U.S. Consumer Product Safety Commission

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IN THIS ISSUE

CONSUMER PRODUCT SAFETY REVIEW

SUMMER 1997
VOL. 2, NO. 1

Improving Pool and Spa Safety

Body entrapment and hair entanglement in pool and spa drains, as well as disembowelments of small children in public wading pools, have captured public attention in recent years.

To increase the safety of swimming pools and spas, the U.S. Consumer Product Safety Commission's (CPSC) staff will recommend guidelines for identifying and addressing these hazards. These guidelines, when approved by the Commission, should be useful for pool owners and operators, park and recreation personnel, public health organizations, equipment purchasers and installers, and inspection officials, as well as individual consumers.

Over the years, CPSC has worked on numerous voluntary safety standards for pools and spas. (For more on drowning, the number one cause of death associated with pools and spas, see *Preventing Drownings*, page 2.)

Hazards

Three general hazard patterns are involved in the pool and spa incidents involving entrapment. For example, CPSC staff is aware of 30 incidents since 1990 involving long hair entanglement in the drain grates of spas and hot tubs, which resulted in 10 deaths.

These cases typically involved a female with long hair, who was underwater with her head near a suction drain. The water flow to the drain swept the hair into and around the drain cover, and the hair became entangled in the cover's holes and protrusions.

Another hazard scenario involved some portion of the body being held against the drain by the circulation pump's suction. CPSC staff knows of nine cases, including 7 deaths, since 1990. There were six incidents in spas, two in swimming pools, and one in a wading pool. Children, ages 8 to 16, were primarily involved.

In at least five cases, a missing or improperly installed drain cover appeared to contribute to the incident. In some instances, the child apparently played with the open drain (for example, inserting a hand or foot in the pipe) and then became trapped by the resulting suction. In one case, a girl, 16, died after being trapped on a 12-inch by 12-inch flat drain grate in a large public spa.

Disembowelment is yet another hazard associated with these products. Between 1980 and 1986, 13 incidents of disembowelment were reported to CPSC. Since 1990, CPSC staff is aware of a boy, 3, and girl, 5, who were partially disemboweled when they sat on the single drain of a public wading pool. In both cases, the children suffered serious permanent injuries.

The disembowelment scenarios typically involved young children, ages 2 to 6. The incidents occurred primarily in public wading pools where a floor drain cover was broken or missing. When the child's buttocks covered the drain opening, the resulting suction force eviscerated the child through

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the ruptured rectum. CPSC staff is not aware of any deaths in this scenario, but the irreversible damage severely affected the child's future health and development.

CPSC Staff Guidelines

The new CPSC staff-recommended guidelines will address the manufacture, installation, retrofitting, and maintenance of pool and spa equipment. The voluntary guidelines are expected to stress that the manufacturers' instructions for maintenance, inspections, and repairs be strictly followed.

To prevent suction-related injuries, several important steps need to be taken. For example, installing a multiple drain system prevents a single pump from providing full suction capability to a single drain opening. The state of North Carolina currently requires new wading pools to be built with at least two main drains per pump, and existing wading pools to be retrofitted with two outlets per pump.

In addition, secure anchoring of the main drain cover and other suction ports is essential. Drain covers should be manufactured and installed according to ASME/ANSI voluntary standards. All fasteners used to affix drain covers should not loosen or be removable without tools and should be corrosion-resistant.

Proper maintenance is particularly important, and a comprehensive maintenance program needs to be developed for each facility. For example, all drain covers, skimmers, and other equipment should be inspected frequently for corrosion, deterioration, missing or broken parts, and any other potential hazards.

If a potential hazard is identified, a qualified pool maintenance professional should be contacted immediately. Corrections might be as simple as installing approved fasteners (corrosion-resistant screws) to the drain cover. Or, the suction drain system might need to be completely reworked or redesigned to eliminate a single drain, single pump setup.

In addition, a record of any injuries at the facility should be collected. This helps identify potential hazards or dangerous features.

— *Troy Whitfield, Directorate for Engineering Sciences*

For More Information

For a copy of CPSC's guidelines on pool and spa entrapment hazards, contact:

Office of the Secretary
U.S. Consumer Product Safety Commission
Washington, DC 20207
301-504-0800

Preventing Drownings

The single greatest hazard associated with swimming pools, spas, and hot tubs is drowning. Young children are particularly at risk. Each year, about 300 children under age 5 drown in residential pools nationwide. Since 1980, CPSC has reports of more than 700 adult and child deaths in spas and hot tubs. About one-third of those were drownings to children under age 5.

Taking the following precautions with pools, spas, and hot tubs will help reduce the risk of a tragedy.

- *Limit access*. Physical barriers provide an important layer of security. For example, fences or walls, at least 4 feet high, should be installed completely around a pool. Fence gates should be self-closing and self-latching. A power safety cover, a motor-powered barrier, can be placed over the water area. For spas and hot tubs, use a locked safety cover.

