

Office of the Chief Coroner
Ontario Forensic Pathology Service

Bureau du coroner en chef
Service de médecine légale de l'Ontario



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November 6, 2020

Catherine Fife, MPP
Chair of the Standing Committee on Public Accounts
Legislative Assembly of Ontario

Dear MPP Fife,

Thank you for providing the opportunity to meet with the Standing Committee and further for your letter of October 23, 2020. The Office of the Chief Coroner and Ontario Forensic Pathology Service is pleased to reply to your request for information.

We have attached the draft document outlining the current policies for coroners which is undergoing final review to ensure alignment with the Auditor General's recommendations. There is no expectation the content will change during the review, and a final version will be available in coming weeks. We will provide a final copy to the Standing Committee when the final revision is complete.

The document outlines the current conflict of interest policy for coroners appointed by the Chief Coroner, and additional policies that oversee and govern the professional conduct of coroners such as the code of ethics and the process of investigating the conduct of a coroner. We would like the Committee to be aware that a copy of the Coroners Code of Ethics be included with a letter of appointment to be signed by new coroners upon their appointment.

The policies in the document also include a clear process to manage perceived or actual conflict of interest, the direct prohibition of double billing, and performance management expectations. These documents will play an integral role in the development of contractual expectations for the new service delivery model for the death investigation system.

Also included in the package, is the Ontario Forensic Pathology Service, 2014 Practice Manual for Pathologists, which provides the professional foundations for pathologists employed by the OFPS. This manual is due for revision in 2021.

We hope these documents fully answers any questions the Committee may have.

Sincerely,

A handwritten signature in dark ink, appearing to be 'DH'.

Dirk Huyer, MD
Chief Coroner for Ontario

A handwritten signature in dark ink, appearing to be 'M. S. Pollanen'.

Michael S. Pollanen, MD, PhD,
FRCPath, DMJ (Path), FRCPC
Chief Forensic Pathologist for Ontario

(Encl.)

Operational Policies for Coroners 2020

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Introduction

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Coroners' Motto

“We Speak for the Dead to Protect the Living”

1.1 References

- i. Chapter 002 – Coroners Investigation Manual version 1.3

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Coroners Code of Ethics

2.1 Purpose

- i. This code is established as a framework for ensuring integrity and ethical coroner behaviour allowing public trust and respect of coroners and the Office of the Chief Coroner.
- ii. A copy of the Coroners Code of Ethics will accompany the coroner's appointment letter, and will be signed by the coroner.
- iii. Coroners who breach their code of ethics are subject to disciplinary actions.

2.2 Scope

This procedure applies to all coroners and Coroner Investigators in Ontario.

2.3 Introduction

According to the Coroners Act, R.S.O 1990 (the Act), one of the Chief Coroner duties is to prepare, publish and distribute a code of ethics for the guidance of coroners.

2.4 Abbreviations and Acronyms

OCC : Office of the Chief Coroner
RSC : Regional Supervising Coroner
Act : Coroners Act, R.S.O. 1990

2.5 Definitions

Not Applicable

2.6 Health and Safety

Not applicable

2.7 Code of Ethics

- i. Coroners shall exercise their duties and responsibilities without fear, favour, prejudice, bias or partiality towards any person.
- ii. Coroners in the exercise of their duties, shall respect the beliefs and/or religious views of the deceased, and where an investigation is for reason only that the deceased person has not had medical attendance prior to the hour of death, shall recognize that the personal choice of the decedent is not in itself reason for further investigation or autopsy, unless there is evidence of other conditions stipulated in section 10 of the Act.

- iii. Coroners shall, in the delegation of their investigative powers to a legally qualified medical practitioner or a police officer, ensure that any individual so authorized will act in accordance with the Act and this Coroners Code of Ethics.
- iv. Coroners shall proceed in the public interest to carry out diligently, and with all due dispatch, their duties and responsibilities as set out in the Act.
- v. Coroners shall have due regard for the fact that they are performing a public duty and that their actions and decisions affect the public interest as well as the interests of private individuals.
- vi. Coroners shall accept their share of professional responsibility towards society in relation to matters of public health, health education and legislation affecting the health and well-being of the community.
- vii. Coroners shall be guided in the performance of their duties by the Chief Coroner or his/her delegate.
- viii. Coroners shall not, in the discharge of their duties, make decisions beyond the scope of their personal expertise and knowledge but shall seek guidance from the appropriate source or sources.
- ix. Coroners shall assist law enforcement agencies and officials involved in the administration of justice in the discharge of their duties so far as possible, having regard to the provisions of the Act.
- x. A coroner shall not interfere in an investigation or inquest which has been undertaken by another coroner unless directed to do so by the appropriate authority.
- xi. Coroners shall disqualify themselves from conducting an investigation or presiding at an inquest where any actual conflict of interest exists or appears to exist. An immediate conflict exists if a coroner has provided active medical care to the deceased person and the apparent circumstances of death could have any potential relationship to the care provided by the coroner.
- xii. Coroners presiding at an inquest shall exercise their duties and responsibilities so as to assist the jury to return a fair, impartial, and proper verdict, based on the evidence.
- xiii. When presiding at an inquest, a coroner shall instruct the jury and receive the jury's verdict with impartiality.
- xiv. A coroner shall bear in mind that an inquest is designed to determine and make public the facts surrounding a particular death or deaths, and that an inquest shall be open to the public except as provided for in section 32 of the Act.
- xv. Coroners shall avoid making any comments concerning the morality of the conduct of persons within the purview of an investigation or inquest.
- xvi. A coroner shall not act in a manner designed to, or having the effect of, publicizing his or her personal medical practice or enhancing his or her personal reputation in the community.
- xvii. A coroner, where an investigation or inquest reveals a need for the amendment of legislation or the enactment of new legislation, shall not be restricted from advocating such change in the law.
- xviii. A coroner shall not release confidential information to the public during the course of an investigation or prior, during or subsequent to an inquest, and shall in particular refrain from post-inquest public debate over matters that occurred

during the course of an inquest. Where the coroner feels that, in the public interest, it is advisable to release certain information, he or she may disclose such information as referred to in section 18 (3) of the Act after consultation with the Chief Coroner or his/her delegate.

- xix. Coroners shall strive to increase their knowledge concerning matters pertinent to the proper and effective performance of their duties and shall where possible, attend required programs and courses conducted by the Chief Coroner for the instruction of coroners in their duties.
- xx. A coroner shall respect the confidentiality of any information received by him or her in the performance of his or her duties except as stipulated in other sections of this code or where otherwise required by law.
- xxi. At all times, coroners shall conduct themselves in a professional and conscientious manner and shall avoid actions which might tend to bring their office into disrepute or affect public confidence in that office.
- xxii. All coroners are prohibited from billing OHIP for the same services conducted as part of a death investigation. Any evidence of double billing will immediately be reported to the Ministry of Health by the Office of the Chief Coroner and may result in suspension or termination.

Coroner Performance Management and Standards

3.1 Purpose

This policy intends to provide performance management expectations for coroners in working with the Office of the Chief Coroner (OCC).

3.2 Scope

This policy applies to all coroners and coroner Investigators in Ontario.

3.3 Introduction

- i. Coroners in Ontario are expected to perform their duties in a competent and professional manner and interact effectively with families and other members of the death investigation team.
- ii. The Office of Chief Coroner procedures, policies and guidelines are provided for coroners to accomplish their duties.
- iii. The OCC must never encounter a situation in which a coroner lacks the requisite knowledge to conduct death investigations and/or fails to seek assistance in a timely manner. Such a situation would result in sub-optimal outcomes for the investigating coroner, the OCC and particularly those affected by an individual's death.
- iv. The importance of a coroner's interpersonal and communication skills with families and other members of the death investigation team cannot be overstated.
- v. To that end, the communication of performance expectations and performance management are ongoing, interactive and collaborative processes in which Regional Supervising Coroners (RSC) and coroners work together to obtain optimal individual and team performance. The OCC death investigation goals can only be achieved if performance expectations are clearly articulated and accepted.

3.4 Abbreviations and Acronyms

Act : Coroners Act, R.S.O. 1990
OCC : Office of the Chief Coroner
RSC : Regional Supervising Coroner
PM : Post-mortem

3.5 Definitions

Performance Management – The tool for improving the work performance and productivity of individuals, teams and organizations.

Quality - The totality of features and characteristics of a product or service that bears on its ability to satisfy given needs.

3.6 Health and Safety

See applicable procedure.

3.7 Performance Metrics

Quality

Quality is defined by the American National Standards Institute and the American Society of Quality as “the totality of features and characteristics of a product or service that bears on its ability to satisfy given needs”.

The principles of total quality include:

- Stakeholder focus;
- Participation and teamwork throughout; and
- A process focus with continuous improvement and learning.

The OCC serves the public interest through conducting death investigations. The stakeholders with the greatest investment in the outcomes of our death investigations are the families of deceased individuals. While it may not be possible to fully satisfy all of the needs of grieving families, the OCC must strive to provide high-quality death investigations in the most sensitive and empathetic manner possible. It must also be remembered that an important end product of coroner work is the Coroner's Investigation Statement, and that the quality of this document reflects the quality of the death investigation.

Key strategic considerations:

- i. We will be a quality driven organization, and our objectives will be:
 - To have a stakeholder focus;
 - Commit individually to ensuring quality and to work as a team to transform our organization;
 - Produce consistent, high quality, useful outputs;
 - Have a common understanding of quality, measure it, and constantly strive to improve the quality of our services; and
 - Be efficient, making the best use of the resources at our disposal
- ii. We will work together to create a credible, reliable death investigation system, and our objectives will be to:
 - Have an operational model and operating processes in place that support integration and collaboration; and
 - Consider and act on the needs and potential contributions of our key stakeholders.

3.8 Expectations of Investigating Coroners in the Performance of Their Duties

Domain	Performance Expectation
Knowledge	The coroner has knowledge of the Act and other relevant legislation, the Guidelines for Death Investigation and correspondence issued from the OCC.
Communication	The coroner communicates with the Regional Supervising Coroner according to procedures for High Profile Notification and Coroners Notification.
	The coroner makes all reasonable efforts to communicate with the family, answers their inquiries respectfully and provides them with guidance regarding the death investigation (e.g. advises them that they must contact the Regional Supervising Coroner's Office in writing to obtain documents generated from an investigation - the Coroner's Investigation Statement, PM examination and toxicology reports).
	Coroners must engage families at the pre-consultation phase for potential Long-term Care home death investigations. Coroners also must submit case selection data forms in the event that a death investigation is not pursued in a Long-Term Care Home.
	The coroner seeks to develop and maintain a professional relationship with the pathologist(s).
	The coroner is encouraged to communicate with the pathologist before the autopsy, in most cases to enhance the quality of the PM examination. This is most important in homicides, criminally suspicious deaths, potential inquest cases and paediatric deaths. If this is not possible at the time of initial investigation, the coroner will indicate a method the pathologist may use to contact him/her and will make himself/herself available to the pathologist. The expectation being the responsible pathologist

	will make efforts to contact the coroner to fulfill this need.
	The coroner completes the Warrant for PM Examination in a legible manner, providing all necessary information to fully inform the pathologist of the relevant facts as he/she plans and performs the PM examination.
	The coroner communicates effectively with the police and, as the lead investigator in non-criminally suspicious deaths, provides them with appropriate direction pursuant to section 9 of the Act (Police assistance).
	The coroner utilizes appropriate electronic methods of communication with the Regional Supervising Coroner and OCC Head Office, including maintaining a confidential e-mail account for transmission and receipt of documents.
Trust	The coroner respects the Office of the Chief Coroner and will follow the Oath of Office for Coroners and the government of Ontario Oath of Office (See Document – Coroners Oath) and the Code of Ethics for Coroners (See Document – Coroners Code of Ethics) signed with his/her appointment letter. Although a Coroner's disagreement with policy or direction received from the OCC may be freely voiced and noted within the organization, this disagreement is not to be shared or debated in a public forum.
	The coroner privately discusses any potential conflict with a Regional Supervising Coroner in a timely manner. If the coroner has concerns about the decision taken by the Regional Supervising Coroner, he/she may ask one of the Deputy Chief Coroners to review the matter. If the coroner is uncomfortable doing so, he/she may approach the Ontario Coroners Association to speak on his/her behalf.
	The coroner understands that he/she functions as a team member. Every effort will be made to resolve

	team disagreements collegially and collaboratively. However, the team acknowledges that under the Act, the Chief Coroner has the authority and responsibility, either directly or through delegation to Deputy Chief Coroners and/or Regional Supervising Coroners, to be the final authority regarding investigative conclusions.
	The coroner understands that OCC stakeholders, including families and the criminal justice system, rely upon his/her honesty and integrity. Breaches of trust and honesty are extreme infractions.
Teamwork	The coroner promotes teamwork.
	The coroner understands that the OCC includes multiple external and internal partners in addition to the Regional Office. The coroner engages the whole team in a respectful manner.
	The coroner understands it is appropriate to discuss and even debate issues respectfully, fairly and vigorously so that his/her opinion is heard. After a team decision is obtained, he/she will accept this decision with equanimity, recognizing that ultimately the final authority and responsibility rests with the Chief Coroner.
Accountability	The coroner accepts accountability for his/her actions.
Attention to Results	The coroner understands that public confidence in the OCC is enhanced by quality death investigations and seeks to achieve a high standard in each and every case.
Behaviour	The coroner has an unrelenting focus on quality.
	The coroner adheres to all of the policies, procedures and guidelines established by the OCC.
	The coroner accepts cases appropriately, using appropriate judgment and processes/procedures in determining which deaths to investigate.

	The coroner understands that disruptive behaviour (for example, as defined by the College of Physicians and Surgeons of Ontario in CPSO Policy Statement #4-07 - Physician Behaviour in the Professional Environment), including rudeness and impoliteness, is inappropriate conduct whether in words or action, and interferes with, or has the potential to interfere with, a quality death investigation. It is never appropriate.
	The coroner understands that he/she represents the OCC and the Government of Ontario.
	The coroner will ask for help when necessary and/or appropriate.
	The coroner is responsive to requests for investigations, takes appropriate measures to be reachable, and responds in a timely manner when on call.
	The coroner understands that he/she may be required to respond to inquiries about his/her death investigations, even when no longer on call.

3.9 References

- i. Chapter 01– Coroners Investigation Manual version 1.3

Conflict of Interest

4.1 Purpose

The purpose of this policy is to outline rules and regulations relevant to conflict of interest (COI).

4.2 Scope

This procedure applies to the management of perceived or actual COI during death investigations. This policy applies to all coroners and Coroner Investigators in Ontario.

4.3 Introduction

It is essential that all parties take steps to avoid any actual or perceived conflict of interest during the investigation and the inquest that may follow. Also, given the various locations around the province and various populations being served, there are certain locations that are more likely to predispose a coroner to potential conflict of interest-related issues than other locations.

4.4 Abbreviations

OCC : Office of the Chief Coroner
CC : Chief Coroner
COI : Conflict of Interest
DCC : Deputy Chief Coroner
RSC : Regional Supervising Coroner
OFPS : Ontario Forensic Pathology Service

4.5 Definitions

Not applicable

4.6 Health and Safety

Not applicable

4.7 Procedure

4.7.1 Undertaking an Investigation

- i. The coroner should consider whether their relationship with the deceased person, the involved police service, the treating institution (or other

relationship) creates a conflict of interest or the appearance of a conflict of interest. (See Procedure– Coroners Jurisdiction). This is not only a concern for the investigation phase but may be an issue for a presiding coroner at an inquest.

