



**BY-LAW NO. 229 - 2000**

**A BY-LAW RESPECTING  
SUDDEN DEATH & FOUND HUMAN REMAINS  
(LE-037)**

**1. PREAMBLE**

1.1 WHEREAS subsection 31(1) of the *Police Services Act* provides that a Board is responsible for the provision of police services and for law enforcement and crime prevention in the municipality and shall:

- b. generally determine after consultation with the Chief of Police, objectives and priorities with respect to police service in the municipality;
- c. establish priorities for the effective management of the police service, and
- e. direct the Chief of Police and monitor his or her performance;

1.2 AND whereas subsection 31(6) of the *Police Services Act* provides that the Board may, by by-law, make rules for the effective management of the police service;

1.3 AND whereas O. Reg. 3/99 prescribes standards for adequacy and effectiveness of police services;

1.4 AND whereas subsection 12(1)(j) of O. Reg. 3/99 requires the Chief of Police to develop and maintain procedures on and processes for undertaking and managing investigations into sudden death and found human remains;

1.5 AND whereas section 29 of O. Reg. 3/99 requires a police services board to have a policy on investigations into sudden death and found human remains;

1.6 AND whereas Part LE-037 of the Policing Standards Manual (2000), a copy of which is attached hereto as Appendix A, contains guidelines directing the Chief and the police service relative to sudden death and found human remains.

NOW THEREFORE THE REGIONAL MUNICIPALITY OF NIAGARA POLICE SERVICES BOARD ENACTS AS FOLLOWS:

**2**                    **DEFINITIONS**

- 2.1                    *"Act"* means *Police Services Act*, R.S.O. 1990, c.P.15, as amended;
- 2.2                    *"Board"* means the Regional Municipality of Niagara Police Services Board;
- 2.3                    *"Chief"* means the Chief of the Niagara Regional Police Service;
- 2.4                    *"Manual"* means the Policing Standards Manual published by the Ministry of the Solicitor General;
- 2.5                    *"Member"* means a member of the Niagara Regional Police Service;
- 2.6                    *"Ministry"* means the Ministry of the Solicitor General;
- 2.7                    *"Service"* means the Niagara Regional Police Service.

**3**                    **BOARD POLICY**

- 3.1                    The Board recognizes that issues relating to sudden death and found human remains form an important part of investigative policing, and it is therefore the policy of this Board that investigations into such matters be conducted professionally and thoroughly, and in accordance with procedures established by the Chief as directed in this By-law.

**4**                    **DIRECTION TO THE CHIEF**

4.1                    **PROCEDURES - SUDDEN DEATH**

- 4.1.1                    The Chief shall establish procedures that address a standardized approach for all sudden death investigations in accordance with Appendix A.
- 4.1.2                    Where an occurrence falls within the definition of a major case, the Chief shall ensure that officers comply with the procedures set out in the Ministry's designated Ontario Major Case Management Manual.

4.2                    **PROCEDURES – FOUND HUMAN REMAINS**

- 4.2.1                    The Chief shall develop procedures to be followed when unidentified human remains are found in accordance with Appendix A.
- 4.2.2                    Where an occurrence falls within the definition of a major case, the Chief shall ensure that officers comply with the procedures set out in the Ministry's designated Ontario Major Case Management Manual.

4.3 **TRAINING**

4.3.1 The Chief shall ensure that all Members involved in the investigation of a sudden death or found human remains have the requisite knowledge, skills and abilities and receives the appropriate training.

**5 CHIEF CORONER'S MEMORANDA**

5.1 The Chief shall ensure that the procedures concerning sudden death are in compliance with any and all memoranda issued by the office of the Chief Coroner.

**6 REPORT TO THE BOARD**

6.1 The Chief shall make a written report to the Board on or before August 30 of each year in respect of sudden death and found human remains investigations. The report shall include:

- a. a summary of the written procedures concerning sudden death and found human remains investigations;
- b. the status of Service compliance with the said procedures;
- c. a summary of the memoranda of the Chief Coroner relating to sudden death; and
- d. the status of Service compliance with the said memoranda.

**7 IMPLEMENTATION**

7.1 This By-law shall come into force upon the date of its passage.

7.2 The Chief shall implement this By-law, where applicable, through general order.

ENACTED AND PASSED this 30th day of November, 2000.

