

## **Accountability and Oversight for Death Investigations in Ontario** **Lorne Sossin<sup>1</sup>**

### **Introduction**

This study has been commissioned by the Inquiry into Pediatric Forensic Pathology in Ontario (the “PFP Inquiry” or the “Inquiry”). The subject of this study is the system under which death investigations are conducted in Ontario, particularly with respect to pediatric death investigations,<sup>2</sup> and how the accountability and oversight of that system might be enhanced.

Death investigations are directed at answering five key questions: (1) Who died? (2) How did the death occur? (3) Where did the death occur? (4) When did the death occur? and (5) By what means did the death occur? While coroners supervise the death investigation process and are responsible for answering these questions, accountability and oversight in death investigations extends beyond the role of coroners to all the participants in death investigations, including coroners, forensic pathologists, physicians, forensic scientists, police officers, and, in the case of some pediatric deaths, child welfare officers as well.

This paper outlines a range of existing accountability and oversight mechanisms relating to death investigations, some of which have been instituted in recent years as a partial response to the events giving rise to this Inquiry. Many of these initiatives, which put in place new guidelines, protocols, audits, and reviews, suggest accountability and

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<sup>2</sup> Pediatric refers to any case involving a child of 0–18 years of age.

oversight are growing priorities for the death investigation system. In some cases, it is too soon to evaluate the impact of these recent initiatives. Whatever the eventual success of these measures, this study concludes that accountability and oversight in the death investigation system could be enhanced even further.

Part of the danger with grafting new audits and reviews on top of existing oversight structures is a fragmentation of accountability, a confusing multiplicity of oversight mechanisms and the emergence of cracks between and among these various oversight bodies. With this concern in mind, this study explores the case for developing one point of contact for accountability matters relating to death investigations in Ontario, and an independent complaints system as part of this institutional centre of accountability with the capacity to address both procedural and substantive concerns relating to death investigations.

Additionally, with respect to oversight in the context of the sudden or unexpected death of children, institutional supports are needed for family members and caregivers to help them better understand and participate more effectively in the death investigation system, including navigating the complaints system if they have unresolved concerns with a death investigation. It should not be necessary for parents to retain a lawyer, which in many cases would be outside their financial reach, simply to be able to navigate their role and rights within the death investigation system. This study also explores the case for developing more significant institutional capacity to support families through the death investigation process.

“Oversight” and “accountability” are used interchangeably in the course of this paper, but it is important to keep in mind that they are distinct concepts.<sup>3</sup> Oversight relates to how errors in death investigations can be detected, corrected, and prevented in the future. Oversight mechanisms are often involved in the decision-making process, with the authority to set standards, enforce compliance, and, where appropriate, impose discipline.<sup>4</sup> Accountability relates to a broader set of concerns about public confidence that death investigations are of high quality and conducted in the public interest. Of all the concerns raised in this Inquiry, the erosion of public confidence in the quality of pediatric death investigations in Ontario, and the implications of flawed death investigations for miscarriages of justice, are perhaps the most grave.

Accountability includes demonstrating compliance with the requirements of the *Coroners Act*,<sup>5</sup> and other applicable legal standards (such as the *Charter of Rights and Freedoms* and applicable human rights and privacy legislation). It includes the development of predictable, consistent, and transparent criteria for death investigations, including guidelines for autopsies and written records of the death investigators’ analysis. Accountability also relates to the accessibility of these criteria to those touched by death investigations, the transparency of death investigations more broadly, and the availability of an independent complaints mechanism.

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<sup>3</sup> See also the various discussions of “accountability” in Philip Stenning (ed.), *Accountability for Criminal Justice* (Toronto: University of Toronto Press, 1995).

<sup>4</sup> A similar distinction was highlighted by Commissioner Dennis O’Connor in the Commission of Inquiry into the Acts of Canadian Officials in Relation to Maher Arar. See that Inquiry’s Report, entitled *A New Review Mechanism for the RCMP’s National Security Activities* (Ottawa, 2006) (the “Arar Inquiry Report”) at p. 457.

<sup>5</sup> R.S.O. 1990, C.37 (the “Act”). Much of the Act concerns the legal duties of coroners in relation to inquests that must be held in some circumstances and may be held in others at the discretion of the coroner. There is a separate accountability and oversight structure to coroner’s inquests that lies outside the scope of this study. For more information on this aspect of the coronial system in Ontario, see D. Marshall, *Canadian Law of Inquests: A Handbook for Coroners, Medical Examiners, Counsel and the Police*, 2nd ed. (Scarborough, Ont.: Thomson Professional Publishing Canada, 1991). See also the Ontario Law Reform Commission’s *Report on the Law of Coroners* (1995).

Death investigations are funded by the public purse. Consequently, accountability also means ensuring that those funds are well spent and that death investigations are efficiently run. This study examines how tracking data on timelines, consistency, and other qualitative benchmarks across the province, and making this information widely accessible, may enhance this aspect of accountability.

This study also considers whether enhancing accountability and oversight in death investigations also may benefit from a review of the *Coroners Act*. Particular areas of concern include clarifying roles and responsibilities of the various participants in death investigations, and especially the relationship between forensic pathologists and coroners. Presently, the Act provides no statutory basis for the role of forensic pathologists in death investigations and places coroners in a supervisory capacity over all aspects of death investigations. The Act also provides for coroners to be appointed “at pleasure,” which appears inconsistent with an independent system of death investigations.

Below, I situate this study in the context of the mandate for the PFP Inquiry and set out the framework for the analysis that is to follow.

### **(1) Mandate of the PFP Inquiry**

The Order in Council (OIC) establishing the PFP Inquiry sets out the mandate of the Inquiry. That OIC reads, in part:

4. The Commission shall conduct a systemic review and assessment and report on:
  - a. the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 as they

- relate to its practice and use in investigations and criminal proceedings;
- b. the legislative and regulatory provisions in existence that related to, or had implications for, the practice of pediatric forensic pathology in Ontario between 1981 to 2001; and
- c. any changes to the items referenced in the above two paragraphs, subsequent to 2001

A key aim of this Inquiry is to examine of the practice of pediatric forensic pathology and its oversight mechanisms as they relate to the criminal justice system in Ontario. The broad purpose is to determine the systemic failings that may have occurred, and, guided by that, to identify those systemic issues that ought to be the subject of recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.

This study is intended to assist the Commission with issues related to oversight and accountability, but as the OIC makes clear, these questions are to be examined alongside a review of the relevant policies, procedures, and practices, quality control, and institutional arrangements relevant to pediatric forensic pathology in Ontario. The integrated and systemic mandate for the Inquiry will guide the approach taken in this study. While the mandate of the PFP Inquiry is pediatric death investigations, the systemic nature of the mandate makes it necessary to examine accountability and oversight from the perspective of the death investigation system as a whole, highlighting where relevant the specific features relating to pediatric death investigations.

## **(2) Framework of analysis**

While death occurs to an individual, its consequences are social, especially where the deceased is a child.<sup>6</sup> The premise of the *Coroners Act* and related legislation is that inquiring into the cause of death, and working to avoid preventable deaths, is in the public interest. Therefore, the existing duties owed by the police, pathologists, coroner, prosecutors, and others involved in death investigation are primarily to the public.

While the death investigation may take place in furtherance of public policy, those most affected by that investigation will usually be the family of the deceased. Again, this is especially so in the context of the death of children. To the extent complaints are raised against the conduct of those involved in a death investigation, these will usually come from family members, caregivers, or others who were directly touched by the death investigation. Thus, the backdrop against which issues of oversight and accountability should be seen includes both the public interest of the community in preventing death and punishing wrongdoing, and the private interests of grieving families or caregivers who must come to terms with loss.

The key framework of analysis employed by this study is the focus on the integrated nature of death investigations, and the relationship between various participants in this process. All those involved in a death investigation (e.g., police, pathologists, coroners, physicians, scientists, etc.) will have a measure of accountability within their professional communities. As I elaborate below, what the current system

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<sup>6</sup> See Stefan Timmermans, *Postmortem: How Medical Examiners Explain Suspicious Deaths* (Chicago: University of Chicago Press, 2006), p. 1

lacks most are coordinating mechanisms for integrated accountability and for oversight of a death investigation as a whole. This focus on the relationship between and among those involved or implicated in a death investigation will lead to a wide range of concrete questions about the interaction of death investigators. For example, to what extent should pediatric forensic pathologists be in direct contact with families and witnesses to a child's death and to what extent should those communications be mediated by police or coroners? To what extent should coroners defer to the findings and conclusions of pediatric forensic pathologists in their conclusions as to the scientific evidence of the cause and manner of death? In what circumstances should child welfare authorities be contacted in the course of a death investigation and with how much information should they be provided? Is there a point at which family members should be denied information about a death investigation because the investigation may point to their being suspects in a homicide?

Whatever the answer to the specific questions set out above (which only scratch the surface of the many questions that relate to the interaction of participants in a death investigation), it is clear that mechanisms of accountability and oversight need to address the integrated nature of death investigations, and not simply the conduct of each individual or professional involved. Mechanisms of accountability and oversight, however, cannot be applied in the abstract. As elaborated below, these mechanisms must relate directly to the goals of death investigations and must be designed with the contexts of death investigations in mind.

The analysis below that seeks to apply this framework is divided into six sections. The first section examines principles of effective accountability and oversight. The

second section discusses the need to view accountability and oversight in the context of death investigations. The third section canvasses the current accountability and oversight mechanisms relating to death investigations in Ontario. The fourth section looks at the issue of accountability in the context of pediatric death investigations where the deceased child was under the supervision of a Children's Aid Society (CAS). The fifth section addresses the issue of accountability and oversight for the Ontario Pediatric Forensic Pathology Unit in the Hospital for Sick Children. The sixth section explores how accountability and oversight for death investigations in Ontario could be enhanced.

#### **A. Principles of Effective Accountability and Oversight**

The question of accountability and oversight in death investigations seems straightforward at first glance. Accountability and oversight mechanisms should allow for the fulfillment of the goals of a death investigation. This answer gives rise to another important question. What are the goals of a death investigation? Arguably, one cannot evaluate the effectiveness of regulation, or the accountability and oversight of regulation, unless the goals of regulation are apparent. Without attempting to be exhaustive, it is possible to glean from the *Coroners Act*, and related public policies, the following goals of a death investigation:

1. to determine, based on evidence and scientific method, the manner and cause of death; and
2. to facilitate prevention of preventable deaths.

Other goals of death investigations may also be discerned with varying degrees of certainty. For example, many observers would see facilitating criminal justice, and the prosecution of criminals, as a further goal of death investigations. Still others would

identify as a goal of death investigations the protection of other third parties (e.g., siblings of the deceased child) from potential harm. Some goals are less direct and more diffuse. For example, another goal of death investigation may be the expansion of scientific knowledge or the promotion of public health. Where pathologists and coroners are affiliated with universities and/or research hospitals, there may also be a pedagogic function in death investigations. Finally, another goal of death investigations is to provide information to the family of the deceased as to how and why their loved one died, and to give support through the death investigation process, including attentiveness to the cultural and religious context within which families may experience that process.

These goals shed light on the question of oversight and accountability. For example, since a goal of death investigations is to determine the manner and cause of death based on evidence and the scientific method, one aspect of oversight will involve evaluating compliance with scientific and medical standards.

Part of a contextual approach to accountability and oversight involves recognizing that not every action undertaken by a forensic pathologist or coroner gives rise to the same concerns of accountability and oversight. There are 320 coroners in Ontario, spread across nine regions, each with a Regional Supervising Coroner. Approximately 80,000 deaths are reported each year in Ontario. Of these deaths, coroners will investigate around 20,000. These investigations will involve about 7,000 autopsies. Of this group, 200–250 autopsies will involve homicides or criminally suspicious death (with 10–15 of these involving children).<sup>7</sup> There are approximately 550 deaths of children in Ontario each year. In 2005, 534 deaths were reported. Of these, 202 were classified as natural deaths;

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<sup>7</sup> See OCCO Institutional Report (November 2007), p. 20 at para. 64.

189 were classified as accidents; 53 were classified as suicides; 70 were classified as undetermined; and 20 were classified as homicides.<sup>8</sup>

Just as the determination of whether regulation is effective turns, to some extent, on the goals of that regulation, so the evaluation of oversight and accountability will depend on a clear view of who is meant to be accountable for whom and for what they must account.

Accountability may be understood broadly as the ability of one person to demand an explanation or justification from another person, and to reward or punish that person on the basis of the second person's performance or explanation.<sup>9</sup> Accountability, in short, means one party can call another party to account for matters within their responsibility.

Accountability is always relational. It involves not simply the assessment of performance, but the question of who is in the best position to perform this assessment and in what circumstances. The Office of the Chief Coroner of Ontario (OCCO) itself exercises direct supervision over death investigations, and all forensic pathologists and coroners who participate in death investigations are subject to a range of policies, protocols, and guidelines, as well as audits and reviews. In addition to these direct forms of accountability, the activities of coroners and pathologists in the context of death investigations may give rise to ancillary oversight from other sources. The Ombudsman of Ontario may receive and investigate complaints about death investigations. The College of Physicians and Surgeons (CSPO) may receive and investigate complaints about the conduct of specific coroners and pathologists according to the applicable

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<sup>8</sup> *Report of the Pediatric Death Review Committee and the Deaths Under Five Committee*, Office of the Chief Coroner, 2006–2007, at p. 6.

