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Reorganizing Pediatric Forensic Pathology

In Chapter 11, Professionalizing and Rebuilding Pediatric Forensic Pathology, I explain that restoring public confidence in pediatric forensic pathology requires the Province of Ontario to take immediate steps to professionalize and rebuild the forensic pathology service in Ontario. This is an essential precondition for the commitment to quality and quality assurance that forensic pathology in Ontario urgently requires.

In this chapter, I explain that to achieve professionalization, the service must be reorganized significantly, from the top down, the bottom up, and in the relationship between the Ontario Forensic Pathology Service and the regional forensic pathology units. I expand on the legislative amendments to the *Coroners Act*, RSO 1990, c. C.37, that are needed to reorganize the service and recommend improvements to strengthen the service agreements between the Office of the Chief Coroner for Ontario (OCCO) and the hospitals that house the regional units. These changes will situate forensic pathology more prominently within our province's death investigation system and will ensure that qualified forensic pathologists direct, supervise, administer, and manage the province's forensic pathology services. These organizational changes are a necessary basis for effectively addressing the shortcomings in the way pediatric forensic pathology was practised and in its oversight, which were identified in the systemic review.

There was widespread agreement among participants at the Inquiry that these organizational changes are necessary to ensure that high-quality, reliable forensic pathology is available to the criminal justice system.

Effective Organization of the Work of Forensic Pathology in Ontario

The Ontario Forensic Pathology Service

In Chapter 11, Professionalizing and Rebuilding Pediatric Forensic Pathology, I explain that statutory recognition of a new entity, the Ontario Forensic Pathology Service (OFPS), is critical in order to professionalize and rebuild forensic pathology in Ontario. The OFPS is the embodiment of a highly skilled service with a structure that advances quality and facilitates oversight. It is the heart of this new approach to quality. As such, it must be established and described in the *Coroners Act*. Because it provides a service to death investigations conducted by the OCCO, it should remain as a branch within that organization. However, legislative recognition reflects the importance of the OFPS as an essential service in the province.

Recommendation 12

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

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

The Role of the Chief Forensic Pathologist

In Chapter 11, I also recommend that the *Coroners Act* be amended to recognize the roles and responsibilities of the leadership of the OFPS – in particular, the Chief Forensic Pathologist. The Chief Forensic Pathologist will direct the OFPS and be professionally responsible for the service it provides. This fundamental responsibility, and other duties, should be included in the legislation in a way that parallels the responsibilities of the Chief Coroner. Consistent with the objective of enhancing the quality of the service, the Chief Forensic Pathologist must be a certified forensic pathologist. Inclusion of this position in the legislation requires that legislative definitions be given to both "pathologist" and "certified forensic pathologist."

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

Recommendation 13

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

a) **"Pathologist" means a legally qualified medical practitioner certified by the Royal College of Physicians and Surgeons of Canada or its equivalent as a specialist in anatomical or general pathology;**

b) **"Certified forensic pathologist" means a pathologist certified by the Royal College of Physicians and Surgeons of Canada or its equivalent as a specialist in forensic pathology.**

Our systemic review made it very clear that the Chief Forensic Pathologist did not have the necessary authority to ensure quality forensic pathology services in the province. It is vital that this situation not only be changed but also be seen to be changed. The fundamental responsibilities of the Chief Forensic Pathologist must therefore be set out in the *Coroners Act*. Beyond those provided for in the legislation, the duties and responsibilities of the Chief Forensic Pathologist must also be clearly described.

A healthy OFPS will be dedicated to service, teaching, and research as the way to ensure future excellence. It will have a culture in which highly trained professionals engage with each other to promote excellence. It will have the autonomy to use its resources to maximum effect. These tasks must all ultimately be the responsibility of the Chief Forensic Pathologist. So, too, is the maintenance of quality of service and sound oversight.

It is important that the Chief Forensic Pathologist have the ultimate authority to determine which individual forensic pathologist has the appropriate training and experience to perform a particular post-mortem examination and, in addition, the location where the examination will be conducted. This authority is particularly important for criminally suspicious pediatric cases or others that present unique forensic challenges. The Chief Forensic Pathologist has the requisite training and experience, and has knowledge of the resources available to the OFPS at any given time, to best fulfill this role. Although the Chief Forensic Pathologist should consult with coroners regarding assignment of autopsies, the ultimate decision-making authority must rest with the Chief Forensic Pathologist.

To make this assignment system as effective as possible, all warrants for post-mortem examination should be directed to the Chief Forensic Pathologist or designate.