THE REGIONAL MUNICIPALITY OF NIAGARA POLICE SERVICES BOARD

Chairperson

Shirley Corduroy

Vice Chairperson

R. Ted Salsci

## Legislative/Regulatory Requirements

Section 29 of the Adequacy Standards Regulation requires a police services board to have a policy on investigations into found human remains.

Section 12(1)(j) requires the Chief of Police to develop and maintain procedures on and processes for undertaking and managing investigations into found human remains.

In addition to the above legislative requirements, a number of Chief Coroner's Memoranda outline protocols to be followed during the investigation of:

- sudden and unexpected deaths of children under five years of age;
- multiple fatality incidents, as well as railway fatalities and aviation fatalities;
- persons dying in hospitals following suspected accidents, suicides or homicides;
- firearm-related suicides; and
- homicides.

## Sample Board Policy

Board Policy # \_\_\_\_\_

It is the policy of the \_\_\_\_\_ Police Services Board with respect to sudden or unexplained death investigations and investigations into found human remains that the Chief of Police will:

- a) develop and maintain procedures that require that investigations into sudden or unexplained deaths and found human remains be considered potential homicides and be undertaken in accordance with the police service's criminal investigation management plan;
- b) ensure that officers investigating sudden or unexplained death and found human remains occurrences have the knowledge, skills and abilities required; and
- c) where an occurrence falls within the definition of a major case, ensure that officers comply with the procedures set out in the Ministry's designated *Ontario Major Case Management Manual*.

## Police Service Guidelines

- Procedures**
1. Every police service's procedures should:
    - a) require that sudden or unexplained death and found human remains occurrences be considered potential homicides and investigations be undertaken in accordance with the police service's criminal investigation management plan;

- b) where an occurrence falls within the definition of a major case, ensure that officers comply with the procedures set out in the Ministry's designated *Ontario Major Case Management Manual*;
- c) provide that a sudden death includes any death resulting from:
  - i) homicide;
  - ii) suicide;
  - iii) accident; or
  - iv) unexplained or unknown causes;
- d) require that officers do not assume that an individual is deceased, unless there is obvious signs of:
  - i) decomposition;
  - ii) decapitation;
  - iii) transection;
  - iv) gross rigor mortis;
  - v) gross outpouring of cranial or visceral contents; or
  - vi) grossly charred body;
- e) address the responsibilities of:
  - i) members receiving information on the location of a suspected deceased person;
  - ii) communications/dispatch personnel; and
  - iii) supervisory and investigative personnel;
- f) address the responsibilities of a first officer(s) at a scene, including:
  - i) considering the scene as a possible homicide scene and taking appropriate actions;
  - ii) providing assistance to preserve life to any victims; and
  - iii) notifying a supervisor;
- g) require officers to consider the need to secure the scene, in cases of sudden death, apparent suicides and found human remains, until after an autopsy is performed to ascertain the cause of death;
- h) ensure all sudden death and suspected suicide scenes be treated as homicide scenes until determined otherwise;
- i) outline the procedures to be followed in an investigation of a sudden death of a child;
- j) set out the procedures to be followed, including notifying next-of-kin and providing assistance to survivors present at the scene, when the death under investigation occurred from:
  - i) natural causes; or
  - ii) accidental causes;
- k) require the notification of a coroner pursuant to the *Coroners Act*;
- l) require that appropriate members comply with the protocols and guidelines set out in Chief Coroner's Memoranda; and

m) require that any found skeletal remains not be excavated before the arrival of a Coroner, and, if required, a forensic anthropologist.

- Information**
2. Every Chief of Police should ensure that appropriate members are kept informed of new guidelines and procedures, as they become available through the Chief Coroner.
  3. Every Chief of Police should ensure that officers investigating sudden or unexplained death and found human remains occurrences have the knowledge, skills and abilities required.



