



Appendix 46

INVESTIGATION GUIDELINE

Revised August 2004

Nursery Products

I. Introduction

A. Background Information

In recent years, nursery product-related injuries to children under five years of age treated in hospital emergency rooms have dropped. On average, there are about 69,000 nursery product-related injuries treated each year in hospital emergency rooms and the majority of these injuries resulted from falls.

Reported fatalities associated with nursery products have averaged about 65 per year for the most recent years for which CPSC death certificate data collection is complete. Deaths related to nursery products have resulted in large part from mechanical and positional asphyxia.

The Juvenile Products Manufacturers Association (JPMA) is the major trade association for makers of nursery products. JPMA has an extensive safety certification program for juvenile products. There are current voluntary standards maintained by the American Society of Testing and Materials (ASTM) for many nursery products (strollers and high chairs, for example). Federal standards also exist for certain nursery products (such as cribs) and adherence to these rules is mandatory under law.

Information collected through nursery product-related investigations is used to analyze the hazard scenarios, product failures, types of injuries, the users of the products, etc. Furthermore, the analyzed data may be used in CPSC efforts such as information/education and standards development.

B. Product Category Description

1. Definitions and General Description

This category of products includes most nursery furniture and products intended for use in the care of children under five years of age. These products are used in home, childcare and commercial settings and include:

- Infant Carriers (Handheld, Soft and Framed)
- Strollers and Carriages
- Cribs
- Baby Walkers and Jumpers (*Consult the current investigation guideline for baby walkers (Appendix 110).*)
- High Chairs (*Replaces Appendix 83.*)
- Changing Tables
- Baby Gates and Barriers
- Playpens and Play Yards (*Replaces Appendix 84.*)

- Baby Bath Seats (*New guideline is being developed. Refer to Appendix 111 in the interim.*)
- Pacifiers (*No longer refer to Appendix 48.*)
- Rattles (*No longer refer to Appendix 48.*)
- Infant Swings
- Bassinets and Cradles
- Portable Bed Rails
- Bouncer Seats
- Activity Centers
- Portable Hook-On Chairs
- Toddler Beds

2. Specific Items of Interest

Field investigators shall conduct an on-site investigation, if the product is available. Otherwise, conduct a telephone interview. On-site investigations are the most desirable, since it affords the investigator the opportunity to gather the best information possible.

- a.) Document all manufacturer brand and serial/model information, including production dates if available.
- b.) Identify all labels regarding certification, testing or conformance with mandatory or voluntary standards. The text of any warning and age labeling on or accompanying the product is also of interest and should be documented and photographed, if possible.
- c.) Currently there is a project to evaluate the adequacy of restraints on nursery products. If the incident being investigated specifically involves the restraint system, then the investigator should use the investigation guideline titled *Restraints on Infant Products, July 2000, Appendix 122.*
- d.) If an entrapment occurred, describe the area in which the child was entrapped. Any openings that were part of the entrapment scenario should be measured and photographed. A doll or manikin should be used, if possible, to reenact the position of the child at the time of the incident.
- e.) If a tipover occurred describe the surface on which the product was placed.
- f.) If a fall occurred, describe any actions the child may have taken that resulted in the fall. Document the height from which the child fell and if the product fell with him/her. Describe the surface on which the child landed, the parts of the product that failed or were involved and any other pieces of furniture or objects that contributed to the incident.
- g.) If a hanging occurred, describe any part(s) of the product that played a role in the hanging such as a protrusion or a gap. Specify if the gap or protrusion was created by a failure of the product.
- h.) If positional asphyxia occurred, describe the area of the product in which it occurred and any other products that were involved (such as bedding, toys, etc.).
- i.) If the incident involved hardware or component failure, describe what failed and how it failed. Note if a similar failure occurred previously and how.
- j.) If an entanglement occurred, describe what part of the product the child was entangled in and what part of the child's body was entangled. However, if restraints were involved, then use the restraint guideline mentioned above.

- k.) If the product was obtained second hand, please determine how it was obtained and if warning or use instructions accompanied the product.
- l.) Determine if non-factory parts (such as screws, nails, or other fasteners) were used to repair, modify or assemble a crib.

