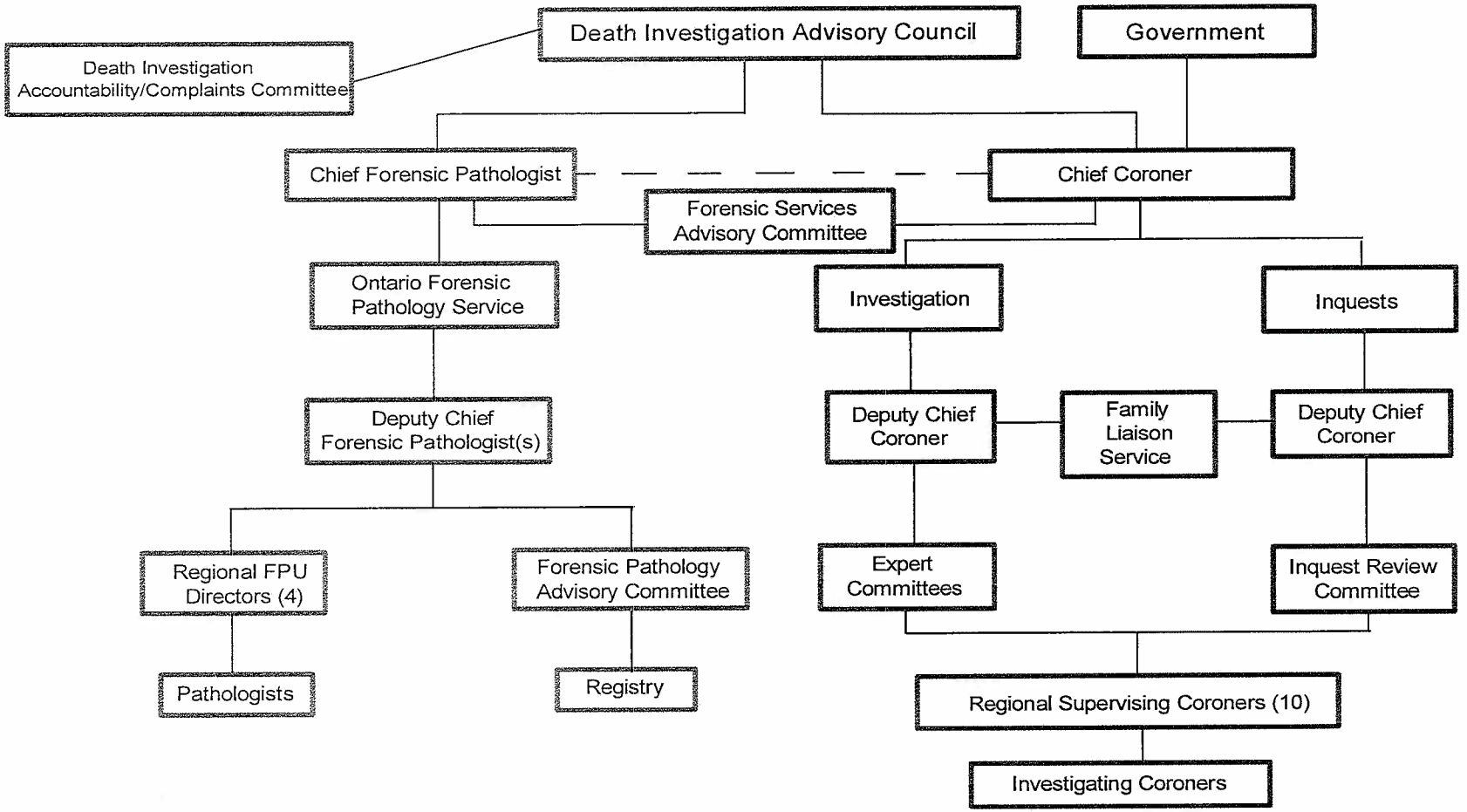
APPENDIX F

Accountability and Oversight Chart - CURRENT



Prepared by OCC: 7-Feb-200

Accountability/Oversight of the OCC



APPENDIX G

Office of the Chief Coroner: Oversight and Accountability

Position	Duties and Responsibility	Authority	Accountability	Oversight
Chief Coroner	Administer the Act and the Regulations Supervise, direct and control all coroners in the performance of their duties Conduct programs for the instruction of coroners in their duties Bring the findings and recommendations of coroners juries to the attention of appropriate persons, agencies and ministries of government Prepare, publish and distribute a code of ethics for the guidance of coroners Perform any such duties assigned by...any other Act or regulation or by the Lieutenant Governor in Council	Section 4(1) Coroners Act	Reports administratively to the Deputy Minister of Emergency Planning and Management of the Ministry of Community Safety and Correctional Service regarding: 1. Developing financial and resource plans for each fiscal year 2. The Minister would continue his current function of being the final appeal to a rejection for an inquest by the Chief Coroner, pursuant to section 22 of the Coroners Act 3. Sharing and implementation of policy for employees of Ontario's Public Service 4. The Minister would continue to be informed of any high profile deaths which might evolve to become sensitive for government Death Investigation Advisory Council	Death Investigation Advisory Council
Deputy Chief Coroners	All the powers of the Chief Coroner during the absence of the Chief Coroner or his or her inability to act	Section 4 (2) of the Coroners Act	Chief Coroner Death Investigation Advisory Council	Chief Coroner Death Investigation Advisory Council

Office of the Chief Coroner: Oversight and Accountability

Position	Duties and Responsibility	Authority	Accountability	Oversight
Regional Supervising Coroners	Assist the Chief Coroner in the performance of his or her duties in the region and perform such other duties as are assigned by the Chief Coroner	Section 5 (2) of the Coroners Act	Deputy Chief Coroner Chief Coroner	Deputy Chief Coroner Chief Coroner Death Investigation Advisory Council
Coroners	Issue a warrant to take possession of a body View the body Make such further investigation as is required to enable the coroner to determine whether or not an inquest is necessary Keep a record of the cases reported For each case, the identity of the deceased, how when where and by what means the deceased came to his death	Section 15 (2) Section 18 (2)	Regional Supervising Coroner Deputy Chief Coroner Chief Coroner	Regional Supervising Coroner Deputy Chief Coroner Chief Coroner Death Investigation Advisory Council

Office of the Chief Coroner: Oversight and Accountability

Position	Duties and Responsibility	Authority	Accountability	Oversight
