Inquiry into Pediatric Forensic Pathology in Ontario

REPORT

Volume 2: Systemic Review

The Honourable Stephen T. Goudge Commissioner

Published by the Ontario Ministry of the Attorney General © Queen's Printer for Ontario 2008

```
ISBN 978-1-4249-7792-5 (Print) (set)
ISBN 978-1-4249-7795-6 (Print) (v. 2)
ISBN 978-1-4249-7796-3 (PDF) (v. 2)
```

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

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

Disponible en français

LIBRARY AND ARCHIVES CANADA CATALOGUING IN PUBLICATION DATA

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

Issued also in French under title: Rapport de la Commission d'enquête sur la médecine légale pédiatrique en Ontario. Includes bibliographical references.

Electronic monograph in PDF format.

Available also in printed form.

ISBN 978-1-4249-7794-9 (v. 1)

978-1-4249-7796-3 (v. 2)

978-1-4249-7798-7 (v. 3)

978-1-4249-7800-7 (v. 4)

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

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

Contents

Volume 1: Executive Summary

Volume 2: Systemic Review

Acknowledgments xv Abbreviations and Acronyms xvii Glossary of Medical Terms xix

1 The Death of a Child and the Criminal Justice System 3

2 Growing Concerns 7The Key Participants 8

Causes of Growing Concerns 1

Amber's Case 11

Nicholas' Case 14

Jenna's Case 18

Sharon's Case 22

Athena's Case 26

Valin's Case 27

The Chief Coroner's Review 32

The Review Parameters 33

The Review Panel 34

Dr. John Butt 35

Dr. Jack Crane 36

Dr. Christopher Milroy 36

Dr. Helen Whitwell 37

Dr. Pekka Saukko 38

Dr. Smith's Involvement in the Chief Coroner's Review 38

The Review Process 38

Results of the Review 41

3 Establishment of the Commission 44

4 Investigation of Suspicious Pediatric Deaths	51
--	----

A Hypothetical Death Investigation: Toronto, 1997 52

The Initial Police Investigation 52

The Coroner's Initial Role 53

Role of the Pathologist and the Police at the Post-Mortem Examination

Role of the Police, the OCCO, and the Pathologist: From Completion

of Report through Trial 58

5 Legislative Context 60

Positions Established by the *Coroners Act* 6

Duties and Powers of Coroners 62

The Work of the Office of the Chief Coroner for Ontario 64

6 The Science and Culture of Forensic Pathology 66

Forensic Pathology as an Evolving Science 69

Controversies in Forensic Pathology 71

The Interpretive Nature of Forensic Pathology 72

Interaction between Forensic Pathology and the Criminal Justice System 7

The Culture of Pediatric Forensic Pathology 76

A Note on Terminology 78

7 Organization of Pediatric Forensic Pathology 80

The Era of Dr. John Hillsdon Smith, Provincial Forensic Pathologist 80

Role and Mandate of the Forensic Pathology Branch 80

Relationship between the Provincial Forensic Pathologist and the OCCO 8

Training and Experience of Pathologists Performing Pediatric

Coroner's Autopsies 82

Oversight by the Provincial Forensic Pathologist 83

Educational Programs 83

Lack of Policies and Guidelines Regarding Coroner's Autopsies 83

Oversight and Quality Control of Coroner's Cases 83

The Era of Dr. David Chiasson, Chief Forensic Pathologist 8

Responsibilities of and Relationship between the Chief Coroner

and the Chief Forensic Pathologist 85

Staffing at the Provincial Forensic Pathology Unit 86

Creation of the Ontario Pediatric Forensic Pathology Unit 87

Appointment of Dr. Smith as Director of the OPFPU 89

Oversight and Associate bility of the ODEDII 00
Oversight and Accountability of the OPFPU 89
Unrealized Research Goals of the OPFPU 92
Attempted Re-visioning of the OPFPU 93
Regional Forensic Pathology Units 94
Establishment and Structures 94
Expertise of Pathologists 95
Oversight and Accountability Relationships 95
The Regional Coroner's Pathologist System 98
Lack of an Independent Complaints Mechanism 99
Steps Taken by Dr. Chiasson to Increase the Oversight of
Pathologists' Work 99
Review of Reports of Post-Mortem Examination within the
Provincial Forensic Pathology Unit 100
Review of Reports of Post-Mortem Examination in All
Criminally Suspicious Cases 100
Spot Audit of Work of the OPFPU 102
Failure to Track Timeliness 102
Content of Reports of Post-Mortem Examination 103
Special Case Reviews 103
Consultative Support 104
Educational Activities 104
Review of Participation in Criminal Proceedings 104
Pediatric Forensic Hospital Rounds 105
Resignation of Dr. Chiasson 106
OCCO Response to Increasing Concerns about Child Abuse 108
Paediatric Death Review Committee 108
OCCO Policies and Pediatric Deaths 109
Memorandum 551(B) 109
Memorandum 616 110
The 1995 Infant Death Investigation Protocol 110
SIDS/SUDS Committee 113
Summary 113
8 Dr. Smith and the Practice of Pediatric Forensic Pathology 115
Training and Experience 116
Dr. Smith's Training 117
Dr. Smith's Experience 118
Consequences in the Cases of Valin, Sharon, and Jenna 120
The Post-Mortem Examination 126

```
Acquiring Information
                            127
      Obtaining Relevant Information
                                        128
      Visiting the Scene 130
      Disregarding Irrelevant and Prejudicial Information
   Recording Information
      Taking Notes of Information Provided Verbally
      Recording the Pathologist's Actions
      Preserving Autopsy Records
   Autopsy Practice 139
      Handling of Exhibits for Testing
The Pathology Opinion
                         144
   Interpreting Artefacts
   Diagnosing Asphyxia
                          148
   Diagnosing Head Injury
   Accounting for Contradictory Evidence
                                            153
   Use of Default Diagnosis
The Report of Post-Mortem Examination
   The Limitations of Form 12 and Form 14
      Limitations Related to History and Explanation
      Limitations Related to Opinions
      Limitations Related to Consultations with Other Experts
                                                               160
   The Use of Parentheses
                           162
   Inclusion of an Opinion on the Manner of Death
                                                    163
   Reporting in a Timely Fashion
Pathologists' Interactions with Other Participants in the Criminal
      Justice System 171
   Interaction with the Police at Autopsy
   Ongoing Communication with the Police 174
Participation in the Justice System
   Providing Evidence in Court
      The Expert as Advocate
      The Inadequately Prepared Expert
      The Overstated Expertise of the Expert
                                              181
      The Expert and Unscientific Evidence
                                             182
      The Expert and Unbalanced Evidence
                                             183
      The Expert's Attacks on Colleagues
      The Expert and Evidence beyond His Expertise
                                                      186
      The Speculating Expert
      The Expert and Casual Language
```