- *Supervise children*. Constant supervision of children around water is essential. Flotation devices should never be used as a substitute for supervision. Knowing how to swim doesn't make a child drownproof. Drownings occur quickly and silently, often without any splashing or screaming. If a child is missing, always look first in the pool, spa, or hot tub.

- *Be prepared for emergencies*. Be sure rescue equipment and a phone with emergency numbers are close by. Responsible adults and teenagers should know CPR (cardiopulmonary resuscitation).

For a single free copy of CPSC's *Safety Barrier Guidelines for Home Pools* and *How to Plan for the Unexpected*, write:

U.S. Consumer Product Safety Commission
Washington, DC 20207

or visit CPSC's web site at
www.cpsc.gov and click on "Library".

Reducing ATV Injuries

Since 1982, an estimated 1,191,000 people have been treated in U.S. hospital emergency rooms for injuries associated with all-terrain vehicles (ATVs).[1] During that time, CPSC has received reports of nearly 3,000 ATV-related deaths.[2]

An ATV is a three or four-wheel motorized vehicle, with large, low-pressure tires, a seat designed to be straddled by the user, and handlebars. It is intended for off-road use by an individual rider on non-paved terrain.

CPSC Chairman Ann Brown recently held an all-day forum to discuss ATV-related safety issues. The public meeting was attended by state officials, consumer representatives, rider groups, technical experts in the ATV field, and other interested parties from across the country.

History of CPSC Actions

As ATVs gained in popularity in the early and mid-1980s, reports to CPSC indicated that injuries and deaths to ATV users were high. In 1986, for example, an estimated 108,000 ATV users were admitted to hospital emergency rooms with injuries, and an estimated 347 ATV users were killed. Of those injured, approximately 45% were children under age 16.

In December 1987, the Department of Justice, on behalf of CPSC, filed a lawsuit against the five ATV distributors alleging that ATVs constituted an imminent hazard under section 12 of the Consumer Product Safety Act. On April 28, 1988, the suit was settled with court approval of a 10-year consent decree negotiated by the parties.[3]

The decree required, among other things, that the distributors stop the sale of new three-wheel ATVs (associated with many incidents) and repurchase all new three-wheel ATVs in dealer inventory. The decree also prohibited the sale of adult-sized ATVs for children under 16.

In addition, the decree required that the distributors include specified warning information with the ATVs and offer a free ATV training course to purchasers and their families. The industry also was required to make good faith efforts to develop a voluntary standard for ATVs. The standard, approved by CPSC in 1989, addressed a wide range of design, configuration, and performance aspects of ATVs.

Injury Data

Since these actions in the 1980s, ATV-related deaths and injuries have declined. From 1990 on, for example, the average annual injury estimate has been about 62,000. The estimate of deaths for 1994 (the most recent year of complete data) is 237.

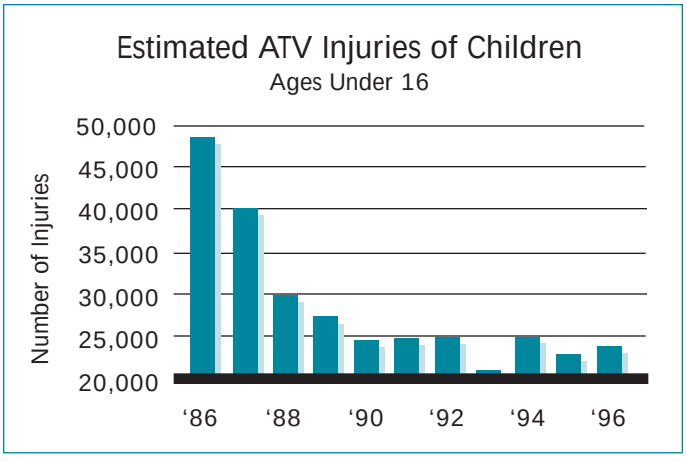

Figure 1

The estimated number of injuries to children under 16 also has declined. In 1986, an estimated 48,400 children entered hospital emergency rooms with ATV-related injuries. This dropped to an average of about 23,000 children a year in the 1990s (Figure 1).

The annual percentage of all ATV-related injuries for children under 16 declined from 45% in 1986 to about 38% in subsequent years.

These figures show that while ATV-related deaths and injuries declined sharply in the late 1980s, they have remained relatively constant through the 1990s.

Further Actions

The ATV consent decree expires in April 1998. With this in mind, CPSC Chairman Ann Brown convened the ATV public forum to gather information on ATV safety and to obtain specific recommendations on actions CPSC should consider. To aid the decision-making process, CPSC staff is currently conducting a special in-depth study of ATV-related injury hazard patterns.

For a copy of the ATV forum proceedings, contact: Office of the Secretary, U.S. Consumer Product Safety Commission, Washington, DC 20207/ 301-504-0800.

