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Document d'information

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PUBLIC ANNOUNCEMENT OF
REVIEW OF CRIMINALLY SUSPICIOUS AND HOMICIDE CASES
WHERE DR. CHARLES SMITH CONDUCTED
AUTOPSIES OR PROVIDED OPINIONS

HISTORY:

In November of 2005, Dr. Barry McLellan, Chief Coroner for Ontario, announced the scope and format of a review into 44 criminally suspicious and homicide cases, dating back to 1991, where Dr. Charles Smith had performed an autopsy or provided an opinion in consultation. The purpose of the review was to determine whether the conclusions reached by Dr. Smith in his autopsy or consultation reports, or during his testimony where applicable, could be supported by the information and materials available for independent review.

At the time of the original announcement in November 2005, 44 cases had been identified for review. They included cases where at some point in time, the death had been determined to be a homicide or criminally suspicious and where Dr. Smith was either the primary or a consulting pathologist. Of the 44 cases, 43 dated back to 1991 when the Provincial Paediatric Forensic Pathology Unit first opened, and the other case was a 1988 death that had received significant public attention. Through the process of collecting information and reviewing files, it became evident that there were 45 cases that met the review criteria.

REVIEW PROCESS:

The scope and format for the review were determined with advice from the Forensic Services Advisory Committee of the Office of the Chief Coroner. This Committee was formed to strengthen the independence and objectivity of the Office, as well as to improve communication with key stakeholders. Advice to the Chief Coroner is provided through this multidisciplinary Committee that includes representatives from the Office of the Chief Coroner, the Centre of Forensic Sciences, various police services, the Prosecution Service and the Defence Bar. Committee members share a common interest in advancing the quality and independence of all aspects of post mortem examinations conducted on coroners' cases.

The review was conducted by a panel of internationally respected experts in forensic pathology. The members of the committee included:

Dr. John Butt - Consultant in Forensic Medicine, specializing in expert opinion and evidence, as well as education about investigation and pathology of sudden death and serious injury. Prior to setting up an independent consulting practice, Dr. Butt was the Chief Medical Examiner for the Province of Nova Scotia and before this, he was the Chief Medical Examiner for Alberta.

Professor Christopher Milroy - Professor of Forensic Pathology at the University of Sheffield, England, consultant pathologist to the British Home Office and Honorary Consultant in forensic pathology for the Sheffield Teaching Hospitals National Health Service Foundation Trust.

Professor Helen Whitwell - Professor of Forensic Pathology at the University of Sheffield and a consultant pathologist to the Home Office. She brought special knowledge and expertise to the panel in the area of neuropathology.

Professor Jack Crane - State Pathologist for Northern Ireland, a Professor of Forensic Medicine at The Queen's University of Belfast, and a consultant pathologist of the Northern Ireland Health and Social Services Boards.

Professor Pekka Saukko - Professor and Head of the Department of Forensic Medicine at the University of Turku in Finland.

The cases were prioritized for review based on whether persons who were convicted or found to be Not Criminally Responsible, as a result of any previous court proceedings still had restrictions imposed on their liberty, including those persons who were out of custody, but on parole or on bail. An initial screening review of the investigation materials from the remaining cases by a subcommittee of the Forensic Services Advisory Committee, with forensic pathology, police, and Crown and Defence counsel members, identified 10 cases where there did not appear to be any potential controversial issues with medical evidence. These cases underwent the same structured review, but were reviewed by other senior pathologists in Ontario, in order to ensure best use of the external reviewers' time to deal with the more potentially difficult and complex cases.

All 45 cases were reviewed through a structured process. The reviewers were specifically asked to provide their opinions on the following:

- whether they agreed that the important examinations were conducted;
- whether they agreed with the facts reported as arising from the examinations conducted and;
- whether they agreed with the interpretation of the examinations conducted with respect to the cause and where an opinion was provided, the mechanism of death.

The materials reviewed by the pathologists included:

- autopsy reports or consultation reports completed by Dr. Smith;
- the coroner's warrant;
- any other autopsy or consultation reports arising from the investigation and, where available, second opinion pathology consultation reports;
- photographs from the autopsy and death scene;
- microscopic slides and any other pathology materials;
- police reports;
- reports from the Centre of Forensic Sciences and
- where available, selected relevant court transcripts arising from all pathology and any related medical evidence, for those cases that proceeded through the criminal courts. The review did not include, and was not designed to include, the entire Court record in each individual case.

Wherever possible, families of the 45 children who formed the basis of this review, and counsel who represented parties on matters arising from the coroner's investigations into these deaths, were contacted directly prior to the start of the review. Wherever possible, families of the children, or their counsel, have also now been informed of the results of the review of their child's death. Families of the children are entitled to receive the reports arising from the review of their child's death consistent with the *Coroners Act*, subject to any ongoing Court proceedings, and the Office of the Chief Coroner will now be making these reports available. Families who have not yet been contacted, may call the Office of the Chief Coroner at 1-877-991-9959 at any time in order to inquire about obtaining reports.

