Inquiry into Pediatric Forensic Pathology in Ontario

REPORT

Volume 1 Executive Summary

Volume 2 Systemic Review

Volume 3 Policy and Recommendations

Volume 4 Inquiry Process

The Honourable Stephen T. Goudge
Commissioner

ISBN 978-1-4249-7794-9 (PDF)

INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

The Honourable Stephen Goudge,
Commissioner

180 Dundas Street West, 22nd Floor
Toronto Ontario M5G 1Z8

Tel: 416 212-6878
1 866 493-4544
Fax: 416 212-6879
Website: www.goudgeinquiry.ca

COMMISSION D'ENQUÊTE SUR LA MÉDECINE LÉGALE PÉDIATRIQUE EN ONTARIO

L'honorable Stephen Goudge,
Commissaire

180, rue Dundas Ouest, 22e étage
Toronto (Ontario) M5G 1Z8

Tél. : 416 212-6878
1 866 493-4544
Téléc. : 416 212-6879
Site Web : www.goudgeinquiry.ca

September 30, 2008

The Honourable Chris Bentley
Attorney General of Ontario
Ministry of the Attorney General
McMurtry-Scott Building
720 Bay Street, 11th Floor
Toronto, ON M5G 2K1

Re: Inquiry into Pediatric Forensic Pathology in Ontario

Dear Mr. Attorney:

With this letter I am delivering the Report of the Inquiry into Pediatric Forensic Pathology in Ontario. I hope the Report will provide the foundation on which to rebuild public confidence in pediatric forensic pathology in Ontario and its future use in the criminal justice system. It has been a privilege to serve as the Commissioner.

Yours very truly,

Stephen Goudge
Commissioner

STG/mm

Inquiry into Pediatric Forensic Pathology in Ontario

The Report consists of four volumes: 1 (Executive Summary), 2 (Systemic Review), 3 (Policy and Recommendations), and 4 (Inquiry Process). The table of contents in each volume is complete for that volume and abbreviated for the other three volumes.

Inquiry into Pediatric Forensic Pathology in Ontario

REPORT

Volume 1: Executive Summary

The Honourable Stephen T. Goudge
Commissioner

Published by the Ontario Ministry of the Attorney General

ISBN 978-1-4249-7792-5 (Print) (set)
ISBN 978-1-4249-7793-2 (Print) (v. 1)
ISBN 978-1-4249-7794-9 (PDF) (v. 1)

Copies of this and other Ontario Government publications are available from Publications Ontario at ServiceOntario Centre, College Park Building, 777 Bay Street at College, Toronto M5G 2E5. Out-of-town customers may write to Publications Ontario, 50 Grosvenor Street, Toronto M7A 1N8. Telephone (416) 326-5300; (416) 325-3408 TTY; or toll-free 1-800-668-9938 or 1-800-268-7095 TTY. Internet: www.publications.serviceontario.ca.

This Report is also available at www.goudgeinquiry.ca for one year following publication, and, thereafter, at www.attorneygeneral.jus.gov.on.ca.

Disponible en français

Library and Archives Canada Cataloguing in Publication Data

Inquiry into Pediatric Forensic Pathology in Ontario
Inquiry into Pediatric Forensic Pathology in Ontario report
[electronic resource]

Issued also in French under title: Rapport de la Commission d'enquête sur la médecine légale pédiatrique en Ontario.
Includes bibliographical references.
Electronic monograph in PDF format.
Available also in printed form.
ISBN 978-1-4249-7794-9 (v. 1)
978-1-4249-7796-3 (v. 2)
978-1-4249-7798-7 (v. 3)
978-1-4249-7800-7 (v. 4)

1. Forensic pathology—Ontario. 2. Forensic pathology. 3. Pediatric pathology. 4. Medical jurisprudence. 5. Child abuse—Investigation—Ontario. 6. Criminal justice, Administration of—Ontario. 7. Child welfare—Ontario. I. Title. II. Title: Rapport de la Commission d'enquête sur la médecine légale pédiatrique en Ontario.

RA1063.4 I57 2008 614'.108309713 C2008-964036-5

Contents

Volume 1: Executive Summary

Volume 2: Systemic Review

Volume 3: Policy and Recommendations

Volume 4: Inquiry Process

Executive Summary

Executive Summary

The Death of a Child and the Criminal Justice System

The sudden, unexpected death of a child is a devastating event for parents, for family, and for the entire community. If something suggests that a criminal act may have been involved, the devastation takes on a further tragic dimension. This reality lies at the core of the work of this Inquiry.

For the parents, the loss is shattering. Children are not supposed to die unexpectedly, and certainly not before their parents. If a suspicion arises that a parent killed the child, the death is only the beginning of the nightmare. The parent is immediately subjected to an intensive police investigation that inevitably stands in the way of any grieving process. If a charge is laid, it is very likely to be a serious one, with the parent removed from the home and often held without bail. The child protection authorities will likely seize the surviving children, remove them from the home, and place them in care. Emotions in the community will often run high. Each new trauma builds on the ones before.

For the surviving children, the impact is profound as well. They are often very young themselves, yet must cope with the sudden inexplicable loss of a sibling. If one of their parents is suspected, the children will likely be removed from their home and family, sometimes for years or even permanently. The same fate may befall children born later to the parents. They must live with the horror that the parent they love is suspected of killing a brother or sister.

For the extended families, there is also much pain. The child's death is their loss too. Some family members will be prepared to sacrifice everything to defend their loved one against any criminal charge. Others may be convinced of the suspected parent's guilt. Splits can emerge that remain painful for years, if not forever.

If the person suspected is not a parent but the child's caregiver, such as a babysitter, there can be similar trauma. Babysitters are often young people themselves.

The shock of being suspected of killing a child in their care is profound. The families of young suspects will also likely exhaust all the family's resources to come to their defence. A suspected caregiver who is charged faces the same lost freedom and the same community stigma as a suspected parent.

For the community itself, the death of a child in criminally suspicious circumstances is deeply disturbing. Children are the community's most precious and most defenceless asset. The sense of outrage and the urgent need to understand what happened are overwhelming.

Thus, the tragedy of a child who dies unexpectedly in suspicious circumstances has many victims. It becomes vital for society to deal with the tragedy in a way that is right and just, and that allows all those affected to come to terms with it. The criminal justice system is central to this task. It must seek to determine whether there is truth to the suspicion that the child was killed and, if so, by whom. Despite the complex and difficult challenges of investigating and adjudicating pediatric death cases, the criminal justice system must do so correctly and fairly, often in a highly charged emotional atmosphere.

The consequences of failure in these circumstances are extraordinarily high. For the parent or caregiver who is wrongly convicted, it almost certainly means time, perhaps years, unnecessarily suffered in jail, a shattered family, and the stigma of being labelled a child killer. Even if the criminal justice system stops short of conviction, family resources, both financial and emotional, are often exhausted in the struggle. And in either case, there may be a killer who goes unpunished. For the community at large, failure in such traumatic circumstances comes at a huge cost to the public's faith in the criminal justice system – a faith that is essential if the justice system is to play the role required of it by society.

The cases we examined at the Inquiry demonstrate how vital the role of the forensic pathologist can be in the success or failure of the criminal justice system in coping with the sudden, unexpected death of an infant in criminally suspicious circumstances. The suspected parent or caregiver will often have been the only person in contact with the child in the hours preceding death. There may be little additional evidence. But if the forensic pathologist determines the cause of the child's death, that opinion may be enough to play a decisive role in whether someone is charged and convicted. In these circumstances, the criminal justice system must be able to rely confidently on the opinion if it is to deliver a just outcome. The fate of the person suspected, the family, the surviving children, and the peace of mind of the community all depend on it.

The far-reaching human consequences of flawed forensic pathology provided the context for our work from the very beginning. Before the hearings began, I had the benefit of meeting with individuals who were directly affected by the

events that precipitated the Inquiry. They spoke poignantly about the pain of losing a child, and the added stress and shame that follow when the loss becomes the subject of criminal proceedings. The central role that flawed pediatric forensic pathology played in these cases was unmistakeable.

One tragic case involved William Mullins-Johnson, who was convicted of the first-degree murder of his niece Valin, in large measure because of the pathology evidence of Dr. Charles Smith. Dr. Smith's opinion was that the little girl had been strangled and sexually assaulted while Mr. Mullins-Johnson was babysitting her. This opinion was ultimately determined to be wrong. Mr. Mullins-Johnson has been found to have been wrongly convicted and was acquitted, but only after spending more than 12 years in prison.

During his testimony at the Inquiry, Dr. Smith was invited by Mr. Mullins-Johnson's lawyer to apologize. Mr. Mullins-Johnson was pointed out to him in the audience. Struggling with emotion, Dr. Smith offered his apology. Mr. Mullins-Johnson's spontaneous and deeply moving response is an eloquent testament to the human cost of failed pathology where a child dies in suspicious circumstances. This was their exchange:

> DR. CHARLES SMITH: Could you stand, sir?
>
> (BRIEF PAUSE)
>
> DR. CHARLES SMITH: Sir, I don't expect that you would forgive me, but I do want to make it – I'm sorry. I do want to make it very clear to you that I am profoundly sorry for the role that I played in the ultimate decision that affected you. I am sorry.
>
> MR. WILLIAM MULLINS-JOHNSON: For my healing, I'll forgive you but I'll never forget what you did to me. You put me in an environment where I could have been killed any day for something that never happened. You destroyed my family, my brother's relationship with me and my niece that's still left and my nephew that's still living. They hate me because of what you did to me. I'll never forget that but for my own healing I must forgive you.

This Inquiry was given two tasks. The first is to determine what went so badly wrong in the practice and oversight of pediatric forensic pathology in Ontario, especially as it relates to the criminal justice system. This task is addressed in Volume 2. It is my report on the systemic review and assessment of the practice and oversight of pediatric forensic pathology in Ontario from 1981

to 2001. It chronicles the systemic failings that occurred as they affected the criminal justice system.

My second task is to make recommendations to restore and enhance the public confidence in pediatric forensic pathology. That is the subject of Volume 3. My recommendations attempt to ensure that pediatric forensic pathology appropriately supports society's interest in protecting children from harm and bringing those who do harm children before the courts to be dealt with according to the law. If implemented, my recommendations will, I hope, also ensure that no one has to endure the horror of being charged criminally or having a family pulled apart or being wrongfully convicted because of flawed forensic pathology.

Growing Concerns and the Establishment of the Commission

From 1981 to 2005, Dr. Smith worked as a pediatric pathologist at Toronto's world-renowned Hospital for Sick Children (SickKids). Although he had no formal training or certification in forensic pathology, as the 1980s came to an end he started to become involved in pediatric cases that engaged the criminal justice system. Then, in 1992, he was appointed director of the newly established Ontario Pediatric Forensic Pathology Unit (OPFPU) at SickKids. He soon came to dominate pediatric forensic pathology in Ontario. He worked at the best children's hospital in Canada. His experience seemed unequalled, and his manner brooked no disagreement. He was widely seen as the expert to go to for the most difficult criminally suspicious pediatric deaths. In many of these cases his view of the cause of death was the critical opinion, and figured prominently in the outcome.

Over the course of the 1990s, Dr. Smith's reputation grew. But public concerns about his professional competence did as well. As early as 1991, a year before Dr. Smith's appointment as director, a trial judge acquitted a girl who, as a 12-year-old babysitter, had been charged with manslaughter in the death of 16-month-old Amber. His reasons for judgment strongly criticized Dr. Smith, the Crown's central witness, for both his methodology and his conclusions. The case is a cautionary tale of the devastating impact that flawed forensic pathology and irresponsible expert testimony can have on the lives of both those whose children die in suspicious circumstances and those accused of having caused the death. It was also a harbinger of things to come.

Over the decade, this judgment was followed by other warning signals about Dr. Smith's competence and professionalism. Unfortunately, throughout the 1990s, these signs were largely ignored by those tasked with the oversight of Dr. Smith and

his work. Ultimately, 14 years after the first warning signal had sounded, the growing concerns could no longer go unrecognized. They culminated in what is now known as the Chief Coroner's Review. In 2005, Dr. Barry McLellan, who had recently become the Chief Coroner for Ontario, called a full review into the work of Dr. Smith in criminally suspicious cases and homicides in the 1990s.

He announced that, to maintain public confidence, five highly respected forensic pathologists external to the Office of the Chief Coroner for Ontario (OCCO) would conduct a formal review of all the criminally suspicious cases since 1991 in which Dr. Smith had conducted the autopsy or provided a consultation opinion. The purpose of the review was to ensure that the conclusions reached by Dr. Smith were reasonably supported on the materials available.

Each of the five reviewers has formal training and certification in forensic pathology, and all are eminently qualified for the task asked of them. I am satisfied that the five forensic pathologists are among the very best in the world. The OCCO was extremely fortunate to obtain their services.

The results of the Chief Coroner's Review may be summarized as follows:

1 In all but one of the 45 cases examined, the reviewers agreed that Dr. Smith had conducted the important examinations that were indicated.
2 In nine of the 45 cases, the reviewers did not agree with significant facts that appeared in either Dr. Smith's report or his testimony.
3 In 20 of the 45 cases, the reviewers took issue with Dr. Smith's opinion in either his report or his testimony, or both.[1] In 12 of those 20 cases, there had been findings of guilt by the courts.[2]

The results of the Review, released on April 19, 2007, constituted the last and most serious blow to public faith in pediatric forensic pathology and the central role it must play in criminal proceedings involving child deaths. Six days later, by an Order in Council signed on April 25, 2007, the Province of Ontario established this Commission.

The Order in Council required the Commission to conduct a systemic review and assessment of the way in which pediatric forensic pathology was practised and overseen in Ontario, particularly as it relates to the criminal justice system from 1981 to 2001, the years in which Dr. Smith was involved. It was also to consider any changes made since 2001. The purpose of the review was to provide the

[1] See Appendix 28 at the end of Volume 4 for summaries of the 20 cases that the reviewers found problematic.
[2] In a 13th case, the Court found the accused not criminally responsible for the child's death by reason of a mental disorder.

basis for the Commission to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.

The Order in Council directed me to the cases examined by the Chief Coroner's Review, particularly the 20 in which the reviewers had serious concerns about Dr. Smith's work. The purpose was not to examine every aspect of these cases, but to determine what they reveal about what can and did go wrong in the practice and oversight of pediatric forensic pathology in those years, to enable recommendations about the future to be made.

Like many public inquiries, this Inquiry was called in the aftermath of a loss of public confidence in an essential public service. The public was understandably shocked by the results of the Chief Coroner's Review. In many of the 20 cases, parents or caregivers were charged with criminal offences that bear a significant social stigma. Some of those charged were convicted and incarcerated. In some of the cases, siblings of the deceased children were removed from the care of their parents. In Valin's case, the Court of Appeal for Ontario has determined that a miscarriage of justice occurred. An examination of the practice and oversight exemplified in these cases is essential if the systemic review is to achieve the purpose intended for it in the Order in Council – namely, to provide the basis for recommendations to restore the public confidence lost as a result of what happened in these cases. The Inquiry was required to address the legitimate questions about what went wrong with the practice and oversight of pediatric forensic pathology in order to fulfill that purpose and to ensure, so far as possible, that what went wrong does not happen again.

The Science of Forensic Pathology

The purpose of forensic pathology is to assist the state to find out why its citizens die. The medical dimension of forensic pathology involves the study of disease and injury in a deceased person, using the basic principles and methodologies of pathology to determine, if possible, the cause of death, and to address the timing of injuries or other medical issues that help explain the death. Its legal dimension is to assist the state's legal systems, most importantly, the criminal justice system, to understand how the death occurred by explaining the relevant pathology.

Forensic pathology typically involves the performance of a post-mortem examination, also called an autopsy, which entails the dissection of the body, an examination of organs and tissues, and ancillary investigations including X-rays, laboratory examinations, and toxicology testing. Forensic pathologists do more than just perform the post-mortem examination, however. They are called on to

meet with other members of the death investigation team to discuss their work. And they must be able to communicate their findings effectively to various participants in the criminal justice system, including police, prosecutors, defence counsel, and the court. In summary, the forensic pathologist focuses on interpreting the post-mortem findings to assist in the end point of the death investigation required by the state, which may include a criminal trial, an inquest, or a coroner's finding of cause and manner of death made without an inquest.

Pediatric forensic pathology encompasses the subset of cases within forensic pathology that involves the deaths of infants, children, and adolescents. Although training and experience in pediatric pathology can add great value to the forensic investigation of a pediatric death, forensic pathology remains the core discipline for death investigations in pediatric forensic cases.

The distinctiveness of forensic pathology can be seen by comparing it to clinical pathology. Although the fundamental scientific principles of pathology apply equally to forensic pathology and to clinical pathology, their analytical frameworks are very different. The clinical pathologist focuses on providing diagnostically useful advice to a clinician to assist in the medical management of a patient. The forensic pathologist, in contrast, focuses on providing diagnostically useful conclusions for the death investigation team and the judicial process.

It follows that, although every forensic pathologist needs to be a competent clinical pathologist, the opposite is not true. Many competent clinical pathologists will never have an interest in forensic work and will never need to obtain the requisite knowledge and expertise in forensic work. A forensic pathologist, however, must be trained in, and develop an aptitude for, the requirements of the legal process. This requires an emphasis in the conduct of the post-mortem examination on identifying forensically significant findings such as injury, collecting potentially relevant evidence, and maintaining its continuity, none of which arise in clinical pathology. It requires that post-mortem documentation serve the needs of the participants in the justice system, including the coroner, police, Crown, defence, and court – another dimension that does not arise in clinical pathology. And it is essential that forensic pathologists be able to testify fairly, objectively, and in language that clearly communicates their findings. Few medical practitioners have, or require, any detailed understanding of the legal system and the legal investigative method. Becoming proficient in these areas is thus one of the features distinguishing forensic pathologists from their clinical counterparts.

The criminal justice system values finality. However, forensic pathology is an evolving science in which controversies exist, and where findings and opinions often require interpretation. This tension underlies much of the discussion in Volume 3. Moreover, the evolution of scientific knowledge will often be accompanied

by controversy – as pathologists debate whether the existing scientific knowledge permits certain opinions to be reasonably formed, and whether new scientific knowledge casts doubt on previously expressed opinions or, at the very least, modifies the levels of confidence with which those opinions can reasonably be expressed.

The reliability of forensic pathology opinions matters a great deal to the criminal justice system. In cases in which there are important issues of pathology, as often occurs in pediatric death cases, flawed pathology can lead to tragic outcomes. The cases we examined at this Inquiry provide graphic evidence of that reality. Flawed pathology can result in a parent, family member, or caregiver being wrongly entangled in the criminal justice system, and wrongfully convicted and incarcerated, as happened to Mr. Mullins-Johnson in Valin's case.

It is equally tragic, however, if flawed pathology steers the criminal justice system away from the true perpetrator, as happened in Jenna's case. In that case, the erroneous pathology failed to focus the criminal investigation on Jenna's babysitter. Instead, Brenda Waudby, Jenna's mother, became the focus of the investigation. As a result, the babysitter, who was the one responsible for Jenna's death, escaped detection for many years.

In either situation, whether the flawed pathology plays a part in a wrongful conviction or in allowing a criminal to escape detection, justice is not served and public confidence in the legal system is diminished. As we will see, both the science and the criminal justice system have important roles to play in ensuring against either possibility.

The Practice of Pediatric Forensic Pathology

My review clearly demonstrates the kinds of serious failures that occurred in the practice of pediatric forensic pathology in Ontario from 1981 to 2001. It must be remembered, however, that what was happening with pediatric forensic pathology reflects in very large measure what was happening with forensic pathology generally. The practices used, the oversight mechanisms available, and the shortcomings were common to both. In this sense, pediatric forensic pathology is a subset of forensic pathology.

Moreover, these serious failures took place within a setting larger than the individual pathologists. As I later describe, the senior officials who oversaw the death investigation system must also be held responsible for the tragic events about which I heard.

I have necessarily drawn heavily on the evidence I heard about the work of Dr. Smith in the criminally suspicious cases that were the subject of the Chief Coroner's Review. The evidence provides little basis, however, on which firm conclusions can

be drawn about his work in hospital pathology or his work for the OCCO in cases that were not criminally suspicious.

This focus on Dr. Smith's work in criminally suspicious cases reflects the reality that the errors he made were a primary cause of the significant loss of public confidence in the use of forensic pathology in pediatric criminal cases which made the review necessary. I have not attempted to determine the frequency with which these kinds of errors were made, or the extent to which flawed practices were followed by Dr. Smith or by others in those years. That was not my task. What is important is to determine the ways in which the practice of pediatric forensic pathology could and did go badly wrong, so that the problems thus revealed can be addressed and, to the extent possible, prevented from happening again.

Although much of what we heard dealt with Dr. Smith, the evidence also showed that, in a number of instances, other pathologists were involved as well. Some made the same errors he did. Many, and in some instances most, followed some of the same practices. In all these instances, however, the serious errors that were made, whether by Dr. Smith or others, exemplify grave systemic problems with the practice of pediatric forensic pathology in Ontario at that time. These troubling problems were not confined to Dr. Smith. Without correction of these systemic failings, these errors could well occur again. They were not merely the isolated acts of a single pathologist which could be fixed by his removal.

My review thus identifies a wide range of failings in the practice of pediatric forensic pathology in Ontario from 1981 to 2001. These failings provide the basis for devising systemic changes to the practices used by pathologists particularly in criminally suspicious pediatric cases. The recommendations I make in Volume 3 respond directly to these findings and will, I hope, ensure that pediatric forensic pathology can properly serve the criminal justice system in the future.

I turn, then, to the various aspects of Dr. Smith's work that I found wanting and that demonstrate systemic failings in the practice of pediatric forensic pathology from 1981 to 2001.