Recommendation 14

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

a) direct the Ontario Forensic Pathology Service and be responsible for the services it provides;

b) supervise, direct, and oversee the work of all pathologists in Ontario under, or in connection with, a coroner's warrant;

c) conduct programs for the instruction of pathologists in their duties;

d) prepare, publish, and distribute a code of ethics for the guidance of pathologists;

e) administer a Registry of pathologists approved to perform post-mortem examinations under coroner's warrant; and

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

Recommendation 15

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

a) ensure that the Ontario Forensic Pathology Service (OFPS) provides a high quality of service;

b) ensure effective oversight of the work performed throughout the OFPS;

c) take responsibility for the service, teaching, and research mission of the OFPS;

d) encourage a collaborative culture of quality within the OFPS;

e) be responsible for the preparation and administration of the annual budget for the OFPS; and

f) be responsible for determining the pathologist who will conduct each post-mortem examination under coroner's warrant in Ontario.

Recommendation 16

The Chief Coroner for Ontario should direct investigating coroners to issue all warrants for post-mortem examination to the Chief Forensic Pathologist or designate.

The Role of the Deputy Chief Forensic Pathologist

If excellence is to be achieved as expeditiously as possible, much work needs to be done in creating and administering the OFPS. The job cannot be accomplished by the Chief Forensic Pathologist alone. Thus, in Chapter 11, Professionalizing and Rebuilding Pediatric Forensic Pathology, I recommend that legislative recognition be given to a sustainable and committed leadership structure for the OFPS that mirrors the leadership structure already in place for coroners. This structure includes one or more deputies.

The Deputy Chief Forensic Pathologist will report to the Chief Forensic Pathologist and have the powers of the Chief Forensic Pathologist in the absence of the Chief or when he or she is unable to act. Although it is preferable that the Deputy Chief Forensic Pathologist be a certified forensic pathologist, the Chief Forensic Pathologist should have the discretion to recommend the appointment as deputy of a pathologist without certification in forensic pathology who nevertheless has the requisite skills and experience. This discretion recognizes the current limited number of certified forensic pathologists.

The OCCO made a strong case that two Deputy Chief Forensic Pathologists should be appointed – one to sit in Toronto as director of the Provincial Forensic Pathology Unit (PFPU), and the other to sit outside Toronto as a director of one of the regional forensic pathology units.

Recommendation 17

The *Coroners Act* should be amended to provide that the Lieutenant Governor in Council may appoint one or more forensic pathologists to be Deputy Chief Forensic Pathologist(s) in Ontario who may act as, and have all the powers and authority of, the Chief Forensic Pathologist during the absence of the Chief Forensic Pathologist, or during his or her inability to act.

The Role of Regional Directors

The geographic cornerstones of forensic pathology service in Ontario today begin with the PFPU headed by the Chief Forensic Pathologist. It is located at the OCCO in Toronto, and those who work there are employees of the OCCO.

In addition to the PFPU, there are currently five regional forensic pathology units: the Hamilton Regional Forensic Pathology Unit at Hamilton General Hospital, the Kingston Regional Forensic Pathology Unit at Kingston General Hospital, the London Regional Forensic Pathology Unit at the London Health Sciences Centre, the Ottawa Regional Forensic Pathology Unit at the Ottawa Hospital, and the Ontario Pediatric Forensic Pathology Unit (OPFPU) at the Hospital for Sick Children (SickKids) in Toronto. Those who work in the units are on staff at the various hospitals and are not employees of the OCCO. The forensic pathology is done on a fee-for-service basis.

Each regional unit has a director (regional director) to oversee the work of the pathologists who provide services to the unit, and they bring some measure of quality control. However, because the roles and responsibilities of these regional directors vary with the service agreement establishing the unit as a provider of autopsy services to the OCCO, they are not consistent. Some of these agreements detail the regional director's responsibilities, while others provide little assistance. In addition, the manner in which these responsibilities are carried out varies considerably. Over the last few years, the Chief Forensic Pathologist has started the process of standardizing the responsibilities to be undertaken by the regional directors, most notably in the areas of peer review and quality control. But there is more work to be done.

The roles and responsibilities of the regional directors need to be formalized and standardized. The position of the regional directors within Ontario's death investigation system should parallel that of the regional coroners. Each must be accountable to the Chief Forensic Pathologist for the work of his or her regional unit. In addition to the supervisory duties this responsibility entails, the regional directors will work with the Chief Forensic Pathologist and the Deputy Chief Forensic Pathologist(s) to craft quality assurance processes, including peer review and other mechanisms for the OFPS as a whole. In terms of regional responsibilities, the regional directors will be responsible for all forensic pathology services provided within their geographical region, whether performed within their units or at other hospitals within the region. The specific duties of the position should be developed by the Chief Forensic Pathologist in conjunction with each regional director. This consultation will allow for individual variation to suit particular circumstances while also providing a common base for this position that ensures quality.