C. Headquarters Contacts

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II. Instructions for Collecting Specific Information

For an on-site or telephone investigation, it is essential to provide a detailed narrative description of the incident in order to provide a clear understanding of the sequence of events, before, during, and after the incident, and the circumstances involved. If a telephone investigation (rather than an on-site investigation) is done, it is still important to obtain as much information about the product as possible. Ask the respondent to describe the product to you in detail, including features that are unique to that product and product identification, such as the model and date of manufacture. If the respondent does not have the product, determine whether it was returned to the store or manufacturer, or if it was destroyed or discarded. Timely contact with the victim's family will improve the likelihood of accurate recollection by the respondent of the circumstances involved in the incident.

A. Synopsis

Describe the sequence of events, report the product(s) involved, the victim's activity during the incident and how the victim became injured. Include the victim's age, sex and type of injury. Specify the location (e.g., home, childcare, etc.) where the incident occurred. If a fall-related incident occurred outdoors, describe the terrain and if indoors, describe the surface to which the child fell.

For data retrieval purposes, please include the following key words in the synopsis as appropriate: ENTRAPPED, HUNG, SUBMARINED, ENTANGLED, ASPHYXIATED, SUFFOCATED, FELL, TIPPED, OVERTURNED, DROWNED, CHOKED

B. Description of Product

1. Nursery Equipment Involved

- a.) Describe the specific type of product involved. Indicate if it was a combination product (e.g., car seat/carrier, stroller/carrier, etc.). However, code the product according to its use at the time of the incident.
- b.) What were the manufacturer, brand, model and serial number of the product?
- c.) How old was the product? (Include date of purchase, if known.) Was it obtained new or used? If used, how old was the product when it was obtained?
- d.) How often was the product used (e.g., daily, weekly, etc.)? Had the product been used by more than one child and if so, how many?
- e.) Describe the condition of the product (e.g., like new, well used, damaged, etc.)

- f.) Had the product been modified, repaired or altered in any way? If so, please describe how and why. Had the product ever been disassembled or taken apart? How and for what purpose?
 - g.) Did the manufacturer specify any age or weight limitations for the product?
 - h.) If there was a component failure, determine where the product was primarily used and stored. Was it exposed to the elements or adverse conditions, such as heat, rain, sunlight, snow, etc? How was the product cleaned? Determine the frequency of cleaning and the type of cleaner used.
2. Labeling and Instructional Literature
- a.) Describe any labeling on the product. Indicate where it was located on the product and its exact wording. Determine if there was a JPMA certification seal on the product packaging.
 - b.) Obtain any instructional literature that came with the product. If the consumer no longer has the literature, did they review it when the product was first obtained? Were there any warning or cautionary statements in the literature?
3. Guidance on Investigating Specific Products

Infant Carrier and Car Seats

- The three basic types of infant carriers are handheld, soft and framed. The handheld carrier is freestanding and intended to carry a child whose torso is completely supported by the product. The caregiver transports the child by means of handholds or handles. The soft carrier is normally of sewn fabric construction and is designed to hold a newborn to 6-month-old baby. The soft carrier is worn by the caregiver from their shoulder(s) and the child is positioned upright. Soft carriers are most often worn in front, but there are some models that can be worn on the caregiver's back. A frame carrier is usually fabric constructed over a stiff frame and is worn on the back of the caregiver. Frame carriers are often referred to as backpack carriers.
- Currently, most hand held infant carriers on the market are carrier/car seat combinations. Specify whether the product involved was a combination, but code the product according to its use at the time of the incident.
- The ASTM standard for hand-held carriers addresses carrier handle strength for occupant support, tip over and falls from elevated surfaces. The standard is **ASTM F2050-00 Standard Consumer Safety Performance Specification for Hand-Held Infant Carriers**.
- Since car seats are under the jurisdiction of the National Highway Traffic Safety Administration (NHTSA), CPSC does not follow up on incidents related to a motor vehicle crash. If the product is a combination car seat/carrier, determine if the incident was reported to NHTSA.
- Most deaths with carriers or car seats (excluding motor vehicle crashes) are due to the product falling off an object or overturning. If a fall occurred, document what the product was placed on or whether it was being carried at the time; if the product fell with the child; if the child was restrained; and from what height the child fell. If the product overturned/tipped over, determine what it was placed on and what it turned over onto. Certain scenarios where the product overturned might involve soft bedding/suffocation

issues or restraint entanglement issues. Specify any extenuating circumstances beyond the tip over that might have led to death or serious injury.

