CONSUMER PRODUCT SAFETY REVIEW

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IN THIS ISSUE

All-Terrain Vehicles

In 2001, the U.S. Consumer Product Safety Commission (CPSC) and members of the all-terrain vehicle (ATV) industry conducted studies of ATV-related injuries and exposure to help understand the recent rise in ATV-related injuries. The 2001 studies can be compared with similar studies conducted in 1997. Included below are highlights from the 2001 studies and comparisons with the 1997 studies.

From 1997 to 2001, the estimated number of ATV-related injuries treated in U.S. hospital emergency rooms rose from 54,700 to 111,700 (a 104% increase). Injuries to children under 16 years old rose 57% *(Figure 1)*.

In this time period, the estimated number of ATV drivers rose from 12 to 16.3 million (a 36% increase); the estimated total number of driving hours rose from 1,575 to 2,364 million (a 50% increase); and the estimated number of ATVs rose from 4 to 5.6 million (a 40% increase). None of these measures accounts completely for the rise in injuries over this time period.

For this study, an injured person may be a driver, a passenger, or a non-rider. For example, a 25-year-old person might be injured as a passenger on an ATV that was driven by a 15-year-old. For the rider characteristics, the incident would be classified as an over age 16 rider incident. However, for the driver characteristics, it would be classified as an under age 16 driver incident.

Age

Both riders (drivers and passengers) who are under 16 and those 16 and older have experienced notable percent increases in injuries and risk between 1997 and 2001.

The riders 16 and over have experienced larger percent increases in injuries, exposure, and risk than the under 16 riders. When measured by injuries per riding hour, however, the risk was substantially larger, both in 1997 and in 2001, for the younger group of riders.,

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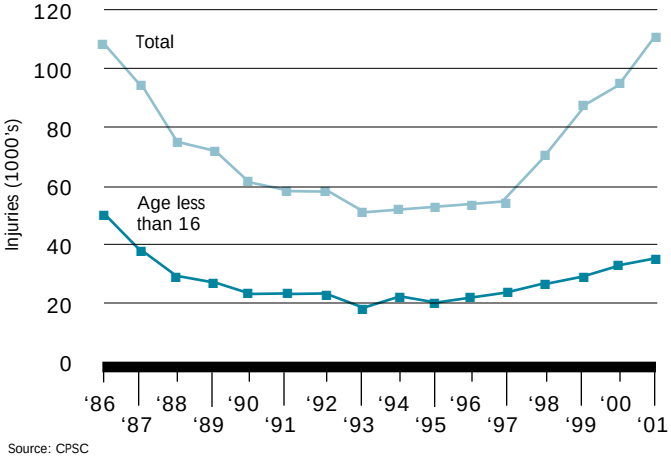

Figure 1

When the focus is on the age of the driver (and not on the passenger), the risk to drivers under 16 is also greater than for older drivers, as measured by injuries per driver or injuries per driving hour.

For a complete copy of *All-Terrain Vehicle 2001 Injury and Exposure Studies*, visit www.cpsc.gov.

Gender

For both riders and drivers, males have a much greater risk than females for injuries per rider and injuries per riding hour. Comparing 1997 and 2001, male riders and drivers have experienced a greater percent increase in injuries and risk by both measures than the female counterparts.

Drivers / Passengers

ATVs come with a warning against carrying passengers. The risk to drivers is larger than that to passengers when measured by injuries per rider. However, the risk is substantially higher for passengers than drivers when measured by injuries per riding hour.

Experience

Drivers with less than one year of driving experience have the highest risk among drivers of differing experience levels. This is particularly true when measured by injuries per driving hour. Drivers in this group tend to drive less than other drivers.

The number of drivers with less than one year of driving experience has had a large percentage increase from 1997 to 2001 with a corresponding increase in injuries.

Driving Hours

Drivers who drive fewer than 25 hours a year have substantially greater risk as measured by injuries per driving hour than drivers who drive more hours per year.

There also has been a large increase in the injuries to drivers with 200 or more driving hours a year. The increase corresponds to increases in the number of these drivers and the total number of driving hours for these drivers.

Engine Size

There has been a very large increase, both in absolute and percentage terms, of injuries associated with the largest ATVs (ATVs with engine sizes of 400 cubic centimeters or greater).

This was accompanied by both a large increase in the number of these vehicles and a large increase in risk associated with these vehicles. However, the risk associated with these vehicles in 2001 was similar to that for ATVs with engine sizes from 200 to 399 cc.

In 2001, the large majority of injuries associated with drivers under 16 occurred with ATVs larger than recommended (90 cc) for this age group.

Driver Training

A large majority of drivers stated that they learned to drive an ATV from a friend or relative or by themselves. A small percentage of drivers (7%) learned from an organized training program, dealer, or salesman.

ATV Market

A significant percentage of ATVs were purchased used (44%). Among the used ATVs, 83% were purchased from a previous owner, as opposed to a dealer.

— *Mark S. Levenson, Ph.D., Directorate for Epidemiology*

CPSC Actions on ATV Safety

CPSC held a regional public hearing on ATV safety in Morgantown, West Virginia on June 5, 2003.