Consistency is important to allow the OFPS to provide sufficient oversight and quality control. Later in this chapter, I make recommendations about the way in which the funding contracts between the province and the hospitals that house the regional forensic pathology units need to be reformulated as service agree-

ments in those cases where this arrangement is not in place. The basic roles and responsibilities of the regional directors should be set out in the new service agreements, but allow room for region-specific terms.

Each regional director should be a certified forensic pathologist, if possible, although this requirement is a longer-term goal. Of immediate importance is the capacity to help lead the OFPS forward. This objective will be enhanced if regional directors hold full-time-equivalent positions with the OFPS, so that their work for the units is not on a fee-for-service basis but is part of a dedicated and coherent service. The degree to which a position is full-time may vary from unit to unit, with the objective of raising it over time as forensic pathology services are able to be concentrated increasingly in the units.

In addition, the regional directors should participate as members of a Forensic Pathology Advisory Committee (FPAC) formed to work with the Chief Forensic Pathologist. In this way, the regional directors will be encouraged to participate in decisions that affect the OFPS. Further details about the scope of the FPAC are discussed in Chapter 13, Enhancing Oversight and Accountability.

Recommendation 18

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

a) **provide oversight of and be accountable for the work of their regional units;**

b) **be a member of the Forensic Pathology Advisory Committee; and**

c) **assist the Chief Forensic Pathologist and the Deputy Chief Forensic Pathologist(s) to create quality assurances processes, peer review processes, and other mechanisms of review.**

Building on the Regional Units

The challenges created by Ontario's immense geography are best addressed by building on the foundation provided by the existing regional forensic pathology units. These units, originally formed to develop regional expertise and to act as centres of excellence, are already housed within established institutions and academic teaching hospitals, and are well positioned to provide service across the province. As such, each benefits from its hospital's infrastructure and academic supports, and can rely on available resources and expertise to deliver high-quality forensic pathology services.

Our systemic review revealed the problems that develop when responsibility is ill defined. It is important that there be clarity in all lines of responsibility. It must be clear that the forensic work of pathologists conducted for the unit, although done in a hospital, is the responsibility of the OFPS, not the hospital, and that accountability flows accordingly. It must also be clear that the clinical pathology done by those same pathologists is the responsibility of the relevant hospital.

The regional units provide a strong foundation for the OFPS, offering expertise, linkages to teaching hospitals, and optimal geographic coverage. However, in order to achieve these objectives, the present funding needs to be increased. The current funding of the regional units is inadequate. It appears to have been arbitrarily set and, in some cases, has remained unchanged for years. It does not reflect the real cost of operating the units, nor does it adequately compensate the directors for their management, supervision, and other duties. A proper costing of the services provided by the units must be done, and the agreements for each unit must reflect that cost. This practice is not only responsible accounting but also a precondition to excellence.

Recommendation 19

To ensure quality of service across the province, the Ontario Forensic Pathology Service should utilize and build on the regional forensic pathology units.

Recommendation 20

The Province of Ontario should fund the actual costs of the regional forensic pathology units.

The Northeastern Regional Forensic Pathology Unit

In addition to the five existing regional forensic pathology units, all of which have contractual agreements with the Ministry of Community Safety and Correctional Services (formerly the Ministry of the Solicitor General), Sudbury Regional Hospital has provided autopsy services for the OCCO since May 1999. On June 14, 2007, the unit was officially named the Northeastern regional forensic pathology unit. Dr. Martin Queen, a certified forensic pathologist at the unit, performs approximately 250 post-mortem examinations a year, close to 90 per cent of which are coroner's cases. This unit provides extensive geographical coverage for the OCCO, including the Sudbury-Manitoulin region, as well as North Bay and Thunder Bay. However, the Northeastern unit is not formally recognized as a

regional forensic pathology unit. It does not have a contract with the ministry or the OCCO, so it does not receive any funding as a unit. Nor does it have a director.

This unit has much to offer the OFPS. Situated within the Sudbury Regional Hospital, it provides an established infrastructure with access to supporting expertise and equipment. The forensic work can be performed by a certified forensic pathologist. The unit itself is connected with a university medical school, the Northern Ontario School of Medicine. The unit's morgue recently underwent significant reconstruction that enables it to handle a volume of cases similar to that of other regional forensic pathology units. This unit should be formally recognized in a service agreement and should receive appropriate funding for the services it provides, including funding for the position of a regional director. This recognition will assist in meeting the service challenge presented by the sheer size of Ontario. I address this issue in greater detail in Chapter 20, First Nations and Remote Communities.

