



U.S. Consumer Product Safety Commission

Ann Brown, *Chairman*

Mary Sheila Gall, *Commissioner*

Thomas H. Moore, *Commissioner*

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Making Cribs Safer

A mother placed her 13 month-old daughter in the crib in the child's bedroom. Shortly afterwards, the mother found her daughter wandering in the hallway. The mother went to inspect the crib. She found that two slats on the crib side rail had dislodged. This created a space about one-foot wide where her child had slipped out.

A mother put her 17 month-old son down for a nap in his crib. The family dog was also in the child's bedroom. The mother left the room, but minutes later heard the dog whimpering. Rechecking the bedroom, she found her son with his neck trapped in the "V" formed by two dislodged crib slats from the side rail. The child was gasping for breath, but survived.

A mother placed her 9 month-old daughter into her crib for a nap. The mother returned later to the bedroom to take the baby out for a walk. She found her infant daughter hanging outside the crib, with her neck and chin entrapped inside the crib. Two crib slats were missing from the side rail, and the baby had slid through this seven-inch wide space. The child was dead.

To prevent further incidents like these, the U.S. Consumer Product Safety Commission (CPSC) recently voted to address the hazard of slats falling out of side rails in full-size and certain other cribs. An advance notice of proposed rulemaking (ANPR) has been published that could result in a mandatory safety standard for the structural integrity of crib side rails and their slats.

Since 1985, CPSC has received reports of at least 138 incidents where crib slats appeared to disengage from the side rails of cribs. Children died in 12 of these incidents; five other incidents resulted in non-fatal injuries.

Children's bodies may fit and slide through the space left by missing or broken slats, but not their heads. The children involved in these incidents generally had their necks trapped in the empty space. In some cases, a parent noticed that slats were loose or detached before any injuries occurred. In other cases, slats detached when a parent raised or lowered the side rail of the crib.

Ensuring crib safety is essential, as cribs are the one nursery product in which children are left for hours by themselves. In addition, cribs are often passed along to relatives and friends, extending the useful life of a crib to perhaps 25 years. Existing CPSC crib regulations do not address the crib slat hazard (see sidebar), and CPSC feels that the current industry voluntary standard requirements are not adequate.¹

Extent of Problem

Crib slat problems are found in cribs produced by many different manufacturers and in new as well as used cribs. Since 1991, CPSC has worked with five manufacturers to conduct recalls or other corrective actions for approximately 680,000 cribs with slat problems. In the incidents reported to CPSC, at least 26 different manufacturers or retailers were involved. Where the age of the crib was reported, about 85% were less than 3 years old.

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Making Cribs Safer

(continued from page 1)

Incidents occurred despite the fact that the industry trade association, the Juvenile Products Manufacturers Association (JPMA), has maintained a crib certification program since 1991. JPMA requires that a manufacturer must test, in accordance with industry voluntary standards (ASTM) specifications, at least 15% of its models quarterly and the balance once a year.

In 1995, about 2.2 million new cribs were sold, amounting to an estimated \$350 million in retail sales. The average cost of a crib is about \$160.

Recent Actions

Before recommending that the Commission begin the development of a federal safety standard, CPSC staff tried to work with industry to address the crib slat hazard. In March 1995, CPSC staff alerted the ASTM crib subcommittee to this problem. This was in response to two 1995 product recalls in which cribs had slats or spindles disengage during use. Since then, CPSC staff has been in frequent contact with the industry about crib slat problems.

After meeting with the ASTM crib subcommittee in May 1996, CPSC staff conducted some limited testing at its engineering laboratory. The purpose was to evaluate the adequacy of current ASTM structural integrity tests and to determine what new requirements might eliminate the crib slat hazard.

Based on this testing, it appeared that the current ASTM test method for crib side rails was not adequate. For example, when CPSC engineers conducted their tests according to ASTM procedures, a crib involved in a child's death and later recalled passed the ASTM side rail test. When CPSC staff put the crib through a more rigorous test, however, the crib failed.

After evaluating the test results of eight crib samples with varying slat construction, CPSC staff recommended that the ASTM standard be changed to increase the stringency of the side rail test. The current ASTM test method for crib side panels requires 50 drops of a 25-pound weight from a height of 3 inches. CPSC staff proposed to increase the number of drops to 1,000 and the weight to 50 pounds. The drop height would remain the same. The 50-pound weight was chosen to represent a 95th percentile, 30 month-old child (35 pounds) and to allow for a margin of safety for such factors as impact distances greater than 3 inches and heavier children (including siblings). The proposal for 1,000 drop cycles was based on the highest observed failure, plus a margin of safety, given the small number of samples tested.

CPSC staff further proposed that this test be preceded and followed by a torque test of each slat similar to

A History of Crib Safety

In 1973 and 1976, CPSC published mandatory safety standards for full-size and non-full-size cribs, respectively. These standards included requirements addressing side height, slat spacing, mattress fit, and other factors. In 1982, these standards were amended to include requirements that prohibit hazardous cutouts in crib end panels.

