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Local Commissioners Memorandum

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To:	Commissioners of Social Services
Issuing Division/Office:	Strategic Planning and Policy Development
Date:	November 16, 2010
Subject:	Guidance for CPS Investigations of Infant Fatalities and Injuries Involving Unsafe Sleeping Conditions
Suggested Distribution:	Directors of Social Services Child Protective Services Supervisors Staff Development Coordinators MDT/CFRT Coordinators
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Attachments:	Attachment A: Sleep environment/SIDS questions from NCCDR
Attachments Available Online:	Sudden Unexplained Infant Death Investigation (SUIDI) reporting form and instructions: www.cdc.gov/sids/SUIDHowtoUseForm.htm

Filing References

Previous ADMs/INFs	Releases Canceled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
10-OCFS-INF-01 10-OCFS-LCM-09 10-OCFS-INF-08			FCA §1012 SSL §§412 and 424 18 NYCRR 432.2(b)	Child Protective Services Program Manual, Chapter IV, Sections D and E	

I. Purpose

The purpose of this Local Commissioners Memorandum (LCM) is to provide guidance to Child Protective Services (CPS) staff regarding factors to consider and evaluate when investigating a report of a death, or serious injury, of an infant that may have been caused by or related to unsafe sleeping conditions. The LCM addresses steps to be taken in these investigations, information that should be obtained and considered, and evaluation of that information in determining whether to indicate a report.

Although this LCM addresses investigations in which a death or injury has occurred, much of the information in it can also provide guidance to CPS staff in assessing circumstances of safety and risk or “imminent danger” to infants created by possibly unsafe sleeping conditions.

The information in this LCM generally applies only to sleep-related injuries or deaths of *infants*, who are uniquely susceptible to sleep-related risks¹, but it could also apply to some older children who have developmental delays or medical conditions that make them susceptible to death or injury caused by the same sleep conditions that can put infants at risk.

II. Background

In recent years, much has become known about the association of sudden infant death syndrome (SIDS) and such unsafe sleep conditions as placing an infant to sleep in a position other than on the infant’s back or placing an infant to sleep on soft bedding, such as on a couch or on any surface containing blankets, pillows, crib bumpers, other soft bedding materials and, most recently, positioners. The Office of Children and Family Services (OCFS) and other organizations have conducted public information campaigns to make the public aware of this information; in the last several years, there has been a sharp reduction in the number of SIDS deaths in this country.

However, in fulfilling its responsibility to review the investigations into the deaths of children that fall into certain categories, including those of children in families that were previously known to local districts, OCFS has noticed that an increased number of infant deaths in recent years appear to be associated with other sleep safety issues, including bed-sharing. Of the 117 fatalities of infants in 2009 that OCFS reviewed, approximately half appeared to involve unsafe sleep conditions.

¹ According to the American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome, “The predominant hypothesis regarding the etiology of SIDS remains that certain infants, for reasons yet to be determined, may have a maldevelopment or delay in maturation of the brainstem neural network that is responsible for arousal and affects the physiologic responses to life-threatening challenges during sleep.” American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome; The changing concept of sudden infant death syndrome: diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics* 2005; 116(5):1245-55. <http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;116/5/1245>

The issue of bed-sharing² by infants and adults is one that is especially fraught with social, cultural, and personal implications, with strong adherents arguing for and against the practice. It is clear, however, that when bed-sharing occurs in conjunction with certain other factors, risk to the safety of the infant is increased. Added risk factors include the following³:

- The bed-sharing occurs in unsafe sleep conditions, such as with soft bedding or on surfaces such as a couch or armchair.
- A person sleeping with an infant is under the influence of alcohol or drugs (including legal, illegal, prescription, and over-the-counter drugs), or is overly exhausted. These increase the likelihood that the person will not waken during a dangerous situation (for example, rolling over on the infant).
- There was maternal smoking during pregnancy and/or smoke in the environment after birth.
- The infant shares the bed with a person who is obese⁴; this increases the danger of the infant being smothered by the person's body.

