

1. Task Number 120109CAA1337		2. Investigator's ID 9085		EPIDEMIOLOGIC INVESTIGATION REPORT
3. Office Code 810	4. Date of Accident YR MO DAY 2011 11 21	5. Date Initiated YR MO DAY 2012 01 09		
6. Synopsis of Accident or Complaint UPC				
<p>A 4 month-old male was found unresponsive, lying perpendicular to and on top of a foam baby recliner installed in his crib, into which he had been placed to sleep the evening prior. When found the victim's head was hanging off the recliner and his face was pressed against a crib bumper affixed to the side of the crib. The victim was transported to a local hospital where he was pronounced dead. The postmortem report listed SIDS as the cause of death and the manner of death as Natural.</p>				<p style="text-align: right;"><i>Am</i> 1/28/12</p> <p>MFR/PRVLBR NOTIFIED</p> <p>COMMENTS: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> OVERRULED; <input type="checkbox"/> ATTACHED</p> <p><input checked="" type="checkbox"/> EXCISIONS/FOIA EXS. 3, 25, 6, 36, 1</p> <p><input checked="" type="checkbox"/> DO NOT RE-NOTIFY <input type="checkbox"/> RE-NOTIFY</p>
7. Location (Home, School, etc) 1 - HOME		8. City NEW CANAAN		9. State CT
10A. First Product 1542 - Baby Mattresses Or Pads		10B. Trade/Brand Name [REDACTED]		10C. Model Number [REDACTED]
10D. Manufacturer Name and Address [REDACTED]				
11A. Second Product 4054 - Other Bedding		11B. Trade/Brand Name Non [REDACTED]		11C. Model Number UNKNOWN
11D. Manufacturer Name and Address Non Responsive [REDACTED]				
12A. Hispanic or Latino 2 - No	12B. Race 1 - White Other:		12C. Race Source 1 - Respondent-Self/Family	
13. Age of Victim 204	14. Sex 1 - Male	15. Disposition 8 - Death	16. Injury Diagnosis 71 - Other/NS/No inj	
17. Body Part(s) Involved 87 - N.S./UNK	18. Respondent 1 - Victim/Complainant	19. Type of Investigation 3 - Other	20. Time Spent (Operational / Travel) 21 / 2	
21. Attachment(s) 9 - Multiple Attachments		22. Case Source 07 - Consumer Complaint		23. Sample Collection Number
24. Permission to Disclose Name (Non NEISS Cases Only) <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Yes for Manuf. Only <input checked="" type="radio"/> Verbal <input type="radio"/> Written				
25. Review Date 01/23/2012	26. Reviewed By 9093		27. Regional Office Director Dennis R. Blasius	
28. Distribution Nelson, Theresa; Moore, Kelly; Kessler, Charles; Lytle, Lori-Ann			29. Source Document Number I11C0712A	

This investigation was initiated as a result of a consumer complaint filed with the CPSC on December 31, 2011 regarding the death of a four month old male on November 21, 2011. The complainant is the victim's mother and she believes that a portable foam baby recliner, (hereinafter referred to as a "baby recliner"), in use at the time of her son's death contributed to his death. Limited information was obtained from the complainant during a January 9, 2012 telephone conversation. This conversation revealed that the incident baby recliner and a crib bumper were being retained as evidence by the local police department and that the involved crib and bedding had been discarded post incident. On January 10, 2012, this Investigator visited the local police department and met with the Property Custodian. During this visit the incident baby recliner and crib bumper were examined and photographed. The photographs taken during this visit are appended as Exhibit 2 of this report. The complainant was contacted a second time via telephone on January 12, 2012 and interviewed more extensively regarding the incident and the involved products. The information contained in this report was obtained in part from the complainant during the January 9, 2012 and January 12, 2012 telephone conversations and in part from examination of the autopsy report (see Exhibit 3), the toxicology report (see Exhibit 4), the Medical Investigator's written report (see Exhibit 5) and photographs taken by the Medical Investigator during a November 29, 2011 reconstruction of the incident at the victim's home (see Exhibit 6). Exhibits 3 through 6 noted above were all submitted by the Medical Examiner's Office in response to a request made by this Investigator. Although requested, the police report, ambulance run report and hospital records have not yet been received, (see Exhibit 9). It is unknown if or when these reports will be received. All parties are identified in Exhibit 1 of this report. **The complainant does not want her identity or the identity of the victim released to anyone, including the manufacturer.**

A review of CPSC's public web-site reveals that the incident baby recliner appears to be subject to Release [REDACTED] (see Exhibit 8). This voluntary recall of the subject baby recliner was due to entrapment, suffocation and fall hazards associated with the product. Additionally, there was one known fatality of an infant who was caught between the baby recliner and the bumper of a crib. The voluntary recall provided for the stop sale and use of the first generation of the subject baby recliner which lacked plastic D-shaped rings affixed to the foam portion of the recliner and [REDACTED] straps affixed to the fabric cover, intended to secure to the D-shaped rings, thus keeping the fabric cover in place. The voluntary recall also provided for the stop use of the second generation of the subject baby recliners, which were equipped with the D-shaped rings and [REDACTED] straps, until such time as parents could obtain new instructions and warnings. The warnings included statements not to use the product on elevated surfaces and not to use it in confined areas such as cribs and play yards. Investigation revealed that the baby recliner involved in the subject incident was a second generation baby recliner, (see Exhibit 2).

The four month-old male victim lived in a single-family residence with his forty-two year-old father, 34 year-old mother, eight year-old sister and five year-old brother. Internet research revealed the incident home is located in an affluent community and consists of eight bedrooms, nine bathrooms and 7831 square feet, (see Exhibit 10). The victim's bedroom was described as being adjacent to the master bedroom in the home. The victim had his own bedroom and did not share a room with either of his siblings. The complainant, an attorney practicing in the financial

sector, described both herself and her husband as “highly educated”. A nanny employed by the family cares for the children during the day, but was not present prior to, or at the time of, the incident.

The victim was born in early [REDACTED]. The complainant reported that the victim’s birth was unremarkable and that he was a “relatively” healthy baby of normal size and weight at birth. The complainant stated that from birth the victim suffered from “severe acid reflux” in that he “**always** threw up ½ of what he ate **all** the time”. (Emphasis noted is the complainant’s and she repeated the statement several times.) The complainant noted that the victim gained weight but opined that, “The only reason he gained weight is because he was eating around the clock”. On or about November 7, 2011, during the victim’s last pediatrician’s visit prior to his death, the then four-month old victim was described as being “the size of a six month old” and he measured “in the 90th percentile for height and weight”. The complainant stated that at his last pediatrician’s visit the victim measured 26” in length and weighed 16 pounds, 6 ounces.

The complainant stated that during one of the victim’s early pediatrician’s visits, (believed to be on or about July 7, 2011), the pediatrician advised the complainant that “to ease the symptoms of acid reflux” she should keep the victim’s head elevated when he was placed down to sleep. On or about November 7, 2011, the victim was brought to a pediatrician’s visit and was placed on 7.5 cc’s of [REDACTED] for acid reflux. The complainant reported that on November 14, 2011 she was advised by the victim’s pediatrician’s office to stop the [REDACTED] and he was placed on 15 mg. of [REDACTED]. This change in medication was the result of the complainant informing the pediatrician’s office that the [REDACTED] “was not working”. The victim had no other reported health issues other than the acid reflux.

The furniture and bedding in the victim’s room at the time of the incident were all purchased new for an unknown amount of money at a local retailer at an unknown time prior to the victim’s birth for the victim’s use. The complainant described the retailer as an “exclusive” retailer which sells only one brand of products. The complainant noted that when her older two children were born she and her husband “did not have the amount of disposable income” that they did when the victim was born. The complainant explained that prior to the victim’s birth, “the family’s disposable income allowed me to go into (the subject retailer) and purchase whatever I wanted”. The complainant further explained that when she visited the subject retailer, she “fell in love with a display room” that was installed in the retail store, and decided to “order everything in it; the crib, the bedding and crib bumpers, the wall art, the curtains. I ordered everything that was on display in that room”. When asked if the bedding and crib bumpers were custom-made, the complainant replied, “No. It was all stock items”. (Product details regarding the furniture and bedding are limited as the furniture and bedding was disposed of in an unknown manner shortly after the victim’s death. The portion of the crib bumper set involved in the incident was collected as evidence by the local police department and was examined and photographed by this Investigator; however it was noted that there was no labeling on, or labels affixed to, the crib bumper in evidence that identified the manufacturer, make or fabric design.)

On July 28, 2011, the complainant was searching the Internet for nursery products to assist with the victim's acid reflux symptoms. The complainant visited a retail Internet web-site, (see Product Identification section of report), and entered the words "acid reflux" into the site's internal search box. The complainant reported that a link to the subject baby recliner was the only product returned in response to her search request. The complainant stated that this is how she became aware of the subject baby recliner. After reading the product's description, and in response to the pediatrician's advice to keep the victim's head elevated, the complainant believed that the subject baby recliner was "exactly what (she) was looking for". The complainant ordered the incident baby recliner new via the Internet on July 28, 2011. The order number the site provided at check-out was # [REDACTED]. The complainant explained that the incident baby recliner was "marked down" from an unknown price as it was advertised on the Internet retail site as being "discontinued". The complainant paid \$99.99 for the baby recliner. (Although a copy of the purchase order was requested, it has not been received.) The complainant did not visit the baby recliner manufacturer's Internet web-site prior to the purchase or prior to her son's death.

The incident baby recliner was received on July 30, 2011. The complainant stated that she never received a purchase receipt. A packing slip which accompanied the baby recliner was discarded upon receipt. The complainant could not recall if any printed material such as product literature or an owner's manual accompanied the incident baby recliner. All product packaging was discarded the day the baby recliner was received. The baby recliner was put into immediate use and the victim was two weeks old at this time. The complainant stated that she was aware of labeling on the bottom of the product which advised not to use the baby recliner in a crib or in any other location than the floor. The complainant stated that she was also aware of labeling on the bottom of the product which advised that the lap belt should always be used.

From the date of receipt, the incident baby recliner was used in the victim's crib on top of a standard sized crib mattress covered with a crib sheet. When asked if she usually fastened the safety belt while her son was in the incident baby recliner, the complainant responded, "not usually". The complainant repeatedly stated to this Investigator, "I know I was using it improperly". The complainant reported that when installed in the crib, there was approximately 1/2" of space, on either side of the baby recliner, between the side of the baby recliner and the crib bumpers installed on the sides of the crib. The complainant noted that during the victim's one month pediatrician's visit, she informed the pediatrician that she was using the incident baby recliner in the crib and "she never advised me not to". The incident baby recliner was used on a nightly basis from the day it was received until the date of the victim's death "to help prevent his acid reflux". The incident baby recliner remained in the victim's crib when not in use. The complainant stated that, with the exception of one occasion, the incident baby recliner was "never" used outside of the victim's crib. (The complainant explained that during an unusual October 2011 snow event the home lost power for several days and the family stayed at a local hotel until power was restored. The complainant further explained that this was the "one and only" time that the incident baby recliner was removed from the victim's crib. The complainant brought the incident baby recliner to the hotel for the victim to sleep in. While at the hotel, the incident baby recliner was used on the floor.) No one other than the victim was ever placed in

the incident baby recliner. The complainant stated that neither of her other two children suffered from acid reflux; as such, she had no experience with this product, or any similar product, prior to its purchase for the victim's use.

At the time of the incident the victim was four and-a-half months old, weighed approximately 27 pounds, measured approximately 26 ½" in length and had a head circumference of 17", (see Exhibit 3). The complainant stated that at the time of his death the victim "could push up with his arms and get his head and chest off the floor", but could not roll over on his own or sit up unassisted. The complainant further stated that the victim would "rock side-to-side" in an effort to roll over, but had not yet successfully done so.

A baby monitor in use at the time of the incident was turned "on"; however the complainant reported that she had left the receiver portion of the monitor downstairs when she retired for the evening. The complainant stated, "I've always been really bad about carrying around the receiver".

At the time of the incident a crib sheet was installed on the standard sized crib mattress installed in the crib, individual crib bumpers were installed on all four sides of the crib, the incident baby recliner was on top of the sheet-covered mattress and three cotton receiving blankets were in the crib. (The crib bumpers in use at the time of the incident consisted of a set of four matching bumpers; two installed on each side of the crib, one installed at the head of the crib and one installed at the foot of the crib. The crib bumpers in use were not continuous in that each bumper was installed separately and could be removed individually.) There was no comforter in use and there were no other items, such as toys, in the crib at the time of the incident. The complainant stated that the items in the crib at the time of the incident were "always" in the crib.

The temperature of the victim's room the evening of the incident was set to 68 degrees Fahrenheit. The complainant stated that the victim was wearing a "nightgown type garment" at time of the incident and noted that "his feet were free". No further details regarding the garment the victim was wearing at the time of the incident were available as it was discarded after the victim's death.

The complainant stated that usually the victim was put to sleep in the incident baby recliner at 8:00 PM each evening. The complainant further stated that "usually" the victim was already asleep prior to being placed in the incident baby recliner. The victim would "usually" wake up around 4:00 AM every morning to feed and then he would be placed back to sleep from whatever time he finished feeding until 7:00 AM at which time he would awake for the day. The complainant described the victim as a "great sleeper" and noted that he "usually" slept eight hours continuously until he woke up for his 4:00 AM feeding. After providing the above typical nightly schedule, the complainant stated that the evening prior to the incident "was not at all typical". The complainant explained that the evening prior to the incident, at or about 7:30 PM, she found lice on her daughter's head. As a result, she stripped her daughter's bed, laundered her daughter's bedding and clothing, washed her hair, sent her husband to the local pharmacy for lice treatment and applied the lice treatment to her daughter's head. The complainant stated that as a

result of the above activities, the victim was not put to sleep until “close to midnight” the evening prior to / of the incident. The complainant further stated that as a result of all the activity in the household, the victim “did not fall asleep much before midnight”. The complainant noted that immediately prior to falling asleep, (estimated to be around 11:30 PM the evening prior to the incident), the victim was fed his last bottle of formula. The complainant could not recall if the victim finished the entire bottle, but noted that “he usually did”. The victim was asleep at the time he was placed into the incident baby recliner installed in his crib.

The complainant stated that the victim’s father placed him into the incident baby recliner the night of the incident but noted that she was “either in the room or went into the room and tended to” the victim shortly thereafter. The victim’s head was on the elevated portion of the incident baby recliner and his feet were on the lower end of the baby recliner when he was put to sleep for the night. The incident baby recliner’s safety belt was not fastened at the time of the incident. With regards to the three cotton receiving blankets in the crib, the complainant stated that one of the blankets was underneath the incident baby recliner directly over the crib sheet; a second blanket was directly over the incident baby recliner and underneath the victim and the third blanket was placed over the victim and was “pulled half-way up to about waist level”. The complainant explained that the blanket directly underneath the incident baby recliner and the blanket directly over the incident baby recliner were always used in this manner to protect the baby recliner’s fabric cover from the victim’s “propensity to vomit up half his bottle” as a result of his acid reflux.

As was his usual schedule, the complainant’s husband left the house for work at 4:00 AM the morning of the incident. He did not enter the victim’s bedroom prior to leaving the house. The victim’s father was not home at the time of the incident.