The Service Agreements

The first service agreement establishing a regional forensic pathology unit was signed in 1991. Over the next few years, similar agreements were signed to establish other regional forensic pathology units across the province. These agreements between the hospitals and the Ministry of the Solicitor General were little more than funding agreements. They failed to create the structures and delineate the relationships necessary to ensure meaningful oversight and quality control at the units, or to define sufficiently the relationships between the units and the OCCO or the Chief Forensic Pathologist.

A number of important changes have been made to the service agreements over the years. Today, the majority of the agreements reference each unit's mission "[t]o provide a centre of excellence for service, education and research related to forensic pathology / medicine," and a commitment to the concept of multidisciplinary teamwork. Most important, the focus of the majority of the agreements has shifted away from the flow of grant money provided to the units and toward providing some clarification of the roles and responsibilities within the units and at the OCCO. These responsibilities include the creation of a governance mechanism in the form of an Executive Team or Board of Directors, identification of the person responsible for the general supervision of the unit, clarification about to whom regional directors report in matters professional and financial, and confirmation that the unit is ultimately accountable to the Chief Coroner for Ontario. These changes, found in all the agreements except that regarding the Hamilton Regional Forensic Pathology Unit, are commendable.

However, in my opinion, the agreements need to go further to enhance oversight and accountability. The agreements state that the person responsible for the general supervision of the units is the Chief Coroner, who is also the person to whom the units are ultimately accountable. Moreover, the agreements identify the Chief Coroner as the person responsible for providing direction and guidelines in relation to acceptable standards of forensic pathology practice in the units, for ensuring that appropriate quality control measures are in place, and for reviewing all homicide and suspicious death reports of postmortem examination before their release. I detail elsewhere in this Report the frailties associated with entrusting professional oversight to those not qualified to provide it.

Between 1997 and 2001, a number of the agreements gave these responsibilities to the Chief Forensic Pathologist, not to the Chief Coroner for Ontario. After 2001, when the province was without a Chief Forensic Pathologist, it appears that these responsibilities were assumed by the Deputy Chief Coroner of Forensic Services and, once that position was vacated, by the Chief Coroner. Unfortunately, this language has remained unchanged, even after the appointment of the current Chief Forensic Pathologist in 2006. These provisions must be changed to reflect the role of the Chief Forensic Pathologist in providing oversight and accountability for the work of the units, including the work of the regional directors.

Some elaboration of the responsibilities of the regional director of the units is also incorporated in most of the current agreements. However, in some agreements, important aspects of professional responsibility for the unit – such as staffing schedules, monitoring report turnaround times, and financial management of the unit – are assigned not to the regional director but to an administrator. Ultimately, it must be made clear that the regional directors are responsible for all aspects of forensic pathology undertaken within their units. The agreements remain deficient, overall, because they fail to assign uniform oversight responsibilities to someone with the requisite expertise. The responsibilities of the regional directors must be expanded, and the role and responsibilities to be undertaken by the Chief Forensic Pathologist must be included in each of the agreements.

Another issue involves the contracting parties to these agreements, the Ministry of Community Safety and Correctional Services and the hospitals. The OCCO, although ultimately accountable for the oversight of the regional units, is not a party to the contracts.

These contracts establishing the regional units are better described as service agreements and need to be rewritten. Given that the OCCO and the OFPS must oversee and be accountable for the work within the units, it would be preferable if

the parties to the agreements were the OCCO and the individual hospitals. These agreements should contain uniform provisions and provide for funding on an equivalent basis, unless regional differences require special provisions.

The OCCO should also seek to enter into a service agreement with the Winnipeg Health Sciences Centre in Manitoba to formalize the provision of forensic pathology services by Dr. Susan Phillips to the OCCO. Currently, Dr. Phillips does some pediatric cases for the OCCO, including pediatric homicides and criminally suspicious cases, and this fact ought to be reflected in an agreement to provide for proper oversight and funding. The same is true for the Children's Hospital of Eastern Ontario (CHEO), which currently conducts non-criminally suspicious pediatric cases for the OCCO. A service agreement with CHEO is needed if this work is to continue. Service agreements will enhance these relationships and ensure that the Chief Forensic Pathologist has the tools to exercise oversight of the autopsies conducted at these institutions, including, in particular, any pediatric autopsies performed at those sites.

All these service agreements should carefully describe the relationship between the OCCO and the regional units. At a minimum, they should contain provisions that enable effective oversight of the work to be performed in the regional units for the OCCO by assigning specific responsibilities to the Chief Forensic Pathologist, the regional directors, the pathologists performing the work, and the hospitals in which the regional units are located.