— Scott Heh, Directorate for Engineering Sciences

References

1. CPSC. National Electronic Injury Surveillance System (NEISS).
2. CPSC. Medical Examiners and Coroners Alert Project (MECAP).
3. United States v. American Honda Motor Co., Civ. No. 87-3525 (D.C.C.).

Fireworks Safety

In a special study, CPSC staff found that firework-related injuries treated in U.S. hospital emergency rooms dropped from an estimated 8,200 in 1995 to 5,100 in 1996 for the one-month period of heaviest use around the July 4th holiday.[1]

Children, ages 14 and under, suffered an estimated 24% of these firework-related injuries. Teenagers, ages 15 to 19, accounted for 18% of the estimated injuries. Injury rates per 100,000 were highest among those victims ages 15 to 19 and 20 to 24 (Figure 2).

Most of the firework-related injury victims (72%) were males. Those using the firework device suffered 49% of the injuries; bystanders sustained 31% of the injuries. Information pertaining to the remaining 20% of injured victims was unknown.[2]

Severity of Injuries

Most injuries (over 80%) were to the hands, eyes, and head from either burns or contusions. The most frequent injuries to hands were burns, while head and eye injuries were mainly contusions or lacerations.

Injuries were reported as either treated and released or hospitalized, after the initial emergency room visit. About 10% of the 1996 estimated firework-related injuries were serious enough to require hospitalization. This was more than twice the average hospitalization rate for injuries associated with other consumer products.

Based on follow-up information obtained from the survey, 40% of all injuries required additional medical care beyond the initial emergency room visit or hospitalization. Sixty percent of these victims were expected to recover or have fully recovered; roughly 10% sustained lasting effects. Outcomes in the remaining incidents were unknown.

CPSC Actions

To reduce these injuries, CPSC enforces several regulations addressing the potential hazards associated with fireworks. CPSC recently issued a performance requirement addressing the tip-over hazard with large multiple-tube mine and shell fireworks. This became effective in March 1997. CPSC also amended its fuse burn regulations in 1997 to reduce further the risk of injuries from short-fuse burn times of fireworks (except firecrackers). In addition, CPSC staff continues to participate in the development of voluntary safety standards.

To ensure that fireworks comply with CPSC regulations, the staff conducts an extensive surveillance program throughout the year. Since most fireworks are imported, CPSC works with the U.S. Customs Service to monitor shipments from overseas. Fireworks samples are sent to CPSC for testing. Shipments that fail to comply with regulations can be prevented from entering the country.

The CPSC staff also works closely with other federal agencies involved in regulating explosives, such as the Department of Transportation and the Bureau of Alcohol, Tobacco, and Firearms. In addition, each year before the July 4th holiday, CPSC holds a news conference and conducts an educational campaign on fireworks safety. These events alert the public to the potential hazards associated with fireworks and publicize guidelines for their safe use. CPSC encourages consumers to attend public firework displays rather than use firework devices on their own.

— Ron Monticone and Michael A. Babich, Ph.D., Directorate for Epidemiology and Health Sciences, and Carolyn K. Meiers, Division of Human Factors, Directorate for Engineering Sciences

References

1. These estimates were derived from CPSC's annual special study of firework-related injuries conducted between June 23 and July 23, 1996. The lower 1996 injury estimate was the result of a general decline in the reporting of firework-related injuries throughout the national sample of NEISS hospital emergency rooms. CPSC's National Electronic Injury Surveillance System (NEISS) is a statistical sample of the approximately 6,000 hospitals nationwide that have emergency departments. One hundred sample hospitals participated in the NEISS system in 1996. Each day, NEISS hospitals report to CPSC all emergency room-treated injuries associated with consumer products and related activities.

2. Monticone, R. 1996 firework injuries. Washington, DC: CPSC, 1997.

Firework Injuries By Age and Sex
(Special Study/1996)

Age Group	Male	Female	Total	Injuries per 100,000
14 and under	915	285	1,200	2.1
15 to 19	510	390	900	4.9
20 to 24	655	100	755	4.3
25 and older	1,400	545	1,945	1.1
Unknown	190	110	300	—
Total	3,670	1,430	5,100	1.8

Figure 2

Child-Resistant Packaging

CPSC recently required that the new over-the-counter painkiller, ketoprofen, be marketed in child-resistant packaging.[1] Under the Poison Prevention Packaging Act (PPPA), CPSC has taken similar action for other non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen and naproxen.

NSAIDs are used for fever reduction and the temporary relief of pain associated with various conditions. These include the common cold, headaches, arthritis, and menstrual cramps.

Ketoprofen, like ibuprofen and naproxen, was once only available by prescription (Rx) and subject to CPSC's child-resistant packaging requirements. When the Food and Drug Administration approved these drugs to be sold over-the-counter (OTC) without a prescription, the PPPA's special packaging requirements for oral prescription drugs no longer applied.

