CONSUMER PRODUCT SAFETY REVIEW

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IN THIS ISSUE

Playpens

The U.S. Consumer Product Safety Commission (CPSC) recently released a report about deaths to babies in playpens.

For years, CPSC has warned about the dangers of soft bedding such as quilts, comforters, and pillows in cribs. This study shows, for the first time, that the same dangers of soft bedding exist in playpens. Soft bedding can become molded around an infant's face and cause suffocation. The study also identified improper and extra mattresses and cushions as a hazard.

Parents and caretakers use playpens today as places for infants and toddlers to both play and sleep. Playpens are often used by parents and caregivers as substitutes for full-sized cribs when babies nap.

Over the years, playpens, portable cribs, and play yards have evolved into virtually identical products. More than 2.5 million of these products are sold annually.

Hazards

Since 1988, CPSC has received reports of over 200 babies who died while in playpens. In almost 100 of these deaths, soft bedding or improper or extra mattresses were present in the playpen, and the children died of suffocation or Sudden Infant Death Syndrome (SIDS).

Over this period, CPSC conducted follow-up investigations of many of these deaths. In some cases, these investigations led to recalls of products. In other cases, CPSC identified hazards not necessarily related to the design and construction of the playpen. These problems included:

- **Soft Bedding.** Soft bedding can be a risk factor for infant suffocation and Sudden Infant Death Syndrome (SIDS). For example, 68 children died in playpens where soft bedding was present and the cause of death was suffocation or SIDS.
- **Mattresses/Cushions.** In addition, 25 deaths involved mattresses or cushions. The majority of these children died as a result of either being wedged between mattresses, foam, couch cushions, and other large objects placed in the playpen or being wedged between these items and the side wall of the playpen. In some cases, mattresses were too small for the playpen.
- **Other Hazards.** Other hazards identified included:
  - Side rails that collapsed, resulting in children being entrapped in the "V" shape created by the two sections of the rail.
  - Protruding rivets or other components, which snagged clothing and strangled the child.
  - Hardware on older-style wooden playpens, which failed or pulled out of the wood, resulting in falls or entrapment hazards.

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- Large mesh on older playpens, which caught buttons on children's clothing and resulted in strangulation.
- Strangulation on drapery or blind cords when the playpen was placed too close to windows.
- Plastic bags inside the playpen resulting in suffocation.
- Modifications to the playpen to keep the baby inside. These were "lids" consisting of plywood, larger mattresses, or some other material – creating entrapment hazards.
- Broken or damaged playpens, with openings that entrapped infants.
- Mesh pockets created when one side of the playpen was left folded down, creating a suffocation hazard for young children.

Location

CPSC staff reviewed cases it investigated to identify locations – in addition to the child's own home – where children died in playpens. For example, 26 deaths occurred while the child was in a playpen at a day care setting. Four deaths occurred while the child was in the care of other babysitters (i.e. not a day care setting). Eleven deaths occurred in playpens at the home of a grandparent.

Victims

Of those babies who died, 38% were females and 58% were males. In 4% of the incidents, gender was not reported.

About half of the victims were infants less than 6 months old. Another 22% were babies between the ages of 6 and 11 months. Seventeen percent of the victims were toddlers between the ages of 12 and 17 months. Eight percent of the victims were 18 months of age or older. Age was not reported in 3% of the cases.

— George W. Rutherford, Jr., M.S., Directorate for Epidemiology

Preventing Deaths and Injuries with Playpens

To help prevent death or injury to a child in a playpen, parents and caretakers should take the following precautions.

- Before using a playpen, make sure it has not been part of a CPSC recall. Contact CPSC at 1-800-638-2772 or visit CPSC's website at www.cpsc.gov. If the playpen has been part of a recall, take advantage of the remedy provided by the manufacturer.
- Always put a baby under 12 months to sleep on his or her back in a playpen with no soft bedding – like quilts, pillows, pillow-like toys, or sheepskins. This can reduce the risk of SIDS and help prevent suffocation.
- Set up the playpen carefully before putting a child in it. Make sure the sides are locked into place. If you have questions, check the manufacturer's instructions or call the manufacturer for assistance. If the side rails do not lock in place, they can collapse and children can strangle in the V-shaped spaces between the rail sections. Infants can suffocate if they roll into a pocket formed at the bottom of a mesh playpen side when the side is down.
- Use only the mattresses or padding provided by the manufacturer. Do not add additional mattresses in playpens. Children can suffocate in the spaces formed between mattresses, from ill-fitting mattresses, and between additional mattresses/padding and the side of the playpen.
- Check that the playpen is in good shape. Using a modified or improperly-repaired playpen can create hazards.
- If using a mesh-sided playpen, make sure the mesh is less than 1/4 inch in size (smaller than the tiny buttons on a baby's clothing). Make sure the mesh is securely attached to the top rail and floor plate and that the mesh does not have tears, holes, or loose threads. The top rail cover should have no tears or holes. If staples are used, they should not be missing, loose, or exposed. These precautions can help prevent strangulation.
- Do not use a playpen with "catch points," such as protruding rivets. Remove any strings or cords on children's clothing or around their necks that could catch on the playpen. These also can be strangulation hazards.

