



## U.S. Consumer Product Safety Commission

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# CONSUMER PRODUCT SAFETY REVIEW

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## CCA-Treated Wood

*The U.S. Consumer Product Safety Commission (CPSC) staff has been looking at possible health risks to children from wooden playground equipment treated with the chemical chromated copper arsenate (CCA). Patricia M. Bittner, M.S., in CPSC's Directorate for Health Sciences, is the Project Manager for this issue. She discusses it below.*

### ***What is CCA-treated wood?***

This is wood treated with a chemical preservative, CCA, to protect it from rotting by insects and microbial agents. CCA contains chromium, copper, and arsenic.

### ***What are the health risks associated with CCA-treated wood regarding children?***

Exposure to the arsenic in CCA-treated wood might increase a person's risk of developing lung or bladder cancer over a lifetime. CPSC staff believes there is a risk to young children who play on CCA-treated playground equipment and pick up arsenic residue on their hands. The children then put their hands in their mouths or on toys, food, or other objects that will go into their mouths.

### ***How did you determine there is an increased health risk?***

To estimate the potential exposure in children, CPSC staff scientists conducted a series of studies to measure how much arsenic comes off CCA-treated wood playgrounds onto a hand and onto a cloth that was wiped on the wood. We were then able to make a correlation between the amount of arsenic that came off on to the hand as compared with the cloth. We then tested playgrounds using the cloth wipes. Our staff used this information – along with data from toxicological studies on arsenic, estimates of how frequently children play on playgrounds, how much they ingest, and other factors – to estimate the increased risk of exposure to arsenic on CCA-treated wood playground equipment.

### ***Do all children have the same risk?***

An individual child's risk depends on many factors. These include the amount of arsenic released from the CCA-treated wood, the amount of arsenic picked up on the hands, the number of days and years the child plays on the wood, and the amount of arsenic transferred to the mouth by hand-to-mouth activity. In addition, arsenic occurs naturally in the air, soil, water, and in some foods.

### ***How great is the risk of getting cancer from CCA-treated wood?***

A number of factors play into anyone's risk of getting cancer over a lifetime – including environment, genetics, diet, and behaviors such as smoking. The risk from CCA-treated wood is in addition to these and represents an increased cancer risk.

***What can parents and caregivers do to minimize the risk to children?***

We recommend that parents and caregivers thoroughly wash children's hands with soap and water immediately after playing on CCA pressure-treated wood playground equipment. In addition, children shouldn't eat while on this playground equipment.

***Are adults at risk?***

We believe that the primary source of arsenic exposure is the typical hand-to-mouth behavior of children under six. Adults, however, should wash their hands after exposure to CCA-treated wood products and not put food directly on these surfaces. They also should use protective gear when cutting or working with this wood.

***How widely used is CCA-treated wood?***

Beginning in the 1930s, CCA was used to pressure-treat lumber for decks, playgrounds, and other outdoor equipment. Since the 1970s, most pressure-treated wood used in residential settings has been treated with CCA.

***Is CCA-treated wood still being used?***

Due to recent actions by the U.S. Environmental Protection Agency (EPA), wood for most consumer uses may no longer be treated with CCA. We expect that some stocks of wood already treated with CCA will still be found on shelves until mid-2004.

***How can you tell if your playground equipment is made from CCA-treated wood?***

It's difficult to distinguish CCA-treated wood after it ages from non-CCA-treated wood. Calling the manufacturer might help. If you know your wood playground equipment (or deck) is not constructed with redwood or cedar, it's likely that it was treated with CCA.

***Do public wood playground structures contain CCA?***

Older play structures at school and public playgrounds probably are made with CCA-treated wood.

***What can you do if your playground equipment is made of CCA-treated wood?***

Based on limited data, some groups suggest that applying certain penetrating coatings, such as oil-based, semi-transparent stains, on a regular basis (once a year or every other year depending upon wear and weathering) may reduce the amount of arsenic that comes out of the wood. CPSC and EPA staffs are conducting studies of coatings and sealants to determine effective ways to reduce the amount of arsenic released from CCA-treated wood. Early results are expected later this year.

***Are there alternatives to CCA?***

Some non-arsenic containing preservatives to pressure-treat wood for consumer uses are already available at retail outlets. Common ones are ammonium copper quaternary (ACQ) and copper boron azole (CBA). Because CCA is being phased out of the marketplace, wood treated with these alternatives will be more commonly available in 2004. Another alternative, of course, is to use naturally rot-resistant woods like cedar and redwood – or non-wood alternatives like metals, plastics, and composites.

***What should you do if you have an outdoor picnic table or deck made of CCA-treated wood?***

The same precautions apply. Everyone should wash their hands after touching these products and not put food directly on the wood surfaces.

**For More Information**

To learn more about CCA-treated wood, please go to [www.cpsc.gov](http://www.cpsc.gov). If you decide to remove your CCA-treated wood playset, EPA states that CCA-treated wood should never be burned in open fires, stoves, fireplaces, or residential boilers or ground up for mulch. Contact EPA at [www.epa.gov](http://www.epa.gov) or your state or local solid waste management office to receive instructions on how to dispose of CCA-treated wood.

## Portable Generators

Between 1990 and 2002, CPSC received reports of 179 carbon monoxide (CO) poisoning deaths associated with portable generators. These products use fuel-burning engines that emit poisonous CO gas in their exhaust.