- ii. If any potential conflict exists, consultation with an RSC is required to discuss the potential conflict and determine how the case will be best managed. The discussion must be documented by the RSC and the coroner.
- iii. Deaths involving a local police service, might require an inquest under the Act, and therefore should be investigated by another police service for purposes of the inquest. The RSC will discuss and arrange for this with the assistance of the Deputy Chief Coroner/Chief Coroner.
- iv. An immediate conflict exists and must be reported to the Regional Supervising Coroner in the event that Investigating Coroner has provided medical care to the deceased person and the apparent circumstances of death could have any potential relationship to the care provided by the coroner. The Regional Supervising Coroner must delegate the case to another coroner when the deceased person was receiving medical care from the coroner.
- v. Upon transition to the new Coroner Investigation Template in QuinC, coroners must complete a mandatory field to indicate whether the coroner has provided medical care to the deceased person and if so, when and under what circumstances. If “yes” is indicated, the case will prompt immediate review by the responsible RSC.

4.7.2 Conflict of Interest Identified After Commencement of Investigation

This approach applies when information is received indicating a potential COI by the Office of the Chief Coroner (OCC) and forwarded or received directly by the Regional Supervising Coroner.

- a) Phase 1 – RSC to review the original death investigation in its entirety:
 - i. determine if any documentation or evidence of declaration/ documentation of a COI;
 - COI must have been (or be) declared with the family, the RSC, and other co-investigators if involved.
 - ii. review to ensure that the integrity of the investigation was not compromised; and
 - documentation in the chart will be reviewed including any other investigative reports
 - iii. documentation of findings.
 - findings will be classified and documented in the case file (addendum note) stating that there was a review of the investigation and anyone requiring notification will be notified
 - classification:
 - No conflict (as stated or situation not representative of a concerning COI)

- Minimal - cases clearly not likely to have been known at the time of the investigation and not relevant to the investigation.
 - Moderate - cases that the coroner should have considered as being potential or had a manner of determining that it existed.
 - Severe - cases that clearly should have been declared and/or noted by the coroner as well as communicated to the RSC. Cases where the conflict of interest clearly impacts on the integrity of the investigation require to be classified as severe as well.
 - RSC will review findings with the DCCs and propose management plan (to be inclusive of the following steps)
- b) Phase 2:
- i. RSC will contact the coroner and inform them that they were identified as possibly having investigated a case with COI;
 - ii. RSC and coroner will meet to review findings of the chart review; and
 - iii. Coroner will then be given the opportunity to review their files (+/- involvement of their own legal guidance/support) and then discuss any issues they feel are relevant to the review of the investigation/conclusions about COI
- c) Phase 3:
- i. RSC will have further discussion with coroner, if required, and review proposed management plan;
 - ii. RSC will formalize management plan with the DCC/CC and present to the coroner; and
 - iii. possible outcomes include:
 - Determination that there was no COI, or that the COI was appropriately managed;
 - For a COI that is classified as minimal there will be discussion with the coroner about how to prevent future occurrences as well as notification about the incident;
 - Moderate conflicts that are discovered will include the approach to the management of a minimal COI as well as but not be limited to:
 - re-investigation of the case - this may require that the case be transferred to another coroner
 - partial to full suspension of the coroner for a period of time to ensure appropriate education of the coroner can occur; and
 - Severe conflicts may be managed as above but may also include other investigative processes being required as well as possible termination as a coroner and coroner-related duties
- d) Step 4:
- i. RSC will ensure appropriate documentation, discussion and notification of all necessary parties and ongoing integrity and confidence in the provincial death investigation system; and

- ii. RSC will share learning points from the review to be incorporated as required in policy, education and/or discussions with all those that are required

4.8 References

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Temporary Absence and Inactive Coroner

5.1 Purpose

The purpose of this policy is to provide rules and regulations on the temporary absences from active coroner duties.

5.2 Scope

This policy applies to all coroners and Coroner Investigators in Ontario.

5.3 Introduction

Recognizing the importance of medico-legal death investigations to the community, the Regional Supervising Coroner (RSC) must balance the needs of an individual coroner for a temporary absence from coroner duties with the community requirements for coroners to be readily available to provide high-quality investigations. In order to assure an appropriate level of knowledge of current science, guidelines, and skill obtained through active participation in coroner activities, a coroner who has not been actively investigating cases for an extended period require structured review and re-education before resuming investigative responsibilities.

5.4 Abbreviations

LOA : Leave of Absence
OCC : Office of Chief Coroner
RSC : Regional Supervising Coroner

5.5 Definitions

See the Coroner Act, R.S.O. 1990, definitions.

Inactive designation applies to a coroner who has not accepted cases for investigation, and/or has not participated in a call schedule, where one exists, for one (1) year or more without being on a temporary absence.

Temporary absence will include (i) Leaves of Absence (LOA) for such issues as medical illness, or other reasons deemed appropriate by the RSC, and (ii) pregnancy/parental leaves.

Extended absence is any absence from coroner duties that is three months in length or longer. (CPSO Policy Statement #2-07 Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close Their Practice Due to Relocation).

Leaves of Absence will ordinarily be defined as a voluntary withdrawal of coroner services such that no death investigations or signing of applications for cremation or out-of-province shipment will be undertaken by the coroner. LOA may be for a period generally not exceeding one (1) year.

Pregnancy/Parental Leaves will be consistent with current Ontario Public Service (OPS) guidelines and directives and will include a withdrawal of coroner services as outlined in Leave of Absence.

5.6 Health and Safety

Universal precautions should be followed when handling biological specimens or human remains. Appropriate personal protective equipment should be worn. All body fluids and tissue, and all contaminated and stained items must be treated as potentially infectious. See other relevant procedures including **Procedure - Contaminated Remains**.

5.7 Policy

5.7.1 Temporary Absence from Investigating Coroner Duties

- a) Temporary absence will include (i) Leaves of Absence (LOA) for such issues as medical illness, or other reasons deemed appropriate by the RSC, and (ii) pregnancy/parental leaves;
 - LOA will ordinarily be defined as a voluntary withdrawal of coroner services such that no death investigations or signing of applications for cremation or out-of-province shipment will be undertaken by the coroner.
 - Pregnancy leave may be for a period of up to 17 weeks prior to the birth of a child (the earliest pregnancy leave can begin is 17 weeks before the employee's due date. However, pregnancy leave can begin as late as the date of the birth), following which parental leave will commence. Parental leave may commence no earlier than the day of birth of a child (or whenever the pregnancy leave ends), or alternatively when a child comes into the care and custody of the parent. Where pregnancy leave has been taken, parental leave will not exceed 61 weeks. Where only parental leave is requested, it will be for a period not exceeding 63 weeks.
 - Temporary absences will not involve any consideration of revoking the coroner appointment.
 - Medical confidentiality can be maintained (i.e. details of condition are not required) for a medical leave of absences if a note from the coroner's physician is provided
- b) An inactive coroner cannot request a LOA.

- c) Since coroners are compensated on a fee-per-case basis, there can be no expectation of entitlement to compensation while a coroner is on LOA or pregnancy/parental leave.
- d) A coroner who will be moving or relocating to a new location outside their area of appointment should request a LOA if the relocation is anticipated to be temporary (e.g. training, locum position, etc.). If the relocation will be permanent, then the coroner ceases to hold office pursuant to subsection 5.2 (2) of the Coroners Act and a request will be made to have the coroner's appointment formally rescinded. The investigating coroner can apply for an appointment for the new area.
- e) Requests by coroners for a Leave of Absence will be made in writing to and approved in conjunction with their respective RSC in consultation with the CC. Considerations should include but not be limited to the following: Length of time, current open caseload, plans for completion of open cases, access to ongoing investigative results and closure of cases, and ability to function as a physician.
- f) A LOA may be extended with the permission of the RSC for a further period of one (1) year. It is the responsibility of the coroner to initiate such a request for extension prior to the expiry of the first LOA period. An extension beyond two (2) years total LOA will not be permitted unless temporary medical issues necessitate a further extension, in which case, consideration will be given to such an extension. After the LOA period, the coroner will be asked to return to their duties, or alternatively, will be asked to resign their position if the coroner is not prepared to return to their duties. Failure to comply may result in referring the matter to the Chief Coroner to consider rescinding of the coroner's appointment.
- g) In keeping with current policies of the Office of the Chief Coroner (OCC), the coroner on temporary absence must submit their coroner badge, photo ID card and coroner dashboard sign for safe keeping to their RSC office.
- h) The RSC will notify police, funeral homes, hospitals and long-term care facilities, and Provincial Dispatch and CC as necessary about the temporary absence of the coroner. The RSC will notify the Operational Services Director to have the coroner's name removed from the Coroner's Online Certificate Solution database.
- i) To accommodate the temporary absence, the RSC will make changes to the call coverage or recruit such additional new coroners as may be required to ensure an appropriate level of service.
- j) When returning from a LOA, Pregnancy or Parental Leave, RSC will conduct notifications (see ix. above) and return name to database. The coroner will resume carrying out investigations and signing for applications for cremation and out-of-province shipment.

5.7.2 Resignation of Coroners

- a) Resignation notification must be communicated in writing to the office by the coroner to their respective RSC. The coroner is expected to be aware that

they are required to complete and submit reports for all ongoing investigations and should be encouraged to cease initiation of new investigations well before their anticipated resignation date.

- b) If the coroner is resigning as a physician there is an expectation that proper notification of the CPSO will occur. Coroner status is predicated on being a legally qualified medical practitioner therefore their legal ability to conduct/complete coroner investigations ceases with loss/resignation of their licence.
- c) The coroner should work with the RSC office to prepare for most effective termination of duties as a coroner/inquest coroner. It is important that the coroner and the RSC develop a plan that is in the best interest of both the needs for completion of outstanding investigations and the coroner's needs. The CC will then be notified to approve the plan and then this information will be shared with the CPSO.

5.7.3 Inactive Investigating Coroner

- a) "Inactive" designation applies to a coroner who has not accepted cases for investigation, and/or has not participated in a call schedule, where one exists, for one (1) year or more without being on a temporary absence.
- b) An inactive coroner must return their coroner badge, photo ID card and coroner dashboard sign for safe keeping to their RSC office and/or OCC upon request.
- c) After two (2) full years of inactivity, the coroner must meet with the RSC to discuss their ongoing involvement with the OCC. The discussion will focus on whether the coroner will return to active duties or whether the coroner should resign at that time. Should it be decided that the inactive coroner will return to active duties, the coroner will first be required to attend appropriate refresher training, as directed by the RSC. If the coroner decides not to return to active duties for reasons other than temporary medical issues, and the coroner will not voluntarily resign their position, the RSC shall notify the Chief Coroner to consider the rescinding of the coroner appointment.
- d) Any inactive coroner who has resigned or had their appointment revoked may apply for reappointment whenever a vacant position is identified. To be reappointed the individual must be the successful candidate in a competitive application process open to other applicants for the position. The successful candidate will be required to complete the Course for New Coroners prior to assuming any investigative duties.

5.8 References

- i. Memo 10-07 – Policy for Temporary Absence and Inactive Coroner
- ii. Coroners Act R.S.O. 1990
- iii. Employment Standards Act, 2000

5.9 Authorization and Revision History

Coroners Under Investigation

6.1 Purpose

The purpose of this policy is to outline rules and regulations that applies to coroners under investigation and/or facing complaints/concerns.

6.2 Scope

This procedure applies to the management of coroners when there are concerns that are being investigated or that require investigations, including those by the College of Physicians and Surgeons of Ontario (CPSO).

As per the Coroners Act:

- i. Section 5.1 (1) A coroner ceases to hold office on ceasing to be a legally qualified medical practitioner
- ii. Section 5.1(2) The College of Physicians and Surgeons of Ontario shall notify the Chief Coroner as soon as possible where the licence of a coroner for the practice of medicine is revoked, suspended or cancelled. 2018, c. 3, Sched. 6, s. 2.

6.3 Introduction

This policy applies when an investigating coroner is under investigation:

- i. For civil or criminal matters
- ii. By the College of Physicians and Surgeons of Ontario (CPSO) or other regulatory/investigative bodies in Ontario or elsewhere
- iii. For a complaint made directly to the Office of the Chief Coroner (OCC)
- iv. Regarding serious concerns identified by the OCC

6.4 Abbreviations

Act : Coroners Act, R.S.O. 1990
CMPA: Canadian Medical Protective Association
OCC : Office of the Chief Coroner
CC : Chief Coroner
DCC : Deputy Chief Coroner
RSC : Regional Supervising Coroner
CPSO: College of Physicians and Surgeons of Ontario
OFPS : Ontario Forensic Pathology Service
IC : Investigating Coroner

6.5 Definitions

See the Coroners Act, R.S.O. 1990, (Act) definitions.

Chief Coroner Review Committee: A committee that will review serious allegations or concerns regarding the work or conduct of a coroner. Recommendations are made to the Chief Coroner for consideration (See Procedure - Chief Coroner's Review).

Complaint/concern is generally interpreted to mean a practice-related issue that was brought to the attention of a coroner, RSC, DC, CC and/or the CPSO or there is a suspicion that a communication is imminent.

Practice Restrictions: The physician's certificate of registration with the CPSO has additional terms, conditions and limitations (TCLs) imposed on it.

Restricted Certificate: A physician with a restricted CPSO certificate must practice in accordance with the specific terms and conditions imposed on the certificate.

Revocation: A physician's certificate of registration may be revoked by order of the CPSO Discipline Committee on grounds of professional misconduct or incompetence, or by the Fitness to Practise Committee on grounds of incapacity. Once revoked, the physician is no longer allowed to practice medicine in Ontario.

Suspension: A physician's CPSO certificate of registration may be suspended by order of certain College committees, namely, the Discipline Committee, Fitness to Practise Committee and the Inquiries, Complaints and Reports Committee. Upon suspension, the physician must immediately cease practising medicine and may not resume practice until the suspension is removed.

6.6 Health and Safety

Not applicable.

6.7 Policy for Non-Assignment of Coroner Duties and Reporting to the CPSO

6.7.1 Notification Requirements/ Mandatory Reporting

- a) Under s. 5.1 of the Coroners Act, there is a requirement for the CPSO to inform the Chief Coroner of coroners that have had their licence revoked, suspended, cancelled. The CPSO provides a list to the Office of the Chief Coroner on a quarterly basis which highlights which physicians have had their license revoked, cancelled or suspended. The OCC cross references the list with all active Ontario coroners.
- b) The CPSO will advise the Chief Coroner as soon as they become involved with any complaint about a coroner regardless of who initiated the complaint.

- c) The Chief Coroner will inform the CPSO of any coroners who are determined to have any practice related concerns requiring notification of the CPSO. The RSC/DC shall notify the CC of any such concerns if the concerns are brought to them initially.
- d) The Chief Coroner will inform the CPSO when a coroner resigns their position. The Chief Coroner will specifically notify the CPSO if a coroner resigns during an OCC investigation into the behaviour or competence of the coroner.
- e) Coroners shall advise, in writing, their Regional Supervising Coroner (RSC) as soon as they become informed of any CPSO, hospital, police or other complaints or an investigation by any other regulatory/investigative bodies. The RSC shall then notify the OCC-OFPS Operations Unit via email at occ.ofps.operations@ontario.ca with supporting documentation.

6.7.2 Non-Assignment of Coroner Duties

- a) If the matter under investigation is deemed significant or serious in the opinion of the RSC, DCC and/or the CC, the coroner will not be assigned any investigations or perform any other coroner services until the matter has been resolved. This will include completion of cremation and shipment of a body outside of Ontario certificates. Any ongoing cases, case-closures will be managed by their respective RSC until their coroner duties are reinstated. A return to active coroner duties will be at the discretion of the CC following satisfactory resolution of the matter.
- b) For concerns not requiring immediate suspension the RSC and coroner will discuss the issue and determine a proposed plan of management which will be shared with the CC for review and if appropriate approve the management approach.
- c) If a notification of concerns/investigation is received from a source other than the CPSO, when the concern is accepted and being investigated, the CPSO will be notified if reporting is indicated.
- d) If the CPSO or other regulatory bodies place restrictions on the license of the coroner, the RSC and DCCs shall review the restrictions and provide resolution recommendations to the CC. The CC shall determine if the coroner may continue with casework or be suspended from casework until the matter has met appropriate resolution.
- e) The non-assignment of cases and notification not to perform other duties may also apply in circumstances where a coroner may be under investigation for a civil or criminal matter, under investigation with respect to a complaint received by the OCC, or where the OCC has identified a serious concern. A

return to duties will be subject to the RSC/DCC assessment of the circumstances. Reinstatement shall be at the discretion of the CC.