Training and Experience

Dr. Smith is a pediatric pathologist, not a forensic pathologist. He has neither formal forensic pathology training nor board certification in that field. In the 1980s and the early 1990s, however, almost all the coroner's autopsies in Ontario were performed by fee-for-service pathologists who had neither training nor certification in forensic pathology. Many of them worked in community hospitals. In a small number of cases, physicians without any specialization in pathology

completed some post-mortem examinations for the OCCO. Many local hospital pathologists who had no experience with pediatric cases and no forensic training performed pediatric autopsies. Whether a pathologist had the necessary skill to perform any given autopsy depended largely on individual work experience.

In the 1980s, most pediatric forensic autopsies in the Toronto area were conducted at SickKids. Most staff pathologists at SickKids conducted coroner's autopsies on a fee-for-service basis as a required part of their duties for the pathology department.

In the 1980s and 1990s, there was a misplaced emphasis on who should lead the practice of pediatric forensic pathology. The prevailing view in Ontario at that time was that pediatric pathologists were best situated to perform forensic autopsies on infants and children. As a result, expertise in pediatric pathology was emphasized over training and qualifications in forensic pathology. The nine pathologists performing coroner's autopsies at SickKids in the 1980s had varying levels of training or work experience in forensic pathology. None of them had formal certification in forensic pathology, nor had they completed fellowships in that discipline.

Some of the SickKids pathologists did not feel comfortable or qualified to perform coroner's autopsies, especially those in criminally suspicious cases. On occasion, they declined to take on cases they felt were beyond their expertise. When that happened, the cases were either given to a colleague who may have had more forensic experience or returned to the unit which is now the Provincial Forensic Pathology Unit (PFPU) at the OCCO.

In 1981, after completing his fellowship in pediatric pathology, Dr. Smith started working full time at SickKids. He had no forensic pathology training, and only limited exposure to criminally suspicious cases and death investigations. Because of his strong interest in autopsies, however, he began to perform more of them than did his pathology colleagues at SickKids, who were primarily interested in clinical pathology. By the 1990s, most of his autopsy work was forensic pathology – that is, autopsies performed under coroner's warrant.

On September 23, 1991, SickKids and the Ministry of the Solicitor General entered into an agreement that created the Ontario Pediatric Forensic Pathology Unit. The OPFPU was the first regional forensic pathology unit created in the province, although others followed in the next few years. It performed autopsies on most infants and children who died in Toronto and the surrounding area, and also on pediatric death cases from elsewhere in the province as needed. The OPFPU was an entity formed by contract and composed of the SickKids pathologists who performed work for the OCCO. It was not a discrete physical unit or a separate entity within the hospital's pathology department.

In 1992, the OCCO and SickKids agreed to appoint Dr. Smith as the first official director of the OPFPU. The OCCO did not select Dr. Smith because of his forensic pathology training or expertise. Indeed, in 1992, Dr. Smith had no forensic pathology training, and by then had been involved in only 10 to 15 criminally suspicious cases. Rather, Dr. Smith was the only pathologist at SickKids who had the interest and the willingness to take on the role. By 1990, Dr. Smith was already devoting much of his time to coroner's cases and had been named staff pathologist in charge of autopsy services at SickKids because of his dedication to coroner's work. He was willing to fill a void that no one else wanted to fill.

Despite his increasing concentration on forensic work, Dr. Smith did not take any forensic pathology training. His continuing medical education, which consisted of attending conferences and reviewing the available literature, focused primarily on pediatric pathology. He told us that at that time he did not view forensic pathology as a separate discipline that could inform his work. He received no training in either injury identification or the appropriate role of the forensic pathologist in the criminal justice system. He had no exposure to any certified forensic pathologists and did not appreciate that there was any value in obtaining knowledge about forensic pathology. As Dr. Smith admitted, "[t]hat thought didn't cross my mind, and certainly no one suggested it." Instead, he picked up his limited understanding of forensic pathology on the job. Dr. Smith now acknowledges that his forensic pathology training was "woefully inadequate," and that this gap contributed significantly to his mistakes in the cases examined by the Commission.

Over time, however, Dr. Smith's reputation grew. In the mid-1980s, he began lecturing on pediatric forensic pathology, particularly about issues relating to the criminal justice system. By the 1990s, he was lecturing on the subject to Crown counsel and police officers and had become a regular participant at educational courses offered for coroners. There is no doubt that he became an effective speaker to these audiences. At the Inquiry, Dr. Smith testified that these speaking engagements helped to build his experience and comfort level in both pediatric pathology and forensic pathology. His growing reputation seems to have been based more on these speaking engagements than his work in criminally suspicious cases. It certainly was not based on any formal training in forensic pathology.

I draw two main lessons from this history. First, Dr. Smith lacked basic knowledge about forensic pathology. It is true that few pathologists were trained in forensic pathology, and that, in several of the cases examined by the Commission, other doctors made the same mistakes he did. It is clear, however, that many

pathologists without proper forensic training shied away altogether from criminally suspicious cases or were careful to obtain the assistance of those few who had the requisite knowledge in forensic pathology. No other pathologists threw themselves into the challenging area of pediatric forensic pathology, untrained, quite the way Dr. Smith did. Moreover, Dr. Smith tended to work in isolation. He did not readily seek advice from or consult with colleagues about his difficult cases. Over the course of time, as we have seen, this behaviour exacted an unacceptable price in a sequence of cases.

Second, when Dr. Smith now says he was unaware of what he did not know and how damaging that lack of knowledge would be to the validity of his work, he violated a cardinal rule of scientific expertise, especially where it is engaged by the justice system. The expert must be aware of the limits of his or her expertise, stay within them, and not exaggerate them to the court. Dr. Smith did not observe this fundamental rule.

It is essential for a well-functioning pediatric forensic pathology system that criminally suspicious pediatric cases be handled by pathologists who are properly trained and experienced in forensic pathology. And, like all experts, these pathologists must know the limits of their knowledge and observe them.

Autopsy Practice

Many of the pathology practices that Dr. Smith followed illustrate systemic failings that could and did occur in the practice of pediatric forensic pathology from 1981 to 2001. He almost never attended the death scene. He did not always ensure that he had all the relevant medical information before he conducted an autopsy. He was sloppy and inconsistent in documenting the information he did receive. He was indiscriminate in accepting and appearing to rely on information about the social history of those allegedly involved with the death. Autopsies were performed without the necessary relevant information, but with irrelevant information that left scientific conclusions skewed by unscientific considerations. In several cases, Dr. Smith failed either to account for contradictory evidence in arriving at his opinion or to consider adjusting his opinion to take new information into account. These failures contributed to misdiagnoses with significant consequences.

His reports were typically nothing more than a recitation of the findings at autopsy, and his conclusions typically gave no elaboration of either a reasoning process or supporting literature that might provide a persuasive connection between facts and conclusion. Post-mortem reports that contained bald conclusions were, at best, of little use to the criminal justice system and, at worst, mis-

leading. And, as the expert reviewers concluded, in many cases reviewed by the Commission Dr. Smith's ultimate opinions were fundamentally wrong. These practices carried adverse consequences for both his work and its utility to the criminal justice system.

Dr. Smith now says that, in engaging in these practices, he was merely doing what pathologists customarily did in those days. On the basis of the evidence I heard, I can agree that there were other pathologists who did what he did. Although I cannot say with certainty how widespread all of these practices were, they exemplify serious systemic problems. Because of the difficulties they caused, they must be addressed if public confidence is to be restored.

Interaction with the Criminal Justice System

Pathologists' interactions with other participants in the criminal justice system – police, Crown counsel, and coroners – are crucial to the smooth functioning of that system. Dr. Smith's interactions with these participants displayed another series of systemic problems in the practice of pediatric forensic pathology.

One of these was timeliness. In the 1980s and 1990s, delays in the production of pathologists' post-mortem reports represented a system-wide problem in Ontario. Most pathologists in those years attempted to manage their delays on an ad hoc basis. They tried to prioritize criminally suspicious and homicide cases and to respond promptly to urgent requests made for a specific report. Although this approach did not resolve the problem, for the most part it did not significantly impede the criminal justice system. Coroners, police officers, and both Crown and defence counsel received post-mortem reports when the need for them became most urgent.

However, Dr. Smith often ignored repeated requests for his reports even when he knew they were needed urgently by the criminal justice system. He frequently blamed others for his delays. In three cases, Dr. Smith produced his report of post-mortem examination only after the police had obtained a subpoena requiring him to bring his report with him to court. In another case, he produced a report only after a judge had made an order compelling him to do so. In my view, this was simply incompatible with the needs of the death investigation team and of the criminal justice system. Leaving this problem to ad hoc solutions was not good enough.

Often, the pathologist assists with the police investigation and the criminal proceedings by helping the police and Crown counsel to understand the pathology evidence and its limits. Sometimes, the defence will retain a pathologist to assist defence counsel. Regardless of who retains the pathologist, his or her task is

not to take a side in the criminal justice system. The role is a neutral one, at all stages of involvement, not just when testifying.

Dr. Smith failed to understand that his role as an expert in the criminal justice system required independence and objectivity. In one case Dr. Smith inappropriately furthered a police investigation by agreeing to discuss his report of post-mortem examination with the deceased child's mother despite knowing that she was a suspect in the child's death and that the police would be intercepting his conversation with the suspect.

In addition, in a number of cases, his early informal expressions of opinions to the police were too categorical, potentially skewing the criminal investigation. His recording of these interchanges was as haphazard as his note-taking at autopsy. These cases exemplify practices that can and did cause great difficulties for the criminal justice system. The systemic challenge is to ensure that they not continue.

Providing Evidence

An infant or child death that results in a criminal charge is as difficult and challenging as any faced by the criminal justice system. The charge is normally serious, and the stakes are high. Where the cause of death is an issue, the expert testimony of the pathologist is often critical. The pathologist's role as an expert witness is to remain impartial and not to act as an advocate for either the Crown or the defence. In keeping with that role, pathologists must ensure that the evidence they present to the court is understandable, reasonable, balanced, and substantiated by the pathology evidence. For pathologists doing forensic work, the ability to do the job required in the courtroom is as essential as the ability to do the job in the autopsy suite.

There were very serious failings in the way Dr. Smith performed this important aspect of his role as a pathologist doing forensic work. Problems with his testimony permeated many of the cases examined by the Commission. They ranged from his misunderstanding of his role, to his inadequate preparation, to the erroneous or unscientific opinions he offered, and, perhaps most important, to the manner in which he testified, which ranged from confusing to dogmatic.

First, Dr. Smith failed to understand that his role as an expert witness was not to support the Crown. At the Inquiry, he was candid on this point. He had never received any formal instruction in giving expert evidence. He acknowledged that, when he first began his career in the 1980s, he believed that his role was to act as an advocate for the Crown and to "make a case look good." He explained that the perception originated, in some measure, from the culture of advocacy that he said

prevailed at SickKids at the time. In the early 1980s, there was a legitimate concern at SickKids that child abuse was under-reported, under-detected, and under-prosecuted. Dr. Smith was a part of that advocacy culture and perceived that his job, at least in part, was to reverse those trends.

Second, Dr. Smith failed to prepare adequately for court. He did not review his file or the autopsy materials before attending court. Instead, his preparation consisted of printing his report of post-mortem examination from his computer and reading it over before court to remind himself of the case. This preparation was insufficient and, not surprisingly, caused difficulties. As expert witnesses, pathologists must prepare for their testimony. After all, they can be of assistance to the court only when they have a complete understanding of the case and the basis of their expert opinion. They can have such an understanding only with proper preparation.

Third, the evidence also showed that, rather than acknowledging the limits to his expertise, Dr. Smith sometimes misled the court by overstating his knowledge in a particular area. When Dr. Smith performed the post-mortem examination in Sharon's case, he had little experience with either stab wounds or dog bites. He had only ever seen one or two cases of each kind. At the preliminary hearing, however, Dr. Smith left the impression that he had significant expertise with both. He did not tell the court he had seen only one or two cases involving penetrating wounds or stab wounds. Dr. Smith told the court: "I've seen dog wounds, I've seen coyote wounds, I've seen wolf wounds. I recently went to an archipelago of islands owned by another country up near the North Pole and had occasion to study osteology and look at patterns of wounding from polar bears." His attempt to so exaggerate his abilities disguised his lack of relevant expertise.

Fourth, several times Dr. Smith gave inappropriately unscientific evidence by resorting to his own experiences as a parent. For example, in Amber's case, Dr. Smith testified that short household falls by children are not fatal. In support of his conclusion, he told the court that he was a father of a young girl and a young boy. He had watched his children "tumble" down the stairs. What his children needed after such a fall was "a little cuddling, a little loving, kissing whatever part of [his] son's or daughter's body may have been injured, looking for a bruise which may show up with time or swelling which may occur." According to Dr. Smith, "My children have fallen from, and … unfortunately bounced down more steps than those and they are still happy and healthy children and that's personal, you can discard that if you want." At the Inquiry, Dr. Smith acknowledged that the reference to his experience as a parent was unscientific and inappropriate. I agree.

Fifth, Dr. Smith sometimes failed to provide a balanced view of the evidence

and to acknowledge the existence of a controversy. He presented his opinion in a dogmatic and certain manner when the evidence was far from certain.

Dr. Smith's sixth error was in his unprofessional and unwarranted criticism of other professionals. In several cases, Dr. Smith expressed opinions in court regarding other experts that were disparaging, arrogant, and, most important, unjustified.

Seventh, Dr. Smith, on occasion, testified on matters well outside his area of expertise. In two cases, Amber's case and Tyrell's case, he provided opinions to the court on the "profile" or characteristics of the perpetrator of shaking and blunt head injuries. This evidence went well beyond the scope of his expertise. Expert witnesses are called to the court to speak to the issues that involve their expertise. They are not given free rein to discuss other matters on which they happen to have an opinion.

Eighth, there were instances where Dr. Smith offered opinions that were speculative, unsubstantiated, and not based on pathology findings. At the Inquiry, Dr. Smith admitted that, in some instances, his speculation was both unhelpful and prejudicial. He explained that he did not know he should not speculate. I find it hard to accept Dr. Smith's explanation. Pathologists provide pathology opinions. I do not see how pathologists can believe that, when there is no pathology evidence, it is open to them to speculate on what could have happened. Although I appreciate that pathologists want to be helpful to the court, speculating about the various possibilities, without any pathology evidence, is unhelpful and potentially prejudicial. I also accept that the court and counsel have a duty to ensure that the pathologist does not give inappropriate evidence. When the court or counsel realizes that the pathologist is speculating, either one should object and put an end to that line of questioning. Pathologists, however, are in the best position to ensure that the evidence they provide is not speculative and is substantiated by the necessary evidence. The pathologist must be responsible for doing just that.

Ninth, from time to time Dr. Smith used language in his testimony that was loose and unscientific. Certain inappropriate expressions are found throughout his testimony. The language of "betting" is one of them. For example, Dr. Smith testified that, if he were a "betting man," he would say that the child's death was non-accidental.

Finally, Dr. Smith did not always testify with the candour required of an expert witness. In some cases, he made false and misleading statements to the court. These statements are troubling. It goes without saying that an expert witness giving evidence under oath should do so with complete candour and honesty. False and misleading statements should form no part of an expert witness's evidence.

Although Dr. Smith's evidence was not invariably deficient, there were many

troubling examples. They clearly demonstrated ways in which the practice of pediatric forensic pathology in Ontario in those years went badly wrong. In cases like those at issue here, where the expert's opinion is critical and the charges are so serious, tragic outcomes in the criminal justice system are hardly surprising. While Dr. Smith, as the pathologist giving expert evidence, must bear primary responsibility for these deficiencies, those charged with overseeing his performance cannot escape responsibility. Indeed, neither can other participants in the criminal justice system – Crown, defence, and the court. Each had an important role to play in ensuring, so far as possible, that results in the criminal justice system were not affected by flawed expert testimony, including that of forensic pathologists.

Dr. Smith and the Challenge of Oversight

Although this is a systemic Inquiry, it is important to give some attention to Dr. Smith's personal characteristics that may have contributed to these failings. It is true that personal characteristics cannot be changed by revising the practices followed by pathologists, but their impact can be controlled. In this sense, Dr. Smith's particular personal characteristics exemplify an important challenge – one that involves ensuring that the quality assurance and oversight mechanisms put in place are able to detect the personal shortcomings of pathologists and prevent them from doing harm. If in future there should be an incompetent pathologist, the systemic challenge is to ensure that those responsible for maintaining an effective and fair criminal justice system are able to do so.

It is in this context I turn to a brief assessment of some of the traits that affected Dr. Smith's flawed practices. In his appearance at the Inquiry, Dr. Smith was candid in acknowledging how disorganized he was. He also admitted his own arrogance and the dogmatic manner in which he often presented his opinions. These qualities were on display in many of the cases examined by the Inquiry. They made impossible the proper performance of the task required of him as an expert. As well, his deeply held belief in the evil of child abuse caused him to become too invested in many of these cases. As a result, the objectivity and self-discipline that must be the foundation of the expert's role proved to be beyond him.

Dr. Smith was adamant that his failings were never intentional. I simply cannot accept such a sweeping attempt to escape moral responsibility. The most obvious examples of conduct that belie Dr. Smith's assertion were his attempts to frustrate oversight. Dr. Smith actively misled those who might have engaged in meaningful oversight of his work. When senior officials at the OCCO raised concerns about his conduct in several of the cases examined by the Commission,

Dr. Smith did not respond candidly. Similarly, when the College of Physicians and Surgeons (CPSO) investigated complaints about his conduct in the cases of Amber, Nicholas, and Jenna, he made false and misleading statements. Dr. Smith's misrepresentations frustrated any meaningful oversight that the two institutions might have offered. His attempts to mislead spanned his entire career as director of the OPFPU and continued even after he had resigned from the position. At those moments when the need for accountability and oversight might have become even more apparent to those in a position to do something about it, Dr. Smith was not above using deception to attempt to throw them off the trail.

Dr. Smith is a complex, multi-dimensional person. The terrible irony is that, in some ways, the negative attributes I have described were compounded by positive qualities. He was willing to take on difficult pediatric cases that his colleagues were not anxious to do. He has a sense of responsibility that led him to cooperate with the work of this Inquiry. In his evidence, he admitted many of his shortcomings that the evidence had laid bare. And, albeit much too late, he owned up to a great deal. In addition, the evidence is clear that others found him engaging. Support staff liked working with him, and many people found him a charismatic and effective speaker. As we now know, although he did so on the basis of terribly deficient training and fundamentally flawed practices, he appeared to be completely assured, and often certain, in circumstances where the science could not provide certainty. These sorts of qualities not only increased the risk he posed as an expert in the criminal justice system but tended to build an unwarranted trust in already lax overseers.

Such an expert can do much damage without effective oversight by those who must provide it and constant vigilance on the part of the participants in the criminal justice system who can protect the system against flawed expert evidence. None of that happened here. The challenge is to ensure that this history does not repeat itself.

Oversight of Pediatric Forensic Pathology

The tragic story of pediatric forensic pathology in Ontario from 1981 to 2001 is not just the story of Dr. Smith. It is equally the story of failed oversight. The oversight and accountability mechanisms that existed were not only inadequate to the task but also inadequately employed by those responsible for using them. This review must focus principally on the roles played in those years by the Chief Coroner for Ontario, Dr. James Young, and the Deputy Chief Coroner, Dr. James Cairns.

At its simplest, accountability is the obligation to answer for a responsibility

conferred. When called on to account, the accountable party must explain and justify his or her actions and decisions, normally against criteria of some kind. Oversight is the other side of the equation. Once a responsibility is conferred, oversight seeks to ensure that those who hold the responsibility are held accountable for their actions and decisions. Quality control or quality assurance measures can be important tools in successfully performing the oversight function. Setting standards, monitoring compliance, and correcting shortcomings are all important quality control measures that are part of effective oversight.

As with my discussion of the practices used in pediatric forensic pathology, my review of oversight and accountability must necessarily describe what was happening for forensic pathology generally. Very few oversight and accountability mechanisms were targeted specifically at pediatric forensic pathology. In large measure, the mechanisms and their shortcomings applied to all of forensic pathology.

My assessment of how those who had oversight responsibility for forensic pathology performed their jobs has been done largely through the lens of the cases conducted by Dr. Smith which were examined at the Inquiry. As with my review of the practice of pediatric forensic pathology, it is important to emphasize that this investigation represents neither a full survey nor a random sampling of the supervisory work done by the individuals who were responsible for pediatric forensic pathology in Ontario from 1981 to 2001. What these cases provide is a clear picture of the ways in which that supervision could and did go wrong, with the tragic consequences I have described. In Volume 3 I propose a number of recommendations (also appended to this summary) that will, I hope, contribute to preventing another such damaging failure of oversight.

The failures of supervision are seen most graphically in a series of events through the 1990s which called for the oversight of Dr. Smith, but in which the response was woefully inadequate. For far too long, Dr. Smith was not held accountable. This breakdown in oversight responsibility is not something that can be dealt with simply by replacing the overseers. Rather, the shortcomings represent systemic failings of oversight that must be corrected if public confidence is to be restored.

Institutional and Organizational Weaknesses

My review clearly reveals that the troubling series of events during the 1990s took place in the context of institutional and organizational weaknesses that made effective oversight difficult. In particular, the legislative framework created by the *Coroners Act*, RSO 1990, c. C.37, provides no foundation for effective oversight of

forensic pathology in Ontario. Although the *Coroners Act* structures the coronial system in Ontario and provides that the coroner is in charge of the death investigation, it makes no mention of a forensic pathology service, those who might run it (such as the Chief Forensic Pathologist), or those who should be allowed to perform post-mortem examinations. There is no reference at all to pediatric forensic pathology. It provides only that the coroner can issue a warrant for the post-mortem examination of the body of a deceased person, and that the person performing that examination (who is not required by the *Coroners Act* to be a pathologist) must report the findings forthwith to the coroner and the Crown attorney, among others. In other words, no legislative framework was or is currently provided to ensure proper oversight and accountability of forensic pathology in general or pediatric forensic pathology in particular.