In addition, the hospitals and the OCCO must ensure that policies are in place to require reciprocal information sharing where either the OCCO or a hospital develops serious concerns about the work of a pathologist who conducts coroner's cases. As a condition of inclusion on the Registry, pathologists must consent to such information sharing where serious concerns arise.

Recommendation 21

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

a) **the unit will assume responsibility for a designated geographic area of the Ontario Forensic Pathology Service;**

b) **each regional director will be accountable to the Chief Forensic Pathologist for the work of his or her unit and will be responsible for the oversight, timeliness, and quality control of all post-mortem examinations performed under coroner's warrant within the unit's designated area;**

c) the Chief Forensic Pathologist will be responsible for the general supervision of the units, for providing direction and guidelines as they relate to acceptable standards of forensic pathology practice in the units, and for ensuring appropriate quality control measures are in place;

d) forensic pathologists performing work for the Ontario Forensic Pathology Service must be included on the Registry of pathologists and will be primarily accountable to their regional director; and

e) each regional director will hold a salaried position with the regional unit, although that may be a full- or part-time position, depending on the local circumstances.

Recommendation 22

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

Recommendation 23

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

Recommendation 24

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

Future Growth of the Units

At present, approximately 50 per cent of the 7,000 coroners' post-mortem examinations conducted annually in Ontario are performed by fee-for-service pathologists who work outside of the regional units. This wide dispersion tends to permit ad hoc practices and to undermine efforts to enhance quality control. It impedes optimal oversight.

As the OFPS moves into the future, it should take action to reduce the use of fee-for-service pathologists outside of the regional units. Dr. Michael Pollanen, Ontario's Chief Forensic Pathologist, has already taken steps to stream all criminally suspicious cases that do not fall within the direct catchments of a regional unit to Toronto – adult cases go to the PFPU, and pediatric cases to the OPFPU. Moreover, the OCCO's protocol in relation to the investigation of sudden and unexpected deaths of children under five years of age specifies that autopsies in these cases must be performed at a unit designated for pediatric cases.[2]

As forensic pathology expertise becomes more available in Ontario, the OFPS should build additional strength and capacity within the PFPU and the regional forensic pathology units. This growth will permit the increasing use of full-time-equivalent positions in those units as the volume of work rises. In the longer term, both steps will assist in professionalizing the forensic pathology service provided in Ontario.

Recommendation 25

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

The Use of Technology

Our systemic review showed the risks that arise when a pathologist works largely alone and seldom consults colleagues or is challenged by them. As with any branch of medicine, teamwork is vital for the best practice of forensic pathology. Given the size of Ontario, the need for separate units to provide a distribution of service throughout the province, and the relatively small number of skilled

[2] The units that are designated for pediatric cases are the OPFPU, the PFPU, the Hamilton Regional Forensic Pathology Unit, the London Regional Forensic Pathology Unit, the Children's Hospital of Eastern Ontario, and the Winnipeg Health Sciences Centre.

practitioners in this specialty, the OFPS faces a continuing challenge to provide the means for interaction among pathologists.

The teamwork necessary to run an effective OFPS can, however, be supported by harnessing information and communications technology to enable those practising in remote areas of Ontario to participate in educational sessions, rounds, and meetings on a regular basis. Equally important, the use of technology can assist greatly in reducing isolation and encouraging consultation and peer review in complex cases.

The Province of Ontario should fund the acquisition of the communications and information technology that will support the networking capabilities of the OFPS. A telemedicine portal should be established at the PFPU and, if not already part of the particular hospital system, at all the regional forensic pathology units. It will enable "real-time" review and consultation among forensic pathologists during post-mortem examinations in difficult cases. Given that this technology is now available in most hospital systems, it should also be possible to use it in all hospitals where pathologists perform post-mortem examinations under coroner's warrant, and not just in the regional units.

Recommendation 26

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

Effective Organization of Pediatric Forensic Pathology in Ontario

The OPFPU

A central issue at the Inquiry was whether the OPFPU at SickKids should continue or be disbanded. The position of director of the OPFPU assisted in positioning Dr. Charles Smith to become the leading expert in pediatric forensic pathology, when he lacked the requisite training and qualifications. The mere fact that he came from SickKids, where the OPFPU was located, added significantly to his stature. Yet, in reality, SickKids had no ownership of his forensic pathology work. Thus, it is argued, Ontario got the worst of both worlds – the reputation without the substance on which that reputation should have been based. Those on the other side of this debate point out the enormous value added by the renowned expertise that SickKids can bring to the work.

