

UNITED STATES OF AMERICA
CONSUMER PRODUCT SAFETY COMMISSION

In the Matter of)	
)	
)	
LEACHCO, INC.)	CPSC DOCKET NO. 22-1
)	
)	Hon. Michael G. Young
)	Presiding Officer
Respondent.)	
)	

**COMPLAINT COUNSEL’S OFFER OF PROOF REGARDING
REPORT OF INVESTIGATION, VIRGINIA DEPARTMENT OF
HEALTH, OFFICE OF THE CHIEF MEDICAL EXAMINER**

Pursuant to 16 C.F.R. § 1025.43(f), Complaint Counsel respectfully submits an Offer of Proof and accompanying unredacted versions of the Report of Investigation of the Virginia Department of Health’s Office of the Chief Medical Examiner, previously identified during Complaint Counsel’s August 7, 2023 examination of Elizabeth Phillips as JX-12A¹ and JX-12B (Exhibits 1 & 2). Versions of these documents were admitted into evidence on August 7, 2023 as JX-12A(1) and JX-12B(1), with redactions of certain content relating to “circumstances reported by third parties and third-party notes regarding placement on a pillow,” pursuant to this Court’s August 2, 2023 Order Deferring Decision on Complaint Counsel’s Motion In Limine To Admit In-Depth Investigation Reports (“August 2 Order”). The documents without the redactions imposed by the August 2 Order, JX-12A and JX-12B, contain evidence concerning a fatal incident involving the Podster and provide relevant information about the product’s use and how it poses a Substantial Product Hazard.

Pursuant to the Commission’s Rules of Practice that govern this proceeding:

¹ JX-12A and JX12A(1) contain additional redactions of Personal Identifiable Information.

When an objection to proffered testimony or documentary evidence is sustained, the sponsoring party may make a specific offer, either in writing or orally, of what the party expects to prove by the testimony of the document. . . . Written offers of proof or of rebuttal, adequately marked for identification shall accompany the record and be available for consideration by any reviewing authority.

16 C.F.R. § 1025.43(f).

Thus, Complaint Counsel submits this Offer of Proof so that JX-12A and JX-12B shall accompany the record in this proceeding without the redactions imposed by the August 2 Order. Accordingly, pursuant to 16 C.F.R. § 1025.43(f), Complaint Counsel requests that the attached exhibits, previously marked for identification as JX-12A and JX-12B, “shall accompany the record and be available for consideration by any reviewing authority.”

Dated this 8th day of August, 2023

Respectfully submitted,

/s/ Thomas J. Mendel

Gregory M. Reyes, Supervisory Attorney
Thomas J. Mendel, Trial Attorney
Brett Ruff, Trial Attorney
Michael J. Rogal, Trial Attorney

Division of Enforcement and Litigation
Office of Compliance and Field Operations
U.S. Consumer Product Safety Commission
Bethesda, MD 20814
Tel: (301) 504-7220

Complaint Counsel for
U.S. Consumer Product Safety Commission

CERTIFICATE OF SERVICE

I hereby certify that on August 8, 2023, I served Complaint Counsel's Offer of Proof Regarding Report of Investigation, Virginia Department of Health, Office Of The Chief Medical Examiner on all parties and participants of record in these proceedings as follows:

By email to the Secretary:

Alberta E. Mills
Secretary
U.S. Consumer Product Safety Commission
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Bethesda, MD 20814
Email: AMills@cpsc.gov

By email to the Presiding Officer:

Judge Michael G. Young
Presiding Officer and Administrative Law Judge
Federal Mine Safety and Health Review Commission
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/s/ Thomas J. Mendel

Thomas J. Mendel
Complaint Counsel for
U.S. Consumer Product Safety Commission

EXHIBIT 1
JX-12A

Decedent is
NON-RESIDENT
of City/ County of Death

Commonwealth of Virginia
Department of Health
Office of the Chief Medical Examiner
CENTRAL DISTRICT
400 EAST JACKSON STREET RICHMOND, VA 23219

Case Number
[REDACTED]

REPORT OF INVESTIGATION

Decedent [REDACTED]

First Name Middle Name Last Name Suffix Sr, Jr, III, etc

SSN [REDACTED]

Home Address [REDACTED] VICTORIA, VA 23974
Number and Street City, State, Zip

Age 3 Mos Days DOB [REDACTED] Sex FEMALE Last Known Occupation NONE

Race WHITE Hispanic? NO Marital Status NEVER MARRIED

MEDICAL EXAMINER AUTHORITY SUDDEN IN APPARENT GOOD HEALTH

Police Notified YES Investigator LUNENBURG COUNTY Phone (434) 696-4452

Jurisdiction LUNENBURG COUNTY SHERIFF'S DEPARTMENT

	DATE (MM/DD/YY)	TIME (24h)	LOCATION	CITY/COUNTY	BY WHOM
LAST KNOWN ALIVE	10/25/2021	UNKNOWN	VCU COMMUNITY MEMORIAL	MECKLENBURG COUNTY, VA	OTHER
EVENT/ INJURY ACUTE ILLNESS	10/25/2021	UNKNOWN	241 OLDMANSION ROAD	LUNENBURG COUNTY, VA	NOT WITNESSED
FOUND	10/25/2021	1220	VCU COMMUNITY MEMORIAL	MECKLENBURG COUNTY, VA	OTHER
DEATH/ PRONOUNCED	10/25/2021	1220	VCU COMMUNITY MEMORIAL	MECKLENBURG COUNTY, VA	DR. WENTZEL
EXAMINATION OF BCDY	10/26/2021	1045	OFFICE OF THE CHIEF MEDICAL EXAMINER - CENTRAL DISTRICT	RICHMOND, VA	ROBINSON, RENEE

