



Injuries and Deaths Associated with Nursery Products Among Children Younger than Age Five

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This analysis was prepared by the CPSC staff. It has not been reviewed or approved by, and may not necessarily reflect the views of, the Commission.

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Executive Summary

U.S. Consumer Product Safety Commission (CPSC) staff presents in this report statistics regarding injuries and deaths associated with nursery products among children younger than the age of 5 years, based on the most recently available information.¹

Emergency Department-Treated Injuries:

- In 2019, there were an estimated 60,600 emergency department-treated injuries associated with (*i.e.*, in use at the time of incident), but not necessarily caused by, nursery products among children younger than age 5 years. This translates to an injury rate of an estimated 305 injuries per 100,000 children under the age of 5 years.² This estimate of emergency department-treated injuries is based on the non-incidental³ injuries *only*.
- High chairs, cribs/mattresses, infant carriers, and strollers/carriages were associated with 64 percent of the total estimated injuries. Falls were the leading cause of injury; and the head, followed by the face, was the body part injured most frequently. A diagnosis of internal organ injury, contusion/abrasion, or laceration was associated with a majority of the injuries.
- Non-incidental data-based analysis was completed for the first time using 2015 data. With the completion of this report, these analyses are now available for 2015, 2016, 2017, 2018, and 2019 injury data. A trend analysis, based on the 3 years 2017–2019, or the 5 years 2015–2019, did not display any statistically significant trend. A longer-term trend analysis is not presented at this time, because the annual estimates of injuries associated with nursery products in years before 2015, were based on all in-scope data, not just non-incidental data.

Fatalities:

- CPSC staff has reports of 357 deaths during the 3-year period from 2015 to 2017—an annual average of 119 deaths among children younger than age 5—associated with (*i.e.*, in use at the time of incident), but not necessarily caused by, nursery products.
- Cribs/mattresses, playpens/play yards, bassinets/cradles, infant carriers, and inclined infant sleep products were associated with 83 percent of the fatalities reported.
- Causes of death included positional asphyxia, strangulation, and drowning, among others. In some instances, the fatalities were attributed to the product; in other cases, the fatalities resulted from a hazardous environment in or around the product.

CPSC staff has evaluated the incidents characterized in the annual reports on nursery products for many durable infant and toddler products, along with previously and subsequently reported incidents, to assess the efficacy of voluntary standards. These evaluations have supported the staff's work with standards

¹ Not all of these incidents are addressable by an action the CPSC could take; however, it was not the purpose of this report to evaluate the addressability of the incidents, but rather, to update estimates of emergency department-treated injuries and to quantify the number of fatalities reported to CPSC staff.

² The population data for the denominator is available at the U.S. Census Bureau website: <https://www.census.gov/newsroom/press-kits/2020/population-estimates-detailed.html>; Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2010 to July 1, 2019 (NC-EST2019-AGESEX); release date: June 2020.

³ In this report, the association of an incident/injury with a nursery product is considered *incidental*, if the occurrence of the incident/injury is deemed not to be dependent on the presence of that nursery product in the incident scenario. See Appendix for examples.

development organizations to refine these standards, and likewise, supported staff briefing packages for notices of proposed rulemaking (NPRs) and final rules that are required by the Danny Keysar Child Product Safety Notification Act, section 104 of the Consumer Product Safety Improvement Act of 2008 (CPSIA).⁴ In fiscal year (FY) 2020, the Commission issued an NPR for crib bumper pads and crib mattresses, a supplemental NPR for infant sleep products, and also issued final rules establishing new standards for baby gates/barriers. The rule on stationary activity centers also took effect in FY 2020. The Commission also issued revised rules on non-full-size cribs, play yards, toddler beds, portable youth bedrails, children's folding chairs, and infant carriers, such as infant slings and handheld carriers.

⁴ There is some overlap between the products covered by this report and the products subject to rules issued under section 104 of the CPSIA. However, this report covers some nursery products that do not fall under section 104.

Introduction

This report presents nursery product-related injury estimates for 2019,⁵ as well as comparisons with historic injury estimates. Detailed information on deaths associated with nursery products that reportedly occurred during the 3-year period from 2015 to 2017, is also presented. Note that reporting is ongoing, and the number of reported fatalities in this report may change.

