SickKids®
THE HOSPITAL FOR SICK CHILDREN

Written Submissions

Prepared for

The Inquiry into Paediatric Forensic Pathology in Ontario

Before the Honourable Stephen T. Goudge, Commissioner

March 20, 2008

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1. Introduction

1. In the discharge of its Mandate, the Commission has examined the role of expert evidence in the justice system focusing on the work of Dr. Charles Smith and the paediatric forensic pathology system over the period 1981 to 2001. It is hoped that this enterprise has provided a sufficient factual platform from which to draw important lessons about the systemic frailties identified in the criminal justice and coronial system (referred to collectively as "the justice system"). From the perspective of The Hospital for Sick Children ("SickKids" or, the "Hospital"), this Inquiry has been a sobering opportunity to re-examine its commitment to providing expertise to the justice system through the mechanism of the Ontario Paediatric Forensic Pathology Unit ("OPFPU"). It should be remembered that the primary mandate of the Hospital is to provide excellent health care; and thus, whatever deficiencies may, with hindsight, be apparent in the Hospital's contribution of expertise to the criminal justice and coronial system, the contribution should be seen in that light.

2. It is respectfully submitted that the Hospital, as well as other such centres of learning and expertise, constitute a valuable resource which may be accessed by the coronial service to enhance the delivery of high quality death investigations and, in some cases to support the criminal justice system. These functions, while essential to the various agencies enlisting such support, are outside the Hospital's core function of health care delivery. While the Hospital clearly has responsibility to maintain the highest standards in the delivery of health care, it has no ability or capability to set or regulate standards of evidence in the justice system. Thus, historically, when hospital expertise was brought to bear in that system, it was operating to a certain extent in foreign territory.

3. The development of Dr. Charles Smith's reputation as an iconic figure in the justice system occurred to meet the needs of the system that created him. There was a gap in the ranks at the Office of the Chief Coroner ("OCCO") which was filled by the advent of Dr. Smith, who was thought to be Canada's pre-eminent paediatric forensic pathologist at the time. The criminal justice system was not long in following suit.

4. It is the position of SickKids that while Dr. Smith was engaged as an expert in the justice system he was operating as an independent, fee-for-service contractor for the OCCO and/or the Crown and was not under the control or supervision of the Hospital. Similarly, the oversight of his activities in the justice system rested with those who sought and retained his services. For obvious reasons, the Hospital was never called upon to monitor or oversee these activities as it had no expertise, insight or mandate in that system. One need look no further than the Suspected Child Abuse and Neglect ("SCAN") Team's analysis of the Justice Dunn's reasons for decision in the Amber case to see how ill-suited the Hospital was to evaluate the role of expert evidence in the justice system.

5. Apart from a purposeful re-examination of the past, it is arguably more important to make findings and recommendations that will restore public confidence in the interface between forensic pathology and the justice system. In this aspect of the Commission's mandate, SickKids is confident that there is significant reason to be positive. The advent of two fully-qualified forensic pathologists (one full-time, one part-time) on the staff of OPFPU at SickKids, the development of Forensic autopsy guidelines and, the institution of a shared oversight framework provide ample grounds for the restoration of public confidence.

2. Background

(a) General

6. The Hospital for Sick Children ("SickKids" or the "Hospital") is a quaternary paediatric academic health sciences centre serving the provincial, national and international community. SickKids carries on a significant clinical, research and teaching enterprise. SickKids Department of Paediatric Laboratory Medicine ("DPLM") and within it, the Division of Pathology and its autopsy service supports this enterprise by providing clinical pathology and autopsy services essential to the diagnosis and understanding of paediatric disease processes. Within the clinical setting, the delivery of a high quality autopsy is an important adjunct to family centred care providing essential information to grieving families and their caregivers.

7. Autopsy Services provide a consultation service to hospitals throughout Ontario, for the examination of post mortem tissues, including referred slides of tissues and organ blocks such as heart, lung or brain, or the referral of fetuses or neonatal infants for a complete post-mortem examination. In addition, Autopsy Services review selected cases from outside of the Greater Toronto geographic area.

8. For well over 60 years, at the request of the OCCO, specialized paediatric pathology services and facilities at SickKids have been made available to assist coroners with the investigation of those infant and childhood deaths which fall under the provisions of the *Coroners Act*. Such investigations cover Sudden Infant Death Syndrome, cardiac and other natural diseases that cause sudden death, as well as deaths from trauma.

9. In September 1991, Ontario's Ministry of the Solicitor General and SickKids reached an agreement that led to the establishment of the OPFPU. The unit handles paediatric coroner's cases for the greater Toronto area and upon request, for the rest of the Province.

10. In April 2007, the Inquiry into Paediatric Forensic Pathology in Ontario was established following the publication of the results of a review conducted by the OCCO regarding certain cases of suspicious child deaths in which Dr. Charles Smith performed the autopsy or had otherwise consulted. In addition to the work Dr. Smith performed as a forensic pathologist for the OCCO, he held an appointment to the medical staff in the Division of Pathology at SickKids from 1981 through to 2005.

11. SickKids was granted standing at the Inquiry and participated fully in the work of the Inquiry, making complete documentary production and providing witnesses for both sworn testimony and policy round table discussions.

12. In response to a request by the Commissioner, SickKids has prepared these written submissions and recommendations.[1] In the paragraphs that follow, we will review the historical development of the OPFPU, the evidence on past and current practices of the OPFPU as it emerged at the Inquiry, and finally make proposals for recommendations for systemic change, as supported by that evidence.

(b) Dr. Charles Smith

13. In 1980, Dr. Smith had completed his four-year residency in pathology, a year of which was spent in paediatric pathology at SickKids. In November, 1980, Dr. Smith wrote and passed the

[1] By memo dated February 21, 2008, Commission counsel circulated the recommendations of Dr. Cutz, a staff pathologist at the Hospital. While the Hospital has no objection to Dr. Cutz offering his personal thoughts, it must be emphasized that Dr. Cutz's views do not necessarily reflect the views of the Hospital, the DPLM, or any of the Hospital witnesses who gave evidence at the Inquiry or otherwise.

American Board of Medical Specialty exam in Anatomical Pathology. The following month, December, 1980, he wrote and passed the Canadian Royal College of Physicians and Surgeons exam in Anatomical Pathology. In 1981, Dr. Smith completed a Fellowship in paediatric pathology.[2]

14. In 1981, Dr. M.J. Phillips was the Pathologist in Chief at the Hospital.[3] Dr. Phillips hired Dr. Smith as a Staff Pathologist in 1981.[4] It was Dr. Phillips' expectation, as set out in the letter confirming Dr. Smith's appointment, that Dr. Smith would assume all of the responsibilities of a Staff Pathologist in an academic health sciences centre providing specialized paediatric care, including the conduct of post mortem examinations for clinicians and for the Coroner.

15. In 1989, Dr. Smith applied to Dr. Malcolm D. Silver, Chairman of the Department of Pathology at the University of Toronto, for a promotion to the position of Associate Professor of Pathology. In his letter of application, Dr. Smith wrote:

> I have a special interest and expertise in paediatric forensic pathology. It is an uncommon type of work, for there is perhaps only one other person in Canada who seeks out this type of activity. My opinion is frequently sought by coroners, crown attorneys, defence counsels [sic], and police departments from across Ontario and in other provinces.[5]

16. Dr. Smith testified at the Commission that his interests in paediatric forensic pathology were likely broader than those of his colleagues at SickKids:

> Dr. Charles Smith: … So…. I was interested in paediatric forensic pathology.
>
> Ms. Jane Langford: Did you perceive your level of interest to differ from your colleagues with respect to paediatric forensic pathology?

[2] Dr. Charles Smith witness statement, PFP303346, pp. 9-11.

[3] See PFP303615, Dr. M.J. Phillips interview summary, p.1.

[4] See PFP117145, Letter to Dr. C. Smith from Dr. M. James Phillips, dated February 19, 1981.

[5] PFP114982, Letter from Dr. C. Smith to Dr. M.D. Silver, dated November 7, 1989.

> Dr. Charles Smith: We all had different areas of interest. Some, Dr. Cutz for example, had a very profound interest in the pathophysiology of Sudden Infant Death Syndrome, and so he directed much of his energies to that specific area of paediatric forensic pathology.
>
> Whereas my interest was, I believe, much broader. My interest in paediatric forensic pathology was much broader, I think, than my colleagues.[6]

17. According to Dr. Phillips' evidence, Dr. Smith became more involved in coronial work over time. Dr. Smith sat on committees and attended meetings at the OCCO which Dr. Phillips was not involved in. It was Dr. Phillips' impression that the people at the OCCO had confidence in Dr. Smith and respected him.[7] As time went on, Dr. Smith took on more of the difficult or contentious coroner's cases. Dr. Smith appeared to have a particular interest in criminally suspicious cases.[8]

18. In 1990, due to Dr. Smith's growing interest in paediatric forensic pathology, Dr. Phillips asked Dr. Smith to assume responsibility for both the autopsy and forensic pathology programmes within the department.[9]

(c) The Establishment of the OPFPU in 1991

(i) The circumstances leading to the creation of the OPFPU

19. In early 1990, Dr. Phillips wrote to then Chief Coroner, Dr. Ross Bennett, regarding a "Proposal for an Ontario Centre for the Study of Infant Deaths".[10] On August 2, 1991, Dr. Phillips wrote again to the Chief Coroner, now Dr. James Young, enclosing a revised

[6] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, pp. 33-34.
[7] PFP303615, Dr. M.J. Phillips' interview summary, p. 6.
[8] PFP303615, Dr. M.J. Phillips interview summary, p. 10.
[9] See PFP113643, Letter dated March 26, 1990 from Dr. J. James Phillips to Dr. Charles Smith.
[10] See PFP129902 and PFP129903.

proposal for funding the provision of paediatric pathology expertise and services available at SickKids to the OCCO.[11]

20. By September 17, 1991 a formal agreement was drawn up by the Ministry of the Solicitor General. Dr. Phillips wrote on that date to Dr. Young, enclosing a signed copy of the agreement with some proposed changes to the agreement, which indicated, among other things, **that the pathologists remain responsible to the Coroner for the forensic autopsy work**.[12] One of the reasons for having pathologists report to the Coroner was to ensure the independence of the review, particularly if the death had occurred at SickKids.

(ii) Agreement between SickKids and the Ministry of the Solicitor General

21. On September 23, 1991, an agreement was entered into between SickKids and the Ministry of the Solicitor General ("the Agreement") for the provision of paediatric forensic pathology services through what was then called the Ontario Paediatric Forensic Pathology Unit (OPFPU). The Agreement included a Schedule A that set out terms of reference for the Unit.[13]

22. Among other things, the Terms of Reference provided guidance on which paediatric coroner's cases would be referred to SickKids, and how the Unit would remain involved in teaching, research and the Paediatric Death Review Committee. Schedule A to the Agreement also contemplated how the funds advanced by the Ministry for the OPFPU would be used, and how professional activities would continue to be compensated.

[11] PFP118163 and PFP118164, Letter to Dr. J. Young from Dr. M. James Phillips, dated August 2, 1991 and Proposal for Paediatric Forensic Pathology at the Hospital for Sick Children, respectively.

[12] PFP117721, Letter from Dr. M. James Phillips to Dr. J. Young, dated September 17, 1991.

[13] PFP117722, Agreement dated September 23, 1991, at page 8.