At approximately 5:00 AM the morning of the incident, the complainant heard the victim crying in his room. The complainant explained that each night after hearing her son cry, she would prepare her son’s early morning bottle at a “wet bar” located in the master bedroom prior to entering his room. After hearing his cry the morning of the incident, she got out of bed, prepared his bottle and prepared to leave her room. The complainant reported that it took her less than five minutes to prepare the victim’s bottle. The complainant stated that prior to leaving her room she noted that she did not hear the victim crying. The complainant left her room, walked down the hallway towards the victim’s room and again noted, prior to reaching the victim’s door, that the victim’s room was quiet. At this time the complainant believed the victim had fallen back to sleep and she returned to her bed. The complainant noted that she did not find this unusual as the victim had been awake much later the evening prior than was normal. The complainant did not enter the victim’s room at this time. The victim was last known alive at approximately 5:00 AM the morning of the incident.

The ME Investigator’s report notes that, “At or about 8:00 hours, (the complainant) was awoken (sic) by the chirp of a car alarm belonging to her nanny who had arrived for her normal workday at the residence”, (see Exhibit 5). The complainant exited her bed, met her nanny at the front door and informed her of the prior night’s events regarding the lice. After speaking with the

nanny, the complainant walked upstairs to the victim's bedroom. At approximately 8:05 AM on November 21, 2011, the complainant discovered the victim unresponsive in his crib.

The complainant stated the following with regards to her son's position and appearance at the time he was found: (He) was lying on his back, completely sideways, towards the bottom, in the (baby recliner). His entire face was pressed into the side crib bumper. His shoulders were still on the (baby recliner). His head was hanging off of the (baby recliner), tipped backwards from his neck. It appeared that the very top of his head was in contact with the mattress.

The blanket underneath the incident baby recliner and the blanket directly over top of the incident baby recliner were both still in place when the victim was found. The complainant stated that the third blanket, which had been placed over top of the victim to waist level the previous evening, was found "kicked off at the foot of the crib; nowhere near (the victim)".

The complainant immediately removed her son from the crib and noted that his face was blue in color. She ran downstairs with the victim in her arms to meet the nanny. An emergency call was placed via the home phone to "911" by one of the two women, (it was not clear who placed the call). The complainant stated that after emergency responders were summoned, she returned to the victim's room and placed him back into the crib, "not knowing what else to do". At some unknown time prior to the arrival of the local police, the family's nanny removed the incident baby recliner from the incident crib, (reason why unknown). It is not clear and could not be determined if the baby recliner was removed prior to the arrival of first responders or between the time first responders (ambulance personnel) arrived and the police arrived.

First responders, ambulance personnel, arrived at an unknown time after the "911" call was placed and found the victim in his crib. First responders initiated CPR on the victim in his home. The complainant stated that first responders "worked on (the victim) for almost a full hour at the house". She noted that Epinephrine was injected into the victim and an "oxygen tent" was placed over him while he was in his bedroom. The complainant stated that first responders "seemed encouraging" about the victim's survival and one first responder noted that the fact that "only his face was blue was a good sign". The victim was transported via ambulance to a nearby hospital where CPR was continued. The complainant stated that at the hospital emergency personnel "did a test for brain activity and found none". At this time the complainant was asked by unknown medical personnel if she wanted hospital staff to stop CPR and she advised that she wanted CPR stopped. The victim was pronounced dead at or about 9:30 AM on November 21, 2011, (see Exhibit 5).

A postmortem examination of the victim's body was conducted on November 22, 2011. In reference to the victim's lungs, the autopsy report reads in part, "****The cut surfaces of both lungs are unremarkable. No masses or consolidations are identified. The pulmonary arteries are patent and free of thromboemboli. The bronchi are patent****". In reference to the victim's neck, the autopsy report reads in part, "****The skin and muscles of the anterior neck are free of hemorrhage and signs of trauma. No fractures of the hyoid bone, thyroid cartilage, or cervical spine are identified. The tongue is free of trauma. The thyroid gland is red/brown and free of

trauma. The oral and nasopharynx are free of trauma****". The autopsy report is appended as Exhibit 3. The toxicology report, dated December 31, 2011, did not detect any drugs, alcohol or carbon monoxide, (see Exhibit 4). The cause of death was initially classified as "Pending Further Study" and the manner of death was initially classified as "Pending"; however the autopsy report was amended on January 5, 2012 as to cause and manner of death. The final cause of death is "Sudden Infant Death Syndrome" and the final manner of death is "Natural". The autopsy report is appended as Exhibit 3.

Although the Medical Examiner's office was notified of the victim's death on November 21, 2011, the ME Investigator did not meet with the local police and the victim's parents to recreate the incident until November 29, 2011 due to scheduling conflicts, (see Exhibit 5). On November 29, 2011, local police and the ME Investigator met with both of the victim's parents and interviewed them regarding the circumstances surrounding their son's death. This Investigator noted that incident details provided by the complainant during the January 9, 2012 and January 12, 2012 telephone conversations were the same as those documented in the ME Investigative report. The ME Investigative report, (see Exhibit 5), reflects that during the November 29, 2011 meeting with the victim's parents, the victim's mother (the complainant) stated that she believed that the victim "suffocated due to the position in which he was found". (It should be noted that police personnel seized a sheet, "that was noted by police to have been securely and appropriately over the mattress", and the crib bumper, "that was noted properly secured to the spindles of the crib", involved in the incident on November 21, 2011. As the family nanny had removed the incident baby recliner from the crib prior to the arrival of the police on the day of the incident, however, this item was not seized by the police until November 29, 2011 after the reconstruction of the incident was complete.) The ME Investigator took photographs of the complainant reconstructing how the victim was placed to sleep the evening prior to the incident and reconstructing how he was discovered unresponsive the following morning. A doll provided by the ME Investigator was used to reconstruct the victim's positioning. These photographs are appended as Exhibit 6.

The following description regarding the reconstruction of how the victim was found unresponsive in the crib is documented in the ME Investigative report, (see Exhibit 5): (The victim) was found laying perpendicular to the (baby recliner). The posterior aspect of (the victim's) neck was resting on the edge of the (baby recliner). The top of (the victim's) head was resting on top of the mattress, and his face was noted pressed against the bumper that was in place at the time (the victim) was found. (One of the photographs taken by the ME Investigator depicts (the complainant's) right hand on the mattress indicating where the top of (the victim's) head was found, showing how hyper-extended his neck was. (The complainant) reported that it appeared to her as if (the victim's) nose and mouth were pressed against the bumper of the crib.

It should be noted that the complainant advised this Investigator via E-mail that she had viewed the CPSC Recall Notice, (see Exhibit 8), and that "the last picture is identical" to how she found her son, (see Exhibit 13). Upon viewing the reconstruction photographs, (see Exhibit 6), and interviewing the complainant a second time on January 12, 2012, it is believed that although the two positions are similar in that the victims' faces are in contact with the bumpers, they are not

identical as the victim was reportedly, “Not on his side at all, but was on his back.” It should also be noted that the complainant stated she had no knowledge of the CPSC recall until after her son’s death.

At some unknown time following the November 29, 2011 reconstruction, the complainant and her husband “disposed of” the incident crib and bedding. When asked a second time if the crib and bedding was available at another location for examination, the complainant responded, “No. We completely got rid of it”.

The complainant spoke with an unknown person at the Medical Examiner’s office on an unknown date after January 5, 2012, (when the final cause of death was amended). The ME representative advised the complainant that the victim’s cause of death was not positional asphyxiation because “there was no damage to the lungs” and “no capillaries burst”. When pressed and after stating that she believed her son had suffocated, the ME representative advised the complainant that, “There is no physical evidence of positional asphyxia” and that without physical evidence, the cause of death would be “Sudden Infant Death Syndrome”. The complainant continues to believe that the baby recliner, specifically the position in which he was found as a result of having been placed in the baby recliner, contributed to her son’s death.

The complainant has not reported her son’s death to either the manufacturer or the retailer and has no plans to do so. The complainant explained that she contacted the CPSC after speaking with a “close friend” who was described as a “national child safety advocate” and “founder of a well known safety firm”.

During the initial January 9, 2012 telephone conversation with the complainant she stated more than once that she was aware of the product labeling “with the warnings” on the incident baby recliner and that she was aware that she was using the product incorrectly. Prior to our January 12, 2012 telephone conversation, this Investigator sent an E-mail to the complainant and asked if she would be willing to reflect on the exact reasons why she did not heed the warnings contained on the label and articulate those reasons when we next spoke. On January 12, 2012, this Investigator spoke at length to the complainant regarding this matter and the following statements were made:

“The physical dimensions of (the baby recliner) lend itself to being used in a crib. Its size and shape lead a parent to believe it’s meant to be placed in a crib. If they made it wider so it couldn’t be used in a crib; that would be smart. It’s such a poor design the way it’s made now”

“Parents are taught ‘babies sleep in cribs’. When have you ever heard someone tell a new parent to put their baby on a floor to sleep? Never. Babies sleep in cribs. Period.”

“The space between the (baby recliner) and the bumper was only ½”. I never thought a ½” gap would be dangerous. The space looked too small to be threatening”

“I had looked at alternative products like foam ramps to keep his head elevated, but this seemed like the best option. It looks like it cradles the baby. It looks like a cozy place to sleep.”

“Find me one mother of a baby with severe acid reflux who would put her baby to sleep on the floor. You’re not going to find one. I’m sure I’m not the only one who feels this way”.

“Warning labels don’t mean anything to me. They are all over the place. I think I’ve just been ‘warning labeled out’.”

“My pediatrician knew how I was using the product and was familiar with the product. I was never advised not to use it in the crib (by the pediatrician).”

“In hindsight I guess it’s true that ‘common sense isn’t too common’”.

“How many parents are going to struggle to get a lap belt buckled around a sleeping child? Not me. I would be afraid of waking him up.”

“It never even crossed my mind that the gap between the (baby recliner) and the bumper was not safe. I was talking to my husband about it after your call and he admitted that it had crossed his mind. But he never said anything to me about it.”

The complainant expressed two concerns that she would like to see addressed. First, she stated that she never would have purchased the incident baby recliner had it not shown up in the search box on the retail web-site as a “solution” to acid reflux symptoms. She would like to see all marketing of the product as an acid reflux prevention tool stopped. (It should be noted that on January 19, 2012 this Investigator visited the retail web-site on which the incident baby recliner was ordered and attempted to duplicate the complainant’s search. It was noted that when “acid reflux” was entered into the search box, nothing was returned – See Exhibit 11). Second, the complainant would like to see the product either redesigned so that it does not fit into a crib or, alternatively, removed from the market.

SAMPLE COLLECTED

The incident portable foam baby recliner was not collected as an official sample as it remains in police custody as evidence. The victim’s mother stated that if and when the unit is returned to her, she would be willing to submit it to the CPSC. The local police department has been advised of the CPSC’s interest in collecting this product.

PRODUCT IDENTIFICATION

First Product: Portable Foam Baby Recliner

The **portable foam baby recliner** was manufactured by: [REDACTED] The physical address of the firm is [REDACTED] The mailing address that appears

on the firm's Internet web-site [REDACTED]
[REDACTED] The firm's toll-free telephone number is [REDACTED] (See Exhibit 12)

The portable foam baby recliner was purchased on-line from [REDACTED]

The incident product is a portable foam baby recliner with a removable fabric cover. The fabric color is light green in color. The portable foam baby recliner is equipped with a three-point seat belt that secures via a buckle. The unit measures approximately 34 ½" in length and 17" in width. As the product is shaped to recline, the height of the product varies. The baby recliner measures 11" in height at the head/top of the unit and 7 ½" in height at the foot/bottom of the unit. There are two "D-shaped" rings affixed to the foam portion of the recliner through which [REDACTED] tabs affixed to the interior of the fabric cover attach. The [REDACTED] tabs were secured through the D-shaped rings at the time of the incident.

The bottom of the unit is labeled in part, "****WARNING****Safety guidelines to prevent injury or death:****FALL HAZARD: ALWAYS use on the floor. This product should not be used inside a crib. NEVER place product on countertops, tables, steps or other elevated surfaces.****SUFFOCATION HAZARD: NEVER use on soft or uneven surface (sofa, bed, cushion), as seat may tip over and cause suffocation. NEVER use with blankets, towels, pillows, or other soft object when child is in seat. Intended for infants 8 pounds or 3.6 kilograms and above. ****NEVER leave child in the seat when straps are loose or undone. Adjust the straps provided so they fit snugly around the infant.****NEVER move or carry unit while child is in seat. Not intended for carrying a baby.****Website: [REDACTED] **NEVER use a cover other than the one manufactured and designed by the manufacturer of the product. NEVER use in a moving vehicle of any kind. NEVER use as a car seat or infant carrier.****Care Instructions****Remove cover from foam seat. Machine wash with cold water, gentle cycle. No bleach. Hang or dry flat – tumble dry low.****". A date code appearing on the bottom of the fabric cover portion of the product reads, "****20 APR 2010****".

There are two labels affixed to the bottom of the baby recliner. One of the two labels reads, "****CFR Title 4, Chapter 3****Model # [REDACTED] **INFANT SEAT******NOTICE: RESILIENT FILLING MATERIALS CONTAINED IN THIS ARTICLE MEET CALIFORNIA BUREAU OF HOME FURNISHINGS FLAMMABILITY REQUIREMENTS****CARE SHOULD BE EXERCISED NEAR OPEN FLAME OR WITH BURNING CIGARETTES****THIS ARTICLE HAS NOT BEEN CERTIFIED FOR COMPLIANCE TO 16 CFR 1633****". The second of the two labels reads, "****[REDACTED] **INFANT RECLINER******US patent [REDACTED] ****Country of Origin and Fiber Content Information:****All new materials consisting of:****Foam Mattress: 100 % Polyurethane****Made in the USA****Liner: 50% Polyester****50% Urethane****All Materials: China****Cover: Sewn and assembled in China****Shell: Center and Side Panels – 100% Polyester China****Bottom Panel – 100% Polyester China****UNDER PENALTY OF LAW THIS TAG IS NOT TO BE REMOVED, EXCEPT BY THE CONSUMER.****Certification is made by the manufacturer that the materials in this article are described in accordance with the law.****". There was no other labeling observed on the portable foam baby recliner.

Second Product: Crib Bumper

As the portion of the involved bumper was not labeled, the information contained in the product identification section of this report regarding the manufacturer of the bumper is based upon verbal information obtained from the victim's mother during a January 12, 2012 telephone interview. The physical description of the crib bumper is based on this Investigator's examination of the bumper at the police department on January 10, 2012.

[REDACTED] Exhibit 15)
[REDACTED] The firm's
telephone number is [REDACTED] (***)The importer of [REDACTED] brand bedding was determined
by an unrelated inspection report on file with the CPSC. Internet research regarding this firm
was unsuccessful.)

The incident crib bumper was reportedly purchased from: [REDACTED]

[REDACTED] (See Exhibit 14)

The side crib bumper, installed on the incident crib at the time of the incident, consists of a zippered fabric cover and foam padding. The measurements of the side crib bumper, as taken by this Investigator, are: 9 ½"H X 50"W X 2"D. The fabric design of the portion of the side bumper facing the interior of the crib is a light blue background with light tan giraffes. The fabric design of the portion of the side bumper facing outwards into the room is blue, brown and tan polka dots on a light blue background on either end of the bumper and a white polka-dotted tan center. The side bumper secures to the side of the crib via twelve 16" fabric ties affixed to the bumper. The fabric design of the ties is giraffe-spotted. There were no identifying labels affixed to the side crib bumper. There was no labeling observed on the side crib bumper. The interior padding of the side crib bumper measured 3 ¼" in depth. (See Exhibit 2 for photographs of the bumper.)