CPSC also was involved, through ASTM, in the development and revision of voluntary standards for cribs. First published in 1986 and 1989, these standards addressed additional hazards, such as entanglement on cornerposts of both full-size and non-full-size cribs, and structural and mechanical failures of full-size cribs.

that in a Canadian crib standard. This test determines whether, after a force is applied, the slat spacing will remain in conformance with the maximum width specified in CPSC's mandatory crib standards. Cribs that do not pass this test pose an entrapment hazard.

The ASTM crib subcommittee is currently evaluating the CPSC staff proposal for a revised test method, but has not yet acted on it. To obtain a copy of or comment on the CPSC crib slat ANPR, please see below.

— *Deborah Tinsworth, Directorate for Epidemiology and Health Sciences*

References

1. CPSC. Options to address crib slat disengagement hazards. Briefing package, 1996.

ANPRs

For a copy of the advance notice of proposed rule-making (ANPR) on **crib slats** or **multi-purpose lighters**, write to: Office of the Secretary, U.S. Consumer Product Safety Commission, Washington, D.C. 20207 or go to CPSC's Internet Web site at <http://www.cpsc.gov>.

Reducing Injuries from Multi-Purpose Lighters

CPSC recently voted to publish an advance notice of proposed rulemaking (ANPR) that could result in a child-resistant performance standard for multi-purpose lighters. CPSC already requires disposable and novelty cigarette lighters to be child-resistant.

Multi-purpose lighters are butane-filled lighters with a long nozzle, typically 4 to 8 inches, that allows the user to reach hard-to-light places (Figure 1). The lighters are activated by a trigger or button, which releases fuel and generates an electric spark. They are most commonly used to light charcoal or gas grills and fireplaces, as well as candles, pilot lights, and camp stoves.

CPSC staff is aware of 53 incidents since 1988 involving fires started by children under age 5 using multi-purpose lighters. These fires resulted in 10 deaths and 24 injuries. Among the 49 fires where the fire starter's sex was known, 44 were boys.¹

Children under age 5 typically are incapable of dealing with fire. About half of those who died in the fires were the children who had started them. Other victims who died were siblings and, in one instance, a mother.

In one injury incident, a 15 month-old baby was hospitalized for second and third degree burns over 80% of his body; his 3 year-old brother had ignited the playpen in which the baby was sleeping. In another case, a 4 year-old boy ignited his own clothing. He was hospitalized with third-degree burns over 50% of his body.

In February 1996, CPSC received a petition from a mother whose daughter was burned over 60% of her body. A 6 year-old boy had triggered a multi-purpose lighter and ignited the girl's clothing. The petitioner stated that the 6 year-old had Down's Syndrome and functioned at a 3 to 4 year-old developmental level. The petitioner asked that the multi-purpose lighter be included within the scope of CPSC's 1994 child-resistant cigarette lighter standard.

Appeal to Children

Some children are attracted to multi-purpose lighters because of their "toy-like" appearance. The lighters have similar physical characteristics to a gun (barrel, trigger, and, in some cases, trigger guard). In one incident, a 3 year-old boy saw the lighter on a basement workbench and, according to his mother, thought it was a toy gun.

The flame of multi-purpose lighters also appeals to children, who are often curious about fire. The flame shoots out of the nozzle and is sometimes larger than those of ordinary cigarette lighters.

Incident reports show how easy it is for young children to operate multi-purpose lighters. For example, after

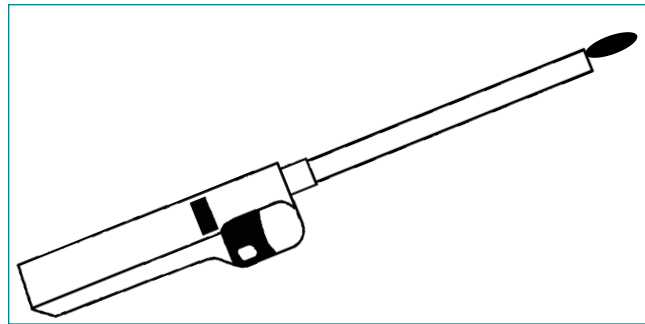


Figure 1. Multi-Purpose Lighter

one fire, fire investigators asked a 3 year-old to demonstrate how he used the lighter. The child switched the multi-purpose lighter to "on" and pulled the trigger with one hand. The father said the trigger pull action was similar to that of the boy's toy guns.

At the time of many reported incidents, children were under typical levels of adult supervision. Fires were started while parents or guardians were present in the house. One mother was downstairs fixing lunch at the time of the incident. In other cases, children started fires while a parent was showering or sleeping.

Increase in Incidents

The number of fires involving multi-purpose lighters has increased in the last two years. Five or fewer fires were reported annually through 1994. In 1995, 11 fires resulted in three injuries and two deaths. For 1996 to date, the staff is aware of 28 fires, which resulted in 16 injuries and four deaths. These numbers represent only the incidents known to CPSC staff; the actual numbers may be higher.

As the sales of multi-purpose lighters increase, the incidents could be expected to increase as well. For example, only one million multi-purpose lighters were sold in 1985 compared to projected sales of 17 to 18 million for 1996.

Requiring a child-resistant feature on multi-purpose lighters is likely to reduce these fire incidents. CPSC staff estimates that the expected benefits of adding a child-resistant feature could equal, or exceed, the expected costs.

