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Oversight of Pediatric Forensic Pathology

Introduction

The tragic story of pediatric forensic pathology in Ontario from 1981 to 2001 is not just the story of Dr. Charles Smith. It is equally the story of failed oversight. The oversight and accountability mechanisms that existed were not only inadequate to the task but were also inadequately employed by those responsible for using them. The role of the Office of the Chief Coroner for Ontario (OCCO) is, therefore, the main subject of this chapter. However, the roles of two other institutions are also important in understanding how Dr. Smith's flawed practices went unchecked for so long: the Hospital for Sick Children (SickKids) in Toronto where he worked, and the College of Physicians and Surgeons of Ontario (CPSO), the professional regulator for all doctors in the province. They too are part of this chapter. In the final section of this chapter, I describe the changes in the oversight regime for forensic pathology that have occurred since 2001.

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

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

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

The failures of supervision are seen most graphically in a series of events through the 1990s which called for the oversight of Dr. Smith, but in which the response was woefully inadequate. I have already described some of the events in general terms, because they were the basis of the broad concerns about Dr. Smith's work which grew over the decade. In this chapter, I focus on the roles of those responsible for him, because it is clear that, for far too long, Dr. Smith was not held accountable. This breakdown in oversight responsibility is not something that can be dealt with simply by replacing the overseers. Rather, the shortcomings represent systemic failings of oversight that must be corrected if public confidence is to be restored.

The troubling series of events during the 1990s took place in the context of institutional and organizational weaknesses that made effective oversight difficult. I describe most of them in Chapter 7, Organization of Pediatric Forensic Pathology. In particular, the legislative framework created by the *Coroners Act*, RSO 1990, c. C.37, provides no foundation for effective oversight of forensic pathology in Ontario. Although the *Coroners Act* structures the coronial system in Ontario and provides that the coroner is in charge of the death investigation, it makes no mention of a forensic pathology service, those who might run it (such as the Chief Forensic Pathologist), or those who should be allowed to perform post-mortem examinations. There is no reference at all to pediatric forensic pathology. It provides only that the coroner can issue a warrant for the post-mortem examination of the body of a deceased person, and that the person performing that examination (who is not required by the *Coroners Act* to be a pathologist) must report the findings forthwith to the coroner and the Crown attorney, among others. In other words, no legislative framework was or is currently provided to ensure proper oversight and accountability of forensic pathology in general, or pediatric forensic pathology in particular.

In addition to being ignored in the legislation, the supervisory role of the

Chief Forensic Pathologist was left unclear in OCCO policies and practices at the time. Relationships between the OCCO and the regional forensic pathology units, in particular the Ontario Pediatric Forensic Pathology Unit (OPFPU) at SickKids, were ill defined and failed to assign clear oversight responsibilities or clear lines of accountability. The directors of the regional forensic pathology units (regional directors) had no expressly articulated oversight whatsoever.

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

As we have seen, despite the lack of clarity in his roles and responsibilities, Dr. David Chiasson tried, during his tenure as Chief Forensic Pathologist, to introduce some quality control measures for the forensic pathology performed in individual cases. But best practices guidelines were limited, peer review by colleagues in an individual case was cursory, and review by the Chief Forensic Pathologist of post-mortem reports was only a paper review. Rounds proved ineffective at providing quality control in criminally suspicious cases. There was no organized tracking of the timeliness of reports or of pathologists' involvement in ongoing cases, nor was there any review of either their testimony or judicial comments about them. There was no institutionalized mechanism for receiving complaints from other participants in the criminal justice system and addressing them in an expeditious and objective way. The lack of tools available to the Chief Forensic Pathologist to achieve compliance by individual pathologists, when coupled with the fee-for-service method of payment that applied in so many cases, compounded the challenges of effective oversight. These failings all contributed to the difficulties of proper quality assurance in individual cases.

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

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

expertise would have added significant value. Overall, Dr. Chiasson felt that Dr. Smith was not open to even the gentlest oversight from him.

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

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

OCCO Oversight of Dr. Smith

Throughout the 1990s, obvious and unmistakable danger signals arose about Dr. Smith's work. His mistakes as a forensic pathologist and his failure to understand his proper role in the justice system were clearly apparent by the end of the 1990s. However, the systemic weaknesses in the oversight and accountability mechanisms, quality control measures, and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 left the system vulnerable to the errors made by Dr. Smith and other pathologists doing pediatric forensic cases. Dr. Young and Dr. Cairns, the de facto overseers of Dr. Smith's work, failed to recognize many of these ominous signals, and the signals they did recognize prompted only inadequate responses. The story of the missed warning signs began early in the decade, with Dr. Smith's participation in Amber's case.

July 1991: Justice Dunn's Reasons for Judgment

As I describe in Chapter 2, Growing Concerns, on July 25, 1991, Justice Patrick Dunn of the Ontario Court (Provincial Division) acquitted S.M. of the charge of manslaughter in the death of Amber after a trial in Timmins. Justice Dunn strongly criticized Dr. Smith in detailed reasons for judgment, which expert witnesses at the Inquiry described as a "masterful analysis" of the forensic pathology

issues raised in the case. Justice Dunn also identified flaws in the approach of SickKids' physicians with regard to fact-finding, communications, documentation, and consultations with other experts.

Justice Dunn identified 16 areas of concern with the conduct of SickKids' physicians in Amber's case. At the Inquiry, Dr. Young acknowledged that the senior officials at the OCCO would have been concerned about each of these areas, in particular Justice Dunn's criticisms of Dr. Smith's objectivity, skill, and familiarity with the latest literature, had they been aware of the decision. However, the OCCO appears not to have learned about the substance of Justice Dunn's decision for several years after it was released. It had no system in place to monitor the progress or result of criminal cases involving pathologists performing forensic work under coroner's warrant.

Justice Dunn's decision was forwarded to Dr. Robin Williams, a pediatric physician, at the time of its release. Dr. Williams, currently the medical officer of health for the Niagara Region, has sat on the Paediatric Death Review Committee (PDRC) since 1990. Dr. Young testified at the Inquiry that Dr. Williams did not forward the judgment to the OCCO, nor did Dr. Smith. With no organized way to obtain judgments involving pathologists doing forensic work, the OCCO's ability to react to Justice Dunn's decision was compromised.

Dr. Young testified that, in 1991, he did not hear about Justice Dunn's decision and was neither familiar with the particulars of the trial nor aware of Justice Dunn's reasons for acquitting S.M. The first time he heard anything about the result was sometime later, when Dr. Smith told him that a defence expert had argued that there was no such thing as shaken baby syndrome and that Justice Dunn had acquitted S.M.

Similarly, Dr. Cairns did not recall hearing about Justice Dunn's decision when it was released in 1991. He learned about it sometime before he read an excerpt from the decision that a lawyer in Nicholas' case sent to him in 1998. Around that same time, Dr. Cairns told Dr. Chiasson about Justice Dunn's decision in Amber's case, but Dr. Chiasson did not read the decision then either.

After the trial, Dr. Smith misrepresented to Dr. Young and Dr. Cairns that Justice Dunn had subsequently told him that he had changed his mind about the medical evidence and, had his understanding of shaken baby syndrome been as complete at the trial, he would have convicted S.M. At the time, Dr. Young and Dr. Cairns regarded Dr. Smith's statements as credible. They both chose to believe Dr. Smith's unlikely story without further investigation and without even reading the decision in question.

Dr. Young testified that he did not finally read Justice Dunn's reasons in Amber's case until 2007, when he was preparing to appear at this Inquiry. He said

that, before the Inquiry, he did not know that a number of expert witnesses had testified for the defence in the case. Although he acknowledged the many opportunities he had to learn about the decision, he stated that he did not learn until 2007 that Justice Dunn was sharply critical of SickKids and of Dr. Smith and his methodology. As I explain below, after his February 1997 meeting with a CPSO investigator about the case, Dr. Young should have known that Justice Dunn's reasons for judgment were sharply critical of Dr. Smith.

May 1995: Crown Counsel's Concerns Regarding Dr. Smith

Tiffani died on July 4, 1993, at the age of three months. Her parents were charged with failing to provide the necessaries of life, aggravated assault, and manslaughter. Dr. Smith's report of post-mortem examination, dated January 17, 1994, concluded that the cause of death was asphyxia. Dr. Smith testified at the preliminary hearing into the charges filed against Tiffani's parents that, although the cause of death was undetermined, he was "suspicious" that whatever killed Tiffani was an "asphyxial type of mechanism."[1]

Crown counsel Sheila Walsh thought that Dr. Smith had "severely backtrack[ed]" from his original verbal opinion that Tiffani's death was non-accidental. She commented to another Crown counsel that Dr. Smith's testimony resulted in Crown counsel looking "like a total fool on this case at the end of the day." Ultimately, Tiffani's parents pleaded guilty to failure to provide the necessaries of life.

In 2000, Ms. Walsh stated in an email to another Crown counsel that she approached Dr. Young about Tiffani's case at a Crown conference shortly after the criminal proceedings concluded in May 1995. Ms. Walsh recorded that she "spoke privately to Dr. Young, expressing [her] concerns about Dr. Smith's conduct in [Tiffani's] case," and that Dr. Young responded that "he was planning to have a meeting about [Tiffani's] case." Ms. Walsh never heard anything more about the matter. In a subsequent memorandum in 2003, she again reported this conversation, but, by then, she did not recall with whom at the OCCO she had raised her concern.

Dr. Young and Dr. Cairns both told the Inquiry that they were not aware of Ms. Walsh's concerns about Dr. Smith's conduct in Tiffani's case. Whether Ms. Walsh spoke to Dr. Cairns, Dr. Young, or another OCCO official need not be resolved. The important point is that the OCCO did not have a system to collect,

[1] See Appendix 28 at the end of Volume 4 for summaries of the 20 cases that the Review Panel found problematic.

track, and resolve concerns received from either Crown counsel or defence counsel regarding the work of pathologists performing forensic autopsies. This gap made it difficult to investigate and respond to such concerns in an efficient and coherent way. Although not all concerns will prove well founded, it is essential that they be investigated, given the important role that pathologists play in the criminal justice system.

Although he testified that he was not aware of Ms. Walsh's specific concerns, Dr. Cairns indicated at the Inquiry that, on four or five other occasions, he was alerted to the fact that Dr. Smith "would be stronger in his opinion when he would be talking at an early stage and then he would weaken that opinion in … court." Dr. Cairns spoke with Dr. Smith a number of times about the concern that he sometimes provided different information at the time when charges were laid and when he later testified at trial. In response, Dr. Smith usually countered that he had received more information by then or that the police had misunderstood his original opinion. Dr. Cairns told Dr. Smith that he should have contacted Crown counsel before the trial to report that he had changed his opinion because of new information. Dr. Cairns was right. He did not, however, document any of his concerns or his conversations with Dr. Smith.

In Chapter 8, Dr. Smith and the Practice of Pediatric Forensic Pathology, I review the serious problems that can arise when pathologists do not commit their opinions to writing, including the possibility for significant misinterpretation of those opinions by police officers and Crown counsel. The fact that Dr. Cairns had to address such concerns more than once with Dr. Smith was a warning sign. The repeated nature of the problem should have resulted in a more formal response than the occasional undocumented discussion.

September 1996: Baby X's Case

Baby X's case is a clear example of a situation where Dr. Cairns failed to provide necessary oversight of Dr. Smith. Instead, he permitted Dr. Smith to abandon his appropriate role as an expert scientist and to assist a police investigation improperly. In this case, Dr. Cairns and Dr. Smith had attended case conferences with the police in April and May 1996 and knew that Baby X's mother was a person of interest in the police investigation. Subsequently, Baby X's mother contacted Dr. Cairns to inquire about the results of the autopsy. Dr. Cairns asked Dr. Smith to meet with Baby X's mother, and Dr. Smith agreed. On September 4, 1996, because of their lawful surveillance of her home, the Ontario Provincial Police (OPP) intercepted a telephone conversation between Dr. Smith and Baby X's mother and learned that Dr. Smith intended to meet with the mother at her home. The

OPP then told Dr. Smith that the police had installed listening devices in the home, which would likely intercept the scheduled conversation. Although it is not clear when Dr. Cairns learned that the house was under surveillance, he certainly knew that fact before Dr. Smith met with Baby X's mother. Despite this knowledge, he did not object to Dr. Smith going forward with the meeting.

In short, Dr. Cairns permitted Dr. Smith to attend at a suspect's house and discuss the contents of the report of post-mortem examination with her while the police secretly recorded their conversation. Dr. Smith met with the Barrie Police Service and the OPP before and after his meeting with Baby X's mother on September 5, 1996. The police did not tell Dr. Smith what to do during his meeting with Baby X's mother, nor did they ask him to solicit any information from her. Nonetheless, with Dr. Cairns' approval, Dr. Smith improperly furthered a police investigation.

Several of the forensic pathologists and coroners who testified at the Inquiry emphasized that it is inappropriate for a pathologist to meet with a person who is a suspect in an ongoing police investigation. The effect of that inappropriate meeting was compounded because the conversation was being intercepted by the police. Dr. Cairns and Dr. Smith compromised the independence of their respective positions as Deputy Chief Coroner and expert witness. This case was a warning sign about Dr. Smith's failure to understand the appropriate role of a pathologist in a criminally suspicious case. Dr. Cairns did not recognize the warning sign and, indeed, permitted the meeting to go ahead.

February 1997: Dr. Young Learns of Justice Dunn's Criticisms

In February 1997, Dr. Young met with C. Michéle Mann, an investigator with the CPSO, to discuss a complaint made by D.M., the father of S.M., regarding the conduct of Dr. Smith and two other SickKids physicians who had been involved in Amber's case. Dr. Young and Ms. Mann both testified at the Inquiry about their meeting. They agreed that they discussed Amber's case in general and some of D.M.'s outstanding questions about elements of the coroner's investigation, such as the order for exhumation and the Chief Coroner's authority to involve a pathologist in an investigation. However, they disagreed about what else they discussed during their meeting.

Ms. Mann testified that, at the outset of the meeting, she reviewed Amber's case with Dr. Young to provide him with some background about D.M.'s complaint. She specifically recalled discussing with Dr. Young the fact that several international witnesses had testified and contradicted Dr. Smith, and that Justice Dunn's decision "had also been very critical of the actions of Dr. Smith in the

investigation of Amber's death." Ms. Mann testified that she was surprised when Dr. Young said he felt "very strongly that S.M. had killed this child." Ms. Mann did not know if Dr. Young had previously read Justice Dunn's decision, but he did not seem surprised by any of the information she provided. He did not ask her any further questions or for a copy of Justice Dunn's decision.

Dr. Young recalled that his meeting with Ms. Mann in February 1997 focused primarily on the specific issues raised by D.M. in his complaint, such as the ordering of the exhumation and the role of coroners and pathologists. He was already aware that Dr. Smith had been criticized in Amber's case for losing an X-ray.[2] While he and Ms. Mann may have discussed criticism of Dr. Smith and other evidence in court, he understood that the trial was "hard fought" and that one or two witnesses had testified that shaken baby syndrome did not exist. His meeting with Ms. Mann did not alter his understanding.

I find that, although Ms. Mann told Dr. Young about the trial of S.M. and specifically that Justice Dunn's judgment was highly critical of Dr. Smith, Dr. Young did not really appreciate the significance of what she told him. His views were coloured by his belief in Dr. Smith's status as the leading pediatric forensic pathologist in the province, by Dr. Smith's misleading account of that trial, and by his own entrenched misunderstanding of the case. Because he did not approach the meeting with the openness and objectivity one expects of an overseer, it did not change his mind about the importance of the judgment. Another opportunity to address the concerns identified by the judge was lost.

Mid- to Late 1990s: General Complaints about Dr. Smith

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

In the late 1990s, Dr. Smith often failed to return telephone calls from police, coroners, and regional coroners and, in so doing, impeded the efficient function-

[2] Justice Dunn in fact criticized Dr. Smith for failing to order complete X-rays. In his responses to the CPSO, Dr. Smith stated that the X-rays were taken but had been misplaced.

ing of the criminal justice system. When people could not get in touch with Dr. Smith, they often contacted Dr. Cairns, who appeared to have the most success in reaching him. Dr. Smith returned Dr. Cairns' calls in a timely fashion. Dr. Cairns exercised a supervisory role toward Dr. Smith in this respect, and he told Dr. Smith that he needed to be more responsive and return telephone calls. Dr. Smith replied that he was very busy and would do his best. However, complaints about Dr. Smith's responsiveness continued, and, despite their frequency, Dr. Cairns did not put his concerns about responsiveness to Dr. Smith in writing.

As I describe in Chapter 8, Dr. Smith and the Practice of Pediatric Forensic Pathology, Dr. Smith frequently did not provide his reports of post-mortem examination to the participants in the criminal justice system in a timely fashion. Police officers raised concerns with the OCCO about the timeliness of Dr. Smith's reports and sometimes asked Dr. Cairns to contact Dr. Smith. On some occasions in the mid- to late 1990s, subpoenas had to be issued to get Dr. Smith to respond.

General concerns about Dr. Smith's delays were sometimes expressed at meetings of the OCCO's senior management group. Difficulties with delay were not unique to Dr. Smith, but his problems were much more significant than those of other pathologists.

Regional coroners discussed Dr. Smith's delays at a number of their own meetings, and they approached Dr. Cairns about Dr. Smith's lack of responsiveness to inquiries and his failure to produce reports in a timely fashion. These complaints increased over time. Dr. Cairns eventually told the regional coroners to consider sending consultation requests elsewhere in light of the significant delay in getting reports from Dr. Smith.

Although the OCCO did not have a system or central mechanism to track outstanding reports, nor any guidelines for turnaround times of reports of post-mortem examination, these complaints from members of the death investigation team alerted the OCCO, certainly by 1994, to Dr. Smith's chronic lateness in producing reports, even after repeated requests. As Dr. Young described at the Inquiry, the OCCO faced a "chronic problem with Dr. Smith about lateness and tardiness and pulling reports out of him."

Dr. Cairns and Dr. Chiasson attempted to address concerns about the timeliness of Dr. Smith's reports through a series of meetings with Dr. Lawrence Becker, a neuropathologist who was pathologist-in-chief and the chief of the Department of Pediatric Laboratory Medicine at SickKids. They understood from Dr. Smith that his reports were delayed because of inadequate secretarial support. They met with Dr. Becker about this issue because Dr. Smith continued to tell them he did not have proper administrative support and would prefer an arrangement where he had a dedicated secretary. Over a number of years, Dr. Cairns and Dr. Chiasson

suggested that Dr. Smith be provided with a dedicated assistant. SickKids did not do so, and the OCCO did not insist. Although we now know that lack of secretarial assistance was not a factor in Dr. Smith's timeliness problems, the OCCO was not aware of that at the time.

The OCCO tried to address Dr. Smith's delay problems through one-on-one conversations. On occasion, Dr. Young told Dr. Smith to "get going" on his reports. Dr. Cairns often called Dr. Smith to urge him to complete a particular delayed report of a post-mortem examination. Dr. Cairns and Dr. Young did not document their attempts to address concerns directly with Dr. Smith. The OCCO believed that Dr. Smith's expertise was unique and invaluable, and it felt it needed to keep using him despite his delays. It considered that continuing to use Dr. Smith – while pushing him to rectify critical delays that might affect court cases – was better than not having him perform coroner's autopsies at all.