**Office of the Chief Coroner**

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**MEMORANDUM #06-04 - Replaces Memoranda 551(B), 631, 97-03, 01-02, 02-03**

**DATE:** December 20, 2006

**RE:** New Protocol to be Used in the Investigation of the Sudden and Unexpected Death of any Child under 5 years of age

**TO:** All Ontario Coroners, Pathologists, Chiefs of Police in Ontario and Children's Aid Societies

**FROM:** James T. Cairns, M.D., Deputy Chief Coroner for Ontario  
Barry McLellan, M.D., FRCPC, Chief Coroner for Ontario

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In 1995, the Office of the Chief Coroner introduced a protocol to be used in investigating the death of any child under 2 years of age. Over the years, the protocol has been significantly refined, and we feel it appropriate at this time to issue an up-to-date version of the protocol, which will be used for the investigation of sudden and unexpected death of all children **under 5 years** of age. The Office of the Chief Coroner has had excellent feedback from all agencies involved in death investigation regarding the old protocol, and we do not think there will be any issues or controversy with the new refined protocol.

Attached with the protocol is the Investigation Questionnaire to be completed by the Coroner for all sudden and unexpected deaths under age 5. Please note that most questions are focused on children under the age of 2.

Coroners and other members of the death investigation team are once again reminded of the importance of not reaching a conclusion that death was due to SIDS until the investigation is complete. This includes a full police investigation, a forensic autopsy at one of the designated Paediatric units (including x-rays, histology and toxicology), and review by the Deaths Under Five Committee at the Office of the Chief Coroner. It has recently been brought to our attention that on occasion families, CAS and police are being advised that deaths are due to SIDS before the investigation is complete. In many cases, this means that police and the CAS shut down their investigations prematurely.

If you have any questions about this new refined protocol, do not hesitate to contact Dr. James Cairns, Deputy Chief Coroner for Ontario, who also chairs the Deaths Under Five Committee and the Paediatric Death Review Committee for Ontario.

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James T. Cairns, M.D.,  
Deputy Chief Coroner for Ontario

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Barry McLellan, M.D., FRCPC,  
Chief Coroner for Ontario



6. Sleeping site where child found (*describe in detail in narrative*)

- a. Adult bed
  - i) Conventional mattress, Size \_\_\_\_\_
  - ii) Waterbed Size \_\_\_\_\_
- b. Crib  f. Car seat
- c. Couch  g. Floor
- d. Bassinet  h. Other (Specify) \_\_\_\_\_
- e. Conventional mattress

YES NO  
\_\_\_\_

7. Were there any blankets/coverings/duvets involved? Describe.

\_\_\_\_\_  
\_\_\_\_\_

YES NO  
\_\_\_\_

8. Was the child sleeping alone? If not, explain.

\_\_\_\_\_  
\_\_\_\_\_

YES NO  
\_\_\_\_

9. Does the possibility of overlaying exist? For example, too little room for too many people, recent alcohol or other drug consumption by person sleeping with child. Explain.

\_\_\_\_\_  
\_\_\_\_\_

10. Last seen alive: By Whom? \_\_\_\_\_  
When? \_\_\_\_\_

YES NO  
\_\_\_\_

11. Was Decedent Moved?

From \_\_\_\_\_  
To \_\_\_\_\_  
By Whom \_\_\_\_\_  
Stated Reason \_\_\_\_\_

12. Transferred to hospital by:  
 a. Ambulance  d. Police  
 b. Taxi  e. Fire/Rescue  
 c. Public transportation  f. Private vehicle

C. ENVIRONMENTAL CONDITIONS WHERE CHILD FOUND

YES NO  
\_\_\_\_

1. Are there any environmental hazards?

- a. Tobacco smoke  h. Toxic gases
- b. Drugs or alcohol  i. Toxic products
- c. Medicines  j. Lead
- d. High room temperature  k. Electrical
- e. Low room temperature  l. Animals, #? \_\_\_\_\_, Type \_\_\_\_\_
- f. Unusual dampness  m. Other
- g. Recent remodelling

2. Outside Temperature \_\_\_\_\_  
Inside Temperature \_\_\_\_\_

3. Cleanliness of dwelling
- a. Neat and clean
  - b. Cluttered but clean
  - c. Filthy and cluttered

**D. PHYSICAL ITEMS COLLECTED**

- a. Clothes baby was wearing
- b. Diaper
- c. Drug paraphernalia
- d. Medications
- e. Over the counter drugs
- f. Feeding formula
- g. Baby bottle last drank from
- h. Bedding
- i. Toys
- j. Other (specify)

**E. TRACE EVIDENCE COLLECTED (LIST)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\* Please attach ambulance call report \***