A recently published study that examined 251 SIDS cases in New Jersey⁵ found that 244 of those deaths were associated with one or more risk factors, with only 44 having a single risk factor. The study identified the percentage of times that each of the following risk factors were associated with the deaths:

- Not placed on back – 70%
- Smoking by one or both parents – 60%
- Upper respiratory infection – 44%
- Bed-sharing – 39%
- Scene risks (for example, use of soft bedding or presence of other children) – 31%
- Under 37-week gestational age – 27%

In response to an increased number of deaths attributed to unsafe sleep environments, and because of the sensitive and complicated nature of cases involving this subject, OCFS has prepared the following guidelines for child protective services staff to use in conducting an investigation of an infant death or injury that is possibly sleep-related. These guidelines suggest methods for information gathering and factors to consider in assessing risk and in applying the information gathered when making a determination. These guidelines are intended to support but not replace or supersede the standards for a child protective services investigation set forth in 18 NYCRR 432.2(b)(3).

²The term “bed sharing,” as used in this document, refers to an infant and one or more other persons sleeping together on any surface, not necessarily a bed. There are many other terms that are sometimes used to describe this practice, including “co-sleeping,” “family bed,” “co-bedding,” and others. “Co-sleeping” more aptly refers to an infant and parent sleeping in close proximity in the same room, but not sharing the same sleep surface.

³ American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome; The changing concept of sudden infant death syndrome, see footnote 1.

⁴ Cindie Carroll-Pankhurst and Edward A. Mortimer Jr. Sudden Infant Death Syndrome, Bedsharing, Parental Weight, and Age at Death, *Pediatrics* 2000; 107, 530-536.
<http://archpedi.ama-assn.org/cgi/content/full/157/1/43>

⁵ Barbara M. Ostfeld, Linda Esposito, Harold Perl and Thomas Hegyi; Concurrent Risks in Sudden Infant Death Syndrome, *Pediatrics* 2010; 125, 447-453.
<http://pediatrics.aappublications.org/cgi/content/abstract/125/3/447>

The publication of this LCM is just one of a series of actions that OCFS is taking to address aspects of sleep safety for infants, including preventive measures that can be taken to reduce unsafe sleep environments. OCFS anticipates providing additional policy guidance in the future that will address measures to prevent infant deaths due to unsafe sleep environments and case practice for assessing risk due to unsafe sleep environments. Earlier this year, OCFS produced a two-hour teleconference for local district and voluntary agency caseworkers. The teleconference illustrated the importance of safe sleep environments, provided information about the nature of child fatalities and risk factors associated with sleep environments, and presented effective strategies for caseworkers to convey information to parents about sleep-related risks. The teleconference is currently being edited to a 10-20 minute DVD that will be available along with handouts for caseworkers to use with caretakers in the home.

III. Program Implications

A. Some Recommended Steps for Obtaining Information

When conducting a CPS investigation of a report of an infant who has died while asleep or incurred a sleep-related injury, the following steps are recommended for gathering information:

- Speak with Emergency Medical Services (EMS), law enforcement, and any other first responders or individuals who were on the scene of the incident, in order to obtain specific information pertaining to the cause and circumstance of the infant injury or death.
- Secure information from the first responders or law enforcement regarding the conditions in the home, condition of the infant when they arrived, and any statements made to the first responders by those present in the home regarding what transpired.
- Locate and view the exact place where the infant's death or injury occurred. In the case of an infant death, identify where the infant was placed, last known alive, and found dead or unresponsive.
- Observe the physical living environment and, when the circumstances permit, take photographs or video of the scene. This should be done even if the body has been removed. If the first responders or law enforcement personnel have taken photos or video, request copies of those items. This may assist CPS in conducting an efficient investigation and reduce duplication of efforts.
- Establish and document the timeline of events regarding the incident, including, but not limited to, the events of the day prior to the time when the infant was placed to sleep, if and when the infant was thereafter observed by anyone in the household, when the infant was discovered to be in distress, through the time when first responders arrived at the home.

- Solicit and record the observations of all persons in the household regarding what they saw and heard with respect to the infant during the timeline established above.
- Consult with the infant's pediatrician and any other service providers.
- When they become available, obtain the medical examiner's report and any reports completed by first responders or law enforcement.

In those communities in which there is a multidisciplinary team (MDT) or a Child Fatality Review Team (CFRT), local districts should follow the local protocols for working with those teams (see [10-OCFS-LCM-09](#)).