Cause of Death: SUDDEN UNEXPECTED INFANT DEATH WITH UNSAFE BEDDING AND POSITIONING

Manner of Death: UNDETERMINED

Autopsy (Y/N): Y

Authorized by: ASSISTANT CHIEF MEDICAL EXAMINER

Pathologist: ROBINSON, RENEE

Autopsy No: [REDACTED]

Location: CENTRAL OCME

This case was reviewed by:

16-Feb-2022 1122 RENE ROBINSON
Date/Time Name of Assistant Chief Medical Examiner Signature of Assistant Chief Medical Examiner

12-Feb-2022 1124 CARLETON, LESLIE
Date/Time Name of Reviewing Medical Death Investigator

MEDICAL HISTORY

- none known alcoholism cirrhosis hepatitis drug abuse asthma bronchitis emphysema
- seizure disorder (cause) _____ cancer _____ diabetes hypertension atherosclerosis
- stroke psychiatric diagnosis (specify) _____ depression dementia (specify) _____
- recent traumas (specify) _____ hip fracture
- acute infections (specify) _____ HIV/AIDS COPD obesity tobacco
- other (specify): _____

Treating MD _____ Phone# _____

Hospitalizations (when/where)

Medications

Tox requested: YES

Summary of Circumstances:

The decedent is a 3-month, [redacted] day infant female who was discovered deceased in her sleeping area. She was transported to the Office of the Chief Medical Examiner, Central District, for examination.

At autopsy, no overt traumatic or natural disease processes are noted, and additional studies are negative for significant findings. Patchy anterior liver consistent with prone positioning at time of death, and by report, the decedent was in a pack and play on a soft doughnut-shaped pillow.

This case is reviewed in conference with OCME pathologists, with consensus on cause and manner of death.

Decedent: [redacted]
CME: _1E/ REV 10/08

DEPARTMENT OF HEALTH
 OFFICE OF THE CHIEF MEDICAL EXAMINER
 400 EAST JACKSON STREET
 RICHMOND, VIRGINIA 23219

Autopsy [redacted]
 File# [redacted]
 Date/Day 10/26/2021, Tuesday
 Time 10:43 a.m.

REPORT OF AUTOPSY

DECEDENT [redacted]

Autopsy Authorized by: Dr. Renée Robinson, MD, Medical Examiner for Lunenburg County.

BODY IDENTIFIED BY:

PERSONS PRESENT AT AUTOPSY:

Removal service tags.

Dr. Renée Robinson, MD; Pam Blizzard.

Rigor: Absent Livor: Purple-pink (non-blanching) Distribution: Regional Posterior torso, left lateral head, and posterior neck, low anterior pelvis, anterior neck Age: 3-months, [redacted] days Race: White Sex: Female Length: 61 cm Weight: 14 lbs.
 Eyes: Blue Hair: Fine, light brown Mustache: N/A Beard: N/A Circumcised: N/A Body Heat: Cool.

CLOTHING, PERSONAL EFFECTS, EXTERNAL WOUNDS, SCARS, TATTOOS, OTHER IDENTIFYING FEATURES:

CLOTHING/PERSONAL EFFECTS: The decedent is received clad in the following: pink onesie and diaper maintaining urine and some formed green-brown stool.

EXTERNAL EXAMINATION: The body is that of a well-developed, well-nourished female infant whose appearance is consistent with the given age of 3-months, [redacted] days. Crown heel measures 61 cm in length (75th percentile for age/length and 75th percentile for weight/length) and weighs 14 lbs. (90th percentile for age/weight). Crown rump measures 42 cm. Intra-canal measurement is 3 cm; outer is 8 cm. Intra-mammary distance is 10 cm. The right palm/third digit measures 4.5 cm and 3 cm, respectively; the left palm/third digit measures 4 cm and 3 cm, respectively. The right foot/great toe measures 7.5 cm and 1.5 cm, respectively. The left foot/great toe measures 7.5 cm and 1.5 cm, respectively. Head circumference is 40.5 cm (50th percentile for circumference/age). Chest circumference is 37 cm. Abdominal circumference is 36 cm. Anterior fontanelle measures 3 cm.

Sclerae, bulbar and palpebral conjunctiva are unremarkable. There is no ocular, facial, or mucosal petechiae. The nose and lips are unremarkable. The right and left ear is generally unremarkable. The mouth is unremarkable. There are no lesions about the lips or buccal mucous membranes and the frenulae are intact. The decedent is edentulous in keeping with age. The tongue is normal in size and the palate is intact. The neck is unremarkable.

The torso is unremarkable. The right upper and lower quadrant of the abdomen demonstrates green discoloration. External genitalia are those of a normally developed infant female. External genitalia, perineum, and anus are unremarkable.

Extremities are well-developed and symmetrical without deformities. Fingernails and toenails are generally short, of equal length, and generally clean. Pedal surfaces are smooth and clean.

MARKS OF THERAPY/SIGNS OF ORGAN DONATION: Endotracheal tube; anterior chest, EKG lead pads, left anterior lower leg, intraosseous line.

RADIOGRAPHS: Lodox imaging is obtained and does not demonstrate any foreign radiodensities or overt bony abnormalities.

HISTORY: Discovered deceased in sleeping area.

