

U.S. Consumer **Product Safety** Commission

Ann Brown, Chairman Mary Sheila Gall, Commissioner

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CONSUMER PRODUCT SAFETY REVIEW

Safe Sleeping for Babies

In order to help reduce infant deaths from Sudden Infant Death Syndrome (SIDS) and suffocation, the U.S. Consumer Product Safety Commission (CPSC) and Gerber Products Co. recently released a national survey on babies' sleeping environment. Survey results found that most families still place their babies to sleep in ways that increase the risk of SIDS.

Sleep practices or environments considered unsafe include placing babies to sleep on their stomachs or sides and putting soft bedding, such as quilts, comforters, or pillows, in the crib of a baby under one year old.

The survey found that African-American families are more likely to place their babies to sleep in ways that increase the risk of SIDS. National infant mortality statistics show that African-American babies are twice as likely to die from SIDS as other babies.

Less than half (43%) of all parents surveyed nationally said they place their babies to sleep on their backs. Among African-American parents, 31% said they put their babies to sleep on their backs.

Two-thirds (67%) of all parents surveyed said they put items such as quilts or comforters in the baby's crib. Eighty-five percent African-American parents said they put these items in the crib.

Learning About Sleep Position

The survey asked parents how they obtained information about placing a baby to sleep. Among all parents surveyed, 40% said they got this information from their pediatrician or nurse practitioner. Among African-American parents, 22% said they obtained this information from those sources.

In contrast, 39% of African-American parents

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Safe Sleeping Practices

The CPSC, the American Academy of Pediatrics, and the National Institute of Child Health and Development recommend the following steps to ensure that babies younger than 12 months sleep safely:

- Place a baby on his/her back on a firm, tight-fitting mattress in a crib meeting current safety standards.
- Remove pillows, quilts, comforters, and sheepskins from the crib.
- Consider using a sleeper with no other covering as an alternative to blankets.
- If using a blanket, place the baby with his/her feet at the foot of the crib. Tuck a thin blanket around the crib mattress and only as far as the baby's chest.
- Make sure the baby's head remains uncovered during sleep.
- Never place a baby to sleep on a waterbed, sofa, soft mattress, pillow, or other soft surface.

Safe Sleeping Continued

were more likely to get information about sleep position from the baby's grandparents. This compared with 18% for the general population.

Asked for reasons why they do not place their baby to sleep on its back, over half of all parents said they feared the baby would choke on its vomit. Seventy-one percent of African-American parents were concerned for this reason. In addition, 40% of African-American parents said they followed family tradition on sleep position. Only 22% of all parents responded that way.

Less than half (44%) of all parents surveyed were able to identify back sleeping as the safest position for babies to reduce the risk of SIDS. Twenty-seven percent of African-American parents identified back sleeping as the safest position.

Since the early 1990s, pediatricians, national health organizations, CPSC, and others have urged parents to place babies to sleep on their backs. During that period, the rate of SIDS deaths in the United States has dropped by about 40%.

Studies also have shown that soft bedding such as quilts, comforters, or pillows may increase the risk of suffocation. Suffocation can occur when soft bedding becomes molded around a baby's face.

 Jacqueline Elder, Office of Hazard Identification and Reduction

For More Information

For more information about the national survey on babies' sleep environments, visit CPSC's website at www.cpsc.gov.

CPSC's website also includes more information about preventing SIDS and suffocation, as well as *Baby Safety Shower* materials. (See *Getting Out the Word*, this page.)

Getting Out the Word

CPSC and Gerber, in conjunction with the Health Resources and Services Administration's Bureau of Primary Health Care (BPHC) and Black Entertainment Television (BET), are launching a national "Safe Sleep" campaign to help lower SIDS rates, especially among African-Americans.

The campaign includes a national television public service announcement about placing babies to sleep safely, baby safety showers to be held at community and migrant health centers, and special programming to be televised on BET this fall.

The BPHC, which is the lead Department of Health and Human Services' bureau in providing access to primary and preventive health care to vulnerable and low-income populations, will provide safe sleeping information to clients in 3,000 health centers across the country. Two-thirds of the more than 12 million patients served at BPHC-supported health centers each year are people of color.