Home Playgrounds

Playground equipment is a leading source of childhood injury. CPSC recently released a report on playground injuries and deaths, highlighting those that occurred on home playgrounds.

The CPSC report was based on findings from a special study of playground equipment-related injuries treated in U.S. hospital emergency rooms from November 1998 through October 1999. CPSC staff also reviewed data on playground-related deaths reported to CPSC from January 1990 through August 2000.

Deaths on Playground Equipment

From January 1990 through August 2000, CPSC received reports of at least 90 fatal incidents that occurred in home locations. This represents about 70% of all playground-related deaths at known locations. A total of 147 deaths to children younger than age 15 were reported for all playground locations.

Almost three-fourths (66) of the deaths in home locations resulted from hanging from ropes, cords, homemade rope swings, and similar items. Other deaths resulted from home equipment tipover or collapse, falls from equipment, and other causes. In all locations, over one-half of the deaths involved hanging. Other causes of playground equipment-related deaths included falls, equipment tipover or collapse, entrapment, or impact with moving components.

Injuries on Playground Equipment

In 1999, there were an estimated 46,930 children under age 15 who went to U.S. hospital emergency rooms with injuries related to home playground equipment (most often swings). This represented more than 20% of the more than 200,000 estimated playground equipment-related injuries treated in emergency rooms.

Children injured in home locations tended to be younger than those injured in other locations. Almost 40% of those injured at home were younger than 5 years, as compared to about 27% of those injured in other locations *(Figure 1)*. This difference likely reflects that pre-school children most often play on backyard playsets rather than in other locations.

Over 80% of the injuries on home equipment were associated with falls. Specifically, 69% involved falls to the surface below the equipment, 10% involved falls to other parts of the same equipment, and 2% involved falls to an unknown surface.

The activity most often associated with falls on home equipment was intentional jumping or dismounting from equipment, primarily swings. Other scenarios involved victims who lost their grip or balance, slipped or tripped, bumped into or were pushed by another person, and reached for an equipment component and missed.

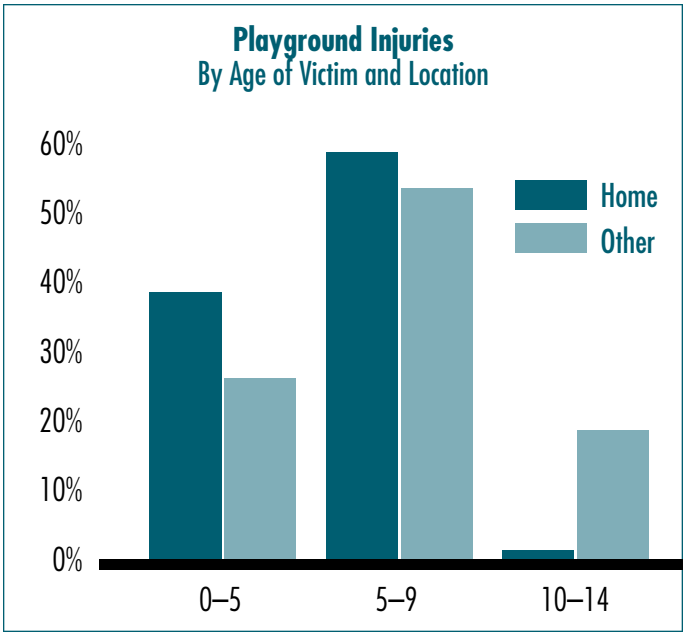

Figure 1

Only about 9% of home locations where injuries occurred had proper protective surfacing, most often sand *(Figure 2)*. Dirt and grass were, by far, the most prevalent surfaces present under the equipment; these are surfaces that do not adequately protect children from serious head injury when they fall.