**A. POSITION OF CHILD**

1. Body Position

- a. On Stomach
- b. On Back
- c. On Left Side
- d. On Right Side
- e. Seated Upright

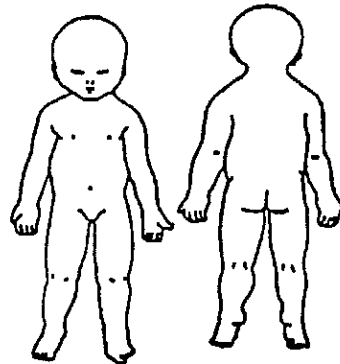
2. Head and Neck Position

- a. Face Directly Up
- b. Face Directly Down
- c. Face to Left
- d. Face to Right
- e. Neck Flexed to Chin
- f. Neck Extended Back

**B. APPEARANCE OF CHILD**

YES NO

- |       |       |  |   |
|-------|-------|--|---|
| _____ | _____ | 1. Rigor mortis  | Time _____                              |
| _____ | _____ | 2. Livor mortis  | (draw on diagram) Time _____            |
| _____ | _____ | a. Consistent with position found  |   |
| _____ | _____ | b. Fixed   |   |
| _____ | _____ | c. Blanches  |   |
| _____ | _____ | 3. Body temperature taken  | _____ degrees Time: _____ Method: _____ |
| _____ | _____ | 4. Child appears clean, well nourished and cared for?  |   |
| _____ | _____ | 5. Is the child sweaty?  |   |
| _____ | _____ | 6. Are there any birthmarks?   |   |
| _____ | _____ | 7. Are there injuries of any type, including bruises, scrapes, cuts, burns, or diaper rash? If so, please describe colors, shapes, sizes and locations in narrative and photograph, if possible. |   |
| _____ | _____ | 8. Mouth and nostrils when found   |   |
| _____ | _____ | a. Occluded  |   |
| _____ | _____ | b. Secretions  |   |
| _____ | _____ | c. Vomitus   |   |
| _____ | _____ | d. Blood   |   |
| _____ | _____ | e. Foreign objects   |   |
| _____ | _____ | f. Other (specify)   |   |
| _____ | _____ | 9. Is the child clothed - How so?  |   |
| _____ | _____ | 10. Is the clothing soiled - With what?  | _____                                   |
| _____ | _____ | 11. Clothing removed after death?  |   |



12. Diaper  
  a. Wet  
  b. Soiled  
  13. Is the bedding soiled - With what? \_\_\_\_\_  
  14. Evidence of resuscitation  
 a. Endotracheal tube  
 b. Nasogastric tube  
 c. Chest ecchymoses  
 d. EKG leads  
 e. Defibrillator pads  
 f. Venipunctures  
 g. IV Lines  
 h. Intraosseus lines  
 i. Other (specify) \_\_\_\_\_

**MEDICAL HISTORY**

YES NO

\_\_\_\_\_  
\_\_\_\_\_

**A. CHILD ILL WITHIN THE LAST TWO WEEKS**

- a. Fever: Temp? \_\_\_\_\_ When? \_\_\_\_\_  
 b. Vomiting  
 c. Diarrhea  
 d. Runny nose  
 e. Pneumonia  
 f. Cough  
 g. Wheezing  
 h. Fussiness  
 i. Appetite changes  
 j. Skin rash  
 k. Constipation  
 l. Colic  
 m. Other (Specify) \_\_\_\_\_

YES NO

\_\_\_\_\_  
\_\_\_\_\_

- n. Was child taken for treatment? Where? \_\_\_\_\_

YES NO

\_\_\_\_\_  
\_\_\_\_\_

**B. DID CHILD RECEIVE ANY MEDICATION 48 HRS BEFORE DEATH**

- a. Aspirin  
 b. Tylenol  
 c. Antibiotics  
 d. Cold Remedies  
 e. Anticonvulsants  
 f. Folk Remedy  
 g. Other \_\_\_\_\_

YES NO

\_\_\_\_\_  
\_\_\_\_\_

- C. RECENT CHANGE IN SLEEP PATTERN**  
**D. RECENT BEHAVIOUR CHANGE**  
**E. TOBACCO/SMOKE/ILLICIT DRUG EXPOSURE**  
**F. PREVIOUS ILLNESS OR INJURY**