Nursery Product-Related Emergency Department-Treated Injury Estimates

Beginning with the 2015 report, the injury estimates in annual nursery products reports are based on non-incidental emergency department-treated injuries.⁶ The association of an incident/injury with a nursery product is incidental, if the occurrence of the incident/injury is considered not dependent on the presence of that nursery product in the incident scenario. For example, if a child gets stung by a bee, or gets bitten by a dog while in an infant stroller, the stroller's involvement in the incident is considered incidental. The fact that the child was in a stroller had no bearing on the incident. Although such incidents are retained in the NEISS database to provide analysts the flexibility and discretion to include or exclude them, the exclusion of incidental injury cases aligns more closely with the way CPSC staff has prepared the CPSIA section 104 rulemaking packages for the Commission. Now that most of the nursery products discussed in this report have a mandatory rule in place, staff believes that annual estimates based on the non-incidental data will provide a better tool for gauging the efficacy of the various standards.

An estimated 60,600 nursery product-related injuries among children younger than 5 years old were treated in U.S. hospital emergency departments (ED) in 2019. Table 1 shows the estimated injuries and the corresponding injury rates for the latest 3 years, as well as the annual averages for this 3-year period. Staff did not observe a trend in injury estimates over the 2017 to 2019 period (p-value of 0.633). The attached Appendix provides annual estimates for 2015 through 2019, as well as more detail about the data-selection processes.

Table 1: Estimated Emergency Department-Treated Injuries to Children Younger than Age Five Associated with Nursery Products: 2017–2019

Calendar Year	Estimated Injuries	Estimated Injury Rates per 100,000 Children ²
2017	61,400	308
2018	59,000	298
2019	60,600	305
2017 – 2019 Average	60,300	306

Source: NEISS, CPSC.

Note: Estimates rounded to the nearest 100. The average calculation is based on unrounded injury estimates. For all 3 years, 2017-2019, the estimates were derived based on non-incidental data only.

Falls were the leading cause of all nursery product-related injuries reported through NEISS for 2019, similar to previous years. About 69 percent of the total injuries involved the head and the face, which were the body

⁵ The source of the injury estimates is the National Electronic Injury Surveillance System (NEISS), a statistically valid surveillance system for collecting injury data. NEISS injury data are gathered from the emergency departments of hospitals selected as a probability sample of all the U.S. hospitals with emergency departments. The surveillance data gathered from the sample hospitals enable CPSC staff to make timely national estimates of the number of injuries associated with specific consumer products.

⁶ These estimates are based on data with all in-scope product codes, *except* incidental injury cases. Cases where a nursery product was present in the incident scene, but played an insignificant role in the sequence of events that led to the injury were considered incidental. The methodology used was similar to historical estimates before 2015. The first report following the transition can be seen at R. Chowdhury, "Injuries and Deaths Associated with Nursery Products Among Children Younger than Age Five," CPSC, December 2016, <https://www.cpsc.gov/s3fs-public/Nursery%20Products%20Annual%20Report%202016.pdf>.

parts injured most frequently. Internal organ injuries, contusions/abrasions, or lacerations were the diagnoses in about 69 percent of the NEISS-reported injuries.

Table 2 shows the breakdown of injury estimates by different product categories for 2019, along with the injury estimates for 2018, for comparison purposes. As in 2018, there were more than 30 product codes associated with the injury estimates in 2019. The associated products have been aggregated into 13 product categories that align with standards development activities as in 2018. The top four categories: high chairs, cribs/mattresses, infant carriers, and strollers/carriages were associated with 64 percent of the total estimated injuries.