Although the OCCO did not have the ability to track turnaround times on any particular report of post-mortem examination, the OCCO had more than enough data to know of Dr. Smith's problems in completing reports in a timely fashion. Given the frequency of the complaints and the seriousness of the problem, Dr. Young and Dr. Cairns should have done more to address Dr. Smith's chronic delays. It is true that the problem was complicated by the facts that Dr. Smith was not an employee of the OCCO, they had few administrative or disciplinary sanctions available to them, and very few pathologists were willing to do forensic work, much less pediatric forensic work. Nevertheless, over time, Dr. Smith's delays lengthened, and the price paid for his delays rose.

Summer 1997: Nicholas' Case

Nicholas' case represents a particularly troubling example of how the organizational weaknesses of the OCCO, together with errors in judgment by Dr. Young and Dr. Cairns, combined to prevent meaningful oversight of Dr. Smith.

Although Nicholas died on November 30, 1995, in Sudbury, Ontario, Dr. Smith did not become involved until he produced a consultation report dated January 24, 1997, for the PDRC. Dr. Smith concluded that, "In the absence of an alternative explanation, the death of this young boy [was] attributed to blunt head injury."

In May 1997, Dr. Cairns attended a meeting with Dr. Smith, the regional coroner, and the Sudbury police at which he and Dr. Smith told the police that the case was being classified as sudden unexplained death syndrome (SUDS) and that an exhumation was necessary to determine whether the cause of death was head trauma. Dr. Cairns subsequently wrote to the Sudbury police and indicated that

both he and Dr. Smith believed that Nicholas died of a head injury in highly suspicious circumstances. Dr. Cairns stated that disinterment was necessary to clarify the issue. He did not involve Dr. Chiasson in the decision to recommend disinterment in Nicholas' case. Indeed, Dr. Chiasson did not become involved in the case until the CAS proceedings in the year following the disinterment.

The exhumation and second autopsy occurred on June 25, 1997. Dr. Smith took his 11-year-old son to the disinterment. In 1998, Maurice Gagnon, Nicholas' grandfather, complained to the CPSO about Dr. Smith's conduct in this respect. In October 1998, the CPSO declined jurisdiction over the matter and forwarded the complaint to the OCCO. Dr. Cairns and Dr. Young consulted with Dr. Smith, who explained that he had taken his son to Sudbury with him to help him stay awake on the drive and had nowhere to leave him during the disinterment. Dr. Cairns told Dr. Smith it was inappropriate for his son to have attended the disinterment. Subsequently, Dr. Young wrote to Nicholas' grandfather, provided Dr. Smith's explanation for the incident, and apologized.

Dr. Smith prepared a report of post-mortem examination dated August 6, 1997, which concluded that the cause of death was cerebral edema consistent with blunt force injury. He added that, "[i]n the absence of a credible explanation, in my opinion the post-mortem findings are regarded as resulting from non-accidental injury." During a meeting between Crown counsel, Dr. Smith, and the police in November 1997, those present determined that, if criminal charges were laid, an acquittal would be inevitable. They felt that Dr. Smith's particular wording suggested that a credible explanation (and hence a reasonable doubt) might well be available on the evidence. Despite this decision, Dr. Cairns told the Inquiry that he maintained complete confidence in Dr. Smith and was not troubled by Dr. Smith's conclusions in the case.

The local children's aid society (CAS) became involved with Nicholas' family in 1998, when Nicholas' mother became pregnant. On April 7, 1998, Dr. Cairns attended a case conference with the CAS in which he said that Nicholas had died of cerebral edema, not of sudden infant death syndrome (SIDS). The following month, on May 7, Dr. Cairns and Dr. Smith attended another case conference with the CAS. In a subsequent affidavit, a CAS social worker swore that, during this meeting, Dr. Smith said he was "99% certain that this child died due to a non-accidental trauma that had been inflicted on the child by the sole caregiver, being the mother." At the Inquiry, Dr. Cairns did not dispute this statement, and recalled that Dr. Smith had a very high degree of certainty about his conclusions. Dr. Cairns shared Dr. Smith's opinion that it was a non-accidental injury. Later in May 1998, the CAS decided to make a protection application for Crown wardship of the unborn child of Lianne Gagnon, Nicholas' mother.

On June 16, 1998, Dr. William Halliday, a Winnipeg neuropathologist, swore an affidavit on behalf of Nicholas' mother in the CAS proceedings. He commented that Dr. Smith's conclusions "went far beyond the boundaries that can be supported by the presenting scientific and forensic facts." Dr. Chiasson reviewed Dr. Halliday's first opinion and discussed it with Dr. Cairns, but he let Dr. Cairns take the lead. Dr. Cairns was not persuaded by Dr. Halliday's affidavit. Instead, he was influenced by Dr. Smith's reputation, stating that, "at this time Dr. Smith was the eminent pediatric pathologist; not only in Ontario but across much of Canada." He did not know Dr. Halliday by reputation but was aware that Dr. Halliday did not practise in pediatrics.

On June 16, 1998, after receiving Dr. Halliday's affidavit, the CAS contacted Dr. Cairns and Dr. Smith and asked whether Dr. Halliday's opinion that there was no evidence of cerebral edema resulting from a blunt head injury was medically reasonable. According to CAS counsel, Dr. Cairns and Dr. Smith "were extremely clear … that the theories put forth by Dr. Halliday were not sustainable and the position of the Coroner's Office had not changed relative to the cause of death."

The very next day, CAS counsel Réjean Parisé faxed an excerpt from Justice Dunn's reasons in Amber's case to Dr. Cairns. In that excerpt, Justice Dunn criticized Dr. Smith's approach and concluded that Dr. Smith refused to consider causes of death other than shaking. Justice Dunn also found that Dr. Smith provided insufficient detail in the report of post-mortem examination, failed to consult with other specialists before conducting the autopsy, and was not aware of new research that had been published on short falls, which was a central issue in Amber's case. Dr. Cairns read the excerpt from Justice Dunn's decision sent to him by Mr. Parisé.

Despite Justice Dunn's pointed criticisms, Dr. Cairns neither obtained a full copy of the decision nor took any other steps to investigate Justice Dunn's findings. Dr. Young testified that Dr. Cairns did not inform him about the faxed excerpts of Justice Dunn's decision. Dr. Cairns admitted that he was influenced by Dr. Smith's claims that Justice Dunn had changed his mind about the medical evidence after the trial. Essentially, Dr. Cairns accepted Dr. Smith's unlikely story about Justice Dunn without question, even after he read excerpts from Justice Dunn's decision. For the second time, a senior OCCO official had Justice Dunn's reasons highlighted for him, and, for the second time, the OCCO took no action. The failure to take the reasons for judgment seriously represents a significant oversight failure.

Later in June 1998, after the Crown had determined that it could not proceed on the basis of his opinion, Dr. Smith swore an affidavit in the CAS proceedings. He stated that he was very certain that Nicholas' death was due to non-accidental

injury. He thought it was likely due to severe cerebral edema caused by blunt impact to the head, but asphyxia was also a possible cause.

On June 19, 1998, Dr. Cairns also swore an affidavit in the CAS proceedings which included the following statement: "I wholly agree with the specific and crucial findings of Doctor Smith that the cerebral edema suffered by the infant was severe rather than mild as characterized by [the pathologist who performed the initial autopsy]." This affidavit expressed a pathology opinion that Dr. Cairns did not have the expertise to provide. His evidence was based entirely on Dr. Smith's views, and he had not reviewed any of the underlying medical evidence in the case. Dr. Cairns told the Inquiry that, in his affidavit, he intended to indicate only that the OCCO accepted Dr. Smith's opinion. But Dr. Cairns' affidavit went much further than that: it contained what purported to be an expert pathology opinion.

In his affidavit, Dr. Cairns had offered himself as an expert qualified to comment on the specific and crucial findings of severe cerebral edema, and the CAS had prepared its case based on the understanding that Dr. Cairns was going to testify as an expert regarding the pathology findings. The CAS and defence counsel were therefore under the understandable but mistaken impression that Dr. Cairns could provide his own expert opinion evidence about the cause of Nicholas' death. Moreover, the CAS believed, correctly in my view, that Dr. Cairns' status as Deputy Chief Coroner for Ontario would likely bolster the strength of the opinion in court.

Dr. Cairns took no steps to correct the CAS misunderstanding. Rather, he explained the limited nature of his expertise to Berk Keaney, the lawyer for Ms. Gagnon and her spouse, in a meeting in December 1998. Mr. Keaney then took it upon himself to correct Mr. Parisé's misunderstanding.

It is extremely important to the proper functioning of the justice system that experts respect and communicate the limits of their expertise. The failure to do so in this case is one example of the larger systemic issue. Had Dr. Cairns clearly restricted himself to matters within his area of expertise, it is likely that the OCCO or the CAS would have obtained an independent pathology opinion much sooner than it did.

On December 1, 1998, Mr. Parisé wrote to Dr. Cairns and Dr. Smith and suggested that another expert opinion would help to buttress Dr. Smith's opinion. In their December 1998 meeting, Dr. Cairns and Mr. Keaney also discussed that there were differing expert opinions from respected pathologists about whether the head injury was accidental or non-accidental. Only after these suggestions by Mr. Parisé and Mr. Keaney, some six months after Dr. Halliday first drew Dr. Smith's opinion into serious question, did the OCCO finally decide, in or around

January 1999, to obtain an independent opinion to resolve the differences of expert opinion in the case.

Dr. Chiasson assisted Dr. Cairns in obtaining an independent opinion from Dr. Mary Case, an experienced American forensic pathologist with certifications in both forensic pathology and neuropathology and an interest in pediatric head trauma. In her report dated March 6, 1999, Dr. Case concluded that the cause and manner of Nicholas' death should have been designated as undetermined. She said there were no findings to support the conclusion that the death was caused by either a head injury or an asphyxial mechanism. The OCCO accepted Dr. Case's opinion as sound and treated it as final.

The OCCO provided Dr. Case's report to the parties on March 23, 1999. The CAS immediately dropped all proceedings against Ms. Gagnon, vacated all temporary orders, withdrew the child protection application, and withdrew her registration from the Child Abuse Register.

Defence counsel received a further expert report after the CAS proceedings were withdrawn. Dr. Derek de Sa, a professor of pathology at the University of British Columbia, stated that he found it difficult to understand how Dr. Smith reached his conclusions. He commented that he had discussed Nicholas' case with several senior colleagues in his department, and that none of them agreed with Dr. Smith. On May 25, 1999, Mr. Keaney sent Dr. de Sa's report to the OCCO, where it was distributed to Drs. Cairns, Chiasson, and Young. The OCCO did not take any additional measures to respond to Dr. de Sa's report.

In reviewing Dr. Case's opinion, Dr. Chiasson concluded that Dr. Smith had rendered an opinion that exceeded what the evidence allowed. However, he did not sit down with Dr. Smith to discuss the case. He did not feel comfortable with pediatric issues, particularly pediatric neuropathology, and he thought that the case fell within a somewhat grey area. In addition, in Dr. Chiasson's experience, Dr. Smith did not take criticism well. This situation illustrates the difficulty caused by the absence of clear lines of accountability between the Chief Forensic Pathologist and a pathologist doing forensic work. The conflicting professional views in this case called out for a frank professional conversation. It was unfortunate that such a conversation did not occur.

Dr. Cairns testified at the Inquiry that his confidence in Dr. Smith's judgment was not shaken by the OCCO's decision to accept Dr. Case's opinion in Nicholas' case. In light of expert opinions from Dr. Case and Dr. de Sa that Dr. Smith's opinion had no basis in the pathology evidence, this lack of concern is troubling. Dr. Cairns, who witnessed Dr. Smith tell the CAS that he was "99% certain" that Nicholas' mother had killed the child, believed the case reflected only a difference of opinion between respected experts. This scenario underscores the problem of

having coroners without forensic pathology training attempt to provide oversight of forensic pathologists.

By contrast, Dr. Young testified that he became concerned about Dr. Smith's work after the OCCO received Dr. Case's opinion. He stated that it was the first time he was aware of questions about the quality of Dr. Smith's work. To address his concerns, Dr. Young met personally with Dr. Smith and told him that his report in Nicholas' case had gone too far and was not supported by good evidence. He advised Dr. Smith to be more conservative in his views and stay within the mainstream of pathology views. Dr. Young did not want Dr. Smith on the "leading edge" of opinion, and he used the analogy of a tree. He said that Dr. Smith's opinion in Nicholas' case was at the far end of one branch, Dr. Halliday's opinions were in various places on the other side of the tree, and Dr. Case was hugging the tree. Dr. Young told Dr. Smith that the OCCO wanted him hugging the tree from now on. Dr. Young testified that he also spoke with Dr. Smith about the need to improve the timeliness of his reports and to document informal corridor consultations with other experts.

This conversation should have involved the Chief Forensic Pathologist. The problem with Dr. Smith's opinion was not that it was on the leading edge but that there was no pathology evidence to support it. Once again, this case further demonstrates the weakness of a coroner-led system of professional oversight. It also illustrates how the OCCO undervalued the importance of training in forensic pathology and did not involve the Chief Forensic Pathologist in important conversations with pathologists about their practice.

Other than Dr. Young's conversation as described, Dr. Smith was not reprimanded after the conclusion of Nicholas' case. Dr. Young did not put any of his concerns about Dr. Smith in writing. He took no measures to improve Dr. Smith's skills or knowledge, and he created no plan of action to improve the situation.

May 1998: The OCCO Asks the CPSO to Decline Jurisdiction to Investigate Dr. Smith

In meetings, correspondence, and discussions with the CPSO in 1997 and 1998, Dr. Young and Dr. Cairns took the position that the CPSO had no jurisdiction to investigate complaints about the actions of coroners or pathologists arising from their coronial work. By then, the CPSO had received a complaint about Dr. Smith from D.M. in relation to Amber's case. Dr. Young gave two main reasons for opposing the CPSO's jurisdiction. First, he believed that the CPSO was not well equipped to manage certain aspects of pathologists' cases such as court testimony and expert opinions, and he was concerned that the CPSO might be seen to be

second-guessing the courts in some instances. Second, he was worried about exposing pathologists to an extra layer of review. If the CPSO asserted jurisdiction over pathologists, he believed it would be even harder to recruit and retain them to work for the OCCO. The OCCO already faced a serious shortage of pathologists, and he thought that the institution needed to defend its pathologists' work and stand up for them.

In October 1997, the leaders of the OCCO and the CPSO agreed that the CPSO Complaints Committee would handle complaints regarding a coroner's actions that were part of the practice of medicine, but that complaints regarding acts done in the exercise of coronial duties would be referred to the OCCO. If a complainant insisted that the CPSO Complaints Committee deal with the matter, the coroner would reply only to the extent required to establish that the acts complained of were not part of the practice of medicine, but were performed in the exercise of coronial duties. At that point, the Complaints Committee could dismiss the matter and refer it to the OCCO. If a complainant appealed this outcome, the CPSO and OCCO agreed they would work cooperatively in submitting to the body hearing the appeal that the OCCO should handle the matter.

When it came to pathologists, Dr. Young took the position in a letter to the CPSO dated March 4, 1998, that the CPSO had no jurisdiction to deal with complaints about a pathologist acting under the *Coroners Act*. That same year, the OCCO and the CPSO agreed that, in all likelihood, an assertion of lack of jurisdiction on the part of the CPSO regarding pathologists performing coroner's autopsies would fail legally. However, due to shortages of pathologists willing to perform coroner's cases, Dr. Young felt compelled to appear to protect pathologists. The CPSO also wanted to avoid duplication of work created by multiple forums. The OCCO and the CPSO agreed not to end up in court fighting about the CPSO's jurisdiction over pathologists and decided that, at the first instance, complaints received by the CPSO regarding the actions of a pathologist as an agent of the coroner would be referred to the OCCO.

In general, Dr. Young was right to be concerned about the shortage of forensic pathologists in Ontario. The scarcity of these professionals was, and is, a major systemic issue in the province. The shortage influenced the way in which the OCCO dealt with many issues related to pathology, not for the better. On this issue, however, focusing on the shortage issue came at the expense of maintaining public confidence in the system through the accountability that comes with requiring pathologists to answer to an independent regulator.

The CPSO could provide an independent and objective investigation of complaints about pathologists. Resisting this oversight was unfortunate and only exacerbated the organizational weaknesses of the OCCO. That is particularly so

because the OCCO itself had no adequate and independent mechanism in place to address complaints about pathologists. The CPSO was much better equipped to handle such complaints.

In May 1998, the CPSO Complaints Committee decided that it had no jurisdiction over D.M.'s 1991 complaint against Dr. Smith because the latter's involvement in Amber's case arose through his coroner's work. On June 16, 1998, D.M. requested a review of the CPSO's decision by the Health Professions Appeal and Review Board (HPARB). On September 1, 2000, the HPARB issued its decision and held that the CPSO had jurisdiction over the matter and referred the complaint back to the Complaints Committee for further investigation.

February to May 1999: Mr. Gagnon's Complaint to the Coroners' Council

In February 1999, Mr. Gagnon, Nicholas' grandfather, submitted a 20-page complaint about Dr. Smith to the Coroners' Council, a body that dealt with significant complaints about the work of coroners. It had been disbanded, however, on December 18, 1998, when the legislature repealed its statutory foundation – ss. 6 and 7 of the *Coroners Act* – and no independent mechanism remained to address complaints about coroners. Dr. Young therefore responded personally to the complaint. At the Inquiry, he testified that he would normally have forwarded a complaint about the substance of a pathologist's work to the Chief Forensic Pathologist. However, he did not refer this complaint, which included a number of specific criticisms of Dr. Smith's pathology findings, to Dr. Chiasson, nor did he delegate the investigation to any of his staff. Indeed, there is no evidence that Dr. Young took any measures to investigate the details of Mr. Gagnon's concerns about Dr. Smith's practices in Nicholas' case. At the Inquiry, Dr. Young testified that it was not possible for him to respond to every aspect of a detailed complaint. He said that complainants often tried to "mess facts together" regarding different cases that were not directly relevant to their complaints. It was, he said, his regular practice to skip sections of complaints which he deemed irrelevant.

Mr. Gagnon's complaint outlined several concerns about Dr. Smith's conduct in Nicholas' case, including the exaggeration of findings of "mild diastasis" into "widely split skull sutures," reliance on undocumented "corridor" consultations, contradictory findings regarding scalp injury, and identification of post-mortem artefacts as abnormal findings. He also referenced Justice Dunn's decision in Amber's case and included lengthy quotations from the judge's findings and criticisms of Dr. Smith.

At the Inquiry, Dr. Young testified that he had no recollection of reading the

section of Mr. Gagnon's complaint quoting Justice Dunn's decision. He thought it most likely that he skipped that section because its subtitle, "Precedent (Crown vs [S.M.]," indicated to him that it concerned a case other than Nicholas' case and was not relevant to Mr. Gagnon's complaint.

On May 6, 1999, after the CAS proceedings concluded, Dr. Young responded to the complaint from Mr. Gagnon. Before sending the letter, he circulated his draft to Dr. Cairns and Dr. Chiasson, Dr. Bonita Porter, the Deputy Chief Coroner of Inquests, as well as OCCO legal counsel Al O'Marra and Ed Maksimowski. In his response, Dr. Young stated that he had read Mr. Gagnon's complaint "in detail" and considered it very carefully. He said he had met with Dr. Smith to discuss the complaint and explained to Mr. Gagnon that "[t]he variety of opinions held by Drs. Halliday, Case, and Smith, clearly illustrates the complexity of the pathology in this case. What all seem to be agreeing upon at this point, and it is also the view of our office that the cause of the death of [Nicholas] is appropriately classified as 'undetermined.'"