Ibuprofen was the first NSAID to make the Rx-to-OTC switch in 1984. Some manufacturers began marketing it without child-resistant packaging, and accidental ibuprofen ingestions by children under age 5 increased. CPSC then required child-resistant packaging for ibuprofen and has taken similar action for subsequent NSAIDs sold over-the-counter.

Before requiring child-resistant packaging, however, CPSC must make several findings. For example, a product must potentially cause serious injury or illness to young children, and special packaging for the product must be technically feasible, practicable, and appropriate.

With ketoprofen, CPSC staff determined that serious adverse effects could occur. These included ulcers, and liver and renal toxicity. In addition, child-resistant packaging was readily available at a low incremental cost.

The two companies marketing OTC ketoprofen recognized its potential to cause serious toxicity in small children. Even before the rule became effective, the companies voluntarily used child-resistant packaging. A mandatory requirement ensures that future manufacturers use child-resistant packaging for ketoprofen and that the packaging meets CPSC's performance standards.

— *Jacqueline Ferrante, Ph.D., Directorate for Epidemiology and Health Sciences*

References

1. 62 Fed. Reg. 28798 (May 28, 1997).
2. Rodgers, GB. The safety effects of child-resistant packaging for oral prescription drugs: two decades of experience. JAMA 1996;275(21):1661-1665.

Saving Lives

For more than two decades, CPSC has enforced the Poison Prevention Packaging Act (PPPA) that requires child-resistant packaging for various drugs and household products.

A CPSC economist published an article in the *Journal of the American Medical Association* that underlined the importance of child-resistant packaging.[2] He calculated that child-resistant packaging reduced the death rate from oral prescription drug poisonings by 45% since 1974, when the PPPA rule began requiring child-resistant packaging. This translated into 460 lives saved from 1974 to 1992.

Even though child-resistant packaging has saved lives, some adults have had difficulty opening the packaging. This led people to defeat the child-resistant packaging by throwing the caps away, leaving the packaging open, or transferring hazardous substances into other non-child-resistant packaging. About 20% of childhood poisonings have been associated with medications belonging to grandparents or other relatives.

CPSC revised its child-resistant packaging regulations last year to ensure that packaging is both child-resistant and "adult-friendly." This is accomplished by testing the packaging with both children under age 5 and with adults ages 50 to 70.

Some adult-friendly child-resistant packaging is already on the market. It will continue to be phased in until January 1998, when most child-resistant packaging must meet the new requirement. (See article on *Safety at Home and Abroad*, page 7.)

Shopping Carts: Buckle Up

Falls from shopping carts are a leading cause of head injury for young children. About half of these injuries are likely to be categorized as severe.[1]

To address these incidents, CPSC recently helped develop a national shopping cart safety program. The other organizations in this effort included the National SAFE KIDS Campaign, the Food Marketing Institute, Johnson & Johnson, and the Safe-Strap Company, Inc. The goals of the campaign are to make safety straps available for every shopping cart and to remind parents to "buckle up" young children.

From 1985 to 1996, an annual average of 21,600 children, ages 5 and younger, were treated in U.S. hospital emergency rooms for all shopping cart injuries. The estimated number of injuries increased significantly during these years, from 16,900 in 1985 to 22,200 in 1996.

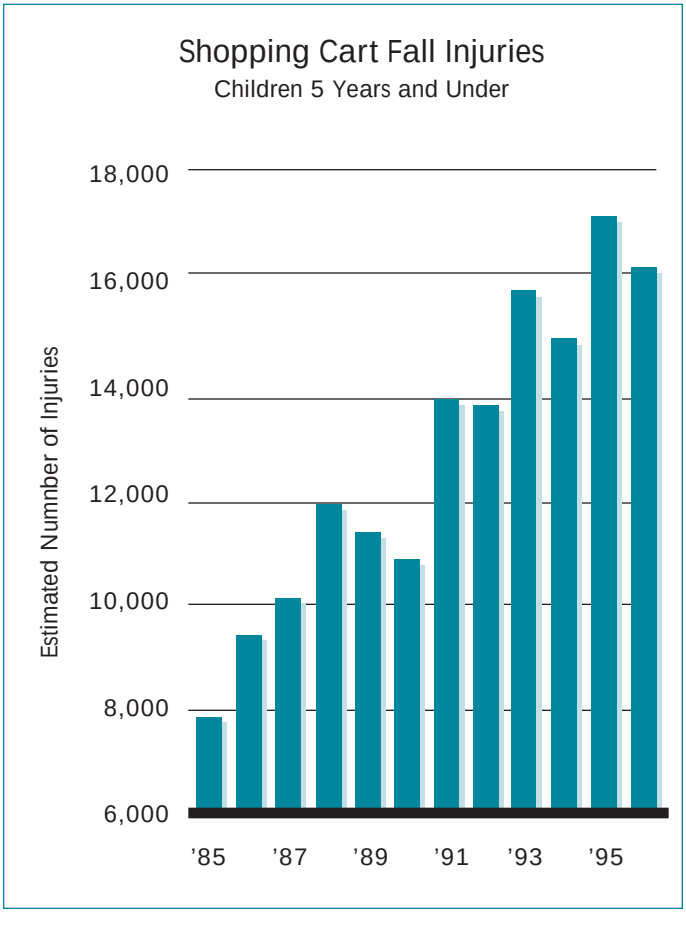

Figure 3

Many of these injuries were fall-related. In fact, from 1985 to 1996, fall-related injuries increased, while other hazard patterns declined. For example, in 1985, fall-related injuries numbered 7,800; in 1996, more than 16,000 injuries were associated with falls (Figure 3).