Particularly for sudden infant deaths that engage diseases that are difficult to diagnose and that do not appear criminally suspicious, SickKids can offer expertise without peer. Sudden infant death syndrome (SIDS) is a good example. Many post-mortem examinations involving sudden and unexpected deaths of infants that are ultimately diagnosed as SIDS have been done at the OPFPU over the years, and the knowledge thus accumulated has done much to assist the understanding of this phenomenon. The argument is that this benefit ought not to be obscured by the regrettable past.

The OPFPU was the first of the regional units, and it is the only unit dedicated solely to the provision of pediatric services. It conducts more than half of Ontario's pediatric coroner's cases. The OPFPU has world-class expertise in pediatric death cases that focus on disease rather than injury. The breadth and depth of its pediatric expertise and technical assistance is not available elsewhere in the province. However, until 2001, when Dr. David Chiasson, a certified forensic pathologist, joined SickKids, the unit had no pathologists with forensic certification. As Dr. Chiasson pointedly explained it, "It's time to emphasize the 'forensic'" of the Ontario Pediatric Forensic Pathology Unit.

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

In my view, the OPFPU should continue to provide pediatric forensic pathology services and act as a regional unit. The pediatric pathology expertise of SickKids' pathologists is too important to be sidelined. However, never again can the director of the OPFPU lack training in forensic pathology and qualifications. Dr. Chiasson, the OPFPU's current director, is a certified forensic pathologist, and his expertise is vital to the work of the unit. Not only is he available to take on the criminally suspicious cases but his expertise enables him to provide effective quality assurance and peer review for all pediatric forensic cases.

Recommendation 27

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

Relationship between the PFPU and the OPFPU

The OPFPU, like the other regional forensic pathology units, operates within the greater provincial system. Unlike the other regional units, however, the OPFPU is closely tied to the PFPU. The OPFPU handles those pediatric forensic cases for Toronto and its broader catchment area that would otherwise be done within the catchment area for the PFPU. Indeed, on an ad hoc basis, it often gets cases from elsewhere in the province. And the Chief Forensic Pathologist, whose office is at the PFPU, assists with cases and consultations at the OPFPU.

It is important to maintain this close association between the PFPU and the OPFPU because, in the future, both units should be involved in pediatric cases under coroner's warrant. Cases that appear criminally suspicious (fortunately, there are not many each year) can be done in either unit, as the Chief Forensic Pathologist directs, depending on available skills and resources at the time. For the majority of pediatric forensic cases, the OPFPU is the better site, since these cases do not appear criminally suspicious, and there are various pediatric experts on hand to assist the pathologist as needed. The OPFPU also has access to a number of technical resources to assist the pathologist. Indeed, even where the autopsy is done at the PFPU, these resources are close enough to be easily accessed.

The close association between the OPFPU and the PFPU is also important for training purposes. We heard evidence that some forensic pathologists shy away from pediatric forensic cases. To address this concern, Dr. Pollanen hopes to expose forensic pathology trainees to pediatric cases early in their careers. The expertise and facilities of the OPFPU have much to offer and can work in conjunction with a fellowship program at the PFPU. I encourage this vision – ultimately, the majority of qualified forensic pathologists at the PFPU and the regional units should be trained and able to perform pediatric forensic cases as well as adult forensic cases. The province cannot bear the risks associated with having all, or even most, of the pediatric forensic autopsies conducted by only one or two pathologists. We need to encourage those practising forensic pathology and new trainees to learn about pediatric forensic pathology.

It is also very important to encourage a culture of collegiality between the

forensic pathologists working in the OPFPU and the PFPU. Numerous attempts have been made over the years to include the pediatric pathologists from the OPFPU in the PFPU rounds, and vice versa. It was hoped that the information exchange would benefit them all. However, the evidence revealed that, in the past, this participation in rounds at the other institution proved difficult, and there was very little interaction between the staff at the two units. Attempts to enhance communication and information sharing between the units, as well as between the PFPU and fee-for-service pathologists working outside of the units, have, however, improved over the years.

Since 2001, there have been a number of positive educational changes. For example, Dr. Pollanen has instituted bimonthly seminars for forensic pathologists about difficult issues in forensic pathology, such as autopsy pitfalls and miscarriages of justice. He has also developed a multidisciplinary expert witness workshop for forensic pathologists.

At present, the close proximity of the OCCO and SickKids in the City of Toronto enables a pathologist from one location to travel to the other with ease when required. The importance of attending rounds at both institutions in order to remain current and involved in both adult and pediatric issues is increasingly emphasized, which I commend. It is vital that the pediatric pathologists doing the pediatric forensic pathology work at the OPFPU (even though it will be non-criminally suspicious for the most part) and the forensic pathologists doing the pediatric forensic work at the PFPU learn from one another.

