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

REPLY SUBMISSIONS OF THE OFFICE OF THE CHIEF CORONER OF ONTARIO

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I N D E X

Introduction

1. Having reviewed the submissions filed by the parties with standing at this Commission of Inquiry, the Office of the Chief Coroner ("OCCO"), wishes to address a number of issues raised therein.

2. The OCCO has not replied to every issue raised by each party. Instead, the OCCO has chosen to address issues it believes to be most relevant to this Commission's mandate. Where the OCCO has chosen not to address an issue it should not be viewed as an admission or adoption of the underlying facts.

3. These submissions have been organized by party. Where more than one party has raised a particular issue, the OCCO will address it only once.

4. Finally, the OCCO has used acronyms as defined in the Submissions of the Office of the Chief Coroner of Ontario, March 20, 2008 ("Final Submissions") throughout these reply submissions.

5. As set out in its Final Submissions, the OCCO urges this Commission to evaluate the actions taken by the OCCO and its leaders recognizing that such actions were well intended and taken with a view to providing the people of Ontario with high quality death investigation, in the face of limited human and financial resources.

Affected Families Group ("AFG")

6. As set out in Parts I and II of the Final Submissions, those in senior management at the OCCO during the 1990s and early 2000s neither ignored nor minimized concerns about Dr. Smith that were brought to their attention. Drs. Young, Cairns and Chiasson acted in

good faith to address any concerns to the best of their abilities and within the constraints in which they were operating at the time.

SM's Acquittal and the Dunn Decision

7. As discussed in the Final Submissions, the criticism of Dr. Smith in Justice Dunn's decision in the SM (Amber) case did not raise flags at the OCCO for a number of reasons:

(i) Dr. Young and Dr. Cairns believed Dr. Smith's account of his encounter with Justice Dunn in which he allegedly told Dr. Smith that he would have reached a different conclusion had his understanding of the medical evidence been different;

- Evidence of Dr. Cairns, November 26, 2007, p. 177, lines 7-12
- Evidence of Dr. Young, November 30, 2007, p. 18, line 7 to p. 19, line 2

(ii) Dr. Cairns had understood that members of the SCAN team at the Hospital for Sick Children ("HSC"), having reviewed the decision, supported Dr. Smith's opinions in the case;

- Evidence of Dr. Cairns, November 26, 2007, p. 174 to p. 175, lines 1 to 20

(iii) Shaken Baby Syndrome ("SBS") was known to be an evolving and controversial topic, and therefore, disagreement among experts was not seen as particularly unusual; and

- Evidence of Dr. Cairns, November 26, 2007, p. 175, lines 1-7

- Evidence of Dr. Young, November 30, 2007, p. 115, lines 7-25

(iv) The decision was not brought to Dr. Young's attention as worthy of concern by any stakeholder in the death investigation system. Specifically, it was not brought to his attention by those in the criminal justice system, who in fact, continued to rely on Dr. Smith for his expertise in pediatric forensic pathology in numerous subsequent court proceedings, presumably despite knowledge of the earlier decision by Justice Dunn.

- Final Submissions, paragraph 330

8. The OCCO's response to the acquittal in the SM case must be viewed in the context of these cumulative factors, not the least of which was the admittedly false representation made by Dr. Smith, whose opinion at the time was highly regarded. At the time Justice Dunn acquitted SM, there was no practice or policy in place for reviewing court decisions in which pathologists working under coroners' warrants testified. There was no precedent for the OCCO to review court decisions on a systematic basis, and in any event, written reasons for decision were, and continue to be, unusual in homicide trials.

- Final Submissions, paragraphs 334-335

9. It is only with the benefit of what is now known with regard to Dr. Smith's competency and with regard to the Shaken Baby Syndrome controversy that the full impact of Justice Dunn's reasons for decision resonate.