The BPHC also will coordinate sharing the "Safe Sleep" materials with state and local health departments. In addition, the BPHC will encourage health centers to hold Baby Safety Showers, a program developed by CPSC to deliver safety and health information to new parents in a party setting.

BET, which reaches 60 million households, will run the public service announcement and weave messages about safe sleeping into its programming. Starting with the new television season in September, BET will develop news stories about SIDS and its impact on African-American communities. It also will include information targeted to new mothers on its health and fitness program, *Heart and Soul*.

Lynn Barclay, Office of Planning and Evaluation

Pool Alarms

To address child drownings in swimming pools, CPSC recently tested three different types of alarms that might help prevent these incidents. These included floating alarms that detect waves on the water surface; underwater alarms that detect waves under the surface; and a wristband alarm worn by children that sounds when exposed to water.

The test results showed that the subsurface alarms generally performed better than the others. The subsurface devices sounded an alarm more consistently and were less likely to sound a false alarm. One surface alarm performed almost as well as the subsurface alarms.

Currently, there are no safety standards for pool alarm systems.

Death and Injury Data

Each year, about 350 children under age 5 drown in

swimming pools (*Figure 1*). Most of these deaths occur in residential settings.

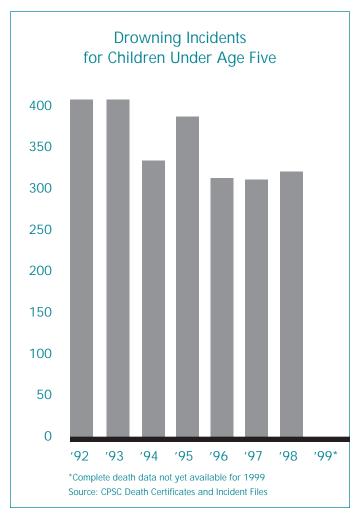
In addition, about 2,600 children under age 5 are treated in hospital emergency rooms for near drowning in swimming pools each year (Figure 2). About 42% of the incidents require hospitalization of the child. About 79% of the near-drowning incidents occur in residential settings.

Testing Procedure

Alarm tests were conducted at six different pools. The pools were both indoors and outdoors and differed in size, shape, and depth. Alarm systems were assembled and placed around the test pools according to manufacturers' instructions.

The alarm systems were tested for both how well they detected a test object that simulated a small child falling into the pool and how susceptible they were to false alarms. The wristband was tested for how well it alarmed when exposed to pool water and whether it alarmed un-

Continued on page 4



Near Drowning Incidents for Children Under Age Five 3500 3000 2500 2000 1500 1000 500 0 '93 '94 '95 '96 '97 '98 '92 Source: CPSC National Electronic Injury Surveillance System (NEISS)

Figure 1 Figure 2

der other conditions, such as during handwashing.

The test objects were two- or three-gallon containers filled with water and tied together. These objects simulated the minimum weights of a 12 to 15 month-old child (approximately 18.3 pounds) up to a 42 to 54 month-old child (approximately 25 pounds). When pushed into the pool, the containers initially sank toward the bottom and then rose to the surface.

To detect false alarms, CPSC staff simulated environmental conditions likely to cause water disturbances, such as wind and rain. Wind was simulated using a large household fan. A garden hose and sprinkler were used to simulate rainfall.

In addition, objects such as a beach ball, a basketball, and a soccer ball were thrown into a pool to see if an alarm distinguished between desired activation and incidental disturbances. The sensors also were left unattended for a period of time (a clear day and during a rainstorm) to determine whether they would false alarm.

Test Results

Test results showed that the subsurface pool alarms generally performed better. They were more consistent in alarming and less likely to false alarm than the surface alarms. The subsurface alarms also can be used in conjunction with solar pool covers, while the surface alarms cannot. The subsurface alarms tested were Poolguard by PBM Industries and Sentinel LINK by Lambo Products Inc.

One surface alarm performed almost as well as the subsurface alarms — the PoolSOS by Allweather Inc.

The wristband alarmed when submerged in pool water or when exposed to another water source, such as tap water.

Conclusion

Every home pool should have a barrier, such as a fence, completely surrounding the pool to protect against child drowning.

