CONSUMER PRODUCT SAFETY REVIEW

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U.S. Consumer Product Safety Commission

Ann Brown, *Chairman*
Mary Sheila Gall, *Commissioner*
Thomas H. Moore, *Commissioner*

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Includes recalls from the National Highway Traffic Safety Administration

Fireworks Safety

Since 1994, fireworks-related injuries have decreased by about one-third. In 1998, the estimated number of people treated in U.S. hospital emergency rooms for these injuries was 8,500, according to a recent study by staff at the U.S. Consumer Product Safety Commission (CPSC).[1] This is in contrast to an estimated 12,500 fireworks-related injuries in 1994.

Special Study

Each year, in addition to its year-round injury data collection, CPSC staff conducts a special study of fireworks injuries that occur around the Fourth of July holiday.

About 60% to 75% of fireworks-related injuries occur during this period. The special fireworks study focuses more closely on the kinds of injuries associated with fireworks and the types of fireworks involved.

For the 1998 study, CPSC staff examined fireworks-related injuries treated in NEISS hospital emergency rooms between June 23 and July 23, 1998.[2] Victims were asked to identify the fireworks type from illustrations shown to them at the emergency room.

Injury Data

According to the data collected in the special study, children suffered a significant number of fireworks-related injuries. In 1998, about 40% of the fireworks-related injuries in the special study occurred to children under age 15. This is similar to the data in CPSC's 1997 special study, where children sustained about 38% of these injuries.

In 1998, according to the special study, those 15 to 24 years old incurred about 35% of fireworks-related injuries. The year before, this age group suffered about 26% of these injuries.

Males incurred a significantly higher percentage of fireworks-related injuries than females. In 1998, males suffered about 75% of the injuries. This was the same as reported in 1997.

According to the 1998 special study, the highest percentage of fireworks-related injuries occurred to people's hands, followed by eye injuries and head and face injuries. In 1998, hand injuries accounted for 35% of the total fireworks-related injuries; eye injuries for 20%; and head and face injuries for 20%. In 1997, hand injuries comprised 35% of the fireworks-related injuries; head injuries for 22%; and eye injuries for 18%.

Over half of the injuries in 1998 involved burns. Eye injuries, however, typically involved contusions or lacerations. This is similar to the pattern of injuries in 1997.

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The type of firework involved in injuries in 1998 also was similar to 1997. Firecrackers were the leading cause of injury, followed by rockets and sparklers. About 15% of the injuries were related to illegal fireworks.

Fireworks Regulations

CPSC enforces a number of fireworks regulations. These include fuse burn time limits, a 50-milligram powder limit on firecrackers, requirements to prevent tipover and blowout of devices, and requirements for specific cautionary labeling. Other regulations affect certain reloadable tube aerial shell fireworks and stability requirements for multiple tube devices.

Millennium Celebration

To highlight the importance of fireworks safety, CPSC has spearheaded a national public awareness campaign to promote fireworks safety during the millennium celebrations and is an official partner of the White House Millennium Council. CPSC is working cooperatively with a broad range of national, state, and local organizations to disseminate information about fireworks safety. (See *Millennium Fireworks Tips.*) The campaign will run from July 4, 1999 through New Year's Day 2001.

— *Michael A. Greene, Ph.D, Directorate for Epidemiology and Health Sciences*

References:

[1]1998 fireworks-related injuries: a study of fireworks-related injuries treated in hospital emergency rooms between June 23 and July 23, 1998. Washington, DC: CPSC, 1999.

[2]CPSC. National Electronic Injury Surveillance System (NEISS). NEISS is a statistical sample of hospitals nationwide that have emergency departments. Each day, NEISS hospitals report to CPSC all emergency room-treated injuries associated with consumer products and related activities.

Millennium Fireworks Tips

Fireworks can be dangerous, causing serious burn and eye injuries. That's why CPSC and its national and state partners strongly recommend that you leave fireworks to the professionals.

But if fireworks are legal where you live and you decide to set them off on your own, be sure to follow these important safety tips:

- Never allow children to play with or ignite fireworks.
- Read and follow all warnings and instructions.
- Be sure other people are out of range before lighting fireworks.
- Only light fireworks on a smooth, flat surface away from the house, dry leaves, and flammable materials.
- Never try to relight fireworks that have not fully functioned.
- Keep a bucket of water handy in case of a malfunction or fire.