Strollers and Carriages

- There is an ASTM standard for strollers and carriages with safety specifications addressing stability, brakes, restraints, latching and folding mechanisms, structural integrity and entrapments in the openings of convertible carriage/strollers. This standard is **ASTM F 833-01 Standard Consumer Safety Performance Specification for Carriages and Strollers**.
- Carriage/strollers allow for an interior recline angle of greater than 150 degrees and a restraint system is provided with this product. A carriage does not require a restraint for an infant, but if the carriage has features that would be used for an older child such as a sit-up back then there must be a restraint system provided.
- Identify the type of stroller involved and its features. Among the stroller designs currently on the market are umbrella, combination, jogging, double, tandem, carriage and multi-occupant (often used in childcare situations). Construction of individual strollers may vary from rigid to more flexible as in the case of a jogging or umbrella stroller. The combination strollers tend to be quite heavy and are often on the high end in terms of cost. Some strollers can be folded for ease of handling and storage.
- If the restraint system was involved, then use the restraint guideline previously mentioned. This includes incidents where the child “submarined” (slipped down) through an opening or got out of the restraints.
- If the stroller or carriage collapsed, document the way in which it folded and during what activity (such as running, walking or going over a curb). Also, determine if there was any additional cargo in the product and the type of terrain or surface the stroller was on. If possible, photograph the latches on the stroller or carriage in both a closed and open position to document their condition.
- If the latching mechanism failed on a combination stroller, describe the latch in detail. Include information about the structural materials used for the mechanism. Document the result of the latch failure (e.g., separation of the carrier portion from the stroller). Question respondent about the ease of operating the mechanism. Inquire about the stroller’s history, including whether the latching mechanism had failed before. Ask how often the stroller was in use (daily, weekly, etc.) and how often it was used on uneven or bad terrain. Had the stroller ever impacted an object, such as a curb or wall?
- Describe the current condition of the stroller or carriage and whether there were any missing or broken parts. Photograph any failed parts of the stroller or carriage and ask the consumer to position it in the manner it was found after the incident.

Cribs

- The most common crib-related death scenarios are entrapment and suffocation due to loose, missing or improperly installed attachment or mattress support hardware; improperly spaced, loose or missing slats; and poor mattress fit. Additionally, suffocation and entanglement in bedding items is also associated with crib-related deaths.
- There are Federal regulations for full-size baby cribs that are published in the **Code of Federal Regulations in Title 16, Part 1508**. The requirements for adjustable crib rails specify that the top of the adjustable rail at its highest position must be 26 inches above

the mattress support when it's set at the lowest position. Also, when the adjustable rail is at its lowest position it must be at least 9 inches above the mattress support set at its highest position.

To prevent strangulation, slats, spindles, corner posts and rods cannot be more than 2 3/8 inches apart at any point.

Hardware that is accessible to the child must not injure the child during normal use of the crib. Locking devices must require two distinct actions or require a minimum of 10 pounds of force for release.

Wood screws cannot be used to connect any of the parts of the crib that must be assembled for use. Wood surfaces must be smooth and free of defects.

End panels and sides cannot have any projection with a depth greater than 3/8 inch or any surface where a child might have a toehold.

Every crib must be sold with detailed assembly instructions, identifying marks, caution statements and compliance declarations.

There is a test to determine if any cutouts in the crib create a risk of head or neck entrapment.

- The ASTM standard for full-size cribs has safety specifications for failure of mattress support hardware, failure of glued or bolted connections, dropside latch failure and teething rail dislodgment. The standard also addresses maintenance and assembly requirements for the instructions that accompany a crib. This crib standard is **ASTM F1169-99 Standard Specification for Full Size Baby Crib**.
- There is also an ASTM standard to address strangulation with items such as pacifier cords or clothing that become entangled on crib corner post extensions on full or non-full-size cribs. This crib standard is **ASTM F966-00 Consumer Safety Specification for Full-Size and Non-Full-Size Baby Crib Corner Post Extensions**.
- If crib hardware contributed to the incident, determine the specific piece of hardware involved and how it failed. Describe whether the hardware was damaged in any way and if it was original to the crib.
- Determine the normal behaviors the child exhibited while in the crib that may have contributed to the incident, such as kicking the sides or rocking the crib. These types of behaviors may contribute to loose hardware or slats.
- If crib slat spacing was involved, measure the space between slats and determine the age of the crib. Loose or missing slats are generally found when the method of attachment to the horizontal rails was inadequate. If that was the case, determine the method of attachment (e.g., glue, nails, staples, a combination, etc.).
- Full size crib mattresses are supposed to be a standard size and should fit tightly with no gaps. If there is a gap between the mattress and crib and no apparent hardware failure, measure the gap. Determine if the mattress in the crib was intended for use in a full size crib.
- The ASTM standard for non-full-size cribs and play yards addresses entrapment in drop-sides that have been left in the down position, entanglement on hardware protrusions, strangulation due to center hinge failure on the rails, collapse of failure of