Dr. Young told Mr. Gagnon that the previous month, on April 12, 1999, together with Dr. Chiasson, he had distributed Memorandum 99-02, "Forensic Pathology Pitfalls," to all coroners and pathologists. It had been prepared in part as a result of the complaint, and it addressed the importance of pathologists staying within the limits of their expertise and documenting their consultations. In Nicholas' case, where Dr. Smith had failed to record his consultations with a SickKids neuropathologist, the OCCO recognized that such gaps in documentation, especially in forensic cases, can cause significant problems.

However, Dr. Young could not assure Mr. Gagnon that the OCCO had dealt with the central issue arising in Nicholas' case from the perspective of its oversight responsibilities for Dr. Smith – the absence of pathology evidence to support his opinion. Such an evaluation of Dr. Smith's work had simply not been done.

Dr. Young's response contained some regrettable and significant inaccuracies. He stated that, as soon as the OCCO became aware of Dr. Halliday's opinion, the OCCO requested an opinion from a third independent forensic pathologist. In fact, the OCCO did not contemplate consulting with an independent expert until Mr. Parisé and Mr. Keaney raised the issue six months after Dr. Halliday's first opinion. In addition, Dr. Young stated that he had read Mr. Gagnon's complaint "in detail" and considered it very carefully. That was not true. Dr. Young testified at the Inquiry that he probably skipped the portion of the complaint that quoted from Justice Dunn's decision.

I found Dr. Young's testimony on this issue very troubling. He insisted that the CPSO should defer to the OCCO to investigate these complaints. Yet his actions displayed a serious disregard for his responsibility to read, investigate, and

respond fairly to complaints from the public. He did not give Mr. Gagnon's complaint the attention it deserved.

February to May 1999: Sharon's Case

At the same time that Dr. Young and Dr. Cairns were responding to Mr. Gagnon's complaint about Dr. Smith, they also learned that several leading experts disagreed with Dr. Smith's opinion in Sharon's case and had concerns that it was creating the possibility of a miscarriage of justice.

Dr. Cairns and Dr. Young became actively involved in Sharon's case in mid-February 1999, when they attended a meeting of the American Academy of Forensic Sciences (AAFS). Dr. Young told the Inquiry that, during the meeting, Dr. Michael Baden, forensic pathologist and the former Chief Medical Examiner of New York City, expressed his understanding to Dr. Young that some experts held the opinion that a dog had caused the injuries in Sharon's case. Dr. Baden's colleague Dr. Lowell Levine, a forensic odontologist, was also aware of the case. Dr. Young then ran into Dr. Robert Dorion, a forensic odontologist from Montreal who had been consulted by defence counsel for Sharon's mother. Dr. Dorion believed that a dog had caused Sharon's injuries. Dr. Cairns also learned that Dr. James (Rex) Ferris, a British Columbia forensic pathologist, had been consulted by defence counsel for Sharon's mother and disagreed with Dr. Smith's opinion. The four experts all questioned Dr. Smith's finding that the cause of death was exsanguination secondary to multiple stab wounds and thought that a miscarriage of justice might be occurring in the case. Dr. Young was concerned that the experts had such "polar opposite" positions to those of the OCCO experts.

Dr. Cairns and Dr. Young decided that they needed to obtain an independent appraisal of the evidence. In this respect, the OCCO's approach to conflicting expert opinions in Sharon's case differed from its initial approach in Nicholas' case. In Sharon's case, to its credit, it reacted very quickly. According to Dr. Cairns, the difference was that the experts who expressed concerns about Sharon's case were "heavy hitters." They all had excellent reputations and were more qualified than Dr. Smith to differentiate stab wounds from dog bites.

After the February 1999 AAFS meeting, Dr. Cairns met with Dr. Smith, Dr. Chiasson, Dr. Robert Wood, a forensic odontologist who had provided an opinion to Crown counsel in Sharon's case concluding that Sharon's wounds were "unequivocally" not dog bites, and Barry Blenkinsop, Chief Pathologist Assistant at the OCCO, who had assisted Dr. Smith during the initial autopsy. Dr. Cairns stated that they needed to address the allegation of a possible miscarriage of jus-

tice. At the meeting, Dr. Wood, Dr. Smith, and Mr. Blenkinsop maintained that a dog did not cause any of Sharon's wounds. Nonetheless, everyone present at the meeting agreed that an exhumation and second autopsy were needed to rule out dog involvement once and for all.

Dr. Chiasson testified at the Inquiry that he saw himself as a mediator at the 1999 meeting regarding a possible disinterment. He had limited experience with dog bites and did not feel he could challenge the opinions of the other experts, all of whose work he respected. Dr. Smith, in particular, seemed clear and firm in his opinion and had conducted the post-mortem examination, which put him in the best position to examine the wound tracks.

Dr. Cairns, Dr. Chiasson, and Dr. Benoit Béchard, the regional coroner, met with Crown counsel and the police in Kingston on March 29, 1999. The OCCO informed Crown counsel and the police about the differences of opinion between the various pathologists and odontologists. Dr. Cairns told Crown counsel and the police that, in his opinion, an exhumation and second autopsy, in the presence of the defence experts, were necessary to resolve the issue. Everyone agreed.

When they were considering the possibility of exhumation, Dr. Cairns reviewed the transcript of Dr. Smith's testimony at the preliminary hearing. At that hearing, Dr. Smith had expressed very strong opinions and was highly dismissive of the possibility of a dog attack. He ridiculed the possibility of a dog attack by equating it with being as likely as the possibility of a polar bear attack.

Dr. Cairns also knew that Dr. Smith had lost a cast of Sharon's skull and a set of X-rays from the first post-mortem examination (although they appear not to have been of evidentiary value). That Dr. Smith had lost these materials was a sign of his disorganization, carelessness, and sloppiness. However, the OCCO believed the evidence in question was unimportant and therefore did nothing about it. This, of course, misses the point – the losses were symptomatic of Dr. Smith's larger failings.

Before the meeting in Kingston, Dr. Chiasson had reviewed Dr. Smith's report of post-mortem examination in Sharon's case for the first time. The report had originally bypassed his regular review process because, after a significant delay necessitating the issuance of a subpoena to Dr. Smith, Dr. Smith provided it directly to Crown counsel. When Dr. Chaisson did finally review it in 1999, he thought that the injuries, in particular the internal wound tracks, were not well defined or described, and that the wound depths were not properly delineated. Dr. Chiasson communicated this information to Crown counsel and the police, and it was used in the application for the disinterment. However, he never discussed his concerns with Dr. Smith. He did not take any measures to address Dr. Smith's report-writing skills or his ability to describe wounds. As Chief Forensic

Pathologist, Dr. Chiasson should have taken this task on as part of his responsibility for the quality of forensic pathology in the province. However, the lines of responsibility and accountability were so blurred that this remedial oversight did not happen.

May 1999: Dr. Porter's Contrary Conclusion in Jenna's Case

The OCCO missed another important warning signal in May 1999 when Dr. Porter reached a conclusion about the timing of the injuries in Jenna's case that was very different from Dr. Smith's opinion.

Jenna died in the early morning hours of January 22, 1997. Dr. Smith, who performed the autopsy, told the police that the cause of death was blunt abdominal injury. Dr. Cairns and Dr. Young attended meetings with the police and Dr. Smith in the initial stages of the investigation. The major issue to be resolved was the timing of the non-accidental fatal injuries. At these meetings, Dr. Smith told the police that Jenna's injuries were sustained within 24 hours of her death. In October 1998 at the preliminary hearing, Dr. Smith indicated that the fatal injuries could have occurred some 24 or 28 hours before death.

After the preliminary hearing, the defence retained Dr. Sigmund Ein, a staff surgeon at the Division of General Surgery at SickKids, who concluded that Jenna sustained her fatal injuries no earlier than six hours before death. In December 1998, contrary to the thrust of his confusing testimony at the preliminary hearing, Dr. Smith agreed with Dr. Ein that the fatal injury occurred on the evening of Jenna's death. Defence counsel passed this information on to Crown counsel, who in turn contacted the OCCO.

Dr. Porter agreed to review the case and provide an opinion on the timing of the fatal injuries. Dr. Chiasson was not asked to provide an opinion in the case, or to review Dr. Porter's opinion, even though the timing of injuries is also a forensic pathology issue. On May 26, 1999, Dr. Porter provided her opinion, based both on her expertise as a clinician and in some part on the opinions of pathology experts, that the time between Jenna's injuries and her death was less than six hours. On June 15, 1999, Crown counsel withdrew the second-degree murder charge against Jenna's mother because the medical evidence could not substantiate that she had care of Jenna at the time of the fatal injuries.

The fact that the Deputy Chief Coroner of Inquests had reached such a different opinion from Dr. Smith, albeit from a clinical, not a forensic pathology, point of view, should have triggered some form of review at the OCCO. At the very least, Dr. Porter's opinion should have been forwarded to the Chief Forensic Pathologist to compare it with Dr. Smith's. Again, it was one of those occasions

that should have prompted more reflection than it did. Ultimately, it was yet another warning signal that was missed.

It was missed in part because of the organizational weaknesses in the OCCO. The Chief Forensic Pathologist had no role in reviewing such starkly different opinions. There was no quality assurance mechanism in place to attempt to identify the cause of the controversy or to recommend steps to avoid such mistakes in the future.

Even by the time Dr. Young testified at the Inquiry, he did not see any problems with the pathology evidence provided by Dr. Smith in Jenna's case. He was not concerned that other experts disagreed with Dr. Smith about the timing of the fatal injuries. He testified that he thought it was problematic when experts gave too narrow a window of time, but he was not concerned if an expert provided a window that was too broad. Dr. Young maintained that Dr. Smith was not wrong, given that the injuries were inflicted within 24 hours before death. In his view, Dr. Smith just did not narrow the time period as far as he could have to six hours before death. Dr. Michael Pollanen, the present Chief Forensic Pathologist, testified at the Inquiry that Dr. Young's analysis of Dr. Smith's pathology opinion was simply incorrect. He said that, although it is often the counsel of caution to give a broader window for time of death or the time that injuries were inflicted, this principle does not apply where part of the broader time frame is excluded by the pathology evidence, as was the case here. It is of fundamental importance to identify precisely when the injuries were inflicted wherever that is possible. In this case, the pathology clearly indicated that the fatal injuries were inflicted within hours of death, and that they could not have been inflicted earlier.

Jenna's case illustrates the danger of having coroners providing oversight of pathologists who are doing forensic work. This structural weakness contributed greatly to the failure of oversight with regard to Dr. Smith. Without the training in forensic pathology necessary for meaningful oversight of pathologists, Dr. Young and Dr. Cairns simply could not see this red flag.

July to September 1999: The Exhumation in Sharon's Case

The exhumation and second autopsy of Sharon occurred on July 13, 1999. Dr. Chiasson conducted the autopsy, and Dr. Smith, Dr. Wood, Dr. Ferris, and Dr. Dorion also attended. Mr. Blenkinsop was the autopsy assistant. Dr. Young attended part of the autopsy. Dr. Chiasson signed his report on September 30, 1999. He concluded: "Based on the findings of this second post-mortem examination and my review of Dr. Wood's report, it is my opinion that: 1. a dog was responsible for at least some of the injuries sustained by the decedent and 2. the

possibility that a weapon was also involved in the infliction of the injuries is not excluded by this second post-mortem examination." Dr. Chiasson accepted Dr. Wood's opinion contained in his September 13, 1999, report that a dog had caused at least some of the injuries to Sharon's skull, neck, and left upper arm. Dr. Wood also concluded that there were markings on the bones that were not consistent with dog bites. Dr. Chiasson deferred to Dr. Wood's expertise in the evaluation of bone because he did not consider bone injuries to be within his area of expertise.

In his supplementary report, which he did not complete until February 14, 2000, Dr. Smith concluded that, "[b]ecause death resulted not from a single injury but the combined effect of numerous injuries, it is not possible on morphologic grounds alone to determine the relative responsibilities of the non-canine versus the canine-like injuries in causing Sharon's death." In September 2000, Dr. Smith and Dr. Wood met with the Kingston police and Crown counsel. Dr. Smith continued to maintain that, although most of the wounds were attributable to dog bites, there were other serious wounds, especially in the thoracic inlet, that were not caused by an animal. Dr. Wood also maintained that some of the wounds were not animal related.

These new opinions differed dramatically from Dr. Smith's initial opinion that none of the wounds on Sharon's body had been caused by an animal and that it was absurd to suggest otherwise. Over time, Dr. Smith's adamant opinion that Sharon died from stab wounds had been gradually undermined by contrary expert opinions. Eventually, even Dr. Smith had to acknowledge and accept the opinions of the opposing experts.

Dr. Chiasson testified that, even though he had conducted the second autopsy, he was not comfortable providing an opinion in Sharon's case. He had limited experience with dog bites. He felt he was in a position of conflict because of his ongoing professional relationships with Dr. Wood, Dr. Smith, and Mr. Blenkinsop. He felt he had been forced into the middle, with credible opinions on either side of the issue. Dr. Chiasson was correct to be concerned about his ongoing professional relationships. In the absence of defined lines of accountability from pathologists to the Chief Forensic Pathologist, he was in a challenging position.

After the second autopsy, Dr. Chiasson did not discuss the case with Mr. Blenkinsop, Dr. Wood, or Dr. Smith. Between the second autopsy and the eventual withdrawal of the charge in January 2001, he never spoke to Dr. Smith directly about the case. Despite his difficult position, this omission was unfortunate. Dialogue among experts, especially over matters of controversy or disagreement, is an essential part of a professional, high-quality, forensic pathology service.

The results of the second autopsy represent another missed warning sign. The OCCO should have been deeply concerned by the fact that the results of the second autopsy were so different from Dr. Smith's initial opinion on cause of death and his testimony at the preliminary hearing. This discrepancy, like the changed opinions in Jenna's case, should have triggered a more formal review at the OCCO. The OCCO now had evidence available to it that, viewed objectively, raised concerns about Dr. Smith's work in the cases involving Amber, Nicholas, Jenna, and Sharon. But this evidence was discounted, minimized, or missed altogether.

Instead, Dr. Young and Dr. Cairns continued to maintain their confidence in Dr. Smith's abilities even after his opinion unravelled, attributing Dr. Smith's errors to a "team failure." Dr. Cairns concluded that Dr. Smith's alarmingly overstated opinions at the preliminary hearing were less of a concern because Dr. Smith may have relied on Dr. Wood's and Mr. Blenkinsop's strong opinions to bolster his own. Once again, Dr. Cairns and Dr. Young failed to take any corrective steps regarding Dr. Smith. They exercised no oversight and required no accountability from Dr. Smith.

November 1999: *the fifth estate* Program

On November 10, 1999, CBC Television's *the fifth estate* aired a program about Dr. Smith which focused on his work in the cases of Nicholas, Amber, and Sharon. Dr. Cairns agreed to be interviewed for the program. He told *the fifth estate* that Dr. Smith was "top notch" and had been doing forensic pathology since 1990. He defended Dr. Smith's credentials in forensic pathology, telling the interviewer that Dr. Smith had his American fellowship in pediatric pathology and that a significant amount of the pediatric pathology sub-specialty exam dealt with forensic pathology. In his own evidence at the Inquiry, Dr. Smith contradicted this assessment and explained that, although the American exam included some questions about forensics, "they were focused on the medical aspects of pediatric forensic pathology."

The fifth estate program discussed Amber's case and Justice Dunn's reasons for judgment acquitting S.M. It reiterated Justice Dunn's strong criticism of Dr. Smith for failing to consider possibilities other than shaking in Amber's case, and expressed concerns that Dr. Smith's assumptions might have coloured his approach to the facts. During his interview on the program, Dr. Cairns commented on Justice Dunn's decision: "I, with due respect, feel that the medical evidence was confusing and that the judge may not have clearly understood all the evidence that was being given." When he gave the interview, Dr. Cairns had

not even read Justice Dunn's full reasons for judgment or the court transcripts. He had not discussed the case with any pathologist other than Dr. Smith. Dr. Cairns concluded that Justice Dunn did not understand all the evidence solely because of what Dr. Smith told him. He was not in a position to comment independently and objectively on the decision, and he ought not to have criticized Justice Dunn's decision based solely on Dr. Smith's opinion. Any reasonable viewer of the program would have assumed (wrongly) that the OCCO had investigated this case before defending Dr. Smith and blaming the judge for getting it wrong.

Dr. Cairns watched *the fifth estate* program when it aired in 1999 and heard the interview with Dr. Case, the independent expert retained by the OCCO in Nicholas' case. Dr. Case said that Dr. Smith's statement that the death was caused either by a head injury or by asphyxia by strangulation was "in the area of irresponsible testimony." This comment did not shake Dr. Cairns' confidence in Dr. Smith's opinion. He thought it was merely another example of experts disagreeing.

Dr. Chiasson also watched *the fifth estate* broadcast. In his opinion, the OCCO was already aware of the issues and criticisms being raised in the broadcast and, consequently, the story did not change the OCCO's approach to Dr. Smith.

Dr. Young testified at the Inquiry that, because he was away when *the fifth estate* episode aired, he did not see it, nor did he make any effort to watch it on his return. He "was not a particular fan of *the fifth estate*," and he did not think the program "represent[ed] the finest in Canadian journalism." Dr. Young stated that nobody asked him specifically about the program, no other media outlets picked up the story, and he had heard there was nothing new in it. As he did not think it contained anything "new or significant," he concluded that he had no reason to watch it. He did not take any action about the story because "no Crown attorney, no defence attorney, no police officer, no one called me and said, 'All these things are going on. We want a review of Dr. Smith.'"

This reaction was unwise. Dr. Young was the Chief Coroner for Ontario, responsible for the OCCO. *The fifth estate* program had seriously criticized one of the experts on whom the OCCO most strongly relied. Rather than assess the information provided by the program himself, Dr. Young chose to rely on his own sense of the community's reaction to the information in the program and on his own absolute faith in Dr. Smith. He owed it to his office to take the program more seriously.

In February 2000, Dr. Smith sued the CBC over *the fifth estate* program. Even though he never bothered to watch the program, Dr. Young requested that the Ministry of the Solicitor General assist Dr. Smith with the legal fees for his law-

suit, which the ministry did. It is difficult to understand how Dr. Young could make the decision to support Dr. Smith's legal action without having watched the episode. His explanation is that he felt it was important that the ministry support its people because, otherwise, people would not work for the ministry. This request was one of several examples where Dr. Young was willing to use the authority of his office to defend Dr. Smith, justified or not, from any criticisms or damage to his reputation.

March 2000: Mr. Gagnon Complains to the Solicitor General

On March 6, 2000, Mr. Gagnon complained to the Solicitor General about Dr. Cairns' conduct in the investigation into Nicholas' death. He alleged that Dr. Cairns erred by failing to review and assess fairly the actual facts of the case and that he was unduly and singularly influenced by the unsustainable opinion of Dr. Smith.

In 2000, there was no structure in place to review independently any complaints about the work of the Chief Coroner or the Deputy Chief Coroner – a gap representing yet another organizational weakness. It was made worse when Dr. Young, who at the time also held the position of assistant deputy minister of public safety in the ministry, prepared the Solicitor General's April 13 reply to the complaint. The reply set out that the OCCO had arranged for an independent review by Dr. Case and, after receiving this opinion, had concluded that no cause of death could be established and that the means of death was undetermined. The OCCO had reviewed Dr. Smith's involvement, the letter continued, and had "concluded that the opinion Dr. Smith came to was within a reasonable range given the facts of the case." The OCCO therefore considered the complaint and the underlying matter "dormant."