In addition to being ignored in the legislation, the supervisory role of the Chief Forensic Pathologist was left unclear in OCCO policies and practices at the time. Relationships between the OCCO and the regional forensic pathology units, in particular the OPFPU, were ill defined and assigned neither clear oversight responsibilities nor clear lines of accountability. The directors of the regional forensic pathology units, such as Dr. Smith, were subject to no expressly articulated oversight whatsoever.

These weaknesses in the institutional arrangements left the working relationships in individual cases largely between the pathologist and the investigating coroner. At the level of the individual case, local coroners, who were most frequently general practitioners, simply did not have the expertise to provide any quality control over the pathologist's work, particularly in the more difficult forensic cases.

From 1994 to 2001, Dr. David Chiasson served as Chief Forensic Pathologist for Ontario. However, his oversight responsibilities were ill defined and he had few mechanisms to use to hold individual pathologists accountable. Nonetheless, during his tenure as Chief Forensic Pathologist, Dr. Chiasson tried to introduce some quality control measures for the pathology done in individual forensic cases. But best practices guidelines were limited. Peer review by colleagues in an individual case was cursory. Review by the Chief Forensic Pathologist of post-mortem reports was only a paper review. Rounds proved ineffective at providing quality control in criminally suspicious cases. There was no organized tracking of the timeliness of reports or of pathologists' involvement in ongoing cases, nor was there any review of either their testimony or judicial comments about them. There was no institutionalized mechanism for receiving complaints from other participants in the criminal justice system and addressing them in an expeditious and objective way. The lack of tools available to the Chief Forensic Pathologist to

achieve compliance by individual pathologists compounded the challenges of effective oversight. These failings all contributed to the difficulties of proper quality assurance in individual cases.

These institutional shortcomings were more than enough to stand in the way of truly effective oversight. In the context of Dr. Smith's flawed practices, they were exacerbated by the professional relationships between him and those who might have done something about his mistakes.

As Chief Forensic Pathologist, Dr. Chiasson felt he did not have overall responsibility for the OPFPU or for Dr. Smith. He had no clear oversight authority by which to hold Dr. Smith accountable. Nor was he in a personal position to exercise any professional suasion over him. He was junior to Dr. Smith, who had by 1994 become the perceived leading expert in the field of pediatric forensic pathology. Dr. Smith never asked him for advice or assistance even in his most complex cases, such as Sharon's case, where Dr. Chiasson's forensic pathology expertise would have added significant value. Overall, Dr. Chiasson felt that Dr. Smith was not open to even the gentlest oversight from him.

Equally important, by the time Dr. Chiasson became Chief Forensic Pathologist, Dr. Smith already had close working relationships with Dr. Young and Dr. Cairns. By the mid- or late 1990s, Dr. Smith and Dr. Cairns consulted on cases at least three or four times a week. As Dr. Smith told the Inquiry, he looked to Dr. Cairns for advice and peer review in forensic issues. When he dealt with the OCCO, Dr. Smith clearly was used to working directly with both of these senior officials. I have no doubt that he viewed them as the supervisors of his pediatric forensic pathology work. And, through the 1990s, that was the essential reality. As the problems became more serious and impossible to ignore, Dr. Cairns and Dr. Young finally, and far too late, moved to exercise this oversight responsibility and hold Dr. Smith accountable.

Thus, the story of failed oversight in Dr. Smith's years is in large part the story of Dr. Young's and Dr. Cairns' failures and of the context in which that happened – the completely inadequate mechanisms for oversight and accountability.

Failures of Oversight through the 1990s

The story of missed warning signs began early in the decade, with Dr. Smith's participation in Amber's case. In July 1991, Justice Patrick Dunn of the Ontario Court (Provincial Division) acquitted S.M. of the charge of manslaughter in the death of Amber after a lengthy trial in Timmins, Ontario. Dr. Smith was the key Crown witness. Justice Dunn identified 16 areas of concern with the work of Dr. Smith and two other SickKids physicians.

At the Inquiry, Dr. Young acknowledged that the leaders of the OCCO would have been concerned about these criticisms of Dr. Smith, and particularly his lack of objectivity, skill, and familiarity with the latest literature, if they had been aware of the decision. But they were not. Dr. Young testified that he did not read or learn much about Justice Dunn's decision until he was preparing to appear at the Inquiry. Instead, he simply accepted Dr. Smith's unlikely – and false – explanation that, after the trial, the trial judge told him that he had not properly understood the forensic pathology evidence and, if given another chance, would now convict S.M.

At the Inquiry, Dr. Young admitted that he had many opportunities to review this important decision. For example, in 1997, after S.M.'s father complained to the CPSO about Dr. Smith, Dr. Young met with the CPSO's investigator. She told Dr. Young about the trial and specifically that Justice Dunn's judgment was highly critical of Dr. Smith. Dr. Young did not really appreciate the significance of what she told him. His views were coloured by his belief in Dr. Smith's status as the leading pediatric forensic pathologist in the province, by Dr. Smith's misleading account of the trial judge's statements, and by his own entrenched misunderstanding of the case.

Throughout the 1990s, coroners, police officers, and Crown counsel brought a litany of concerns about Dr. Smith's work practices to the attention of the OCCO. People complained repeatedly about Dr. Smith's failure to produce reports in a timely fashion; his unresponsiveness; his carelessness; and the inconsistencies between his written reports, his pre-trial comments, and his sworn evidence. In many instances, nothing was done to respond to these concerns. When the OCCO did respond, it was mainly through Dr. Cairns' informal verbal and undocumented requests to Dr. Smith that he try to improve, all of which were inadequate and had no effect.

A second case ought to have raised alarm bells. In 1997, Dr. Smith and Dr. Cairns supported the exhumation of an 11-month-old boy after reviewing the post-mortem report prepared by a Sudbury pathologist. Dr. Smith believed that the pathologist had erroneously diagnosed the case as sudden infant death syndrome (SIDS) when there was evidence of non-accidental head injury. The boy, Nicholas, had died suddenly while in the care of his mother. She saw him crawl underneath a sewing table and fall from a standing to a sitting position. She assumed he had hit his head.

After Nicholas' body was exhumed, Dr. Smith performed the second autopsy. He wrote a report in which he concluded that Nicholas' death resulted from a non-accidental injury. Over time, a number of the pathology findings he relied upon to support his conclusion were disproved one by one, and the Crown concluded that

it could not proceed with charges against Nicholas' mother. Nevertheless, Dr. Smith's opinion never wavered. Nor did Dr. Cairns' support of Dr. Smith and his conclusions. When Nicholas' mother became pregnant, the children's aid society (CAS) became involved, and Dr. Smith and Dr. Cairns both filed affidavits with the family court. Dr. Cairns' affidavit entirely supported Dr. Smith's opinion. It also appeared to be an independent expert pathology opinion, although Dr. Cairns is a general practitioner with no forensic pathology expertise.

A forensic pathology expert retained by the family disputed Dr. Smith's conclusions, but Dr. Cairns was not persuaded. The CAS lawyer then requested that the OCCO conduct an independent review of the case. The OCCO retained a well-regarded American expert who determined that there was no evidence to suggest that Nicholas had died of a head injury. As a consequence, the CAS withdrew its child protection application. Nonetheless, Dr. Smith continued to enjoy the full support of Dr. Young and Dr. Cairns.

Nicholas' grandfather repeatedly complained to the OCCO and others about the conduct of Dr. Smith and Dr. Cairns. His letters were well researched and well reasoned. Given what we now know, many of his concerns about Dr. Smith, Dr. Cairns, and the OCCO were legitimate. Unfortunately, the leaders of the OCCO did not listen. Despite a clear opinion that Dr. Smith's conclusions in the case were unsubstantiated and baseless, Dr. Young continued to assert that Dr. Smith's opinion fell within a reasonable range. Dr. Young's response was to defend Dr. Smith – a pathologist he and the others at the OCCO had touted for so long.

Jenna's case was another missed signal. The 21-month-old Jenna died suddenly in January 1997, a victim of many non-accidental injuries. Her mother and a 14-year-old male babysitter were both suspects. At the hospital, an emergency physician noticed some signs of a possible sexual assault, including possible rectal stretching, tears in the little girl's vulva, and a curly hair in her vulva area. Dr. Smith had performed the autopsy, but did not conduct a complete sexual assault examination. Although he examined her vaginal area externally, he did not take any swabs. And although he collected a hair from Jenna's vaginal area, he did not submit it for forensic analysis.

On the basis of Dr. Smith's opinion about the timing of Jenna's injuries, the police charged Jenna's mother, Brenda Waudby, with murder. Armed with contrary opinions, Ms. Waudby's lawyer eventually persuaded the Crown that Dr. Smith's evidence about the timing of Jenna's injuries was wrong. One such opinion was from Dr. Bonita Porter, a Deputy Chief Coroner. Dr. Young was unaware of her involvement despite its coming from the office for which he was responsible. Ultimately, the murder charge was withdrawn, but only after a lengthy preliminary hearing in which Dr. Smith was the key Crown witness.

Sharon's case constituted yet another missed signal. Sharon died in June 1997, when she was seven-and-a-half years old. She had obviously been savagely attacked, and her body displayed dozens of penetrating wounds. Dr. Smith performed the post-mortem examination. At the time, he had very little experience with penetrating wounds, having seen only one or two other cases involving stab wounds and one or two cases involving dog bites. At the conclusion of the examination, he told the police that the cause of death was loss of blood secondary to multiple stab wounds. Sharon's mother, Louise Reynolds, was charged with murder.

Ms. Reynolds denied that she had killed Sharon. Her defence was that Sharon had been attacked by a pit bull and that Sharon's injuries were therefore bite marks, not stab wounds. Dr. Smith was the key Crown witness at the preliminary hearing. He categorically denied suggestions by defence counsel that a dog had attacked Sharon, saying dismissively, "As absurd as it is to think that a polar bear attacked Sharon, so is it equally absurd that it's a dog wound." Ms. Reynolds was committed to stand trial on the charge of second-degree murder.

In February 1999, at a meeting of the American Academy of Forensic Sciences, Dr. Young and Dr. Cairns learned that four respected experts strongly disagreed with Dr. Smith's conclusions in the case and had concerns that a miscarriage of justice was unfolding. They believed that Sharon was the victim of a dog attack. As a result, Dr. Young and Dr. Cairns recommended exhumation of Sharon's body in order to conduct a second autopsy.

Various experts were asked for their opinions following the second autopsy. Although there were conflicting opinions, all agreed that, contrary to the evidence Dr. Smith had given at the preliminary hearing, a dog caused many, if not all, of Sharon's injuries. As the evidence mounted that Dr. Smith had misdiagnosed Sharon's case, the Crown withdrew the charge against Ms. Reynolds.

Dr. Cairns also knew that Dr. Smith had lost a cast of Sharon's skull and a set of X-rays, and that Dr. Smith had been so late in producing his initial report that the Crown had obtained a subpoena to compel it. These signs of disorganization, carelessness, and sloppiness continued to be of little concern to the OCCO.

The same week that the Crown withdrew the charges against Sharon's mother, the Crown stayed the proceedings in another case of alleged child homicide involving Dr. Smith. As in the other cases, the defence in this case had obtained opinions from prominent experts who directly contradicted Dr. Smith's opinion.

All this attention led Dr. Young to conclude not that Dr. Smith's work had been flawed, but that he had become a "lightning rod" who should not continue to do autopsies for the OCCO. Thus, on January 25, 2001, at Dr. Young's insistence,

Dr. Smith requested that he be excused from the performance of coroner's autopsies and that an external review be conducted into his work.

After a decade of inaction, Dr. Smith's errors and the attention they had attracted finally caused the leadership at the OCCO to act, but only tentatively. Dr. Young concluded that Dr. Smith should no longer perform autopsies in criminally suspicious cases and homicides. He also proposed an external review of Dr. Smith's cases to assess his competence. Dr. Young told the media and the Ministry of the Attorney General that the OCCO would undertake such a review. But before the external review could get off the ground, Dr. Young reconsidered the idea without telling the media or the ministry. Although Dr. Young decided as early as February 2001 that no external review was to be conducted, his actions and those of Dr. Cairns caused significant confusion and misunderstanding among both the stakeholders in the criminal justice system and the public at large about whether a review was being undertaken, and, if so, what its extent would be.

In the fall of 2001, Jenna's case was reinvestigated. The police officer in charge spoke with Dr. Smith about the hair that had apparently been observed in Jenna's vaginal area but not filed as an exhibit at the preliminary hearing. Dr. Smith said that he had seized the hair, and the police officer went to Dr. Smith's office and retrieved a sealed white envelope labelled "hair from pubic area." The seal indicated that the contents had been seized during Jenna's autopsy.

Dr. Cairns met with Dr. Smith to discuss the issue. He had reviewed Dr. Smith's evidence at the preliminary hearing, where Dr. Smith had denied knowledge of a hair. In their discussions, Dr. Smith told Dr. Cairns that the police officer in attendance at the autopsy had refused to take the hair. Dr. Smith also said that he had put the envelope containing the hair in his jacket pocket and had taken it with him to the preliminary hearing.

Dr. Cairns did not believe any aspect of Dr. Smith's description of the events. For the first time, he concluded that Dr. Smith could not be believed, and he questioned Dr. Smith's competence as a forensic pathologist. He contacted the interim registrar of the CPSO to inform him of his conversation with Dr. Smith. At the time, the CPSO was investigating a complaint by Jenna's mother about Dr. Smith. Dr. Cairns also recounted the meeting to Dr. Young and told him he had discussed the matter with the CPSO. Dr. Young agreed that Dr. Smith's story was not credible.

However, despite Dr. Cairns' and Dr. Young's concerns about the conduct of Dr. Smith in Jenna's case, his status at the OCCO did not change after his meeting with Dr. Cairns. He continued to sit on important OCCO committees. He continued to perform non-criminally suspicious autopsies for the OCCO. And he continued to hold the position of director of the OPFPU.

Dr. Cairns testified that the OCCO thought Dr. Smith's role was sufficiently limited because he could not perform post-mortem examinations in any more criminally suspicious cases. However, when Dr. Young looked back on this episode when he testified at the Inquiry, he could not muster any explanation for his ongoing support and trust in Dr. Smith as of April 2002, stating rather forlornly, "I don't know why we didn't stop him doing everything at that time … I just don't know."

By April 2002, there were three active complaints regarding Dr. Smith before the CPSO. In addition to the complaint arising from Jenna's case, there were complaints about Dr. Smith's handling of Nicholas' and Amber's cases. On April 10, 2002, at the request of counsel for Dr. Smith, Dr. Young sent a letter to the CPSO chief investigator. Dr. Smith's counsel had drafted the letter, and Dr. Young sent it virtually unaltered. Dr. Young requested that his letter be provided to the panel of experts convened by the CPSO to review Dr. Smith's practices.

Dr. Young's letter said that, in the opinion of the OCCO, Dr. Smith, as one of only five or six pathologists in Canada with certification in pediatric pathology, was "qualified to undertake the work requested of him in each of these investigations [Jenna, Nicholas, and Amber]." He stated that the OCCO believed that the conclusions reached in Amber's and Nicholas' cases were within the range of reasonable expectation. He further opined that he was not aware of any professional misconduct by Dr. Smith in the Amber or Nicholas investigations. Finally, Dr. Young stated, "To the best of my knowledge, at no time did Dr Smith act in bad faith or with the intent to obstruct or hinder these Coroner's investigations."

By the time he sent this letter, Dr. Young had been fully apprised by Dr. Cairns of Dr. Smith's dubious story about the hair in Jenna's case. This information caused him to question Dr. Smith's ethics and judgment. He knew that the hair and the sexual assault examination raised ethical and criminal questions and might give rise to findings of bad faith or obstruction. Yet Dr. Young still felt it appropriate to write to the CPSO on Dr. Smith's behalf in this way. At the Inquiry, Dr. Young acknowledged that his statement that Dr. Smith did not act in bad faith or obstruct or hinder the investigations was "not a correct statement."

Apart from writing this admittedly incorrect statement, Dr. Young's letter made no attempt to lay out for the CPSO the facts about the hair in Jenna's case. And despite defending Dr. Smith's work and expertise, he made no mention of the fact that, 15 months earlier, the OCCO had removed Dr. Smith from criminally suspicious pediatric cases.

Dr. Young's letter misled the CPSO. Based on this letter, its recipient, the investigator, assumed that the OCCO had no concerns about Dr. Smith's competence or performance. Dr. Young told the Inquiry that he sent this letter in an attempt

to be fair to Dr. Smith. He did so, however, at a cost to the public interest. Coming as it did after the long series of incidents described above, the letter was not balanced or objective or candid. It was not a letter worthy of a senior public office-holder in Ontario.

In July 2002, Dr. Cairns, like Dr. Young in his letter to the CPSO, defended Dr. Smith. This time it was in relation to Dr. Smith's pathology opinion in Paolo's case. In so doing, Dr. Cairns exceeded his expertise, the effect of which was to shield Dr. Smith's opinion from further scrutiny.

Even before that, however, Dr. Cairns had caused some confusion about Dr. Smith's status at the OCCO. In October 2001, Crown counsel requested that the OCCO review Dr. Smith's work in Paolo's case as requested by the defence. In the course of their correspondence regarding the case, Dr. Cairns failed to inform the Crown about the nature of the 2001 review of Dr. Smith's work and Dr. Smith's status regarding coroner's cases. In all, he made three incorrect representations to Crown counsel. First, he said that Dr. Smith's work in approximately 20 cases had been reviewed. Second, he said there was no suggestion from these reviews that Dr. Smith was incompetent or negligent in these cases. Third, he said that, following the review, Dr. Smith was returned to the autopsy roster in June 2001 and that, as far as the OCCO was concerned, Dr. Smith was competent to conduct any autopsy. None of Dr. Cairns' three statements was correct.

Despite being copied on a letter to defence counsel in which Crown counsel repeated the inaccurate information he provided about the OCCO review, Dr. Cairns did not take any steps to correct the misunderstandings. This failure to act had the effect of misleading Crown and defence counsel about the rigour of the OCCO review process and the scope of Dr. Smith's practice after June 2001.

On or about July 31, 2002, Dr. Cairns reported to the Crown that he was of the view that there was complete consistency between Dr. Smith's opinion in Paolo's case and that of the other medical experts. He saw no contradictions whatsoever and had no concerns about the autopsy report or any of the medical evidence.

Dr. Cairns was wrong. Once experts reviewed the case, Dr. Smith's opinion was sufficiently discredited by other pathology experts that, in 2007, the Supreme Court of Canada ordered a new trial for the accused parents. Dr. Cairns did not have the expertise to provide this opinion. Moreover, at the time Dr. Cairns provided this unqualified opinion, he was fully apprised of the serious concerns about Dr. Smith's competence, integrity, and judgment arising from cases such as Jenna's case.

And still, the concerns mounted. In the fall of 2002, the OCCO learned that Dr. Smith had been stopped by the Ontario Provincial Police for speeding and responded to a police officer's questions completely unprofessionally. The CPSO

also rendered its decision in the three complaints, in which it noted many deficiencies and omissions by Dr. Smith.

In June 2003, a trial judge delivered reasons for judgment staying proceedings against two parents charged with the first-degree murder of their daughter. The charges were stayed because of unreasonable delay, including the delay caused by Dr. Smith in producing a two-and-a-half-page addendum to his post-mortem report. Dr. Cairns had given evidence in the case about the growing controversy surrounding Dr. Smith and the OCCO's review of his work. The trial judge found that Dr. Cairns' testimony at the preliminary hearing, while in good faith and not intentionally misleading, had the effect of misleading the defence and resulted in the defence making unnecessary applications for the production of all the criminal files it understood were the subject of the OCCO's review.

Following this decision, Dr. Smith remained on the OCCO roster for non-criminally suspicious autopsies, remained director of the OPFPU, and continued to sit on OCCO committees charged with the review of pediatric deaths.

In December 2003, the OCCO finally removed Dr. Smith from the roster for performing all coroner's warrant autopsies. The decision was made amid continuing media coverage about Dr. Smith, including coverage of the June 2003 stay of proceedings for delay. The fact that Dr. Smith was a lightning rod for criticism was a very significant, if not primary, concern of the OCCO in its decision to stop using his services altogether. There was a general sense among members of OCCO committees that Dr. Smith's continued work with the OCCO might damage its reputation, and a sense that the OCCO needed to cut all ties with him. In addition, pathologists were expressing concerns about completing criminally suspicious autopsies that Dr. Smith had started.

Nevertheless, Dr. Smith continued to hold his position as director of the OPFPU. At his request, the OCCO allowed him to retain his existing title until the completion of the CPSO proceedings in the complaints arising out of the cases involving Nicholas, Jenna, and Amber. On May 26, 2004, the CPSO proceedings were resolved when the CPSO Complaints Committee issued a caution to Dr. Smith.

As director of the OPFPU, Dr. Smith continued to perform administrative responsibilities and to review reports of post-mortem examination completed by other pathologists within the unit even after January 2001. He reviewed reports before they were sent to the coroner to ensure the propriety of the terminology used to classify the cause of death and to ensure that they did not include any history or discussion that was beyond the level desired by the OCCO. At times, he raised concerns with his colleagues about findings in their reports. In his testimony on November 8, 2001, at the preliminary hearing in a case in which he had

performed the autopsy, Dr. Smith stated that, as director of the OPFPU, he continued to exercise a supervisory function over pathologists performing pediatric forensic autopsies at SickKids.

Dr. McLellan was appointed as Chief Coroner for Ontario in April 2004. Finally, at his insistence, Dr. Smith resigned as director of the OPFPU effective July 1, 2004.