Participants at the meeting discussed the increase of deaths and injuries associated with ATVs over recent years and commented on a petition submitted to CPSC last year. The petition, submitted by consumer groups in September 2002, requested a ban of adult-size four-wheel ATVs sold for the use of children under 16.

To respond to this petition, CPSC will look at its recent injury studies and other information, including that obtained at this hearing in West Virginia.

History

Prompted by large numbers of ATV-related deaths and injuries, CPSC conducted regulatory proceedings in the 1980s.

In the late 1980s, ATV distributors entered into consent decrees with CPSC. Among other things, the consent decrees stopped the sale by dealers of three-wheel ATVs; placed engine size restrictions on ATVs sold for use by children under 16; and implemented driver-training programs.

The consent decrees expired in 1998. However, most features of the consent decrees are still in place under voluntary agreements entered into between the major manufacturers, distributors, and CPSC.

Young Children and Plastic Toys

For several years, CPSC staff has investigated the potential health risks to children under 3 years old from plastic teethers, rattles, and toys. Some of these products are made from polyvinyl chloride (PVC) and may contain various dialkyl phthalate (DAP) plasticizers, especially diisononyl phthalate (DINP).

DINP is used to soften PVC to enhance the mouthing and teething qualities of the product. The potential for DINP to cause toxic effects in children depends on the amount of DINP that is released from a product when it is mouthed or chewed and the amount of time children spend with that product in their mouth.

To understand children's potential exposure to DINP through mouthing, CPSC staff recently completed a study to better define the amount of time children mouth all products, including those with phthalates.

This CPSC study revealed an even smaller potential for exposure to DINP for children mouthing and chewing soft plastic toys than previously reported. Teethers, rattles, and pacifiers sold in the U.S. do not currently contain DINP.

Study Plan

The CPSC study was conducted in two phases in two geographical areas, Houston, TX and Chicago, IL. These areas were selected to ensure that the subjects were reasonably representative of the population with regard to race, income, type of child care, and gender. For the sample, 55% were boys and 45% girls.

Researchers defined mouthing as any behavior in which an item came into contact with the observed child's lips, tongue, or inside the mouth.

For Phase I of the study, 491 children were randomly selected to participate. A parent or legal guardian observed the child and recorded all mouthing behaviors, including frequency and length of time, for four 15-minute segments over two days.

Phase II of the study was conducted with 169 children. A trained observer recorded the child's mouthing behavior for a total of four hours on at least two different days, at different times of the day.

The observer identified the item being mouthed as precisely as possible. All items (including non-children's products) were identified. But items classified as soft plastic toys were of particular interest because these items could contain a plasticizer such as DINP.

The observer used a stopwatch that stored the duration of each separate mouthing event, so the observer did not have to look away from the child to record when the item went in and out of the child's mouth.

Average hourly mouthing times were calculated from the two-hour observation period for all the children. The average daily mouthing times were calculated by multiplying the hours awake by the average hourly mouthing time.

Results

For all objects (except pacifiers), estimated average daily mouthing times were 70 minutes for children between 3 months and 1 year of age, 48 minutes for children between 1 year and 2 years, and 37 minutes for children between 2 and 3 years of age.

For all soft plastic items (except pacifiers) that could contain DINP, the daily average mouthing times for each age group were less than five minutes. For soft plastic toys specifically, the daily average mouthing times for the youngest children averaged 1.3 minutes; for 1 to 2 year olds, 1.9 minutes; and for the oldest children, 0.8 minutes *(Figure 2)*.

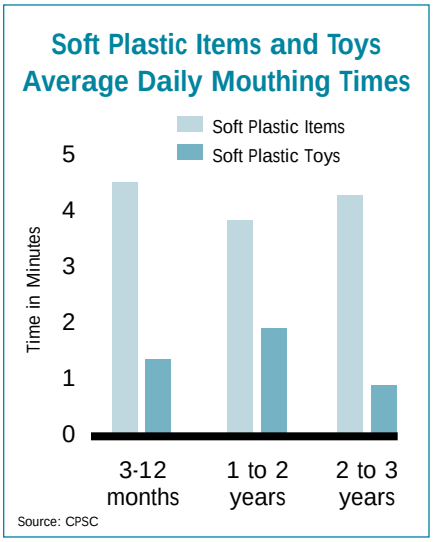

Figure 2

There is a significant relationship between age and mouthing duration for soft plastic teethers and rattles. While a small number of children were observed mouthing these items, most of these children were between 4 and 16 months old, with only one child over 16 months. The maximum mouthing times for these items were for children under 1 year. Soft plastic toys did not show a decreasing mouthing pattern with age, but rather had about the same level of mouthing between 6 months and 24 months, then almost no mouthing for children over 24 months.

Discussion

This study was undertaken to estimate children's exposure to phthalates as a result of mouthing soft plastic

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Young Children *Continued from page 3*

toys. The data from the 169 children observed by the trained observers confirmed that children mouth such items but at a very low rate.