The Solicitor General's response to Mr. Gagnon's complaint, drafted by Dr. Young, was substantively inaccurate. Dr. Case directly contradicted Dr. Smith's opinion. The OCCO had accepted Dr. Case's opinion that there were "no findings" to support Dr. Smith's determination of asphyxia or head trauma. Dr. Young had met with Dr. Smith to talk to him about concerns that he was "out on a limb," not "hugging the tree." No independent expert ever suggested to the OCCO that Dr. Smith's opinion in Nicholas' case fell within a reasonable range. There was therefore no basis for Dr. Young to make that assertion.

January 22, 2001: Charge Stayed in Tyrell's Case

In January 2001, the Crown terminated the criminal proceedings in Tyrell's case and Sharon's case. Both proceedings ended after Crown counsel learned that several well-respected experts disagreed significantly with the opinion of Dr. Smith, who had performed the initial autopsy in both cases.

Tyrell died on January 23, 1998, at the age of four years. His caregiver reported that Tyrell hit his head on a marble table or a tile floor during a household fall before his death. Subsequently, the police charged Tyrell's caregiver with second-degree murder. Dr. Smith, who conducted the post-mortem examination, advised the police, and testified at the preliminary hearing, that the caregiver's explanation of a household fall could not account for the severity of Tyrell's head injury. Dr. Smith consulted neuropathologist Dr. Becker on the case and incorporated Dr. Becker's comments into his own report without attributing the findings to him.

In 2000 and 2001, a number of defence experts provided contrary opinions, stating that the reported fall could have caused Tyrell's fatal head injuries. The defence provided these opinions to Crown counsel. The criminal proceedings concluded on January 22, 2001, when Crown counsel Frank Armstrong stayed the charge of second-degree murder against Tyrell's caregiver. At the time, neither Dr. Cairns nor Dr. Young had heard about Tyrell's case. Dr. Cairns called Mr. Armstrong and asked him "what the problem was with Dr. Smith in this case." Mr. Armstrong replied that there was no problem with Dr. Smith. Rather, Dr. Smith said the cause of death was non-accidental head injury, while a defence expert said it was an accidental head injury. Mr. Armstrong had also consulted with a SickKids neurosurgeon, Dr. Robin Humphreys, who could not say whether the injury was accidental or non-accidental. Consequently, Dr. Cairns understood that, given the conflicting expert evidence, Mr. Armstrong did not believe that the Crown had a reasonable prospect of conviction. Mr. Armstrong was also concerned that he had only recently learned that Dr. Becker had performed the neuropathology that Dr. Smith incorporated without attribution into his report. Dr. Cairns concluded that this case was simply another one where reasonable experts could differ.

January 25, 2001: Charge Withdrawn in Sharon's Case

The same week as the stay of proceedings in Tyrell's case, the Crown withdrew the charge of second-degree murder against Ms. Reynolds. A number of events led to the Crown's decision.

In the summer of 2000, Dr. Young spoke to Crown counsel Ed Bradley about Sharon's case at a conference they were both attending. Mr. Bradley, the lead prosecutor in the case, had recently received a brief report from Dr. Ferris concluding that Sharon died as a result of a dog attack, and he subsequently interviewed Dr. Ferris in person and received a more detailed report. To his credit, Dr. Young suggested that they retain a leading international expert to provide an authoritative opinion on the case. Dr. Cairns arranged to get an opinion from Dr. Steven Symes, a forensic anthropologist from the University of Tennessee whom Dr. Chiasson had helped to identify as an appropriate expert. In his December 7, 2000, report, Dr. Symes concluded that most of the injuries were definitely caused by a dog attack and that some fresh fine incisions on the skull were caused by a knife with a thin bevel edge. Mr. Blenkinsop maintained that the incisions on the skull identified by Dr. Symes were not artefacts from the autopsy.

In December 2000, Mr. Bradley consulted with Dr. Cairns about Sharon's case. Dr. Cairns appeared skeptical of Dr. Smith's conclusions and told Mr. Bradley that there were other explanations for the wounds that Dr. Smith maintained were not related to an attack by an animal.

Mr. Bradley then spoke to Dr. Smith in January 2001 about the opinions of Dr. Symes and Dr. Ferris. Dr. Smith acknowledged that he could see where these experts were coming from, although he still felt "in his heart" that he was correct that some of Sharon's injuries were not caused by a dog.

On January 25, 2001, the Crown withdrew the charge of second-degree murder against Sharon's mother. In its submissions on withdrawal, the Crown noted that it no longer had proof that the death was caused by stab wounds and therefore no longer had a reasonable prospect of conviction. Neither Dr. Cairns nor Dr. Young were surprised that the Crown withdrew the charge in this case. Indeed, Dr. Young had provided input on the content of the Crown's submissions.

January 25, 2001: The OCCO Decision to Remove Dr. Smith

Within a single week, in January 2001, the Crown had withdrawn or stayed serious charges in Sharon's case and Tyrell's case. In both cases, eminent experts had contradicted Dr. Smith's views regarding the pathology issues. There was significant media attention surrounding the termination of proceedings in these cases, and, in particular, regarding Dr. Smith's role in them. Prominent news outlets reported that Dr. Smith's "professional conduct came under heavy assault."

That same month, Dr. Young became concerned about the adverse publicity surrounding Dr. Smith. He thought that Dr. Smith had become a "lightning rod" and that both Dr. Smith and the OCCO would benefit if Dr. Smith temporarily

stopped doing coroner's cases. Before this time, nobody at the OCCO had considered not permitting Dr. Smith to perform coroner's autopsies. At the Inquiry, Dr. Young and Dr. Cairns explained that they were still not concerned about the competence or quality of Dr. Smith's work. Rather, they were seeking to maintain public confidence in the work of the OCCO and to protect its reputation. In addition, they thought that the controversy surrounding Dr. Smith might impede his ability to conduct coroner's cases. In contrast, Dr. Chiasson had some concerns about Dr. Smith's competence, noting at the Inquiry that he thought "where there's a lot of smoke, there was some fire going on here, yes."

Dr. Cairns and Dr. Young met with Dr. Smith very shortly before or on January 25, 2001. They discussed the fact that Dr. Smith had become a lightning rod and that everything he did would attract an undue amount of attention. They told Dr. Smith he should not do any more coroner's cases in the immediate future. They gave him the option to resign voluntarily because it would be better for his reputation and would make it easier for the OCCO to reinstate him eventually. Soon after this conversation, on January 25, the very day the Crown withdrew the charge in Sharon's case, Dr. Smith wrote a letter to Dr. Young in which he asked to be removed from performing forensic autopsies and requested an external review of his work. Dr. Young acceded to Dr. Smith's request.

Dr. Young did not issue a press release announcing Dr. Smith's resignation. He considered it an internal matter and feared that a press release would not only damage Dr. Smith's reputation and career but also possibly preclude the OCCO from using his services in the future. However, within a day or so of January 25, 2001, a reporter from the *Kingston Whig-Standard* asked Dr. Young whether Dr. Smith was still doing work for the OCCO. Dr. Young told the reporter that Dr. Smith was no longer engaged in work for the OCCO and that, before he resumed any coroner's cases, an external review would be conducted. Dr. Young subsequently told other media outlets including the *Toronto Star* that he had ordered an independent review of several cases handled by Dr. Smith.

The 2001 Reviews

After Dr. Smith resigned, the senior officials of the OCCO briefly considered conducting a broad external review of his work. Such a review was discussed at a January 26, 2001, meeting at the OCCO. They did not have a clear idea of the form or size of the review, although they knew it would have to include Sharon's and Tyrell's cases. After the January 26 meeting, the OCCO searched the computer files in an attempt to gather a list of Dr. Smith's cases and asked forensic

pathologists outside Canada about their interest in participating in a review. They were able to find all the cases Dr. Smith had conducted under a coroner's warrant after 1986, but, in most of them, they did not have information about whether or not the case went to trial. In addition, they had no records of any of the cases in which Dr. Smith had provided a consultation. This gap demonstrates a significant systemic failure. The inability of the OCCO to produce comprehensive lists of the post-mortem reports completed by Dr. Smith, the consultation reports he had prepared, the status of the cases for which Dr. Smith had performed the post-mortem examination or provided a consultation opinion, and the results of those cases was problematic – and it significantly complicated all of the reviews of Dr. Smith's work, both at that time and much later.

The OCCO's senior officials also stated publicly that it was going to conduct an external review specifically of Sharon's case. Within a day or so of January 25, 2001, Dr. Young told a reporter from the *Kingston Whig-Standard* that he would likely have an external expert review Sharon's case. Five days later, on January 31, Dr. Cairns advised Crown counsel in Paolo's case, who was inquiring about Dr. Smith's status, that the OCCO was reviewing Dr. Smith's work in Sharon's case and Tyrell's case.

In Dr. Young's mind, the sole purpose of any external review was to determine whether Dr. Smith was fit to return to work for the OCCO. He did not consider that an examination of Dr. Smith's cases might also be in the public interest to determine what pathology lessons might be learned or whether there were possible wrongful convictions in cases involving Dr. Smith's work. Each of the leaders of the OCCO had different views of what an external review would consider. Dr. Chiasson understood that a review would encompass all criminal cases, past and present, in which Dr. Smith was involved. Dr. Cairns and Dr. Young, in contrast, anticipated that a review would encompass only those cases that were still before the criminal courts.

By February 12, 2001, however, Dr. Young had quietly stopped any external review. On February 8, 2001, Sharon's mother filed a lawsuit against Dr. Smith, Dr. Wood, and others. And, by that time, there were several complaints about Dr. Smith before the CPSO. Dr. Young testified that he decided to put the external review on hold because he was not prepared to reinstate Dr. Smith until the resolution of the lawsuit and the complaints. From his perspective, the only purpose of an external review was to consider Dr. Smith's possible reinstatement, and once the reinstatement was not imminent, the review became unnecessary. The senior OCCO leaders subsequently decided that an external review even of Sharon's case was not required because there had already been an exhumation and consultation with many external reviewers.

Dr. Young's decision to terminate the review was not based on legal advice, although he briefly discussed the decision with OCCO counsel. That was not well understood at the OCCO. While testifying at the preliminary hearing in Athena's case in November 2001, Dr. Cairns said that he thought the review had been suspended because of legal advice. It is evident that even Dr. Cairns was unaware of Dr. Young's rationale for his cancelling the external review.

Dr. Young did not issue a press release about his decision not to proceed with a review, nor did he tell Dr. Smith. He made no public statement about his decision until approximately June 2001, when he told the *Toronto Star* that he was not proceeding with the review of Dr. Smith's work. In fact, in a television interview that had aired on February 16, 2001, Dr. Young indicated that the OCCO was going to review Sharon's case and others and that "the review will probably be conducted by experts from the United States or Britain."

Dr. Young did not tell either the media or the Crown that he had cancelled the review. At a meeting on January 31, 2001, the OCCO had asked for the Crown's assistance in tracking down Dr. Smith's cases in order to conduct a comprehensive review of his work. From approximately January to April 2001, the OCCO sought and received the assistance of Crown counsel and the police to identify criminal cases in which Dr. Smith had been involved. Despite these requests and the help it received, at no point did the OCCO tell the Crown or the police about its decision to terminate the proposed external review.

Because they were never informed of its termination, Crown counsel assumed that the OCCO was conducting the planned external review of a cross-section of Dr. Smith's cases. Justice John McMahon, then director of Crown attorneys for the Toronto region, understood that the OCCO would tell the Crown of any problems that were discovered during the review. He believed that the OCCO would consider the possibility of wrongful convictions and asked the OCCO to inform him of any findings that could affect any ongoing or completed criminal prosecution. When he heard nothing further from the OCCO about the progress or status of the review, he understandably assumed that the OCCO had discovered no problems.

The Crown was not alone in its belief that the OCCO was conducting a review of Dr. Smith's cases. A number of police services and defence lawyers believed that the OCCO was reviewing all Dr. Smith's current criminal cases to ensure that his opinions were medically sound and that his testimony accorded with accepted standards. In cases where there could be any reasonable dispute about the cause of death, they believed that the OCCO would refer each case to independent reviewers. Some defence counsel also understood that the OCCO was undertaking a review of Dr. Smith's past criminal cases.

In 2001, Dr. Chiasson, Dr. Cairns, and Dr. Barry McLellan, then regional coroner for the Greater Toronto Area East Region, did engage in a sort of internal review after identifying Dr. Smith's cases. It was, at best, a superficial review. If a case did not involve any criminal aspect, the OCCO did not conduct any internal review. If Dr. Chiasson had already completed a forensic pathology case review form during his regular review of post-mortem reports in criminally suspicious cases, the case was deemed to have passed an internal review. (The limitations of this paper review are described in Chapter 7, Organization of Pediatric Forensic Pathology.) If he had not completed such a form, Dr. Cairns, Dr. McLellan, or Dr. Chiasson tried to conduct a paper review of the file to determine if it revealed a significant error. No reports or notes were generated regarding this internal review process. No running total or summary was maintained, and, in any event, only one of the reviewers, Dr. Chiasson, had the qualifications necessary to assess the pathology in question.

In April 2001, counsel for William Mullins-Johnson twice requested that the OCCO conduct a review of Dr. Smith's work in Valin's case. Mr. Mullins-Johnson had been convicted of first-degree murder. The theory was that Mr. Mullins-Johnson murdered Valin while committing a sexual assault. Dr. Smith was the only pathologist who testified at the trial that the child was sexually assaulted at or around the time of death. The other pathologists opined that Valin had been the victim of a sexual assault, but did not find signs of a recent sexual assault. Because Dr. Smith had prepared a consultation report but had not performed the post-mortem examination, the OCCO did not have any record of Dr. Smith being involved in Valin's case. For that reason, it did not respond to this request, at least not in 2001.

More generally, on April 4, 2001, defence counsel James Lockyer wrote to Dr. Young, saying that, in his view, "a thorough review of Dr. Smith's past cases is necessary." Dr. Young testified at the Inquiry that, at the time, he did not consider this letter from Mr. Lockyer a request for a broad review of Dr. Smith's past cases. He was familiar with Mr. Lockyer, whom he described as "very persistent" and "like a dog with a bone." He thought that if Mr. Lockyer had wanted to call for a broad review of Dr. Smith's cases, he would have done so publicly and in a much more forceful manner than a letter. However, it is difficult to see how Mr. Lockyer's letter could have been clearer.

Dr. Young also told the Inquiry that Mr. Lockyer's was the only request for a full review that he received from any player in the justice system. However, he accepted that there might have been confusion about whether the OCCO was already conducting such an independent review because the OCCO did not properly communicate its decision to cancel it. Indeed, the fact that others did not request a review may be attributable to the misapprehension that the OCCO was already undertak-

ing a comprehensive review of Dr. Smith's work in criminal cases. Dr. Young caused these misunderstandings and did little, if anything, to correct them.

May 2001: The *Maclean's* Article

In May 2001, *Maclean's* magazine published "Dead Wrong," an article about Dr. Smith which criticized his work in a number of cases, including Amber's case. The article discussed Justice Dunn's "harsh commentary" and his criticism of Dr. Smith "for not even following his own prescribed autopsy procedures."

Dr. Cairns gave an interview to *Maclean's*, before the publication of the article, in which he defended Dr. Smith's work. He commented that Dr. Smith was a "wonderful asset" in the investigation of child deaths and was quoted as saying: "He's a friend, I admire his work and he is greatly admired at the Hospital for Sick Children." Dr. Cairns informed *Maclean's* that, although the recent controversies had taken a toll on his colleague, Dr. Smith had been involved in many successful legal cases.

Dr. Young told the Inquiry that he "read at least part of the article," but did not recall reading portions of it pertaining to Amber's case. He thought he probably skipped those parts, in the same way he skipped the portion of Mr. Gagnon's complaint that dealt with Amber's case. Despite not being sure if he had read the entire article, Dr. Young concluded that it was unbalanced and unfair to Dr. Smith. He put very little store or confidence in the article and did not ask anyone to review the pathology in the cases it discussed.

Even when Justice Dunn's decision was specifically and repeatedly raised with Dr. Cairns and Dr. Young, they chose to ignore it, preferring to rely on Dr. Smith's story that Justice Dunn had later changed his mind. By repeatedly ignoring this obvious red flag about Dr. Smith, Dr. Cairns and Dr. Young failed to fulfill their responsibilities for the quality of pathology evidence used in death investigations.

Dr. Smith was very upset about the article and spoke to Dr. Young about it. He subsequently launched a lawsuit against *Maclean's* over it. In his response to a letter from two concerned parents who had been affected by Dr. Smith's evidence and had read the article, Dr. Young commented that, in his view, the *Maclean's* article was "dead wrong," in that it was full of inaccurate assumptions and statements, and that it was currently the subject of a lawsuit. He did so, apparently, without even having read the entire article.

June 2001: The Carpenter Review – Dr. Smith Resumes Some Coroner's Autopsies

Dr. Smith did not conduct any coroner's autopsies from January to June 2001. However, he continued to testify in those cases where he had previously conducted autopsies or consultations and which came to trial after January 2001.

In June 2001, the OCCO arranged for Dr. Blair Carpenter, the chief of pathology at the Children's Hospital of Eastern Ontario, to review six of Dr. Smith's non-criminally suspicious files. The purpose of Dr. Carpenter's review was to determine whether Dr. Smith could resume work on coroner's cases that were not criminally suspicious. SickKids urgently needed Dr. Smith to resume some coroner's work because of the significant burden coroner's autopsies were placing on its other pathologists. Dr. Chiasson selected the cases for review at random, but ensured that Dr. Carpenter reviewed at least one trauma case. The OCCO sent Dr. Carpenter the reports of post-mortem examination for his review, along with histology and photographic material. Dr. Carpenter's report was very positive. He concluded that Dr. Smith's work did not give rise to any concern regarding quality, accuracy, and competency. Following Dr. Carpenter's review, the OCCO allowed Dr. Smith to resume performing non-criminally suspicious coroner's autopsies.

After January 2001, with one exception described below, Dr. Smith did not perform any coroner's autopsies where criminal suspicions were raised. However, the OCCO never advised local coroners or regional coroners that Dr. Smith was no longer performing autopsies in criminally suspicious pediatric cases. The OCCO was, quite astonishingly, relying on indirect word of mouth to make people aware of Dr. Smith's situation. It surely would have been fundamental to any notion of quality assurance or oversight that the OCCO tell coroners that the director of the OPFPU, the leading expert in the field, was no longer doing criminally suspicious pediatric cases as of January 2001.

Once he resumed some work for the OCCO, Dr. Smith, in several instances, started an autopsy where there were no criminal suspicions and, when something of concern arose during the autopsy, stopped the procedure and contacted the OCCO. Dr. Chiasson took those cases over. The OCCO relied on Dr. Smith or other SickKids staff to notify it when a case that initially presented as routine raised criminal suspicions during the course of the post-mortem examination. The coroner, the police, and Dr. Smith made decisions about whether or not cases were criminally suspicious. The OCCO also relied on the pathology assistants at SickKids, who were to contact the OCCO if Dr. Smith started to perform a criminally suspicious autopsy and indicated he would continue with the autopsy.

Dr. Smith performed one criminally suspicious autopsy after January 2001. It involved a child who was left alone on a hot night and was later found deceased and dehydrated. No other pathologist was available to perform the autopsy. After consulting with the Toronto Police Service – Homicide Bureau, the OCCO decided to let Dr. Smith conduct the autopsy and, subsequently, Dr. McLellan sent the case for review by another expert.

Although Dr. Smith was not allowed to perform criminally suspicious autopsies after January 2001, he nonetheless continued as director of the OPFPU. He also continued to provide guidance to pathologists at SickKids.

