CONSUMER SAFETY INITIATIVES: PROTECTING THE VULNERABLE

HEARING

BEFORE THE

SUBCOMMITTEE ON TELECOMMUNICATIONS, TRADE, AND CONSUMER PROTECTION

OF THE

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HOUSE OF REPRESENTATIVES

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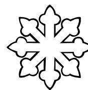

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CONSUMER SAFETY INITIATIVES: PROTECTING THE VULNERABLE

TUESDAY, MAY 16, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON TELECOMMUNICATIONS,
TRADE, AND CONSUMER PROTECTION,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2322, Rayburn House Office Building, Hon. W.J. "Billy" Tauzin (chairman) presiding.

Members present: Representatives Tauzin, Oxley, Stearns, Gillmor, Cubin, Rogan, Shimkus, Pickering, Ehrlich, Bliley (ex officio), Markey, Eshoo, Luther, Sawyer, Green, and McCarthy.

Also present:Representatives Ganske, and DeLauro.

Staff present: Hugh Halpern, parliamentarian; Robert Gordon, majority counsel; Robert Simison, legislative clerk; and Bruce Gwinn, minority professional staff.

Mr. TAUZIN. The subcommittee will please come to order. I am pleased to continue this subcommittee's tradition of bipartisan hearings on consumer protections. We will be examining four consumer safety initiatives at this hearing: children's safety restraints in automobiles, the regulation of electric bicycles, flammability standards for children's sleepwear, and regulation of fixed-site amusement parks.

Testifying on H.R. 4145, the Child Passenger Protection Act, by Representative Shimkus, will be Rosalyn Millman deputy administrator of the National Highway Traffic Safety Administration on the first panel. And Mrs. Judith Stone, president of the Advocates for Highway and Auto Safety; and Mr. Tom Baloga, president of Britax Child Safety on the second panel. They will discuss the need for improvements in the Nation's standards for child safety restraints. Clearly, we must protect children from injuries. But we must do so in a way that does not compromise NHTSA's other important safety missions.

While I think there is general agreement on the ultimate objective, I look forward to hearing the different ways in which our witnesses propose to improve the safety of our children.

We will also be reviewing a bill introduced by Representative Rogan. H.R. 2592 will transfer oversight of electric bicycles from the National Highway Traffic Safety Administration to the Consumer Produce Safety Commission. Low-speed electric-powered bicycles are currently regulated by NHTSA as motor vehicles because they have motors that can operate independently of pedaling.

Motor vehicles are required to have a number of safety features that are proactively costly or wieldy or consume too much power for the use on a low-speed bicycle.

H.R. 2592 would reclassify low-speed electric bikes as consumer products instead of motor vehicles, making them subject to the oversight by the Consumer Products Safety Commission. And since they are used a bicycles, they should be regulated as such with the appropriate safety standards and comparable oversight.

On the second witness panel, Dr. Malcolm Currie, president and CEO of Currie Technologies, will tell us how this bill would not only help reduce air pollution and improve fitness by encouraging bicycle use but also help the development of the electric bike industry provide better and safer transportation for consumers.

Testifying on flammability standards for children's sleepwear, Dr. David Herndon, chief of staff and director of research for Shriners Burns Hospital; and Dr. Phillip Wakelyn, the senior scientist at the National Cotton Council, will provide us with their views on their decision by the commission to grant exemptions for tight-fitting and infant sleepwear under the Flammability Fabrics Act.

The commission has examined this act several times and determined that there was no unreasonable risk of injury associated with single-point small open-flamed ignition of tight-fitting cotton sleepwear. Today's witnesses will help us determine if the commission made this determination using the appropriate data and data analysis.

I would like to extend particular thanks on this issue to Consumer Products Safety Commission Commissioner Moore, who will be testifying on the first panel, for providing this subcommittee with information and background on this commission. All three commissioners will hopefully be able to enlighten us as to whether we are doing what we can to keep our children safe and protected in the way that parents can and should support.

Today's hearing will also examine ideas for making our amusement parks safer for consumers. In 1981, Congress amended the Consumer Product Safety Act to transfer jurisdiction over fixed-site amusement parks from the CPSC to the States. Representative Markey has introduced legislation, H.R. 3032, to return jurisdiction to the CPSC, appropriating 500,000 annually for this task.

On our first panel, Cosumer Products Safety Commission Chairman Ann Brown and Commissioners Mary Gall and Thomas Moore, can hopefully help us understand what sort of resources the commission could be able to commit to this task and what thoughts of value the commission could add to make our parks safer.