Of the fall victims during 1995 and 1996, 66% were treated for head injuries in hospital emergency rooms. Fifty-four percent of these head injury victims (or 5,940 children) suffered severe injuries, such as concussions and fractures.

A 1994 CPSC special study showed that 51% of the fall victims fell from the seat of the shopping cart. Forty-nine percent fell from the basket.

The shopping cart safety campaign consists of several elements. One million discounted shopping cart safety straps will be made available to grocers in local communities; some straps will be provided free. Educational materials, for consumers and for grocery stores and their employees, will be distributed nationwide. Local consumer groups also will help educate grocers. Consumers are advised to use safety straps in shopping carts with young children and, if the straps are unavailable, to request them from individual store managers.

Consent decrees in two states, Texas and New York, require shopping cart manufacturers to equip every new cart sold and distributed in their state with a safety strap.

— Jacqueline Elder, Office of Hazard Identification and Reduction

Reference

1. CPSC. National Electronic Injury Surveillance System (NEISS).

Bean Bag Chairs

Two boys, ages 6 and 13, zipped themselves inside a bean bag chair and suffocated to death. A 4-year old boy crawled inside a bean bag chair and suffocated when his 3-year old brother closed the zipper. A boy, 14, went inside a large bean bag chair filled with foam pellets. Unable to get out, the boy suffocated when the foam pellets clogged his nose and throat.

From 1973 to 1995, CPSC received reports of 5 deaths and 26 non-fatal incidents associated with bean bag chairs.[1] Victims ranged in age from 14 months to 14 years. Typical hazard patterns for deaths or injuries included suffocation from being inside the bag and from pellets clogging breathing passageways; choking from pellets in the mouth; and earaches from pellets in the ear. Some of the children were hiding inside the bean bag chair. One

child zipped himself in, reportedly pretending it was a space capsule.

To address this hazard, CPSC staff has negotiated corrective action programs with 16 known bean bag chair manufacturers since 1994. The manufacturers, which represent 90% to 95% of the bean bag industry, have voluntarily recalled zippered bean bag chairs distributed to consumers and retailers nationwide and rendered the zippers inoperable. More than 12 million zippered bean bag chairs were subject to the manufacturers' corrective actions.

New Voluntary Standard

At CPSC's staff urging, the industry also developed a voluntary standard for bean bag chairs. The standard's performance requirements, effective in November 1996, modify the bean bag chair's design to prevent toddlers and young children from opening the chair's zipper. Specifically, chairs intended to be refilled must have a locking zipper that opens only with a special tool. Chairs not intended to be refilled must have a permanently disabled zipper or no zipper.

In addition, the requirements include permanent warning labels for bean bag chairs. The label wording differs, depending on whether the chairs can be refilled. Durability testing is also part of the standard. This is intended to ensure that materials, which could tear easily and allow pellets to escape and be inhaled, are not used in manufacturing bean bag chairs.

— Susan B. Kyle, Ph.D., Directorate for Epidemiology and Health Sciences, and Judith Hayes, Office of Compliance

Reference

1. CPSC. National Electronic Injury Surveillance System (NEISS) and Medical Examiners and Coroners Alert Project (MECAP).

Safety at Home and Abroad

CPSC staff made presentations on pictogram testing and child-resistant packaging at the 5th International Conference on Product Safety Research, sponsored by the European Consumer Safety Association (ECOSA). The conference was held in Barcelona, Spain, in April 1997, with attendees from Europe, the United States, Canada, and Australia.

Pictogram Testing

One CPSC paper discussed pictogram testing for the CPSC-required revised warning label for packages of charcoal. All charcoal packages filled on or after November 1997 must contain this new pictogram. The previous warning label did not contain a pictogram.

Each year in the United States, about 30 people die of carbon monoxide poisoning associated with the burning of charcoal in enclosed areas, such as homes, vehicles, and tents. Many victims are ethnic minorities, including Asian and Hispanic, who may not read English.

To address this issue, CPSC staff tested several pictograms communicating the safety message that charcoal should never be burned in enclosed areas. Test subjects included individuals expected to have difficulty understanding a conventional, written warning label. The pictogram best understood by the most people was selected for the new warning label on charcoal packages.

