



U.S. Consumer Product Safety Commission

Nancy Nord, *Chairman*
Thomas H. Moore, *Commissioner*

CONSUMER PRODUCT SAFETY REVIEW

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New Labeling Requirements for Generators

On January 4, 2007, the U.S. Consumer Product Safety Commission (CPSC) voted unanimously (2-0) to require manufacturers of portable generators to warn consumers of carbon monoxide (CO) hazards through a new "Danger" label. The label states, "Using a generator indoors CAN KILL YOU IN MINUTES."

Manufacturers will be required to place the "Danger" label on all new generators and the generators' packaging. The label warns consumers that a generator's exhaust contains carbon monoxide, a poison that cannot be seen and has no odor, and that generators should never be used inside homes or garages, even if doors and windows are open.

The death toll from CO associated with generators has been steadily rising in recent years. At least 64 people died in 2005 from generator-related CO poisoning. Many of the deaths occurred after hurricanes and major storms. CPSC staff is aware through police, medical examiner and news reports of at least 31 non-work related CO deaths associated with portable generators from October 1 through December 31, 2006.

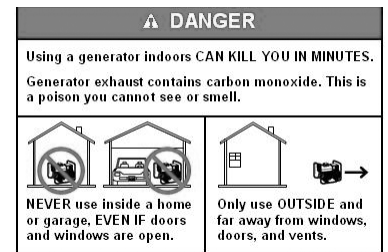
"These deaths from carbon monoxide poisoning are preventable," said Acting CPSC Chairman Nancy Nord. "The warning labels are meant to stop consumers before they make what could be a fatal mistake."

Generators should be used outdoors only, far from windows, doors and vents. The CO produced by one generator is equal to the CO produced by hundreds of running cars. It can incapacitate and kill within minutes.

The new "Danger" label requirement took effect on May 14, 2007 and is required for any portable generator manufactured or imported after that date.

In a separate action, the Commission has begun rulemaking to address safety hazards with generators by approving an advance notice of proposed rulemaking (ANPR). The Commission directed staff to investigate various strategies to reduce consumers' exposure to CO and to enable and encourage outdoor use of generators. The notice also invites public comment on these alternatives. These strategies include:

- generator engines with substantially reduced CO emissions
- remote or integral sensors for an interlocking or automatic shutoff device that will shut down the generator in the presence of a hazardous concentration of CO
- weatherization requirements
- theft deterrence
- noise reduction



Generator On-Product Label

IN THIS ISSUE

New Generator Labels.....	1
Carbon Monoxide Poisoning Treatment.....	2
Students Research Li-Ion Batteries.....	3
ATV Annual Report.....	5
Report Unsafe Products.....	6
MECAP News.....	8
CPSC Recalls.....	10

Treatment of Carbon Monoxide Poisoning

In December of 2006, a powerful winter storm slammed into the Pacific Northwest causing major damage and widespread power outages to the region, including the heavily populated, Seattle metropolitan area. In the days following the storm, with power outages lingering and temperatures near the freezing mark, people turned to portable generators and grills as alternate sources for electricity and heat. Unfortunately, many people brought their generators and grills inside their homes causing a lethal build-up of poisonous carbon monoxide (CO) gas. According to media reports, at least seven people died from CO poisoning, and over 250 people were treated for carbon monoxide exposure in emergency departments. Dr. Neil Hampson of the Virginia Mason Center for Hyperbaric Medicine treated many of the injured. He called this rash of poisonings a “carbon monoxide poisoning epidemic”. The Consumer Product Safety Review interviewed Dr. Hampson to get his thoughts in the aftermath of the recent storm.

Talk about this storm. What happened?

Dr. Hampson: We had a wind storm that knocked out power to 1.1 million out of the 1.7 million households in our region. We had a lot of people without power in cold winter weather. People turned to charcoal inside the house to heat and cook, and used generators to generate electricity. It was a real problem. We treated 70 people for carbon monoxide poisoning in our hyperbaric chamber, which is a record of sorts. We treated 46 in one 24 hour period.

This region has a large immigrant population. Language problems, in addition to lack of awareness, contributed to the situation. Our newspaper, The Seattle Times, was very concerned about the rash of exposures and printed carbon monoxide warnings in six languages



Dr. Hampson joined Virginia Mason in 1988 and is the medical director of the Center for Hyperbaric Medicine. He is an internationally recognized authority in the area of carbon monoxide poisoning and active in clinical research in the field of hyperbaric medicine.

on the front page. That helped tremendously, and in fact, we saw no more deaths from CO after those warnings were printed.

Once people are exposed, what are the different means of treating carbon monoxide poisoning?

Dr. Hampson: The key to treatment is oxygen. First, remove the patient from the exposure to the poison and then try to clear the poison from their system. While carbon monoxide binds to the hemoglobin in red blood



Photos courtesy Virginia Mason Medical Center

Hyperbaric Chamber

cells quite tightly, it does bind reversibly. So, if you have enough oxygen molecules in the vicinity, you can displace the carbon monoxide off the red blood cells, breathe it out and thereby clear it from the system. The human body can clear the blood of carbon monoxide when breathing room air in about 24 hours; breathing oxygen, in about 5-6 hours; breathing hyperbaric oxygen, in only 60-90 minutes. The vast majority of people who go to an ER and are diagnosed with carbon monoxide poisoning get treated with oxygen in the ER. The most severely poisoned patients are referred for treatment with hyperbaric oxygen.

What is hyperbaric oxygen treatment?

Dr. Hampson: “Hyper” means increased and “baric” means pressure. We can pressurize a chamber (see inset photo) to three atmospheres absolute pressure, or three times sea level pressure, and have the patient breathe 100% oxygen. You can raise the blood oxygen level twenty fold in this environment.

continued on page 7

College Students Assist CPSC with Li-Ion Battery Research

There are an estimated three billion lithium-ion batteries in use worldwide in a variety of portable electronic applications, including PDAs, laptops, cell phones, and DVD players. In recent months, there has been intense public and media scrutiny over these devices and their potential for causing fires and injuries.

Concerned about the possible impact on public safety, four students from Worcester Polytechnic Institute (WPI) in suburban Massachusetts went to work on the problem. Michael Macri, Daniel Capozzo, Siobhan Fleming, and Brian Foley invested 14 weeks at WPI and at CPSC Headquarters studying the problems related to Li-Ion battery technologies. Their goal was to put forward recommendations to the agency that might improve the safety of the technology and prevent possible injuries.

These four students are among dozens who have taken part, over the past 15 years, in a unique experiential learning program offered by WPI in coordination with CPSC. In fact, the WPI program is ground breaking in that every student is required to successfully complete a major project in order to graduate. Professor David Lucht, is one of several Interactive Qualifying Project (IQP) advisors. "The entire undergraduate curriculum is project-based, and this is the keystone of the four-year experience. This project is equivalent to three full courses, and our students pay tuition to do this. This is their moment!"

