INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

In the matter of the Public Inquiries Act, R.S.O. 1990, c. P.41

And in the matter of Order-in-Council 826/2007 and the Commission issued effective April 25, 2007, appointing the Honourable Stephen Goudge as a Commissioner

REPLY OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO TO WRITTEN SUBMISSIONS SUBMITTED BY PARTIES WITH STANDING

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I. REPLY RE: REGISTRY OF FORENSIC PATHOLOGISTS

A Forensic Pathology Registry should be Developed and Administered by the OCCO/CFP

1. Several parties have submitted that the Chief Forensic Pathologist of Ontario ("CFP") and/or the Office of the Chief Coroner of Ontario (the "OCCO") should develop and maintain a registry of forensic and pediatric pathologists credentialed to perform post mortem examinations in Ontario (the "Registry") and that a "Forensic Pathology Advisory Committee" should develop a process for the selection and de-listing of pathologists on this Registry.[1]

2. The College of Physicians and Surgeons of Ontario (the "CPSO") supports the development and maintenance of a Registry. It reiterates its recommendation that there should be information sharing between the CPSO and the organization maintaining the Registry,[2] so that the CPSO receives all information the Registry obtains or generates (such as evaluations/assessments) relating to a physician on the Registry. This collaborative approach will assist in ensuring better protection of the public and coincide with the movement by the CPSO to conduct practice assessments on physicians to ensure competence.

Suggestion that the CFP Enjoy "Professional Autonomy"

3. The OCCO also submits that:

> "... The CFP have professional autonomy. This recognizes the **independence** of forensic pathology. To ensure appropriate system integration of death investigation, the CFP

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[1] OCCO Written Submissions of March 20, 2008, p. 164, para. 442; and pp. 174 to 175, paras. 463 and 464; OCAA Written Submissions of March 20, 2008, p. 3, para. 8(2); and p. 4, para. 8(5); AFG Written Submissions of March 20, 2008, p. 79, para. 311; and CLA Written Submission of March 20, 2008, pp. 39 and 51 (Recommendations 22, 23 and 34).

[2] CPSO Written Submissions of March 20, 2008, p. 45 (Recommendation 5).

> should be administratively accountable to the CCO. This recognizes **interdependence** of pathologist and coroner to facilitate high quality death investigation.[3]

4. The CPSO submits that any recommendation made by this Honourable Commission in this regard must recognize that pathologists are members of the CPSO and at all times, accountable to regulation by the CPSO.

II. REPLY RE: ACCREDITATION AND GUIDELINES

Accreditation of Coroners and Pathologists

5. The OCCO recognizes the need for credentialing and accreditation of all physicians involved in death investigations and that this requires partnership with the CPSO among others.[4] The CPSO agrees and reiterates its willingness to participate in the determination of the requirements and the implementation of any such recommendations made by this Honourable Commission.[5]

Guidelines re: Expert Testimony

6. Both Affected Families Group ("AFG") and Mullins-Johnson Group/AIDWYC have made submissions with respect to the promulgation of guidelines for forensic pathologists (or, more broadly, any physician) with respect to the provision of expert evidence.[6] If recommended, the CPSO will be pleased to work with any other appropriate bodies to create and implement guidelines or protocols with respect to standards of practice for pediatric forensic pathology (including with respect to expert testimony by physicians).[7]

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[3] OCCO Written Submissions of March 20, 2008, p. 167, para, 449.
[4] OCCO Written Submissions of March 20, 2008, pp. 173 to 174, para. 460.
[5] CPSO Written Submissions of March 20, 2008, p. 10, para. 12.
[6] AFG Written Submissions of March 20, 2008, p. 84, para. 328; and Mullins-Johnson Group/AIDWYC Written Submissions of March 20, 2008, pp. 68 to 69.
[7] CPSO Written Submissions of March 20, 2008, p. 39, para. 61.

The CPSO agrees with the submission of AFG that this could be part of a broader initiative dealing with physicians giving expert evidence.[8]

III. REPLY RE: OVERSIGHT

Creation of a Death Investigation Advisory Council or Independent Body/Complaints Process under the Coroners Act

7. The OCCO recommends the creation of a Death Investigation Advisory Council to provide oversight for death investigation in Ontario. The OCCO recommends that a subcommittee of this Council should have the ability to hear complaints regarding all participants in the death investigation team, including those with respect to coroners and pathologists. Finally, it explicitly states that the terms of reference should include the responsibility to allow for gate keeping and coordination of complaints without duplicating functions performed by regulators (i.e. CPSO).[9]

8. AFG and Aboriginal Legal Services of Toronto and Nishnawbe Aski Nation ("ALST-NAN") submit that an independent complaints process should be established under the *Coroners Act* for members of the public or others affected by findings made by a coroner or forensic pathologist during the death investigation.[10]

9. Defence for Children International ("DCI") submits that a Governing Council for the OCCO to whom both the Chief Coroner of Ontario and the CFP report should be created.[11] It further recommends the creation of a complaints system allowing for complaints to be made to a committee of the Governing Council regarding those

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[8] AFG Written Submissions of March 20, 2008, p. 84, para. 328.
[9] OCCO Written Submissions of March 20, 2008, pp. 190 to 191, paras. 518(a), 518(b) and 518(b)(iv)(C).
[10] AFG Written Submissions of March 20, 2008, p. 89, para. 357; and ALST-NAN Written Submissions of March 20, 2008, p. 102, para. 250.
[11] DCI Written Submissions of March 20, 2008, p. 3 (Recommendation 1) and p. 11, para. 21.

performing a statutory duty pursuant to the *Coroners Act* and permitting a joint investigation with the appropriate professional regulatory body.[12]

10. The CPSO submits that if any such bodies are created to oversee death investigations and deal with complaints against pathologists or Coroners, such bodies should be required to share with the CPSO any information they obtain regarding a physician who is a member of the CPSO.

11. The CPSO is concerned with the recommendation for joint investigations by the CPSO and another body with oversight duties. While the CPSO endorses information sharing, it submits that joint investigations could create a lack of accountability by any one institution in conducting an appropriate investigation. Further, the CPSO is mandated by legislation to investigate information it receives about its members.

IV. REPLY RE: CPSO'S INVESTIGATION INTO THE PRACTICE OF DR. SMITH

12. AFG recognizes that the CPSO was the only body that exercised oversight with respect to Dr. Smith.[13]

13. AFG submits, however, that the CPSO's Complaints Committee erred in concluding that Dr. Smith met the standard expected of a forensic pathologist.[14] It relies on the expert evidence at this Inquiry which found that he failed to do so.[15] With respect, in reaching its conclusions in the three cases it reviewed, the Complaints Committee relied on a panel of three experts whose qualifications were never challenged by any party prior to or during this Inquiry. The two decisions of the Complaints Committee that were

[12] DCI Written Submissions of March 20, 2008, p. 3 (Recommendation 1) and p. 12, para. 23.
[13] AFG Written Submission of March 20, 2008, p. 20, para. 77.
[14] AFG Written Submission of March 20, 2008, p. 21, paras. 81 and 82.
[15] AFG Written Submission of March 20, 2008, p. 21, para. 82.

challenged were affirmed, on appeal, by the Health Professions Appeal and Review Board. The fact that a newly constituted expert panel, with the benefit of both additional information and hindsight, came to different conclusions years later, does not in any way establish that the Complaints Committee failed in its role.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

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