CONSUMER PRODUCT SAFETY REVIEW

WINTER 2003
VOL. 7, NO. 3

U.S. Consumer Product Safety Commission

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Bicycle Head Injuries

The U.S. Consumer Product Safety Commission (CPSC) staff recently conducted a study of bicycle-related head injuries to children younger than 15 years old. George W. Rutherford, the lead researcher on the team from the Directorate for Epidemiology, discussed the results of the study.

Why did you decide to do a study on bicycle-related head injuries?
Our work focuses on saving lives and keeping families safe. One way we do this is to conduct research on potential product hazards. Data on hospital emergency room-treated injuries had indicated that after several years of declining injuries, bicycle-related head injuries to children under 15 had increased during the years 1997 to 2000 *(Figure 1, page 2)*. Because data on participation had indicated an overall decrease in the number of bicycle riders, and because studies of helmet use had reported increased helmet use, we believed that a study to investigate this phenomenon was needed.

Have bike-related head injuries to children continued to increase after 2000?
No. Data from CPSC's National Electronic Injury Surveillance System (NEISS) for 2001 indicate a sharp downturn in the frequency of head injuries, returning to the level before the increase from 1997 through 2000. While data for 2002 are not complete, preliminary estimates indicate that the total will be the same as or lower than the total for 2001. We now believe that the apparent upward trend from 1997 to 2000 was a false alarm. Further, the trend in head injuries appears to have returned to the ongoing decrease that started in 1992.

How did you conduct this study?
We used CPSC's NEISS to identify victims of bicycle-related injuries treated in hospital emergency rooms during the time period from June 2001 through November 2001. To learn more about the injuries, we contacted over 450 victims or family members of victims by telephone and asked them a series of questions. In addition, we looked at other NEISS bicycle injury data and bicycle-related death data.

What did your study show?
We learned a number of things. One is that bicycle helmets are effective in preventing emergency room-treated head injuries. The data showed that children treated in emergency rooms for bicycle-related head injuries were almost three times more likely to have not been wearing a helmet than those treated for bicycle-related injuries to other body parts.

What did you learn about bike helmet use?
While 62% of the respondents said that the victim usually wore a helmet while

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riding, only about 34% were actually wearing a helmet at the time of the injury. Of those with head injuries, only about 17% reported that they were wearing a helmet at the time of injury.

Why was there such a discrepancy in reported bike helmet use?

People may have overestimated regular helmet use, especially when they were being interviewed by a representative of the federal government. Or, riders who usually wore a helmet were injured on one of the occasions when they didn't have one on.

Does this study point toward some problems with regard to bike helmet use?

If respondents overstated the frequency of wearing a helmet, helmet use may not have increased as dramatically as was previously estimated. Recent surveys have reported that between one-half to two-thirds of bike riders under age 15 regularly wear a helmet. If riders who usually wore a helmet were injured on one of the few occasions when they weren't wearing one, we need to stress the importance of always wearing a helmet when riding.

Did the study reveal any other positive information about injuries and helmet use?

The data showed that helmets may be helpful in reducing the severity of injuries. Questions about three symptoms of severe head injuries—loss of consciousness, disorientation and vomiting—were included in the questionnaire. Among the victims who suffered head injuries, more than half of those not wearing helmets experienced one or more of these symptoms. For the group wearing helmets, these symptoms were reported less frequently.

What about deaths?

We examined mortality data from the National Center for Health Statistics (NCHS) and found that deaths related to bicycle-related head injuries decreased substantially from 1991 through 1999. In 1999, there were 26% fewer deaths among children under 15 involving head injuries from bicycling than there were in 1991. The sharpest decline is since 1994, when many jurisdictions began passing laws requiring helmet use among children. In 1994, there were 123 head injury-related deaths to this age group from bicycling. By 1999, this number had declined by 33% to 83 head injury-related deaths. Other bicycle-related deaths also declined over this period.

What's your bottom line about the results of this study?

Bike helmets are effective both in preventing emergency room-treated injuries and in reducing the severity of head injuries. In addition, deaths related to head injuries have decreased since 1991.