September 2001: The Report of the Ombudsman on Mr. Gagnon's Complaint

Well before Dr. Smith's removal from the roster for criminally suspicious cases, Mr. Gagnon complained to the Ombudsman of Ontario about the OCCO's investigation into Nicholas' death. On June 26, 2000, he requested that the Ombudsman investigate his complaints regarding Dr. Smith and Dr. Cairns and the complaints process at the OCCO.

On November 10, 2000, Dr. Young wrote to the Ombudsman regarding the complaint. In this letter, he stated that Dr. Cairns had responded appropriately and expeditiously to the conflicting opinions of Dr. Smith and Dr. Halliday by arranging for an independent review. He also maintained that the varying opinions in the case illustrated "the complexity of forensic pathology in young children" and that Dr. Smith's opinions fell within a reasonable range of the science. As noted above, in the face of Dr. Case's clear conclusions to the contrary, Dr. Young should not have stated that Dr. Smith's opinion was within a reasonable range.

Then, on November 23, 2000, Virginia West, the Deputy Solicitor General, wrote to the Ombudsman. She stated that Dr. Young had reviewed the actions of Dr. Smith and Dr. Cairns throughout the case and that the ministry had concluded that Dr. Cairns acted in an appropriate manner.

The Ombudsman, however, concluded on September 24, 2001, that the Solicitor General should consider establishing an independent complaints handling body with special expertise to review complaints and ensure the accountability of the coroner system. In 2002, a formal mechanism was instituted for complaints regarding the Chief Coroner or the Deputy Chief Coroner, whereby complaints would be sent directly to the deputy minister's office and investigated independently of the OCCO. No independent process has yet been established for coroners or for pathologists.

October 2001 to April 2002: The Hair in Jenna's Case

In late 2001 and early 2002, concerns regarding Dr. Smith's conduct at the autopsy in Jenna's case came to light.

In October 2001, Detective Constable Larry Charmley, who was in charge of the re-investigation in Jenna's case, spoke by telephone with Dr. Smith about a hair that had apparently been observed in Jenna's vaginal area, but had not been filed as an exhibit. Dr. Smith told him he had collected and kept the hair because the police did not want to take it or to submit it for forensic testing. He believed he still had the hair. Dr. Smith also said that he had arranged for an expert in child sexual abuse to examine Jenna, and the expert had found no evidence of sexual assault. Detective Constable Charmley asked Dr. Smith to retrieve the hair so that the police could seize it as evidence.

On November 6, 2001, Dr. Smith confirmed that he had the hair. Nine days later, on November 15, Detective Constable Charmley went to Dr. Smith's office and retrieved a sealed white envelope with the words "hair from pubic area" written on the outside. A seal on the envelope indicated that the contents were seized from Jenna's autopsy.

In February 2002, a newspaper reported that the police had recovered the hair from Dr. Smith. Media reports criticized both the police investigation and Dr. Smith's post-mortem examination. Following these reports, and certainly before the end of the first week of April 2002, Dr. Smith's spouse, who was also a coroner, called Dr. Cairns to express her concern that Dr. Cairns and the OCCO were not supporting Dr. Smith. Dr. Cairns offered to meet with them both to discuss this issue.

Dr. Cairns subsequently met with Dr. Smith and his spouse at the OCCO, and their meeting lasted between two and two-and-a-half hours. Dr. Cairns advised the Inquiry that Dr. Smith asked why the OCCO was not supporting him.[3] Dr. Cairns told Dr. Smith that he could not understand Dr. Smith's statements that the police officer at Jenna's autopsy refused to take the hair. He found this suggestion "preposterous." He further told Dr. Smith that, had an officer really refused to take a hair, he would have expected Dr. Smith to call Dr. Cairns or Dr. Chiasson to ask what to do. He asked why, if the officer had refused to take the hair, Dr. Smith did not record this fact in his report of the post-mortem examination. Dr. Cairns also asked if Dr. Smith had kept rough notes recording this event, but Dr. Smith told him that he had not. Dr. Cairns responded that he did not

[3] Dr. Smith testified that he had no specific recollection of the meeting, but he did not dispute the recollection of Dr. Cairns.

understand why Dr. Smith had not made a "huge note in massive letters" highlighting what would have been a bizarre event.

During their meeting, Dr. Cairns informed Dr. Smith that he had reviewed the transcript of Dr. Smith's evidence at the preliminary hearing. He observed that Dr. Smith had testified that it would have made a difference in his post-mortem examination if he had been aware that a treating physician and nurse were concerned that Jenna may have been sexually assaulted and had observed a possible pubic hair in her vaginal region. Dr. Smith told Dr. Cairns that he had the hair in an envelope in his jacket pocket when he testified at the preliminary hearing. As Dr. Cairns told the Inquiry, Dr. Smith's story was "getting stranger and stranger." He asked Dr. Smith why he did not say he had the hair in his pocket when he was directly asked about it during his testimony, but Dr. Smith did not respond.

Dr. Smith also told Dr. Cairns that Dr. Dirk Huyer, a physician with the Suspected Child Abuse and Neglect (SCAN) Program at SickKids, had attended at least part of the autopsy, although his attendance was not recorded in the report of post-mortem examination. Dr. Cairns found it even more incredible that Dr. Huyer would not have collected the hair. In Dr. Cairns' experience as an emergency physician, finding a hair would mandate a full sexual assault examination, including swabs, but no swabs had been taken. The fact that this procedure had not been done reinforced in Dr. Cairns' mind that Dr. Huyer could not have been present at the autopsy. When asked about Jenna's case, Dr. Huyer could not recall one way or the other if he was present.

Dr. Cairns did not believe any aspect of Dr. Smith's description of the events. For the first time, he concluded that Dr. Smith could not be believed, and he questioned Dr. Smith's competence as a forensic pathologist.

April 2002: Dr. Cairns Advises the CPSO and Dr. Young about the Hair in Jenna's Case

During the first week of April 2002, shortly after he met with Dr. Smith and his spouse, Dr. Cairns contacted Dr. John Carlisle, the interim registrar at the CPSO. At the time, the CPSO was investigating a complaint by Jenna's mother about Dr. Smith. Dr. Cairns relayed to Dr. Carlisle the information Dr. Smith had provided about the hair in Jenna's case, including the fact that he had kept the hair in his possession since the investigation and had not submitted it for analysis or given it to the police before 2002. Dr. Cairns told Dr. Carlisle that he had no previous knowledge of the facts provided by Dr. Smith and that he believed, based on the facts, Dr. Smith was in serious difficulty.

Dr. Cairns told Dr. Carlisle that the OCCO would not argue that the CPSO did

not have jurisdiction over the matter. As Dr. Young told the Inquiry, the OCCO had always been clear in its position that the CPSO had jurisdiction over physicians in matters giving rise to criminal misconduct or ethical concerns. Dr. Young testified that he considered the issues regarding the hair and the sexual assault examination in Jenna's case as possibly engaging criminal or ethical questions.

On the day after his meeting with Dr. Smith and his spouse, Dr. Cairns recounted the meeting to Dr. Young and told him that he had discussed the matter with the CPSO. Dr. Young also thought that Dr. Smith's story was not credible. In his experience, police officers do not refuse to take samples. In addition, he was concerned about Dr. Smith's story that he took the hair home and then brought it to court. He could not figure out why Dr. Smith was choosing to disclose the hair at that time. Dr. Smith's conduct in the Jenna case did cause Dr. Young to question Dr. Smith's judgment and ethics.

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

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

April 2002: Dr. Young Supports Dr. Smith to the CPSO

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

Dr. Young's letter said that, in the opinion of the OCCO, Dr. Smith, as one of only five or six pathologists in Canada with certification in pediatric pathology, was "qualified to undertake the work requested of him in each of these investiga-

tions [Jenna, Nicholas, and Amber]." He stated that the OCCO believed that the conclusions reached in Amber's and Nicholas' cases were within the range of reasonable expectation. He further opined that he was not aware of any professional misconduct by Dr. Smith in the Amber or Nicholas investigations. Finally, Dr. Young stated, "To the best of my knowledge, at no time did Dr Smith act in bad faith or with the intent to obstruct or hinder these Coroner's investigations."

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

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

Dr. Young's letter misled the CPSO. Based on this letter, its recipient, Ms. Doris, assumed that the OCCO had no concerns about Dr. Smith's competence or performance. Dr. Young told the Inquiry that he sent this letter in an attempt to be fair to Dr. Smith. He did so, however, at a cost to the public interest. Coming as it did after the long series of incidents described above, the letter was not balanced or objective or candid. It was not a letter worthy of a senior public office-holder in Ontario.

July 2002: Dr. Cairns Offers an Expert Pathology Opinion in Paolo's Case

In July 2002, Dr. Cairns, like Dr. Young in his letter to the CPSO, defended Dr. Smith. This time it was in relation to Dr. Smith's pathology opinion in Paolo's case. In so doing, Dr. Cairns exceeded his expertise, the effect of which was to shield Dr. Smith's opinion from further scrutiny. Even before that, however, Dr. Cairns caused some confusion about Dr. Smith's status at the OCCO.

In October 2001, Lucy Cecchetto, Crown counsel, requested that the OCCO review Dr. Smith's work in Paolo's case as requested by the defence. In the course of their correspondence regarding the case, Dr. Cairns failed to inform Ms.

Cecchetto about the nature of the 2001 review of Dr. Smith's work and Dr. Smith's status regarding coroner's cases. In all, he made three incorrect representations to Ms. Cecchetto.

First, he said that Dr. Smith's work in approximately 20 cases had been reviewed. In 18 of those cases, there was no difference of opinion with Dr. Smith, and, in the other two cases, the difference of opinion was limited to where experts might reasonably disagree. Second, he said there was no suggestion from these reviews that Dr. Smith was incompetent or negligent in these cases. Third, he said that, following the review, Dr. Smith was returned to the autopsy roster in June 2001 and that, as far as the OCCO was concerned, Dr. Smith was competent to conduct any autopsy. None of Dr. Cairns' three statements was correct.

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

On or about July 31, 2002, Dr. Cairns advised Ms. Cecchetto orally that he had completed his review in Paolo's case, including a review of the autopsy and all the medical evidence. Dr. Cairns reported that he was of the view that there was complete consistency between Dr. Smith's opinion and that of the other medical experts. He saw no contradictions whatsoever and had no concerns about the autopsy report or any of the medical evidence. Dr. Cairns told Ms. Cecchetto that, in his opinion, nothing would be served by doing anything further or seeking out any other opinions.

The Crown requested a written report from Dr. Cairns because defence counsel was considering whether or not to pursue a fresh evidence application. On September 27, 2002, Dr. Cairns wrote to Ms. Cecchetto and confirmed that he had conducted a "thorough review" of Dr. Smith's work in Paolo's case, including the autopsy report, photographs, and expert testimony at the trial. He confirmed that he had "no concerns regarding the opinion given by Dr. Smith and [saw] no reason what so ever for [the OCCO] or the Crown to hire another expert."

Dr. Cairns was wrong. Once experts reviewed the case, Dr. Smith's opinion was sufficiently discredited by other pathology experts that the Supreme Court of Canada ordered a new trial for Paolo's parents. As with his affidavit in Nicholas' case, Dr. Cairns did not have the expertise to provide this opinion. A proper review required expertise in forensic pathology. Moreover, at the time Dr. Cairns provided this unqualified opinion, he was fully apprised of the serious concerns about Dr. Smith's competence, integrity, and judgment arising from cases such as Jenna's. This incident provides yet another example of the importance of experts understanding

and respecting the limits of their expertise. As he candidly acknowledged at the Inquiry, Dr. Cairns had absolutely no business offering this opinion.

November–December 2002: Dr. Smith's Confrontation with the OPP

The next episode involved a different concern regarding Dr. Smith: an alleged abuse of his authority as director of the OPFPU, a position Dr. Young permitted Dr. Smith to hold notwithstanding all the warning signals that had been sounded.

On November 18, 2002, Inspector J.J. (Jim) Szarka of the OPP wrote to Dr. Young stating that one of his officers from the Cobourg office of the Northumberland OPP had stopped Dr. Smith for speeding on November 9, 2002. According to the officer, Dr. Smith became angry when he was issued a ticket and said, "Do you know who I am? I am the Head of Pediatric Forensic Pathology for this province." After asking what location the officer worked out of, Dr. Smith reportedly said, "Next time Cobourg needs forensics on a child they won't get one from our office." The officer then asked Dr. Smith if he was going to deny Cobourg his services and put an investigation of a child death at risk because of a speeding ticket, to which Dr. Smith reportedly replied yes. Inspector Szarka noted the obvious seriousness of the matter and asked for Dr. Young's reply.

Dr. Young discussed the matter with Dr. Smith. Dr. Young told the Inquiry that he had informed Dr. Smith that his conduct had been wrong and that he owed the police an apology. On December 23, 2002, Dr. Young wrote to Inspector Szarka, indicating that he had reviewed the complaint with Dr. Smith and stating, "Without agreeing to the accuracy of the description of what took place, [Dr. Smith] sincerely regrets any suggestion or impression that services would not be available." Dr. Young also noted that the provision of services was never in jeopardy.

Dr. Young testified at the Inquiry that he did not perceive that the allegation by the OPP raised the prospect that Dr. Smith was misusing his title as director of the OPFPU. This reaction is difficult to fathom, especially in light of the fact that, by then, Dr. Young said that he already had concerns about Dr. Smith's integrity and judgment arising from Jenna's case. Dr. Smith remained as director of the OPFPU for more than a year and a half after this disturbing incident. Dr. Young could not yet bring himself to remove Dr. Smith.

The OCCO Response to the CPSO Decisions

On October 15, 2002, the Complaints Committee of the CPSO rendered its decisions in the complaints arising out of the cases involving Jenna, Nicholas, and

Amber. In all three cases, the committee concluded that Dr. Smith met the overall standards of a pathologist assisting the coroner, although it noted a number of deficiencies and omissions, including that Dr. Smith

a) failed to review clinical information before performing the autopsy;
b) failed to perform a rape kit examination;
c) failed to document significant findings regarding sexual assault;
d) produced post-mortem photographs of substandard quality;
e) provided an estimate of the time during which the fatal injuries were received that was far too broad, and failed to consult with another expert on this issue;
f) employed an overly dogmatic approach in court;
g) over-interpreted some of the pathology;
h) failed to take complete radiographs or have a radiologist review the X-rays;
i) gave testimony that was sometimes weak and deferred to defence witnesses without a critical evaluation of their opinions; and
j) made unsubstantiated findings.

Dr. Smith was subsequently cautioned in person by the CPSO. The medical profession perceives a caution by the CPSO as a significant outcome, and many physicians will appeal a decision of the Complaints Committee to issue a caution to the Health Professions Appeal and Review Board. When the Complaints Committee declined to refer any of the three cases to the Discipline Committee, D.M. and Jenna's mother unsuccessfully appealed the decision not to refer their matters to discipline to the HPARB.

In its decision regarding Jenna's case, the Complaints Committee did not mention the issue of the hair. Dr. Young had no concerns that the hair was not discussed in this decision. He viewed the hair as engaging credibility issues rather than substantive forensic issues, and he thought it likely that the hair would be of no evidentiary value.

The OCCO took no further action with respect to Dr. Smith following the October 15, 2002, decisions of the Complaints Committee. Dr. Young read all three decisions of the CPSO, and they did not change his attitude toward either Dr. Smith's competence or his continued performance of some autopsies for the OCCO. Dr. Young did not feel they could afford to stop Dr. Smith from performing OCCO autopsies in non-criminally suspicious cases. In failing to react once again to serious expert criticisms of Dr. Smith, Dr. Young put his concerns about the scarcity of forensic pathologists ahead of his oversight of Dr. Smith.

Although he did nothing to address concerns about Dr. Smith, Dr. Young did see fit to intervene, once again, with the CPSO on Dr. Smith's behalf. Following

the decisions, Dr. Smith raised concerns that some of the problems identified by the Complaints Committee were beyond his control as a pathologist. On February 17, 2003, Dr. Young wrote to the registrar of the CPSO to clarify that coroners were responsible for some of the errors attributed to Dr. Smith and that the OCCO was attempting to address these errors through new policies. He outlined that the investigating coroner, not the pathologist, was responsible for ensuring that the pathologist had all the available information before the autopsy. The investigating coroner was also responsible for directing efforts with regard to consultations or testing. In addition, the pathologist could not be faulted for substandard photographs (as in Jenna's case), as they were taken by the investigating police service.

Although Dr. Young testified at the Inquiry that he did not question the findings the Complaints Committee made about Dr. Smith, and that he merely wanted to highlight areas where coroners shared responsibility, the fact that he still considered it appropriate to write to the CPSO in the way he did at Dr. Smith's request is worrisome. It illustrates his failure to understand his role as an overseer of Dr. Smith. It was not his role to protect Dr. Smith from his professional regulator.

June 2003: Charges Stayed in Athena's Case

On June 23, 2003, the trial judge in Athena's case delivered his reasons for judgment staying the proceedings against Athena's parents because of unreasonable delay. In his reasons, Justice W. Brian Trafford criticized Dr. Smith's role in the delay and commented on Dr. Cairns' testimony in the case. As I describe in Chapter 8, Dr. Smith and the Practice of Pediatric Forensic Pathology, Dr. Smith took over eight months to produce a one-and-a-half-page addendum to his postmortem report in Athena's case. This unacceptable delay led, in part, to Justice Trafford's decision to stay the proceedings.

Well before that, Dr. Cairns had played a role in Athena's case. In November 2001, Dr. Cairns testified at the preliminary hearing, in large part regarding the controversy surrounding Dr. Smith. He attempted to describe the OCCO's 2001 review of Dr. Smith's work. He testified that a number of autopsies were selected at random and sent out for independent review. He gave evidence that the review of Dr. Smith's work consisted of a review of six cases by Dr. Carpenter and a review of 17 criminal cases by Dr. Cairns, Dr. Chiasson, and Dr. McLellan. Of the 17 cases, 10 were externally reviewed at the request of either Crown counsel or the defence. Aside from the decision to stop the independent review in Sharon's case because of legal advice in connection with the lawsuit initiated by Sharon's mother, Dr. Cairns testified that the other independent reviews had

been completed. He also gave evidence that he, Dr. Chiasson, and Dr. McLellan reported to Dr. Young with the results of their review by June 2001 and told him that Dr. Smith was competent to perform any pediatric autopsy. The preliminary hearing judge committed Athena's parents to stand trial, and the matter proceeded to trial.

In 2002, Dr. Cairns was summonsed, in the context of a third-party records application by the defence, to attend at the trial in Athena's case before Justice Trafford. Dr. Cairns swore two affidavits in response to the defence application. The documents attached to his October 23, 2002, affidavit included a chart of the cases subject to the OCCO's review that he had provided to the defence in November 2001. Dr. Cairns testified in Athena's case on November 28 and 29, 2002.

On June 23, 2003, Justice Trafford issued the stay of proceedings on the ground of unreasonable delay, a decision later upheld by the Court of Appeal for Ontario. In his reasons for ruling, Justice Trafford found that Dr. Cairns' testimony at the preliminary hearing, while in good faith and not intentionally misleading, had the effect of misleading the defence and resulted in the defence making unnecessary applications for the production of all the criminal files they understood were the subject of review. Justice Trafford cited three examples of Dr. Cairns' misleading testimony. First, Dr. Cairns described the Carpenter review as part of the independent review, when it was not. Second, Dr. Cairns testified that, with the exception of Sharon's case, the independent review had been completed, whereas, in fact, Dr. Young had indefinitely suspended it. Third, Dr. Cairns testified that the review concluded that Dr. Smith was competent to perform all autopsies, whereas, in fact, no such opinion had been given and, indeed, Dr. Smith had been removed from the roster for criminally suspicious pediatric cases.