FINAL ANATOMIC DIAGNOSES:

- I. Normal infant female
- II. Cultures, (see separate microbiology reports)
 - a. Nasal swab negative for respiratory pathogens, including Sars-Cov-2 (COVID-19)
 - b. CSF, negative for pathogens
 - c. Blood culture, positive for mixed flora including pseudomonas aeruginosa, haemophilus influenza, gram positive coccus (likely contaminants)
- III. Toxicology negative for substances tested, and vitreous electrolytes/glucose non-contributory (see separate toxicology and lab reports)
- IV. Central nervous system within normal limits
- V. Negative inborn errors of metabolism screen (see separate genetic report).
- VI. Radiologic skeletal survey negative for overt abnormalities
- VII. Heart, within normal limits
- VIII. Unsafe bedding (placed on doughnut-shaped soft pillow) with patchy anterior livor noted
- IX. Lungs, chronic bronchitis


Cause of Death: Sudden unexpected infant death with unsafe bedding and positioning

Final Report: 2/11/2022

The facts stated herein are true and correct to the best of my knowledge and belief.

2/11/2022
 Date Signed

Richmond City
 Place of Autopsy


 Signature of Pathologist
 Renée Robinson, MD

GROSS DESCRIPTION**INTERNAL EXAMINATION & SEROUS CAVITIES:**

The body is opened with the standard Y-shaped incision. The pleural and peritoneal surfaces are smooth and glistening, and no excess pleural or peritoneal fluid is identified. The diaphragms are intact. The organs maintain their normal interrelationships. No appreciable adhesions are noted in any body cavity.

HEART:

The heart weighs 26 grams (expected, 23-49g) and has a normal distribution of the coronary arteries. The heart is right dominant. The coronary ostia are patent. The myocardium is homogenous, red-brown, and firm without pallor, hemorrhage, or softening. The ventricular walls are within normal limits. The endocardial surfaces and four cardiac valves are unremarkable. Ductus and foramen ovale are closed.

AORTA:

The arch of the aorta is normally formed and is unremarkable.

NECK ORGANS:

The thymus occupies its usual mediastinal location and weighs 40 grams (expected, 8-58). It is of the usual shape and pale pink. On section, it has the usual prominent lobulation. Hyoid bone and larynx are intact. There is no extravasated blood in the prevertebral cervical fascia; *dry layered neck dissection is performed.*

LUNGS:

The upper airway contains no debris or foreign material. Laryngeal mucosa is smooth and unremarkable with no petechiae. The right and left lungs weigh 61 grams and 45 grams respectively (expected, right 40-11g and left 38-80g). Pleural surfaces are smooth and shiny. Pulmonary arteries contain no emboli. Major bronchi are unremarkable. Sectioning of lungs reveals pink, crepitant parenchyma with no focal consolidation or cavitory lesions.

LYMPH NODES:

No enlarged lymph nodes are noted in any of the internal lymph node groups.

LIVER:

The liver is of the usual shape, and weighs 228 grams (expected, 135-343g). Glisson's capsule is smooth and glistening. Parenchyma is dark reddish-brown with no accentuation of markings or focal discoloration.

GALLBLADDER:

The gallbladder is in the normal position with a tan-red to tan-green serosal surface and contains bile. There is no bile stasis and no dilatation of the bile duct tree. The gallbladder mucosa is velvety red and unremarkable.

SPLEEN:

The spleen weighs 24 grams (expected, 9-33g) and has a smooth, glistening capsule and a firm, dark red cut surface, and appears enlarged.

PANCREAS:

The pancreas is located in the normal position and unremarkable on external and serial cross sectioning examination.

ADRENAL GLANDS:

The adrenal glands lie in their normal positions and are unremarkable on external and serial cross sectioning examination.

GI TRACT:

Esophageal mucosa is gray-white and smooth with normal longitudinal folds. There is normal demarcation of cardia and esophagus. The stomach contains minimal mucoid white material. Rugae are normally prominent. Pylorus is well-demarcated. The large intestine maintains mucoid green stool. The appendix is present.

KIDNEYS:

The right and left kidneys weigh 19 grams and 18 grams, respectively (expected, right 10-36g and left 11-37g). Subcapsular surfaces are smooth and delineated from the medullary pyramids. Calyces, pelvis and ureters are unremarkable.

BLADDER:

The ureters maintain uniform caliber and drain into an unremarkable bladder contains no urine.

GENITALIA:

The vagina is intact with no gross pathology. The cervix, uterus, fallopian tubes, and ovaries are within normal limits.

BRAIN & MENINGES:

Scalp and skull are unremarkable. Dura, falx and sinuses are intact. There are no epidural, subdural or subarachnoid collections of blood or exudate. The brain weighs 668 grams (fresh; expected, 518-890g). Cerebral hemispheres are symmetrically well developed and show a normal convolitional pattern. There is no evidence of pressure phenomenon. Vessels at the base of the brain are in normal anatomic relations and the brain stem is normally formed. Cerebellar hemispheres are symmetrically well-developed and show a normal pattern of foliation. Pituitary is unremarkable.

The brain and dura are cut fresh and are negative for significant findings, externally and on cut section.

The orbital roof is removed bilaterally, and the eyes/optic nerves are inspected in situ, and are without trauma.

The petrous bone overlying the internal auditory meatus is removed and the canals inspected; unremarkable.

A posterior neck/back dissection is performed and is unremarkable. The spinal cord is inspected and is

unremarkable.

MUSCULOSKELETAL: The vertebrae, clavicles, sternum, ribs, and pelvis are without fracture. The musculature is distributed and unremarkable. The bone marrow of the ribs is uniformly red, granular and otherwise unremarkable.