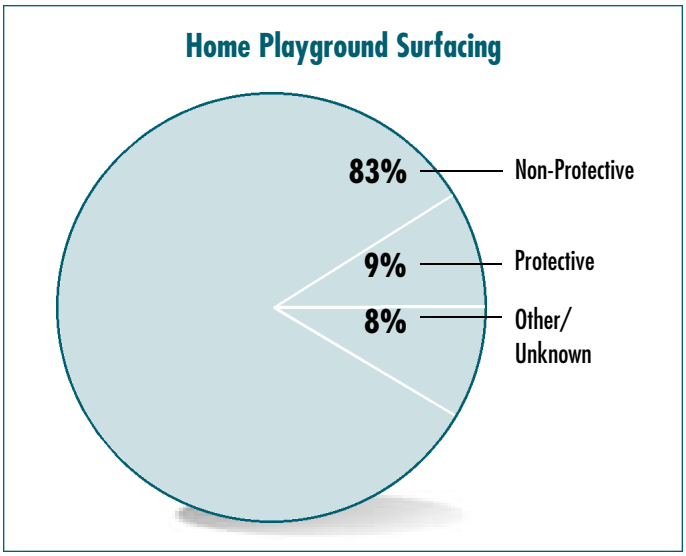

Figure 2

For all playground locations, young children incurred a greater proportion of injuries to the head and face than older children. Almost one-half (49%) of all playground injuries to children younger than 5 years involved the head or face, as compared with 28% for older children.

Overall, fractures were the most commonly reported injury, accounting for 39% of all injuries on manufactured equipment. Almost 80% of these fractures involved the wrist, lower arm, and elbow. Other injuries included lacerations (22%), contusions/abrasions (20%), and strains/sprains (11%).

Safety Standards

In recent years, CPSC staff has worked with industry to strengthen playground safety standards to help protect children while they play. CPSC staff worked closely with ASTM on the safety standard for home playgrounds. In 1998, the standard was revised to include:

- A requirement that ropes be secured at both ends to prevent the rope from being looped back on itself in a manner that could create a strangulation hazard. Also requires a warning in the playset instructions against attaching items such as jump ropes, clotheslines, pet leashes, cables, and chains, which may cause a strangulation hazard.
- Guardrail requirements on platforms higher than 30 inches and protective barrier requirements on platforms higher than 48 inches to help prevent falls.
- A requirement that a CPSC consumer information sheet for playground surfacing materials accompany the playset manual/instructions.

— *Deborah Tinsworth, Directorate for Epidemiology*

For more information

To order an additional copy of the *Home Playground Safety Checklist,* call the Federal Consumer Information Center (FCIC) toll-free at 1-888-878-3256 and ask for item 627H, or go to the FCIC website at www.pueblo.gsa.gov. Consumers also can order the checklist by sending their name and address to FCIC, Dept. 627H, Pueblo, Colo. 81009.

For more information on playground safety, visit the CPSC website at www.cpsc.gov to check out the *Handbook for Public Playground Safety* and other publications. Or, call the toll-free CPSC Hotline at 1-800-638-2772.

Home Playground Safety Checklist

To help prevent injuries from falls and other hazards on home playgrounds, the following measures are recommended.

1. **Install and maintain a shock-absorbing surface** around the play equipment.

- Use at least 9 inches of wood chips, mulch, or shredded rubber for play equipment up to 7 feet high.
- If sand or pea gravel is used, install at least a 9-inch layer for play equipment up to 5 feet high.
- Or, use surfacing mats made of safety-tested rubber or rubber-like materials.

2. Install **protective surfacing** at least 6 feet in all directions from play equipment. For swings, be sure surfacing extends, in back and front, twice the height of the suspending bar.

3. **Never attach** – or allow children to attach – **ropes**, jump ropes, clotheslines, or pet leashes to play equipment; children can strangle on these.

4. Check for **hardware,** like open "S" hooks or protruding bolt ends, which can be hazardous.

5. Check for **spaces that could trap children**, such as openings in guardrails or between ladder rungs; these spaces should measure less than 3.5 inches or more than 9 inches.

6. Make sure platforms and ramps have **guardrails** to prevent falls.

7. Check for **sharp points** or edges in equipment.

8. Remove **tripping hazards,** like exposed concrete footings, tree stumps, and rocks.

9. Regularly check **play equipment** and **surfacing** to make sure both are in good condition.

10. Carefully **supervise children** on play equipment to make sure they are safe.

Residential Fires

CPSC's recent report on residential fires included information on fires associated with candles and other causes.

Candle Fires

The study showed that while deaths from residential fires have decreased by almost half from 4,560 in 1980 to 2,660 in 1998, those caused by candles have increased dramatically *(Figure 3)*.

Candle deaths increased 750% from 20 deaths in 1980 to 170 deaths in 1998. In most cases, candles caused house fires when the candles were left unattended, tipped over, and ignited nearby combustibles.

Almost half of home candle fires started in the bedroom. Mattresses or bedding were the most common items that ignited, followed by furniture (dressers, desks, and tables) and then curtains. Tealights and tapers were common causes of candle fires.

A child playing with the candle itself or near the candle was one of the biggest contributors to candle fires. Faced with fire, many children hid in a closet or under a bed, which led to fatalities. In fact, children under age 5 have a fire death rate more than twice the national average.