(iii) The reporting requirements on the activities of the OPFPU

23. The Agreement contemplated that there would be quarterly reports to the OCCO on the activities in the OPFPU. In practice, quarterly reports were not issued. Rather the activities of the Unit were reported annually at the time the Hospital submitted its annual Request for Financial Assistance application to the Ministry responsible for the OCCO. In addition, the funding of the unit's activities was discussed from time to time at meetings with the Director of the Unit and members of the OCCO.[14]

24. The Agreement also required that accounting records be kept with respect to the funds that were advanced under the Agreement. SickKids tracked the $200,000 received from the Ministry in a separate cost centre, to which some but not all of the costs associated with running the OPFPU were attributed.[15]

25. With regard to the reporting accountability of individual pathologists conducting forensic autopsies, paragraph 4(c) of Schedule A of the Agreement preserved the pathologist's individual accountability to the requesting Coroner in order to maintain the independence of the pathologist's professional opinion.[16] The usual practice was that individual pathologists provided the completed post mortem examination reports to an administrative assistant in the Division of Pathology, who would then arrange for copies to be provided to the OCCO. Generally, a copy would also be provided to the Coroner who had signed the warrant authorizing the post mortem examination. A copy of the report was retained for the Division of Pathology

[14] See for example, PFP134482, Memorandum dated November 6, 1996, from Dr. David Chiasson to Dr. Charles Smith re Paediatric Forensic Pathology Unit.

[15] See Appendix D to the Hospital's Institutional Report, PFP301353, Accounting records for SickKids Cost Centre #51513 (Coroner's Fund), from 1994 to date.

[16] See PFP117721.

records, even if the case was referred in from elsewhere. Copies of all post mortem examination reports for patients who died at SickKids were, and are, maintained as required by the *Hospital Management Regulation,* enacted under the *Public Hospitals Act.* [17]

(d) The Organization and Structure of the OPFPU

(i) The OPFPU: a specialized unit in the Division of Pathology at SickKids

26. From the perspective of the Division of Pathology, the OPFPU was a mechanism for organizing and funding the specialized paediatric autopsy services required by the OCCO. The OPFPU is made up of individuals who are also members of the Division of Pathology and who have other significant academic and clinical responsibilities in addition to their work for the OCCO. Consequently, there is no organizational chart for the OPFPU as it is not a separate entity, *per se*, within the Division. Rather, it is a resource and service organized within the Division of Pathology, to provide Coroner's autopsies.

27. The Hospital did not exercise an oversight role in respect of the work product of the Unit. This was evidenced by their specific request for the inclusion of paragraph 4(c) of Schedule A of the Agreement, which preserved the pathologist's individual accountability to the requesting Coroner in order to maintain the independence of the pathologist's professional opinion.[18] In addition to this, the Hospital recognized that it had no expertise in the criminal justice system or the coronial system, which were served by the work product of the OPFPU. Without any

[17] R.R.O. 1990, Reg. 965, section 19(4)(k)(v).
[18] See PFP117721.

expertise in the area, effective oversight of work quality would be impossible and was therefore not contemplated.[19]

28. Individual pathologists within the Division of Pathology continued to receive requests to conduct autopsies pursuant to Coroner's warrants, with the support of pathology assistants, laboratory technicians and clerical assistance provided from the pool of the Division's administrative assistants. For example, a rotation schedule for 1993 shows the continued practice of assigning various individual Staff Pathologists "on call" responsibilities for the various services provided by the Division, including medico-legal autopsies.[20]

(e) Dr. Smith and the Directorship of the OPFPU

(i) Dr. Smith's appointment as the Director of the OPFPU in 1992

29. By the time that the OPFPU was created in 1991, Dr. Smith had become the pathologist at SickKids most directly engaged in the medico-legal work of the Department. During the late 1980s and early 1990s, Dr Smith had established himself as the SickKids pathologist most interested in the forensic aspect of pathology and, had demonstrated a willingness to make this aspect of his practice more predominant than the clinical and research aspects. To some extent, his interest and aptitude coincided with the less than universal interest in doing medico-legal work, which involved suspicious or homicidal deaths where the potential for court appearances and other time-consuming interfaces with the justice system was not viewed with enthusiasm by all pathologists.

[19] The Hospital did, however, recognize that it may have some administrative responsibilities over the Unit. Please see the evidence referred to in part 4(a)(i) of these submissions.

[20] PFP117059, On call Schedule for the calendar year 1993.

30. By 1990, Dr Smith was devoting the majority of his working time at the hospital to coroner's cases. In recognition of his commitment to this field, he was named Staff Pathologist in Charge of Autopsy Services.[21]

31. When the OCCO negotiated the Agreement in 1991, it was understood that the Chief Coroner wished to have a role in the appointment of the Director who, although a member of the Hospital's medical staff, was accountable to the OCCO in respect of the discharge of the medico-legal autopsy duties.[22]

32. In March 1992, Dr. Jim Young wrote to Dr. Phillips suggesting that the Paediatric Forensic Pathology Unit would benefit from having someone accountable for its activities and for liaising with the Coroner's Office.[23] Dr. Young proposed that Dr. Charles Smith be appointed to this role and therefore, in May 1992, Dr. Smith was asked to assume the role of Director.[24]

33. During cross examination, Dr. Cairns, the Deputy Chief Coroner at the relevant time agreed that the OCCO played a large role in the development of Dr. Smith's expertise and status in the field of paediatric forensic pathology:

> Mr. Peter Wardle: So, I guess the point I'm making, Dr. Cairns, is Dr. Smith didn't come out of nowhere and become an icon overnight, did he?
>
> Dr. James Cairns: That's – that's exactly correct.
>
> Mr. Peter Wardle: And his career steps all the way along from the mid 80's right forward to the point we're at now, the mid to late 90's; all of those steps were

[21] See PFP117704, Memo from Dr. M.J. Phillips to Mr. Bruce Laughton, dated March 9, 1990.

[22] See PFP044014, Letter dated March 10, 1992 from Dr. James G. Young to Dr. M.J. Phillips dated March 10, 1992; PFP044015, Letter dated May 29, 1992 from Dr. M.J. Phillips to Dr. Charles Smith; and PFP118077, Letter dated August 5, 1992 from Dr. M.J. Phillips to Dr. James G. Young.

[23] PFP044014, Letter to Dr. M.J. Phillips from Dr. J. Young.

[24] PFP113646, Letter to Dr. Charles Smith from Dr. M.J. Phillips, dated May 29, 1992.

> taken with the active encouragement and involvement of the Office of the Chief Coroner?
>
> Dr. James Cairns: That's correct.
>
> …
>
> Mr. Peter Wardle: …your office did have a substantial role in the development of Dr. Smith's career. You assisted his career.
>
> Dr. James Cairns: I would say that is correct.[25]

34. When Dr. Chiasson was appointed Chief Forensic Pathologist in 1994, he was aware that although Dr. Smith was a paediatric pathologist by training, he did not have certification or any specialized training in forensic pathology.[26] No formal training or certification in paediatric forensic pathology was available at the time.

(ii) Dr. Smith's resignation as the Director of the OPFPU

35. Following concerns that were raised about his forensic work by the OCCO and by others, Dr. Smith wrote in January 2001 to Dr. Jim Young, then Chief Coroner, asking to be excused from the performance of medico-legal autopsies for the OPFPU and requesting an external review of his work.[27]

36. Dr. Smith's eventual decision to resign as Director of the OPFPU was a matter between Dr. Smith and the OCCO. According to the evidence given by Dr. McLellan:

> Dr. Barry McLellan: Yes, I -- I met with Dr. Smith. I indicated that I did not feel he should be continuing in that role. As a result of our meeting, Dr. Smith agreed and, subsequently, wrote to me indicating that he wished to step down.
>
> ….

[25] Transcript of the evidence of Dr. James Cairns, November 28, 2007, pp. 113-114, and 126.

[26] Transcript of the evidence of Dr. David Chiasson, December 7, 2007, pp. 140-141.

[27] See PFP114567, Letter dated January 25, 2001 from Dr. Charles Smith to Dr. Jim Young.

> We agreed at the meeting …that that was the most appropriate course of action, so I didn't have to go any further. You'll note that the letter is written July 9th but retroactive to July 1st. And in hospitals, appointments frequently start or end on January the 1st or July 1st. So I can only assume at the time of our meeting, we agreed that July 1st was an appropriate day for him to stop. I do recall indicating to Dr. Smith that I required a letter to that effect. I do recall it being beyond July 1st and not yet having a letter, but Dr. Smith did reply on July 9th.[28]

37. Following Dr. Smith's resignation as Director of the OPFPU, and at the request of the OCCO, SickKids offered to make Dr. Glenn Taylor available to take up the role of Director of the OPFPU, following Dr. Taylor's return to SickKids in 2003 from British Columbia's Children's Hospital.[29]

3. The OPFPU today

38. As demonstrated by the evidence before this Commission, as well as the opinions expressed at the policy round table discussions, the OPFPU as constituted today is a very different entity than it was during Dr. Smith's Directorship. The Unit is now directed by a board certified forensic pathologist and managed co-operatively by an Executive Team with membership from the Hospital, and the OCCO, the latter including the Chief Forensic Pathologist. Several witnesses, whose evidence will be referred to below, describe the current constitution of the OPFPU as the **ideal vehicle for the delivery of high quality paediatric forensic pathology to the coronial and criminal justice system**.

(a) Current Contract between SickKids and the OCCO

[28] Transcript of the evidence of Dr. Barry McLellan and Dr. Michael Pollanen, November 13, 2007, pp. 68-70.

[29] See PFP117883, PFP117881 and PFP117880.

39. The contract between the Hospital and the OCCO was re-negotiated in 2004[30] in a process instituted by Dr. MacLellan of the OCCO and Dr. Taylor on behalf of SickKids. The contract in its current form addresses the shared oversight and management of the OPFPU.[31]

40. The renegotiated contract provided for the creation of an Executive Team to oversee the functioning of the OPFPU. The Executive Team is to meet on an annual basis, or more often as required, to discuss issues related to the interaction between the Hospital and the OCCO.[32]

41. The Executive Team is made up of the SickKids Vice President with oversight for Laboratory and Diagnostic Services, the head of the Division of Pathology at the Hospital, the Unit Director, the Chief Coroner and the Chief Forensic Pathologist.[33]

42. Under the terms of the new contract, the Hospital now has formal input into the decision of who is appointed Director of the OPFPU.[34]

(b) Current OPFPU leadership and oversight

43. When Dr. Taylor became Director of the Unit in July 2004, he continued to carry out the reviews of the forensic reports being generated by members of the Unit, a practice which had been instituted by Dr. Smith at the request of the OCCO. Dr. Taylor was of the view that this

[30] See PFP117857, 2004 contract.

[31] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 299, see also PFP033773, the 2007 contract.

[32] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 299-300.

[33] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 19, 2007, pp. 90-91, see also PFP033773, the 2007 contract.

