U.S. Consumer Product Safety Commission

Hal Stratton, *Chairman*
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CONSUMER PRODUCT SAFETY REVIEW

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National Burn Center Reporting System

Clothing-related burns to children often involve gasoline and other flammable liquids, according to a recent U.S. Consumer Product Safety Commission (CPSC) study of burn incidents.

In addition, the study found that none of the burn incidents appeared to involve tight-fitting children's sleepwear or infant garments size 9 months or smaller. Both types of clothing are exempt from CPSC's standards for the flammability of children's sleepwear.

CPSC staff analyzed 209 incidents associated with clothing-related burn injuries to 213 children under age 15. Two children died from the burns. Three-quarters of the children were boys. The youngest child was 2 months old; the oldest was 14 years old. The most frequently treated children were 11-year-old boys *(Figure 1)*. The ignition source most frequently associated with these injuries was outdoor fires *(Figure 2 on page 2)*.

This was the first study based on data from the National Burn Center Reporting System (NBCRS). CPSC developed this system in cooperation with the American Burn Association and Shriners Hospitals for Children.

The NBCRS is a surveillance system that collects data about clothing-related burn injuries to children under 15 years old from U.S. burn centers that treat children. These incidents involve the ignition, melting, or smoldering of clothing.

Ninety-two burn centers agreed to participate in the reporting system. After one year of operation, 44 burn centers had submitted burn incidents from March 2003 to June 2004.[1]

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[1]The data collected through the NBCRS is not a statistical sample of incidents and may not be a complete account of incidents during the time period.

Continued on page 2

Age and Sex of Burn Victims

	Age (Years)															
	<1	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**Total**
Male	3	0	4	10	13	7	7	14	9	9	14	25	10	23	15	163
Female	1	3	3	5	5	7	2	7	2	0	5	1	4	2	3	50
Total	4	3	7	15	18	14	9	21	11	9	19	26	14	25	18	213

Source: National Burn Center Reporting System (2004)

Figure 1

National Burn Center Reporting System cont. from page 1

Flammable Liquid Involvement

Of the 209 incidents reported, 107 involved flammable liquids spilled or poured on or near an ignition source. The victims in these incidents ranged from 1 to 14 years old. The children most frequently involved were 11 years old, and 100 of the 110 injured children were boys.

Gasoline was the most frequently reported flammable liquid, involved in 73 of the 107 incidents. Lighter fluid was the second most frequently involved.

Flammable liquids were most often involved in incidents with outdoor fires. Forty-seven of the 107 incidents with flammable substances involved outdoor fires. These fires included campfires, bonfires, trash fires, and brush fires, among other uncontained outdoor fires.

Clothing Worn For Sleeping

Thirty-six of the 209 incidents involved clothing worn for sleeping. The children in these incidents ranged in age from 2 months to 13 years old. Seven-year-old children were most frequently burned. Eleven incidents included children and structure fires – the most frequent scenario.

Nineteen of the 36 incidents involved daywear (such as shirts) used for sleeping. Seven-year-old boys were most frequently injured in these incidents, involving a house fire, candles, a stove/range, and a lighter.

Eight incidents involved what appeared to be traditional sleepwear subject to CPSC's sleepwear flammability standards. Traditional sleepwear includes pajamas, nightgowns, and bathrobes. These garments must be flame-resistant (FR).

The children involved in the traditional sleepwear incidents ranged in age from 2 months to 12 years. In one incident, a flammable liquid was involved. In other incidents, children were injured because they were close to, accidentally contacted, or played with the ignition source. One child was burned after tossing a blanket that contacted a halogen lamp.

When CPSC staff was able to recover and examine the burned garments, they appeared to comply with CPSC's sleepwear flammability standards.

Ignition Source Involved in All Burn Incidents

Ignition Source	# of Incidents
Outdoor fire	62
Lighter	37
Candle	18
Structure fire	13
Stove/range	13
Matches	10
Fireworks/firecrackers	8
Container fire	4
Explosion	4
Fireplace	4
Heater	3
Grill	3
Hot water heater	3
Lawn equipment	3
Product set on fire (balls, towel)	3
Cigarette	2
Halogen lamp	2
Other	8
Unknown	9
Total # of Incidents	209

Source: National Burn Center Reporting System (2004)

Figure 2

Clothing Not Worn for Sleeping

In 146 incidents, children were burned while wearing clothing not worn for sleeping.[2]

Eleven-year-old males were most frequently involved in these incidents, followed by 13-year-old males.

The most frequent scenarios included: 22 incidents of children playing with lighters (7 of these incidents involved a flammable liquid); 20 incidents of children standing too close to an outdoor fire (17 involved a flammable liquid); and 13 incidents of children starting or stoking an outdoor fire (all 13 involved a flammable liquid).

CPSC Safety Standards

To protect people from burns, CPSC enforces the Standard for the Flammability of Clothing Textiles for general wearing apparel and the Standards for the Flammability of Children's Sleepwear.

The Standard for the Flammability of Clothing Textiles provides a national standard method of testing and rating the flammability of textiles and textile products for clothing. This prohibits the use of dangerously-flammable clothing textiles.

The Standards for the Flammability of Children's

[2]In 28 additional incidents, it was unknown if the garment was used for sleeping. One other incident was included in two categories because of the description of garments involved.

Sleepwear require that children's sleepwear be flame resistant (FR). With these standards, children's sleepwear must self-extinguish if a flame from a candle, match, lighter, or a similar small-flame item causes it to catch fire.

The sleepwear standards are not intended to protect children from burns during larger-scale fires, such as structure fires, outdoor fires, or fires involving flammable liquids.

The children's sleepwear flammability standards were issued in the 1970s to address the unreasonable risk of injury or death to children from ignition and continued burning of sleepwear. The most common ignition scenarios involved children playing with matches and lighters. The most common garments ignited were traditional sleepwear – nightgowns, pajamas, and robes.