6.7.4 Reporting to the CPSO

A Regulation under the Act (Regulation 273/09) requires the Chief Coroner to notify the Registrar of the CPSO in circumstances where a coroner has restrictions imposed on their ability to provide services under the Act for concerns regarding professional misconduct, incompetence or incapacity. If the coroner contravenes a federal, provincial or territorial law, a municipal by-law or a by-law or rule as referred to in S. 28, Medicine Act, 1991 - O. Reg. 856/93, the Chief Coroner will notify the Registrar of the CPSO.

6.8 References

- i. Memorandum 10-08 – Non-Assignment of Coroner Duties and Reporting to the College of Physicians and Surgeons of Ontario
- ii. Coroners Act R.S.O. 1990

Chief Coroner's Review

7.1 Purpose

The purpose of this document is to define the standard procedure for the Chief Coroner's Review process.

7.2 Scope

This procedure applies to reviews initiated by the Chief Coroner.

7.3 Introduction

- i. The process is intended for use only in exceptional circumstances, and is designed to be fair, transparent, effective and efficient.
- ii. Only the Chief Coroner can initiate a Review.

7.4 Abbreviations and Acronyms

OCC : Office of the Chief Coroner
RSC : Regional Supervising Coroner

7.5 Definitions

Coroner means the coroner against whom allegations of serious concerns are made regarding his/her work or conduct.

The Steering Committee means the "Chief Coroner's Investigative Panel Steering Committee".

Chief Coroner includes his or her delegate.

Panel means a "Chief Coroner's Investigative Panel".

Panel Rules means rules and guidelines developed by the Steering Committee, which govern the activities of the Panel.

Senior Manager means the Chief Coroner, a Deputy Chief Coroner, or a Regional Supervising Coroner.

7.6 Health and Safety

Not applicable.

7.7 Procedure

7.7.1 Purposes

The purposes of the Steering Committee and Panels are:

- i. To assure that, when serious allegations of concerns are identified/made regarding the work or conduct of a coroner, the matter will be fully and fairly scrutinized and where necessary, appropriate corrective measures will be taken to ensure that future performance will meet the expectations of the Chief Coroner, the justice system, and the Ontario public; and
- ii. To manage the review of allegations regarding a coroner's work and conduct in a fair, consistent, timely, and effective manner

7.7.2 Membership and Mandate of the Chief Coroner's Investigative Panel Steering Committee

Members of the Steering Committee are appointed by the Chief Coroner. The Chief Counsel to the Chief Coroner, or delegate, is a Steering Committee member ex officio.

The Steering Committee:

- i. Provides general oversight of the Investigative Panel process;
- ii. May formulate and amend rules and guidelines for Investigative Panels ("Panel Rules");
- iii. Summarizes the activities of Panels and provides a report to the Chief Coroner; and
- iv. As a deliberative body, neither takes a role in deciding whether or not the Chief Coroner should appoint a Panel, nor acts as an appeal or review body regarding the process or conclusions of any Panel

7.7.3 Criteria for Appointment of Investigative Panel

The Chief Coroner decides whether or not to appoint a Panel taking into account factors including, but not limited to, the severity and chronicity of the issues, the complexity of the matter and volume of relevant evidence, the response of the coroner to previous corrective measures, and the potential for loss of public confidence in the Office of the Chief Coroner.

7.7.4 Appointment and Membership of Panel

- a) The Chief Coroner will appoint a Panel by means of a Letter of Direction, copied to the coroner, naming the members, designating the Chair, and setting out the specific issue(s) for the Panel's consideration.
- b) Members may be Senior Managers, including members of the Steering Committee, or any other person. The Chief Counsel to the Chief

Coroner, or delegate, is a member ex-officio. The Chief Coroner will not sit on a Panel.

- c) The Chief Coroner, in consultation with the President of the Ontario Coroners Association, may appoint an active coroner in good standing to a Panel.
- d) Should it be found that a Panel member has substantial involvement in the matter to be heard, or for any other reason, could not impartially hear the matter, the member will recuse him/herself from the Panel.
- e) If any member of the Panel can no longer serve for any reason, the Panel will continue. The Chief Coroner may, at any time during the Panel's existence, appoint a new Panel member, and/or designate a new Chair.

7.7.5 Mandate of Investigative Panel

- a) The Panel considers concerns regarding the allegations of actions of the coroner and advises the Chief Coroner of its findings, to assist the Chief Coroner in making an informed decision in exercising his or her authority to supervise, direct, and control the actions of coroners under Section 3 of the Coroners Act, R.S.O. 1990.
- b) The Panel shall inquire only into matters specified in the Letter of Direction.

7.7.6 Main Steps:

- a) The Chief Coroner will send the Letter of Direction to the Panel Chair, provide a copy to the coroner with a covering letter, which includes information on the Review Process. The Letter of Direction will state the allegation(s) that the Panel will investigate.
- b) Once the Letter of Direction is received by the Panel Chair, no further allegation(s) may be added, nor may an existing allegation be amended so as to increase its substance. Only the following amendments are permitted:
 - Withdrawal of one or more allegations;
 - Reduction in the substance of an allegation; and
 - Minor changes to particulars, for example, dates and times
- c) The Panel Chair will gather all information in the possession of the Office of the Chief Coroner, which is relevant to the evaluation of the allegation(s) in the Letter of Direction. Subject to an undertaking, the Panel Chair will forward a copy of the materials to the business address of the coroner, by registered mail or in another form, which establishes proof of receipt, and provide an opportunity for the coroner to respond in writing, subject to a deadline set by the Panel Chair.
- d) The coroner may request an extension for his or her response, in writing, giving reasons; and the Panel Chair will respond in writing. The Panel Chair will decide whether or not to grant the extension, taking

into account the relevant circumstances, and will provide written reasons if the extension is not granted.

- e) For each allegation in the Letter of Direction, the coroner may deny, accept, or not respond to the allegation. If the coroner does not respond to an allegation, the Panel will presume that the coroner denies the allegation.
- f) The Panel may consider, as adequate proof, the coroner's acceptance in writing of an allegation, or a component of an allegation.
- g) The Chief Coroner will assign a person to provide administrative support to the Panel Chair.
- h) The Panel's review is performed in accordance with Panel Rules.
- i) The Panel makes its findings based solely upon written materials and/or physical evidence.
- j) Subject to the Panel Rules, the coroner may make written submissions to the Panel.
- k) The Chair may request supplementary materials from the Chief Coroner.
- l) The standard of proof required for a Panel's finding is the "balance of probabilities".
- m) The Panel produces a report, which includes its findings of fact and reasons, and may include recommendations. The Panel Report will include:
 - The allegation(s);
 - The materials upon which the Review was based;
 - Summary of facts;
 - Reasons;
 - Findings with respect to each allegation; and
 - Recommendations for ameliorative action, if required
- n) The Panel reports to the Chief Coroner. The Panel's conclusions are, however, not binding upon the Chief Coroner. After reviewing the Panel's report:
 - If the Chief Coroner chooses to dismiss the matter, the Chief Coroner will advise the coroner in writing and enclose a copy of the Panel report; or
 - If the Chief Coroner chooses not to dismiss the matter, the Chief Coroner will advise the coroner in writing, enclose a copy of the Panel report, and provide an opportunity for response by the coroner before deciding the disposition of the matter.

7.7.7 Independent Experts

Subject to the approval of the Chief Coroner, the Chair of a Panel may retain one or more experts to provide assistance.

7.7.8 Timelines

Unless otherwise directed by the Chief Coroner, a Panel will provide its report within 90 days of the Letter of Direction.

7.7.9 Duration of Panel

Within 14 days of its report to the Chief Coroner, the Chief Coroner may direct in writing that the Panel provide a supplementary report. In the absence of such direction, the Panel is dissolved and functus officio 14 days after it provides its report.

7.7.10 Confidentiality and Distribution of Reports

- i. Panel members, who are not Senior Managers, and retained expert(s), may be required to sign an undertaking of confidentiality.
- ii. The Chief Coroner may provide anonymized summaries of selected Panel investigations to Ontario coroners for the purposes of education and deterrence.
- iii. Subject to paragraphs 1.7.2(iii), 1.7.6.15 and 1.7.10(ii), the proceedings and decisions of any Panel are strictly confidential and will not be released to any person without leave of the Chief Coroner.

7.8 References

- i. Memorandum 06-01 – Chief Coroner’s Review Process

This document is authorized for use effective:			Date: TBA
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ONTARIO FORENSIC PATHOLOGY SERVICE
2014 PRACTICE MANUAL FOR PATHOLOGISTS

Preface

Ontario Forensic Pathology Service

The *Coroners Act* defines the roles and responsibilities of pathologists in death investigation and enhances the quality, organization and accountability of forensic pathology services. The *Coroners Act*:

- Defines the Ontario Forensic Pathology Service (OFPS) as the unified system under which pathologists provide forensic pathology services, including autopsies.
- Defines the position of the Chief Forensic Pathologist as overseer of forensic pathology services.
- Defines the positions of the Deputy Chief Forensic Pathologist and pathologist.
- Requires a registry of pathologists accredited to perform medicolegal autopsies.
- Requires the Chief Forensic Pathologist to communicate with the College of Physicians and Surgeons of Ontario on adverse findings related to competency and professionalism of a registered pathologist.

Registered pathologists have legal authority under the *Coroners Act* to attend scenes and to order ancillary tests as required, pursuant to their duties.

Practice Manual for Pathologists

The Practice Manual for Pathologists comprises the:

- A. Code of Ethics
- B. Practice Guidelines for Medicolegal Postmortem Examinations;
- C. Quality Management System; and
- D. Pathologist Register Protocol.

Together, these documents provide the professional and policy foundation for the OFPS and promote consistent and high quality practices across Ontario.

Forensic Pathology Advisory Committee (FPAC)

This Practice Manual was developed using a consultative approach by obtaining the input from the Forensic Pathology Advisory Committee (FPAC) of the OFPS. The members are:

Dr. Michael Pollanen, Chief Forensic Pathologist (Chair)
Dr. Toby Rose, Deputy Chief Forensic Pathologist
Dr. Jayantha Herath, Medical Director, Provincial FPU
Dr. Dirk Huyer, Chief Coroner of Ontario
Dr. John Fernandes, Medical Director, Hamilton FPU
Dr. Chris Milroy, Medical Director, Eastern Ontario Regional FPU (Ottawa)
Dr. Michael Shkrum, Medical Director, London FPU
Dr. Martin Queen, Medical Director, Northeastern Regional FPU (Sudbury)
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Dr. David Chiasson, Senior Forensic Pathologist, SickKids

On the Cover: Pulmonary Blastomycosis

Contact

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Section A - Code of Ethics

Preamble

Pathologists are physicians who often practice in a legal context. This context is different in every province and territory, but we are united in the values we hold and our commitment to the principles of good medical practice. We aspire to practice our branch of medicine according to the highest standards in the world.

Fundamental Duties

- I. We have a duty to the medicolegal death investigation system in which we practice. We will follow the laws, regulations and practice guidelines that are in place where we work. We will participate in the development of these laws, regulations and practice guidelines when invited to do so. If we have an honest disagreement with the leaders of the system in which we practice, we will be forthright and respectful in our opposition.
- II. We have a duty to the court system. We are independent, neutral, scientific agents who are obliged to tell the truth and to strive to leave a truthful impression. We serve the court, not the prosecution and we will make ourselves available to attorneys representing the prosecution and the defence. We recognize that our duty may extend beyond the end of our testimony. We will preserve, describe, document and catalogue evidence according to the highest standards of practice in this area.
- III. We have a duty to our profession. We will be active participants in professional societies, associations and other organizations that promote good pathology practice. We recognize the value of vigorous debate and discussion and we will engage in these activities in a way that respects the professional judgement and autonomy of other pathologists. We will train the next generation of pathologists.
- IV. We have a duty to forensic science and medicine. We are dedicated to the advancement of the forensic sciences. We will continuously challenge our own assumptions and test them against the best available current evidence. We will challenge each other's assumptions. We will engage in mutually respectful debate and discussion. We will learn new skills and contribute to the development of new techniques.
- V. We have a duty to society. We will communicate effectively and truthfully with members of the public. We will educate the public about what we do and the importance of what we do. We will be advocates for good pathology practice.



Section B - Practice Guidelines for Medicolegal Postmortem Examinations

1. General Practices for medicolegal postmortem examinations

1.1 Introduction

These Practice Guidelines are intended to assist the pathologist in deciding how best to perform medicolegal postmortem examinations. For the purposes of this document, a practice guideline should be viewed as an adequate standard. The applicability of a practice guideline in a specific case is balanced by the state of the body (e.g., decomposition), information known at the time of the postmortem examination and professional judgment. The practice guidelines are not designed to inhibit professional autonomy, but were developed to:

- Ensure completeness of the postmortem examination.
- Minimize non-reviewable errors at postmortem examination.
- Ensure appropriate samples are collected at postmortem examination.
- Ensure appropriate ancillary testing is performed after postmortem examination.

These Practice Guidelines replace previously distributed guidelines and memos relating to medicolegal postmortem examinations, unless otherwise referenced or stated.

For the purposes of this document, *homicide* is defined as death due to the actions of another person or persons. A *criminally suspicious* case will be defined as a death that may be related to the action of another person or persons and may lead to criminal charges. It is recognized that some factors may limit the application of the guidelines in specific instances. These situations commonly include (but are not limited to) the following situations:

- Hospitalization.
- Decomposition, including skeletonization.
- Partial remains (i.e., absent body parts).
- Embalmed body.

These Practice Guidelines were designed to assist pathologists to ensure the quality of medicolegal postmortem examinations. Improper use of this document by non-forensic pathologists is discouraged.

1.2 Role of the pathologist

The main roles of the pathologist in a medicolegal postmortem examination are to:

- Attend or assess scenes as required either before or after the postmortem examination.
- Perform the medicolegal postmortem examination as directed by the warrant.
- Obtain the assistance of any person or persons in performing the postmortem examination and in conducting any other examinations and analyses.
- Conduct or direct any person other than a coroner to conduct other examinations and analyses that he or she considers appropriate in the circumstances.
- Provide a professionally independent and impartial opinion on the cause and mechanism of death and other medicolegally relevant issues within the scope of forensic and anatomic/general pathology.
- Report preliminary findings to the Chief Forensic Pathologist (CFP), the coroner and investigators as appropriate.
- Provide a final report of the postmortem examination and any other examinations or analyses to the coroner, the regional coroner and to the CFP.
- Provide expertise to the coronial or legal system.

Medicolegal postmortem examinations are not the same as hospital postmortem examinations. Medicolegal postmortem examinations are performed to advance a death investigation in the interest of the public. In addition, the medicolegal postmortem examination does not require consent by the next-of-kin and can be performed despite objections of the family. Thus, the pathologist has additional ethical obligations to the next-of-kin and the general public to ensure that the principles of medical ethics are observed. This includes respect for the dignity of the deceased and medical confidentiality.

In some cases, a cause of death or suspected cause of death may have health implications for surviving family members (e.g., inherited heart disease or thrombophilic syndrome). The pathologist may suggest to the coroner that first-degree relatives be investigated for such a disorder.

The main roles of the forensic pathologist in an individual homicide or criminally suspicious case are to:

- Attend or assess scenes as required either before or after the postmortem examination.
- Perform the medicolegal postmortem examination as directed by the warrant.
- Obtain the assistance of any person or persons in performing the postmortem examination and in conducting any other examinations and analyses.
- Conduct or direct any person other than a coroner to conduct other examinations and analyses that he or she considers appropriate in the circumstances.
- Provide a professionally independent and impartial opinion on the cause and mechanism of death and other medicolegally relevant issues within the scope of forensic pathology.
- Report preliminary findings to the Chief Forensic Pathologist (CFP), the coroner and investigators as appropriate.
- Provide a final report of the postmortem examination and any other examinations or analyses to the coroner, the regional coroner and to the CFP.
- Participate as team member in the death investigation by providing expertise in forensic pathology.
- Provide expertise to the criminal justice system.