[34] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 300, see also PFP033773, the 2007 contract.

review was a quality assurance function. At that time, Dr. Chiasson reviewed Dr. Taylor's reports.[35]

44. Dr. Taylor instituted business meetings for the staff of the OPFPU. With the assistance of Dr. Chiasson, Dr. Taylor also instituted more regular rounds to review the forensic cases.[36]

45. Currently, Dr. Chiasson, a board certified forensic pathologist, is the Director of the OPFPU.[37] Both Drs. Taylor and Cutz agreed during their evidence that the Director of the OPFPU should be an accredited forensic pathologist.[38]

46. Dr. Chiasson considers that part of his role as Director of the Unit is to ensure that proper quality assurance mechanisms are in place in the Unit regarding the post mortem examination reports being produced. He believes that he has a role in oversight of the Unit.[39] SickKids accepts that by virtue of Dr. Chiasson's training and credentialing in forensic pathology, as well as his work experience in the forensic pathology service at the OCCO, he is well positioned to oversee some quality assurance aspects of this coronial work, and report appropriately to the Chief Forensic Pathologist as required. This unfortunately was not the situation when Dr. Smith was the Director, as Dr. Smith was not formally trained in forensic pathology and therefore had no foundation upon which to base any oversight.

[35] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 297-298.

[36] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 298.

[37] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 302, see also PFP117879 and PFP129336.

[38] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 19, 2007, pp. 120-121.

[39] Transcript of the evidence of Dr. David Chiasson, December 8, 2007, pp. 183-184.

47. As Director of the Unit, Dr. Chiasson reviews all coroner's cases before they are released from the OPFPU. This review may include a review of the post mortem report, the slides and the images associated with the report.[40]

48. All medico legal cases are now presented at rounds, either the departmental autopsy rounds or special forensic rounds. This includes the presentation of criminally suspicious cases and homicides. These rounds are viewed by the Hospital as a quality assurance process,[41] as they allow for the testing of the pathologist's findings through questions posed by medically and scientifically trained peers and the consequent exploration of differential diagnoses.

49. Dr. Chiasson continues to hold the business meetings instituted by Dr. Taylor with all the pathologists performing coroner's cases every three months at the Unit to discuss ways to improve the work being done within the Unit and the oversight of the work in the Unit.[42]

50. In Dr. Taylor's opinion, there is a free interchange of ideas and expertise within the Unit today, which has lead to a collegial atmosphere within the Unit.[43] Proper oversight of the work product of the Unit is ensured by the review process, the rounds, and the availability of business meetings to discuss any issues affecting the Unit and its work.

51. The Hospital does not currently have a system in place, nor does it agree that it would be appropriate for the Hospital to create a system whereby the Director of the Unit or anyone at the

[40] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 305-306.

[41] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 306, see also transcript of the evidence of Dr. David Chiasson, December 8, 2007, pp. 182.

[42] Transcript of the evidence of Dr. David Chiasson, December 8, 2007, pp. 181, see also PFP137639 as an example of the minutes of a business meeting

[43] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 306-307

Hospital would be responsible for the oversight of pathologists while giving evidence at the behest of the Crown, defence, or any other parties in a judicial setting.

(c) Expertise

52. The Unit and Hospital today provide the OCCO with the very best and most appropriate expertise required in the given circumstances of a case. This expertise includes a full roster of paediatric pathologists, two qualified forensic pathologists, two paediatric neuropathologists, paediatric radiologists, as well as a wide array of other paediatric medical sub-specialists. In sum, these professional resources represent significant expertise in the performance of paediatric forensic autopsies at the OPFPU, which is unparalleled in any other setting in Ontario.

53. During his testimony, Dr. Cairns acknowledged that the situation facing the OCCO and the OPFPU today is a very different situation than in the past:

> Mr. William Carter: So what we have today is a situation where we have a specially qualified paediatric forensic pathologist working at the Hospital for Sick Children, and on forensic matters reporting to a highly qualified, if I may use the term, general forensic pathologist in the person of the Office of the Chief Forensic Pathologist for Ontario?
>
> Dr. James Cairns: That's correct.
>
> Mr. William Carter: Okay, now these are luxuries that could only have been dreamed of in 1981, is that right?
>
> Dr. James Cairns: Absolutely.
>
> Mr. William Carter: Right. So it's our role and function here to walk back over the past and examine the steps and choices that were made and see what we can learn from them, but we can take some comfort from the fact that where we are today it's a very good place and a far cry from where we were when we began this journey?
>
> Dr. James Cairns: I would agree entirely.[44]

[44] Transcript of the evidence of Dr. James Cairns, November 29, 2007, pp. 28-29.

54. Dr. Chiasson triages all cases that come to the OPFPU through the coronial system. If Dr. Chiasson is not available, the triage is performed by the pathologist on duty. All criminally suspicious cases are streamed to Dr. Chiasson or Dr. Pollanen (accredited forensic pathologists) for post mortem examination. Non-criminally suspicious cases are performed by the OCCO approved paediatric pathologist on duty. Should the pathologists on duty discover any issues which concern them during the performance of their post mortem examination, they will discuss these concerns with Dr. Chiasson, Dr. Pollanen or Dr. Taylor, and one of the forensically trained/experienced pathologists may take over the post mortem examination as necessary.[45]

55. Members of the Unit also rely on the July 2007 Autopsy Guidelines in Sudden Unexpected Death of Infants and Children Under 5 Years, section 2.2, as indicators of potential histories or signals which should direct the performance of a criminally suspicious autopsy to Dr. Chiasson or Dr. Pollanen.[46] Although not included in the document in its current format, it is anticipated by Dr. Chiasson that the next version of these Guidelines will include steps to be taken should a non-criminally suspicious post mortem examination become criminally suspicious at any point during the performance of the post mortem or subsequent investigations.

56. When asked whether he agreed with the concept of "double doctoring" in paediatric forensic cases, Dr. Chiasson testified that he prefers the current model being employed at the OPFPU in potentially criminally suspicious coroner's cases:

> Dr. David Chiasson: … the model we have now… at Sick Kids… I'm a major proponent of this, as you might think, but in fact, in some ways we… quadruple-doctor… at SickKids, or even more.

[45] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 302-303, see also transcript of the evidence of Dr. David Chiasson, December 7, 2007, pp. 121-123.

[46] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 303, see also PFP137592.

> And by that, I mean we have a paediatric radiologist whose (sic) a doctor, he looks at the x-rays beforehand, so that's part of the investigation. We have a… very experienced pathologists (sic) assistant, and I think… that's a critical element to performing any autopsies; to have a good pathologist assistant, but in the case of paediatrics that's particularly so. And… the training and… expertise of a paediatric forensic pathologist assistant is… really very valuable. And I happen to work with one who is a PhD, so he's… my second doctor who… I'm very fortunate to work with.
>
> Then there's the… forensic pathologist who's doing the case.
>
> Then there's the neuropathologist, which is critically important in… a lot of these… as you're all aware, from the nature of the cases. If I have a problem, I… contact Dr. Halliday, who happens to be down the hall; and he's able to attend the autopsy and render his expertise about the brain and ultimately cut the brain.
>
> And then, I think we're up to four there, but even beyond that, if there is a paediatric pathology issue that I identify, then I'm very fortunate because I have very experienced paediatric pathologists who are also… down the hall.[47]

57. Dr. Chiasson further testified that being geographically close to the other paediatric sub-specialists, especially the neuropathologists, is of significant assistance in that he can request that a sub-specialist attend the autopsy and observe should he feel it necessary.[48] In other words, Dr. Chiasson's current position within a specialized paediatric centre ensures that the required clinical expertise is brought to bear in any given paediatric death investigation, avoiding the legal risks inherent when differential diagnoses are not adequately explored.

58. Dr. Chiasson believes that the OPFPU as currently constituted is the ideal format for the practice of paediatric forensic pathology:

> Dr. David Chiasson: …I've said this is a unique concept. It's a unique way to tackle what is a very difficult issue within forensic pathology and that's… how to best do paediatric forensic pathology.

[47] Transcript of the evidence of Dr. David Chiasson, December 7, 2007, pp. 113-114.

[48] Transcript of the evidence of Dr. David Chiasson, December 7, 2007, pp. 118-120.

> I've bought into this model. I think there's a unique concept and also unique opportunities to develop research, education mandates to provide the evidence for evidence-based paediatric forensic pathology in this case.
>
> So I'm obviously a big believer in… the setup that we have now in place at this Hospital for Sick Children.[49]

59. Further, Dr. Pollanen, Chief Pathologist for Ontario, agrees that the system currently in place between the OCCO and the OPFPU is a reasonable option for addressing undifferentiated paediatric death cases that may, or may not, ultimately engage the criminal justice system:

> Dr. Michael Pollanen: So you've outlined the -- the typical undifferentiated paediatric case that would come to any death investigation system in the western world, and there are many different options available to us on how to manage such a case…
>
> So in our current system, and I believe there's merit to this, such a case would be streamed to the Sick Children's Hospital where the case would benefit from the presence of a paediatric pathologist and in fact a forensic pathologist, because Dr. Chiasson is -- is on staff there.
>
> The -- and the other ancillary services that are available also at the Children's Hospital can be brought to bear on the case. So it's a -- it's a reasonable approach.[50]

(d) Communication with OCCO/CFP

60. Dr. Chiasson testified that today, there is extensive communication and collaboration between the Director and members of the OPFPU and the Chief Forensic Pathologist and OCCO:

> Dr. David Chiasson: … I've certainly maintained a fairly regular contact with… the Chief Forensic Pathologist. He is, in fact, part of – of the coterie of pathologists who are now doing autopsies. So he… plays a role in my business meetings.

[49] Transcript of the evidence of Dr. David Chiasson, December 8, 2007, pp. 192-193.

[50] Transcript of the round table discussion dated February 11, 2008, "Organizing Paediatric Forensic Pathology in Ontario", Dr. Michael Pollanen, pp. 138-141.

> I play a role as the Director in any meetings that he organizes with the forensic—the other Directors of the Units. I've been involved in working with him on the… protocols for criminally suspicious deaths as it applies specifically to children.
>
> And in turn, he's been involved with our own protocol dealing with Sudden and Unexpected Deaths where it's not criminally suspicious at the outset. So we have protocols that are similar, but… somewhat different in terms of our approach.
>
> So… that kind of ongoing relationship… is happening. I attend the continuing forensic pathology education sessions on… Wednesdays, and part of that now has evolved into having business meetings with the forensic pathologists.[51]

61. Dr. Pollanen also spoke of the level of communication that occurs today between his office and the OPFPU:

> Dr. Michael Pollanen: But -- but the point being there that while the -- the unit at Sick Kids is geographically separated from my Department, there are important linkages.
>
> So for example, there are occasions where I will go over to review a case that's being done at Sick Kids, while the body is still on the table. And that type of interaction is also very fruitful.
>
> So it's not as is if we have, you know, a loan (sic) department in which bodies are arriving; autopsies are occurring. It's an integrated service and that's something that -- that -- it's a challenge to deliver, but it's a challenge that we have to accept if we want to maintain these important partners that are… distributed geographically across the -- the Province.[52]

4. Concerns Expressed Regarding SickKids' past involvement with the Coronial Service and Dr. Smith

(a) Oversight of coronial work

62. Historically, the Hospital did not consider itself as having a role in the oversight of the work product of the Unit or Dr. Smith's particular work product for the OPFPU. The Hospital recognized that neither it nor its medical staff had expertise in the criminal justice system or the

[51] Transcript of the evidence of Dr. David Chiasson, December 8, 2007, pp. 182-183.