- a. Lung disease  
 b. Heart disease  
 c. Apnea monitor used? \_\_\_\_\_  
 d. Seizures  
 e. Fractures How? \_\_\_\_\_  
 f. Head injury How? \_\_\_\_\_  
 g. Other illness or injury \_\_\_\_\_

YES NO

\_\_\_\_\_  
\_\_\_\_\_

**G. HAS CHILD EVER BEEN TO EMERGENCY ROOM OR HOSPITALIZED?**  
If so, why?

\_\_\_\_\_  
\_\_\_\_\_

YES NO

\_\_\_\_\_  
\_\_\_\_\_

**H. PREVIOUS CONTACT WITH CHILDREN'S AID SOCIETY**  
If so, why?

\_\_\_\_\_  
\_\_\_\_\_

YES NO

\_\_\_ I. HAS CHILD RECEIVED WELL VISITS AND IMMUNIZATIONS

\_\_\_ J. FEEDING HISTORY

- \_\_\_ a. Breast-fed
- \_\_\_ b. Formula fed Type \_\_\_\_\_
- \_\_\_ c. Time of last feeding before death \_\_\_\_\_
- \_\_\_ d. Amount of food taken \_\_\_ oz.

YES NO

\_\_\_ K. WAS CHILD RECENTLY EXPOSED TO ILL PERSON OR PET

\_\_\_ L. FAMILY HISTORY (Immediate or Extended Family)

- |                             |                         |
|-----------------------------|-------------------------|
| ___ a. SIDS/SUD             | ___ f. Pneumonia        |
| ___ b. Accident (childhood) | ___ g. Prematurity      |
| ___ c. Childhood death      | ___ h. Abuse or neglect |
| ___ d. Congenital anomalies | ___ i. VICLAS check     |
| ___ e. Infection            |                         |

\_\_\_ M. NAME OF MOST RESPONSIBLE PHYSICIAN CARING FOR CHILD PRIOR TO DEATH

TEL. \_\_\_\_\_

**PRENATAL/BIRTH HISTORY**

A. PLACE OF CHILD'S BIRTH \_\_\_\_\_

B. ATTENDING PHYSICIAN \_\_\_\_\_

C. \_\_\_ FULL TERM \_\_\_ GESTATIONAL

YES NO

\_\_\_ C. CONGENITAL ABNORMALITIES AT BIRTH

\_\_\_ D. ANY COMPLICATIONS OF PREGNANCY OR BIRTH

\_\_\_ E. ANY MATERNAL HEALTH PROBLEMS DURING PREGNANCY

- |                            |                                     |
|----------------------------|-------------------------------------|
| a. ___ Anemia              | e. ___ Physical Trauma              |
| b. ___ Diabetes Mellitus   | f. ___ Sexually Transmitted Disease |
| c. ___ High Blood Pressure | g. ___ Other (Specify)              |
| d. ___ Infections          |                                     |

\_\_\_ F. WAS MOTHER TAKING ANY MEDICATIONS FOR THE ABOVE

\_\_\_ G. REGULAR PRENATAL VISITS

\_\_\_ H. DURING PREGNANCY, WAS MOTHER TAKING ANY:

- |                  |                    |
|------------------|--------------------|
| a. ___ Alcohol   | e. ___ Tobacco     |
| b. ___ Cocaine   | f. ___ Other _____ |
| c. ___ Heroin    | g. ___ Unknown     |
| d. ___ Marijuana |                    |

**WITNESSES INTERVIEWED**

| <u>NAME</u> | <u>ADDRESS</u> | <u>TELEPHONE</u> |
|-------------|----------------|------------------|
| _____       | _____          | _____            |
| _____       | _____          | _____            |
| _____       | _____          | _____            |
| _____       | _____          | _____            |
| _____       | _____          | _____            |
| _____       | _____          | _____            |





## **Protocol for the Investigation of Sudden and Unexpected Deaths in Children Under Five (5) Years of Age**

Every sudden and unexpected death of a child under five years of age must be actively investigated as potentially suspicious and premature conclusions should not be made regarding the cause and manner of death until the complete investigation is finished and all members of the team, listed below, are satisfied with the conclusion.