MICROSCOPIC SECTIONS:

HEART: Within normal limits

LUNGS: Chronic bronchitis with prominent intraparenchymal lymphoid follicles.

KIDNEYS/ADRENAL GLANDS: Within normal limits

THYMUS: Within normal limits

PANCREAS: Within normal limits

SPLEEN: Congestion, within normal limits

LIVER: Within normal limits

THYROID: Within normal limits, parathyroid within normal limits

GENITOURINARY: Within normal limits

GASTROINTESTINAL: Within normal limits

UPPER AIRWAY: Submucosal chronic inflammation with some areas of margination

CNS: Within normal limits (frontal lobe, midbrain, hippocampus, meninges; spinal cord histologically mal-oriented)

OTHER LAB PROCEDURES: Photo Micro Toxicology X-Ray Fingerprints Dental DNA GSR
PERK HIV Hepatitis Bacteriology Virology Accelerants Other

DISPOSITION OF EVIDENCE:

TOXICOLOGY – Heart blood.

OCME – Heart blood, iliac blood, purple top tube of blood, bile, liver.

INVESTIGATOR – None.

FUNERAL HOME – Clothing.

SUMMARY:

The decedent is a 3-month, [REDACTED] day infant female who was discovered deceased in her sleeping area. She was transported to the Office of the Chief Medical Examiner, Central District, for examination.

At autopsy, no overt traumatic or natural disease processes are noted, and additional studies are negative for significant findings. Patchy anterior livor consistent with prone positioning at time of death, and by report, the decedent was in a pack and play on a soft doughnut-shaped pillow.

This case is reviewed in conference with OCME pathologists, with consensus on cause and manner of death.

As with all death investigations, opinions expressed herein are amenable to change should new, reliable, and pertinent information come to light.

The Virginia Vital Events and Screening Tracking System provides five manners of death including: natural causes, accident, suicide, homicide, and undetermined. The manner of death is a forensic determination by the pathologist predicated upon the totality of the known evidence and circumstance surrounding the death; it is not a legal determination of criminal or civil responsibility of any person(s) for the death.

CAUSE OF DEATH: Sudden unexpected infant death with unsafe bedding and positioning.

MANNER OF DEATH: Undetermined.

Reporting Form



INVESTIGATION DATA

Last Name: [Redacted] First Name: [Redacted] M. F. Case# _____
 Sex: Male Female Date of Birth: [Redacted] Month Day Year Age _____ SS# _____

Race: White Black/African Am. Asian/Pacific Islander Am. Indian/Alaskan Native Hispanic/Latino Other

Infant's Primary Residence Address:

Address: [Redacted] City: Victoria Zip: 23574

Incident Address:

Address: [Redacted] City: Lunenburg Zip: 23552

Contact Information for Witness:

Relationship to the deceased: Birth Mother Birth Father Grandmother Grandfather
 Adoptive or Foster Parent Physician Health Records Other: Neighbor

Last Name: [Redacted] First Name: [Redacted] M. F. SS# _____
 Home Address: [Redacted] City: Lunenburg State: VA Zip: 23552

Place of Work: _____ City: _____ State: _____ Zip: _____
 Phone (H): [Redacted] Phone (W): [Redacted] Date of Birth: [Redacted]

WITNESS INTERVIEW

1 Are you the usual caregiver? Yes No

2 Tell me what happened:
See above

3 Did you notice anything unusual or different about the infant in the last 24 hrs? No Yes Describe: She was on her side, turned right her (one) hand (stomach) moving

4 Did the infant experience any falls or injury within the last 72 hrs? No Yes Describe: _____
 When was the infant LAST PLACED? _____
 Month Day Year Military Time Location (room)

6 When was the infant LAST KNOWN ALIVE (LKA)? 10/25/01 10:30 Living room
 Month Day Year Military Time Location (room)

7 When was the infant FOUND? 10/25/2001 _____ Back bedroom
 Month Day Year Military Time Location (room)

8 Explain how you knew the infant was still alive. was lying on her side and stomach moving

9 Where was the infant - (P)laced, (L)ast known alive, (F)ound (circle P, L, or F in front of appropriate response)?

P L F Bassinet	P L F Bedside co-sleeper	P L F Car seat	P L F Chair
P L F Cradle	P L F Crib	P L F Floor	P L F In a person's arms
P L F Mattress/box spring	P L F Mattress on floor	(P) L (F) Playpen	P L F Portable crib
P L F Sofa/couch	P L F Stroller/carriage	P L F Swing	P L F Waterbed
P L F Other _____			

WITNESS INTERVIEW (cont)

- 10 In what position was the infant LAST PLACED? Sitting On back On side On stomach Unknown
 Was this the infant's usual position? Yes No → What was the infant's usual position? _____
- 11 In what position was the infant LKA? Sitting On back On side On stomach Unknown
 Was this the infant's usual position? Yes No → What was the infant's usual position? _____
- 12 In what position was the infant Found? Sitting On back On side On stomach Unknown
 Was this the infant's usual position? Yes No → What was the infant's usual position? _____
- 13 FACE position when LAST PLACED? Face down on surface Face up Face right Face left
- 14 NECK position when LAST PLACED? Hyperextended (head back) Flexed (chin to chest) Neutral Turned
- 15 FACE position when LKA? Face down on surface Face up Face right Face left
- 16 NECK position when LKA? Hyperextended (head back) Flexed (chin to chest) Neutral Turned
- 17 FACE position when FOUND? Face down on surface Face up Face right Face left
- 18 NECK position when FOUND? Hyperextended (head back) Flexed (chin to chest) Neutral Turned
- 19 What was the infant wearing? (ex. t-shirt, disposable diaper) pink striped t-shirt, white disposable diaper
- 20 Was the infant tightly wrapped or swaddled? No Yes → Describe: _____