The children's sleepwear flammability standards originally required that all sleepwear, sizes 0 to 14, be flame resistant. Some fabrics are inherently flame resistant; others require treatment with chemical flame retardants to be flame-resistant.

During the 1980s, consumer demand increased for untreated cotton and other natural fiber sleepwear. Some parents were choosing to put their children in loose-fitting cotton T-shirts. Non-flame-resistant cotton garments like long underwear and daywear that resembled sleepwear also were being sold. While these were not marketed as sleepwear, some consumers purchased these garments for sleeping.

In the 1990s, CPSC began a rulemaking to ensure safer sleepwear choices for consumers (including safer cotton sleepwear alternatives). It exempted from the flammability requirements sleepwear garments that were size 9 months or smaller or tight-fitting (touching the body at seven key points). In addition, CPSC required labels on tight-fitting sleepwear to include fire safety information for consumers.

This first year of data collection through the NBCRS did not reveal any incidents involving infants wearing sleepwear size 9 months or smaller or older children in tight-fitting sleepwear.

— *Debra Ascone, Directorate for Epidemiology*

For More Information

For a complete copy of the National Burn Center Reporting System study, please go to CPSC's Web site at **www.cpsc.gov.**

Poison Prevention

More than 40 years ago, at least 450 children age 5 and younger died annually from accidentally ingesting hazardous consumer medicines or household chemicals. Today, these types of child-related poisoning deaths have dropped to approximately 30 each year.

Poison control centers nationwide still receive about one million calls for help for children age 5 and younger. But, widespread public education, nationwide poison control centers, and CPSC-mandated child-resistant, adult-friendly packaging have resulted in a dramatic decrease in child deaths due to poisoning.

A major part of the educational effort to inform consumers about poisoning dangers occurs during National Poison Prevention Week, which takes place each year in March. It is one of the longest-running public health awareness programs in the U.S.

The Poison Prevention Week Council coordinates the annual observance of National Poison Prevention Week. The Council reaches millions of people through broadcast and print media coverage, as well as with school posters and other printed material.

— *Rhodia K. Dulic, Office of Information and Public Affairs*

Safety Tips

To help prevent child poisonings, follow these tips.

- Keep all household products and medicines locked up, out-of-sight and out-of-reach.
- Use child-resistant packaging properly by closing the container securely after each use or choose child-resistant single dose packaging, which does not need to be re-secured.
- When products are in use, keep children in your sight, even if you must take them along when answering the phone or doorbell.
- Keep items in original containers.
- Leave the original labels on all products, and read the label before using.
- Do not put decorative lamps and candles that contain lamp oil where children can reach them. Lamp oil can be very toxic if ingested by young children.
- Always turn on the light when giving or taking medicine so you can see what you are taking. Check the dosage every time.
- Avoid taking medicine in front of children.
- Clean out the medicine cabinet periodically and safely dispose of unneeded and outdated medicines.

Call the Poison Control Center at **1-800-222-1222** immediately in case of suspected poisoning.

Window Covering Cords

CPSC staff and industry recently analyzed fatal incidents involving young children and window covering cords. The study was done to better understand how to prevent these deaths and to determine the effectiveness of the voluntary safety standard for window covering cords.

For several years, CPSC staff and the Window Covering Manufacturers Association (WCMA) have worked together to address the issue of young children strangling in window covering cords.

The current voluntary safety standard for these products prohibits cord loops, restricts continuous loops and chains by requiring tension devices, and requires prevention of loops in the inner cord of horizontal blinds.

To comply with the voluntary safety standard, the industry made three major design changes to its products. 1) It eliminated single-tassel loops from horizontal blind pull cords. These loops were strangulation hazards for young children; almost all cords now end in two separate tassels. 2) It supplies tension devices for all vertical blinds, which eliminates a free-hanging loop when installed. 3) It assembles all horizontal blinds with inner cord stops on the pull cords, to prevent the formation of a loop when pulling on the inner cords.

To address the hazards present in existing blinds purchased before these actions, the industry offers consumers free repair kits to retrofit their horizontal or vertical blinds to conform with the latest voluntary safety standard.

In-depth Investigations

To conduct the window cord covering study, CPSC staff and industry representatives reviewed investigations of 66 fatal incidents involving children and window covering cords that occurred between 1996 and 2002. (These incidents do not represent a statistical sample.)

The hazard patterns were deduced from what was known about the product, the ligature (cord) marks on the victim, and information provided in police reports and investigator interviews with people familiar with the incidents. There were no witnesses to any of the incidents.

The victims ranged in age from 8 months to 78 months old. The children involved most frequently were 12 to 15 months, but children up to 6 and one-half years also were entangled in window covering cords *(Figure 3)*.

CPSC staff identified three leading hazard scenarios and the associated window covering cord products. These included:

- Strangulation in a loop that was part of the product's configuration, such as single tassel cords in horizontal-type blinds and free hanging cord loops in vertical-type blinds. The majority of these incidents involved the continuous loop of vertical blinds or draperies.
- Strangulation in a loop formed by a cord that was knotted or tied up in some way. The majority of these incidents involved the pull cords of horizontal blinds.
- Strangulation in a loop formed in the inner cord of a horizontal blind.

Approximately 61% (40 out of 66) of the incidents involved products with a cord-lift control system (typically used with horizontal blinds). Thirty-six percent (24 out of 66) of the incidents involved products with a continuous-loop control system (typically used with vertical blinds and draperies).