A pool alarm can provide an additional layer of protection. Pool alarms should have a remote alarm feature

For More Information

For a complete copy of the CPSC study on pool alarms or free consumer publications on pool safety, including CPSC's *Guidelines for Pool Safety Barriers*, visit CPSC's website at www.cpsc.gov.

that sounds inside the house. Some alarms include this; with others, it must be purchased separately. But pool alarms are not a substitute for constant supervision of children or for a barrier completely surrounding the pool.

The wristband can provide some protection. The caregiver, however, must remember to put it on the child and know that the wristband will sound when exposed to other water sources, not just pool water.

According to recent estimates by the National Spa and Pool Institute (NSPI), there are about 7 million residential pools in the continental United States. About 24,000 pool alarms are sold annually, and sales have doubled since 1994.

Troy Whitfield, Directorate for Engineering

CPSC Home Swimming Pool Safety Guidelines

Pools should have layers of protection to prevent drownings.

- Fences and walls should be at least four feet high and installed completely around the pool. Fence gates should be self-closing and self-latching. The latch should be out of a small child's reach.
- If a house forms one side of the barrier to the pool, doors leading from the house to the pool should alarm when they are opened.
- A power safety cover (a motor-powered cover that can be placed over the water area) should be used when the pool is not in use.
- If a child is missing, always look in the pool first. Seconds count in preventing death or disability. Keep rescue equipment by the pool, and be sure a phone is located at the poolside with emergency numbers posted. Someone in the household should know CPR.
- Pool alarms can be used as an added precaution. CPSC advises consumers to use remote alarm receivers, so the alarm can be heard inside the house or in other places away from the pool area.

Window Falls

Every year, thousands of young children are injured or killed in falls from windows. Many of these incidents occur to children two years old or younger.

To help prevent these falls, there are new safety standards for window guards. These voluntary standards, developed at the urging of CPSC staff, ensure that window guards are strong enough to prevent falls and that those for single family homes and the lower floors of apartment buildings can be opened easily for escape in the event of a fire.

Description of Incidents

From January 1, 1990 through May 15, 2000, CPSC knows of at least 120 window fall-related deaths to children 10 years old and younger. In 1999, CPSC estimates that over 4,000 children 10 years old and younger were treated in U.S. hospital emergency departments for injuries associated with window falls. About two-thirds of those injured were boys. Many of these incidents occur in the following patterns.

- These falls frequently occur from second- and thirdstory windows in apartment buildings or single-family homes.
- The windows are often left open, with just a screen in place.
- The falls usually occur from windows in bedrooms (either the child's or parents') or in living rooms.
- Furniture, like beds, sofas, or chairs, is often near or under the window.
- Frequently, no adults are present at the time of the incident.

Window Fall-Related Deaths

The age distribution of the 120 children, 10 years and younger, who died from window falls from January 1, 1990 to May 15, 2000 is presented in *Figure 1*. More than half (67) of the deaths occurred to children ages 2 and younger. (Because death data is still being collected, primarily for 1999 and 2000, these figures most likely represent an undercount of deaths.)

Information on the nature of the injuries is available for 51 of the deaths. Forty-six of these deaths involved fatal head injuries; the remaining 5 deaths were chest or stomach injuries. The causes of death were massive multiple injuries, fractured skull, hemorrhage, blunt impact, or brain hernia.

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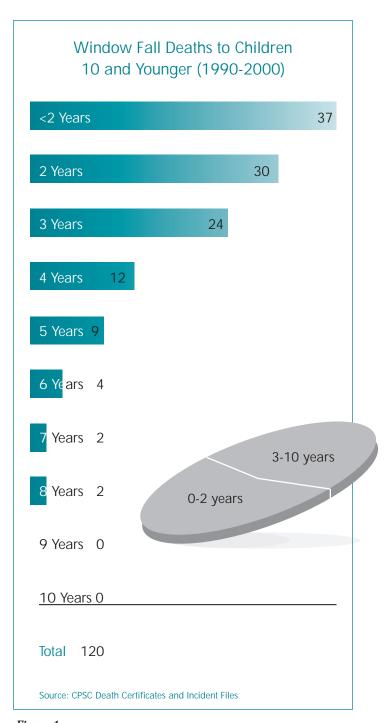


Figure 1

Window Fall-Related Injuries

The age distribution of children, 10 years and younger, who were treated in U.S. hospital emergency departments for window fall-related injuries in 1999, is presented in *Figure 2*. More than one-third (39%) of the injuries occurred to children ages 2 and younger.

