Backgrounder
Document d'information

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**Results of audit into tissue samples
Arising from homicide and criminally suspicious
Autopsies performed at the hospital for sick children**

In March 2005, Dr. Barry McLellan, Chief Coroner for Ontario, announced that an audit would be conducted at the Hospital for Sick Children to determine whether tissues samples (specifically microscopic slides and tissue blocks), arising from homicide and criminally suspicious autopsies performed at the Hospital for Sick Children, could be located.

The audit included all such cases performed at the Hospital for Sick Children since 1991, when the hospital opened its Pediatric Forensic Pathology Unit. The audit also included those cases where it was known that the autopsy had been performed at some other hospital and tissues had subsequently been sent to pathologists at the Hospital for Sick Children for review and opinion.

The audit arose primarily as a result of a case where tissue samples, documented as having been sent to the Hospital for Sick Children for review, could not be found. Concerns had been expressed that this could potentially have limited any future independent review of the pathology findings in this case.

Seventy cases were identified as a result of this audit. The audit included all microscopic slides, tissue blocks and, where known, special tissue samples arising from these cases.

This is the first such comprehensive tissue audit performed by the Office of the Chief Coroner and involved a manual review of many thousands of microscopic slides and tissue blocks.

Dr. Charles Smith was the Hospital for Sick Children pathologist involved in 40 of the 70 cases audited.

Slides and tissue blocks arising from the autopsy can be accounted for in all 70 cases reviewed. In a few cases, a small number of microscopic slides cannot be found, but in all of these cases, tissue blocks have been identified which will allow new slides to be prepared if required in the future.

As a result of this audit, tissue blocks arising from the autopsy of a four-year-old girl that were previously unaccounted for, were located. These tissue blocks were located in Dr. Smith's office at the Hospital for Sick Children. All slides and tissue blocks arising from this original autopsy have now been found which will permit further review of the pathology in the future.

The Office of the Chief Coroner is aware of public concern around the safeguarding of tissue samples arising from all autopsies. The Office of the Chief Coroner is also aware of concerns expressed around the conclusions reached in a number of cases where Dr. Smith was either the primary or consulting pathologist.

As a result of these concerns, and in order to maintain public confidence, Dr. McLellan today announces that a formal review will take place of the pathology materials arising from all of the homicide or criminally suspicious autopsies since 1991 where Dr. Smith conducted the autopsy, or where he provided an opinion. This review will focus on whether the conclusions reached by Dr. Smith can be supported by the information and materials available, including the tissues and slides identified as a result of the audit.

The formal review announced by the chief coroner today, pending any response on the part of the government to calls for a public inquiry, is being made in an effort to ensure that the conclusions reached by Dr. Smith in autopsy or consultation reports can be supported by the information available.

The specific format of the review will be announced in the near future. This review will be a major undertaking involving a detailed review of 40 cases since 1991. This review will involve pathologists external to the Office of the Chief Coroner.

The Forensic Services Advisory Committee — a committee formed by the Office of the Chief Coroner to strengthen the independence and objectivity of investigations and to improve communications amongst stakeholders — will be consulted prior to establishing the exact review and reporting processes.

Advice is provided to the chief coroner through this multidisciplinary committee, which includes representatives from the Crown's office and defence bar, with the common interest on the part of all members to advance the quality and independence of all components of post-mortem examinations conducted on coroner's cases.

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