<sup>9</sup> See Edward Rubin, "The Myth of Non-Bureaucratic Accountability and the Anti-Administrative Impulse," in Michael Dowdle (ed.), *Public Accountability: Designs, Dilemmas and Experiences* (Cambridge: Cambridge University Press, 2006), p. 52.

standards of medical practice. Where the work of pathologists or coroners takes place in a hospital, there is a measure of oversight exercised by the hospital. Pathologists and/or coroners who testify in criminal proceedings are subject to a form of oversight by cross-examination, other expert opinions, and judicial determinations of credibility and persuasiveness. Coroners may be judicially reviewed where their decisions are improper or sued in civil court where legal standards have been breached. Other regulatory schemes apply to coroners for breaches of human rights and privacy standards. Each of these accountability structures is discussed below.

While we may associate all of them with oversight, the question will be whether they provide effective and independent accountability for death investigations as a whole. Addressing this question will require an understanding of the context within which death investigations are conducted in Ontario. This context involves a series of considerations that may have to be balanced if accountability and oversight are to be enhanced.

## **B. Balancing Accountability and Oversight with the Context of Death Investigations**

The goal of accountability and oversight cannot be viewed in a vacuum. Accountability and oversight must be balanced with the realities and resource constraints of the death investigation system. If a set of oversight measures is impractical and unsuited to the realities of death investigations, they will simply be ignored, or lead to other systemic problems such as delay, cost, or low morale. Below, some of these competing considerations will be explored.

**(1) The goal of a practical and workable system of review and oversight that does not create a “chill” on recruitment and retention of forensic pathologists**

One of these complicating considerations is the shortage of pathologists and coroners able to conduct these investigations. Death investigation requires specialized skills and training, yet the resources and structures necessary for the recruitment of qualified experts have not been available. The lack of a certified subspecialty in forensic pathology in Canada,<sup>10</sup> the lack of competitive compensation (relative to, for example, pathology positions in teaching hospitals), the emotional and workplace challenges inherent in death investigations (especially in pediatric settings), and the harsh public spotlight in cases of error, all have exacerbated the shortage of qualified forensic pathologists and coroners. While this dynamic is provincial, national, and international in scope, it has had a disproportionate impact on death investigations in rural parts of Ontario.

The impact of the limited number of pathologists and (to a lesser extent) coroners is exacerbated by the other functions that may accompany death investigations—for example, testifying in court.

When one adds more accountability and oversight, such as peer or outside review processes, or requirements for documenting more aspects of a death investigation, there is a potential danger that existing resources will be stretched too thin, and that the field will become even less appealing for new medical professionals to enter. However, this concern is not well documented and appears to be more intuitive than inherent in developing more robust accountability and oversight mechanisms. What is well documented, however, is the critical shortage of qualified forensic pathologists in Ontario (especially those with expertise in pediatric death investigations). Thus, a review process

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<sup>10</sup> A national certification process is in progress and may be available as early as 2008. The Royal College of Physicians and Surgeons recognized training in forensic pathology as a “certificate of special competence” in 2003.

that contemplates one forensic pathologist reviewing the work of others, or participating in a review of prior cases over which there is a complaint, is predicated on the availability of qualified forensic pathologists to conduct this oversight role. If the existing forensic pathology capacity is the only available, greater accountability and oversight may come at a significant price, namely, delay in death investigations and/or greater workload pressures on forensic pathologists.

An effective system of accountability and oversight must be one that is attentive to the goal of recruitment and retention among the professionals involved in death investigation.

## **(2) The goals of various steps in the death investigation process**

To be effective, accountability and oversight mechanisms should not be a cumbersome afterthought but should be woven into the fabric of death investigations. Mechanisms that can detect and correct errors as a death investigation proceeds are far more effective than mechanisms that do so long after the conclusion of a flawed death investigation. This is especially apposite in contexts where the results of a flawed death investigation may contribute to a flawed criminal prosecution and a miscarriage of justice. Finally, accountability and oversight must take into consideration the differing realities of death investigations in various parts of the province.

A death investigation in Ontario is divided into five principal steps or stages. The first stage is reporting a death to the coroner and a decision by the coroner as to whether a death investigation is warranted in the circumstances. If so, the investigating coroner

attends the scene of the death to obtain information and conducts a preliminary review of the deceased's body.

The second stage of the death investigation is the decision as to whether to conduct an autopsy. Where justified in the eyes of the investigating coroner, a warrant for an autopsy will be issued and a pathologist will then conduct the autopsy. Apart from the examination of the deceased's body and related testing, the forensic pathologist also incorporates into this analysis information received from police and from the investigating coroner about the circumstances of the death.

The third stage of the death investigation consists of the pathologist communicating the results of the autopsy to the coroner (and, where appropriate, to the police), in addition to other testing, such as toxicology tests.

The fourth stage of a death investigation involves the coroner analyzing the results of the pathologist's report, along with all of the other information obtained in the investigation, to determine the cause and manner of death. The investigating coroner indicates these findings in a form known as the Coroner's Investigation Statement, and signs the Medical Certificate of Death (these forms are discussed below).

The fifth and final stage of the death investigation is where the Regional Supervising Coroner, with input from the investigating coroner, decides if the case should be referred to a review (for example, by the Pediatric Death Review Committee) or whether a Coroner's Inquest should be held.

There is a clear need for accountability and oversight at each stage of the death investigation process. With respect to the initial stages, and a decision as to whether a death investigation is warranted, and, if so, whether an autopsy is to be conducted, the

emphasis in accountability may be on transparent criteria set out in guidelines and consistent application of those criteria. With respect to the third stage and the analysis of an autopsy, that emphasis may change to peer review or case conferences. The fourth stage, which involves conclusions being drawn from the death investigation, may call for more thorough oversight through audits or complaint-based investigation.

### **(3) The goal of transparency and the need for confidentiality and privacy**

As emphasized above, a key goal of the death investigation process is to enhance public confidence. A death investigation may be a public process but it often has a profound impact on the lives of the individuals affected by it. Where a child dies, the parents, siblings, caregivers, and others all may have concerns and interests at stake. Managing the flow of information to interested parties, to the police and the courts, and to other death investigators for purposes of peer review and case conferencing, presents significant challenges for the death investigation system.

The death investigation also deals with private information, both relating to the deceased and often to family and loved ones of the deceased. Respect for rights of privacy and the importance of confidentiality in the context of possible criminal prosecution are important values that may compete with the concern for transparency.

A system of accountability and oversight must be designed in ways that are both consistent with the goals of transparency on the one hand and respect for privacy and confidentiality on the other.

### **(4) Independence and autonomy and the importance of both collaboration and non-interference**

A final, potentially competing goal in the death investigation process is the independence and autonomy of the professionals involved. The Chief Coroner supervises independent death investigations. The outcome of these investigations must be based on objective and evidence-based considerations. Oversight of coroners from outside the Chief Coroner's Office could give rise to the perception that the Chief Coroner is vulnerable to the influence of external actors or political considerations.

Similarly, while forensic pathologists operate under the administrative direction of the investigating coroner in a death investigation, it is clear that the pathologist alone should be accountable for the proper application of standards and methods for autopsies and post-mortem examinations. While the investigating coroner is responsible for the decision to conduct an autopsy, and for what is done with the results of the autopsy, the forensic pathologist is responsible for the autopsy itself and related testing and analysis. It would appear to be improper, absent unusual circumstances (such as where a coroner is also a forensic pathologist), for a coroner to interfere with the autonomy of a forensic pathologist's professional findings.

Coroners and forensic pathologists both complement each other's expertise and may serve as a check on each other's potential for "tunnel vision." Because of the need to balance collaboration and autonomy, a system of accountability and oversight depends on clear lines of responsibility and authority between forensic pathologists and coroners.

### **C. Existing Oversight and Accountability Mechanisms for Death Investigations**

As alluded to above, there are multiple and overlapping oversight mechanisms relating to death investigations in Ontario. Below, these various mechanisms are examined with a view to outlining their strengths and limitations.

### **(1) The role of the Office of the Chief Coroner**

The Office of the Chief Coroner in Ontario (OCCO) is a branch of the Public Safety Division of the Ministry of Community Safety and Correctional Services (MCSCS). The OCCO is supported by 2 Deputy Chief Coroners, 9 Regional Supervising Coroners, and 329 investigating coroners. The Chief Coroner reports to the Minister of MCSCS and is “accountable to the government for its budget and other administrative matters.”<sup>11</sup>

Under s. 4 of the *Coroners Act* the Chief Coroner has the obligation and authority to “supervise, direct and control” all coroners in the province. Coroners, in turn, supervise the death investigation process, including the input of forensic pathologists. The OCCO engages in a number of accountability and oversight activities, some recently adopted in the wake of the events that have given rise to this Inquiry. These accountability and oversight measures build on three foundations.

The first foundation for many types of accountability and oversight initiatives are the forms which memorialize key aspects of the autopsy and death investigation process—for example, Form 1 (Warrant to Take Possession of a Body), Warrant for Post-Mortem Examination, and Form 3 (Coroner’s Investigation Statement (CIS)). The CIS is completed at the conclusion of the death investigation and includes answers to the five

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<sup>11</sup> OCCO Institutional Report, Submission to this Inquiry (November 2007), at p. 13.

key questions that must be addressed by the coroner.<sup>12</sup> In terms of the manner of death, the CIS must specify whether the death was natural, accidental, homicide, suicide, or undetermined. A Medical Certificate of Death (Form 16) must also be completed at the close of a death investigation.

A second foundation for oversight is the “soft law” mechanisms,<sup>13</sup> such as protocols and guidelines, which have been put in place to ensure compliance with policies and procedures of the OCCO. In 2003, *Guidelines for Death Investigations* was released as part of the OCCO’s Quality Assurance program. A revised version of these guidelines was issued in the spring of 2007. Autopsy guidelines for autopsies in homicides and criminally suspicious deaths were issued in 2005 and revised in 2007. The 2007 revised version includes a four-part quality assurance protocol consisting of (1) early central notification; (2) peer review of the autopsy report; (3) adherence to uniform autopsy process through use of guidelines; and (4) consultation with colleagues in difficult or controversial cases.

The autopsy guidelines, issued by the Chief Forensic Pathologist, also specifically address the issue of balance in reporting findings for purposes of the criminal justice system. The guidelines emphasize the evidence-based nature of the autopsy and the importance of providing “unbiased” opinions and evidence-based expert testimony.

A third foundation for oversight involves existing peer review such as case conferences. Case conferences may occur informally where the Chief Forensic Pathologist conducts morning case conferences on the previous day’s autopsies, or

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<sup>12</sup> See supra at note 2.

<sup>13</sup> “Soft law” refers to guidelines and protocols issued by an administrative body to guide its actions or decisions. Soft law may be distinguished from “hard law,” which consists of legislation enacted by the legislature or regulations approved by legislation. While administrative bodies can expect compliance with guidelines and protocols, they are not legally binding.

weekly rounds for all staff forensic pathologists to review specific types of cases (for example, homicides or traffic fatalities).

Where a case proceeds to the conclusion of the death investigation (and into the commencement of the criminal justice process), a more formal case conference may be held. Normally the following people would be in attendance at this type of case conference: the regional senior coroner; the investigating coroner; the forensic pathologist who conducted the autopsy; an Ontario Centre of Forensic Sciences (CFS) representative; a police representative; and other experts if necessary. The Crown prosecutor would not normally attend the case conference but could if requested. The purpose of the case conference is to ensure that, where the police lay charges, they have a clear understanding of the evidence in a case and the degree of certainty of that evidence based on the death investigation. The case conference, especially where it takes place once all the relevant testing and analysis associated with a death investigation is complete, provides oversight on the communication process between the police, coroners, and forensic pathologists.

The OCCO links its case conference practices to recommendations arising out of Justice Campbell's review of the death of Tammy Homolka and from Justice Kaufman's report on the wrongful conviction of Guy Paul Morin in 1998.<sup>14</sup> Case conferences usually occur within two weeks of the autopsy in any homicide or criminally suspicious death, and in any event prior to the laying of charges in such cases.

These foundations allow for a variety of oversight mechanisms within the jurisdiction of the OCCO.

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<sup>14</sup> Supra note 12.

First, the Chief Coroner of Ontario (CCO) may conduct informal and internal reviews of the work of any coroner or forensic pathologists as part of the CCO's supervisory authority. This kind of review will play a role in recruitment, staffing, promotion, and other personnel decisions. The decision to temporarily cease conducting autopsies in homicides and criminally suspicious deaths in Ottawa in the summer of 2007 due to "staffing issues" is an example of this form of internal oversight.<sup>15</sup> Because it may involve personnel matters, it is more likely to remain confidential. While not a regular part of the CCO's review process, it should be noted that the CCO may also initiate ad hoc more comprehensive reviews, such as the independent review Chief Coroner McLellan initiated in June of 2005 for 45 cases involving a criminally suspicious death or homicide in which Dr. Charles Smith was either the primary or consulting pathologist.<sup>16</sup>

Second, since 1989, the OCCO has maintained a Pediatric Death Review Committee (PDRC). The OCCO also established a Deaths Under Five Committee (DU5C); this committee began as the SIDS/SUDS Committee, and then evolved into the Deaths Under Two Committee before its mandate expanded in 2006). These committees provide a crucial forum for multidisciplinary reviews of death investigations.