On the second panel we are privileged to have before us Kathy Fackler, a cofounder of the computer software design firm; recipient of A Point of Light Award by President Bush for her work in child abuse prevention programs; more recently a full time mother of two sons, one of whom was tragically injured on a roller coaster ride in California. Kathy will talk to us about her son's injury and her resulting efforts as a local and national amusement ride safety activist.

Mr. John Graff, president and CEO of the International Association of Amusement Parks and Attractions, will describe for us the

safety standards and procedures already in place at fixed-site amusement parks and his views on whether additional Federal regulation would complement or interfere with current State oversight.

As you can see, all four issues are terribly important consumer protection provisions and laws. We are pleased to have before us today such a distinguished panel of witnesses to help us understand and lay a foundation for potential reforms.

Now the chairman of our full committee has asked that I go to the floor and handle the Internet bill that is on the floor, I think under suspension, so I will have to leave in just a few minutes, but we will take opening statements and then begin. We will also have a visit and a presentation of views from a colleague, Mr. Rosa DeLauro, who has a great interest in the flammable children's sleepwear issue. Then we will hear from our distinguished other panel.

So the Chair is now pleased in the absence of my friend, Mr. Markey, who is on his way, to welcome the chairman of the full committee, Mr. Bliley, for an opening statement.

Chairman BLILEY. Thank you, Mr. Chairman. The rules of the House of Representatives grant this committee jurisdiction over all consumer affairs and consumer protection. Today's hearing focuses on a number of consumer protection safety initiatives to protect America. The first two issues will be H.R. 4145, the Child Passenger Protection Act, and H.R. 2592, a bill to facilitate the development of electric bicycles. I want to congratulate Representatives John Shimkus and Jim Rogan for their fine work on these bills.

H.R. 4145 would direct the National Highway Traffic Safety Administration to undertake new efforts to make riding safer for children. Generally, I support efforts to protect kids; but I recall the tragic consequences of overzealous air bag legislation. That being said, Mr. Shimkus' bill is an excellent starting point for directing NHTSA's efforts at keeping kids safe.

Representative Rogan's bill, H.R. 2592, is an equally important consumer protection initiative. Low-speed electric-powered bicycles are currently regulated by the National Highway Traffic Safety Administration as vehicles instead of as bicycles. I pretty much think a bike is a bike and not a motorcycle. This is a proenvironment, proconsumer bill that simply reclassifies these electric bicycles in the appropriate agency according to their intended use.

I hope that outside interest groups and the Consumer Products Safety Commission will avoid the temptation to use this bipartisan bill as a vehicle for other agendas. In particular, it worries me when I hear that the commission doesn't want to follow existing laws in regulating consumer products, asking for waivers from the Consumer Products Safety Act, the Federal Hazardous Substance Act, the National Environmental Policy Act, and the Small Business Regulatory Enforcement Act.

The General Accounting Office has already admonished the commission for failing to use adequate data collection and analysis in certain areas. Exempting the commission from congressional and executive mandates for fact-finding and data analysis would only exacerbate this problem. The commission has made several notable improvements over the last few years in their procedures, and I be-

lieve that they would do a fine job overseeing electric bikes without additional waivers or exemptions.

Today's hearing will also examine the spate of recent deaths and injuries at fixed-site amusement parks. Representative Markey has introduced legislation, H.R. 3032, to return jurisdiction over fixed-site amusement parks to the commission, appropriating $500,000 annually for this task. This hearing will hopefully shed some light on the current safety standards for amusement parks, whether regulation of fixed sites is better left to the States or the commission, and whether the commission has the resources to undertake this task.

The last issue that will be examined by this hearing is the decision by the commission to grant exemptions for infant sleepwear. Today's witnesses will help us determine if the commission made this determination using the appropriate data and data analysis to protect our children. I thank the witnesses for joining us today and look forward to building a better foundation of understanding on these important consumer protection issues. Thank you.

Mr. ROGAN [presiding]. I thank the chairman of the full committee for his comments. The Chair is pleased to recognize our friend and colleague, Dr. Ganske, for an opening statement.

Mr. GANSKE. Thank you, Mr. Chairman. And thank you for holding this hearing. There will be many important issues that will be talked about, but I particularly want to thank our colleague, Rosa DeLauro, for being here today and for talking about a very important issue for children's safety as it relates to the flammability of children's sleepwear.

A couple years ago, the Consumer Product Safety Commission changed the standards and weakened the standards of flammability of children's sleepwear. We are going to hear testimony today from representatives of the Shriners hospitals about how there has been an increase in children's burns related to easier flammability of children's sleepwear.