1.3 Attendance at the postmortem examination

Attendance at the postmortem examination is limited to technical staff (e.g., pathologist assistants), medical professionals, appropriate trainees, coroners and investigators from relevant agencies including police, fire and traffic. In cases where the Special Investigations Unit (SIU) investigates a death, the postmortem examination will be attended by the SIU, but police are typically not permitted to attend. Any decision to deviate from this protocol will be taken jointly by the pathologist and the regional coroner.

The family may request that other individuals be allowed to attend a postmortem examination, based on religious, cultural or spiritual beliefs. These requests should be considered on an individual basis and in consultation with the CFP and regional coroner.

1.4 Documentation and disclosure

The pathologist must ensure that all samples collected at the postmortem examination are documented in the report, including:

- Tissues retained and fixed in formalin.
- Whole organs or en bloc specimens.
- Trace evidence, or other physical exhibits from the body.
- Swabs and smears.
- Samples of tissues or body fluids for toxicology, biochemistry, or microbiology testing.
- Postmortem radiographs.
- All photographs and digital images taken by investigators or the pathologist, including images of fixed tissues or organs.
- Tissue samples referred to consultants.

The pathologist must ensure that all consultation and laboratory reports are referenced in the postmortem examination report.

Disclosure refers to the provision by the pathologist of reviewable documents and photographs that derive from the postmortem examination for the purpose of a court proceeding. The pathologist must provide copies of the postmortem report and other documents when requested by appropriate counsel.

1.5 Continuity

Continuity of the body confirms that the autopsy is being done on the correct body. The continuity of the body must be confirmed by the pathologist, who must be satisfied before starting the autopsy that the body is the one referred to in the coroner's warrant. Continuity can be confirmed by such means as a police seal or appropriate nametag, or the body may be directly identified to the pathologist by the coroner, police or other authorized person. If the pathologist is not satisfied, he or she must ask the coroner to validate the continuity. The postmortem examination report should indicate how continuity was achieved.

1.6 Identification

Formal legal identification of the body is the responsibility of the coroner. If identification cannot be established in the community setting, consultation with a forensic pathology unit with identification expertise should be obtained. This should be facilitated through the Regional Supervising Coroner (RSC).

For cases that present as unidentified or presumptively identified, the pathologist must notify the appropriate RSC office once the identity has been confirmed using the Notice of Identification Form via EATS email or fax.

Continuity of the body and identification must be established before the body is released. Forensic pathology units and pathology departments should have a protocol in place to confirm the identity of a body before it is released.

1.7 Role of the assistant

Technicians and pathologists' assistants are integral and valuable participants in postmortem examinations who work under the direction and supervision of the pathologist. The scope of their duties in any postmortem examination will be determined by the extent of their training and experience and the nature of the case.

Dissection must not start until the pathologist has personally confirmed continuity/identity and has completed the external examination of the body. Duties that can be performed by appropriately trained and experienced technicians or pathologists' assistants include: opening the body and head, eviscerating the organs (the method of organ removal is up to the pathologist), weighing organs, sample collection and reconstruction of the body. However, the pathologist must perform dissection of the individual organs. This dissection can also be performed by residents and fellows under the supervision of the pathologist. The scope of duties of residents and fellows must be appropriate to their level of training and the type of case.

1.8 Collection and submission of toxicologic samples

Routine samples must be collected in all medicolegal postmortem examinations. The samples should include heart blood, peripheral (femoral) blood and urine, where available. Other samples including liver (if blood is absent) or stomach contents may be collected at the discretion of the pathologist. If samples are not submitted for toxicology testing, blood and urine samples are sent for storage at the Provincial Forensic Pathology Unit in Toronto.

Toxicology testing is not required for all cases and should only be requested if required for determining the cause of death or a pertinent medicolegal issue. Toxicology samples should be submitted as soon as possible with sufficient information to permit the forensic toxicologist to decide on the type and scope of laboratory testing. Information required on the submission form includes the clinical history (or investigative background) and major anatomical findings at postmortem examination. Toxicology testing will be performed using the following categories:

- **Alcohol only.** This includes ethanol, acetone and other volatile substances in an ethanol intoxication-related death. It is not necessary to request alcohol testing in sudden natural deaths of chronic alcoholics, if there is a satisfactory anatomical cause of death.

- **Exclusionary toxicology.** Exclusionary toxicology screening for drugs of abuse and alcohol is indicated in cases with a potential anatomical cause of death (injury or disease), but where toxicology is required to exclude drugs/alcohol as a contributory factor. Common examples include drowning, or ischemic heart disease with a past history of illicit drug use.
- **Possible drug/alcohol-related deaths.** Deaths caused by acute drug or alcohol toxicity typically have no anatomical cause of death and occur in circumstances suggestive of drug/alcohol use (e.g., history of drug abuse, pill material in the stomach). In these cases, it is important to provide information about the drugs that maybe involved in death.

Toxicology is performed in homicides and is also required in the following cases:

- Sudden/unexpected deaths in infants and children under five.
- Workplace deaths subject to mandatory inquest.
- Fatal motor vehicle collision.
- Aviation deaths.
- Fire-related deaths (at least carboxyhemoglobin).

1.9 Tissue and organ retention, storage and disposition

Regulation 180 under the Coroners Act addresses the retention of tissues and organs after medicolegal postmortem examinations and sets out retention periods for different categories of specimens. If there is a reason for early disposal or extended retention of any specimen, the pathologist must obtain the approval of the Chief Forensic Pathologist and Chief Coroner in writing (Request for Retention of Specimens Form).

Whole organs or substantial portions of organs

Retention of any whole organ (e.g., brain or heart) and/or any substantial portion of an organ from a medicolegal postmortem examination must be authorized by the Chief Forensic Pathologist or designate. In general, a “substantial portion” of an organ is anatomically recognizable by a lay person. This does not refer to stock jars or larger “surgical specimen”-type samples.

Retention of a whole organ and/or a substantial portion of an organ from a medicolegal postmortem examination should be considered and authorization obtained if retention is required to:

1. Determine the cause of death or a significant medicolegal issue (e.g., mechanism of injury) in a case that is likely to enter the criminal justice system.
2. Diagnose a heritable, rare or obscure condition or disease that has probable implications for the healthcare of the family.

In most cases, retention of a whole organ and/or a substantial portion of an organ from a medicolegal postmortem examination can be avoided by overnight fixation followed by histologic sampling, with return of the organ to the body before the body is released to the next-of-kin via a funeral home. This is the recommended practice, particularly when a family objects to organ retention.

Ordinarily, brains from cases of sudden unexplained deaths in childhood or infancy (e.g., SIDS) should not be retained. Pediatric brains can be adequately examined and sampled after rapid fixation. Neuropathologic examination can also be performed on fixed samples obtained from the brain.

If retention of a whole organ and/or a substantial portion of an organ is authorized, the pathologist must notify the coroner orally and in writing (Form 1.0 Notification to Coroner of Organ Retention) at the conclusion of the postmortem examination to ensure the family is notified and they provide disposition instructions. The preliminary and final postmortem examination reports must indicate which organs and/or substantial portion of organs were retained.

Requests for neuropathology or cardiovascular pathology consultations should be made in writing (Cardiovascular Pathology Request Form and Forensic Neuropathology Request Form).

Once examination of the whole organ is complete, the organ must be retained for two years unless approval is obtained for early disposal or extended retention from the Chief Forensic Pathologist and Chief Coroner in writing (Request for Retention of Specimens Form).

Disposition

At the end of the postmortem examination, all organs and tissues must be returned to the body. The organs and tissues should be placed in a bag and into the thoracoabdominal cavity. The body must be reconstructed by suturing the torso and scalp incisions before it is released to the funeral homes.

When the family has requested through the coroner (Form 2.0 Disposition Request of Retained Organs) that a retained organ or substantial portion of an organ should be returned to them, this should be arranged through the funeral home.

The best practice for disposition of any retained organs and tissues that are not to be returned to the family is cremation through a funeral home.

Stock jars

Pathologists can retain stock jars of small representative tissue samples in formalin from any autopsy. These samples are to be retained for two years after the postmortem examination.

Slides, paraffin blocks and dried blood samples

Adult cases: Slides, paraffin blocks and dried blood samples are to be retained for a minimum of 20 years, after which they may be destroyed.

Pediatric cases (18 years of age or younger): Slides, paraffin blocks and dried blood samples are to be retained for a minimum of 50 years, after which they may be destroyed.

Body fluids

Body fluids sampled for toxicology testing or storage will be retained for two years at the Provincial Forensic Pathology Unit in Toronto.

1.10 Complete and limited postmortem examinations

In a complete postmortem examination, the findings of the external and internal examinations should be documented as follows:

External examination

- Clothing and personal effects:
 - Jewellery and any personal effects should be documented and removed and returned to the family, where possible.
 - When illicit drugs or large amounts of money are found, police should be notified to attend and seize. Expensive valuables and large amounts of money can be kept in safe-keeping with security staff until release to the funeral home.
- Length and weight of the body.
- Build and nutritional state of the body.
- Identifying features:
 - Colour of hair
 - Scars and tattoos
 - Presence or absence of teeth
- Head, neck, torso, extremities, hands, fingers, external genitalia and perineum should be examined in a systematic manner, and positive findings including evidence of natural disease recorded:
 - Eyes should be examined for petechial hemorrhages.
 - Postmortem changes and the state of the body.
 - Evidence of attempted resuscitation or other therapeutic interventions.
 - Injuries should be described using the approach detailed below ([see Section 1.16: Sudden death from injury \(non-homicidal\)](#)).
- If there is any indication on the warrant, medical history or external examination that a medical device such as pacemaker or automatic defibrillator is present, it should be deactivated and removed from the body

prior to the start of the internal examination. The Investigating or Regional Coroner can assist in identifying the manufacturer of the device, who will deactivate the device. These items may be a hazard during the postmortem examination, funerary processes and cremation.

Internal examination

Some postmortem examinations require both an external examination and an internal examination (by dissection). The following lists case types that almost always require an internal examination ([see Limited examination for possible exclusions](#)):

(The asterisks indicate case types performed only by Category A and/or C Pathologists on the Register)

1. All sudden unexpected deaths in infants and children.*(Category A and/or Category C)
2. All sudden and unexpected deaths in young adults (mostly < 40 years of age), particularly if there is a potential to discover a heritable cause of death. Molecular autopsy may be applicable in these cases ([see Section 1.12: Molecular autopsy](#)).
3. All homicide and criminally suspicious deaths.*(Category A)
4. All cases investigated by the Special investigations Unit (SIU) (e.g., death in police custody).*(Category A)
5. Deaths likely due to drug/alcohol intoxication, including unexpected death in the context of chronic alcoholism.
6. Deaths likely due to trauma, where the history and circumstances are unclear about the lethality or timing of the putative injury.
7. All cases associated with extremes of temperature (e.g., heat, fire and cold) and immersion in water.
8. All unexpected deaths that are likely related to a complication of a therapeutic intervention, or with coronial concerns about the quality of healthcare.
9. Drivers and pedestrians in fatal collisions of motor vehicles. *(Category A depending on circumstances and pending criminal charges)
10. Cases where the relevant medicolegal issues cannot be resolved by a forensic pathologist by reviewing the scene, circumstances and correlating these data with an external examination of the body.*(Category A)

All internal examinations should include dissection and examination of the head, brain and thoraco-abdominal organs. The neck organs including the hyoid bone and tongue and the pelvic organs should also be dissected and examined. The major organs and tissues should be examined using standard dissection methods, but the precise technique is left to the discretion of the pathologist.

All major organs should be weighed and macroscopic lesions should be described.

Limited examination

At the discretion of the pathologist, and after discussion with the Investigating and Regional Supervising Coroner, an autopsy in certain types of cases may be limited to an external examination. For each case, the cause of death must be readily apparent by external examination and/or history, and the external examination must not reveal unexpected findings. If after discussion, there is any question about the suitability of a case for an external examination, a complete autopsy should be conducted.

Pathologists should consider any suspicious circumstances and whether there are questions that only an internal examination could answer (e.g., recurrence of cancer; medical event leading to car crash, etc.). In these cases, a complete postmortem examination must be done.

The following are types of cases where a limited postmortem examination by a Category B pathologist could be considered:

1. Apparent witnessed suicidal descent from great height or impact with a moving train or subway. (This excludes accidental descent or impact.)
2. Apparent suicidal hanging.
3. Apparent suicidal plastic bag asphyxia or exposure to asphyxiant gases (e.g., helium).
4. Apparent suicidal deaths by carbon monoxide toxicity from automobile exhaust, barbeque or other source of CO, provided that a fatal CO level is available for review by the pathologist before the body is released.

In cases of apparent suicidal gunshot wounds (to be performed by Category A pathologists only), a limited internal examination with recovery of projectiles could be performed, e.g., internal examination of head only.

Limited postmortem examinations (“external examination only”) should not be done when the purpose is to differentiate between natural disease and a toxicological cause of death. These and all other cases require complete autopsies with internal examinations by dissection.

All limited postmortem examinations require a written report. The pathologist can use the Routine Postmortem Examination Report template (see Toolkit), but with the Internal Examination portion deleted.

In case of doubt about the suitability for an “external examination only”, call the OFPS Forensic Pathologist on call through Provincial Dispatch at 416-314-4100 or at 1-855-299-4100.

In all cases, body fluid samples should be obtained for possible toxicologic analysis. If an internal examination is not performed, the body fluid samples should be obtained by percutaneous punctures.

At the end of autopsy (external, limited or complete), the pathologist should call the investigating coroner to report the findings and the Preliminary Cause of Death. This communication should be documented ([see Section 1.13: Communication with police, coroner and other investigators](#)).

1.11 Histology and ancillary tests

If death has occurred due to a natural condition, histology should be used to provide reviewable documentation of the lethal disease/lesion. Routine histology of the major organs is left to the discretion of the pathologist. Histology is often not helpful in decomposed bodies.

Laboratory tests beyond histology and toxicology can be used in specific cases. The most commonly used informative tests include: microbiology, biochemistry of vitreous fluid (e.g., diabetic ketoacidosis) and genetic testing (e.g., suspected familial arrhythmic disorders in young people, genetic thrombophilias in young people with pulmonary thromboembolism).

1.12 Molecular autopsy

The molecular autopsy uses DNA technology to help determine the cause of sudden death in young people, typically less than 40 years of age. Detection of genetic mutations and diagnosis of associated diseases allows for screening, diagnosis and life-saving intervention in surviving family members such as siblings or children, who may share the mutation. The molecular autopsy can detect genetic disorders that present as:

- Young people with apparent sudden death from cardiac arrhythmias with negative autopsies and structurally normal hearts (e.g., channelopathies such as long QT syndrome). This includes deaths in police custody and unexpected drowning of young people swimming in open water.
- Some types of structural cardiomyopathy (e.g., hypertrophic cardiomyopathy; arrhythmogenic cardiomyopathy [ARVC]).
- Clotting disorders (e.g., unexplained pulmonary thromboembolism).
- Connective tissue pathologies presenting as aortopathies or arteriopathies (e.g., Ehlers-Danlos or Marfan syndromes).

Cases which are strongly suspected to be due to drug overdose may not require genetic testing.

Currently, the Molecular Autopsy Laboratory at the Provincial Forensic Pathology Unit (PFPU) has the capability to receive tissue from appropriate cases and isolate DNA, which can then be used for genetic screening.

A possible genetic cause for sudden cardiac death must be considered at the time of postmortem examination when tissues are still available. Furthermore, a detailed examination of the heart is necessary to help identify or exclude subtle cardiomyopathic conditions or congenital anomalies, e.g., coronary artery anomaly.

