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This publication should be considered a staff document. It has been approved informally by CPSC Commissioners Thomas H. Moore and Mary Sheila Gall.

Children and In-Home Drownings

Staff from the U.S. Consumer Product Safety Commission (CPSC) recently released a report on non-pool home drowning incidents involving children under 5. From 1996 through 1999, CPSC is aware of 459 children under 5 who died from complications of drowning or near-drowning in products located in and around the home.

The products included bathtubs, 5-gallon buckets, spas or hot tubs, toilets, and other products holding water (*Figure 1*). (Swimming and wading pools were not part of the study; see *Preventing Swimming Pool Drownings*, page 3.)

In-Home Drowning Deaths Children Under 5, '96 – '99.*

Bathtubs	292
5-Gallon Buckets	58
Spas and Hot Tubs	55
Toilets	16
Other Products	38
Total Consumer Product-Related Drowning Deaths	**459**

*Drowning deaths as reported to CPSC's databases. Not included are drowning deaths associated with swimming pools or wading pools.

Figure 1

Bathtubs

The most frequent cause of children's drowning deaths in the home was submersion in bathtubs. From 1996 through 1999, CPSC had reports of 292 children under 5 who died from drowning in bathtubs. These included incidents involving other products used in the tub, such as bath seats or bathinettes.

The children most frequently involved in the fatal drowning incidents were those under 1-year-old (*Figure 2, page 2*). There were 148 children under 1 who died after a drowning or near-drowning incident in a bathtub, constituting just over half of all bathtub fatalities for children under 5. Of the remaining children, 93 were between 12-months and 23-months-old; 20 children were 2-years-old; 14 children were 3-years-old; and 17 children were 4-years-old.

The majority of the children, 179 of the 292, were reported to have been in the bathtub without a bathing aid. In 29 of the bathtub drowning incidents, the victims were reported to have been using baby bath seats. Of these 29 incidents, 24 involved children in the age range of 5 to 10 months, the recommended age for bath seat use.

Other products were involved in 17 of the bathtub drowning incidents, including baby baths or bathinettes (6 incidents), inflatable pool products (5 incidents), and a kick board (1 incident). Products not intended for use in water situations, but involved in some of the 17 incidents, included one seat/carrier and one bassinet/cradle.

Whether the child was supervised in the bathtub was known in 231 incidents. In 222 of these incidents, the child was reported to have been left unsupervised in the bathtub.

In 189 of the 292 cases of children under 5 who drowned in a bathtub, the child was placed into the bathtub by a parent or caregiver. In 103 of these 189 incidents, another child (most often a sibling) was placed in the bathtub with the victim or was watching the victim during some portion of the bath.

Continued on page 2

Drownings *cont. from page 1*

In 41 of the 292 bathtub drowning deaths, the victim either fell into the bathtub, climbed into the bathtub, or was placed in the bathtub by another child. In these cases, the parent or caregiver did not intend for the child to be in or near the bathtub at the time of the incident.

5-Gallon Buckets

From 1996 through 1999, CPSC has reports of 58 children under 5 who died from complications related to drowning after falling into 5-gallon buckets. All of the children were 18-months-old or younger when the incident occurred. Fifty-six of the children died from complications within one month of the incident; the other two children survived longer, but eventually died at ages 2 and 4 of complications related to the 5-gallon bucket drowning incident.

The 5-gallon buckets were used for a number of household tasks, but most frequently for cleaning the home. Thirty-eight of the children died when they fell into 5-gallon buckets filled with cleaning solutions of water and bleach, detergent, soap, pine cleaner, and/or ammonia. Most of the 5-gallon bucket drowning deaths involved buckets containing dirty water that had not been emptied for some time.

The 5-gallon buckets were found in multiple locations in the homes. Most frequently, the buckets were in the kitchen (20 incidents). Buckets also were found outside the homes on patios, in backyards, and in apartment hallways (9 incidents), in bathrooms (7 incidents), in bedrooms (7 incidents), in garages, utility rooms, and laundry rooms (6 incidents), in living rooms (3 incidents), and in hallways within the residence (2 incidents). The location of the bucket was unknown in the remaining 4 incidents.

Spas and Hot Tubs

Unlike buckets or bathtubs that do not need to hold water beyond their immediate use, residential spas and hot tubs hold a large amount of standing water for an extended period of time. These spas and hot tubs can be found in backyards, on decks and porches, and inside homes.

From 1996 through 1999, CPSC was aware of 55 children under 5 who died as a result of drowning in residential spas or hot tubs. Five children were under 1-year-old; 26 children were between 12-months and 23-months-old; 16 were 2-years-old; 6 were 3-years-old; and 2 were 4-years-old.

In some incidents, the children reportedly accessed the spas and hot tubs through open gates, broken gates, and sliding glass doors. Some of the children were found under soft covers on the spa; other children gained access to the spa when a cover was left open.

Toilets and Other Products

From 1996 through 1999, 16 children under 5-years-old drowned in household toilets. The incidents all involved children under age 3, usually falling headfirst into the toilet. Eight children were under 1-year-old; 5 children were between 12-months and 23-months-old; and 3 children were 2-years-old when they drowned in the toilets.

In addition, during this time period, 38 children under 5 drowned in other products around the home. Eleven children drowned in buckets other than 5-gallon buckets.

From 1996 through 1999, 7 children drowned in home landscape ponds. All the children were 2-years-old or younger when they fell into the ponds and drowned.

Other drowning incidents involved sinks (4 children), water coolers (3 children), garbage cans (3 children), bathroom floors (2 children), cookware (2 children), an outdoor garbage dump, an outdoor drainage pot, a horse trough, a fish tank, a diaper pail, and a septic tank. Thirty-two of the 38 children fell into the product in which they drowned.

Bathtub Drowning Deaths, Children Under 5, '96-'99.