locking mechanisms, floors or sides, and choking on vinyl bitten off the top rail. The standard also addresses non-full-size wooden crib slat dislodgment from breakage or failure, collapse of the mattress support, detachment of screws, dislodgment of teething rails and cord or string entanglement. This standard is **ASTM F406-02 Standard Consumer Safety Specification for Non-Full-Size Cribs/Play Yards**.

- If a finial, corner post extension or other protrusion was involved, measure its height/length above the upper edge of the end of the side panel.

Baby Walkers

Consult the current investigation guideline for baby walkers (Appendix 110).

High Chairs

This portion of the Nursery Products Guidelines replaces Appendix 83 for high chairs.

- The ASTM voluntary standard for high chairs addresses tray disengagement, falls resulting from children standing up in the high chair, entrapment between the feeding tray and seat, and tip over. The standard is **ASTM F404-99a Standard Consumer Safety Specification for High Chairs**.
- Many of the current problems with high chairs center around restraints. Among the hazards associated with high chair restraints are submarining under the tray, standing up, falling out and entangling in straps. For guidance on investigations involving high chair restraints of all types, including passive crotch, straps and the tray, use the restraint guideline.
- There have been some recent entrapment incidents related to high chairs that do not involve restraints, such as entrapment between the passive restraint (center post) and side of the high chair. If that was the case, then document the dimensions of the area where the child was entrapped and what part of his/her body was involved.

Changing Tables

- Falls are the primary hazard with baby changing tables. If a fall occurred, determine whether the table had a barrier, lip or rim to prevent the child from rolling off; whether a restraint strap was available and if it was used. Also, measure the height from which the child fell.
- There have been several recent incidents involving entrapment in the section of the table under the changing surface. If the incident involved such an entrapment, record the dimensions of the opening.

Baby Gates and Barriers

- The ASTM standard for expansion gates and expandable closures addresses head and neck entrapment, and the ability of a pressure gate to withstand a push-out force. This standard is **ASTM F 1004-00 Standard Consumer Safety Specifications for Expansion Gates and Expandable Enclosures**.
- Old style accordion baby gates may still be obtainable and can present an entrapment/hanging hazard. If one of these products was involved in the incident, try to determine its age and whether it was obtained new or used.

- Baby gates or barriers that are held in place by pressure should not be used to guard the top portion of a stairway, unless they are attached to the wall. If one of these products was involved in the incident, determine how the gate was held in place.

Playpens and Play Yards

This portion of the Nursery Products Guideline replaces Appendix 84 for playpens.

- There is an ASTM standard that covers both play yards and non-full-size cribs (**ASTM F406-02 Standard Consumer Safety Specifications for Non-Full-Size Cribs/Play Yards**). The details of this standard are explained in the crib section of these guidelines.
- In recent years some deaths have occurred due to the sides collapsing on playpens/play yards when the locking mechanism failed. If the incident involved a collapse of this sort, then determine how the mechanism was supposed to work; if the caregiver had problems keeping the sides in a locked position; if one or both of the sides collapsed and if the mechanism had ever failed previous to the incident.
- If the playpen/play yard collapsed, ask the caregiver to demonstrate their understanding of how the product works.
- Play yards usually come with a thin mattress pad, because caregivers may perceive this as being uncomfortable for the child they sometimes add other bedding, mattresses, etc. This can lead to a suffocation or entrapment hazard. Added mattresses often do not fit the space, that coupled with the flexibility of the play yard's sides may lead to entrapment. If the incident was due to additional items of bedding placed in the play yard, please describe what they were and the position of the child relative to these items. Also document the size, thickness, manufacturer and model of any mattress in the product and whether it was added or original to the product. Additionally, measure the interior dimensions of the play yard.

Baby Bath Seats

For guidance on investigating baby bath seats incidents refer to the Appendix 111 for bathtubs. A separate guideline is being developed for baby bath seats. In the interim, if there are any questions concerning baby bath seat assignments, please contact:

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Pacifiers and Rattles

No longer refer to Appendix 48 for Small Parts.