Tardy Post Mortem Reports and Complaints about Timeliness and Responsiveness

10. Dr. Chiasson and Dr. Cairns engaged in concerted efforts to address the issue of Dr. Smith's timeliness and lack of responsiveness using the tools at their disposal. As set out in the Final Submissions, these efforts were limited by the fact that Dr. Smith was not an employee of the OCCO, the service agreement between the OCCO and the OPFPU did not define an oversight role for the CFP, and the fact that the human resource shortage provided no real alternative. Drs. Chiasson and Cairns tried to address what they perceived to be administrative disorganization. They were not aware of any concern with Dr. Smith's skills in forensic pathology. The evidence shows that:

    (i) Dr. Chiasson and Dr. Cairns communicated regularly with Dr. Smith about improving the timeliness of his post mortem reports, and Dr. Smith repeatedly complained of poor administrative support as the main factor related to his tardiness;

    (ii) Dr. Chiasson and Dr. Cairns met regularly with Dr. Becker at the HSC, urging him to rectify what was perceived to be a lack of administrative support for Dr. Smith at the OPFPU. They were met with assurances from Dr. Becker that such support would improve, though ultimately this never occurred;

    (iii) Dr. Cairns raised the issue with the RSCs, and attempted to redirect pediatric autopsies to other pathologists, which resulted in backlogs in other locations; and

(iv) Dr. Cairns took it upon himself to contact Dr. Smith when concerns about his lack of responsiveness were brought to Dr. Cairns' attention. He repeatedly urged Dr. Smith to respond promptly to queries from other stakeholders in death investigation and Dr. Smith repeatedly pledged to improve.

- Final Submissions, paragraphs 162-165; 297-318

Dr. Smith's Status as an Icon

11. As outlined in the Final Submissions, by the time Dr. Smith was appointed the Director of the OPFPU, he was a well-established and highly regarded expert in the field of pediatric forensic pathology. Dr. Smith himself promulgated this reputation, well before Dr. Young and Dr. Cairns became CCO and Deputy Chief Coroner, respectively.

- Final Submissions, paragraphs 249, 252, 253, 255, 258 and 259

12. Contrary to the allegations set out in AFG's submissions, the OCCO sought Dr. Smith out, in part, because of his status in the field. The OCCO did not create Dr. Smith's reputation nor did it purposefully seek to advance it throughout the 1990s. While it is true that the OCCO did rely on Dr. Smith's expertise and invited him to provide education and consulting services to various other members of the death investigation team, this was because of the office's belief that Dr. Smith provided an expertise that was seen to be woefully lacking in the province. To suggest that the OCCO preferred promoting Dr. Smith to advancing public interest is completely unsupported by the evidence.

- Final Submissions, paragraphs 263-264

Knowledge of Facts in Sharon Case

13. In paragraph 135(c), AFG claims that there is unequivocal evidence that around the time of the American Academy of Forensic Sciences meeting in February 1999, Dr. Cairns was aware that the cast of Sharon's skull was missing. This claim is ***not*** supported by the evidence. He was asked by the Commissioner and by Commission Counsel about his memory of the timing of this knowledge and was not able to provide a definitive answer:

> MS. LINDA ROTHSTEIN: Now, do you recall, Dr. Cairns, that at this that at this stage in the chronology you also you knew that a cast of Sharon's skull that Dr. Smith had had made had, in fact, gone missing or at least could not be accounted for?
>
> DR. THOMAS CAIRNS: In preparing for the testimony, I tried to recall, and I do recall that at some stage a cast that had been made by Dr. Smith had gone missing, but where it -- at what time frame that was -- I know it was seemingly present at the preliminary hearing and was given back to Dr. Smith following that.
>
> - Evidence of Dr. Cairns, November 26, 2007, p. 233, lines 3-13
>
> COMMISSIONER STEPHEN GOUDGE: Sorry, Dr. Cairns. Did -- at some point did you discover the cast had gone missing?
>
> DR. THOMAS CAIRNS: At some stage, yes.
>
> COMMISSIONER STEPHEN GOUDGE: But you just don't remember –
>
> DR. THOMAS CAIRNS: I don't remember –
>
> - Evidence of Dr. Cairns, November 26, 2007, p. 234, lines 9-15

Removal of Dr. Smith from Criminally Suspicious Cases

14. In paragraph 143 of its submissions, the AFG asserts that one of Dr. Young's main concerns when charges were withdrawn in both the Tyrell and Sharon cases was the

impact the controversy would have on the OCCO itself. The AFG states that Dr. Young "…appears to have given no thought to the impact Dr. Smith's past work might have had on those criminally accused as a result of his opinions." This implies that the two concepts are mutually exclusive. The OCCO takes issue with this submission.