The study showed that house fires dropped from 655,000 in 1980 to 332,300 in 1998, the latest year for which data is available. In contrast, house fires caused by candles increased, from 8,500 in 1980 to 12,900 in 1998. CPSC staff is working with ASTM and the candle industry to develop safety standards for candles to help reduce fires.

Other Findings

The CPSC staff report also highlighted the following fire-related information.

Fires in residential properties accounted for about 75% of all structure fires in 1998 and resulted in 90% of civilian fire deaths.

The estimated 332,300 residential structure fires in 1998 resulted in an estimated 2,660 civilian deaths, 15,260 civilian injuries and $3.56 billion in property losses.

For the first time in at least five years, the percentage of fire deaths involving cooking equipment (15%) exceeded the percentage involving heating equipment (11%). Electric ranges and ovens accounted for the same percentage of deaths as their gas-fueled counterparts (6%). Electrical distribution equipment, like heating equipment, was involved in about 11% of fire deaths.

Cooking equipment was the type of equipment most frequently involved in fires and fire injuries (28% and 30%, respectively). Most cooking equipment-related fires and injuries involved electrical products (62% and 70% of cooking fires and injuries, respectively).

Among the different forms of material first ignited in fires, upholstered furniture was most frequently involved in fire deaths (20%), followed by mattresses and bedding (15%). Mattresses and bedding, however, accounted for more fires and injuries (6% and 15%, respectively) than upholstered furniture (3% and 9%, respectively).

Among the different forms of heat involved in the ignition of fires, smoking material ignitions accounted for 30% of fire deaths. Candle fire deaths accounted for 6% of fire deaths, followed by lighters (5%) and matches (3%).

Smoking material ignitions accounted for 7% of fires and 13% of fire injuries. Candles accounted for 4% of fires and 8% of injuries. Injuries from lighters (6%) exceeded injuries from matches (4%), while the percentage of fires involving these forms of heat was about equal (2%).

For a copy of the complete report, *1998 Residential Fire Loss Estimates*, visit the CPSC website at www.cpsc.gov.

Fire loss estimates presented in this report were fires, deaths, injuries and property losses associated with consumer products. Estimates excluded losses from incendiary and suspicious fires. The product categories selected, except for smoking material, represented products within the jurisdiction of CPSC.

— *Jean Mah and Signe Hiser, Directorate for Epidemiology*

Estimated Residential Structure Fire Deaths
Selected Products by Form of Heat of Ignition

Product	1980	1994	1995	1996	1997	1998
TOTAL RESIDENTIAL	4,560	2,980	3,010	3,440	2,760	2,660
Cigarette, Other Tobacco Prod.	1,940	860	1,020	1,100	860	800
Total Match	220	140	110	100	100	90
Child Play	190	130	90	70	90	80
Other	30	10	20	20	10	10
Total Lighter	270	260	200	150	160	140
Child Play	240	230	190	130	160	130
Other	30	30	10	20	10	10
Candle	20	80	80	130	160	170

Figure 3

Grilling Safety

CPSC staff has worked on a number of initiatives to help prevent deaths and injuries related to grilling. These include both gas and charcoal grills.

Gas Grills

CPSC staff helped industry develop a new safety standard to prevent over-filling of propane gas tanks. This standard will help prevent propane leaks that can cause fires and explosions.

Propane gas is highly flammable. Each year, about 600 fires or explosions occur with gas grills, resulting in injuries to about 30 people.

The new safety standard for propane gas tanks requires that an "over-fill prevention device" be installed in new gas tanks. The new propane gas tanks have valve handles with three "lobes" (prongs) and are marked on the handle "OPD." Older tanks have valve handles with five prongs and do not have the "OPD" marking.

Gas Grill Safety Tips

Here are some safety tips to reduce the risk of fire or explosion from gas grills.

- Check grill hoses for cracking, brittleness, holes, and leaks. Make sure there are no sharp bends in the hose or tubing.
- Move gas hoses as far away as possible from hot surfaces and dripping hot grease.
- Always keep propane gas containers upright.
- Never store a spare gas container under or near the grill or indoors.
- Never store or use flammable liquids, like gasoline, near the grill.
- Never keep a filled container in a hot car or car trunk. Heat will cause the gas pressure to increase, which may open the relief valve and allow gas to escape.

A different industry standard (adopted in 1995 at the urging of CPSC) provided for several safety features in gas grills, hoses, and connections. The safety standard called for the following: a device to limit the flow of gas if the hose ruptured; a mechanism to shut-off the grill if it overheated; and a device to prevent the flow of gas if the connection between tank and grill was not leak-proof.