TOTAL BATHTUB DROWNING DEATHS	**292**
AGE	
Birth to 11-months-old	148
12-months-old to 23-months-old	93
2-years-old	20
3-years-old	14
4-years-old	17
PRODUCT INVOLVEMENT	
No other product involved	179
Bath seat involved	29
Other product involved	17
Unknown	67
SUPERVISION	
No supervision	222
Supervised	9
Unknown	61
HOW VICTIM GOT INTO BATHTUB/ SIBLING INVOLVEMENT	
Placed in bathtub by caregiver	
Without another child	83
With another child	103
Unknown	3
Fell/crawled into bathtub or Placed into bathtub by another child	
Without another child	14
With another child	26
Unknown	1
Unknown how victim got into bathtub and unknown whether another child was involved	62

Figure 2

Home Safety Tips

To help prevent in-home drownings of children, CPSC staff recommends taking the following precautions.

- Never leave a baby alone in a **bathtub** for even a second. Don't leave a baby in the care of another

young child. If you must leave the room, take the baby with you.

- A **baby bath seat** is not a substitute for supervision. Babies can slip or climb out of bath seats. Never use a baby bath seat in a non-skid, slip-resistant bathtub because the suction cups may not adhere to the bathtub surface or may detach unexpectedly.
- Never leave unattended a **bucket** containing any liquid. When finished using the bucket, empty it immediately. Store buckets where young children cannot reach them.
- Always secure the **safety cover on a spa or hot tub** when it is not in use. Some non-rigid covers, such as solar covers, can allow a small child to slip into the water, while the cover still appears to be in place.
- Keep the **toilet** lid down to prevent access to the water. Consider using a toilet clip to stop young children from opening the lids and/or consider placing a lock or latch on the bathroom door out of reach of young children to prevent unsupervised access to the bathroom.

— *Debra Sweet, Directorate for Epidemiology*

Preventing Swimming Pool Drownings

About 350 children under age 5 drown in swimming pools each year. To prevent these drownings, be sure to use several layers of protection.

- **Fences and walls** should be at least 4 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 your house forms one side of the barrier to the pool, then doors leading from the house to the pool should be protected with **alarms** that sound when a door is unexpectedly opened.
- A power **safety cover —** a motor-powered barrier that can be placed over the water area — can be used when the pool is not in use.
- Keep **rescue equipment** by the pool and be sure a phone is poolside with emergency numbers.
- For above-ground pools, **steps and ladders** to the pool should be secured and locked, or removed when the pool is not in use.
- **Pool alarms** can be used as an added precaution.
- If a child is missing, **always look in the pool first**. Seconds count in preventing death or disability.
- Learn **CPR** (cardiopulmonary resuscitation) for emergencies.

Baby Walkers

With baby walker-related injuries continuing to decrease, CPSC terminated its mandatory rulemaking proceeding on baby walkers this past spring. Baby walkers used to account for more injuries than any other type of nursery product. The majority of these injuries occurred when children in baby walkers fell down stairs.

In response to those injuries, CPSC began a rulemaking proceeding on baby walkers in 1994. At that time, CPSC staff also worked with ASTM to add new performance requirements addressing stair-falls to the voluntary safety standard on baby walkers.

The new voluntary requirements were published in early 1997. Around that time, manufacturers began to market baby walkers designed to stop at doorway entrances to stairways or at the top of stairs.

To determine the effectiveness of these measures, CPSC staff conducted special studies of recent baby walker incidents, especially those involving falls down stairs. The staff determined that most of these incidents involved baby walkers that did not meet the new voluntary standard and were probably manufactured before publication of the new safety requirements.

According to the Juvenile Products Manufacturers Association, walkers that comply with the ASTM stair-fall requirements currently account for more than 98% of the walkers for sale in the U.S. The CPSC staff believes the high level of industry compliance has contributed to the substantial reduction in walker-related injuries.

Walker-Related Injuries

In recent years, injuries associated with baby walkers have declined significantly (*Figure 3*). In 1995, an estimated 20,100 children younger than 15 months were treated in U.S. hospital emergency departments for baby walker-related injuries. By 2000, that number had dropped to an estimated 7,400 young children, a decline of 63%.

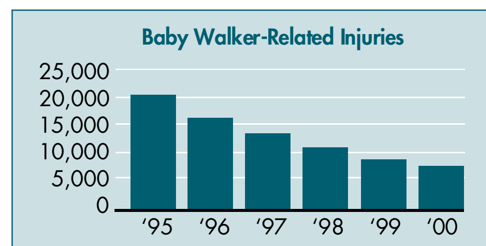

Figure 3

This drop cannot be attributed to a decrease in births over the six-year time period or a decrease in baby walker sales. CPSC staff expects injuries to continue to decline as new baby walker designs replace old-style walkers in U.S. homes.

— *Barbara J. Jacobson, Directorate for Health Sciences*

Unpowered Scooters

With the introduction of the new, popular unpowered scooters in 2000, injuries increased rapidly and peaked dramatically in 2001. The injuries have since declined.

U.S. hospital emergency room-treated injuries involving unpowered scooters spiked to an estimated 13,530 in April 2001 at the height of the scooters' popularity. This increase in injuries can be attributed largely to the fact that many more people (especially children) were buying and riding unpowered scooters than in the past.

That estimate compares with approximately 3,000 injuries per month in recent months *(Figure 4)*. Still, injuries remain relatively high. Prior to 2000, estimates of injuries associated with scooters have been under 3,000 *each year.*

As the injuries increased, CPSC also received many reports of product failures and problems with the scooters. Some scooters were recalled.

At the urging of CPSC staff, the voluntary standards-setting organization ASTM developed a provisional safety standard for unpowered scooters and published it in 2001.

Scooter Usage

According to the National Sporting Goods Association (NSGA), approximately 11,622,000 people ages 7 and older rode a scooter at least one time during the year 2000.

In 2000, children ages 7-11 were the primary users of scooters. In this age group, approximately one out of every three children rode a scooter at some time during 2000. This group represented about 60% of the scooter users and accounted for almost 60% of the emergency-room-treated injuries.

Among children 12–17, one in eight rode a scooter during 2000. Among adults 18 and older, one in every 106 people rode a scooter during the year. The 7–11 age group experienced 1,063 scooter-related injuries per million population in 2000. By comparison, adults 18 and older experienced 23 injuries per million population.