As a particular example, it is essential that forensic pathologists practising at the OPFPU also have exposure to adult forensic cases. Dr. Chiasson continues to perform adult post-mortem examinations at the PFPU to maintain his skills, and this precedent should be emulated.

Communication will be further enhanced with the use of technology, enabling busy practitioners at these and the other units to assist one another regularly without leaving their offices. The use of technology to maintain open channels of communication between the units will become increasingly important if and when the PFPU moves to larger premises outside the city core. The evidence supports the need for continued interaction between the PFPU and the OPFPU because the accumulated expertise of colleagues in the two units will increase the quality of forensic pathology in pediatric cases, especially those engaging criminal suspicions.

Recommendation 28

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

a) **for pediatric forensic cases that do not appear to be criminally suspicious, the post-mortem examination should usually be conducted at the Ontario Pediatric Forensic Pathology Unit;**

b) **for criminally suspicious pediatric forensic cases, the post-mortem examination should be conducted by an appropriate pathologist at the Ontario Pediatric Forensic Pathology Unit or at the Provincial Forensic Pathology Unit, as determined by the Chief Forensic Pathologist or designate; and**

c) **particularly in difficult cases, the pathologists at each unit should take advantage of the expertise available at the other unit.**

Information Sharing between SickKids and the OCCO

Our systemic review revealed a disturbing wall of silence between SickKids and the OCCO in relation to Dr. Smith. This breakdown in communication must be avoided in future. SickKids must share with the Chief Forensic Pathologist any significant concerns about the clinical pathology performance of those doing forensic pathology work for the OCCO. Indeed, as I have said, such communication should occur at *all* the regional forensic pathology units. The host hospitals must agree to share with the Chief Forensic Pathologist the serious concerns they have about any aspect of a pathologist's work, if the pathologist is also to perform coroner's work. This information sharing should be required by all the service agreements, including that between SickKids and the OCCO.

Pediatric Forensic Pathology across Ontario

Apart from the OPFPU, pediatric forensic pathology is now performed in three other locations across Ontario – the regional forensic pathology units in Hamilton and London, and CHEO in Ottawa – as well as at the Health Sciences Centre in Winnipeg. I see no reason why this distribution should not continue, at least for non-criminally suspicious cases.

For criminally suspicious pediatric cases, it should be the responsibility of the Chief Forensic Pathologist or designate to determine whether the autopsy will be performed at one of these locations or transferred elsewhere, most commonly to either the OPFPU or the PFPU.

Recommendation 29

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

a) **for pediatric forensic cases within the geographical area of the designated regional units that do not appear to be criminally suspicious, the post-mortem examination should be conducted at the appropriate regional forensic pathology unit or by Dr. Susan Phillips or another approved forensic pathologist in Winnipeg; and**

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

Protocol for Criminally Suspicious Pediatric Cases

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

The October 2007 Guidelines on Autopsy Practice for Forensic Pathologists: Criminally Suspicious Cases and Homicides (the Autopsy Guidelines) move a long way in this direction. However, even more should be done to ensure that these difficult cases are performed by experienced forensic pathologists with pediatric expertise. To achieve this goal, it is essential that the number of forensic pathologists with pediatric forensic experience be expanded as quickly as possible. As I will discuss in Chapter 13, Enhancing Oversight and Accountability, once the Registry is established, the Chief Forensic Pathologist will determine which forensic pathologists are sufficiently qualified by training and experience to perform autopsies in criminally suspicious pediatric cases. I refer to that group identified in the Registry as "approved" pediatric forensic pathologists. Ultimately, once numbers permit, the goal must be to have only certified forensic pathologists with pediatric forensic experience perform these cases.

Recommendation 30

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

Recommendation 31

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

Recommendation 32

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

Double Doctoring

The concept of "double doctoring" generated considerable discussion at the Inquiry. In particular, a few participants favoured a double doctoring system in which both a forensic and a pediatric pathologist must be present at every suspicious child death autopsy.

Ontario has neither the human nor the financial resources to implement such a system, and I am not persuaded that this system is necessary to ensure quality. The regional forensic pathology units that conduct pediatric forensic autopsies are all located in hospitals with a variety of specialists, such as pediatric pathologists and neuropathologists, who can be called on to assist when their expertise is required. This less formal form of double doctoring achieves the goal of benefiting from different areas of expertise in the performance of pediatric forensic autopsies. It has proven successful in other jurisdictions, both from a human resources and a financial perspective. This collaboration is best achieved through a policy that encourages the Chief Forensic Pathologist and others within the OFPS to use available resources as needed in an individual case.