— Barbara Jacobson, Directorate for
Epidemiology and Health Sciences

References

1. CPSC. Commission options on petition 96-1, from Judy L. Carr, to amend the safety standard for cigarette lighters to include multi-purpose lighters. Briefing package, 1996.

Dangers of Carbon Monoxide

During the winter months, the number of deaths and injuries from carbon monoxide (CO) poisoning is at its height. Most of the incidents involve heating systems, such as furnaces and heaters.

In 1995, an estimated 5,900 people were treated in hospital emergency departments for injuries associated with carbon monoxide.¹ An estimated 214 people died of CO poisoning in 1993 (the latest complete year available).^{2,3}

CO is a colorless, odorless gas produced by burning any fossil fuel. The initial symptoms of CO poisoning are similar to flu and include dizziness, fatigue, headache, nausea, and irregular breathing. Exposure to high levels of CO can cause death.

Of the deaths associated with CO poisoning, over two-thirds involved gas-fueled appliances, including space heaters, furnaces, water heaters, ranges and ovens, gas grills, and propane lanterns (Figure 1). Appliances powered by solid fuels, including charcoal grills and wood and coal heating systems, accounted for 20% of the deaths. Liquid-fueled appliances, including kerosene heating systems and appliances powered by gasoline, accounted for 12% of the deaths.

Most of the deaths occurred from October through March, the primary months when people use heating equipment. Seventy percent of the victims were males. Most of the deaths (82%) occurred in the home; the remaining incidents occurred in sport or recreational areas, streets and/or highways, and industrial sites. The deaths in streets and/or highways involved victims spending the night in a van or car. Typically, the victims were

Appliances by Fuel Type	No. of Deaths	No. of Injuries
TOTAL	214	5,900
Gas	146	4,100
Furnace	59	1,800
Space Heater	59	1,600
Range/Oven	6	400
Lantern	6	0
Water Heater	12	100
Other	3	200
Solid	43	1,300
Charcoal Grill	29	100
Wood/Coal Heating	14	1,200
Liquid	25	500
Gasoline Appliances	14	100
Kerosene Heating	11	100
Oil Heating	0	300

Figure 1. CO Deaths (1993) and Injuries (1995) by Residential Appliance

burning charcoal to keep warm. The deaths at industrial sites involved victims staying at the work site overnight and using portable heaters and propane generators.

For CO-related injuries, gas-fueled appliances, primarily furnaces and heaters, accounted for 69% of all incidents. Solid-fueled appliances were associated with 22% of the injuries, with liquid-fueled appliances accounting for 8%.

Like the deaths, most of the injuries occurred from October through March. The injury rate for children ages 5–14 was about 39 per million U.S. population, the highest of all age groups. This was followed by children under age 5, with a rate of 36 per million. Persons over age 65 had the lowest risk of injury, with a rate of 5 persons per million.

Preventing CO Poisoning

Consumers can take at least two actions to help prevent carbon monoxide poisoning in the home.

Each year, a qualified professional should check all fuel-burning appliances. In addition, consumers should install CO detectors that meet the requirements of Underwriters Laboratories' October 1995 standard.

A professional home inspection for CO should include checking the following:

- *Furnaces, water heaters, and stoves.* Check appliances that burn natural or propane gas, heating oil, wood, or other fuel for potential leaks of CO gas.
- *Chimneys, flues, and vents.* Inspect chimneys and flues for leakage and blockage by creosote or debris. Check for loose or disconnected vents to furnaces, water heaters, boilers, or vented space heaters.

- *High temperature plastic venting (HTPV) pipes.* CPSC is investigating reports that HTPV pipes connected to furnaces may separate or crack — allowing CO to enter a home. Be sure to inspect any gas-fired mid-efficiency furnaces or boilers installed between 1987-1996.

Other important tips for preventing CO poisoning include:

- *Charcoal grills.* Never use charcoal grills in enclosed spaces, such as a home, garage, vehicle, or tent.
- *Ventilation.* Make sure appliances have adequate ventilation. Consult the owner's manual for recommendations.

For more information, write for a free copy of: *Combustion Appliances and Indoor Air Pollution*, CPSC, Washington, DC 20207.

Estimates of nonfatal injuries from CO exposure are difficult to determine. Many victims do not seek medical attention and often are misdiagnosed because some symptoms are similar to those of colds and flu. These injury numbers, therefore, should be considered minimum estimates.

— *Kimberly E. Long, M.S., Directorate for Epidemiology and Health Sciences*

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1. U.S. Consumer Product Safety Commission. National Electronic Injury Surveillance System (NEISS).
2. U.S. Consumer Product Safety Commission. Death Certificate File.
3. National Center for Health Statistics.

Improving Smoke Detectors

Households with smoke detectors that do not work outnumber households with no smoke detectors at all.

That was a major finding of the National Smoke Detector Project, an activity organized by CPSC, the U.S. Fire Administration, the National Fire Protection Association, and the Congressional Fire Services Institute.

While nearly 90% of U.S. households now have smoke detectors installed, about six years ago fire departments began to observe fires where smoke detectors were installed but not operating.

The National Smoke Detector Project was formed in 1991 to address this issue. Since then, numerous organizations joined this public-private partnership, including the fire services, consumer groups, business and insurance organizations, health and injury prevention representatives, and voluntary standards groups. Major findings include the following points.