In appropriate cases, the pathologist should use the Molecular Autopsy Collection Kit, which is available from the PFPU, to collect and submit to the PFPU biopsy cores of the recommended tissues:

- Tube 1 – cardiac muscle.
- Tube 2 – preferred
(1)kidney (2)spleen (3)liver (4)cardiac (5)skeletal muscle.

Kits and further information can be obtained by contacting a Forensic Services Technologist at the PFPU at 416-314-4100 or at fst@ontario.ca.

All tissue samples submitted will have DNA isolated and stored at the PFPU. This material will be available to family members or Arrhythmia Clinics, should testing be required in the future.

It is recommended that in cases of apparent sudden cardiac death, the Report of Postmortem Examination should:

- Consider a potentially inherited cause of death.
- Advise first degree family members to seek cardiological assessment in an Arrhythmia Clinic or Cardiomyopathy Clinic that specializes in the investigation of such cases.
- Disclosed that tissue was obtained and submitted for DNA isolation and will be stored and made available to family should testing be requested in the future.

It is most appropriate that clinical cardiologists determine the nature and scope of testing after assessing family members. However, pathologists may order testing when the results are necessary for their own investigative purposes, e.g., sudden death in the setting of police restraint, criminally suspicious deaths, etc.

Pathologists, who require assistance in interpreting cardiac pathology or who have further questions about DNA isolation and possible testing, are encouraged to contact a forensic pathologist at the PFPU at 416-314-4040 or at ofps@ontario.ca. Cardiovascular pathology consultations are available (and

encouraged) as a resource for medicolegal postmortem examinations ([see Section 1.9: Tissue and organ retention, storage and disposition](#)).

If testing is conducted, results should be included in the Report of Postmortem Examination and communicated to the coroner to share with family members. Since interpretation of such tests is very complex and requires correlation with clinical factors, final interpretation should be left for the clinical team managing the surviving family members.

1.13 Communication with police, coroner and other investigators

Documenting the preliminary cause of death

If the cause of death is apparent at the conclusion of the gross examination, the pathologist should report the cause of death to the police and coroner. The police and coroner will then understand that the cause of death has been determined without requiring the results of further testing. At the conclusion of the gross examination, the cause of death provided to the police and coroner can be recorded in writing on the OFPS Preliminary Autopsy Findings.

If the cause of death is not readily apparent at the conclusion of the gross examination, the pathologist should give the cause of death as pending, under investigation or other similar language. This will ensure that the police and coroner understand that the cause of death is yet to be determined.

A preliminary opinion on the cause of death (or other critical matters such as the timing or mechanism of injury) must not be given to the police if toxicology, histology, examination of fixed tissues or organs or other ancillary testing are required to determine the cause of death. The importance of this cannot be over-emphasized. If definitive actions such as detention of a person by police are based on a preliminary opinion on the cause of death that cannot be substantiated later, then significant difficulties will arise within the justice system.

Two forms (Preliminary Police Report and Preliminary Autopsy Findings Report) are used in adult and pediatric homicide and criminally suspicious cases to facilitate information sharing between police and pathologists. These forms may also be used for routine cases to ensure effective information exchange. The Preliminary Autopsy Findings Report should be signed by both the pathologist and the police, with copies retained in their respective case files.

The pathologist's opinions should be clearly communicated to the coroner, police and other investigators and understood by them. There should be a frank and open discussion about the scope and limits of any expert opinion on the cause of death or related issues. Early case conferencing is encouraged as an effective method to ensure that frank and open discussion can occur.

1.14 Communication with the Ontario Forensic Pathology Service (OFPS)

Occasionally, pathologists may feel uncertain about performing a specific autopsy or may require advice or clarification from a senior forensic pathologist. At any time, even during an autopsy, pathologists can reach the on-call OFPS Forensic Pathologist by calling Provincial Dispatch at 416-314-4100 or at 1-855-299-4100.

Immediately following the postmortem examination, the pathologist must submit a completed electronic Postmortem Examination Record to the OFPS with information including the preliminary cause of death as provided to the coroner or to police.

1.15 Sudden death from disease

Most postmortem examinations performed in cases of sudden non-traumatic death disclose a fatal condition related to the cardiovascular system or other lethal lesion. In many cases, when the gross examination fails to reveal an anatomical cause of death, toxicologic studies will disclose that death was related to drug/alcohol use. Thus, the majority of sudden deaths can usually be explained after macroscopic, microscopic and toxicologic examinations.

However, there is a discrete group of cases of sudden death in people under 40 years of age without a demonstrable anatomic or toxicologic cause of death. Some of these cases may be related to channelopathies (e.g., long QT syndrome). In addition, many cardiomyopathies have now been shown to have a genetic basis. Genetic sampling is recommended in cases of young people without an anatomical or suspected toxicological cause of death, and in many cases of cardiomyopathy and some other disorders ([see Section 1.12: Molecular autopsy](#)).

Sudden death may also be related to epilepsy. However, it is usually unnecessary to retain the brain for neuropathologic examination in cases of seizure disorder.

When a reportable communicable disease is diagnosed, this must be reported by the pathologist to Public Health. The list of reportable diseases can be found online by searching for “Reportable Communicable Diseases”.

1.16 Sudden death from injury (non-homicidal)

Many postmortem examinations performed for the coroner relate to major trauma. In these cases, the main objectives of the postmortem examination are to document injuries and to collect samples for toxicologic analysis. The injuries on the body surface and internal injuries must be adequately described in the postmortem examination report. It is unacceptable to simply list injuries without providing a description of the wounds.

The basic description of an injury is both qualitative and quantitative and should include:

- Type (e.g., contusion, abrasion, laceration).
- Location and position (e.g., forehead above the right eyebrow).
- Size, colour and shape (e.g., 5 cm linear horizontal yellow bruise).

In most cases of major blunt trauma and cases with penetrating/perforating wounds, the injuries are best described by anatomical continuity. This method of description uses a narrative that links the external and internal injuries in one section of the postmortem examination report, rather than separating the description of the external and internal injuries.

A basic description of an internal injury should include:

- Type (e.g., laceration, fracture, etc.).
- Organ or anatomic site.
- Associated hemorrhage (e.g., indicate presence of internal or soft tissue hemorrhage and measure the volume of blood in body cavities).
- In cases of hanging (suspension by ligature), adequately describe the ligature mark.

In cases of neck compression, dissection of the neck structures can be performed in situ after the removal of the brain and the thoraco-abdominal organs (layered anterior neck dissection or dry neck dissection). This will decompress the blood vessels of the neck and reduce the likelihood of artifactual hemorrhage. The strap muscles of the neck are sequentially reflected, beginning from the distal end of each individual muscle and dissecting toward the larynx. Intramuscular hemorrhage should be documented. The hyoid bone, thyroid cartilage and cricoid cartilage are then examined for fractures.

In fatal motor vehicle collisions involving pedestrians, measure the distance of injuries of the lower extremities from the heel. In addition, record the presence and location of 'dicing' injuries on decedents recovered from inside vehicles after fatal vehicular collisions.

In cases of drowning, the cause of death is determined by correlation of postmortem examination findings and the circumstantial information and involves exclusionary reasoning.

In all deaths associated with fire, describe the distribution of soot on the mucosa of the respiratory tract (if present). In non-suspicious fires where the carboxyhaemoglobin level has been measured by a hospital lab, it need not be repeated.

The extent of histological examination is left to the discretion of the pathologist. If death has occurred due to a natural condition, histology should be used to provide reviewable documentation of the lethal disease/lesion.

The pathologist may consider retaining a whole organ or a substantial portion of an organ for examination. The permission of the Chief Forensic Pathologist or designate is required if any organ is to be retained ([see Section 1.9: Tissue and organ retention, storage and disposition for procedures including notification of next of kin](#)).

Fixation and retention of an organ may be considered to:

- Determine the cause of death or a significant medicolegal issue (e.g., mechanism of injury) in a case that is likely to enter the criminal justice system.
- Diagnose a heritable, rare or obscure condition or disease that has probable implications for the healthcare of the family.

In most cases, retention of a whole organ and/or a substantial portion of an organ from a medicolegal postmortem examination can be avoided by overnight fixation followed by histologic sampling, with return of the organ to the body before the body is released to the next-of-kin via a funeral home. This is the recommended practice, particularly when a family objects to organ retention.

1.17 Complex cases

Complex cases include:

- Deaths related to therapeutic complications (e.g., death during insertion of a cannula).
- Anesthetic or intra-operative deaths.
- Post-operative death.
- Deaths during or after pregnancy or delivery.
- Deaths after prolonged hospitalization.
- Obscure deaths.
- Cases with competing causes of death.

These cases are often challenging. The postmortem examination may provide the foundation for further analysis by other experts. For example, several specialty committees in the Office of the Chief Coroner review many of these cases after the postmortem examination report is issued. This ensures a multi-disciplinary team approach to some of the complex issues that go beyond the postmortem examination. The pathologist is a key contributor of the postmortem

examination findings to the larger multi-disciplinary team that will analyze the case from varying perspectives.

1.18 Forensic cases (homicides and criminally suspicious cases)

In general, postmortem examinations in homicide and criminally suspicious deaths will be performed in by a Category A forensic pathologist on the OFPS Register of Pathologists at a forensic pathology unit. There are specific guidelines for postmortem examinations in homicide and criminally suspicious cases. Cases to be referred to a Category A forensic pathologist include:

- Homicides and criminally suspicious cases.
- Deaths from penetrating or perforating injury, including gunshot wounds or stab wounds, even when apparently self-inflicted.
- Deaths of children (deaths of children less than 5 years of age due to non-natural causes).
- Deaths of persons where the Special Investigations Unit (SIU) is investigating because of police involvement.
- Multiple fatalities (3 or more) arising from a single incident, other than a motor vehicle collision.
- High profile deaths where significant media attention is anticipated including deaths of well-known public figures.
- Deaths attributed to fires.
- Deaths attributed to infectious diseases¹, where:
 - The agent is unknown;
 - Infectious implications arise for residents either within the local environment (e.g., long-term care); or
 - Infectious implications arise for residents beyond the local environment (e.g., SARS).
- Skeletal remains and/or deaths in uncontrolled environments, such as a body in a forest.
- Aviation related deaths.

¹ *Suspected cases of diseases caused by risky known or newly emerging pathogens may require a medicolegal autopsy for public health purposes. The Forensic Services and Coroners Complex in Toronto has a separate, secure and enclosed suite to provide containment for biosafety risks up to containment level 3 (CL3). This level applies to infectious agents that may cause serious or potentially lethal disease after inhalation such as SARS, tuberculosis, anthrax, plague, tularemia, etc.*

Autopsies on individuals who are suspected to have one of these illnesses should be performed at the FSCC CL3 suite by forensic pathologists at the Provincial Forensic Pathology Unit. A pathologist who asked to do an autopsy on such a case should contact the Regional Supervising Coroner and the OFPS on-call Forensic Pathologist at 416-314-4100 or at 1-855-299-4100.

- Deaths requiring advanced identification methods.
- Deaths where the original pathologist feels the postmortem examination should be conducted by a forensic pathologist.
- Exhumations and second postmortem examinations.

1.19 Postmortem examinations of infants and children (Under 5 Years)

Postmortem examinations of infants and children are performed by Category A forensic pathologists or Category C pathologists on the OFPS Register of Pathologists:

- Homicide/criminally suspicious or accidental deaths of infants or children including all cases of abuse or neglect are performed by forensic pathologists approved for this purpose by the Chief Forensic Pathologist.
- Sudden unexpected death in infancy (SUDI) cases will be performed by a forensic pathologist, or approved by a forensic pathologist to be performed by a pediatric/perinatal pathologist. (Category C).
- Complex known congenital/pediatric diseases, post-operative deaths and deaths from therapeutic complication will usually be performed by a pediatric/perinatal pathologist.
- Perinatal death, defined as death during, at the time of, or shortly after birth, including home birth and death within one week of birth in the case of prematurity are best performed by perinatal pathologists. The placenta should accompany the infant.

The current definition of SIDS is: “the sudden death of an infant one year of age or younger, which is unexpected by the infant's history and where a thorough postmortem examination, including an autopsy, death scene investigation and review of the infant's medical history, fails to demonstrate an adequate cause of death”. The autopsy should not commence until the pathologist is satisfied with the extent of the pre-autopsy information, usually by reviewing the “Death Under 5 Questionnaire” filled out by the coroner.

Postmortem examinations of infants and children should follow the Guidelines for Autopsy Practice: Sudden Unexpected Deaths of Infants and Children Under 5 Years, Second Edition, March 2012 (see Toolkit). The guidelines give details about the special procedures to be followed in pediatric cases:

- Radiological skeletal survey prior to the autopsy must be performed and examined by a Radiologist to exclude the presence of fractures. The body must not be released until the Radiologist's oral report has been received.
- Routine body measurements appropriate for the age group.
- External and internal photographs to document positive and negative findings.

- Systemic internal examination of the head, neck, chest, abdomen and pelvis with documentation of organ weights and recommended histological sections.
- Ancillary testing in all cases including toxicology, microbiology, metabolic/genetic screening:
 - Vitreous fluid should be obtained and can be used for potential biochemical analysis at the discretion of the pathologist.
 - Other ancillary tests (e.g., skin fibroblast culture) or the retention of other tissue samples at the discretion of the pathologist.

Decision-making around organ donation in deaths of infants can be complicated and requires discussion between a forensic pathologist and a Regional Supervising Coroner ([see Section 1.26: Organ and tissue donation](#)).

1.20 Final postmortem examination report

The postmortem examination report (Report of Postmortem Examination) is prepared using standardized headings to ensure provincial consistency. A suggested template is available in the Toolkit. The standardized sections are as follows:

- Demographic and related information.
- History provided to pathologist.
- Identification.
- External examination.
- Signs of recent injury.
- Internal examination.
- Ancillary tests.
- Tissue retention:
 - Details regarding retained whole organs must be noted in the postmortem examination report.
 - Example of tissue retention statement: “Small tissue samples have been retained in formalin. No whole organs have been retained.”
- Summary and opinion.
- Cause of death.
- Signature.

In the ‘Summary and Opinion’ section of the report the pathologist should briefly explain the rationale or basis for the major conclusions reached, including the cause of death.

Cause of death

Whenever possible the cause of death statement should follow WHO guidelines using ICD10 nomenclature (i.e., 1(a) due to 1(b), etc.). There are some exceptions:

- Deaths that are causally best described in a descriptive statement.
- Deaths related to therapeutic complications. The recommended formulation is "A complicating B for the treatment of C" where A is the immediate cause of death arising from B, which denotes the medical or surgical procedure performed, due to a disease, condition or injury denoted by C (e.g., hemopericardium from right ventricle perforation complicating Swan-Ganz catheterization for the treatment of multiple trauma).

1.21 “Unremarkable”

If an organ or tissue is free of macroscopically apparent lesions, it can be described as “unremarkable” or a similar term. If an organ or tissue is “unremarkable”, this implies that it has been removed, dissected and examined. If an organ has not been removed, dissected and examined, the report must indicate that the organ was “not examined” (e.g., hyoid bone, tongue, prostate, uterus, urinary bladder). The postmortem examination report should accurately reflect the extent of the internal examination. The OFPS strongly encourages examination of all organs, including those listed above, at all postmortem examinations.

1.22 Timeliness of final postmortem examination reports

Postmortem examination reports must be completed in a timely manner. However, submission of preliminary postmortem examination reports (not fully informed by ancillary testing, such as toxicology) is discouraged.

Timeliness of postmortem examination reports is a key performance indicator. Turnaround time is influenced by case complexity, return of ancillary test results, pathologist workload and staffing levels. The OFPS policy regarding turnaround time is:

- Ninety percent (90%) of autopsy reports are to be completed within 90 days of the day of the postmortem examination.
- Cases involving homicides, pediatric deaths, deaths in custody and cases in which the coroner has requested that the report be prioritized (due to requests from family or other parties) are to be expedited as a matter of routine.

- No more than 10% of cases should be greater than six months old. There must be a justifiable reason (e.g., delays caused by molecular autopsy for channelopathy, etc.) for delay in those cases.