Adults, 25 years and older, accounted for 78% of these deaths. Most (72%) of the victims were male.

### In-depth Investigations

CPSC staff conducted follow-up in-depth investigations of 70 generator incidents that resulted in 97 fatalities.

The main reasons reported for using a portable generator were to provide electricity to a location because of a temporary power outage or to provide power to a temporary location.

For example, 28 of the investigated deaths were associated with generators used during a temporary outage stemming from problems with weather or power distribution. Twenty-five of the investigated deaths were associated with generators being used to supply power to a temporary shelter, storage-shed (offsite from the home), or boat that did not have electricity.

Sixty-seven of the investigated deaths took place at home. For example, 25 of these deaths occurred when the generator was in the home's basement or crawl space. In another 22 deaths, the generator was reported

as being inside the home. Seventeen deaths occurred when the generator was placed in the garage or enclosed carport of the home.

With most of the investigated deaths, there was either no venting of the portable generator or no information about whether venting occurred. Eleven deaths occurred where venting of the portable generator was reported. For example, there were deaths where the garage door, window, or other door was open near the generator. In one instance, the generator was located in a screened porch with all the windows opened. In yet another incident, the generator was placed outside the home on the back porch with the kitchen window slightly open, and the deceased was found in a bedroom inside the home.

— *Susan Vagts, Directorate for Epidemiology*

### Portable Generator Meeting May 20, 2004

CPSC staff will hold a forum to address the CO poisoning hazard posed by portable generators. The meeting is on May 20, 2004, at the CPSC headquarters building in Bethesda, MD. To register, please go to [www.cpsc.gov](http://www.cpsc.gov) and click on *What's Popular*. For more information, contact Janet Buyer at [jbuyer@cpsc.gov](mailto:jbuyer@cpsc.gov) or 301-504-7542.

## Using Portable Generators Safely

The primary hazards associated with portable generators are carbon monoxide (CO) poisoning from the toxic engine exhaust and electric shock.

You cannot smell or see CO gas. If you feel sick, dizzy, or weak while using the generator, get to fresh air **RIGHT AWAY**. See a doctor. You may have CO poisoning. To avoid these hazards:

- Never use a generator indoors, including in homes, garages, basements, crawl spaces, and other enclosed or partially-enclosed areas. CO gas can build up very quickly and kill you. Opening doors and windows or using fans will not provide enough fresh air.
- Follow the instructions that come with your generator. Locate the unit **outdoors** and away from

doors, windows, and vents that could allow CO to come indoors. To protect your generator from moisture, operate it on a dry surface under an open, canopy-like structure.

- Plug appliances directly into the generator. Or, use a heavy duty, outdoor-rated extension cord that is rated (in watts or amps) at least equal to the sum of the connected appliance loads.
- If you must connect the generator to the house wiring to power appliances, have a qualified electrician install the appropriate equipment in accordance with local electrical codes. Or, check with your utility company to see if it can install an appropriate power transfer switch.
- Install battery-operated CO alarms in your home, according to the manufacturer's installation instructions. For more information about portable generators, please visit [www.cpsc.gov](http://www.cpsc.gov).

## Bleachers

CPSC has reports of 19 people who died in incidents associated with falls from bleachers between 1980 and 2003. Since 2001, at least 3 deaths occurred from falls from bleachers in high schools or at a school gym.

In 2002, an estimated 3,350 children under age 15 entered U.S. hospital emergency rooms with injuries associated with falling from, or through, bleachers onto the surface below. Between 1998 and 2002, the number of fall-related injuries associated with bleachers to children under 15 decreased, but the decline was not statistically significant.

### Hazards

Falls from bleachers can occur when guardrails are missing from the backs or open sides of bleachers. Falls also can occur when there are big enough openings between components in the seating and guardrails.

Many bleachers in facilities today pose a fall hazard, especially to children. This is due, in part, because these bleachers may have been built and installed when the building codes did not require guardrails and allowed big enough openings that permitted a child to fall through them. In addition, when a jurisdiction adopts a new building code, it typically does not require the code to be applied retroactively to structures like older bleachers.

Bleachers can pose additional hazards. They can collapse if they are not operated or maintained properly. Falls on bleachers also can occur when there are missing or inadequate components that assist in access and egress, such as aisles, handrails, and non-skid surfaces.

### Bleachers Guidelines

To address bleacher deaths and injuries, CPSC issued voluntary guidelines in 2000 that provide recommendations for retrofitting bleachers to prevent falls *from* bleachers. The guidelines also include information about preventing falls *on* bleachers. The guidelines are summarized below.

- Guardrails should be present on the backs and portions of the open ends of bleachers where the footboard, seatboard, or aisle is 30 inches or more above the floor or ground below. Bleachers with the top row nominally 30 inches above the ground may be exempt from this recommendation.
- The top surface of the guardrail should be at least 42 inches above the leading edge of the footboard, seatboard, or aisle, whichever is adjacent.