The philosophy of the program is simple but powerful: put theoretical learning into action. Through a real life project, the students become experts in subject matter, learn how to apply knowledge and skills, and learn about themselves and their capabilities.

Mark Kumagai, the students' CPSC advisor and mentor, stated that this concept gets the engineer working on real world problems with societal as well as technical impact. These students are tackling issues that matter to people and communities. "That's why CPSC makes for a great WPI project. We've done this for over 15 years and hope to continue in the future," says Kumagai.

The preparation begins in the classroom. Siobhan Fleming, mechanical engineering student, describes the IQP as a way to give students practical experience early on in their college curriculum. "It starts off in the classroom in an interdisciplinary course where students learn about writing for business, presenting, team dynamics, working in companies, interviewing and business computer applications like Excel and Powerpoint." Then the students are matched to a project. Not all projects pro-

posed by government and industry are selected for the WPI program. The school works to find appropriate and meaningful assignments for students. While the professors and advisors are flexible and often times very creative about the kinds of projects they select, they insist that all must have some socially redeeming value. The project must also be team oriented and generally outside the student's major. That way, students can learn about a field that is less familiar to them, thereby broadening their horizons. The lack of familiarization also provides an equal footing, where no one student has intimate knowledge of the subject, providing an unfair advantage.

For Daniel Capozzo, researching Li-Ion batteries was outside his major of Management Information Systems. "That was a good thing because it gave me a chance to think outside the box. While the four of us knew each other, we never worked together before the project. This was an opportunity to work as a team where everyone could contribute equally."



From L to R: Michael Macri, Mechanical Engineering; Brian Foley, Physics; Siobhan Fleming, Mechanical Engineering; Daniel Capozzo, Management Information Systems

All four of the students agreed that working at the CPSC and studying Li-Ion batteries was a terrific opportunity. "We agreed that while all the projects had interesting aspects, the CPSC project had a lot of potential for us to do something that would make an impact," said Foley.

Michael Macri, mechanical engineering major, sought out CPSC for his project. "I had heard about the recalls that the agency was doing and thought it would be a good opportunity to be a part of that mission."

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Their methodology broke the project into two pieces: research the potential dangers of Li-Ion battery technology and their applications, and then suggest actions that could mitigate those dangers. Fleming recalls how the team went about tackling the project. “We decided that each of us would focus on a different element. Dan focused on current standards from UL, IEEE, ANSI and IEC. Brian looked at the IDI’s [In-Depth Investigations], which detailed incidents where batteries failed. Mike analyzed the data using fault trees to graphically view the issues, and I worked on what outside agencies and companies were doing.”

The two largest recalls of consumer electronics were products using Li-Ion batteries. — Fleming

To ensure their research was comprehensive, they explored every possible angle. Macri recalls attending a meeting discussing the United Nations’ battery standard. “That was definitely a ‘wow’ moment!” In addition to attending high-level meetings, they also interviewed experts in the field. “I learned a lot about batteries in the time that I was here says Capozzo. “The best part was learning about battery applications. I knew I was doing something cool when I interviewed a researcher from NASA about battery applications in space!”

Li-Ion batteries are used in many applications such as high-powered electronics. “The reason for this is that they carry three times the amount of voltage as regular alkaline batteries,” says Fleming. “But Li-Ion batteries have had many problems and have been recalled. The two largest recalls of consumer electronics were products using Li-Ion batteries. From October 2003 to June 2006, more than 2 million products were recalled. Some examples were mobile telephones, flashlights and DVD players. Most recently, 6.5 million laptop batteries were recalled.”

Foley adds, “200 injuries have occurred from the products that were recalled, 36 from mobile telephones, 55 from notebook computers and still others from DVD players, flashlights and conference telephones. Some injuries have been minor like first degree burns, others more serious burns, lacerations and smoke inhalation.” To get further data on these incidents, the team researched in-depth investigation reports.

“We looked at 46 incidents in all. The primary cause of fire was thermal runaway, a rapid build up of heat inside the battery cell,” states Macri. “The internal temperature of the battery cell reaches a critical point, and a heat generating chain reaction is created causing pres-

sure and more heat. Overcharging, internal short circuiting, cell damage, and excessive heating (e.g., lack of cooling mechanisms or ventilation) are all potential causes.”

“Clearly, research needs to continue and new technologies need to be evaluated for safety,” says Foley. “We are encouraged by what we have seen in battery additives, new materials and other mitigation technologies, but these solutions are still being developed.”

After completing their research and weighing all the factors, the students developed two recommendations, which they hope will be adopted and reduce further incidents. “First,” says Capozzo, “we encourage industry and standards organizations to continue roundtable discussions to discuss Li-Ion battery issues. Our suggestion would be to strengthen the voluntary standards and third party certifications to include a more stringent drop test, an X-ray test and an aging test to monitor degradation over time. These tests would better reflect customer usage.” For their second recommendation, the team encouraged consumer education on the dangers of Li-Ion batteries. “We would like to see a consumer fact sheet describing the dangers of devices with Li-Ion batteries, particularly aftermarket batteries,” says

The primary cause of fire was thermal runaway, a rapid build up of heat inside the battery cell. — Macri

Fleming. “We would also recommend strongly worded labels to be placed on products warning of overheating and fire danger.”

The culmination of the project was a comprehensive written report of their recommendations. The team of Macri, Fleming, Capozzo and Foley then presented their report to a crowded room of faculty, advisors, CPSC employees and Commissioners. The response was overwhelmingly positive. Nancy Nord, Acting Chairman of the CPSC, agrees. “These four have really advanced learning on this topic from our standpoint, and we appreciate the contributions they have made.”

What’s next for these four future leaders? “We are hopeful that the CPSC, manufacturers and the standards community will take our recommendations forward,” remarks Fleming. “Also, we plan to apply for the President’s IQP award back at school,” says Macri. “It’s awarded to the team that has made the biggest impact.”

Capozzo added, “One of the best parts about this assignment was working with the CPSC team. We really learned a lot from them, and they were very warm and welcoming. After this experience, I think we would all consider working for the government after graduation.”

2005 ATV Annual Report

The Consumer Product Safety Commission recently released the 2005 ATV Annual Report. This document summarizes the number of estimated fatalities and injuries associated with all-terrain vehicles (ATVs). The full report is available at: www.cpsc.gov/LIBRARY/atv2005.pdf. CPSC staff has been routinely analyzing ATV data since the early 1980s. The collection and analysis of ATV data will continue to play an important role in CPSC's ongoing rulemaking for both adult and youth ATVs and aims to reduce ATV-related deaths and injuries.