1.23 Submission of Report of Postmortem Examination to the OFPS

A copy of each Report of Postmortem Examination must be provided to the investigating coroner, Regional Supervising Coroner's Office and to the OFPS for quality assurance. The report must include all ancillary testing results and the Warrant for Postmortem Examination. Associated invoices are submitted to the Regional Supervising Coroner for payment.

1.24 Amendment of reports

For various reasons, a Report of Postmortem Examination may require amendment. The reasons may vary from the misspelling of a name to a substantial misinterpretation of the circumstances or the autopsy findings.

If a substantial error or inaccuracy is discovered after the report has been distributed, an amended report must be issued. The new report must be marked "Amended Report" at the top of the first page and must indicate "This report replaces the report dated (date)".

The amended report must make clear what amendments have been made to the original report. The amended report should be submitted using the usual procedure. The original report and the amended report are retained in the case file.

Changes or amendments to reports are not to be made for reasons other than correction of errors or inaccuracies. Reports must not be amended merely at the request of a client.

1.25 Retention of records

The retention of records from a postmortem examination including the Report of Postmortem Examination, notes and diagrams, ancillary test results and images is as follows:

Type of Death	Retention Period
Homicide	At least 50 years following completion of final report
All other deaths	At least 20 years following completion of final report

1.26 Organ and tissue donation

The OFPS and the Office of the Chief Coroner support organ and donation for transplantation whenever possible.

Category B pathologists who are asked about possible organ or tissue donation should contact the on-call OFPS Forensic Pathologist by calling Provincial Dispatch at 416-314-4100 or at 1-855-299-4100.

Discussion about organ/tissue donation needs to occur between a Category A pathologist, investigating coroner and Regional Supervising Coroner to ensure that issues raised by the death investigation can be addressed by the autopsy following harvesting.

2. Practices for homicide and criminally suspicious cases

2.1 Indications

This section describes the guidelines that are applicable to postmortem examinations in criminally suspicious cases or homicides. Application of specific guidelines will depend on the case (e.g., routine histology cannot be performed on skeletonized bodies) and judgment of the pathologist.

These guidelines should be followed for autopsies of individuals who die in criminally suspicious circumstances or where the scene appearance or history raises concerns about an un-natural or violent death. These may include suspicious or obscure deaths such as:

- Obvious homicides.
- No readily apparent cause of death, indicating the possibility of mechanical asphyxiation (e.g., strangulation).
- The body is in a concealed location, including apparently 'dumped' bodies.
- The body is in an uncontrolled environment (e.g., found in a public place, outdoors, naturally occurring bodies of water, unlocked premises).
- Any other case that the forensic pathologist deems appropriate.

In practice, most cases that are initially criminally suspicious will be revealed to be sudden natural deaths or deaths related to drug/alcohol intoxication. However, it is important to keep an open mind to the possibility of a concealed violent death. On this basis, it is recommended that the pathologist have a low threshold for performing special dissections and collecting biological samples.

2.2 The scene

When the body is still *in situ* at a scene, the forensic pathologist may attend the scene. Under the Coroners Act, a pathologist may enter and inspect any place where a dead body is and examine the body.

When the body has been removed, examination of the scene may provide useful information, even after the postmortem examination has been carried out. Under the Act, a pathologist may enter and inspect any place from which the pathologist has reasonable grounds for believing a body was removed.

If consulted about a homicide or criminally suspicious death, the pathologist should carefully consider attending the scene. When a scene has not been attended, photographs, video recordings and other imaging techniques should be made available in the subsequent briefing of the forensic pathologist, prior to the postmortem examination.

2.3 Pre-postmortem examination briefing with investigators

Pathologists should ensure that investigators and coroners provide the available details regarding the circumstances of the death. This briefing should be done before the postmortem examination or at the scene. The briefing should include witness accounts, as well as any explanation advanced by a suspect. The briefing can be augmented by the Preliminary Police Report form to facilitate information sharing between police and pathologists.

Adequate and appropriate briefing is essential if pathologists are to glean the maximum information from the postmortem examination since the postmortem examination alters the body. If pathologists are not told of a possible explanation in advance of the postmortem examination, the evidence to confirm or contradict the explanation may no longer be available.

Pathologists must not assume that any of the explanations that have been advanced for the death is necessarily correct. However, the information from the briefing can be essential in forming properly reasoned conclusions and/or deciding the scope of ancillary testing.

Pathologists must record any briefing given to them in sufficient detail to enable the pathologist (or some other individual) to understand the main issues raised in the briefing.

2.4 External examination, photography and sample collection

Initial photographs should include the continuity seal and the body clothed and with any medical paraphernalia still attached.

A minimum set of photographs of the body should be obtained in all cases, since the absence of injuries may be as relevant to the case as the presence of injuries:

- Face.
- Conjunctivae.
 - Labial mucosa (inner surface of lips).
- Neck.

- Anterior surface of entire body.
- Posterior surface of entire body.
- Dorsum of hands.
- Palms of the hands.
- Wrists.
- All external injuries should be photographed with scale.

External samples are to be obtained at the discretion of the pathologist after discussion with investigators:

- Any trace evidence, including loose hairs and fibers.
- Hair sample.
- Fingernail clippings.
- Any visible stains on the body, particularly on the face, genitalia, perineum or thighs.
- Any visible clumped pubic hair.
- Swabs and smears from the mouth.
- Swabs and smears from the vagina or penis.
- Swabs and smears from the anus/rectum.

Fingernail clippings must be obtained with a new disposable, sterile nail clipper using a separate clipper for each hand. The nail clippings and nail clippers should be submitted together to the laboratory in a sealed envelope.

All physical exhibits (e.g., trace evidence and swabs) collected at postmortem examination should be transferred into the custody of the police at the conclusion of the gross examination. The only items that should be retained in the custody of the pathologist are tissues or organs (where approved, [see Section 1.9: Tissue and organ retention, storage and disposition](#)) for further pathologic or histologic examination.

2.5 Dissection

Perform internal examination of the head, chest, abdomen, pelvis and neck. In many cases, it is helpful to perform a layered dissection of the anterior neck. Other special dissections are performed as required.

2.6 Histology, ancillary testing and consultations

Collection of the following samples, if available, is required:

- Blood from heart.
- Blood from femoral blood vessels.
- Urine.

In cases with hospitalization, blood drawn at admission (and prior to transfusion) may be the best sample for toxicologic testing. In these cases, it is appropriate to discuss with the coroner sample procurement. Vitreous fluid can be obtained and can be used for biochemical studies.

Routine histology and toxicology are performed in all homicide and criminally suspicious cases, as determined by the state of the body.

2.7 Death associated with restraint

The section describes the guidelines for the postmortem examination of an individual who dies suddenly during restraint or physical struggle, often with law-enforcement officers. Such individuals may appear agitated or aggressive or have features indicative of excited delirium. These guidelines also apply to restraint-related deaths that occur in other circumstances such as medical/psychiatric therapy. These guidelines should be used in cases where death follows the use of one or more of the following:

- Pepper spray.
- A conducted energy weapon (e.g., Taser).
- Hand or ankle cuffing.
- Hogtying.
- Neck holds (e.g., carotid sleeper hold).
- Prone-positioning.

The body may be examined using an alternate light source prior to postmortem examination. Lesions that may be related to conducted energy weapon use (electrothermal lesions or penetrating injuries from electrode deployment) should be photographed, described, measured (including the clearance between the lesions) and studied histologically. If patterned injuries are present (e.g., tram-track contusions), appropriate photographs using a scale are essential.

In all cases, the following external samples are to be obtained:

- Any trace evidence.
- Pulled scalp hair.

- Fingernail clippings.
- If there is reason to believe that law-enforcement officers used pepper spray, swabs of periorbital skin can be collected.

Internal examination of the head, neck, chest, abdomen and pelvis is performed. The entire gastrointestinal tract must be opened to determine if foreign objects are present. The following special dissections should also be performed and documented photographically:

- Layered dissection of the anterior neck and face.
- Layered dissection of the anterior torso.
- Layered dissection of the posterior neck and posterior torso.
- Removal of the testes with dissection of the tunica vaginalis and testicular parenchyma.
- Other special dissections, including dissection of the extremities, at the discretion of the forensic pathologist.

The hyoid-larynx complex can be radiographed, even if no fracture is visible.

Routine histologic sections should be obtained and additional sections can be submitted as follows:

- Skin and subcutaneous fat: documentation of injuries as deemed appropriate by forensic pathologist.
- If significant fractures or injury to subcutaneous fat are found at postmortem examination, the forensic pathologist should consider histologic studies for fat embolism.
- Any additional histologic sections deemed appropriate by the forensic pathologist.

In appropriate cases, a postmortem blood sample should be collected and submitted for hemoglobin electrophoresis. In all cases, vitreous fluid should be obtained and can be submitted for biochemical analysis. Comprehensive toxicologic testing should be performed in all cases.

2.8 Death associated with sexual violence

Rape-homicides are rare, but must be recognized by the forensic pathologist since such cases may not be identified until a postmortem examination is performed. It is important to have a low threshold for performing special dissections and collecting biological samples in any case that could reasonably be related to sexual assault. Inclusion criteria for application of these guidelines include:

- Indication or suspicion of sexual assault at the scene of body recovery.
- The lower body garments, including underwear, are disturbed, torn or cut.
- Death of a female or child that may be due to manual or ligature strangulation.
- Some cases with human bite marks.
- Most cases of nude bodies in uncontrolled environments.

The potential value of examination of the body with an alternate light source should be considered and discussed with the forensic identification officer. If performed, appropriate evidentiary samples should be obtained.

A special survey for bite marks should be made. If a suspected bite mark is found, appropriate biological swabs should be obtained. Consultation with a forensic odontologist is required prior to manipulation of the bite mark or dissection of the body, since special photography is usually required.

In all cases, the following external samples are to be obtained:

- Any trace evidence, including loose hairs and fibers.
- Any physical evidence or samples of stains revealed by the alternate light source.
- Hair sample.
- Fingernail clippings.
- Swabs and smears from the mouth.
- Swabs and smears from the vagina or penis.
- Swabs and smears from the anus/rectum.
- Any visible stains on the body, particularly on the face, genitalia, perineum or thighs (dry and wet).
- Any visible clumped pubic hair.
- Any ligature marks may be sampled using the taping method.
- Any bite marks should be swabbed before washing the body.

Internal examination will usually include the following dissections with appropriate photographic documentation:

- Layered dissection of the anterior neck and face.
- Layered dissection of the posterior neck and posterior torso.
- Layered dissection of the pelvic organs with en bloc excision of the external genitalia (female only), perineum (male and female) and anus (male and female) must be performed, if injuries are found or suspected to be present. The specimen can be provisionally dissected at postmortem examination, and then immersion- fixed in formalin for definitive dissection after fixation.
- Consider dissection of the extremities (e.g., wrist and ankle ligature marks).

If key injuries are found after examination of the formalin-fixed genital-pelvic specimen, then a police photographer can return to photograph the specimen. This will ensure that the photographic record is complete. Otherwise, if the pathologist obtains photographs, these should be disclosed.

If the hyoid-larynx complex is fractured, radiographs may be obtained. Routine histologic sections of major organs and tissues should be prepared. Additional considerations include:

- Skin, subcutaneous fat, and skeletal muscle: documentation of injuries as deemed appropriate by the forensic pathologist.
- Pelvic organs: if injuries are present, the injuries should be studied using representative sections.
- Anus: if anorectal injuries are present, it is essential that they be confirmed histologically. All histologic sections should be 'trimmed in' after formalin-fixation of the pelvic specimen to avoid histologic artifacts.
- Any additional histologic sections deemed appropriate by the forensic pathologist.

Vitreous fluid should be obtained and routine toxicology should be performed.

2.9 Blunt trauma of head or body

These guidelines should be used in the following types of cases:

- Blunt impact head trauma.
- Homicidal beating, including punching, kicking and stomping.
- Bodies with unexplained widespread acute bruising.
- Custodial death with injuries that might relate to baton impacts.
- Selected cases of vehicular impact or alleged fatal descent from height.

Criminally suspicious cases or homicides with blunt force injuries may also have other types of injuries. For example, the beating of a child might well be an asphyxial death or sexual assault.

Consider examining the body with an alternate light source prior to postmortem examination. Any relevant items such as physical exhibits or stains must be collected and submitted to police. Some exceptions to this include cases of vehicular impact or cases with prolonged hospitalization.

Internal examination of the head, neck, chest, abdomen and pelvis is performed. In cases where blunt injuries are widespread (i.e., not concentrated on the head), the forensic pathologist performs the following special dissections:

- Layered dissection of the anterior neck and face.
- Layered dissection of the anterior torso (i.e., such as in stomping and kicking injuries).
- Layered dissection of the posterior neck and torso.

In the case of blunt impact head trauma with injuries that could have been caused by a specific instrument(s), the following should be considered:

- Additional scale photographs of the scalp injuries.
- Shaving of hair to allow better demonstration of the wounds.
- Removal of the pericranial membrane to allow precise photography of the fracture pattern (e.g., pond fractures and intersecting fracture lines).
- Depressed fractures should be carefully photographed and measured, particularly if the pattern is characteristically geometric in appearance. Consider en bloc excision of depressed fractures or mold-casting of the depressed fractures.
- Consider obtaining the assistance of a forensic anthropologist to assist in reconstructing extensively fragmented skulls. This may facilitate determining the number of individual impact sites, if there are overlapping injuries, and can assist with a detailed assessment of basal skull fracture patterns.

With the approval of the Chief Forensic Pathologist or designate, the pathologist may retain the brain for examination after fixation (see [Section 1.9: Tissue and organ retention, storage and disposition for procedures including notification of next of kin](#)). The pathologist must notify the coroner orally and in writing (Notification to Coroner of Organ Retention Form) at the conclusion of the postmortem examination to ensure the family is notified and they provide disposition instructions. The preliminary and final postmortem examination reports must indicate that the brain was retained. After notifying the coroner orally and in writing, the pathologist may elect to refer the brain to a consultant. Fixation and retention of the brain is recommended if there is:

- A significant survival interval in hospital.
- Neurosurgical intervention.
- A clinical diagnosis of diffuse axonal injury.
- Hypoxic change, which makes cutting the brain in the fresh state impractical.
- A need to facilitate macroscopic documentation and histologic sampling of injuries.

If traumatic subarachnoid hemorrhage or post-traumatic cerebral infarction is present, consider removal of the vertebral arteries. The two most common methods are en bloc excision of the base of skull and cervical spine, or segmental excision of the vertebral arteries. If removed segmentally, segments to be excised include: distal intracranial (present at the base of the brain, after

brain removal); proximal intracranial (need to be excised from the foramen magnum once brain is removed); transitional or distal extracranial segment after the artery emerges from the cervical spine; the intraosseous extracranial segment; and the point of origin of the extracranial segment at the subclavian arteries.

Routine histologic sections should be obtained, including representative sections of the brain and its coverings and focal injuries. Routine toxicologic testing will be performed. Blood from sequestered hematomas should also be collected (e.g., subdural hematoma).

2.10 Penetrating or perforating trauma from projectiles or sharp instruments

The body should be radiographed (conventional radiography or real-time fluoroscopy) prior to postmortem examination. The clothing should be examined for defects and bloodstains that correlate with injuries on the body.

All external evidence of injury should be photographed with scale. It is particularly important to photograph the external wounds of all penetrating and perforating injuries using both regional photographs to demonstrate the anatomical location of the wounds, and close-up photography to show the wound features.

Gunshot residue sampling can be performed on the hands, if applicable. The police will perform the sampling. The forensic pathologist should consider sampling bloodstains on the surface of the body, particularly in cases of sharp force injury.