Summary

As this review demonstrates, for over a decade, while the danger signals about Dr. Smith kept coming, those in charge at the OCCO who ultimately might have done something about the mounting problem did far too little. It is a graphic demonstration of how the oversight of pediatric forensic pathology could and did fail, almost completely. In large measure, responsibility for this failure lies in three areas: the grave weaknesses that existed in the oversight and accountability mechanisms, the inadequate quality control measures, and the flawed institutional arrangements of pediatric forensic pathology in particular, and forensic pathology as a whole.

The legislative framework for death investigations in Ontario provided by the *Coroners Act* created no foundation for effective oversight of forensic pathology. It contained no recognition whatsoever of forensic pathology, the essential service it provides, or those who should be responsible for it.

The institutional arrangements for forensic pathology at the time were no more helpful. The position of Chief Forensic Pathologist was left very ill defined by the OCCO, and with no clear responsibility for oversight. Although in the organizational structure of the OCCO the Chief Forensic Pathologist was accountable to the Chief Coroner, in the absence of any definition of this supervisory role, the actual relationship between the two positions was equally obscure. The same lack of clarity infected the relationships between the OCCO and the regional forensic pathology units, especially the OPFPU, and rendered any effective oversight by the OCCO of the practice of pediatric forensic pathology in the OPFPU that much more difficult. The role of director, the position Dr. Smith held at the OPFPU, had little, if any, defined oversight responsibility for the work done in the unit. In addition, it was completely unclear to whom the director was accountable, and for what. In practice, the pathology conducted by a director like Dr. Smith was done without any effective oversight.

Given these weaknesses in the institutional arrangements, as well as the inadequacies of the quality control measures introduced in the 1990s, formalized oversight of Dr. Smith's pathology work was virtually non-existent. It was left to the

de facto supervision by Dr. Young and Dr. Cairns that derived from their long-standing relationship with Dr. Smith, together with their positions of ultimate responsibility at the OCCO. In reality, this loose supervision was the only operative oversight available for Dr. Smith's pediatric forensic pathology. Both men served Ontario for many years in a number of responsible positions, and I am sure in many respects they did so effectively and well. But in this task they failed.

Because of their positions, Dr. Young, as Chief Coroner, and Dr. Cairns, as his deputy, clearly had authority over Dr. Smith in his role as director of the OPFPU and in his work on individual cases had they chosen to exercise it. Ultimately, they could have removed him from both functions. Unfortunately, this authority was never translated into effective oversight. On their watch, he was never removed as director, and only much too late was he asked to stop his forensic work. Many factors, in addition to the institutional weaknesses I have described, contributed to this failure.

Perhaps most important, neither Dr. Young nor Dr. Cairns had any specialized training in pathology, let alone forensic pathology, and they clearly did not understand the deficit position that lack of expertise put them in. Dr. Young's and Dr. Cairns' lack of expertise contributed to their failure to recognize Dr. Smith's deficiencies in forensic pathology despite the mounting evidence that accumulated during the 1990s. It meant that many of the problems the expert reviewers have now made so glaringly obvious did not shake their absolute faith in Dr. Smith until the very end, and after much damage had been done.

Dr. Young and Dr. Cairns also had few, if any, tools for effective oversight of Dr. Smith's work. There were not many best-practice guidelines against which his performance, case by case, could be measured. This gap left them with nothing but anecdotal information about his practices and his performances in the criminal justice system, and individual complaints in particular cases could not, and did not, displace their faith in the person they felt was the dominant figure in the field.

In addition, Dr. Young and Dr. Cairns had a kind of symbiotic relationship with Dr. Smith. They actively protected him and played a substantial role in the development of his career. They found his growing profile in the field to be of benefit to the OCCO, and the OCCO had a vested interest in continuing to be able to use his services. Dr. Young, in particular, was afraid that, given the small number of qualified people in the field, without Dr. Smith there would be nobody to do the work in criminally suspicious pediatric cases. In short, Dr. Smith needed the OCCO to continue his work, and, for the same reason, the senior leadership at the OCCO needed him to do it. This symbiosis stood between the OCCO and its ability to assess Dr. Smith's work without bias – an objectivity that is vital to effective oversight.

Any possibility of objective assessment was made all the more difficult by the working relationship among the three men. Dr. Young and Dr. Cairns both shared with Dr. Smith the same commitment to the "think dirty" approach – that is, approaching every sudden and unexpected child death with a high index of suspicion – to uncovering possible child abuse. By the end of the 1990s, they had worked together for a decade and had become close professional colleagues who valued each other's work. Dr. Young and Dr. Cairns considered Dr. Smith an important member of the senior team at the OCCO. As Dr. Young said, they took as a given a level of competence at the top end of the organization. To doubt Dr. Smith would have been to doubt one of their own. In my view, this professional closeness made objective oversight of Dr. Smith very difficult for the senior leadership at the OCCO. The unfortunate consequence was that, when this oversight failed, it was at the cost of lost public confidence in the governance capability of the OCCO itself.

At the Inquiry, Dr. Cairns candidly acknowledged his responsibility for this failure of oversight. As he said, he put undue faith in Dr. Smith because he put him on such a pedestal. In a touch of irony, he expressed profound disappointment in himself, as one who advocated the "think dirty" approach, in not being more suspicious or even objective in his assessment of Dr. Smith's performance and for taking such a long time to realize what was actually happening.

Like Dr. Cairns, Dr. Young also apologized at the Inquiry. As he recognized, these events happened on his watch, and he bears ultimate responsibility for them. At first, as the storm clouds gathered, Dr. Young was guided more by his concern that, for the sake of the OCCO, Dr. Smith's services had to be continued than by whether those services were providing deeply flawed forensic pathology. As the end neared, Dr. Young was more concerned with the possibility of the adverse publicity that Dr. Smith might bring to the OCCO than about the possible impact of Dr. Smith's shortcomings on the OCCO's responsibility for high-quality death investigations. He gave no thought to whether the office might have played a role in past wrongful convictions as a result of Dr. Smith's work. Concerns about the OCCO's reputation, while valid, cannot stand in the way of the paramount imperative of ensuring high-quality death investigations.

Finally, as the last act played out, Dr. Young continued to defend the indefensible in the name of saving the reputation of the OCCO. Even after Dr. Cairns had lost faith in Dr. Smith's integrity and competence, with the revelation of Dr. Smith's actions concerning the hair in Jenna's case, Dr. Young took no action; instead, he supported Dr. Smith's abilities as a pathologist and his professional expertise. Dr. Young was the last to see the writing on the wall, and, at the Inquiry, he was left to say what he might have said with equal validity at many moments in

the preceding decade: "I don't know why we didn't stop him doing everything at that time … I just don't know."

In the end, as Chief Coroner, Dr. Young must bear the ultimate responsibility for the failure of oversight. As he took on additional positions in the government, he proved unable to exercise the authority of the Chief Coroner's position he already held: to ensure vigilant oversight of Dr. Smith. When he finally did act, it was to protect the reputation of the office, and not out of concern that individuals and the public interest may already have been harmed. Sadly, the de facto oversight of Dr. Smith that resulted was far too little, far too late.

Restoring Confidence in Pediatric Forensic Pathology

The systemic review and assessment that I conducted identified a significant array of failures that must be addressed if public confidence in pediatric forensic pathology and its use in the criminal justice system is to be restored. These systemic issues emerged from my examination of Dr. Smith's work and its oversight, and from what I heard about the practice and oversight of pediatric forensic pathology generally during the years on which I was mandated to report. The responses to these systemic issues can in some instances be targeted at pediatric forensic pathology specifically. In many instances, however, effective responses require broader change, often to forensic pathology as a whole.

In the last few years, under the new leadership at the OCCO, including the present Chief Forensic Pathologist, Dr. Michael Pollanen, many important improvements have been made to start to address the failings identified at the Inquiry. In the Report, I review these changes in detail. It is both commendable and heartening to see the winds of change blowing in the right direction.

However, as these leaders recognize, there is much more to do. At the end of this executive summary, I include a complete list of the 169 recommendations I propose in order to fully address the systemic problems our review revealed and to restore public confidence. In Volume 3, I explain the rationale for each of them. In what follows here, I outline the main themes they address.

Professionalizing and Rebuilding Pediatric Forensic Pathology

For more than a decade, Dr. Smith was viewed as one of Canada's leading experts in pediatric forensic pathology and the leading expert in Ontario. Yet he had little forensic expertise and his training was, as he himself described, "woefully

inadequate." He achieved the status of a leading expert in the field in large part because there was no one who had the training, experience, and expertise to take him on. He worked all too much in isolation. This situation was prolonged because there was then, as there is now, a severe shortage of forensic pathologists in Ontario; there are even fewer forensic pathologists with the knowledge and experience to do pediatric forensic cases or to provide the culture of peer review on which quality depends.

The most important and fundamental challenge ahead is to correct this situation by creating a truly professionalized Ontario forensic pathology service. The objective must be the professionalizing of all of forensic pathology and cannot be limited to pediatric forensic pathology.

The professionalization of forensic pathology must be built on these four cornerstones:

1 legislative change that provides both proper recognition of the vital role forensic pathology plays in death investigation and the foundation for proper organization of a forensic pathology system;
2 a commitment to providing forensic pathology education, training, and certification in Canada and strengthening the relationship between service, teaching, and research;
3 a commitment to the recruitment and retention of qualified forensic pathologists; and
4 adequate, sustainable funding to grow the profession.

Legislative Recognition of a Professionalized Forensic Pathology Service

The *Coroners Act* provides the legal framework for death investigation in Ontario. Even though forensic pathology is the core specialized discipline in death investigation, the *Coroners Act* does not mention the role of the pathologist, let alone the forensic pathologist. The *Coroners Act* contains no concept of a forensic pathology service, makes no reference to the Chief Forensic Pathologist, and nowhere contemplates oversight of the work of forensic pathologists.

A legislated structure is essential to provide the framework within which the discipline of forensic pathology can evolve and grow to meet the requirements of modern death investigation. Legislative recognition represents an essential public expression of the importance our society must attach to this service, as we try to re-establish public confidence in it. The *Coroners Act* must be amended to correct this shortcoming.

Fundamental to professionalizing forensic pathology is the creation of a formal entity, the Ontario Forensic Pathology Service (OFPS), to be responsible for all post-mortem examinations performed by pathologists under coroner's warrant. The purpose of the service is to provide forensic pathology services for coronial death investigations and oversight and quality assurance of those services. Approximately 7,000 forensic post-mortem examinations are performed in this province each year, including approximately 400 cases initially investigated as criminally suspicious or homicide cases. Enshrining the OFPS in the *Coroners Act* as a separate and distinct service within the OCCO will reflect the fundamental importance of forensic pathology to sound death investigations and will ensure that the practice of forensic pathology is defined in a structure that fosters excellence, provides leadership, and ensures oversight.

The development of a sustained and committed leadership structure devoted to excellence is vital to the viability of the OFPS. There must be legislative recognition of the roles and responsibilities of the leaders of this service; their duties should not be defined only by a job description. The evidence I heard persuades me that the leadership structure for forensic pathology should mirror the leadership structure for coroners. I therefore recommend legislative recognition of the following positions:

1 a Chief Forensic Pathologist who must be a certified forensic pathologist; and
2 one or more Deputy Chief Forensic Pathologists.

An Educational Foundation for a Professionalized Forensic Pathology Service

Perhaps it was easy in the past to ignore and to undervalue the importance to society of forensic pathology. Although it is the public face of pathology, it is an extremely tiny discipline. Thus, while the shortage of properly trained and accredited forensic pathologists is acute, the absolute number that must be added to properly staff the discipline is not daunting, although that number is impossible to fix precisely today.

This shortage does not exist only in Ontario. It is a worldwide problem. However, in Ontario, and indeed throughout Canada, the development of the profession of forensic pathology has been seriously hampered by the fact that there have been no domestic postgraduate training programs in the science. Canadian forensic pathologists have been forced to seek training and certification in other countries. This situation must be corrected if Ontario is to have properly trained forensic pathologists in sufficient numbers to sustain a truly professionalized service.

Fortunately, there are signs that change has begun. The Royal College of Physicians and Surgeons of Canada has formally recognized forensic pathology as a subspecialty. While it has not yet accredited any training programs in Canada, Dr. Pollanen has recently taken on two pathologists in a new fellowship program in forensic pathology.

It is most important that the development and accrediting of domestic training programs leading to examinations and certification by the Royal College of Physicians and Surgeons of Canada be expedited. Recognition and approval by the Royal College in the form of accredited training programs and certification is a vital part of elevating the status of forensic pathology to its proper place and encouraging the growth of Canadian training opportunities in forensic pathology. This factor alone will help entice medical students to consider seriously a career in this specialty.

It is also critical that this training include education about the justice system and, in particular, the criminal justice system. Forensic pathologists must understand the objectives of the criminal justice system, how it operates to achieve those goals, and how they can best fulfill their roles as experts. All of the internationally renowned forensic pathologists who participated in the Inquiry emphasized how important it is for forensic pathologists to understand the criminal justice system and their role within it. After all, their work is done for the justice system, and it is essential to it.

Recruitment and Retention of Forensic Pathologists

Forensic pathology has never been a popular career choice in Canada. Heavy workloads and poor remuneration have discouraged pathologists from undertaking forensic work in favour of careers in clinical pathology, which is better paying and, until very recently, was viewed as less controversial.

This historical trend has been aggravated by a number of problems specific to the discipline in Ontario. As we learned, most pathologists doing forensic work today are in the later stages of their careers and are not being replaced by new trainees. Moreover, the small group of those practising forensic pathology in Ontario has been forced to spread itself more thinly than in the past, particularly given the increased number and complexity of its cases.

Growing the specialty has been made more difficult to achieve because forensic pathology – indeed, all pathology – has been under severe public scrutiny for some time. For more than a year, pathologists have repeatedly been in the national headlines, and their alleged errors have spawned not just this Inquiry but inquiries in Newfoundland and Labrador, and New Brunswick as well.

It is too early to know with certainty whether these events will have a lasting chilling effect on attempts to recruit and retain qualified forensic pathologists, but active steps must be taken to prevent such a result. Various measures must be taken immediately to revitalize the profession so that the province is not left with an insufficient number of qualified pathologists.

One essential measure is to provide, within the OFPS, career paths similar to those available to coroners in Ontario: fellows, junior pathologists, regional directors, deputies, and Chief Forensic Pathologist. This hierarchy allows for clearly defined roles and recognizes the importance of engaging those working within the profession in careers that can offer increasing responsibility and remuneration. It addresses the present situation, described as "relatively flat," with no straightforward career progression or advancement offered. The present model will not encourage those exploring challenging career options to seek employment within an organization that does not offer an opportunity to grow professionally.

A second measure is to change the existing remuneration pattern. Government-employed forensic pathologists at the PFPU are paid far less than hospital pathologists across the province. The differential in favour of hospital pathologists is magnified by the additional benefits hospital pathologists receive over those employed directly by the ministry, such as funds for continuing medical education and other benefits offered by the hospitals themselves. The differential has an obvious adverse effect on recruitment. Those familiar with it all agreed that this salary differential is a major obstacle to hiring forensic pathologists in full-time positions at the PFPU. It is essential that the Province of Ontario take immediate steps to ensure equal compensation for all forensic pathologists, whether on staff at a hospital or at the PFPU.

It is also critical that sufficient funding be provided to ensure that the facilities where forensic pathology is practised reflect the level of excellence expected of the OFPS and are equipped with state-of-the-art equipment to assist the forensic pathologists in their work. This factor is important – particularly if the regional units are to perform an increasing percentage of the forensic work across the province, including the most difficult cases. It is also a vital part of making forensic pathology an attractive career choice at a time when it, like all pathology, has been negatively affected by adverse publicity.

Adequate and Sustainable Funding

Our systemic review has highlighted the many ways in which forensic pathology has been undervalued for decades. Not surprisingly, it has also been underfunded – again, for decades. Inadequate resources continue to undermine the laudable

efforts of the new leadership of the OCCO to fix the many problems identified by our systemic review. This situation cannot be allowed to continue. Unless the Province of Ontario acts quickly to implement a significantly increased and sustainable funding model for forensic pathology, these problems cannot be fixed – and the system cannot be rebuilt, as it must be. Resources are essential to professionalize and grow forensic pathology in Ontario, so that wrongful convictions in these kinds of cases can be avoided, and those who have killed children will be properly dealt with according to law.

Many of my proposals that relate to the qualifications and practices of forensic pathologists, including the practice of quality assurance, depend on there being an adequate number of forensic pathologists. There is a global shortage of forensic pathologists. Ontario lags behind many jurisdictions in part because it has been impossible for pathologists to receive education, training, and, ultimately, certification in Ontario. It is essential that adequate resources be provided for the training, recruitment, retention, and continuing education of forensic pathologists in Ontario. Ontario's forensic pathologists should be encouraged to engage in teaching and research, in addition to the provision of services in death investigations. They should also be able to practise in appropriate facilities. These changes, and others that I address in Volume 3, can only be made if funding is adequate and sustained over the long term.

Effective Organization and Oversight of Forensic Pathology in Ontario

The Ontario Forensic Pathology Service

The Chief Forensic Pathologist must direct the OFPS and be professionally responsible for the service it provides. This fundamental responsibility, and other duties, should be included in the legislation in a way that parallels the responsibilities of the Chief Coroner. Consistent with the objective of enhancing the quality of the service, the Chief Forensic Pathologist must be a certified forensic pathologist.

The institutional arrangements between the OCCO and the regional forensic pathology units, including the OPFPU, must be clarified and strengthened. The service agreements should carefully describe these relationships. At a minimum, they should contain provisions that enable effective oversight of the work to be performed in the regional units for the OCCO, by assigning specific responsibilities to the Chief Forensic Pathologist, the regional directors, the pathologists performing the work, and the hospitals in which the regional units are located.

The OPFPU

A central issue at the Inquiry was whether the OPFPU at SickKids should continue or be disbanded. Holding the title of director of the OPFPU assisted in positioning Dr. Smith to become the leading expert in pediatric forensic pathology, when he lacked the requisite training and qualifications. The mere fact that he came from SickKids, where the OPFPU was located, added significantly to his stature. Yet, in reality, SickKids had no ownership of his forensic pathology work. So, it is argued, Ontario got the worst of both worlds – the reputation without the substance on which that reputation should have been based. Those on the other side of this debate point out the enormous value added by the renowned expertise that SickKids can bring to the work. Particularly for sudden infant deaths that engage diseases that are difficult to diagnose and that do not appear criminally suspicious, SickKids can offer expertise without peer. Sudden infant death syndrome is a good example. Many post-mortem examinations involving sudden and unexpected deaths of infants that are ultimately diagnosed as SIDS have been done at the OPFPU over the years, and the knowledge thus accumulated has done much to assist the understanding of this phenomenon. The argument is that this benefit ought not to be obscured by the regrettable past.

Notwithstanding the OPFPU's unfortunate legacy as the setting in which Dr. Smith's flawed practices went unchecked, I agree with SickKids that the OPFPU has much to offer our province. Its work in non-criminally suspicious forensic cases deserves to be fostered. It also provides a unique setting within a highly respected hospital for training in the pediatric aspects of forensic pathology. Such training should be made available to forensic pathologists for a concentrated period – perhaps three to six months – in the OPFPU environment. The training could form part of a forensic pathology fellowship program and could offer continuing medical education to those who wish to incorporate pediatric forensic pathology into their practice. In this way, the "pediatric" as well as the "forensic" of the OPFPU will benefit the medical profession and, in particular, pediatric forensic pathology.

In my view, the OPFPU should continue to provide pediatric forensic pathology services and act as a regional unit. The pediatric pathology expertise of SickKids' pathologists is too important to be sidelined. However, never again can the director of the OPFPU lack forensic training and certification. Nor can the OPFPU be isolated from the forensic pathology being done elsewhere within the OFPS.

Protocol for Criminally Suspicious Pediatric Cases

A fundamental conclusion of our systemic review was that Dr. Smith's lack of forensic training caused great harm. The evidence is clear that forensic pathologists, rather than pediatric pathologists, should take the lead in criminally suspicious pediatric cases. They are better qualified to conduct these autopsies. They begin each case with the relevant training in injury identification and the proper preservation of evidence. It is difficult to rebuild the forensic framework and gain evidentiary control at a later stage if a pathologist not trained or experienced in forensic work begins the autopsy. The expertise of other pediatric pathology specialists can be engaged at almost any point thereafter. Therefore, for all criminally suspicious pediatric forensic cases, a forensic pathologist must conduct the postmortem examination.

The Governing Council

Our systemic review revealed very significant failures of oversight of Dr. Smith by the senior leadership of the OCCO. The failure by the Chief Coroner to oversee effectively a senior colleague of such importance to the work of the OCCO has shaken public confidence in the ability of the current leadership structure to provide proper overall oversight of the work of the institution. In my view, the public's loss of confidence is justified: these serious failures can only be seen as a failure of governance. To provide effective oversight of the work of the OCCO and to restore public confidence, a major institutional change in governance is required.

Hence, the most significant component of my oversight and accountability recommendations is the development of a new governance structure for the OCCO. It requires a Governing Council to ensure more objective and independent governance of the institution, including the work of both the Chief Coroner and the Chief Forensic Pathologist and those they oversee in the coronial and forensic pathology services in Ontario.

In my view, it is not sufficient that the leadership has been replaced by a new cohort of talented individuals. It would be wrong to imagine that the conditions in place during the 1990s were a unique confluence of events and that their recurrence could be avoided simply by installing different individuals in the OCCO's leadership positions. A sound system of oversight and accountability cannot rely on who happens to occupy the OCCO's leadership positions at any given time. Systemic change is necessary. First, there must be a governance structure that ensures that those responsible for governing the OCCO have sufficient expertise

to provide institutional oversight of the forensic pathology work done for the OCCO. Second, it is essential that those governing the OCCO not suffer the loss of independent judgment and objectivity that came with the professional closeness of the past. This means that the Chief Coroner should no longer be the ultimate level of responsibility for the OCCO. In my opinion, the creation of a Governing Council is required if the OCCO is to provide effective institutional oversight of forensic pathology in the public interest.