- Out of about 96 million U.S. households, 11 million have no smoke detectors, and an additional 16 million have detectors but none of them work.¹
- Low-income households are more likely to have no working detectors.¹
- Reasons for nonworking detectors include disconnection due to unwanted or nuisance alarms, dead or missing batteries, debris buildup, and component failure from age, corrosion, or other reasons. Factors associated with nuisance alarms include detector type, location, and contamination, such as dust or other debris in the detector. Removal of batteries for other uses was seldom identified.^{1,2}

Based on these findings, the following actions were taken.

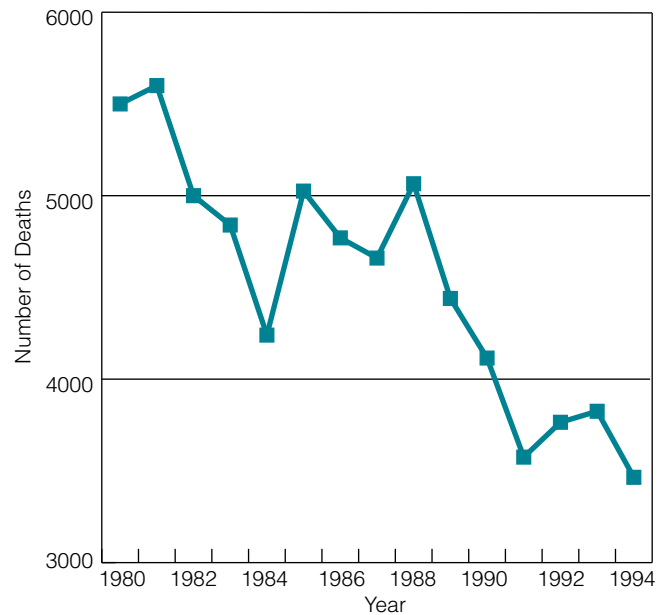


Figure 1. 1980–1994 Residential Fire Deaths

- Consumer awareness messages were revised and expanded to target the causes of nonworking detectors. In addition, new messages were suggested for dealing with nuisance alarms and the need to replace detectors that are 10 years or older.^{3,4}
- Local community-based consumer awareness programs were recommended to target low-income households.⁴ Program participants installed or gave away over 1 million smoke detectors, primarily in low-income households.
- CPSC staff recommended to Underwriters Laboratories (UL) improvements to its smoke detector standards to help the reliability of detectors.

The project also highlighted advances in technology, such as the recent introduction of long-life detector batteries which last for the life of the detector. In addition, in order to reduce consumers' tendencies to remove batteries because of nuisance alarms, some companies now offer a convenient feature to temporarily silence the alarm. There also is ongoing research on a new generation of detectors. These would eliminate nuisance alarms by applying electronic logic that could reliably discriminate between a fire and a non-fire incident.

Project participants have observed a steady decline in residential fire deaths in the United States (Figure 1)⁵ and agree that smoke detectors contributed substantially to this positive trend.

—*James F. Hoebel, Directorate for Engineering Sciences*

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Continued on page 6

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3. Koester RL, et. al. Community-based smoke detector program. Washington, DC: U.S. Consumer Product Safety Commission, February 1996.
4. Rossomando C, Perroni C. The national smoke detector project consumer awareness committee, final report. Washington, DC: U.S. Consumer Product Safety Commission, September 1995.
5. Smith LE, Long K. 1994 residential fire loss estimates memorandum. Washington, DC: U.S. Consumer Product Safety Commission, 1996.

Preventing Home Electrical Wiring Fires

More than 40,000 homes a year catch fire because of unsafe electrical wiring. Older homes are especially at risk.

To help prevent these fires, CPSC launched a program that offers a home electrical safety kit to community groups, professionals, and local officials. The safety kit includes a video entitled *Wired for Safety* and other information on home wiring hazards. The program's goal is to show how older homes can be inspected for wiring hazards and greatly improved without necessarily replacing entire electrical systems.

To encourage corrections of electrical wiring hazards, CPSC selected four older homes across the country to demonstrate how to inspect older wiring systems and to repair any problems. The homes were located in Capitol Heights, MD; Redlands, CA; Atlanta, GA; and St. Louis, MO.

The homes were inspected using the new National Fire Protection Association inspection code, *NFPA 73, Residential Electrical Maintenance Code for One- and Two-Family Dwellings*. Then, a local electrical contractor was videotaped as he corrected such unsafe conditions as worn-out components, overloaded circuits, and extension cords substituted for permanent house wiring.

The risk of electrical-wiring fires is greatest in older homes. A 40 year-old home is three times more likely to catch fire from electrical causes than homes 11 to 20 years old. In 1993 (the latest available data), electrical-wiring fires resulted in 330 deaths, 1,720 injuries, and \$689 million in property losses.

CPSC worked on this project with, among others: Fannie Mae Foundation, National Association of Home Builders Research Center, Underwriters Laboratories, U.S. Fire Administration, American Family Insurance, ITT Hartford, Nationwide Insurance Enterprise, Department of the Army, National Fire Protection Association, and the National Electrical Safety Foundation.

For organizations interested in obtaining a free home wiring safety kit, please fax a request to: *Wired for Safety* at 301-504-0862 or 301-504-0399. Organizations are encouraged to make copies of the video for distribution to member groups.