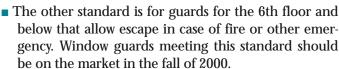
Window Protection

Window guards can be easily installed in windows to prevent a child from falling if the window is open. The guards screw into the side of a window frame and have bars no more than four inches apart. They are sold in

different sizes for various size windows and adjust for width.

There are two voluntary safety standards for window guards.*

• One standard is for permanently-affixed guards (not removable for emergency escape) for use on the 7th floor and above. Several window guards meeting this standard are on the market.



An alternative to window guards is window stops. Window stops limit the distance a window can open. To prevent falls, window stops should be installed so that windows open no more than four inches. Some new windows come with window stops already installed.

 Prowpit Adler and Susan Kyle, Ph.D., Directorate of Epidemiology

ASTM PS 120-99 Provisional Standard Safety Specification for Window Fall Prevention Devices with Emergency Escape (Egress) Release Mechanisms

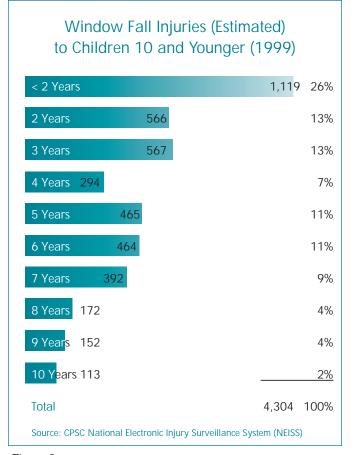


Figure 2

Preventing Window Falls

Every year, thousands of young children are injured or killed in falls from windows. To help prevent these tragedies, take the following actions – especially for windows in bedrooms.

- Safeguard your windows with window guards or window stops.
 - Install window guards to prevent children from falling out of windows. (For windows on the 6th floor and below, install window guards that adults and older children can open easily in case of fire.)
 - Install window stops so that windows open no more than 4 inches.
- Never depend on screens to keep children from falling out of windows.
- Whenever possible, open windows from the top -not the bottom.
- Keep furniture away from windows, to discourage children from climbing near windows.

^{*}ASTM PS 112-98 Provisional Standard Safety Specification for Window Fall Prevention Devices for Non-Emergency Escape (Egress) and Rescue (Ingress) Windows

Consumer Product Incident Report

Please contact us about any injury or death involving consumer products. Call us toll free at: 1-800-638-8095. Visit our website at www.cpsc.gov. 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

TC-49

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, March, April, and May 2000, 1027 cases were reported to CPSC. Included here are samples of cases to illustrate the type and nature of the reported incidents.

ASPHYXIATIONS/ SUFFOCATION

*A male, 6 months, was laid to sleep in an old crib for the evening. The next morning, he was found, unresponsive, between the siderail of the crib and the mattress. The screws holding the siderail to the headboard and footboard were loose, allowing the siderail to move. The cause of death was positional asphyxia. (Thomas D. Owens, M.D., Medical Examiner, Orange/Durham Counties, NC)

*A female, 5 months, was left unattended while she played with a caterpillar-type toy in her living room. She was found later with a small ball on the end of the toy's antenna lodged in her throat. The cause of death was asphyxiation. (Juan U. Contin, M.D., Chief Medical Examiner, County of El Paso, El Paso, TX)

A female, 9 months, was found in her crib, hanging from an electrical cord of a ceiling fan. The cord had been hanging down along the back of the crib. The cause of death was asphyxiation.

(Noel Palma, M.D., Medical Examiner, District 15, Palm Beach County, West Palm Beach, FL)

A male, 5 months, was laid to sleep in the bottom bunk of a bunk bed by his grandmother. He rolled off under the bed and became entangled in a plastic dry cleaning bag. The cause of death was asphyxiation.