15. In fact, in cross-examination Dr. Young also agreed that he was concerned about the need to preserve public confidence in the OCCO. This was an eminently reasonable concern for the Chief Coroner of Ontario. Preserving public confidence requires the OCCO to fulfill its mandate of high quality death investigation to ensure that no death will be overlooked, concealed or ignored and to promote public safety. This necessarily entails a fair and principled approach in its interactions with the justice system. Hence, Dr. Young's first order of business was to direct the OCCO to conduct an external review of Dr. Smith's cases, and during the brief time that this process was carried out, a focus was placed on criminally suspicious cases, past and present. The process was halted however, due to other reasons as outlined in the Final Submissions.

- Evidence of Dr. Young, December 4, 2007, p. 11, lines 13-18
- Evidence of Dr. Cairns, November 28, 2007, p. 93, line 25 to p. 94, line 1

2001 "Review" Process

16. In addressing Justice Trafford's criticism of Dr. Cairns' presentation of the "review" of Dr. Smith in 2001, it is noteworthy that the chart that Dr. Cairns prepared for the court was done so under severe time constraints and in an effort to assist the court with its own request.

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

17. Paragraph 159 of the AFG submissions claims that the "internal review" turned up nothing of concern with respect to Dr. Smith's competence and was "a whitewash". The process that took place in 2001 was cut short well before its exact nature and scope could be defined and almost as soon as it had begun. In effect, a comprehensive review never took place, for the reasons described in the Final Submissions.

- Final Submissions, paragraphs 392-420

The Fifth Estate and Maclean's Magazine Article

18. Dr. Young testified that he felt the article that appeared in Maclean's Magazine in May 2001 did not provide a balanced representation of the facts pertaining to Dr. Smith. Consequently, Dr. Young placed very little store in the article and its contents.

- Evidence of Dr. Young, November 30, 2007, pp. 7-8

19. Dr. Young did not view The Fifth Estate program on Dr. Smith, which aired in November 1999. Commission Counsel questioned why Dr. Young did not further investigate the merits of the program and its contents, given the serious allegations about the pathology work conducted in connection with the OCCO. Dr. Young explained that reports about the OCCO's work appeared in the media on a regular basis, some of which were accurate and some of which were not. As both Dr. Young and Dr. Chiasson explained, in its management of a senior pathologist, the OCCO would not be driven by the media.

- Evidence of Dr. Young, November 30, 2007, p. 193, lines 20-24; p. 194, lines 13-21

- Evidence of Dr. Chiasson, December 10, 2007, p. 105, lines 13-24

20. Having said that, Dr. Young noted that if there was a real concern, several media outlets would have picked up the story, or it would have been brought to his attention personally. Yet this did not happen. As Dr. Young testified:

> "You know, during the entire course of this, no Crown attorney, no defence attorney, no police officer, no one called me and said, All these things are going on. We want a review of Dr. Smith.
> If -- if these issues are going on and everybody's aware of them, they -- they were awfully, awfully quiet about them."

- Evidence of Dr. Young, November 30, 2007, p. 194, lines 4-14; p. 195, lines 1-18

21. At paragraph 162, AFG submits that Dr. Young attempted "…to seek reimbursement for Dr. Smith in his costs for suing Macleans". In fact, Dr. Smith had filed a statement of claim against the CBC for The Fifth Estate program. Dr. Young became aware of the statement of claim because Dr. Smith asked for the Ministry's financial support for his corresponding legal fees.

- Evidence of Dr. Young, November 30, 2007, p. 196, lines 2-8

22. Though Dr. Young cannot recall whether he supported Dr. Smith's position in the lawsuit, he did agree to request that the Ministry provide at least a limited amount of funding. The reason Dr. Young supported Dr. Smith in his request for funding needs to be clarified. Dr. Young made this decision against a backdrop in which coroners and pathologists were demanding support for legal fees in all such proceedings. There was a

concern that if support was not provided, there would be very few coroners and pathologists willing to work for the OCCO.