Reported ATV-Related Deaths

As of December 31, 2005, CPSC staff had reports of 7,188 ATV-related deaths occurring since 1982. The number of new reports increased by 694 since the December 31, 2004 tabulation and includes deaths occurring over the period 1999 to 2005 inclusive. Data collection for 2002 through 2005 is ongoing, and consequently, the number of reported deaths for this period is expected to rise before the next annual report. Of the 7,188 reported deaths, 2,178 of the victims (30 percent) were younger than 16 years of age, and 917 (13 percent) were younger than 12 years of age.

The numbers of reported ATV-related deaths for each state, the District of Columbia and Puerto Rico are complete for the period 1982 through 2001. The states with the highest numbers of deaths occurring in this period were: California (297), Pennsylvania (274), Texas (221), Michigan (210), and New York (207). Together, these five states accounted for 24 percent of all reported ATV-related deaths in the U.S. during this time period. Counts of deaths for the period 2002-2005 cannot be used for comparisons among states because data collection in some states is more complete than in other states for those years.

Estimated Deaths and Risk of Death

The number of ATV associated deaths gleaned from news clips, medical examiner's reports and death certificates received by CPSC staff may constitute a minimum count. To adjust for the potential undercount associated with incomplete sources of data, CPSC staff generated annual fatality estimates using the statistical technique known as "capture-recapture" estimation. *Table 1* shows the annual estimated numbers of ATV-related deaths for ATVs with three, four or an unknown number of wheels, in addition to the annual estimates and risk of death for

Annual Estimates of ATV-Related Deaths And Risk of Death for Four-Wheel ATVs

As of December 31, 2005

Year	ATVs with 3, 4 or Unknown Wheels	Deaths Involving 4-Wheel ATVs	4-Wheel ATVs in Use (millions) ¹	Estimated Risk of Death per 10,000 4-Wheel ATVs In Use
2004	767	734	6.9	1.1
2003	757	721	6.2	1.2
2002	603	566	5.5	1.0
2001	593	549	4.9	1.1
2000	552	502	4.2	1.2
1999 ²	536	488	3.6	1.4
1998	287	245	3.1	0.8
1997	291	243	2.7	0.9
1996	267	208	2.4	0.9
1995	276	212	2.2	1.0
1994	244	168	2.0	0.8
1993	211	144	1.9	0.7
1992	241	158	1.9	0.8
1991	255	152	1.8	0.8
1990	250	151	1.8	0.9
1989	258	153	1.6	0.9
1988	286	152	1.4	1.1
1987	282	126	1.1	1.1
1986	347	95	0.7	1.3
1985	295	55	0.4	1.5

¹ Rounded

² Beginning in 1999, deaths were coded under the 10th Revision of the International Classification of Diseases (ICD-10). This change allows for improved identification of ATV-related deaths.

Source: CPSC, Directorate for Epidemiology, Division of Hazard Analysis. Italics denote the period for which reporting is incomplete.

Table 1

four-wheel ATVs (per 10,000 in use) from 1985 to 2004. The risk of death associated with four-wheel ATVs was calculated by dividing the annual estimate of fatalities associated with four-wheel ATVs by the estimated number of four-wheel ATVs in use in a given year and then multiplying by 10,000. Because reliable operability rate data are not available for three-wheel ATVs, the risk of death is given only for four-wheel ATVs.

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Estimated ATV-Related Injuries and Risk of Injury

An estimated 136,700 ATV-related injuries were treated in hospital emergency rooms nationwide in 2005. *Figure 1* presents annual estimates by age group for ATV-related injuries treated in hospital emergency rooms from 1992 through 2005. Although the 2005 estimate reflects an increase of less than one percent over the 2004 injury estimate, it is 24 percent higher than the 110,100 estimated number of injuries occurring in 2001, which is a statistically significant increase. The 2005 injury estimate for children younger than 16 years of age was 40,400 and represents about 30 percent of the estimated total number of 2005 injuries. The 2005 injury estimate for children under 16 is an 18 percent increase over the 2001 estimate of 34,300 in this same age group. This increase is also statistically significant. Children younger than 16 have accounted for about 36 percent of the total

estimated number of injuries from 1985 through 2005 inclusive.

In 2005, the estimated number of injuries increased in every age group except the youngest (under 16 years of age) and the oldest (55 years of age and older). With one exception, changes were not statistically significant. Increases were generally less than 10 percent in each age group except the 45 to 54 age range, where the statistically significant increase was over 20 percent.

Table 2 (on page 7) shows estimates of four-wheel ATV-related injuries and risk of injury. Four-wheel ATV injuries constituted 95 percent of the total injury estimate for ATVs with three, four or an unknown number of wheels in 2005. Risk of injury (per 10,000 four-wheel ATVs in use) is defined as the estimated number of injuries divided by the number of vehicles in use, multiplied by 10,000.