At the Inquiry, Dr. Cairns candidly admitted that his evidence during the preliminary hearing and application suggested that the internal review was more thorough and rigorous than it was. He agreed that his evidence was extremely confusing and had a misleading effect. The defence ended up thinking that the OCCO had conducted a rigorous, scientific review. In addition, during his testimony in 2002, Dr. Cairns had provided a chart to the defence that appeared to detail the results of the external and internal reviews in 17 of Dr. Smith's criminally suspicious cases. However, the chart inaccurately described the level of agreement of other experts with Dr. Smith's conclusions and was misleading. It would lead reasonable people to conclude that the OCCO had conducted an internal review and an external review, and that the reviewers had agreed with Dr. Smith in most cases. None of this was true.

Following Justice Trafford's decision, Dr. Smith remained on the OCCO roster

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

December 2003: The OCCO Removes Dr. Smith from the Roster for Coroner's Autopsies

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

On October 2, 2003, Dr. Smith, Dr. McLellan, Dr. Young, Dr. Cairns, Dr. Porter, and Mr. O'Marra met to discuss Dr. Smith's ongoing relationship with the OCCO. The OCCO leadership and Dr. Smith discussed whether he should continue performing autopsies for the OCCO or participating in OCCO committees, such as the PDRC and the Deaths under Two Committee.

Two weeks later, on or about October 16, Dr. Young and Mr. O'Marra met again with Dr. Smith. They asked him to resign from performing autopsies for the OCCO. Notes of the meeting recorded concerns about Dr. Smith being a lightning rod and that, although likely unfair, even his name on a report caused concerns and resulted in defence counsel "smell[ing] blood." At the Inquiry, Dr. Young stated that, although he focused on the reputation and lightning rod problems in this meeting as a way of sparing Dr. Smith's feelings, he also had concerns by this point about the quality of Dr. Smith's work. He therefore told Dr. Smith at the meeting that the OCCO needed to sever its relationship with him and asked for his timely response.

Dr. Smith did not resign after these discussions in October 2003. In December, two months later, Dr. Young finally informed Dr. Smith that he would no longer be allowed to perform any autopsies for the OCCO. Nevertheless, Dr. Smith continued to hold his position as director of the OPFPU. He asked the OCCO if he could retain his existing title until the completion of the CPSO proceedings in the

complaints arising out of the cases involving Nicholas, Jenna, and Amber. On May 26, 2004, the CPSO proceedings were resolved when the CPSO Complaints Committee issued a caution to Dr. Smith.

It is not clear exactly when Dr. Smith was informed he could no longer participate on OCCO committees. Dr. Young's recollection is that he spoke with Dr. Smith sometime in the first half of 2004 and asked him to resign from the committees. In any event, he was removed from the committees by the summer of 2004.

June 2004: The OCCO Removes Dr. Smith as Director of the OPFPU

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

In July 2002, because of Dr. Young's significant other commitments as assistant deputy minister of public safety and commissioner of public safety, Dr. McLellan became Acting Chief Coroner for Ontario and was charged with responsibility for almost all the OCCO's daily management. However, Dr. Young retained responsibility for handling issues involving Dr. Smith.

Dr. Young testified at the Inquiry that he kept on in this role because he had handled most of the past significant events regarding Dr. Smith. Dr. McLellan testified that he suggested to Dr. Young and Dr. Cairns that Dr. Smith be removed from ongoing involvement in OCCO committees and autopsy work, as well as from his position as director of the OPFPU. Dr. McLellan was concerned about Dr. Smith's ongoing roles, and in particular was worried about how family members and other members of the death investigation team might feel about his continued involvement with the OCCO. When Dr. Young disagreed and decided that Dr. Smith should remain in these positions, Dr. McLellan asked Dr. Young to continue dealing with Dr. Smith, and Dr. Young agreed.

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

Summary

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

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

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

Given these weaknesses in the institutional arrangements, as well as the inadequacies of the quality control measures introduced in the 1990s, oversight of Dr. Smith's pathology work was virtually non-existent. The one exception was the de facto supervision by Dr. Young and Dr. Cairns that derived from their longstanding relationship with Dr. Smith, together with their positions of ultimate responsibility at the OCCO. In reality, this loose supervision was the only operative oversight available for Dr. Smith's pediatric forensic pathology. Both men served Ontario for many years in a number of responsible positions, and I am sure in many respects they did so effectively and well. But in this task they failed.

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

Perhaps most important, neither Dr. Young nor Dr. Cairns had any specialized training in pathology, let alone forensic pathology, and they clearly did not understand the deficit position that this lack of expertise put them in. Although Dr. Cairns offered what purported to be expert pathology opinions of his own in several cases, he now recognizes how inappropriate that was and how unqualified he was to do so. For his part, in giving evidence at the Inquiry, Dr. Young attempted to defend as reasonable Dr. Smith's opinion about the timing of the fatal injury in Jenna's case, when the overwhelming expert consensus was not just that the opinion was unreasonable but that it was bad forensic pathology. Dr. Young's and Dr. Cairns' lack of expertise contributed to their failure to recognize Dr. Smith's deficiencies in forensic pathology despite the mounting evidence that accumulated during the 1990s. It meant that many of the problems the expert reviewers have now made so glaringly obvious did not shake their absolute faith in Dr. Smith until the very end, and after much damage had been done.

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

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

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

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

Like Dr. Cairns, Dr. Young also apologized at the Inquiry. As he recognized, these events happened on his watch, and he bears ultimate responsibility for them. In my view, this apology is appropriate because, in addition to what I have already described, Dr. Young's own attributes contributed to the failure.

While still Chief Coroner, and as these events unfolded, Dr. Young simultaneously took on even more senior positions in the provincial government, first as assistant deputy minister of public safety and then, in addition, as commissioner of public safety. He candidly acknowledged to the Inquiry that he was a "big-picture person" who got bored with detail, who scanned the paper that came to him but did not read it, and who did not have time to analyze things in detail. As he said, "I'm vision. I look at things in big ways and, frankly, I get bored doing the same thing every day and I'm not well suited to it." With the additional burdens imposed by his new responsibilities, Dr. Young's inattention to day-to-day administration was a recipe for a failure of oversight. Whether it was his failure to pursue Justice Dunn's judgment and its implications, or to read all of Mr. Gagnon's complaint before responding, or to watch *the fifth estate* program and explore the validity of its criticisms, or, in 2001, to structure and follow through with any coherent plan for the review of Dr. Smith's cases, the regular vigilance required for effective oversight was missing.

At first, as the storm clouds gathered, Dr. Young was guided more by his con-

cern that, for the sake of the OCCO, Dr. Smith's services had to be continued than by whether those services were providing deeply flawed forensic pathology. As the end neared, Dr. Young was more concerned with the possibility of the adverse publicity that Dr. Smith might bring to the OCCO than about the possible impact of Dr. Smith's shortcomings on the OCCO's responsibility for high-quality death investigations. He gave no thought to whether the office might have played a role in past wrongful convictions as a result of Dr. Smith's work. Concerns about the OCCO's reputation, while valid, cannot stand in the way of the paramount imperative of ensuring high-quality death investigations.

Finally, as the last act played out, Dr. Young continued to defend the indefensible in the name of saving the reputation of the OCCO. Even after Dr. Cairns had lost faith in Dr. Smith's integrity and competence, with the revelation of Dr. Smith's actions concerning the hair in Jenna's case, Dr. Young took no action; instead, he supported Dr. Smith's abilities as a pathologist and his professional expertise. Dr. Young was the last to see the writing on the wall, and, at the Inquiry, he was left to say what he might have said with equal validity at many moments in the preceding decade: "I don't know why we didn't stop him doing everything at that time … I just don't know."

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

The Role of SickKids

From at least 1995 to 1997, Dr. Becker and others at SickKids had concerns about both the timeliness and the quality of Dr. Smith's pathology work for the hospital. Notwithstanding their ongoing concerns about delays and diagnostic discrepancies in Dr. Smith's work, it appears that no one at SickKids took any formal disciplinary action against Dr. Smith, nor did they tell the OCCO about their misgivings. Ultimately, I cannot determine what might have happened had SickKids informed the OCCO of its concerns, but there can be no doubt that, if they had been known, these concerns should have informed the actions of the OCCO from 1995 to 1997. By choosing not to provide this information, SickKids impeded the OCCO's ability to provide meaningful oversight.

Unlike the OCCO, SickKids tracked the turnaround times for all surgical

pathology cases, hospital autopsies, and coroner's autopsies conducted or reviewed at the hospital. At the end of each month, the pathology department produced a list of every pathologist's incomplete cases which was distributed both to Dr. Becker and to the individual pathologist. Although most pathologists met Dr. Becker's expectations, Dr. Smith typically did not.

Dr. Smith often had the highest number of incomplete surgical pathology, hospital autopsy, and forensic autopsy reports in the department. In addition, his reports were frequently incomplete for the longest periods of time. In some instances, it took four months for Dr. Smith to finish a surgical report that should have taken, at most, two weeks.

Dr. Smith's tardiness frustrated concerned parents and delayed the work of clinicians who required surgical pathology test results before making important decisions related to patient care. Clinicians and family members were forced from time to time to contact Dr. Smith throughout the 1990s and even in the early 2000s, urgently requesting his surgical reports, sometimes to no avail. Dr. Becker tried to deal with these persistent problems by speaking to Dr. Smith directly about the urgent cases and, in some instances, even getting another pathologist to complete the report.

At the Inquiry, Dr. Smith acknowledged that, throughout his tenure at SickKids, there were persistent problems concerning his timeliness in completing both surgical and autopsy reports. Although he was aware of his delays and the problems they caused, the improvements he was able to make from time to time proved only temporary. He acknowledged that frequent delays in the completion of his reports adversely affected the work of his colleagues and may have diminished the quality of patient care in some instances.

As well as timeliness, the hospital also had concerns about Dr. Smith's diagnostic accuracy. Clinicians rely on pathologists' diagnoses to make critical decisions about treatment. Diagnostic discrepancies in surgical pathology can have profound effects on patient care. As pathologist-in-chief, Dr. Becker dealt with diagnostic concerns about Dr. Smith's surgical pathology reports on several occasions. Around 1997, there was demonstrable concern at SickKids about Dr. Smith's clinical skills in the reading and interpretation of microscopic slides.

In one instance, a surgeon complained about a diagnosis made before March 1997 in which Dr. Smith's misdiagnosis of ganglion cells resulted in a young patient undergoing an unnecessary surgery. Understandably, the surgeon was extremely concerned, as Dr. Smith's error profoundly affected patient care. According to Dr. Glenn Taylor, the current pathologist-in-chief at SickKids, the diagnosis of ganglion cells is regarded as difficult, and such misdiagnosis is a very common source of civil litigation against pediatric pathologists.

On March 21, 1997, Dr. Paul Thorner, the associate head of pathology at SickKids, wrote a memo to Dr. Becker regarding diagnostic discrepancies in four of Dr. Smith's surgical pathology cases. The identification of four misdiagnoses within a short time frame was concerning. The first involved an error in what should have been a rather straightforward diagnosis. In the second case, the proper diagnosis was one that was easy to confuse with the diagnosis made by Dr. Smith. The third case involved diagnosis of an unusual lesion that might be difficult to recognize. These three cases did not affect patient care, but the fourth one did.

In the fourth case, Dr. Smith misdiagnosed two frozen sections of tissue. Frozen sections are the first tissue samples reviewed by a pathologist while the patient remains under anesthetic in the operating room. Dr. Smith reported that the two frozen sections were reactive, or non-malignant. Based on Dr. Smith's diagnosis, the patient was removed from the operating room to recover. Subsequently, the tissue samples were blocked and the permanent slides were prepared. Dr. Smith correctly read the permanent section as malignant. The child had to return to the operating room for placement of a chemotherapy line. At a minimum, the child required a second surgical procedure. More seriously, the proper treatment may have been delayed unnecessarily.

In April 1997, Dr. Becker prepared a letter addressed to Dr. Smith about "a disproportion in the number of complaints about diagnostic inconsistencies from pediatricians and surgeons" regarding Dr. Smith's surgical pathology work. The letter indicated that Dr. Becker was curtailing Dr. Smith's responsibilities in surgical pathology until Dr. Smith completed continuing medical education courses to improve his surgical pathology skills. The letter was unsigned and appears not to have been sent.[4] Dr. Smith testified that no one ever advised him of significant concerns regarding his surgical pathology work or informed him that, as a result, he should cease performing surgical cases. Dr. Becker's letter also stated that, as Dr. Smith would not be conducting surgical pathology on a regular rotation, his "salary from the Division of Pathology will be reduced by $20,000 for 1997." However, Dr. Smith's salary was not reduced in this manner. Whether the letter was sent or not, it clearly reflects Dr. Becker's serious concerns with Dr. Smith's diagnostic skills.

Also in 1997, a SickKids oncologist complained about two surgical pathology cases in which Dr. Smith had made errors. In one case, Dr. Smith had correctly identified two components of the tumour, but, on review, Dr. Thorner and Dr.

[4] Dr. Becker died in July 2002. It was therefore not possible to hear his evidence on this point.

Taylor found a third component, which meant a change in treatment. The additional diagnosis would not have been within the realm of normal experience for pathologists who do not regularly see these lesions. Dr. Thorner testified that Dr. Smith should have noted there was something he did not recognize and requested assistance from his colleagues. In the other case, Dr. Smith failed to recognize that a Wilms' tumour had spread beyond the kidney. Dr. Taylor was asked to review the case approximately one year later, when the child presented with a recurrence of the tumour. He found that the tumour had spread beyond the kidney, and that this invasion was evident in the original slides reviewed by Dr. Smith. If Dr. Smith had correctly diagnosed the spread of the tumour, the child would have received a more aggressive treatment.

These cases were a small minority of all the surgical pathology work that Dr. Smith conducted during the course of his career. However, at times, his colleagues were clearly frustrated with his diagnostic mistakes. This frustration was evidenced by an email written by Dr. Thorner to Dr. Becker in May 1997 in which he referred to two complaints regarding Dr. Smith as "another nail for the coffin." However, it must be said that the complaints regarding diagnostic issues did not rise to the level where the pathologist-in-chief formally restricted Dr. Smith's privileges.

Failure to Share Information with the OCCO

SickKids decided not to share its concerns about Dr. Smith's frequent delays in completing reports in a timely fashion or its misgivings about his diagnostic errors with the OCCO. Despite meeting frequently with representatives of the OCCO to discuss that office's concerns regarding Dr. Smith's delays, representatives of SickKids never indicated that they had the same difficulty with his work for them.

Dr. Young testified that, if the OCCO had known about concerns with Dr. Smith's work regarding diagnostic discrepancies in surgical work, that information would have affected his judgment regarding Dr. Smith's work for the OCCO. Dr. Cairns shared this view and told the Inquiry that Dr. Smith's skills in histopathology were critical to his performance as a forensic pathologist. In pediatric cases, in particular, there may be increased reliance on histopathology because external signs of violence can be very subtle.

This failure to share relevant information about diagnostic discrepancies was wrong. Where a pathologist conducts clinical pathology for a hospital and forensic pathology for the OCCO, it is important that the two institutions communicate about these serious kinds of concerns.

The Role of the CPSO

The College of Physicians and Surgeons of Ontario is the professional regulator for the medical profession in Ontario. The medical profession is largely self-regulating, and that regulation is achieved through the CPSO. Doctors must be members of the CPSO in order to practise medicine in the province. It is essential that the CPSO act first and foremost in the public interest to govern the medical profession.

The CPSO regulates the practice of medicine by issuing certificates of registration to doctors, by monitoring and maintaining standards of practice through peer assessment and remediation, by investigating complaints against doctors on behalf of the public, and by disciplining doctors who may have committed acts of professional misconduct or displayed incompetence. The role and authority of the CPSO is set out in the *Regulated Health Professions Act*, SO 1991, c. 18; Schedule 2 of that Act, the *Health Professions Procedural Code (HPPC)*; and the *Medicine Act, 1991*, SO 1991, c. 30.

The Complaints about Dr. Smith

The three complaints against Dr. Smith initiated by D.M., Mr. Gagnon, and Ms. Brenda Waudby were complex complaints for the CPSO investigators who dealt with them. The complexity arose from the seriousness of the complaints and the number of areas of concern raised in each complaint.

Complaint in Amber's Case (D.M. Complaint)

In the first case, D.M. contacted the CPSO on November 5, 1991, and expressed concerns regarding Dr. Smith and two other SickKids physicians. D.M. reported that his daughter, S.M., had been acquitted of manslaughter by Justice Dunn on July 25, 1991, in a decision that was critical of the SickKids physicians. A letter from D.M. to the CPSO, dated November 6, 1991, enclosed Justice Dunn's judgment and other documentation in support of D.M.'s complaint that "doctors at The Hospital for Sick Children were negligent in formulating a diagnosis of child abuse (shaking) in the death of the infant Amber that resulted in a charge of Manslaughter" against D.M.'s 12-year-old daughter.

On March 24, 1992, D.M. sent a formal letter of complaint to the CPSO which outlined his concerns about Dr. Smith, the other SickKids physicians, and the SCAN Program at SickKids regarding "their wrongful diagnosis of the shaken baby syndrome." The criticisms outlined in D.M.'s complaint were very closely linked to the criticisms set out in Justice Dunn's decision in Amber's case. D.M.'s

complaint also focused on the strongly held opinions of the approximately 10 defence experts who had disagreed with Dr. Smith and the other SickKids doctors during the trial.

On April 1, 1992, the CPSO investigator wrote to Dr. Smith, providing him with a copy of the complaint against him and requesting his response to it. In his response the following month, on May 4, Dr. Smith stated:

> [O]n two occasions during my week of testimony, the Judge, Patrick Dunn, discussed my evidence with me at length. He repeatedly indicated to me that he believed [S.M.] to be guilty, and that he believed the opinions provided by [the SickKids doctors] and me.
>
> …
>
> I remain as convinced as ever, that [Amber's] head injury resulted from a non-accidental injury. Furthermore, in the months which have passed since her death, the increasing body of medical literature in the area of child abuse serves to underscore my opinions.

In October 1996, CPSO investigator C. Michéle Mann took over investigation of D.M.'s complaint because the previous investigator had left the CPSO. There did not appear to have been any activity on this investigation between October 1992 and October 1996, other than one letter written to D.M. in October 1995. This was an inordinate period of delay.

When she read the file in October 1996, Ms. Mann was surprised and concerned by Dr. Smith's comments regarding his discussions with Justice Dunn. She thought that judges were not allowed to discuss a case with a witness during the trial. However, at the time, Ms. Mann believed Dr. Smith's statement to be an accurate portrayal of his discussion with Justice Dunn, and she did not contact Justice Dunn to seek his comments on Dr. Smith's remarks. She believed that, if these discussions had occurred, it was a matter for the criminal courts to deal with and not a matter for the CPSO, as it did not involve the practice of medicine. Investigator Elizabeth Doris, who took the file over from Ms. Mann in 2000, reached the same conclusion. It is unfortunate that neither of them probed Dr. Smith's comments more deeply. Primary responsibility, however, must lie with Dr. Smith for misleading the CPSO by falsely attributing those statements to Justice Dunn.