There was a non-statistically significant increase from an estimated total of 59,000 injuries in 2018, to 60,600 injuries in 2019. Between 2018 and 2019, six increases and six decreases were observed in various products groups, but none of the changes were statistically significant. The increases were in cribs/mattresses (from 10,900 to 11,800), baby gates/barriers (from 2,900 to 3,000), baby bouncer seats (from 2,600 to 2,800), playpens/playyards (from 1,900 to 2,400), portable baby swings (from 1,800 to 2,000), and baby bottles/warmers/sterilizers (from under 1,200 to 1,300). The decreases were in high chairs (from 12,100 to 12,000), infant carriers (from 8,200 to 7,700), strollers/carriages (from 7,600 to 7,200), changing tables (from 4,200 to 3,400), baby walkers/jumpers (from 3,400 to 3,000), and the “other” category (from 1,600 to 1,300).

**Table 2: Estimated Emergency Department-Treated Injuries to Children Younger than Age Five
By Type of Nursery Product: 2018–2019**

PRODUCT CATEGORY	ESTIMATED EMERGENCY DEPARTMENT-TREATED INJURIES	
	2018	2019
TOTAL	59,000	60,600
High Chairs	12,100	12,000
Cribs/Mattresses	10,900	11,800
Infant Carriers (Excludes Motor Vehicle Incidents)	8,200	7,700
Strollers/Carriages**	7,600	7,200
Changing Tables**	4,200	3,400
Baby Walkers/Jumpers/Exercisers	3,400	3,000
Baby Gates/Barriers	2,900	3,000
Baby Bouncer Seats	2,600	2,800
Playpens/Play Yards	1,900	2,400
Portable Baby Swings	1,800	2,000
Baby Bottles/Warmers/Sterilizers	--- ⁷	1,300
Bassinets/Cradles	--- ⁷	--- ⁷
Baby Baths/Bath Seats/Bathinettes	--- ⁷	--- ⁷
Other ⁸	1,600	1,300

Source: NEISS, CPSC. Estimates are rounded to the nearest 100.

Note: The injury estimates may not add up to the total due to rounding.

Deaths Associated with Nursery Products

⁷The injury estimates are not presented because they fail to meet standard reporting criteria for NEISS, which require the estimated number of injuries to be 1,200 or higher, the sample size to be 20 or larger, and the coefficient of variation to be less than 33 percent.

⁸ In both 2018 and 2019, the “Other” category included: pacifiers/teething rings, diapers (excluding diaper rash cases), night lights, potty chairs/training seats, harnesses, and safety pins. In 2018, the “Other” category also included diaper pails, while in 2019, it included baby rattles and crib mobiles/gyms.

Although all of the Commission’s databases are used to identify nursery product-related deaths, death certificates are a major source of information for this analysis. At the time of the data extraction for this analysis, the Commission’s death certificates database was at least 98 percent complete for each year in the period from 2015 through 2017. The deaths reported here are from 2015 through 2017, the latest 3-year time frame with sufficiently available information, similar to previous annual reports.⁹

Table 3 provides a summary of nursery product-related reported deaths (total and average annual) for 2015 through 2017, along with data previously reported for 2014 through 2016, for comparison purposes. Reporting is ongoing, and the number of reported fatalities may change. Moreover, these reports are anecdotal and do not constitute a statistical sample or a complete count of nursery product-related deaths. As such, CPSC staff strongly discourages drawing any inferences based on the year-to-year increase or decrease shown in the reported data.

CPSC staff has received reports of a total of 357 deaths associated with nursery products—an annual average of 119 deaths—during this period. About 32 percent (113 total, or an annual average of 38) were associated with cribs/mattresses. Playpens/play yards accounted for 19 percent (69 total, or an annual average of 23) of the reported deaths. Bassinets/cribbeds were also associated with 19 percent (a total of 67 or an annual average of 22) of the reported deaths, while infant carriers were associated with 9 percent (a total of 32 or an annual average of 11) of the reported deaths. Infant inclined sleep products accounted for 5 percent (a total of 17 or an annual average of six) of the reported deaths. The remaining 59 reported fatalities were associated with a range of products, including infant portable swings, baby bouncers, baby bath/bathinettes, baby gates/barriers, infant strollers/carriages, high chairs, changing tables, and a variety of other sleep-products (*e.g.*, in-bed sleepers and toddler beds), seating products (*e.g.*, floor seats), and miscellaneous products.