- When bleachers are used adjacent to a wall that is at least as high as the recommended guardrail height, the guardrail is not needed if a 4-inch diameter sphere fails to pass between the bleachers and the wall.
- Any opening between components of the guardrail or under the guardrail should prevent passage of a 4-inch sphere.
- Any opening between the components in the seating, such as between the footboard, seatboard, and riser, should prevent passage of a 4-inch diameter sphere where the footboard is 30 inches or more above the ground and where the opening would permit a fall of 30 inches or more.
- The preferable guardrail design uses only vertical members as in-fill between the top and bottom rails. If there are openings in the in-fill that could provide a foothold for climbing, the widest measurement of the opening where the foot could rest should be limited to a maximum of 1.75 inches. Opening patterns that provide a ladder effect should be avoided. If chain link fencing is used on guardrails, it should have a mesh size of 1.25-inch square or less.
- Aisles, handrails, non-skid surfaces, and other items that assist in access and egress on bleachers should be incorporated into any retrofit project where feasible.
- The option of replacing bleachers as opposed to retrofitting should be considered.
- Materials and methods used for retrofitting should prevent the introduction of new hazards, such as bleacher tipover, bleacher collapse, guardrail collapse, and contact or tripping hazards.
- Bleachers should be thoroughly inspected at least quarterly by trained personnel and problems corrected immediately. Records of these actions should be retained.
- A licensed professional engineer, registered architect, or company that is qualified to provide bleacher products and services, should inspect the bleachers at least every two years and provide a written certification at such time that the bleachers are fit for use.
- Records of all incidents and injuries should be retained.

— *Janet Buyer, Directorate for Engineering*

### For More Information

For a complete copy of *Guidelines for Retrofitting Bleachers*, please go to [www.cpsc.gov](http://www.cpsc.gov).

## Residential Fire Losses

An estimated 337,300 unintentional, residential structure fires occurred in 1999 (the latest year available for complete data), according to a CPSC staff report.

The report provides estimates of product-related fire losses in U.S. residential fires attended by the fire service. These estimates are based on data produced by the U.S. Fire Administration's (USFA) National Fire Incident Reporting System (NFIRS) and the National Fire Protection Association (NFPA). Other major findings from the report include the following.

- These fires resulted in an estimated 2,390 civilian deaths, 14,550 civilian injuries, and \$4.24 billion in property losses.
- Cooking equipment accounted for the largest percentage of fires (29%), 13% of the deaths, and 28% of the injuries. Most of these losses were associated with range and oven fires.
- Heating and cooling equipment fires accounted for 14% of the fires, 13% of the deaths, and 9% of the injuries.
- Twelve percent of the fires were attributable to electrical distribution system components (e.g. wiring, lighting, etc.). These fires led to 8% of the total deaths and 7% of the total injuries.
- By item first ignited, upholstered furniture ignition was involved in the greatest number of deaths, accounting for 440 residential fire deaths, or 18% of the total deaths. Mattress or bedding ignitions accounted for 330 residential fire deaths, or 14% of total deaths.
- By heat source, smoking materials were the largest contributor to deaths, accounting for 33% of fire deaths. Lighters, candles, and matches accounted for 5%, 4%, and 3% of fire deaths respectively.

A major revision to the NFIRS data coding system took effect with 1999 data. For that reason, CPSC staff discourages comparisons of 1999 estimates with estimates from earlier years. (A further explanation is included in the methodology section of the full report.)

Intentional fires and their associated losses are excluded from the estimates.

— *David Miller, Directorate for Epidemiology*

### For More Information

For a complete copy of the report, *1999 Residential Fire Loss Estimates*, please go to [www.cpsc.gov](http://www.cpsc.gov).

## Lead Candle Wicks Banned

CPSC recently banned the manufacturing, importing, and selling of candles with lead-cored wicks. CPSC staff determined that these products could present a lead poisoning hazard to young children. Lead poisoning in children is associated with behavioral problems, learning disabilities, hearing problems, and growth retardation.

Some candle wicks contain a metal wire in the center to keep it straight and upright during candle production and burning. This metal is most often zinc, but lead also has been used.

### Children at Risk

CPSC staff found that some lead-cored wicks could emit relatively large amounts of lead into the air during burning. Children may then inhale the vaporized lead, placing them at risk. They also may be exposed to lead by mouthing objects on which lead has settled or by handling these objects and then mouthing their hands.

CPSC staff estimates that an indoor air lead level of 430 micrograms per hour from burning candles could result in hazardous exposure to children. Some of the candles tested by CPSC staff emitted lead levels in excess of 3,000 micrograms per hour (about seven times the rate that could lead to elevated levels of lead in a child).

The primary source of lead poisoning in the U.S. is lead from paint in older homes. Because lead accumulates in the body, however, even exposure to small amounts can contribute to the overall level of lead in the blood.

Safer alternatives to lead-cored wicks, including zinc, synthetic fibers, cotton and paper, are used by most candle and candle wick manufacturers. Currently, candles that use a metallic core in the wick most likely contain zinc. Because consumers cannot tell if a metal-cored wick contains lead or an alternative, consumers may wish to contact retailers for information about the materials used in their candles.

— *Kristina M. Hatlelid, Directorate for Health Sciences*

# Toys

## Toy-Related Deaths

CPSC has reports of 13 children who died in toy-related deaths in 2002. Victims ranged in age from 2 to 12 years old. Nine of the fatalities involved males. The deaths occurred, as follows:

**Choking or Aspiration Deaths:** Eight deaths occurred when the child choked on or aspirated a toy. The toys included three balloons, one toy dart, one dart tip, two toy balls, and one suction cup from a toy eyeball. These children ranged in age from 2 to 11.

**Head Injury Deaths:** Three of the toy-related deaths resulted from head injuries. These deaths involved two tricycles and one riding toy. The ages of the victims ranged from 2 to 12. Two of the deaths resulted from a collision with a motor vehicle. One death occurred when a child struck a tree as a result of his riding toy being towed by a motor vehicle.