— William H. King, Jr., Directorate for Engineering Sciences

The Toy Story

Toys were associated with injuries serious enough to warrant an estimated 150,800 trips to U.S. hospital emergency rooms in 1995.¹ Almost half of the victims were less than 5 years old; about 80% of the injuries were to children under age 15.

CPSC also received reports of 21 toy-related deaths during 1995.* Seventeen victims were under age 5. The two youngest children were 7 months old, and the oldest was 9 years old.

Of the injuries associated with toys, 62% were lacerations and contusions/abrasions, and almost 60% (88,600) were to the head area. Consistent with prior years, almost two-thirds (61%) of the injury victims were males.

Where the toy was identified, riding toys, such as tricycles, wagons, and scooters, were associated with more injuries than any other toy group (Figure 1). Riding toys accounted for about 34,100 visits to U.S. hospital emergency rooms or about 23% of all toy-related injuries. During 1995, wagons and tricycles were associated with the largest number of injuries within the riding toy group, with 8,900 and 8,600 injuries respectively.

The second-largest group of toy-related injuries occurred with projectile and flying toys, with about 8,100 emergency room-treated injuries. Over half of these injuries (lacerations, contusions, and abrasions) occurred primarily to the face and eye when children were struck by these toys.

Among the deaths associated with toys, choking was reported in 12 of 21 fatalities. Eight choking deaths involved balloons, with victims ranging from 7 months to 5 years. Other toys involved in choking deaths were a small rubber ball, a marble, an imported game piece, and a part of a ball toss game. Riding toys accounted for six fatal incidents; four of these occurred when children on riding toys were struck by motor vehicles.

CPSC enforces numerous regulations covering toy safety. The most recent, CPSC's Child Safety Protection Act [Pub.L.No.103-267(1994)], effective in 1995, is intended to reduce toy-related choking deaths and injuries to young children. The Act requires warning

*This number may not include all toy-related deaths in 1995 because reporting is still in progress from some sources.

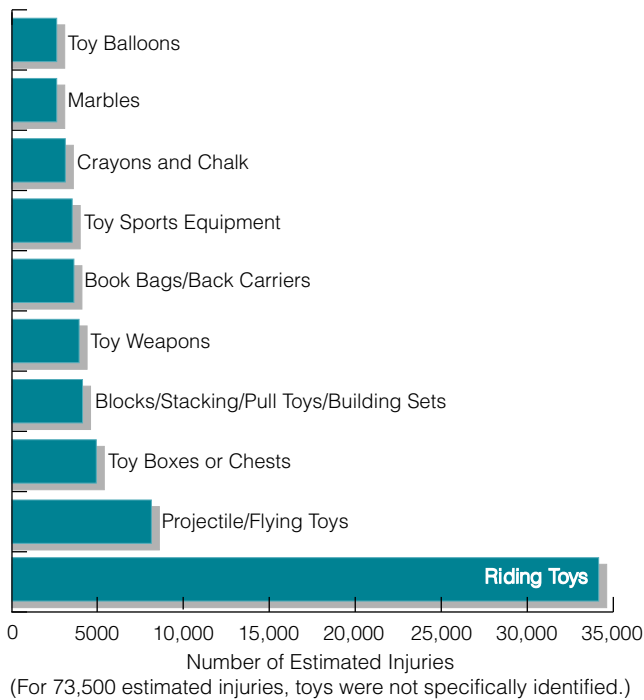


Figure 1. 1995 Toy Injuries by Reported Toy Group

labels on balloons, small balls, marbles, and toys or games intended for young children. Any ball with a diameter of 1.75 inches (44.4mm) or less that is intended for use by children under age 3 is banned.

The Act also requires manufacturers, importers, distributors, and retailers to notify CPSC about choking incidents caused by balloons, small balls, marbles, and small parts from toys and games. CPSC staff follow up on these reports to determine whether corrective measures, such as recalls, are necessary. During fiscal year 1996, CPSC completed recalls and corrective actions involving 116 toys and children's products.

—*Suzanne P. Cassidy, Directorate for Epidemiology and Health Sciences*

References

1. U.S. Consumer Product Safety Commission. National Electronic Injury Surveillance System (NEISS), death certificates, in-depth investigations, and injury or potential injury files, 1995.

Imported Toys

To ensure the safety of imported toys, CPSC staff works with the U.S. Customs Office to inspect toys as they arrive at shipping docks around the country. In fiscal year 1996, CPSC staff sampled 275 shipments of toys. Of these, 107 shipments were seized or detained for safety violations. This amounted to a total of 831,000 toys, with a retail value of \$2.2 million.

Drawstrings on Children's Clothing

As children put on their winter outerwear this season, there could be fewer serious or fatal incidents of entanglements with jacket or sweatshirt drawstrings.

CPSC staff has worked actively to prevent incidents where drawstrings from children's clothing catch on other products and result in injuries and deaths. Eliminating these incidents is the goal of recently-issued CPSC guidelines. A voluntary clothing string standard, which closely parallels these guidelines, appears likely to be issued within the next few months by ASTM.

Since 1985, CPSC has received reports of 19 deaths and 42 non-fatal incidents involving the entanglement of children's clothing drawstrings. The drawstrings caught on such products as playground slides and platforms, school bus handrails or doors, and crib corner posts.