Internal examination of the head, neck, chest, abdomen and pelvis is performed. Dissection and examination of the internal wound paths should include:

- Assessment of the direction of the wound path in three dimensions.
- Documentation of internal injuries and measurement of volumes of blood in body cavities.
- Recovery of all projectiles if relatively intact. In the case of birdshot, a representative sample is obtained. If a bullet has fragmented, the lead core, main fragment and/or a portion of a jacket can be sampled.
- In the case of shotgun wounds all wadding should be recovered.
- In the case of stab wounds, the depth should be measured, if possible.
- In the case of stab wounds, the tip of the sharp instrument may be found embedded in bone. Such tips should be collected and retained.

Routine histology and toxicology should be performed. If organs were removed for transplantation or during emergency surgery it may be helpful to examine the

organs if available (e.g., not transplanted or disposed of). The regional coroner can assist in obtaining such organs.

2.11 Suspected child abuse

These guidelines are to be used in the following types of cases:

- Known history of child abuse.
- Unusual/suspicious scene.
- History of an unusual fall or 'accident'.
- Poor hygiene, lice infestations or other evidence of neglect.
- Cachexia or dehydration of unclear nature.
- Bruising or other injuries of unclear nature.
- Thermal burns or scalds of unclear nature.
- Prior sudden and unexplained infant death in a sibling.
- History of recurrent life-threatening episodes (ALTE).

In general, the pathologist must keep an open mind to the possibilities of occult violent death, child abuse, sexual assault, maltreatment and neglect. On this basis, it is recommended that the pathologist have a low threshold for performing special dissections and collecting biological samples.

The pathologist should consider the special challenges of pediatric forensic pathology, which include (but are not limited to):

- The pathology of the different forms of acute and chronic physical child abuse.
- The pathology of neglect and starvation.
- The evolving nature of forensic pathology of infantile head injury, including the so-called 'shaken baby syndrome'.
- The pitfalls of postmortem examination diagnosis of mechanical asphyxia in infants and small children (i.e., the problems with under- and over-diagnosis).
- Issues related to the medicolegal interpretation of multiple fractures.
- Postmortem and postmortem examination artifacts that can be over-interpreted as injuries (e.g., postmortem anal dilation).
- The scope and limits to the use of histology for dating injuries.
- Diseases and conditions that can mimic child abuse.

Pathologists who suspect child abuse have a legal obligation to personally report the case to the relevant Children's Aid Society "forthwith".

Pathologists performing postmortem examinations on infants and children should carefully balance the physician's role as patient or child welfare advocate and the forensic pathologist's special duty to provide unbiased evidence to the criminal justice system as expert witnesses.

2.12 External examination, photography and sample collection

A standardized radiographic skeletal survey should be performed prior to postmortem examination. The skeletal survey should be assessed by a radiologist and reported to the pathologist, ideally before dissection commences and in all case before the body is released. Bones showing radiological abnormalities suspicious for trauma should be excised for specimen radiography and histologic examination after de-calcification.

An external examination is performed according to the standard practice of forensic pathology. Appropriate body measurements should be obtained.

The potential value of examination of the body with an alternate light source should be considered and discussed with the forensic identification officer. If performed, appropriate evidentiary samples should be obtained.

Pertinent photographs should be obtained. Photographic services will be provided by the police identification officer. The pathologist may elect to obtain additional photographs not obtained by the police, but the existence of these photographs should be disclosed in the postmortem examination report. The minimum set of photographs should include:

- Overview – anterior and posterior surfaces of entire body.
- Face – overview of anterior, right and left sides; close-up views of ears; nose and philtrum; ocular conjunctivae; lips; and inner labial mucosa / frenula.
- Neck – anterior, posterior and sides.
- Hands – dorsal and palmar aspects.
- Wrists – ventral, dorsal and lateral aspects.
- Feet.
- External genitalia / perineum, including anus, buttocks and medial thighs.

All injuries including patterned injuries should be photographed with an appropriately positioned scale.

A survey for bite marks should be made. If a suspected bite mark is found, appropriate biological swabs should be obtained, including a control swab. Consultation with a forensic odontologist prior to manipulation of the bite mark or dissection of the body is required.

The following external samples can be obtained as indicated:

- Any trace evidence, including loose hairs and fibers.
- Swabs of any stains/secretions particularly on the face, genitalia, perineum or thighs as noted by the naked eye or revealed by the alternate light source examination.
- Pulled scalp hair.
- Cutting or scrapings of the fingernails.
- Swabs and smears from the mouth.
- Swabs and smears from the vagina or surface of the penis.
- Swabs and smears from the anus.

2.13 Dissection

An internal examination of the head, neck, chest, abdomen and pelvis is performed. In many cases, the following special dissections with photographic documentation are indicated:

- Layered dissection of the anterior torso.
- Forensic dissection of the anterior neck and face.
- Forensic dissection of the posterior neck.
- Forensic dissection of the posterior torso.
- Forensic dissection of the extremities.

If sexual assault is suspected, then special dissection of the pelvic organs with en bloc excision of the external genitalia (female only), perineum (male and female) and anus (male and female). The specimen can be provisionally dissected at postmortem examination, and then immersion fixed in formalin for definitive dissection after fixation if indicated.

Other special dissections may be performed, including:

- En bloc excision and fixation of a liver-pancreas-duodenal specimen.
- Excision and fixation of fractured ribs or the ribcage.
- En bloc excision and fixation of epiphyses-metaphyses in cases with radiological evidence of metaphyseal lesions. Contralateral long bone segments are also to be excised for comparison purposes.

In most cases, retention of the brain and spinal cord can be avoided by overnight fixation followed by histologic sampling, with return of the organ to the body

before the body is released to the next-of-kin via a funeral home. This is the recommended practice, particularly when a family objects to organ retention.

If there is evidence of head injury, authorization by the Chief Forensic Pathologist or designate may be given to retain the brain, spinal cord and eyes with retro-bulbar optic nerves and extra-ocular muscles and fat for examination after fixation ([see Section 1.9: Tissue and organ retention](#)).

2.14 Tissue retention, histology and ancillary testing

The brain and spinal cord (+ eyes) may be retained with authorization for examination after formalin fixation. Retention of any other organ for specialty consultations also requires the authorization of the Chief Forensic Pathologist or designate ([see Section 1.9: Tissue and organ retention](#)).

Histological sections are submitted as follows:

- Heart: sufficient sampling sections.
- Lung: at least one section from each lobe.
- At least one each of liver, kidney, spleen, adrenal gland, thyroid gland, pituitary gland, gastrointestinal tract, stomach, pancreas, lymph nodes.
- Brain: to include at least sections of cerebral cortex; basal ganglia; hippocampus; midbrain/pons; cerebellum; deep cerebral white matter; and spinal cord.
- Pelvic organs: if injuries are present, the injuries should be studied using representative sections.
- Anus: if ano-rectal injuries are present.
- Eyes and optic nerves (if retained).
- Bone and bone marrow, including any fractures, recent or old.
- Skin, subcutaneous fat, and skeletal muscle: documentation of injuries as deemed appropriate by pathologist.
- Any other histological sections as deemed appropriate by the pathologist.

If fractures or significant injuries to subcutaneous fat are found at postmortem examination, the pathologist should consider histologic studies for fat embolism.

3. Postmortem examination report in homicide and criminally suspicious cases

3.1 Structure of the report

The postmortem examination report (Report of Postmortem Examination) will be prepared using standardized headings to ensure provincial consistency:

- Demographic and related information.
- Qualifications.
- Declaration.
- History provided to pathologist.
- Scene.
- Procedures.
- Identification and Continuity.
- External examination.
- Signs of recent injury.
- Internal examination.
- Ancillary tests.
- Supplementary Information.
- Summary and opinion.
- Cause of death.
- Signature.

3.2 Demographic and related information

This section includes: name, age and sex of decedent including relevant accession numbers and name of coroner. Give date of postmortem examination and names of attendees, including assistants and investigators.

3.3 Qualifications

This is a brief synopsis of your curriculum vitae including qualifications, appointments, present and past positions and the nature of your expertise.

3.4 Declaration

The declaration statement states the nature of your duty, such as:

In preparing this report and in giving oral evidence, I understand that my primary duty is to the court. I have complied with and will continue to comply with that duty. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters that I regard as relevant to the opinions I have expressed.

The postmortem examination is performed under a Coroner's Warrant for Postmortem Examination, using the Ontario Forensic Pathology Service Practice Manual for Pathologists (2014).

3.5 History provided to the pathologist

This is a brief summary of information provided by the police, coroner, medical records and other sources. In this section, the pathologist will specify both the information and the source of the information.

3.6 Scene

If the pathologist attended the scene, a brief scene description should be included. If the pathologist did not attend the scene, but digital images were reviewed before the postmortem examination, give a brief description of the scene from the digital images.

3.7 Procedures

Required only in cases with special procedures (describe or list special procedures, e.g., special dissections, alternate light source examination).

3.8 Identification and continuity

Indicate how the body was identified to the pathologist. Describe continuity.

3.9 External examination

The pathologist has discretion on how to present the findings of the external examination (e.g., narrative description or by sub-headings).

3.10 Signs of recent injury

The pathologist has discretion on how to present the injuries (e.g., narrative description or by sub-headings). Description of penetrating or perforating injuries in continuity is encouraged.

3.11 Internal examination

The pathologist has discretion on how to present the findings of the internal examination although systemic headings and organ subheading are encouraged.

If an organ or tissue is free of macroscopically apparent lesions, then the organ or tissue can be described as “unremarkable” or a similar term. If an organ or

tissue is “unremarkable”, this implies that it has been removed, dissected and examined. If an organ has not been removed, dissected and examined, then the postmortem examination report must indicate that the organ was “not examined”. The postmortem examination report should accurately reflect the extent of the internal examination.

3.12 Ancillary testing

In this section, describe the results of ancillary testing and histology under specific subheadings. List any whole organs retained (with authorization). List the toxicologic samples and other biological samples provided to the police and provide seal numbers for samples (tabular format).

3.13 Supplementary information

In this section, summarize any other supplementary activities. This might include a summary of post-postmortem examination information that was obtained in a case conference.

3.14 Summary and opinion

The postmortem examination report should include a written opinion in all cases. The extent and nature of the opinion will be dictated by the circumstances of the case. However, the pathologist must provide, at a minimum, an opinion that canvasses the medicolegal issues that are raised by the history and postmortem findings. The reasoning for the opinion, including the cause of death, should be explained if the cause of death is not self-evident. Typical medicolegal issues that could be discussed in a homicide case include: mechanism of injury and death; how the injuries occurred; issues related to nature and use of a weapon; timing of injury and death; presence/absence of defensive types of injuries; and if disease or intoxication contributed to death. In some cases it will be important to identify and briefly discuss the evidentiary or scientific issues that might make your opinion controversial or less certain. In such cases, the reader should be given an indication of the strength of your opinion. Obviously, it will not be possible to predict all medicolegal issues that might be important in the case.

The postmortem examination report in homicide cases is not written only for other physicians. Since the prosecutor and defense lawyer will read your report, your opinion must be set out in language that can assist the reader. Carefully consider the language you use to communicate your opinion (e.g., ‘consistent with’) and to give a balanced view of causal possibilities. If a specific conclusion is offered, but there is an alternate explanation or conclusion, it is often helpful to explain why one alternative is preferred over another.

Expert opinions should, whenever possible, be evidence-based and not only informed by anecdotal experience. The pathologist must ensure that all postmortem examination findings that form the basis of the opinions are documented in a form that can be reviewed by other pathologists (e.g., macroscopic photography, histology). The pathologist must not base any expert opinion on untested/untestable evidence, such as reported confessions or assumptions that cannot be independently validated or corroborated by other evidence. It is best to avoid a 'default diagnosis'.

The emphasis on the independent, objective and evidence-based approach in forensic medicine can be viewed as a commitment to *think truth*. The pathologist's duty is as an independent expert witness to the court. This duty does not include intentionally advancing opinions that are beneficial either to the prosecution or defense.

Facts may emerge during the death investigation, sometimes even in the course of a trial, which may make it appropriate that the pathologist modify an originally held opinion. The pathologist has a duty to give any new facts due consideration and ensure that his or her opinion remains objective and unbiased. If previously held conclusions can no longer be upheld, an amended opinion must be promptly and clearly stated. In these circumstances, an amended report should be written and submitted ([see Section 1.24: Amendment of reports](#)).

When opinions are based, in whole or in part, on consultation with other experts, those experts as well as the content of the opinions expressed by them should be acknowledged. The consulted experts should express in writing, where feasible, any significant findings or opinions they contributed.

3.15 Cause of death

The cause of death must not be speculative. In the cause of death statement, do not use terms such as: asphyxia, consistent with asphyxia and homicidal violence of undetermined etiology. If the cause of death cannot be objectively determined by combining information from the history, postmortem examination and ancillary testing, then the cause of death should be listed as unascertained or undetermined or equivalent. The pathologist must not base any expert opinion on untested/untestable evidence such as reported confessions or assumptions that cannot be independently validated or corroborated by other evidence.

The cause of death statement should be set out in the WHO or 'death certificate' format (i.e., 1(a) due to 1(b), etc.), whenever possible. Do not use conventions that are not universal (e.g., bracketing terms that derive only from the clinical history).

3.16 Peer review

All draft reports of postmortem examination from homicides and suspicious cases must be peer reviewed before they are finalized and submitted ([see Section 5.5: Peer review of postmortem examination reports](#)).

3.17 Signature

The final report should be signed and dated.

4. Guidance on special dissections

4.1 Anterior neck

- Leave the upper “Y” portion of the primary postmortem examination incision unreflected until the neck is ready for special dissection.
- The anterior neck is dissected after the brain is removed and the torso is eviscerated. The neck is elevated such that the venous system is adequately drained.
- Make an incision from the shoulder tips, along the sides of the neck (just posterior to the anatomical course of the sternomastoid muscle) such that the incisions join the scalp incision used to remove the brain. Typically, the scalp incision joins the incision made along the sides of the neck at the mastoid process (behind the ear).
- The skin of the sides of the neck and the anterior neck can be reflected by incising the subcutaneous fat/platysma layer. This is most readily done by first reflecting the skin at the sides of the neck to the level of the jaw and then reflecting the skin of the anterior neck to the level of the chin. It is helpful to have an assistant rotate the head in the direction away from the side that is being dissected.
- Once the entire anterolateral neck is exposed, the skin of the cheeks can be reflected. The facial skin is reflected by cutting through the external auditory canal and continuing the subcutaneous incisions to the level of the nose and lateral canthus (eye).
- A complete dissection of the face can be performed by further careful reflection/dissection. However, this is seldom necessary since the majority of the face is dissected by elevating the skin of the cheeks.
- Once the entire anterolateral neck is exposed, there will be a relatively thick fibrous/fibrofatty membrane over the superficial strap muscles in the midline. This membrane should be removed by dissection.
- Each strap muscle can now be elevated and reflected superiorly (i.e., cutting the origin of the muscle, but leaving the muscle attached to the anatomical insertion point).
- The hyoid and laryngeal cartilages are exposed *in situ* to determine if fractures are present. This may involve removal of the thyroid gland.
- Eviscerate the neck organs with the tongue by incising the floor of the mouth along the mandible. The neck organs can now be removed.

4.2 Posterior neck

- The body should be placed prone and elevated such that the neck appears slightly flexed.
- The posterior neck is dissected using an inverted “T”-shaped incision along the nape of the neck. The vertical portion of the inverted “T”-shaped incision extends along the midline from the occiput to the spinous process of the 7th cervical vertebra. The lower horizontal portion extends from shoulder to shoulder over the scapulae and passes over the spinous process of the 7th cervical vertebra.
- The skin is reflected laterally such that two large flaps are created. Once the skin is reflected the trapezius muscles will be visible.
- Compared to the strap muscles of the anterior neck, the muscles of the posterior neck are more numerous with complicated anatomical courses. On this basis, it is convenient to approach dissection of the layers of the posterior neck using the following muscular groupings: superficial, intermediate, deep paraspinal and deep subcapital.
- Elevate the superficial and intermediate muscles in layers. It is critical to keep the dissection field wide at all levels; otherwise the deep dissection field will be too narrow to examine the upper neck ligaments.
- Once the superficial and intermediate muscles are elevated, the deep paraspinal muscles on the surface of the cervical spine will remain, along with the deep subcapital muscles.
- Dissection of the deep paraspinal and subcapital muscles requires excision of the muscles from the surface of the vertebrae, since the deep subcapital muscles insert onto the spinous processes of the atlas and axis. This dissection will reveal the deep cervical spinal ligaments, dorsal surfaces of the cervical vertebrae and the transitional segment of the extracranial vertebral artery.
- The atlanto-occipital and atlanto-axial ligaments can be easily identified and assessed for integrity and hemorrhage.
- If indicated, the vertebral arteries and the cervical spinal cord can be removed.
- It should be noted that artefactual hemorrhages are often present in the deep posterior-lateral neck muscles if a special anterior neck dissection was performed. Similar changes can be found near the mastoid at the terminal of the scalp incision used to remove the brain. It is important not to over-interpret such findings.