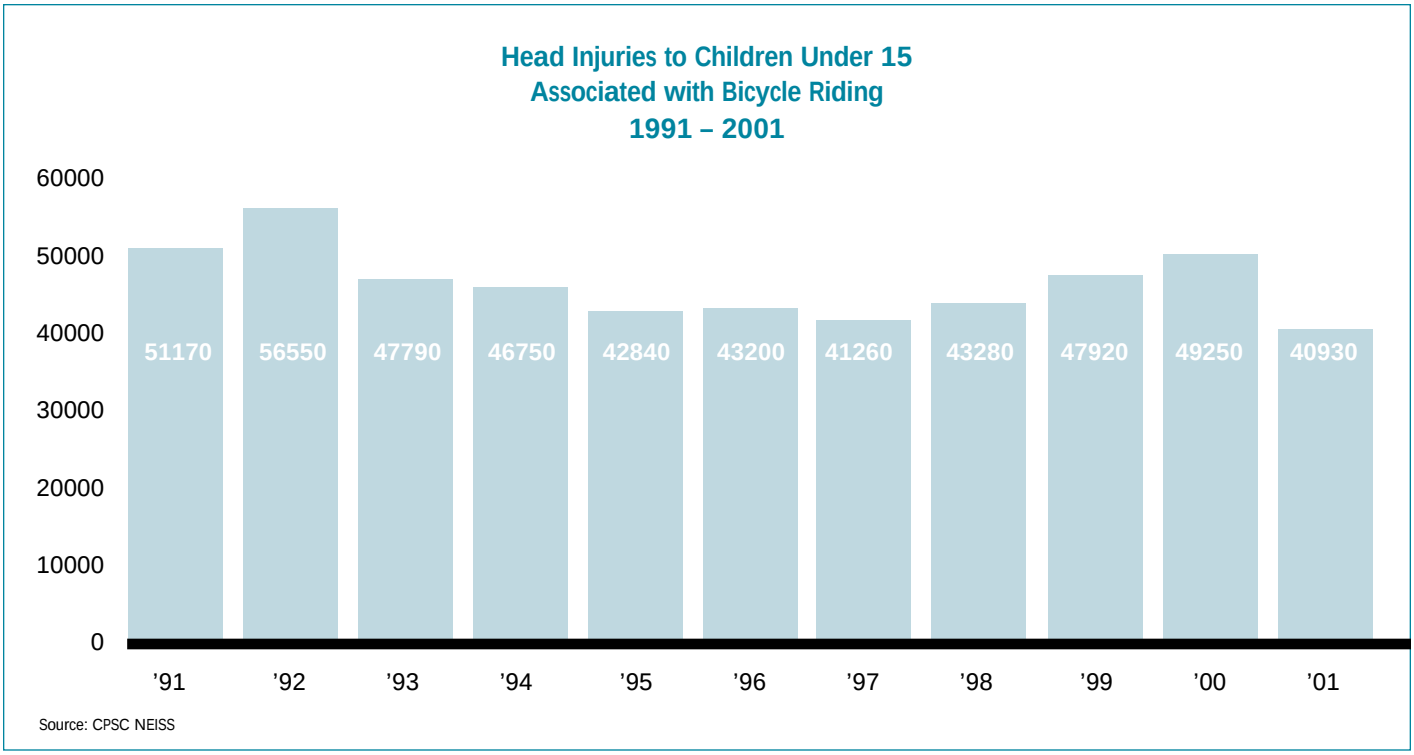

Figure 1

Child-Resistant Cigarette Lighters

The following article, written by CPSC staffers Linda E. Smith, Michael A. Greene, Ph.D., and Harpreet A. Singh, was excerpted from Injury Prevention *(2002;8:192-196).*

CPSC's safety standard for cigarette lighters, which requires certain disposable lighters and novelty lighters to be child-resistant, has led to a 58% reduction in fires attributable to young children, according to a recent CPSC study.

Between 1985 and 1987, when there was no safety standard, children under 5 started 71% of cigarette lighter fires attributed to children playing. Between 1997 and 1999, when the standard was in effect, children under 5 started 48% of cigarette lighter fires attributed to children playing.

When applied to national fire loss data, these findings show that an estimated 3,300 fires, 100 deaths, 660 injuries, and $52.5 million in property losses were prevented by the standard in 1998 alone. This totals $566.8 million in 1998 societal savings *(Figure 2).*

Data Collection and Analysis

To collect the data for the pre-standard period between 1985 and 1987, CPSC field staff contacted local fire jurisdictions and asked to be notified of all fires started by children playing with cigarette lighters. CPSC field staff then conducted follow-up investigations, which identified the age of the child who started the fire, the characteristics of the lighter involved, fire casualties, property loss, and a description of the incident scenario.

The post-standard data collection was conducted between October 1997 and February 1999. Once again, CPSC's field offices requested notification from nearby fire jurisdictions on all fires started by children playing with lighters. When a child younger than age 5 started a fire, the fire department was asked to complete a CPSC questionnaire providing additional details on the child's age and the lighter characteristics. Lighters used in fires started by children under 5 were collected whenever possible.

Since lighter fires may have decreased for reasons other than the standard, the analysis focused on the change in the proportion of cigarette lighter fires caused by children younger than 5 compared to children 5 and older. The procedure had the effect of controlling for other factors that were likely to have contributed to a reduction of fire losses over the years. These factors included public education, improvements in building construction, reductions in the size of the smoking population, and the increased presence of smoke alarms. These factors should have affected children of all ages about the same amount, while the standard would be expected to reduce fires only among children under 5.

Discussion

The analysis showed that there was a 58% reduction in the number of child play lighter fires among children under 5 that was attributable to the CPSC safety standard. Some of the children under 5 who started fires

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Determining Child Resistance

The child resistance of a cigarette lighter is determined by tests conducted by lighter manufacturers using panels of children between the ages of 42 and 51 months. Lighters used for the tests have no fuel. When activated, they produce an audible or visual signal. Child-resistant lighters must be designed so that at least 85% of children included in the test panel are not able to operate the lighters under timed test conditions.

The CPSC standard is intended to make cigarette lighters child-resistant, but not childproof. While the standard can increase the time needed for a child to operate the lighter, it may not prevent some children, with enough practice, from operating the lighters.

Estimated 1998 Cigarette Lighter Child Play Fire Losses Prevented by CPSC Standard

Case	Fires	Deaths	Injuries	Property Loss (millions)	Total Societal Cost (millions)
Actual 1998 Fire Losses	2,400	70	480	$38.2	$412.2
1998 Expected Fire Losses if Standard Had No Effect	5,700	170	1,140	$90.7	$979.0
1998 Fire Losses Prevented	3,300	100	660	$52.5	$566.8

Source: CPSC

Figure 2

Toys

In 2001, the number of deaths and injuries related to toys was affected by an increase in incidents involving the popular unpowered scooters. Scooter incidents peaked in the spring of 2001 and have declined substantially since then.

Toy-Related Deaths

CPSC staff received reports of 25 children who died from toy-related injuries that occurred in 2001. Children ranged in age from 3 months to 12 years old. Of these, 21 were boys. Toy-related deaths occurred in the following ways.

Choking or Aspiration: Nine children died from choking or aspiration in incidents involving four balloons, a toy building block, a toy dart, a toy ball and two unspecified toys. These children ranged in age from 3 months to 8 years.

Head Injury: Four of the toy-related deaths were the result of head injuries associated with non-powered scooters. The children ranged from 8 to 12 years. Three deaths resulted from a collision with a motor vehicle, and one death resulted from a fall on a steep slope.

Multiple Injuries: The four children who died from multiple injuries ranged in age from 2 to 12 years. Three deaths involved non-powered scooters, and one death was associated with a toy scooter/kiddie car. All of these deaths resulted from collisions with motor vehicles (two cars, a van, and a garbage truck).

Drowning: Two children drowned in incidents involving riding toys. A 1-year-old male rode his tricycle onto a torn swimming pool cover and subsequently drowned in the pool. A 2-year-old male drowned when he fell into a residential spa while riding a tricycle.