For more information about fireworks safety, visit CPSC's website at: www.cpsc.gov/cpscpub/pubs/july4/4thjuly.html.

For More Information

For a complete copy of the report, *1998 Fireworks-Related Injuries*, please contact:

Office of the Secretary
U.S. Consumer Product Safety Commission
Washington, DC 20207

301-504-0800
or visit CPSC's website at www.cpsc.gov.

Safety at Child Care Settings

CPSC staff recently conducted a national study that identified potential safety hazards at child care settings across the country. The staff found at least one of the targeted safety hazards at two-thirds of the 220 licensed child care settings visited.[1]

CPSC staff looked at eight product areas with potential safety hazards. These included: cribs, soft bedding, playground surfacing, playground surfacing maintenance, child safety gates, window blind cords, drawstrings in children's clothing, and recalled children's products.

These potential hazard areas were chosen because they are a source of injury to children in and around their homes and could be equally hazardous in child care settings.

Some of the targeted hazards were more obvious ones, like problems with used cribs or playground surfacing. For example, more babies (about 40 to 50 each year) die in incidents involving cribs than any other piece of nursery equipment. Since 1990, at least nine children have died in crib-related incidents in child care settings.[2]

For young children, playground-related injuries account for more visits to U.S. hospital emergency rooms than any other child care-related injury. For example, in 1997, about 60,000 children under 5 were treated in hospital emergency rooms for all playground-related injuries. About 8,000 of these injuries occurred in child care/school settings.[3]

Other potential hazards, like soft bedding or window blind cords, were selected because caregivers might not be aware of potential dangers. CPSC recently issued new guidelines on soft bedding in cribs, urging that all soft bedding be removed from cribs when babies are put down to sleep. (See *Soft Bedding*, page 5.)

About one child a month strangles in window covering cords. These deaths have occurred both at home and in child care settings.

Background Data

CPSC has reports of at least 56 children who have died in child care settings since 1990. At least 28 of these children died from suffocation and/or asphyxia related to nursery equipment or soft bedding.

About 31,000 children, 4 years old and younger, were treated in U.S. hospital emergency rooms for injuries at child care/school settings in 1997. The playground-related injuries (8,000 in 1997) were the largest single cause.

There are 21 million children under age 6 in this country; almost 13 million of them are placed in non-parental child care during some portion of the day. About 29% of these children are in center-based care, including child care centers, Head Start programs, and nursery schools. The other 71% of these children are in non-center-based care, including family child care, in-home care, and care by a relative.

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ECOSA Conference

For the first time, CPSC will co-sponsor the International Conference on Product Safety Research with the European Consumer Safety Association (ECOSA). This seventh annual international conference will be held on September 30 and October 1, 1999 near Washington, DC in Bethesda, MD.

The 1999 conference will focus on such topics as new consumer product safety issues; benefits of protective safety equipment; fire hazards and effective intervention strategies; children's hazards; and costs and benefits of product safety improvements.

The conference is especially designed for those from consumer safety agencies and injury control organizations, consumer groups, national and international standardization bodies, testing laboratories, consumer product manufacturers and designers, the research community, and trade associations.

Last year, the ECOSA-sponsored conference was held in Amsterdam. ECOSA is a non-profit organization concerned with the safe design of consumer products.

For more information about the 1999 conference, visit www.ecosa.org and click on "news." Or, contact: ECOSA Secretariat, P.O. 75169, NL-1070 AD Amsterdam, The Netherlands (e-mail: R.Molenaar@consafe.nl or S.Geldhof@consafe.nl at ECOSA or akirshner@cpsc.gov at CPSC).

There are about 99,000 licensed child care centers in the U.S. In addition, there are about 283,000 regulated or licensed family child care providers. In CPSC's staff review of state licensing requirements for child care, however, most of the hazards included in this child care study were not addressed.

For example, although cribs are covered by both federal regulations and voluntary safety standards, many states did not require child care centers to use cribs that met all of these standards. Although virtually all child care settings use nursery equipment, like high chairs and strollers, none of the states reviewed had requirements for addressing recalled nursery equipment.