B. Factors to Consider: Important Information to Obtain

Child Protective Services (CPS) workers should obtain as much information as possible about any and all circumstances that might be relevant to ascertaining the possible cause(s) of an infant's sleep-related death or injury, and to assessing possible future risk to any other children in the home. Information should be gathered that will allow CPS investigators to determine the events and circumstances on the day of the incident -- prior to, during, and after the death or injury -- and to assess them along with any other relevant facts about the family or infant.

The Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services has created a comprehensive Sudden Unexplained Infant Death Investigation (SUIDI) Reporting Form, which CPS investigators may find to be a helpful guide in determining some questions to ask and factors to consider when conducting sleep-related investigations. The easy-to-use checklist form and explanatory information are available at www.cdc.gov/sids/SUIDHowtoUseForm.htm.

By performing a thorough and complete investigation of each child fatality, CPS investigators will not only be able to make an accurate determination in the case and assess the need for services or other actions, but will also be adding to a body of knowledge that can lead to improved preventive measures both locally and nationally. CPS workers are also urged to review those questions in the National Center for Child Death Review (NCCDR) Case Report Form 2.1 (see [10-OCFS-INF-01](#)) that relate to infants, SIDS, and sleep environment; to be cognizant of collecting as much information as possible to respond to these questions; and to document that information in the case record (these questions are listed in Attachment A of this policy). This will enable OCFS Regional Office staff to enter the information into the NCCDR system, which both enhances the national database that supports the understanding of what causes child fatalities and enables OCFS to generate its own locally specific reports on infant fatalities. It is only by collecting and analyzing data on infant deaths that we can improve our understanding of the causes of unexplained infant deaths and identify trends, both of which support the development of more effective future prevention campaign efforts.

What follows is a brief listing of the information that CPS caseworkers should attempt to obtain when investigating reports of an infant death or injury that may be related to unsafe sleep conditions. This list does not necessarily contain every factor that should be considered, as the relevant factors may vary from one report to another. The following information may be obtained by following the steps noted in the previous section and by observation, interviews, review of previous reports, or other means.

- Determine all aspects of the sleeping conditions at the time of the infant's death or injury including, but not limited to:
 - where the infant was sleeping (in a crib, bed, on a couch, or elsewhere), including an assessment of the firmness of the surface;
 - what, if any, other objects were on the sleeping surface, including pillows, blankets, stuffed animals, or any other objects, and their location in relation to the infant when the infant was placed to sleep, while sleeping, and when found;
 - the positions of the infant when placed to sleep, while sleeping, and when found. A reenactment using a doll may be helpful in determining this information. Specifically,
 - was the infant placed to sleep face up, face down, on its side;
 - where on the sleep surface was the infant placed to sleep;
 - where on the sleep surface was the infant found in distress;
 - was the infant found face up, face down or on its side, or between objects such as cushions when found in distress;
 - was the infant's head covered with anything when found;
 - temperature of the room and the amount of clothing worn by the infant;
 - the condition of the room in which the incident occurred;
 - the presence and location of other persons or animals in relation to the infant while sleeping;
 - any other aspects of the environment in which the infant slept.
- If a shared sleeping situation has been identified, be sure to:
 - determine all of the above information regarding the sleep surface and sleeping conditions, paying special attention to the positional relationship of the infant with any other occupant of the sleeping surface;
 - identify the number, identity, and size of occupants, including pets, of the bed, couch or other sleeping surface.
- Inquire into the infant's usual sleeping arrangements, including the infant's usual sleeping location and normal sleeping schedule, and whether the sleeping arrangements at the time of the incident varied from the infant's normal routine.
- Determine if the infant had any medical condition, either a pre-existing condition or one that existed on the day of the incident (for example, mild cold, infection, sleep apnea, use of a respiration monitor), that could enhance risk to an infant in a sleep situation and, if so, if the caretakers were aware of that risk.