Other Diagnoses: Three deaths were associated with other diagnoses. These included: a girl (age not known) who fell off a plastic toy box and suffered a cervical spinal cord injury; a 3-year-old boy who suffocated inside a toy box; and a 3-year-old boy who strangled in the cords of two remote-controlled toys he took to bed with him.

Unspecified: Three children died in incidents where there was no specified cause of death. All of these involved non-powered scooters and motor vehicles.

In addition, four adults, ages 18 to 57, were killed in incidents associated with toys in 2001. All were males. Three of the fatalities occurred with non-powered scooters; one fatality occurred with a remote-controlled airplane.

Toy-Related Injuries 1997 to 2001

Calendar Year	Injuries	Injuries for Children under 15
1997	141,300	108,600
1998	153,400	121,500
1999	152,600	118,300
2000	191,000	150,800
2001	255,100	202,500

Source: CPSC NEISS

Figure 3

Toy-Related Injuries

In 2001, an estimated 255,100 people went to U.S. hospital emergency rooms with toy-related injuries *(Figure 3)*. This was an increase from 2000 and was primarily attributed to incidents with unpowered scooters. (Unpowered scooter injuries rose from 42,505 injuries in 2000 to 99,812 injuries in 2001.)

Of the 255,100 injuries, 79% (202,500) were to children under 15, and 30% (77,100) were to children under 5. Twenty-one percent (52,600) of the injuries were to people 15 and older.

Overall, males were involved in 60% of the toy-related injuries. Most of the victims (98%) were treated and released from the hospital.

In 2001, riding toys (including unpowered scooters) continued to be associated with more injuries (121,700 or 48%) than any other category of toy. In 2000, riding toys (including unpowered scooters) were associated with an estimated 65,000 injuries.

— *Joyce McDonald, Directorate for Epidemiology*

Crib Safety

In recent years, CPSC has received reports of about 30 deaths of infants and toddlers each year from crib-related incidents.* While these deaths have declined considerably from the yearly toll of 150 to 200 in the early 1970s, the number of deaths associated with cribs remains higher than with any other nursery product.

To address this situation, CPSC staff recently looked at current crib-related deaths, with an emphasis on hardware and structural problems that could be addressed through safety standards or other means.

The analysis included fatal crib-related incidents that occurred between January 1, 1997, and July 15, 2002. During this period, a total of 156 crib-related deaths were reported to CPSC. About 80% of the victims were younger than one year, and about 60% of the victims were male. Of the 156 deaths, 62 involved full-size cribs, 17 involved non-full-size or portable cribs, and 77 involved cribs of unknown type.

Overall, the greatest number of deaths (54) involved positional asphyxia/suffocation, a broad category that included a number of cases for which extensive detail about the circumstances was not available *(Figure 4)*. This was followed by hardware problems (29 deaths); entrapment between the crib and another object (13 deaths); entanglement in window covering cords near the crib (12); entrapment between the mattress and side rail, with further detail unknown (11); structural failure (10); improper mattress (9); bedding entanglement (8); and other or unknown circumstances (10).

Almost all the cases involving hardware problems involved missing or loose screws, brackets, or other attachment devices that fastened the sides of the cribs to the end panels. Generally, a side of the crib would loosen, creating a space that the child would slip through and become entrapped by the head or chest. Structural failures of cribs most often involved broken or missing crib rails or slats.

Few of the cribs, portable or non-full-size, appeared to be new. Many were older models in poor condition. In some cases, repairs had been at-

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* Products marketed as portable crib/play yard combinations were included only if the product was used primarily as a crib. Deaths involving Sudden Infant Death Syndrome (SIDS) were excluded.

CPSC and Cribs

Past CPSC efforts to address crib-related hazards have included the publication of mandatory standards for full-size cribs in 1973 and non-full-size cribs in 1976. These standards included requirements for side height, slat spacing, mattress fit, and other aspects of crib performance and construction.

In 1982, these standards were amended to include mandatory requirements that prohibited hazardous cutouts in crib end panels. CPSC's rulemaking proceeding to address crib slat disengagement hazards, initiated in 1996, is currently on hold, pending evaluation of industry conformance to the revised voluntary standard.

CPSC staff has also been involved in the development of voluntary standards for cribs through ASTM International. In 1986 and 1988, ASTM published standards to address hazards of entanglement on corner posts on full-size and non-full-size cribs and structural and mechanical failures of full-size cribs, respectively. An ASTM voluntary standard for the performance of non-full-size cribs was published in 1997.

In April 1999, the voluntary standard for full-size cribs was revised to include improved slat performance requirements. ASTM published this standard in June 1999.

Crib-Related Deaths: Hazard Pattern by Age of Victim

Hazard Pattern	Age of Victim (in months)					
	Total	< 6	6 - 11	12 - 17	18 +	Unk.
Positional Asphyxia/Suffocation	54	43	8	1	1	1
Hardware Problems	29	2	24	2	1	0
Entrapment, Crib & Other Object	13	4	3	4	2	0
Window Cord Entanglement	12	0	1	10	1	0
Entrapment, Mattress & Side Rail	11	1	9	1	0	0
Structural Failure	10	3	6	1	0	0
Improper Mattress	9	4	5	0	0	0
Bedding Entanglement	8	0	7	1	0	0
Other/Unknown	10	2	3	4	1	0
Total	**156**	**59**	**66**	**24**	**6**	**1**

Source: CPSC

Figure 4

Portable Heaters

Safer portable propane heaters are now on the market. These heaters should prevent carbon monoxide (CO) poisoning deaths when used in poorly-ventilated enclosed spaces, such as tents and trailers.

The new heaters are equipped with an oxygen depletion sensor (ODS). The ODS is a thermally-activated shutoff device that will stop the flow of gas to the burner when the oxygen concentration near the heater falls below 18%. This prevents the heater from producing high concentrations of CO. Oxygen depletion sensors have been used successfully for many years in residential unvented space heating applications, such as gas logs.