[52] Transcript of the round table discussion dated February 11, 2008, "Credentialing and Growing the Paediatric Forensic Pathology Service in Ontario", Dr. Michael Pollanen, pp. 148-149.

coronial system served by the OPFPU. Without any expertise in the area at that time, effective oversight of work quality would be impossible and was therefore not contemplated.[53]

63. Dr. Phillips' evidence was that effectively, the OCCO ran the OPFPU. Dr. Phillips viewed Dr. Smith, in his role of Director of the Unit, as acting as an agent of the OCCO. Dr. Smith was in frequent contact with the OCCO, who set the "ground rules" for the OPFPU.[54]

64. As the Director of the Unit, it was Dr. Smith's responsibility to review all post mortem reports for post mortem examinations done under coroner's warrant. The OCCO would not accept a report until Dr. Smith had signed off on it. It was Dr. Taylor's evidence that when he joined the Hospital in 1995, Dr. Smith's role as Director of the Unit included an administrative role as well as an oversight role in that he reviewed all the post mortem reports generated within the Unit.[55]

65. Dr. Smith testified as to his duties and responsibilities as the Director of the OPFPU:

> Dr. Charles Smith: … I had several responsibilities. The first one was to make sure there was someone who could provide paediatric forensic autopsy service.
>
> So there… was always a staff pathologist who was available… who participated in doing the coroner's cases. The second thing that I was expected to ensure that the – the policies or procedures that were mandated by the Office of the Chief Coroner were carried out by the pathologists or in the department.
>
> Later-- a short while later, I was asked to review the final autopsy reports of the staff pathologists before those reports were sent to … the Regional Coroner or the Office of the Chief Coroner.
>
> Ms. Jane Langford: And when you say, "review those post mortem reports", what specifically was your responsibility vis a vis those post mortem reports?

[53] The Hospital did, however, recognize that it may have some administrative responsibilities over the Unit. Please see the evidence referred to in part 4(a)(i) of these submissions.

[54] PFP303615, Dr. M.J. Phillips interview summary, p. 5.

[55] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 74-75.

> Dr. Charles Smith: Besides proofreading for typos, which was not an important role, really my attention was directed at looking for the wording in the reports to ensure that the wording in them, such as wording about cause of death was in keeping with the… practice or the policies that the Office of the Chief Coroner wanted, so I was looking at wording.
>
> It was not my role to re-examine the slides. It was not my role to provide a second opinions (sic). It was simply to make sure that whatever the pathologist did, the written record was in keeping with what the Office of the Chief Coroner wanted.[56]

66. When Dr. Cairns was appointed Deputy Chief Coroner in September 1991, it was his understanding that Dr. Smith was the *de facto* Director of the OPFPU at SickKids, soon to be appointed to official Director of the OPFPU. Dr. Cairns also understood that Dr. Hillsdon Smith, the Chief Forensic Pathologist did not intend to supervise Dr. Smith's work at the OPFPU. In Dr. Cairns view, it was unclear who, if anyone, would supervise Dr. Smith's work as a pathologist or as the Director of the OPFPU as there were no pathologists employed at the Coroner's Office and the Chief Forensic Pathologist clearly had no intention of supervising Dr. Smith.[57]

67. In 1994, when Dr. David Chiasson was appointed Chief Forensic Pathologist, it was Dr. Cairns' understanding that Dr. Chiasson could supervise Dr. Smith's work at the OPFPU.[58]

68. In Dr. Cairns view, the responsibility for supervision of Dr. Smith's forensic pathology work rested with the OCCO:

> Mr. William Carter: Now, the supervision of Dr. Smith's forensic work, as opposed to his whatever surgical autopsy [sic] work he did, which amounted to at least half of his clinical time, rested with the Coroner's office, did it not?
>
> Dr. James Cairns: Yes, it did.[59]

[56] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, pp. 38-40

[57] Transcript of the evidence of Dr. Thomas (sic) Cairns, November 26, 2007, pp. 97-98.

[58] Transcript of the evidence of Dr. Thomas (sic) Cairns, November 26, 2007, pp. 99.

69. Dr. Young explained his understanding of why the OCCO remained responsible for the oversight of the Unit to Mr. Gover, counsel for the OCCO:

> Mr. Brian Gover: And why, according to the service agreements, is the Chief Coroner responsible for professional services at the forensic unit?
>
> Dr. James Young: Well, the cases are being done under coroner's warrant and if – those that order it and those that are legally responsible for it should be the people that are – are looking after the quality assurance as well.[60]

70. As Chief Forensic Pathologist, Dr. Chiasson also viewed oversight of Dr. Smith and the OPFPU as the primary responsibility of the OCCO and the Chief Forensic Pathologist:

> Dr. David Chiasson: … clearly the work of the Paediatric Forensic Pathology Unit was – was entirely – we were -- the coroner's office was the only client to the PFPU and… I accepted that the coroner's office was the one that had oversight as far as… the product, if you will; the… autopsy reports and the work done by… the unit; recognizing at the same time that Dr. Smith and all the other pathologists were employees of the Hospital.
>
> …
>
> Ms. Linda Rothstein: So, if I put it this way, did you see the OCCO as having primary responsibility for the supervision of the work of the OPFPU, including that of Dr. Charles Smith, the answer is…?
>
> Dr. David Chiasson: Yes.[61]

71. This being said, Dr. Chiasson was of the view that as the Director of the Unit, Dr. Smith did have some role in ensuring the appropriateness of the work product of the Unit, that being the post mortem reports. [62]

72. In discussing the communication between the Hospital and the OCCO regarding the OPFPU, Dr. Smith gave evidence that in essence, all policy decisions regarding the OPFPU were made by

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[59] Transcript of the evidence of Dr. Thomas (sic)Cairns, November 29, 2007, pp. 69.

[60] Transcript of the evidence of Dr. James Young, December 3, 2007, pp. 134.

[61] Transcript of the evidence of Dr. David Chiasson, December 7, 2007, pp. 131-132.

[62] Transcript of the evidence of Dr. David Chiasson, December 7, 2007, p. 134.

the OCCO, and that as Director of the Unit, he had no authority to make policy changes without the approval of the OCCO:

> Ms. Jane Langford: Dr. Smith, what authority, if any, did you have as Director of the Unit to improve the conductivity between the Unit and the Chief Coroner's Office and the Chief Forensic Pathologist?
>
> Dr. Charles Smith: … I had no authority… I couldn't make policy decisions, or … implement policies, or procedures, without… authorization of the… Office of the Chief Coroner.[63]

73. During most of Dr. Smith's tenure, coroner's cases were only discussed at the pathology department rounds if the OCCO provided consent. It was Dr. Phillips' recollection that consent was not given to discuss criminally suspicious cases at SickKids pathology rounds, as these cases were conducted "behind closed doors" and pathologists other than the one conducting the post mortem were not even permitted access to the autopsy suite while a criminally suspicious autopsy was being performed.[64]

74. Drs. Taylor and Cutz testified that rounds took place in the department of pathology at the Hospital, in which coroner's cases were discussed, if permission was granted by the OCCO to discuss the specific case. Neither Dr. Taylor nor Dr. Cutz recall permission being granted for a criminally suspicious coroner's case to be presented at Hospital rounds.[65]

[63] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, pp. 47-48.

[64] PFP303615, Dr. M.J. Phillips interview summary, p. 7.

[65] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 118-119.

75. Both Drs. Taylor and Cutz had some recollections of forensic pathology rounds taking place in the mid 1990's. Neither was able to recall clearly as to how often, or where the rounds occurred.[66]

76. The evidence heard at the Commission demonstrates that during the 1990's and early 2000's, the Hospital was not given a role to play in the oversight and quality assurance processes then in place regarding post mortem reports produced pursuant to Coroner's warrants at the OPFPU. According to the evidence given by representatives of the OCCO, they did not envision the Hospital or even the Director of the Unit as having any role in the oversight and quality assurance processes in place at the OPFPU.

77. The role of the Director of the Unit was not thought of as one that carried with it a quality assurance function. The role, as described by Drs. Young and Cairns, was an administrative one. In addition, the Director took his direction on coronial work from the OCCO, and not his Hospital superiors. In these circumstances, it is unfair to expect that the Hospital would undertake a substantive role in the oversight of the Director's work for and at the request of the coronial system.

(i) Timeliness (Hospital policies)

78. As set out in further detail below, the evidence before the Commission was unequivocal that issues relating to timeliness of post mortem reports and turn around times are a systemic issue that affect virtually all pathologists working within the coroner's system in the province, to some degree. Similarly, it was abundantly clear that Dr. Smith's issues relating to timeliness were more extreme than other pathologists in the province. Further, the evidence was clear that Dr.

[66] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 119-122.

Smith's superiors at the Hospital made concerted efforts to address Dr. Smith's chronic delay, but that ultimately, they were unable to effect any significant change on this issue until the arrival of Dr. Taylor as Division Head. Those managing the coronial service opted to continue using Dr. Smith's services in spite of these issues regarding timeliness when faced with the option of late service versus no service at all.

79. Dr. Phillips acknowledged that timeliness in completing post mortem reports was an issue within the OPFPU. Dr. Phillips viewed this as within the ambit of his administrative responsibilities and made many attempts to improve the turn around time of cases.[67] Dr. Phillips spoke to Dr. Smith about the timeliness issues on many occasions. Dr. Smith's responses included the fact that he was very busy, had many cases, and he was waiting for test results to complete his reports.[68] Dr. Smith acknowledged in his testimony that he had improperly offered inadequate resources as an excuse for his own procrastination.[69]

80. It was Dr. Taylor and Dr. Cutz's belief that Dr. Becker, the Chief, Department of Paediatric Laboratory Medicine took steps to address the delays associated with Dr. Smith's reports:

> Dr. Glenn Taylor: My understanding is that Dr. Becker brought up the topic many times with him in … various ways.
>
> Ms. Jennifer McAleer: Okay, and… what was the result, as far as you knew?
>
> Dr. Glenn Taylor: Now, I can't think of what happened towards the – towards 1999… but I don't think that there was a lot of change during the years '95 to say mid-'99 when I was there.
>
> Ms. Jennifer McAleer: Does that accord with your recollection, Dr. Cutz?

[67] PFP303615, Dr. M.J. Phillips interview summary, p. 5.

[68] PFP303615, Dr. M.J. Phillips interview summary, p. 9.

[69] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, pp. 62-63.

> Dr. Ernest Cutz: No, actually, the late report was a regular feature in our staff meetings, where, you know, people were reminded to… complete their reports.
>
> At one point there was a list distributed which listed, you know, which reports and which staff had delinquent reports, in terms of, you know, to do some kind of a follow up.
>
> But as far as I could see there was no change on Dr. Smith's part… I could see Dr. Becker was really frustrated and didn't really know what – what he should do, because… there was no improvement.[70]

81. Dr. Cairns testified that as Deputy Chief Coroner, he was aware of Dr. Smith's issues regarding timeliness, and had spoken to Dr. Smith regarding these issues. He stated:

> Dr. Thomas (sic) Cairns: They were warning signs, and they were taken seriously. The problem we had was that Dr. Smith was the paediatric pathology expert. He was the guru, and, therefore, the dilemma was if we stop using him, we're – stop using a resources that, at that time by everybody was considered to be an invaluable resource.
>
> ... So which was the lesser of two evils; to stop using him because he was delayed or to accept the delays and push on the critical delays that may be affecting court cases and – and that's the situation we were in.
>
> ... There was no one, at the time, that was considered with the same expertise as Dr. Smith, and it was considered inappropriate or wrong to – to stop using him, at the time.
>
> Ms. Linda Rothstein: As a systemic issue, Dr. Cairns, do you believe that the OCCO has the primary role in ensuring that post-mortem reports… be completed by its fee-for-service pathologists, are completed in a timely fashion?
>
> Dr. Thomas (sic) Cairns: Yes. [71]

82. Dr. Young acknowledged that issues regarding timeliness and turnaround times were issues that were not confined to Dr. Smith and the Hospital for Sick Children, but rather systemic issues which were influenced partly by forces outside an individual pathologist's control, for example

[70] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 242.