**Teamwork** is essential in these investigations and the team should include the following:

1. The Investigating Coroner
2. Investigative officers and Forensic Identification officers from the local police service
3. The Regional Coroner, who should be notified as soon as possible of each case
4. The Pathologist performing the autopsy
5. The Radiologist who reports on the x-ray findings
6. The Toxicologist
7. The *Deaths Under Five Committee* of the Office of the Chief Coroner
8. The *Paediatric Death Review Committee* of the Office of the Chief Coroner, as deemed necessary

### **CORONER'S INVESTIGATION: Essential Components**

1. Attend and examine the child's body.
2. Arrange for a proper police investigation.
3. If possible, view the death scene with the police.
4. In all cases, order a complete autopsy including full skeletal survey and toxicology screen. The autopsy must be done in one of four Paediatric Forensic Pathology Units in the province (Hamilton, London, Ottawa, or Toronto).
5. Review the past medical history of the child with family doctor and other relevant agencies.
6. The results of the FULL investigation will be reviewed by the *Deaths Under Five Committee* of the Office of the Chief Coroner. The Committee will make the final decision on the "cause" and "manner" of death.

### **Deaths Under Five Committee (DU5C) of the Office of the Chief Coroner**

Members of the Committee include: Paediatric Forensic Pathologists, Police Officers, Crown Attorney, and Senior Officials from the Office of the Chief Coroner. The Committee is Chaired by the Deputy Chief Coroner for the Province of Ontario.

## **POLICE INVESTIGATION: Essential Components**

1. Examine and photograph the death scene and collect relevant evidence.
2. Interview the caregiver at the time of death and other relevant witnesses.
3. Check background of caregivers with different agencies e.g. Children's Aid Society.
4. Police should attend and photograph autopsy. Most police services now use their CIB, Major Crime, or Homicide Bureau to investigate child deaths. This practice is to be encouraged.
5. Ensure the *Deaths Under Five Committee* conclusions are known prior to closing the case.

While it is essential that a full police investigation be carried out in all sudden and unexpected deaths of children, this investigation should be conducted in a manner that does not compound the profound sense of loss, guilt or depression that parents experience under these circumstances.

## **Autopsy Examination**

It is essential that a **FULL** autopsy examination be ordered and carried out in all cases of sudden and unexpected death in children. As previously stated, these autopsies will only be performed in one of four Paediatric Forensic Pathology Units in the province. These centres have the necessary experts and staff to conduct a full paediatric forensic autopsy.

A full autopsy will include:

1. Skeletal survey
2. Toxicology screen
3. Metabolic screen

## **Definitions**

### **Sudden Infant Death Syndrome (SIDS)**

*Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant under one year of age, which remains unexplained after a thorough case investigation, which must include a complete autopsy, examination of the death scene, a police investigation and a review of the clinical history.*

It is clear from this definition that the diagnosis of SIDS cannot be made by autopsy alone, but can only be made by the Coroner when the results of the full investigation (police, autopsy, x-rays, toxicology, clinical history) are known. SIDS is really a diagnosis of exclusion.

In such cases, the autopsy report would read as follows:

*"No definitive anatomical or toxicological cause of death has been established."*

## **Sudden Unexpected Death (SUD)**

If **any** part of the death investigation in a child under one year of age is positive then the death will not be classified as a SIDS. The following are some examples where this would apply:

- a) Negative autopsy but evidence of an old healed fracture, which has not been adequately explained by the investigation.
- b) Negative autopsy but a previous history of child abuse.
- c) Negative autopsy but some positive toxicology, which although not considered to be a cause of death cannot be explained e.g. blood alcohol of 30 mg in a 5-month-old child.

Where there is any significant concern regarding any part of the death investigation the cause of death should be classified as a "Sudden Unexpected Death", and the manner of death will be recorded as "undetermined".

### **A Sudden Unexpected Death may be due to:**

- 1. SIDS
- 2. Accidental injury
- 3. Non-accidental injury due to:
  - a) Neglect
  - b) Abuse
- 4. A previously undiagnosed natural disease process

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James T. Cairns, M.D.  
Deputy Chief Coroner for Ontario

Chair, Deaths Under Five Committee  
Chair, Paediatric Death Review Committee  
Office of the Chief Coroner

October 2006