Earlier models of portable propane heaters were not equipped with an ODS and were intended for outdoor use only. These new ODS-equipped heaters are specifically designed to be used safely inside tents, cabins, and campers. Users, however, must comply with the manufacturers' instructions to ensure that there is adequate ventilation. CPSC staff still recommends shutting off any camping heater or lantern before going to sleep.

CPSC staff worked closely with the American National Standards Institute (ANSI) Camping Equipment Subcommittee and heater manufacturers to develop and implement a new safety standard for portable camping heaters. (These are heaters that use a disposable one-pound bottle of propane gas as their fuel source.) The new standard limits both the allowable amount of CO the portable propane heaters can produce and the amount of oxygen the heaters can deplete in a room. The new ODS-equipped heaters were specifically developed by manufacturers to meet the requirements in this new safety standard.

According to CPSC estimates, in 1998 (the latest year for complete data), 18 people died from CO poisoning when portable propane heaters were used in poorly-ventilated enclosed spaces. Typically, the incidents occurred in tents, campers, trailers, or motor vehicles (passenger vans, passenger cars, and cabs of semi-trucks). Many of these deaths could have been prevented if the victims had been using the new heaters equipped with an ODS.

Consumers can find the safer heaters under various brands in major retail stores. The new heaters can be identified by package labels that read in part: "Designed for Indoor Use," "Low Oxygen Automatic Shut-Off System," and "Oxygen Depletion Sensor" or by a star with the words "CSA 4.98."

— David Tucholski, Directorate for Laboratory Sciences

Safety Tips for Portable Heaters

To help prevent CO poisoning associated with portable heaters, the following information may be helpful.

- New ODS-equipped heaters are designed specifically for indoor use, such as in tents, campers and trailers.
- Always follow the manufacturer's instructions for ventilation.
- Older generation heaters without an ODS are intended for outdoor use only and must never be used in any enclosed areas, including tents, cabins, campers, and other vehicles. This is especially important at high altitudes, where the risk of CO poisoning is increased.
- Do not keep on any type of camping heaters and lanterns while sleeping.

CO Guidelines

CPSC has developed guidelines to help first responders address calls from consumers about carbon monoxide (CO) levels in their homes. These guidelines are intended for those working in professional and volunteer fire departments, emergency community service units, and others.

The procedures are designed to help first responders provide for their own safety when answering a call, determine the level of care needed by the residents, make a preliminary assessment of the CO condition in the residence, and determine when it is safe for occupants to re-enter the home.

CO is associated with about 500 unintentional non-fire-related deaths each year. About 60% of these deaths are from motor vehicle exhaust, and about 40% are associated with consumer products. CO in its pure form is colorless and odorless.

To download or order a hard copy of *Responding to Residential Carbon Monoxide Incidents*, visit www.cpsc.gov.

NOTES FROM THE FIELD

Recall Awareness

The CPSC Western Regional Office and Washington State recently joined forces to enhance awareness of recalled consumer products.

After two local children died from recalled products in 2001, the Washington State legislature directed the Washington State Department of Health to produce a product safety education campaign to promote greater awareness of recalled infant and children's products. The legislature provided start-up funding.

As a result, Children's Hospital and Regional Medical Center, the Washington State Department of Health, and CPSC's Western Regional Office collaborated on a product recall campaign that targeted parents, guardians, and child care providers of children under 5.

To determine the level of awareness about recalled products, Children's Hospital used state funding to contract for a statewide telephone survey of 400 parents, followed by parent focus groups. This research helped determine what key messages to accentuate, what media channels to use to deliver and disseminate materials, and which resources to highlight. A follow-up survey is planned to help measure the effectiveness of the campaign.

Informational materials—including fact sheets, posters, and flyers—were developed and produced in English and Spanish. The materials listed the CPSC website and toll-free number as the place to go to learn more about recalled products. The campaign also urged parents, guardians, and child care providers to sign up for CPSC's email subscription service.

Sample materials were mailed to all licensed child care providers in Washington State, SAFE KIDS Coalition members, and local health departments, as well as to health care providers, hospitals, clinics, and other community partners. The campaign also is working with local media to generate regular coverage of recalled products and to establish links to the CPSC website on media outlet home pages.

For more information, contact : Katharine Fitzgerald Children's Hospital and Regional Medical Center, 206-528-5245 (email: kfitzg@chmc.org, Eugene Staebell CPSC, 253-631-6806 (email: estaebell@cpsc.gov).

—Larry Cornell, CPSC Western Region, Oakland, CA

Lighters *cont. from page 3*

in 1997-1999 used lighters that were not child-resistant. If all lighters in homes had been child resistant, the standard's effectiveness would have been even greater. It is reasonable to expect that the number of pre-standard, non-child-resistant lighters in homes will continue to decline over time.

History of Standard

In 1985, CPSC was petitioned to begin rulemaking to require disposable cigarette lighters to be resistant to operation by children. It was estimated that children younger than 5 playing with cigarette lighters ignited 5,900 residential fires that resulted in 170 deaths and 1,150 injuries annually during 1986-1988. Disposable lighters were involved in 97% of those fires and accounted for about 95% of the estimated 488 million lighters sold annually during that period.

In response to those findings, CPSC developed the safety standard for cigarette lighters, which applies to products manufactured or imported after July 12, 1994. The standard requires disposable and novelty cigarette lighters to have a child-resistant mechanism that makes the lighters difficult for children younger than 5 to operate.

Crib Safety *cont. from page 5*

tempted with such items as shoelaces, string, dishtowels, wire, coat hangers, tape, and inappropriate hardware. In other instances, the caregivers had pushed the crib against the wall or other object to stabilize a loose side.

Past CPSC research on crib-related deaths revealed hazards with old, used, and structurally unsound cribs. However, some of the previously identified problems now occur less frequently. Based on current findings, it appears that mandatory and voluntary efforts to address entrapment from improper slat spacing, entanglement on corner post projections, entrapment in end-panel cutouts, and failure of mattress support hardware have been reasonably successful.

But problems remain with continued use and re-use of these products. Additional safety requirements to improve the performance of attachment hardware or minimize the need for these items are currently being considered by CPSC staff.