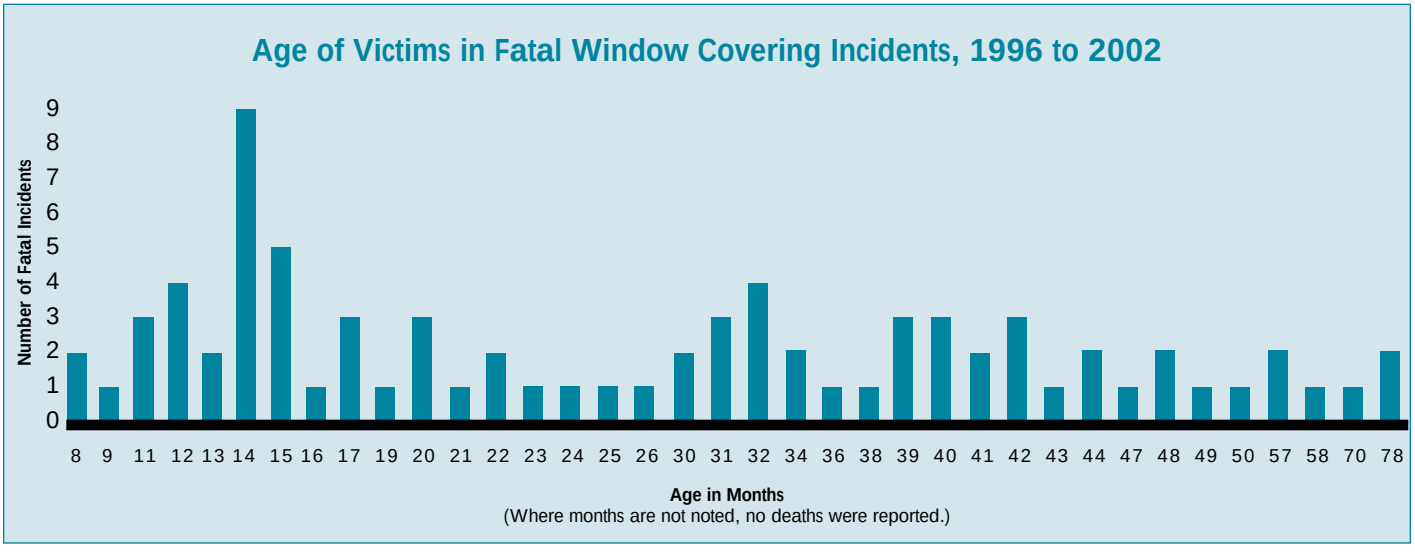

Figure 3

Conformance to Voluntary Standard

CPSC staff came to the following conclusions with regard to how well the current voluntary standard addressed the fatal incidents that were reviewed.

Approximately 82% (54 out of 66) of these incidents involved older products whose cord configurations did not meet the current voluntary safety standard requirements. These products likely were manufactured before the standard became effective industrywide. Six products met the standard, and six others could not be categorized.

Of the 66 incidents examined, 40 incidents would have been addressed by product conformance to the current voluntary standard. Of these, 23 would have been addressed by using a tension device in the vertical blind; four would have been addressed by eliminating a loop in the operating cord in the horizontal blind; and 13 would have been addressed by using inner cord stops in the horizontal blind.

Of the 18 incidents that would not have been addressed by product conformance to the current voluntary standard, most involved strangulation in a cord that was modified (usually tied into a knot) by a user.

A determination could not be made in the remaining eight incidents.

CPSC staff noted that the efficacy of tension devices and inner cord stops depends on users to correctly install or adjust the safety devices. If the safety devices are not properly installed, the products are still operable with potential hazards.

The current voluntary standard does not address incidents where the cords were modified, where victims wrapped cords around their necks, and in one instance, where the victim strangled in the loop above a stop ball.

In addition, the current safety standard allows an exposed loop for products that use a stop ball. The loop is accessible when the blind is raised, and CPSC staff is aware of at least one fatal incident associated with this type of window covering.

CPSC staff is actively working with industry to revise the current voluntary safety standard to address these issues and prevent further deaths.

— Caroleene Paul, Directorate for Engineering

For More Information

For a complete copy of the report, *Analysis of Fatal Incidents Associated with Window Covering Cords (1996-2002)*, please go to **www.cpsc.gov.**

Cigarette Lighters

In 2004, CPSC voted to issue an Advance Notice of Proposed Rulemaking to gather information for a possible mandatory safety standard for cigarette lighters to prevent mechanical malfunction of lighters. The current voluntary safety standard for lighters addresses the risk of fire, death, and injury associated with the mechanical malfunction of lighters.

From 1997 through 2002, CPSC staff estimated that 3,015 injuries resulting from malfunctioning lighters were treated in U.S. hospital emergency rooms. Most of these injuries involved thermal burns to the face, hands, and fingers.

For the same time period, CPSC received 256 incident reports related to cigarette lighter malfunctions and failures. Sixty-five percent of these cigarette lighter failures resulted in fires, leading to 3 deaths and 6 serious injuries.

The societal costs due to deaths, injuries, and property losses from mechanical malfunctions of lighters are about $38 million. This estimate is based on an annual average of 2 deaths, 990 injuries and $500,000 in property losses estimated using CPSC's Injury Cost model.

There are approximately 900 million cigarette lighters sold in the U.S. each year. About 400 million of these are imported from China.

The process of rulemaking for a federal standard would allow for additional fact-finding about deaths and injuries and about industry conformance to the voluntary standard.

Child-Resistant Lighters

CPSC has a mandatory standard for child-resistant cigarette lighters (effective in 1994) which addresses the hazard of children under 5 years old starting fires with lighters. The standard for child resistance applies to imported as well as domestically-manufactured disposable and novelty lighters.

As a result of the mandatory standard, an estimated 100 fire deaths associated with children playing with lighters were prevented in 1998 alone. Children under age 5 accounted for 170 of the deaths in 1994 and 40 of the deaths in 1998.

In 1994, there were 10,400 residential fires associated with children playing with lighters. By 1998, that number declined to 5,500 fires.

Even lighters with child-resistant mechanisms are not childproof, so all lighters should be kept out of the reach of children.

—Rohit Khanna, Directorate for Engineering Sciences

Electrocutions

Electrocutions in the U.S. have decreased from 630 in 1991 to 411 in 2001, a reduction of 35%, according to data from the National Center for Health Statistics. During this period, the estimated number of electrocutions related to consumer products decreased from 250 to 180, a 28% reduction *(Figure 4)*.