In April 1994, CPSC invited manufacturers and retailers of children's clothing to discuss the hazard, drawstring alternatives, and a reasonable time frame for redesigning clothing. In July 1994, CPSC announced that 28 manufacturers and four retailers of children's clothing had agreed to voluntarily eliminate drawstrings from the necks and hoods of their jackets and sweatshirts by spring or fall 1995.

CPSC issued *Guidelines for Drawstrings on Children's Clothing* in November 1995 to inform manufacturers, retailers, and consumers of the voluntary effort to prevent drawstring deaths. The guidelines call for eliminating drawstrings from necks and hoods of children's upper outerwear, such as jackets and sweatshirts. Drawstrings around the waist and bottom of upper outerwear should be limited to 3 inches of exposed drawstring and be sewn at the back center of the garment to prevent the string from being pulled too long on one side.

By 1996, CPSC was aware of almost no children's jackets being manufactured that had neck or hood drawstrings. Instead, manufacturers had changed to elastic, velcro, snaps, or buttons.

To obtain a copy of the CPSC guidelines, write: *Guidelines for Drawstrings*, CPSC, Washington, DC 20207 or visit CPSC's Internet Web site at <http://www.cpsc.gov> (go to "Consumer/CPSC Publications/Children's Safety/Drawstrings").

—*Jean Kennedy, Office of Compliance and Deborah Tinsworth, Directorate for Epidemiology and Health Sciences*

MECAP NEWS

Medical Examiners and Coroners Alert Project and Emergency Physicians Reporting System

The MECAP-EPRS Project is designed to collect timely information on deaths and injuries involving consumer products. Please contact us whenever you encounter a death or situation which 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 are also 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 July, August, and September 1996, 759 cases were reported to CPSC. Included here are samples of cases to illustrate the type and nature of the reported incidents.

Asphyxiations/Suffocations

*A 1 month-old female was placed to sleep on a folded mattress in a playpen by her mother. The child was found unresponsive, face-down, wedged into the nylon side of the playpen. The cause of death was suffocation. (Susan Starrett for Kanthi von Guentner, M.D., Deputy Medical Examiner, Honolulu, HI)

A 5 month-old male was put to sleep in a portable crib at his grandmother's house. The victim's mother found the victim with a plastic bag over his head and chest. The Medical Examiner's office believes the bag was unintentionally left in the crib. The cause of death was asphyxiation. (Mark Breithaupt for Frederick T. Zuibe, M.D., Medical Examiner, Pomona, NY)

*A 13 month-old male was found unresponsive hanging by his neck in his crib. The victim's tank-top shirt was caught on a metal rod at the top of the drop-sided crib rail. The cause of death was asphyxia. (James Ribe, Coroner, Los Angeles, CA)

A 2 month-old female was sleeping on a waterbed with two adults and another child. The victim was found with her head between the edge of the waterbed and the headboard. The cause of death was asphyxia. (Nancy Moore for William D. McDearmon, M.D., Medical Examiner and John Butts, M.D., Chief Medical Examiner, Chapel Hill, NC)

*A 19 month-old male was sleeping on a bunk bed with a railing around the perimeter. The victim was found hanging between the mattress and the side of the bed with his feet dangling down. His face was in toward the mattress. The cause of death was asphyxia. (Kim Williams for Geetha Natarajan, M.D., Chief Medical Examiner, Newark, NJ)

*A 5 year-old female was found hanging from a swing set. The swing set had a strap attached to a trapeze bar. The strap was found around the victim's

neck. The cause of death was asphyxia. (Tom Drumstra for Justin Uku, M.D., Chief Medical Examiner, Erie County, Buffalo, NY)

Poisonings

A 60 year-old male and his 62 year-old brother were camping during a hunting trip. They were found dead in their closed tent with a propane lamp in the "on" position. Apparently the brothers had closed the tent's opening due to a rainstorm. The cause of death was carbon monoxide poisoning. (Jill Leath for Ross E. Zumwalt, Chief Medical Examiner, Albuquerque, NM)

*A 1 year-old male ingested a cup of kerosene which was left on a table by the victim's uncle. Apparently, the victim picked up the cup and drank the kerosene. He died a month later of complications from the kerosene ingestion. (William F. Hamilton, Medical Examiner, Gainesville, FL)

A 65 year-old male was found in his garage unresponsive. Apparently, the victim was fixing his garden tractor with the ignition in the "on" position and the garage door closed. The garage was found full of fumes. The cause of death was acute carbon monoxide intoxication. (Chris Leja for Thomas Gilchrist, M.D., Medical Examiner, Farmington, CT)

Drownings

A 2 year-old male was found unresponsive by his mother floating in an in-ground swimming pool. The victim's mother had just finished cleaning the pool and left the victim for a few minutes to go back into the house to get a flotation device for the victim. In her absence, the victim climbed down the pool ladder and entered the swimming pool. The cause of death was drowning. (Mary Stotkie, Deputy Coroner and John Plunkett, M.D., Medical Examiner, Dakota County, MN)