— Deborah Tinsworth, Directorate for Epidemiology

MECAP NEWS

Medical Examiners and Coroners Alert Project and Emergency Physicians Reporting System

The MECAP-EPRS 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.

To report a case or ask for information about MECAP, please call our toll-free number, 1-800-638-8095, or our toll-free fax number, 1-800-809-0924, or send a message via Internet to AMCDONAL@CPSC.GOV.

*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 data base and will be used to assess the hazards associated with consumer products.

During the months of July, August, and September of 2002, 1,007 cases were reported to CPSC. Included here are samples of cases to illustrate the type and nature of the reported incidents.

ASPHYXIATIONS / SUFFOCATIONS

*A male, 3, was found unresponsive by his parents in his home and rushed to a local hospital. The medical staff initially believed the child was in cardiac arrest. An autopsy revealed that a small red balloon had blocked his airway. The cause of death was asphyxiation.
(Richard P. Bindie, M.D., Forensic Pathologist for James Langon, M.D., Coroner, Schuylkill County, Pottsville, PA)

A female, 5 months, was placed on an adult bed for a nap by her child care provider. The caregiver lay down with the child and then went to another room for her own nap. Several hours later, the caregiver found the child unresponsive with her head in a small plastic trash can wedged between the bed and a wall. The plastic liner of the trash can was around the child's head and shoulders. The cause of death was asphyxiation.
(R. D. Zurowski, M.D., Medical Examiner, Northern Virginia District, Commonwealth of Virginia, Fairfax, VA)

*A male, 3, was found unresponsive in the basement playroom of his home. He was found, in a standing position, with the rope of a plastic toddler swing tangled around his neck. The cause of death was neck compression.
(Thomas F. Gilchrist, M.D., Associate Medical Examiner, State of Connecticut, Farmington, CT)

A female, 2 months, was found unresponsive with her face in a large plastic trash bag on the floor next to a bed. The child had been placed on an adult bed by a relative, while the child's mother went to the grocery store. The cause of death was positional asphyxia.
(Cheryl L. Loewe, M.D., Assistant Medical Examiner, Wayne County, Detroit, MI)

A female, 7 months, was given a bottle of milk and placed on her back to sleep on her parents' king-size bed. Several hours later, she was found unresponsive between the side of the bed and a wall, with her face pressed into a comforter. CPR was performed at the home, and the child was rushed to the hospital, where she died. The cause of death was suffocation.
(Ron Flud, M.P.A., Coroner-Medical Examiner, Clark County, Las Vegas, NV)

CARBON MONOXIDE POISONINGS

*A female, 96, was found unresponsive on the floor of her home, which smelled of gas. Gas company employees found high levels of carbon monoxide and discovered a faulty vent door on the furnace. The cause of death was carbon monoxide poisoning.
(Patricia J. McFeely, M.D., Deputy Medical Investigator, Office of the Medical Investigator, State of New Mexico, Albuquerque, NM)

*Two males, 37 and 24, were found dead inside a tent at a campground. The men were still in their sleeping bags, and a small charcoal grill with used charcoal was found inside the tent. The cause of death was carbon monoxide poisoning.
(Rhonda B. Wright, RN, Medical Examiner, Cabarrus County, Concord, NC)

*A male, 47, was sleeping in a lower-level bedroom at a friend's house. The next morning, he was discovered unresponsive in the bed. Testing by the local gas company revealed that a natural gas boiler was emitting carbon monoxide. A door between the bedroom and the boiler was slightly open. The cause of death was carbon monoxide poisoning.
(Roberta J. Geiselhart for Garry F. Peterson, M.D., Chief Medical Examiner, Hennepin County, Minneapolis, MN)

A male, 60, was found unresponsive in a closed garage. A lawn mower was found running in the garage. He was taken to a local hospital where he was pronounced dead. The cause of death was carbon monoxide poisoning.
(Brad B. Randall, M.D., Coroner, Minnehaha County, Sioux Falls, SD)

DROWNINGS

A male, 20 months, was placed by his mother in the bathtub along with another child. The mother left the bathroom for a few minutes. When she returned, she found her child face down and unresponsive in the bathtub. She called 911 and initiated CPR. EMS responded, continued CPR, and took the child to the hospital, where he was pronounced dead. The cause of death was drowning.
(Richard C. Harruff, M.D., Ph.D., Chief Medical Examiner, King County, Seattle, WA)

A male, 19 months, was seated in a flotation device in an apartment's swimming pool. His mother was nearby and believed family or friends in the pool also were watching the child. About ten minutes later, the mother noticed that the child's flotation device was upside down and empty. The child was found unresponsive, floating face up in a corner of the pool. He was taken to the hospital, where he was pronounced dead. The cause of death was asphyxia due to drowning.
(Ron Flud, M.P.A., Coroner-Medical Examiner, Clark County, Las Vegas, NV)

A female, 19 months, was found face down and unresponsive at the bottom of her family's pool. The mother initiated CPR until a police officer arrived and took over. The Fire and Rescue squad took the child to the hospital, where resuscitation efforts failed. The child, who had been put to bed in a back bedroom, must have exited the house through a sliding glass door that accessed the pool. The cause of death was drowning.
(Eroston Price, M.D., Associate Medical Examiner, District 17, Broward County, Fort Lauderdale, FL)

ELECTROCUTIONS

*A female, 38, was found lying in her yard. While standing barefoot on wet grass, she had been holding the electric cord to a metal fan. CPR was initiated, and 911 was called. She was rushed to the hospital where she was pronounced dead. The cause of death was electrocution.
(Hal Bennett for Brian Frist, M.D., Chief Medical Examiner, Cobb County, Marietta, GA)

*A male, 5, was playing in a swimming pool with other children at his babysitter's house. He got out of the pool and walked over to a garage door. He touched the garage door and was immediately electrocuted. The cause of death was acute cardiac dysrhythmia secondary to presumed low voltage electrocution.
(Richard Greathouse, M.D., F.A.A.P., Coroner, Jefferson County, Louisville, KY)