Moreover, as recommended above, forensic pathologists must take the lead in criminally suspicious pediatric cases, as determined by the Chief Forensic Pathologist. Therefore, the Chief Forensic Pathologist or designate must be given the tools to ensure that the particular type of case and the skill set of the forensic

pathologist are properly matched and that, in complex cases, collaboration with appropriate experts takes place as needed.

Recommendation 33

For all forensic cases, but particularly for criminally suspicious pediatric cases, the Ontario Forensic Pathology Service should reinforce a policy that encourages collaboration between the forensic pathologist and other relevant professionals.[3]

Protocol for Pediatric Cases That Become Criminally Suspicious during Autopsy

Given that a number of pediatric forensic cases do not initially present suspiciously, pediatric pathologists may be assigned autopsies that do not appear to be criminally suspicious. However, in a small number of cases, something unexpected arises during the autopsy, and they become criminally suspicious.

Before 2007, there were no formal OCCO guidelines regarding how pathologists should determine whether a case might raise criminal suspicions. The April 2007 Autopsy Guidelines introduced criteria for initially determining whether a case should be regarded as criminally suspicious. These have since been incorporated into the October 2007 Autopsy Guidelines. They include a known history of child abuse, unusual or suspicious appearance of the death scene, history of an unusual fall or accident, poor hygiene or other evidence of neglect, injuries or bruising or burns of an unclear nature, previous sudden and unexplained infant death of a sibling, and history of recurrent life-threatening episodes. If any of these criteria apply, the remainder of the guidelines for homicidal and criminally suspicious deaths in infants and children are to be followed.

These criteria should continue to be used to identify a pediatric case as criminally suspicious at the outset. Where these criteria do not apply initially to a pediatric case, only a very low threshold must be met to re-designate the case as criminally suspicious. This precaution will ensure that, at the earliest sign of any suspicion, the pathologist will turn the case over to a qualified forensic pathologist. Even at the beginning, indicators such as the history provided by the coroner or the police, or physical evidence such as suspicious healing fractures on X-rays,

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

are important factors that necessitate consultation with a qualified forensic pathologist before either continuing with the autopsy or turning it over to the more specialized professional.

A detailed protocol should be developed to assist pathologists in cases where an unexpected finding arises during a pediatric autopsy. The protocol should set out that, in such cases, the pathologist should stop the autopsy, consult with a qualified forensic pathologist, and notify the Chief Forensic Pathologist or designate before proceeding. The protocol should help forensic pathologists identify circumstances that would meet this low threshold. Ongoing training and education will assist forensic pathologists in recognizing when, mid-autopsy, cases are possibly no longer within the realm of pediatric disease and, consequently, raise criminal suspicion.

Recommendation 34

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

Protocol for Criminally Suspicious Adult Cases

The evidence clearly demonstrates that criminally suspicious cases, whether pediatric or adult, are best undertaken by experienced forensic pathologists. As with pediatric cases, the current Autopsy Guidelines go a long way in that direction for adult cases. The ultimate objective for adult cases is that the post-mortem examination be performed by a certified forensic pathologist.

At present, there are insufficient numbers to achieve that goal. As I have said, building this pool of expertise is of vital importance. In the meantime, and pending the creation of the Registry, the Chief Forensic Pathologist should ensure that the current Autopsy Guidelines are followed in criminally suspicious cases. Once the Registry is established, only those forensic pathologists approved to do so will perform post-mortem examinations in these cases. And ultimately, these examinations will be done only by certified forensic pathologists. That goal should be reached as soon as possible.

Recommendation 35

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

Recommendation 36

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

Recommendation 37

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

There is a need to recognize the importance of forensic pathology in death investigations in the *Coroners Act*. Equally pressing is the need to ensure clear lines of responsibility for the forensic pathology work that is done for the OCCO. The role of the Chief Forensic Pathologist will be vital in this endeavour: he or she should be ultimately accountable for the work and, just as important, should have the necessary powers and resources to direct how the work is to be done. However, the Chief Forensic Pathologist cannot do it alone and must be assisted by Deputy Chief Forensic Pathologists as well as regional directors. The regional forensic pathology units reflect the geographic reality of Ontario and, in the case of the OPFPU, reflect the teaching, research, and other assets offered by SickKids. All of the regional forensic pathology units should be continued, and the relationship with the unit in Sudbury should be formalized. All of the units, however, need to be provided with adequate funding and with service agreements that recognize the responsibilities of the Chief Forensic Pathologist. Such a reorganization of forensic pathology should provide a solid foundation for the service, teaching, and research that is necessary to have a forensic pathology service that earns, and maintains, the confidence of the public.