The PDRC originated out of a concern about inconsistent description of deaths and inconsistent use of the protocols for investigation. It has the expertise to review practices and protocols by hospitals and other institutions with responsibilities for caring

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<sup>15</sup> For a report on the Ottawa closure, see R. Tripp, "Pathologists Working Overtime," *Whig Standard* (August 24, 2007).

<sup>16</sup> The review was called by the Chief Coroner on the advice of the Forensic Services Advisory Committee (a multidisciplinary, stakeholder advisory body discussed further below). The review itself was conducted by five internationally recognized experts in forensic pathology and the report of their findings was issued in April of 2007. The report indicated that the reviewers expressed concerns in 20 of the 45 cases relating to the opinion of Dr. Smith, his testimony in Court, or both. For a summary of the report and the process of the review, see the OCCO "Backgrounder" on the review, at [http://www.mcscs.jus.gov.on.ca/english/pub\\_safety/office\\_coroner/OCC\\_Smith\\_BG.pdf](http://www.mcscs.jus.gov.on.ca/english/pub_safety/office_coroner/OCC_Smith_BG.pdf) (issued April 19, 2007).

for children (e.g., schools, daycares, etc.). In 1994, the PDRC undertook a review of protocols involving death investigations for children. The result was “Memorandum 621,” which established the model for child death investigations in Ontario.

The PDRC reviews are designed not to assign blame in the death of a child but to assist with ongoing death investigations and to prevent other deaths in the future. The PDRC’s Terms of Reference are as follows: (1) to determine the cause and manner of death; (2) to ensure, in medical cases, that an appropriate diagnosis was rendered; (3) to provide expert evidence, where requested, at inquests and criminal proceedings; (4) to do, or promote research where appropriate; (5) when directed, to undertake random reviews or directed reviews; and (6) to provide, or stimulate educational activities through identification of problem issues and/or referral to agencies for action, development of protocols, or the dissemination of educational materials to parents, hospitals, child welfare agencies, government ministries and others.<sup>17</sup>

The PDRC will review all cases where a child has died with an open file with a Children’s Aid Society. The PDRC may also review medically complex cases or cases where concerns have been raised by a family member, caregiver, or child welfare officer.

The PDRC review will include the Coroners Investigation Statement, the autopsy report, toxicology and other pathology reports, police reports, child welfare agency reports, and medical files, if relevant. The Committee is chaired by the Deputy Chief Coroner and has over 20 members, including coroners, forensic pathologists, pediatric physicians, child welfare consultants, representatives of community agencies, a CAS representative, police officers, counsel, and a medical health officer.

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<sup>17</sup> Report of the Pediatric Death Review Committee and Death Under Five Committee, Office of the Chief Coroner of Ontario (2007), [http://www.ontca.ca/images/stories/PDRC\\_FINAL\\_2007.pdf](http://www.ontca.ca/images/stories/PDRC_FINAL_2007.pdf), at p.2 (accessed December 1, 2007).

Third, the Deaths Under Five Committee has a somewhat narrower scope; its primary mandate is to review all classifications of deaths of children under the age of five, and in particular to review the manner and cause of death determinations in each of these cases. Like the PDRC, it has multidisciplinary membership drawn from coroners, forensic pathologists, physicians, police officers, and child welfare consultants.

Fourth, audit provisions recently have been adopted by the OCCO, including a 31-point audit of the CIS form.<sup>18</sup> These audits are to be undertaken by the Regional Supervising Coroners and are intended to result in constructive feedback to investigative coroners and to address any gaps in compliance with the *Guidelines for Death Investigations*.

Fifth, if the death investigation process raises systemic reform issues, a Regional Coroner's Review may be undertaken. These reviews will often arise where a particular hospital's procedures or policies have been called into question by an investigating coroner. The review may involve discussions between a Regional Supervising Coroner and representatives of a hospital or other institution implicated in systemic concerns.<sup>19</sup> While the review results in a written report, that report is not made public (although it may be shared with the family of the deceased).

Sixth, the Chief Coroner has established a Chief Coroner Review Process that commenced in April 2006. The purpose of these reviews is to ensure a full, fair, and transparent investigation where concerns about a death investigation have been raised, either through internal means or by virtue of a complaint. The reviews themselves are undertaken by an Investigative Panel overseen by a Steering Committee. The OCCO can

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<sup>18</sup> This is now referred to as the Audit of Coroner's Investigation Statement/Form 3 described in the OCCO Institutional Report (November 2007) at p. 36.

<sup>19</sup> See *ibid.* at pp. 32–33.

refer a matter to a Panel and the Panel then produces a report for the Chief Coroner, addressing whatever concerns and allegations have been raised. The Chief Coroner may but is not bound to act on the Investigative Panel's report.

Seventh, and finally, the OCCO engages in and supports numerous education and training activities. Since 1992, every coroner upon appointment attends an orientation training session held over three days covering all of the basic aspects of a death investigation. Training is particularly important because coroners need to be physicians but need not have any formal qualifications in pathology. Additional voluntary annual training sessions are provided by the Ontario Coroners Association (OCA).<sup>20</sup> A significant amount of training and education is also now available for forensic pathologists. Where pathologists are on staff at teaching hospitals, or affiliated with universities, these opportunities are greatly enhanced. Training and education provide the means to translate oversight into prevention and higher quality death investigations.

As the discussion above suggests, the dilemma with the OCCO may not be an absence of accountability and oversight but rather how to coordinate the various accountability and oversight mechanisms that may play a role in a death investigation.

## **(2) The role of the Chief Forensic Pathologist**

The Office of the Chief Forensic Pathologist (CFP) is not subject to a statutory mandate under the *Coroners Act*. The scope of this office is set out in the duties and responsibilities outlined in the Ministry's job description for this position. Among other

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<sup>20</sup> The OCA is a voluntary professional association to which approximately 85% of Ontario coroners belong. See <http://www.ontca.ca/>.

duties, the CFP is responsible for the operation of the Provincial Forensic Pathology Unit. There are presently three forensic pathologists who work within this Unit, but a larger number of hospital-based forensic pathologists are contracted on a fee-for-service basis to conduct autopsies on behalf of the OCCO.

Prior to 1993, the Chief Forensic Pathologist reported to the Assistant Deputy Minister in the Ministry of the Solicitor General through a parallel structure to the Chief Coroner. In 1994, Forensic Pathology Services were integrated within the OCCO, and from that point onward, the Chief Forensic Pathologist has operated under the administrative direction of the Chief Coroner. While investigating coroners will ordinarily accept the medical and scientific conclusions of forensic pathologists, they are under no obligation to do so, and the ultimate determinations of a death investigation are clearly set out in the *Coroners Act* to be the responsibility of coroners and not pathologists.

The oversight relationship between staff forensic pathologists and the CFP is relatively clear. The reach of the CFP in terms of oversight to regional offices and to the many part-time, fee-for-service pathologists is uncertain and appears to depend on the personality of the CFP and the willingness of fee-for-service pathologists to accept guidance and direction. While the CFP can and has set policy and issued guidelines relating to autopsies and other aspects of death investigations, the fee-for-service pathologists do not report to the CFP, and the CFP lacks the capacity to monitor compliance with these policies and guidelines across the province.<sup>21</sup> The CFP also

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<sup>21</sup> It is worth adding that investigating coroners also have difficulty monitoring compliance of relevant guidelines by forensic pathologists, both because coroners may lack sufficient expertise in forensic pathology and because the chronic shortage of forensic pathologists provides a disincentive to impose more onerous conditions on existing forensic pathologists.

performs an important role with respect to research and education on forensic pathology in the province, but again in this context, qualification standards for forensic pathologists are not mandatory as a condition of participating in death investigations in Ontario.

### **(3) Ministry of Community Safety and Correctional Services**

As noted above, accountability may mean many things in the context of a death investigation. Because the OCCO, which oversees the work of pathologists and coroners involved in death investigations, falls under the jurisdiction of the Ministry of Community Safety and Correctional Services (MCSCS), there is a measure of accountability provided by that Ministry and its Minister. Because the OCCO is intended to be an independent office, however, the extent of supervision from the Ministry and Minister must necessarily be circumscribed. The Chief Coroner of Ontario is accountable to the government for its budget and for demonstrating value for the public funds expended on death investigations (just as the government is accountable to the public for providing sufficient funding to maintain a high-quality death investigation system).

The OCCO is also accountable for adhering to applicable government guidelines and policies (in relation, for example, to procurement and human resources). There may also be additional contractual accountability such as that arising between the Ministry and the Hospital for Sick Children (HSC) with respect to the operation of the Ontario Pediatric Forensic Pathology Unit in the HSC, discussed below.

In a Westminster parliamentary democracy, political accountability for all executive action, including the operation of independent bodies such as the OCCO, falls to the Minister responsible for that body. The Minister of Community Safety and

Correctional Services, therefore, must account to the Legislature for all of the actions of the OCCO. However, this accountability does not contemplate interference in the work of such independent bodies, just as the Attorney General’s responsibility to account for the operation of the Courts in Ontario does not contemplate a role for that Minister in interfering with the work of the Courts. Where a potential miscarriage of justice has occurred as a result of a flawed death investigation, it falls to the responsible Minister to refer the matter to the Courts to consider. Ontario lacks an independent oversight mechanism for potential miscarriages of justice of the kind provided for in the U.K. by the Criminal Cases Review Commission.<sup>22</sup> The federal Minister of Justice, however, has investigative powers with respect to potential miscarriages of justice in Ontario, as well as the other provinces and territories, and can delegate them to qualified individuals.<sup>23</sup>

#### **(4) College of Physicians and Surgeons of Ontario**

Because all coroners must, under the terms of the *Coroners Act*, be physicians, and because pediatric pathologists and forensic pathologists will also be physicians, the College of Physicians and Surgeons of Ontario (CPSO) plays a significant role in the accountability and oversight of death investigations. The CPSO, more specifically, has the jurisdiction to investigate complaints against its members and make disciplinary rulings under Schedule 2 of the *Regulated Health Professions Act, 1991* (RHPA), as well

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<sup>22</sup> For background information on this Commission, an independent public body that was set up in March 1997 by the 1995 *Criminal Appeal Act* and whose purpose is to review possible miscarriages of justice in the criminal courts of England, Wales, and Northern Ireland and refer appropriate cases to the appeal courts, see <http://www.ccrcc.gov.uk/>. The accomplishments of this body, and its challenges, are discussed in K. Campbell and C. Walker, “Medical Mistakes and Miscarriages of Justice: Perspectives on the Experiences in England and Wales,” a paper prepared for this Inquiry (November 2007).

<sup>23</sup> *Criminal Code of Canada* RSC 1985 c.C-34 ss.696.1-696.6. The Minister of Justice has investigative powers under the Inquiries Act and these can be delegated to qualified persons under s.696.2(3).

as to initiate investigations in the absence of a complaint if there are reasonable and probable grounds to believe a physician has engaged in misconduct or is incompetent, or on referral from the Quality Assurance Committee.<sup>24</sup>

The Complaints Committee of the CPSO is an investigative body that determines, *inter alia*, whether disciplinary action and/or quality assurance action is warranted.<sup>25</sup>

While this Committee has jurisdiction to consider complaints against coroners, at least if the investigation originates with a complaint “the investigation must always relate to the complaint; it cannot expand to a general review of the entire practice of the member.”<sup>26</sup>

Thus, the CPSO’s oversight relates to specific claims about specific members - the CPSO lacks the mandate and the capacity to undertake general evaluations of death investigations, and it is unclear how the CPSO would evaluate the conduct of a coroner whose activities spanned the medical and legal aspects of a death investigation.

The Complaints Committee of the CPSO has broad discretion as to the type of disposition that it can make, but the typical outcomes include referring allegations to a discipline hearing, requiring the member to appear before a panel of the Complaints Committee to be cautioned, and dismissing the complaint.<sup>27</sup>

*In Between: DM (Complainant) and Charles Randal Smith, M.D. (Member Complained Against)* Dr. Smith’s decision to conduct an autopsy was brought before the Complaints Committee of the CPSO.<sup>28</sup> The Complaints Committee decided to take no

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<sup>24</sup> See RHPA, Sched. 2, s.75. .

<sup>25</sup> R. Steinecke, “A Complete Guide to the *Regulated Health Professions Act*” (Aurora: Canada Law Book, 2005), at 4–10. Note that the Executive Committee also has the power to refer a specified allegation of professional misconduct or incompetence to the Discipline Committee pursuant to s.36(1) of Schedule 2 to the RHPA

<sup>26</sup> *Ibid.* at 4–11.

<sup>27</sup> *Ibid.*, 4–20.