Third Product: Crib

As the involved crib was not available for examination, the information contained in the product identification section of this report regarding the crib is based upon verbal information obtained from the victim's mother during a January 12, 2012 telephone interview.

The incident crib was reportedly manufactured by: [REDACTED] (see Exhibit 15) /
[REDACTED] The firm's
telephone number is [REDACTED] (***)The importer of [REDACTED] brand cribs was determined by
an unrelated inspection report on file with the CPSC. Internet research regarding this firm was
unsuccessful. Also see Exhibit 7.)

The incident crib was reportedly purchased from: [REDACTED]

[REDACTED] (See Exhibit 14)

The incident crib was described as a full size baby crib equipped with two fixed sides. The model name of the crib was reported to be [REDACTED]. The brand name of the crib was reported to be [REDACTED]. The color of the crib was a dark espresso. The dimensions of the crib, as provided by the complainant, were "58" long by 30 1/4" wide". No further product identification information was available as the crib was discarded post incident.

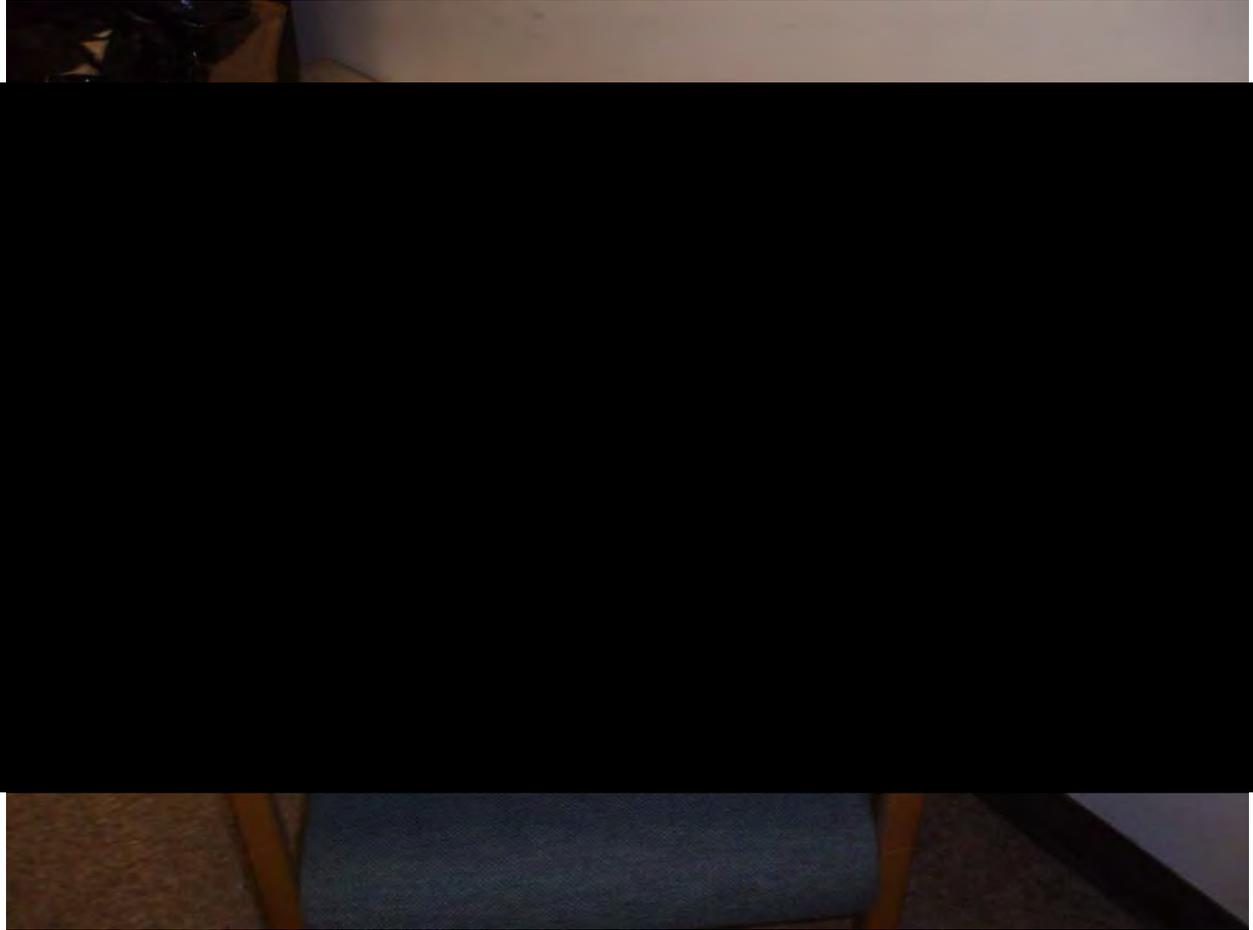
ATTACHMENTS

- Exhibit 1: Identification of Parties
- Exhibit 2: Photographs 2.1-2.21 taken by CPSC Investigator (Portable Foam Baby Recliner & Bumper)
- Exhibit 3: Autopsy Report
- Exhibit 4: Toxicology Report
- Exhibit 5: ME Investigator Report
- Exhibit 6: Photographs 6.1-6.12 taken by the ME Investigator (Recreation of Incident / Portable Foam Baby Recliner)
- Exhibit 7: Crib product information downloaded from the Internet
- Exhibit 8: CPSC Release [REDACTED]
- Exhibit 9: Missing Document Form
- Exhibit 10: Incident Residence Information downloaded from the Internet
- Exhibit 11: Search results downloaded from Retailer's Internet web-site
- Exhibit 12: Firm (Portable Foam Baby Recliner) information downloaded from the Internet
- Exhibit 13: E-mail from complainant describing similarity of victim to photo in CPSC Recall
- Exhibit 14: Retail Information (Crib & Bedding retailer)
- Exhibit 15: Manufacturer Information (Crib & Bedding)

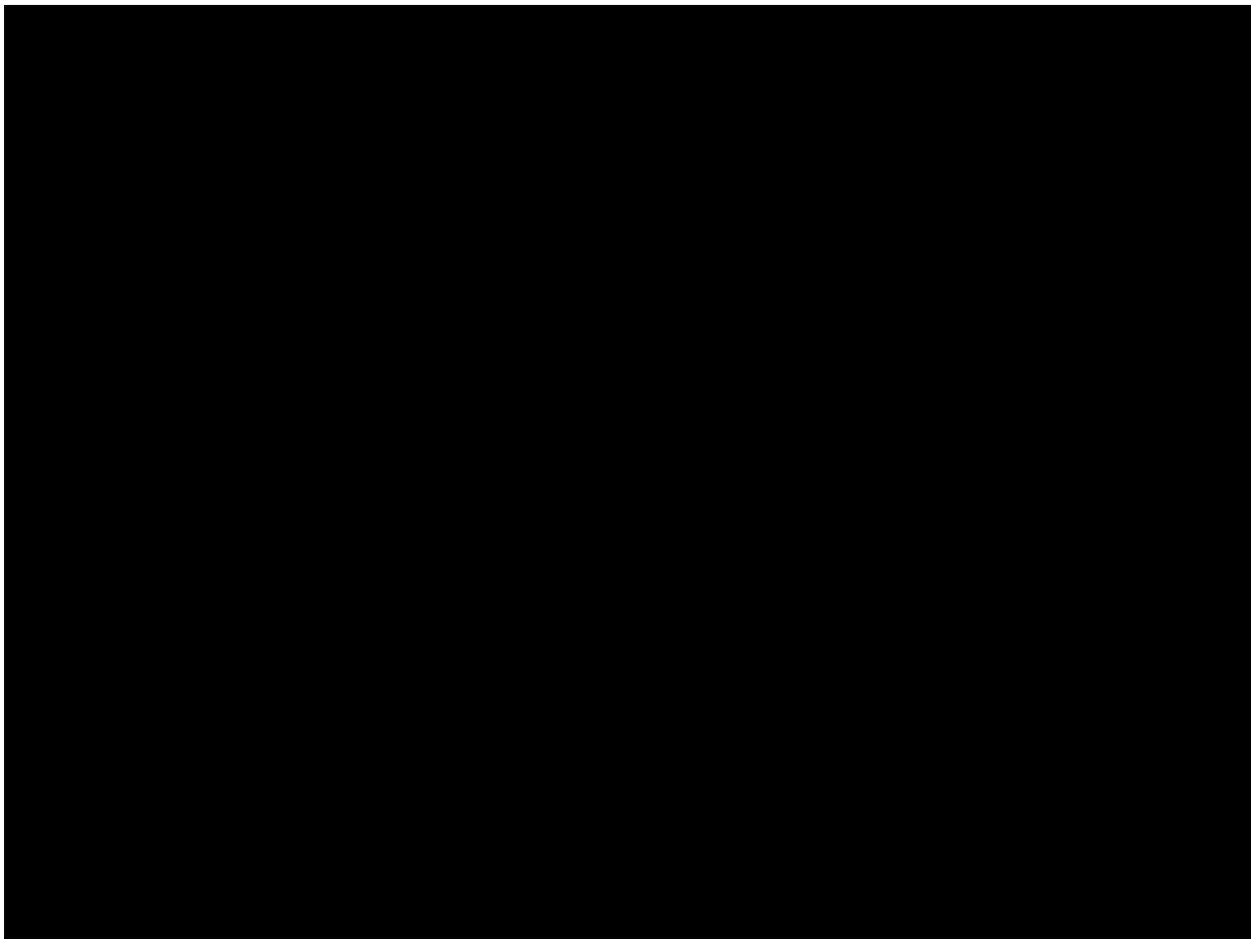
IDENTIFICATION OF PARTIES

1. [REDACTED] Complainant
[REDACTED]
E-mail: [REDACTED]
Telepho [REDACTED]
Telephone [REDACTED] (Work)
Interviewed 1/9/2012 & 1/12/2012 via telephone
Forwarded an Authorization for Release of Medical Records form via USPS on 1/13/12.
Not yet received
2. New Canaan Police Department
[REDACTED] Property Manager
[REDACTED]
Met with Ms. [REDACTED] on 1/10/2012. Ms. [REDACTED] provided access to the incident baby recliner & the incident crib bumper. Police sergeant, (name unknown) advised report was not yet completed & no verbal information would be provided at this time.
Written request for a copy of the police report was hand-delivered to the Records Officer
No response to date regarding the written police report
3. Office of the Chief Medical Examiner
Attn: Medical Records
11 Shuttle Road
Farmington, CT 06032
FAX: 860-679-1257
Written request for Autopsy Report, Toxicology Report, ME Investigative Report & ME Investigative photographs submitted via FAX on 1/9/2012
All requested records received 1/18/2012
4. Norwalk Hospital
Attn: Medical Records / Correspondence Staff
34 Maple Street
Norwalk, CT 06856
Correspondence Staff: [REDACTED]
Written request for medical records submitted 1/13/12 via USPS – no response to date 1/20/12: Follow up phone call placed to Correspondence Staff – could not provide any information via telephone re: specific medical records. I advised that first request contained HIPAA exemption letter & she advised that parental release would be best. I advised I'm waiting on release from victim's mother.
5. New Canaan Volunteer Ambulance Corp.
182 South Avenue
New Canaan, CT 06840

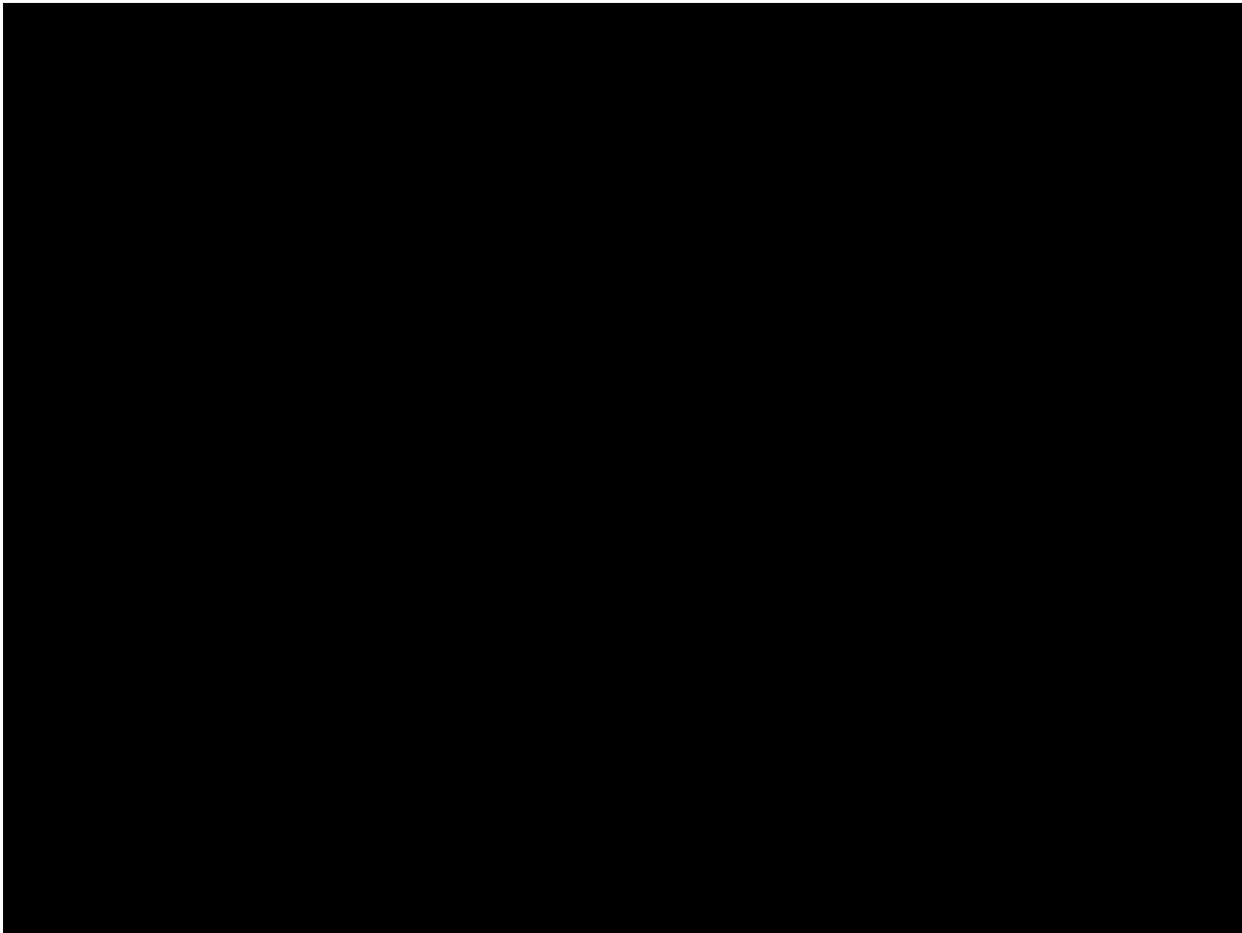
Written request for Ambulance run report submitted via USPS 1/13/2012 – No response to date.