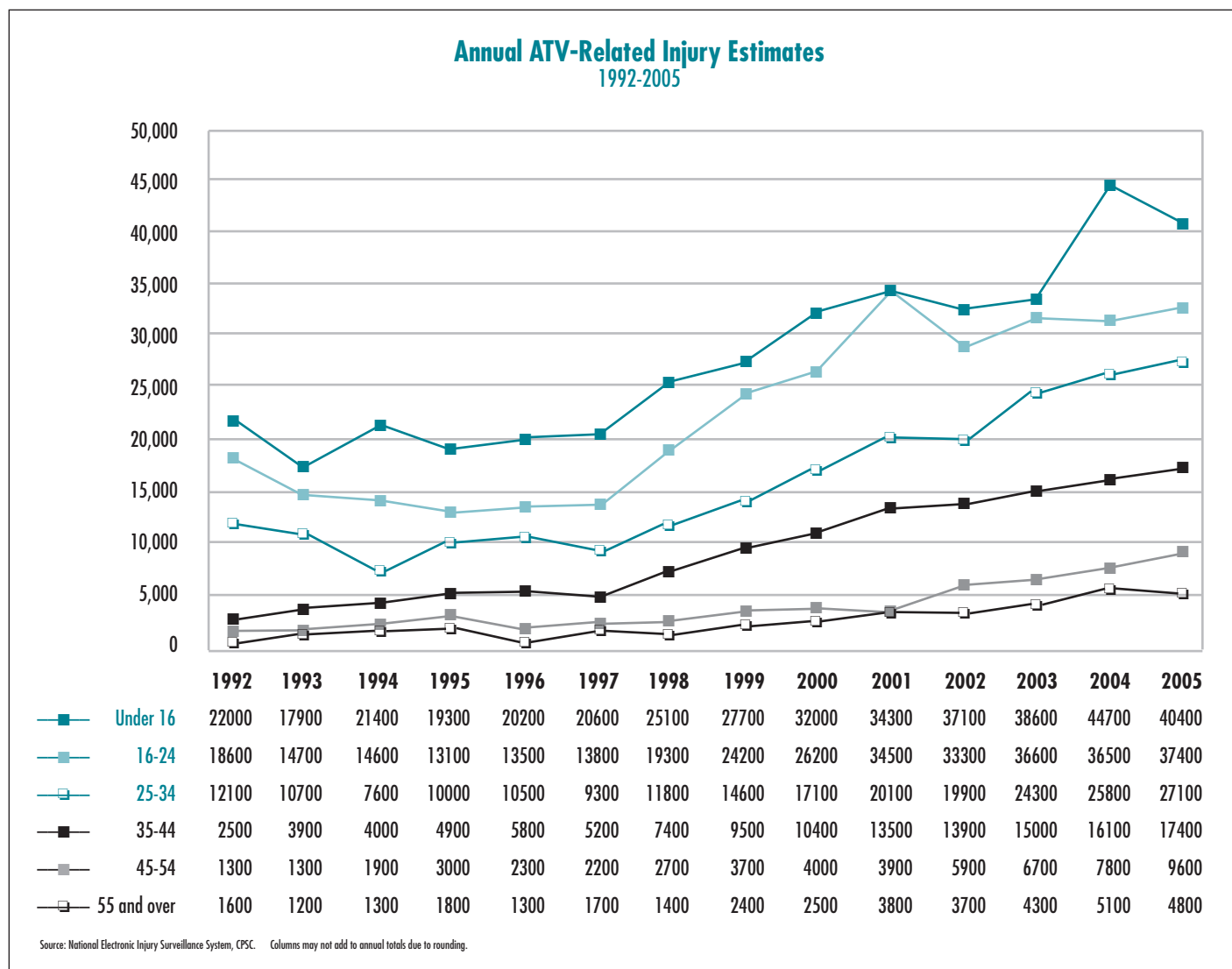


Figure 1

Estimated Number of Injuries and Risk of Injury Associated with Four-Wheel ATVs Jan. 1, '85 - Dec. 31, '05

Year	Injury Est.	Est. 4-Wheel ATVs in Use (M) ³	Est. Risk of Injury per 10,000 4-Wheel ATVs in Use
2005	130,000	7.6	171.5
2004	129,500	6.9	187.9
2003	116,600	6.2	188.4
2002	104,800	5.5	190.0
2001	98,200	4.9	200.9
2000	82,300	4.2	197.2
1999	68,900	3.6	193.0
1998	57,100	3.1	184.7
1997	39,700	2.7	146.1
1996	40,700	2.4	168.1
1995	36,200	2.2	165.7
1994	33,300	2.0	165.4
1993	32,000	1.9	164.9
1992	33,000	1.9	175.1
1991	34,400	1.8	188.1
1990	30,800	1.8	175.1
1989	35,700	1.6	217.8
1988	39,400	1.4	276.1
1987	33,900	1.1	305.9
1986	23,400	0.7	319.2
1985	14,700	0.4	391.1

Source: U.S. Consumer Product Safety Commission, Directorate for Epidemiology, Division of Hazard Analysis; National Electronic Injury Surveillance System; and the Directorate for Economic Analysis.
³Rounded

Table 2

Report an unsafe product or
an injury or death involving
a consumer product

Call our hotline toll-free at
1-800-638-2772

or visit our website at

<http://www.cpsc.gov/incident.html>

CPSC does **not** have jurisdiction over:

- Automobiles (including tires, trucks and motorcycles)
- Watercraft (including boats, rafts and personal watercraft)
- Foods, medicines, cosmetics, and medical devices
- Dissatisfaction with business practices

By authority of 15 U.S.C. 2054, any information collected may be shared with product manufacturers, distributors, or retailers. No names or other personal information will be disclosed without explicit permission.



Carbon Monoxide from page 2

Most practitioners agree that severely poisoned patients with carbon monoxide poisoning should be treated with hyperbaric oxygen, if there is access to a chamber. There are 500 chambers in the United States. We treat people as soon as possible after exposure, because outcome relates to delay. If it gets beyond 24 hours, you might not consider treatment. The most common approach is to do one hyperbaric treatment, and see how the patient is doing. If they are still symptomatic or are showing abnormal findings, we would do additional treatments, up to three typically. They are about two hours long each.

Are there side effects?

Dr. Hampson: The side effects of hyperbaric treatment are as follows:

- Ear clearing difficulty when the pressure changes, similar to what might be experienced when flying in an airplane. We have a nurse inside the hyperbaric chamber teaching patients how to move their jaw or drink water to equalize their ear pressure.
- Claustrophobia. This is a much bigger concern in a one person chamber. The multi-person chamber we have is the diameter of a Boeing 737. If you can go on a commercial airplane, you can go into our chamber without much difficulty.
- The third risk is that oxygen in itself can be irritating to the brain. There is the rare risk that hyperbaric treatment can cause someone to have seizures or convulsions similar to someone with epilepsy.

Are children's treatments different from adults?

Dr. Hampson: We don't have different protocols for children and adults, which is a good thing because a lot of the exposures are family groups and we can treat them all at the same time.

Any recommendations for our readers?

Dr. Hampson: The biggest thing that people could do would be to use carbon monoxide alarms in their homes. They work. Everybody has smoke alarms in their homes, but not everybody has carbon monoxide alarms. Smoke alarms don't detect carbon monoxide. Carbon monoxide alarms cost only 30-50 dollars and are a good investment. I encourage people not to just buy them for themselves, but to think of them as a gift for somebody. I think that's perhaps the most effective thing you could do for prevention at this point.

MECAP NEWS

Medical Examiners and Coroners Alert Project

The MECAP Project is designed to collect timely information on deaths and injuries involving consumer products. Please contact us whenever you encounter a death or situation that you believe should be considered during a safety evaluation of a product.

You can report a case or ask for information about MECAP in several ways.

- Call our toll-free number, 1-800-638-8095.
- Use our toll-free fax number, 1-800-809-0924.
- Send an e-mail message to tschroeder@cpsc.gov.

MECAP reports also can be reported directly to the CPSC Web site.

- Go to www.cpsc.gov.
- Click on *Report an Unsafe Product*.
- Scroll down and click on *File MECAP Reports*.

*Indicates cases selected for CPSC follow-up investigations. Cases reported but not selected for follow-up also are important to CPSC. Every MECAP report is included in CPSC's injury database and will be used to assess the hazards associated with consumer products.

CPSC received 1308 MECAP cases during the months of September, October, and November of 2006. Some of those cases are listed below to show the type and nature of the reported incidents.

ASPHYXIATIONS/SUFFOCATIONS

*A male, 6 months, was spending the night at his aunt's home. She placed him in a crib, and she and her husband checked on him several times during the night. Early the next morning, she found the infant entrapped between the drop-side of the crib and the mattress. The drop-side railing had cracked causing the gap where the infant was trapped. The cause of death was asphyxia due to entrapment.