In 1998, to estimate risk of potential exposure, CPSC staff used a Dutch daily mouthing duration study that estimated an average of 12 minutes for 3 to 12 month olds and 2 minutes for 13 to 26 month olds for teethers, rattles, and toys. Based on this data, CPSC concluded that few, if any, children were at risk from liver or other organ toxicity from the release of DINP from soft plastic toys.

CPSC staff recommended, however, performing a more precise study to better define the amount of time children mouth products that could contain phthalates.

The mouthing times recorded in the Dutch and CPSC studies differ because the Dutch study includes mouthing of teethers, rattles and soft plastic toys while the CPSC study identifies mouthing times of soft plastic toys only. Because teethers and rattles sold in the United States are not made with phthalates, they were not included in the mouthing times used to estimate phthalates exposure.

In addition, the CPSC study may more accurately reflect the frequency and duration of repeated mouthing behaviors because the trained observers used stopwatches that recorded and stored the separate mouthing events. The observer was able to click the stopwatch on and off as quickly as the child mouthed the object, which frequently lasted only seconds. In the Dutch study, the parents were told to record mouthing times to the nearest minute.

Children's mouthing behavior has been viewed as a part of childhood development. The extensive data and diversity of this study allow CPSC staff to make hazard assessments across a wide variety of consumer products.

— *Celestine Kiss, Directorate for Engineering Sciences*

For More Information

For an extended discussion of phthalates and children's products, go to www.cpsc.gov.

Phthalates in Plastic Toys

CPSC staff has long been involved with the safety of phthalates in plastic toys. Phthalates are the chemicals used to make a particular plastic, polyvinyl chloride (PVC), flexible. In the early 1980s, di-(2-ethylhexyl) phthalate (DEHP) was the primary plasticizer used in pacifiers, baby bottle nipples, and other PVC toys.

In 1983, CPSC staff determined that DEHP in children's products might result in a substantial exposure of children to a substance that causes cancer in animals.

To further study the issue, CPSC convened a panel of scientific experts. This panel (called a Chronic Hazard Advisory Panel or CHAP) reviewed scientific data and other relevant information regarding potential risks of cancer, birth defects, or gene mutations from DEHP in consumer products. It concluded that DEHP could put children at risk of cancer from oral exposure to children's products containing DEHP.

As a result, CPSC reached a voluntary agreement with industry that eliminated DEHP from pacifiers, rattles, and teethers. Although other toys were not included in the agreement, manufacturers in general switched to another phthalate. The phthalate substituted for DEHP was diisononyl phthalate (DINP).

In 1997 and 1998, the industry completed chronic toxicity studies on DINP. While the studies indicated that DINP caused liver toxicity and cancer in rodents, CPSC staff concluded that "few, if any, children are at risk of liver or other organ toxicity from mouthing teethers, rattles, and other PVC toys that contain DINP."

Nonetheless because of uncertainties, CPSC announced a voluntary agreement with toy manufacturers to remove DINP from rattles and teethers and another phthalate, dioctyl phthalate, from pacifiers and baby bottle nipples. A number of large retail chains also agreed not to sell rattles, teethers, pacifiers, or baby bottle nipples that contained phthalates.

Additional CPSC Actions

At that time, CPSC was petitioned to ban PVC in all toys and other products intended for children age 5 and under, and to issue a national advisory on the health risks associated with soft plastic vinyl toys.

CPSC decided to respond to the petition after the completion of several recommended actions. These included the following.

Playgrounds and Children Under 2

CPSC staff recently conducted a special in-depth study of playground injuries to children under 2 years old.

During the special study period from October 2000 to September 2001, an estimated 8,250 children under 2 were treated in U.S. hospital emergency rooms for injuries associated with playground equipment. Of those injured, 95% were 12 to 23 months of age, and 58% were male.

From January 1990 to August 2002, CPSC received 6 reports of children under 2 dying in incidents involving playground equipment.

Injury Scenarios

The most common injury scenario was a fall, accounting for 50% of the total injuries, followed by an impact injury (22%), where a child collided with or was struck by playground equipment.

The third most common injury scenario (13%) involved children going down a slide, whether by themselves or on another's lap, and getting a leg or foot twisted. The resulting injuries were often fractures or sprains. Many of these incidents appeared to include a child's shoe (often a sneaker) contacting the slide's surface or sidewall. The child's foot would "catch" on the surface or sidewall, causing the leg or foot to bend.

Overall, slides were responsible for about half the playground equipment-related injuries to children under 2, regardless of hazard pattern.

Entrapments were involved in 270 estimated injuries. None of the entrapments were head or neck-related.

Types of Injuries

Fifty-two percent of the injuries were lacerations, contusions and abrasions, and 30% were fractures, sprains, and strains.

The head and facial region of the body was involved in 53% of all the injuries (mainly contusions, abrasions, and lacerations). Nineteen percent of the head/facial

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- *A CHAP on DINP.* CPSC convened another panel of experts to determine whether DINP was a carcinogen, mutagen, or teratogen, or posed some other chronic hazard. The CHAP concluded in 2001 that "the human risk from cancer induced by DINP is negligible or non-existent."
- *A Behavioral Observation Study.* CPSC staff conducted a behavioral observation study (see article on page 3) to determine how much time young children actually spend mouthing objects and what types of objects they mouth. The study reported that the average mouthing time for all soft plastic toys was less than two minutes per day.
- *A Phthalate Migration Study.* To more accurately predict risk, CPSC measured the amount of phthalate that migrated out of toys and to which children could be exposed.