While the greatest injury total was in the 7–11 age group, the actual risk of injury per day of riding was much lower than other age groups. This was because children were by far the largest group of scooter riders and the most frequent riders.

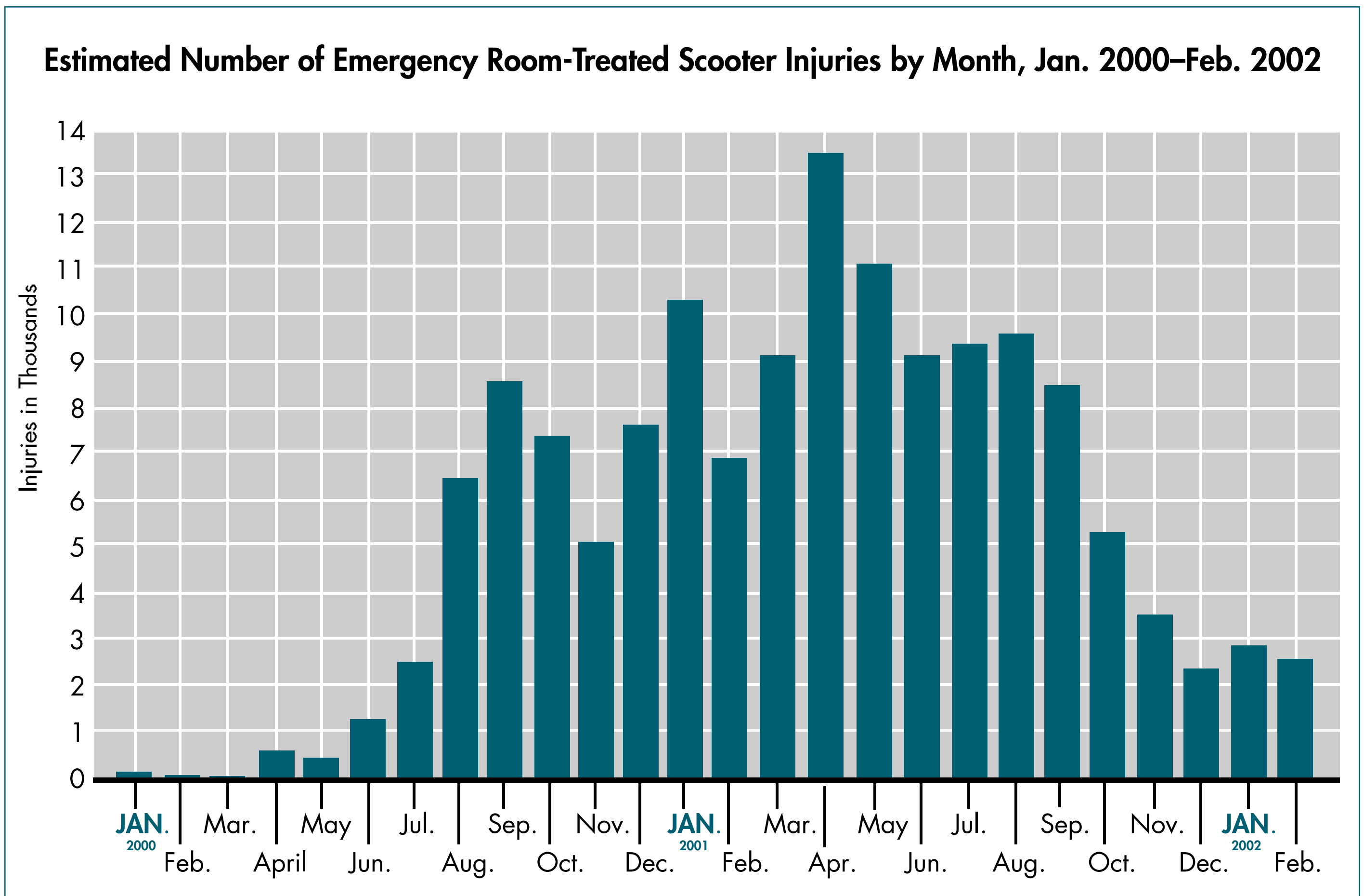

Figure 4

Scooter-Related Deaths

From January 1999 through February 2002, 20 deaths related to unpowered scooters have been reported to CPSC. All of these deaths have occurred since the summer of 2000. All but three happened in 2001.

Thirteen of the 20 deaths involved motor vehicles striking the victims. With the exception of two 18-year-olds, all of the victims in these cases were children 12 or younger.

Six deaths resulted from falls. Four of the six deaths from falls were to adults. The two children who were killed were 10-year-olds who died of head injuries after falls. Neither was wearing a helmet.

For one death (an adult), the circumstances involved were not reported.

CPSC Special Study

To help identify issues that might be addressed in the ASTM safety standard and to provide information to parents and children who purchase scooters, CPSC staff conducted a special study of scooter injuries, using telephone interviews with injury victims or their parents.

During the study period (December 2000 to June 2001), U.S. hospital emergency rooms treated an estimated 61,340 injuries associated with unpowered scooters. Of these, 46,040 (75%) were falls.

The overwhelming majority of scooter-related injuries occurred to children between 4 and 15 years old, although a small percentage occurred to adults ages 20 and older (8%).

The hazard patterns associated with the most injuries (and for which an identifiable single hazard pattern could be determined) included falls: when the scooter wheel(s) hit something small (like a rock); while doing tricks; and when trying to stop.

■ **Fell When Wheel Hit Something Small** (15,220 injuries): Twenty-seven percent of the estimated injuries from completed investigations occurred when a rider fell after hitting something small – such as a pebble, crack, or other irregularity in the riding surface. The most frequent injury was a fracture of the arm or hand (29%).

The 12-and-over age group represented 37% of those injured. Experienced scooter riders were also overrepresented in this category – with 71% of those injured described as “somewhat” or “very” experienced (compared with 57% across all hazard patterns).