In 1991, the rate for consumer product-related electrocutions was 0.99 per million U.S. population. In 2001, that rate dropped to 0.63 electrocutions per million, reflecting a decrease of 36%.

Products Involved in Electrocutions

Of the 180 consumer product-related electrocutions in 2001, larger appliances, such as air conditioners, sump pumps, pool pumps, water heaters, clothes dryers, washing machines, water coolers, ranges, and range hoods, were responsible for the largest proportion (19%) of the electrocutions.

Damaged or exposed wiring, where the exact nature of the wiring was unspecified, accounted for 11% of the electrocutions. Installed household wiring accounted for another 10% of the electrocutions.

Ladders coming in contact with power lines were responsible for 9% of the deaths. Power tools, such as saws, drills, welding equipment, pressure washers, and impact wrenches, also constituted 9%.

Gardening and farming equipment was the next most frequently reported group (7%) of products. Lighting equipment (lamps, fixtures, work lights, etc.) was involved in 6% of the deaths. In another 5% of the deaths, the victims contacted high voltage power lines, although the mode of contact was not specified.

Antennas and small appliances (microwaves, extension cords, etc.) were each responsible for 4% of the electrocutions. Non-powered/gasoline-powered tools (such as a wire-cutter or a chain-saw) and recreational equipment (such as a deer hunting stand or a flying toy airplane) accounted for 3% and 2% of the deaths, respectively.

Miscellaneous other products, such as pipes and poles that were or became energized, electric fences, battery chargers, or unspecified power cords, accounted for another 9% of the deaths. No product was specified for the remaining 2% of the electrocutions.

-- Risana T. Chowdhury, Directorate for Epidemiology

For More Information

For a complete copy of the report *2001 Electrocutions Associated with Consumer Products*, please go to **www.cpsc.gov.**

Electrocutions and Electrocution Rates in U.S. 1991-2001

Year	U.S. Total Electrocutions	Consumer Product-Related Electrocutions		
		Estimates	Percent of Total	Electrocution Death Rates per Million Population
1991	630	250	40%	0.99
1992	530	200	38%	0.78
1993	550	210	38%	0.82
1994	560	230	41%	0.89
1995	560	230	41%	0.88
1996	480	190	40%	0.72
1997	490	190	39%	0.71
1998	550	200	36%	0.74
1999	440	170	39%	0.62
2000	400	150	38%	0.53
2001	411	180	44%	0.63

Source: National Center for Health Statistics, U.S. Census Bureau

Figure 4

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 Web site 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

The MECAP 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 tschroeder@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 June, July, and August 2004, 1,023 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 playing in a sandbox while his grandmother was mowing the lawn with a lawn and garden tractor. When she reached the end of one strip of lawn, she backed up the tractor. She felt a bump under the mower, and the engine stalled. She turned around and saw her grandchild under the back of the mower. The tractor was too big for her to move, so she called emergency medical services (EMS). EMS personnel arrived, tilted the tractor, and took the child to the hospital, where he was pronounced dead. The cause of death was mechanical asphyxiation.
(John D. Howard, M.D., Chief Medical Examiner, Pierce County, Tacoma, WA)

*A female, 4, was playing on a combination playground set with other children. She was at the top of a slide playing with an adjacent rope climbing ladder. The other children later noticed she was hanging from the rope and untangled her. The cause of death was asphyxia by hanging.
(Paul D. Nora, M.D., Assistant Medical Examiner for Michael B. McGee, M.D., Chief Medical Examiner, Ramsey County, St. Paul, MN)

*A male, 8, was returning to the barn on a 4-wheeled all-terrain vehicle (ATV) after helping his father with farm chores. His father followed about 30 minutes later. He found the boy under the overturned ATV; the handlebars were on the boy's chest. The boy had lost control of the ATV on a rutted farm road. The cause of death was traumatic asphyxiation.
(John Steers, Medical Examiner, La Crosse County, La Crosse, WI)

*A male, 8 weeks, was being held by his father on a recliner chair, where they both fell asleep. The father woke about two hours later to find that the infant was no longer on his chest. He looked down and saw the child lying on his side between the father's recliner and an adjacent recliner. The cause of death was positional asphyxiation.
(Gordon Sonne, Sheriff-Coroner, Monterey County, Salinas, CA)

A male, 28, was found unresponsive on a weight bench by his roommate in the basement of their home. A weight bar with 200 pounds of weights was found lying on his neck. The cause of death was asphyxia due to neck compression.
(Carl J. Schmidt, M.D., Chief Medical Examiner, Wayne County, Detroit, MI)

A female, 2 months, was placed on her back on a futon couch by her mother. The mother returned later to find the infant lying on her side with her face against the futon couch. The cause of death was positional asphyxia.
(Alan G. Klimek, Medical Examiner, Brown County, Green Bay, WI)

CARBON MONOXIDE (CO) POISONINGS

*A female, 83, and her husband, 80, were found unresponsive in the basement of their home. A recent storm had knocked out electricity to their area, and they had set up a generator in their basement to power some appliances. The cause of the deaths was CO poisoning.
(William T. Gormley, M.D., Assistant Chief Medical Examiner, Central District, Commonwealth of Virginia, Richmond, VA)

*A female, 81, and her husband, 86, were found unresponsive in their home. A fire was still smoldering in the fireplace, and the flue was closed. The cause of the deaths was CO toxicity.
(Jonathan R. Lucas, M.D., Deputy Medical Examiner, County of San Diego, CA)

*A female, 15, became ill after taking a shower and went to her bedroom to lie down. About 10 minutes later, her sister found her unresponsive. The teenager was rushed to the hospital, where high levels of CO were found in her blood. She died the next day. An expert later determined that the source of CO was an improperly vented natural gas water heater. The home had a CO alarm that was broken and had not been replaced. The cause of death was carbon monoxide poisoning.
(Phil Pascuzzi for Gary F. Peterson, M.D., J.D., Medical Examiner, Hennepin County, Minneapolis, MN)