- The primary hazard with pacifiers and rattles is choking. If the incident involved choking, use the appropriate test fixture to determine whether the pacifier or rattle meets Federal standards (**Code of Federal Regulations in Title 16, Part 1511 for pacifiers and Title 16, Part 1510 for rattles**). Also, determine the dimensions of the product.
- Pacifiers have labeling requirements. Photograph any product packaging that is available.
- If the pacifier was used with a leash, document the length, construction material, condition and manufacturer, if applicable.

Infant Swings

- The ASTM standard for infant swings addresses tip over, structural failure, entanglement in restraints and entrapment in leg holes. This standard is **ASTM F 2088-01 Standard Consumer Safety Specification for Infant Swings**.
- In recent years, there have been some issues with entrapment and positional asphyxia in infant swings. If either of these scenarios occurred, determine in what part of the swing the child was entrapped and what aspect of the swing led to positional asphyxia.
- If the incident involved restraints either in a fall, entanglement, “submarining” or hanging situation, then use the restraint guideline.
- Some infant swings are combination products where the seat is actually an attached infant carrier. If that was the case, state it in the report and if the incident involved the carrier portion detaching, describe how.

Bassinets and Cradles

- The ASTM standard for bassinets and cradles has performance specifications to address the following hazards: suffocation, tip over, collapse and hood detachment. The standard is **ASTM F2194-02 Safety Specification for Bassinets and Cradles**.
- Bassinets and cradles may only come with a thin mattress-type pad. A caregiver may perceive this as uncomfortable for the child and add additional mattresses, pillows, bedding, etc. This can lead to suffocation. If the incident involved excess bedding items, please specify what they were and the child’s position relative to these items.
- Some of the newer bassinets on the market almost resemble a bouncy seat. There is a concern that the side heights of these bassinets may not be adequate to prevent a fall. Please measure the side height of the bassinet regardless of the type. Measure from the top of the mattress to the top of the side and indicate whether the child was placed on additional bedding that would have elevated their position in the bassinet.
- Bassinets may have an incline feature. If it was in use at the time of the incident, indicate the degree to which it was inclined. Also, document the presence and type of any restraining device and whether it was in use while the child was in an inclined position.
- There have been some recent incidents of entrapments with bassinets. If a failure of the structure (including fabric) led to the incident, please document what failed and the position of the child.
- Bassinets tend to be lightweight in comparison to a crib. Structural integrity may be an issue. If any part of the structure collapsed or broke during the incident, determine what part of the structure was involved and how it failed.
- Bassinets are now being marketed in various styles, including the old basket style. Some are part of a combination product (such as a bassinet/play yard) and some are simply fabric stretched over a frame (versus rigid sides). Many bassinets have legs and some do not. Additionally, some have hoods. Since there is a great deal of variety in construction, describe the bassinet thoroughly.

- Since cradles move as a rule, there is a possibility that a child could be rolled by the movement into a hazardous position. If the incident resulted from such a scenario, please document in what position the child was found.

Portable Bed Rails

- The primary hazard with portable bed rails is entrapment of a child between the bed rail and mattress. If the incident involves such an entrapment document it in detail, including whether a gap was created and how large it was; the exact position of the child relative to the mattress and bed; the type of bed; how the bed rail attached to the bed and any previous incidents. Some children actually fall between the bed and rail through the gap. Although these types of fall incidents generally do not have as serious an outcome as an entrapment, any severe injury should be documented.
- The ASTM voluntary standard for portable bed rails addresses entrapment of the child between the mattress and bed rail through labeling requirements. The standard is **ASTM F2085-01 Standard Consumer Safety Specification for Portable Bed Rails**.
- Ask the caregiver to demonstrate how the bed rail is installed and observe whether a gap is present or if it fits against the mattress firmly. Does the presence of bedsheets effect the fit of the bed rail?
- Document the type of bed that the bed rail was being used on and what type of foundation it was resting on, such as a box spring, bunkie board, wooden slats or metal rails.
- The gap between the ends of the portable bed rail and the bedpost, head or footboard may create an entrapment area. If the incident involves this scenario, please measure the entrapment area, the length of the bed rail and the length of the bed.
- Although not common, hanging from a protrusion on bed rail hardware is another hazard. This would probably occur with an older bed rail so document the age of the product and what the protrusion was.
- Children have slipped between horizontal members of the bed rail and through holes in the mesh. Document whether the child did this head or feet first and whether it resulted in a fall, hanging or entrapment.
- Determine whether the caregiver had to readjust the bed rail on a regular basis or did it stay in position until it was moved by the caregiver.