■ **Fell Doing Tricks** (7,120 injuries): Approximately 13% of the injuries for which a hazard pattern could be identified occurred when the rider was doing tricks. Tricks included hopping while the scooter was in motion or stationary, jumping over obstacles with the scooter, doing wheelies, scootering on ramps, or other similar activities. The most common injury was a fracture to the leg or foot.

A disproportionately high number of these injuries occurred to the 12-and-over age group (42% of the 7,120 injuries). The 12-and-over group represented 31% of injuries in all hazard patterns.

■ **Fell When Trying to Stop** (5,130 injuries): Nine percent of the estimated injuries for which a hazard pattern could be identified were attributed to falls that occurred while trying to stop. The estimate includes cases in which the victims stated that they tried to stop, but were going too fast and jumped off. Over half of the injuries were fractures, most often to the arm or hand. This hazard pattern was associated with a disproportionately high number of victims in the 12-and-over age group (47%).

Other Study Findings

The CPSC special study also contained the following conclusions.

■ **Condition of the Scooter** – Almost 9 of every 10 scooters (89%) involved in the injuries were described as being in either “excellent,” “like new,” or “good” condition at the time of the injury.

■ **Manufacturers** – Two manufacturers of scooters were identified in 48% of the injuries for which the manufacturer was known. Those manufacturers represented about 63% of the scooters sold since the new type of scooter appeared.

■ **Cost of the Scooter** – Cost of the scooter was not known in a large number of cases. Forty-seven percent of the injuries for which the price of the scooter was known involved scooters costing $50 or less. Scooters produced by major manufacturers were almost all priced above $75.

■ **Safety Equipment Use** – Only 43% of scooter riders reported that they used safety equipment always or usually when riding scooters. Forty-nine percent reported that they rarely or never wore any safety equipment.

Comparison with Other Products

CPSC staff compared scooter injury rates with injury rates for similar products – including skateboards, in-line skates, and bicycles *(Figure 5, page 6)*.

The comparison showed that:

■ Scooter riding had the lowest rate of emergency-room-treated injury per 1,000 participants among the four products/activities (3.09 per 1,000).

Methodology: Data in this report came from six sources: the National Electronic Injury Surveillance System (NEISS); the data collected through telephone investigations for the CPSC scooter special study, using injuries reported through NEISS; the National Sporting Goods Association's (NSGA) study ***Sports Participation in 2000;*** CPSC's Death Certificate Database (DTHS); CPSC's Injury or Potential Injury Incident database (IPII); and the United States 2000 Census.

Injury Rates and Comparison with Other Riding Products, 2000 (Ages 7+)

Product/ Activity	ER*-Treated Injuries	Participants	Rate per 1,000 Participants	Days of Participation	Injury Rate per 10,000 Days of Participation
Scooters	35,952	11,621,000	3.09	347,467,900	1.03
Skateboards	82,794	9,059,000	9.14	329,747,600	2.51
In-Line Skates	86,215	21,817,000	3.95	503,972,700	1.71
Bicycles	535,279	42,546,000	12.58	2,608,069,800	2.05

*Emergency Room

Sources: CPSC, NSGA

Figure 5

■ Bicycling had the highest rate of emergency-room-treated injuries (12.58 per 1,000).

■ Bicycle riders reported more than twice as many days of riding (61.3) on average than did scooter riders (29.9) in 2000. But the injury rate for bicycles (2.05 per 10,000 days) was still double the rate for scooters (1.03 per 10,000 days).

■ When considering the injury rates per 10,000 days of participation for these four activities, skateboarding was associated with the highest rate of injury. The skateboarding rate (2.51 per 10,000 days) was almost 2 1/2 times the rate for scooters.

■ Scooters were associated with the lowest rate of injury among those four products, regardless of which exposure measure was used.

Effects of Scooter Trend on Other Activities

The scooter study also looked at the effect of scooter use on similar activities like skateboarding, bicycling, and in-line skating. After obtaining a new scooter, more respondents reported using a non-scooter product less than those who reported using the non-scooter product more. In fact, there is evidence of decreasing injuries associated with bicycles and in-line skates. Skateboard injuries increased slightly.

Overall, while the number of scooter-related injuries was large, the reduction in injuries associated with other riding products/activities almost canceled out this increase in terms of the overall public health burden of injuries associated with products of this type.

For More Information

The following firms, in cooperation with CPSC, have issued recalls for unpowered scooters: Kash N'Gold Racer, Kent Kickin' Mini-Scooter, Excite Super Speeder II, and Viper.

For more information about these recalls or a complete copy of the CPSC study *Unpowered Scooters,* please visit www.cpsc.gov.

Conclusions

The CPSC analysis reached the following conclusions.

■ While scooter injuries increased rapidly over the study period, the trend appears to be reversing. There are still, however, considerably more injuries each month associated with scooters than there were before the introduction of the new type of scooter.

■ The effect of the increase in scooter injuries on total injuries appears to have been largely cancelled out by decreases in injuries associated with bicycles and in-line skates.

■ Compared with other riding products/activities used by children, scooters had the lowest rate of injury per 1,000 participants and the lowest rate of injury per 10,000 days of use among four products (scooters, skateboards, bicycles, and in-line skates).

■ Many of the scooter products involved in the injuries were inexpensive imitations of the scooters initially introduced into the market. Many of these brands have gone out of business.

■ Almost 50% of the persons injured during the study period were reported to have rarely or never worn any safety equipment while riding the scooter.

– George W. Rutherford Jr., MS, Robin L. Ingle, MA, and Alberta E. Mills, BA, Directorate for Epidemiology

Safe Scootering

The best investment against injury while riding an unpowered scooter is protective gear—which can cost less than $30. CPSC recommends the following safety guidelines.

■ Wear a helmet, along with knee and elbow pads.

■ Make sure both handle bars and the steering column are securely locked in place before riding.

■ Routinely check all nuts and bolts to be sure they are secure.

■ Ride the scooters on smooth, paved surfaces without any motor vehicle traffic. Avoid streets and surfaces with water, sand, gravel, or dirt.