RESULTS:

A total of 45 cases were reviewed. The first question dealt with the examinations that were conducted, recognizing that in three cases Dr. Smith was performing a post-exhumation autopsy and in four cases he was providing an opinion in consultation, not having had the opportunity to conduct an autopsy himself. In all but one of the 45 cases, the reviewers agreed that Dr. Smith had conducted the important examinations that were indicated. In one case, there was concern that a complete examination had not taken place and in this same case that a specimen taken at autopsy had not been submitted at the time for potential testing. This concern was made known to appropriate Crown and Defence counsel who had carriage of this case prior to the case coming to conclusion in the Criminal Courts.

The second question was whether the experts agreed with the facts reported as arising from the examinations performed. In nine cases the experts did not agree with significant facts that appeared in either a written report or that came forward during expert testimony in Court. A common theme centred around the timing of certain injuries, including fractures.

The final question was whether the reviewers agreed with the interpretation of the examinations conducted with regard to the cause and where Dr. Smith provided an opinion, the mechanism of death. In 20 of the 45 cases, the reviewers had some issue with the opinion of Dr. Smith that appeared in a written report, testimony in Court, or both. The concerns raised by the reviewers in these 20 cases ranged from relatively minor to potentially more serious issues. In a number of these cases the reviewers felt that Dr. Smith had provided an opinion regarding the cause of death that was not reasonably supported by the materials available for review.

There were restrictions of liberty arising from findings of guilt, including 12 convictions and one finding of Not Criminally Responsible, in 13 of these cases where the reviewers did not agree with significant facts or with the interpretation of the examinations conducted. To date the reports of the reviewers have been provided to Crown and Defence counsel in three of these 13 cases. The reports in all of the remaining cases will be provided to the Crown and they will then be appropriately disclosed to Defence counsel.

The Chief Coroner appreciates the public concern that may arise as a result of the reviewers having expressed differing opinions in cases where there were subsequent convictions or a finding of Not Criminally Responsible. As indicated, the opinions of the external reviewers and the concerns leading to this opinion for all of these cases have been, or are in the process of being shared with appropriate Crown and Defence counsel. The significance of the concerns expressed by the reviewers, specifically with respect to the role any medical evidence may have played in a finding of guilt, will therefore be appropriately considered.

It is important to provide a context for the concerns expressed by the reviewers in two cases with respect to Dr. Smith's opinion on the cause of death and mechanism of death. In two cases the reviewers noted that the opinions reached by Dr. Smith were not inconsistent with the body of knowledge available at the time — the early 1990's — with respect to paediatric head injury. In fact, there is still disagreement between medical experts today as to the significance of certain findings in some cases of paediatric head injury. Although the reviewers disagreed with Dr. Smith's opinion, they felt that his conclusions in these two cases were consistent with what other Pathologists and medical experts may well have concluded at the time he provided his opinion.

It is also important to provide a context for the overall results of this review. Dr. Smith was conducting his work as one member of a larger death investigation team. This means that Dr. Smith was, in part, relying on information provided to him by coroners, police, and other forensic experts. Dr. Smith, working as a pathologist within the Coroner's system, frequently presented his findings and opinions at meetings and rounds where other pathologists and coroners would have had an opportunity to provide feedback and, where appropriate, disagree with the opinion being presented. In a number of these cases other pathologists may have reviewed or audited Dr. Smith's work as part of a quality assurance process. In certain cases where expert testimony was given, Defence experts appear not to have recognized concerns that have now been brought forward as a result of this review.

LESSONS LEARNED:

Lessons have been learned in the Ontario Coroner's System through previous cases and as a result of this review. Maintaining public confidence in the Ontario Coroner's System was an underlying reason for conducting this review. Some of the positive changes that have taken place and some of the processes that are now in place to ensure the highest quality of forensic death investigation include:

- In 1995, the Office of the Chief Coroner developed a protocol for coroners, pathologists, police, and other members of the death investigation team to follow when investigating paediatric deaths. This protocol, focusing on deaths of children under the age of two years, has subsequently been presented at a number of educational courses and has become the standard operating procedure for all members of the death investigation team. The protocol has been shared with other jurisdictions and has been used as a template for other death investigation systems. A number of improvements have subsequently been made to the protocol. Late last year, a revised protocol was released through the Office of the Chief Coroner whereby all child deaths under the age of five years are now subjected to this standardized investigation.