21 Please indicate the types and numbers of layers of bedding both over and under infant (not including wrapping blanket):

Bedding UNDER Infant	None		Number	Bedding OVER Infant	None		Number
Receiving blankets	<input checked="" type="checkbox"/>		1	Receiving blankets	<input checked="" type="checkbox"/>		
Infant/child blankets	<input type="checkbox"/>			Infant/child blankets	<input type="checkbox"/>		
Infant/child comforters (thick)	<input type="checkbox"/>			Infant/child comforters (thick)	<input type="checkbox"/>		
Adult comforters/duvets	<input type="checkbox"/>			Adult comforters/duvets	<input type="checkbox"/>		
Adult blankets	<input type="checkbox"/>			Adult blankets	<input type="checkbox"/>		
Sheets	<input type="checkbox"/>			Sheets	<input type="checkbox"/>		
Sheepskin	<input type="checkbox"/>			Pillows	<input type="checkbox"/>		
Pillows	<input type="checkbox"/>		1	Rubber or plastic sheet	<input type="checkbox"/>		
Rubber or plastic sheet	<input type="checkbox"/>			Other, specify: _____			
Other, specify: _____							

- Which of the following devices were operating in the infant's room?
 None Apnea monitor Humidifier Vaporizer Air Purifier Other _____
- 24 What was the temperature of the infant's room? Hot Cold Normal Other _____
Approx 72°
- 25 Which of the following items were near the infant's face, nose, or mouth?
 Bumper pads Infant pillows Positional supports Stuffed animals Toys Other _____
- 26 Which of the following items were within the infant's reach?
 Pacifier Nothing Other _____
 Blankets Toys Pillows
- 27 Was anyone sleeping with the infant? No Yes → Name these people. _____
- | Name | Age | Height | Weight | Location in Relation to Infant | Impaired (intoxicated, tired) |
|-------|-------|--------|--------|--------------------------------|-------------------------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

- 28 Was there evidence of wedging? No Yes → Describe: _____
- 29 When the infant was found, was s/he: Breathing Not breathing
 If not breathing, did you witness the infant stop breathing? No Yes

WITNESS INTERVIEW (cont.)

30 What had led you to check on the infant?

JUST WALKING THROUGH CHANGING ROOM

31 Describe infant's appearance when found.

- a) Discoloration around face/nose/mouth
- b) Secretions (foam, froth)
- c) Skin discoloration (livor mortis)
- d) Pressure marks (pale areas, blanching)
- e) Rash or petechiae (small, red blood spots on skin, membranes, or eyes)
- f) Marks on body (scratches or bruises)
- g) Other

Unknown	No	Yes	Describe and specify location:
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>pale inside</u>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>more inside</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>periphon under chin</u>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

32 What did the infant feel like when found? (Check all that apply.)

- Sweaty
- Limp, flexible
- Rigid, stiff
- Warm to touch
- Cool to touch
- Unknown

body was limp, arms and legs were pulled up

33 Did anyone else other than EMS try to resuscitate the infant?

Who: [Redacted] [Redacted] [Redacted] 10 25 01 Month Day Year Military Time

34 Please describe what was done as part of resuscitation:

mouth to mouth and chest compressions were done. Started 2 minutes prior to arrival then while on phone with dispatch until squad arrived + took over.

35 Has the parent/caregiver ever had a child die suddenly and unexpectedly? No Yes → Explain

INFANT MEDICAL HISTORY

1 Source of medical information:

- Mother/primary caregiver
- Doctor
- Other healthcare provider
- Medical record
- Family
- Other:

2 In the 72 hours prior to death, did the infant have:

	Unknown	No	Yes		Unknown	No	Yes
a) Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	h) Diarrhea	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b) Excessive sweating	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	i) Stool changes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
c) Lethargy or sleeping more than usual	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	j) Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d) Fussiness or excessive crying	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	k) Apnea (stopped breathing)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e) Decrease in appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	l) Cyanosis (turned blue/gray)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f) Vomiting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	m) Seizures or convulsions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
g) Choking	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	n) Other, specify:			

3 In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?

No Yes → Describe: possible ear infection, kept grabbing right ear

4 In the 72 hours prior to the infant's death, was the infant given any vaccinations or medications?

(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

No Yes → List below

	Name of vaccination or medication	Dose last given	Date given			Approx. time	Reasons given/ comments:
			Month	Day	Year		
1	<u>Vaccinated @ Birth</u>						
2	<u>albuterol</u>		<u>10</u>	<u>25</u>	<u>01</u>	<u>02:00 am</u>	<u>to take every 4hrs</u>
3							
4							

INFANT MEDICAL HISTORY (cont.)