■ Do not ride the scooter at night.

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 December 2001 and January 2002, 823 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, 2, was found unconscious on the ground outside of his home by a neighbor. Emergency Medical Services (EMS) personnel responded and found a small rubber ball obstructing the boy's airway. EMS used the Heimlich maneuver to remove the ball, and the boy was taken to a hospital where he died a short time later. The cause of death was "mechanical obstruction of upper airway by rubber ball." (Mark Guilbeau, PhD., for Carol Terry, M.D., Associate Medical Examiner, Fulton County, Atlanta, GA)

A male, 3 months, was placed on his right side on a double bed to sleep. His head was on a single pillow, and his mother covered him with a sheet and comforter. When his mother returned about 40 minutes later, she found the child unresponsive with his face in the pillow. The cause of death was suffocation by rebreathing into bedding. (Jane Turner, M.D., Assistant Medical Examiner, City of St. Louis, MO)

A male, 18 months, was placed on a waterbed while in his combination baby carrier/car seat. He was left unattended for about 40 minutes. His mother returned to find the child face down on the waterbed with the baby carrier/car seat on top of him. He died three days later. The cause of death was hypoxic encephalopathy secondary to positional asphyxia. (Richard Greathouse, M.D., Coroner, Jefferson County, Louisville, KY)

A widow, 78, was mowing her lawn with her riding mower. She was later found unresponsive with the mower on top of her, and the mower wheels still running in reverse. The cause of death was mechanical asphyxia. (Kathrine Descheneaux for Thomas Andrew, M.D., Chief Medical Examiner, State of New Hampshire, Concord, NH)

A male, 8 months, was placed on his back on a soft-sided waterbed for a nap. His mother took a nap in another room. She returned later to find the child unresponsive and face down on the bed. He was entangled in piled bed linens. The cause of death was asphyxia due to suffocation. (Deputy Medical Examiner, Elizabeth Peacock, M.D., Travis County, Austin, TX)

CARBON MONOXIDE POISONINGS

*A male, 66, was found dead on a cot in a tent. A propane heater with its fuel tank empty was found in the tent. The heater was turned on but not running, and the line to the propane fuel tank was open. The cause of death was asphyxia due to carbon monoxide poisoning. (Louis Roh, M.D., Deputy Medical Examiner, Westchester County, Valhalla, NY)

*A male, 52, was found dead sitting in a chair in his living room. A gasoline-powered generator, which was turned on, was discovered in the basement, and the gas tank was empty. The generator was being used to provide heat for the home after a fallen tree branch had cut off electricity. The cause of death was inhalation of carbon monoxide. (Norman Thiersch, M.D., Medical Examiner, Snohomish County, Everett, WA)

*A male, 12, was found unresponsive in his bed. A portable generator was operating on the deck of the home. A door and window were open, and extremely high levels of carbon monoxide were present in the home. The cause of death was carbon monoxide poisoning. (E. L. Kinnison, M.D., Assistant Chief Medical Examiner, Tidewater District, Norfolk, Virginia)

DROWNINGS

*A male, 21 months, was found floating face down in an unused hot tub in the backyard of his grandparents' home. The hot tub had several floating toys in it, and was uncovered because the lid was broken. The boy was taken to a hospital where he died less than an hour later. The cause of death was asphyxia due to drowning. (Gordon Sonne, Sheriff-Coroner, Monterey County, Salinas, CA)

A male, 11 months, fell into the hot tub at his home, and died. The child had been left with an older sibling who had fallen asleep. The hot tub was level with the floor, and a sliding glass door leading to it was left open. The cause of death was drowning. (Chris McNeil for Arkady Katsnelson, M.D., Director of Pathology Services, Office of the State Medical Examiner, Farmington, CT)

A female, 17 months, was found in a hot tub filled with water in the master bedroom of her home. She died three days later at a hospital. The cause of death was hypoxic encephalopathy due to near drowning. (John B. Parker, M.D., Associate Medical Examiner, Gwinnett County, Lawrenceville, GA)

A female, 18 months, was found floating unresponsive in her family's 4-foot backyard pool. The child was in the care of a parent who lost sight of the child for a short time. The child opened a gate, climbed a ladder, and entered the pool. The cause of death was drowning. (Robert Golden for Gwen Harleman, M.D., Deputy Medical Examiner, Suffolk County, Hauppauge, NY)

MECAP COMMENDATION

Dr. Elizabeth K. Balraj, Coroner, Cuyahoga County, Cleveland, OH, 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 staff who review records.

Dr. Balraj's office has been one of the most consistent reporters to CPSC of fatality cases in which consumer products have played a role. In the past four years, her office has reported 1,257 such cases. Dr. Balraj's office also has been very helpful in CPSC's investigations of many of these deaths by providing requested information and reports.

Dr. Balraj is a graduate of the Women's Christian College and the Christian Medical College Hospital in Vellore, India. She immigrated to the

United States in 1966 and worked in Anatomic Pathology at Akron General Hospital, Akron, OH, and St. Luke's Hospital, Cleveland, OH. She began working in and did her Forensic Pathology fellowship at the Cuyahoga County Coroner's Office in 1972. She was appointed Coroner of Cuyahoga County in 1987. She was elected Coroner in 1988 and has been reelected to that office ever since.

Dr. Balraj is Board Certified in Anatomic Pathology and Forensic Pathology. She is an Assistant Professor in Forensic Pathology at Case Western Reserve University School of Medicine and has lectured there since 1973. She is a past president, chairperson, and current member of the Board of Directors of the Ohio State Coroners' Association. She also is a member of the National Association of Medical Examiners, diplomate of the American Board of Pathology, and a fellow of the American Academy of Forensic Sciences.