The creation of the Governing Council is fundamentally about good governance. Its membership should therefore be based on competency and not constituency. Its membership should form the basis for an independent, multidisciplinary governance body with the skills to ensure meaningful oversight of the death investigation system, including both the coronial service and the forensic pathology services. Its members should therefore be senior decision makers from related public institutions with experience acting in the public interest, or their nominees. In order to ensure an independent perspective on forensic pathology services, its membership should also include a certified forensic pathologist from outside Ontario.

Our systemic review also demonstrated the pitfalls of poorly defined responsibilities for oversight and accountability. The Governing Council must ensure that these responsibilities are clearly articulated within the OCCO as a whole, within the OFPS, and between the coronial service and the forensic pathology service. The Governing Council must charge the OCCO's leadership with the creation of an institutional commitment to quality, with core values that emphasize the pursuit of excellence, the importance of teamwork, and the need for collegiality and knowledge sharing.

Until recently, the OCCO placed little emphasis on the quality management of forensic pathology. It still lacks the resources to create a full quality assurance environment. The OCCO must develop a comprehensive quality management philosophy, with adequate structures in place to implement that philosophy. In particular, the OFPS must have qualified staff dedicated to quality assurance.

Critical to quality assurance is a robust system of peer review of post-mortem examinations in individual cases. In recent years, the new leadership has greatly improved the procedures in this respect – particularly in criminally suspicious cases, where it is most important. These gains should be consolidated and built upon as we go forward.

The Registry

Our systemic review also revealed that, in the 1990s, pathologists in Ontario were enlisted to perform coroner's warrant work without regard for their training and experience in forensic pathology. The main example, of course, is that criminally suspicious pediatric cases were deliberately triaged to Dr. Smith, without any appreciation of his woefully inadequate training in forensic pathology.

To address this failing, it is vital that a Registry of approved forensic pathologists be created. As its most central function, the Registry would designate the forensic pathologists who, because of their experience and expertise, are approved to conduct autopsies under coroner's warrant. Since different skill sets are required for different types of cases, the Registry should be divided into specific tiers with, at a minimum, three categories: forensic pathologists approved to perform criminally suspicious adult cases, those approved to perform criminally suspicious pediatric cases, and those approved to perform routine coroner's cases only.

The Role of the Forensic Pathologist

Basic Principles for Best Practices

In my view, it is important that certain basic principles guide all autopsy practices in forensic pathology, including pediatric forensic pathology. Each of the specific recommendations I make about best practices reflects these principles. They are as follows:

1 At autopsy, the forensic pathologist should "think truth" rather than "think dirty." To do so requires an independent and evidence-based approach that emphasizes the importance of thinking objectively. The pathology evidence must be observed accurately and must be followed wherever it leads, even if that is to an undetermined outcome. This approach guards against confirmation bias, where evidence is sought or interpreted in order to support a preconceived theory.
2 In performing autopsies, forensic pathologists must remain independent of the coroner, the police, the prosecutor, and the defence to discharge their responsibilities objectively and in an impartial manner. The role required of them in the criminal justice system necessitates this independence.
3 The forensic pathologist's work at autopsy must be independently reviewable and transparent. This objective requires care in recording and preserving the information received pre-autopsy, the steps taken at autopsy, and the materials

preserved after autopsy. This transparency is necessary to ensure that the pathologist's opinions can be properly reviewed and confirmed or challenged.

4 The forensic pathologist's work at autopsy must be understandable to the criminal justice system. The autopsy must be performed so that it can be described in clear and unambiguous language to lay people.

5 The teamwork principle is fundamental for sound autopsy practice. This includes teamwork between forensic pathologist and coroner, and between forensic pathologist and colleagues in the same and associated specialties. Particularly in difficult cases, the forensic pathologist must seek assistance and consult with colleagues. As in all branches of medicine, in forensic pathology, teamwork promotes excellence.

6 Fundamentally, the forensic pathologist's practices at autopsy must be founded on a commitment to quality.

These principles must inform all aspects of autopsy practice in forensic pathology, whether scene attendance, or the acquisition of relevant information by the pathologist, or the preservation of the autopsy's work product, or the timeliness of post-mortem reports.

Our systemic review of autopsy practices in Dr. Smith's years revealed the absence of any articulated principles of this kind on which a set of best practices could be built. The review also revealed that these principles were all too often ignored in the conduct of post-mortem examinations. It is important that we never return to this era.

I recognize that significant progress has already been made in developing best practices that reflect these principles. My recommendations are intended to build on that existing foundation and thereby promote accurate, understandable, and transparent forensic autopsies. If that intention is realized, pediatric forensic pathology and the criminal justice system will both be the better for it.

Effective Communication with the Criminal Justice System

Serving the criminal justice system is a central function of forensic pathology. In criminally suspicious deaths, the role of forensic pathology can be critically important in ensuring that justice is done. That is particularly true in pediatric forensic pathology. Our systemic review revealed a number of ways in which the opinions expressed by Dr. Smith and other pathologists were not only substantively flawed, but, equally important, were communicated in ways that promoted misinterpretation or misunderstanding on the part of police, prosecutors,

defence counsel, and the courts. Forensic pathology and the justice system each have their own cultures. Vigilance on the part of both is essential if communications between them are to be effective and well understood.

Our systemic review identified a number of aspects of a forensic pathologist's opinion that can cause misunderstanding. They require particular attention when an opinion is being prepared. My recommendations are designed to give forensic pathologists some guidance in doing so. These aspects are as follows:

1 whether the substance of the opinion and the language in which it is expressed is susceptible to varied meanings or otherwise does not elucidate the pathology issues at stake;
2 whether the level of confidence or certainty that the expert has in the opinion is accurately expressed;
3 whether the opinion addresses other explanations for the pathology findings;
4 whether the opinion is in an area of controversy within the forensic pathology community;
5 whether all or part of the opinion falls outside the pathologist's area of expertise;
6 whether the opinion is based, in whole or in part, on non-pathology information provided to the pathologist;
7 whether the opinion relies, in whole or in part, on other expert opinions provided to the pathologist; and
8 whether the opinion includes the facts and the reasoning process relied on to form the opinion.

The OCCO should develop a Code of Practice and Performance Standards describing the principles that should guide forensic pathologists as they write their reports and the information that should be contained in them. In the same way, it should also address the giving of evidence by forensic pathologists. Both are essential to improve communication by forensic pathologists with the justice system.

One of the principal lessons learned at the Inquiry is that, although it is vital that forensic pathologists be highly skilled scientists, it is equally vital that they be able to communicate their opinions effectively to the criminal justice system. Improvements in the quality of forensic pathology must be paralleled by improvements in the effectiveness with which forensic pathologists are able to communicate to the criminal justice system. It is with the better achievement of this objective in mind that I make a number of specific recommendations on how opinions and their limitations should be articulated, in light of the principles I have set out.

The Roles of Coroners, Police, Crown, and Defence

My recommendations are designed to restore and enhance public confidence in pediatric forensic pathology and its future use in the criminal justice system. It is therefore not surprising that much of the focus must be on forensic pathologists and the issues surrounding their training, education, accreditation, oversight, and accountability. But it must also be recognized that other participants in the criminal justice system have important roles to play in protecting the public against the introduction of flawed or misunderstood pediatric forensic pathology into the system. Coroners, police, Crown counsel, and defence counsel have much to contribute in helping to achieve this objective. My specific recommendations on this subject are designed to ensure that they will be as effective as possible in this task.

Coroners perform an active role in the death investigation in cases where a postmortem examination is done. The coroner can significantly affect the opinion ultimately provided by the forensic pathologist. The coroner can be an important source of information for the forensic pathologist. Although they both must work in close cooperation, ultimately the coroner must respect the forensic pathologist's expertise and independent judgment. The coroner also has an important role to play in facilitating early case conferencing, particularly of criminally suspicious pediatric death investigations, to promote the exchange of relevant information among the participants in the death investigation process, including the forensic pathologist. This process assists in ensuring accurate opinions that address the real pathology issues in the case. My recommendations address the interplay between, and respective roles of, coroners and forensic pathologists.

The police can also assist. They too are sources of important information for the forensic pathologist. It is particularly important that criminally suspicious pediatric death investigations be conducted, where possible, by officers having specialized training and expertise in such cases. At the very least, all police services should have access to such expertise.

Following the revelation of some of the concerns that brought about this Inquiry, the Ministry of the Attorney General (Criminal Law Division) has recently developed a number of initiatives respecting the prosecution of child homicide cases, such as the creation of a specialized child homicide resource team. These are important initiatives, that, with several additions, must be continued. They will enhance the role that the Crown must play in guarding against the adverse consequences of flawed pathology.

For their part, defence counsel must remain fully conscious of their ethical

duty of competence and not take on a criminal pediatric homicide or similar case beyond their competence or skills. Legal Aid Ontario also has an important role to play in providing remuneration levels sufficient to ensure that only experienced and competent counsel take on these serious criminal matters.

Counsel, whether Crown or defence, should properly prepare forensic pathologists they intend to call to give evidence. And both should understand the benefits that can accrue from early voluntary disclosure of their anticipated forensic evidence.

Finally, probing cross-examination is an important component of the truth-seeking process in the criminal justice system. However, the complexities of forensic pathology were apparent throughout our Inquiry and can prevent counsel from playing their role. To address this, the Ministry of the Attorney General and the Ministry of Community Safety and Correctional Services should fund regular joint courses for defence and Crown counsel dealing with forensic pathology generally and pediatric forensic pathology in particular. Counsel will then be better equipped to understand and observe the scope and limitations of the forensic pathologists' expertise and opinions.

The Role of the Court

Judges also play an important role in protecting the legal system from the effects of flawed scientific evidence. Although this objective will be greatly assisted by the use of rigorous quality assurance processes in preparing expert opinions, by the integrity and candour of expert witnesses, and by vigorous testing of expert evidence by skilled and informed counsel, the judge must bear the heavy burden of being the ultimate gatekeeper in protecting the system from unreliable expert evidence – evidence that can, as our Inquiry showed, contribute to miscarriages of justice.

The case law I discuss in Volume 3 makes clear that the judge must determine whether the expert scientific evidence has sufficient threshold reliability to be considered by the trier of fact. This exercise should not be confined to so-called "novel science." I describe a number of considerations that may assist the judge in performing this task. They include:

1 the reliability of the witness, including whether the witness is testifying outside his or her expertise;
2 the reliability of the scientific theory or technique on which the opinion draws, including whether it is generally accepted and whether there are meaningful peer review, professional standards, and quality assurance processes;

3 whether the expert can relate his or her particular opinion in the case to a theory or technique that has been or can be tested, including substitutes for testing that are tailored to the particular discipline;
4 whether there is serious dispute or uncertainty about the science and, if so, whether the trier of fact will be reliably informed about the existence of that dispute or uncertainty;
5 whether the expert has adequately considered alternative explanations or interpretation of the data and whether the underlying evidence is available for others to challenge the expert's interpretation;
6 whether the language that the expert proposes to use to express his or her conclusions is appropriate, given the degree of controversy or certainty in the underlying science; and
7 whether the expert can express the opinion in a manner such that the trier of fact will be able to reach an independent opinion as to the reliability of the expert's opinion.

It is important to note that this gatekeeping will not be an "all or nothing" task, but that each part of the proposed expert testimony must be vetted to ensure that it has sufficient reliability to be considered by the trier of fact. Properly prepared expert reports, along with a certification that the expert understands the duty to provide impartial advice to the court, are also helpful and should facilitate the process of ensuring the threshold reliability of expert evidence. Once experts are properly qualified, care should be taken to ensure that they stay within the bounds of their expertise. No justice system can be immunized against the risk of flawed scientific opinion evidence. But with vigilance and care, we can move toward that goal.

Pediatric Forensic Pathology and Potential Wrongful Convictions

In light of the flawed practice and oversight of pediatric forensic pathology revealed by the Inquiry, a number of parties urged that there be further review of additional cases, beyond those examined by the Inquiry, to determine if any resulted in potentially wrongful convictions.

In my view, there is one set of cases in which a further review is justified. Simply put, the changes in pathology knowledge concerning shaken baby syndrome and pediatric head injuries over the last two decades provide cogent reasons for a carefully constructed review of these cases. There may be among them cases where convictions were registered on the basis of pediatric forensic

pathology that today would be seen as unreasonable. A similarly motivated examination has taken place in England. And a number of responsible leaders in the field told the Inquiry that they think such a review should be carried out here.

I agree. In my view, restoring public confidence in pediatric forensic pathology requires that such a review be conducted. Its objective would be to identify those cases in which the pathology opinion can be said to be unreasonable in light of the understandings of today, and in which the pathologists' opinions were sufficiently important to the case to raise significant concerns that the convictions were potentially wrongful. My recommendations outline the design for such a review, as well as the enhancement of existing processes within the criminal justice system to address potential miscarriage of justice associated with flawed pediatric forensic pathology.

I also struggled with the issue of compensation for those involved in the cases that were examined at the Inquiry. My mandate prevented me from making recommendations about individual compensation. Moreover, significant challenges would have to be addressed in creating a compensation scheme for those involved in these cases who became entangled in the criminal justice system simply because of flawed pediatric forensic pathology and through no fault of their own. In light of these complexities, I urge the Province of Ontario to see if, nonetheless, a viable compensation process can be set up.

First Nations and Remote Communities

There are formidable challenges in delivering adequate coronial and forensic pathology services to First Nations and other remote communities in Northern Ontario. These challenges cannot be taken as a licence for acceptance of the status quo. Today, for example, death scenes are seldom attended by coroners, let alone pathologists. And many families who suffer the death of a child are left too much in the dark about autopsy procedures and even why their child died. The people of Northern Ontario are entitled to coronial and forensic pathology services that are reasonably equivalent to those services provided elsewhere in the province, even though doing so will cost more in the North.

For First Nations, inadequacies in the delivery of pediatric forensic pathology services are seen as only part of much larger systemic issues: inadequate medical care; limited financial and human resources; high mortality rates, particularly for children and young people in a number of communities; and what are seen as institutional failures to respond to the unique cultural, spiritual, religious, and linguistic character of First Nations.

It is important that, in the discharge of its duties, the OCCO address these

issues with sensitivity and understanding. For example, the OCCO should consult with Aboriginal leaders in developing policies for accommodating, to the extent possible, diverse Aboriginal practices concerning the treatment of the body after death.

Coroners also have an important role in communicating with affected families about the death investigation, particularly if the body is removed from the community for post-mortem examination in a faraway city. In the absence of compelling reasons in the public interest, it is unacceptable for a family, already suffering the loss of a child, to be left uninformed of important information relating to the death investigation. Communications need to be improved not just with individual families, but also with First Nations governments and communities. The OCCO should work in partnership with First Nations governments and political organizations to develop communications protocols with priority for the North, where the need is particularly acute. Through such consultation, I am confident that positive change can occur.

Pediatric Forensic Pathology and Families

I end this executive summary where I began. The sudden, unexpected death of a child is a terrible tragedy. For the parents, the loss is shattering. It is all the more devastating when flawed pathology focuses suspicion on a grieving parent and invites legal proceedings to separate that parent from surviving children. It is, of course, no less troubling when flawed pathology imperils the search for the truth – wherever it may lead.

Although my mandate requires me to focus on the role of pediatric forensic pathology in the criminal justice system, in order to fully restore public confidence, we need to look at how pediatric forensic pathology can better serve child protection proceedings and the needs of families affected by a suspicious pediatric death.

When a child has died in suspicious circumstances and has surviving siblings, the child protection system must make very difficult decisions under extraordinary time pressures. Information, particularly from the pediatric forensic pathologist, is often crucial. Balancing this requirement against the imperative of the criminal justice system can be challenging. The Province of Ontario, with the assistance of the Ontario Association of Children's Aid Societies and others, should develop province-wide standards, supplementing those that already exist, on the sharing of information arising out of the investigations of suspicious child deaths by the police and children's aid societies. Local protocols should be created across the province to permit local jurisdic-

tions to implement the provincial standards in a manner that best suits their particular communities.

Families of a deceased child must be kept informed as much as possible about the death investigation. It is vital that this be done in a caring and compassionate way. The OCCO should develop a Family Liaison Service dedicated to communicating with these families.

As this Inquiry demonstrated, pediatric forensic pathology is a complex science. Therefore, it is important to provide capable legal representation in child protection proceedings in which that science plays an important role. Legal Aid Ontario should work with the family law bar to ensure that proper funding is available for this purpose.

Although I was asked to do so by several parties, I see no basis to recommend a review of any additional child protection cases on the premise that they might have been affected by flawed pathology. However, while no further review is warranted, our mandate permits us to assist families in cases already identified. The Inquiry has already facilitated counselling for those families affected by flawed pediatric forensic pathology. For a number of the individuals, the counselling has been very helpful in assisting them to deal with these tragic episodes and move on with their lives. The Inquiry was initially able to commit funding to counselling for a two-year period – the duration of the Inquiry. Where the counselling began during the life of the Inquiry, I recommend that funding be provided for up to a further three years if the individual and the counsellor think it would be useful.

Conclusion

Finally, I conclude with the consolidated list of my detailed recommendations on each of these important subjects. They arise directly out of the review I was required to conduct for the years from 1981 to 2001. They address the systemic failings in the practice and oversight of pediatric forensic pathology that were identified at the Inquiry. In my opinion, these are the steps that must be taken to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in the criminal justice system.

In the last few years, new leadership has made a significant start in addressing this challenge. But as they acknowledge, much more must be done. To stop now risks a return to the troubled years examined at the Inquiry. However, the steps taken so far, together with the sense of hope for the future they have begun to engender in those who continue to work in this field, provide a firm foundation on which to build.

My recommendations are intended to do just that. If acted upon, they represent the best way to protect the administration of justice from flawed pathology, to leave behind the dark times of the recent past, and to create the forensic pathology service that the criminal justice system needs and the people of Ontario deserve.

Consolidated Recommendations

The complete recommendations appear below. Page references in square brackets indicate where the recommendations can be found in Volume 3.

Chapter 11
Professionalizing and Rebuilding Pediatric Forensic Pathology

1 The Province of Ontario should amend the *Coroners Act* in order to

a) establish the Ontario Forensic Pathology Service as the provider of all forensic pathology services for the province;
b) recognize and define the principal duties and responsibilities of the Chief Forensic Pathologist;
c) recognize one or more Deputy Chief Forensic Pathologists;
d) require that all post-mortem examinations performed under coroner's warrant be performed by "pathologists," a term that should be defined in the *Coroners Act*; and
e) create a Governing Council to oversee the duties and responsibilities of the Office of the Chief Coroner for Ontario. [See page 288.]

2 As expeditiously as possible, the Royal College of Physicians and Surgeons of Canada should

a) approve the accreditation of one-year training programs in forensic pathology offered by Canadian medical schools to candidates with Royal College certification in either anatomical or general pathology;
b) certify forensic pathologists upon successful completion of an accredited training program and a Royal College examination in the subspecialty of forensic pathology; and

c) finalize the process by which pathologists currently practising forensic pathology in Ontario may become certified by the Royal College. [See page 295.]

3 The Ontario Forensic Pathology Service and the Chief Forensic Pathologist should actively encourage

a) faculties of medicine to promote interest in forensic pathology by exposing students in the early years of their programs to forensic pathology; and
b) forensic pathologists to work with the faculties of medicine to educate students about forensic pathology. [See page 296.]

4 The Governing Council and the Chief Forensic Pathologist should ensure that the Ontario Forensic Pathology Service is built upon the three essential and interdependent pillars of service, teaching, and research. [See page 298.]

5 The Province of Ontario, the Governing Council, and the Chief Forensic Pathologist should work with the University of Toronto to establish a Centre for Forensic Medicine and Science, which would

a) educate both practitioners and students in a variety of medical disciplines related to the forensic sciences; and
b) be affiliated directly with the Provincial Forensic Pathology Unit and the Ontario Pediatric Forensic Pathology Unit. [See page 299.]

6 All individuals and institutions that provide or oversee the education of medical students in Ontario should focus on the critical importance of the criminal justice system in medico-legal education. In particular, the Royal College of Physicians and Surgeons of Canada should ensure that any accredited fellowship programs in forensic pathology provide education in relation to expert evidence, the justice system, and the relevant aspects of evidence law and criminal procedure. [See page 301.]

7 All individuals and institutions that provide or oversee the provision of forensic pathology services in Ontario should focus on the critical importance of continuing medical education and, in particular,

a) the Chief Forensic Pathologist or designate should assume primary responsibility for fostering ongoing and interdisciplinary education about the role of the forensic pathologist in the justice system; and

b) the Province of Ontario should adequately fund continuing education for forensic pathologists regarding recent developments in the science of forensic pathology and the role of the forensic pathologist in the justice system. [See page 301.]

8 The Province of Ontario should provide the resources necessary to address the acute shortage of forensic pathologists in Ontario. In particular, the Province of Ontario should

a) provide adequate and sustainable funding for fellowships in forensic pathology in each of the regional forensic pathology units across the province;
b) fund full-time positions within the profession that will support the three pillars of service, teaching, and research, including but not limited to, Deputy Chief Forensic Pathologist(s), director positions at the regional forensic pathology units, and staff forensic pathologist positions;
c) provide sufficient resourcing to ensure that forensic pathologists' caseloads do not exceed recommended standards;
d) include Ontario Forensic Pathology Service pathologists in the Laboratory Medicine Funding Framework Agreement, to ensure that all pathologists are compensated fairly, whether they work on staff at a hospital or at the Provincial Forensic Pathology Unit, or take steps that will achieve and maintain an equivalent result;
e) increase the number of full-time-equivalent positions in Ontario's regional forensic pathology units;
f) ensure that each unit where post-mortem examinations are performed pursuant to coroner's warrant is fully equipped, up to date, and properly resourced; and
g) fund the construction of a new, modern facility to house the Office of the Chief Coroner for Ontario and related forensic sciences. [See page 305.]