DROWNINGS

A female, 37, was using a riding lawn mower in her backyard. Her daughters heard a scream. They found their mother pinned under the mower with her head submersed in a backyard ditch. The cause of death was drowning.
(John P. McGoff, M.D., Coroner, Marion County, Indianapolis, IN)

A female, 2, was found unresponsive in her family's swimming pool. The pool was protected by a security fence, but a dog had dug a hole under the fence. The cause of death was drowning.
(John D. Howard, M.D., Chief Medical Examiner, Pierce County, Tacoma, WA)

A female, 22 months, was napping with her mother. The child awoke and walked across the street to her grandfather's house, where her siblings were playing. The child was later discovered in an in-ground swimming pool that was unfenced. The cause of death was freshwater drowning.
(Katherine Descheneaux for Thomas A. Andrew, M.D., Chief Medical Examiner, State of New Hampshire, Concord, NH)

A female, 2, was watching television while visiting her grandparents. The grandmother gave the child some cereal and then went to the bathroom. About five minutes later, the grandmother came out of the bathroom and couldn't find the child. She eventually found the child floating in an in-ground pool. The pool had no safety fence. The cause of death was hypoxic encephalopathy due to drowning.
(Staci Wilcox for Frank Sheridan, M.D., Chief Medical Examiner, San Bernardino County, San Bernardino, CA)

A female, 2, was at a family gathering at a relative's house. She was later found unresponsive in a neighbor's swimming pool. The fence between the houses had two slats missing from it. The cause of death was asphyxia by drowning.
(Stephen D. Cohle, M.D., Chief Medical Examiner, Kent County, Grand Rapids, MI)

ELECTROCUTIONS

A male, 46, was installing a recessed light in his home. He was later found unresponsive with the electrical wires on the light crossed, causing the light's metal container to become electrified. The cause of death was electrocution.
(James Baroni, Chief Deputy Medical Examiner for Ronald O'Hallaran, M.D., Chief Medical Examiner, Ventura County, Ventura, CA)

FIRES

*A female, 2, was asleep in her bed while her mother worked nearby. The mother lit a candle for religious purposes and left the room with the candle unattended. Some time later, the mother and other occupants of the house awoke to loud noises and screams from the child's bedroom. Though they tried to save the child, they were unsuccessful because of the heavy smoke and flames. The cause of death was smoke inhalation and thermal burns.
(Gordon Sonne, Sheriff-Coroner, Monterey County, Salinas, CA)

A female, 83, lit some incense in her living room and forgot about it. She later smelled smoke and returned to the living room, where she found a fire in progress. The woman tried to extinguish the fire, but her clothes caught on fire. She went outside the home, where her neighbors put out the fire. She was taken to the hospital, where she died four months later. The cause of death was thermal burns.
(Richard Harruff, M.D., Chief Medical Examiner, King County, Seattle, WA)

A female, 64, lit a candle in her kitchen when she lost her power during a storm. She went to bed and forgot about the candle. She awoke to find a fire in her kitchen. She tried to extinguish it but was overcome by smoke. The cause of death was smoke inhalation and thermal injuries.
(John Stanley, Coroner, Dane County, Madison, WI)

MISCELLANEOUS

*A male, 9 months, was moving himself around his kitchen in his baby walker. He pushed the walker up to a kitchen island where a working crock pot was plugged in. He pulled on the cord, and the pot and its contents fell on top of him. His baby sitter tried unsuccessfully to catch the pot but only burned her hands. The cause of death was multiple complications of thermal cutaneous burns.
(Staci Wilcox for Frank Sheridan, M.D., Chief Medical Examiner, San Bernardino County, San Bernardino, CA)

*A male, 4, was playing in the yard of a home-based childcare center. The husband of the center's operator was using a riding lawn mower to cut the grass on a steep incline in the yard. The mower began to slip gears, so the man depressed the clutch and coasted the mower back down the hill. The man felt a thump, and the engine stalled. He turned and saw the child's legs sticking out from under the mower. The cause of death was massive head injury.
(Elizabeth Frank for William G. Eddins, M.D., Medical Examiner, Western District, Roanoke, VA)

*A female, 9, was a passenger in a go-kart driven by her brother, 11. He lost control of the go-kart while trying to avoid a rough patch in the path. The go-kart had a roll bar, but both children were ejected from the go-kart. The brother survived, but his sister was pronounced dead at a hospital. Neither child was wearing a helmet. The cause of death was a massive skull fracture.
(Thomas Thelen, R.N., Medical Examiner, Eau Claire County, Eau Claire, WI)

A male, 14, was riding his friend's motorized skateboard down a hill. He let up on the throttle, lost control, and was thrown from the skateboard. The cause of death was multiple blunt force trauma.
(P. Michael Murphy, Coroner, Clark County, Las Vegas, NV)

— *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 Web site at ***www.cpsc.gov.***

Brake Cleaner and Brake Parts Cleaner

Product: About 2.8 million cans Pyroil® Brake Parts Cleaner and NAPA® Brake Cleaner by The Valvoline Company, a Division of Ashland Inc. The recall involves 13-ounce cans of Pyroil® Non-Chlorinated Brake Parts Cleaner and NAPA® Non-Chlorinated Brake Cleaner. This product is used by professional mechanics as well as "do-it-yourself" consumers who perform brake repairs on their own vehicles. The recalled cans contain one of the following four digits in their date codes, which are found on the bottom of the cans: Pyroil (Part No. 4003) C014, C024, C184, C194, C304, D024, D034, D214, D224, D264, E104, F074, F084, F094, F104, F234, F244, F284, G134, G144, G194, G294, H034, H194. NAPA (Part No. 4800) C024, C094, C184, C194, C224, C234, C304, C314, D014, D034, D054, E054, E064, E144, E244, E254, F174, F184, G284, H124, H304, H314, I074, I084. The cans were sold at auto parts retail stores nationwide from March 2004 through September 2004 for about $2. The aerosol cans were made in the United States.