FIRES

*A male, 20 months, was found unresponsive in his bedroom after a fire. The child and his 4-year-old sister were playing unattended in the bedroom. They knocked over a halogen floor lamp, which ignited combustibles on a bed. The 4-year-old was able to escape, but rescuers could not reach the other child due to heat and flames. The cause of death was smoke inhalation. (E. L. Kinnison, M.D., Assistant Chief Medical Examiner, Tidewater District, Norfolk, Virginia,)

*Two males, 17 and 11, and a female, 6 months, were found dead inside their home after a fire. The home was heated by space heaters that ignited combustibles placed too close to the heaters. Security bars without emergency release mechanisms were found on all of the first floor windows. Two other family members escaped from a second floor window or through the front door. The cause of death for the three children was soot and smoke inhalation. (Cheryl Loewe, M.D., and Yung A. Chung, M.D., Associate Medical Examiners, Wayne County, Detroit, MI)

MISCELLANEOUS

A male, 2, was playing in his bedroom with a 12-year-old relative. The 2-year-old was climbing a dresser when a 25-inch television on top of the dresser fell onto his head. He was taken to a hospital where he died two days later. The cause of death was acute head injuries. (E. L. Kinnison, M.D., Assistant Chief Medical Examiner, Tidewater District, Norfolk, Virginia)

A male, 3, was in his third-floor apartment with his mother. He pushed out a window screen and fell out the window, striking a concrete slab below. The unconscious boy was taken to the hospital where he died two days later. The cause of death was blunt force head trauma. (William E. Hauda, M.D., Medical Examiner, Northern Virginia District, Fairfax County, Falls Church, VA)

—Denny Wierdak, Directorate for Epidemiology

CPSC Recalls

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

Plush Bears

Product: About 4 million **plush Snuggle® bears by Unilever Home and Personal Care USA.** The plush, cream-colored bears come in three sizes: a 5-inch bean bear, an 8-inch bean bear and a 10-inch stuffed bear. The 5-inch bears come in four styles: Pajama Bear wears blue, one-piece pajamas with a yellow moon and star design; Nightcap Bear wears a blue nightcap with a yellow moon and star design; Purple Blanket Bear holds a purple blanket; and Pink Blanket Bear holds a pink blanket. The 8-inch bean bear is made of terry or plush fabric. The 10-inch plain stuffed bear is in a sitting position and has tan paws and ears. All the bears have tags that read "Snuggle®" and "Made in China." Grocery and discount department stores nationwide sold the Snuggle fabric softener that included the 5-inch and 8-inch bears between May 1999 and July 2001. The Pajama and Nightcap 5-inch bears also were given away to consumers who sent in two proofs of purchase for Snuggle fabric softener between November 2001 and December 2001. The 10-inch bears were distributed from May 1997 through May 1998 to consumers who sent in a proof of purchase for Snuggle fabric softener and up to $4.

Problem: The eyes and noses of these bears can come off, posing a choking hazard to young children. Unilever Home and Personal Care USA has received 32 reports of the eyes and noses coming off these bears. In three of these reports, children placed detached eyes from these bears in their mouths. No injuries were reported.

What to do: Take these bears away from young children immediately and contact Unilever Home and Personal Care USA for information on how to receive a coupon for free Snuggle fabric softener. Contact Snuggle at 800-896-9479 anytime, or visit its website at www.Snuggletime.com.

Toasters

Product: About 2.1 million VersaToast™ **wide-slot toasters by Applica Consumer Products Inc.** Applica made and sold these toasters under the Black & Decker® brand. The recall includes both two-slice and four-slice Black & Decker® brand VersaToast™ wide-slot toasters. "BLACK & DECKER®," "VersaToast™" and "WIDE SLOT" are written on the side of the toaster near the cooking controls. The toasters have either white or black plastic enclosures. They have model number T1200, T1250, T1400 or T1450 written on the bottom of the toaster. Discount department stores, including Wal-Mart, Service Merchandise, Kohl's Department Stores and Bradlees, sold the toasters nationwide from June 1999 through January 2002. The two-slice toasters sold for between $10 and $20. The four-slice toasters sold for between $18 and $30.

Problem: The heating element in these toasters can continue to operate after use, posing a fire hazard. CPSC and Applica are aware of nine reports of fires associated with these toasters after a period of non-use, resulting in minor property damage to kitchen cabinets. One minor injury was reported to the firm, but it has not been confirmed and is under investigation.

What to do: Stop using these recalled toasters immediately. For more information on receiving a refund, consumers should call Applica Consumer Products Inc. toll-free at 866 264-9230 anytime, or go to the firm's website at www.householdproductsinc.com.

Handheld Saws

Product: About 1.9 million **handheld saws by Roto Zip Tool Corporation.** The recall includes Revolution®, Rebel™ and Solaris™ model Spiral SawTM power tools. The brand name and "ROTOZIP SPIRAL SAW" are written on the side of the tools. The saws are mostly black or red. The recalled saws include the following saw models and serial number ranges: Revolution® 01 through 1,145,000; Rebel™ 01 through 415,000; Solaris™ 01 through 270,000. Home, hardware and department stores, and infomercials sold these saws nationwide from December 1999 through January 2002 for between $50 and $190.

Problem: The handles on these saws can separate from the body, causing the operator to be cut. CPSC and Roto Zip Tool Corp. have received 360 reports of loose or separating handles on the saws. As a result, there have been 19 reports of injuries to consumers, including some cuts requiring stitches.

What to do: Consumers should remove the handle from their recalled saw if there is a loose fit between the tool handle and the tool body, and contact Roto Zip Tool Corp. to receive a free replacement handle. For more information, contact the Roto Zip Tool Corp. toll-free at (800) 920-1467 between 7 a.m. and 7 p.m. CT any day of the week, or visit the firm's website at www.rotozip.com.

Dehumidifiers

Product: About 1.4 million **dehumidifiers by Whirlpool Corp.** The recalled dehumidifiers were sold under the Whirlpool, Kenmore and ComfortAire brand names. The dehumidifiers are white plastic, about 2-feet high and have a front-mounted water bucket. They have serial numbers that begin with QG, QH, QJ, QK or QL. The serial number can be found on a label located on the wall behind the water bucket. Department and appliance stores nationwide sold the dehumidifiers from February 1997 through December 2001 for between $130 and $260. Dehumidifiers with water buckets located in back are not involved in the recall.