Chief Forensic Pathologist	Direct the Ontario Forensic Pathology Service Supervise, direct and control all pathologists performing post mortem examinations under a coroner's warrant Conduct programs for the instruction of pathologists in their duties Prepare, publish and distribute a code of ethics for the guidance of pathologists The Chief Forensic Pathologist will maintain a registry of all pathologists who may perform autopsies under a coroners warrant	Section 15 (4) Section 28 (2) To be appointed by an Order-in-Council under the Coroners Act	*Accountable to the Chief Coroner for the provision of forensic pathology services, including post mortem examinations, timely submission of reports, quality review of conclusions and opinions contained therein	Death Investigation Advisory Council
Deputy Chief Forensic Pathologists	All the powers of the Chief Forensic Pathologist during the absence of the Chief Forensic Pathologist or his or her inability to act	Section 15 (4) Section 28 (2) To be appointed by an Order-in-Council under the Coroners Act	Chief Forensic Pathologist Death Investigation Advisory Council *Chief Coroner	Chief Forensic Pathologist Death Investigation Advisory Council
Regional Forensic Pathology Directors **For the purposes of these functions, the Regional Directors would be considered paid employees of the OCCO and accountable to the Chief Forensic Pathologist**	Assist the Chief Forensic Pathologist in the performance of his or her duties in the region and perform such other duties as are assigned by the Chief Forensic Pathologist	Section 15 (4) Section 28 (2) As an agent/consultant to the Chief Forensic Pathologist administering the Ontario Forensic Pathology Service	Deputy Chief Forensic Pathologist Chief Forensic Pathologist *Chief Coroner	Deputy Chief Forensic Pathologists Chief Forensic Pathologist

Office of the Chief Coroner: Oversight and Accountability

Position	Duties and Responsibility	Authority	Accountability	Oversight
Pathologists	Conduct post mortem examinations under a coroner's warrant and perform any duties arising therefrom	Section 15 (4) Section 28 (2) As an agent/consultant to the Chief Forensic Pathologist directing the Ontario Forensic Pathology Service	Regional Forensic Pathology Directors Deputy Chief Forensic Pathologists Regional Forensic Pathology Directors *Chief Coroner	Regional Forensic Pathology Directors Deputy Chief Forensic Pathologists Chief Forensic Pathologist
Forensic Consultants (Odontology, anthropology, etc)	Conduct examinations and perform any duties arising therefrom	Section 15 (4) Section 18 (2) As an agent/consultant to the Chief Forensic Pathologist directing the Ontario Forensic Pathology Service	Chief Forensic Pathologist *Chief Coroner regarding forensic opinions	Death Investigation Advisory Committee

- ***Accountability*** is the obligation to demonstrate and take responsibility for performance in light of commitments and expected outcomes.
- ***Oversight*** is management by overseeing the performance or operation of a person or group.