5 At any time in the infant's life, did s/he have a history of?

	Unknown	No	Yes	Describe:
a) Allergies (food, medication, or other)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒
b) Abnormal growth or weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⇒ 10 lbs gain @ 38 weeks
c) Apnea (stopped breathing)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒
d) Cyanosis (turned blue/gray)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒
e) Seizures or convulsions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒
f) Cardiac (heart) abnormalities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⇒
g) Metabolic disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒
h) Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⇒

6 Did the infant have any birth defects(a)?

No Yes

Describe: _____

7 Describe the two most recent times that the infant was seen by a physician or health care provider:

(include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls)

	First most recent visit	Second most recent visit
a) Date	10 / 18 / 21 Month Day Year	____ / ____ / ____ Month Day Year
b) Reason for visit	congestion	
c) Action taken	cond first test (both negative)	
d) Physician's name	Dr. Vinel Mammucari	
e) Hospital/clinic	Keyville Pediatrics	
f) Address	130 J Street Keyville	
g) City, ZIP	VA 23947	
h) Phone number	____	____

8 Birth hospital name: St Francis Hospital Midlothian
Street: 13710 St Francis Blvd Midlothian VA 23114

City _____ State _____ ZIP _____
Date of discharge: _____
Month Day Year

9 What was the infant's length at birth? 19 inches or _____ centimeters

10 What was the infant's weight at birth? 6 pounds 0 ounces or _____ grams

11 Compared to the delivery date, was the infant born on time, early, or late?
 On time Early - How many weeks early? _____ Late - How many weeks late? _____

12 Was the infant a singleton, twin, triplet, or higher gestation?
 Singleton Twins Triplet Quadruplet or higher gestation

13 Were there any complications during delivery or at birth? (emergency c-section, child needed oxygen)
 No Yes ⇒ Describe the complications: _____

14 Are there any alerts to pathologist? (previous infant deaths in family, newborn screen results)
 No Yes ⇒ Specify: _____

INFANT DIETARY HISTORY

1 On what day and at what approximate time was the infant last fed?
10, 25, 2004 Monday 8:30:am
 Month Day Year

2 What is the name of the person who last fed the infant? [REDACTED]

3 What is his/her relationship to the infant? Mother

4 What foods and liquids was the infant fed in the last 24 hours (include last fed)?

	Unknown	No	Yes	Quantity	Specify: (type and brand if applicable)
a) Breast milk (one/both sides, length of time)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒	_____ ounces
b) Formula (brand, water source - ex. Similac, tap water)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	⇒	<u>2</u> ounces <u>parent's choice gentle ease</u>
c) Cow's milk	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒	_____ ounces
d) Water (brand, bottled, tap, well)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒	_____ ounces
e) Other liquids (tea, juices)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒	_____ ounces
f) Solids	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒	_____
g) Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	⇒	_____

5 Was a new food introduced in the 24 hours prior to his/her death?
 No Yes ⇒ Describe (ex. content, amount, change in formula, introduction of solids)

6 Was the infant last placed to sleep with a bottle?
 Yes No ⇒ Skip to question 7 below

7 Was the bottle propped? (i.e., object used to hold bottle while infant feeds)
 No Yes ⇒ What object was used to prop the bottle? _____

8 What was the quantity of liquid (in ounces) in the bottle? 4 ounces

9 Did death occur during? Breast-feeding Bottle-feeding Eating solid foods Not during feeding

10 Are there any factors, circumstances, or environmental concerns that may have impacted the infant that have not yet been identified? (ex. exposed to cigarette smoke or fumes at someone else's home, infant unusually heavy, placed with positional supports or wedges)
 No Yes ⇒ Describe concerns: _____

PREGNANCY HISTORY

1 Information about the infant's birth mother:

First name [REDACTED] Middle name [REDACTED]
 Last name [REDACTED] Maiden name [REDACTED]
 Date of birth: _____ SS # _____
 Current Address [REDACTED] City Vienna State VA ZIP 23174
 How long has the birth mother been a resident at this address? 4 Years and _____ Months

2 At how many weeks or months did the birth mother begin prenatal care?
 _____ Weeks _____ Months No prenatal care Unknown
started around Jan.

3 Where did the birth mother receive prenatal care? (Please specify physician or other health care provider name and address.)
 Physician/provider Dr. Schatz Hospital/clinic NEW EAST FRANCIS Phone (____) _____
 Street _____ City _____ State _____ ZIP _____

PREGNANCY HISTORY (cont.)

4 During her pregnancy with the infant, did the biological mother have any complications?

(ex. high blood pressure, bleeding, gestational diabetes)

No Yes ⇨ Specify

high blood pressure, diabetes

5 Was the biological mother injured during her pregnancy with the infant? (ex. auto accident, falls)

No Yes ⇨ Specify

6 During her pregnancy, did she use any of the following?

	Unknown	No	Yes	Daily consumption	Unknown	No	Yes	Daily consumption
a) Over the counter medications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		d) Cigarettes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b) Prescription medications	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>aspirin</u>	e) Alcohol	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c) Herbal remedies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		f) Other	<input type="checkbox"/>	<input type="checkbox"/>	

7 Currently, does any caregiver use any of the following?

	Unknown	No	Yes	Daily consumption	Unknown	No	Yes	Daily consumption
a) Over the counter medications	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>excedrin</u>	d) Cigarettes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b) Prescription medications	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>Zoloft</u>	e) Alcohol	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c) Herbal remedies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		f) Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

INCIDENT SCENE INVESTIGATION

1 Where did the incident or death occur?

babysitters house

2 Was this the primary residence?

Yes No

3 Is the site of the incident or death scene a daycare or other childcare setting?

Yes No ⇨ Skip to question 8 below

4 How many children were under the care of the provider at the time of the incident or death? 5 (under 18 years or older)