As a reconstructive surgeon, I have worked on many children in the past who have been badly burned. In fact, I have worked at the Shriners Hospital in Boston. This is, Mr. Chairman, this is an issue that we ought to move in committee and actually get on to the floor. I believe the changes by the Consumer Product Safety Commission were ill-advised and we should go back to the standards as they were a few years ago. And I am happy to announce today that I also am going to be a cosponsor for Ms. DeLauro's bill. With that, I will yield back.

Mr. ROGAN. The Chair will recognize the gentleman from Illinois for an opening statement.

Mr. SHIMKUS. Thank you, Mr. Chairman. I think it is a good day for our children as we address some very important issues. This year, I join my colleague, Senator Peter Fitzgerald on the Senate side, to address the infant child safety seat standards which we are going to hear, get a chance to ask questions about. NHTSA, who has a good record of trying to protect the public, needs to update its standards. At present, they use a 1973 bench seat of a Chevrolet Impala. They don't use side impacts, roll-overs, rear impacts. And I appreciate the fact that National Highway Traffic Safety Ad-

ministration has come to talk to me, and we are going to work on issues.

I think that hopefully the hearing will help hash out too a way that we can make sure that the safety standards that we want for all our children, that the National Highway Traffic and Safety Administration is being a good steward of our public funds in making sure that these are really good standards; that we are testing them in a manner that we want our children protected.

So I appreciate the hearing today, and I look forward to moving this process forward. I also join my colleagues, Congressman DeLauro and Congressman Ganske—I am very supportive of what she is trying to do and get involved in addressing some matters on this sleepwear issue.

I have my son here with me in the office. I was going to bring him over as Exhibit A—but he is sleeping and not in sleepwear because he is in his little onesie outfit—to carry around. But he will probably migrate over here later on, and hopefully I will have my process of testimony and questions done before he disrupts the rest of the hearing.

As many of you know, the spouses are in town for the first lady's luncheon, so a lot of us get to be working dads today as we cart our children around with us. And I am looking forward to that. I appreciate the hearing. I look forward to the panel testimony. I yield back my time. Thank you, Mr. Chairman.

Mr. ROGAN. The Chair thanks the gentleman from Illinois. The Chair will recognize himself for a brief opening statement. First, I want to thank Chairman Tauzin for calling this hearing on these key issues of consumer product safety. As the author of one of the bills that will be discussed here today, H.R. 2592, I especially want to thank him for his support in the effort to promote the use of electric bicycles as an alternative form of transportation and recreation.

This particular bill would amend the Consumer Product Safety Act to provide that low-speed electric-bicycles are consumer products and are not subject to the same regulations as mopeds and motorcycles. As I think most of our colleagues know, a legislative remedy to the current classification problem associated with electric bikes is necessary because the National Highway Traffic Safety Administration currently interprets the statutory definition of motor vehicles as applying to bicycles with low-powered motors that can operate independently of pedaling. As a result, electric bicycles are subjected to motor vehicle requirements.

NHTSA has never indicated whether it believes that this position represents a valid policy. Rather it has claimed that such standards must be enforced as a requirement under the current law.

Unfortunately, subjecting electric bicycles to motor vehicle requirements would mean the addition of a large array of costly and unnecessary equipment on the electric bike: brake lights, turn signals, automotive-grade headlights, rear view mirrors and more. These additions would restrict operating requirements which consumers do not want. These additions would also raise the cost of an electric bicycle by hundreds of dollars and in many cases doubling the cost of the bike. Predictably, such regulations also would kill the growing U.S. market fpr electric bikes and put the U.S.

Firms who manufacture these bikes at a competitive disadvantage vis-a-vis foreign companies.

H.R. 2592 is a straightforward clarification of existing law that will help consumers and manufacturers alike. It will promote better health, especially among seniors, by convincing more people to ride bicycles and forego automobiles when traveling over short distances. As a result, it should help in the fight against air pollution. And finally, the bill would benefit American manufacturers of electric bicycles to helping make these bikes more palatable to consumers.

In short, it is good legislation that deserves to move quickly through the committee process to the House floor and on to the Senate. And once again, I want to thank Chairman Tauzin, the chairman of the subcommittee, for his leadership.

I am now pleased to welcome and recognize for an opening statement the distinguished gentleman from Massachusetts, the ranking member of the subcommittee.

Mr. MARKEY. Thank you, Mr. Chairman, very much. And thank you for convening this hearing and thank you to Mr. Tauzin, who I know is on the floor at this very moment. I am looking very much forward to the statements of each of our witnesses on a series of consumer issues related to NHTSA and to the Consumer Product Safety Commission.