Problem: The dehumidifiers can overheat, posing a fire hazard. Whirlpool has received 13 reports of the dehumidifiers overheating and causing fires, three of which resulted in extensive property damage. No injuries have been reported.

What to do: Stop using these dehumidifiers and unplug them immediately. Contact Whirlpool to arrange for a free repair at 866-640-7139 anytime or visit the firm's website at www.repair.whirlpool.com.

Air Compressors

Product: About 458,000 portable **air compressors by Ingersoll-Rand Company.** The recalled portable compressors were sold between 1983 and 1991 and have single-phase electric motors up to 3hp or gasoline engines up to 8hp with tank sizes up to 30 gallons. The compressors were marketed under various brand names, including Ajax, Charge Air Pro, Energair, Guardian Power, MacTool, Power Force, Rallye, Rand 4000, and Steel Driver. The compressors have serial numbers beginning with the prefix "C" or "DC". The model numbers begin with the following prefixes - 1B, 1D, 1E, 1I, 2B, 2D, 2E, 3B, 3D, 3E, 4B, 4E, 5E, 5G, 15E, 23HP, 75, 75E, 250E, AB, AIR, AJ, C, CAP, CB, CL, CO, CP, CR, CS, CT, EA, GC, GP, HP, HPC, IR, IRC, LTD, MT, OI, PF, RA, RL, RP, RY, SC, SDS, SE, THP, and WB. Model and serial numbers are located on a plate or sticker attached to the outside housing of the air compressor. On some oil-less models, the model and serial numbers are affixed to an internal floor baffle beneath a removable plastic cabinet. Hardware and construction supply stores nationwide sold the air compressors from 1983 through 1991 for between $150 and $400.

Problem: Internal corrosion to the inner wall of the air receiver tank can cause the air tank to unexpectedly rupture allowing pressurized air to suddenly and forcefully escape, posing risk of injury to consumers. Ingersoll-Rand has received 11 reports of sudden tank failure in these portable air compressors. No injuries have been reported. Air compressor receiver tanks do not have an infinite life. Tank life is dependent upon several factors, some of which include operating conditions, ambient conditions, proper installations, field modifications, and the level of maintenance. The exact effect of these factors on air receiver life is difficult to predict. Due to the current age of these products, Ingersoll-Rand is voluntarily undertaking this action to take these products out of service.

What to do: Stop using the air compressors immediately and contact Ingersoll-Rand for instructions on returning the compressor, freight paid. Consumers will have the option of being sent a check for $100.00 or receiving a $200.00 credit towards the purchase of a new DD2T2 air compressor. For more information, consumers can contact Ingersoll-Rand at 877-552-2952 between 8 a.m. and 5 p.m. ET Monday through Friday or visit the firm's website at www.air.ingersoll-rand.com.

Baseboard Heaters

Product: About 450,000 moveable **baseboard heaters by Honeywell Consumer Products Inc. (HCP).** The recalled HZ-514 HCP baseboard heaters are about 40 inches long, 8 inches tall, and 4 inches wide at their widest point. The white baseboard heaters have the name "Honeywell" printed on the front of the unit. The recalled heaters have: a six-digit date code beginning with "97" on a sticker on the back or the bottom of the unit, or a date code beginning with the digit "8" or "9" stamped on the flat metal prong of the electrical cord's plug, or a date code beginning with the digits "00" stamped on the flat metal prong of the electrical cord's plug and "TYPE I" or nothing stamped on the bottom of the unit. Department stores and home centers nationwide sold these baseboard heaters from October 1997 through January 2001 for between $30 and $50. Baseboard heaters with "01" stamped on the metal prong of the electrical plug or "TYPE II" stamped on the bottom of the unit are not included in this recall.

Problem: The heating element in these baseboard heaters can short-circuit and ignite combustible material under the heater, posing fire and burn hazards to consumers. CPSC and HCP have received 53 reports of these heaters short-circuiting, including two cases where the floor beneath the heater was damaged due to fire. No injuries have been reported.
What to do: Stop using these heaters immediately, unplug them, and contact HCP at 800-311-4204 between 8 a.m. and 10 p.m. ET Monday through Sunday or log on to the company's website at www.honeywell.com to determine whether its heater is part of the recall. Consumers with recalled units will be given instructions on how to mail them back to HCP in order to receive a free replacement heater.

Ross Root Feeders

Product: About 345,000 **Ross Root Feeders by Easy Gardener Inc.** The recalled root feeders are being recalled to replace their mixing chamber caps. The root feeder is a device used to distribute food, water and insecticide to the roots of trees and shrubs. The root feeders are about 30-inches tall, have a green hose connection and plastic yellow handles. "ROSS" and "MODEL 1200C" are imprinted on the side of the root feeder. The recall includes model 1200C Ross Root Feeders with "24207" or "24208" imprinted on the top of the clear, plastic chamber caps. Ross Root Feeders with the number "24208-A" caps are not part of the recall. Home and garden centers and hardware stores sold these feeders from October 1994 through January 2002 for about $33.
Problem: The mixing chamber caps on these feeders can detach during use and strike nearby consumers, resulting in injuries. Easy Gardener has received one report of a woman who received dental and other mouth injuries when struck by a cap from one of these root feeders
What to do: Stop using the recalled feeders immediately, dispose of the mixing chamber cap, and contact Easy Gardener to receive a free replacement cap. For more information, contact Easy Gardener at 800-621-4769 between 7 a.m. and 7 p.m. CT Monday through Friday, or visit their recall website at www.rosscap.com.