4.3 Back

- The body is placed prone. It is often helpful to elevate the chest.
- The posterior neck is dissected as outlined above ([see Section 4.2: Posterior neck](#)).
- An inverted “Y”-shaped incision is made along the posterior midline such that the main part of the incision extends from the spinous process of the 7th cervical vertebra (from the inverted “T”-shaped incision) to the coccyx and then over the gluteal regions (i.e., the arms of the “Y”).
- The skin is reflected laterally such that two large flaps are created along the sides of the torso. In addition, two smaller lateral flaps are created at the posterior neck; the skin of the medial buttocks is also reflected
- The superficial muscles of the back (trapezius, latissimus dorsi, superficial muscles of the scapulae and superficial cervical paraspinal muscles) can be elevated to expose the intermediate and deep musculature.
- The muscles of the scapular region are incised, including the deep muscles at the deep portion of the chest. This requires ‘winging’ or complete elevation of the scapula by incision of the muscular attachments of the scapula to the back musculature.
- The intermediate deep muscles of the posterior neck and back and the gluteal muscles can be elevated individually or examined using multiple parallel longitudinal incisions that run along the length of the muscle.
- The deep paraspinal muscles are incised along the vertebral column; the neural arches and spinous processes are palpated.
- The posterior convexity of the ribcage is exposed and the ribs are examined.
- The spinal cord can be removed using the posterior approach, if indicated.
- If the dissection of the back needs to be supplemented by dissection of the limbs, then skin incisions can be extended from the inverted “T”-shaped incision and the inverted “Y”-shaped incision to the wrists and ankles, respectively. It is important to correlate any area of acute subcutaneous hemorrhage on the limbs with intravenous needle punctures (e.g., hospitalization or field resuscitation). This will ensure the areas of bruising are not iatrogenic, but are more likely related to an injury.

C

Section C - Quality Assurance

5. Quality Assurance for Postmortem Examinations

The OFPS has a robust quality assurance program comprised of the following:

5.1 Practice guidelines

The pathologist uses these practice guidelines for homicides, criminally suspicious and routine cases to demonstrate a commitment to a uniform approach to the quality of forensic pathology in Ontario. Standardized reporting templates and forms are available in the Pathologist 'Toolkit'.

5.2 Pathologist Register

Under the *Coroners Act*, medicolegal autopsies may be performed only by pathologists who are appropriately credentialed and registered by the OFPS. On the basis of their qualifications, registered pathologists may be approved by the Chief Forensic Pathologist to perform:

- All medicolegal autopsies including homicide and criminally suspicious cases (Category A).
- Routine cases only (Category B).
- Non-suspicious pediatric cases (Category C).

5.3 Consultation

The pathologist consults with other pathologists in difficult or challenging cases. This includes consultation with the Chief Forensic Pathologist in potentially controversial matters. If pathologists feel uncertain about performing a specific autopsy or require advice or clarification from a senior forensic pathologist at any time, even during an autopsy, they can reach the on-call OFPS Forensic Pathologist by calling Provincial Dispatch at 416-314-4100 or at 1-855-299-4100.

5.4 Postmortem Examination (PME) Record

Immediately following the postmortem examination, the pathologist must submit a completed PME Record to the OFPS providing information, including preliminary cause of death as given to police. The Record is to be electronically submitted to the OFPS.

The PME Record is reviewed daily by the Chief Forensic Pathologist or designate. The PME Records provide baseline statistics for quality and performance monitoring.

5.5 Peer review of postmortem examination reports

All postmortem examination reports on homicide, criminally suspicious, pediatric and SIU cases are subjected to peer review prior to release of the report to the coroner and legal authorities. The peer review of the postmortem examination reports is administered by the Chief Forensic Pathologist and performed by forensic pathologists.

The main objectives of the peer review are to determine whether:

- The postmortem examination report can be independently reviewed by another pathologist.
- The postmortem examination report provides an expert opinion about the medicolegally relevant issues, including the cause of death.
- Opinions are balanced and reasonable and can be substantiated by evidence.

The originating pathologist should submit all materials that will allow for an effective review of the case by the peer-reviewing pathologist. The minimum requirement is the postmortem examination report, background information of the case (history and scene), images from the gross examination and ancillary reports (e.g., neuropathology, toxicology). In some instances, the histology slides will also need to be submitted for peer review.

Upon submission of a postmortem examination report for peer review to the OFPS, the OFPS will advise the applicable regional supervising coroner that the postmortem examination report has been submitted for peer review.

The reviewing pathologist should ensure that the review is appropriately comprehensive and addresses the medicolegal issues raised by the postmortem examination report. The peer reviewer should record the scope of materials used for the review.

The originating and reviewing pathologists can discuss the case as required. If there is a significant difference in opinion about the cause of death or other major medicolegal interpretations between the originating and reviewing pathologists,

the Chief Forensic Pathologist should be notified. The Chief Forensic Pathologist (or designate) will then undertake a comprehensive review of the case and notify the regional supervising coroner. The Chief Forensic Pathologist will consult with the originating and reviewing pathologists prior to completion of his/her review.

The results of the peer review process should be reported using the postmortem examination report Peer Review Form for homicide and criminally suspicious cases. The output of the peer review will be sent to the originating pathologist prior to submission of the postmortem examination report to the coroner.

The pathologist who performed the postmortem examination is responsible for the postmortem examination report and provides testimony on the case. The peer reviewer is not a substitute expert witness for the pathologist who performed the postmortem examination.

The completed peer review form and the existence of a review by the Chief Forensic Pathologist are disclosable.

The OFPS turnaround time standard for peer review is 10 working days.

5.6 Submission of final Reports of Postmortem Examination

A copy of each Report of Postmortem Examination must be provided to the investigating coroner, Regional Supervising Coroner's Office and to the OFPS for quality assurance. The report must include all ancillary test results and the Warrant for Postmortem Examination. Associated invoices are submitted to the Regional Supervising Coroner for payment.

5.7 Audit of autopsy reports for routine cases

Autopsy reports on routine cases are audited for administrative and technical accuracy. Medical Directors of Forensic Pathology Units review reports of routine cases performed in their units. Reports from community hospitals are audited by the Chief Forensic Pathologist or designate.

The administrative audit focuses on completeness and adherence to guidelines. All community hospital reports undergo administrative audit, and 10% of routine autopsy reports from Forensic Pathology Units undergo this type of audit.

The technical audit focuses on the content of the report to ensure that the approach, conclusions and opinions derived from the evidence are appropriate. In general, 10% of routine reports are reviewed on this basis.

Technical audit is also done for 100% of reports that fall into certain categories. These are:

- Cases with an undetermined cause of death.
- Non-traumatic and non-toxicologic deaths of individuals younger than 40 years old.
- Reports from pathologists performing fewer than 20 autopsies per year.

If a report originating from community hospitals is subjected to technical audit by the Chief Forensic Pathologist or designate, an email is sent to the pathologist with feedback even if no issues are identified.

5.8 Key performance indicators

The Peer Review and Audit activities of the quality assurance program allow for review and collection of data with respect to key performance indicators (KPIs) for autopsy reports:

- Submission compliance (the submission of the PME records and Reports of Postmortem Examinations by pathologists is tracked and measured).
- Completeness (administrative aspects such as whether history, summary and opinion are provided).
- Consistency (technical aspects such as appropriateness of work conducted and congruence of the opinion and cause of death with the findings in the case).
- Turnaround time (measured as the percentage of cases completed within 90 days).

The OFPS is committed to regular and open reporting of results tracked against these measures to clients and stakeholders and to the public.

5.9 Detection and follow-up of significant quality issues and critical incidents

Significant quality issues include substantial errors, omissions and other deficiencies.

A critical incident is a significant quality issue that contributes to a serious error in death investigation. All critical incidents are analyzed to determine root cause and corrective action.

5.10 Peer review of courtroom testimony by forensic pathologists

Forensic pathologists who testify submit one transcript of courtroom testimony each year for review by another forensic pathologist.

Courtroom testimony is assessed for:

- Accuracy and evidence-base.
- Professionalism and objectivity.
- Clear language.
- Presentation of limitations, uncertainties and alternate hypotheses.

5.11 Complaints

The OFPS tracks complaints to ensure that complaints are resolved in a timely manner and to reveal trends or gaps in service so that corrective action can be taken to avoid future complaints.

5.12 Continuing Professional Development (CPD)

Other important aspects of quality assurance are participation in professional development activities and continuing medical education in forensic pathology to maintain specialist competence as required by the Royal College of Physicians and Surgeons of Canada. The OFPS collaborates with the Office of the Chief Coroner and the University of Toronto, Centre for Forensic Science and Medicine, to provide educational activities in forensic pathology.

CPD is also used to address performance concerns about knowledge, skills or behaviours regarding the practice of a registered pathologist. The objective of CPD in this context is to improve the performance of the registered pathologist through education. This may include:

- Supervised training at a forensic pathology unit.
- Report writing guidance.
- Mock trials.
- Regular appraisal.
- Assessment of continuing education plans.
- Feedback through audit.

Failure to improve the performance of the registered pathologist may lead to reclassification, suspension or removal from the Register.

5.13 Continuous improvement

The OFPS continually strives to become better in what we do, by finding more effective and efficient ways to deliver services and by preventing errors from occurring.

D

Section D - Pathologist Register Protocol

6. Introduction

Under the *Coroners Act*, the Chief Forensic Pathologist is required to maintain a Register of Pathologists who are qualified to provide services under the Act.

The purpose of the Register Protocol is to provide information to pathologists and the public as to the operation of the Register. The Protocol will be guided by the following principles:

- Ensuring high quality postmortem examinations performed by pathologists with appropriate skills.
- Promoting public confidence in the Ontario Forensic Pathology Service (OFPS).
- Establishing a practical, principled and predictable set of standards to guide the accreditation of forensic pathologists to the Register and proportionate responses where those standards are not met.
- Providing a fair, transparent, timely and effective process for entry, renewal and removal from the Register, consistent with the educational, remedial and quality assurance purposes of the Register.

Only those pathologists on the Register will be eligible to perform postmortem examinations pursuant to a coroner's warrant under the *Coroners Act*.

The Register is a public document, which is available on the website of the Ministry of Community Safety and Correctional Services.

Performance management of registered pathologists related to quality of postmortem examinations is the responsibility of the Chief Forensic Pathologist. A Credentialing Committee of senior forensic pathologists of the OFPS advises the Chief Forensic Pathologist on appointments, continuing professional development, renewals, reclassifications, suspensions and removals from the Register.

When there is an issue of professional misconduct or incompetence, the Chief Forensic Pathologist is legislatively obliged to report any registered pathologist to the College of Physicians and Surgeons of Ontario (CPSO).

6.1 Classification

6.1.1 Every pathologist on the Register will be assigned to one of three categories:

- A. All medicolegal postmortem examinations.
- B. Medicolegal postmortem examinations excluding homicide and criminally suspicious cases and excluding cases of infants and children under five years of age.
- C. Postmortem examinations of infants and children under five years of age only and excluding homicide and criminally suspicious cases.

6.2 Applications

6.2.1 Every pathologist is entitled to apply to be on the Register.

6.2.2 The CFP has the authority to accept, deny or defer an application to the Register or to a particular classification within the Register.

6.3 Criteria

6.3.1 In considering an application, the CFP may take into account the following factors:

- Educational standards as set out by the CFP, including successful completion of the Royal College of Physicians and Surgeons of Canada (“RCPSC”) forensic pathology examination or equivalent.
- Experiential and other standards as deemed appropriate by the CFP.
- Other factors as deemed appropriate by the CFP.

6.4 Procedure on applications

6.4.1 Candidates must complete and provide the relevant documentation to the OFPS to support their applications, including references.

6.4.2 The Credentialing Committee reviews applications and makes recommendations to the CFP regarding appointments.

6.4.3 The CFP may conduct an interview with an applicant.

6.4.4 Where the CFP decides to deny or defer an application to the Register or to a particular classification within the Register, the CFP will provide reasons for the decision.

6.4.5 The CFP will respond in writing to all applications.

6.5 Reapplication

6.5.1 After one year from the date of receipt of a decision to deny a pathologist an appointment to the Register or to a classification within the Register, a pathologist may reapply to be appointed to the Register or to a particular classification within the Register.

6.5.2 After three unsuccessful attempts to be appointed to the Register, or to a particular classification within the Register, a pathologist is ineligible to reapply for such an appointment for a period of two years.

6.6 Term of appointment

6.6.1 Pathologists shall be appointed to the Register, subject to suspension and/or removal pursuant to section 2.11, for a period of five years.

6.7 Renewal

6.7.1 All pathologists on the Register will automatically be considered for renewal within the year that their term is expected to expire. The OFPS will communicate in writing with all pathologists regarding renewal.

6.7.2 The CFP may grant, deny or defer renewal to the Register.

6.8 Criteria for renewal

6.8.1 In deciding to grant, deny or defer renewal to the Register, the CFP may take into account the following factors:

- The advice of the Credentialing Committee based on:
 - Whether the pathologist has met the continuing educational and quality assurance requirements.
 - Whether the pathologist has met the experiential and other standards.
 - Whether the pathologist's conduct while on the Register and compliance with direction provided by the CFP, merits renewal.

- The results of an interview that the CFP may conduct with a pathologist to discuss issues that arise from the renewal process.
- Other factors as deemed appropriate by the CFP.

6.9 Procedure on renewal

- 6.9.1 The OFPS will supply a renewal letter to each pathologist who has been granted renewal, which will be signed and returned by the pathologist to the OFPS indicating whether they accept renewal.
- 6.9.2 Where the CFP intends to deny or defer renewal to the Register, the CFP will provide notice in writing to the pathologist, including reasons for the CFP's denial or deferral.
- 6.9.3 The pathologist will have 30 days from the receipt of the notice to provide a written response.
- 6.9.4 The CFP will provide a final decision in writing to the pathologist.

6.10 Term of renewal

- 6.10.1 Pathologists will be renewed, subject to suspension and/or removal pursuant to section 2.11, for five years.

6.11 Reclassification, suspension or removal from the register

- 6.11.1 A pathologist who wants to be considered for reclassification must apply as per section 6.4.
- 6.11.2 On the advice of the Credentialing Committee, the CFP may suspend or remove a pathologist from the Register, or from a particular classification within the Register, where the CFP believes it is in the public interest.
- 6.11.3 If the CFP intends to suspend or remove a pathologist from the Register, or from a particular classification within the Register, the CFP will provide notice in writing, including reasons for the intended removal or reclassification.
- 6.11.4 The pathologist will have 30 days from the receipt of the notice to provide a written response.

6.11.5 The CFP will provide a final decision in writing to the pathologist.

6.11.6 At the discretion of the CFP, external advice or review of the matter by another forensic pathologist may be requested.

6.12 Voluntary resignation from the register

6.12.1 A pathologist on the Register may, on three months written notice, resign voluntarily from the Register or from a particular classification within the Register.

6.13 Privacy and transparency

6.13.1 The supporting documentation in relation to the Register is to be treated as confidential.

6.14 Non-compliance

6.14.1 The CFP may deviate from compliance with this Protocol, where the CFP deems it in the public interest to do so.