I am especially appreciative that the subcommittee has been given the chance to consider the need for action to improve safety at amusement park rides as the 2000 summer season begins. It is time to close the roller coaster loophole. H.R. 3032, the National Amusement Park Ride Safety Act has been cosponsored by 25 Members of Congress from both parties. In addition, it has been endorsed by three of the Nation's leading consumer safety organizations: the Consumers Union, the Consumer Federation of America, and the U.S. Public Interest Research Group, as well as the National Safe Kids Campaign. I would ask that their letters of endorsement be made a part of the hearing record at this time, Mr. Chairman.

Mr. ROGAN. Without objection.

[The letters follow:]

PREPARED STATEMENT OF MARY ELLEN R. FISE, GENERAL COUNSEL, CONSUMER FEDERATION OF AMERICA

Consumer Federation of America is pleased to offer its strong support for H.R. 3032, the National Amusement Park Ride Safety Act. This legislation closes a gaping loophole in CPSC law, which currently prohibits the safety agency from regulating rides in fixed site amusement parks while allowing authority over mobile rides. The distinction does not make sense and consumers pay the price in terms of lives lost and injuries incurred.

Fourteen states and DC have no program whatsoever to inspect rides in fixed site amusement parks. In other states, inspections vary. Regardless of any state authority, there is no comprehensive mechanism for the **collection of data** about unsafe rides. Furthermore, no compliance authority exists for **inspection** of hazardous equipment or for the **recall** of unsafe or defective ride machinery. The federal government can not **set safety standards** for these rides or invoke its **imminent hazard authority** to seize amusement ride products which pose imminent and unreasonable risks of death or severe personal injury. Manufacturers, distributors and others have no **obligation to report** to CPSC when they learn of an amusement ride that could injure or even kill its patrons. Because of these gross deficiencies in consumer protection, it is clear that for consumers visiting fixed site amusement parks the watchwords are: "**Rider Beware!**"

More than 28 deaths have occurred on rides at fixed site amusement parks in the last 13 years and there is an increasing trend in the number of injuries over the last several years. The National Amusement Park Ride Safety Act will help reduce these preventable deaths and injuries. CFA commends Representative Markey for his leadership on this issue and strongly urges Congress to initiate work toward passage of this important safety legislation.

CONSUMERS UNION
March 8, 2000

Congressman EDWARD MARKEY
House Subcommittee on Telecommunications, Trade and Consumer Protection
2108 Rayburn Building
Washington, DC 20515-2900

DEAR CONGRESSMAN MARKEY: Consumers Union is pleased to support H.R. 3032, the National Amusement Park Ride Safety Act. This bill would restore to the Consumer Product Safety Commission (CPSC) the jurisdiction to investigate accidents or exercising other jurisdiction over fixed-site amusement park rides, jurisdiction removed from the agency in a 1981.

Consumers Union believes that the current situation, whereby the CPSC may investigate amusement park rides that move from site to site, but not those at a fixed site, has led to nonsensical and potentially dangerous results. If the CPSC discovers that one manufacturer's ride at a mobile site has a safety problem that needs to be addressed, the CPSC can require the problem be addressed. If, however, the ride is at a fixed site, current law prevents the CPSC from addressing an obvious safety problem.

We agree with your statement that overall the record of amusement parks is generally good. However, the CPSC's statistical analysis comparing serious injuries on fixed and,mobile, sites provides compelling evidence on the need for this legislation. The statistical estimates show that as of the CPSC's July 1999 summary, emergency room injuries for fixed rides increased from 2400 in 1994 to 4500 in 1998. This compares with the lower and more steady increase for mobile rides, with 2000 injuries in 1994 and 2100 in 1998.

This legislation also addresses the problem that 13 states have no inspection program at all for amusement park rides. Others exempt certain parks or certain geographical areas. The tragic deaths on amusement park rides of four people in one week of August, for a total of 6 deaths last year, tells us that safety is still a problem. The CPSC should have the jurisdiction to inspect the variety of amusement park rides across the country, develop action plans to correct defects, require reports whenever a substantial hazard is identified, and regardless of whether they are fixed or mobile sites, and use it's collective knowledge to address safety problems comprehensively.

Consumers Union applauds you for introducing this bill. We look forward to working with you to see H.R. 3032, the National Amusement Park Ride Safety Act enacted into law.

Sincerely,

SALLY GREENBERG
Senior Product Safety Counsel

U.S. PUBLIC INTEREST RESEARCH GROUP
February 29, 2000

The Honorable EDWARD MARKEY
2108 Rayburn Building
House of Representatives
Washington, DC 20515-2107

DEAR REPRESENTATIVE MARKEY: We are writing on behalf of the members of the United States Public Interest Research Group to officially endorse the National Amusement Park Safety Act, H.R. 3032. We applaud your leadership in preventing future amusement park deaths and injuries.

