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Current position:

Forensic Pathologist and Coroner – Eastern Ontario Forensic Pathology Unit

Director of Education and Vice Chair - Department of Pathology and Laboratory Medicine

Faculty of Medicine, University of Ottawa.

Education history:

Medical graduate of the School of Medicine, Faculty of Medical Sciences, University of the West Indies, St Augustine campus, Trinidad and Tobago (MB.BS degree), class of 1996

Histopathology (Anatomical Pathology) and sub-specialty training Forensic Pathology in the United Kingdom

Fellowship of the Royal College of Pathologists of the United Kingdom (FRCPath) and Diploma in Medical Jurisprudence (DMJ Path) by examination

HOW DID YOU INITIALLY BECOME INTERESTED IN FORENSIC PATHOLOGY?

I attended a brand-new School of Medicine of the Faculty of Medical Sciences of the University of the West Indies, St Augustine campus in Trinidad and Tobago where the problem-based learning (PBL) curriculum was introduced. This was a 5-year program in which anatomical pathology and laboratory medicine was introduced from year 1 and necessitated student attendance in small groups at postmortem examinations. This stimulated my interest in anatomical pathology, and two of my lecturers served as mentors. One lecturer then went on to pursue a fellowship in forensic pathology during my third year of medical training and was back in post as a forensic pathologist by the time I had graduated and was pursuing my 18-month internship. I chose to pursue my 3-month internship elective in forensic pathology and got the opportunity to work with that former lecturer again and that exposure solidified my interest in forensic pathology.

WHAT ADVICE DO YOU HAVE FOR ASPIRING FORENSIC PATHOLOGISTS, INCLUDING RECOMMENDATIONS TO MATCH INTO A PATHOLOGY RESIDENCY PROGRAM AND ACCEPTANCE INTO A FORENSIC PATHOLOGY FELLOWSHIP?

My best advice to undergraduate and medical students is to state your interest in pursuing a career in anatomical pathology from very early on. Reach out to the pathologists at your

local anatomical pathology department/forensic pathology unit to establish links with staff pathologists there and express your interest in pathology, request a formal elective attachment, indicate an interest in undertaking research projects and volunteer to perform such under supervision, and select a mentor in that unit to guide you along how best to chart a suitable career pathway. It is best to get involved in guided scholarly academic activity under the supervision of a mentor (or others) from very early on and develop a very low threshold for delivering oral and poster presentations at professional meetings, academic writing and submitting articles for publication in peer-reviewed journals. You can start with simple interesting case reports. These activities will boost your curriculum vitae and increase your chances of getting into residency programs and fellowships.

WHAT IS THE MOST REWARDING ASPECT OF BEING A FORENSIC PATHOLOGIST?

For me, the most rewarding aspect of being a forensic pathologist is taking on a very challenging case in a head-on manner and doing an extremely good job with it in the interest of justice.

WHAT IS THE GREATEST CHALLENGE OF BEING A FORENSIC PATHOLOGIST?

For me, the greatest challenge of being a forensic pathologist is also taking on a very challenging case in a head-on manner and doing an extremely good job with it in the interest of justice.

WHAT DO YOU THINK ARE THE MOST IMPORTANT ISSUES/CHALLENGES OF FORENSIC PATHOLOGY TODAY?

The answer to this question must be region-specific. In US and Canada, the most important current issues in forensic pathology are (i) the ever-increasing caseloads from the ongoing opioid epidemic (with the US having less than half of the required number of forensic pathologists to undertake the annual workloads) and (ii) the inability for the US to correspondingly attract interest and increase recruitment of trainees into the specialty.

In low and middle income countries, the issues can relate to simply not having or having a few properly trained and qualified forensic pathologists.

WHAT HAS BEEN YOUR MOST MEMORABLE CASE AND WHY?

Two cases hold that title but for completely different reasons. Both cases were done in the United Kingdom by me whilst I was still very newly qualified.

The first case was a domestic homicide in which an estranged wife was smothered by her husband in an incident that was facilitated by the use of a volatile anesthetic agent (enflurane) that was stolen from the hospital in which he worked in its pathology department

as the chief biomedical scientist. The death was initially treated as non-criminally suspicious and a routine coronial postmortem examination was performed by an anatomical pathologist who did not have any forensic pathology training or qualifications and no anatomical cause of death was found at initial examination. Tissue samples were taken for histological examination and bodily fluids were sent for routine toxicological analyses as the only ancillary investigations which were indicated.

Subsequent to this examination, the police received three separate calls of concern in relation to her death on the day after the postmortem examination and as the on-call Home Office Registered Forensic Pathologist, I was asked to perform a second postmortem examination as the case was now being treated as criminally suspicious. One of the three calls of concern suggested that the decedent had been concerned that she was being chronically poisoned by her husband. Fast-tracking of the routine postmortem toxicological analyses yielded a blood concentration of ethanol that would have been associated with a moderate degree of intoxicant effect as the only positive finding.

My second postmortem examination was performed 6 days after the initial examination with the benefit of a signed draft report and verbal briefing from the anatomical pathologist who had performed the initial examination. Contrary to what was conveyed to me both verbally and in writing prior to my examination, the decedent had signs of mechanical asphyxia with fingertip grips marks on the upper limbs, a pair of discoid, fingertip-type bruises of the left and right parieto-occipital scalp and large areas of localized, deep intramuscular hemorrhages of the musculature of the back over the scapular and lumbar regions. Consideration of the husband's account of the circumstances of the decedent's death alongside the anatomical findings raised pathological concern that she had been smothered in a face down position on a sofa. Further toxicological analysis identified enflurane in her urine for which no medical explanation was possible. She had not received recent general anesthesia. Using this information, further investigative work by the police with the hospital revealed that a cannister of enflurane was unaccounted for and her husband eventually admitted to having taken it home. He was convicted of murder. This is a very memorable case for me as a murder could have gone undetected - https://www.dailymail.co.uk/news/article-511574/Hospital-scientist-jailed-life-murdering-wife-cushion.html

As an aside in this case, the signed draft postmortem examination report of the anatomical pathologist had indicated that layered dissection of the anterior neck structures had been performed and was unremarkable but the anterior neck structures and tongue were in situ and had not been eviscerated at the time of second examination. Weights for each lung had been provided in the draft report but the right lung was still attached to its main bronchus and the trachea and had not been weighed. Weights for both kidneys were also provided in the draft report but both kidneys were still within their cushions of perinephric fat and had not also been weighed The anatomical pathologist was referred to the UK medical regulatory

body by the head of department for his dishonest work and fraudulent report but only received a slap on the wrist.

The second case was a cannibalistic homicide - https://www.pinknews.co.uk/2008/10/09/former-mr-gay-uk-stabbed-victim-30-times-then-sliced-off-flesh-court-told/

WHAT HAS BEEN THE MOST UNEXPECTED FINDING YOU HAVE ENCOUNTERED DURING A CASE?

A fecothorax in a decomposed elderly man who had an incarcerated right inguinal hernia with massive semi-liquid fecal loading of his large intestine which had become adherent to the right hemidiaphragm and had somehow ruptured into the right pleural cavity which contained 2.5L of feces.

WHAT DO YOU ENJOY MOST ABOUT WORKING WITH YOUR TEAM?

Working in a collegial manner to get the job done whilst contributing to undergraduate teaching of medical, postgraduate training of residents, research and other scholarly academic activities.