- Explore if the infant was given any medication prior to sleep, either prescribed or over-the-counter. If so, CPS needs to see the container and inquire about the dosage given.
- Inquire as to what steps were taken by household occupants after discovery of the infant.
- Explore any drug or alcohol use during the period preceding the infant's death or injury by adults who were in the home and/or sleeping with the infant, including the use of prescribed or over-the-counter medications (for example, sleep aids, anti-depressants).
- Explore whether there are any other factors besides drug or alcohol use that may have impacted the subject caregiver's physical ability or judgment on the day of the incident, such as pre-existing medical conditions, sleep deprivation caused by employment, or other factors.
- Determine if there was smoking in the infant's living environment, on the day of the infant's death/injury and/or on an ongoing basis.

Obtain any additional information about the family or infant that may be relevant to the investigation, including:

- Determine if any adult in the home, or an adult sleeping with the infant at the time of the death or injury, has a history of drug or alcohol abuse, or if they smoke;
- Determine if the infant or the infant's siblings had previously experienced sleep-related events that either resulted in harm or risk of harm to an infant in the household;
- Examine if there were prior sleep-related safety issues identified;
- Explore if the issues of unsafe sleep or bed sharing and other risk factors were addressed with the medical examiner or coroner and how the ME/coroner responded.
- Inquire of the adults whether the adult(s) have been previously counseled on safe sleep and, if so, what was said, by whom, and when; make a similar inquiry of appropriate medical professionals and/or service providers, such as the infant's pediatrician or the family's visiting nurse.

Finally, CPS staff must be mindful of addressing the trauma and grief that accompanies an infant fatality or injury resulting from an unsafe sleep environment. It is important for CPS caseworkers and supervisors to work closely together to assess whether parents, other caretakers, surviving siblings or other members of the families they are investigating need services, including bereavement counseling, and to provide referral and follow up as necessary. It is also important for supervisors to recognize that caseworkers themselves may experience trauma when working on these cases, and to also

support CPS caseworkers investigating these cases with trauma/grief counseling whenever warranted.

C. Making the Determination

While a report of an injury or a death due to an unsafe sleep environment is always traumatic, as with any report of suspected child abuse or maltreatment, following a complete and thorough investigation CPS must make a determination of whether there is some credible evidence of child abuse or maltreatment, as those terms are defined in the Social Services Law and the Family Court Act.

Note: For fatality cases, the standard of evidence for the purpose of substantiating the allegation of DOA/Fatality remains some credible evidence.

Cases involving a DOA/Fatality allegation should also generally include other allegations such as lack of supervision, inadequate guardianship, lack of medical care, etc. For the purpose of this guidance, these other allegations are referred to as the underlying allegations.

In making a determination in a fatality report, CPS must determine whether the facts of the case, as developed by CPS during its investigation and using the “some credible evidence” standard, satisfy each of the elements of the definitions of abuse [as defined in section 412(1) of the Social Services Law / section 1012(e) of the Family Court Act] or maltreatment [as defined in section 412(2) of the Social Services Law / section 1012(f) of the Family Court Act].

Each of the respective elements of abuse or maltreatment must be supported by some credible evidence.

For example, in assessing whether a child was maltreated in regard to an allegation of lack of supervision or inadequate guardianship, CPS must satisfy each of the following elements in order to substantiate the allegation:

- a) the child’s physical, mental or emotional health or condition was impaired or placed in imminent danger of impairment; **AND**
- b) the subject of the report failed to exercise a minimum degree of care in providing proper supervision or guardianship to the child; **AND**
- c) the subject’s failure to exercise a minimum degree of care caused the impairment or imminent danger of impairment.

Remember, in a child abuse or maltreatment case (other than one specific circumstance in the definition of “neglected child in residential care”), the element of “intent” is not required.

In a fatality case, OCFS recommends that you first apply the facts of the case developed during the investigation to the definitions of abuse or maltreatment in regard to the underlying allegations.

If there is no credible evidence to support the underlying allegation(s), it is reasonable to conclude that the DOA/Fatality allegation should not be substantiated.

If the underlying allegation(s) is substantiated, then CPS should assess whether there is a nexus (causal connection) between the injury, harm, risk of injury, or risk of harm that was substantiated in the underlying allegation with the death of the child. (For example, did the underlying failure to exercise a minimum degree of care cause the death of the child?) If there is, then the DOA/Fatality allegation should be substantiated.