FIRES

*A male, 10, and five other people died in a housefire. An overloaded extension cord that provided power to an air conditioner, a television, a VCR, and other items caused the fire. Two others in the home escaped. The cause of death was smoke inhalation.
(James B. Holt, M.D., Medical Examiner, Chatham County, Pittsboro, NC)

A male, 28 days, and two other young children died in a housefire. The fire was caused by candles that were accidentally knocked over in the bathroom. The cause of death was soot and smoke inhalation.
(Jose K. Abrenio, M.D., Medical Examiner, Central District, Richmond, VA)

MISCELLANEOUS

*A male, 4, became excited about a television program. He began shaking the television set, which was on a cart. The cart and television tipped over, and the television struck the child's head. He was taken to the hospital where he was pronounced dead. The cause of death was blunt impact to the head.
(Rebecca A. Hamilton, M.D., District Medical Examiner, District 21, Fort Myers, FL)

A male, 33, was lighting fireworks when one exploded in his face. He was taken to the hospital where he died from his injuries. The cause of death was head injury.
(C. Chase Blanchard, M.D., Deputy Medical Examiner, Jackson County, Kansas City, MO)

— *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.

DIGITAL CABLE SET-TOP BOX

Product: About 1 million DCT2000 **digital cable set-top boxes by Motorola Inc. Broadband Communications Sector** installed earlier this year. Digital cable operators distributed these set-top boxes **nationwide** in conjunction with digital cable services from March 2002 through June 2002. These digital cable set-top boxes are black, about 17-inches wide and 2.5-inches high. "MOTOROLA" and "INTERACTIVE DIGITAL COMMUNICATIONS" are written on the front of the units. The model number, "DCT2000", is written on the cover of the user guide that came with the box. Motorola's DCT2000 set-top box provides cable subscribers access to various digital, audio, and interactive TV services, including expanded channel counts; digital-quality video and audio; interactive program guides for viewing convenience and control; parental control; and virtual channels for community and local information.
Problem: Pins in the rear of the box that connect to the power cord could break, which could pose an electric shock hazard to consumers. CPSC and Motorola have not received any reports of these set-top boxes causing shock or injury.
What to do: Consumers with these DCT2000 digital cable set-top boxes can continue to use them as normal, but they should not remove the power cord from the rear of the set-top box. If it is necessary to unplug the boxes, power cords should always be unplugged from the wall outlet or other energy source. Motorola estimates about 30,000 of these set-top boxes have power cord pins that could break. Cable operators are contacting their customers to determine if they have a set-top box included in the recall that needs to be replaced. For more information, contact your local cable provider or Motorola at (866) 281-1588 anytime, or visit its website at **www.motorola.com/broadband**.

CORDLESS DRILL/DRIVER

Product: About 950,000 **cordless drill/drivers by Black & Decker (U.S.) Inc.** The recalled cordless drill/drivers are orange and bear the word "Firestorm" or are jade and bear the words "Quantum Pro." The drill/drivers have the following model numbers and date codes: 14.4 volt Firestorm, CD632, 990852 thru 20005052; 14.4 volt Firestorm, HP532, 990152 thru 20001652; 14.4 volt Firestorm, FS1442, 20002252 thru 20011852; 14.4 volt Quantum Pro, Q145, 990252 thru 20001152; 15.6 volt Firestorm, FS1560, 993752 thru 20000752; 18 volt Firestorm, FS1802, 20002452 thru 20010652; 18 volt Firestorm, HP932, 990152 thru 20012452; 18 volt Quantum Pro, Q185, 990252 thru 20011052. The model numbers are located on the name plate on the side of the drill and the date codes are located on the bottom of the handle where the battery is inserted (remove battery to locate date code). These drill/drivers were manufactured in China. Home centers and hardware stores throughout the U.S., Puerto Rico and Canada sold the drill/drivers from March 1999 through December 2001 for between $50 and $200. The drill/drivers were sold separately and as part of various tool kits.
Problem: The drill's switch can malfunction and overheat, posing the possibility of a fire hazard to consumers. Black & Decker has received 45 reports of drill switches overheating, causing two minor burns.
What to do: Consumers should stop using their drill/drivers immediately, remove the battery, and call Black & Decker at (866) 821-5444 between 8 a.m. and 4:30 p.m. ET Monday through Friday to arrange for a free repair. For additional information, consumers can log on to the company's website at **www.blackanddecker.com**.

STUFFED POOL ANIMAL

Product: About 310,000 **stuffed polyester pool animals by Dollar Tree Stores Inc.** There are eight types of stuffed polyester pool animals involved in this recall: crab, duck, frog, octopus, seahorse, shark, turtle and whale. The brightly colored stuffed animals have a sewn-in label that reads, in part, "DOLLAR TREE DISTRIBUTION, INC.," "MADE IN CHINA" and "RN# 87254." Dollar Tree, Only One Dollar, Only $1, Dollar Express and Dollar Bills stores sold the stuffed animals nationwide from April 2002 through August 2002 for $1.
Problem: The seams can separate exposing the polyester stuffing and foam beads. The foam beads pose a choking hazard to young children. CPSC and Dollar Tree Stores have received one report of the seam ripping, exposing the polyester stuffing and a plastic bag containing foam beads. No injuries have been reported.
What to do: Take these stuffed animals away from young children immediately and return them to the store where purchased for a full refund. For more information, consumers can call Dollar Tree Stores at (800) 876-8077 between 9 a.m. and 5 p.m. ET Monday through Friday or visit the firm's website at **www.dollartree.com**.

TOY SPONGE

Product: About 280,000 **animal toy sponges by Dollar Tree Stores Inc.** There are three types of sponge animals involved in this recall: whales, turtles and fish. The sponge animals are made of soft terry cloth and have suction cups for attaching to tiled or smooth surfaces. The toys have a sewn-in label that reads in part, "DOLLAR TREE DISTRIBUTION, INC.," "MADE IN CHINA" and "RN# 87254." Dollar Tree, Only One Dollar, Only $1, Dollar Express and Dollar Bills stores sold the stuffed animals nationwide from May 2001 through September 2002 for $1.
Problem: The eyes on the toys can detach, posing a choking hazard to young children. CPSC and Dollar Tree Stores have received one report of an eye coming off. No injuries have been reported. This recall is being conducted to prevent the possibility of injuries.
What to do: Take these sponge animals away from young children immediately and return them to the store where purchased for a full refund. For more information, consumers can call Dollar Tree Stores at (800) 876-8077 between 9 a.m. and 5 p.m. ET Monday through Friday or visit the firm's website at **www.dollartree.com**.