Problem: The affected aerosol cans contain a defective spray valve that might stick when depressed, possibly emptying the can's flammable contents. Valvoline has received nine complaints about sticking spray valves. One consumer was injured when the product sprayed into his eye.

What to do: Stop using the recalled aerosol cans immediately and contact Valvoline for a free replacement. Call Valvoline at (800) 255-3533 between 8:30 a.m. and 5:30 p.m. ET Monday through Friday, or visit its Web site at **www.valvoline.com.**

Cell Phone Batteries

Product: About 1 million batteries in Kyocera Wireless Corp. Cell Phones by Hecmma Group. The recalled batteries are included in Kyocera Slider, K400, and 3200 Series cell phones. The following are cell phone model names along with their cell phone model number, battery model number and battery description: Slider Series, SE44/SE47, CV90-L305N-01, CV90-L305P-01, CV90-L305T-01, CV90-L349T-01. Battery has the Kyocera name printed in red and black along with the model number. K400 Series, "Phantom", "Blade","Rave", KE413, KE433, KE/KX414, KE/KX424, KE/KX434, CV90-K3040-03, CV90-K3040-09, CV90-K3040-10, CV90-K3040-11. Battery has the Kyocera name printed in red and white along with the model number. 3200 Series, 3225, 3250 (appears above or below phone display), CV90-K3040-03, CV90-K3040-09, CV90-K3040-10, CV90-K3040-11. Battery has the Kyocera name printed in red and white along with the model number. The cell phones with the recalled batteries were sold by ALLTEL, Virgin Mobile, Cricket Communications, MetroPCS, US Cellular and Verizon Wireless stores nationwide; telemarketing retailers; various Web sites; and regional phone carriers. The 3200 Series and K400 Series phones were sold from December 2003 to September 2004 for between $30 and $100. Slider Series phones were sold from May 2004 to September 2004 for between $30 and $170. The recalled batteries were also sold separately during the same periods for between $30 and $60. The batteries were made in China and assembled in Mexico.

Problem: Some of the cell phone batteries supplied by the battery manufacturer may be counterfeit. This can cause the batteries to short-circuit, overheat, and pose a burn hazard to consumers. Kyocera has received 14 reports of battery failures, resulting in smoke and minor property damage. Two minor burn injuries have been reported.

What to do: Stop using the recalled batteries in cell phones. Kyocera will contact consumers directly to arrange for delivery of a free replacement battery. If consumers with recalled batteries are not contacted by Kyocera, consumers should call the company to receive a free replacement battery. The batteries should be stored in an environment with non-flammable materials. Call Kyocera Wireless Corp. toll-free at (866) 559-3882 between 6 a.m. and 6 p.m. PT Monday through Friday, or request a replacement battery online at **www.kyocera-wireless.com.**

Arc Fault Circuit Interrupters

Product: About 700,000 Arc Fault Circuit Interrupters (AFCI) by Schneider Electric North American Division. The recalled Square D QO® and Homeline® Arc Fault Interrupter circuit breakers are used with 15- and 20-amp branch circuits. They are required to be installed in bedroom circuits in accordance with the 2002 National Electrical Code. The recalled units were manufactured after March 1, 2004, and have a blue test button. The AFCI circuit breakers have one of the following date codes – CN, DN, EN, FN, GN, HN, or JN – stamped in red on the breaker label located just above the wiring terminal. The recalled units also have one of the following catalog numbers printed on a label on the front of the breaker: QO115AFI, QO115AFIC, QO120AFI, QO120AFIC, QOB115AFI, QOB120AFI, HOM115AFI, HOM115AFIC, HOM120AFI, HOM120AFIC, QO115VHAFI, QO120VHAFI, QOB115VHAFI, or QOB120VHAFI. Electrical distributors and retailers sold the AFCIs between March 2004 and September 2004 for between $30 and $130. The AFCIs were made in Mexico.

Problem: An AFCI is an electrical circuit protection device (circuit breaker) that detects electrical arcs from cracked, broken, or damaged electrical insulation and shuts off power to the circuit before the arcing leads to a fire. An electronic component failure inside the AFCIs can cause the devices to not detect an electrical arc. Although the AFCIs will function as regular circuit breakers, they may not detect an arc fault, posing a safety risk to consumers. Schneider Electric is investigating one reported fire during a new home construction that may be related to this problem. No injuries have been reported.

What to do: Return uninstalled AFCIs to the retailers or distributor from whom the unit was purchased for a free replacement unit. Installed AFCIs will be replaced free of charge through electrical contractors. Call Schneider Electric toll-free at (877) 202-9046 between 7:30 a.m. and 5 p.m. ET Monday through Friday or logon to the company's Web site at **www.us.squared.com/recallafci.**

Bowflex Power Pro and Ultimate Fitness Machines

Product: About 680,000 Power Pro units and 102,000 Ultimate units by The Nautilus Group. The recalled fitness machines are the Bowflex Power Pro with and without a "Lat Tower" and Ultimate models built before September 1, 2002. The "Lat Tower" attaches to the back of the bench and has pull-down pulleys attached. The name "Bowflex" and the model name are printed on the front of the machines. The fitness machines were sold through specialty fitness stores, infomercials, and direct sales nationwide from January 1995 through April 2004 for between $1,200 and $1,600. The fitness machines were made in China and Taiwan.

Problem: The seat pin on the Power Pro with "Lat Tower" and Ultimate models can break or become disengaged, allowing the seat to move suddenly. Also, the incline support bracket on the Power Pro without a "Lat Tower" can break, allowing the incline bench to move suddenly. Both hazards pose a fall risk to the user. Nautilus has received 46 reports of the seat pin failure, including two serious injuries requiring stitches to the head. Additionally, Nautilus received 42 reports of the incline support bracket failure including injuries to the back, neck, and head.