Pictograms interest the international community because of the diversity of languages and the need to standardize safety warnings and signs.

Child-Resistant Packaging

The second presentation, a poster display on child-resistant packaging standards, detailed the test procedures for ensuring that this packaging also is not difficult for adults to use (adult-friendly). For example, the new CPSC adult-test procedure replaces the original test panel of people, ages 18 to 45, with a panel of adults, ages 50 to 70.

In addition, the U.S. test procedures and requirements were compared with those developed by the International Organization for Standardization (ISO). The most notable difference is the scope of packaging covered by the requirements. The ISO standards apply only to reclosable packaging.

In the U.S., however, any type of package that contains a regulated substance must meet the child-resistant standards. For example, unit-dose blisters, which are nonreclosable, must be child-resistant if they contain a regulated substance. Under the Federal Poison Prevention Packaging Act, 25 different substances require child-resistant packaging, including oral prescription drugs, ethylene glycol, methanol, sulfuric acid, aspirin, and acetaminophen.

The next ECOSA conference will be in Amsterdam in May 1998. For information, contact: Willem van Weperen, e-mail scvnl@xs4all.nl.

— Suzanne Barone, Ph.D., Directorate for Epidemiology and Health Sciences

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 February and March 1997, 428 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, 24, was sitting or fell on a subway escalator step. His upper body clothing became jammed in the escalator's bottom comb plate. The victim called for help. Emergency personnel arrived, cut the victim's clothing free, and administered CPR. The victim was taken to the hospital, where he was pronounced dead. The cause of death was strangulation. (Michael Garvey for Dr. Garcau, Medical Examiner and Dr. Germaniack, Chief Medical Examiner, Washington, DC)

*A female, 2 months, was fed and put down for a nap in her crib. The victim was later found with her head wedged between the crib slats. The cause of death was asphyxia. (Leah Bush, M.D., Medical Examiner, Tidewater District, Norfolk, VA)

*A female, 3, was playing on a jungle gym with a rope attached to the gym equipment. An older sister found the victim with her neck entangled in the rope. The cause of death was asphyxia. (Paul Branam for Dr. Floro, Medical Examiner, Duval County, Jacksonville, FL)

*A male, 4 months, was found unresponsive under a crib mattress. He was taken to the hospital where he was pronounced dead. The cause of death was positional asphyxia. (Dr. Gore, Medical Examiner, Orlando, FL)

*A male, 5 months, was found wedged between the mattress and a side rail of his crib. The cause of death was positional asphyxia. (Sue Townsend, Coroner, Aiken County, Aiken, SC)

*A male, 9 months, was put to sleep on a bed and later found with a window blind cord wrapped around his neck. The cause of death was strangulation. (Lorraine Siciliano for Stephen P. Adams, M.D., Deputy Chief Medical Examiner and Paul L. Morrow, M.D., Chief Medical Examiner, Burlington, VT)

*A male, 19 months, fell from the top of a wooden bunk bed and became trapped between the bed and the wall. He was found hanging with his head wedged between the top rails and his body wedged between the bed and the wall. The cause of death was asphyxia. (Jacqueline M. Dobbins for Edmund R. Donoghue, M.D., Chief Medical Examiner, Cook County, Chicago, IL)

*A male, 3, attempted to get his pajamas out of a chest of drawers. The chest fell over, pinning him to the floor. The cause of death was asphyxia. (Kevin P. Murray, Medical Examiner, Norfolk, VA)

A male, 5 months, was fed and put to sleep on a waterbed. Two hours later, the victim was found not breathing and wedged between the mattress and waterbed frame. The cause of death was positional asphyxia. (Nancy Moore for Charles L. Garrett, M.D., Medical Examiner and John Butts, M.D., Chief Medical Examiner, Chapel Hill, NC)

POISONINGS

A female, 9, went to sleep in a small trailer next to her family's home travel trailer. The small trailer was heated with a propane stove vented through the roof. The vent, which was usually left open, had closed. The cause of death was carbon

monoxide poisoning. (Diane Stephans for R.D. Felton, Medical Investigator and Tim Hindmarsh, M.D., Medical Examiner, Lynn County, OR)

A male, 18, died in his basement bedroom from the carbon monoxide released from a faulty gas water heater. When other family members awoke in the morning, they felt sick and called "911." Readings were taken for carbon monoxide, and the highest concentration was found in the basement. The cause of death was carbon monoxide poisoning. (Eugene Bombich for Richard Kik, M.D., Deputy Medical Examiner, Kalamzoo County, MI)

DROWNINGS

A male, 2, was being cared for by his father, who fell asleep. The victim went through an unlocked rear screen door, climbed on a plastic chair, and entered a 3-foot above-ground pool. When the father woke up, he found the child floating face down in the pool. The cause of death was drowning. (Mary H. Dudley, M.D., Medical Examiner and George E. Bolduc, M.D., Chief Medical Examiner, Maricopa County, Phoenix, AZ)