For certain incident scenarios in which direct product involvement or failure was not evident, consultation with staff from the CPSC’s Directorate for Engineering Sciences was necessary to determine the most appropriate product category to place the fatalities in. Details of the methodology are provided in the attached Appendix.

⁹ These deaths do not constitute a statistical sample of known probability and do not necessarily include all nursery product-related deaths that occurred during the 2015–2017 period. However, they do provide at least a minimum number for deaths associated with nursery products during that time. Furthermore, the number of reported incidents may change should staff receive additional reports. In addition, the number of fatalities for each product/group of products presented in this and previous annual nursery product reports are not expected to match the number of fatalities presented in any rulemaking packages on the same product/group of products because of the difference in the data inclusion criteria applied. See Methodology section of the Appendix for the process used in this report.

**Table 3: Reported Deaths Among Children Younger than Age Five
By Type of Nursery Product**

PRODUCT CATEGORY	TOTAL DEATHS		AVERAGE ANNUAL DEATHS	
	2014-2016	2015-2017	2014-2016	2015-2017
TOTAL	322	357	108	119
Cribs/Mattresses ¹⁰	107	113	36	38
Playpens/Play Yards	64	69	21	23
Bassinets/Cradles	59	67	20	22
Infant Carriers (Excludes Motor Vehicle Incidents)	30	32	10	11
Infant Inclined Sleep Products ¹¹	11	17	4	6
Portable Baby Swings	11	10	4	3
Baby Bouncer Seats	7	8	2	3
Baby Baths/Bath Seats/Bathinettes	6	7	2	2
Baby Gates/Barriers	5	7	2	2
Strollers/Carriages	6	5	2	2
Changing Tables	2	4	1	1
High Chairs	2	1	1	<1
Baby Walkers/Jumpers/Exercisers	0	1	0	<1
Other ¹²	13	16	4	5

Source: CPSC epidemiological databases: Consumer Product Safety Risk Management System (CPSRMS) and NEISS from 2015 to 2017, for reported deaths.

Deaths for 2014-2016, which are shown in italics, represent changes since publication of the previous annual report, due to availability of additional information.

Note: The average annual deaths do not add up to the total due to rounding.

A closer look at the top product categories with the largest numbers of reported deaths provides some insight into the hazard patterns. Between 2015 and 2017, these product categories were associated with 83 percent of the reported fatalities; for the earlier period (2014-2016), they accounted for 84 percent of the total reported fatalities.

Between 2015 and 2017, 113 deaths were associated with cribs/mattresses. The majority of these deaths were associated with a cluttered sleep environment (the presence of extra bedding in the crib, such as pillows, blankets, and/or comforters, among others) that led to asphyxiation of the infant. Approximately 10 percent of the 113 deaths resulted from a range of hazards associated with the crib, including incomplete assembly; missing, broken, or nonfunctioning components; ill-fitting mattress; or ineffective crib repairs. Some of these incidents occurred in, or on, older, reassembled, recalled, or secondhand cribs. The remaining crib fatalities involved the presence of hazardous crib surroundings. Examples include: strangulations from

¹⁰ Certain products, such as nursing pillows and lounger pillows, have incidents that occur with the products in which the products were located, such as cribs, play yards, and bassinets. For this report, these items were categorized with the product in which they were located, to avoid double counting.

¹¹ Beginning with the annual report published in 2018, the Infant Inclined Sleep Products group is presented in a row of its own in Table 3. These products come with one or more inclined sleep surface adjustment positions for the seat back that are greater than 10 degrees, but do not exceed 30 degrees. Specific examples are infant hammocks, recliner seats, and nappers, among other products.

¹² Of the 16 deaths in this category in 2015–2017, 10 deaths were associated with products used in the sleep environment that are not among the product categories listed in Table 3. Among the 10, an infant lounging pillow and an unspecified “travel bassinet” were involved in one death each; toddler beds (product code 4082) were involved in three deaths; and in-bed sleepers were involved in the remaining five deaths. In addition to the 10 deaths, there were two drowning deaths, where an infant was left unattended on a non-bathing baby seat (product code 4074) in a water-filled tub; two asphyxiation deaths, one on a teether, and one on a baby bottle nipple; one death in a rocker, where an infant, left unrestrained, was found rolled over in a prone position; and an additional death, where the decedent was described found as follows: “crib was situated on a changing table.” Upon careful review of the last case, staff concluded that the product was some undetermined nursery product, small enough to be positioned on top of a changing table.