Ms. Mann met with D.M., D.M.'s spouse, and S.M. on November 9, 1996. D.M. indicated that he wanted his complaint against Dr. Smith to proceed to the CPSO Complaints Committee for a full review and for a decision to be rendered as to whether medical standards had been breached. By December 15, 1997, Ms.

Mann had prepared the file for this process, and the case was listed for a Complaints Committee hearing in March 1998.

On October 15, 1997, members of the CPSO Executive Committee met with Dr. Young and Dr. Cairns. They agreed that, pending an amendment to clarify the legislation, complaints regarding acts performed by medical doctors in the discharge of duties for the OCCO would not be brought to, nor adjudicated by, the Complaints Committee, but instead would be dealt with by the Chief Coroner and the Coroners' Council. The CPSO Complaints Committee would deal only with complaints regarding acts that were part of the practice of medicine. If a complainant insisted that the Complaints Committee deal with a complaint about a coroner, the coroner complained of would be required to reply only to the extent necessary to establish that the acts complained of were not part of the practice of medicine, but were performed in the exercise of OCCO duties. At that point, the Complaints Committee would dismiss the matter and refer it to the OCCO. This process represented the functioning policy of the CPSO as of October 1997.

By letter dated March 4, 1998, Dr. Young wrote to Ms. Mann regarding D.M.'s complaint against Dr. Smith. Dr. Young's position was that, "[a]s the complaint against Dr. Smith relates to actions performed by him pursuant to the *Coroners Act* the complaint should be properly addressed to me." Dr. Young expressed his view that the CPSO did not have jurisdiction "to deal with complaints about the actions, findings or opinions of a pathologist acting pursuant to the *Coroners Act*."

Later that same month, the Complaints Committee sought the direction of the Executive Committee as to the applicability to the D.M. complaint of the October 1997 policy statement that had resulted from the Executive Committee meeting with Dr. Cairns and Dr. Young. The CPSO director of investigations, Howard Maker, wrote to the co-chairs of the Complaints Committee, Dr. Rocco Gerace and Dr. David Walker, seeking their direction regarding the jurisdictional issues.

At the time, Dr. Gerace's expectation was that both the CPSO and the OCCO had the same intent regarding protection of the public interest. Dr. Gerace surmised that a decision had been made not to duplicate activity, but to ensure that concerns were dealt with adequately and effectively. He assumed that the investigation would be done appropriately by either the OCCO or the CPSO. At the time, the CPSO had no reason to believe that the OCCO would not investigate the complaints properly. He was surprised and disappointed to learn at the Inquiry that, in the second complaint submitted to the CPSO in relation to Nicholas' case, Dr. Young had not read the entire complaint filed by Mr. Gagnon.

On March 23, 1998, Dr. Gerace sent an email to Mr. Maker regarding jurisdictional issues and the complaint against Dr. Smith. He wrote that it appeared the CPSO had "a responsibility to take on the Smith case." This email reflected his view at the time that the CPSO Complaints Committee should consider all complaints against physicians. In cases where the expertise of the Complaints Committee was lacking, he knew there was an opportunity to seek assistance or an independent opinion from an expert in the area.

In April 1998, however, the Executive Committee concluded differently: "When a physician acts under the instruction of a coroner and reports back to the coroner, then any complaint received by the College with respect to that physician's actions as agent of the coroner's office should be referred to the Chief Coroner's Office."

The Complaints Committee met over three days from March 9 to 11, 1998, to address the complaint by D.M. against Dr. Smith. At this time, Dr. Gerace, who was a member of the Complaints Committee that reviewed D.M.'s complaint, was taken aback by Justice Dunn's decision, considering it "quite scathing in respect to Dr. Smith's performance both at the time of his performing the autopsy and his testimony." In May 1998, the Complaints Committee decided to take no further action on D.M.'s complaint. Because Dr. Smith's involvement in this matter was undertaken as an agent of the OCCO, the Complaints Committee concluded that it did not have jurisdiction to deal with the complaint.

In his testimony at the Inquiry, Dr. Gerace said that, in his view, Dr. Smith was engaged in the practice of medicine when he performed his post-mortem examinations and that the CPSO should have taken jurisdiction of the complaints made against him. I agree. The decision to decline jurisdiction of D.M.'s complaint was a missed opportunity for the CPSO to deal with the complaints alleged against Dr. Smith by 1998.

On June 16, 1998, D.M. requested a review by the HPARB of the CPSO's decision to decline jurisdiction to resolve his complaint. The HPARB is an independent adjudicative agency that hears appeals from decisions made by complaints committees of health colleges. When the HPARB issued its decision, on September 1, 2000, it determined that the CPSO did indeed have jurisdiction over the complaint. It referred the complaint back to the Complaints Committee for further investigation. Ms. Doris was assigned to take charge of the file.

Complaints in Nicholas' Case (Gagnon Complaint)

The CPSO received a complaint in October 1998 regarding Dr. Smith's conduct at Nicholas' disinterment from Maurice Gagnon, Nicholas' grandfather. Mr. Gagnon raised two areas of concern. First, the disinterment of Nicholas' body

occurred later in the day than the Gagnon family had been advised it would occur, resulting, to the distress of the family, in some onlookers being present. Second, Dr. Smith brought his young son to the disinterment with him.

Ms. Mann was assigned to investigate this matter, and she wrote to Mr. Gagnon indicating that the CPSO had no jurisdiction to take any action regarding complaints against a physician acting as a coroner in pursuance of authority under the *Coroners Act*. Ms. Mann discussed this delineation of responsibility with Mr. Gagnon, and he agreed that she should send a copy of his complaint to Dr. Young, so that the OCCO could look into his concerns. During her discussion with Mr. Gagnon, Ms. Mann indicated that the best avenue for redress for his concerns was through the OCCO and the Coroners' Council. In providing this advice, Ms. Mann was reflecting the policy as passed by the CPSO Executive Committee.

On November 30, 1999, Mr. Gagnon wrote to Dr. John Bonn, registrar, CPSO, initiating a second complaint and asking if the CPSO would assume jurisdiction over Dr. Smith since the Coroners' Council had been disbanded. Mr. Gagnon indicated that he was dissatisfied with Dr. Young's response to his complaint and alleged that Dr. Smith was guilty of professional misconduct in the case.

After the HPARB issued its September 1, 2000, decision in the D.M. complaint, which held that the CPSO had jurisdiction to investigate complaints against physicians working under the jurisdiction of the OCCO, the CPSO Complaints Committee assigned an investigator to look into Mr. Gagnon's second complaint. In 2000 and 2001, the CPSO investigated Dr. Smith's conduct in Nicholas' case.

Complaint in Jenna's Case (Waudby Complaint)

In the third complaint case, the CPSO received a complaint in May 2001 from Jenna's mother, Ms. Waudby, about Dr. Smith. Ms. Waudby's complaint addressed Dr. Smith's opinion on the timing of injuries to Jenna; the fact that Dr. Smith did not conduct a "rape kit" examination, although the hospital staff had noted signs of sexual abuse; and the fact that Dr. Smith had lost a hair collected from Jenna's body. Ms. Doris investigated this complaint.

During the course of her investigation, Ms. Doris collected materials provided by the complainant, responding materials provided by Dr. Smith, hospital records from Peterborough Civic Hospital and SickKids, a collection of expert opinions, preliminary hearing testimony, police reports, witness statements, additional materials provided by the Peterborough Lakefield Community Police Service, materials provided to the panel of assessors assigned by the CPSO, materials from the OCCO, and autopsy photographs. Ms. Doris prepared an

investigative summary, which included information regarding telephone calls and correspondence with the parties.

The OCCO did not initially comply with the CPSO requests for provision of documents related to Ms. Waudby's complaint. A letter from Dr. Cairns to Ms. Doris, dated August 9, 2001, indicated that the criminal case had been reactivated and that a further police investigation was under way. For this reason, Dr. Cairns maintained that he was unable to furnish the CPSO with the requested documents until the investigation was completed.

Further Investigation and Decision of the CPSO in the Three Complaints

In July 2001, the CPSO Complaints Committee had convened a three-member panel of experts to assess the complaints made by D.M., Mr. Gagnon, and Ms. Waudby. The CPSO requested an independent medical opinion from the panel regarding the three complaints.

On September 4, 2001, Ms. Doris requested that the registrar appoint investigators to conduct an investigation under s. 75(c) of the *HPPC* with respect to the complaints made by D.M., Mr. Gagnon, and Ms. Waudby. An appointment under s. 75(c) allows the investigator broader powers – something Ms. Doris wanted because she had experienced difficulty in obtaining certain materials during the course of her investigation before this appointment.

In September 2001, the CPSO advised Dr. Smith that it had approved the appointment of investigators under s. 75(c) of the *HPPC* and that the investigators would be inquiring into and examining his practice with respect to pathology. Dr. Smith was advised that the CPSO was making efforts to assemble a team of experts, who would be asked to provide an opinion as to whether the care Dr. Smith provided met the expected standard of practice in the profession.

In December 2001, the CPSO confirmed the appointment of three panel members: Dr. Cynthia Trevenen, a pediatric pathologist at the Alberta Children's Hospital; Dr. Lloyd Denmark, a pathologist and the deputy chief medical examiner in Alberta; and Dr. Stephen Cohle, a certified forensic pathologist from Michigan. Dr. Cohle was to act as the chair of the panel. The panel members were asked "to provide an opinion as to whether the care provided by Dr. Smith meets the standard of practice of the profession."

On February 14, 2002, Ms. Doris wrote to the panel of assessors and asked them to address nine specific questions related to D.M.'s complaint. She provided them with approximately 1,000 pages of material to review in assessing this complaint. She also provided a similar list of questions and material for the panel to review in the Gagnon and Waudby complaints. Other than one request for addi-

tional excerpts of testimony related to Jenna's case, Ms. Doris believed that the panel of assessors was satisfied she had provided them with sufficient information to permit them to answer the questions posed.

On April 10, 2002, Dr. Carlisle wrote a memo to file regarding his conversation with Dr. Cairns about Jenna's case. Dr. Carlisle's memo indicated that Dr. Cairns informed him that he had discussed Ms. Waudby's complaint with Dr. Smith and that Dr. Smith had told Dr. Cairns that "he had not conducted a rape kit examination" and that "he had not taken any of the samples or specimens that would ordinarily be associated with such an examination." Moreover, Dr. Smith had found "what he believed to be a hair." He had collected the hair and placed it in a sealed envelope, which he had kept in his possession since the time of the investigation. Dr. Smith had not revealed the existence of the hair to anyone, he had not submitted it for analysis, and he had not given it to the police. Dr. Cairns indicated, as a result of this revelation, "he believed that Dr. Smith would be in some serious difficulty and that he did not wish to be party as Deputy Chief Coroner to any deception."

In response to this information, Dr. Carlisle indicated that his memo would be for his record and would "not form part of the Complaints File."

On April 10, 2002, Dr. Carlisle wrote a memorandum to Ms. Doris regarding Ms. Waudby's complaint against Dr. Smith. He wrote that, as he had indicated earlier to Ms. Doris, he had spoken with officials in the provincial government regarding Jenna's case. Dr. Carlisle told Ms. Doris that there was some level of frustration at the OCCO, but he did not relate the details of his conversation with Dr. Cairns or the contents of his memo to file to her. He wanted to know the progress of the investigation, and Ms. Doris provided him with those details.

When asked about the April 10, 2002, memo to file at the Inquiry, Dr. Gerace testified: "I would not consider the practice [of writing a memo that would not form a part of the file] to be advisable. In fact, that practice would not occur at the present time." He went on to describe the current approach to the receipt of information:

> We have a practice at the College that if information comes to any member of the staff about a member, that the person providing that information is told up front that that information will be acted upon.
>
> There are no confidential documents that are not acted on. So, if a conversation of this sort were to have occurred today, I would send a note to the relevant individuals outlining the content of that conversation.

I agree with the CPSO's current approach.

On April 10, 2002, Dr. Young wrote to Ms. Doris regarding the CPSO's investigation of Dr. Smith. As discussed above, that letter was not balanced, objective, or candid. At the time she received this letter, Ms. Doris was not aware that, since January 2001, the OCCO had not allowed Dr. Smith to conduct autopsies in criminally suspicious cases. She told the Inquiry that the information that Dr. Smith was no longer performing autopsies in criminally suspicious cases would have been relevant to the determinations of the Complaints Committee and would have been provided to them, if disclosed.

On June 18, 2002, Dr. Cohle interviewed Dr. Smith on behalf of the assessment panel. Before the interview, Ms. Doris provided Dr. Smith with a copy of the questions he would be asked. The CPSO recording secretary took notes of the interview, and it appears that the meeting was collegial and professional.

Ms. Doris met with Dr. Cohle in the morning, before his interview with Dr. Smith, and provided him with a "summary of evidence for medical review" prepared by the police and a copy of Detective Constable Charmley's notes. During the interview, Dr. Smith stated that, in Jenna's case, the police had said that the hair was a contaminant and had refused to take it.

Dr. Gerace testified that Dr. Cohle would not have been in a position to evaluate Dr. Smith's credibility. While this may be true, this aspect of the process appears to have been a missed opportunity for the CPSO to test the veracity of Dr. Smith's statements. It is unfortunate that the statements of others, which would have contradicted Dr. Smith, were not read to Dr. Smith during this interview, and that Dr. Smith's explanation seems simply to have been accepted.

On July 22, 2002, Dr. Cohle provided the opinion of the panel of experts relating to the complaints. He noted certain deficiencies, but concluded that Dr. Smith did not fall below a reasonable standard of care in any of the areas of concern raised by the CPSO in the three complaints.

On October 15, 2002, the CPSO Complaints Committee issued its decisions in the D.M., Gagnon, and Waudby complaints. The Complaints Committee reviewed the expert panel's findings and found that the deficiencies noted by the panel generally fell into two broad categories: Dr. Smith's work was not as thorough as it should have been; and, where doubt existed, Dr. Smith was overly dogmatic in stating his conclusions. The committee accepted the expert panel's opinion that Dr. Smith's overall approach was acceptable and concluded:

> Nevertheless, the Committee is extremely disturbed by the deficiencies in his approach in this case, as set out above.
>
> Accordingly, the Committee will require Dr. Smith to attend before a panel of the Complaints Committee, to be cautioned with respect to those points. A

> caution in person is a serious outcome for members of the medical profession. It is a tangible symbol of the disapproval of one's peers and a sharp reminder about the need for improvement in future practice.

On November 20 and 29, 2002, D.M. and Ms. Waudby, respectively, wrote to the HPARB and requested that it review the decisions of the CPSO Complaints Committee. On November 10, 2003, and January 22, 2004, the HPARB issued decisions confirming the committee's decisions in Ms. Waudby's and D.M.'s complaints, respectively.

On May 26, 2004, Dr. Smith was cautioned by the CPSO Complaints Committee.

Members of the committee who administer the caution complete a "Record of Interaction," which records indicators of each member's attitude with respect to the caution. A Record of Interaction form completed by Dr. Dale Mercer, the acting committee chair, in relation to Dr. Smith's caution indicated that Dr. Mercer's overall sense regarding the extent to which the caution served as a useful educative function was "10" or "very useful." Dr. Mercer also noted that Dr. Smith "understands his role in this complaint & had instituted appropriate changes."

While the CPSO did play its role as one accountability mechanism for doctors, with hindsight a more vigorous response would have been preferable. There is no doubt that the misinformation it received from Dr. Smith, its acceptance of this misinformation without testing it, and its failure to be informed of relevant facts by the OCCO contributed to what happened. However, this review remains yet another lesson in the need for active vigilance if oversight and accountability mechanisms are to do their job properly.

The New Era

Even before the Province of Ontario called this Inquiry, the winds of change had begun to blow through the OCCO, which is the organization primarily responsible for pediatric forensic pathology in the province. Vital to this change were three individuals who found themselves in key roles well suited to their skills, temperaments, and enthusiasms.

First, Dr. McLellan became Chief Coroner for Ontario in April 2004 and served in that capacity until September 2007. Shortly after becoming Chief Coroner, he met with Dr. Smith and insisted that he resign his position as director of the OPFPU. Dr. McLellan then went on to call both the Tissue Audit at the OPFPU and the Chief Coroner's Review. He provided principled and courageous leadership to the OCCO, and the province benefited greatly from his efforts.

Second, in October 2005, Dr. Chiasson became the director of the OPFPU. After Dr. Smith resigned the position, Dr. Taylor took over as director until Dr. Chiasson, a certified forensic pathologist, was appointed. Dr. Chiasson now takes the lead on the large majority of cases at the OPFPU that raise criminal suspicions.

Finally, Dr. Pollanen became Chief Forensic Pathologist in April 2006, having been a staff member at the Provincial Forensic Pathology Unit (PFPU) since 2003. Dr. Pollanen has excellent academic credentials, along with a firm commitment to improving the science and practice of forensic pathology.

These leaders have brought about a fundamental change in the general approach to the oversight of forensic pathology in the province. The OCCO has made significant progress to correct a number of the very troubling gaps in oversight that were evident throughout the 1980s and 1990s. Perhaps most important, Dr. Pollanen and Dr. McLellan have made it clear to forensic pathologists in the province that performing a high-quality autopsy that is objective and evidence-based is the most effective way a pathologist can participate in the criminal justice system. However, as the OCCO acknowledges, much remains to be done.

The New Guidelines

An Evidence-Based, Objective Approach to Pediatric Forensic Pathology

The OCCO's approach to forensic pathology and expert evidence in recent years has focused on the need for experts to remain objective and open-minded. During Dr. McLellan's tenure, the concept of "thinking dirty" was removed from standard presentations the OCCO gave to death investigators. In 2006, the OCCO replaced the 1995 Protocol for the Investigation of Sudden and Unexpected Deaths in Children under 2 Years of Age, which had introduced the concept of "thinking dirty" into the investigation of infant deaths.

In addition to emphasizing that pathologists serving as expert witnesses must be scrupulously objective, the OCCO has endorsed and promoted the use of an evidence-based approach to forensic pathology, one that requires opinions to be firmly anchored in reviewable facts from the autopsy and the peer-reviewed medical literature. An evidence-based approach is readily amenable to scrutiny through mechanisms such as cross-examination. Moreover, it accepts that there are limits to knowledge and that, as a result, autopsies may yield an undetermined conclusion as to the cause of death. In these respects, it is quite different from the traditional experience-based approach to forensic pathology, where pathologists might feel quite justified in reaching firm opinions based only on their own experiences.

Role of the Forensic Expert in the Criminal Justice System

In the months before Dr. McLellan became Chief Coroner, a number of individuals, many from the defence bar, expressed concerns to him about a perception that the OCCO and the pathologists working under coroner's warrants were not entirely objective. Criminal defence counsel advised him that they were sometimes unable to speak with pathologists who had performed the autopsy in advance of court appearances and that they had difficulties retaining pathologists to provide opinions for the defence. Dr. McLellan was properly troubled by the perception that the OCCO and its pathologists were not fully independent of the prosecution. On July 12, 2004, therefore, he issued a memorandum to all Ontario coroners, pathologists, forensic anthropologists, and forensic dentists to address these concerns. Dr. McLellan wrote that "[t]he ultimate objective of the Crown in putting forward scientific evidence is to ensure that such evidence is presented to the court with no more or less than its legitimate force and effect." The forensic expert must make every effort to communicate to the Crown "any limitations upon the inferences to the reliability drawn from … evidence," and the Crown should advise all experts not to take an adversarial position.