What to do: Stop using the incline support mechanism and contact Bowflex to receive a free repair kit. Consumers who participated in the Bowflex safety recall earlier in 2004, and owners of Ultimate units do not need to call Bowflex for a repair kit, as they will receive one automatically. Nautilus is contacting owners of affected machines by direct mail where the name is known to the firm. Contact Bowflex at (800) 820-8604 between 5 a.m. and 8 p.m. PT Monday through Saturday, or visit the firm's Web site at **www.bowflex.com.**

Exercise Products

Product: About 460,000 Ab Lounge™, Ab Lounge™ 2, and Ab Lounge™ Ultimate Exercisers by Fitness Quest Inc. The recall includes the Ab Lounge™, Ab Lounge™ 2, and Ab Lounge™ Ultimate exercisers. The machines have the name "Ab Lounge" or "Ab Lounge 2" printed on the upper front fabric of the seat. The recall involves machines with the following serial numbers: Ab Lounge™ machines: ALX-000001 through ALX-037999, and all machines that start with serial numbers 03 44 through 04 36. Ab Lounge™ 2 machines: AL2X-000001 through AL2X-059060, and all machines that start with serial numbers 04 03 through 04 36. Ab Lounge™ Ultimate machines: all machines that start with serial numbers 04 28 through 04 34. The serial number is located on a label on the bottom of the front frame. Ab Lounge™ exercise products with straight brackets that do not fold are not part of this recall. The exercise products were sold at infomercial, Internet, catalog, and discount department and sporting goods stores, including Wal-Mart and Dicks Sporting Goods, nationwide since October 2003 for between $100 and $210. The exercise products were made in China and Thailand.

Problem: When opening or folding up these exercise machines, consumers can catch their fingers in the hinges. This can result in lacerations, crushing, or amputation to finger tips. This does not occur while users are exercising. Fitness Quest has received 15 reports of injuries, including lacerations, crushing, and amputations to finger tips.

What to do: Stop using these exercisers and contact the firm for a free repair kit. The firm is contacting all consumers who purchased the Ab Lounge™ directly from Fitness Quest via infomercial or Web site. Due to the large number of repair kits required to meet demand, these consumers may experience a delay of a few weeks before they receive their kits. Any consumer who owns an Ab Lounge™ purchased at a retail store should stop using the equipment and contact Fitness Quest immediately to receive the repair kit. Contact Fitness Quest at (800) 321-9236 between 9 a.m. and 5 p.m. ET Monday through Friday or logon to **www.fitnessquest.com.**

TV/VCR Carts

Product: About 300,000 TV/VCR carts by Sauder Woodworking Co. The recalled TV/VCR carts are white, light brown, and light reddish brown; have decorative hardware and trim; and are about 29 inches wide, 17 inches deep, and 25 inches high. The carts are equipped with a top shelf for a television 20 inches or smaller and a middle shelf for a VCR and a lower storage area. The recalled carts include models 3355, 6355, 7755, 9855 and 9755, which can be found on the instruction book that came with the cart. Department, discount, and home electronic stores nationwide sold the 3355, 6355 and 7755 model from October 1991 through May 1999 for between $80 and $100. The 9855 and 9755 models were sold exclusively at Target stores. The carts were made in the United States.

Problem: The carts can tip over and the television can fall off, posing a risk of serious injury or death if the TV and cart fall on a child. Sauder Woodworking received one report of a cart tipping over, though no injuries have been reported.

What to do: Stop using the TV/VCR carts immediately and do the following: remove the television and all contents; turn the cart over and remove the four casters from the bottom of the cart. This will bring the tip-stability of the cart into compliance with the latest industry standards. Contact Sauder Woodworking Co. to receive a free retrofit kit and safe use information. When updated, this cart will be suitable for use with TVs weighing 50 pounds or less. This includes most TVs that are 20 inches or smaller. Contact Sauder Woodworking Co. toll-free at (888) 800-6315 between 8:30 a.m. and 5:00 p.m. EST Monday through Friday, or visit the company's Web site at **www.sauder.com** to receive a free repair kit.

Monster Rockets

Product: About 230,000 Super Soaker Monster Rockets by Hasbro Inc. The Super Soaker Monster Rocket is composed of a 7-foot inflatable Mylar rocket with a plastic and foam fin section. The rocket has a blue and orange launch base with a water pressure tank attached to one leg of the base. The tank, which has an orange cap, is connected to the pump mechanism, which launches the rocket using pressurized air and water. The water toy has the words "Monster Rocket" printed on the body of the rocket. Toys 'R' Us, Wal-Mart, Target, KB Toys stores, and other toy retailers nationwide sold the rockets from January 2004 through August 2004 for about $30. The rockets were made in China.

Problem: The cap on the water tank can unexpectedly and forcibly project off when it is quickly unscrewed from the tank, posing a risk of impact injuries to users or bystanders. In addition, the rocket's tail can strike a user or bystander on descent, if the rocket is not fully launched, posing a risk of injury. Hasbro has received four reports of the cap being unexpectedly projected off the rocket, resulting in three injuries, including a slight concussion and a cut requiring stitches. Additionally, Hasbro has received four reports of children being struck by the descending rocket, including three cuts that required stitches.

What to do: Stop using the rockets immediately and contact Hasbro to receive a replacement product of equal value. Contact toll-free Hasbro Inc. at (866) 487-4737 anytime or logon to the company's Web site at **www.supersoaker.com.**

Basketball Shoes

Product: About 187,000 pairs of adidas Superstar Ultra and Pro Team Shoes by adidas America Inc. The adidas Pro Team and Superstar Ultra basketball shoes come in various color combinations. The recalled shoes have a six-digit article number on the inside part of the shoe tongue. The shoes were sold at adidas stores, major athletic shoe stores, independent shoe stores nationwide, and at thestore.adidas.com. The Superstar Ultra shoes were sold between January 2004 and October 2004 for about $120. The Pro Team shoes were sold between July 2004 and October 2004 for about $80. The shoes were made in China.