Description of Study

To conduct the study, CPSC staff visited four different types of child care settings. These included: 23 Government Services Administration (GSA)-managed child care centers (sponsored by Cabinet-level and independent federal government agencies); 77 non-profit centers; 68 in-home settings; and 52 for-profit centers.

These child care settings were spread across the country. These included 73 child care settings in the east, 76 in the west, and 71 in the central part of the country. Within each region, about 10% of the child care settings were GSA-sponsored; 40% were non-profit; 30% were in-home; and 20% were for-profit.

Where possible, participating child care settings were selected randomly from regional or national lists of licensed child care providers. When such lists were not available, selections were made from a variety of other sources, including Internet sites and local yellow pages.

CPSC staff used a prepared checklist to observe conditions related to the eight product areas. Information from the checklists was entered into a database for further analysis.

Child Care Safety: First Lady Speaks Out

First Lady Hillary Rodham Clinton joined CPSC Chairman Ann Brown to kick off a national campaign to alert parents and caregivers to safety hazards in child care settings. On April 12, 1999, at a child care center in downtown Washington, DC, the First Lady and Chairman Brown announced the results of the CPSC staff's study and the availability of the CPSC child care safety checklist.

Results of the Study

Many child care settings provide safe environments for young children. Yet CPSC staff found the following results at the child care settings included in this study.

- 8% of the child care settings had cribs that did not meet current safety standards.
- 19% of the child care settings had cribs that contained soft bedding.
- 24% of the child care settings did not have safe playground surfacing.
- 27% of the child care settings did not keep the playground surfacing well-maintained.
- 13% of the child care settings did not use child safety gates where necessary.
- 26% of the child care settings had loops on the window blind cords.
- 38% of the child care settings had children wearing clothing with drawstrings at the neck.
- 5% of the child care settings had products that had been recalled by CPSC.

Preventing Injuries

CPSC staff found that most (two-thirds) of the child care settings in the study had at least one safety hazard, putting children in these settings at risk of possible injury or death. CPSC staff's review of state licensing requirements indicated that most of the hazards included in the study were not adequately addressed in these requirements.

To help prevent deaths and injuries at child care settings, CPSC released a *Child Care Safety Checklist* for parents and child care providers. (See page 6.)

This checklist is intended to help adults easily identify potential safety hazards both at child care settings and at home. CPSC staff is sending the checklist to national child care groups, state licensing authorities, and other child care providers and organizations. Many of these groups are reprinting and distributing the checklist.

— Carol Cave, Directorate for Field Operations, and Debra Sweet, Directorate for Epidemiology and Health Sciences

Soft Bedding

Dr. N.J. Scheers, Project Manager of the Infant Suffocation Project, discusses the new recommendations for soft bedding in cribs and the association of soft bedding with sudden infant death syndrome (SIDS).

What's new about how babies should be placed to sleep?

We're recommending that when you put a baby down to sleep, be sure all soft bedding — like comforters, quilts, pillows, sheepskins, and pillow-like toys — is removed from the crib.

How is this new recommendation on soft bedding different from the old one?

For years, we recommended that soft bedding not be placed underneath babies. That's because babies, including those correctly placed to sleep on their backs, can roll over, and the bedding can become molded around the infant's face, nose, and mouth. Based on further research, we're now recommending, in addition, that no comforters or heavy quilts be used to cover the baby.

One critical recommendation that remains unchanged is that babies should be put down to sleep on their backs, on a firm, tight-fitting mattress, in a crib that meets all current safety standards.

What research findings led to this new recommendation on soft bedding?

Research found that babies are at increased risk for SIDS if they get their heads covered by soft bedding while sleeping. The research showed that this can occur even when they're sleeping on their backs or sides.

How is soft bedding related to SIDS?

Since the Back-to-Sleep campaign, deaths from SIDS have dropped dramatically, by over 2,000 a year. However, about 3,000 babies still die of SIDS each year, and past studies suggest that some may have suffocated when placed to sleep on top of soft bedding.

If comforters or quilts are not recommended to keep babies warm, what can be used?

Consider putting the baby in a sleeper. If you must use a blanket, use a thin one. Place the baby with his or her feet at the foot of the crib. Then tuck the blanket around the crib mattress, extending the blanket only as far as the baby's chest. (See picture at left.)