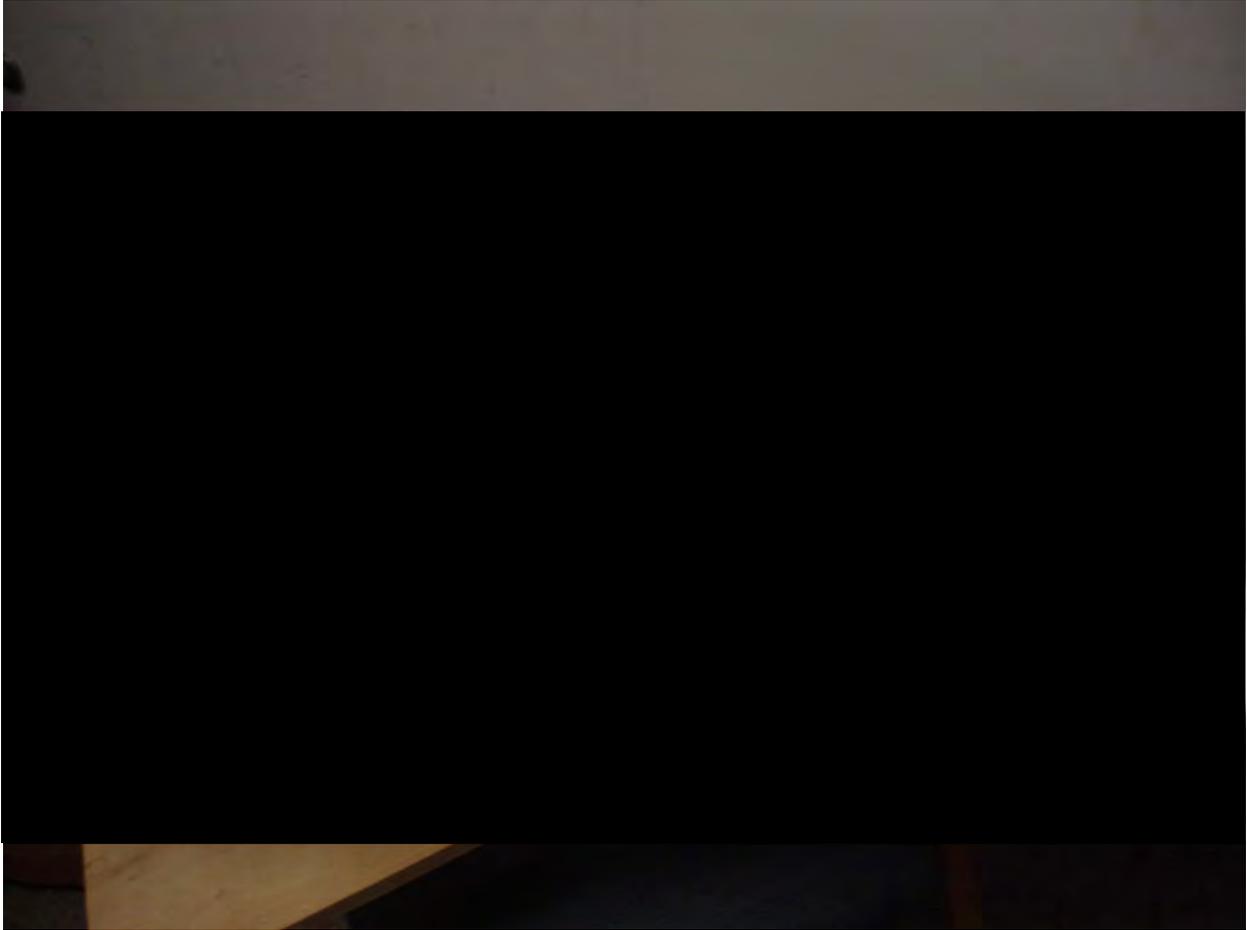
**Exhibit 2.1: View of Incident Infant Sleep Recliner
IDI #120109CAA1337**



**Exhibit 2.2: Close Up view of 3-point lap belt on Incident Infant Sleep Recliner
IDI #120109CAA1337**



**Exhibit 2.3: Alternate Close Up view of 3-point lap belt on Incident Infant Sleep Recliner (flash "on")
IDI #120109CAA1337**



**Exhibit 2.4: Bottom view of Incident Infant Sleep Recliner
IDI #120109CAA1337**

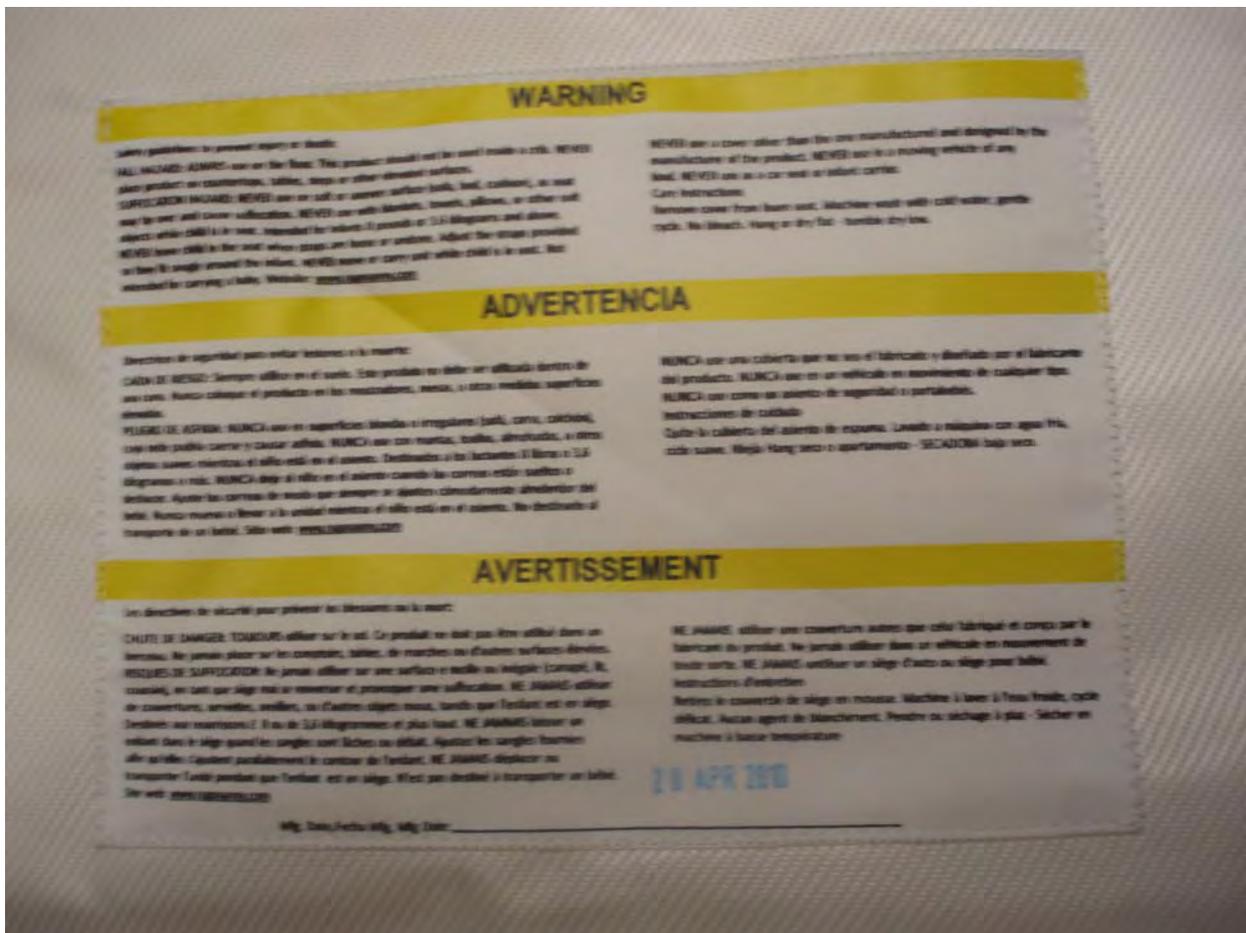


Exhibit 2.5: View of label affixed to bottom of Incident Infant Sleep Recliner IDI #120109CAA1337 (Close up views of label follow)

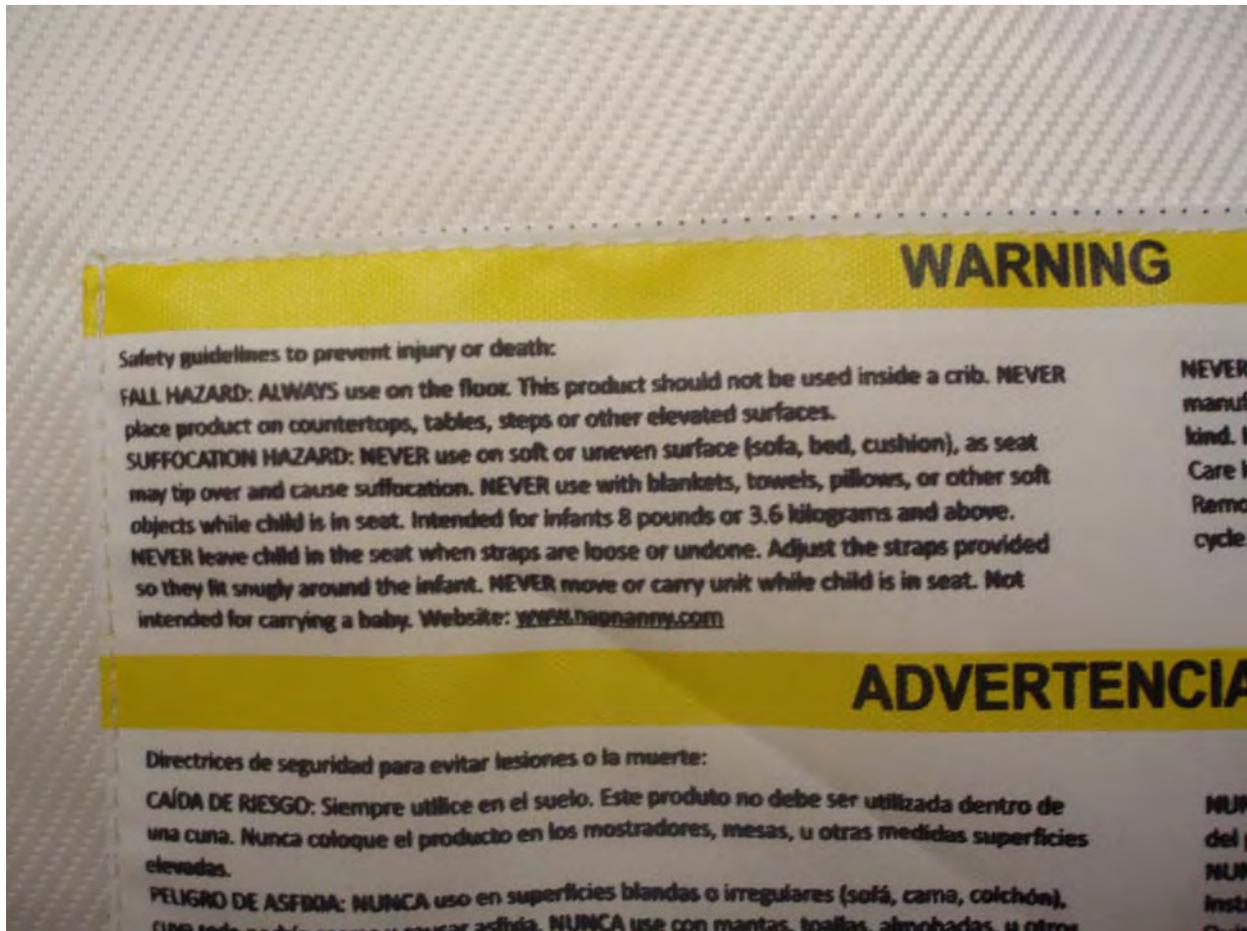


Exhibit 2.6: Close Up of warning label affixed to bottom of Incident Infant Sleep Recliner IDI #120109CAA1337

Label reads in part, *****WARNING*****Safety guidelines to prevent injury or death:*****FALL HAZARD: ALWAYS use on the floor. This product should not be used inside a crib. NEVER place product on countertops, tables, steps or other elevated surfaces.***SUFFOCATION HAZARD: NEVER use on soft or uneven surface (sofa, bed, cushion), as seat may tip over and cause suffocation. NEVER use with blankets, towels, pillows, or other soft object when child is in seat. Intended for infants 8 pounds or 3.6 kilograms and above. ***NEVER leave child in the seat when straps are loose or undone. Adjust the straps provided so they fit snugly around the infant.***NEVER move or carry unit while child is in seat. Not intended for carrying a baby.***Website [REDACTED]**

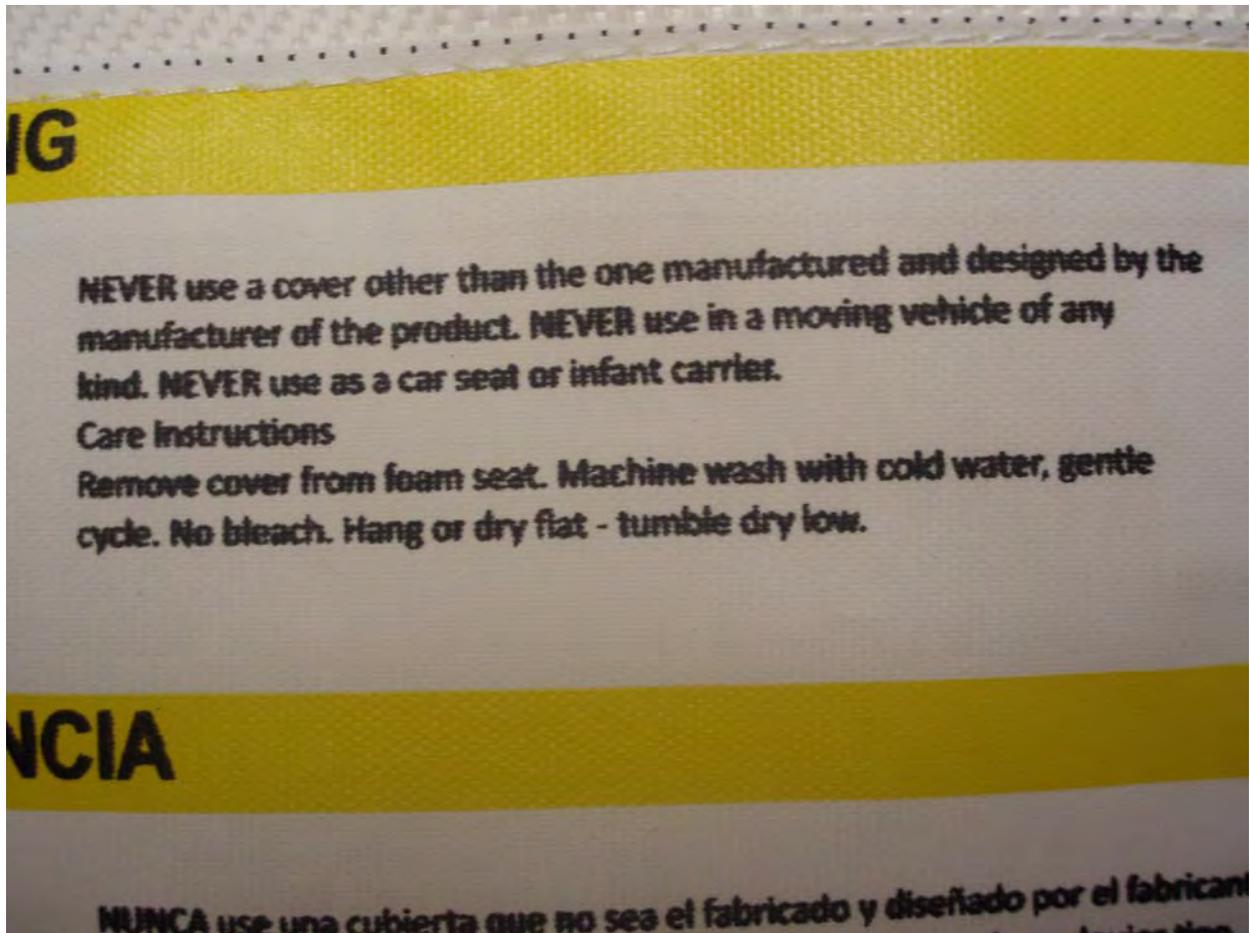


Exhibit 2.7: Close Up of warning label affixed to bottom of Incident Infant Sleep Recliner (Right-hand portion of label seen in Exhibits 2.5 & 2.6)
IDI #120109CAA1337

Label reads in part, "***NEVER use a cover other than the one manufactured and designed by the manufacturer of the product. NEVER use in a moving vehicle of any kind. NEVER use as a car seat or infant carrier.***Care Instructions***Remove cover from foam seat. Machine wash with cold water, gentle cycle. No bleach. Hang or dry flat – tumble dry low.***"

ne doit pas être utilisé dans un
surfaces élevées.
ou inégale (canapé, lit,
location. NE JAMAIS utiliser
si que l'enfant est en siège.
NE JAMAIS laisser un
les sangles fournies
MAIS déplacer ou
destiné à transporter un bébé.