Bouncer Seats

- The ASTM standard for bouncer seats addresses collapse or disassembly, stability, and falls from elevated surfaces. The standard is **ASTM F2167-01 Standard Consumer Safety Specification for Infant Bouncer Seats**.
- If a collapse/disassembly incident occurred, determine any obvious cause for the failure.
- If a tip over occurred due to instability of the bouncer, describe the surface the product was placed on.
- If the bouncer fell from an elevated surface, describe the surface from which it fell, the height of the fall and any features of the bouncer that contributed to the incident.

Stationary Activity Centers

- The ASTM specifications for stationary activity centers (these products look similar to baby walkers, but have no wheels) addresses seat strength for occupant support, tip over, finger entrapment and small parts. The standard is **ASTM F 2012-00a Standard Consumer Safety Performance Specification for Stationary Activity Centers**.
- If the seat failed, specify the weight of the child and the material from which the seat was constructed.
- If the activity center tipped over, describe the child's actions that may have contributed to the incident.
- If a finger entrapment occurred, measure and photograph the entrapment area.
- Any incidents involving small parts should be well documented with photos and measurements. Describe whether the small part resulted from breakage or disassembly of a component part.

Portable Hook-On Chairs

- The ASTM standard for hook-on chairs addresses falls due to detachment of the chair from the table, component failure, and tip over. The standard is **ASTM F1235-98 Standard Specification for Consumer Safety for Portable Hook-On Chairs**.
- If the hook-on chair detached from the table specify whether the child pushed off the table or failure of the product was involved.
- If the child fell when the chair and table tipped over, specify the size and approximate weight of the table, and what material the table was made of. In addition, determine any actions of the child that may have contributed to the tip over scenario.

Toddler Beds

- The ASTM standard for toddler beds addresses head and neck entrapment in end structures, between the guard and side rails or in the mattress supports. The standard is **ASTM F1821-97 Standard Consumer Safety Specification for Toddler Beds**.
- If an entrapment occurred, specify and photograph the exact location and measure the entrapment area.

Others

There are other nursery products that are not mentioned here and new products will appear on the market. Multi-use or combination products are becoming increasingly prevalent. If the guidance given here is not sufficient, please contact the persons listed in this guideline for instructions.

C. Description of the Victim

1. What was the age of this child (in years and months) at the time of the incident?
2. What were the height and weight of the child at the time of the incident?
3. What is the sex of the child?

4. What developmental abilities did the child display? Could the child walk, roll over, sit up, escape the product, etc.?
5. Please describe the type of any injury incurred in the incident, including the part of the body involved. If the incident resulted in a fatality, please determine the official cause of death.
6. Describe the medical treatment (e.g., tests, x-rays, sutures, cast, observation, oral or topical medication, etc.) received by the injured child and include the long-term prognosis. Specify whether the treatment was at home, in a doctor's office/clinic or at a hospital. If the child was hospitalized, document the length of the stay.

D. Description of Environment

1. Indicate whether there were any other children involved in the incident.
2. Specify whether the incident occurred indoors or outdoors. If it was outdoors, indicate if weather or terrain was a factor.
3. If any structural features such as steps, porches, thresholds, balconies, curbs, etc. were involved, describe the structure and obtain the relevant dimensions.

III. Instructions for Photographing and/or Diagramming the Product

Photograph and/or diagram the entire product and obtain relevant measurements of product components related to the incident, such as areas of entrapment. Components of the product that were specifically involved in the incident should be photographed in detail, including close-ups. Try to provide visual cues to indicate the size of items in the pictures.

If possible, using a doll or a manikin close in size to the victim, photograph the position of the child in the product. This is particularly important in entrapment and hanging incidents.

Product labeling should also be photographed or diagrammed, indicating the position of the labeling on the product and the content of the labeling.

IV. Instructions for Obtaining Documents Related to the Investigation

If the incident resulted in a death, obtain copies of any official reports such as, police, EMS or coroner's/medical examiner's reports that are available. Also obtain copies of any assembly instructions and owner's or safety manuals that came with the product. If an instructional video was provided with the product, please indicate what information was covered in the video. Whether literature or a video was provided, ask the consumer/caregiver to describe his understanding of the product's installation and usage instructions.