(Mark S. Jordan, M.D., Medical Examiner, Rockingham County, NC) A female, 9 months, was left unattended in a car seat at a daycare facility. She was found entangled in the car seat harness. The cause of death was asphyxiation.
(Juan U. Contin, M.D., Chief Medical

(Juan U. Contin, M.D., Chief Medical Examiner, County of El Paso, El Paso, TX)

*A female, 7, was found partially hanging near a backyard swing set. A flat nylon rope was twisted around her neck. The rope had been tied by children between a backyard swing set and a clothesline pole. The cause of death was asphyxiation. (Michael S. Carona, Sheriff-Coroner, Orange County, Santa Ana, CA)

CARBON MONOXIDE POISONINGS

A female, 43, was found lying on her bed in her home. Carbon monoxide was actively venting into the house from a broken vent pipe. The cause of death was carbon monoxide poisoning. (Jose K. Abrenio, M.D., Medical Examiner, Central District, Richmond, VA)

*Three females, 27, 8, and 4, were found in a bedroom of their apartment. They were overcome by carbon monoxide gas from a built-in gas wall heater with a partially blocked flue. The cause of death was carbon monoxide poisoning. (Edmund R. Donoghue, M.D., Chief Medical Examiner, Cook County, Chicago, IL)

*A male, 54, was found unconscious in his home and transported to the hospital, where he died a short time later. He had been feeling ill for three days, ever since workmen had started fixing his chimney. The chimney was found to be blocked with debris, causing combustion gases from the gas furnace to enter his home. The cause of death was carbon monoxide poisoning. (Kandice Tabeling for John Hunt, D.O., Deputy Medical Examiner, Kalamazoo County, Kalamazoo, MI)

DROWNINGS

A male, 2, was found submerged at the bottom of his family's swimming pool. The child had entered the pool area through a screen door. The door did not fully close because of a broken hinge. The cause of death was drowning. (Joshua Perper, M.D., Chief Medical Examiner, District 17. Broward

Two children, 4 and 7, were playing in the backyard of their grand-mother's house. The 4-year old male was found floating face down in a three-foot high pool with a partial deck. The cause of death was drowning

County, Fort Lauderdale, FL)

(Rose M. Psara, R.N., Chief Investigator for Dr. Michael A. Graham, M.D., Chief Medical Examiner, City of St. Louis, MO)

A male, 21 months, was found in an above-ground swimming pool. He gained access to the pool through a gate that had warped over the winter, making the latch ineffective. The cause of death was drowning. (Scott M. Grim, Coroner, Lehigh County, Allentown, PA)

FLECTROCUTIONS

A male, 35, was wiring an exhaust fan in his attic. He called to his wife to turn off the electricity. His wife saw him shaking and turned off the circuit breaker. The cause of death was electrocution.

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

FIRFS

*A female, 9, was found after a fire occurred in a wood-framed building. The cause of the fire was believed to be a lighted candle, which was being used after a power failure. The cause of death was inhalation of smoke and soot. (Jacqueline Dobbins for Edmund R. Donoghue, M.D., Chief Medical Examiner, Cook County, Chicago, IL)

A female, 27, and a male, 23 months, were found in an apartment bedroom after a fire. The origin of the fire was an electrical outlet with three items plugged into an extension cord. The cause of death was smoke inhalation.

(Sam Gulino, M.D., Medical Examiner, Jackson County, Kansas City, MO)

A male, 4, was found after a fire in a bedroom of his babysitter's house. One of the babysitter's children had left on a burner of an electric stove after cooking. The cause of death was carbon monoxide intoxication.

(Marvin S. Platt, M.D., Medical Examiner, Summit County, Akron, OH)

A male, 60, was thawing pipes under the sink of his home with a blowtorch. The blowtorch ignited a container of flammable liquids, and

he was severely burned. The cause of death was sepsis due to severe burns.

(Michael Stier, M.D, Central District, Albemarle County, Charlottesville, VA)

*A male, 20 months, was inside a house with five other children while an adult removed clothes from a clothesline outside. One of the children found a lighter in a dresser, ignited a piece of paper, and dropped it on a mattress. The mattress caught fire and trapped the 20-month old in the room. The cause of death was carbon monoxide toxicity and thermal injuries.

(Bobbi Jo O'Neal, Deputy Coroner, Charleston County, SC)

A male, 83, was driving a riding lawnmower, which tipped over. He was doused with gasoline and caught fire. The cause of death was thermal injuries.