NE JAMAIS utiliser une couverture autres que celui fabri
fabricant du produit. Ne jamais utiliser dans un véhicule
toute sorte. NE JAMAIS utiliser un siège d'auto ou sièg
Instructions d'entretien
Retirez le couvercle de siège en mousse. Machine à lav
délicat. Aucun agent de blanchiment. Pendre ou sécha
machine à basse température

20 APR 2010

Exhibit 2.8: Date code on bottom of label seen in Exhibits 2.5-2.7
IDI #120109CAA1337

Date code reads, "20 APR 2010"

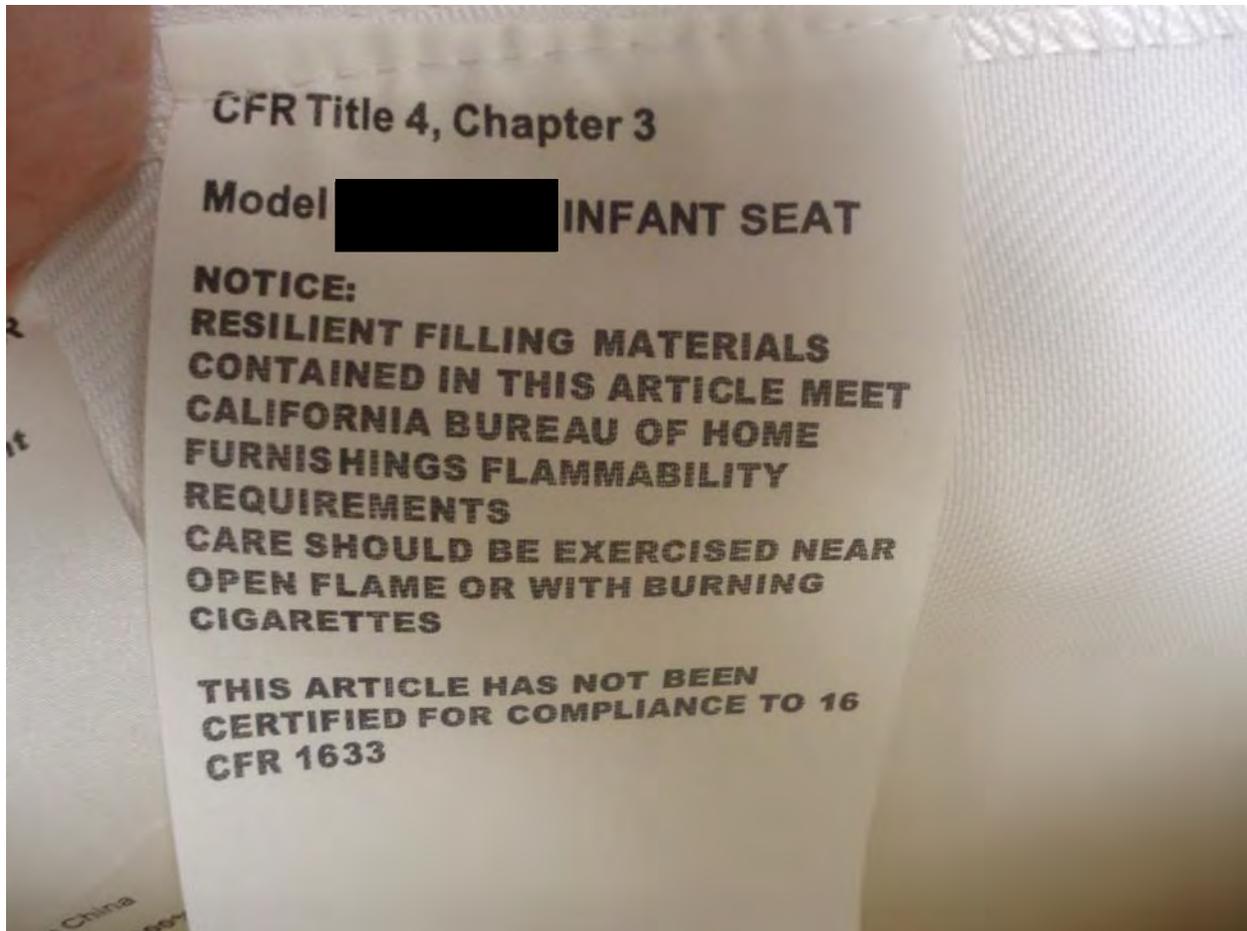


Exhibit 2.9: View of one of two labels affixed to inner foam portion of Incident Infant Sleep Recliner IDI #120109CAA1337

Label reads, “***CFR Title 4, Chapter 3***Model [REDACTED] INFANT SEAT***NOTICE: RESILIENT FILLING MATERIALS CONTAINED IN THIS ARTICLE MEET CALIFORNIA BUREAU OF HOME FURNISHINGS FLAMMABILITY REQUIREMENTS***CARE SHOULD BE EXERCISED NEAR OPEN FLAME OR WITH BURNING CIGARETTES***THIS ARTICLE HAS NOT BEEN CERTIFIED FOR COMPLIANCE TO 16 CFR 1633***”

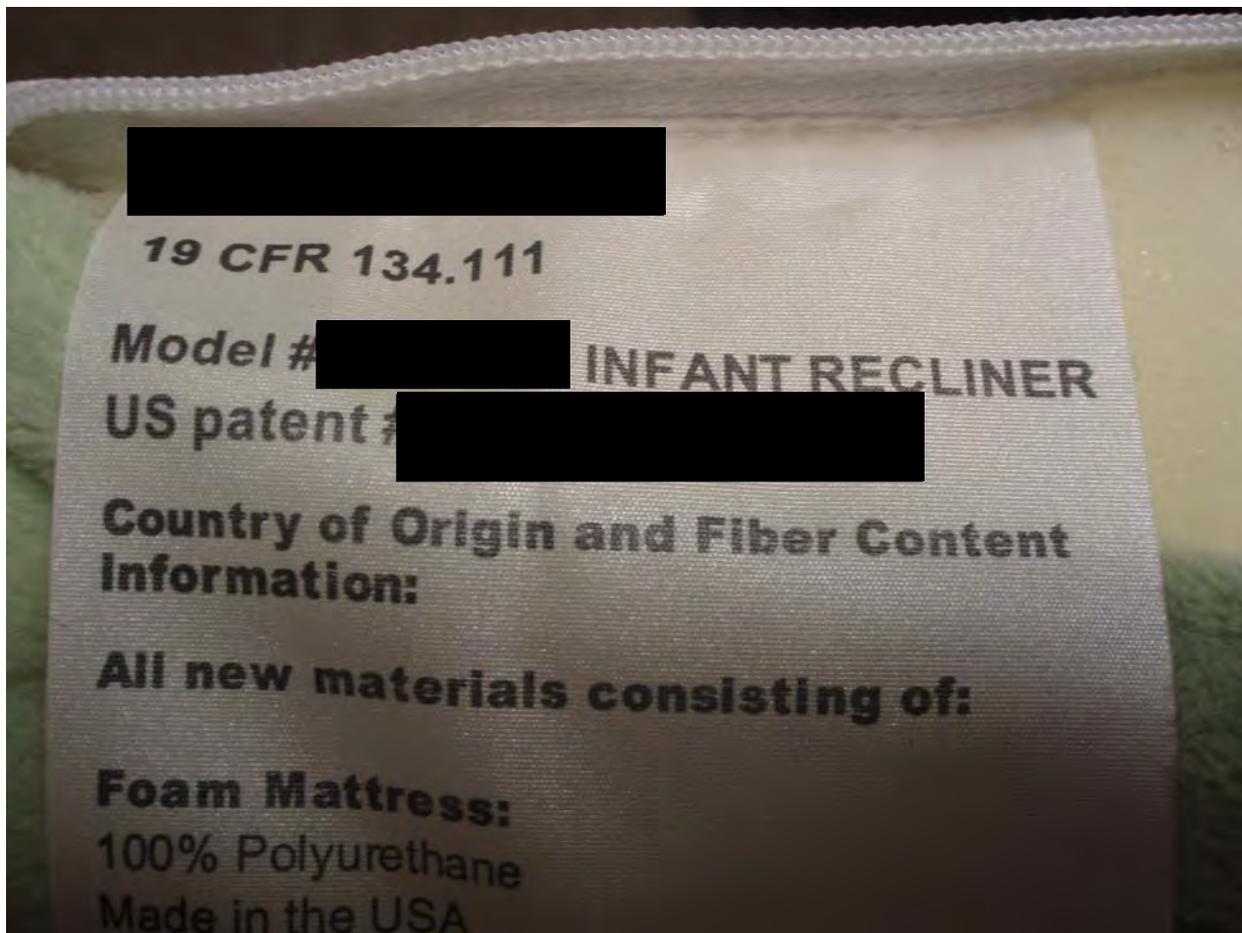


Exhibit 2.10: Top half of second label (first label seen in Exhibit 2.9) affixed to inner foam portion of Incident Infant Sleep Recliner
IDI #120109CAA1337

Label reads in part, “* [REDACTED] INFANT RECLINER***US patent [REDACTED] ***Country of Origin and Fiber Content Information:***All new materials consisting of:***Foam Mattress: 100 % Polyuerethane***Made in the USA***”

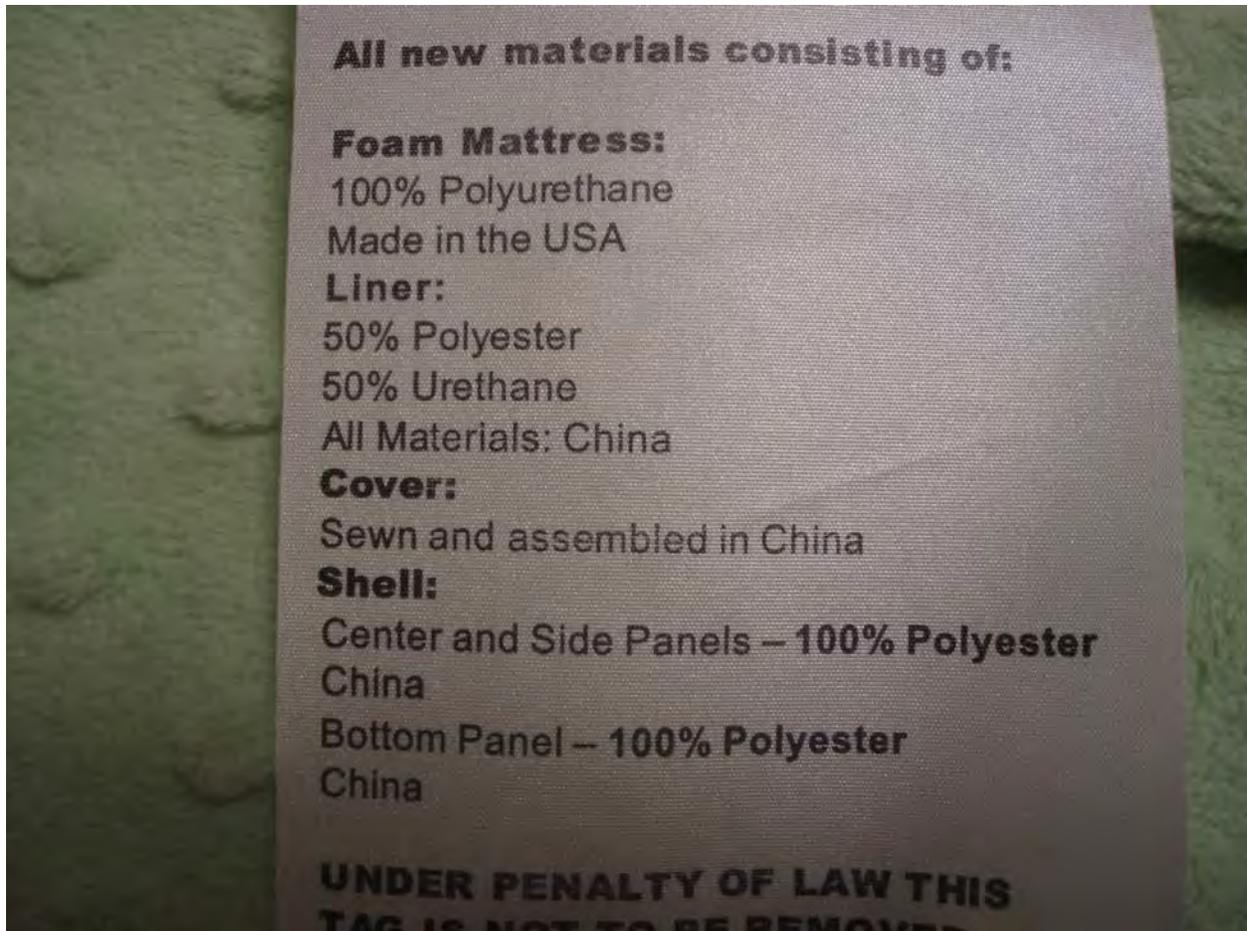


Exhibit 2.11: Middle half of label seen & described in Exhibit 2.10
IDI #120109CAA1337

Label reads in part, “***Liner: 50% Polyester***50% Urethane***All Materials: China***Cover: Sewn and assembled in China***Shell: Center and Side Panels – 100% Polyester China***Bottom Panel – 100% Polyester China***”



Exhibit 2.12: Bottom half of label seen in Exhibits 2.10 and 2.11
IDI #120109CAA1337

Label reads in part, “***UNDER PENALTY OF LAW THIS TAG IS NOT TO BE REMOVED, EXCEPT BY THE CONSUMER.***Certification is made by the manufacturer that the materials in this article are described in accordance with the law.***”



**Exhibit 2.13: Close Up of one of two D-rings affixed to foam cushion portion of Incident Infant Sleep Recliner & a Velcro-tab affixed to the fabric cover secured through the D-Ring
IDI #120109CAA1337**



**Exhibit 2.14: Close Up of second of two D-rings affixed to foam cushion portion of Incident Infant Sleep Recliner & a Velcro-tab affixed to the fabric cover secured through the D-Ring
IDI #120109CAA1337**



**Exhibit 2.15: View of Bumper affixed to side of crib at the time of the incident
IDI # 120109CAA1337**

(Close Up / Explanation of Area identified by arrow can be found at Exhibit 2.19)



**Exhibit 2.16: Close Up View of Design (Giraffes) on Bumper installed in crib at time of the incident
IDI #120109CAA1337**



**Exhibit 2.17: View of one of 12 ties affixed to Bumper installed in crib at the time of the incident
IDI #120109CAA1337**

(Close Up / Explanation of Area identified by arrow can be found at Exhibit 2.19)



Exhibit 2.18: View of opposite side of Bumper installed in crib at the time of the incident that that seen in Exhibits 2.15 through 2.17

(This side of the Bumper was facing outwards at the time of the incident. The side with the giraffe design was facing towards the interior of the crib at the time of the incident.)