9 The Ontario Forensic Pathology Service should immediately recruit appropriately credentialed forensic pathologists offshore to address the shortage in the province. [See page 306.]

10 The Province of Ontario should provide sufficient resources to permit the recruitment of appropriately credentialed forensic pathologists from other countries. [See page 306.]

11 The Province of Ontario should commit to providing funding sufficient to sustain the changes required to restore public confidence in pediatric forensic pathology. [See page 307.]

Chapter 12
Reorganizing Pediatric Forensic Pathology

12 The *Coroners Act* should be amended to establish and define the Ontario Forensic Pathology Service as follows:

> "Ontario Forensic Pathology Service" means the branch of the Office of the Chief Coroner for Ontario which, as directed by the Chief Forensic Pathologist, provides all forensic pathology services performed under or in connection with a coroner's warrant.[1] [See page 309.]

13 The *Coroners Act* should be amended to include the following definitions for pathologist and certified forensic pathologist:

a) "Pathologist" means a legally qualified medical practitioner certified by the Royal College of Physicians and Surgeons of Canada or its equivalent as a specialist in anatomical or general pathology;
b) "Certified forensic pathologist" means a pathologist certified by the Royal College of Physicians and Surgeons of Canada or its equivalent as a specialist in forensic pathology. [See page 310.]

14 The *Coroners Act* should be amended to provide that the Lieutenant Governor in Council appoint a certified forensic pathologist to be the Chief Forensic Pathologist for Ontario to

a) direct the Ontario Forensic Pathology Service and be responsible for the services it provides;
b) supervise, direct, and oversee the work of all pathologists in Ontario under, or in connection with, 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) administer a Registry of pathologists approved to perform post-mortem examinations under coroner's warrant; and

[1] The language of this and other proposed amendments to the *Coroners Act* is recommended language only.

f) perform such other duties as are assigned to him or her by, or under, this or any other Act, or by the regulations, or by the Lieutenant Governor in Council. [See page 311.]

15 The Governing Council should create a document outlining additional duties and responsibilities of the Chief Forensic Pathologist, which would include to

a) ensure that the Ontario Forensic Pathology Service (OFPS) provides a high quality of service;
b) ensure effective oversight of the work performed throughout the OFPS;
c) take responsibility for the service, teaching, and research mission of the OFPS;
d) encourage a collaborative culture of quality within the OFPS;
e) be responsible for the preparation and administration of the annual budget for the OFPS; and
f) be responsible for determining the pathologist who will conduct each post-mortem examination under coroner's warrant in Ontario. [See page 311.]

16 The Chief Coroner for Ontario should direct investigating coroners to issue all warrants for post-mortem examination to the Chief Forensic Pathologist or designate. [See page 312.]

17 The *Coroners Act* should be amended to provide that the Lieutenant Governor in Council may appoint one or more forensic pathologists to be Deputy Chief Forensic Pathologist(s) in 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 during his or her inability to act. [See page 312.]

18 The Governing Council, on the recommendation of the Chief Forensic Pathologist, should appoint a regional director for each regional forensic pathology unit who will

a) provide oversight of and be accountable for the work of their regional units;
b) be a member of the Forensic Pathology Advisory Committee; and
c) assist the Chief Forensic Pathologist and the Deputy Chief Forensic Pathologist(s) to create quality assurances processes, peer review processes, and other mechanisms of review. [See page 314.]

19 To ensure quality of service across the province, the Ontario Forensic Pathology Service should utilize and build on the regional forensic pathology units. [See page 315.]

20 The Province of Ontario should fund the actual costs of the regional forensic pathology units. [See page 315.]

21 The Office of the Chief Coroner for Ontario should enter into service agreements regarding each of the regional forensic pathology units. These agreements should, at a minimum, provide that

a) the unit will assume responsibility for a designated geographic area of the Ontario Forensic Pathology Service;
b) each regional director will be accountable to the Chief Forensic Pathologist for the work of his or her unit and will be responsible for the oversight, timeliness, and quality control of all post-mortem examinations performed under coroner's warrant within the unit's designated area;
c) the Chief Forensic Pathologist will be responsible for the general supervision of the units, for providing direction and guidelines as they relate to acceptable standards of forensic pathology practice in the units, and for ensuring appropriate quality control measures are in place;
d) forensic pathologists performing work for the Ontario Forensic Pathology Service must be included on the Registry of pathologists and will be primarily accountable to their regional director; and
e) each regional director will hold a salaried position with the regional unit, although that may be a full- or part-time position, depending on the local circumstances. [See page 318.]

22 Ontario hospitals should create policies requiring them to report any serious concerns about the work of any hospital pathologist who performs autopsies under coroner's warrant to the Chief Forensic Pathologist, whether or not the concerns arise out of work performed under coroner's warrant. The Office of the Chief Coroner for Ontario should also create policies requiring it to report any serious concerns about the work of a forensic pathologist to the hospital where the pathologist practises. [See page 319.]

23 The Ontario Forensic Pathology Service should ensure that, as a requirement for inclusion on the Registry, pathologists consent to hospitals reporting serious concerns to the Chief Forensic Pathologist and to the Chief Forensic Pathologist reporting serious concerns to the hospitals. [See page 319.]

24 With the support of the Ministry of Health and Long-Term Care and the Ministry of Community Safety and Correctional Services, the Ontario Forensic Pathology Service and each hospital with which a regional unit is associated should create protocols to clearly define the areas and limits of the hospital's responsibilities, to avoid confusion about the oversight roles of the Chief Forensic Pathologist and the hospital. [See page 319.]

25 The Ontario Forensic Pathology Service should increase the number of full-time-equivalent positions in all the units, as well as the proportion of forensic autopsies that are performed within those units. [See page 320.]

26 The Province of Ontario should fund a telemedicine portal in the Provincial Forensic Pathology Unit and at each of the regional forensic pathology units, if not already a part of the particular hospital system. [See page 321.]

27 The Ontario Pediatric Forensic Pathology Unit should continue as a regional forensic pathology unit located at SickKids. Its director must be a certified forensic pathologist. [See page 323.]

28 For pediatric forensic cases that are to be done in Toronto, the Chief Forensic Pathologist or designate should direct that

a) for pediatric forensic cases that do not appear to be criminally suspicious, the post-mortem examination should usually be conducted at the Ontario Pediatric Forensic Pathology Unit;
b) for criminally suspicious pediatric forensic cases, the post-mortem examination should be conducted by an appropriate pathologist at the Ontario Pediatric Forensic Pathology Unit or at the Provincial Forensic Pathology Unit, as determined by the Chief Forensic Pathologist or designate; and
c) particularly in difficult cases, the pathologists at each unit should take advantage of the expertise available at the other unit. [See page 325.]

29 For pediatric deaths outside the area regularly serviced by the Ontario Pediatric Forensic Pathology Unit, the Chief Forensic Pathologist or designate should direct that

a) for pediatric forensic cases within the geographical area of the designated regional units that do not appear to be criminally suspicious, the post-mortem examination should be conducted at the appropriate regional

forensic pathology unit or by Dr. Susan Phillips or another approved forensic pathologist in Winnipeg; and

b) for criminally suspicious pediatric forensic cases, the post-mortem examination should be conducted by the pathologist and at the unit designated by the Chief Forensic Pathologist or designate. [See page 326.]

30 Until the Registry of pathologists is created, the provisions of the 2007 Guidelines on Autopsy Practice for Forensic Pathologists: Criminally Suspicious Cases and Homicides should be followed in all criminally suspicious pediatric forensic cases. [See page 327.]

31 Once the Registry is created, the Chief Forensic Pathologist or designate should ensure that, in all criminally suspicious pediatric forensic cases, the post-mortem examination is conducted by an approved pediatric forensic pathologist. [See page 327.]

32 As soon as numbers permit, the Chief Forensic Pathologist should ensure that, in all criminally suspicious pediatric forensic cases, the post-mortem examination is conducted by a certified forensic pathologist with pediatric forensic experience. [See page 327.]

33 For all forensic cases, but particularly for criminally suspicious pediatric cases, the Ontario Forensic Pathology Service should reinforce a policy that encourages collaboration between the forensic pathologist and other relevant professionals.[2] [See page 328.]

34 The Ontario Forensic Pathology Service should establish a protocol for pediatric forensic cases that appear non-criminally suspicious at the outset, but become criminally suspicious during the post-mortem examination. The pathologist must trigger the application of the protocol as soon as a suspicion arises, and the protocol should provide for immediate access to a forensic pathologist and, ultimately, to the Chief Forensic Pathologist. [See page 329.]

---

[2] I have not always distinguished between policies, protocols, guidelines, and practices in my recommendations, although others sometimes do draw distinctions on the basis that some of these documents are intended to be mandatory, others discretionary. From my perspective, they all provide instructions that should be followed.

35 Until the Registry of pathologists is created, the provisions of the 2007 Guidelines on Autopsy Practice for Forensic Pathologists: Criminally Suspicious Cases and Homicides should be followed in all criminally suspicious adult forensic cases. [See page 330.]

36 Once the Registry is created, the Chief Forensic Pathologist or designate should ensure that in all criminally suspicious adult forensic cases, the post-mortem examination is conducted by an approved forensic pathologist. [See page 330.]

37 As soon as numbers permit, the Chief Forensic Pathologist should ensure that, in all criminally suspicious adult forensic cases, the post-mortem examination is conducted by a certified forensic pathologist. [See page 330.]

Chapter 13
Enhancing Oversight and Accountability

38 The Province of Ontario, having created the Governing Council by statute, should amend the *Coroners Act* to set out the powers and responsibilities of the Governing Council, including

a) oversight of the strategic direction and planning of the Office of the Chief Coroner for Ontario, including the coronial service and the Ontario Forensic Pathology Service;
b) budgetary approval;
c) senior personnel decisions; and
d) administration of the public complaints process. [See page 338.]

39 The Chief Coroner should be accountable to the Governing Council for the operation and management of the coronial service. The Chief Forensic Pathologist should be accountable to the Governing Council for the operation and management of the Ontario Forensic Pathology Service. [See page 339.]

40 The Governing Council should report annually to the Ministry of Community Safety and Correctional Services. Its annual report should be available to the public. [See page 339.]

41 The Province of Ontario should establish the membership of the Governing Council through a regulation to the *Coroners Act*. The Lieutenant Governor in Council should appoint the following members to a fixed term:

- a nominee of the Chief Justice of Ontario. He or she may act as chair of the council, or the chair may be otherwise designated by the Ministry of Community Safety and Correctional Services;
- the Chief Coroner for Ontario;
- the Chief Forensic Pathologist for Ontario;
- the dean of medicine of an Ontario medical school or his or her delegate;
- a nominee of the Minister of Health and Long-Term Care;
- a nominee of the Attorney General of Ontario;
- a nominee of the Minister of Community Safety and Correctional Services;
- the Director of the Centre of Forensic Sciences or his or her delegate; and
- three others named by the Ministry of Community Safety and Correctional Services, one of whom should be a certified forensic pathologist from outside Ontario. [See page 339.]

42 The Governing Council should guide the development of quality assurance, oversight, and accountability mechanisms for the work of the Office of the Chief Coroner for Ontario, including both the Ontario Forensic Pathology Service and the coronial service. [See page 341.]

43 The Ontario Forensic Pathology Service should create a publicly accessible Registry of pathologists who have been approved to perform post-mortem examinations under coroner's warrant. [See page 344.]

44 The Chief Forensic Pathologist should have responsibility for administering the Registry. [See page 344.]

45 With the approval of the Governing Council, the Chief Forensic Pathologist should design the details of the Registry, including fair and transparent procedures for admission, renewal, and removal. The Registry should have separate categories for those forensic pathologists approved to perform criminally suspicious adult cases, those approved to perform criminally suspicious pediatric cases, and those approved only to perform routine coroner's cases. [See page 344.]

46 As the Ontario Forensic Pathology Service grows in size and skill, the criteria for inclusion in the Registry should become more rigorous. As soon as possible, only certified forensic pathologists should be approved to perform criminally suspicious adult cases and only certified forensic pathologists with significant pediatric forensic experience should be approved to perform criminally suspicious pediatric cases. [See page 344.]

47 The Governing Council should appoint an executive director with responsibility for the administration of both the coronial service and the Ontario Forensic Pathology Service. [See page 346.]

48 The positions of Chief Coroner and Chief Forensic Pathologist should be full-time. [See page 347.]

49 A Forensic Pathology Advisory Committee should be formed to advise the Chief Forensic Pathologist in setting objectives, policies, protocols, and guidelines for the provision of forensic pathology services. Its membership should include the regional directors. [See page 348.]

50 The Ontario Forensic Pathology Service should appoint dedicated quality assurance staff, including a full-time quality assurance manager, to track quality assurance mechanisms. [See page 349.]

51 In order to enhance quality assurance of the work of pathologists, the Ontario Forensic Pathology Service should

a) in accordance with the October 2007 Autopsy Guidelines, continue to require direct notification of the Chief Forensic Pathologist of preliminary autopsy results in all criminally suspicious deaths;
b) in accordance with the October 2007 Autopsy Guidelines, continue to require full peer review of all reports of post-mortem examination in criminally suspicious cases by either a regional director, a staff pathologist at the Provincial Forensic Pathology Unit, or the Chief Forensic Pathologist or designate;
c) develop a system for peer review of reports of post-mortem examination in non-criminally suspicious cases where the autopsy was conducted at a regional forensic pathology unit or the Provincial Forensic Pathology Unit. The review system may be less comprehensive than the peer review system for criminally suspicious cases;

d) develop a system for peer review of opinions made supplementary to the report of post-mortem examination in criminally suspicious cases;
e) develop a system for peer review of consultation opinions in criminally suspicious cases; and
f) develop best practices for daily morning rounds at the regional forensic pathology units. The regional directors should report to the Chief Forensic Pathologist regarding implementation of these best practices. [See page 353.]

52 The Chief Forensic Pathologist should institute a program of annual performance reviews. He or she should conduct annual performance reviews of the work of the regional directors. The regional directors should conduct annual performance reviews of the work of forensic pathologists within their units. [See page 355.]

53 The Chief Forensic Pathologist and the senior leadership of the Ontario Forensic Pathology Service should lead the creation of a culture in which constructive criticism of a forensic pathologist's work is encouraged regardless of position and reputation. [See page 356.]

54 In order to ensure adequate oversight of the casework of the Chief Forensic Pathologist, beyond that provided for in the October 2007 Autopsy Guidelines, out-of-province expertise should be used on a random basis to assess the casework of the Chief Forensic Pathologist. [See page 356.]

55 The Paediatric Death Review Committee, the Forensic Services Advisory Committee, and the Deaths under Five Committee should continue. [See page 357.]

56 The Office of the Chief Coroner for Ontario should implement a central tracking system for, at a minimum, coroner's cases in which post-mortem examinations are conducted. The Province of Ontario should provide the resources necessary to create, implement, and administer the central tracking system. [See page 358.]

57 In order to enhance quality assurance of the work of forensic pathologists during criminal proceedings, the Ontario Forensic Pathology Service should develop

a) a system of peer review of testimony given by forensic pathologists in criminal proceedings; and
b) a program to obtain feedback from defence and Crown counsel regarding the work of forensic pathologists in criminal proceedings. [See page 359.]

58 Where brought to his or her attention, the Chief Forensic Pathologist should review any adverse comments made by judges about the work of forensic pathologists in criminal proceedings, and take whatever steps are appropriate as a result. [See page 359.]

59 In order to ensure quality through impartial review mechanisms, the Ontario Forensic Pathology Service should

a) develop a system of random external audits of a sample of autopsy reports from the regional units and the Provincial Forensic Pathology Unit; and
b) strive to make itself accountable to external organizations that benchmark services. [See page 360.]

60 The Ontario Forensic Pathology Service should strive to enhance the continuing education of forensic pathologists listed on the Registry. [See page 361.]

Chapter 14
Improving the Complaints Process

61 The Office of the Chief Coroner for Ontario should establish a public complaints process that

a) is transparent, responsive, and timely; and
b) encompasses all the medical practitioners and specialists involved in the death investigation process, including coroners and forensic pathologists. [See page 366.]

62 The complaints process to be established by the Office of the Chief Coroner for Ontario should be separate and apart from the complaints process offered by the College of Physicians and Surgeons of Ontario, and should focus on forensic pathologists' performance of their roles and their compliance with Ontario Forensic Pathology Service requirements. [See page 367.]

63 The College of Physicians and Surgeons of Ontario should continue its practice of investigating complaints about forensic pathologists acting under coroner's warrant. [See page 367.]

64 With the approval of the Governing Council, the Chief Coroner for Ontario and the Chief Forensic Pathologist should design the specific procedures for the complaints process to

a) reflect the principles of transparency, responsiveness, timeliness, and fairness;
b) focus on remedial and rehabilitative responses, rather than punitive ones, except where the public interest is jeopardized; and
c) provide for appeals by the complainant or the physician to the complaints committee of the Governing Council where they are not satisfied with the initial resolution of the complaint by the Chief Coroner or the Chief Forensic Pathologist or their designates. [See page 368.]

65 The complaints committee of the Governing Council should deal with complaints concerning the work of the senior leadership of the Office of the Chief Coroner for Ontario, with a further review by the deputy minister if necessary. [See page 369.]

66 The Office of the Chief Coroner for Ontario and the College of Physicians and Surgeons of Ontario should each be prepared to inform the other of

a) the fact that it has a serious concern about the work or conduct of a forensic pathologist or coroner;
b) relevant information it has gathered during the investigation process; and
c) the outcome of its investigation. [See page 371.]

67 The Chief Forensic Pathologist should ensure that all forensic pathologists are required, as a condition of their inclusion on the Registry, to consent to the Office of the Chief Coroner for Ontario and the College of Physicians and Surgeons of Ontario sharing information relating to serious concerns about their work or conduct. [See page 371.]

Chapter 15
Best Practices

68 The Ontario Forensic Pathology Service should explicitly adopt a set of basic principles that include those set out in this chapter; guidelines for best practices at autopsy should be founded on these principles. [See page 374.]

69 a) Evidence-based forensic pathology is incompatible with an approach of "thinking dirty." It, instead, involves keeping an open mind to the full range of possibilities that the evidence might yield, without preconceptions or presumptions about abuse, and collecting evidence both to support and to negate any possibilities.

b) "Thinking truth," the orientation now adopted by the Office of the Chief Coroner for Ontario, accurately captures the appropriate approach to forensic pathology and helps promote an evidence-based culture. [See page 377.]

70 a) The Ontario Forensic Pathology Service should encourage forensic pathologists throughout the province to attend the scene of death more frequently.

b) The Office of the Chief Coroner for Ontario should develop guidelines with respect to scene attendance by forensic pathologists throughout the province. The guidelines should draw upon the Toronto memorandum and the experience with scene attendance by forensic pathologists at the Provincial Forensic Pathology Unit and the Hamilton Regional Forensic Pathology Unit. Such guidelines should

i) recognize the strengths and limitations of scene attendance;
ii) identify the circumstances in which scene attendance by the forensic pathologist would be valuable;
iii) emphasize the need for communication between the investigating coroners, police, and forensic pathologists in determining when scene attendance will take place; and
iv) outline a protocol to be followed at the scene when forensic pathologists are in attendance. [See page 379.]

71 Where it is not feasible for the forensic pathologist to attend the scene, the Ontario Forensic Pathology Service (OFPS) should develop and encourage enhanced "real time" communication, including the transmission of digital

photographs, and even the use of video and telemedicine technology, so that the forensic pathologist can view the scene, where helpful, prior to the body being removed. The OFPS should be provided with the resources necessary to do so. [See page 380.]

72 Compensation for forensic pathologists should reflect the added work represented by their attendances at the scene. [See page 380.]

73 a) The contents of warrants for post-mortem examination should conform to the current guidelines of the Office of the Chief Coroner for Ontario.
b) In accordance with current guidelines of the Office of the Chief Coroner for Ontario, the investigating coroner should strive to provide full and accurate information to the forensic pathologist. In particular, all relevant hospital and medical records should, if at all possible, be provided to the forensic pathologist prior to the commencement of the post-mortem examination.
c) The coroner should refrain from expressing medical conclusions in any early communications with the forensic pathologist. Although the coroner makes the final determination about cause and manner of death, the coroner is well advised to await the considered opinions of the forensic pathologist before expressing those conclusions.
d) In accordance with existing policy of the Office of the Chief Coroner for Ontario, direct telephone or in-person communication between the coroner and the forensic pathologist should take place prior to the autopsy for every criminally suspicious case and for autopsies of children under the age of five.
e) Province-wide protocols for police officers should be developed that articulate the types of information that should and should not be provided to the forensic pathologist. Such protocols should also address how police and coroners can coordinate what information is provided to the forensic pathologist and by whom. [See page 384.]

74 a) The police and coroners should be encouraged to provide initial information to the forensic pathologist in writing.
b) Additional information communicated to the forensic pathologist at any time should be provided in writing or, if verbal, should be recorded by both the person communicating the information and the person receiving it.
c) Investigation questionnaires should be utilized by police and coroners to provide information to forensic pathologists in all cases of sudden infant

death. The completed questionnaire should be provided to the forensic pathologist before the post-mortem examination begins. [See page 386.]