A 2 year-old male was in the care of a babysitter at the child's home. The babysitter thought the victim was taking a nap. The victim was able to push open the sliding glass door in the bedroom and enter the screened-in pool area. The child was found floating face down in

the pool. The cause of death was drowning. (Michael D. Bell, M.D., Medical Examiner, and James A. Benz, M.D., Chief Medical Examiner, Palm Beach County, West Palm Beach, FL)

A 1 year-old male was found at the bottom of a hot tub. A family member had removed the hard cover of the hot tub preparing to enter the tub, but walked away for a few minutes. The victim climbed up the two steps of the hot tub and entered the tub. The cause of death was drowning. (K. Barbey for Eric L. Kiesel, M.D., Chief Medical Examiner, Everett, WA)

Fire

*An 87 year-old female died in a house fire started by a toaster oven. The victim's clothing caught on fire and she received second and third degree burns. The cause of death was smoke inhalation. (David R. Schomburg for Pierre-Marie Charles, M.D., Medical Examiner and Charles S. Hirsh, M.D., Chief Medical Examiner, New York City, NY)

A 1 year-old female, a 20 year-old female, and a 21 year-old male died in an apartment fire. A smoldering barbecue grill caused a wooden deck to catch on fire, and the fire destroyed four units of the apartment building. The cause of death was inhalation of smoke and carbon monoxide. (Diane Stephans for Dr. Gunson, Deputy State Medical Examiner, Washington County, OR)

An 86 year-old female died in a house fire caused by faulty electrical wiring. The cause of death was thermal burns. (Norman Thiersch, M.D., Medical Examiner, Seattle, WA)

A 91 year-old male was cooking when his cooking mitten caught on fire which then caused his pajamas to catch on fire. The cause of death was complications of 86% body thermal burns. (Kathy Blea for Michelle D. Weiss-Samaras, M.D., Medical Examiner and Thomas E. Henry, M.D., Chief Medical Examiner, Denver, CO)

*A 50 year-old male died in a house fire caused by smoldering fireworks which ignited a wood porch. The cause of death was carbon monoxide intoxication. (Jacqueline Dobbins for J.

Lawrence Cogan, M.D., Medical Examiner and Edmund R. Donoghue, M.D., Chief Medical Examiner, Cook County, Chicago, IL)

Four females, ages 11, 13, 27, and 33, and a 34 year-old male died in a house fire caused by a short in the wiring of a space heater in conjunction with an overloaded circuit. The cause of death was smoke inhalation. (J. Glass for R.M. Brissie, M.D., Coroner/Medical Examiner, Jefferson County, Birmingham, AL)

A 74 year-old male poured gasoline into a running lawnmower. The gasoline ignited and caused the victim's clothing to catch on fire. The cause of death was thermal burns. (Mary Coffman for Jeffrey Barnard, M.D., Chief Medical Examiner, Dallas County, Dallas, TX)

Falls

*A 25 year-old male was working on a roof when the ladder he was using collapsed causing him to fall three stories. The cause of death was head injuries. (Delores Butler for Sajed Laiser, Medical Examiner and Haresh Mirchandani, M.D., Chief Medical Examiner, Philadelphia, PA)

A 26 year-old female fell from her bicycle while riding over a dirt path. She sustained a bad spiral fracture of the left leg which caused the leg veins to produce a thrombosis. The cause of death was pulmonary thromboemboli. (Deputy John Rensselear, Coroner, Kern County, Bakersfield, CA)

A 20 year-old male was skateboarding with two friends on a sidewalk at college. He was on an incline in a dark area when he fell off the skateboard and struck his head on the sidewalk. He was unresponsive when paramedics arrived. The cause of death was hypoxic encephalopathy due to blunt injuries to the head. (Daniel L. Matticks, M.S., Medical Examiner Investigator for Brian Blackbourne, M.D., Medical Examiner, San Diego, CA)

Electrocutions

*A 75 year-old male entered a crawl space under his house to work on

electrical wiring of a furnace/sump pump. The crawl space was flooded with water four to six inches deep due to rain. Electrical wiring from the sump pump was found lying on the ground in the water. Apparently, the victim was electrocuted by the wiring connected to the sump pump. (Nikolas J. Harishome, M.D. Medical Examiner, King County, Seattle, WA)

A 35 year-old male touched a metal sink while plugging a microwave oven into an electrical outlet. The outlet's plastic cover was broken, leaving part of the outlet exposed. The victim accidentally touched an uncovered part of the outlet and was electrocuted. (Pat Staruk for Elizabeth Laposata, M.D., Chief Medical Examiner, Providence, RI)

A 52 year-old male was found lying face up in about three to four inches of water in his basement, after being electrocuted while using a power rodder to clear a drain. The power rodder was partially submerged in water. (Jacqueline M. Dobbins for Scott Denton, M.D., Medical Examiner and Edmund R. Donoghue, M.D., Chief Medical Examiner, Cook County, Chicago, IL)

Miscellaneous

A 4 year-old male was attempting to climb on a stand which had an aquarium on it. The victim accidentally pulled the aquarium over and it fell on top of the victim. The cause of death was massive craniocerebral trauma. (Joseph Toland, M.D., Medical Examiner, Norfolk, VA)

*A 4 year-old female attempted to climb on her dresser by pulling out the bottom drawer and standing on it. The dresser fell on top of the victim, and she was found with the dresser lying across her chest and neck. The cause of death was traumatic compression with anoxic brain injury. (Jill Leath for Ross E. Zumwalt, Chief Medical Examiner, Albuquerque, NM)

—*Suzanne Newman, Directorate for Epidemiology and Health Sciences*

Recent CPSC Recalls

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

Product: About 212,000 Century Fold-N-Go Travel **Playards** (also known as playpens), Model 10-710, measuring 26" x 38", sold in Toys R Us stores beginning in June 1994 for about \$50 and Model 10-810, measuring 28" x 41", sold in juvenile products and discount stores beginning in February 1995 for about \$80.