<sup>28</sup> *Between: DM (Complainant) and Charles Randal Smith, M.D. (Member Complained Against)* [2000] File #5421 [DM].

action with regard to Dr. Smith on the grounds that the CPSO has no jurisdiction over work undertaken for coroners. The Committee concluded that

Dr. Smith's involvement in this matter was undertaken as an agent of the Chief Coroner's office. Under the *Coroners Act*, jurisdiction to deal with complaints against physicians acting as Coroners or otherwise as agents of the Chief Coroner, in the performance of those functions, is conferred upon the Chief Coroner.<sup>29</sup>

This finding was challenged at a review conducted by the Health Professions Appeal and Review Board.<sup>30</sup> HPARB considered the question of whether the Complaints Committee's jurisdiction over its members is ousted when they are acting under a Coroner's warrant under subsection 28(1) of the *Coroners Act*.<sup>31</sup> The Board made no findings on the merits since the Committee had not investigated the complaint. Rather, the Board sent the case back to the Complaints Committee, concluding:

As indicated by the aforementioned provisions made under the *Medicine Act, 1991*, and the *Regulated Health Professions Act, 1991* the College has authority over its members with regard to complaints in connection with matters of professional conduct. There is no provision in the *Medicine Act, 1991*, the *Regulated Health Professions Act, 1991* or the *Coroners Act*, which ousts the authority of the College when a member is acting as an agent for the Coroner's office. While there may be overlap with regard to Dr. Smith's Accountability to both the Coroner's office and the College, the involvement of the Coroner's office does not displace the College's responsibility to govern its members.<sup>32</sup>

This ruling was not taken on judicial review and, as a result, the CPSO acknowledged its jurisdiction over coroners and pathologists. The complaint was returned

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<sup>29</sup> DM at p. 3.

<sup>30</sup> The Health Professions Appeal and Review Board (HPARB) is established under the *Regulated Health Professions Act* and has jurisdiction to hear complaint reviews where an applicant alleges that an investigation by the Complaints Committee of a health college was inadequate or its decision was unreasonable. By way of disclosure, the author is a part-time member of HPARB.

<sup>31</sup> DM, *supra* note 28, at p. 4.

<sup>32</sup> *Ibid.* at p. 6.

to the Complaints Committee of the CPSO in December of 2000. In the Spring of 2001, two other complaints against Dr. Smith were received by the CPSO.

In December of 2001, the Committee convened a panel of three experts, including a forensic pathologist, a pediatric pathologist and a Deputy Chief Medical Examiner, all from outside Ontario. The experts were asked to opine on whether the “care provided to patients by Dr. Smith” met the standard of practice of the profession, and whether his practice, behaviour or conduct exposed or was likely to expose patients to risk of harm. While it is not known how the CPSO would frame questions to experts in the context of investigations of coroners and forensic pathologists, the questions in this case reflect a focus on patient care and protecting the public from physicians who may threaten patients. This question seems misaligned with the context of death investigations.<sup>33</sup>

In the context of the complaint against Dr. Smith, the OCCO wrote to the Complaints Committee to express its support of Dr. Smith and indicated its belief that other forums would be more appropriate to challenge the performance of a forensic pathologist. In October, 2002, the Complaints Committee found that a “caution” was warranted as a response to the three complaints filed against Dr. Smith, but decided to take no further disciplinary action.<sup>34</sup>

While the CPSO plays an important role in oversight with respect to coroners and forensic pathologists, I would suggest that questions remain as to the effectiveness of this oversight in relation to death investigations as a whole. There are at least three challenges to effective oversight from the CPSO over coroners and pathologists.

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<sup>33</sup> CPSO Institutional Report (November 2007) at para. 113.

<sup>34</sup> *Ibid.* at para. 123.

First, there is uncertainty as to the “standard of care” exercised by coroners and pathologists in death investigations since they work with deceased bodies rather than live patients. As Stephen Cordner and David Ranson observe in their paper for the Inquiry:

It is important to understand that forensic pathology is quite different to the rest of medicine. Medicine exists to serve patients. Starting with doctors’ training as medical students, everything revolves around the patient. Doctors’ obligations to patients are central. This culture, imbued during medical training, survives intact through to the practice of virtually every branch of medicine, including all the disciplines within pathology, with the exception of forensic pathology. In forensic pathology there is no traditional patient.<sup>35</sup>

While, as noted above, there are protocols and guidelines for specific tasks in a death investigation, these protocols and guidelines often lack precision. This may be true in other areas of medical practice as well. However, in many of those areas there are other indicators one may look to for assistance with evaluations (such as literature on positive or negative outcomes in the context of particular procedures on particular patients) that are not relevant in the context of a death investigation. Other aspects of a coroner’s duties, such as managing an inquest, appear more related to legal than medical skills. Second, given the shortage of forensic pathologists, the CPSO may not always have access to the expertise it needs to conduct an investigation into misconduct by a coroner or pathologist. This concern, it should be added, arises with respect to any independent oversight of death investigations. Third, the CPSO oversight is primarily complaint-based, and it may be challenging for an aggrieved party to obtain the requisite knowledge and disclosure to have the basis for a complaint.

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<sup>35</sup> S. Cordner, H. McElvie, F. Leahy and D. Ranson, “A Model Forensic Pathology Service” (December 2007), p. 18

Under any scheme of oversight for death investigations, the CPSO has a significant role to play. The CPSO has the mandate and infrastructure to exercise independent oversight in the context of physicians who play a role in death investigations. Importantly, oversight from the medical profession continues to play an important role in oversight of physicians involved in death investigations in the U.K,<sup>36</sup> notwithstanding the development of a forensic pathology registry and a forensic pathology complaints mechanism, as discussed further below.

### **(5) Judicial review**

The Office of the Chief Coroner is a statutory office and has statutory authority for a range of decisions. Many of those decisions may be the subject of judicial review on administrative law and constitutional grounds. Most of these challenges arise from the process of coroner's inquests.<sup>37</sup>

On at least one occasion, judicial commentary in the context of a judicial review of an inquest has had a significant impact on the death investigation process in Ontario. In *Beckon v. Ontario*, the Ontario Court of Appeal reviewed a decision by a coroner's

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<sup>36</sup> See Campbell and Walker, *supra* note 22, at pp. 28–30. Campbell and Walker note that Professor Sir Roy Meadow was subject to a “fitness to practice” hearing by the medical professional disciplinary body in the U.K. resulting in a finding of serious misconduct relating, in part, to Meadow’s misleading testimony in criminal justice proceedings. The Court of Appeal, however, subsequently reversed this ruling.

<sup>37</sup> See, for example, *Barnett Estate v. Ontario (Deputy Chief Coroner)* [1996] 94 O.A.C. 1 (Ont. C. J.), where an estate trustee unsuccessfully sought to judicially review the decision of the Coroner that there was no foundation to include racism in the police force as an issue in an inquest; *People First of Ontario v. Ontario (Coroner)*, [1991] 54 O.A.C. 182 (Ont. C.A.) where a group with standing at an inquest unsuccessfully sought to judicially review a decision by the Coroner limiting its participation; and *Gentles v. Ontario (Regional Coroner)* [1998] 165 D.L.R. (4th) 652 (Ont. C.J.), where the decision of the Coroner to limit disclosure of relevant documents at an inquest into the death of an inmate at the Kingston Penitentiary was held to be a breach of natural justice.

jury regarding cause of death.<sup>38</sup> The coroner appealed a judgment quashing a verdict returned by a coroner's jury that the applicant's husband had committed suicide. The appeal was dismissed because the coroner had failed to instruct the jury that there was a legal presumption against suicide. The presumption against suicide recognized in *Beckon* represents one of the very few non-scientific criteria that coroners and pathologists are legally obliged to apply.

Judges not only oversee the *Coroners Act* and its interpretation, but also may be an important source of accountability and oversight with respect to the pathologists and coroners who testify as expert witnesses in criminal proceedings. For example, a judge can make an adverse finding of credibility and simply not consider testimony that the judge believes to be flawed. The second type of oversight is that the defence can call another forensic pathologist who challenges the coroner's findings. Notwithstanding its limitation, the adversarial system of criminal justice remains an important tool for accountability and oversight in the context of death investigations.

In addition to judicial review on administrative law grounds and the evaluation of death investigations in criminal proceedings, the decisions of the coroner also are subject to other judicially supervised constraints, such as the *Charter of Rights*. For example, in *R. v. Colarusso*,<sup>39</sup> the Supreme Court held that a coroner who released evidence to the police during a criminal investigation violated s. 8 of the *Charter*. The accused had been impaired and killed an innocent driver in an accident. At the hospital, an officer had helped hospital staff take urine samples that were later used by the police to assess his impairment and were given to the coroner.

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<sup>38</sup> *Beckon v. Ontario (Deputy Chief Coroner)* [1992] 57 O.A.C. 21. (Ont. C.A.).

<sup>39</sup> [1994] 1 S.C.R. 20.

Another form of judicial oversight over death investigations occurs when coroners and/or pathologists are sued in civil court. Section 53 of the *Coroners Act* creates a statutory immunity that precludes coroners being liable for damages for harms resulting from their death investigations. It provides:

**53. Protection from Liability**—No action or other proceeding for damages lies or shall be instituted against a coroner or any person acting under the coroner’s authority for an act done by him or her in good faith in performance or intended performance of any power or duty under this Act or the regulations, or for any neglect or default in the performance in good faith of any such power or duty.

The protection under s. 53 is limited to prohibiting actions “for damages,” and extends only to coroners and those working under the authority of a coroner.<sup>40</sup> It does not prohibit suits against coroners and/or pathologists for acts that fall outside of the duties and powers outlined in the Act. Further, if it can be established that a coroner did not act in good faith, then the protection from liability for damages does not apply.

In *Reynolds v. Kingston (City) Police Services Board*,<sup>41</sup> the Ontario Court of Appeal held that a suit alleging negligence and misfeasance of public office could proceed against Dr. Charles Smith in relation to his role as expert witness in the conviction of a woman for second degree murder in the death of her daughter. The Court held that the extent of the immunity afforded to Dr. Smith was an issue that could only be resolved at trial. In the course of his reasons, Borins J.A., writing for the Court of Appeal, cited the following passage from the reasons of Wilson J., who had dissented in the Ontario Divisional Court hearing of the *Reynolds* case:

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<sup>40</sup> See, for example, *Sheng v. Toronto (Metropolitan) Police Services Board* [1996] O.J. No. 2693 (Ont. C. J.).

<sup>41</sup> 2007 ONCA 166.

The courts have not examined the provisions of the *Coroners Act* that define the duties and limit the privilege afforded to someone like Dr. Smith. The determination of the boundaries of witness immunity, and the distinction between investigation and testimony in this specific context, involve nuanced questions of fact.

In light of *Reynolds* and the other jurisprudence surrounding the civil liability of coroners in Ontario, the extent to which civil suits may provide an effective forum for accountability and oversight remains uncertain.

While courts play an important role in the oversight of coroners and pathologists in settings of judicial review, criminal justice proceedings, and civil justice proceedings, the limitations of judicial oversight are readily apparent. Judges lack the expertise to review the work of pathologists and coroners effectively. Too often, the language of science in a death investigation and the language of law will not be aligned. A judicial review typically occurs many months or sometimes years after the events in question, and is vulnerable to the quality of advocacy and the sufficiency of the record that an applicant is able to obtain to ground a judicial challenge. Added to the barriers litigants might face if contemplating a civil action against coroners and/or pathologists is the expense of mounting such litigation (especially in a death investigation setting where expert testimony would likely be needed) and the possibility of an adverse costs award if the litigation is unsuccessful. While judicial review assists with clarifying the meaning and scope of statutory authority, and is a vital recourse where the rights of affected parties may be jeopardy, it arguably does little to improve the quality of or quality control over death investigations.

## **(6) Ontario Ombudsman**

The Ontario Office of the Ombudsman (the “Ombudsman”) has a mandate to support “accountability, transparency and oversight” in the provision of government services. It may investigate individual complaints or systemic concerns but has no powers to make orders or to compel government officials to adopt its recommendations. In 2006–2007, 16 complaints against the Coroner’s Office were filed with the Ombudsman.<sup>42</sup> At this time, however, the Ombudsman has not made any recommendation for reform of the OCCO.

An example of an initiative by the Ombudsman in relation to the death investigation process was the establishment of a Special Ombudsman Response Team (SORT) to investigate the death of John Connelly, a 22-year-old University of Toronto student whom the investigating coroner believed committed suicide in 2001. The Connelly family complained that the coroner’s investigation was biased and predisposed from the outset to a finding of suicide, and the Ombudsman’s SORT review was established in 2006 to investigate these allegations.<sup>43</sup>

The Ombudsman is an officer of the Legislature and has greater independence than any oversight mechanism discussed above. The Ombudsman’s Office, however, lacks expertise in death investigations and lacks the ability to provide remedies in the context of individual death investigations or to remedy systemic flaws. While there is a significant, ongoing role for the Ombudsman’s Office in ensuring the processes followed by the OCCO are appropriate and in compliance with their obligations, the Ombudsman’s Office remains only a partial answer to the question of complaints-based oversight in the context of death investigations.

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<sup>42</sup> See Ombudsman Ontario 2006–2007, *Annual Report*, at p. 66.

<sup>43</sup> See Ombudsman Ontario 2005–2006, *Annual Report*, at p. 38.