People who have grills that do not meet the 1995 standard should either get a new grill or be especially attentive to using the gas grill safely. (See *Gas Grill Safety Tips.)*

Charcoal Grills

Cooking on a charcoal grill also can be hazardous. Charcoal produces carbon monoxide (CO) when it is burned. CO is a colorless, odorless gas that can accumulate to toxic levels in closed environments. Each year about 20 people die as a result of CO fumes from charcoal being burned inside. To reduce the risk of CO poisoning:

- Never burn charcoal inside of homes, garages, vehicles, tents, or campers.
- Never use charcoal indoors, even if ventilation is provided.
- Do not store the grill indoors with freshly used coals since charcoal produces CO fumes.

In 1996, CPSC revised the label on charcoal packaging to more explicitly warn consumers of the deadly CO gas that is released when charcoal is burned in a closed environment. The new label reads:

> *WARNING…CARBON MONOXIDE HAZARD… Burning charcoal inside can kill you. It gives off carbon monoxide, which has no odor. NEVER burn charcoal inside homes, vehicles or tents.*

The new label also visually conveys the written warning with drawings of grills inside a home, tent, and vehicle. The drawings are enclosed in a circle with an "X" through it.

—Donald Switzer, Directorate for Engineering

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

PLEASE DUPLICATE THIS FORM FOR FUTURE USE. CPSC FORM 175A (6/96) OMB CLEARANCE NO. 3041-0029

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 through June 2001, 1623 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, 4 months, was put to bed in a portable play yard at his grandparent's house. The play yard contained a mattress designed for another product with slightly smaller dimensions. The next morning the child was discovered unresponsive, with his face between the mattress and the mesh-sided play yard. The cause of death was asphyxiation.
(Noel Palma, M.D., Medical Examiner, District 15, Palm Beach County, West Palm Beach, FL)

*A male, 8 months, was found unresponsive on his living room floor. A balloon was found in his airway. The cause of death was asphyxiation by foreign body.
(Edward A. Leis, M.D., Deputy Chief Medical Examiner, State of Utah, Salt Lake City, UT)

A female, 7 months, was placed on a couch to sleep. She was later found unresponsive with her face wedged between the cushions. The cause of death was positional asphyxiation.
(Roberta Geiselhart for Garry F. Peterson, M.D., Chief Medical Examiner, Hennepin County, Minneapolis, MN)

CARBON MONOXIDE POISONINGS

*A male, 66, was found dead in his closed garage. A gas-powered generator was found with its power button in the "on" position, and its gas tank empty. The cause of death was carbon monoxide poisoning.
(Adrian C. Moorman, Coroner, San Mateo County, Redwood City, CA)

A male, 5 months, died from carbon monoxide in his home. Another person in the home was taken to the hospital. The source of the carbon monoxide was a space heater. The cause of death was carbon monoxide toxicity.
(A.J. Parish, Coroner, Sebastian County, Fort Smith, AR)

A male, 60, was found dead in his home. His oven was found to be producing high levels of carbon monoxide. The cause of death was carbon monoxide poisoning.
(Roberta Geiselhart for Garry F. Peterson, M.D., Chief Medical Examiner, Hennepin County, Minneapolis, MN)

DROWNINGS

A female, 21 months, was found floating face down in a backyard pool at a family get-together. She apparently had gone through an open garage door and climbed over a small fence to get to the pool. The cause of death was drowning.
(Baxter Dunn, Sheriff-Coroner, San Joaquin County, French Camp, CA)

FIRES

*A male, 39, was found unresponsive inside his mobile home after a fire. The fire started when a kerosene space heater flared up, igniting curtains and other close-by combustibles. He died two days later. The cause of death was complications of thermal injuries.
(C. Madden, M.D., Medical Examiner, Forsyth County, Winston-Salem, NC)

*A male, 46, was trying to start his log splitter in his garage. After he pulled the starter cord several times, the gas tank on the log splitter exploded, engulfing the man in flames. He died five days later. The cause of death was burns of the body.
(Duc Van Duong, M.D., Assistant Medical Examiner, Westchester County, Valhalla, NY)

A male, 37, was using a flammable liquid to clean his bedroom floor. A nearby hot water heater pilot light apparently ignited the liquid, and he suffered serious burn injuries. He died the next day. The cause of death was complications of thermal burns.
(Ann L. Bucholtz, M.D., Medical Examiner, Maricopa County, Phoenix, AZ)

A male, 59, was found in his home after a fire. The fire was caused by flammables placed too close to an electric space heater. Burglar bars on the window impeded his rescue. The cause of death was smoke inhalation.
(Jay M. Glass, M.P.A., Chief Deputy Medical Examiner, Jefferson County, Birmingham, AL)

MISCELLANEOUS

*A female, 23 months, was in the living room while her mother was in the kitchen of their fourth floor apartment. The mother heard her daughter scream and saw her fall through the living room window. The child was found on the ground below, along with the window screen. The cause of death was skull fracture and brain contusion.
(Sigmund Menchel, M.D., Associate Medical Examiner, King County, Seattle. WA)

MECAP COMMENDATION

Dr. James J. Woytash, Chief Medical Examiner, Erie County, Buffalo, NY, has been selected to receive CPSC's MECAP Commendation.