(Carol Koop for Susan Roe, M.D., Medical Examiner, Ramsey County, St. Paul, MN)

MISCELLANEOUS

A male, 13, lost control of his skateboard while riding down a steep incline on a highway. He was not wearing a helmet and hit his head on the pavement. The cause of death was head trauma.

(Sue R. Townsend, Coroner, Aiken County, Aiken, SC)

A male, 62, was in his shop at home sharpening an ax. The electric grindstone he was using shattered and struck his leg. The cause of death was exsanguination due to femoral artery laceration.

(Joseph Diehl, M.D., Medical Examiner, Umatilla County, OR)



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

Product: About 7 million **infant swings** by Graco Children's Products Inc. The infant swings are battery-powered or wind up and are either the traditional A-frame or open top design. Some models have removable seats that can be used as an infant carrier. Mass merchandise, juvenile products, and major discount stores nationwide sold the Graco swings through approximately January 1998 for between \$70 to about \$120.

Problem: The restraint system on these older swings consists of a waist belt only and a hinged or removable tray. If parts are missing, the restraints are not used, or the tray pops off, infants can slip down into the seat and strangle or fall from the swing. Graco has received 209 incidents, including six deaths, after children fell from or became caught in the infant swings.

What to do: Stop using the swings immediately and call Graco at **800-934-9082** anytime to receive a free safety restraint. Consumers may also visit Graco's website at www.gracobaby.com/serv/ga3rcal7.htm or write to Customer Affairs, Graco Children's Products Inc., P.O. Box 100, Elverson, PA 19520.

Product: About 8.9 million **flying dolls** by Galoob® Toys, Inc. The Sky Dancers® flying dolls are princess/ballerina-type dolls with a launcher that include the Pretty Lights Sky Dancers, Mini-Sky Dancers and Fairy Flyers. The launchers come in shapes such as dolphins, flowers, a moon, ponies, and a sun and rainbow. The launchers were sold in both hand-held and table-top versions. Mass merchandise and toy stores nationwide sold the dolls from November 1994 through June 2000 for between \$8 to \$25.

Problem: The hard plastic Sky Dancers® dolls can fly rapidly in unpredictable directions and can hit and injure both children and adults. Galood® has received 170 reports of the dolls striking children and adults, resulting in 150 reports of injuries such as eye injuries, broken teeth, a mild concussion, a broken rib, and facial lacerations that required stitches.

What to do: Stop using the flying dolls immediately and call Galoob® for instructions on how to return the toy sets to receive a product of equal value. For more information, consumers should call Galoob® toll-free at **877-598-5599** anytime, or visit the firm's website at www.galoob.com/skydancer.html.

Product: About 87,000 **vinyl window blinds** by Ace Hardware Corp. The recalled vinyl blinds are white miniblinds and woodgrain roll-up blinds with sizes ranging from 23-inches wide by 42-inches long to 72-inches wide by 120-inches long. Writing on the label of the white miniblinds reads "Safe Nonleaded Vinyl Formulation." Writing on the label of both blinds reads "MANUFACTURED IN THAILAND FOR ACE HARDWARE CORP." Ace Hardware and other hardware stores nationwide sold the window blinds from August 1999 through May 2000 for between \$6 to \$27.

Problem: The blinds contain lead exceeding government guidelines and do not have required labeling that warns they contain lead. Lead poisoning in children is associated with behavioral problems, learning disabilities, hearing problems and growth retardation. CPSC and Ace Hardware are not aware of any lead poisonings involving these window blinds.

What to do: Remove the window blinds from windows and keep them away from children. Consumers can return the window blinds to the store where they were purchased for a refund. For more information, call Ace Hardware Corp. toll-free at **877-223-4391** between 7 a.m. and 6 p.m. CT Monday through Friday.

Product: About 1.8 million **pacifiers** by Playtex Products, Inc. The pacifiers are the Classic Patterns "Cherubs" and Soft Comfort latex pacifiers. The pacifier comes in a variety of colors and designs, and the word "Playtex" is embossed on the pacifier's swivel handle. The pacifiers were packaged individually or in sets of two. Stores nationwide sold the pacifiers before June 2000 for about \$2 to \$4, depending on whether it was a single or double pack.

Problem: The latex is aging faster than normal. The nipple can detach from the shield and present a choking hazard to babies. Playtex has received 21 reports of pacifier nipples detaching from the shields. No injuries have been reported.