- Evidence of Dr. Young, November 30, 2007, p. 197, line 10 to p. 198, line 5

Holding Dr. Smith Accountable

23. AFG alleges that Dr. Smith was not held accountable by the OCCO. It alleges that the OCCO "fostered an environment" where meaningful oversight could not occur. It further states that it is "incomprehensible that the 2001 review never contemplated a retrospective examination of past cases for purposes of determining whether there were errors which may have led to miscarriages of justice." It also alleges that both Drs. Young and Cairns were more focused on public perception and the reputation of the office than Dr. Smith's errors and their consequences.

24. These assertions fly in the face of the swift action taken by both Dr. Young and Dr. Cairns when it was brought to their attention that a possible miscarriage of justice was about to take place in the Sharon case. Confronted with evidence that Sharon may have died as a result of dog bites, and not a scissor attack as determined by Dr. Smith, they acted quickly to inform all stakeholders and took steps that led to the unusual circumstance of exhuming Sharon's body for a second autopsy that ultimately resulted in charges being withdrawn against Sharon's mother.

- Final Submissions, paragraphs 234-243

25. Indeed, AFG acknowledges that "…Dr. Young and Dr. Cairns clearly acted responsibly in raising concerns about the case," following their return from the American Academy of Forensic Science meeting in February 1999.

- AFG Submission, p. 72, paragraph 281

Disbanding the OPFPU

26. In paragraph 315 of its submissions, AFG recommends that the OPFPU be disbanded and that all autopsies in criminally suspicious cases be conducted at the Provincial FPU or at other Regional FPUs. AFG further recommends that pathologists at the HSC continue to perform non-criminally suspicious autopsies under coroners' warrants. With respect, this recommendation is a reaction to past events and as such fails to recognize the significant benefit to pediatric death investigation the OPFPU offers the OCCO and the criminal justice system.

27. This Commission has heard a great deal of evidence with regard to the current organization of the OPFPU and its close relationship with the OCCO, and in particular with the CFP. In its Final Submissions, the OCCO outlines the advantages of maintaining a close relationship with the OPFPU and has set out what it believes should be implemented to further enhance the relationship.

- Final Submissions, paragraphs 102, 456(f)

28. The OPFPU, situated in the HSC, offers world-class expertise, highly advanced ancillary services and a unique perspective on a very narrow and admittedly complex area of forensic pathology not available elsewhere.

Miscellaneous Recommendations

29. The OCCO takes issue with AFG's recommendation as set out at paragraph 336 of its submissions. First, it is not the primary role of the CFP to determine whether the criminal justice system requires additional expert reports. Second, at present all reports entering the criminal justice system are subject to a thorough peer review process and it is the OCCO's hope that with the creation of the OFPS this peer review process will only be further strengthened. Third, where appropriate peer review and oversight is entrenched in the system, the public must have confidence in the work produced by pathologists working within that system. Finally, there has been no evidence at this Inquiry to suggest that those currently conducting criminally suspicious pediatric cases lack the skills or expertise available outside of the province.

30. At paragraph 349, AFG submits that in criminally suspicious cases guidelines for the disposal of a child's body should ensure that disposal does not happen until the family has been advised in writing of their right to a second autopsy and has confirmed in writing that they do not wish such an autopsy to take place. The OCCO is not and has never been responsible for the ultimate disposal of a claimed body, following an autopsy. It has always been the responsibility and practice of the OCCO to release the body to the next of kin following the completion of an autopsy. It is for the next of kin to determine when and how a body is disposed. With respect, AFG's submission with regard to body disposal is unworkable and unnecessary given the OCCO's current obligations and practice.

31. At paragraphs 355 and 356, AFG suggests changes to the *Coroners Act* in relation to the release of information and with respect to applications for an exhumation. In Part III of its Final Submissions, the OCCO has set out proposed amendments as well. Respectfully, the OCCO submits that its proposed amendments should be preferred as they take into account current practice and the practical realities of death investigation.