IDI #120109CAA1337

The measurements of the Bumper installed in the crib at the time of the incident, as taken by this Investigator, are: 9 ½" H X 50" W X 2" D



Exhibit 2.19: Arrow points to very faint discoloration on fabric / Police Officials believe that this is where the victim's mouth was at the time of the incident / This location is also identified by an arrow in Exhibits 2.15 & 2.17

IDI #120109CAA1337



**Exhibit 2.20: View of the inner portion of the Bumper installed in the crib at the time of the incident – Bumper padding measures approximately 3 ¼” in depth
IDI #120109CAA1337**

(As the Bumper, when fully zippered as used, measures 2” in depth, it appears that the interior padding is compressed when installed within the fabric of the Bumper.)



**Exhibit 2.21: View of the Bumper installed in the crib at the time of the incident – Bumper is shown un-zipped with the interior padding exposed. This padding can also be seen in Exhibit 2.20
IDI #120109CAA1337**



STATE OF CONNECTICUT
Office of the Chief Medical Examiner
11 Shuttle Road, Farmington, CT 06032

M.E. CASE NUMBER [REDACTED]

Date of Death: 11/21/2011
County of Death: Fairfield

Time of Death: 9:30 AM
City of Death: Norwalk

This is to certify that [REDACTED] M.D., Associate Medical Examiner, performed a postmortem examination on the body of [REDACTED] at the Office of the Chief Medical Examiner on 11/22/2011 at 10:30 AM

EVIDENCE OF TREATMENT:

- An endotracheal tube is in place.
- A vascular catheter is in place in the right anterior cubital fossa and proximal right shin.

EXTERNAL EXAMINATION:

The body is that of a well-developed infant male, weighing approximately 27 lbs, and measuring approximately 26 ½" in length.

Head Circumference = 17"

Chest Circumference = 17"

Abdominal Circumference = 17 ¼"

Foot Length = 3 3/8"

Postmortem x-rays are taken and reveal no obvious abnormalities.

Head: The scalp hair is short and light brown. The irises are blue, the pupils are equal, and the conjunctivae are clear. Natural teeth are unerupted in the upper and lower jaws. See Evidence of Trauma.

Chest and Back: See Evidence of Trauma.

Neck, Abdomen, Upper, and Lower Extremities: No evidence of trauma.

External Genitalia: Normal male, no evidence of trauma.

RIGIDITY:

Rigor is partially established in the face and extremities.

LIVIDITY:

Lividity is posterior and blanching.



STATE OF CONNECTICUT
Office of the Chief Medical Examiner
11 Shuttle Road, Farmington, CT 06032

M.E. CASE NUMBER: [REDACTED]

EVIDENCE OF TRAUMA:

Head, Chest, and Back:

1. A 1/8" x 1/8" tan/orange abrasion of the mid left cheek of the face.
2. A 3/4" x 1/2" tan/orange abrasion on the left upper chest.
3. A 5/8" x 1/2" tan/orange abrasion on the mid left lower chest.
4. A 1 1/2" x 1" pink abrasion on the mid right back.

INTERNAL EXAMINATION:

The body is opened through the usual Y-shaped incision, revealing approximately 1/2" of yellow subcutaneous adipose tissue and red/brown musculature. No aromatic odor is noted to the body organs. No fractures of the ribs, spine, or pelvis are identified. All body organs are in their normal anatomic relationships.

HEART:

The heart weighs 29 grams. The cut surfaces of the coronary arteries are patent and free of atherosclerosis. The cardiac valves are unremarkable. The cut surfaces of the myocardium are homogeneous red/brown, without fibrosis or hemorrhage. The aorta is of normal course and caliber and shows no atherosclerosis.

LUNGS:

The right lung weighs 40 grams, and the left lung weighs 39 grams. The pleural surfaces of both lungs are pink/gray and intact. The cut surfaces of both lungs are unremarkable. No masses or consolidations are identified. The pulmonary arteries are patent and free of thromboemboli. The bronchi are patent.

LIVER:

The liver weighs 429 grams. The capsule is smooth and intact. The color is red/brown and the cut surfaces are unremarkable. The gallbladder contains less than 3 ml of green bile. No gallstones are identified.

SPLEEN:

The spleen weighs 19 grams. The capsule is dark purple/gray and intact. The cut surfaces are unremarkable.



STATE OF CONNECTICUT
Office of the Chief Medical Examiner
11 Shuttle Road, Farmington, CT 06032

M.E. CASE NUMBER: [REDACTED]

URINARY TRACT:

The right kidney weighs 20 grams, and the left kidney weighs 20 grams. Both capsules strip with ease, revealing similar smooth red/brown cortical surfaces. The cut surfaces of both kidneys show distinct corticomedullary junctions. The renal arteries are patent. The ureters are patent and free of congenital anomalies. The bladder contains no obtainable urine, and is unremarkable.

ADRENAL GLANDS:

The adrenal glands are free of hemorrhage or tumor.

GASTROINTESTINAL TRACT:

The stomach contains approximately 10 ml of tan mucoid material. The gastric mucosa and rugal pattern are normal. The esophagus, pancreas, appendix, small, and large intestines are unremarkable.

INTERNAL GENITALIA:

The testes and prostate are unremarkable.

NECK:

The skin and muscles of the anterior neck are free of hemorrhage and signs of trauma. No fractures of the hyoid bone, thyroid cartilage, or cervical spine are identified. The tongue is free of trauma. The thyroid gland is red/brown and free of trauma. The oral and nasopharynx are free of trauma.

SCALP:

The scalp is reflected by the usual intermastoid incision, revealing no infiltration of blood in the cutaneous or subcutaneous surfaces. No fractures of the skull bones are identified. No intracranial hemorrhages are seen.



STATE OF CONNECTICUT
Office of the Chief Medical Examiner
11 Shuttle Road, Farmington, CT 06032

M.E. CASE NUMBER: [REDACTED]

BRAIN:

The brain weighs 840 grams. The leptomeninges are thin over the surfaces of the brain. No congenital vascular anomalies are identified. On multiple coronal sections, no abnormalities are identified.

TOXICOLOGY:

Blood, gastric contents, vitreous humor, liver, and brain obtained at autopsy, are sent for toxicologic evaluation.

See Toxicology report.

HISTOLOGY:

Representative sections of organs are taken for microscopic examination:

- A. Brain:
No specific pathologic change is seen.
- B. Heart:
No specific pathologic change is seen.
- C. Lungs:
No specific pathologic change is seen.
- D. Liver:
No specific pathologic change is seen.
- E. Kidneys:
No specific pathologic change is seen.
- F. Gastrointestinal Tract:
No specific pathologic change is seen.
- G. Spleen:
No specific pathologic change is seen.
- H. Pancreas:
No specific pathologic change is seen.
- I. Adrenals:
No specific pathologic change is seen.
- J. Thyroid:
No specific pathologic change is seen.
- K. Thymus:
No specific pathologic change is seen.



STATE OF CONNECTICUT
Office of the Chief Medical Examiner
11 Shuttle Road, Farmington, CT 06032

M.E. CASE NUMBER [REDACTED]

FINDINGS:

I. SUDDEN INFANT DEATH SYNDROME

CAUSE OF DEATH:

PENDING FURTHER STUDY

MANNER OF DEATH:

PENDING

FINAL CAUSE OF DEATH (Amended 01/05/2012):

SUDDEN INFANT DEATH SYNDROME

FINAL MANNER OF DEATH:

NATURAL

This is a true statement of the postmortem findings upon the body of [REDACTED]

[REDACTED]

M.D.

Associate Medical Examiner
05 January 2012

Unless the Office of the Chief Medical Examiner is notified in writing, any tissue retained in the course of this case will be destroyed 5 years after the date of the autopsy. Specimens sent to other institutions for analysis are subject to the retention policies of that institution.



Office of the Chief Medical Examiner State of Connecticut

11 Shuttle Road Farmington, CT 06032
(860) 679-3980

TOXICOLOGY REPORT

DATE OF REPORT: 12/31/11

LAB NUMBER:	DECEASED:	ME CASE NUMBER:
[REDACTED]	[REDACTED]	[REDACTED]

SPECIMENS SUBMITTED BY: Dr. [REDACTED]

Sample Type	Amount	Received	Received By	Sample Type	Amount	Received	Received By
Blood, Cardiac	25 mL	11/23/11	[REDACTED]	Brain	87 g	11/23/11	[REDACTED]
Liver	39 g	11/23/11	[REDACTED]	Vitreous	0.5 mL	11/23/11	[REDACTED]
DNA Label		11/23/11	[REDACTED]	DNA Label		11/23/11	[REDACTED]
Gastric Contents	10 mL	11/23/11	[REDACTED]				

ANALYTICAL FINDINGS

SCREEN	Blood, Cardiac	Analyte	Results	Method
Alcohol			None Detected	Micro Diffusion
Acidic/Neutral Drugs			None Detected	GC/MS
Basic Drugs			None Detected	GC/MS
Carbon Monoxide		Carbon Monoxide	None Detected	Micro Diffusion
Cocaine Metabolite			None Detected	ELISA
Opiates			None Detected	ELISA
Oxycodone			None Detected	ELISA



REPORT OF INVESTIGATION/CASE REVIEW

ME104 (Revised 10/08)

M.E. Case No. [REDACTED]

State of Connecticut
 OFFICE OF THE CHIEF MEDICAL EXAMINER
 11 Shuttle Road, Farmington, Connecticut 06032
 (860) 679-3980

DECEASED	Name (First, Middle or Maiden, Last)		Age	Race	Sex
	[REDACTED]		4 mos	White	<input checked="" type="checkbox"/> male <input type="checkbox"/> female
INJURY (if any)	Last Residence (No., Street)			Town	State
	[REDACTED]			[REDACTED]	[REDACTED]
DEATH	Place of Injury			Date of Injury	
	[REDACTED]			[REDACTED]	
DEATH	Place of Death (No., Street)			Town	State
	Norwalk Hospital, 34 Maple Street			Norwalk	CT
	Reported By (Name)		Affiliation		
Dr. [REDACTED]		Norwalk Hospital			
Death Reported to O.C.M.E.		Death Determined By		Date	
Date 11/21/2011 Time 10:25		Dr. [REDACTED]		Date 11/21/2011 Time 09:30	
INFORMANT	Other Informants (Names)				Phone Number(s)
	[REDACTED]				[REDACTED]

Lt. DeMaio, New Canaan Police Department					

CIRCUMSTANCES OF DEATH

The deceased [REDACTED] is a 4 1/2 month old white male who resides with his parents, [REDACTED] at the address indicated herein. On November 21, 2011, the undersigned was contacted at his residence while off-duty by Investigator Wojak, from the Office of the Chief Medical Examiner, to initiate the process of performing a reconstruction on this case. On November 22, 2011, the undersigned arrived at the New Canaan Police Department and met with Lt. Vincent DeMaio and Sgt. Peter Condos and was briefed on the circumstances of the case. Due to scheduling conflicts, there was no attempt made on November 21, 2011 to perform the reconstruction. However, on November 29, 2011, the undersigned returned to the New Canaan Police Department, and proceeded to the [REDACTED] residence along with Lt. DeMaio and Sgt. Condos. Upon arrival, the undersigned met with [REDACTED] and [REDACTED] the decedent's father and mother, respectively, and held a discussion with them about the circumstances detailed herein.

Mrs. [REDACTED] proceeded to answer questions concerning [REDACTED] birth and general health. Thereafter, the conversation focused on the events of November 21, 2011. Mrs. [REDACTED] reported hearing [REDACTED] crying at or about 05:00 hours. Thinking that [REDACTED] may have been hungry, Mrs. [REDACTED] went to prepare a bottle for [REDACTED]. While walking towards [REDACTED] room, Mrs. [REDACTED] realized that [REDACTED] had stopped crying and she returned to bed as she believed [REDACTED] had fallen back to sleep. At or about 08:00 hours, Mrs. [REDACTED] was awakened by the chirp of a car alarm belonging to her nanny, [REDACTED] who had arrived for her normal work day at the [REDACTED] residence. Mrs. [REDACTED] then went downstairs, met [REDACTED] at the door, and briefed her on the prior night's events with the children. Mrs. [REDACTED] then walked upstairs and went into [REDACTED] room, whereupon she discovered [REDACTED] unresponsive in his crib. Mrs. [REDACTED] reportedly picked [REDACTED] up from the crib and went downstairs to meet [REDACTED]. Upon calling 911, Mrs. [REDACTED] returned [REDACTED] to his crib where he was found by first responders who initiated CPR in the field and transported him to Norwalk Hospital. [REDACTED] was subsequently pronounced dead at Norwalk Hospital at or about 09:30 hours by Dr. [REDACTED]. During said conversation, the undersigned learned that Mrs. [REDACTED] believed that [REDACTED] may have suffocated due to the position in which he was found. In an effort to better understand Mrs. [REDACTED] explanation, the undersigned, along with Mr. and Mrs. [REDACTED] Lt. DeMaio, and Sgt. Condos, walked upstairs to [REDACTED] room. [REDACTED] room appears very clean, orderly, and properly furnished. A crib is noted against the wall on the right side upon entering the room. Said crib only contains a mattress. However, police officials reported to the undersigned that on November 21, 2011, police officials noted and seized multiple items from the crib, including a bumper that was noted properly secured to the spindles of the crib and a sheet that was initially noted by police to have been securely and appropriately over the mattress. The [REDACTED] was not present when police arrived on November 21, 2011 because it had been removed from the crib by [REDACTED].

Upon request from the undersigned, Mrs. [REDACTED] using a doll provided to her by the undersigned, began a reconstruction inside [REDACTED] bedroom. Mrs. [REDACTED] reported that [REDACTED] had been initially placed seated upright in a [REDACTED] (photo 1116275_S01). The [REDACTED] a foam seat with a lapbelt restraining strap, was reportedly covered by a thin receiving blanket due to [REDACTED] propensity to vomit as a result of his Acid Reflux. Mrs. [REDACTED] positioned the doll in an upright position to depict how [REDACTED] was placed to sleep when she last saw him alive on December 20, 2011 at or about 23:30 hours (photos [REDACTED] and [REDACTED]). Mrs. [REDACTED] then repositioned the doll to depict how [REDACTED] was found on the morning of December 21, 2011 (photos [REDACTED] thru [REDACTED]). Mrs. [REDACTED] reported that [REDACTED] was found laying perpendicular to the [REDACTED]. The posterior aspect of [REDACTED] neck was resting on the edge of the [REDACTED]. The top of [REDACTED] head was resting on top of the mattress, and his face was noted pressed against the bumper that was in place at the time that [REDACTED] was found. Photo No. [REDACTED] depicts Mrs. [REDACTED] right hand on the mattress indicating where the top of [REDACTED] head was found, showing how hyperextended his neck was. Mrs. [REDACTED] reported that it appeared to her as if [REDACTED] nose and mouth were pressed against the bumper in the crib. Photos 1116275_S09 thru 1116275_S12 are of the [REDACTED] tags. The [REDACTED] was seized by police officials after the reconstruction was completed. Upon completion of the reconstruction, the undersigned left his contact information with Mr. and Mrs. [REDACTED] and urged them to contact the undersigned if they had any questions. Police officials also removed, at the request of the parents, several [REDACTED] 15 mg tablets. Said medication was being given to [REDACTED] in the morning hours. The prescriber is [REDACTED] MD.