For what ages do these recommendations apply?

We recommend that all soft bedding be removed from cribs of children under 12 months.

Is it safe to put babies down to sleep in places other than cribs?

We recommend that babies not be placed to sleep on soft surfaces like waterbeds, sofas, soft mattresses, and pillows. There's always the possibility of suffocation if the soft surface molds around the baby's face.

Do pediatricians agree with these new recommendations on soft bedding?

The American Academy of Pediatrics, along with the National Institute of Child Health and Human Development, joined CPSC in issuing a recent safety alert that warned against placing babies to sleep in an environment with soft bedding.

For More Information

For a copy of the complete *CPSC Staff Study of Safety Hazards in Child Care Settings*, please visit CPSC's website at www.cpsc.gov or contact: Office of the Secretary, U.S. Consumer Product Safety Commission, Washington, DC 20207, 301-504-0800.

To get all CPSC product recall information faxed directly to you (or to a child care facility), send a fax with your name and fax number to 301-504-0399. To receive recall information by e-mail, send an e-mail message to listproc@cpsc.gov and, in the message area, enter: Join CPSCINFO-L.

References:

[1]CPSC staff study of safety hazards in child care settings. Washington, DC: CPSC, April 1999.

[2]CPSC. Medical Examiners and Coroners Alert Project (MECAP). MECAP is a national voluntary reporting system for 2,500 coroners and medical examiners nationwide to report consumer product-related deaths to CPSC. CPSC also purchases death certificates from 50 states and the District of Columbia for deaths related to consumer products.

[3]CPSC. National Electronic Injury Surveillance System (NEISS).

Child Care Safety Checklist

Here are some safety tips for parents and child care providers to use at child care settings. For a complete version of the checklist (in English or Spanish), visit CPSC's website at www.cpsc.gov or send a postcard to:

Child Care Safety Checklist
CPSC
Washington, DC 20207

☐ CRIBS
Make sure cribs meet current national safety standards and are in good condition. Look for a certification safety seal. Older cribs may not meet current standards. Crib slats should be no more than 2 3/8" apart, and mattresses should fit snugly.

☐ SOFT BEDDING
Be sure that no pillows, soft bedding, or comforters are used when you put babies to sleep. Babies should be put to sleep on their backs in a crib with a firm, flat mattress.

☐ PLAYGROUND SURFACING
Look for safe surfacing on outdoor playgrounds — at least 12 inches of wood chips, mulch, sand or pea gravel, or mats made of safety-tested rubber or rubber-like materials.

☐ PLAYGROUND MAINTENANCE
Check playground surfacing and equipment regularly to make sure they are maintained in good condition.

☐ SAFETY GATES
Be sure that safety gates are used to keep children away from potentially dangerous areas, especially stairs.

☐ WINDOW BLIND AND CURTAIN CORDS
Be sure mini-blinds and venetian blinds do not have looped cords. Check that vertical blinds, continuous looped blinds, and drapery cords have tension or tie-down devices to hold the cords tight.

☐ CLOTHING DRAWSTRINGS
Be sure there are no drawstrings around the hood and neck of children's outerwear clothing. Other types of clothing fasteners, like snaps, zippers, or hook and loop fasteners (such as Velcro), should be used.

☐ RECALLED PRODUCTS
Check that no recalled products are being used and that a current list of recalled children's products is readily visible.

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 January, February and March 1999, 1,013 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, 3 months, was found trapped between the mattress and the side of his crib by his mother. The child's father attempted CPR. The cause of death was positional asphyxia.

(Drew Toler for Thomas Young, M.D., Pathologist, Jackson County, Kansas City, MO)

*A female, 8 months, was swinging in an infant swing. She caught her neck on the shoulder harness strap of the swing and died. The cause of death was accidental hanging.

(Mary Coffman for Jeffrey Barnard, M.D., Medical Examiner, Dallas County, Dallas, TX)

A female, 1, was placed in a daybed to sleep. She was later found by her mother with her head between the metal rails of the headboard and her body resting on the metal mattress frame of the bed. The cause of death was asphyxia.