CPSC Risk Assessment

CPSC staff evaluated the above studies, as well as other information. For example, the new data from the CPSC behavioral observation study, which was not available at the time to the CHAP, demonstrated that children were exposed to DINP at even lower levels than the CHAP members assumed.

Further, CPSC staff determined that not all soft plastic toys even contain DINP. Since the risk to children under 3 was not sufficient to warrant action, there was no justification for taking action on toys intended for older children who mouth products even less.

Finally, since children mouth other children's products less than they do toys, teethers, and rattles and since dermal exposure was expected to be minimal, CPSC staff did not believe that other children's products containing DINP were likely to present a health hazard to children.

Based on the above, CPSC staff concluded that there was no demonstrated health risk posed by PVC toys or other products intended for children 5 and under. The Commission agreed with the staff and voted to deny the petition requesting a ban of PVC in toys and other products. It also voted not to issue a national advisory on the health risks associated with soft plastic toys, as requested in the petition.

— *Marilyn Wind, Ph.D., Directorate for Health Sciences*

Playgrounds *Continued from page 5*

injuries were fractures, concussions or internal injuries. The leg/foot was the second most often reported region of the body injured with 34% of the injuries. Of these, 65% were fractures, sprains or strains.

Public vs. Home Playgrounds

Of the estimated injuries, 41% involved public playground equipment. Of these, 60% of the injuries occurred in a public park. Thirty-three percent of the injuries involved home playground equipment. Of these, 65% were in the yard of a home.

The rest of the injuries involved equipment not specified as either public or home.

Of total injuries, 66% occurred in an outdoor location, 10% in an indoor location, and 25% in an unknown location.

The most common type of protective surfacing was wood chips, associated with 12% of the injuries. The most prevalent surfacing overall was grass (a non-protective surface), which was associated with 17% of the injuries. Protective surfacing under and around play equipment is recommended to reduce the risk of serious head injuries.

— Joyce McDonald, Directorate for Epidemiology

Nursery Products

CPSC staff recently completed a report on injuries and deaths associated with nursery products *(Figure 3)*.

Injuries

An estimated 69,500 children under age 5 were treated in U.S. hospital emergency rooms in 2001 for injuries associated with nursery products. This figure is comparable to the 2000 estimate of 69,100. The leading cause of these nursery product-related injuries was falls.

Deaths

From 1997 through 1999, there were 195 deaths (or an annual average of 65 deaths) associated with nursery products. About 41% (80 total or 27 annually) of the reported deaths involved cribs.

Playpens and play yards had the second highest number of deaths reported with 23 or 8 annually. Infant carriers and car seats, and baby bath seats both had the third largest number of reported deaths with 18 or 6 annually.

— Joyce McDonald, Directorate for Epidemiology

Nursery Product-Related Injuries/Deaths to Children under 5

PRODUCT CATEGORY	ESTIMATED INJURIES CY 2001	TOTAL DEATHS 1997-1999	AVERAGE ANNUAL DEATHS 1997-1999
TOTAL	**69,500**	**195**	**65.0**
Infant Carriers and Car Seats (Excludes Motor Vehicle Incidents)	15,370	18	6.0
Strollers and Carriages	13,070	5	1.7
Cribs	11,380	80	26.7
High Chairs	7,430	7	2.3
Baby Walkers and Jumpers	6,200	5	1.7
Changing Tables	1,990	3	1.0
Baby Gates and Barriers	1,670	2	0.7
Playpens and Play Yards	1,590	23	7.7
Baby Bath Seats	-----*	18	6.0
Other	10,140	34	11.3

*The number of cases collected was too small to project a national estimate.

Source: CPSC

Figure 3

Consumer Product Incident Report

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

YOUR NAME

YOUR ADDRESS

CITY STATE ZIP

YOUR TELEPHONE

NAME OF VICTIM (IF DIFFERENT FROM ABOVE)

ADDRESS

CITY STATE ZIP

TELEPHONE

DESCRIBE THE INCIDENT OR HAZARD, INCLUDING DESCRIPTION OF INJURIES

VICTIM'S AGE _____ SEX _____ DATE OF INCIDENT

DESCRIBE PRODUCT INVOLVED _____

PRODUCT BRAND NAME/MANUFACTURER _____

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

WHEN WAS THE PRODUCT PURCHASED? _____

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

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

TC-49

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

MECAP NEWS

Medical Examiners and Coroners Alert Project and Emergency Physicians Reporting System

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

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

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

During the months of December 2002 and January 2003, 546 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, and his sister were in their bedroom waking up from an afternoon nap. Their father heard a noise. He went upstairs and found his son under a dresser. Paramedics were called and rushed the child to the hospital, where he died. The cause of death was traumatic asphyxia. (Richard R. Ballinger, Coroner, DuPage County, Wheaton, IL)