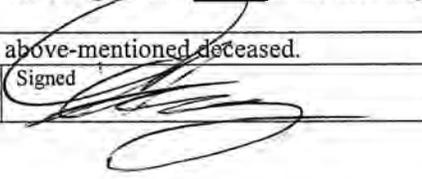
CERTIFICATION	I certify that I have made inquiry into the cause and manner of death of the above-mentioned deceased.		
	Date	Name of Medical Examiner Investigator	Signed
	12/11/2011	Alfredo Camargo	



Exhibit 6.1: Recreation of placement of [REDACTED] in Crib by ME Investigator
ME Photograph #1116275_S01
IDI #120109CAA1337

*****NOTE: A Crib Bumper was installed on the side of the crib identified by the arrow at the time of the incident. The Bumper is absent in all of the recreation photographs taken by the ME Investigator – appended as Exhibit 6.1 through 6.8. Photographs of the Incident Bumper are appended within Exhibit 1 of this report.**

*****NOTE: The ME photograph #'s are included in this Exhibit as the photographs are referenced by number in the ME Investigative report, appended as Exhibit 5.**



Exhibit 6.2: Recreation of placement of Victim into [REDACTED] by Victim's Mother (Photograph taken by ME Investigator)

ME Photograph #1116275_S02

IDI #120109CAA1337



Exhibit 6.3: Recreation of Victim's position when he was last seen alive in the [REDACTED] (Recreation by Victim's Mother – Photograph taken by ME Investigator)

ME Photograph #1116275_S03

IDI #120109CAA1337



Exhibit 6.4: 1st in a series of 4 photographs showing the Victim's mother recreating how the victim was found in the [REDACTED] (Recreation by Victim's Mother – Photograph taken by ME Investigator)
ME Photograph #1116275_S04
IDI #120109CAA1337

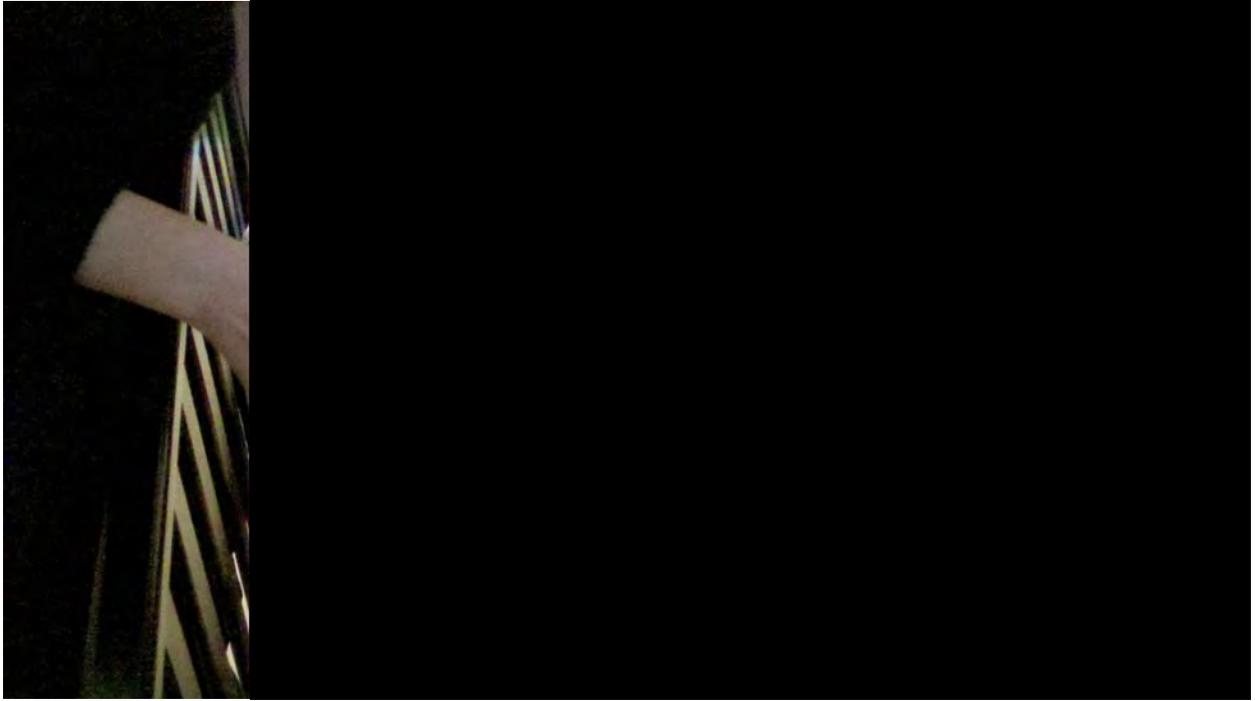


Exhibit 6.5: 2nd in a series of 4 photographs showing the Victim's mother recreating how the victim was found in the [REDACTED] (Recreation by Victim's Mother – Photograph taken by ME Investigator)
ME Photograph #1116275_S05
IDI #120109CAA1337

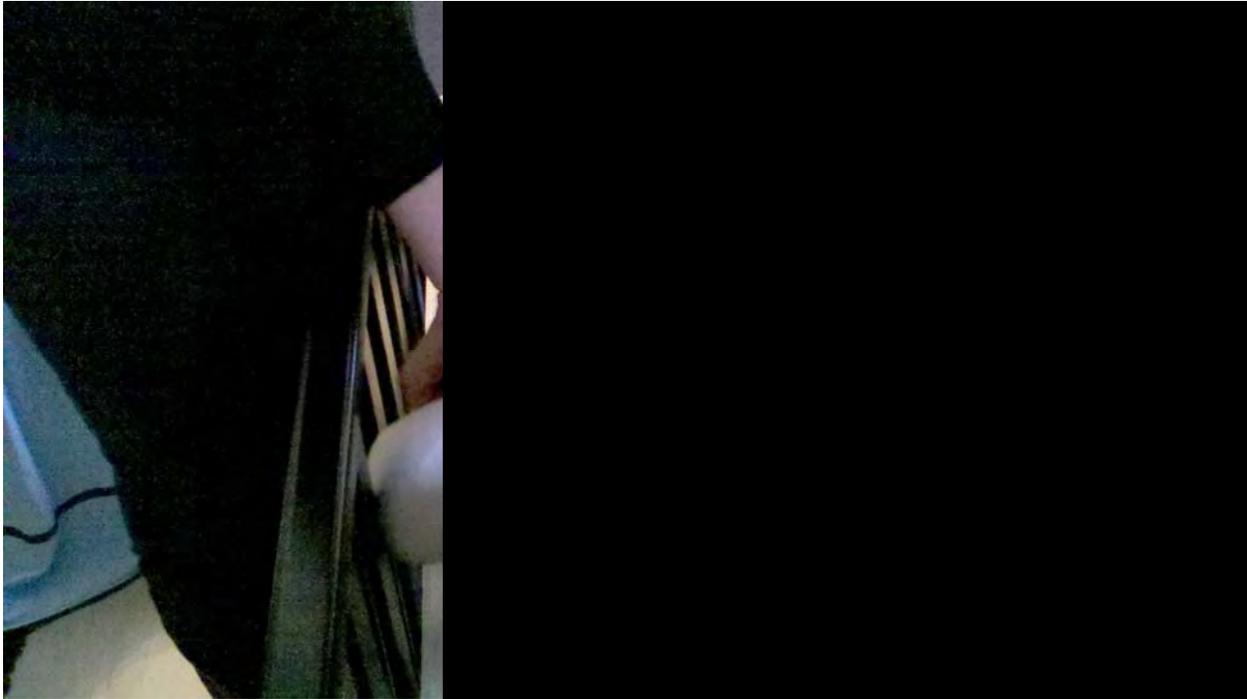


Exhibit 6.6: 3rd in a series of 4 photographs showing the Victim's mother recreating how the victim was found in the [REDACTED] (Recreation by Victim's Mother – Photograph taken by ME Investigator)

ME Photograph #1116275_S06

IDI #120109CAA1337



Exhibit 6.7: 4th in a series of 4 photographs showing the Victim's mother recreating how the victim was found in the [REDACTED] (Recreation by Victim's Mother – Photograph taken by ME Investigator)
ME Photograph #1116275_S07
IDI #120109CAA1337



Exhibit 6.8: Photograph taken by ME Investigator depicts the Victim's mother's right hand on the mattress indicating where the top of the Victim's head was found, showing how hyper-extended the victim's neck was.

ME Photograph #1116275_S08

IDI #120109CAA1337

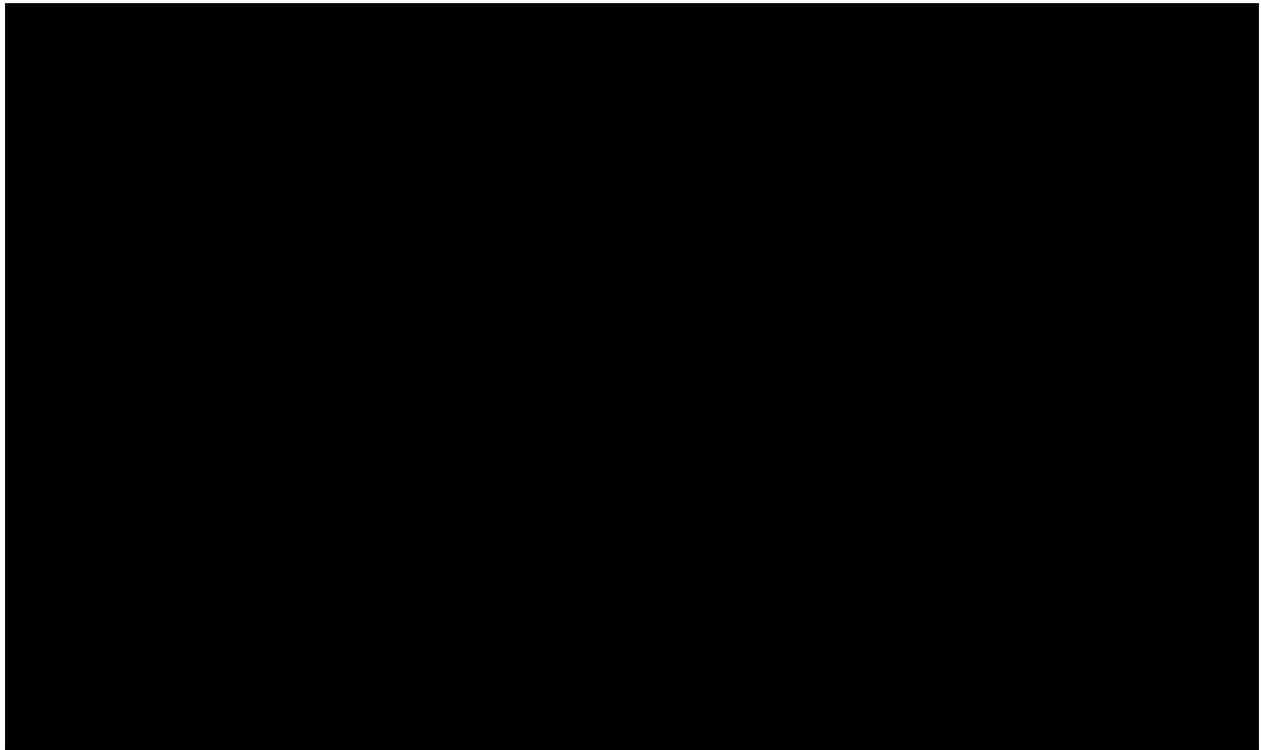


Exhibit 6.9: 2 labels affixed to the [REDACTED] Photograph taken by ME Investigator
ME Photograph #1116275_S09
IDI#120109CAA1337

***Labels & content of labels can be viewed in Exhibit 1 – Photographs taken by CPSC Investigator

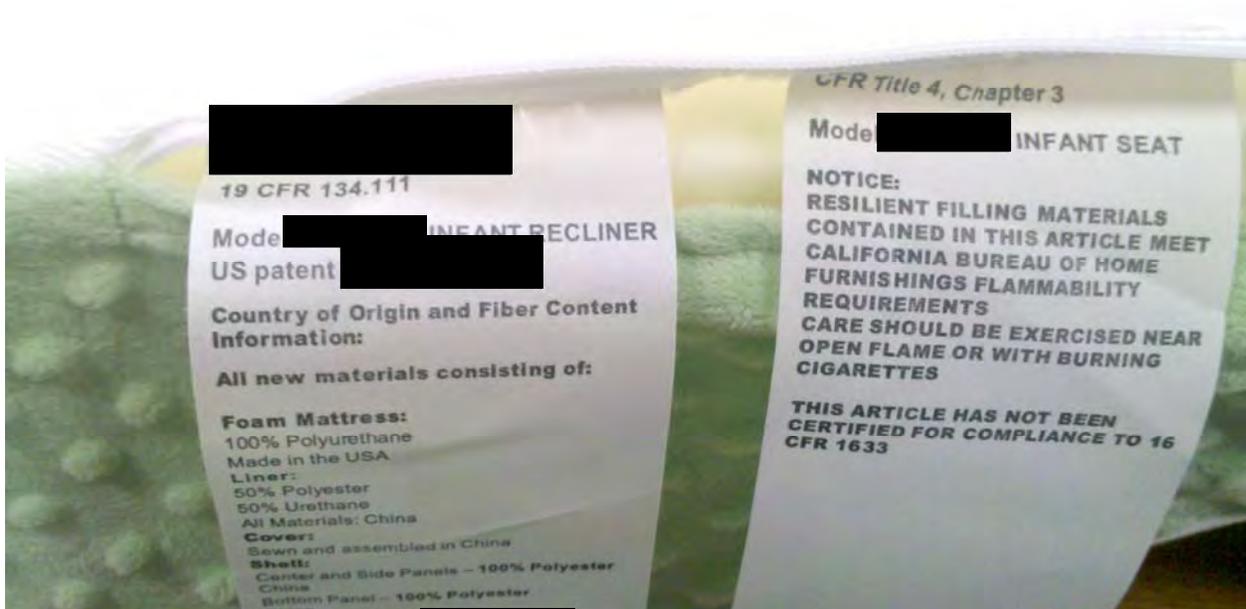


Exhibit 6.10: 2 labels affixed to the [REDACTED] Photograph taken by ME Investigator
ME Photograph #1116275_S10
IDI#120109CAA1337