**Deaths Due to Drowning:** There was 1 death due to drowning that involved a tricycle. A 5-year-old male, who had been riding around the deck of a pool, was found drowned with his tricycle in the pool.

**Incidents with an Unspecified Cause of Death:** In one case, a 10-year-old female was stuck by a motor vehicle while riding a scooter across a street. While no specific cause of death was given, it was likely due to some type of blunt force trauma.

For 2002, CPSC also has reports of 2 persons over 14 who were killed in incidents associated with toys. One incident involved a developmentally-delayed 15-year-old girl who choked on a balloon. The other incident in-

involved a 60-year-old man who was hit in the chest by a remote-controlled plane.

## Toy-Related Injuries

In 2002, there were an estimated 212,400 toy-related injuries treated in U.S. hospital emergency rooms. This was a statistically significant drop in the estimated 255,100 toy-related injuries from 2001 (*Figure 1*).

The decrease in toy-related injuries from 2001 to 2002 correlates with a drop in riding toy-related injuries for the same period. The estimated injuries related to riding toys (including non-powered scooters) decreased from 121,700 in 2001 to 81,300 in 2002. Still, in 2002, riding toys (including non-powered scooters) continued to be associated with more injuries (81,300 or 38%) than any other category of toy.

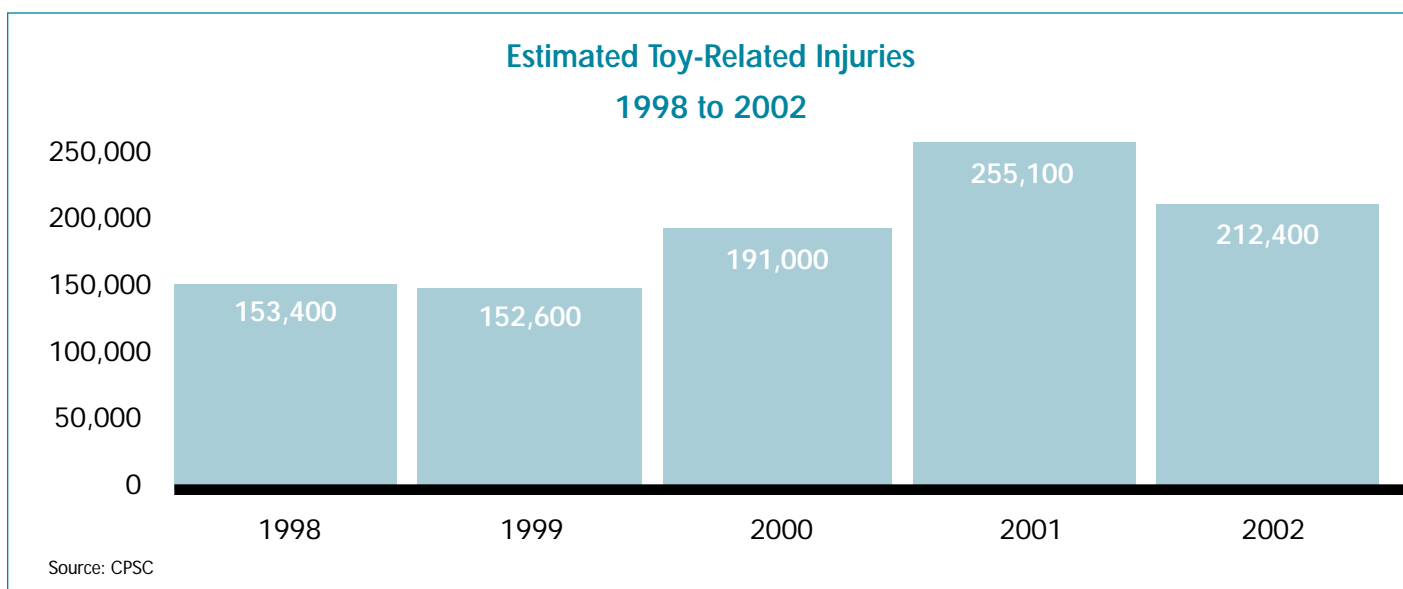
Seventy-eight percent (165,200) of the injuries for 2002 were to children under 15, and 34% (72,400) were to children under 5. Twenty-two percent (47,200) of the injuries were to persons 15 and older.

Overall, males were involved in 58% of the toy-related injuries. Most of the victims (97%) were treated and released from the hospital.

Forty-seven percent of the total injuries (100,300) occurred to the head and face area. Arms accounted for 25% of the injuries (52,200), while the leg and foot area accounted for 17% (36,000).

The individual body parts having the most injuries overall were faces (45,400), heads (27,100) and mouths (16,200). Lacerations, contusions, and abrasions were involved in over half of the total injuries (53%).

— Joyce McDonald, Directorate for Epidemiology



*Figure 1*

# Consumer Product Incident Report

Please contact us about any injury or death involving consumer products. Call us toll free at: **1-800-638-8095**. Visit our website at **www.cpsc.gov**. Or, fill out the form below. Send it to: U.S. Consumer Product Safety Commission/EHDS, Washington, DC 20207 or fax it to: **1-800-809-0924**. We may contact you for further details. Please provide as much information as possible. Thank you.