[71] Transcript of the evidence of Dr. Thomas (sic) Cairns, November 26, 2007, pp. 93-94.

toxicology reports and the reports of other specialists consulted in preparing the post mortem report, as well as the complexity of the given case.[72]

83. When asked about his issues regarding timeliness and delays in turnaround times, Dr. Smith testified:

> Ms. Jane Langford: How, Dr. Smith, do you explain the persistent pattern of late reports that these cases and the documents, reveal?
>
> Dr. Charles Smith: I'm embarrassed by them.. I… have no one to blame but myself. I recognize that I'm not organized; that I'm an untidy person.[73]

84. Dr. Becker was aware of and took steps to address Dr. Smith's issues regarding timeliness. Ultimately, he was unable to force any change in Dr. Smith's coronial practice, as the ultimate decision of whether to use Dr. Smith's services was at the discretion of the OCCO, not SickKids.

85. Although reporting delays were pervasive to the coronial service, those in charge at the OCCO made a conscious decision to tolerate Dr. Smith's lack of timeliness in the face of the alternative, which was to abstain from using what they perceived to be the best available paediatric forensic pathology services at that time.

(ii) Accessioning and Storage of Materials

86. Evidence was given by Hospital witnesses regarding the practices and policies in place related to the accessioning and storage of tissues received at the Hospital for autopsies or

[72] Transcript of the evidence of Dr. James Young, December 4, 2007, pp. 171-172.

[73] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, pp. 62-63.

requests for consultation. It is clear that policies and practices were in place which relied on the co-operation of pathologists for the storage and accessioning of tissues.[74]

87. Despite the existence of these practices and policies, it was clear that in many instances, Dr. Smith failed to follow the departmental practices and instead kept tissues, blocks and materials in his office. In some instances these materials were not accessioned and as such the Hospital had no knowledge of or ability to track these materials through the Hospital's electronic system.

88. According to Dr. Phillips' evidence, it was unusual for a pathologist to keep tissue samples from an autopsy pursuant to a coroner's warrant after the post mortem report was completed, aside from tissues for fixation and sectioning. If materials were sent from another hospital, they would be returned to the originating hospital. If the autopsy was done at SickKids, the materials would be filed according to the department's practice. Dr. Phillips could not recall whether there were any written policies or rules to this effect during his tenure as Pathologist in Chief.[75]

89. When asked about his failure to maintain control over tissue blocks and materials, Dr. Smith testified:

> Ms. Jane Langford: You are also subject, Dr. Smith, to criticism for your failure to maintain care and control over tissue blocks, slides and other evidence.
>
> Can you explain your behaviour in this regard?
>
> Mr. Charles Smith: Again, I have no one to blame but myself.

[74] See transcript of the evidence of Maxine Johnson, December 17, 2007, pp. 113-114, 131-132; see also PFP198580, SickKids policy "Filing gross specimens", effective date October 31, 1986; PFP138616 SickKids policy "Filing blocks", effective date October 31, 1986; and PFP138745 SickKids policy "Referred In specimens- B cases", effective date September 3, 1987.

[75] PFP303615, Dr. M.J. Phillips interview summary, p. 9.

> I think it is… an expression of my disorganization and untidiness and perhaps, also… an expression of the fact that I wasn't fully attuned to. The importance of the procedures related to things like continuity of evidence.[76]

90. Regardless of the criticisms levelled against Dr. Smith in this regard, the evidence before the Commission demonstrates that in the 2005 Tissue Audit regarding cases performed under coroner's warrant at SickKids, the vast majority of tissues were located. It was Maxine Johnson's evidence that most of the tissues requested by the OCCO were related to coroner's autopsies performed at SickKids, and as such it was "fairly easy" to locate the tissues requested, as the materials were filed with archival materials, according to Hospital practice and policy[77]. Ms. Johnson further testified that it was slightly more difficult to locate materials sent to Dr. Smith by the OCCO for consultation, but ultimately, these materials were found, because they had, for the most part, been properly accessioned according to Hospital policy. Finally, Ms. Johnson stated that the most difficult materials to locate were those sent to Dr. Smith directly for consultation, where the external, referring pathologist did not send the material through the OCCO. Often, this category of materials had not been accessioned by Dr. Smith, and were therefore not traceable through the Hospital's computer-based accessioning system. Ultimately, Ms. Johnson testified that she believes that the Tissue Audit was largely successful, in that staff were able to locate most of the requested material.[78]

91. It is clear that during the relevant time period, the Hospital had established practices regarding the accessioning and storage of all autopsy and consultation materials. These practices, however, relied on the co-operation of the pathologist receiving and examining the

[76] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, pp. 64.

[77] See for example, policies referred to at footnote 74 above.

[78] Transcript of the evidence of Maxine Johnson, December 17, 2007, pp. 133-136.

materials. Today, the Hospital continues to have written policies which address the accessioning and tracking of all materials received in the department.[79]

92. The most challenging situation facing the Hospital was one in which materials were sent directly to pathologists for review in a private consultations, rather than through established systemic channels of communication wherein tracking and accessioning systems could be applied effectively and uniformly. While the Hospital has, and had at the time, established practices to account for these materials, the ultimate efficacy of these practices were and are dependent on the individual pathologist's compliance with established practice.

(iii) Access to administrative assistance

93. At various stages in the 1990s and 2000s, Dr. Smith blamed his delays and other shortcomings on his inability to access adequate secretarial support at SickKids.

94. While Dr. Smith's allegations regarding his access to administrative assistance will be addressed in some detail in the paragraphs that follow, it is important to note that whether or not Dr. Smith had adequate access to administrative support by way of secretarial assistance would ultimately have had no bearing whatsoever on Dr. Smith's abilities to perform paediatric forensic pathology. Issues regarding secretarial resources cannot explain any shortcomings in Dr. Smith's understanding of the scientific principles of forensic pathology nor can it explain the scope and nature of the evidence that Dr. Smith gave in court rooms or other judicial setting.

[79] See PFP155816, SickKids Policy "OPA1007/01- Receipt and Accessioning of All Cases".

95. Maxine Johnson testified that from 1989 to 1994, assistant Nancy Fayder was assigned to Dr. Smith. From 1995 to 1997, Ms. Johnson was assigned to Dr. Smith. From 1997 to 2001, Burnett Wint was the assistant assigned to assist Dr. Smith.[80]

96. According to the evidence of Ms. Johnson:

> Mr. Robert Centa: And during the time in pathology did Dr. Smith ever tell you that he had inadequate secretarial support to permit him to complete his reports of post mortem examination in a timely fashion?
>
> Ms. Maxine Johnson: No, he did not.
>
> Mr. Robert Centa: Did he ever tell you that the secretaries that were assigned to him were not completing his reports of post mortem examination in a timely fashion?
>
> Ms. Maxine Johnson: No.
>
> Mr. Robert Centa: And did he ever tell you the – that he was forced to type his own reports because of insufficient secretarial support?
>
> Ms. Maxine Johnson: Dr. Smith was never forced to type his reports as far as we were cons—concerned. This was one (1) of the functions of our jobs as admin assistants, was to facilitate getting those reports completed. Dr. Smith made a choice to type his own reports.[81]

97. Further, Ms. Johnson gave evidence that she was never approached by any of the administrative assistants assigned to Dr. Smith regarding any concerns about their ability to complete Dr. Smith's work in a timely manner.[82]

98. When asked whether it would have been within her role to take action had she heard of any concerns expressed that Dr. Smith had inadequate administrative assistance, Ms. Johnson testified:

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[80] Transcript of the evidence of Maxine Johnson, December 17, 2007, pp. 13-14.

[81] Transcript of the evidence of Maxine Johnson, December 17, 2007, pp. 16-17.

[82] Transcript of the evidence of Maxine Johnson, December 17, 2007, pp. 18.

> It would have been and I did.[83] Because we had ample secretarial support that Dr. Smith or any of the other pathologists could access anytime they felt like they had a backlog of cases that they hadn't gotten to, so there should never have been an issue for Dr. Smith.[84]

99. In his written evidence provided to the Commission and filed as evidence, Dr. Smith stated:

> Dr. Smith understands that he failed to properly recognize and make use of the administrative support staff who were available to him as HSC. Again, this was a symptom of his disorganization. For example, Dr. Smith admits that while he personally preferred to type his own post mortem reports, he could have delegated this work to an administrative assistant and possibly improved his own timeliness as a result.[85]

100. The Commission also received evidence of the untidy and cluttered appearance of Dr. Smith's office. Ms. Maxine Johnson gave evidence regarding efforts taken by administrative staff on several occasions to organize Dr. Smith's office and bring order to the materials contained in his office, so that any delay relating to unsigned out cases could be addressed.[86]

101. In testifying with regard to his repeated delays in turn around times, Dr. Smith acknowledged:

> Dr. Charles Smith: …I realize, at times, in my frustration, I pointed the finger at others and that was wrong for me to do and… I'm sorry for implicating others, and for the inconvenience or the problems that… my own actions may have resulted in.[87]

102. The evidence before the Commission clearly demonstrates that SickKids made available to Dr. Smith the resources he required to carry out the duties he owed to the OCCO. Dr. Smith's

[83] See for example PFP137530.

[84] Transcript of the evidence of Maxine Johnson, December 17, 2007, pp. 21.

[85] Dr. Charles Smith witness statement, PFP303346, p. 20.

[86] Transcript of the evidence of Ms. Maxine Johnson, December 17, 2007, pp. 63-64.

[87] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, p. 63.

admitted failure to access these support services is not something the Hospital had the power to address. As with issues related to timeliness, ultimately only the OCCO could determine that Dr. Smith's delays and delinquencies were sufficient to stop sending him coronial work.

(iv) General

103. Dr. Phillips was aware of the fact that Dr. Smith's office was very messy. In his experience, although the office appeared messy, Dr. Smith seemed to have a good handle on his work and was not disorganized. Dr. Phillips did not recall ever asking Dr. Smith to locate anything in his office that Dr. Smith could not locate. Dr. Phillips spoke to Dr. Smith about the state of his office many times. Dr. Phillips cannot recall if he ever asked any hospital employees to clean up Dr. Smith's office.[88]

104. Dr. Cutz recalls seeing the Fifth Estate program in November 1999 regarding Dr. Smith. Following the airing of the program, it was discussed at the department's staff meeting. Dr. Cutz testified that from the Hospitals' perspective, it was unclear as to whether the program was based on misinformation, given that the OCCO appeared to be supporting Dr. Smith on the program.[89]

(b) Dr. Smith's Surgical work

105. Over the course of the Inquiry, a number of documents were referred to by Commission counsel and parties with standing raising issues of timeliness and diagnoses in Dr. Smith's hospital based surgical pathology work.[90]

[88] PFP303615, Dr. M.J. Phillips interview summary, p. 10.

[89] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 284-285.