*A male, 16 months, was placed in his full size crib for the night. Later, he was discovered unresponsive, lying on his stomach in a corner of the crib with his face against the mattress and his arm hanging out of the crib. He was rushed to the hospital where he died four days later. A screw that attached the side rail to the crib had come loose, allowing the child's head to become wedged between the detached side rail and the crib's frame. The cause of death was positional asphyxia. (Phil Pascuzzi for Gary F. Peterson, MD, JD, Medical Examiner, Hennepin County, Minneapolis, MN)

*A male, 13, was driving a 4-wheel all-terrain vehicle (ATV) along a path in a wooded area. As he drove up an incline, his ATV slid sideways. The ATV pinned him to a tree with the handlebars leaning against his throat. The ATV kept running, and he could not free himself. Later, his parents, who were riding ATVs nearby and were alerted by another rider, released the boy. Emergency medical personnel responded, but the boy was pronounced dead at the scene of the accident. The cause of death was asphyxia due to compression of the neck. (John Kraemer for Dennis F. Klein, M.D., Deputy State Medical Examiner, Des Moines, IA)

*A male, 34, went archery hunting using a tree stand. Although experienced using tree stands, he was using this particular model for the first time. When the man did not return home, a search was instituted, and the man was found hanging by his safety harness from a tree. The cause of death was asphyxiation due to hanging. (Lyell P. Cook, Coroner, Erie County, Erie, PA)

A female, 4 months, was laid down on a pillow on a couch for a nap by her grandmother. The infant was wrapped in a blanket and placed on her stomach. She was later found unresponsive, with her face down between a couch cushion and the back of the couch. The cause of death was mechanical asphyxiation due to unsafe sleeping environment. (Jeffery M. Jentzen, M.D., Medical Examiner, Milwaukee County, Milwaukee, WI)

CARBON MONOXIDE POISONINGS

*A male, 72, was found unresponsive in front of a stove on his kitchen floor. The stove was on, and a strong odor of gas was in the room. Tools were found spread out nearby. The cause of death was carbon monoxide poisoning. (Jerri McLemore, M.D., Medical Investigator, Office of the Medical Examiner, State of New Mexico, Albuquerque, NM)

*A male, 53, was found unresponsive on his bed at home. His electrical service had been turned off, and he had been using a gasoline-powered generator to power an electric

space heater. When the victim was found, the gas tank on the generator was empty. The cause of death was carbon monoxide intoxication. (Mary H. Dudley, M.D., Deputy Medical Examiner, Jackson County, Kansas City, MO)

*A male, 35, was found unresponsive in his home. His electrical service had been turned off. He was using a kerosene heater for warmth and a generator for electricity. The cause of death was carbon monoxide poisoning. (Carol Koop for Susan Roe, M.D., Assistant Medical Examiner, Ramsey County, St. Paul, MN)

DROWNINGS

*A male, 3 months, was placed in a cloth-covered wire-framed infant carrier by his mother. The mother then placed the carrier and child in the bathtub and ran the water for a bath. She turned off the water, placed a stopper in the tub, and left the child for a few minutes. She returned to find the child floating face down in about six inches of water. Ambulance personnel rushed the child to the hospital where he died nine days later. The cause of death was anoxic brain damage due to asphyxia by drowning. (William W. Goodhue, Jr., M.D., First Deputy Medical Examiner, Honolulu County, Honolulu, HI)

A female, 22 months, was playing in a blow-up wading pool with other children. Her father was watching her but left for a short time. He was summoned by another child who said the girl was under water. The cause of death was drowning. (Terrence R. Steiner, M.D., District Medical Examiner, District 23, St. Augustine, FL)

A female, 10 months, was inside her home with her mother. Her mother went to get the mail and returned to find her child floating in their swimming pool. The child had gone through an unlocked sliding door to gain access to the pool. The cause of death was drowning. (Joshua A. Perper, M.D., LL.B., M. Sc., Chief Medical Examiner, District 17, Broward County, Fort Lauderdale, FL)

FIRES

*A female, 92, was found unconscious by a neighbor during a fire at her home. She was taken to the hospital where she was declared dead. The fire was caused by a failure in the aged electrical system in the home, which was built in the 1930s. The cause of death was smoke inhalation. (Kevin P. Murray, M.D., Medical Examiner, Tidewater District, Commonwealth of Virginia, Norfolk, VA)

A male, 9, was refilling a kerosene heater because his neighborhood's electricity had been cut off during a storm. The heater was still hot, and a flash fire erupted. The home was destroyed, and the child perished inside it. The cause of death was carbon monoxide poisoning due to mobile home fire. (Douglas Chen, M.D., Medical Examiner, Anson County, Wadesboro, NC)

A male, 79, was found unresponsive on his living room sofa after a fire. An old heating pad ignited the sofa that was made of a spongy, highly flammable material. The cause of death was severe burns. (Donald Kundel, M.D., Deputy Medical Examiner, St. Louis County, Duluth, MN)