YOUR NAME \_\_\_\_\_

YOUR ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

YOUR TELEPHONE \_\_\_\_\_

NAME OF VICTIM (IF DIFFERENT FROM ABOVE) \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_

DESCRIBE THE INCIDENT OR HAZARD, INCLUDING DESCRIPTION OF INJURIES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VICTIM'S AGE \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF INCIDENT \_\_\_\_\_

DESCRIBE PRODUCT INVOLVED \_\_\_\_\_

PRODUCT BRAND NAME/MANUFACTURER \_\_\_\_\_

IS PRODUCT INVOLVED STILL AVAILABLE?  YES  NO PRODUCT MODEL AND SERIAL NUMBER \_\_\_\_\_

WHEN WAS THE PRODUCT PURCHASED? \_\_\_\_\_

This information is collected by authority of 15 U.S.C. 2054 and may be shared with product manufacturers, distributors, or retailers. No names or other personal information, however, will be disclosed without explicit permission.



**U.S. Consumer Product Safety Commission**  
Washington, DC 20207

TC-49

# MECAP NEWS

## Medical Examiners and Coroners Alert Project and Emergency Physicians Reporting System

The MECAP-EPRS Project is designed to collect timely information on deaths and injuries involving consumer products. Please contact us whenever you encounter a death or situation that you believe should be considered during a safety evaluation of a product.

To report a case or ask for information about MECAP, please call our toll-free number, 1-800-638-8095, or our toll-free fax number, 1-800-809-0924, or send a message via Internet to [AMCDONAL@CPSC.GOV](mailto:AMCDONAL@CPSC.GOV).

\*Indicates cases selected for CPSC follow-up investigations. Cases reported but not selected for follow-up also are important to CPSC. Every MECAP report is included in CPSC's injury data base and will be used to assess the hazards associated with consumer products.

*During the months of July and August of 2003, 885 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, 16 months, was found unresponsive with his face wedged in the corner of his crib against the mattress. CPR was administered, and the child was rushed to the hospital where he died four days later. A loose screw caused the side panel of the crib to pull away from the end panel. This produced the opening where the child's head became entrapped. The cause of death was asphyxia.

(Phil Pascuzzi for Gary F. Peterson, M.D., J.D., Medical Examiner, Hennepin County, Minneapolis, MN)

\*A female, 10 months, was placed on a mattress on the floor for a nap by her father. When her father checked on her about ten minutes later, he found the child unresponsive on the floor with a window-blind cord wrapped around her neck. He attempted resuscitation until an ambulance arrived and rushed the child to the hospital, where she was pronounced dead. The cause of death was asphyxia.

(Dolores Jones-Butler for Edwin Lieberman, M.D., Assistant Medical Examiner, Philadelphia, PA)

\*A female, 7 months, was placed on her side in a stroller to sleep by her mother. About an hour later, the mother found the child, unresponsive and facedown, in the stroller seat. Her head was stuck between the stroller and its front tray. The mother's friends attempted resuscitation until emergency personnel arrived and took the child to the hospital. The child died four days later. The cause of death was mechanical asphyxia.

(Manfred C. Borges, Jr., M.D., Deputy Chief Medical Examiner, District Twenty, Collier County, Naples, FL)

\*A male, 7, was found unresponsive with the handlebars of his all-terrain vehicle across his chest. His mother, who had found him, attempted CPR, and the child was rushed to the hospital where he died. The cause of death was hypoxia.

(Stephen McBee, Medical Examiner, Morgan County, Berkeley Springs, WV)

## CARBON MONOXIDE POISONINGS

\*A man, 24, was found unresponsive in his home. He had placed a gasoline-powered generator in his home because of a power shortage. The generator was not vented to the outside, and the home had no carbon monoxide detectors. The cause of death was carbon monoxide poisoning.

(Elizabeth Frank for Malcolm Tenney, M.D., Medical Examiner, Western District, Commonwealth of Virginia, Roanoke, VA)



## DROWNINGS

\*A female, 10 months, was placed in a baby bathtub seat in a bathtub by her mother. The mother left the child and her 2-year-old sister in the bathtub with the bathroom door open. Some time later, the mother returned to find the 10-month old facedown in the bathtub. The mother removed the child and performed CPR until emergency personnel took over and rushed the child to the hospital. The child was pronounced dead later that night. The child, who had recently learned to walk, had stood up and fallen out of the bathtub seat into the water. The seat stayed attached to the bathtub. The cause of death was drowning.

(Frank D. Ratti, M.D., Chief Deputy Medical Examiner, Lane County, Eugene, OR)

A female, 2, was found facedown and unresponsive in a swimming pool while she was staying at a relative's home. Rescue personnel took her to a hospital where she was pronounced dead. A sliding glass door had been left open, providing access to the pool area. The cause of death was drowning.

(Reinhard W. Motte, M.D., Associate Medical Examiner, Dade County, Miami, FL)

## FIRES

A female, 68, and a male, 60, were found unresponsive in their home after a fire. The fire started in one of the five electrical cords behind an entertainment center. The home had no smoke detectors. The cause of death was carbon monoxide poisoning.

(Barry L. Bloss, Coroner, York County, York, PA)

\*A male, 44, was found unresponsive in his home by firefighters. The man and three family members escaped the blaze initially, but he re-entered his home to try and save his two dogs. The fire started when a candle was knocked over. The cause of death was the inhalation of toxic fumes.