A female, 11 months, was found dead floating in a backyard swimming pool. The victim gained access to the pool through a 68-inch wide opening on the side of the fence which surrounded the pool. The fence was under repair at the time of the incident. The cause of death was drowning. (Angelo K. Ozoa, M.D., Medical Examiner-Coroner, Santa Clara County, San Jose, CA)

*A male, 7 months, was in a baby bath ring in a tub with 6 inches of water. The mother left the bathroom to dress a 2 year-old sibling. When the mother returned, she found the baby out of the ring, lying face down in the water. The bath ring's suction cups were still attached to the bathtub. The cause of death was drowning. (Jacqueline M. Dobbins for Edmund R. Donoghue, M.D., Chief Medical Examiner, Cook County, Chicago, IL)

*A female, 11 months, was discovered, head-down, in a half-filled bucket of water and bleach-cleaning solution. The bucket was a five-gallon plastic utility bucket. The victim's mother had left the room for approximately 10 minutes. The cause of death was drowning. (Stephen L. Putthoff, D.O., Deputy Medical Examiner, Fort Worth, TX)

FIRES

A male, 5, was the victim of a house fire, which was caused by a faulty lamp. The cause of death was smoke inhalation and thermal burns. (Mary Coffman for Jeffrey Barnard, M.D., Medical Examiner, Dallas County, Dallas, TX)

A female, 87, was cooking dinner on a gas stove. Her sleeve caught fire and ignited her robe. The cause of death was complications of thermal injury. (Alisa Mills for Nicholas T. Forbes, M.D., Chief Medical Examiner, Rochester, NY)

*A male, 12, died in a house fire started by a faulty clothes dryer. All other members of his family escaped unharmed. The cause of death was carbon monoxide poisoning. (Sue Townsend, Coroner, Aiken County, Aiken, SC)

A male, 66, died in a fire in his house trailer. The fire was started when he poured gasoline into a wood-burning stove. The cause of death was carbon monoxide poisoning. (Barbara Gage for James Beyer, M.D., Chief Medical Examiner, Northern Virginia District, Fairfax, VA)

ELECTROCUTIONS

A female, 36, was cleaning her porch by spraying it with water. She bent down to pick up a light that had an exposed wire. She collapsed and was pronounced dead at the hospital. The cause of death was electrocution. (Ann L. Bucholtz, M.D., Medical Examiner and George E. Bolduc, M.D., Chief Medical Examiner, Maricopa County, Phoenix, AZ)

A male, 31, died while working on a faulty washing machine. The cause of death was electrocution. (Chris Leja for Arkady Katsnelson, M.D., Medical Examiner, Farmington, CT)

MISCELLANEOUS

*A male, 23, was riding his new skateboard down a smooth, freshly-paved driveway. He was not wearing a helmet. As reported by a friend, the skateboard's wheels wobbled, which caused the victim to drift to the road's edge. The victim fell off the skateboard, hitting his head on the pavement. The cause of death was subdural hematoma. (Mark Ihde, Sheriff-Coroner, Sonoma County, Santa Rosa, CA)

A female, 12, died after a bookcase at school fell on top of her. She had just struggled to remove a book from the shelf and was walking away, when the bookcase fell over. The bookcase was not bolted down. The cause of death was brain injury. (Lorraine Siciliano for Stephen P. Adams, M.D., Deputy Chief Medical Examiner and Paul L. Morrow, M.D., Chief Medical Examiner, Burlington, VT)

— Suzanne Newman, Directorate for Epidemiology and Health Sciences

Recent CPSC Recalls

The following voluntary recalls were conducted by firms in cooperation with CPSC. For more information about CPSC recall activities, you can access CPSC press releases on the Internet at http://www.cpsc.gov or CPSC's gopher site at cpsc.gov.

Product: About 1.2 million Evenflo Company **portable play yards**, sold under the Happy Camper, Happy Cabana, and Kiddie Camper model names. These play yards were sold nationwide since January 1990 for about $60 to $130.
Problem: If the hinges on the product are not fully rotated, the product can collapse, possibly trapping the child in the "V" formed by the folded top rails. If leaned or sat upon, the rotating plastic hinges in the middle of the folding top rails can crack or break. Evenflo and CPSC are aware of 3 deaths involving the play yard. Evenflo has received 107 reports of children receiving cuts and bruises from broken hinges and has replaced about 6,000 portable play yards for hinge-related problems.
What to do: All owners should call Evenflo at 1-800-447-9178 to receive free hinge covers. If play yard has cracked or broken hinges, stop using it and ask for a replacement play yard.

Product: About 355,500 Cosco Quiet Time™ **wind-up infant swings**, Models 08-975 and 08-977, with date codes from 0593 through 4095. The model number and date code are located on a label on the underside of the swing's seat. These swings were sold nationwide beginning in February 1993 for about $45 to $49.
Problem: Screws connecting the tubular metal hanger and seat support can loosen and fall out, causing the seat to fall. Infants can be injured from the fall. Cosco has over 300 complaints about the screws, including 44 reports of injuries such as bumps and bruises and one concussion.
What to do: Stop using the swing and call Cosco at 1-800-221-6736 for a free repair kit.