This award recognizes outstanding contributions to CPSC's Medical Examiners and Coroners Alert Project (MECAP), including initiating innovative MECAP reporting techniques. In most cases, MECAP reports are made by the coroner's staff, medical examiner's staff, or by visiting CPSC personnel who review records.

Dr. Woytash's office has been a consistent reporter to CPSC of fatality cases in which consumer products have played a role. This has helped CPSC in carrying out its mission to protect consumers from unreasonable risk of injury or death from consumer products. Dr. Woytash's office has also been extremely cooperative in providing CPSC with autopsy reports and other pertinent information related to deaths involving consumer products.

Dr. Woytash was appointed as Erie County's Chief Medical Examiner in November 2000, and also serves as the Erie County Chief of Pathology. Dr. Woytash has degrees in Medicine and Dental Surgery from the State University of New York at Buffalo. Dr. Woytash also served as a Clinical Assistant Professor of Pathology for the US Navy from 1995 to 1999 and as a physician in the US Navy's Medical Corps from 1990 until his honorable discharge as a Commander in 1999.

Left to Right: Karen Biel-Constantino, Dr. Woytash, Colleen Brzyski

Dr. Woytash's key staff includes Karen Biel-Constantino, a Registered Nurse with a BS degree in nursing, and Colleen Brzyski, a graduate of Simon's School of Mortuary Science, Syracuse, NY, and a licensed New York State Funeral Director. Ms. Brzyski is directly involved with MECAP reporting and reports approximately 70 cases per year to CPSC.

*A male, 47, was riding a bicycle down a hill on a sidewalk. When he applied the brakes, the front wheel buckled and wedged into the frame of the bike. The bicyclist went over the top of the bicycle and hit his forehead on a curb. He was not wearing a helmet. The cause of death was blunt-force head injury.
(Warren E. Rupf, Sheriff-Coroner, Contra Costa County, Martinez, CA)

– 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 CPSC's website at www.cpsc.gov.

Fire Sprinklers

Product: About 35 million fire sprinklers with O-ring seals by Central Sprinkler Company, an affiliate of Tyco Fire Products LP, and about 167,000 O-ring models sold by Gem Sprinkler Company and Star Sprinkler, Inc. The sprinklers were installed nationwide in a wide variety of buildings, including houses, apartments, hospitals, day care facilities, schools, dormitories, nursing homes, supermarkets, parking garages, warehouses and office buildings. The fire sprinkler heads have the words "CENTRAL" or "STAR," the letters "CSC," the letter "G" in triangle, or a star-shaped symbol stamped on either the metal sprinkler frame or on the deflector. Central manufactured 33 million "wet" sprinklers with O-rings from 1989 until 2000, and 2 million "dry" sprinklers with O-rings from the mid-1970's to June 2001. Gem Sprinkler Co. and Star Sprinkler Inc. manufactured 167,000 sprinklers with O-rings from 1995 to 2001. A complete list of all models included in this recall can be found at www.cpsc.gov/cpscpub/prerel/prhtm101/01201.html.
Problem: The performance of these O-ring sprinklers can degrade over time. The sprinkler heads can corrode, or minerals, salts and other contaminants in water can affect the rubber O-ring seals. These factors could cause the sprinkler heads not to activate in a fire. Central has received four reports of "wet" sprinklers failing to activate during a fire and nine similar reports on "dry" sprinklers. These incidents resulted in two property damage claims against Central.
What to do: Building and homeowners should check their fire sprinklers immediately to see if they are part of this voluntary replacement program. For more information on how to identify sprinklers subject to this program and to learn how to participate in this program, call the Notice Packet Request Line at **1-800-871-3492** anytime or access the program's website at www.SprinklerReplacement.com. Central is replacing the sprinklers free-of-charge.

Strollers

Product: About 650,000 multi-use strollers by Century Products Company. The Take 2, Travel Solutions, Pioneer, Travelite and Pro Sport 4-in-1 strollers are for toddlers when used alone and for infants when a car seat/carrier is connected to the top of the stroller. The model names can be found on the footrest, seat pad, legs of the frame or on a white label on the side locks. Mass merchandise, juvenile products and discount department stores nationwide sold these strollers from approximately December 1996 through March 2001 for between $100 and $200.
Problem: The strollers can unexpectedly collapse or the car seat/carrier can fall to the ground. Century has received 681 reports of incidents, including 250 injuries. The injuries include three concussions, two skull fractures, one fractured elbow and two chipped teeth. The remaining injuries include bruises and cuts.
What to do: Stop using these strollers and call Century toll-free at **1-800-766-9998** anytime to order a free repair kit. Consumers can also get the repair kit by visiting the company's website at www.centuryproducts.com or by writing to Consumer Affairs, Century Products, Box 100, Elverson, PA 19520.