(Lisa J. Kohler, M.D., Chief Medical Examiner, Summit County, Akron, OH)

A male, 85, and his wife, 87, were found unresponsive near the back door of their home after a fire. Their efforts to open the door were heard by a responding fireman, but the door was blocked from the inside. The fire was caused by an extension cord. The cause of death was smoke inhalation.

(Vincent J.M. Di Maio, Chief Medical Examiner, M.D., Bexar County, San Antonio, TX)

A male, 25, was found unresponsive in a friend's apartment after a fire. Six other residents of the apartment building had escaped after being alerted by drivers on a nearby highway. An unattended candle started the fire. The cause of death was smoke inhalation.

(Carl L. Parrott, Jr., M.D., Coroner, Hamilton County, Cincinnati, OH)

## MISCELLANEOUS

A male, 71, was riding on his riding lawn mower when it flipped over on a hill about five feet high. The mower then ran over him. The man was taken to the hospital where he died four days later. The cause of death was multiple traumas.

(R. Carter Payne, RN, Medical Examiner, Cabell County, Huntington, WV)

A male, 20 months, was found unresponsive by a neighbor on an asphalt driveway. He had fallen out of the window of his second-story apartment. He was rushed to the hospital where he died the next day. The cause of death was blunt force injury to the head.

(Thomas H. Gill, M.D., Deputy Medical Examiner, Jackson County, Kansas City, MO)

\*A female, 13, was riding a 3-wheeled all-terrain vehicle in a grassy open field. The girl removed her hands from the handlebars, and the vehicle hit a bump and flipped over. She was thrown over the handlebars, and the vehicle landed on top of her. The girl was taken to a hospital where she died later that day. She was not wearing a helmet. The cause of death was blunt force trauma to the head.

(Stephen J. Nelson, M.A., M.D., Chief Medical Examiner, District 10, Bartow, FL)

—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](http://www.cpsc.gov).

### Bottled Water with Sport Caps

**Product:** About 3.2 million bottled water with push-pull sports cap by CCDA Waters LLC. The bottled water with the affected push-pull sports caps was sold under the brand names Dannon Fluoride to Go, Pure American, Enon Springs, Alhambra Junior Sport Drinking Water, and Sparkletts Junior Sport Drinking Water. The bottled water was sold as singles and multi-packs in 8-oz., 8.5-oz, and .33-liter sizes. The bottled water with this sports cap was sold at a variety of retail outlets including gas stations, grocery, convenience, mass merchandise and drug stores from March 2002 through September 2003, for between \$0.59 for a single bottle and \$3.29 for multi-packs. The product was manufactured in the United States.

**Problem:** When pulled to open, the drinking spout on the sports cap can unexpectedly come off, posing a choking hazard for young children. There have been 10 complaints with no injuries reported.

**What to do:** Take the bottled water with the sports cap away from children immediately and return it to the store where purchased for a refund. For more information, consumers can contact the CCDA Water Consumer Line toll-free at (800) 322-4616 between 9 a.m. and 5 p.m. Eastern Time, Monday through Friday, or visit the firm's Web site at [www.dannonwater.com](http://www.dannonwater.com).

### Toy Necklaces

**Product:** About 1.4 million toy necklaces by L.M. Becker & Co. Inc. The necklaces consist of a 10-inch black cord with a 7/8-inch-diameter gray metal pendant. The metal pendant has assorted symbols on one side. The necklaces were sold from vending machines in malls, and discount department and grocery stores nationwide from March 2002 through April 2003 for about 50 cents. The necklaces were manufactured in India.

**Problem:** The necklace's pendant contains high levels of lead, posing a risk of poisoning to young children. The firm received one report of a child who swallowed the necklace's pendant, which reportedly resulted in high blood lead levels.

**What to do:** Stop using the necklaces and contact the company for instructions on how to get a refund. Consumers can also call L.M. Becker & Co. Inc. at (888) 869-6569 between 8:30 a.m. and 4:30 p.m. CT Monday through Friday, or go to the firm's Web site at [www.toyjoy.com](http://www.toyjoy.com).

### Portable Play Yards with Raised Changing Tables

**Product:** About 538,000 "Pack 'n Play" portable play yards with raised changing tables by Graco Children's Products Inc. Only "Pack 'n Play" portable play yards with raised changing tables are part of this recall. They also are sold with an infant bassinet. "GRACO" and "Pack 'n Play" are written on the side of the play yard. These play yards have model numbers 2016, 35235, or model numbers that begin with 9531 or 9533. The last three digits of the model number will vary. The model number can be found on a label on the white plastic center cone under the play yards. "MADE IN CHINA" also is written on the bottom label. Models 2016, 35235, 9531 and 9533 that are currently sold at retail and that have green stickers on the boxes, indicating that the unit has been modified, are not recalled. Discount, department and juvenile product stores nationwide sold these portable play yards from October 2001 through September 2003 for between \$99 and \$119.

**Problem:** When children are placed in these portable play yards when the changing table is still in place, they can crawl under and lift the table up. If this occurs, a child's head and neck can become trapped between the changing table and the play yard rail, causing a strangulation hazard. The Commission and Graco are aware of the death of a 13-month-old girl, who strangled when her neck became trapped between the Pack 'n Play rail and the raised changing table.

**What to do:** Never place a child in these portable play yards when the changing table is still in place. Consumers should immediately contact Graco to receive a free warning label to be affixed to the changing table. Consumers can contact Graco at (800) 233-1546 anytime, or visit the firm's Web site at [www.gracobaby.com](http://www.gracobaby.com).