We believe that the Consumer Product Safety Act, which charges the Consumer Product Safety Commission ("CPSC") with the responsibility of protecting the public against unreasonable risks of injuries and deaths associated with consumer products, must give the CPSC reculatory authority over fixed location amusement parks. Federal oversight is crucial to the prevention of any future deaths and injuries asso-

ciated with fixed site amusement parks due to the vast variation in state laws and the absence of any regulation in some states.

The CPSC has illustrated its ability to identify and prevent injuries from many consumer products including mobile amusement park rides. The National Amusement Park Ride Safety Act will grant the CPSC the same scope of authority to protect against unreasonable risks of harm on fixed-site rides that it currently retains for carnival rides that are moved from site to site.

U.S. PIRG applauds your efforts to protect consumers from the serious dangers posed by amusement park rides. We look forward to working with you on this important safety issue.

Sincerely,

RACHEL WEINTRAUB
Staff Attorney

NATIONAL SAFE KIDS CAMPAIGN
May 15, 2000

The Honorable EDWARD MARKEY
United States House of Representatives
Washington, DC 20515

DEAR REPRESENTATIVE MARKEY: On behalf of the National SAFE KIDS Campaign and our Chairman, former Surgeon General C. Everett Koop, M.D., I would like to express our appreciation for your sponsorship of H.R. 3032, the National Amusement Park Ride Safety Act.

With six fatalities at amusement park rides in 1999—the most in any single year in more than a decade—and an estimated 9200 people treated for ride-related injuries in hospital emergency rooms in 1998, the time has come for Congress to close the "roller coaster loophole" and enable the U.S. Consumer Product Safety Commission (CPSC) to have authority over fixed-site amusement parks. Current law allows the CPSC to have jurisdiction over carnival rides moved from site to site, but not rides located on permanent grounds. As states have a variety of amusement park safety laws on the books—including 11 states with no inspection laws whatsoever—the CPSC must be granted jurisdiction of fixed-site amusement park rides in order for *all* states to benefit from federal investigation of safety hazards.

The National Amusement Park Ride Safety Act, if passed, will help to ensure the health and safety of our nation's most precious resource—it's children. If the National SAFE KIDS Campaign can be of any assistance to you, please do not hesitate to contact me or Tanya Chin Ross, Public Policy Associate, at 202/662-0600. Thank you for your leadership on this important safety initiative.

Sincerely,

HEATHER PAUL, PH.D.
Executive Director

Mr. MARKEY. The amusement ride safety act does not single out this industry, quite the contrary. Our purpose is to ensure that this industry is treated no differently than any other industry when it comes to basic consumer safety oversight of activity that places small children on large machines designed to move them at high speeds.

When a child dies in a plane crash or a train wreck or a school bus, crack Federal investigators from the National Highway Traffic Safety Board fly to the scene, reconstruct the accident, interview all the players, write a report, share that report with the industry, and the public and the State authorities and often order safety checks or repairs on similar vehicles.

But when 8-year-old Jessica Bailey and her mother were catapulted to their deaths in New Jersey on the side of a roller coaster car falling backwards or when a 17-year-old from Coney Island is crushed by the car in which he is riding, dying from massive internal injuries, what happens? The CPSC checks to see if the ride is a so-called "mobile ride." Or if it is, like most roller coasters, a fixed-site ride. And if it turns out that your son or daughter was

unlucky enough to get injured or to die on a fixed-site ride, guess what? No NTSB, no Consumer Product Safety Commission, no nothing happens here in Washington or around the country.

As a result, the accident is never investigated by anyone whose mission it is to share what is learned with all 50 States. And no one has the power to ensure that a repair that is ordered in New Jersey, or New York, is also ordered on the same rides in Florida, or Texas or California or any of the other 49 States in the Union. That is wrong. That is not smart. But it is the law. The industry tries to make sense of this by suggesting that it is not like all those other activities, that is, that when it comes to safety, it is in another league than autos or planes or trains. But the fact is the fatality rate per distance traveled on a roller coaster is only slightly better than the rate in a car and worse than the rate in a plane or a train or a bus.

So roller coasters are not in a league of their own. They are in the same league as other activities where the Federal safety role is unquestioned. This amusement park industry surely does not merit immunity from Federal oversight, not when an accident in one State could be replicated very easily in any one of the other 49 States, but the Federal Government cannot investigate or share that information with the other 49 States.