## **(7) Information and Privacy Commissioner**

Another independent source of oversight over death investigations is provided by the Ontario Information and Privacy Commissioner (IPC). The main role of the IPC is assessing the treatment of coroners' documents under the *Freedom of Information and Protection of Privacy Act* (the Act).<sup>44</sup>

A representative example of a case involving the Coroner's Office from 2006 is *IPC Order PO-2487—Ministry of Safety and Correctional Services*. In this case, two individuals were involved in a motor vehicle accident that resulted in the death of a young woman. Their representative submitted a request to the Ministry of Community Safety and Correctional Services under the Act, seeking copies of all documentation in connection with the accident. One of these documents was the Coroner's Investigation Statement, which was denied on the basis that the disclosure would constitute an "unjustified invasion of personal privacy" within the meaning of the *Freedom of Information and Protection of Privacy Act*.<sup>45</sup> The Ministry contended that "because some of the personal information is subject to the presumption in section 21(3)(a), and all of it falls under section 21(3)(b) ... disclosure of the personal information in the records would constitute a presumed unjustified invasion of the deceased's and other identifiable individuals' personal privacy under sections 21(3)(a) and (b)."<sup>46</sup> The Commissioner upheld the Ministry's decision. Since the privacy of another individual was involved, the

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<sup>44</sup> *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F. 31.

<sup>45</sup> See s.49(b) of the Act.

<sup>46</sup> *IPC Order PO-248, Appeal PA -050147-1—Ministry of Safety and Correctional Services*. Information and Privacy Commission of Ontario (July 26, 2006).

Ministry was found to be exercising valid discretion in refusing to disclose a Coroner's Investigation Statement.

The inability of interested parties, including family members, to obtain information about a deceased person used in death investigations may represent a significant barrier to accountability. For example, in the case of the Connelly family's complaint about the investigation conducted into their son's death (mentioned above as the subject of an Ombudsman's investigation), family members were unable to obtain information about their son's death through freedom of information requests. Ann Cavoukian, Ontario's Information and Privacy Commissioner, was interviewed about the Connelly's plight, and in response referred to this aspect of Ontario's privacy legislation as a "flaw" and an "oversight." She added: "It's unfair to distraught parents and relatives of a deceased individual who want to access some information to puzzle together the answers relating to the death. They're traumatized. They can't get anything."<sup>47</sup>

As in the context of the Ombudsman, the IPC has an important independent but partial role to perform in the context of complaint-based oversight in death investigations. Although the IPC guards against the release of information by the coroner that might damage the privacy of affected parties, such restrictions may also in some circumstances hinder information requests that might help people access other accountability mechanisms, such as complaints and civil lawsuits.

## **(8) Human Rights Tribunal**

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<sup>47</sup> See the transcript of the interview with Ann Cavoukian from *The Fifth Estate*, January 18, 2006, at <http://www.cbc.ca/fifth/aknockonthedoor/victim.html>.

In addition to privacy and confidentiality concerns, the death investigation process must comply with the Ontario *Human Rights Code*. The Ontario Human Rights Tribunal has confirmed its jurisdiction over decision-making of coroners. In *Braithwaite and Illingsworth* (2006),<sup>48</sup> it was alleged that s. 10 of the *Coroners Act* violates the *Human Rights Code* in that it provides for mandatory coroner's inquests when a prisoner dies, but does not include an equivalent guarantee where an involuntary patient in a psychiatric facility dies. The OCCO argued that its inquest process was not covered under the *Human Rights Code*. The Tribunal rejected this view and affirmed that the Code extends to the decision-making of coroners.<sup>49</sup> *Braithwaite*, like *DM* (discussed above in the context of the CPSO), appears indicative of a culture at the OCCO predisposed to object to oversight by external bodies.

The Human Rights Tribunal and its application of the *Human Rights Code* to death investigations remains an important recourse both for individual and systemic concerns. It also suggests how concerns about fragmentation and a lack of coordination might arise. A single decision by a coroner in a death investigation could trigger an internal complaint, a complaint to the CPSO, civil litigation, a constitutional challenge, and/or a human rights complaint.

## **(9)Public inquiries**

While the mandate of this Inquiry is, in part, to examine how the mechanisms of accountability and oversight in relation to pediatric death investigations may be

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<sup>48</sup> See 2006 HRTO 15. The decision of the Ontario Human Rights Tribunal was successfully appealed to the Ontario Superior Court but the Court upheld the Tribunal's decision on its jurisdiction over coroners. See Ontario (A.G.) v. Ontario Human Rights Commission, [2007] O.J. No. 4978 (Sup. Ct.), at para. 42.

<sup>49</sup> *Ibid.* at para. 23.

improved, it is important to emphasize that the Inquiry itself provides an important form of oversight and accountability. The nature and scope of public inquiries make them well-suited to the kind of integrated analysis discussed above. An Inquiry can look at the system as a whole and is not limited to just the role of a particular office, or particular professionals.

The limitations of public inquiries as mechanisms of oversight and accountability, however, are also apparent. Inquiries are not always called when they are needed. The decision to hold an Inquiry, and the decision over the scope of its terms of reference, are determinations based on political judgment, not objective need. Inquiries usually occur well after the facts they are exploring. Because they are legally unable to make findings of criminal guilt or civil liability, some question whether Inquiries can achieve meaningful accountability.<sup>50</sup>

The distinctive advantage of public inquiries is in their ability to make findings and recommendations on which governments and other institutions can act. For example, the Royal Commission Inquiry into Civil Rights, headed by Justice McCruer, issued its final report in 1971. The Report made several findings with respect to the coronial system in Ontario and the need to modernize that system. These recommendations led the Ontario government to refer the matter to the Ontario Law Reform Commission, which issued a report the following year. The government adopted the recommended approach and this resulted in the *Coroners Act, 1972*.

In addition to a full-scale public inquiry, governments may also call for a more limited judicial inquiry. An example of this was the appointment of Justice Roland

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<sup>50</sup> For further discussion, see D. Mullan and A. Manson (eds.), *Commissions of Inquiry: Praise or Reappraise?* (Toronto: Irwin, 2003).

Haines in January of 2004 to review the regulation and oversight of provincial abattoirs. This review is an example of a more limited form of inquiry without the full powers of Part 3 of the Ontario *Inquiry Act*. Additionally, judges and former judges may be involved in other government review mechanisms. For example, in April of 2007, following the results of the CCO’s review of 45 cases involving Dr. Smith, the Attorney General appointed former Chief Justice Patrick LeSage to assist the Criminal Convictions Review Committee in examining how Crown prosecutors treat forensic evidence and expert testimony.<sup>51</sup>

While public inquiries provide an independent and transparent review mechanism for systemic flaws and serious miscarriages of justice, because of the expense, complexity, and episodic nature of such inquiries, and the fact that the establishment of an inquiry is dependent on a political decision, this mechanism is inevitably a last resort. The most important role of this Inquiry may be in providing a mechanism for a thorough investigation of how and why other forms of accountability and oversight in the context of death investigations failed to prevent miscarriages of justice.

## **(10) The media**

The circumstances giving rise first to the review of death investigations and resulting criminal prosecutions involving Dr. Charles Smith, and ultimately to this Inquiry, demonstrate the significance of media scrutiny. In particular, a report by the CBC’s *The*

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<sup>51</sup> The appointment of LeSage is discussed in the Ministry of the Attorney General “Backgrounder” entitled “Preventing and Addressing Miscarriages of Justice,” at <http://www.attorneygeneral.jus.gov.on.ca/english/news/2007/20070828-truscott-2-bg-en.pdf> (issued August 28, 2007).

*Fifth Estate* in November of 1999 and a feature article in *Macleans* magazine on April 15, 2001, brought the questions surrounding Dr. Smith’s competence and trustworthiness into the domain of public scrutiny.

That media report on such criticisms, however, is no guarantee that those in a position to supervise death investigations will become aware of those criticisms.<sup>52</sup> Media reports may also be misleading, sensationalist, or even false. In *Young v. Toronto Star Newspapers Ltd.*,<sup>53</sup> a newspaper account of a death investigation was found to be libellous for falsely suggesting a mistrial in a criminal prosecution was due to questions about the Centre for Forensic Sciences. While such false reports are hopefully rare, the media at best serves as a catalyst for other mechanisms of accountability and oversight.

## **(11) NGOs**

Another mechanism for oversight is independent advocacy groups, an example of which is the Association in Defence of the Wrongly Convicted (AIDWYC).<sup>54</sup> This organization reviews murder convictions where it believes the accused is “factually innocent” (for example, because of proof through DNA or other means that the person was not involved with the crime). AIDWYC played a key role in surfacing concerns with the death investigation system.

One example is the case of William Mullins-Johnson who was released from prison in September 2005. Dr. Charles Smith gave testimony at his trial and concluded that his daughter had been sexually assaulted at the time of her death, which was crucial

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<sup>52</sup> Dr. Young, for example, has testified that he did not watch or look into the contents of *The Fifth Estate* report of concerns around Dr. Smith until preparing for this Inquiry.

<sup>53</sup> (2005) 77 O.R. (3d) 680 (C.A.).

<sup>54</sup> For background material on AIDWYC, see <http://www.aidwyc.org/>.

to Mullins-Johnson’s conviction. AIDWYC had doubts about the integrity of the conviction and represented Mullins-Johnson in proceedings that resulted in his release and ultimate vindication. In October 2007, the Ontario Court of Appeal acquitted Mullins-Johnson of the 1993 murder of his four-year-old niece.<sup>55</sup>

## **(12) Families**

Death investigations are conducted in fulfillment of a public duty under the *Coroners Act*. In the case of children, the families of the deceased are especially affected by, and interested in, death investigations. The coroner owes a very limited duty to the families of the deceased under s.18(2) of the Act to make available information about the coroner’s findings of fact as to how, when, where, and by what means a person died, including a record of the investigation into the death. The Act provides no timelines within which this information must be provided to family members.

In many instances, families will rely on death investigations to understand what happened to a loved one who has died. Family members and caregivers may see the death investigation as central to the pursuit of justice where a loved one has died through the wrongdoing of others. Still other contexts involve families disagreeing with the findings of a death investigation—believing a loved one was the subject of a crime, for example, where the coroner has concluded death was accidental. Finally, there are cases where family members are implicated in possible criminal activity as a result of death investigations and may be in jeopardy as a result.

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<sup>55</sup> See *R. v. Mullins-Johnson* 2007 ONTCA 720. K. Makin, “The Pain of the Wrongfully Convicted: “Formal acquittal not enough for tearful Mullins-Johnson,” *Globe and Mail* (October 16, 2007).

All of these settings change the dynamic of the family's role in oversight and accountability. Currently, when families believe a death investigation has been mishandled, they may bring a complaint to the CPSO with respect to the conduct of the physicians involved (usually coroners and pathologists) and/or may bring a complaint to the Ombudsman's Office. They may also bring a complaint directly to the Chief Coroner, which may be a catalyst for further internal review. Finally, families may approach groups such as AIDWYC or the media for help in pursuing their concerns about a death investigation. Families are presently provided with no institutional support in navigating these various oversight mechanisms and often must retain legal counsel to be able to effectively pursue formal complaints.

Families often play a central role in problems with and resulting from death investigations coming to the attention of the media and groups such as AIDWYC. While such outside scrutiny may serve as a valuable and effective form of oversight, it is also sometimes unpredictable, unreliable, and may lead to inadvertent adverse consequences. It is unpredictable because not every death investigation that merits outside scrutiny receives it. It is unreliable because outside parties will often operate with partial rather than full information, and often that information is coloured by a particular perspective. Families rarely will have the resources to retain experts to assist in their attempt to challenge substantive determinations in a death investigation and rarely will have the resources to retain legal assistance in order to understand and assert their rights in the death investigation process.

To conclude, as with many of the accountability and oversight measures described above, outside scrutiny by families is an important, but partial, form of accountability and oversight over death investigations.

## **Summary**

As the above discussion demonstrates, the death investigation system in Ontario is subject to multiple and overlapping oversight bodies both internal to and external of the OCCO. Multiple oversight is not necessarily a bad thing. As Commissioner O'Connor noted in the Arar Inquiry Report after detailing the various bodies with some oversight jurisdiction relating to the RCMP, "As in other areas of governance, there is much to be said for checks and balances and multiple perspectives when it comes to review."<sup>56</sup> As elaborated more fully in the final section of this study, however, enhancing accountability and oversight requires mechanisms that are both effective and independent, as well as coherent. Presently, the mechanisms with the most potential to be effective, such as the CCO Review process, lack independence, while the mechanisms with the most independence, such as the CPSO and the Ombudsman, provide only partial oversight for death investigations. Further, there is little coordination, information exchange, or gatekeeping between the various sources of oversight for death investigations in Ontario.

Before seeking to address this dilemma, the study turns to existing mechanisms of accountability and oversight in relation to two areas with particular resonance for pediatric death investigations in Ontario, the relationship between the OCCO and Children's Aid Societies involving the death of children under CAS supervision, and the

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<sup>56</sup> Supra note 5, at p. 496.

relationship between the OCCO and the Ontario Pediatric Forensic Pathology Unit at the Hospital for Sick Children.

#### **D. Accountability and Oversight Between OCCO and Children’s Aid Societies (CAS)**

In the death of children who are under the supervision of a Children’s Aid Society, special considerations arise with respect to accountability and oversight. In their paper for this Inquiry, Nicolas Bala and Nico Trocme examine child protection issues in the context of pediatric forensic pathology and, in particular, address the implications of death investigations for siblings of deceased children.<sup>57</sup>

My focus, by contrast, is on the accountability and oversight of death investigations that involve collaboration between coroners and child welfare officials. The merits of collaboration between child welfare officials and coroners in death investigations involving children under CAS protection have long been apparent. The establishment of the Pediatric Death Review Committee (PDRC) represented (and continues to represent) the most important forum for sharing expertise and perspective between coroners and Children’s Aid Societies—in particular, this collaborative approach to oversight led to the “Joint Child Mortality Task Force” formed in 1996, which released a report in 1997. This report was, in turn, informed by and contributed to recommendations arising out of six systemic inquests into deaths involving children under CAS supervision between 1996 and 1998.