[90] See for example PFP137837, PFP137855, and PFP137856.

106. Any issues regarding Dr. Smith's clinical work at the Hospital could only be relevant to this Commission if it could be seen to impact his ability to perform forensic paediatric work for the coronial service.

107. Although there was a period in 1996-1997 when Dr. Becker became concerned about the quality of some of Dr. Smith's diagnoses, these were addressed by an adjustment to his heavy caseload. This appears to have had the desired effect since there were no complaints subsequent to 1997.

108. It should be noted that in 1999, Dr. Smith successfully completed his American Board of Medical Specialties examination in paediatric pathology, a certification not available in Canada.[91] The achievement of this qualification should provide additional assurance of his clinical competency at the relevant time.

109. It is unfortunate that Dr. Becker, having died in 2002, was not available to explain his assessment of the situation and his management approach. Nonetheless, it is apparent that whatever the concern, it was transient and had no bearing on the concerns before the Commission.

110. The question of Dr. Smith's diagnostic deficiencies arose when Ms. Rothstein, referring to several documents, asked Dr. Cairns "would it have been relevant for you and Dr. Chiasson to know about that concern that the hospital had about Dr. Smith's pathology work?"[92] Among the documents referred to by Ms. Rothstein was what appears to be a draft letter to Dr. Smith from

[91] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, p. 24.

[92] Transcript of the evidence of Dr. Thomas (sic) Cairns, November 26, 2007, pp. 105.

Dr. Becker, dated April 18, 1997.[93] Dr. Smith testified that he was never made aware of its contents.[94] His evidence on this point was not challenged by any counsel for any party at the Commission. It should be concluded that this letter was not sent or delivered to Dr. Smith.

111. Dr. Paul Thorner, the Associate Head of the Division of Pathology at the relevant time,[95] testified that although Dr. Smith may have been taken off the week day rotation for surgical pathology for a series of months, he was never completely taken off the surgical pathology rota in 1997, as he continued to perform surgical pathology during the weekends that he was scheduled to be on-call.[96]

112. Dr. Smith testified that as far as he was aware, he was never removed from the surgical pathology rotation due to concerns about his competency in surgical pathology, nor was his Hospital salary ever reduced by $20,000.00 due to concerns arising from his surgical pathology work (a suggestion arising from the April 18th draft letter).[97] Again, no counsel for any party nor Commission Counsel, challenged Dr. Smith's evidence on this point.

113. Dr. Cairns testified that the Hospital did not make anyone at the OCCO aware of the steps taken by the Hospital to deal with delays or deficiencies in Dr. Smith's surgical pathology, and that such information would have been of assistance to the OCCO in assessing Dr. Smith's diagnostic abilities and managing Dr. Smith's coronial work.[98]

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[93] PFP137850, Letter to Dr. Smith from Dr. Becker, unsigned, dated April 18, 1997.
[94] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, pp. 62.
[95] Transcript of the evidence of Dr. Paul Thorner, January 11, 2008, pp. 17-18, 22-23.
[96] Transcript of the evidence of Dr. Paul Thorner, January 11, 2008, pp. 132, see also PFP117047
[97] Transcript of the evidence of Dr. Charles Smith, January 28, 2008, p. 62.
[98] Transcript of the evidence of Dr. Thomas (sic) Cairns, November 26, 2007, pp. 102-105, 111-112.

114. Dr. Cairns explained:

> Dr. Thomas (sic) Cairns: In more detail, you can ask Dr. Chiasson, but what is being brought here is an issue of diagnostic discrepancies. So these are issues where other colleagues at the Hospital are saying that he is not interpreting histological slides appropriately… one of the fundamental things about a pathologist is the ability to diagnose things down the microscope—
>
> Ms. Linda Rothstein: Your point, Dr. Cairns, is that it would have been relevant for you and other members of the OCCO to know that Dr. Smith's colleagues at the Hospital for Sick Children had identified errors in his surgical pathology diagnostic abilities.
>
> Dr. Thomas (sic) Cairns: Very much so.[99]

115. However, under cross examination, Dr. Cairns agreed that the determination of whether such information ought to be shared with an outside agency (i.e. the OCCO) would be one that was rightfully made by the clinician at the Hospital responsible for the pathologist:

> Mr. William Carter: So the judgement about whether or not to communicate those types of concerns rests with clinician responsible for the management of the specific pathologist?
>
> Dr. James Cairns: Obviously, the decision as to whether that is shared has to rest with the individual who's reviewing it, and their decision as to whether they feel it's relevant to share that information with an outside agency that's working with the Hospital.[100]

116. Dr. Cairns conceded that if in fact Dr. Smith was never removed from the surgical pathology rotation, despite the existence of the draft letter written by Dr. Becker, he would not expect the Hospital to notify the OCCO that they had considered removing him from the surgical pathology roster but had chosen not to.[101]

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[99] Transcript of the evidence of Dr. Thomas (sic) Cairns, November 26, 2007, pp. 108-109.

[100] Transcript of the evidence of Dr. Thomas Cairns, November 29, 2007, pp. 63.

[101] Transcript of the evidence of Dr. Thomas Cairns, November 29, 2007, pp. 67.

117. In Dr. Thorner's view, the nature of the problems Dr. Becker was facing with regard to Dr. Smith's surgical pathology were in the nature of management issues.[102]

118. Dr. Thorner agreed that a potentially effective manner of dealing with these management problems was to scale back the amount of surgical pathology Dr. Smith was performing to allow him to "catch up":

> Mr. William Carter: So if you were a manager, such as Dr. Becker was, one of the things you might want to do is relieve your colleague of some of the circumstances which would enable him to address the situation and get caught up?
>
> Dr. Paul Thorner: Yes.
>
> Mr. William Carter: And one of the things you might want to do is diminish his exposure to the surgical workload for a period of time.
>
> Dr. Paul Thorner: That would be reasonable.
>
> Mr. William Carter: And, so you might take him off the surgical rotation, recognizing that he would still be doing some surgical by virtue of being on weekends, and indeed, if he was on call for the medicolegals, he might get the odd surgical piece at night…
>
> Dr. Paul Thorner: Yes.
>
> Mr. William Carter: Is that fair?
>
> Dr. Paul Thorner: I think that's fair.
>
> Mr. William Carter: And, so in the context of Dr. Becker's management of Dr. Smith's work difficulties, the decision to adjust his exposure to the surgical pathology case load would be seen as a reasonable one, would it not?
>
> Dr. Paul Thorner: Yes, I think so.
>
> Mr. William Carter: And we know that following this period, the number of complaints about his surgical pathology diminishes. At least, as far as we're aware, there were none following 1998.
>
> Dr. Paul Thorner: Right.

[102] Transcript of the evidence of Dr. Paul Thorner, January 11, 2008, pp. 163-164.

> Mr. William Carter: OK. So it would appear that it may have been an effective strategy. Is that fair?
>
> Dr. Paul Thorner: That seems fair.
>
> Mr. William Carter: And would you agree with me that this method of managing medical staff is, in your experience, a … reasonable one and not uncommon; adjusting the workload of those who seen to be getting above their heads?
>
> Dr. Paul Thorner: Yes.[103]

119. Dr. Thorner gave evidence that in his view, Dr. Becker most likely viewed the issues regarding Dr. Smith's clinical work as largely associated with poor work habits and disorganization, which would not be something worth reporting to the coroner, in light of the fact that the OCCO was already well aware of those management issues.[104]

120. On the face of the record there appears to be ample evidence to support the management approach taken by the late Dr. Becker. It is the Hospital's submission that no finding adverse to Dr. Becker, or the Hospital, can be made given Dr. Becker's inability to testify and given the complete absence of any cross-examination of Dr. Smith by any party in respect of his clinical skills which Dr. Smith believed were never in doubt.

121. In 2005, the Hospital, through Dr. Taylor, commissioned an external review of Dr. Smith's surgical pathology work, to be performed by Dr. Dimmick.[105] Dr. Dimmick is a highly respected paediatric pathologist and professor at the University of British Columbia practicing at the B.C.'s Children's Hospital.[106] The purpose of this review was to provide an independent

[103] Transcript of the evidence of Dr. Paul Thorner, January 11, 2008, pp. 165-166.

[104] Transcript of the evidence of Dr. Paul Thorner, January 11, 2008, pp. 167-168; see also Transcript of evidence of Dr. David Chiasson, December 7, 2007, at pp. 166-170, re the OCCO's awareness of Dr. Smith's delays relating to his hospital work.

[105] See PFP138185

[106] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 19, 2007, pp. 10-11, p. 237.

evaluation of the standard of Dr. Smith's clinical practice. It was not prompted by any recent evidence of clinical shortcomings.[107]

122. In selecting the cases to be sent to Dr. Dimmick for review, Dr. Taylor specifically selected cases in which Dr. Smith's opinion would have impacted patient care decisions. Dr. Dimmick was not told by Dr. Taylor what methodology to use in reviewing the slides and cases, and chose to review the slides and form his own conclusions before reviewing Dr. Smith's reports based on the slides.[108] Clearly, Dr. Dimmick's review was objective and credible based on the approach adopted by Dr. Taylor and Dr. Dimmick in setting the parameters and methodology of the review.

123. Of the 60 cases that Dr. Dimmick reviewed, he agreed with Dr. Smith's diagnosis in 57 of the cases, which is a 95% agreement rate. In the remaining three cases, Dr. Dimmick disagreed with Dr. Smith in a minor fashion that would not have had any impact on patient care. The results of Dr. Dimmick's review confirmed Dr. Taylor's views that Dr. Smith was a competent surgical pathologist.[109]

124. In Dr. Thorner's view, Dr. Smith was a satisfactory surgical pathologist:

> Dr. Paul Thorner: I thought he read slides in quite a satisfactory manner. I mean, there are – we have a few examples here where there are some problems, and some of those were problem cases for sure.

[107] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 19, 2007, pp. 8-10.

[108] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 19, 2007, pp. 12-16.

[109] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 19, 2007, pp. 17, see also Dr. Dimmick's report at PFP137906

> But I think overall he read slides in a satisfactory manner. I wasn't concerned about that.[110]

125. Dr. Phillips was never advised of any issues with regard to Dr. Smith's surgical pathology work during his tenure as Pathologist in Chief, nor does he recall any issues being raised regarding Dr. Smith's competency with regard to surgical or autopsy pathology at rounds.[111]

126. The Commission must rely on the expertise of the pathologists called as witnesses to determine what impact, if any, any deficiencies in surgical pathology may have on Dr. Smith's ability to perform medico-legal coroner's autopsies.

127. In assessing the relevance of any issues that Dr. Smith may have had with his surgical pathology practice, Dr. Chiasson testified that in his role as the Director of the Unit today, he does not have the expertise to carry out any surgical pathology work at the Hospital:

> Dr. David Chiasson: Well, paediatric surgical pathology, per se, is… it's a different art, it's a different form of work. The issues are quite different than forensic pathology work.
>
> I perform, I think, as a competent forensic pathologist – paediatric forensic pathologist working in that Unit, and I don't do any surgical pathology. And nor do I feel qualified to do surgical pathology. Neither do I feel disadvantaged by, you know – issues in… the paediatric clinical side of things.
>
> So… from that point of view, I don't think… that the two are related.[112]

128. Dr. Chiasson deferred to the opinions of Dr. Taylor as to the magnitude of the concerns expressed regarding Dr. Smith's work.[113]

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[110] Transcript of the evidence of Dr. Paul Thorner, January 11, 2008, pp. 132

[111] PFP303615, Dr. M.J. Phillips interview summary, p. 9, 11

[112] Transcript of the evidence of Dr. David Chiasson, December 7, 2007, pp. 167.