What to do: Stop using the pacifiers immediately and return them directly to Playtex for a free replacement pacifier or a \$3 coupon toward the purchase of another Playtex infant feeding or soothing product. Consumers should send the pacifiers to Playtex Pacifiers, Playtex Products Inc., 20 Troy Road, Whippany, NJ 07981. Playtex will reimburse consumers for postage. For more information, call Playtex toll-free at **800-522-8230** or visit its website at www.playtexbaby.com/recall.htm.

Product: About 2.7 million trimmer heads with metal chains and 857,000 trimmer replacement chain sets by Weed Wizard Acquisition Corp. Only Weed Wizard trimmer heads with metal chains are part of this recall. There is no writing on the Weed Wizard trimmer heads, but the packaging reads "Weed Wizard," "The Solution to Trimmer Line Problems," "Fits 99% of All Gas Trimmers", and "MADE IN U.S.A." Home centers, mass merchants, discount stores, and television advertisements nationwide sold Weed Wizards with metal chains from May 1987 through April 2000 for between \$19 to \$25. The replacement chain kits were sold from January 1992 through April 2000 for about \$8.

Problem: The end link of the trimmer's metal chain can rapidly and unexpectedly detach during use, propelling the link into the air at a high velocity. Weed Wizard and CPSC have received 47 reports of metal links detaching from trimmers resulting in 41 injuries, including the death of a 3-year old girl who was struck in the head by a metal link.

What to do: Stop using the Weed Wizards with metal chains immediately and contact the firm to obtain free plastic replacement blades and installation instructions. For a free replacement kit, call Weed Wizard toll-free at **888-810-7536** anytime, or visit the firm's website at www.weedwizard.com.

Product: About 200,000 Homelite® handheld power blowers/vacuums by John Deere Consumer Products. The blowers/vacuums are red and black with the Homelite® logo written on the inlet cover door. They can be identified by the following UT and serial numbers on a sticker attached to the unit near the blower tube: UT Numbers - UT08052, UT08052A, UT08052B, UT08052C, UT08057, UT08057A, UT08057B, UT08058A,

UT08058B, UT08059, UT08059A, UT08059B, UT08066, UT08066A, UT08066B, UT08067, UT08067A, UT08067C, UT08069, UT08069B, UT08070R, UT08071R, UT08076, UT08076A, UT08084, UT08085, UT08086, UT08089, UT08090, UT08091, UT08105, UT08107, UT08108. Serial Numbers ñ HT2130001 through HT3659999, MA0010001 through MA3659999, HA00100001 through HA3659999, MB0010001 through MB0459999. Home center and hardware stores including Home Depot, Eagle Hardware and Ace Hardware sold the blowers/vacuums nationwide from August 1998 through January 2000 for about \$150.

Problem: The fuel line location can cause it to contact the edge of the engine shroud causing the line to prematurely wear. This can result in a gasoline leak, presenting a fire hazard and causing burn injuries to consumers. John Deere Consumer Products has received two reports of the fuel line leaking from these power blowers/vacuums. There have been no reports of fires or injuries. What to do: Stop using these blowers/vacuums immediately and contact the nearest Homelite® service dealer for a free inspection and repair. To locate the local service dealer or for more information, call John Deere Consumer Products at 800-242-4672 anytime.

Product: About 105,000 "3-in-1 **Cradle Swings**" by Fisher Price. The cradle swings are model numbers 79321 and 79322 with a detachable seat that can be used as a carrier. The model number is on the underside of the motor housing and on the bottom of the seat. "Fisher-Price" is on the front of the motor's housing and on the bottom of the seat. Mass merchandise, juvenile products, and major discount stores sold the 3-in-1 Cradle Swings nationwide from March 1997 through January 1999 for about \$100.

Problem: When used as a carrier, the locks for the handle can unexpectedly release causing the seat to flip forward. When this happens, infants can fall to the ground and suffer serious injuries. There have been 28 reports of the carrier's handle unexpectedly releasing when used as a carrier, resulting in injuries to 10 infants. The injuries include a skull fracture, bumps, bruises, and scrapes to the head.