Dr. McLellan's memo sets out some important observations about the risk of experts aligning themselves with the Crown. Developed through familiarity with the prosecution, this bias can result in experts incorrectly believing that their function is to support the theory of the police and the Crown. As noted in the July 12 memorandum, such a misperception among experts has the potential to contribute to miscarriages of justice.

The Autopsy Guidelines

In 2005, Dr. Pollanen implemented the Guidelines on Autopsy Practice for Forensic Pathologists in Criminally Suspicious Cases and Homicides (Autopsy Guidelines), province-wide guidelines for post-mortem examinations in criminally suspicious deaths. They reflect an evidence-based, objective approach to pathology evidence and are intended to assist forensic pathologists, minimize non-reviewable errors at autopsy, and ensure proper documentation, procedures, and testing during the post-mortem examination. In October 2007, the second edition of the guidelines was released.

The Autopsy Guidelines provide directions on the importance of balanced, objective, and evidence-based opinions. They reiterate that pathologists should not think dirty but should keep an open mind and think objectively. The duty for every pathologist is to be an independent expert to the court. They must remain professionally independent of the coroner, police, prosecution, and defence bar in order to discharge their responsibilities in an objective manner.

The Autopsy Guidelines set out principles for disclosure, emphasizing the importance of reviewability of documentation, disclosure of all samples, and inclusion of all consultation reports. They also provide a number of guidelines for the forensic pathologist's opinion, with emphasis on independent reviewability, a full explanation of reasoning, and the exclusion of speculation. They are intended, in short, to ensure that reports provide readers with an understanding of the analytical process and the evidence base behind the cause of death opinion.

The 2006 Protocol Regarding Deaths of Children under Five

In 2006, the OCCO expanded the scope of its protocol regarding investigation of sudden and unexpected deaths of children under two to cover all such deaths in children five and younger. In December 2006, the OCCO issued the revised protocol that replaced the 1995 Protocol for the Investigation of Sudden and Unexpected Deaths in Children under 2 Years of Age.

The 2007 Autopsy Guidelines for Criminally Suspicious Pediatric Cases

In April 2007, the OCCO introduced Autopsy Guidelines for Homicidal and Criminally Suspicious Deaths in Infants and Children. These guidelines were subsequently incorporated directly into the October 2007 Autopsy Guidelines in a section addressing autopsies in homicidal or criminally suspicious deaths in infancy or childhood. The summary of the specific guidelines on child deaths reiterates the fundamental principles of forensic pathology generally, including the importance of keeping "an open mind to death by child abuse and diseases or conditions that may mimic child abuse," being "mindful of the pitfalls in pediatric forensic pathology by emphasizing balanced, reasonable and evidence-based expert opinions," and balancing the "role of physicians as patient or child welfare advocates and our special duty to provide unbiased evidence to the criminal justice system as expert witnesses."

Improvements in Peer Review and Quality Assurance

In recent years, the OCCO has also made important advances in designing systems for peer review and quality assurance of reports of post-mortem examination.

Although the *Coroners Act* remains silent on the role of the Chief Forensic Pathologist, policies and guidelines issued by the OCCO describe the Chief Forensic Pathologist's role in quality control. The 2007 Autopsy Guidelines mandate early central notification to the Chief Forensic Pathologist of preliminary autopsy results (including the nature of the case, necessary further testing, and a

cause of death or pending cause of death) in criminally suspicious cases. The purpose of the notification is to ensure that, within 24 hours, Dr. Pollanen or his designate can provide feedback about other issues which may need to be investigated, as well as to allow for early case conferencing. The 2007 Autopsy Guidelines also recommend consultation with the Chief Forensic Pathologist in potentially controversial matters.

Peer review of autopsy reports is central to the current quality assurance system for criminally suspicious cases. As of August 2004, the regional directors assumed responsibility for review of autopsy reports in their regions. As set out in the Autopsy Guidelines, all autopsy reports in criminally suspicious cases are now peer reviewed by the Chief Forensic Pathologist, by a regional director, or by a forensic pathologist at the PFPU before release to the coroner and the criminal justice system. The regional directors review the reports of other pathologists within their units, and the Chief Forensic Pathologist reviews the reports of the regional directors. The Chief Forensic Pathologist's reports are reviewed by either a colleague at the PFPU or a regional director. Within the PFPU, staff forensic pathologists provide peer review of their colleagues' reports. In cases performed outside a forensic pathology unit, such as at the Winnipeg Health Sciences Centre, the Chief Forensic Pathologist reviews reports in criminally suspicious cases. The main issues assessed in peer review are the independent reviewability of the report and the cause of death opinion.

The extent of the current peer review of each individual report of post-mortem examination is more comprehensive than Dr. Chiasson's paper review in the 1990s. The originating pathologist must submit the report, background information, images from the gross examination and ancillary reports, and, in some cases, histology slides to the peer reviewer. If necessary, such as in most pediatric homicides, examination of the histology is undertaken. The peer review form provided in the Autopsy Guidelines requires the reviewing pathologist to indicate whether he or she agrees with the cause of death and the other medico-legal opinions, not merely whether the original opinions are "reasonable."

The Autopsy Guidelines also incorporate a process for further examination where there is a difference of opinion between the originating and the reviewing pathologist. If there is a significant difference of opinion about the cause of death or other major forensic issues, the Chief Forensic Pathologist is notified and must then both undertake a comprehensive review and prepare a written report.

The Autopsy Guidelines process for review of reports of post-mortem examination applies only to reports in cases giving rise to criminal suspicions. The Autopsy Guidelines define a criminally suspicious case broadly as a death "that

may be related to the action of another person or persons." Within the regional forensic pathology units, peer review in non-criminally suspicious cases is undertaken at the discretion of the regional directors, and reviews vary in their scope and procedures. Some of the regional directors review all coroner's cases, while others conduct only random or sporadic reviews. In practice, it appears that all pediatric cases are subject to some form of review within the units performing pediatric cases. In addition, all autopsy reports in the deaths of children under five are subject to review by the Deaths under Five Committee, which includes a number of pathologists among its members.

For its part, for example, the OPFPU has implemented a more rigorous process for peer review of all reports of post-mortem examination before they leave the unit. In 2004, when Dr. Taylor became the director of the unit, he continued to review his colleagues' forensic autopsy reports. As a quality assurance measure, he then implemented a system whereby his own reports were reviewed by Dr. Chiasson. This system continues under the current director, Dr. Chiasson, with Dr. Taylor reviewing Dr. Chiasson's reports. Where necessary, Dr. Chiasson reviews the images and slides that are available. SickKids now also has a form for comments regarding the review. These forms are kept as part of the pathologist's permanent file on the matter, though they are not submitted with the report to the coroner's office.

With Dr. Chiasson's assistance, Dr. Taylor also began to hold regular rounds to review forensic cases. Since October 2003, the OCCO has granted permission for all criminally suspicious cases to be presented at SickKids forensic pathology rounds, which are attended by SickKids pathologists and representatives of the OCCO. Currently, the results of all post-mortem examinations are presented by the pathologist at either a weekly clinico-pathological round or a monthly forensic pathology round, depending on the nature of the case and whether the decedent was a hospital patient. The rounds do not provide an in-depth review of all the slides and circumstantial evidence, but they are very valuable in confirming whether peers think the pathologist is on the right track. Alternative interpretations, suggestions, and additional areas of study are discussed at rounds, where there is both an educational and a peer-review component.

Death Investigation Communications Regarding Forensic Pathology

In September 2002, Dr. McLellan issued a memorandum to all coroners, pathologists, and chiefs of police, among others, regarding case conferences for homicides and criminally suspicious cases. For the first time, the OCCO recommended

that a case conference be held within two weeks of the autopsy for every homicide and criminally suspicious death.

In 2003, the OCCO issued the first written Guidelines for Death Investigation to develop consistent expectations for coroners across Ontario. The OCCO released a second edition in April 2007. Before the introduction of the first edition, the main guidance for coroners, apart from the Coroners' Investigation Manual, was the legislation.

The Guidelines for Death Investigation require the investigating coroner to contact the regional coroner in cases involving the deaths of children under five years of age or children who have had previous CAS involvement, and in homicides or deaths with suspicious circumstances. They set out the desirability of discussion between the coroner and the pathologist and outline elements that should be included in the warrant for post-mortem examination issued to the pathologist. They also emphasize the importance of attendance at the scene wherever possible.

Policies and Oversight Mechanisms Regarding Timeliness of Reports

According to the job description prepared by the Ministry of Community Safety and Correctional Services, the Chief Forensic Pathologist is responsible for all forensic autopsies in the province. This responsibility includes the timely completion of reports of post-mortem examination. However, the Chief Forensic Pathologist lacks the adequate tools to ensure this timely production. The OCCO, for example, still does not have a central mechanism to track incomplete autopsy reports.

In July 2004, the OCCO first developed a policy requiring reports of post-mortem examination to be completed within certain timelines. Memorandum 04-13 decreed that, where there are no other outstanding reports (such as toxicology reports), autopsy reports should be completed within 12 weeks of the autopsy. In cases where the completion of reports is dependent on other reports and/or investigation materials, autopsy reports should be completed within four weeks after receiving the requisite reports or relevant investigation materials. Despite this policy, the OCCO continues to experience delays by many pathologists in producing their reports. There are a number of reasons for delays, including volume of work, and delays in ancillary testing such as toxicology studies at the Centre of Forensic Sciences (CFS) in Toronto. The senior management committee of the OCCO has been involved in continuing discussions with the CFS about improving its turnaround times.

The Expertise of Pathologists Performing Autopsies

The major change in the performance of pediatric forensic autopsies since the 1990s is that all of them must be performed at specified regional pediatric centres, with the exception of some limited cases such as those where a child had numerous congenital problems or where an older child was hit by a car. On March 1, 2002, the OCCO announced in Memorandum 02-03, "Paediatric Medicolegal Autopsies," that forensic autopsies of children under the age of two were to be conducted in one of four pediatric subspecialty centres – at the regional forensic pathology units in London, Hamilton, or Toronto (the OPFPU), or in Ottawa at the Children's Hospital of Eastern Ontario (CHEO). In practice, almost all deaths of children, regardless of their age, are sent to these centres. Where pediatric deaths occur outside a defined catchment area for one of the regional centres, they are generally sent to the OPFPU. Approximately 50 per cent of pediatric forensic autopsies are performed there. Cases in Northwestern Ontario near the Manitoba border are sometimes directed to Dr. Susan Phillips, a pathologist at the Winnipeg Health Sciences Centre, an academic teaching hospital in Manitoba.

The leadership of the OCCO has continued to monitor the quality of pediatric forensic autopsies being performed at these four Ontario locations. For example, since the fall of 2007, criminally suspicious pediatric autopsies have not been performed at CHEO in Ottawa because Dr. Pollanen had developed some concerns about quality there.

In the 2005 Autopsy Guidelines, the OCCO additionally stated that only a forensic pathologist – a certified anatomical or general pathologist with specific training or certification in forensic pathology and/or recognized experience as a forensic pathologist – may perform autopsies in criminally suspicious cases. The 2007 Autopsy Guidelines added that only those forensic pathologists with pediatric experience or pediatric pathologists with significant forensic experience may perform the autopsy in the criminally suspicious death of an infant or child.

At the OPFPU, the director is responsible for triaging its cases. If he or she is not available, the pathologist on duty will triage the case. The pathologists apply the Autopsy Guidelines to determine whether a case is criminally suspicious. In July 2007, the OPFPU developed its own Autopsy Guidelines in Sudden Unexpected Deaths of Infants and Children under 5 Years, which adopted the OCCO criteria for determining if a case is criminally suspicious and provided its own guidelines for cases that are not. If a case is considered criminally suspicious under the Autopsy Guidelines, Dr. Chiasson or Dr. Pollanen performs the post-mortem examination; for all other cases, the pathologist on duty will be

responsible. If there are any concerns, the pathologist will contact Drs. Chiasson, Taylor, or Pollanen.

Development of Regional Forensic Pathology Units

As I discuss in Chapter 7, Organization of Pediatric Forensic Pathology, the original agreement establishing the OPFPU contained no provisions regarding oversight of, or accountability for, its activities. The original 1991 agreement remained in place until 2004.

That year, a much more detailed agreement was signed between SickKids and the ministry regarding the OPFPU, and the parties have ratified a similar agreement every year since 2004. The revised agreement adds considerable clarity to the relationship. It speaks to the responsibilities of the director and the Chief Coroner. It specifies that the director would be appointed by the Chief Coroner, with the approval of the local hospital administration and the head of the pathology department at SickKids. The revised agreement provides for a governance mechanism in the form of an executive team comprising SickKids representatives, the OPFPU director, and, more recently, a representative of the OCCO. The 2004 agreement also provides that the unit be staffed by "dedicated pathologists, acceptable to both the local hospital and the university, with appropriate training (American Board of Pathology accredited fellowship in forensic pathology, pediatric pathology or equivalent) and/or concentrated case experience in forensic pathology. American Board of Pathology Subspecialty Certification in forensic pathology, pediatric pathology, or equivalent formal certification is highly desirable."

However, the revised agreement for the OPFPU failed to delineate the role of the Chief Forensic Pathologist to provide for the oversight of the work of the director, and to give the director responsibility for oversight of the professional work of the unit. Indeed, after 2001, with the absence of an appointed Chief Forensic Pathologist, the agreements regarding the London, Ottawa, and Kingston units were amended to reallocate the oversight responsibilities of the Chief Forensic Pathologist to the Deputy Chief Coroner, Forensic Services, and, subsequently, to the Chief Coroner. Therefore, as of 2007, the agreements suggest that responsibilities for providing direction regarding accepted standards of forensic pathology and ensuring quality control measures rest with the Chief Coroner, as does the responsibility to review all homicide and suspicious death reports before release. Even with the appointment of the current Chief Forensic Pathologist, the agreements were not revised to reflect the Chief Forensic Pathologist's role in oversight of the work of the units. Nor do they set out that

the regional directors should have responsibility for professional oversight of the forensic pathology work of the units. The agreements should reflect the role of the Chief Forensic Pathologist and the regional directors in overseeing and being accountable for the work of the units.

Unlike the agreements regarding the other regional units, which, as discussed in Chapter 7, Organization of Pediatric Forensic Pathology, were revised to clarify accountability and reporting relationships, the agreement establishing the Hamilton unit has remained largely unchanged since the 1990s. It does not incorporate any clarification of accountability and reporting relationships as set out in the other agreements.

In addition to the regional forensic pathology units in place since 2000, all of which are established through contractual agreements between the hospitals in which they are housed and the ministry, the Northeastern regional forensic pathology unit was developed under the OCCO's new leadership. The Northeastern unit, located at Sudbury Regional Hospital, is an informal unit because it is not the subject of a contractual agreement with the ministry, and thus does not receive any additional funding. The Northeastern unit performs autopsies for the Sudbury Manitoulin regions, as well as North Bay and Thunder Bay. Dr. Martin Queen, a certified forensic pathologist, performs the criminally suspicious cases at the unit. The Northeastern regional unit does not, however, perform pediatric cases, which are sent to the OPFPU.

Mechanisms for Review of Participation in the Justice System

The OCCO currently does not have any mechanism in place to review the testimony of forensic pathologists. There is also no mechanism allowing the Chief Forensic Pathologist or the OCCO to monitor the opinions that a pathologist provides to the Crown or the police, apart from the post-mortem report. In addition, the OCCO has limited ability to locate, let alone review, supplementary reports produced after the final report of post-mortem examination is released by the OCCO to the criminal justice system. The Autopsy Guidelines have, however, introduced a clear requirement that, in cases where a pathologist's previous conclusions can no longer be substantiated, the pathologist must clearly state his or her amended opinion, and should also provide a supplementary letter or amended report of post-mortem examination to the coroner. The coroner or the regional coroner forwards such supplementary opinions to the appropriate actors in the justice system.

Committee Development

By 2004, the OCCO had a well-developed system of committees for review of pediatric cases – the PDRC and the Deaths under Two Committee. Under the new leadership, there has been an expansion of the mandate of the Deaths under Two Committee (renamed the Deaths under Five Committee as of October 2006) to include a review of all death investigations relating to children under the age of five years.

More broadly, Dr. McLellan's tenure saw the development in 2004 of the Forensic Services Advisory Committee (FSAC), a multidisciplinary committee designed to provide independent and external advice to the Chief Coroner and, in so doing, ensure the quality and independence of post-mortem examinations in coroner's cases. The FSAC was created in part to respond to the concerns raised by criminal defence lawyers about the OCCO's perceived lack of objectivity. The FSAC comprises representatives from the OCCO, the CFS, the Crown, and the police, as well as criminal defence lawyers and forensic pathologists.

The FSAC has generated a list of forensic pathologists willing to provide opinions to the defence. It addresses issues around the education of forensic pathologists and the need for standardized electronic records for autopsy reports. And, as I describe in Chapter 2, Growing Concerns, it played a central role in determining the scope and process of the Chief Coroner's Review.

Educational Activities

Throughout most of the 1990s, the OCCO ran some educational programs for coroners and pathologists, a few of which engaged forensic pathology issues. The new leadership team at the OCCO has built on these endeavours. Recently, Dr. Pollanen developed an expert witness workshop to provide education and mock trial experience to forensic pathologists. Crown and defence experts assist in teaching the workshops. Dr. Pollanen also instituted bimonthly seminars for pathologists and coroners about difficult issues in forensic pathology. Recent topics have included autopsy pitfalls and miscarriages of justice.

New Physical Facilities

The OCCO advised the Inquiry that it is working toward the development of a new forensic sciences complex because the current facilities are inadequate for the size and demands of death investigations. Dr. Porter stated that the OCCO's current facilities are too small and cannot adequately respond to changing demands.

Similarly, Dr. McLellan commented that the current physical plant facilities, which are more than 30 years old, are too small and make performance of high-quality work much more difficult. Indeed, Dr. Stephen Cordner, the director of the Victorian Institute of Forensic Medicine in Australia, described the OCCO's current facilities as cramped and outdated when he toured them. The proposed complex would replace the current PFPU and the OCCO, and house the CFS, the PFPU, the administrative offices of the OCCO, and the Inquest Courts. The complex would provide increased body storage capacity and physical space for pathology. Suffice it to say that it is vital that the OCCO be properly housed if it is to provide the services that the criminal justice system and the people of Ontario deserve.

Conclusion

The story of the oversight of pediatric forensic pathology in Ontario during the Dr. Smith years is unsettling. In previous chapters, I explore the inadequate institutional and legislative structures surrounding pediatric forensic pathology from 1981 to 2001. In this chapter, I have traced how the deeply flawed oversight of Dr. Smith contributed to many serious errors in the practice of pediatric forensic pathology in the province. At the OCCO, the de facto oversight of Dr. Smith was conducted by Dr. Cairns and Dr. Young, neither of whom had the expertise to oversee forensic pathology work. Both failed to heed danger signals about Dr. Smith's work, even when the errors became obvious and demanded a response. To the extent that Dr. Young took any action, it was largely to protect the reputation of his office and Dr. Smith, rather than to serve the public interest.

Although the deficiencies revealed by my review of the oversight of pediatric forensic pathology between 1981 and 2001 are deeply disturbing, I am heartened by the significant progress that has been made in the last few years. The new leaders of the OCCO have adopted policies and practices that will move the organization in the right direction. However, they continue to be constrained by an inadequate legislative framework, limited resources, and a serious shortage of forensic pathologists.

More can and must be done. In Volume 3, I detail my recommendations for comprehensive changes to the legislative and institutional arrangements for oversight of pediatric forensic pathology. Only through comprehensive systemic changes can confidence in the oversight of pediatric forensic pathology in Ontario truly be restored.