### "Comforts" Pacifiers

**Product:** About 154,000 "Comforts" pacifiers by Apothecary Products Inc. The pacifiers are available in both silicone and latex formulations in the following colors: powder blue, red, purple, and pink. The name "Kroger" appears on the package, along with the words "Pacifiers," "Latex," "Silicone," "0-6 months," or "6-18 months." The model numbers are located on the back of each package and are the last five digits of the UPC code: 35826 35827 35828 35829. Many Kroger-owned stores sold the pacifiers from August 2002 through August 2003 for about \$3.50 to \$5.00. The pacifiers were manufactured in China.

**Problem:** These pacifiers fail federal safety tests, come apart, and can pose a choking hazard to infants and small children. No incidents or injuries have been reported.

**What to do:** Stop using these pacifiers and return the pacifiers to the store where purchased for a full refund. Consumers can contact Apothecary Products at (866) 274-7956 between 9 a.m. and 5 p.m. CT Monday through Friday, or call The Kroger Co. toll-free at (800) 632-6900 between 8 a.m. and 9 p.m. CT Monday through Friday.

### Multicolored Sidewalk Chalk

**Product:** About 50,000 packages of multicolored and solid-colored sidewalk chalk by Agglo Corporation and imported by Toys "R" Us, Inc. The sidewalk chalk is packaged in a clear-plastic backpack-type carrying case with these words on the label: "Chalk To Go...Totally Me!...24 pieces, sidewalk chalk in different colors, fun chalk shapes." The label on the package also says "Conforms to ASTM-D4236." The sidewalk chalk comes in several shapes: butterfly, spider, ice cream cone, bottle, cylinder, and triangular stick. The chalk pieces are solid-colored or multicolored, including red, blue, green, yellow, and purple. The sidewalk chalk was sold at Toys "R" Us stores nationwide from March 2003 to November 2003 for about \$4.99 per package. The sidewalk chalk was manufactured in China.

**Problem:** The multicolored and solid-colored sidewalk chalk contains high levels of lead, posing a risk of poisoning to young children. No incidents or injuries have been reported.

**What to do:** Stop using the chalk and return the sidewalk chalk to Toys "R" Us for a refund. Consumers may call toll-free on (866) 274-6340 24-hours-a-day Monday through Friday or visit the Toys "R" Us Web site: [www.toysrusinc.com](http://www.toysrusinc.com).

**Product:** About 26,000 packages of multicolored Sidewalk Chalk by Agglo Corporation and imported by Target Corporation. The sidewalk chalk is packaged in plastic that is molded to five sticks of chalk and a cardboard backing that is labeled "Double Dipp'n Fun." Each stick of chalk is triangular-shaped and multicolored, with three colors layered together (green, red, yellow, or blue). This recall does not affect solid color chalk sold in the same packaging.

**Problem:** The multicolored sidewalk chalk contains high levels of lead, posing a risk of poisoning to young children. The Wisconsin Department of Health tested the chalk and identified the lead in the chalk. No incidents or injuries have been reported.

**What to do:** Stop using the sidewalk chalk and return the multicolored sidewalk chalk to Target stores for a refund. Consumers can call Target Corporation at (800) 440-0680 between 7 a.m. and 6 p.m. CT, Monday through Friday, or go to the company's Web site at [www.target.com](http://www.target.com).

### Frying Pans

**Product:** About 244,000 Ultrex Thermal/Double Wall Frying Pans by Innova Inc., and distributed by HSN LP (previously referred to as the Home Shopping Network). HSN LP sold pans exclusively from January 2002 through September 2002 for between \$7 and \$16 (individually) and for between \$100 and \$300 (in sets). The pans were manufactured in China.

**Problem:** The non-stick part of the pan can separate forcefully and be propelled when the pan is preheated, used on high heat, or used for frying, deep-frying or braising. This can pose a serious burn hazard from hot oil or food contents spilling onto consumers. Innova and HSN LP have received 31 reports of these fry pans separating, including seven consumers who received burns from hot oil and eight reports of property damage.

**What to do:** Stop using these fry pans immediately. HSN and Innova have contacted consumers instructing them to return the pans to Innova, in exchange for replacement cookware, an HSN credit, or a refund. Consumers with any questions should call Innova on (877) 368-3405 between 9 a.m. and 7 p.m. CT Monday through Friday or log on to [www.hsn.com](http://www.hsn.com) for more information.

### All-Terrain Vehicles (ATVs)

**Product:** About 75,000 Kawasaki Prairie all-terrain vehicles (ATVs) by Kawasaki Motors Manufacturing Corp. The recalled Kawasaki ATVs include both 2-wheel and 4-wheel drive versions of the Prairie 300 and 400 units, with model years between 1997 and 2000. The ATVs come in green or red and have the words "Kawasaki" and "Prairie" printed on each side of the vehicle; "300" or "400" printed on the left side; and "4x4" printed on the side of the seat (for the 4-wheel drive models only). The ATVs were sold at authorized Kawasaki dealers nationwide from September 1996 through December 2000 for between \$4,500 and \$6,100. The ATVs were manufactured in the U.S.A.

**Problem:** The lower front suspension arm can separate from the steering assembly, resulting in a loss of steering control and posing a serious risk of injury to the rider. Kawasaki has received 42 reports of incidents, including nine injuries, such as broken bones, bruising, scrapes, and lacerations.