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<sup>57</sup> See Nicolas Bala and Nico Trocme, “Child Protection Issues and Pediatric Forensic Pathology” (October 2007).

More recently, the OCCO and Ministry of Children and Youth Services established a Joint Child Death Review Committee, co-chaired by the Child Welfare Secretariat and the OCCO. This Review Committee has established and revised (as recently as 2006) a Joint Directive on Child Death Reporting and Review (the “Joint Directive”) so as to enhance accountability for death investigations involving children.<sup>58</sup> The Joint Directive sets out a series of timelines for the death investigation of children under CAS supervision, including the mandatory issuance of a Serious Occurrence Report immediately after the death of the child, the issuance of a “Child Fatality Case Summary” within 14 days, and the decision by the PDRC as to whether a review is necessary within 21 days (if a review is undertaken, the PDRC will issue its report within 90 days).<sup>59</sup>

Despite the success of this collaboration, the PDRC Report for 2007 indicates concerns with CAS involvement in death investigations, including inconsistencies in compliance with the Joint Directive, and poor communication and information sharing in the conduct of death investigations.<sup>60</sup>

Although the Provincial Advocate for Children and Youth has monitoring powers, that office cannot conduct full investigations, and thus there is limited power to review and investigate a situation where a child under CAS supervision dies. In April 2006, Bill 88, the *Ombudsman Amendment Act (Children’s Aid Societies), 2006* proposed that the Ombudsman be given authority to investigate the conduct of a CAS but the bill lost momentum when the House adjourned in the summer of 2006. Concerns around

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<sup>58</sup> The collaboration between the Ministry of Children and Youth Services and the OCCO is described in the Report of the PDRC (2007), *supra* note 7, at p. 5.

<sup>59</sup> *Ibid.*

<sup>60</sup> *Ibid.* at p. 23.

accountability for CAS supervision of children continue to be a focus of the Ontario Ombudsman.<sup>61</sup>

Accountability for CAS involvement in individual cases may be provided by the Family Court system and by the Children’s Services Review Board. Accountability for CAS involvement in death investigations, however, is less clear, and would appear principally to fall within the purview of the multidisciplinary committees of the OCCO through its expert review bodies, and in particular the PDRC and the DU5C.<sup>62</sup>

While the PDRC does not have the authority to impose policies or practices on the CAS, its ability to monitor compliance with existing directives and policies and the representation by CAS officials on the OCCO’s multidisciplinary committees suggest the basis for effective accountability and oversight.

### **E. Accountability and Oversight Between the OCCO and the Ontario Pediatric Forensic Pathology Unit in the Hospital for Sick Children**

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<sup>61</sup> In his statement as part of the 2006–2007 Annual Report, the Ombudsman complained of his inability to investigate complaints against a CAS. The Ombudsman advocates that his office be given this power on the basis that there is no credible and independent oversight over CAS activities. In particular, the PDRC is cited in the Ombudsman’s Annual Report as an inadequate form of accountability over the CAS sector since it is only applicable where a death has occurred. The PDRC provides no opportunity for independent investigative oversight to address complaints against a CAS before the errors become fatal. *Supra* note 31, at p. 13.

<sup>62</sup> The 2006–2007 Report of the PDRC and DU5C includes a cluster of recommendations for the improvement of CAS operations. These include but are not limited to child welfare officials’ participation in death investigations. For example, the Report expresses a concern that CAS staff rely too heavily on parental self-reporting without independent verification and often fail to keep files updated and in compliance with reporting standards. The Report also cites inconsistency in supervision and oversight of CAS staff and the premature closing of files due to parents’ lack of co-operation and/or refusal to sign consent for collateral contacts. With respect to death investigations, the Report highlights inconsistent death investigations by CAS and recommends, among other reforms, further training for CAS staff and mandatory protocols for CAS joint investigations with police. The Report also provides a “best practices” guideline for CAS staff based on the PDRC’s examination of 30 CAS internal reviews of deaths of children under CAS supervision. These best practices emphasize accountability measures (such as including the membership of the review team, notes from follow-up meetings with family, etc.), and reference to the applicable guidelines. *Supra* note 7, at pp. 23–24.

Another distinctive setting for purposes of accountability and oversight of pediatric death investigations is the Ontario Pediatric Forensic Pathology Unit (OPFPU) located in the Hospital for Sick Children (HSC). The government established the OPFPU in 1990 to provide pediatric expertise in death investigations involving children.<sup>63</sup>

The Ministry funded this Unit based on a contractual agreement between the Ministry and HSC. The agreement provided for an annual sum of money (\$200,000) to cover the expenses of this Unit. This sum has remained constant since 1990. There was no requirement that any of the pathologists affiliated with the OPFPU be formally trained in forensic pathology and no attention to oversight in the agreement.

The OPFPU participated in death investigations whenever a child hospitalized at HSC died in circumstances that led to a coroner's investigation, all coroner's investigations in Toronto involving children under the age of 12, cases of older children where its expertise was needed, and cases within its purview from nearby communities if those communities lacked expertise in pediatric forensic pathology. The OPFPU also was available for consultation on all pediatric cases in Ontario. Its mission was to provide support for the OCCO, leadership in education and research related to pediatric forensic pathology, and to provide evidence and testimony, where requested, for criminal justice proceedings.

Accountability and oversight for the OPFPU has been problematic. Pathology services are provided for the OPFPU by HSC personnel (and, specifically, its Pathology Division) and those services are subject to HSC procedures and governance. The

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<sup>63</sup> One of the motivations for this shift appears to have been the public inquiry conducted by Justice Grange in 1984 into the prosecution of Susan Nelles, a nurse at HSC, for the deaths of four infants in 1981. One of the lessons coming out of that inquiry was the view that pediatric deaths could be better understood if treating pediatric physicians, child abuse experts and pediatric pathologists all were centred in one location.

agreement between the Ministry and HSC contemplated that the Director of the OPFPU would report to the Deputy Chief Coroner or to the Head of the Pathology Division at HSC “depending on the nature of the issue at hand.” Additionally, the Director is subject to guidelines and protocols issued by the Chief Forensic Pathologist of Ontario. The result of these multiple lines of supervision is to create confusion as to who in fact supervises and/or deals with complaints arising from the OPFPU’s participation in death investigations.

While some of HSC’s procedures apply to autopsies performed by the OPFPU (for example, with respect to the disposal of human tissue), the hospital has not undertaken any specific oversight of the Unit. The understanding of the Ministry and HSC appeared to be that the OCCO would remain responsible for the operation of the Unit. The agreement between the Ministry and HSC, however, clarified that the Ministry would not be liable for any damages arising from third-party claims against the OPFPU and that HSC would indemnify the Ministry if damages resulted from a claim or proceeding arising from the negligent or wilful act of any of HSC’s employees.

In addition to an absence of meaningful oversight, the integration of the OPFPU within the pediatric pathology unit at HSC (including interaction with the Suspected Child Abuse and Neglect (SCAN) team) may have created a particular kind of institutional culture that contributed to the “think dirty” ethos, discussed in other research conducted for this Inquiry. While there may have been good reasons to establish the OPFPU and locate it in HSC, the viability and desirability of this arrangement continuing should be the subject of further study.

From the perspective of accountability and oversight, the OPFPU suffers the disadvantage of not being fully integrated into the HSC's oversight system, while its physical isolation from the OCCO hinders the operation of the OCCO's existing accountability and oversight mechanisms. The Director of the OPFPU falls under the authority of both HSC and OCCO, but without clear coordination between these two bodies or collaborative avenues for corrective oversight where concerns are raised.

#### **F. Toward an Effective and Independent System of Accountability and Oversight for Death Investigations**

An accountability and oversight framework in the context of death investigations must be both effective *and* independent. If oversight is effective in the sense of identifying and correcting potential errors but the process takes place internally, behind closed doors, and in an environment of secrecy, it will do little to enhance public confidence. By contrast, if an oversight process is highly transparent and independent, but fails to identify and correct potential errors, this will also be unacceptable. Thus, the question that the analysis below seeks to address is what way forward would most enhance the effectiveness and independence of oversight over death investigations in Ontario.

There are two inescapable truths that must animate an effective and independent system of accountability and oversight for death investigations. The first is that mistakes and errors will happen (and should be seen as part of the scientific and evidence-based analysis that lies at the heart of death investigations). The second is that, to every extent possible, errors must be corrected, and future errors prevented, if miscarriages of justice are to be avoided. Below, I canvass the mechanisms that might enhance the effectiveness and independence of accountability and oversight of death investigations in Ontario

This section is divided into five parts. The first part examines enhancements to the structure of coroners in Ontario. The second part discusses expanding peer review mechanisms in the death investigation process. The third part addresses how to improve integrated and inter-agency accountability. The fourth part will canvass complaint-based overview mechanisms and the need for independent expertise and family support services in relation to a complaints regime. Finally, the fifth part considers the need for better performance evaluation and audit oversight for death investigations.

### **(1) Structure of Coroner's Office**

The structure, organization, resources, and staffing of the Coroner's Office clearly has a significant impact on accountability and oversight. For example, whether the Ontario Pediatric Forensic Pathology Unit is to remain within the Hospital for Sick Children will necessarily influence accountability and oversight mechanisms. In that regard, I note that other studies provided to this Inquiry provide a more detailed analysis of the advantages and disadvantages of a stand-alone pediatric forensic pathology unit.<sup>64</sup>

I have suggested above the need for clarifying the respective roles and responsibilities of coroners and forensic pathologists in death investigations, especially given the silence of the current *Coroners Act* as to the autonomy and authority of forensic pathologists in relation to death investigations. The most straightforward way to clarify roles and responsibilities would be through an amendment to the Act or Regulations enacted pursuant to the Act. It may be possible, however, to achieve greater clarity

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<sup>64</sup> See Cordner, *supra* note 33.

through other instruments, including a memorandum of understanding between the CCO and CFP, a policy guideline issued by the Ministry, or an exchange of written protocols.

A key dimension to clarifying roles and responsibilities between coroners and forensic pathologists is how to resolve disputes between these two groups. Disputes may arise in the context of individual cases where an investigating coroner disagrees with or decides not to adopt the analysis of a forensic pathologist, or more broadly between the Chief Coroner of Ontario (CCO) and the Ontario Centre of Forensic Sciences (CFS) on matters of policy, staffing, resources, or other systemic issues.

Existing guidelines, peer review, and multidisciplinary committee oversight provide important resources for resolving disputes in individual cases. The goal of these mechanisms is to recognize both the professional autonomy of the forensic pathologist and the statutory responsibility of the investigating coroner to make determinations on the outcome of the death investigation.

Broader disputes between the CCO and CFS on systemic matters under the existing system would now fall to the CCO to resolve, as it is the office with overall authority relating to death investigations. However, as with the CCO Review process discussed above, investing the CCO with this authority creates inherent conflict in the CCO's ability either to engage in independent oversight or to resolve internal disputes. The CCO, in effect, is asked to serve both as CEO and as Chair of the Board over the organization. These dual roles are incompatible with effective accountability and independent oversight. For this reason, some modification to the structure of the CCO is necessary. One model that would address this concern is to have a Board or Council with overall authority over coroners and pathologists (referred to below, for ease of reference,

as a Board of Coroners & Forensic Medicine (BCFM)). In Australia, both the Victorian Institute of Forensic Medicine Council and the National Coroner's Information System Committee provide governance systems based on this model.<sup>65</sup>

Both the CCO and CFS could be ex-officio members of a governing Board, but neither would control it. Such a Board could provide oversight for both coroners and pathologists, as outlined in more detail below. Such a Board could also be accountable to the responsible Minister, thus preventing any direct reporting relationship between the CCO, CFS, and government officials.

With respect to ministerial accountability, there appears to be good cause to question whether the MCSCS is the proper Ministry to oversee death investigations. The fact that the OCCO is within the same ministerial portfolio as the police contributes to the perception that death investigations are conducted to support police investigations and the criminal justice system. Given the small fraction of death investigations that involve any potential criminal activity, it may be worth exploring alternative ministerial accountability for death investigations. For example, if the purpose of a coronial system is ultimately public health through prevention of preventable deaths, it is worth asking why the OCCO does not fall under the purview of the Ministry of Health. Alternatively, given the importance of the inquest system within the OCCO's death investigation system, there also appears to be a case for the OCCO coming under the purview of the Attorney General's Ministry. Whatever the ministerial home of death investigations, the

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<sup>65</sup> For more background on the Australian model, see the 2004–2005 Annual Report of the NCIS, at [http://www.vifp.monash.edu.au/ncis/web\\_pages/NCIS%20Annual%20Report%200405.pdf](http://www.vifp.monash.edu.au/ncis/web_pages/NCIS%20Annual%20Report%200405.pdf)

principle of non-interference by the government in the death investigation process should remain paramount.<sup>66</sup>

With the importance of independence in the structure of the OCCO in mind, it is problematic that coroners are at present “at pleasure” appointments, pursuant to s.3(1) of the *Coroners Act*. These kinds of appointments have been long recognized as signalling a lack of independence in Canadian administrative law.<sup>67</sup> At a minimum, a fixed term for appointments of coroners would recognize the need for independence.