(Jerrie Gass for Douglas Posey, Jr., M.D., Associate Medical Examiner, Georgia Bureau of Investigation (GBI), Decatur, GA)

*A female, 1 month, was laid down on her stomach to sleep in a bassinette. Her mother found her the next morning, cold and unresponsive. The child was wedged between the side of the bassinette and a pillow, with her face against the pillow. The cause of death was asphyxia.

(N. Turner Gray, M.D., Medical Examiner, Tidewater District, Norfolk, VA)

*A female, 4, was playing in her backyard with her younger brother. Her brother came inside without her, and her father called her to come inside. She didn't answer so he went to find her. He found her unresponsive with one end of an elastic cord around her neck and the other end of the cord hooked over the top of a sliding board that was part of a wooden playground set. The cause of death was strangulation.

(Shirley Stover-Wilkins for Margarita Arruza, M.D., District Medical Examiner, District 4, Jacksonville, FL)

A female, 4 months, was laid on top of her parents' bed to sleep. She was later found face down on top of a plastic bag filled with laundry next to the bed. She died three days later. The cause of death was anoxic encephalopathy due to asphyxia.

(Warren E. Rupf, Sheriff-Coroner, Contra Costa County, Martinez, CA)

*A male, 2, was being bathed by his father when he started coughing heavily. The child's lips and face turned blue, and he stopped breathing. Resuscitative efforts were unsuccessful. An autopsy revealed that a plastic peg from a toy had lodged in the boy's airway. The toy was intended for children age four and up. The cause of death was suffocation due to obstruction of the left mainstream bronchus.

(K. Lehman, M.D., Associate Medical Examiner, GBI, for Mark Bowen, Chief Deputy Coroner, Richmond County, Augusta, GA)

CARBON MONOXIDE POISONINGS

*A female, 84, lost her electrical power after a tropical storm. Her son placed a gasoline-powered portable generator in the attached garage of her home as he had done before.

The garage door was closed but the son opened a garage window. The son returned the next morning, and found his mother unresponsive in her bed. Emergency responders found high levels of carbon monoxide in the home. The cause of death was acute carbon monoxide poisoning.

(P. Arthur Hoyt, Jr. Medical Examiner, Tidewater District, Norfolk, VA)

*A male, 67, and his wife, 62, rented a small portable gasoline-powered generator after a storm brought down electrical power lines in their area. They put it in their basement so no one would steal it. The couple did not show up at a family function the next day so their daughter went to check on them. She found them unconscious, and the man died at a hospital the following day. His wife survived but suffered a stroke due to the carbon monoxide poisoning. The home did not have a carbon monoxide detector. The cause of death was carbon monoxide toxicity.

(Jesse Paulley, Deputy Coroner for Dr. Ronald M. Holmes, Coroner, Jefferson County, Louisville, KY)

A male, 88, was in a shed with his lawnmower, a tool box and tools. He was later found unresponsive with the mower running, and the shed door closed. The cause of death was carbon monoxide poisoning.

(Virginia Chapman for Richard Mc Laughlin, EMT, RP, Assistant Deputy Medical Examiner, Office of the Chief Medical Examiner, the State of New Hampshire, Concord, NH)

*A male, 19, was sleeping in a trailer at a public fairground. It was hot so he had a fan plugged into a gasoline-powered generator inside the trailer. He did not show up at another location the next day so some friends went to check on him. They found the man unresponsive inside the trailer with the generator still running. The cause of death was asphyxia due to inhalation of products of combustion.

(Dawn Foster for Gregory A. Schmunk, M.D., Medical Examiner, Polk County, Des Moines, IA)

DROWNING

*A female, 2, was playing on a swing set in her backyard with her mother and four year old brother. The mother removed the automatic cover on their in-ground pool then had to use the bathroom in the house. When she returned, she found the child floating face down in the pool. The cause of death was drowning.

(Glenn N. Wagner, D.O., Chief Medical Examiner, County of San Diego, San Diego, CA)

*A female, 20 months, was playing in the backyard under her grandmother's care. The grandmother became distracted while working in the garden, and lost sight of the child. Another relative helped the grandmother search for the child but they could not find her. They called police who arrived along with paramedics to search for the child. A paramedic entered a murky in-ground pool in the backyard and found the child in the deepest part of the

pool. The property has a fence around it but there was no separate fence around the pool. The cause of death was asphyxia due to fresh water drowning.

(Warren E. Rupf, Sheriff-Coroner, Contra Costa County, Martinez, CA)

*A female, 10 months, was taking a bath with her three year old sister. The mother heard the door bell ring, and went to answer the door since she was expecting someone. A few minutes later, the mother returned, and found the infant floating face down in the water while her sister continued to play. The cause of death was drowning.

(Joanne M. Fruth, M.D., Medical Examiner, Granville County, Oxford, NC)

*A female, 18 months, was sleeping in her crib in her new home. Her family had lived in the home for about a week. The child woke up, and her six year old brother took her out of the crib. She watched him play video games for a while then wandered off. Several minutes later, the mother woke and didn't see her daughter. The mother went to their in-ground pool that adjoins a bathroom, and found the child floating in it. The child died one week later. The cause of death was complications of near drowning.

(Barbara C. Wolf, M.D., Associate Medical Examiner, District 21, Fort Myers, FL)

*A female, 11 months, was placed in a bath seat in the bathtub by her mother. She was getting a bath with her 22 month old sister. After cleaning up the children, the parents went to do some chores in the house while the children played in the tub. The father returned a short time later to find the younger child floating face down in the bath water while her older sister played in the tub. The cause of death was near drowning.

(Phillip E. Keen, M.D., Medical Examiner, Maricopa County, Phoenix, AZ)

*A female, 23 months, was at home with her mother and several family members. The mother fell asleep on a couch. The mother woke up and couldn't find her child in the house. Several family members helped her search, and one of them found the child floating face down in their hot tub. The hot tub has no security fence around it. The cause of death was drowning.

(Glenn N. Wagner, D.O., Chief Medical Examiner, County of San Diego, San Diego, CA)

ELECTROCUTIONS

A male, 30, was in his attic installing a recessed light in a bathroom below him. He was later found unresponsive near an electrical junction box and the light fixture. The cause of death was electrocution.

(Jeffrey A. Simon for Mark J. Shuman, M.D., Associate Medical Examiner, District 11, Miami, FL)

A male, 58, went to his back yard to work on his hot tub. His wife went to give him some water, and found him face down and unresponsive on the grass beside the hot tub. The cause of death was electrocution.

(Luis A. Sanchez, M.D., Chief Medical Examiner, Harris County, Houston, TX)

FIRES

*A male, 5, was found unresponsive in a bedroom after a fire in his grandparents' home. Two of his cousins escaped the blaze, but his grandparents also died. The fire began when combustibles were placed too close to an electric space heater. The home did not have a working smoke detector. The cause of death was smoke inhalation.