See https://www.cpsc.gov/s3fs-public/Nursery%20Products%20Annual%20Report%20Dec2019_2.pdf p.8, for a list of products associated with deaths in the “Other” category in 2014–2016.

nearby cords or strings; suffocations from plastic bags located in/near the crib; asphyxiations due to co-sleeping with other children in the crib; entrapments between crib rail and a tied-down cover (*e.g.*, a twin mattress); and one case of hyperthermia, resulting from a broken thermostat in the infant's sleep area.

Playpens/play yards were associated with 69 deaths between 2015 and 2017. This total includes one new fatality in 2016, for which additional information became available since publication of the previous annual report. A majority of the deaths were due to asphyxiation, where the infant suffocated on a blanket/pillow/other soft bedding placed inside the play yard. The presence of a hazardous environment in or around the product, such as makeshift covers (*e.g.*, cardboards) used on top of play yards to contain the infant, use of ill-fitting, non-original mattresses and sofa cushions in the play yards, or co-sleeping arrangements with other infants in the play yard, were associated with some of the deaths. A few of the fatalities involved faulty products.

Between 2015 and 2017, staff identified 67 deaths associated with bassinets/cradles. The majority of these deaths were associated with extra bedding, with pillows involved in many of the suffocation deaths. A few of the bassinet-related deaths involved product failure and/or the presence of hazardous surroundings around the bassinet.

Thirty-two deaths associated with infant carriers were identified during 2015–2017. This total includes one new fatality in 2016, for which additional information became available since publication of the previous annual report. Placement of the infant in the carrier in a hazardous manner was the most common scenario. Examples include an infant left unsupervised for an extended period of time in a vehicle with the windows rolled up, resulting in death due to hyperthermia; an infant, partially restrained in the seat with shoulder straps only, who slid forward in the seat, and strangled at the chest clip; and an infant positioned improperly in a carrier on the caregiver's body, which led to suffocation. Some fatalities resulted from carriers tipping over when placed on nonrigid surfaces, trapping the infant inside.

Finally, between 2015 and 2017, infant inclined sleep products were associated with 17 deaths. This total includes one new fatality in 2015, for which additional information became available since publication of the previous annual report. These products come with one or more inclined sleep surface adjustment positions for the seat back that are greater than 10 degrees, but do not exceed 30 degrees. While 15 of these 17 fatalities happened in deep-seated recliner seats with rocking features, one fatality occurred in a foam recliner seat that was placed on a couch, and another involved a napper attachment of a larger nursery product. Some of the decedents were placed prone in the product, on soft bedding; some of the decedents were found to have rolled over, either completely or partially, ending up in a compromised position that resulted in asphyxiation deaths; a couple of the fatalities described the decedent as being found in a chin-to-chest position; and in one case, an older sibling climbed into the product, creating an unsupervised hazardous situation that ultimately led to the suffocation death of the infant.

In conclusion, the hazard patterns described indicate that although a nursery product was involved, many of the fatalities were associated with how the product was used, including putting the product in a hazardous situation, and/or using it in a hazardous manner.

Appendix

Methodology

Injuries (In-Scope Data):

- Database: NEISS from 01/01/2019 through 12/31/2019.
- Product codes: 1500–1558, excluding 1550.¹³ When multiple nursery products were coded as involved in an injury report, staff identified a “primary” product code based on the narrative description and used that for classification in this analysis.
- Age of victim: 0 through 4 years.
- Screened to ensure that no motor vehicle incidents were included.
- All cases of diaper rash (identified as side-effects of antibiotics use or exposure to prolonged moisture) were excluded.