5 How many adults were supervising the child(ren)? 2 (18 years or older)

6 What is the license number and licensing agency for the daycare?

License number: _____ Agency: _____

7 How long has the daycare been open for business? _____

8 How many people live at the site of the incident or death scene?

2 Number of adults (18 years or older) 5 Number of children (under 18 years old)

9 Which of the following heating or cooling sources were being used? (Check all that apply.)

<input checked="" type="checkbox"/> Central air	<input type="checkbox"/> Gas furnace or boiler	<input type="checkbox"/> Wood burning fireplace	<input type="checkbox"/> Open window(s)
<input type="checkbox"/> A/C window unit	<input type="checkbox"/> Electric furnace or boiler	<input type="checkbox"/> Coal burning furnace	<input type="checkbox"/> Wood burning stove
<input checked="" type="checkbox"/> Ceiling fan	<input type="checkbox"/> Electric space heater	<input type="checkbox"/> Kerosene space heater	
<input type="checkbox"/> Floor/table fan	<input type="checkbox"/> Electric baseboard heat	<input type="checkbox"/> Other ⇨ Specify _____	
<input type="checkbox"/> Window fan	<input type="checkbox"/> Electric (radiant) ceiling heat	<input type="checkbox"/> Unknown	

10 Indicate the temperature of the room where the infant was found unresponsive:

Thermostat setting _____ Thermostat reading _____ Actual room temp. _____ Outside temp. _____

11 What was the source of drinking water at the site of the incident or death scene? (Check all that apply.)

<input type="checkbox"/> Public/municipal water source	<input type="checkbox"/> Bottled water	<input type="checkbox"/> Other ⇨ Specify _____
<input checked="" type="checkbox"/> Well	<input type="checkbox"/> Unknown	

12 The site of the incident or death scene has: (check all that apply)

<input type="checkbox"/> Insects	<input type="checkbox"/> Mold growth	<input type="checkbox"/> Odors or fumes ⇨ Describe: _____
<input type="checkbox"/> Smoky smell (like cigarettes)	<input checked="" type="checkbox"/> Pets	<input type="checkbox"/> Presence of alcohol containers
<input type="checkbox"/> Dampness	<input type="checkbox"/> Peeling paint	<input type="checkbox"/> Presence of drug paraphernalia
<input type="checkbox"/> Visible standing water	<input type="checkbox"/> Rodents or vermin	<input type="checkbox"/> Other ⇨ Specify _____

13 Describe the general appearance of incident scene: (ex. cleanliness, hazards, overcrowding, etc.)

cluttered, approx 6 inside cats, 1 ferret

INVESTIGATION SUMMARY

1 Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the infant that have not yet been identified?

2 Arrival times: Law enforcement at scene: 11:29 Military Time DSI at scene: _____ Military Time Infant at hospital: 12:14 Military Time

Investigator's Notes

Indicate the task(s) performed.

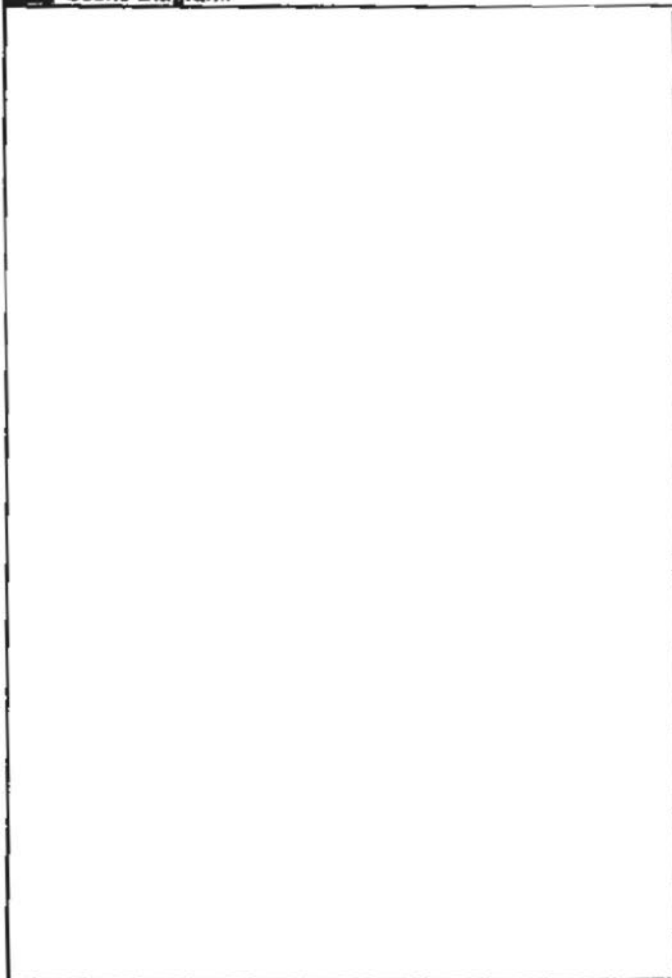
- Additional scene(s)? (forms attached)
- Materials collected/evidence logged
- Notify next of kin or verify notification
- Doll reenactment/scene re-creation
- Referral for counseling
- 911 tape
- Photos or video taken and noted
- EMS run sheet/report

If more than one person was interviewed, does the information differ?