(Nizam Peerwani, M.D., Chief Medical Examiner, Tarrant County, Fort Worth, TX)

*A male, 53, was found unresponsive in the bedroom of his home. He had placed a gasoline-powered generator on his back porch to provide the primary source of electricity for his home. Fire officials determined the fire started within the generator. The cause of death was smoke, soot, and super-heated gas inhalation.

(Albert Boudy, Medical Examiner Investigator for Daniel K. Brown, M.D., Regional Medical Examiner, Georgia Bureau of Investigation, Augusta, GA)

A male, 39, was painting his bathroom. A hot water heater in the bathroom ignited the fumes from his paint, and he was burned over 60% of his body. He died three weeks later. The cause of death was thermal injuries.

(Carolyn Siegler for Robert R. Lyons, coroner, Sacramento County, Sacramento, CA)

MISCELLANEOUS

*A male, 11, was a passenger on a four wheeled all-terrain vehicle (ATV) driven by a nine year old friend. The ATV struck something on the ground and rolled over. Both children were ejected from the ATV, which landed on top of the boy. He died at the scene, and the nine year old driver was treated at a hospital. Neither was wearing a helmet. The cause of death was craniocerebral traumatic injuries.

(Shirley Stover-Wilkins for Marie H. Hansen, M.D., Associate Medical Examiner, District Nine, Orlando, FL)

*A male, 44, was cleaning the swimming pool for his family. A piece of the pool's high pressure filter line burst off and struck him in the head. The cause of death was blunt force head injury.

(Karina Gomez for Frank Sheridan, M.D., Chief Medical Examiner, San Bernardino County, San Bernardino, CA)

A female, 3, was playing with a ball with suction cups on it in her living room. The ball landed on a large television set, and the child climbed up on an entertainment center to get it. Family members there could not respond in

time, and the television set fell on the child. The cause of death was blunt force head injuries.

(Luis A. Sanchez, M.D., Chief Medical Examiner, Harris County, Houston, TX)

*A female, 13, was a passenger on an ATV driven by her 12 year old cousin. The driver lost control of the ATV on a path through the woods, and it struck a tree. The passenger was ejected while the driver remained on the ATV. The driver suffered minor injuries but the passenger died at a hospital three hours later. Neither was wearing a helmet. The cause of death was atlanto-occipital dislocation.

(J.P. Bihorel for Sam P. Gulino, M.D., Deputy Chief Medical Examiner, District 13, Hillsborough County, Tampa, FL)

*A female, 2, and her five year old sister were watching television in the living room of their home. The television set was on top of a four drawer dresser approximately two feet high that was being used as a television stand. The television fell on the two year old, and she died later at a hospital. The other child was uninjured. The cause of death was blunt force head trauma.

(Christopher Rogers for Lisa Scheinen, M.D., Deputy Medical Examiner, County of Los Angeles, Los Angeles, CA)

*A male, 77, was replacing the filters on the pump of his swimming pool. He placed the top back onto the filters and began to tighten the lid. The filter exploded, and the man was hit in the head by some debris from the explosion. The cause of death was blunt force head injury.

(Warren E. Rupf, Sheriff-Coroner, Contra Costa County, Martinez, CA)

*A male, 22, was riding his ATV on a dirt trail with some friends. They came upon a steep hill, and the man decided to climb it on the ATV. He had almost reached the top of the hill when he couldn't make it any farther and started backing down the slope. His ATV flipped backwards, and pinned him against a tree. His friends removed the ATV, but the man died at the scene. The cause of death was blunt force traumatic injuries.

(L.J. Policastro for Carol Ann Robinson, EMT, County Medical Examiner, Marshall County, Moundsville, VA)

A female, 3, was in the living room with her mother. The mother, who was eight months pregnant, was sitting on the couch watching television. The child began to turn the turntable that the large screen television set was placed on. The mother told the child to stop but the television fell and landed on the child. The child died a short time later at a hospital. The cause of death was blunt force head injuries.

(Luis A. Sanchez, M.D., Chief Medical Examiner, Harris County, Houston, TX)

— Denny Wierdak, Directorate for Epidemiology



CPSC Recalls

The following product recalls were conducted by firms in cooperation with CPSC. For more information about recalls, visit the CPSC website at www.cpsc.gov.

Mason Jar Candles

Product: About 3.7 million Old Williamsburgh Mason Jar Candles, sizes 3.5 to 5.0 oz. by Old Williamsburgh Candle Corp. This recall involves all scents and colors of Mason Jar Candles in 3.5, 4.0, 4.5, and 5.0 oz. sizes. The size of the candle is specified on the label at the bottom of the jar, on the last line of the label. Replacement Mason Jar Candles, which are not included in the recall, have a "Q" on either side of the label. The jar candles were sold through dollar stores, discount stores, and grocery stores nationwide from May 2006 through December 2006 for between \$1 and \$1.50. The candles were manufactured in the United States.

Problem: The wick can move from the center of the jar to the side causing the glass to overheat and possibly crack or shatter. Exposure to broken glass and molten wax poses laceration and burn hazards to consumers. Old Williamsburgh Candle Corp. has received 11 reports of the candles cracking or shattering, including one laceration injury.

What to do: Consumers should immediately stop using the candles and return them to the place of purchase for an exchange or full refund. For additional information, call Old Williamsburgh Candle Corp. toll-free at (866) 564-1500 between 9 a.m. and 5 p.m. ET Monday through Friday, or visit the firm's Web site at www.oldwilliamsburgh.com.

Dishwashers

Product: About 2.3 million Maytag® and Jenn-Air® brand dishwashers by Maytag Corp. The recall involves Maytag® and Jenn-Air® under counter or portable plastic tub dishwashers. The dishwashers have black, white, almond, bisque and stainless steel front panels. The following model and serial numbers are printed on a label located on the dishwasher's plastic frame on top of or to the left of the door opening. Consumers should contact Maytag to determine if their dishwasher is included in this recall.

The dishwashers were sold at department and appliance stores and by home-builders nationwide from July 1997 through June 2001 for between \$370 and \$800. The dishwashers were manufactured in the United States.

Brand	Model numbers MUST begin with...	AND serial numbers MUST end with...
Maytag®	MDB3, MDB4, MDB5, MDB6, MDB9, MBD, MDC3, MDC4, MDC5, DWU9	SM, SQ, SS, SU, SW, SY SZ, UB, UD, UF, UH, UK, UM, UQ, US, UU, UW, UY, UZ, WB, WD, WF, WH, WK, WM, WQ, WS, WU, WW, WY, WZ, YB, YD, YF, YH, YK, YM, YQ, YS, YU, YW, YY, YZ
Jenn-Air®	JDB3, JDB4, JDB5, JDB6, JDB7	UB, UD, UF, UH, UK, UM, UQ, US, UU, UW, UY, UZ, WB, WD, WF, WH, WK, WM, WQ, WS, WU, WW, WY, WZ, YB, YD, YF, YH, YK, YM, YQ, YS, YU, YW, YY, YZ

Problem: Liquid rinse-aid can leak from its dispenser and come into contact with the dishwasher's internal wiring which can short-circuit and ignite, posing a fire hazard. Maytag has received 135 reports of dishwasher fires, resulting in product and/or property damage. Four injuries have been reported, including three reports of smoke inhalation and one serious hand laceration when operating a fire extinguisher to put out a fire in the dishwasher.