ENGINES USED ON FUN KART TYPE GO-KART

Product: About 160,000 **engines used on fun-karts by Briggs & Stratton Corp.** The recalled engines are used only on fun-karts, which look and ride like go-karts, but are for personal use. The engine models included in the recall are: **5HP Model Series 1352XX** - All Model Series 1352XX on fun-karts and **FunPower Model Series 1362XX** - Includes only 1362XX engines built on or before June 22, 1995 (950622XX). (Example: **Model** 136212, **Type** 0615 A1, **Date Code** 950622YB). Has a 2" tall plastic fuel cap. The engines involved in this recall were manufactured in the United States. Briggs & Stratton sold the engines between May 1992 and June 1995 to fun-kart manufacturers such as Avenger Inc., Bob's Kart Shop, Brister Thunder Karts, Carter Brothers Manuf., Hamilton, Kartco Inc., Ken-Bar Manuf. Co., Manco Products Inc., T&D Metal Products Co., and U.S.A. Industries Inc. The engines were also sold separately to authorized distributors and dealers who may have resold them to consumers building homemade go-karts. Retail, specialty, and power equipment stores nationwide sold the fun-karts from 1992 through 1997 for between $600 and $2,000.
Problem: Fuel from the engine can spill out if the fun-kart overturns, posing serious fire and burn hazards to consumers. Briggs & Stratton has received nine reports of incidents involving fun-karts that overturned and caught fire, including four consumers who suffered burns.
What to do: Stop using the fun-karts immediately and contact a local Briggs & Stratton dealer for a free engine repair. Consumers also can contact Briggs & Stratton at (800) 999-9444 between 8 a.m. and 5 p.m. CT Monday through Friday, or log on to the company's website at **www.briggsandstratton.com** to arrange for the free repair or to find a local dealer.

PORTABLE BASKETBALL HOOP

Product: About 70,000 **portable basketball systems by Huffy Sports Company**. These are portable, vertically mounted Huffy-brand basketball systems that come unassembled with a plastic base weighted down by either sand or water added during assembly. The basketball poles are painted black and the Huffy brand name appears on the backboard, main pole, or plastic base. The protruding bolt on the player side of the pole is located about 20 inches from the ground. Sporting goods, department and toy stores sold the Huffy-brand portable basketball systems from November 2001 through May 2002 for between $100 and $200.
Problem: The basketball hoops can have a sharp protruding bolt on the player's side of the pole that can cause serious leg or body lacerations to consumers. Basketball players can be cut when they collide with the pole as they drive toward the basket or when they fall or are pushed into the pole. CPSC and Huffy Sports have received 11 reports of injuries that include scrapes and lacerations from protruding bolts. Ten consumers required stitches for their injuries.
What to do: Consumers should examine their units immediately. If there is a protruding bolt in the area of play, contact Huffy Sports to receive free bolt covers. Consumers can contact Huffy Sports at (800) 558-5234 between 8 a.m. and 4:30 p.m. CST Monday through Friday or the firm's website at **www.huffysports.com**.

TOY CHEST

Product: About 3,300 **toy chests by XL Machine Ltd**. These blue toy chests measure 18.5 inches by 12 inches by 12 inches, and were sold under the Playskool brand name. On the toy chest lid top are depictions of "Mr. and Mrs. Potato Head" characters and the "PLAYSKOOL" logo. The front panel has a "Glow Worm" figure and a dog. The bottom of the toy chests contains "DISTRIBUTED BY: XL MACHINE LTD, MINNEAPOLIS, MN 55347." The chests were made in China. Target stores sold the toy chest nationwide from October 2001 through December 2001 for about $50.
Problem: Screws in the chests' lid support hinges can loosen over time, and come out from the base of the toy chests. If this happens, the lids of the toy chests can collapse suddenly, possibly causing injuries to children's head, neck, fingers or hands. CPSC and XL have received one report of screws in the lid support hinge of a toy chest coming out, resulting in a bruise to the neck.
What to do: Consumers should take these toy chests away from young children immediately and return them to the Target store where it was purchased for a refund or store credit. For more information, contact XL Machine toll-free at (866) 746-8097 anytime, or go to Target's website at **www.target.com**.

LASER PRINTER

Product: About 100,000 **multi-function printers and laser printers by Brother International Corp. (Brother)**. The recall involves Brother laser printers with model numbers HL-1040, HL-1050, HL-1060, and multi-function printers with model number MFC-P2000. The model number can be found on the top of each unit and adjacent to the Brother® logo. The printers are beige or putty in color, and all were manufactured in China, with the exception of model HL-1060, which was manufactured in Japan. Retailers, dealers and office super stores nationwide sold these printers from June 1997 through December 2000 for between $300 and $700.
Problem: The printers can overheat, posing a fire hazard to consumers. Brother has received two reports of overheating and fire, with one of the incidents involving minor property damage. No injuries have been reported.
What to do: Stop using the recalled printers immediately and bring them to an authorized service center for a free repair. For more information or to determine the location of a local, authorized service center, call Brother toll-free at (866) 236-6835 between 9 a.m. and 7:30 p.m. ET Monday through Friday, or log on to the company's website at **www.brother.com/usa**.