High Chairs

Product: About 325,000 high chairs by Peg Perego USA Inc. The high chairs have seats that can be raised or lowered, and a lever on the back of the chair that allows the seat to be tilted back. The chairs are the "Prima Pappa," "Roller," "and "Martinelli Pappa and Nanna." The models names are located on the footrest or on the seat back. Chain stores and independent retailers sold these high chairs from June 1996 through October 1999 for about $180.
Problem: When the seat is reclined, the high chairs have a space between the armrest and backrest in which a child's head or arm can become entrapped. This can pose a risk of suffocation or injury to the heads or arms of young children. Peg Perego and CPSC have received 51 reports of entrapment when children placed their heads or arms in the space between the armrest and backrest. Two children suffered scratches to the head, one had a bruised arm, and another had a scratched arm. There have not been any reports of suffocation.
What to do: Stop using the high chairs immediately and call Peg Perego toll-free at **1-877-737-3464** anytime, or log on to the company's website at www.perego.com to receive free replacement armrests that will eliminate the entrapment hazard. High chairs with 9-inch armrests are not included in this recall.

Car Seats/Carriers

Product: About 3.4 million Evenflo Joyride® infant car seats/carriers with model numbers beginning with 203, 205, 210, 435 or 493. The model numbers can be found on a label underneath or on the side of the car seat/carrier. Juvenile product, mass merchandise and major discount stores nationwide sold the car seats/carriers from January 1988 through December 1998 for about $30 when sold alone, $48 when sold as a Travel Tandem® and $89 when sold with a matching stroller.
Problem: When the seat is used as an infant carrier, the handle can unexpectedly release causing the seat to flip forward. When this happens, an infant inside the carrier can fall to the ground and suffer serious injuries. There have been 240 reports in the United States of handles unexpectedly releasing, resulting in 97 injuries. Injuries include skull fractures, concussions, a broken leg and numerous scratches and bruises.
What to do: Call Evenflo toll-free at **1-800-557-3178** anytime, or visit the company's website at www.joyridecarseat.com to receive a free repair kit. Consumers should not carry the seat by the handle until it has been repaired.

Notebook Computer Batteries

Product: About 284,000 notebook computer batteries by Dell Computer Corporation. The batteries were sold in Dell Inspiron 5000 and 5000e notebook computers and sold separately for use in both of these systems. The words "DELL," "MADE IN JAPAN," and "Inspiron 5000 Battery Module" are printed on the top of the batteries. Batteries with identification number "99" or the series "00 51" or less, and the letter "P" in the first line are being recalled. Dell sold these batteries nationwide through catalogs and over the Internet from January 2000 through March 2001. The computers with these batteries were sold for between $2,100 and $3,100, and individual batteries were sold for between $100 and $130.
Problem: The batteries can overcharge, causing them to become very hot, release smoke, and possibly catch fire. Dell has received one report of a battery overcharging, resulting in minor property damage. No injuries have been reported.

What to do: Stop using the batteries immediately and call Dell toll-free at (877) 237-3355 or go to Dell's website at www.dell.com to order a free replacement battery. Consumers can also write to the company at Dell Computer Corp., RR2E, MSC #8222, One Dell Way, Round Rock, TX 78682.

Product: About 570,000 AC adapters by Apple. The small rectangular black AC adapter box has a permanently attached cord on one end that connects to the computer and a detachable two-prong cord on the other end to plug into an AC outlet. The label located on the side of the adapter reads in part, "Macintosh PowerBook 45W AC Adapter" and "Model Number: M4402." Electronic and computer stores worldwide and Apple's website sold these AC adapters with PowerBook G3s from May 1998 through March 2000. They were also sold separately for about $69.
Problem: The AC adapters could overheat, posing a fire hazard. Apple received six reports of these adapters overheating. No injuries have been reported.
What to do: Stop using these AC adapters and contact Apple to receive a free replacement. For more information, contact Apple at **1-866-277-2096** between 8 a.m. and 8 p.m. CT Sunday through Saturday, or go to their website at www.apple.com/adapterexchange/.