In addition to revisiting the structure of the OCCO, it is also important to consider the staffing of that office. Recruiting more full-time coroners and more full-time staff forensic pathologists would play a key role in augmenting accountability and oversight. Creating progressive mechanisms of peer review or developing additional guidelines for memorializing case conferences or other accountability-enhancing initiatives will invariably add to the workload of death investigators. Without new resources and additional forensic pathologists, it is likely that such measures will be avoided or that they will lead to other problems (for example, greater delay in death investigations or fewer opportunities for training and education).

The challenge facing the death investigation system in Ontario is not simply the need for more pathologists but the need for more *qualified* pathologists. The planned certification program in forensic pathology is a promising beginning. Enhancing accountability and oversight, in short, almost certainly will require increasing the number

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<sup>66</sup> Other papers commissioned by this Inquiry comment on the proper ministerial relationship with the OCCO; see, in particular, R. Hanzlick, “Options for Modernizing the Ontario Coroner System” (December 2007), who recommends that the OCCO be housed in its own agency, or if that is not feasible, that it be housed within the Ministry of Health.

<sup>67</sup> See *Ocean Port Hotel v. B.C. (General Manager, Liquor Control and Licensing Branch)* 2001 SCC 52, where the Court found an “at pleasure” appointment to a liquor licensing board, while lawful, to lack independence.

of qualified coroners and pathologists (and especially full-time coroners and full-time staff forensic pathologists) in Ontario.

A detailed look at the recruitment and retention of death investigators (and particularly well-qualified forensic pathologists) lies beyond the scope of this paper. Uncompetitive salary, overwork, and regional disparities in equipment and working conditions, however, have been cited on numerous occasions in this Inquiry as part of the explanation for the difficulties in filling coroner and pathology vacancies and suggest some new resources will be needed to address this concern. In addition to resources, closer affiliation with university teaching hospitals may also enhance the attractiveness of these positions.<sup>68</sup>

The relationship between the Victorian Institute for Forensic Medicine (VIFM) and Monash University in Australia has been cited as a particularly effective model in this regard. The mandate of the VIFM is as follows:

- to provide, promote, and assist in the provision of forensic pathology and related services in Victoria and, as far as practicable, oversee and co-ordinate those services in Victoria;
- to promote, provide and assist in the postgraduate instruction and training of trainee specialist pathologists in the field of forensic pathology in Victoria;
- to provide training facilities for doctors, medical undergraduates and such other persons as may be considered appropriate by Council to assist in the proper functioning of the Institute; and
- to conduct research in the fields of forensic pathology, forensic science, clinical forensic medicine and associated fields as approved by Council.<sup>69</sup>

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<sup>68</sup> In 2004, the Toronto Forensic Pathology Unit and the Department of Laboratory Medicine and Pathobiology at the University of Toronto established a clinical fellowship in forensic pathology. The present Chief Forensic Pathologist also holds a professorship at the University of Toronto.

<sup>69</sup> For more background on the VIFM, see <http://www.vifm.org/>. See also Cordner, *supra* note 33.

In Ontario, as elsewhere, such linkages would have ancillary advantages in terms of accountability and oversight as well, through the university system of tenure, supervision, and performance reviews.

In addition to the structure and status of coroners and pathologists, new equipment and new technology may also play an important role in enhancing accountability and oversight. For example, the ability to conduct virtual post-mortem examinations through new scanning and telecommunications technology may permit supervision and peer review of death investigations across regions that otherwise would lack the capacity to implement such oversight measures.

## **(2) Peer review**

The most effective way for errors to be detected, corrected, and prevented is by way of peer review, as an integral part of the death investigation system itself. Some have suggested a “two-coroner” model, whereby homicide or criminally suspicious deaths, or sudden and unexpected deaths of children, should trigger a special process by which a death investigation is carried out with two investigating coroners so that peer review of the decision-making of each is integrated into the death investigation protocol. Others suggest that a single investigating coroner retain jurisdiction over such death investigations but that an enhanced review process be put in place to oversee their findings at key junctures in the death investigation process (the new audit of investigating coroner CIS forms reflects this approach). Case conferences and the work of the PDRC and DU5C , discussed above, provide additional opportunities for peer review.

In each of these settings, peer review raises other concerns. First, when should peer review take place? If it takes place during the death investigation process, it may cause delay to death investigation timelines. If it takes place long after the conclusion of a death investigation, correcting errors may be more difficult and, in the case of criminal justice proceedings, may occur too late. A second concern is whether peer review ought to be memorialized so there is a written record, for example, of whether the various pathologists or coroners involved had a consensus or different perspectives on key aspects of a death investigation. A third concern is how to address the insular nature of peer review whereby experts in a given field tend to see their work in isolation from the work of others.

In many cases, however, death investigation is more than the sum of its parts. Flaws in death investigation may occur, for example, due to communication breakdowns between the police and pathologists, or between pathologists and coroners, or between an expert witness and Crown counsel. This dynamic has already been recognized as part of the response to the events giving rise to this Inquiry—the OCCO, for instance, recently adopted a policy (in April of 2007) requiring an in-person meeting or telephone conversation between the investigating coroner and pathologist prior to an autopsy being conducted in homicide or criminally suspicious death cases involving children under the age of five.

Where peer review is undertaken across disciplines, however, other tensions may emerge. Coroners may lack the specialized training in forensic pathology to provide effective peer review of a forensic pathologist, while forensic pathologists may lack a sufficiently broad understanding of death investigations to review the work of coroners,

and the independence and autonomy of the professionals involved in a death investigation may be compromised by peer review that lacks expertise in a particular professional's field.

Finally, the public may view experts as likely to support one another's views. It is for this reason, for example, that the Province of Ontario established the Health Professions Appeal and Review Board, a publicly appointed body, mentioned above, which, on request of a party, reviews decisions of Complaints Committees of the regulated health colleges such as the CPSO including decisions not to investigate health professionals following a complaint. In other words, there must be a public and transparent dimension to oversight in order for it to enhance public confidence. Peer review alone cannot provide this dimension.

The current case conference system provides an important forum for peer review in the course of a death investigation, although the consistency of this practice across regions in Ontario and in all cases of sudden or unexpected deaths of children is uncertain. A modest option would be to have a second coroner and/or forensic pathologist sign off on the CIS and/or autopsy report in a designated cluster of high-risk or complex cases, including all cases of sudden or unexpected deaths involving children. Where this form of peer review is undertaken, a written record of the review of the second coroner would be important to retain for transparency purposes and to assist with *ex post* reviews and/or audits. This review need not (and perhaps ought not) opine on the correctness of the view expressed by a coroner or forensic pathologist but could, rather, confirm the sufficiency of the analysis and reasonableness of the conclusions.

Given the various opportunities for consultation, collaboration, and peer review already integrated into the death investigation process, it is difficult to see a strong case for significant new initiatives. Consolidating the existing procedures and ensuring they are applied effectively throughout the province, however, would enhance accountability and oversight.

### **(3) Integrated and inter-agency accountability**

The need for integrated and inter-agency review of death investigations has already been recognized and, in part, underlies the establishment of the PDRC, DU5C, and the joint task forces and review committees established between OCCO and child welfare agencies.

The process for a Chief Coroner's Review of a death investigation established in 2006 may be another important outlet for oversight that could include overseeing communication between pathologists and coroners, among other aspects of a death investigation, if those issues are raised in concerns or complaints forwarded to the Chief Coroner. Significant gaps remain, however, in the accountability and oversight of how agencies and individuals involved in death investigations interact with one another.

For example, there appears to be insufficient oversight over the testimony of pathologists and coroners in criminal justice proceedings. Critical comments about the testimony of Dr. Charles Smith by Justice Patrick Dunn in the course of acquitting a 12-year-old girl being prosecuted for manslaughter in 1992, for example, never reached the

investigating coroner supervising the work of Dr. Smith.<sup>70</sup> Even when the remarks of Justice Dunn were widely reported in the media, there remained no process in place by which such concerns reached the Office of the Chief Coroner.

Implementing a process of routine review of all judicial commentary about the work of pathologists and coroners in the context of criminal justice proceedings would address an important gap in the accountability of death investigations. It may be possible to add this mandate to the purview of the PDRC or other existing review structures. It may be unrealistic, however, to expect existing staff resources to be able to provide this degree of tracking and analysis of the testimony of pathologists and coroners in criminal justice proceedings. Another option is creating an expert review committee analogous to the PDRC but with a mandate to focus on the testimony of pathologists and/or other participants in death investigations in the context of criminal justice proceedings. The multidisciplinary makeup of such an expert review committee could include legal, medical, forensic, and other relevant expertise.

Whatever the structure designed to address accountability and oversight with respect to testimony about death investigations in criminal justice proceedings, what is lacking in the current death investigation system in Ontario is a single point of contact and coordination for data collection, analysis, reporting, privacy protection, and accountability.

Enhancing institutional capacity in this way recognizes that, in a death investigation, it is possible for every professional involved to have discharged his or her individual responsibilities in compliance with applicable standards and protocols and for

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<sup>70</sup> T. Boyle, “Lack of oversight, shortage of pathologists contributed to ‘miscarriages of justice,’” *Toronto Star* (December 10, 2007).

the death investigation as a whole nonetheless to be flawed. The multiple sites of accountability canvassed above for death investigators may have many advantages (just as multiple oversight over the police from the courts, internal discipline, the Special Investigations Unit, and civilian oversight is said to ensure greater accountability).<sup>71</sup> However, the specialized nature of death investigations and the multidisciplinary nature of those investigations, especially in pediatric settings, suggest more of a need for coordination and coherence. With this concern in mind, a separate accountability office may be needed, especially in the context of pediatric death investigations leading to criminal prosecutions.<sup>72</sup> Such an office should not be part of the direct reporting relationships within the OCCO. If there were a Board of Coroners & Forensic Medicine of the kind suggested above, it would be advisable for the head of an accountability office to report directly to this Board.

#### **(4) Complaints-based oversight**

In addition to other institutional forms of accountability and oversight, it is important that those affected by death investigations, and the professionals who participate in those investigations, have recourse to an independent complaints mechanism when they believe misconduct or a breach of applicable standards to have occurred.

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<sup>71</sup> For an analysis of the multiple oversight mechanisms in the police context in Ontario, see L. Sossin, “Oversight of Executive–Police Relations in Canada: The Constitution, The Courts, Administrative Processes and Democratic Governance,” in M. Beare and T. Murray, *Police and Government Relations: Whose Calling the Shots* (Toronto: University of Toronto Press, 2006).

<sup>72</sup> As a possible model, the Minister of Children and Youth Services announced in December of 2006 the creation of an Accountability Office in order to “toughen enforcement and monitor children’s aid societies’ performance in meeting legislated requirements and regulations for the care and protection of children and direct corrective action when they are not.” The Accountability Office is also intended to provide ministry staff training and tools to monitor compliance with these new performance standards. See <http://www.newswire.ca/en/releases/archive/December2006/05/c3824.html>.

The Ontario Coroner’s Council provided a complaints procedure against coroners. The Coroner’s Council ceased operating in February of 1999.<sup>73</sup> As discussed above, a new Chief Coroner’s Review process, established in 2006, now provides for an internal mechanism to address complaints about the conduct of a death investigation.

The Ontario Coroner’s Association (OCA) continues to enhance accountability and oversight through the dissemination of a Coroner’s *Code of Ethics* (adopted in July of 2005).<sup>74</sup> Section 1 of this Code stipulates that “Coroners shall exercise their duties and responsibilities without fear, favour, prejudice, bias or partiality toward any person.”

Section 9 of the Code suggests a special relationship between coroners and those involved in criminal justice investigations and prosecutions: “Coroners shall assist law enforcement agencies and officials involved in the administration of justice in the discharge of their duties so far as possible, having regard to the provisions of the *Coroners Act*.” While it is possible to see the coroner’s role in assisting law enforcement as providing objective and evidence-based death investigations, including a check and balance function for police investigators, this aspect of the Code may make it appear to the public as if coroners have an ethical obligation to support the police in criminal justice proceedings. It may be worthwhile for the OCA to consider revising the Code in light of the findings of this Inquiry.

In any event, there does not appear to be any ongoing mechanism for supervising or enforcing the compliance of coroners with this Code.

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<sup>73</sup> One of the families alleging misconduct on the part of Dr. Smith brought a complaint to the Coroner’s Council in May of 1999. While the Council has been abolished by the time the complaint was lodged, the Chief Coroner’s Office did investigate the allegations which had advanced. See CPSO Institutional Report (November 2007) at paras. 84-86.

<sup>74</sup> See <http://www.ontca.ca/Final%20code%20old%20order%20july%2018%20Dr.pdf>. (accessed December 1, 2007).

As discussed above, some limited complaints-based oversight currently is provided by the College of Physicians and Surgeons of Ontario (CPSO). For the reasons outlined above, the CPSO performs an important but partial oversight role in relation to death investigations.