DIGITAL CAMERAS

Product: About 75,000 **DC5000-model digital cameras worldwide by Eastman Kodak Company**. These are Kodak DC5000-model cameras. The brand name and model number are written on the front of the camera at the bottom right-hand corner. All DC5000 cameras carry a plate on the bottom of the camera containing the Kodak product identifier reading "KJCAA" followed by an eight-digit serial number. The serial number range is 01800001 through 11700825. This recall includes the DC5000 model only. No other Kodak cameras are affected by this recall. Department, electronic, computer and camera stores, as well as mail-order and web retailers sold these cameras nationwide from June 2000 through August 2002 for between $600 and $700.
Problem: Due to a manufacturing defect, consumers using these cameras can suffer an electrical shock. Kodak has received 12 reports, including six in the U.S., of consumers who experienced an electrical shock while changing batteries, or installing or removing the memory card or USB cable. There have been no reports of serious injury.
What to do: Consumers should immediately stop using the Kodak DC5000 Zoom Digital Camera and contact Kodak. The company will cover the cost of inspection, any necessary repair and shipping to and from Kodak repair centers. To receive a postage-paid mailer to return your camera, or for more information, contact Kodak online at **www.kodak.com**. Consumers also can contact Kodak toll-free at (888) 793-2977 between 9 a.m. and 8 p.m. ET Monday through Friday. For consumers outside the United States, please contact your local Kodak digital camera support center or visit **www.kodak.com**.

Product: About 9,100 **Coolpix 2000-model digital cameras imported into the United States by Nikon Inc**. The recall includes the Nikon Coolpix 2000-model digital cameras with serial numbers 3010001 to 3060980 and 3510001 to 3561916. The brand name and model number are located on the front of the camera, and the serial number is on the bottom of the camera. The camera is mostly silver-colored with lavender around the lens. Department, electronic, computer and camera stores, as well as mail-order and Web retailers sold these cameras nationwide from July 30, 2002 through August 2002 for about $250. No other Nikon products are involved in this recall.
Problem: A short circuit can occur in the battery compartment, creating a possible thermal burn hazard to consumers if the battery compartment lid is touched. Nikon has received 14 reports of these cameras shorting, but none occurred in the United States. No injuries have been reported. Minor heat damage to the battery compartment has been reported.
What to do: Consumers with a recalled Nikon Coolpix 2000 camera should immediately remove the batteries and contact Nikon to receive a free replacement Coolpix 2000 digital camera. For more information, contact Nikon at (800) 645-6687 between 9 a.m. and 7 p.m. ET Monday through Friday, or go to Nikon's website at **www.nikonusa.com**.

CEILING FAN

Product: About 60,000 **ceiling fans by Fanimation Design and Manufacturing Inc**. The recalled ceiling fans include the following models: the Islander series with model number FP320 and date codes 01-00 through 03-02; the Louvre series with model number FP1320 and date codes 01-00 through 03-02; and the Tropicana series with the model number FP1600 and date codes 12-01 through 04-02. The model number and date codes can be found on the manufacturer's sticker, located just above the motor of the fan. Lighting showrooms, fan specialty stores and electrical distributors nationwide sold the fans from February 2000 through July 2002 for between $550 to $850.
Problem: The hanger bracket can break, which could cause the fan to fall from the ceiling and seriously injure anyone standing nearby. Fanimation has received four reports of hanger brackets breaking, including three instances where the fan fell from the ceiling. No injuries have been reported.
What to do: Stop using the fans immediately and contact Fanimation at (888) 284-8938 between 9 a.m. and 5 p.m. CT Monday through Friday for a free, easy-to-install backup bracket. Customers will not have to disconnect the fan or remove the existing bracket. For more information, consumers can log on to the company's website at **www.fanimation.com**.

BABY WALKERS

Product: About 50,000 **baby walkers by Bikepro, Inc**. The recalled walkers are intended for babies age 6 months or older. The walkers are blue, green, pink and yellow. They have a musical tray, a thick foamed padded seat and some are equipped with stoppers on the side. These model numbers are recalled: 305, 308RK, 309STP, 384, 386, 388, 388STP, 389STP, 392STP, 393STP, 395 and 399STP. The model numbers are located on the outside of each box. The baby walkers bear a warning label that states in part: "WARNING: NOTE: NEVER LEAVE CHILD UNATTENDED" or "NEVER LEAVE YOUR BABY ALONE IN THIS BABY WALKER" or "USE ONLY FOR CHILDREN WHO CAN SIT UNASSISTED." The baby walkers may bear a label stating "BEBELOVE." Independent discount stores located in Arizona, California, Colorado, Texas, Michigan, Missouri and New York sold these baby walkers from January 2000 through August 2001 for between $18 and $22.
Problem: The baby walkers can fit through a standard doorway and are not designed to stop at the edge of a step. Babies using these baby walkers could be seriously injured or killed if they fall down stairs. Bikepro, Inc. has not received any reports of injuries involving these walkers. This recall is being conducted to prevent the possibility of injury.
What to do: Stop using these walkers immediately and return them to the store where purchased for a full refund. For more information, contact Bikepro, Inc. at (800) 261-2559 between 9 a.m. and 5 p.m. PT Monday through Friday.

Product: About 3,500 **baby walkers by Oriental International Trading Company**. This recall includes the "Honey" model baby walker. The walkers are intended for a baby 5 months and older. They were sold in blue, yellow or pink with a padded seat and an activity tray. Model numbers included in the recall are 820, 860, 862 and 802. The model numbers are printed on the seat backs. A warning label on the walker reads in part, "WARNING: Suitable for babies between five and ten months old." Independent discount stores located in Arizona, California, Texas, Illinois, North Carolina and New York sold these baby walkers from May 2001 through June 2002 for between $18 and $22.
Problem: The walkers will fit through a standard doorway and are not designed to stop at the edge of a step. Babies using these walkers can be seriously injured or killed if they fall down stairs. Oriental International Trading has not received any reports of injuries involving these walkers. This recall is being conducted to prevent the possibility of injury.
What to do: Stop using these walkers immediately and return them to the store where purchased for a full refund. For more information, consumers can contact Oriental International Trading Company at (866) 666-9868 between 9 a.m. and 5 p.m. PT Monday through Friday. Consumers can also visit the firm's website at **www.bike-stroller.com**.

— Carolyn T. Manley, Office of Compliance

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Consumer Product Safety Review is published quarterly by the U.S. Consumer Product Safety Commission, Washington, DC 20207.
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