Restaurant Toys

Product: About 2.6 million toddler toys by Burger King Corp. and Alcone Marketing Group. The "Hourglass Space Sprout" is a multicolored toy with a green smiling head, a clear hourglass filled with beads, and two red balls with yellow spots and arms. The "Look for Me Bumblebee" has a purple base with a green leaf, a yellow head, and three rings that fit over the head. On the back of the toys are the words, "Sassy®," "Burger King™" and "MADE IN CHINA." Burger King Restaurants nationwide distributed the toys inside Kid's Meals from January 2001 through July 2001.
Problem: The toys can break causing small beads or balls to be released, posing a choking or aspiration hazard to young children. Burger King Corp. has received 18 reports of the toys breaking. There are six incidents where children had the balls in their mouths, but no injuries were reported.
What to do: Immediately take the toys away from children and call **1-800-661-9173** for instructions on returning the toy for a free replacement toy. Information also is available at Burger King's website at www.burgerking.com.

Product: About 330,000 toys by Creative Consumer Concepts, Inc., and Whataburger, Inc. The "Whatagear" compass toys were distributed with kids' meals at Whataburger Restaurants. The toys have varied features such as flashlights, magnifying lenses or tools, and come in various solid colors. Whataburger Restaurants in Alabama, Arizona, Florida, Louisiana, New Mexico, Oklahoma and Texas distributed the toys from March 2001 through April 2001.
Problem: The clear, plastic lens covers on the compass toys can come off and pose a choking hazard to young children. Creative Consumer Concepts, Inc. has received four reports of the lens covers coming off. No injuries have been reported.
What to do: Take the toys away from children immediately and return the toy to any Whataburger Restaurant for a free replacement. For more information, call Creative Consumer Concepts toll-free at **1-866-327-2216** anytime; write to Creative Consumer Concepts Inc., ATTN: Compass, 10955 Granada Lane, Overland Park, KS 66211; or go to the firm's website at www.c3.to.

Product: About 234,000 toys by McDonalds Corporation. The Scooter Bug toy is about 3 inches long and 2 1/2 inches wide. The bug has a yellow face with red antenna, orange feet and a purple body with green spots. When rolled across the floor, the bug's legs move back and forth. The words "Fisher Price" are on the top of the toy. McDonald's restaurants in the U.S. and Canada distributed the toys with Happy Meals from November 2000 through February 2001.
Problem: The bug's antenna can break off posing a choking hazard to young children. McDonald's has received two reports of children choking and one report of a child gagging on the broken-off antenna.
What to do: Take the toy away from children immediately and return the toy to any McDonald's restaurant for a replacement toy. For more information, consumers should visit McDonald's website at www.mcdonalds.com. Questions about this recall should be directed to CPSC's hotline at **1-800-638-2772.**

Product: About 400,000 toys by Burger King Corporation and Alcone Marketing Group. The "Rattling, Paddling Riverboat" toys are red plastic boats about 2 to 3 inches in diameter. When the boat moves across the floor, beads in the boat's paddle wheel make a rattle sound. The following words are imprinted on the bottom of the boat, "Sassy, MFG FOR BURGER KING CORP, MADE IN CHINA." Burger King restaurants nationwide distributed the riverboat toys inside Kid's Meals in January and February 2001.
Problem: Metal pins with plastic caps that attach the paddle wheel to the riverboat toy can come out and pose a choking hazard. Burger King Corp. has received 10 reports that the pin on the toy came out. One child was found with the pin in her mouth, which her father removed. No injuries have been reported.
What to do: Immediately take the toy away from children and call **1-800-661-9173** for instructions on returning the toy for a free replacement toy. Information is also available at Burger King's website at www.burgerking.com.

Zapper Toys

Product: About 835,000 Zapper toys by the following eight firms: Bonita Marie International, Dillion Importing Co., Oriental Trading Co. Inc., Play By Play Toys & Novelties Inc., Rhode Island Novelty, Sherman Specialty Co. Inc., Toy Investment Inc., and U.S. Toy Co. Inc. The vinyl Zapper toys are about 2 to 3 inches long and come in 12 different styles: smiley face, globe with glasses, troll, bumble bee, lion, bear, tiger, raspberry face, fish, frog, snake and lizard. When the toy is squeezed, the balloon tongue attached to its mouth inflates and rolls out. Toy stores, doctor and dentist offices, and carnivals and circuses sold and distributed these toys from October 1998 through March 2001 for about $1.
Problem: The balloon tongues and the cylinders holding the tongues on these toys can detach posing a choking and aspiration hazard to young children. The Promotional Resources Group of Companies Inc., previously recalled about 105,000 Bug Zapper toys on June 6, 2000. That company received a report of a 3-year-old who inhaled a balloon tongue that detached from a Zapper toy into his sinus cavity. He required medical treatment to remove the part from his nose.
What to do: Immediately take these toys away from young children and take the toy back to where they were purchased for a refund, or throw them away. If consumers have questions, call CPSC at **1-800-638-2772** anytime.

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