Hospital for Sick Children ("HSC")

32. In its Final Submissions, the OCCO has acknowledged its role in providing immediate oversight to the OPFPU and in particular to the pathologists working therein on a case by case basis. Dr. Cairns acknowledges that the OCCO had a primary role in overseeing the work of Dr. Smith. That said, the HSC also must accept responsibility for its role in overseeing Dr. Smith and the OPFPU:

- Evidence of Dr. Cairns, November 26, 2007, p. 94, lines 6-25, p. 95, lines 1-9

(a) The OCCO relied upon the HSC's world renowned reputation and the fact that a leading pathologist, Dr. Phillips had mentored, nurtured and employed Dr. Smith;

(b) Dr. Smith "wore the mantle" of the HSC when giving education seminars, participating on the PDRC and DU2, and when testifying as an expert witness in court; and

- Evidence of Mr. Struthers, February 8, 2008, p. 85, lines 4-7

(c) The HSC identified concerns regarding Dr. Smith's surgical pathology skills, but did not share those concerns with the OCCO.

33. As set out in the Final Submissions, the OPFPU was created to benefit both the OCCO and the HSC, and in fact was first proposed by Dr. Phillips in 1990. Its creation was recognition of the HSC's contribution to pediatric pathology within the coroner's system. In light of this long history, it is untenable for the HSC to now distance itself from the OPFPU and Dr. Smith.

- Letter, PFP117761

34. While at present the HSC has an interest in distancing itself from the work of Dr. Smith, there can be no doubt that during the 1980s and 1990s, the hospital benefited from Dr. Smith's growing reputation in a complex and unique field of pathology.

Association in Defence of the Wrongly Convicted ("AIDWYC") and Mullins-Johnson Group ("MJ")

Factual Errors

35. At paragraph 18, AIDWYC/MJ suggest that Dr. Queen was a junior member of "Dr. Smith's staff". This is incorrect. Dr. Queen was a staff pathologist with the Provincial FPU between 1996 and 1999.

36. At paragraph 23, AIDWYC/MJ assert that Dr. Johnston is still the Director of the Ottawa FPU. Dr. Johnston is no longer the Director, having been replaced by Dr. Virbala Acharya in the fall of 2007. It is anticipated that Dr. Jacqueline Parai will replace Dr. Acharya as Director in July 2008.

- Memorandum to file, PFP142091
- Issue Note, PFP142081

Proposed Recommendations

37. AIDWYC/MJ have made a number of recommendations regarding various reviews of past pediatric cases, criminally suspicious cases and cases where the findings were based on controversial pathology. Broadly, it is the OCCO's position, as is made clear in the Final Submissions, that it does not have the human or financial resources to act as the lead agency in any review process.

- Final Submissions, paragraph 457

38. As is clear from the evidence, the Chief Coroner's Review that took place between 2005 and 2007 was unprecedented. It is fair to assert that at the outset of the process, the OCCO did not fully appreciate the amount of time, effort and resources that would be redirected to complete the review. The OCCO had no additional funding or human resources for the process and as such the attention of the individuals involved was diverted from death investigation, the OCCO's primary responsibility. This cannot occur on a regular basis.

- Evidence of Dr. McLellan, November 13, 2007, p. 130, lines 5-11; November 14, 2007, pp. 146-147, line 11

39. It is with the experience of the Chief Coroner's Review that the OCCO asserts that it cannot take the lead in any of the reviews as recommended by AIDWYC/MJ.

40. It should also be made clear that at present the ongoing review of cases involving Dr. Smith between 1981 and 1991 is being managed by a representative of AIDWYC and the Ministry of the Attorney General. As this Commission has heard, the OCCO identified a number of cases for potential review. At a meeting of the Forensic Services Advisory

Committee in June 2007, it was agreed that AIDWYC and the Ministry would work together to determine what next steps are necessary.

- Evidence of Dr. Pollanen, February 21, 2008, p. 85, lines 11-22
- June 2007 Minutes, PFP058377
- September 2007 Minutes, PFP136180

41. Should this Commission accede to the proposal that there be a province-wide Shaken Baby Syndrome Review, the OCCO submits the following:

(a) Any such review will require a major injection of resources and a multi-disciplinary team that is both international and inter-ministerial;

(b) The review is likely to take several years to complete and will therefore require separate staff and facilities, with an appropriate budget; and

(c) The scrutiny of any such review would be heightened. As such, the process must be seen to be objective, transparent and independent from any branch or division of government.