Nightlights

Product: About 156,000 electroluminescent **nightlights by Intermatic Inc.** The recalled Electroluminescent Night Lights have model numbers GN172 and GN165, which are molded on the back of the lights. The model GN172 lights are gray in color and are about 1 1/2 inches square by 1/4 inch thick with two metal electrical prongs. The model GN165 lights are gray in color and are about 4-3/8 inches in height, 1-5/8 inches wide and 1/4 inch thick with two metal electrical prongs. Also molded on the back of the nightlights are the words "Intermatic Inc." and "Made in Taiwan." Hardware stores and electrical distributors nationwide, including True Value Hardware Stores, sold these nightlights between January 1999 and December 2001 for about $4.
Problem: The nightlights can short-circuit, posing shock and burn hazards to consumers. Intermatic has not received any reports of incidents. This recall is being conducted to prevent the possibility of injury.
What to do: Stop using these lights immediately. If the nightlights are plugged in, turn off the power, and remove them from the wall socket. Consumers should return the nightlights to the store where they were purchased for a full refund or mail the lights for a full refund or a replacement nightlight of equal value to: Intermatic Inc., 7777 Winn Road, Spring Grove, IL 60081, Attn: Larry Kubisiak. Intermatic will also send consumers $2 for shipping and handling. For more information, consumers can call Intermatic at 800 391-4555 between 8 a.m. and 4:30 p.m. CT Monday through Friday.

Ice Cream Scoops

Product: About 190,000 **ice cream scoops by Dansk International Designs Ltd.** All the recalled Dansk ice cream scoops are made of aluminum and have a 4.5-inch handle. They were sold in four styles: the plain 3.5-inch spade, the plain 2.5-inch scoop, the Penguin-shaped 2.5-inch scoop and the Snowman-shaped 2.5-inch scoop. Each of the scoops is silver colored. The plain scoop and plain spade have the word "DANSK" written on the handle. Ice cream scoops sold by Dansk with a black cap at the end of the handle are not part of this recall. Dansk Factory Outlet Stores and Lenox Warehouse Clearance Centers nationwide sold these ice cream scoops between January 1988 and November 2001 for about $9.
Problem: A cap at the end of the handle of the scoop can fly off with substantial force, especially if the scoop is immersed in hot water. The metal cap poses a risk of impact injury to nearby consumers. Dansk has received 10 reports of the caps on these scoops flying off, sometimes traveling several feet. No injuries have been reported.
What to do: Consumers should stop using these ice cream scoops immediately and return them to any Dansk or Lenox Factory Outlet store for a $20 coupon. For more information, consumers should call Dansk toll-free at 866-855-9303 between 9 a.m. and 4:30 p.m. ET Monday through Friday. If the toll-free 866 number is not operational in your area, consumers can use the Dansk Customer Service number, 800-293-2675, to reach the company.

Pedal Cars

Product: About 75,000 **pedal cars by Alpha International Inc.,** also known as Gearbox Pedal Car Company. There are 17 models of the pedal cars included in the recall. Models include three fire trucks, four police cars, eight sedans, one yellow taxi, and one dump truck. Model names are as follows: **Fire Trucks:** "Fire Truck," "John Deere" and "Texaco"; **Police Cars:** "NYPD," "Chicago Police," "Highway Patrol" and "EMERGENCY 911"; **Sedans:** pink "Champion," blue "Champion," "Texaco" "John Deere," "Citgo," "Raley's Coca-Cola," "Raley's Keebler," and "Red Lion." All of the pedal cars are made of metal and come in a variety of colors. Most of the cars have a "Gearbox" logo on the seat back, the hubcaps, and/or the pedals. The pedal cars were manufactured in Korea. The two "Raley's" cars were sold exclusively at Raley's supermarkets from July 2000 through December 2000. Department, toy, and specialty/collectible stores sold all of the other pedal cars from November 1999 through January 2002 for between $100 and $500.
Problem: The paint coating on some of these pedal cars contains high lead levels. CPSC standards ban toys and other children's products containing high levels of lead. Young children could ingest the lead from the car's paint coating, presenting a lead poisoning hazard. Alpha International has not received any reports of injuries involving these pedal cars. This recall is being conducted to prevent the possibility of injury.
What to do: Take these pedal cars away from young children immediately. Consumers can contact Alpha International at 800-368-6367 between 9 a.m. and 5 p.m. CT Monday through Friday to receive a replacement car or return the products to the place where purchased to receive a full refund.

Electric Pressure Washers

Product: About 50,000 Black Cat™ **electric pressure washers by MCM International.** The recalled Black Cat™ pressure washers have a sticker with a cat and the words "Black-Cat" on each side of the unit. The model numbers - either BC-2000 or TW-1750 - can be found on a label on the right side of the power station. The label also reads in part, "Made in China," "High Pressure Cleaning Machines," and the "Production Date" (which should fall between March 2001 and July 2001). The GFCI plugs have a green "Reset" button and a blue "Test" button; some plugs also have a label that reads "CONNECT TO INDIVIDUAL BRANCH CIRCUIT ONLY." On the back of the GFCI plug near the electrical prongs are the words "WELLONG" and "Rainproof." Target and Menard's stores nationwide sold these pressure washers from August 2001 to September 2001 for between $85 and $100.
CPSC reminds consumers that any electrical product that is used near water should contain a GFCI, in the plug or outlet. Prior to the implementation of the voluntary standard calling for the inclusion of GFCI plugs with high-pressure cleaning machines, there were several electrocution deaths and injuries. These incidents did not involve the Black Cat pressure washer.
Problem: MCM International imported the pressure washers from a manufacturer in China who installed counterfeit ground fault circuit interrupter (GFCI) plugs on some of the units, without MCM's approval. All of the plugs are labeled "WELLONG"; however, the pressure washers with counterfeit "WELLONG" GFCI plugs appear virtually identical to those with genuine "WELLONG" GFCIs. It will require a professional inspection to identify the counterfeit GFCIs. GFCIs are important safety devices that are intended to protect consumers against shock or electrocution. CPSC and MCM International have not received any reports of incidents in which the GFCI plugs failed to operate. This recall is being conducted to prevent the possibility of injury.
What to do: Stop using these pressure washers and call MCM International at 800-304-1316 between 8 a.m. and 5 p.m. CT Monday through Friday to arrange to have the unit inspected. If necessary, MCM International will replace the installed GFCI plug with a genuine WELLONG GFCI plug.

— Carolyn T. Manley, Office of Compliance

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