MISCELLANEOUS

* A male, 14, was driving a four-wheeled all-terrain vehicle on a dirt logging trail through a wooded area. He hit a bump and lost control of the vehicle, which flipped and landed on top of him. He was not wearing a helmet and died at the scene of the accident. The cause of death was a head injury. (Hunter Hansen, D.O., Medical Examiner, Cherokee County, Murphy, NC)

A male, 38, was driving a snowmobile along the shoulder of the road. The snowmobile hit a driveway culvert and became airborne. The driver fell from the vehicle and struck a telephone pole. He was taken to a hospital where he died the next day. The cause of death was multiple blunt force injuries. (Brian P. Ehret for Mary I. Jumbelic, M.D., Chief Medical Examiner, Onondaga County, Syracuse, NY)

A male, 31, was loading his paintball gun when the gun's compressor came loose and exploded. Shrapnel from the gun hit the man in the head and throat. The cause of death was a massive head injury. (Chris McNeil for H. Wayne Carver, II, M.D., Chief Medical Examiner, Office of the State Medical Examiner, Farmington, CT)

A male, 58, was riding his bicycle down a hill without a helmet. He fell from his bike and hit the back of his head on the pavement. He was taken to the hospital where he died 11 days later. The cause of death was complications of closed head injury. (Ramon B. Lang, M.D., Deputy Medical Examiner, Kent County, Grand Rapids, MI)

— *Denny Wierdak, Directorate for Epidemiology*

CPSC Recalls

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

Drill Battery Chargers

Product: About 2 million Skil® Warrior drill battery chargers by Robert Bosch Tool Corp. These chargers were sold with or as accessories for Skil Warrior drills. The drills are black with red trim. Red lettering on the drills reads "SKIL." The chargers have their volt size written in red lettering. The recall includes 9.6 volt, 12 volt, 14.4 volt and 18 volt chargers. The chargers were included with tool model numbers 2375, 2380, 2475, 2480, 2482, 2580, 2582 and 2882. Chargers also were sold separately with model numbers 92950, 92970, 92980 and 92990 with part number 2610995852. The model and part numbers are written on labels found on the back of the plug or on the side of the chargers. Home centers, hardware, and discount department stores sold these chargers nationwide from July 1994 through February 2003 for between $21 and $30.
Problem: The transformer inside the charger can overheat. If this occurs, the charger housing can melt and deform, possibly igniting flammable materials near or on the charger. Robert Bosch Tool Corp. has received one report of a charger causing a fire that resulted in property damage, and 160 reports of chargers overheating.
What to do: Unplug the charger immediately. Replacement drills and chargers will be provided at no cost to the consumer. For more information, consumers should contact Robert Bosch Tool Corp. at (800) 661-5398 between 7 a.m. and 7 p.m. CT any day, or go to the Skil website at **www.Skil.com**.

Back-Up Power Supply Systems

Product: About 900,000 back-up power supply devices by American Power Conversion Corporation (APC). These devices are primarily used to protect computers in case of a power failure. The recalled Back-UPS® CS Uninterruptible Power Supply devices include the Back-UPS CS350 and the Back-UPS CS 500 models. The model number can be found on the front of the unit, along with the words "Back-UPS CS" and "APC." In addition, one of the following numbers shows up on the bar code label located on the bottom of the unit: BK350, BK500, BK500BLK. The recalled power supply devices also have one of the following serial numbers: AB0048 through AB0251, BB0104 through BB0251, and JB0125 through JB0251, which can be found on the bottom of the unit. Units with an "R" at the end of the serial number within the above ranges are not part of this recall. Retailers, computer and electrical distributors, and catalogs nationwide sold the power supply devices from November 2000 through December 2002 for between $70 and $130.
Problem: The power supply device can fail, causing the unit to overheat, which may pose a fire hazard to consumers. APC has received six reports of units overheating resulting in the melting of the unit's outer casing and three reports of minor property damage. No injuries have been reported.
What to do: Stop using the power supply devices by turning off the power to all connected equipment, turning the Bac-UPS CS off, and then unplugging it from the electrical outlet. To obtain a free replacement unit, consumers should contact the company at (866) APC-RELY (272-7359) between 9 a.m. and 5 p.m. ET Monday through Friday or log on to the company's website at **www.apc.com/rely.**

Analog Projection Televisions

Product: About 80,000 large-screen, analog projection televisions by Zenith Electronics Corp. The recalled televisions were manufactured between 1995 and 1998. This recall is an expansion of a 1998 recall program involving 111,000 projection television sets. The projection televisions recalled in this expansion and the earlier program have 46 to 60 inch screens and were manufactured from April 1995 through July 1997, and August 1998 through November 1998. The date of manufacture can be found on the white label on the back of the set. These televisions were manufactured in Mexico. Projection televisions manufactured after 1998 are not included in this recall. Major appliance and department stores nationwide sold these televisions from about April 1995 through April 1999 for between $1,200 and $2,800.
Problem: A tear in a gasket can cause coolant fluid to leak from the picture tube assembly. This can cause smoking, charring, and electrical arcing inside of the television, posing a fire hazard to consumers. Since 1998, Zenith has received 45 reports of incidents involving coolant leakage, causing smoking or charring with the televisions, including four cases where minor property damage occurred outside of the unit. No injuries have been reported.
What to do: Contact Zenith at (800) 777-5195 anytime to arrange for a free inspection and repair. Consumers also can visit the company's dedicated website at **www.projorecall.com**.