**What to do:** Stop using the ATVs immediately and contact the Kawasaki dealer to schedule an appointment for a free inspection, replacement of the pinch bolt, or repair of damaged parts. For more information, contact the Kawasaki dealer or call Kawasaki toll-free at (866) 802-9381 between 8:30 a.m. and 4:45 p.m. PT Monday through Friday. Consumers also can visit the Kawasaki Web site at [www.kawasaki.com](http://www.kawasaki.com).

**Product:** About 14,000 Magnum, Trail Boss, and ATP model all-terrain vehicles (ATVs) by Polaris Industries Inc. The recall involves the Polaris model year 2003 and 2004 Magnum 330 4x4 and Magnum 330 Mossy Oak ATVs and model year 2004 Magnum 330 2x4, Trail Boss 330, ATP 330, and ATP 500 ATVs. The recalled ATVs have the following model numbers, which can be found on the certification decal located on the front center body panel: A03CD32(AA)(AC), A04CD32(AA)(AB)(AC), A04CB32(AA)(FC), A04CA32(AA)(AB), A04JD32AA, and A04JD50(AA)(AB)(CA). The name "Polaris" is prominently displayed on the right and left side of the seat and/or on the side body panels. Authorized Polaris dealers nationwide sold the ATVs from February 2003 through October 2003 for between \$3,500 and \$6,500. The ATVs were manufactured in the United States.

**Problem:** Damage to the fuel tank grommet can cause a fuel leak, posing a serious fire hazard to consumers. Polaris has received 265 reports of fuel leaks, including one report of a fire that damaged an ATV. No injuries have been reported.

**What to do:** Stop using these ATVs immediately. Polaris will notify all consumers with the recalled models and will arrange for a free repair from its dealership or an authorized service center. Consumers can contact Polaris at (800) POLARIS between 8 a.m. and 12 midnight ET Monday through Sunday or log on to its Web site at [www.polarisindustries.com](http://www.polarisindustries.com).

### Hedge Trimmers

**Product:** About 59,200 Professional Hedge Trimmers by Shindaiwa Inc. The hedge trimmers have red engine covers, a red fuel cap and a label on the recoil starter that reads "Professional Shindaiwa." The recall includes all model DH 230/231 and HT 230/231 with serial numbers up to 3080000. The serial numbers are printed on a nameplate on the engine cover. Shindaiwa dealers nationwide sold these products from August 1997 to August 2003 for between \$370 and \$450 depending on the model. The hedge trimmers were manufactured in Japan.

**Problem:** The fuel cap on the hedge trimmer can leak, posing a fire and burn hazard. No incidents or injuries have been reported.

**What to do:** Stop using the hedge trimmer and return the red fuel cap to the dealer for a replacement cap. Consumers can contact Shindaiwa toll-free at (800) 521-7733 between 8 a.m. and 5 p.m. PT Monday through Friday.

### Lawnmowers

**Product:** About 30,000 Honda Harmony Walk-Behind Lawnmowers by Honda Power Equipment Manufacturing Inc. These are Honda Harmony 21-inch, walk-behind mowers with model numbers HRB216TXA or HRB216HXA. The model numbers are located on a metal plate behind the engine, just in front of the rear discharge opening. These black and red mowers have "Honda Harmony" printed in white on the front. The lawnmowers were sold at Power Equipment dealers and Home Depot stores nationwide from November 2000 through June 2003 for between \$700 and \$760. The lawnmowers were manufactured in the United States.

**Problem:** If the lawnmower strikes an object with sufficient force, the crankshaft can bend. Vibration created by a bent crankshaft can eventually result in a fatigue failure of the Roto-stop™ blade brake control assembly. This can allow the cutting blade to continue rotating after the blade control lever is released, posing a risk of injury to consumers. American Honda has received six reports of broken stop plates. No injuries or property damage have been reported.

**What to do:** Call American Honda at (800) 426-7701 between 9 a.m. and 5 p.m. ET Monday through Friday or go to the Web site at [www.hondapowerequipment.com](http://www.hondapowerequipment.com) to locate a servicing Honda Lawn and Garden dealer. Honda Lawn and Garden dealers will repair these mowers by replacing the Roto-stop™ mechanism.

**Product:** About 9,900 Husqvarna Royal 53S or ROY53INTEK Walk-Behind Lawn Mowers by Husqvarna Forest and Garden Company. The walk-behind lawn mowers are gas-powered and have an orange body with a black push-handle. They are capable of being operated with or without a bag attachment. The recalled lawn mowers have serial numbers between 24600001 to 31000205. The model number and serial number can be found on a decal mounted above the left rear wheel axle. The mowers were distributed by Husqvarna dealerships and Lowe's Home Improvement Centers from December 2002 through August 2003 for about \$500. The lawn mowers were manufactured in the U.K.

**Problem:** A loose blade bolt could cause the blade to come loose or the blade adapter to crack, resulting in the blade falling off. Should this condition occur, the operator or a bystander could be injured. Husqvarna has received 15 reports of blades coming off, 41 reports of loose blades, and one report of a consumer being struck in the toe by a blade.

**What to do:** Contact Husqvarna technical support representatives to receive a free service kit including a new blade adapter, blade bolt, and associated hardware with a complimentary blade to be installed by a Husqvarna dealer. Consumers can contact Husqvarna technical support representatives between 9 a.m. and 5 p.m. ET Monday through Friday at (800) 448-7543, Ext. 3.

– Carolyn T. Manley, Office of Compliance

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