129. When asked whether his concerns with Dr. Smith's surgical pathology work would lead to concerns regarding Dr. Smith's competency to do work for the OCCO, Dr. Taylor testified:

> Dr. Glenn Taylor: Probably not. Again, they're – they're different disciplines, in a sense, and the type of mistakes that are brought out by these documents are mistakes that could be made fairly easily by someone who's doing paediatric surgical pathology, but not doing surgical paediatric oncological or cancer pathology.
>
> …
>
> There may be no relation of the person's ability in one sub-specialty area to another sub-specialty area. And as far as surgical pathology goes, and an autopsy pathology goes… there's a bit of a divide there.
>
> I mean, there are basics in microscopic interpretation of tissues and so on, but the finer points, which are actually what matter most often in surgical pathology, may not be in the -- in say a person who does autopsies on a regular basis, in that person's knowledge base or experience, and vice-versa.[114]

130. Dr. Taylor did concede that if a pathologist expressed a degree of certainty inappropriately in surgical pathology, as Dr. Taylor felt that Dr. Smith may have in one surgical pathology sample, this may be a concern which would cross over into that pathologist's medico-legal or coroner's autopsy work.[115]

131. Any concerns at the Hospital regarding Dr. Smith's surgical pathology work were properly identified and addressed by his superiors in a manner that allowed Dr. Smith the opportunity to catch up on his outstanding cases and that encouraged additional education in order to ensure high quality surgical pathology for the patients of the Hospital. The evidence

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[113] Transcript of the evidence of Dr. David Chiasson, December 7, 2007, pp. 168-169, see also transcript of the evidence of Dr. David Chiasson, December 11, 2007, pp. 209-210.

[114] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 231-232.

[115] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, p. 236, see also PFP137856.

indicates that the admittedly extreme steps of removing Dr. Smith from the surgical rota or reducing his pay never occurred.

132. In any event, it is clear from the evidence of Dr. Taylor and Dr. Chiasson, both experienced pathologists with forensic training and/or experience, that these perceived deficiencies would not have had an impact on Dr. Smith's abilities to perform coronial forensic autopsies. As such, there would have been no reason to report any perceived inadequacies to the OCCO.

133. Finally, it is clear that the Hospital appropriately conducted an independent review of Dr. Smith's surgical work based on extrinsic considerations. As evidenced in the report of Dr. Dimmick, Dr. Smith's surgical pathology work was of high quality and in no way had any negative impact on patient care.

(c) Suspected Child Abuse and Neglect "SCAN" team

134. The Hospital's Suspected Child Abuse and Neglect ("SCAN") Team became involved in a number of the index cases to the Inquiry when the children were admitted to the Hospital prior to death and followed by the SCAN team. As a result, members of the SCAN team were involved with the criminal justice system in a manner similar to that which pathologists are involved. Further, there was, for some time, interaction between members of the Division of Pathology and members of the SCAN team in apparent attempts to identify clinico-pathological correlations which would assist in providing additional information to those involved in the death investigation as well as the treatment of similar conditions in living children.

135. It cannot be denied that the SCAN Team performs an important function. Methodologies and practices have evolved since the early days in the 1970's and 1980's.

(i) General

136. The SCAN Team was originally formed in 1973 to develop some expertise in the area of child maltreatment and liaise with the Children's Aid Societies as necessary regarding patients at the Hospital.[116]

137. Although its composition has evolved over the years, The SCAN Team is currently staffed by 3 paediatricians (with a 1.6 full time equivalent or "FTE"), a paediatric ophthalmologist who provides consultations, and 2 nurse practitioners (equalling 1.6 FTE).[117]

138. The SCAN Team's approach to investigation and interviews has changed over the years, and had changed even prior to the release of Campbell J.'s decision in the Tyrell case, to reduce reliance on psychosocial assessments and to modify the interview process.[118]

139. Members of the SCAN Team panel testified that although in the past, they had no formal training on how to give expert testimony in Court, the team did consult legal counsel who gave the Team some training on giving testimony and the mechanics and intricacies of the legal process. They also testified that some of their training in giving testimony was "on the job"

[116] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 30-31.

[117] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 59-60.

[118] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 91-94.

training that they received from meeting with Crown counsel prior to testimony or attending Court to watch their colleagues testify.[119]

140. The SCAN team currently has formal peer review processes in place by way of twice weekly SCAN team meetings wherein the entire team meets to discuss the cases the Team is involved in, both in terms of in-patients, and patients who attended the Hospital but were not admitted. Should disagreement over a case arise that cannot be resolved within the group, the Team will turn to external consultants for their opinions to resolve the internal disagreement.[120]

141. In addition, the Team has monthly meetings in which they invite external consultants to join them, for example Dr. Huyer, where they will discuss individual cases.[121]

(ii) Involvement with pathology

142. During the 1990's, both Drs. Taylor and Cutz recalled interaction with members of the SCAN team, in a variety of circumstances, including their attendance at autopsies. Both testified to taking into account the views of SCAN physicians when coming to conclusions regarding their post mortem examinations.[122]

143. Dr. Driver and Dr. Huyer testified to attending autopsies performed on patients they had been clinically involved with when the autopsies took place at the Hospital. These autopsies were performed by Dr. Smith as well as other members of the Division of Pathology. As

[119] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 48-53.
[120] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 10, 2008, pp. 231-232.
[121] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 232.
[122] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 175-182.

clinicians, they did not have an active role in the autopsies but felt that the findings of the autopsy could enhance their clinical practice.[123]

144. Dr. Huyer testified that on at least two occasions, he was asked to perform a genital evaluation on a deceased child during the autopsy to determine whether any sexual assault had taken place. When he performed such an examination, Dr. Huyer was of the view that he likely provided a written report regarding his findings.[124]

145. Since his return to the Hospital in 2003, Dr. Taylor does not recall any members of the SCAN team attending any autopsies that he has performed. Dr. Cutz agreed that there appears to be less interaction with the SCAN team in recent years, although neither recall any change in Hospital policy in this regard.[125]

146. Dr. Shouldice testified that today, there is no formal relationship, and very little interaction, between the SCAN program and the Division of Pathology. The SCAN team does not currently provide opinions to the Division of Pathology with regard to injuries in deceased children.[126] Dr. Shouldice, however, agreed with Dr. Huyer that there may be some general contribution to be made to a death investigation, arising from consultation with a clinician with

[123] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 114-120.

[124] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 121.

[125] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 18, 2007, pp. 182-184.

[126] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 126-127.

expertise in the area of child maltreatment regarding the characteristics of injuries suffered prior to death.[127]

147. In terms of current practice, Dr. Chiasson's evidence was consistent with both Dr. Huyer's and Dr. Shouldice's when he testified that although he has had rare occasion to consult the SCAN team, on those occasions that he did, he would not co-sign the post mortem report with the member of the SCAN Team, but rather take their opinion into account in coming to his final conclusion on the case in question.[128]

148. Clearly, the SCAN Team's purpose has evolved and adapted to the needs of its patients, and of the judicial system it serves. In its early days, the SCAN Team was a leader in the field of child abuse and neglect research, treatment, and advocacy. The evidence of Dr. Michele Shouldice before the Commission supports a finding that it remains in that position today.

(iii) The Dunn J. Decision re Amber

149. At no point in the history of the SCAN program has there been any formal process in place by which the SCAN team receives and reviews any Court decision in cases in which a team member has testified.[129]

150. Following the receipt of the Dunn J. decision, the SCAN team held a meeting attended by members of the SCAN team, Dr. Smith, and Crown to discuss the judgment. Dr. Mian, who organized the meeting, sent an email invitation to attendees stating:

[127] Transcript of evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp.126-128.

[128] Transcript of the evidence of Dr. David Chiasson, December 11, 2007, p. 188.

[129] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 179.

> Following the Judge's decision and comments in the Amber case, we decided to organize a conference to review the case, what it has to teach us and how we can do things better in the future.[130]

The Hospital submits that this meeting represented a *bone fide* attempt on the part of the SCAN Team to understand and learn from Justice Dunn's decision.

151. When asked whether this meeting would have been a good time to identify "red flags" about Dr. Smith's practice, Dr. Huyer explained that the tenor or purpose of the meeting was not to address such considerations, nor were they brought to bear at the meeting by those involved from the Hospital perspective or otherwise.[131] In other words, the meeting did not identify any systemic concerns relating to forensic pathology arising out of the case.

152. There was no evidence before the Commission regarding whether the Dunn J. decision was sent to the Department of Pathology management team, and Dr. Phillips did not recall any discussions within the pathology department about the Amber case.[132]

153. Clearly, the Dunn J. decision was considered at the SCAN team meeting mostly from a scientific evidence perspective, as the physicians involved concluded that the science was misunderstood by the Court. This conclusion was founded in part on the following factors: that the defence had adduced conflicting expert evidence; comments that were made by unidentified participants at the meeting regarding Justice Dunn; and Dr. Smith's representation of his alleged discussion with Justice Dunn of the evidence. In that context, the scientific debate over Shaken

[130] See PFP153149, email from Dr Marcellina Mian to Dr. Brenda Rau, dated January 6, 1992.

[131] Transcript of the evidence of Dr. Katy Driver, Dr, Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 142.

[132] PFP303615, Dr. M.J. Phillips interview summary, p. 10.

Baby Syndrome overshadowed the Court's criticisms of Hospital procedures in the Team's analysis of the judgment. [133]

154. Notwithstanding the SCAN team's rejection of Justice Dunn's conclusion on the scientific evidence, the team recognized there was value in his criticisms of SCAN team procedures. Dr. Driver testified before the Commission that the procedures used by the SCAN team were revisited in light of the Dunn J. decision:

> Ms. Linda Rothstein: … Dr. Driver, while I can. What, if any, changes were made to SCAN's procedures or policies as a result of your team's review of this Decision?
>
> Dr. Katy Driver: I think more documentation. Even the consult received -- often would get verbal -- a kind of consultation to come and see a child. We formalized a process that everything should come in writing; who was asking the SCAN team to get involved and the reason why. … I think we -- more formalized opinions of the experts to give us in writing; used to review radiology -- x-ray after it was taken with the available radiologist and act on basis of that.
>
> … so there was more formalized consultation process from all the experts that we consulted as well as our involvement; when was the contact made, the timing, who was present, what happened.
>
> … So there was a lot more formalization of the pros -- procedure.[134]

155. It is the Hospital's respectful submission that the SCAN team carefully considered the implications of Justice Dunn's decision and made changes to address some of the concerns that had been raised in the decision. It is only in light of subsequent events that Justice Dunn's decision can be viewed as prescient.

5. Recommendations

[133] Transcript of the evidence of Dr. Katy Driver, Dr. Dirk Huyer and Dr. Michelle Shouldice, January 9, 2008, pp. 193-196.

[134] Ibid, pp. 193-194.

Recommendation 1 – Maintain the Coroners' Cases at the OPFPU at SickKids

156. It is the aim of the Hospital to ensure that the OPFPU be able to continue to provide first-rate forensic autopsy services to the province of Ontario. This includes autopsies performed under Coroner's warrant, and, when necessary, qualified expert witnesses to provide reliable evidence in court. For this to occur, it is vital that the OPFPU be a 'Centre of Excellence'. Only then will public confidence be restored.