42. In summary, it is not possible that any such review take place within the current mandate or budget of the OCCO.

Miscellaneous Recommendation

43. The OCCO takes issue with Recommendation 24. The OCCO presently and the OFPS, in the future, will rely on individual professionals to provide forensic pathology services. While the OCCO can oversee the work performed in the province and on behalf of the OFPS (principally through the management of the Registry), it cannot mandate what

professionals do on their own time. In any event, there would be no workable method for the OCCO/OFPS to track consults undertaken extra-provincially.

College of Physicians and Surgeons of Ontario ("CPSO")

44. The OCCO is not governed by the *Regulated Health Professions Act* ("RHPA") or the *Public* Hospitals *Act* ("PHA")[1]. As such, any reporting requirements imposed on the OCCO by the CPSO must take into account the unique features of death investigation and the physician's role within it.

45. That said the OCCO recognizes the important role the CPSO plays in the oversight and review of medical professionals working within the death investigation system. The actions taken by the current leaders of the OCCO should in no way be construed as discounting the CPSO's jurisdiction or a reluctance to report where the obligation to report is mandated.

- Final Submissions, paragraph 518

46. The OCCO is concerned with the recommendations proposed in the CPSO's submissions. Given the unique features of death investigation, the OCCO must play a primary role in the effective oversight of coroners and pathologists, but that does not diminish the role of the professional regulator.

47. The OCCO needs to be engaged in any process initiated by the CPSO to create standards or protocols with regard to reporting requirements as they relate to physicians working within the coroner's system. Accordingly, the OCCO submits the process contemplated

1 Reporting to the CPSO regarding clinical concerns is governed by section 33 of the PHA, which provides that changes to a physicians privileges in a hospital setting must be reported by the hospital administrator and section 85 of the RHPA which set out reporting obligations for an employer where a physician's employment arrangement has been terminated, revoked, suspended or otherwise restricted. See paragraphs 24 and 25 of the CPSO's submissions.

in Recommendation 3 should occur on a more comprehensive basis prior to any decisions being made by the CPSO.

48. In Recommendation 5, the CPSO proposes that those pathologists placed on the provincial Registry consent to information being shared between the board managing the Registry and the CPSO. The OCCO cannot accept this proposed recommendation. The OCCO is unaware of any such requirement imposed in other health care settings.

49. Clearly, the potential consequences for such a requirement have not been fully considered. The CPSO's proposal has privacy implications and would no doubt have a chilling effect on those applying for inclusion on the Registry.

Ontario Crown Attorneys' Association ("OCAA")

Dual Doctoring[2]

50. The issue of dual doctoring is dealt with in the Final Submissions. While the OCCO does not support the concept of mandatory dual doctoring, it has developed a triage system which it believes will work effectively to harness the appropriate skills required when a case presents itself.

- Final Submissions, paragraph 456(e)
- Evidence of Dr. Pollanen, December 5, 2007, pp. 146-147
- Evidence of Dr. Chiasson, December 7, 2007, p. 111

2 While the Commission has heard this practice called "double doctoring", given the negative implications of this term, the OCCO prefers the term "dual doctoring"

Counsel Monitoring Letter ("Court Letter")

51. The OCAA and other parties have proposed the use of a court letter to provide feedback to the OCCO with regard to the performance of pathologists giving evidence in a trial. As Dr. Pollanen testified, it is the OCCO's position that the peer review model of post mortem reports and court transcripts is a better mechanism for review.

- Final Submissions, Part III, paragraph 463(c)
- Evidence of Dr. Pollanen, December 5, 2007, pp. 281-284

52. While it is recognized that CFS scientists are subject to the court letter review process, respectfully the OCCO submits that the work of the forensic scientist is not analogous to the work of the forensic pathologist in this regard. Unlike physicians, forensic scientists are not governed by a professional regulatory body. Should the OCCO be required to receive court letters it would then be faced with the dilemma as to when and whether negative court letters are required to be reported to the CPSO and/or disclosed to the Crown in subsequent cases.