Cigarette Lighters

Product: About 500 novelty cigarette lighters by Young's J.K. Inc. The refillable, dolphin-shaped cigarette lighters are butane gas-fueled and made of metal. There are three models involved in this recall. One of the lighters features a dolphin with a large ball and is labeled "1988.8 Young's Wholes 14.9." Another lighter features a single dolphin and is labeled "00005011 $14.00 EA." The last model features two dolphins and a ball, and has no label. Gas stations, smoke shops, grocery, and gift and liquor stores sold the lighters in Oregon and Southwest Washington from 1996 through October 2001 for between $8 and $20.
Problem: These lighters do not have child-resistant mechanisms, as required by federal law. Young children can ignite the lighters, presenting fire and burn hazards. CPSC has received one report of a 2-year-old using one of these lighters to ignite an upholstered chair. The fire resulted in the death of his 6-year-old brother and permanent brain damage to the 2-year-old.
What to do: Stop using the lighters immediately and return them to the store where purchased for a refund. For more information, consumers can contact Young's J.K. collect at (503) 998-9801 between 8 a.m. and 5 p.m. PT Monday through Friday.

Portable Wood Cribs

Product: About 364,000 portable wood cribs by Hufco-Delaware Company and Evenflo Company Inc. The portable cribs are made of wood and are smaller than traditional baby cribs. The majority of these portable wood cribs were sold under the Gerry® brand name, and some were sold under the Evenflo® brand name. The recalled portable wood cribs have one of the following model numbers that can be found on a label on the mattress platform underneath the mattress: 8212, 8222, 8232, 8242, 8252, 8282, 8301, 8302, 8311, 8312, 8321, 8322, 8331, 8332, 8341, 8342, 8351, 8352, 8381, 8382, 8512, 8522, 8532, 8542, 8552, 8582, 8712, 8752. Department and baby products stores nationwide sold these portable wood cribs from January 1991 through December 2002 for about $99. No other cribs are included in this recall.
Problem: If the hardware used to assemble the crib is not tight, the mattress support platform and mattress can fall to the floor. This poses a risk of injury to young children in the crib. There have been 41 reports of mattresses falling through portable wood cribs. Of these incidents, 17 children suffered bumps, bruises or scratches.
What to do: Stop using these portable wood cribs immediately, and call (800) 582-9359 anytime for a free upgrade kit that provides additional support for the mattress platform. Consumers also can obtain further information about the portable wood cribs by logging onto **www.evenflo.com** or **www. portablewoodcrib.com**.

Children's Board Book Sets

Product: About 360,000 children's board book sets by Random House Inc. The boxed sets included in the recall have children's characters on the front of the box, a colored plastic handle and plastic snaps. The book set titles are "MONSTERS TO GO!," "DISNEY PRINCESS - DISNEY THE PRINCESS COLLECTION 2," "DISNEY'S WINNIE THE POOH - A VERY MERRY CHRISTMAS," and "BARBIE - MY BARBIE FUN BOX." Each book set contains four board books inside. Only book sets with plastic snaps are included in the recall. Book sets with metal snaps are not part of the recall. Book stores, discount department stores, and online retailers sold the recalled books nationwide from August 2002 through January 2003 for about $10.
Problem: The book sets were sold in cardboard boxes with plastic snaps. The plastic snaps can detach, posing a choking hazard to young children. CPSC and Random House have not received any reports of injuries involving these book sets. This recall is being conducted to prevent the possibility of injuries.
What to do: Cut off the lid of the box with the plastic snaps and throw away the rest of the box. Send the lid with the plastic snaps to Tri-State, c/o Anthony Armetta, 325 Rabro Drive, Hauppauge, NY 11788 to receive a free replacement book set, and a refund for postage. For additional information, contact Random House at (800) 805-8534 ET Monday through Friday or visit the firm's website at **www.randomhouse.com**.

Children's Soap Making Kits

Product: About 145,000 children's soap making kits by Pace Products Inc. The soap kits were sold under the name "Soap Making for Kids." The kits include a plastic mold tray, three bars of glycerine, string and an instruction book. "SCHOLASTIC INC." and "Made in U.S.A." are printed on the back of the soap kit box. Scholastic Book Clubs and Book Fairs sold the recalled soap kits at schools nationwide from March 2000 through November 2002, and bookstores sold the recalled soap kits from March 1998 through November 2002 for about $8.
Problem: The soap may get too hot when heated in the microwave oven and leak from the tray mold posing a burn hazard to children. CPSC has received three reports of burn injuries from the heated soap, including a 6-year-old girl who received burns to her hand.
What to do: Consumers should take these soap kits away from children immediately and contact Pace Products at (800) 541-7670 between 8 a.m. and 5 p.m. ET Monday through Friday to receive instructions on returning the soap kits for a refund. Consumers also can visit the firm's website at **www.paceplace.com**.