(Terry Browne, Deputy Coroner for Cyril H. Wecht, M.D., J.D., Coroner, Allegheny County, Pittsburgh, PA)

*A male, 3, was playing in his yard on playground climbing equipment when his scarf caught on the climbing apparatus. His mother found him hanging from the playground equipment. The cause of death was asphyxia.

(Delores Jones-Butler for Carolyn Rivercomb, M.D., Medical Examiner, Philadelphia, PA)

A male, 5 months was found wedged between a mattress and the metal grating at the foot of an adult bed. The victim was taken to the hospital, where he died. The cause of death was mechanical asphyxia.

(D. Jones for John Jofko, M.D., Medical Examiner and William Massello, III, M.D., Pathologist, Western District, Roanoke, VA)

A male, 3 months, was placed face down on a soft adult pillow inside his bassinet to sleep. He was found unresponsive. The cause of death was positional asphyxia.

(Manfred C. Borges, Jr., M.D., Associate Medical Examiner, Collier County, Naples, FL)

*A male, 7 months, was gagging on a piece of balloon, when his father found him. The father also found several balloons lying on the floor. The cause of death was asphyxia and upper airway obstruction.

(Antoinette J. Tibbs for L. Sathyavagiswaran, M.D., Chief Medical Examiner, Los Angeles County, Los Angeles, CA)

A female, 7 months, was placed on an adult-size bed to sleep. She was found wedged between the headboard and the mattress of the bed. The cause of death was positional asphyxia.

(Rebecca Bluedorn, RN, for Theodore Soboslay, M.D., Coroner, Trunbull County, Warren, OH)

*A female, 24 weeks, was seated in an infant swing. She slid down in the seat and was strangled by the waist strap. The swing's lap belt, which went between the infant's legs, was missing. The cause of death was asphyxia.

(Butch M. Houston, M.D., Medical Examiner, Milwaukee, WI)

POISONINGS

A male, 68, used a propane heater to warm an unvented camping trailer during cold weather. He was found dead by his son. The cause of death was carbon monoxide poisoning.

(Michael S. Birchmeyer for Mary Jumbelic, M.D., Chief Medical Examiner, Onondaga County, Syracuse, NY)

*Two males, 47 and 52, were found dead in their home. The gas furnace had malfunctioned. The cause of death was carbon monoxide poisoning.

(Venus Azar, M.D., Medical Examiner, Richmond, VA)

DROWNINGS

A female, 2, went to an apartment complex playground with her 8-and 10-year-old cousins. The victim disappeared. She was found floating face up in the apartment complex pool. The victim gained access to the pool through an open gate. The cause of death was drowning.

(Parviz Pakdaman, M.D., Medical Examiner, Santa Clara County, San Jose, CA)

*A male, 39, was scuba diving. He called to his girl friend that he was having trouble with the regulator on his equipment and then sank below the water's surface. He was recovered, and CPR was attempted. The cause of death was drowning.

(Gary G. Bluemink, M.D., Medical Examiner, Norfolk, VA)

FIRES

A male, 86, died in a house fire caused by a faulty electric heater. The cause of death was burns to 75% total body surface.

(Samantha L. Wetzler, M.D., Medical Examiner, Richmond, VA)

A male, 18, died in a house fire. His mother had poured gasoline from one container to another in a utility room. A gas water heater in the room ignited fumes from the gasoline. The cause of death was smoke inhalation.

(Susan Haddak for William R. Bell, M.D., Medical Examiner and Gary D. Cumberland, M.D., Chief Medical Examiner, Pensacola, FL)

A female, 55, died in a house fire caused by a faulty electrical outlet. The cause of death was smoke inhalation.

(Nancy Moore for John Butts, M.D., Chief Medical Examiner, Chapel Hill, NC)

*A male, 88, died in a house fire caused by a faulty heater control on an electric blanket. The cause of death was thermal burns.

(Nancy Moore for John Butts, M.D., Chief Medical Examiner, Chapel Hill, NC)

ELECTROCUTIONS

A male, 31, was installing an icemaker at a friend's house. He was holding a water pipe in one hand and using cutters with the other hand. He cut a live 220 volt electrical conduit. The cause of death was electrocution.

(Nancy Moore for John Butts, M.D., Chief Medical Examiner, Chapel Hill, NC)

A female, 82, died while using a hedge trimmer. Her gold metal necklace made contact with a loosely-connected electrical plug in the hedge trimmer. The cause of death was electrocution.