We seek to restore common sense Federal safety oversight to this industry so that serious accidents are thoroughly investigated by the CPSC and every effort is made to prevent foreseeable tragedies from repetitioning themselves across all 50 States.

Regarding the other issues which we will consider this morning, I want to reiterate my concern about sport utility vehicles and rollovers. Sport utility vehicles are twice as likely to be involved in a deadly roll-over as the average car on the roadway. I want to again urge NHTSA to move quickly to develop a dynamic test for vehicle stability so that consumers are provided the best possible information available on roll-overs.

I also want to note that I will be introducing legislation later this week to enhance the Consumer Product Safety Commission's enforcement powers. This legislation will enhance the Consumer Product Safety Commission's ability to order companies to effectively remedy defective products and recall such products from the marketplace. A disturbing pattern has developed where companies are concealing their knowledge of potentially lethal product flaws from consumers and regulators only to be revealed after a tragedy. Eliminating the cap on civil penalties for knowing violations of consumer product safety laws and increasing the penalties for criminal violations would help to correct this trend.

And finally, I want to encourage the Consumer Product Safety Commission to look, again, at issues relating to crib safety as well as child sleepwear safety regulations. The testimony today from the Shriners hospitals, which treat one-fifth of all major pediatric burn injuries in the United States, said they have witnessed a 150 percent increase in sleepwear-related burns since the commission adjusted its rules, I believe, warrants a reexamination of what can be done to help prevent infant burn injuries. I thank you, Mr. Chairman, and I look forward to the testimony from all of our witnesses.

Mr. ROGAN. Thank the ranking member. The Chair is now pleased to recognize our friend and colleague, the gentleman from Florida, Mr. Stearns, for an opening statement.

Mr. STEARNS. Thank you, Mr. Chairman, for holding this hearing today to examine consumer safety initiatives. And also I appreciate the witnesses taking their time to come here and testify. The issue before this subcommittee centers around safety and the role of government. H.R. 4145, the Child Passenger Protection Act, introduced by my good friend, Mr. Shimkus from Illinois, updates Federal test standards for child restraints to reduce the number of children killed or injured in automobile accidents in the United States. While I commend the National Highway Traffic Safety Administration in its efforts to improve child restraints, I also believe, Mr. Chairman, in support to determine whether the current initiatives, the current initiatives are adequate or need further modernization.

Furthermore, while it is essential to have the highest standard when evaluating child restraints, it is just as vital to utilize public information and educational efforts to teach parents about the proper use of safety seats. So I look forward to learning more about the initiatives in the NHTSA on child safety seats. Additionally, we also examine flammability standards for children's sleepwear. While the issue of children's sleepwear standards has been before the Consumer Product Safety Commission on previous occasions, some advocate that such standards are not adequate in protecting children from burn accidents and that the labeling standards for garments need updating.

I hope to learn more about the role of the CPSC in reducing injuries and what it is doing concerning garment safety standards.

On another note, the legislation offered by my friend from California, Mr. Rogan, is a common sense bill. His legislation H.R. 2592 offers relief from the regulatory morass of the Federal Government. This bill removes NHTSA's authority to regulate low-speed electric bicycles by transferring regulation to the CPSC and provides for a uniform national definition of electric bicycles.

Regrettably, while I support bestowing the CPSC jurisdiction over electric bicycles, I am opposed to legislation giving the commission authority to regulate fixed amusement parks. As rider accident statistics indicate, fixed amusement parks are a safe form of entertainment and H.R. 4042, the National Amusement Park Ride Safety Act, amounts to a solution in search of a problem. There are more people injured while bowling as compared to attendance at fixed amusement parks. Would we advocate giving the Consumer Product Safety Commission authority to regulate bowling balls? While no one here advocates allowing unsafe conditions to persist, I question whether another level of bureaucracy and Federal regulation is absolutely necessary.

Additionally, I question the commission's regulatory expertise in maintaining oversight safety of fixed amusement parks. In fact, State regulations in oversight coupled with industry's self-regulation has insured that these amusement parks are one of the safest forms of entertainment today. Furthermore, when compared to States, the commission by far lacks the necessary resources to come even close to inspecting all these amusement parks. Quite simply,

safety and consumer protection over fixed amusement parks is a task best left to the States and to the industry itself. Thank you, Mr. Chairman.