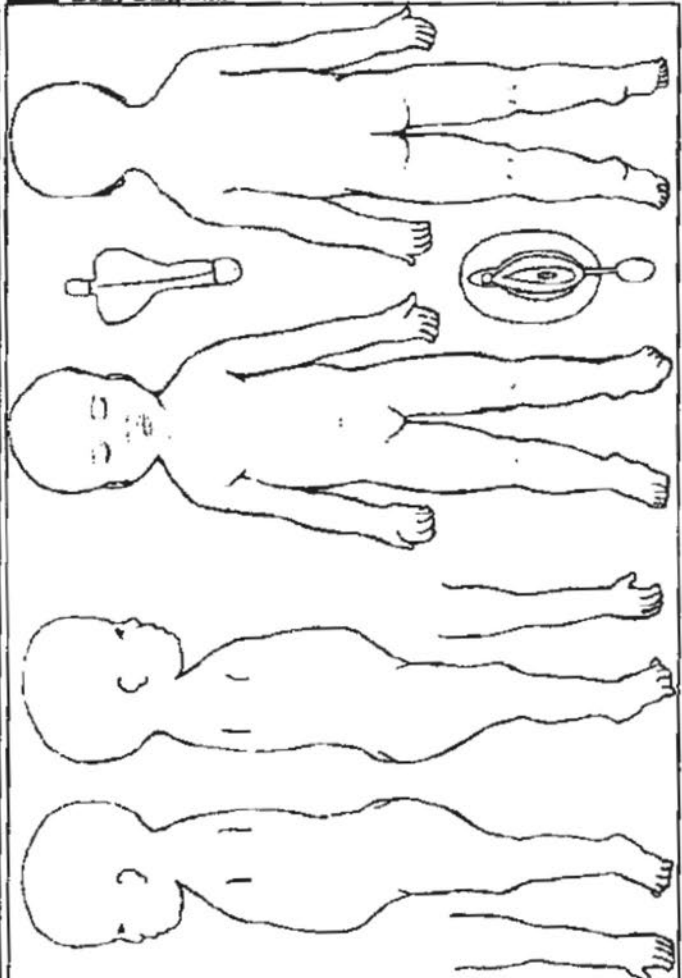
- No
- Yes ⇨ Detail any differences, inconsistencies of relevant information: (ex. placed on sofa, last known alive on chair.)

INVESTIGATION DIAGRAMS

1 Scene Diagram:



2 Body Diagram:



SUMMARY FOR PATHOLOGIST

Case Information
Sleeping Environment
Infant History
Family Info
Exam
Investigator Insight
Pathologist

Investigator Information: Name TC Townes Agency Lunenburg Phone 434-1096-4452
Investigated: 10/25/21 : : Pronounced Dead: / / : :
Month Day Year Military Time Month Day Year Military Time

Infant's Information: Last First M. Case #
Sex: Male Female Date of Birth / / Age Months
Month Day Year Month Day Year Months
Race: White Black/African Am. Asian/Pacific Islander Am. Indian/Alaskan Native Hispanic/Latino Other

1 Indicate whether preliminary investigation suggests any of the following:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Asphyxia (ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sharing of sleeping surface with adults, children, or pets |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in sleeping condition (ex. unaccustomed stomach sleep position, location, or sleep surface) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperthermia/Hypothermia (ex. excessive wrapping, blankets, clothing, or hot or cold environments) |
| <input type="checkbox"/> | <input type="checkbox"/> | Environmental hazards (ex. carbon monoxide, noxious gases, chemicals, drugs, devices) |
| <input type="checkbox"/> | <input type="checkbox"/> | Unsafe sleeping conditions (ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diet (ex. solids introduction etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent hospitalization |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous medical diagnosis |
| <input type="checkbox"/> | <input type="checkbox"/> | History of acute life-threatening events (ex. apnea, seizures, difficulty breathing) |
| <input type="checkbox"/> | <input type="checkbox"/> | History of medical care without diagnosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent fall or other injury |
| <input type="checkbox"/> | <input type="checkbox"/> | History of religious, cultural, or ethnic remedies |
| <input type="checkbox"/> | <input type="checkbox"/> | Cause of death due to natural causes other than SIDS (ex. birth defects, complications of preterm birth) |
| <input type="checkbox"/> | <input type="checkbox"/> | Prior sibling deaths |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous encounters with police or social service agencies |
| <input type="checkbox"/> | <input type="checkbox"/> | Request for tissue or organ donation |
| <input type="checkbox"/> | <input type="checkbox"/> | Objection to autopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Pre-terminal resuscitative treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Death due to trauma (injury), poisoning, or intoxication |
| <input type="checkbox"/> | <input type="checkbox"/> | Suspicious circumstances |
| <input type="checkbox"/> | <input type="checkbox"/> | Other alerts for pathologist's attention |

Any "Yes" answers should be explained and detailed.

Brief description of circumstances: _____

2 Pathologist Information:

Name _____ Agency _____
Phone (_____) _____ Fax (_____) _____

Slept in playpen @ home
Slept on Zippy pillow for elevation
No falls
No one played rough/shook her

[REDACTED] got here a about 9 or 50
 Played in my arms and with me
 till about 10-10:30 Laid down for nap
 Checked on alot. Husband checked about
 11 and seen [REDACTED] was on side
 but looked normal. Moved her up and
 straight on [REDACTED] pillow and then noticed
 Rail and screamed for me and we
 started CPR while i did CPR he called
 911 continued till Squad got here.

(10)

10/25/21

12:10 pm

I observed on the kids playing and laughing. I noticed [redacted] was on her side in the [redacted] pillow. I immediately picked her up to get her back comfortable in the pillow. I noticed her looking Pale and started to check her breathing. She was unresponsive, I immediately went in to the living room with my wife [redacted] and she started CPR. We called 911 while doing CPR and continued until Squad got here.

[redacted]
[Signature]

10/25/21

EXHIBIT 2
JX-12B
(filed *in camera*)