Problem: The top rails on these playards may collapse unexpectedly, trapping a child at the neck in the "V" formed by the collapsed top rail. An 18 month-old boy died recently when the playard collapsed.

What to do: Stop using the product immediately and call Century at 800-541-0264 for a free repair kit and installation instructions or write: Century Products Company, 9600 Valley View Road, Macedonia, OH 44056. Consumers should not use the playard until the new top rails are installed.

Product: Approximately 500,000 disposable butane **cigarette lighters** in red, yellow, green, blue, and purple plastic bodies, with a paper label that reads, "CAUTION...MADE IN CHINA", sold from June 1995–April 1996 for less than \$1.

Problem: Lighters do not have safety devices that prevent young children from igniting the lighters.

What to do: Stop using the lighters immediately and return to the store where purchased for a full refund, or call Paik International of Flushing, NY at 212-545-1667.

Product: Approximately 110,000 refillable **novelty and disposable cigarette lighters** which operate with push-button electronic ignition mechanisms, in silver, copper or gold-tone metal with relief figures of birds, dragons, crocodiles, and other animals and sold for \$5–\$10 from September 1994–March 1996.

Problem: Lighters do not have safety devices that prevent young children from igniting the lighters.

What to do: Stop using the lighters immediately and return them to the place of purchase for a full refund, or call NBO Group toll-free at 800-716-0100.

Product: About 14,000 children's **Little Wood Wagons** sold by Mills Fleet Farm, The Right Start Catalog and Stores, and True Value Hardware, with a pull handle, 3-inch wheels. Wagons measure 7.5" x 12.5" x 4", and sold for between \$20–\$25 from June–September 1996.

Problem: The wagons contain prohibited levels of lead in the red painted sides that can cause lead poisoning in young children who ingest the paint.

What to do: Immediately take the wagons away from children and look for a date-of-manufacture decal on the

bottom. If there is no decal, consumers should return the wagon to the store where purchased for an exchange or refund, or call Radio Flyer at 800-621-7613, 24-hours-a-day to receive a replacement wagon without leaded paint.

Product: About 3 million **holiday candles** made of clear, gel-like substance in a textured vase-shaped clear glass jar about 3" high, with UPC label numbers on the bottom of the jar, beginning with number "076001", sold from October 1995–April 1996 for about \$4.

Problem: Candles can flare up during use causing the candles' glass holders to overheat and break, resulting in burn or broken glass injuries. CPSC is aware of 142 instances of candles flaring up and glass breaking, resulting in burns and cuts.

What to do: Stop using the candles immediately, pull out the wick, and dispose of the gel-like substance. Remove the UPC label and mail it along with the wick to Candle-lite, P.O. Box 42486, Cincinnati, OH 45242 for a full refund.

Product: Approximately 990,000 2-piece **baby monitor sets**, Gerry Deluxe Model 602, that resemble walkie-talkies in pale gray and royal blue plastic casing, with date codes "8806" (June 1988)–"9905" (May 1990).

Problem: Inside wires were improperly connected, resulting in overheating with the possibility of causing fire. CPSC is aware of one fire without injuries, and two other fires—one with a fatality and the other with an injury. In addition, there were 13 incidents of the monitors getting warm to the touch and skin burns.

What to do: Consumers should contact Gerry toll-free at 800-672-6289 for instructions on how to return the recalled monitors and to receive a free replacement monitor.

Product: Nearly 31,000 brown and white **extension cords** imported from China and packaged in a green and white sleeve labeled, in part, "JUMPOWER". Retailers in Michigan, New York, New Jersey and Puerto Rico such as Universal International, \$1 Depot, and Galaxy, sold these extension cords from April–July 1996 for about \$5.

Problem: Undersized wires in the cords present fire, shock, and electrocution hazards.

What to do: Stop using the recalled cords and return them to the store where purchased for a full refund from Northeastern Plastics Inc., or call 800-638-8270.

Refund Program

Product: Approximately 500,00 Cabbage Patch Kids Snacktime dolls, sold since fall 1996.

Problem: Reports of people getting their hair and fingers caught in the mouths of the dolls. A serious safety hazard has not been identified.

What to do: For a full cash refund of \$40, return dolls to the Mattel Distribution Center, 14310 Ramona Ave., Chino, CA 91710 or call Mattel at 1-800-335-1700.

Consumer Product Incident Report

Please contact us about any injury or death involving consumer products. Call us toll free at **1-800-638-8095**. Or, fill out the form below. Send it to **CPSC-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? _____



United States Consumer Product Safety Commission, Washington, DC 20207

PLEASE DUPLICATE THIS FORM FOR FUTURE USE.