Mr. ROGAN. The Chair is now pleased to recognize our friend and colleague from Texas, Mr. Green, for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman. I appreciate the subcommittee's attention to today's legislative initiative to design and protect and enhance the lives of our constituents. I am long a supporter of the Consumer Product Safety Commission. I would like to commend Chairman Brown for her continuing efforts to protect my constituents. Her leadership and vigilance has saved the lives of many Americans. I am also pleased that NHTSA, the National Highway Transportation Safety Administration, is here today to provide members with an update on their efforts to provide safer child seats. I have two grown children, but when they were younger my wife and I really did not know what made one seat better that another. Is, for example, is a $60 seat safer than a $200 seat?

I would also like to commend Mr. Markey on his legislation we are considering today. Just as NHTSA expands significant resources to ensure our children's safety in motor vehicles, we need to also make sure our children are safe when they are in amusement parks. And again I understand the concern about the fixed facilities because I have Astro World that is close to my district that is fixed site that offers some of the best roller coasters in south Texas; but we also want to make sure they are safe. And I know the State of Texas does inspect them on a regular basis.

With that, Mr. Chairman, I will submit the remainder of my statement and yield back my time.

Mr. ROGAN. Thank you. If there is no objection from the committee members, the Chair will be pleased to accept written statements from any members of the committee. Without objection so ordered. The Chair thanks our friend from Texas for his statement. The Chair is pleased to recognize our friend and colleague from Maryland, Mr. Ehrlich, for an opening statement.

Mr. EHRLICH. In view of the children's hint, I will submit my statement. I just want to make one quick comment with regard to the CPSC. We have been working with representatives over the last year—many of you know we had our first baby—and shortly before our son was born, the commission contacted my office and offered to host a baby safety shower in our district. We did it and it was very, very successful.

Moreover, now that we have a 9-month-old running around, the commission contacted us again with regard to a child safe home inspection program. We are going to be doing that in a few weeks. This is the way we can publicize how to make your home safer for infants and toddlers, and I am looking forward to that. We will probably be put to the test. I am looking forward to that test, but this is a way we can help really move public opinion and constituents with respect to something that impacts our lives in a very important way. I yield back.

Mr. ROGAN. The Chair thanks the gentlemen. Chair is pleased to recognize our good friend and colleague from Minnesota, Mr. Luther.

Mr. LUTHER. Thank you, Mr. Chairman. And I will be brief as well. I just want to say first of all that I appreciate the subcommittee focusing on the consumer protection part of our jurisdiction. I think it is very appropriate to have this hearing, and I look forward to further hearings. I also want to just say on really a personal note that I am very thankful for the work of CPSC for developing the voluntary guidelines for bleacher safety after a young boy in Minnesota died when falling from a bleacher in our State. In general, I believe that the CPSC and its current Chairwoman Brown are doing a very excellent job responding to the needs, the public safety needs, of our country. I look forward to Mr. Markey's bill in that I believe that it will capitalize and expand on the commission's proven competence in the area of product safety. Again, thank you, Mr. Chairman, for the time and I yield back.

Mr. ROGAN. Chair thanks the gentleman. The Chair is pleased to recognize our friend and colleague from Wyoming, Mrs. Cubin, for an opening statement.

Mrs. CUBIN. Thank you, Mr. Chairman; and thank you for scheduling this very timely hearing. As a mother of two sons and hopefully someday a grandmother, if they would just get a girlfriend, get married and have babies, I think—I know we have a ways to go, but we are working on it. I am.

Anyway, as a mother I really think that one of the main thoughts that occupy a mother's mind is the safety and health of her children. So I am very delighted we are addressing these issues today. And of course the first one that we will be addressing is that of protecting children by updating and improving the standards for motor vehicle safety seats. I think Mr. Shimkus' legislation is necessary to give the National Highway Traffic Safety Administration a push in making the purchase and installation of proper child safety seats easier and more consumer friendly.

The next piece of legislation we will consider today also purports to protect children in the context of the safety of their sleepwear. It is encumbent on this Congress to ensure that the Consumer Protection Safety Commission is exercising due diligence when it comes to the safety of our children's sleepwear. If a stricter standard is necessary to protect infant children from serious burn injuries and possibly death, then such a standard should be adopted without hesitation. I am confident this this panel will learn a great deal from today's witnesses, and I do look forward to hearing from them.

Last, I want to address the issue of transferring jurisdiction over the fixed-site amusement parks from the States back to the Consumer Protection Safety Commission. I am not entirely sure why this legislation is necessary since currently 41 States already have regulatory requirements in place. Of the nine remaining States, most of them are in the process of enacting legislation or have few or no amusement park facilities.