Be aware that officials outside of the child welfare system use terminology that is not consistent with that used by CPS. Medical examiners / coroners use terms whose meanings or implications for them may be different than they are in child protective terminology. For example, if a child dies of natural causes, or dies because of what the medical examiner / coroner refers to as an “accident,” that does not in and of itself mean that there was not maltreatment in a case. It generally means, for the purpose of the medical examiner / coroner, that the case was not a homicide. Become familiar with the terms used by the medical examiner / coroner and how they are defined.

Depending on the case, CPS should consider consulting with medical and/or other appropriate professionals for the purpose of assessing the evidence collected during the investigation to assist CPS in making its determination.

Be aware that the decision by law enforcement not to arrest the subject or by the district attorney not to prosecute, in and of itself, is not controlling in CPS’ decision as to whether there is some credible evidence to substantiate one or more allegations. The district attorney and law enforcement use a standard of evidence that differs from the one used by CPS.

The death of an infant, or any child, arising from an unsafe sleep situation is a tragic event to the family. It is understandable that CPS caseworkers may be reluctant to add to a family’s trauma. However, CPS has a legal obligation to conduct a complete investigation and to make a determination based on the facts of that investigation. Doing so may also help to prevent other similar tragedies from occurring in the future.

/s/ Nancy W. Martinez

Issued by:

Name: Nancy W. Martinez

Title: Director

Division/Office: Strategic Planning and Policy Development



Understanding HOW
and Why Children Die
& Taking Actions to
Prevent Child Deaths

Child Death Review Case Reporting System

Case Report 2.1

Excerpted Questions Regarding Infant Fatalities and Sleep Conditions

5. SIDS AND UNDETERMINED CAUSE UNDER ONE YEAR OF AGE

a. Child exposed to 2nd-hand smoke?

No Yes U/K

If yes, how often?

Frequently

Occasionally

U/K

b. Child overheated? No Yes U/K

If yes, Outside temp ____ deg. F

Check all that apply:

Room too hot, temp ____ deg. F

Too much bedding

Too much clothing

c. History of seizures?

No Yes U/K

If yes, # _____

If yes, witnessed?

No Yes U/K

d. History of apnea?

No Yes U/K

If yes, # _____

If yes, witnessed?

No Yes U/K

e. For SIDS, go to Section H, page 11. For undetermined injury cause to infants also complete G12, page 11, then go to Section H. For undetermined or unknown medical cause to infants also complete G11, page 10, then go to Section H.

H. OTHER CIRCUMSTANCES OF INCIDENT- ANSWERABLE SECTIONS

1. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE:

WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT?

No, go to H2 Yes U/K, go to H2

<p>a. Incident sleep place:</p> <table style="width:100%;"> <tr> <td><input type="radio"/> Crib</td> <td><input type="radio"/> Playpen/other play structure but not portable crib</td> <td rowspan="7" style="vertical-align: top;">If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K</td> </tr> <tr> <td>If crib, type:</td> <td><input type="radio"/> Couch</td> </tr> <tr> <td><input type="radio"/> Not portable</td> <td><input type="radio"/> Chair</td> </tr> <tr> <td><input type="radio"/> Portable, e.g. pack-n-play</td> <td><input type="radio"/> Floor</td> </tr> <tr> <td><input type="radio"/> Unknown crib type</td> <td><input type="radio"/> Car seat</td> </tr> <tr> <td><input type="radio"/> Bassinette</td> <td><input type="radio"/> Stroller</td> </tr> <tr> <td><input type="radio"/> Adult bed</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Waterbed</td> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>	<input type="radio"/> Crib	<input type="radio"/> Playpen/other play structure but not portable crib	If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K	If crib, type:	<input type="radio"/> Couch	<input type="radio"/> Not portable	<input type="radio"/> Chair	<input type="radio"/> Portable, e.g. pack-n-play	<input type="radio"/> Floor	<input type="radio"/> Unknown crib type	<input type="radio"/> Car seat	<input type="radio"/> Bassinette	<input type="radio"/> Stroller	<input type="radio"/> Adult bed	<input type="radio"/> Other, specify:	<input type="radio"/> Waterbed	<input type="radio"/> U/K		<p>b. Child put to sleep:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<p>c. Child found:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K
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<input type="radio"/> Waterbed	<input type="radio"/> U/K																			
<p>g. Child in a new or different environment than usual?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, specify:	<p>h. Child last placed to sleep with a pacifier?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>i. Was a fan being used in the room at the time of death?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, type:																		

j. Circumstances when child found:

<p><u>Child's airway was:</u></p> <input type="radio"/> Unobstructed by person or object <input type="radio"/> Fully obstructed by person or object <input type="radio"/> Partially obstructed by person or object <input type="radio"/> U/K	<p><u>Child's position most relevant to death:</u></p> <input type="radio"/> On top of <input type="radio"/> Under <input type="radio"/> Between <input type="radio"/> Wedged into <input type="radio"/> Pressed into <input type="radio"/> Fell or rolled onto <input type="radio"/> Tangled in <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p><u>With what objects or persons, check all that apply:</u></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Adult(s)</td> <td><input type="checkbox"/> Water bed mattress</td> <td><input type="checkbox"/> Clothing</td> </tr> <tr> <td><input type="checkbox"/> Child(ren)</td> <td><input type="checkbox"/> Air mattress</td> <td><input type="checkbox"/> Cord</td> </tr> <tr> <td><input type="checkbox"/> Animal(s)</td> <td><input type="checkbox"/> Bumper pads</td> <td><input type="checkbox"/> Plastic bag</td> </tr> <tr> <td><input type="checkbox"/> Blanket</td> <td><input type="checkbox"/> Crib rail</td> <td><input type="checkbox"/> Wall</td> </tr> <tr> <td><input type="checkbox"/> Pillow</td> <td><input type="checkbox"/> Couch</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Comforter</td> <td><input type="checkbox"/> Chair, type:</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Mattress</td> <td><input type="checkbox"/> Car seat/stroller</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pillow-top mattress</td> <td><input type="checkbox"/> Stuffed toy</td> <td></td> </tr> </table>	<input type="checkbox"/> Adult(s)	<input type="checkbox"/> Water bed mattress	<input type="checkbox"/> Clothing	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Air mattress	<input type="checkbox"/> Cord	<input type="checkbox"/> Animal(s)	<input type="checkbox"/> Bumper pads	<input type="checkbox"/> Plastic bag	<input type="checkbox"/> Blanket	<input type="checkbox"/> Crib rail	<input type="checkbox"/> Wall	<input type="checkbox"/> Pillow	<input type="checkbox"/> Couch	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Comforter	<input type="checkbox"/> Chair, type:	<input type="checkbox"/> U/K	<input type="checkbox"/> Mattress	<input type="checkbox"/> Car seat/stroller		<input type="checkbox"/> Pillow-top mattress	<input type="checkbox"/> Stuffed toy	
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<p>k. Caregiver/supervisor fell asleep while feeding child? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, type of feeding:</p> <input type="radio"/> Bottle <input type="radio"/> Breast <input type="radio"/> U/K	<p>l. Child sleeping in the same room as caregiver/supervisor at time of death?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>m. Child sleeping on same surface with person(s) or animal(s)? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> With adult(s): # ___</td> <td><input type="checkbox"/> #U/K</td> <td>Adult obese: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> With other children: # ___</td> <td><input type="checkbox"/> #U/K</td> <td>Children's ages: _____</td> </tr> <tr> <td><input type="checkbox"/> With animal(s): # ___</td> <td><input type="checkbox"/> #U/K</td> <td>Type(s) of animal: _____</td> </tr> <tr> <td><input type="checkbox"/> U/K</td> <td></td> <td></td> </tr> </table>	<input type="checkbox"/> With adult(s): # ___	<input type="checkbox"/> #U/K	Adult obese: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<input type="checkbox"/> With other children: # ___	<input type="checkbox"/> #U/K	Children's ages: _____	<input type="checkbox"/> With animal(s): # ___	<input type="checkbox"/> #U/K	Type(s) of animal: _____	<input type="checkbox"/> U/K		
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<input type="checkbox"/> U/K														

2. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? No, go to H3 Yes U/K, go to H3

<p>a. Describe product and circumstances:</p>	<p>b. Was product used properly?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>c. Is a recall in place?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>d. Did product have safety label?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>e. Was Consumer Product Safety Commission (CPSC) notified?</p> <input type="radio"/> No, call 1-800-638-2772 to file report <input type="radio"/> Yes <input type="radio"/> U/K
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