53. With respect, the OCCO is also concerned that court letters may not provide an objective review of the pathologist's participation in the court process.

Aboriginal Legal Services of Toronto and Nishnawbe Aski Nation ("ALST-NAN")

54. This Commission's mandate includes a systemic review and assessment of the policies, procedures, practices, accountability and oversight mechanism, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario, as they relate to its practice and use in investigations and criminal proceedings.

55. ALST-NAN was granted standing to participate at this Inquiry on the following basis:

> "The ALST-NAN Coalition is well-placed to assist the Commission with issues raised by the use of and access to pediatric forensic pathology in investigations of criminal proceedings that may be unique to Aboriginal people"
>
> - August 17, 2007 Ruling on Standing and Funding

56. With respect, the submissions filed by ALST-NAN fall well beyond the bounds of this Commission's mandate and the basis upon which it was granted standing. As such, the OCCO has chosen not to respond to many of the specific issues raised in these submissions.

57. The OCCO recognizes that the challenges presented by the geography and sparse population of Northern Ontario have made it difficult to provide full death investigation services to remote and Aboriginal communities. The OCCO has endeavoured to address these issues by engaging in ongoing discussions with the communities affected and participating fully in addressing these issues at the Inquiry.

> - Final Submissions, Part III, paragraphs 456(h), (i), 476, 478, 487(a), 491-494, 506
> - Evidence of Dr. Eden, February 29, 2008, pp. 44-55

Lay Coroners

58. ALST-NAN proposes the use of "community based investigators" or "community health representatives", who are neither physicians nor police officers to conduct death investigations within their communities. They propose an amendment to the *Coroners Act* to remove the requirement that coroners be physicians. The OCCO takes significant issue with this proposal.

59. This Inquiry has heard ample evidence with regard to the benefits of physician-coroners.

- Evidence of Drs. Edwards, Lauwers and Lucas, January 7, 2008, pp. 102-106

60. As Dr. Eden testified during the Thunder Bay roundtable series, physicians and police officers possess the investigative skills required for death investigation, and can provide ***objective*** and ***independent*** service to communities, which the OCCO believes is of fundamental importance to the system.

- Evidence of Dr. Eden, February 28, 2008, p. 109, lines 5-9; pp. 135-141
- Evidence of Dr. McRae, February 28, 2008, pp. 177, lines 18-25

Allegations against Individuals

61. ALST-NAN has made a number of serious and inflammatory allegations against Dr. Young and others within the OCCO. With respect, these allegations are not supported by the evidence presented at this Inquiry and as such merit no response.

Defence for Children International ("DCI")

62. With respect, it is the OCCO's position that the submissions filed by DCI betray a lack of understanding of the evidence heard at this Inquiry and of the Commission's overall mandate.

PDRC

63. The PDRC exists to provide expert advice to the OCCO regarding child death investigations. In particular, as set out in the Final Submissions, the thrust of the PDRC's

mandate is to address medical care and CAS issues as they arise in pediatric deaths. The PDRC has no advocacy role and has no direct role in "investigating" the conduct of physicians or social workers. The lessons learned as a result of the Committee's reviews are disseminated to relevant stakeholders (e.g. hospitals, families).

- Final Submissions, paragraphs 54-61
- Evidence of Dr. Lauwers, January 8, 2008, p. 199, lines 13-19
- Evidence of Dr. Cairns, November 26, 2007, p. 31, line 24 to p. 32, line 25

64. The OCCO takes issue with DCI's proposed recommendations relating to the PDRC. The proposed recommendations are beyond the scope of this Commission's mandate, as they are not directly related to the provision of pediatric forensic pathology services. In addition, the proposed recommendations fail to recognize the core mandate of the PDRC and the significant contribution the committee provides to death investigation in the province.

Proposed Amendments to the *Coroners Act*

65. DCI submits that a number of amendments be made to the *Coroners Act*. One such proposed amendment is for the separation of the judicial and investigative roles of the coroner. DCI acknowledges that this issue was not "covered in great detail at this Inquiry".

66. With respect, this issue was not covered at this Inquiry because it is beyond the scope of this Commission's mandate. The role and function of the coroner at inquests has no bearing on pediatric forensic pathology services in Ontario.