

**Fixing a Broken System: the Coroners  
Amendment Act, 2008**

**Submission on Bill 115 to the Standing  
Committee on Justice Policy**

**April 2, 2009**

**The Registered Nurses' Association of  
Ontario (RNAO)**

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# **RNAO Submission on Bill 115**

## **Summary of Recommendations**

RNAO recommends support for Bill 115, with the following amendments:

1. Maintain the Minister's power to order an inquest (i.e., maintain Section 22 of the Act by removing clauses 13 and 16 of the Bill)
2. Table in the Legislature annual reports of the Death Investigation Oversight Council (DIOC).
3. Table in the Legislature reports of the DIOC complaints committee.

## **Introduction**

The Registered Nurses' Association of Ontario (RNAO) is the professional organization for registered nurses who practice in all roles and sectors across this province. Our mandate is to advocate for healthy public policy and for the role of registered nurses in enhancing the health of Ontarians. We welcome this opportunity to present this submission on Bill 115, *the Coroners Amendment Act, 2008*, to the Standing Committee on Justice Policy.

RNAO welcomes Bill 115, which addresses many of the recommendations of the Goudge Inquiry into Pediatric Forensic Pathology in Ontario. We believe that the legislation will go a long way to ensuring the professionalism of forensic pathology in Ontario, and to solving the systemic problems that Justice Goudge identified with respect to oversight, accountability and transparency. However, we recommend that the Bill be amended to provide greater Ministerial responsibility for and oversight over the overseers.

This Bill concerns very crucial matters: the right to know how loved ones came to pass away; saving lives in the future via coroners' recommendations (and what better closure can people get than knowing that the loss of their loved ones helped to save lives?); and public confidence in the criminal justice system. There is a lot at stake, and we must ensure that this legislation misses no opportunity to serve the public interest.

## **Background**

### **The Goudge Commission**

In April 2007, Cabinet established a Commission led by Justice Stephen Goudge to address deep concerns with the work of Dr. Charles Smith with respect to his investigations of certain suspicious child deaths.<sup>1</sup> This followed a review of Dr. Smith's investigations by the Chief Coroner for Ontario in which five external forensic pathologists took issue either with Dr. Smith's opinion in his reports or his testimony or both, in 20 of 45 cases reviewed. In 12 of those 20 cases, convictions were obtained against the accused.<sup>2</sup>

The trigger for the review was the realization that a number of people had been falsely convicted of murder based on Dr. Smith's faulty conclusions in his autopsies of suspicious child and infant deaths. Nurses share the horror of these false convictions, which have devastating effects on the wrongly convicted and their families. There is nothing more terrible than being falsely convicted of murdering a child. It hits close to home for nurses because of the Susan Nelles case.

Ironically, Dr. Smith was involved in the controversial 1981 Hospital for Sick Children baby deaths investigation that resulted in charges of murder being laid against Susan Nelles, a registered nurse.<sup>3</sup> Those charges were eventually dismissed in court, and Ms. Nelles later recovered her legal costs in an agreement with the government. No compensation could repay for the ordeal she and her family suffered. Furthermore, the case was a harrowing assault on the nursing profession.

The Goudge Inquiry's mandate was appropriately wide-ranging: "to conduct a systemic review and assessment of policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from 1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings."<sup>4</sup> Justice Goudge released his report on October 1, 2008.<sup>5</sup>

The report was a scathing indictment of the Ontario system, one in which questions were raised about the quality of Dr. Smith's forensic pathology work for years without any effective system response or effective oversight. By his own belated reckoning, Dr. Smith's forensic pathology training was "woefully inadequate,"<sup>6</sup> and he was unaware of how the limitations of knowledge compromised the validity of his work.<sup>7</sup> Furthermore, the report further concluded that Dr. Smith frustrated oversight with a lack of candour when challenged.<sup>8</sup>

There were warning signs as early as 1991, when a trial judge severely rebuked Dr. Smith for his methodology and conclusions.<sup>9</sup> Justice Goudge catalogued a sequence of errors which finally triggered some action by the Office of the Chief Coroner of Ontario (OCCO). In 2001, Dr. Smith ceased performing post-mortems in criminally suspicious cases. However, the OCCO continued to support Dr. Smith and misled both the Crown and the College of Physicians and Surgeons of Ontario, when they sought information about his work. It was not until December 2003 that the OCCO stopped Dr. Smith from doing any coroner's warrant autopsies.<sup>10</sup>

The Goudge Report detailed the broad systemic failure of the pediatric forensic pathology system and resulted in 169 recommendations addressing all forensic pathology, and not just pediatric forensic pathology. The recommendations covered many areas, including: professionalization and rebuilding pediatric forensic pathology; funding; organization and oversight; effective communication with the criminal justice system; and the roles of coroners, police, the Crown and defence.

## Bill 115

Bill 115 proposes an ambitious program to restore the badly-shaken public confidence in Ontario's forensic pathology system, by strengthening professionalism and accountability. It draws heavily on the Goudge Report and contains a number of elements:

- It establishes an Ontario Forensic Pathology Service, which is charged with facilitating the provision of pathologists' services under the Act. Cabinet appoints the Chief Forensic Pathologist and Deputy Chief Forensic Pathologists, all of whom must be certified in forensic pathology. The Chief Forensic Pathologist must maintain a register of pathologists who may serve under the Act. Post-mortem results are reported to the Chief Forensic Pathologist.
- It establishes a Death Investigation Oversight Council (DIOC), which oversees and advises the Chief Coroner and the Chief Forensic Pathologist. Cabinet appoints the DIOC. The DIOC advises on appointment and dismissal of both the Chief Coroner and the Chief Forensic Pathologist.
- The chair of the DIOC appoints DIOC members to a complaints committee. Any person could make a complaint about a coroner or, a pathologist about a post-mortem. Complaints about coroners would be forwarded to the Chief Coroner and complaints about pathologists would be sent to the Chief Forensic Pathologist. Complaints about those two individuals would be handled directly by the complaints committee. This committee would report to the DIOC.
- The Chief Coroner, who currently may delegate investigative powers to a police officer or physician, will be able under an amended s.16 of the Act to appoint any person to exercise the investigative powers and duties of a coroner. By regulation, the Minister can determine the persons who may be appointed under this section. As Justice Goudge pointed out in Recommendation 157 of his Report, the coroner's investigative powers could, in the appropriate case, be delegated to health care professionals other than physicians. Nurse practitioners and registered nurses frequently find themselves practicing in circumstances where taking charge of a body or performing other tasks is not only appropriate and well within their education and expertise, but is also completely necessary in the absence of a coroner. RNAO strongly supports the expanded s.16 in the Act to allow delegation to nurse practitioners and registered nurses in appropriate cases.
- Controversially, the authority of the Minister to order an inquest is repealed. It is a rare event for a Minister to use this power,<sup>11</sup> but it is a

democratic check against arbitrary refusal by a coroner to hold an inquest. The Bill would concentrate considerable power in the DIOC, and RNAO believes that keeping this safeguard and political accountability mechanism is absolutely appropriate.

### **RNAO's View on Bill 115**

The Coroner's Office has a uniquely sacred and important role. When cause of death is unknown, families want to learn to the fullest extent possible what caused the death of their loved one. And society must know what caused deaths so it can reduce avoidable deaths in the future. For example, workplace fatalities are avoidable and would often be reasonable candidates for inquests.

Accordingly, we need the capacity and commitment to have deaths investigated when it is in the public interest.

Furthermore, we need a high quality, professional forensic pathology service. As Justice Stephen Goudge pointed out in his report, the consequences of failure in pediatric forensic pathology are extraordinarily high, for the families of the victims, for the families of the wrongly accused, and for public's faith in the criminal justice system.<sup>12</sup> He recommended broad systemic changes and this Bill provides great strides in this regard.

Nevertheless, given what is at stake, we need adequate oversight, including oversight of the overseers. Overseers are human, and capable of making mistakes, just like anyone else. The Goudge Report shows how a respected Chief Coroner and Deputy Coroner had oversight responsibility and tragically did not deliver in the Smith case. Furthermore, the forensic task is not always a simple one. The science of pathology, as with all sciences, is continually evolving and comes with inherent limitations. Some practitioners and their supervisors will understand better than others the limitations of the science and the limitations of their own knowledge.

By maintaining the Minister's right to order an inquest, there would be another safeguard for those who believe that they have been unfairly denied an inquest that would answer questions they want answered about death. This would also maintain political accountability, which would be further enhanced by making public the reports of the Oversight Council and the complaints committee.

By making reports public from the Oversight Council and the complaints committee, there will be greater transparency and another check against incorrect or unfair decisions.

## Conclusion

RNAO is gratified that Bill 115 has broad support in principle across the Legislature. It will bring a much-needed enhancement of support for quality death investigation in Ontario. It will sharply improve oversight, accountability and transparency in the service. RNAO however recommends that the bill be amended to strengthen political accountability through more direct reporting to the Legislature and through maintaining the Minister's right to order inquests.

## Recommendations

RNAO recommends support for Bill 115, with the following amendments:

1. Maintain the Minister's power to order an inquest (I.e., maintain Section 22 of the Act by removing clauses 13 and 16 of the Bill).
2. Table in the Legislature annual reports of the Death Investigation Oversight Council (DIOC).
3. Table in the Legislature reports of the DIOC complaints committee.

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<sup>1</sup> Ontario Executive Council. (2008). *Order in Council*. Retrieved March 29, 2009 from: <http://www.attorneygeneral.jus.gov.on.ca/english/news/2007/20070425-pi-oic-en.pdf>

<sup>2</sup> Inquiry into Pediatric Forensic Pathology in Ontario. (2008). Executive Summary, p. 7.

<sup>3</sup> Taylor, M. (2007). *Field Notes* (accompanied "Fall From Grace – Charles Smith", a video), Canadian Broadcasting Corporation. Retrieved March 29, 2009 from: [http://www.cbc.ca/national/blog/video/healtheducation/fall\\_from\\_grace\\_1.html](http://www.cbc.ca/national/blog/video/healtheducation/fall_from_grace_1.html).

<sup>4</sup> Inquiry into Pediatric Forensic Pathology in Ontario. (2008). Retrieved March 31, 2009 from <http://www.goudgeinquiry.ca/>

<sup>5</sup> Ibid.

<sup>6</sup> Inquiry into Pediatric Forensic Pathology in Ontario. (2008). Executive Summary, p. 13

<sup>7</sup> Inquiry into Pediatric Forensic Pathology in Ontario. (2008). Executive Summary, p. 14.

<sup>8</sup> Inquiry into Pediatric Forensic Pathology in Ontario. (2008). Executive Summary, p. 19-20.

<sup>9</sup> Inquiry into Pediatric Forensic Pathology in Ontario. (2008). Executive Summary, p. 6.

<sup>10</sup> Inquiry into Pediatric Forensic Pathology in Ontario. (2008). Executive Summary, pp. 20-31.

<sup>11</sup> It was used in 1986 the case of two boaters who went missing (Arthur Simmons and Julie Schneider).

<sup>12</sup> Inquiry into Pediatric Forensic Pathology in Ontario. (2008). Executive Summary, p. 4.