(Eroston A. Price, M.D., Medical Examiner, Ft. Lauderdale, FL)

MISCELLANEOUS

A male, 2, hugged a 64-pound TV while watching his favorite character on a TV show. The TV was on a particleboard stand. The TV fell off the stand onto the child. The cause of death was blunt force trauma of the head.

(Terry Browne, Deputy Coroner for Cyril H. Wecht, M.D., J.D., Allegheny County, Pittsburgh, PA)

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

CPSC Recalls

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

Product: About 78,000 **power mowers** by Toro Co. The mowers are Lawn-Boy Silver Series, Four Cycle, walk-behind 21-inch mowers. The model numbers are: 10200, 10202, 10212, 10236, 10302, 10307 (with serial number ranges 7900001-7999999); 10249 (8900001-8999999); 10313, 10321 (7900001-8999999). The model number and serial number are printed on a decal on the right rear of the mower. Lawn-Boy dealers and mass merchant retail outlets, including Sears, Lowe's and Home Depot, sold these mowers from January 1997 through November 1998 for between $280 and $400.
Problem: Interference with the mower's mulching fan can cause the mower blade to crack and break off. Broken pieces of the blade can be propelled from under the mower, possibly injuring someone. One consumer was struck on the ankle while mowing, resulting in a bruised tendon.
What to do: Stop using the mowers until they are repaired. Contact Lawn-Boy at **1-800-444-8676** between 7:30 a.m. and 4:30 p.m. CDT M-F or at www.lawnboy.com to locate the nearest Lawn-Boy service dealer for free repair or for more information.

Product: About 274,000 **battery-powered children's riding vehicles** by Peg Perego. The vehicles run on 12 volts, powered by two 6-volt batteries and were manufactured before December 1997. The plastic vehicles have the following model names: Corral 270, Diablo, Dragon, Gaucho, Gaucho Grande, Gaucho High Torque, Gaucho Sport, Magica, Magnum, Ranger GT, Thunderbolt, Thundercat, and Tornado. The model name and Peg Perego appear on each vehicle. Peg Perego vehicles are intended for children from 3 to 8 years old and have speed ranges from 2.5 to 5 mph. Toy stores and retail catalogs sold the vehicles nationwide from 1990 through 1997 for about $100 to $550. Vehicles made since 1998 and 6-volt, single battery vehicles are not recalled.
Problem: The pedals can stick and electrical components can overheat, presenting fire and injury hazards to children. There have been about 320 reports of electrical components overheating or pedals sticking. Thirty fires have been reported, resulting in one child suffering second-degree burns to his hand and at least $55,000 in property damage. One child suffered a concussion and six children were bruised when accelerator pedals stuck and the vehicles hit trees, fences, walls, or parked automobiles.
What to do: Remove the vehicles' batteries right away and don't let children use them until repairs are made. Contact Peg Perego at 1-888-893-7903 between 8 a.m. and 8 p.m. EST M-F or at www.perego.com/recall1.htm to order a free repair kit that can be installed by consumers or by an authorized Peg Perego service center. Service centers will not have repair kits.

Product: About 1,000,000 **carbon monoxide alarms** distributed by Kidde Safety, including 650,000 Nighthawks and 350,000 Lifesavers. The Nighthawk models were made between November 8, 1998 and March 9, 1999. The manufacturing date is on the back of the unit as year, month, day. "NIGHTHAWK" and "Carbon Monoxide Alarm" are on the front of the unit. If "Carbon Monoxide Detector" is on the front, the unit is not part of the recall. The Lifesaver units being recalled are models 9CO-1 and 9CO-1C made between June 1, 1997 and January 31, 1998. The manufacturing date is on the back of the unit as the first six numbers in the serial number, located above the UPC code. The date is written as day, month, year. "LIFESAVER" and "Carbon Monoxide Alarm" are on the front of the unit. Hardware and mass merchandise stores nationwide sold the alarms beginning in 1998 for about $20 to $50.
Problem: The Lifesaver models could alarm late or not at all, and the Nighthawk models could alarm late. The alarms are used to detect carbon monoxide (CO) leaking from fuel burning appliances. When they don't work, consumers can be unknowingly exposed to hazardous levels of CO and suffer injury or death. Kidde Safety and CPSC are not aware of any injuries involving these products.
What to do: Visit the Kidde Safety recall web site at www.nhawk.com and follow the instructions or call **1-888-543-3346** between 8 a.m. and 8 p.m. EST M-S for help identifying recalled units and to get a postage-paid envelope to return the alarm. Lifesaver models will be repaired; Nighthawk models will be tested, and repaired if needed. All returned alarms will be recertified to UL-2034. Kidde says it will return consumers' alarms within 30 days.