The Role of an Expert in the Criminal Justice System before the Trial Cooperating with Other Experts 191 Frustrating the Oversight Process Misrepresentations about Justice Dunn 193 Misrepresentations about Report Delays Misrepresentations in Response to Growing Concerns 197 Summary 201 9 Oversight of Pediatric Forensic Pathology Introduction 205 OCCO Oversight of Dr. Smith July 1991: Justice Dunn's Reasons for Judgment May 1995: Crown Counsel's Concerns Regarding Dr. Smith 210 September 1996: Baby X's Case 211 February 1997: Dr. Young Learns of Justice Dunn's Criticisms Mid- to Late 1990s: General Complaints about Dr. Smith Summer 1997: Nicholas' Case May 1998: The OCCO Asks the CPSO to Decline Jurisdiction to Investigate Dr. Smith 220 February to May 1999: Mr. Gagnon's Complaint to the Coroners' Council 222 February to May 1999: Sharon's Case May 1999: Dr. Porter's Contrary Conclusion in Jenna's Case July to September 1999: The Exhumation in Sharon's Case November 1999: *the fifth estate* Program 229 March 2000: Mr. Gagnon Complains to the Solicitor General 231 January 22, 2001: Charge Stayed in Tyrell's Case January 25, 2001: Charge Withdrawn in Sharon's Case January 25, 2001: The OCCO Decision to Remove Dr. Smith 233 The 2001 Reviews 234 May 2001: The *Maclean's* Article 238 June 2001: The Carpenter Review – Dr. Smith Resumes Some Coroner's Autopsies September 2001: The Report of the Ombudsman on Mr. Gagnon's Complaint 240 October 2001 to April 2002: The Hair in Jenna's Case April 2002: Dr. Cairns Advises the CPSO and Dr. Young about the Hair in Jenna's Case April 2002: Dr. Young Supports Dr. Smith to the CPSO

188

The Expert Who Misleads

July 2002: Dr. Cairns Offers an Expert Pathology Opinion in Paolo's Case	24
November – December 2002: Dr. Smith's Confrontation with the OPP 24	6
The OCCO Response to the CPSO Decisions 246	
June 2003: Charges Stayed in Athena's Case 248	
December 2003: The OCCO Removes Dr. Smith from the Roster for	
Coroner's Autopsies 250	
June 2004: The OCCO Removes Dr. Smith as Director of the OPFPU 25	1
Summary 252	
The Role of SickKids 255	
Failure to Share Information with the OCCO 258	
The Role of the CPSO 259	
The Complaints about Dr. Smith 259	
Complaint in Amber's Case (D.M. Complaint) 259	
Complaints in Nicholas' Case (Gagnon Complaint) 262	
Complaint in Jenna's Case (Waudby Complaint) 263	
Further Investigation and Decision of the CPSO in the Three	
Complaints 264	
The New Era 267	
The New Guidelines 268	
An Evidence-Based, Objective Approach to Pediatric Forensic	
Pathology 268	
Role of the Forensic Expert in the Criminal Justice System 269	
The Autopsy Guidelines 269	
The 2006 Protocol Regarding Deaths of Children under Five 270	
The 2007 Autopsy Guidelines for Criminally Suspicious Pediatric	
Cases 270	
Improvements in Peer Review and Quality Assurance 270	
Death Investigation Communications Regarding Forensic Pathology 277	2
Policies and Oversight Mechanisms Regarding Timeliness of Reports 27	3
The Expertise of Pathologists Performing Autopsies 274	
Development of Regional Forensic Pathology Units 275	
Mechanisms for Review of Participation in the Justice System 276	
Committee Development 277	
Educational Activities 277	
New Physical Facilities 277	
Conclusion 278	

Volume 3: Policy and Recommendations

Abbreviations and Acronyms xiii Glossary of Medical Terms xv

- 10 Restoring Confidence in Pediatric Forensic Pathology 28
- 11 Professionalizing and Rebuilding Pediatric Forensic Pathology 284
- 12 Reorganizing Pediatric Forensic Pathology 308
- 13 Enhancing Oversight and Accountability 331
- 14 Improving the Complaints Process 363
- 15 Best Practices 372
- 16 Effective Communication with the Criminal Justice System 406
- 17 The Roles of Coroners, Police, Crown, and Defence 437
- 18 The Role of the Court 470
- 19 Pediatric Forensic Pathology and Potential Wrongful Convictions 514
- 20 First Nations and Remote Communities 546
- 21 Pediatric Forensic Pathology and Families 567
- 22 Conclusion and Consolidated Recommendations 588

Volume 4: Inquiry Process

23 The Scope and Approach of the Inquiry 635 Appendices 675

Commissioner and Inquiry Staff 985