What to do: Consumers should immediately stop using these dishwashers, disconnect the electric supply by shutting off the fuse or circuit breaker controlling it and inform all users of the dishwasher about the risk of fire. Contact Maytag for either a free in-home repair, or a \$75 cash back reimbursement following the purchase of a new Maytag®, Jenn-Air®, Whirlpool® or KitchenAid® dishwasher. Consumers should not return the dishwasher to the retailer where it was purchased, as retailers are not prepared to take units back. For more information, contact Maytag Corporation at (800) 675-0535 anytime, or visit the firm's Web site at www.repair.maytag.com.

Wrist Straps for Video Game System Controller

Product: About 2 million wrist straps used with controllers for the Nintendo Wii Video Game System by Nintendo of America Inc. The wrist straps are sold with Nintendo's Wii video game system (pronounced "we"). Its controller, called the Wii Remote, is shaped like a TV remote. Sensors determine the Wii Remote's

position in 3-D space, which means that a tennis swing, for example, is done through movement of a consumer's hand rather than by just fingers and thumbs. The cords on the wrist straps included in this program are 0.6 mm in diameter. The replacement cords are 1.0 mm in diameter. The Wii video game systems have been sold since November 19, 2006 for approximately \$249. The Wii Remote has separately been sold from November 19, 2006 for approximately \$39. All Wii video game systems purchased after December 11, 2006 should have the new 1.0 mm cord. All individually sold Wii Remotes purchased after December 18, 2006, should have the new 1.0 mm cord. The video game was manufactured in Japan and China.

Problem: If consumers swing the hand-held "Wii Remote" game controllers using excessive force and accidentally let go, the cord connecting the controller to the wrist strap can break, potentially causing the controller to strike bystanders or objects. Nintendo has received reports of cords on wrist straps breaking, including three reports of minor injuries not requiring medical attention. All of these incidents occurred when consumers were playing the game, "Wii Sports."

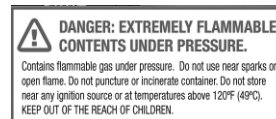
What to do: Consumers should contact the firm for a replacement wrist strap. For more information, contact Nintendo toll-free at (800) 859-4519 between 6 a.m. and 7 p.m. PT, or visit their Web site at www.support.nintendo.com.

Multi-Purpose Gas lighters

Product: About 1.8 million Multi-Purpose Gas Lighters by CFM U.S. Corp. The recall involves three models of multi-purpose butane lighters sold under the brand name, The Grill Care Company®. The lighters are 9 or 11 inches long and have the words "The Grill Care Company" and "NOM" printed on the label affixed to each lighter. The lighter's body comes in several colors. Only lighters that have Spanish warnings and do not have English warnings are included in this recall. The gas lighters were sold at Wal-Mart from February 2006 through January 2007 for between \$1 and \$4. The multi-purpose lighters were manufactured in China.

Problem: The lighters do not have a label in English containing precautionary information concerning the proper use and operation. Failure to follow the instructions in the warning label could result in injury. No incidents or injuries reported.

What to do: Consumers should contact CFM to obtain safety warning labels in English and instructions for proper placement of the labels on the lighters. For additional information, contact CFM toll-free at (866) 333-4833 between 9 a.m. and 5 p.m. ET Monday through Friday.



Pressure Washers and Air Compressors

Product: About 620,000 pressure washers and 72,000 air compressors with pneumatic tires and plastic hubs by DeVilbiss Air Power Company. The recalled pressure washers and air compressors were sold under the following brands and model numbers:

Brand	Model Numbers	Manufacture Dates
Pressure washers		
Delta	DTH2450, DTH2450-1, D2750H, D2400H-2, D2400H-3, D2700K-1, DTT2450	1/27/04 through 8/3/05
Excell	XR2750-1, XR2600, XR2600-1, XR2600-2, XR2500-1	1/26/04 through 11/2/05
Porter-Cable	PCV2250-2, PC2525SP-1, PCE1700-3, PCH2401-1, PCK3030SP-1, PCV2500, PCH2800C, PCE1700-2, PCH2425-2	6/4/04 through 10/24/05
Pressure-Wave	PWH2500, PWH2500K	1/6/05 through 10/31/05
Water Driver	WHAB2627-1	6/11/04 through 7/19/05
Air Compressors		
Porter-Cable	CFR350B-1, C3151-1, C3551-1, PTA51 Service Kit	12/16/04 through 5/5/06

On the pressure washers, the brand, model number and manufacturing date are located on the name plate on the rear of the engine base, and on the air compressors they are located on the front of the motor housing. Only pressure washers and compressors with pneumatic tires with plastic tire hubs are affected; pressure washers and compressors with solid tires or metal tire hubs are not affected. The recalled pressure washers were sold at home center and hard-

ware stores nationwide from January 2004 through November 2005 for between \$300 and \$1,400. The recalled air compressors were sold at home center and hardware stores nationwide between December 2004 and October 2006 for between \$300 and \$500. Both items were manufactured in the United States.

Problem: The pressure washers and air compressors have pneumatic tires with plastic hubs that can burst, posing a laceration or fracture hazard to consumers. DeVilbiss has received 26 reports of injuries including fractures, lacerations and bruises.

What to do: Consumers should stop using these products immediately and contact DeVilbiss to obtain the location of the nearest service center to receive a free replacement of the tires. For additional information, contact DeVilbiss toll-free at (866) 323-9867 between 8 a.m. and 5 p.m. ET Monday through Friday or visit the firm's Web site at www.devap.com.

Toy Ovens

Product: About 985,000 Easy-Bake Ovens by Easy-Bake, a division of Hasbro, Inc. The Easy-Bake Oven is a purple and pink plastic oven that resembles a kitchen range with four burners on top and a front-loading oven. "Easy Bake" is printed on the front of the oven. Model number 65805 and "Hasbro" are stamped into the plastic on the back of the oven. The Easy Bake Oven is an electric toy and is not recommended for children under eight years of age. Ovens sold before May 2006 are not included in this recall. The easy bake ovens were sold at Toys R Us, Wal-Mart, Target, KB Toys and other retailers nationwide from May 2006 through February 2007 for about \$25. The ovens were manufactured in China.