Product: About 424,000 GE Spacemaker **radio cassette players** distributed by Thomson Consumer Electronics. The model number is 7-4285 and is located on the top of the unit. It may or may not be followed by a letter. The player is designed for under-the-cabinet use. Each has an AM/FM stereo cassette player, a light, and a programmable appliance outlet with timer. The outlet is on the left side of the unit. "GE Spacemaker...AM/FM Stereo Cassette Player...Programmable Appliance Outlet" is on the front of the unit. Department, electronic and discount stores nationwide sold the radio cassette players from January 1992 through December 1995 for about $50 to $80.
Problem: The player has an appliance outlet that can overheat, presenting a fire hazard. Thomson Consumer Electronics has received three reports of the appliance outlets overheating and catching fire, causing minor property damage. No injuries were reported.
What to do: Unplug the units and call Thomson at **1-800-464-7022** anytime for instructions and a free replacement unit or contact Thomson at www.home-electronics.net/recall or write Thomson Consumer Electronics, Spacemaker Recall, INH 950, P.O. Box 6127, Indianapolis, IN 46206-6127

— *Marc Schoem and Terri Rogers, Office of Compliance*

NHTSA Recalls

The National Highway Traffic Safety Administration (NHTSA) is the government agency responsible for improving safety on our Nation's highways. As part of its efforts to achieve this goal, NHTSA is authorized to order manufacturers to recall and repair vehicles or items of motor vehicle equipment (including air bags, tires, and child safety seats).

The following safety recall campaigns are being conducted in cooperation with NHTSA. For more information about NHTSA recall activities, you can access NHTSA on the Internet at http://www.nhtsa.dot.gov or by calling the NHTSA Auto Safety Hotline at 1-888-DASH-2-DOT (1-888-327-4236).

AmTran Corporation

AmTran is recalling 8,217 **1993-1999 Genesis, FE, 1996-1999 RE, 1997-1999 Conventional, and 1993-1997 Volunteer** school buses equipped with flip seats at the emergency exits. The seat cushion hinge on the combination flip seat is located in such a manner that it is within easy reach of the passenger sitting in the seat located behind the combo flip seat. The hinges on the combo flip seat can pinch or sever fingers, resulting in personal injury. [NHTSA Recall No. 99V061/ AmTran Recall No. 99-303]

Bayerische Motoren Werke

BMW is recalling 32,500 **1999 BMW 323i and 328i** vehicles built with a side air bag system consisting of door-mounted thorax air bags (rear door air bags are optional), a Head Protection System (HPS) for front occupants, a central electronic sensor and diagnostic system, left and right satellite impact sensors, and associated wiring, manufactured from June 1998 through March 1999. This system is unduly sensitive to certain non-crash impacts, such as contacting large potholes or curbs at substantial speed. This could cause the side air bag and HPS to deploy without an actual side crash. Owners who do not receive the free remedy within a reasonable time should contact BMW at 1-800-831-1117. [NHTSA Recall No. 99V063]

DaimlerChrysler

Chrysler is recalling 263,000 **1995-1997 Dodge Ram van and wagon** model vehicles manufactured from August 1994 through August 1997. If water/road salt gets on the interior floor of the vehicle in the proximity of the air bag electronic control module (AECM), the AECM can corrode. The resulting corrosion can cause the driver side air bag to deploy inadvertently. Deployment of the air bag without warning could cause a driver to lose vehicle control, increasing the risk of a crash and personal injury. Owners who do not receive the free remedy within a reasonable time should contact Chrysler at 1-800-992-1997. [NHTSA Recall No. 99V023/Chrysler Recall No. 815]