75 a) As a general rule, police and coroners should not "filter out" relevant information that is to be provided to the forensic pathologist. The forensic pathologist is best situated to determine what is relevant to his or her work.

b) That being said, police and coroners should generally not transmit information that is clearly irrelevant, innuendo, or purely speculative. Coroners and police officers also have discretion as to how relevant information is communicated to the forensic pathologist. This might mean, for example, that information is communicated in ways that reduce its potential misuse or its inflammatory character.

c) The forensic pathologist should remain vigilant against confirmation bias or being affected by extraneous considerations. This is best done through increased professionalism and education, an enhanced awareness of the risks of confirmation bias, the promotion of an evidence-based culture, complete transparency concerning both what is communicated and what parts of it are relied upon by the pathologist, and a cautious approach by the pathologist to the use of circumstantial or non-pathology information. [See page 390.]

76 Any information provided by the coroner or the police to the forensic pathologist should be carefully recorded both by the conveyor of the information and by its recipient. [See page 391.]

77 a) Autopsies should not normally be audiotaped or videotaped. However, what is done at the autopsy should be fully transparent and independently reviewable. Therefore, what is done and by whom at the autopsy should be carefully documented. This documentation includes careful recording through photographs and contemporaneous note-taking by support staff and the forensic pathologist.

b) Best practice also requires the appropriate retention, storage, and transmittal of organs, tissues, samples, and exhibits in accordance with the current autopsy guidelines of the Office of the Chief Coroner for Ontario and policies in place at hospitals where forensic autopsies are performed.

c) In accordance with the current guidelines of the Office of the Chief Coroner for Ontario, materials kept for testing and independent reviewability should be carefully documented. [See page 392.]

78 a) In accordance with the October 2007 Autopsy Guidelines, the Office of the Chief Coroner for Ontario should continue to encourage forensic pathologists to exercise caution in providing preliminary opinions. In particular, a preliminary opinion on the cause of death or other forensic issues, such as timing or mechanism of injury, should not be provided if ancillary investigations have any reasonable chance of altering the preliminary opinion. In such circumstances, the cause of death should be given as "pending further tests."

b) Whether forensic pathologists express a preliminary opinion or indicate that the cause of death is "pending," they should ensure that this is fully understood, including in particular any qualifications or limitations that exist for the preliminary opinion. [See page 395.]

79 a) When a forensic pathologist provides a preliminary opinion at the conclusion of the autopsy, it should be reduced to writing. Either the pathologist should provide the opinion in writing to the police, retaining a copy for his or her records, or the attending police should carefully record the opinion in their notebooks. If this second procedure is followed, the forensic pathologist should review what the police have recorded for accuracy, and indicate in writing that it conforms with her or his opinion, including its limitations. The forensic pathologist should also retain a copy of the relevant entries.

b) If the notification form of the Office of the Chief Coroner for Ontario is used to record the forensic pathologist's preliminary opinion, it should be provided to the police and coroner with a copy retained by the pathologist. [See page 397.]

80 a) Using the suggestions contained in this Report, the Office of the Chief Coroner for Ontario (OCCO), and in future the Ontario Forensic Pathology Service (OFPS), should address the important challenge of timely production of forensic pathology reports needed by the criminal justice system.

b) The components of a solution to this difficult problem should include the following:

i) There should be realistic and well-understood timelines for the completion of post-mortem reports. Those set out in the OCCO's July 2004 memorandum would seem to be appropriate.

ii) The OCCO should develop a central tracking system which will permit better knowledge, and therefore better management, of the problem of untimely production of reports.

iii) Growing the profession of forensic pathology will be of great assistance.
iv) The OCCO should be provided with sufficient resources to ensure that there are no administrative impediments to the timely production of reports.
v) The development of better lines of communication between the OCCO and the regional forensic pathology units through their service agreements will assist in minimizing the pressure of clinical pathology work as an impediment to timely forensic pathology reports.
vi) Particularly for difficult, criminally suspicious cases, the OCCO should develop a guideline for prioritizing reports that are urgently needed by the criminal justice system.
vii) Sanctions must be available. Those in positions of responsibility, starting with the regional director, should use their management skills to address the problem. Ultimately, the Chief Forensic Pathologist can utilize the tool of possible removal from the Registry. With increased remuneration for reports provided to the fee-for-service forensic pathologists, this may be enough. At the extreme, actual removal from the Registry may in fact be necessary to preserve the integrity of the OFPS. [See page 401.]

81 a) To shorten delays in producing post-mortem reports, the Office of the Chief Coroner for Ontario should continue to instruct forensic pathologists to submit samples for toxicology testing as soon as possible.
b) The Office of the Chief Coroner for Ontario and the Centre of Forensic Sciences should together quickly create a guideline that prioritizes and expedites toxicology testing in clearly articulated types of cases, such as those that are criminally suspicious.
c) The Office of the Chief Coroner for Ontario and the Centre of Forensic Sciences should continue their discussions on a priority basis to improve the turnaround times for toxicology reports needed by forensic pathologists to complete their reports. [See page 402.]

82 Forensic pathologists should practise teamwork in conducting autopsies. The Ontario Forensic Pathology Service should be charged with creating a culture in which this is expected. [See page 404.]

83 The Office of the Chief Coroner for Ontario should continue to develop guidelines to assist forensic pathologists in adhering to best practices at or

surrounding the autopsy. Those guidelines should incorporate, where appropriate, the specific recommendations about best practices made in this Report. Such guidelines should complement the proposed Code of Practice and Performance Standards for forensic pathologists. [See page 405.]

Chapter 16
Effective Communication with the Criminal Justice System

84 Several general principles should inform the way that pathology opinions are communicated:

a) Pathology opinions often depend on technical knowledge and expertise that are not easily understood by lay persons. Particularly in pediatric forensic pathology, opinions may be highly nuanced. However, the criminal justice system in which these opinions are used craves certainty and simplicity. This divergence in the cultures of the two professional areas poses a serious risk of misunderstanding between them, one that is further increased by an adversarial process designed to push and pull these opinions in different directions. To reduce the risk of their being misunderstood, the most important parts of a forensic pathologist's opinion should be expressed in writing at the earliest opportunity.

b) The ability of the various consumers of a forensic pathologist's opinion – including peer reviewers, coroners, and stakeholders in the criminal justice system or child protection proceedings – to understand, evaluate, and potentially challenge the opinion requires that it be fully transparent. It should clearly state not just the opinion but the facts on which the opinion is based, the reasoning used to reach it, the limitations of the opinion, and the strength or degree of confidence the pathologist has in the opinion expressed.

c) Although some of the consumers of a forensic pathologist's opinion are experts, such as peer reviewers, many are lay persons who have little or no understanding of technical language. It is essential that the pathologist's opinion be understood by all the users. It must therefore be communicated in language that is not only accurate but also clear, plain, and unambiguous.

d) In expressing their opinions, forensic pathologists should adopt an evidence-based approach. Such an approach requires that the emphasis be placed on empirical evidence, and its scope and limits, as established in large measure by the peer-reviewed medical literature and other reliable sources. This approach places less emphasis on authoritative claims based

on personal experience, which can seldom be quantified or independently validated. [See page 408.]

85 a) The use of the term "asphyxia" should be avoided as an articulated cause of death. If it must be used to describe the mechanism of death, it should be elaborated on to avoid confusion.

b) Forensic pathologists in Ontario should be educated as to the dangers associated with the term "asphyxia" and, under the auspices of the Chief Forensic Pathologist, reach a common understanding as to when it should and should not be used.

c) More generally, forensic pathologists should be careful to express their opinions in terms that are not susceptible to varied meanings, but that do elucidate the issues addressed by the opinions. [See page 410.]

86 a) Forensic pathologists should analyze the level of confidence they have in their opinions and articulate that understanding as clearly as they can. Pending the development of a common language for this purpose, pathologists should use their own formulations to capture, as accurately as possible, their own level of confidence.

b) Under the auspices of the Chief Forensic Pathologist, work should be done, in a multidisciplinary setting, to develop, to the extent possible, some common language to describe what forensic pathologists have to say. That multidisciplinary setting should include leading practitioners and academics from both forensic pathology and the legal profession.

c) One objective should be to build consensus on how levels of confidence should be articulated.

d) The results of this work should be reflected in a proposed Code of Practice and Performance Standards for forensic pathologists. [See page 413.]

87 a) Proof beyond a reasonable doubt is a legal standard applicable to the totality of evidence, and it has no correlation with science or medicine. Forensic pathologists should be educated and trained not to think in terms of "proof beyond a reasonable doubt," and they should not formulate or articulate their opinions in terms of this legal standard.

b) Participants in the justice system should similarly be educated to avoid efforts to compel forensic pathologists to express their opinions in terms of this legal standard. [See page 414.]

88 Forensic pathologists should be educated and trained so that their level of confidence or certainty in their opinions remains essentially the same and not dependent on the forum in which those opinions are expressed. [See page 414.]

89 a) Forensic pathologists should not engage in "default diagnoses." The absence of a credible explanation is not a substitute for sufficient pathology findings to support the existence of abuse or non-accidental injury. In particular, a formulation such as "in the absence of a credible explanation, the post-mortem findings are regarded as resulting from non-accidental injury" should not be used.

b) If the evidence is not sufficient to support a cause of death, it should be characterized as "undetermined." [See page 417.]

90 a) Forensic pathologists should outline in their post-mortem or consultation reports the alternative or potential diagnoses that may arise in a case. They should also evaluate alternative explanations that are raised by the pathology or by the reported history associated with the deceased's death. They should describe precisely what alternative explanations have been considered and why they can or cannot be ruled out. The same principles should inform all forensic pathologists' communications, including their testimony.

b) More generally, forensic pathologists' opinions, written or verbal, should be responsive to the needs of the justice system. They should address the live or pertinent issues in the case, for instance, and articulate in a transparent way what they have to say about those issues and why. [See page 417.]

91 a) Forensic pathologists should clearly communicate, where applicable, areas of controversy that may be relevant to their opinions and place their opinions in that context.

b) They should also clearly communicate, where applicable, the limits of the science relevant to the particular opinions they express.

c) They should remain mindful of both the limits and the controversies surrounding forensic pathology as they form their opinions and as they analyze the level of confidence they have in those opinions.

d) These obligations extend to the content of post-mortem or consultation reports, to verbal communications, and to testimony. [See page 419.]

92 Forensic pathologists have a positive obligation to recognize and identify for others the limits of their expertise. They should avoid expressing opinions that fall outside that expertise. When invited to provide such opinions, they should make the limits of their expertise clear and decline to do so. [See page 420.]

93 a) Forensic pathologists should never use circumstantial evidence or non-pathology information to bear the entire burden of support for an opinion.
b) Caution in using such evidence or information at all should be particularly pronounced where the circumstantial evidence is potentially unreliable or contentious or comes close to the ultimate issue that the court must decide.
c) Forensic pathologists' opinions must ultimately fall within their particular area of expertise. They should not rely on circumstantial evidence to a point where the opinion no longer meets that requirement.
d) There is some limited scope for forensic pathologists quite properly to use non-pathology or circumstantial evidence in forming their opinions. They need not operate in complete isolation. However, their use or consideration of circumstantial evidence should always be transparent: they should always disclose both the extent to which they have used or relied on such evidence and the impact such evidence has had on their reasoning and opinions.
e) Forensic pathologists can consider hypothetical questions that involve circumstantial evidence in determining whether, or to what extent, a reported history can be excluded or supported by the pathology findings. [See page 422.]

94 a) When forensic pathologists base their opinions, in whole or in part, on consultation with other experts, they should identify those experts as well as the content of the opinions those experts expressed.
b) When informal "corridor" consultations influence formal opinions, the same identification and acknowledgment procedures should be followed. In addition, the consulted experts should express in writing, where feasible, any significant findings or opinions they contributed. [See page 423.]

95 a) The articulation of the basis for the forensic pathologist's opinion in a completely transparent way is at the cornerstone of evidence-based pathology.

b) Forensic pathology opinions, whether given in writing or in oral communication, should articulate both the pathology facts found and the reasoning process followed, leading to the opinions expressed. [See page 427.]

96 Forensic pathologists, in order to communicate their opinions in plain language to their lay readers, should consider including a glossary of medical terms, and, in some cases, relevant secondary literature, in their post-mortem or consultation reports. [See page 427.]

97 The Office of the Chief Coroner for Ontario should develop a Code of Practice and Performance Standards for forensic pathologists in Ontario which describes, among other things, the principles that should guide them as they write their reports and the information that should be contained in them. It should draw on existing sources, including the *Code of Practice and Performance Standards for Forensic Pathologists* in England and Wales. It should include at least the following:

a) the principles set out in Recommendation 84;
b) guidance on the content of their autopsy and consultation reports (particularly where they may be used by the justice system), including

i) the subjects mandated by the *Code of Practice and Performance Standards for Forensic Pathologists* in England and Wales;
ii) details of each expert's academic and professional qualifications, experience, and accreditation relevant to the opinions expressed in the report, as well as the range and extent of this expertise and any limitations on it;
iii) the levels of confidence or certainty with which the opinions are expressed;
iv) any alternative explanations that are raised by the pathology or by the reported history associated with the deceased's death, with an analysis of why these alternative explanations can or cannot be ruled out;
v) what the pathologist has to say that is relevant to the live or pertinent issues in the case and why;
vi) any area of controversy that may be relevant to their opinions, placing their opinions in that context;
vii) any limits of the science relevant to the particular opinions;
viii) the extent to which circumstantial or non-pathology information has been used or relied on, and its impact on the reasoning and opinions;
ix) any other expert opinions relied upon;

x) the pathology facts found and the reasoning process that was followed, leading to the opinions expressed; and
xi) a glossary of medical terms, if helpful, to assist in communicating opinions in plain language to lay readers.

c) guidance on

i) language to be used or avoided, and the dangers associated with the use of particular terms;
ii) how best to think about and articulate levels of confidence or certainty;
iii) the need to avoid the formulation or articulation of opinions in terms of proof beyond a reasonable doubt;
iv) the need to avoid default diagnoses;
v) the importance of recognizing and identifying for others the limits of their own expertise and of avoiding the expression of opinions that fall outside that expertise; and
vi) the cautions that should surround the use of circumstantial evidence or non-pathology evidence. [See page 429.]

98 The Code of Practice and Performance Standards for forensic pathologists in Ontario should also address giving evidence, again drawing on existing sources for its content, particularly the *Code of Practice and Performance Standards for Forensic Pathologists* developed in England and Wales. It should also include specific guidance on how forensic pathologists should deal with hypothetical questions and the differing views of colleagues. [See page 433.]

99 a) Forensic pathologists should avoid potentially misleading language, such as the phrase "consistent with," and adopt neutral language that clearly reflects the limitations of the opinion expressed.
b) Work should be done in a multidisciplinary setting to build consensus on words and phrases that forensic pathologists should utilize or avoid as potentially misleading. The results of this work should be reflected in the Code of Practice and Performance Standards for forensic pathologists. [See page 435.]

100 Forensic pathologists should be regularly reminded of the dangers of being misinterpreted or misunderstood by the criminal justice system. To that end, those engaged in forensic pathology should be provided with regular continuing education and training to enhance their effective communication with the criminal justice system. [See page 436.]

Chapter 17
The Roles of Coroners, Police, Crown, and Defence

101 The coroner and forensic pathologist should work in close cooperation where there is a post-mortem examination. In doing so, the coroner should respect the forensic pathologist's expertise and independent professional judgment. [See page 438.]

102 The Office of the Chief Coroner for Ontario should continue to facilitate early and ongoing case conferencing, particularly for criminally suspicious pediatric death investigations. Such case conferencing promotes the exchange of relevant information among the participants, an objective and informed investigation, and forensic pathology opinions that are accurate and address the real issues in the case. [See page 442.]

103 Case conferences should be recorded in notes that ultimately form part of disclosure in criminal cases. [See page 442.]

104 Case conferences are excellent opportunities for members of the death investigation team to communicate among themselves. However, they do not provide the only opportunity for communication. The members of the death investigation team should engage in regular and ongoing communication, particularly when the death investigation uncovers new evidence. That evidence should be presented to the forensic pathologists to allow them to reconsider their opinion in light of the new information. Any such communications should be documented by the parties involved in those communications. [See page 443.]

105 Participants at case conferences should understand the respective roles of coroners and forensic pathologists, and how those roles affect the scope and nature of the opinions that they are able to render. A proper understanding of those roles may assist in preventing pressure from being exerted on forensic pathologists to change their opinions in order to conform to a coroner's determination of cause or manner of death. It may also assist in preventing police and Crown counsel from placing unwarranted reliance on non-expert opinions rendered by coroners for purposes other than the criminal justice system. [See page 443.]

106 Coroners should avoid offering opinions in court proceedings that do not fall within their expertise. The danger is not only that the opinions may be wrong but also that they may be accorded undue weight because they emanate from the coroner's office. [See page 444.]

107 The Ministry of Community Safety and Correctional Services, police colleges, and the Ontario Forensic Pathology Service should work together to provide specialized training on pediatric forensic death investigations for select officers, and more basic training for other officers on forensic pathology and the issues identified at this Inquiry. [See page 446.]

108 Criminally suspicious pediatric death investigations should be conducted, where possible, by officers having specialized training and expertise in such cases. [See page 447.]

109 a) The Ministry of Community Safety and Correctional Services should create and maintain a roster of officers with specialized training and expertise in pediatric death investigations.
b) Those officers should be available, when needed, to provide advice to any police service in Ontario respecting the investigation of these cases.
c) This roster, together with 24-hour contact information for the on-call officer(s), should be disseminated to all police services in Ontario. [See page 447.]

110 The police should be trained to be vigilant against confirmation bias in their investigative work generally, and for pediatric forensic cases in particular. This training is best accomplished through increased professionalism, an enhanced awareness of the risks of confirmation bias, the promotion of an evidence-based culture, and complete transparency regarding what is communicated between the police and the forensic pathologist. [See page 447.]

111 The Ministry of the Attorney General (Criminal Law Division) should implement its initiatives on the prosecution of child homicide cases and the use of a Child Homicide Team as soon as possible. [See page 450.]

112 Members of the Child Homicide Team should be experienced in homicide prosecutions and knowledgeable about the scientific method generally and pediatric forensic pathology in particular. Their education should be ongoing. [See page 450.]

113 Defence counsel should be entitled to approach the Child Homicide Team when significant disagreements between the defence counsel and the prosecutor arise in individual child homicide cases. That right should be formalized in ministry policies and made known to Crown counsel and the defence bar. [See page 450.]

114 The Child Homicide Team should, as an important component of its role, review cases in which plea offers have been made to the defence. This role will arise either as part of the mandated consultation by the prosecuting Crown with the team at every stage of the prosecution, or at the initiative of the defence. [See page 452.]

115 a) In accordance with Ministry of the Attorney General initiatives, a prosecuting Crown should report to his or her supervisor and to the division lead for child homicide cases adverse judicial comments or his or her own concerns about the participation of a pediatric forensic pathology expert witness in the criminal justice system.
b) To enhance the oversight and accountability of such witnesses, the division lead for child homicide cases should report such comments or concerns to the Chief Forensic Pathologist. [See page 454.]

116 In furtherance of the ministry initiatives, the ministry should develop, in consultation with others, guidelines or protocols modelled on the protocols for the Crown and the Centre of Forensic Sciences that followed the Commission on Proceedings Involving Guy Paul Morin. These would address:

a) what adverse judicial comments or other identified concerns about pediatric forensic pathology expert witnesses should be reported;
b) how these comments or concerns should be reported;
c) what transcripts, if any, should be obtained, and by whom; and
d) under what circumstances this information is disclosable, and in relation to what categories of cases. [See page 455.]

117 Crown counsel should properly prepare forensic pathologists for giving evidence. This preparation involves, among other things, meeting with the pathologist in advance of the court proceedings. Such meetings will assist the Crown in understanding the limitations on the expert's expertise and opinions. The preparation of the expert should also focus on presenting the evidence in a way that is clear, unambiguous, understandable, and grounded in the witness's expertise. [See page 456.]

118 The following principles should inform the approach of both parties to the evidence of forensic pathologists:

a) Both parties should ensure that they understand the scope and limitations of the forensic pathologists' expertise and opinions. They should exercise care not to ask questions that invite forensic pathologists to speculate, or to stray outside of their expertise or the outer boundaries of the science.
b) Both parties should be vigilant not to introduce, through their questions, terminology that breeds misunderstanding or misinterpretation.
c) Subject to the court's discretion, both Crown and defence counsel should also allow forensic pathology experts reasonable time to consider their responses to new information that may be relevant to their opinions or any limitation on them. [See page 457.]

119 In accordance with a lawyer's ethical duty of competence, no lawyer should defend a criminal pediatric homicide or similar case that is beyond his or her competence or skills. [See page 460.]

120 The Province of Ontario, together with Legal Aid Ontario, should ensure that serious criminal cases involving pediatric forensic pathology are defended by lawyers who possess the necessary skill and experience to do so. This means, among other things, that the compensation for defending these cases should be significantly increased, and that the eligibility criteria for defending these cases should be appropriately defined.

The following represent ways in which these objectives may be achieved:

a) The Extremely Serious Criminal Cases Panel should be extended to cover all criminal pediatric homicide cases, including charges of manslaughter and criminal negligence causing death, as well as similar cases which involve forensic pathology or other complex medical evidence that must be critically evaluated and potentially challenged.
b) At least for pediatric homicides or similar cases, the eligibility criteria for Extremely Serious Criminal Cases should be tightened to ensure that these cases are defended by highly skilled lawyers. Although the experience and skills of some lawyers will be sufficient to meet heightened eligibility criteria without specific education and training in pediatric forensic pathology, such education and training should also inform the eligibility criteria.
c) Legal Aid Ontario should consider the criminal specialty designation by the Law Society of Upper Canada as a factor in determining whether counsel fulfill heightened eligibility criteria.

d) Legal Aid Ontario should regularly authorize junior or associate counsel for these cases, also to be paid at correspondingly increased rates. These counsel should not have to meet all of the eligibility criteria applicable to the lead or senior counsel. [See page 460.]