Product: About 17,000 Fisher-Price **toy police cars** sold in the Little People® Roadside Rescue™ vehicle set. The toys were sold nationwide since February 1997 for about $8.
Problem: The back of some police cars could crack and break apart, presenting a potential choking hazard to young children. No injuries have been reported.
What to do: Call Fisher-Price at 1-888-407-6479 for a free replacement vehicle.

Product: About 277,000 Husqvarna **chain saws**, Model Nos. 42, 51,55,242, and 254 with serial numbers beginning with 531 and below, and Model Nos. 61 and 257 with serial numbers beginning with 324 and below. The chain saws are orange and have "Husqvarna" printed on both sides of the motor. These chain saws were sold nationwide for $400 to $600.
Problem: Heat from the muffler can damage the front hand guard if the removable exhaust deflector is not attached properly. A damaged hand guard exposes consumers to a risk of injury from the chain. Husqvarna has received one report of a death and one report of a serious hand injury after the base of the saw's hand guard melted.
What to do: Stop using the chain saw and take it to the nearest authorized Husqvarna dealer for free replacement of the muffler and any hand guards with heat damage. Call Husqvarna at 1-800-438-7297 for information.

Product: About 100,000 Sears DieHard **battery chargers**, Model No. 200.71310, made by Schumacher Electric Corp. The recalled battery chargers have date codes H961 through H972 molded into the plastic base. Battery chargers with the number 1682 on a white sticker on the back of the charger have been modified and are not recalled. Sears sold the battery chargers for about $65 from January 1996 through February 1997.
Problem: The battery charger could short, causing the transformer to overheat posing a potential fire hazard. CPSC is aware of one alleged fire involving this battery charger. No injuries resulted.
What to do: Return the charger to the nearest Sears Auto Center, Sears Hardware store, or Sears Dealer store for a free replacement. For information, call Sears at 1-800-SEARS64.

Product: About 63,000 Graco Stationary Entertainers with **white plastic seat rings** under a padded seat cover. The Entertainer has a rotating seat surrounded by a plastic tray with attached toys. The tray is supported by three adjustable legs. These Entertainers were sold nationwide beginning in November 1995 for about $59 to $69. Entertainers with yellow seat rings are not recalled.
Problem: The white plastic seat ring has sharp edges that can cut or scratch a child's legs during use. Graco has more than 400 reports of children's legs being cut, scratched, or scraped.
What to do: Stop using the Entertainer and call Graco at 1-800-423-9078 for a free replacement seat ring.

Product: About 57,000 **fleece fabric garments** sold by Levi Strauss & Co. under the Levi's® Jeans for Women, Dockers® Khakis for Women, and Dockers® Authentics for Men labels. The shirts are made of a cotton-polyester blend fabric with a raised fiber surface often called sherpa. The recalled garments have product codes 55930, 55956, 53601 54601, 53604, 54604, 53605, 54605, or 67191. The product codes are inside the garment on the care label. These garments were sold from August 1995 to February 1997 for about $25 to $30.
Problem: The fabric in some of these garments was found not to comply with federal standards for flammability. Levi Strauss & Co. is recalling others because the fabric may fail. Fabrics that do not comply with the federal standard typically burn faster than newspaper. One incident of a shirt flaring up when exposed to flame has been reported; no injuries resulted.
What to do: Return the garment to the store where purchased for a full refund. For information call Levi Strauss & Co. at 1-800-USA-LEVI.

— Marc Schoem, Office of Compliance

Consumer Product Incident Report

Please contact us about any injury or death involving consumer products. Call us toll free at: 1-800-638-2772. Or, fill out the form below. Send it to: U.S. Consumer Product Safety Commission/EHDS, Washington, DC 20207 or fax it to: 1-800-809-0924. We may contact you for further details. Please provide as much information as possible. Thank you.

YOUR NAME

YOUR ADDRESS

CITY STATE ZIP

YOUR TELEPHONE

NAME OF VICTIM (IF DIFFERENT FROM ABOVE)

ADDRESS

CITY STATE ZIP

TELEPHONE

DESCRIBE THE INCIDENT OR HAZARD, INCLUDING DESCRIPTION OF INJURIES

VICTIM'S AGE SEX DATE OF INCIDENT

DESCRIBE PRODUCT INVOLVED

PRODUCT BRAND NAME/MANUFACTURER

IS PRODUCT INVOLVED STILL AVAILABLE? ☐ YES ☐ NO PRODUCT MODEL AND SERIAL NUMBER

WHEN WAS THE PRODUCT PURCHASED?

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

U.S. Consumer Product Safety Commission
Washington, DC 20207

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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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