(Additional Screenings Applied to Arrive at Non-Incidental Data):

- If the official diagnosis indicated that no injury had been sustained, the case was excluded.
- If the product’s involvement was incidental, such as a child being stung by a bee, or getting bitten by a dog while in an infant stroller, the case was excluded.
- If a child suffered a medical crisis while seated in a high chair (*e.g.*, choking on food), or gained access to adult medication by climbing on a crib, the case was excluded.
- If a child was injured by other young children (*e.g.*, pulled out of an infant swing by a young sibling), the case was excluded.

Based on the non-incidental data only, trend analysis for 2017–2019 shows no statistically significant trend (p-value=0.918).

This is the first year that a 5-year trend analysis was completed using non-incidental data only. The 2015–2019 data showed no statistically significant trend (p-value=0.794).

Deaths:

- Databases: CPSRMS and NEISS from 01/01/2015 through 12/31/2017; date of extraction was 08/18/2020.

Information available from CPSRMS and NEISS on incidents that have not been investigated is often incomplete or provides insufficient information on the hazard scenario. If these incident reports are investigated at a later date, or as other associated reports come in, the initial information is corroborated or contradicted, and the fatality numbers reported may change.

- Product codes: 1500–1558, excluding 1550¹²; 4074 for *children’s chairs*, 4075 for *portable youth bed rails*, and 4082 for *toddler beds*.
- Age of victim: 0 through 4 years.
- Screened to ensure no duplicates were included; all records of the same incident that were reported through different data sources were associated and included as a single report.
- Miscoded products were recoded correctly. A common example was a play yard miscoded as a crib.
- As with the emergency department-treated injuries, deaths involving certain products were grouped together. For instance, baby baths and bathinettes were counted together with bath seats; exercisers were counted with baby walkers and jumpers; and as noted above, any extra-bedding-in-crib

¹³ Product code 1550 (*Infant and Toddler Play Centers excluding Jumpers, Bouncers, and Exercisers*) represents a toy, not a nursery product.

incidents were counted with cribs; while incidents with extra bedding in a play yard were counted with play yards.

- Staff carefully screened to determine whether cases were in scope or out of scope. An example of an out-of-scope case would be an incident where no direct or circumstantial information was available to determine *how* the death occurred, or if Sudden Infant Death Syndrome was the only information available from the official report(s). These criteria differ from the inclusion criteria used in various rulemaking packages prepared by CPSC staff. In the latter, *all* data are included, but such incidents may be classified differently; for example, the incidents could be classified into “non-product-related” or “no information” categories, as appropriate (and are excluded from the data-based evidence used for rulemaking purposes). As such, the number of fatalities for each product/group of products presented in this and previous annual nursery product reports are not expected to match the number of fatalities presented in any rulemaking packages on the same product/group of products.

In some cases that were considered in scope, the death was not associated directly with the nursery product. However, hazards in the vicinity of the product, often created inadvertently by caregivers, led to the deaths. For instance, extra bedding inside the crib, or plastic bags that were within easy reach of the crib, have led to some deaths. These deaths have been included with crib deaths. Similarly, clutter and extra bedding inside the play yard, or placement of the play yard within easy reach of a window blind cord, have led to some fatalities. These have been counted with play yard deaths. While these deaths may not be due to product failure only, they highlight some common misconceptions and oversights, poor instructions or warnings, and/or foreseeable use patterns in the use of these products. Therefore, these deaths were included.

Staff excluded any report to the CPSC of a nursery product-related incident that occurred outside of the United States.