121 For criminal pediatric homicides and similar cases, Legal Aid Ontario normally should, if requested, fund the attendance of forensic pathologists in court when pathologists retained by the Crown or other significant experts relevant to the pathology issues present testimony in the case. [See page 462.]

122 Legal Aid Ontario's hourly tariff rates for forensic pathologists and similar experts should be increased to ensure defence access to their expertise and provide relative equivalence to the fees paid by the Crown. As well, in determining the number of hours to be authorized, whether an out-of-province forensic pathologist should be authorized, or whether more than one forensic pathologist or expert should be authorized, Legal Aid Ontario's discretion should be informed by the lessons learned at this Inquiry – including the complexity of criminal pediatric homicide cases and the potential for miscarriages of justice where forensic pathology evidence cannot be skilfully evaluated and, if necessary, challenged. [See page 462.]

123 The total funding available to Legal Aid Ontario should be sufficient to enable the recommendations in this chapter to be implemented. [See page 463.]

124 Expert witnesses to be called by the prosecution should make themselves available to meet with defence counsel in advance of the court proceedings to explain their opinions and any limitations on them. As part of their trial preparation, defence counsel should seriously consider meeting with such experts. This is particularly appropriate in forensic pathology cases. [See page 463.]

125 The defence is often well served (as is the forensic testimony presented to the criminal justice system) by early, voluntary disclosure of its anticipated forensic evidence. The defence should be encouraged, in its own interest, to provide such early disclosure. It should not be compelled to do so. [See page 466.]

126 A court-monitoring program for forensic pathologists should be established by the Office of the Chief Coroner for Ontario, in consultation with the Ministry of the Attorney General and the Criminal Lawyers' Association. [See page 467.]

127 a) The Ministry of the Attorney General and the Ministry of Community Safety and Correctional Services should fund regular joint courses for defence counsel and the Crown dealing with forensic pathology generally and pediatric forensic pathology in particular.

b) This education should assist lawyers in developing the specialized knowledge necessary to act as counsel in pediatric forensic pathology cases. Educational programs could be live or online, but there should also be web-based materials so that lawyers in pediatric forensic pathology cases may access them as a resource when the course is not being offered. [See page 468.]

128 Law schools should be encouraged to offer courses in basic scientific literacy and the interaction of science and the law. [See page 469.]

Chapter 18
The Role of the Court

129 When a witness is put forward to give expert scientific evidence, the court should clearly define the subject area of the witness's expertise and vigorously confine the witness's testimony to it. [See page 475.]

130 A concern about the reliability of evidence is a fundamental component of the law of evidence. Threshold reliability plays an important role in determining whether proposed expert evidence is admissible under the *Mohan* test. Reliability can be an important consideration in determining whether the proposed expert evidence is relevant and necessary; whether it is excluded under any exclusionary rule, including the rule that requires evidence to be excluded if its prejudicial effect exceeds its probative value; and whether the expert is properly qualified. Trial judges should be vigilant in exercising their gatekeeping role with respect to the admissibility of such evidence. In particular, they should ensure that expert scientific evidence that does not satisfy standards of threshold reliability be excluded, whether or not the science is classified as novel. [See page 487.]

131 In determining the threshold reliability of expert scientific evidence, the trial judge should assess the reliability of the proposed witness, the field of science, and the opinion offered in the particular case. In doing so, the trial judge should have regard to the tools and questions that are most germane to the task in the particular case. [See page 496.]

132 The trial judge's gatekeeping function may be facilitated, in some cases, by written descriptions in the expert reports of the nature of the relevant discipline and how it engages with the various criteria of reliability. In forensic pathology, these descriptions could include areas of controversy relevant to the case and a reading list of scientific literature on the subject. [See page 498.]

133 Judges should consider whether there are parts of the proposed expert evidence that are sufficiently reliable to be admitted and others that are not or which must be modified to be admitted. [See page 500.]

134 The National Judicial Institute should consider developing additional programs for judges on threshold reliability and the scientific method in the context of determining the admissibility of expert scientific evidence. [See page 502.]

135 It would be useful if the Canadian Judicial Council, in conjunction with the National Judicial Institute, could examine the feasibility of preparing a Canadian equivalent to the *Reference Manual on Scientific Evidence* prepared by the Federal Judicial Center in the United States. [See page 502.]

136 a) A code of conduct for experts giving evidence in criminal proceedings should be created.
b) It should be incorporated into the criminal justice system. This may best be done through the introduction of practice directions and amendments to pretrial conference forms.
c) The code should provide that experts have a duty to assist the court on matters within their expertise and that this duty overrides any obligation to the person from whom they received instructions or payment.
d) Experts should be required to certify that they understand this duty as part of their reports and agree to be bound by the obligations contained in the code of conduct before giving evidence. [See page 505.]

137 Court-appointed or joint experts are not recommended for cases involving pediatric forensic pathology. Rather, effective use of the adversarial system, which allows each party to call its own evidence and to cross-examine the other party's witnesses, is particularly appropriate in areas of dispute or controversy in these cases. [See page 506.]

138 a) Trial judges can play an important role in enforcing compliance with the existing *Criminal Code* provisions respecting disclosure of anticipated expert testimony and in taking steps, even where there has been full compliance, to ensure that all parties are fully prepared and informed and, as a result, can effectively test the expert testimony presented.

b) Pretrial judges have an equally important role to play in cases in which pediatric forensic pathology or other complex expert evidence may figure prominently. They can facilitate the narrowing of the issues between the parties. They can facilitate the production of further particulars of the proposed expert's opinion or the grounds on which it is based. Finally, they can explore with the defence the voluntary early disclosure of the report by its proposed witness or a summary of the anticipated opinion of that witness, as well as how and when that disclosure might take place. [See page 509.]

139 It will often be in the best interests of all concerned for expert witnesses to meet before trial to discuss and clarify their differences. In appropriate cases, judges, particularly pretrial judges, can encourage and facilitate such meetings between willing experts, without requiring that they take place. [See page 511.]

140 a) In cases in which expert evidence is important, trial judges should make use of the model charge language provided by the Canadian Judicial Council model instructions.

b) Judges should remind jurors that they should apply their common sense to expert testimony and that it is up to them to decide whether to accept all, part, or none of the expert's opinion.

c) In addition, judges should, in appropriate cases, provide structured questions to assist the jury in determining the ultimate reliability of the expert's opinion. These questions may resemble the ones available to judges to assess threshold reliability as discussed in this Report. [See page 513.]

Chapter 19
Pediatric Forensic Pathology and Potential Wrongful Convictions

141 In cases in which it is sought to set aside convictions based on errors in Dr. Charles Smith's work identified by the Chief Coroner's Review, the Crown Law Office – Criminal should assist in expediting the convicted person's

access to the Court of Appeal and in facilitating a determination of the real substantive issues in the cases, unencumbered by unnecessary procedural impediments. Such assistance could include

- consenting to defence applications for extensions of time within which to appeal;
- working toward agreement with the defence on evidentiary or procedural protocols for applications to extend time within which to appeal or for introducing fresh evidence on appeal or respecting the appeal itself;
- permitting the use of transcripts of the evidence tendered at inquiries (such as this one) by forensic experts or others; or
- narrowing the issues that need be resolved by the Court. [See page 516.]

142 The ongoing review of Dr. Charles Smith's 1981–91 homicide cases should be completed. The results should be made known to the public in a manner consistent with the privacy interests of those concerned, and in a manner that will not interfere with any future legal proceedings. [See page 527.]

143 The significant evolution in pediatric forensic pathology relating to shaken baby syndrome and pediatric head injuries warrants a review of certain past cases because of the concern that, in light of the change in knowledge, there may have been convictions that should now be seen as miscarriages of justice.

a) The objective of that review should be to identify those cases in which there was a conviction and in which the pathology opinion, if now viewed as unreasonable, was sufficiently important to raise significant concern that the conviction was potentially wrongful.
b) Guided by the example provided by the Chief Coroner's Review, the review should utilize a small volunteer subcommittee of the Forensic Services Advisory Committee representing the Crown, the defence, the Office of the Chief Coroner for Ontario (OCCO), and the Chief Forensic Pathologist.
c) Human and financial resources to support the subcommittee's work should be provided by the Ministry of the Attorney General, not the OCCO, because the objective concerns the administration of justice. As well, the ministry should be responsible for compensating any external reviewers retained in connection with this review.
d) The review should include convictions after either plea or trial.
e) The review should not be limited to cases where the convicted person is still in custody.

f) The review should be completed only in those cases where the convicted person consents.
g) Although the procedure used should be up to the subcommittee, the following approach is recommended for its consideration:

   i) the subcommittee should begin with the 142 cases identified by Dr. Michael Pollanen;
   ii) the subcommittee should review the cases with the help of the OCCO records to eliminate those cases in which the available pathology or non-pathology information makes it clear that there would be no significant concern about a potential wrongful conviction;
   iii) the subcommittee should then obtain the information necessary to determine those cases in which there was a conviction and eliminate the remainder;
   iv) the subcommittee should then obtain the requisite records (such as police files) for the identified cases and use that additional information to further eliminate cases using the criterion in paragraph (ii) above;
   v) the subcommittee should proceed further with the cases that remain only if the consent of the convicted person is obtained;
   vi) the subcommittee should, where the convicted person gives consent to the review, obtain transcripts of relevant court proceedings, if possible;
   vii) the subcommittee should refer the cases that remain for external review by forensic pathologists, where the subcommittee is of the view that the pathology was sufficiently important that, if it is unreasonable procedurally or substantively in light of current knowledge, there is a significant concern that the conviction was potentially wrongful. The external review cannot be permitted to have an adverse impact on the ability of the Ontario Forensic Pathology Service to perform its regular duties;
   viii) the external reviewers should report on the reasonableness of the pathology opinions expressed in these cases, in light of current knowledge, including whether the court was fairly advised of the extent of the controversy relating to shaken baby syndrome / pediatric head injury, as it is now understood; and
   ix) the convicted persons should be advised of the results of the external review so that they can determine whether to utilize the existing processes available to address individual cases of potential wrongful conviction.

h) The public should be advised of the results of the review, in a manner consistent with the privacy interests of those involved, and in a manner that will not interfere with any future legal proceedings. [See page 533.]

144 The Forensic Services Advisory Committee through a subcommittee should be available to consider other cases in which it is alleged that flawed pediatric forensic pathology may have contributed to wrongful convictions and to recommend to the Office of the Chief Coroner for Ontario what further steps, if any, should be taken.

a) Depending on the workload created by such referrals, the subcommittee should either be made a standing committee or be constituted as needed.
b) The Ministry of the Attorney General should provide the subcommittee with adequate human and financial resources to staff its work. The Office of the Chief Coroner for Ontario should also not be required to compensate any external reviewers retained in connection with its work.
c) Where the subcommittee has referred a case for external review, and where that review results in findings that the pathology opinion earlier expressed was unreasonable and sufficiently important to raise significant concern that the conviction was potentially wrongful, the Crown Law Office – Criminal should assist in expediting the convicted person's access to the Court of Appeal and in facilitating a determination of the real substantive issues in the cases, unencumbered by unnecessary procedural impediments. Such assistance should be similar to that provided where the Chief Coroner's Review identified errors in Dr. Charles Smith's work.
d) The Crown Law Office – Criminal should also provide similar assistance, to the extent to which it is applicable, to a convicted person seeking ministerial review pursuant to s. 696.1 of the *Criminal Code*, if that is the appropriate forum to address the issue of a potential wrongful conviction. [See page 535.]

145 The Province of Ontario should bring to the attention of the federal government the two advantages identified in this Report of the model of the Criminal Cases Review Commission (CCRC) – a structure that may make it easier to find the necessary expertise, and an independence that may secure a greater degree of public confidence in its decisions – for cases involving pediatric forensic pathology. These points should inform any future discussion about adopting a CCRC model in Canada. [See page 541.]

146 The Province of Ontario should address the difficulties faced by those seeking to access the s. 696.1 *Criminal Code* process on the basis of flawed pediatric forensic pathology by

a) ensuring, together with Legal Aid Ontario, that they can obtain legal aid funding for the necessary pathology expertise to support their applications. Legal Aid Ontario should adequately fund s. 696.1 applications. As well, consideration should be given to having Legal Aid Ontario fund, under appropriate circumstances, the retention of defence forensic pathologists as a basis for determining whether an application to the minister of justice has sufficient merit to be filed; and
b) urging the federal government to enhance the investigative role of the Criminal Convictions Review Group (CCRG) of the Department of Justice to address allegations that flawed forensic pathology contributed to wrongful convictions. This could include enhanced use of forensic experts retained by the CCRG to investigate and evaluate an application for ministerial relief. [See page 541.]

147 The Province of Ontario, together with Legal Aid Ontario, should consider enabling legal aid funding, under appropriate circumstances, of forensic pathologists prior to a determination that the appeal has sufficient merit to be funded and as a basis for determining whether an appeal based on fresh evidence has merit. [See page 542.]

148 The Province of Ontario should address the identified challenges to see if it is possible to set up a viable compensation process. The objective is to provide expeditious and fair redress for those who, through no fault of their own, have suffered harm as a result of these failures of pediatric forensic pathology, thereby helping to fully restore public confidence. [See page 545.]

Chapter 20
First Nations and Remote Communities

149 a) Northern Ontario should be divided into two coronial regions – the Northwest Region, to be based in Thunder Bay; and the Northeast Region, to be based in Sudbury.
b) Each of these two regions should be headed by its own regional coroner and properly resourced to fulfill its duties under the *Coroners Act*.

c) More generally, the Province of Ontario should provide adequate resources to ensure coronial and forensic pathology services in Northern Ontario that are reasonably equivalent to those services provided elsewhere in the province, even though doing so will cost more in the North. [See page 549.]

150 The Office of the Chief Coroner for Ontario should seek to enter into a service agreement with the Winnipeg Health Sciences Centre to ensure that the same or analogous protocols and procedures as recommended in this Report with respect to peer review, accountability, and quality assurance are in place in Winnipeg for Ontario cases autopsied there. [See page 550.]

151 The Northeastern regional forensic pathology unit should become a formal forensic pathology unit with a director and funding for transfer payments. As such, it should perform pediatric forensic autopsies as determined by the Chief Forensic Pathologist. [See page 552.]

152 Steps should be taken to enhance the likelihood that investigating coroners will attend the death scene in accordance with the Office of the Chief Coroner for Ontario's existing guidelines. Such attendances improve the quality of many death investigations and provide an opportunity for coroners to communicate with affected families and build relationships with affected communities. [See page 554.]

153 The attendance or non-attendance of investigating coroners at death scenes should be tracked as part of the quality assurance processes of the Office of the Chief Coroner for Ontario (OCCO). Similarly, compliance with the OCCO guideline indicating that coroners must document their reasons for not attending the scene and discuss them with the regional coroner should also be tracked. [See page 554.]

154 The Office of the Chief Coroner for Ontario should consider, in consultation with remote communities and First Nations, the development of specific guidelines that better address those circumstances in which investigating coroners will be expected to attend death scenes in remote communities. [See page 554.]

155 The medical profession and medical schools, such as the Northern Ontario School of Medicine, together with the Province of Ontario, the Nishnawbe

Aski Nation, the Office of the Chief Coroner for Ontario, and others, should work in partnership to increase the numbers of physicians working in remote areas. Even more specific to the mandate of this Inquiry, the fee provided to coroners to attend death scenes, particularly in remote communities, should be increased so that it is not a disincentive to attendance. [See page 555.]

156 a) Where it is not feasible for investigating coroners to attend the scene, all available technology, such as digital photography, should be used to provide timely information to the coroners and enable them, in turn, to provide direction or guidance, as may be needed, to the police or the forensic pathologist.

b) The Office of the Chief Coroner for Ontario should develop, in partnership with remote communities and First Nations, enhanced technology, such as remote teleconferencing, which is ultimately designed to provide "real-time" information to the coroner and the forensic pathologist. Resources should be made available to enable this technology to be developed and used. [See page 556.]

157 a) The use of police officers as coronial surrogates was evidently intended for emergency situations only. It should not be the norm or the default position for all deaths within the coroner's jurisdiction.

b) The Office of the Chief Coroner for Ontario should engage in a consultative process with those communities most affected to evaluate various models for delegating coronial investigative powers to others, including health care professionals or community-based individuals with specialized training. [See page 559.]

158 The Office of the Chief Coroner for Ontario should consult with Aboriginal leaders in developing policies for accommodating, to the extent possible, diverse Aboriginal practices concerning the treatment of the body after death. [See page 561.]

159 Coroners should receive training on cultural issues, particularly surrounding death, to facilitate the performance of their responsibilities. [See page 561.]

160 Coroners play an important role in communicating with affected families about the death investigation. Such communication should include information about where the body is being transported, whether and why a

post-mortem examination is being conducted, what that involves, when it is expected to take place, what if any issues arise in connection with organ or tissue removal, when the body or any organs or other body parts will be returned, and, if requested, what the results of the post-mortem examination or other relevant reviews reveal. In the absence of compelling reasons in the public interest, it is unacceptable for a family already suffering the loss of a child to be left uninformed and unaware of this and other information relating to the death investigation. [See page 563.]

161 In remote communities, community leaders play a vital role in providing support for families and community members affected by a death, particularly that of a child. They can also help to identify systemic issues that are raised by individual deaths, including the pediatric forensic pathology work associated with those deaths. Community leaders can work with the OCCO and, where applicable, First Nations governments and political organizations toward needed change. It is therefore important that regional coroners and investigating coroners meet with community leaders to build relationships and facilitate partnerships. [See page 564.]

162 a) The Office of the Chief Coroner for Ontario should work in partnership with First Nations governments and political organizations to develop communication protocols. Priority should be given to the development of such protocols for the North, where the need is particularly acute.

b) Whatever model is developed to enhance communications, it should involve people within the coroner's system who understand and are familiar with the relevant Aboriginal cultures, languages, and spiritual or religious beliefs and practices. [See page 565.]

Chapter 21
Pediatric Forensic Pathology and Families

163 a) The Province of Ontario, with the assistance of the Ontario Association of Children's Aid Societies and others, should develop province-wide standards, supplementing those that already exist, on the sharing of information arising out of the investigations of suspicious child deaths by the police and children's aid societies.

b) The provincial standards should:

- Specifically address the expectations surrounding the sharing of information relating to joint or parallel investigations arising out of child deaths where other children may be at risk.
- Emphasize the importance of the timely and accurate communication of such information, and its updating as circumstances change, particularly by the police to child protection workers to ensure that decisions regarding surviving children are accurate.
- Remove any misconceptions that inhibit the appropriate sharing of information, and reinforce the point that, although it is important to protect the integrity of an ongoing criminal investigation, the need to withhold information from the child protection system in order to do so should not be overstated. The significance of decisions being made in the child protection forum, and how the sharing of information can promote better fact-finding in that forum, should also not be underestimated.
- Articulate the roles to be played by coroners, forensic pathologists, and Crown counsel in the sharing of information in investigations arising out of the suspicious death of a child.

c) Local protocols should also be created across the province to permit local jurisdictions to implement the provincial standards in a manner that best suits their particular communities.
d) The timely development of these local protocols should be facilitated through the creation of a template for such protocols to accompany the provincial standards.
e) Local children's aid societies, police, coroners, forensic pathologists, and Crown counsel should receive joint training on the provincial standards and their local implementation to ensure that all parties have common understandings and interpretations of the standards and protocols and their application locally. [See page 576.]

164 The Office of the Chief Coroner for Ontario (OCCO) should develop a Family Liaison Service dedicated to communicating with families, particularly those that have suffered the loss of a child. The service should ensure that it communicates with the affected families in an effective, timely, caring, and compassionate manner. The Province of Ontario should provide additional funding to the OCCO to enable this service to be developed. [See page 579.]

165 a) Disclosure of autopsy results to parents should be made verbally and in writing in a timely manner that is sensitive to the parents' loss and bereavement.

b) The Office of the Chief Coroner for Ontario should meet with the Ontario Association of Children's Aid Societies and leading police forces to develop a policy respecting the timely release of the post-mortem information where there is an ongoing criminal investigation. [See page 580.]

166 The Office of the Chief Coroner for Ontario's current policy for organ and tissue retention and disposition should be continued. Coroners should be encouraged to communicate with families about the need for organ and tissue retention in a timely manner that is respectful of these families and their cultural or religious beliefs. [See page 581.]

167 The Province of Ontario should provide funding to permit counselling for individuals from families affected by flawed pediatric forensic pathology in cases examined at this Inquiry for up to a further three years, for a total of five years from the time of commencement, if the individual and the counsellor think it would be useful. [See page 582.]

168 In the discharge of his or her mandate, the director of the Child Abuse Register in Ontario should be encouraged to grant the request of persons wrongly listed on the register as a result of faulty pediatric forensic pathology to have their names removed from the register if there is no longer credible evidence of abuse. [See page 583.]

169 a) Legal Aid Ontario should work with the family law bar to ensure that family lawyers are funded for child protection proceedings in which pediatric forensic pathology plays an important role. The tariff for counsel who litigate these cases should be increased to create incentives for experienced and specially trained lawyers to take on legally aided cases and to reflect their added expertise. Legal Aid Ontario should fund an adequate number of hours to ensure that family counsel can properly fulfill their duties.

b) In appropriate cases, Legal Aid Ontario should authorize funding for one or more forensic pathologists and, where necessary, out-of-jurisdiction pathologists, including their travel expenses.

c) Legal Aid Ontario should raise the hourly rate for forensic pathology experts to a level that is commensurate with funding of experts retained by the Crown. This is necessary to ensure that experts of comparable skill to that of experts retained by the Crown are prepared to assist the family lawyer. This increase should occur expeditiously in pediatric forensic pathology cases.

d) Legal Aid Ontario should increase the number of hours of funding authorized for forensic pathologists. [See page 586.]