Ford Motor Company

Ford is recalling 757,000 **1992-1997 Ford Aerostar Mini Vans** manufactured from August 1991 through August 1997. These vehicles were produced with a higher than specified electrical load through the accessory power feed circuit that connects to the A2 (accessory) terminal within the ignition switch. As a result, during startup, electrical arcing of the A2 terminal to the terminal bridge could potentially cause pitting of the bridge. This condition, over time, could create a short circuit and allow current to flow through the ground wiring, causing overheating and the potential for a vehicle fire. Owners who do not receive the free remedy within a reasonable time should contact Ford at 1-800-392-3673. [NHTSA Recall No. 99V029/Ford Recall No. 99S02]

Ford will also recall 895,000 certain **1997-1999 RHD Explorer** equipped with 4.0L OHV/SOHC engines and speed control built from May 29, 1996 through March 4, 1999; **1998-1999 Explorer/Mountaineers** equipped with 4.0L OHV/SOHC or 5.0L engines or **1998-1999 Rangers** equipped with 2.5L, 3.0L FFV/EFI or 4.0L engines and speed control built from January 5, 1998 through March 4, 1999; **1998-1999 Mustangs** equipped with 3.8L, 4.6L 2-valve or 4-valve engines and speed control built from March 2, 1998 through March 4, 1999; **1999 F250/F350/F450/F550** (over 8,500 lbs.) trucks equipped with 5.4L or 6.8L engines and speed control built from March 2, 1998 through March 4, 1999; and **1999 F-53 stripped chassis** equipped with 5.4L or 6.8L engines and speed control built from March 2, 1998 through March 4, 1999. The speed control cable can interfere with the speed control servo pulley and not allow the throttle to return to idle when disengaging the speed control. If the speed control is used and this condition is present, a stuck throttle could result, increasing the potential for a crash. Owners who do not receive the free remedy within a reasonable time should contact Ford at 1-800-392-3673. [NHTSA Recall No. 99V062/Ford Recall No. 99S09]

Harley-Davidson Motor Company

Harley-Davidson is recalling 14,211 **1999 FLHT, FLHTC, FLHTCUI, FLHTCI, FLHTPI, FLTR, FLTRI, FLHR, FLHPI, FLHP, FLHRCI, FXDL, FXDWG, FXDS CONV, FXD, and FXDX** motorcycles manufactured from February 1998 through January 1999. The engine cam bolt can lose its clamp load and/or break. This condition can cause the engine to quit running with or without prior warning. In some instances, the engine could run erratically before quitting. Owners who do not receive the free remedy within a reasonable time should contact Harley-Davidson at 1-414-342-4680. [NHTSA Recall No. 99V003/Harley-Davidson Recall No. 095]

General Motors Corporation

GM is recalling 2,090 **1996-1998 Chevrolet Astro and GMC Safari minivans** equipped with integrated child seats and manufactured from May 1996 through September 1997. Some of these vehicles may be missing a seat belt retractor clutch spring and/or pawl spring in the child seat. If the clutch spring was missing, the seat belt would lock in the retracted position and could not be used. If the pawl spring was missing, the seat belt restraint would continually play out and not lock. These conditions could increase the occupant's risk of injury in the event of a vehicle crash. Dealers will inspect the seat belts on the child seats, and if necessary, replace the child seat. Owners who do not receive the free remedy within a reasonable time should contact Chevrolet at 1-800-222-1020 or GMC at 1-800-462-8782. [NHTSA Recall No. 99V009/GM Recall No. 98071]

GM is also recalling 988,587 **1994 Chevrolet C10, C20, C30, C3500, Suburban, GMC C15, C25, C35, C3500, and Suburban vehicles** manufactured from March 1993 through September 1994. These vehicles were built with the polarity of the wiring for the brake switch reversed from what was specified on the switch drawing. With the reversed polarity, the contacts in the brake switch can wear out prematurely. The brake switch will perform normally until the brake switch contacts wear out, resulting in loss of the brake lamps without any warning to the driver. This would fail to warn a following driver that the vehicle is braking and could lead to a crash. Owners who do not receive the free remedy within a reasonable time should contact Chevrolet at 1-800-222-1020 or GMC at 1-800-462-8782. [NHTSA Recall No. 99V025/GM Recall No. 98065]

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