What to do: Stop using the swing's seat as a carrier immediately and call Fisher-Price at **800-505-0600** anytime to receive a free repair kit that will lock the carrier's handle in place. Consumers can also visit the Fisher-Price website at www.fisher-price.com/us/help/cradle.asp.

Product: About 235,000 "Bounce 'n Play Activity Domes" by Fisher Price. The Activity Dome is a portable play and nap space for indoor or outdoor use that resembles a pop-up tent. A notice tag on the bottom of the product has Model number 79534 on the left side of the tag and a 6-character code on the bottom of the tag. All codes that end with 8 are included in the recall. All codes that end with number 9 and begin with numbers 001 through 286 are included in the recall. Mass merchandise, juvenile products, and major discount stores sold the Bounce 'n Play Activity Domes nationwide from December 1998 through March 2000 for about \$50. Fisher-Price Bounce 'n Play Activity Domes with a green dot on the bottom of the product have been repaired and are not recalled.

Problem: The nylon band that holds the surface level can detach allowing the surface to tilt. This can cause an infant to slide down against one end and be trapped in a position in which it is difficult to breathe, posing a suffocation hazard. There have been 28 reports of the nylon band detaching and causing the play and nap surface to tilt. No injuries have been reported.

What to do: Stop using the Bounce 'n Play Activity Dome immediately and call Fisher-Price at **800-505-0600** anytime Monday through Friday to receive a free repair kit that will strengthen the support for the play and nap surface to keep it level. Consumers can visit the Fisher Price website at www.fisher-price.com/us/help/cradle.asp#BounceNPlay.

Product: About 207,000 PowerClean™ and PureAir™ **vacuum cleaners** by BISSELL® Homecare Inc. The recall includes one model of the BISSELL® PowerClean™ vacuum and three models of the BISSELL® PureAir™ vacuum cleaners. The PowerClean™ vacuum has model number 3540-1 and is black. The PureAir™ vacuum has model number 3540-2 and is blue. The PureAir™ Deluxe vacuum has model number 3541 and is purple. The PureAir™ Platinum vacuum has model number 3541-P and is purple. The model number is located on a label on the back of the vacuum. These vacuums also have date codes from 98176000 through 99254999 located in the bottom right-hand corner of the label. Major discount, appliance, and department stores sold these vacuum cleaners nationwide from July 1998 through March 2000 for between \$89 and \$159.

Problem: The power cord insulation can tear where the cord attaches to the vacuum, exposing bare wires. This poses a risk of shock and burns to consumers. BISSELL® is aware of 54 reports of the cords on these vacuums tearing. There has been one report of a consumer suffering a burn injury on her hand.

What to do: Stop using the vacuum cleaners immediately and contact BISSELL® to arrange for a free repair through BISSELL's authorized service network. For the location of the nearest authorized service center or for more information, contact BISSELL toll-free at **888-445-6688** between 8 a.m. and 7:30 p.m. ET Monday through Friday or visit its website at www.bissell.com/recall/recall_press_release.htm.

Product: About 475,000 **teething rings** by Whitehall-Robins Healthcare. The teething rings were sold with .25 oz. tubes of Baby Anbesol® Grape Gel. The teethers are yellow and shaped like rabbits. They are about 3 inches long and 2.25 inches high with two holes molded into the teething ring for infants to grasp. The package reads, "BABY'S TEETHING KIT," and "FAST TEETHING PAIN RELIEF." Mass merchandise, drug, and grocery stores nationwide sold the Baby Anbesol® with these teethers from May 1999 through June 2000 for about \$6.

Problem: When bent, these teething rings can fit into an infant's mouth and trigger a gagging reflex. This poses a risk of vomiting, which could result in choking and aspiration. Whitehall-Robins Healthcare has received two reports from consumers of children gagging on the teething rings, including one report of a child starting to choke.

What to do: Take the teething rings away from infants immediately and contact Whitehall-Robins Healthcare for information on returning the teething ring in order to receive a free Anbesol® product. Consumers can call Whitehall-Robins Healthcare at 800-525-2607 between 9 a.m. and 5 p.m. ET Monday through Friday, or go to the firm's website at www3.young-america. com/2506-2/Recall.asp. Only the teething rings and not the Baby Anbesol® Grape Gel are being recalled.

— Marc Schoem and John Shumlansky, Office of Compliance

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