Problem: Young children can insert their hands into the oven's opening and get their hands or fingers caught, posing an entrapment and burn hazard. Easy-Bake has received 29 reports of children getting their hands or fingers caught in the oven's opening, including five reports of burns.

What to do: Consumers should contact Easy-Bake between 8:30 a.m. and 4:30 p.m. ET seven days a week to receive a free retrofit kit with consumer warning. Caregivers should keep the Easy Bake Oven away from children under eight years of age. For additional information, contact Easy-Bake at (800) 601-8418, or visit the firm's Web site at www.easybake.com.

Toy Bunnies

Product: About 500,000 (an additional 700,000 were sold worldwide) "Laugh and Learn" Learning Bunny Toys by Fisher-Price. This recall involves the Laugh and Learn Learning Bunny that measures about 10 inches tall. The yellow bunny with one green and one orange ear has musical and counting sound effects. The words, "Laugh and Learn" are printed on the bunny's shirt. Product numbers involved in the recall are: K0468, K2960, K2961, K2962, K2963, K2964, K2965, K3440, K6898, K7884, L0327, and K5862. The product numbers are located on the fabric tag sewn to the body of the bunny. Only bunnies with three dimensional pompom noses are included in this recall. Bunnies with flat or embroidered noses are not subject to this recall. The bunny toys were sold at discount department stores and toy stores nationwide May 2006 through December 2006 for about \$15. The laugh and learn bunny toys were manufactured in China.

Problem: The pink pompom nose can detach, posing a choking hazard to young children. No incidents or injuries reported.

What to do: Consumers should immediately take these recalled toys away from children and contact Fisher-Price to arrange for the return of the bunny to receive a voucher for a replacement toy of the customer's choice. For additional information, contact Fisher-Price at (866) 447-5003 anytime, or visit the firm's Web site at www.service.mattel.com.

Baby Rattles and Photo Frame Ornaments

Product: About 460,000 Plush Baby Rattles and Photo Frame Ornaments by Target. This recall involves plush rattles and frame ornaments sold in the "See. Spot. Save." department of Target stores. The two styles of rattles include a pink bear and a green moose. The plush animals either have a rattle inside or a plastic ring attached. The photo frame ornaments are a pink bear or green moose holding either a square or heart-shaped frame. The rattles and photo frame ornaments were sold at Target stores exclusively nationwide from November 2006 through December 2006 for \$1. The items were manufactured in China.

Problem: Small parts on the plush rattles and frame ornaments can break or detach, posing a choking hazard to young children. Additionally, the rattles' plastic ring can break and expose sharp points. Target has received 11 reports of the pompoms, eyes, nose and bows detaching from rattles and frame ornaments, including one report of a baby mouthing a detached part. No injuries have been reported.

What to do: Consumers should stop using the rattles and photo frames immediately and return them to the nearest Target store for a Target GiftCard worth the value of the returned item plus applicable sales tax. For more information, contact Target at (800) 440-0680 between 7 a.m. and 6 p.m. CT Monday through Friday, or visit Target's Web site at www.Target.com.

Teether Beads

Product: About 375,000 Bright Starts Star Teether Beads and Bright Starts Teether Beads by Kids II Inc. The Bright Starts Star Teether Beads (model 8483) has textured soft plastic beads in bright colors and various shapes connected to a flexible plastic ring. The beads on this model are shaped as stars, spirals and ovals. The Bright Starts Teether Beads (model 8549) has plastic beads in bright colors that are shaped as an oval and are connected to a flexible plastic ring. The teethers were sold at discount department and juvenile specialty stores nationwide from June 2006 through January 2007 for between \$1 and \$3. The teethers were manufactured in China.

Problem: The flexible plastic ring that holds the teether beads in place can crack or break, and the beads can detach, posing a choking hazard to infants. Kids II has received 24 reports of the plastic ring cracking or breaking and the beads becoming detached from the ring. No injuries have been reported.

What to do: Consumers should take this product away from children immediately and contact Kids II for information on receiving a free replacement. For additional information, contact Kids II toll-free at (877) 325-7056 between 7:30 a.m. and 4:30 p.m. ET Monday through Friday, or log on to www.kidsii.com.

Curling Irons

Product: About 322,000 Curling Irons by Conair Corp. This recall involves ceramic, gold-matte finish curling irons. The irons have a 1, 1¹/₄, or 1¹/₂ inch barrel, metal counter rest, vertically placed ON-OFF buttons, and a heat set dial that ranges from 0 to 30. A four-digit date code can be found on the plug prong. Date codes included in this recall range from November 2005 through July 2006 (e.g. 0706). The name "Conair" is printed on the handle of the iron. The curling irons were sold at discount retailers and drug stores nationwide during January 2006 for about \$25. The curling irons were manufactured in China.

Problem: The handle of the curling iron can come apart exposing its line cord, posing a shock or electrocution hazard to consumers. No incidents or injuries reported.

What to do: Consumers should immediately stop using the recalled curling iron and contact Conair to receive a free replacement. For additional information, contact Conair at (800) 687-6916 between 8:30 a.m. and 4:30 p.m. ET Monday through Friday, or visit the firm's Web site at www.conair.com/ironrecall.html.

Tower Fans

Product: About 300,000 Holmes® Oscillating Tower Fans distributed by The Holmes Group. The recall involves the Holmes HT30 Oscillating Tower Fan. The model number can be found on the silver label on the back of the unit. The tower fans are white. "Holmes®" is printed on the front of the base. The fans were sold at Target, Bed Bath & Beyond and additional department and specialty stores nationwide from July 2002 through June 2005 for about \$30. The tower fans were manufactured in China.

Problem: Electrical arcing in the fan's wiring can cause a fire hazard. The Holmes Group has received 16 reports of property damage, including one reported injury involving minor burns and smoke inhalation.

What to do: Consumers should immediately stop using the fans and contact The Holmes Group for instructions on receiving a free replacement unit. For additional information, call The Holmes Group at (800) 524-9204 anytime or visit the firm's Web site at www.holmesfanrecall.com.

Children's Rings

Product: About 280,000 Children's "Rachael Rose Kidz" Rings by Shalom International Corp. The children's rings are silver or gold-colored with designs or stones in a variety of colors. The rings come four to a package. "Kidz by Rachael Rose," "Family Dollar \$1" and "SKU 1905580" are printed on the packaging. The rings were sold at Family Dollar stores nationwide from December 2005 through January 2007 for about \$1. The children's rings were manufactured in China.

Problem: The recalled jewelry contains high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. No incidents or injuries reported.

What to do: Consumers should immediately take these recalled rings away from children and return them to any Family Dollar store for a full refund, or contact Shalom International for information on how to receive a full refund. For additional information, contact Shalom International at (800) 359-8162 between 9 a.m. and 5 p.m. ET, Monday through Friday, or visit Family Dollar's Web site at www.familydollar.com.

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