Stuffed Bears

Product: About 80,000 "Founding Bear" stuffed bears by Build-A-Bear Workshop. The recall includes the "Founding Bear," and the "Founding Bear II." The "Founding Bear" is about 19-inches long, and the "Founding Bear II" is about 18-inches long. Both stuffed bears are chocolate brown and have cream-colored paws and snout. "OUR FOUNDING BEAR" is written on a cardboard tag that was originally attached to the bear's ear. Build-A-Bear Workshop stores and website sold these stuffed bears nationwide between March 2000 and December 2002 for between $22 and $25.
Problem: The nose of the stuffed bear can be pulled or twisted off, posing a choking hazard to a young child. Build-A-Bear Workshop has not received any reports of injuries resulting from these stuffed bears. This recall is being conducted to prevent possible injuries.
What to do: Take these stuffed bears away from young children immediately. Build-A-Bear Workshop will exchange the bear for any other item they sell of equal value or provide a Build-A-Bear Workshop gift card. Consumers should return the stuffed bears to any Build-A-Bear Workshop store or contact the firm for instructions on mailing the bear. For more information, call Build-A-Bear Workshop toll-free at (866) 236-5683 between 9 a.m. and 6 p.m. CT Monday through Friday, or visit the firm's website at **www.buildabear.com**.

Beanbag Chairs

Product: About 30,000 beanbag chairs manufactured in 1999 by Baseline Design. The recalled beanbag chairs are designed with 12-inch double zippers and have various designs, including a smiley face, a football-shape, a baseball-shape, a basketball-shape and solid green, yellow, pink and blue neon colors. The beanbags have a tag that states, in part, "Made by Baseline Design." Wal-Mart stores located in the Northeast U.S. sold the beanbag chairs from September 1999 through December 1999 for about $30.
Problem: Some of these beanbag chairs have zippers that can be opened, allowing access to the polystyrene beads inside the chairs. This poses a suffocation hazard to young children who can unzip the chair and inhale the small beads. Baseline Design is aware of three incidents in which the chairs were unzipped freely. Two of the incidents involved young children who were able to open the beanbag chair zippers and handle the small polystyrene beads, including one child who received medical attention after inhaling the beads.
What to do: Consumers should check if they can unzip their Baseline Design beanbag chairs. If the zippers can be unzipped freely, Baseline Design will provide owners with a free replacement beanbag chair with zippers that do not open. Consumers should be sure young children cannot use the chairs if the zipper can be opened freely and should be sure children are not exposed to the beads inside the chair. For more information and instructions, consumers should call Baseline Design at (800) 497-3626, Ext. 3046, between 8 a.m. and 5 p.m. ET Monday through Friday or visit the firm's website at **www.foamex.com**.

Plush Toys

Product: About 11,200 "Busy Bug" plush toys by the Betesh Group. The recalled toy is a small plush bug with two springy black antennae with orange round fabric ends. The bug has a blue stuffed round face with a red musical nose that blinks when pressed. The body of the bug is segmented in various colors and patterns. Striped elastic legs are attached to the body along with crinkly, iridescent wings. "Smart Scents" and "Made In China" are printed on a label on the side of the bug. The UPC code 778267862920 is on the packaging. Discount department stores sold these recalled toys from August 2002 through January 2003 for about $7.
Problem: The antennae of the plush toy can be chewed or pulled off, posing a choking hazard to young children. CPSC and The Betesh Group have received two reports of children gagging on the fabric antennae ends that separated from the toy.
What to do: Take the plush toys away from young children and return to the place of purchase or mail the toy to The Betesh Group at One East 33rd Street, New York, NY 10016, Att: Consumer Relations, to receive a refund including postage. For additional information, contact Betesh toll free at (866) 473-0118 anytime.

"Fun Buckets"

Product: About 1,400 "Fun Buckets," by Playnation Play Systems. The "Fun Bucket" is a vinyl bucket attached to a rope used to lift small items up to backyard play sets' forts. This recall involves "Fun Buckets" sold as an add-on option for backyard play sets. The 14-inch-deep buckets are either yellow or green vinyl and have a black nylon strap attached to the rope. The "Fun Bucket" was sold with a heavy wood bracket to attach it to the roof of a play set fort. Distributors of backyard play sets nationwide sold the fun buckets from February 1998 through February 2003 for about $25.
Problem: As children play on the play set's slide or platform, the 6 to 8-ft free-hanging rope can become entangled around the child's neck. This presents a strangulation hazard to young children. Playnation is aware of two incidents where the bucket's rope became entangled around the necks of two 4-year-olds. Both of the children were freed without injury. However, CPSC knows of 135 children who have died in the last 10 years from all types of ropes, leashes or jump ropes that were attached to backyard play sets.
What to do: Take down the "Fun Buckets" immediately and return them to the store where purchased for a refund or a credit toward another product. For more information, consumers can contact Playnation at (770) 792-9300 between 10 a.m. and 5 p.m. ET Monday through Friday, or visit the firm's website at **www.playset.com**.

— Carolyn T. Manley, Office of Compliance

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