***Labels & content of labels can be viewed in Exhibit 1 – Photographs taken by CPSC Investigator

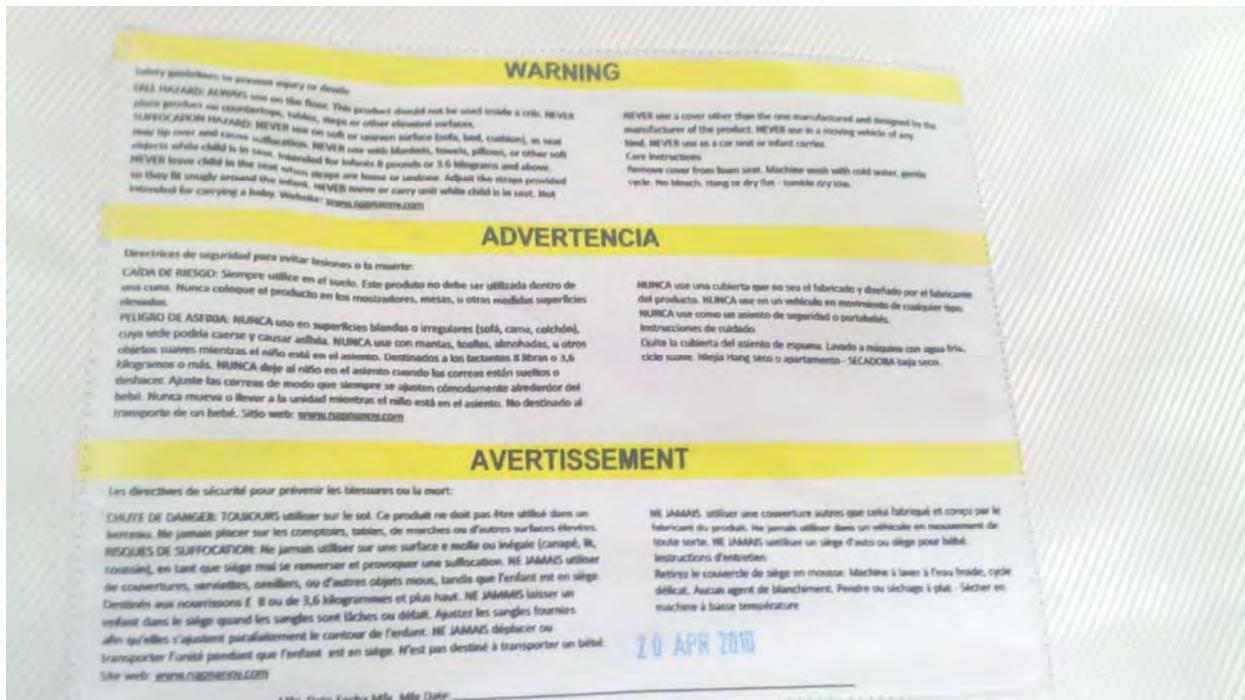


Exhibit 6.11: View of Labeling on bottom of [REDACTED] / Photograph taken by ME Investigator
ME Photograph #1116275_S11
IDI #120109CAA1337

***Labels & content of labels can be viewed in Exhibit 1 – Photographs taken by CPSC Investigator

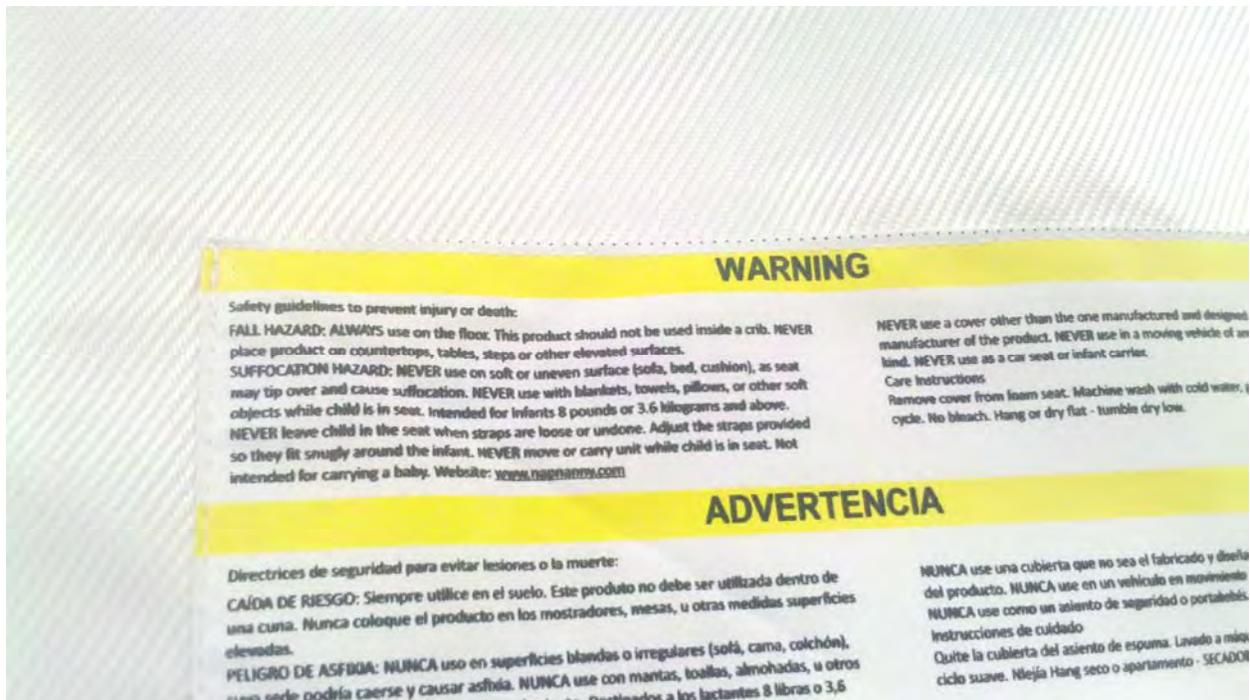


Exhibit 6.12: View of Labeling on bottom of [REDACTED] Photograph taken by ME Investigator
ME Photograph #1116275_S12
IDI #120109CAA1337

***Labels & content of labels can be viewed in Exhibit 1 – Photographs taken by CPSC Investigator



NEWS from CPSC

U.S. Consumer Product Safety Commission

Office of Information and Public Affairs

Washington, DC 20207

FOR IMMEDIATE RELEASE

Release

CPSC Recall Hotline: (800) 638-2772

CPSC Media Contact: (301) 504-7908

WASHINGTON, D.C. - The U.S. Consumer Product Safety Commission (CPSC), in cooperation with [REDACTED] is announcing the voluntary recall of 30,000 [REDACTED] baby recliners. CPSC is investigating a report of a 4-month-old girl from Royal Oak, Mich. who died in a [REDACTED] that was being used in a crib. According to preliminary reports, the infant was in her harness and found hanging over the side of the product, caught between the [REDACTED] and the crib bumper.

CPSC and [REDACTED] are aware of one other incident in which an infant became entrapped when the [REDACTED] was used in a crib, contrary to the product instructions. In that incident, the infant fell over the side of the [REDACTED] despite being harnessed in, and was caught between the baby recliner and the side of the crib. The infant sustained a cut to the forehead.

CPSC and the firm have received 22 reports of infants, primarily younger than 5-months-old, hanging or falling out over the side of the [REDACTED] despite most of the infants being placed in the harness. One infant received a bruise as a result of hanging over the side of the product.

Infants can partially fall or hang over the side of the [REDACTED] even while the harness is in use. This situation can be worse if the [REDACTED] straps, located inside the [REDACTED] cover are not properly attached to the "D"-rings located on the foam, or if consumers are using the first generation model [REDACTED] that was sold without "D"-rings.

In addition, if the [REDACTED] is placed inside a crib, play yard or other confined area, which is not a recommended use, the infant can fall or hang over of the side of the [REDACTED] and become entrapped between the crib side and the [REDACTED] and suffocate.

Likewise, if the [REDACTED] is placed on a table, countertop, or other elevated surface and a child falls over the side, it poses a risk of serious head injury. Consumers should always use the [REDACTED] on the floor away from any other products.

The [REDACTED] is a portable recliner designed for sleeping, resting and playing. The recliner includes a foam base with an inclined indentation for the infant to sit in and a fitted fabric cover and a three point harness. The first generation model of the [REDACTED] can be identified by the absence of "D"-rings in the foam base. In second generation models, the harness system has "D"-rings in the foam base and [REDACTED] straps inside the fitted fabric cover.

The recalled [REDACTED] were sold at toy and children's retail stores nationwide and online, including at [REDACTED] from January 2009 through July 2010 for about \$130.

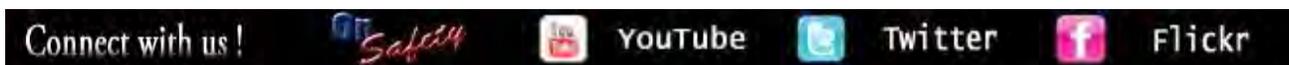
The recalled product was manufactured in the United States and China.

Consumers with a first generation [REDACTED] models, without "D"-rings, should stop using the recalled baby recliners immediately and contact the firm to receive an \$80 coupon towards the purchase of a new [REDACTED] with free shipping. Consumers with a second generation [REDACTED] with "D"-rings, should immediately stop using the product until they are able to visit the firm's website to obtain new product instructions and warnings. Consumers will also view an important instructional video to help consumers ensure the harness is properly fastened. Consumers who are unable to view the video or new instructions online, should contact the firm to receive free copies by mail. For more information, contact [REDACTED] toll-free at [REDACTED] between 9 a.m. and 5 p.m. ET Monday through Friday or visit the firm's website a [REDACTED]

cigarette lighters, and household chemicals - contributed to a decline in the rate of deaths and injuries associated with consumer products over the past 30 years.

Under federal law, it is illegal to attempt to sell or resell this or any other recalled product.

To report a dangerous product or a product-related injury, go online to: www.saferproducts.gov, call CPSC's Hotline at (800) 638-2772 or teletypewriter at (800) 638-8270 for the hearing impaired. Consumers can obtain this news release and product safety information at www.cpsc.gov. To join a free e-mail subscription list, please go to <https://www.cpsc.gov/cpsclist.aspx>.



Task Number: 34232; ECC3559

Date: Lcpwct { '42.'4234

Status of Missing Document(s)

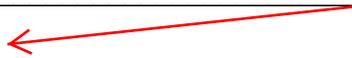
The official records below were requested for this investigation report, but could not be obtained.

1. Police Report tgegkxg'4B94234

2. Ambulance Run Report

3. Hospital Records / Victim's Medical Records

4. _____



Date: 1/20/12 Investigator No. 9085

Regional Office: CFIE Supervisor No. 9093

Re: CPSC Report [REDACTED]

[REDACTED]

I finally took time to look at the CPSC recall. The last picture is identical to how I found [REDACTED]. He was healthy other than acid reflux. I found him in the morning not breathing and blue. I assumed he suffocated, but the ME said SIDS. Either way I believe the [REDACTED] was a contributing factor.

[REDACTED]

Sent from my iPhone

On Jan 9, 2012, at 12:19 PM, [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

*****!!! Unless otherwise stated, any views or opinions expressed in this e-mail (and any attachments) are solely those of the author and do not necessarily represent those of the U.S. Consumer Product Safety Commission. Copies of product recall and product safety information can be sent to you automatically via Internet e-mail, as they are released by CPSC. To subscribe or unsubscribe to this service go to the following web page:
<https://www.cpsc.gov/cpselist.aspx> *****!!!

120109CAA1337 ADDENDUM:

On January 24, 2012, two questions were raised by headquarters staff concerning IDI #120109CAA1337. Specifically, the question arose whether the ½” measurement between the incident baby recliner and the bumper installed in the crib at the time of the incident, as initially provided by the victim’s mother, was accurate and whether or not the victim’s mother had received any additional warning labels, printed information or any indication that the incident baby recliner had been recalled when she received the baby recliner. To address the concerns, on January 25, 2012 an E-mail was prepared and sent to the victim’s mother, (see attached). In response to the E-mail, the victim’s mother telephoned this Investigator at approximately 11:30 AM the same day and provided the following information:

1st Question: In looking at a ruler and in thinking about the incident baby recliner in the crib with the bumper installed, the victim’s mother reported that there was “usually” 2 inches (2”) on either side of the incident baby recliner between it and the bumper. The victim’s mother stated that this measurement was accurate when the baby recliner was “centered in the crib”. The victim’s mother stated that the incident baby recliner was centered in the crib when the victim was placed into it the evening prior to the incident. The victim’s mother further stated that when she found the victim unresponsive in the crib, the incident baby recliner had been “pushed to the opposite side” of the crib and “was no longer centered in the crib”. (This is previously unknown information as the victim’s mother had not mentioned this during previous interviews nor does the ME Investigative report, appended as Exhibit 5 to the original report, mention this.) The victim’s mother noted during the 1/25/12 telephone conversation, “The last thing on my mind when I found (the victim) was the measurement between the baby recliner and the bumper, but, in thinking about it now, it was at least 3 ½” to 4” on the side where his head was located because his head was fairly large”. (When asked about the ½” measurement that she initially provided to this Investigator and which is captured in the original report, the victim’s mother responded, “I threw the figure out there to make the point of it not being a lot of space at all, but in thinking about it and looking at a ruler, it was closer to 2”).

2nd Question: The information captured in the original report is accurate. There were no additional warning labels, printed information or any indication that the product had been recalled at the time the victim’s mother received the incident baby recliner. The victim’s mother stated that there was also no indication on the retail web-site from which the incident baby recliner was purchased as to why the product was “discontinued”, (other than the site noting it was being discontinued). The victim’s mother stated that the retail web-site offered the baby recliner in pink, blue and green; however only the green colored units were being offered at the discontinued sales price. The victim’s mother stated that she thought it was being discontinued “because of the ugly color”. The victim’s mother first learned of the recall when a friend conducted an Internet search for the product’s brand name approximately 1 ½ weeks after her son’s death. The victim’s mother repeated what was captured in the original report: The only items in the box that she received from the Internet retailer were the incident baby recliner and a packing slip.

FW: Two follow-up questions

Sent: Thursday, January 26, 2012 10:52 AM

To: [REDACTED]

[REDACTED] *Product Safety Investigator*
U.S. Consumer Product Safety Commission
Division of Compliance & Field Operations / Eastern Region

From [REDACTED]
Sent: Wednesday, January 25, 2012 11:10 AM
To: [REDACTED]
Subject: Two follow-up questions

Good Morning [REDACTED]

I hope this E-mail finds you as well as can be expected. I wanted to let you know that my report regarding [REDACTED] death was completed and submitted to CPSC's headquarters for review. Reviewers of the report have asked me to obtain confirmation / more specific information on 2 issues that I'm hoping you'll be willing to provide. This is the final time I should need additional information from you, as I know that it's difficult for you.

First, in discussing the physical dimensions of the [REDACTED] you noted that the product "looked like it belonged in a crib" and you stated that there was "approximately **half an inch** (1/2") on either side of the [REDACTED] between the side of the recliner and the bumper". Could you please think about the 1/2" measurement you provided and either confirm that it was, in fact, approximately, 1/2" on either side from the side of the [REDACTED] to the bumper when the recliner was placed into the crib or, if you now believe that it was a greater or lesser measurement - even by an inch or two - now that I'm asking you to specifically think about the size of half an inch, could you please provide that measurement? (At the time you made the statement about the amount of room between the [REDACTED] and the bumper, you were not responding to a question by me but rather you voluntarily provided the information as we were discussing the dimensions of the product.) This measurement is extremely critical to the CPSC's understanding of how [REDACTED] died.

Second, can you please tell me if you recall any warnings or labels being in the box from the Internet retailer, [REDACTED], or any indication at all when you received the baby recliner that it had been recalled? I remember you stating that there was "nothing in the box that was received except for the [REDACTED] and the packing slip", but I wanted to confirm this with you a second time.

If there is any way I can ever be of any assistance to you in the future, please contact me.

Sincerely,

[REDACTED]

[REDACTED] *Product Safety Investigator*
U.S. Consumer Product Safety Commission
Division of Compliance & Field Operations / Eastern Region