157. SickKids is uniquely positioned to provide the complex mix of expertise and facilities to form the platform from which such a Centre may be supported. Nowhere else in the province or, indeed Canada, is there such a broad range of highly focussed expertise in paediatric pathology. On top of this there are two qualified paediatric neuropathologists and two forensic pathologists. The facilities are those of an outstanding university-affiliated paediatric health sciences centre.

158. The overwhelming majority (90%+) of paediatric autopsies involve non-criminally suspicious circumstances. There has been no evidence at the Inquiry to suggest that these autopsies have not been and, are not now being properly and reliably performed at the OPFPU. Thus, it is axiomatic that these Coroners autopsies should continue to be performed at the Hospital. To move these autopsies to another setting would be to create a significant risk of sub-optimal post-mortem examination and analysis, as the myriad of resources available at the Hospital would be lost to those investigating the cause of death. There has been no justification advanced for such a move, which would create the potential for misdiagnoses and the risk of additional miscarriages of justice.

159. The balance of the cases, the 5 to 10% which have the potential to involve the criminal justice system, should be performed wherever the resources are most appropriate for the nature of the case, and where the public will have the greatest assurance of superior quality, reliable death investigations. The most desirable location may be a matter of debate which varies from time to time depending on the circumstances of the case and the available human and technical resources. Currently, the OPFPU enjoys an unprecedented level of expertise in both the forensic and paediatric pathology disciplines. The Hospital is ready and willing to continue to perform criminally suspicious cases as long as the Chief Forensic Pathologist for Ontario is satisfied that reliable services and expertise are available. It is recognised that from time to time, some of these cases may be performed at the Toronto Forensic Pathology Unit.[135]

Recommendation 2 – The OPFPU Agreement Should be Revised to clearly articulate accountability for oversight and adequate resources

160. In order to provide the necessary governance structure and framework for a true Centre of Excellence, the governing agreement between the parties giving life to the OPFPU should specifically provide that :

a) the quality assurance program, which encompasses the conduct, reporting and review of autopsies performed in the OPFPU, is periodically assessed by the Executive Team or committee (defined in f), below);
b) the Director of the Unit be a qualified forensic pathologist;
c) cases identified as 'criminally suspicious' be performed by the Director of the Unit or qualified delegate;
d) the Hospital be accountable for the availability of the facilities;

[135]Transcript of Roundtable, "Credentialing and Growing the Paediatric Forensic Pathology Service in Ontario", February 11, 2008, Dr. Glenn Taylor, pp. 144-145.

e) the Director report to the Head of the Division of Pathology in respect of operational matters and to the Chief Forensic Pathologist for Ontario in respect of forensic pathology matters;

f) there be an Executive Team or Committee compromised of representatives of both parties responsible for setting policies within the framework of the Agreement and, responsible for reporting annually in writing jointly to the CEO of the Hospital and, the OCCO.

Recommendation 3 – Increased Funding for the OPFPU

161. The funding for the Unit should be based on a model that reflects the actual costs to the Hospital of performing autopsy services for the OCCO, which are not provided for in the Hospital's global funding from the Ministry of Health and Long Term Care ("MOHLTC") and, which are thus, an additional cost burden on the Hospital. The current level of funding, in the amount of $200,000 per annum, plus the regulated fees for the facility and pathologists' services and scheduled services, does not adequately reimburse the Hospital for the cost of providing forensic pathology services to the OCCO.

162. The Hospital respectfully requests that the Commissioner recommend the development and application of a funding model based on the real, average per unit cost of a paediatric forensic autopsy. The three year running average for the number of Coroner's cases performed at the OPFPU should be used as the multiplier against the per unit cost per case for the purpose of calculating the annual funding allocation.

163. The Hospital further recommends that the resulting total amount be made available annually from those sources deriving the benefit of such services. SickKids respectfully submits that the OCCO and the criminal justice system derive a benefit relative to about 75% of the Coroner's autopsies performed at the OPFPU. The balance, 25%, reflects the benefit that SickKids derives from autopsies performed under Coroner's warrant in respect of children who

die at the Hospital. As a quaternary academic, paediatric health sciences centre, the benefit to paediatric medicine derived from autopsy experience and knowledge eventually translates into better paediatric health care. This latter benefit should be supported by designated funding from the MOHLTC, as it benefits paediatric health care throughout the province.

164. Further, funding should be increased to reflect the educational and research mandate of the OPFPU at SickKids. While the members of the OPFPU are expected to perform autopsies pursuant to coroner's warrants, they are also expected to perform research leading to the development of new knowledge and to participate in educational initiatives. Funding should reflect not only the resources required to perform coroner's autopsies, but also the resources required to allow for effective participation in research and education. As described in further detail below, funding should take into account the time and resources required to advance these important public service objectives.

Recommendation 4 – Training and Education Enhancements

165. As a Centre of Excellence, the OPFPU should be a resource for other forensic pathology units across the province. Existing telemedicine and intranet audio-visual facilities should be up-graded to permit pathologists performing autopsies elsewhere to consult with OPFPU pathologists for real-time consultations. In addition, professional colleagues at remote hospital autopsy sites should be able to participate in OPFPU rounds by telemedicine links. This recommendation would address the current systemic deficits in the number of trained paediatric pathologists and forensic pathologists, as well as pathologist's assistants

166. The OCCO should have the resources to fund 'mini-fellowships' where pathologists from across Ontario could be attached to the OPFPU for a period of three to 12 months for continuing education and training in paediatric forensic pathology.

167. A mandatory rotation of three to six months in the OPFPU should be part of the specialist/fellowship training program of the OCCO. [136]

168. In his evidence before the Commission, Dr. Taylor spoke of the increasing difficulty of recruiting fellows to train in paediatric pathology at SickKids, due to the lack of recognition for the subspecialty of paediatric pathology at the Royal College of Physicians and Surgeons of Canada. The American Board no longer recognizes Canadian graduate training.[137] Consequently, it would assist in addressing the Canadian shortage of specialized paediatric pathologists if the Commissioner were to recommend the establishment of RCPSC certification in paediatric pathology.

169. Further, the Hospital respectfully submits that the current recommendations for training in order to qualify for the newly-recognized subspecialty certification in Forensic Pathology should specify a minimum time for training in paediatric pathology. The Commission heard evidence about the unique aspects of paediatric pathology, and in order to ensure that adequate specialty expertise is brought to bear in paediatric death investigations, a minimum training component in paediatric pathology for forensic pathologists should be recommended. The

[136] Transcript of Roundtable, "Credentialing and Growing the Paediatric Forensic Pathology Service in Ontario", February 11, 2008, Dr. Michael Pollanen, pp. 31-32.

[137] Transcript of the evidence of Dr. Ernest Cutz and Dr. Glenn Taylor, December 19, 2007, p. 256.

Hospital respectfully suggests that a rotation in a paediatric pathology environment should become a minimum requirement for specialist certification in forensic pathology.[138]

Recommendation 5 – Centre for Forensic Science at University of Toronto

170. The Hospital currently supports the academic mission of the University of Toronto, as an affiliated teaching partner of the University's Faculties of Medicine and Life Sciences.

171. The Hospital supports the proposal of Dr. Pollanen for a multi-disciplinary Centre for Forensic Sciences, to be housed at the University of Toronto.[139] The proposed Centre would include students and professionals from all relevant disciplines, for example medicine, law, nursing, social work, and forensic sciences:

> Dr. Michael Pollanen: This proposal is based upon existing structure. In other words, there is a -- there is currently at the University of Toronto and at the Office of the Chief Coroner, no mechanism of creating a completely integrated service and research and teaching mechanism.
>
> For example, the University of Toronto does not create new departments of -- of service related to academic and scholarly achievement, so the -- this proposal that -- that the Steering Committee has put together tries to achieve the goal; the -- the goal that's been described by every member of this panel, of creating an integration, a unification, of the pillars of teaching, research, and provision of service by using a mechanism that is well-developed at the University of Toronto, that flows out of their policy of interdisciplinary.
>
> …
>
> And these -- these Centres -- these interdisciplinary Centres, or extra-departmental units -- then become homes for the scholarly achievement, and research achievement, and educational platforms, within the University's structure, and then are linked to the provision of service through other organizations or other structures; as opposed to the complete integration, for

[138] Transcript of Roundtable, "Credentialing and Growing the Paediatric Forensic Pathology Service in Ontario", February 11, 2008, pp. 122-125, and 129.

[139] See PFP 174480 and PFP174925.

> example, that is achieved at the VIFM, which by -- by the creation of statute has produced a corporate body, which has all mandates.
>
> And -- and the reality in the University of Toronto, the way to achieve the same goal is to create a Centre and link it with a service of. That's the -- that's the current reality.[140]

172. The Centre envisioned could provide a starting point for advocacy for the inclusion of forensic elements in several curricula and for the expansion of the related subspecialty certification in forensic pathology at the Royal College level:

> Mr. William Carter: -- Dr. Pollanen following on your comments, Dr. Gotlieb, as I understand it, the model that you envision would enable a multi-disciplinary approach to inform the development of a forensic component to the clinical services that are provided in the affiliated hospitals?
>
> Dr. Michael Pollanen: Correct. And the -- and the major mechanism was -- and this -- this came out of meetings with individuals on the steering committee and others -- was to, in the first instance, identify Royal College training programs that currently exist, for example, emergency medicine, obstetrics, gynaecology, paediatrics, and then determine what type of forensic education those medical specialities would require.
>
> And that's one (1) of the -- the goals that the -- that the centre would have -- the putative centre -- would be to -- to look at the various curricula at the post-graduate level and say, What injection of forensic relevance do we -- do you need, and then the best instantiation of that being the -- the Royal College program in forensic pathology being sort of a stand- alone.
>
> But, for example, we could see this as also a catalyst, for example, to develop a Royal College certification of special competency in forensic paediatrics, which is clearly required, but this would be the -- this would be the hub, as it were, to -- to launch such an issuance.[141]

173. The Hospital would embrace the opportunity to contribute to this valuable multi-disciplinary venture through providing a training environment and expertise in the paediatric

[140] Transcript of the round table discussion dated February 11, 2008, "Credentialing and Growing the Paediatric Forensic Pathology Service in Ontario", Dr. Michael Pollanen, pp. 90-92.

[141] Transcript of the round table discussion dated February 11, 2008, "Credentialing and Growing the Paediatric Forensic Pathology Service in Ontario", Dr. Michael Pollanen, pp. 127-128.

aspects of forensic sciences. Hospital staff members could be available for class room education and make Hospital facilities and services available for on site, clinical learning.

174. In so doing, the Hospital could continue to ensure excellence in death investigations related not only to criminally suspicious deaths, but also those deaths in which grieving parents are entitled to an answer as to what caused the tragic death of their child.

6. Conclusion

175. The Hospital thanks the Commission for the opportunity to participate fully in its mandate.

176. SickKids also recognizes and appreciates the significant and productive contribution of the parties with standing to the important work of this Commission.

177. Finally, the Hospital anticipates with confidence a report which will make a valuable contribution to the future of paediatric forensic pathology in Ontario.

ALL OF WHICH IS RESPECTFULLY SUBMITTED,

Dated this 20th day of March, 2008 _____

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