Problem: A portion of the sole of the heel can separate or tear during use, which can result in injuries. adidas America has received two reports of injuries involving these shoes, including one sprained ankle and one strained Achilles tendon.

What to do: Stop using the recalled shoes, and contact adidas America to receive a prepaid mailing label and a refund or gift certificate. For more information, call adidas America toll-free at (877) 568-4632 anytime, or visit the adidas America Web site at **www.adidas.com/recall.**

Cooler Pumps

Product: About 150,000 Evaporative Cooler Pumps by Little Giant Pump Company. The recalled pumps circulate water in evaporative coolers which cool the air in a room or building through the evaporation of water. The recalled units have a light blue motor cap and include the following model and item numbers, which can be found on a label on the motor cap: CP1 – 115, 540005; CP1 – 230, 540015; CP2 – 115, 541005; CP2 – 230, 541015; CP3 – 115, 542005; CP3 – 230, 542015. Units with beige motor caps are not included in this recall. Industrial/HVAC distributors and hardware stores sold the pumps from February 2003 through August 2004 for between $35 and $85. The pumps were made in China.

Problem: The motor caps on the cooler pumps are not made with flame-retardant material and an internal electrical failure can ignite the cap, posing a fire hazard to consumers. The firm has received 26 reports of pump fires with two incidents involving property damage.

What to do: Stop using the pump immediately and contact Little Giant to receive a replacement cap and instructions free of charge. Contact the company toll-free at (888) 271-1369 between 8 a.m. and 5 p.m. CT Monday through Friday and between 8 a.m. and 12 p.m. CT on Saturday or logon to the company's Web site at **www.littlegiant.com/Safety_Recall_Notice.pdf.**

Water Dispenser

Product: About 124,000 Avanti Water Dispenser by Avanti Products Inc. There are six models of water dispensers with hot water faucets included in the recall. The water dispensers have "Avanti" written on the front of the base. They have model number WD32, WD 50, WD 50.1, WDT51, WDR 52 or WHC 59. The model number is written on a silver sticker on the back of the unit. Model number WDR 52 is a combination refrigerator and water dispenser. All six models have removable drip trays and can hold either 3- or 5-gallon bottles of water. The dispensers were sold at Office Depot, Staples, and other appliance and electronic stores nationwide from July 2000 through August 2004 for between $120 and $250. The dispensers were made in China.

Problem: The hot water faucet on these units has a child-resistant safety feature to prevent young children from accessing the hot water. The device can malfunction so that the faucet will not turn off, causing burn injuries to children. Avanti has received 10 reports of the hot water not shutting off, nine of which resulted in burn injuries to children, including a 10-month-old baby who suffered burns on his arm and chest.

What to do: Consumers with small children should immediately disable the hot water by turning the red switch on the back of the dispenser to off and contact Avanti to get a free repair. Contact Avanti at (800) 366-0339 between 8 a.m. and 5 p.m. ET Monday through Friday, or visit its Web site at **www.regcen.com/waterdispenser.**

Folding Lawn Chairs

Product: About 20,700 Mainstays Garden Folding Lawn Chair by Rio Brands. The recalled folding lawn chairs have green plastic arms with green steel folding frames or blue plastic arms with blue folding steel frames. They are constructed of matching vinyl webbing. The chairs measure 31-inches high and 22.5-inches wide. The left hand arm of the chairs has the word "RIO" on it. Only the chairs with green or blue plastic arms are included in this recall. The chairs were sold exclusively at Wal-Mart stores nationwide from January 2004 through March 2004 for about $8. The chairs were made in China.

Problem: The chair arms can break, posing a fall hazard to consumers. Wal-Mart has received 26 incident reports involving broken plastic arms. In 17 of these incidents, consumers have reported injuries such as a fractured wrist, torn ligament, minor back injuries, bruises, and abrasions.

What to do: Stop using the product and return the chairs to Wal-Mart for a refund. For additional information, call Rio Brands customer service at (800) 866-8520 between 8:30 a.m. and 5 p.m. ET Monday through Friday or visit its Web site at **www.riobrands.com** or visit Wal-Mart's Web site at **www.walmartstores.com.**

Sweep+Vac Battery-Operated Vacuum Cleaner by Swiffer

Product: About 175,000 Sweep+Vac by Swiffer Vacuum Cleaners by Procter & Gamble Company (P&G). The recalled Sweep+Vac by Swiffer is a battery-operated, upright vacuum cleaner used to vacuum floors. The vacuum cleaner stands about 4-feet-tall and has a green base and silver pole. The name "Swiffer" is printed across the front of the base in white letters. UPC numbers included in this recall are 37000-46522 and 37000-02553. The UPC numbers are printed on the product's packaging. The swiffer was sold at retail and grocery stores nationwide from September 2004 through November 2004 for about $30. The swiffer was made in China.

Problem: In some cases, when the vacuum cleaner is left in the "on" position, the rotor can lock up and cause the unit to overheat. This poses a smoke and fire hazard. Procter & Gamble has received 14 complaints of the Sweep+Vac overheating, including one report of a fire with minor property damage. No injuries have been reported.

What to do: Stop using the product immediately and disconnect the Sweep+Vac by removing the top section of the pole. To disconnect the vacuum cleaner, press the small green button on the pole, about 12 inches below the handle, then pull the handle straight out. This eliminates any possibility of the unit overheating. Contact Procter & Gamble for more information on returning the product to receive a refund. Call (800) 487-5915 daily between 9 a.m. and 6 p.m. ET or visit **www.swiffersweepandvac.com** to receive shipping materials to return the Sweep+Vac unit to Procter & Gamble and receive a refund.

-- Carolyn T. Manley, Office of Compliance

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