- The Office of the Chief Coroner has two review committees focusing exclusively on complex paediatric deaths. The Deaths Under Five Committee reviews the investigation materials and coroners' conclusions on all deaths under the age of five years to ensure consistency in the examinations conducted and the conclusions reached. The Paediatric Death Review Committee reviews complex paediatric deaths, including all cases where Children's Aid was involved prior to the death.

- All autopsies conducted on children under the age of five years are now performed in only one of four centres throughout the province: London, Ottawa, Hamilton and Toronto. This change was introduced in early 2002 to ensure that these complex autopsies are performed at centres where there is the greatest expertise in pathology and paediatric specialties, and where the resources for special tests such as CT or MR imaging are most accessible.

- All forensic autopsies on criminally suspicious cases, homicides, and cases going to inquest, now undergo a standardized audit process. A process of audit began in 1995 and has subsequently undergone a number of improvements. The current audit process, under the direction of the Chief Forensic Pathologist, is intended to ensure that all important examinations have been performed and that the facts arising from these examinations and the conclusions reached are logical and clearly supported by the materials available for any independent review.

- Guidelines have been prepared for autopsies on all criminally suspicious and homicide cases, under the direction of the Chief Forensic Pathologist. These guidelines have recently been updated to include a paediatric module. The guidelines include the important examinations to be completed and the documentation and specimen retention expected, to ensure that the conclusions reached are independently reviewable.

- Guidelines have also been produced for coroners focusing on the important observations to make at scenes, documentation expected in coroners' reports and the essential communication that is expected with pathologists and other members of the death investigation team. It is the coroner, at the conclusion of the investigation, that is responsible for certifying the death, including determining the cause and the manner of death. Arising from this review, an audit was performed of the Coroner's Warrant for Autopsy and the Coroner's Investigation Statements. In 11 of the 45 cases reviewed, the Warrants were completed with less information than what is currently expected based on the guidelines, although in no cases was it felt that the deficiencies identified impacted on the conclusions reached by Dr. Smith. Regardless, there is need for better communication between coroners and pathologists. As a result of this audit, it will soon be policy for direct telephone or in person communication between the coroner and pathologist, prior to the commencement of the autopsy, for every criminally suspicious or homicide case and for all deaths under the age of five years.

- A special course has been developed for pathologists who provide expert testimony in court. With the assistance of Crown counsel, Defence counsel and pathology experts, the importance of balanced and fair testimony are emphasized through a two-day course that includes mock examination and cross-examination. This course will be offered again in June 2007.

- Early case conferences are now held following all homicides and criminally suspicious cases, wherever there are outstanding issues or significant unanswered questions following the autopsy. These case conferences include a senior coroner, the pathologist who conducted the examination, scientists from the Centre of Forensic Sciences, police and any other experts as appropriate. These case conferences are held, in part, to ensure that all members of the death investigation know what has been found at the time of the autopsy and what outstanding examinations or test results are necessary before appropriate conclusions can be reached by the pathologist.

A number of these steps to improve the quality of investigations have been, and will continue to be, shared with other jurisdictions through educational courses and presentations.

FURTHER REVIEW:

This review covered the work of Dr. Smith from 1991 to 2002. Dr. Smith did, however, also conduct autopsies and provide opinions on cases between 1981 and 1991. Given the results of this review, there may well be cases prior to 1991, which raise similar concerns. With this in mind and also being mindful of the fact that the greatest concern surrounds cases with findings of guilt and restrictions of liberty, the Office of the Chief Coroner will work with the Ministry of the Attorney General to try to identify all such cases where Dr. Smith conducted an autopsy, or provided an opinion in consultation, prior to 1991.

As this list of cases is developed, the Prosecution Service will take the lead to disclose the overall results of this review to the person whose liberty was restricted. If any such person asserts their innocence and requests that their case be reviewed, the Office of the Chief Coroner will then assist the Prosecution Service and the Defence to arrange for an independent review of Dr. Smith's forensic pathology work and opinion. The results of the individual review will then be appropriately shared with the person requesting the review through the disclosure process.

As indicated in the original announcement, the start date of 1991 was an arbitrary one that coincided with the opening of the Paediatric Forensic Pathology Unit. This additional step is being taken at this time to ensure that cases of greatest potential concern are reviewed, regardless of when the work was conducted.

Conducting this review has been an essential step for the Office of the Chief Coroner. The Office of the Chief Coroner performs more than 20,000 death investigations and pathologists working for the Office conduct almost 7,000 autopsies every year. Coroners' investigations lead to many important recommendations to advance public safety and information gained through death investigations is essential for the administration of justice. The public must have confidence in the death investigations conducted by this Office. The Office of the Chief Coroner is unaware of any other jurisdiction that has as many processes in place to ensure the highest quality of death investigation, including independently reviewable post mortem examinations.

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