Historical Data

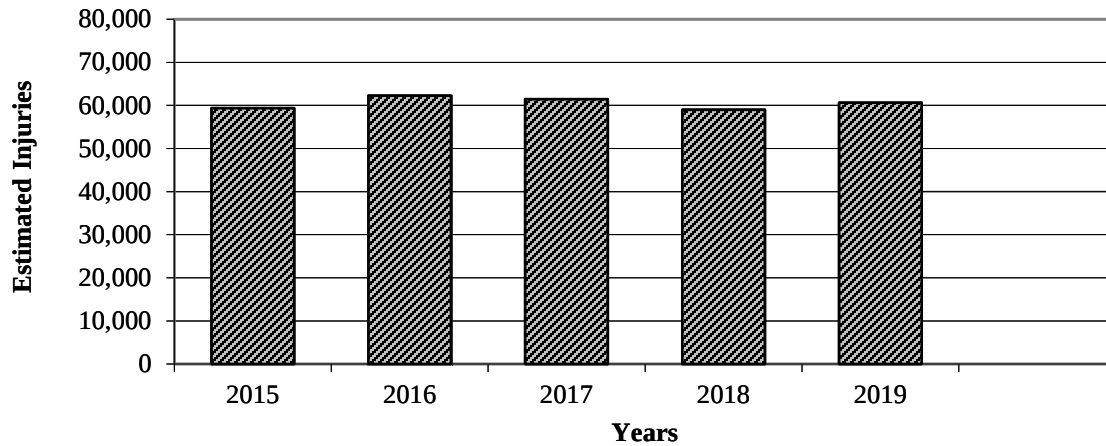
Table 4 and Figure 1 present the 5-year injury estimates covering 2015 through 2019, based on ED-treated, **non-incident**al data on nursery products. Figure 2 presents the corresponding 5-year estimated injury rates per 100,000 children under 5.

Table 4: Nursery Product-Related ED-Treated Injury Estimates: 2015-2019

Calendar Year	Estimated Injuries	95% Confidence Interval
2015	59,400	41,200 – 77,500
2016	62,300	41,700 – 82,800
2017	61,400	42,700 – 80,100
2018	59,000	38,400 – 79,600
2019	60,600	38,000 – 83,200

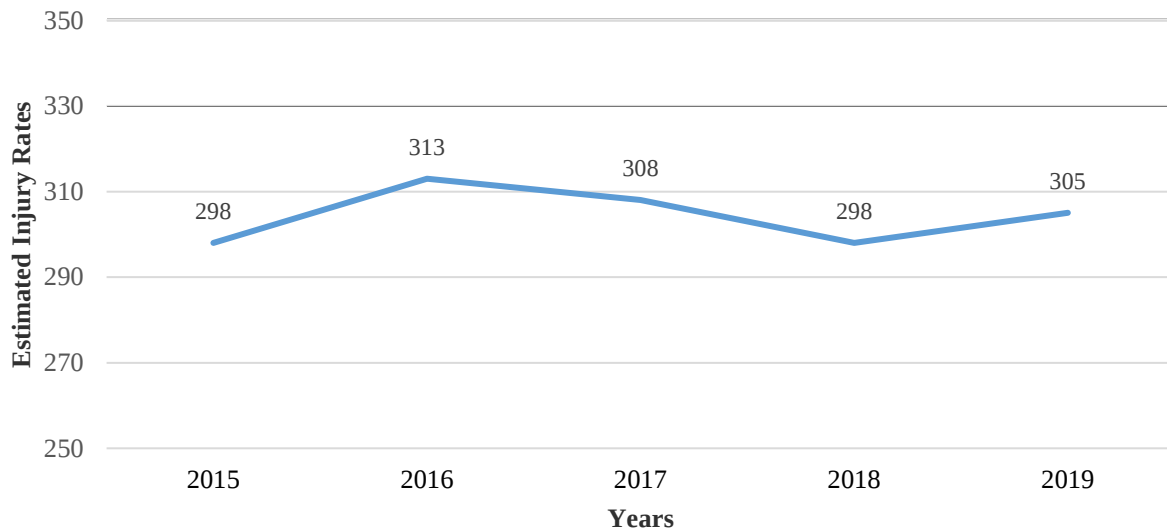
Source: NEISS, CPSC. Estimates rounded to nearest 100.

Figure 1: Nursery Product-Related ED-Treated Injury Estimates: 2015 – 2019



Source: NEISS, CPSC. Estimates are rounded to nearest 100.

Figure 2: Nursery Product-Related ED-Treated Estimated Injuries per 100,000 Children Under 5 Years: 2015 – 2019



Source: NEISS, CPSC. Estimates are rounded to nearest 100.

The population data for the denominator is available at the U.S. Census Bureau website:

<https://www.census.gov/newsroom/press-kits/2020/population-estimates-detailed.html>; Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2010 to July 1, 2019 (NC-EST2019-AGESEX); release date: June 2020.