

**Submission to the Standing Committee on  
Justice Policy on Bill 115 –  
An Act to amend the Coroners Act**

**Speaking Notes**

**April 2, 2009**

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

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## **Speaking Notes on Bill 115**

My name is Wendy Fucile, and I am the President of the Registered Nurses' Association of Ontario. With me today is Kim Jarvi, a senior economist at RNAO. We are the professional organization representing registered nurses who practise 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 all Ontarians.

We welcome this opportunity to present to the Standing Committee on Justice Policy our recommendations on Bill 115, the Coroners Amendment Act, 2008.

Overall, RNAO is very supportive of Bill 115, which addresses many of the recommendations of the Goudge Inquiry into Pediatric Forensic Pathology in Ontario. This legislation will go a long way towards restoring confidence in the professionalism of forensic pathology in Ontario and to addressing the systemic problems identified by Justice Goudge with respect to oversight, accountability and transparency.

As someone who has spent considerable time watching and appearing before coroners' inquests, I know Bill 115 is on the right track. RNAO suggests the Bill would benefit from an amendment to provide greater Ministerial responsibility and oversight, and I will address that issue in a few minutes.

Bill 115 has its genesis in the Goudge Commission and the case of Dr. Charles Smith. It was a situation that must never be repeated. For that reason alone, Bill 115 deserves all our support.

For nurses, it hits close to home because of the Susan Nelles case. As it turns out, Dr. Smith was involved in the controversy in 1981 around the baby deaths at the Hospital for Sick Children in Toronto. Investigation of those deaths led to charges of murder being laid against Susan Nelles, a registered nurse. Those charges were eventually dismissed in court and Ms. Nelles subsequently recovered her legal costs. We all know, however, that nothing could compensate Susan Nelles and her family for the ordeal they suffered. Furthermore, the case was a harrowing assault on the nursing profession.

Justice Goudge's final report, released on October 1, 2008, was a scathing indictment of the Ontario system. Questions had been raised about the quality of Dr. Smith's forensic pathology work for years without any effective systemic response or effective oversight. By his own belated reckoning, Dr. Smith's forensic pathology training was "woefully inadequate". In fact, there had been warning signs as early as 1991 when a trial judge severely rebuked Dr. Smith for his methodology and conclusions, but it was not until over a decade later, in 2003, that the Office of the Chief Coroner of Ontario finally stopped Dr. Smith from performing any coroner's warrant autopsies.

Justice Goudge painted a picture of broad systemic failure and his 169 recommendations addressed the entire spectrum of forensic pathology, not just pediatric forensic pathology.

Bill 115 picks up where Justice Goudge left off, with an ambitious program to restore the badly-shaken public confidence in Ontario's forensic pathology system and strengthen professionalism and accountability.

Key elements of the Bill that RNAO is fully supportive of include:

- Establishing an Ontario Forensic Pathology Service to facilitate the provision of pathologists' services. The Chief Forensic Pathologist, appointed by Cabinet, must maintain a register of pathologists who may serve under the Act.
- Establishing a Death Investigation Oversight Council (DIOC) to oversee and advise the Chief Coroner and Chief Forensic Pathologist.
- Providing for a complaints committee comprised of DIOC members. Anyone can make a complaint about a coroner or a pathologist and each complaint would be handled directly by the complaints committee.
- Amending section 16 of the Act to allow the Chief Coroner to delegate investigative powers and duties of a coroner to any person. Currently, only a police officer or physician can be delegated a coroner's investigative powers. As Justice Goudge pointed out in Recommendation 157, there

will be appropriate cases where investigative responsibilities could be delegated to health care professionals and others with specialized skills. Nurse practitioners and registered nurses frequently find themselves practising 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 wording in Bill 115 that allows delegation in appropriate cases to nurse practitioners and registered nurses.

Where RNAO disagrees with Bill 115 is in its removal of the Minister's authority to order an inquest. A Minister would only use this power in rare instances. But it is a democratic check against arbitrary refusal by a coroner to hold an inquest. Bill 115 concentrates considerable power in the DIOC. Retaining the safeguard and political accountability of Ministerial authority to order an inquest is entirely appropriate.

When cause of death is unknown, families need to learn to the fullest extent possible what caused the death of their loved one. Society also has an interest in knowing what caused deaths so it can reduce avoidable deaths in the future.

Bill 115 is all about improving oversight of the overseers to ensure there will never again be a Dr. Charles Smith in this province. Overseers are human, and capable of making mistakes, just like anyone else. Pathology, like all sciences, is

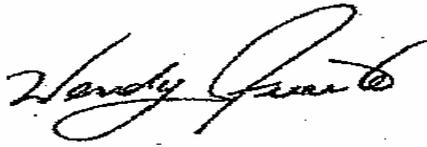
continually evolving, and the forensic task is not a simple one. Some practitioners and their supervisors understand better than others the limitations of the science and the limitations of their own knowledge.

By maintaining the Minister's right to order an inquest, we would have another safeguard for those who believe they have been unfairly denied an inquest and seek answers to their questions. Political accountability, which includes making public the reports of the Oversight Council and the complaints committee, is essential if we are to have the transparency, oversight and accountability we all seek from Bill 115.

**In conclusion,** Bill 115 is a positive response to the need for oversight, accountability and transparency in death investigation and is faithful to the tremendous contribution of Justice Goudge to showing us the way. RNAO recommends that the Bill be amended to strengthen political accountability by:

1. Maintaining the Minister's power to order an inquest;
2. Requiring annual reports of the Death Investigation Oversight Council to be tabled in the Legislature and made public; and,
3. Ensuring reports of the complaints committee to the Oversight Council be tabled in the Legislature and made public.

Thank you.

A handwritten signature in black ink, appearing to read "Wendy Fucile". The signature is fluid and cursive, with a large initial "W" and a long, sweeping underline.

Wendy Fucile, RN, BScN, MPA, CHE

President, RNAO