The Ombudsman’s Office also investigates complaints against the coroner or other participants in a death investigation, as discussed above. The Ombudsman’s Office lacks specialized expertise in death investigations, and may be better suited to procedural rather than substantive concerns in the context of death investigations.

The existing system lacks an effective *and* independent complaints mechanism that covers the entire death investigation system, including physicians, pathologists, coroners, scientists, police officers, and others. An office with clear jurisdiction over complaints relating to all aspects of death investigations in Ontario is advisable to address this gap. This could be a function of an accountability office or a function added to an existing oversight body.

Another model that would address the concerns noted above would be a stand-alone death investigation complaints mechanism along the lines of the U.K. Home Office Disciplinary Panel, which can hear complaints pursuant to the Home Office Register of Forensic Pathologists, Disciplinary Rules.<sup>75</sup> This process builds in expert reports by consulting forensic pathologists from peer jurisdictions and was used to investigate and adjudicate the complaint into the conduct of U.K. forensic pathologist Dr. Alan Williams, who was alleged to have withheld evidence in a high-profile prosecution of a woman for

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<sup>75</sup> See Issue 1, [www.homeoffice.gov.uk/documents/Disciplinary-Rules-Issue-1.pdf](http://www.homeoffice.gov.uk/documents/Disciplinary-Rules-Issue-1.pdf), 2005.

killing her son.<sup>76</sup> The Forensic Science Regulation Unit of the Home Office also provides a list of accredited forensic pathologists and performs other regulatory functions in relation to death investigations.<sup>77</sup>

If a complaints mechanism other than the CPSO, Ombudsman, and/or the internal CCO Review process is needed, there will also have to be thought given to an appropriate gatekeeping protocol to avoid unnecessary duplication and overlapping investigations. In other words, the function of such a body may extend beyond to investigating and resolving complaints and include information exchange, coordination and protocols regarding the sequencing of investigation to avoid fragmentation, duplication and inefficient processes.

It is not enough, however, merely to provide the recourse for complaints and coordination of oversight. For certain groups, such as families involved in the death investigation of a child, it is also important to provide institutional resources for people to navigate the complaints system (without having to retain lawyers or other advocates). These resources could include accessible public information about the standards applicable to death investigations, and could include an independent officer responsible for providing informational and advocacy services to family members or other individuals aggrieved through the death investigation process, including information and assistance relating to the complaints mechanism(s) available. Another alternative to

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<sup>76</sup> The disciplinary tribunal found Dr. Williams' conduct fell below the standard of competence. In August of 2007, this was confirmed, in part, on appeal. For the decision in this matter, see <http://www.homeoffice.gov.uk/documents/Forensic-Path-Appeal-0807.pdf>. See also Campbell and Walker, *supra* note 22.

<sup>77</sup> For more background, see <http://www.homeoffice.gov.uk/about-us/organisation/directorate-search/crcsg/ppod/fspu/forensic-path>.

enhance the institutional capacity of the OCCO would be the creation of a family services office.

The emphasis on the family in oversight and accountability is consistent with reforms elsewhere. The recently proposed reforms to the U.K. coronial system, for example, emphasize a more robust role for families in death investigations, including a right to relevant information in a death investigation, the right to ask for reconsideration of certain coroner decisions in a death investigation, and *A Charter for Bereaved People Who Come Into Contact with the Coroner's Service*.<sup>78</sup>

#### **(5) Audits, performance objectives, and annual reports**

In addition to the peer review, multidisciplinary reviews, and complaints mechanisms, effective and independent oversight also requires an objective and accessible system of conveying information about the performance of Ontario's death investigation process to the public.

Some mechanisms for conveying information could have significant impact at relatively little cost. For example, posting all death investigation guidelines and protocols on-line would allow those touched by death investigations to gain a better understanding of the standards and expectations relating to the death investigation process. It is notable

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<sup>78</sup> A copy of this document is available at [http://www.dca.gov.uk/legist/coroners\\_draft\\_charter\\_bereaved.pdf](http://www.dca.gov.uk/legist/coroners_draft_charter_bereaved.pdf).

that, at the moment, the OCCO does not have its own website but appears as a cursory link on the Ministry site.<sup>79</sup>

Other initiatives that could enhance this aspect of effective and independent accountability and oversight include the preparation of a free-standing OCCO Annual Report. Such an Annual Report could include information on the total number of deaths in Ontario, the total number of investigations by a coroner, the total number of homicides and criminally suspicious deaths, the total number of pediatric deaths, timelines for death investigations, and other relevant statistics. Separate sections of an Annual Report could detail the peer review process, the proceedings of multidisciplinary reviews such as the PDRC, training and education initiatives, data relating to the testimony of death investigators in criminal proceedings, as well as the number, timeline, and outcome of any complaints received. An Annual Report would also detail the staffing and resources of the office, as well as any priorities or performance objectives designated for the OCCO. The recent reports of the PDRC and DU5C (in 2004 and 2007) demonstrate the value of qualitative and quantitative data on death investigations. More comprehensive information conveyed on a more regular basis could be of significant value to enhancing accountability and oversight.

Whether contained in an Annual Report or otherwise obtained, these qualitative and quantitative data enhance the ability of the OCCO to set clear objectives and priorities for each year and to create benchmarks for the evaluation of its performance. Such objectives could relate to timelines for death investigations, targets for education and training, multidisciplinary initiatives, plans for new equipment or initiatives, and

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<sup>79</sup> See [http://www.mcscs.jus.gov.on.ca/English/pub\\_safety/office\\_coroner/about\\_coroner.html](http://www.mcscs.jus.gov.on.ca/English/pub_safety/office_coroner/about_coroner.html).

perception tracking of family members involved in death investigations and of multidisciplinary collaborators in death investigations.

Audits, both internal and external, represent another important aspect of reviewing performance. The new 31-point CIS audit is an example of an internal measure that may provide important information on performance that could be benchmarked over time. Since 1995, the death investigations supervised by the OCCO have been subject to provincial audits. The audit process involves potentially all homicides and criminally suspicious deaths.

External audits may include ministry initiatives or audits by the Auditor General. In 2007, for example, the Provincial Auditor General of Ontario reviewed the Ontario Centre of Forensic Sciences (CFS), which provides independent forensic laboratory services to a range of “clients” including law enforcement, fire marshals, and Crown prosecutors, as well as pathologists and coroners.<sup>80</sup> In 2006–2007, the CFS issued over 12,000 analytic reports dealing with over 10,000 cases. The Auditor General of Ontario audited the CFS with respect to its efficiency (e.g., timelines, staffing sufficiency, etc.) and its effectiveness in support of the administration of justice in Ontario. The audit consisted of a paper review of sample cases, and extensive interviews with members of CFS and the client groups served by CFS. The audit found that quality control mechanisms within CFS worked well, but revealed that turnaround times for case reports in the CFS were double the equivalent turnaround times for forensic service facilities in

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<sup>80</sup> See [http://www.auditor.on.ca/en/reports\\_en/en07/302en07.pdf](http://www.auditor.on.ca/en/reports_en/en07/302en07.pdf). In order to enhance the independence and objectivity of the CFS, a Forensic Services Advisory Committee (FSAC) was established in 1998 (as a response to one of the recommendations coming out of the Guy Paul Morin Inquiry). The mandate of the FSAC is to provide independent and external advice and feedback to the Chief Coroner of Ontario on policies, programs, and proposals relating to forensic services.

the United Kingdom and Sweden.<sup>81</sup> The audit also found that enhancing CFS information systems and monitoring procedures could lead to more efficient and effective operations generally and improve turnaround times more specifically.

The Auditor General of Ontario report also provides an opportunity for a response by the government body (in this case, the MCSCS) to indicate whether it accepts or takes issue with the audit's findings and recommendations. While audits are necessarily retrospective and systemic in nature, regular audits could provide both independent and effective accountability and oversight for death investigations.

## **Summary**

Enhancing accountability in some cases will mean devoting more of the existing resources of the OCCO to accountability and oversight. The development of new death investigation protocols and autopsy guidelines, and the establishment of the PDRC, DU5C, and the new CCO Review and CIS Audit measures, all reflect significant and important endeavours aimed at providing more and better oversight for death investigations in Ontario. Many of these initiatives individually, or in combination, arguably could have prevented the inadequate death investigations and miscarriages of justice that lay at the heart of this Inquiry.

In other settings, particularly the oversight of multidisciplinary and inter-agency dimensions to death investigations, it may be unrealistic to expect accountability and oversight to be meaningfully enhanced without new resources in the death investigation system. For example, of the initiatives mentioned in this study, enhancing the information

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<sup>81</sup> *Ibid.* at p. 60.

and advocacy supports for families, engaging in more sophisticated auditing and performance tracking, providing new and more accessible information on death investigation, and providing a centralized clearing house for both information and complaints in relation to death investigation, all suggest the need for new resources. These resources could come in the form of a new accountability office, family services office, and other enhancements to the institutional capacity of the death investigation system in Ontario.

## **Conclusions**

This study has examined existing accountability and oversight mechanisms relating to death investigations—and particularly pediatric death investigations—in Ontario. This discussion revealed that there are multiple mechanisms for accountability and oversight and that new mechanisms already have been put in place as a response to the events giving rise to this Inquiry. Some may legitimately claim that the system, as it is currently structured, does not lack accountability or oversight, and would conclude either that the system as it existed in the time period covered by this Inquiry, if it operated properly, should have identified and corrected any errors in the death investigations in which Dr. Charles Smith participated, or that, given the improvements to the system in the past few years, the system as it now operates would identify and correct similar errors today.

While the existing oversight and accountability measures, including the promising set of recent reforms set in motion by the events giving rise to this Inquiry, should not be ignored, the current system appears inadequate based on the goals for accountability and oversight set out above.

The structure and organization of the OCCO could be enhanced with accountability and oversight in mind, including clarifying the respective roles and authority of coroners and forensic pathologists and ensuring the autonomy of each group within the death investigation process. Central to this restructuring of the death investigation system would be the creation of a Board or Council with oversight jurisdiction covering both coroners and forensic pathologists.

There remains no independent and credible complaints-based system to investigate allegations of negligence, error, or wrongdoing in relation to death investigations as a whole. While the Chief Coroner Review instituted in 2006 provides an important recourse for those with complaints and concerns, it is neither independent nor does it provide resources for family members or others attempting to navigate the complaints process.

This study has also identified a need for an agency that has both independence and expertise. Drawing on the U.K. Home Office experience, it may be worth considering an Accountability Office that would have both the necessary expertise to review the work of forensic pathologists and the necessary profile and composition to inspire public confidence. Such a body should be linked with criminal justice and child welfare stakeholders, given that pediatric forensic pathology is so intimately connected with both systems.

There also appear to be gaps in the supervision of inter-agency communication and interaction between various actors in a death investigation. While the PDRC and DU5C committees of the OCCO provide an important forum for inter-agency collaboration and supervise compliance with applicable guidelines and protocols, their

mandate does not, to date, appear to extend to important areas of inter-agency interaction identified in this Inquiry. For example, no body at present appears to supervise how the police convey information about a deceased's family circumstances to a forensic pathologist, or how a pathologist conveys information to a court. A new expert review committee with this mandate may also be advisable. Committees of the OCCO, however, may also lack the independence to provide credible critiques of investigating coroners, forensic pathologists, and other participants in death investigations who fall under the authority of the OCCO.

To address these gaps, a range of areas have been identified in this study where accountability and oversight could be enhanced. These areas focused on the structure and governance of the OCCO, mechanisms of peer review, integrated and inter-agency accountability, complaints mechanisms, enhanced collection and dissemination of data regarding death investigations, additional family services, and, finally, performance evaluation and audits. In some cases, existing resources and institutional bodies may be used to address these gaps, while in other cases it will be necessary to enhance the institutional capacity for accountability and oversight of death investigations. Additionally, other dimensions of the death investigation process, such as providing greater supports for and a greater role for family members in the context of pediatric death investigations, may also require new capacity and new resources.

Accountability is never static. Accountability has been used in diverse contexts to mean different things to different parties. As Jerry Mashaw has observed:

Accountability is a protean concept, a placeholder for multiple contemporary anxieties.... I don't doubt that accountability is a problem, but what sort of problem?

And why so much concern about it now. Are well-understood structures of accountability failing to keep pace with real changes in how our world is organized? Or have we suddenly become sensitive to problems that were there all along?<sup>82</sup>

A review of Ontario’s coronial system reveals that it too has never been static and has continually evolved. As Ian Freckelton and David Ranson note in their text, *Death Investigation and the Coroner’s Inquest*, “[o]ne of the more enduring characteristics of the office of coroner has been its ability to evolve to meet the needs of the time; coronership has always seemed to be a work in progress.”<sup>83</sup> While the “needs of the time” in the wake of this Inquiry likely will be many, it will be difficult to escape the conclusion that accountability and oversight will become significant priorities. It is hoped that this study will contribute constructively to the vibrant debate about the future of Ontario’s system of pediatric death investigations.

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<sup>82</sup> Jerry Mashaw, “Accountability and Institutional Design: Some Thoughts on the Grammar of Governance,” in Michael Dowdle (ed.), *Public Accountability: Designs, Dilemmas and Experiences* (Cambridge: Cambridge University Press, 2006), p. 116.

<sup>83</sup> (London: Oxford University Press, 2006), at p. 752.