The amusement park industry currently adheres to very strict safety standards, and statistics prove that more people are injured doing leisurely activities than are hurt on theme park rides. In fact, Wyoming does not have any amusement parks. However, during the summer months, you cannot swing a golf club without hitting a carnival in just about any direction in any small town in the

State. The Consumer Protection Safety Commission regulates carnivals and has proven that their jurisdiction is not necessarily a prescription for safety because that is where the injuries have mostly occurred.

In the April 2000 issue of U.S.A. Today, an article on park safety demonstrates that the two most tragic cases were in carnivals over which the CPSC has had authority for a number of years. So, Mr. Chairman, I do look forward to all the information that we will get, and hopefully we will move forward in a wise way.

Mr. ROGAN. I thank the gentlewoman. The Chair is pleased to recognize our friend and colleague from Ohio, Mr. Sawyer, for an opening statement.

Mr. SAWYER. Thank you, Mr. Chairman. I will forego the opening statement. Just let me make a couple of observations. In Ohio, the Department of Agriculture has overseen amusement park safety standards for a very long period of time. I remember when that legislation was revisited some 20 years ago in the Ohio general assembly. It was occasioned by an incident in which a father and his daughters were riding in a ferris wheel and the safety bar popped open, caught on the framework of the ferris wheel, and systematically just dumped them out as people looked on in horror.

The work that has been done since that time to improve not only the standards of equipment but the frequency of inspection and the skill of those who come to that task I think has been laudable. My hope would be that while there may be room for a national framework in this sort of undertaking, that we provide a vehicle for the States to act in lieu of a Federal inspection, set to Federal standards perhaps; but so that those people who are closest to the rides, those people who are there and in place will have the opportunity to do their job. And if they do it to that standard that that will suffice instead of putting together a large and duplicative national operation to do the same thing.

With regard to child restraints and safety seats in automobiles, I just hope that we will pay close attention when Deputy Administrator Millman testifies this morning that we should be careful that the legislation not specify the timing or outcome of actions. This is an enormously complex arena and the dynamics of automobile crashes and the consequences on human beings are complicated almost beyond our capacity to replicate in any way except in actual testing. So I would hope that we would not prejudge what the outcome of that testing should be but rather continue to encourage NHTSA to engage in a thorough and comprehensive system of measurement of outcomes. With that, Mr. Chairman, I yield back the balance of my time.

Mr. ROGAN. The Chair thanks the gentleman. The Chair is pleased to recognize for an opening statement our friend and colleague from Mr. Ohio, Mr. Gillmor.

Mr. GILLMOR. I don't have any.

Mr. ROGAN. The Chair is even more pleased. Does the gentlewoman from California wish to make an opening statement?

Ms. ESHOO. I thought you said "gentleman." That is why I wasn't responding. Thank you, Mr. Chairman, and good morning to all of the members of the committee. As the title of this hearing suggests, it is this committee's intention to protect the vulnerable; and

I salute the chairman for his leadership in this area. I am looking forward to hearing the testimony regarding legislation involving the safety of electric bicycles and amusement park rights; and I am especially interested to learn how better data can be obtained regarding the types of injuries which occur at these large businesses.

I think the CPSC should expand the National Electronic Injury Surveillance System to include all injuries treated in emergency departments. I think that that would be a very important start. Collecting data involving injury causation at amusement parks is one place where they can begin right now. I am chiefly concerned with the legislation H.R. 4145, the Child Passenger Protection Act. This legislation, while well intentioned and possessing some potentially positive components, nevertheless, I believe, seeks to micromanage the National Highway Traffic Administration.

The recent NHTSA administrator, Dr. Ricardo Martinez, is a renowned emergency physician at Stanford University Hospital, which is in my district. Over the last 6 years, Dr. Martinez and NHTSA advanced the use and the improvement of child passenger safety seats to an unprecedented level. NHTSA conducted testing, created standards, and oversaw education campaigns that were run by safety groups and funded by automobile manufacturers. NHTSA also helped to reach hundreds of firefighters, police officers, emergency nurses and doctors on how to instruct parents to correctly install these seats. And the agency succeeded in getting the President personally involved in the rulemaking that improved the installation of child safety seats.

Every Federal agency can improve its performance. I am anxious to learn how NHTSA sees how they, too, can improve in this arena. But this legislation as it is currently drafted, in my view, does not further NHTSA's success. It institutes unreasonable deadlines, it interferes with ongoing research and crash testing, and it fails to adequately fund the demands it makes of the agency. I am also concerned that the bill's findings do not recognize the recent accomplishments of NHTSA.

NHTSA's success in this area is commendable not just in certain aspects. Its leadership, including its supportive groups that advocate and create safety standards, I think has been outstanding. It is one of the true successes of this administration.

Mr. Chairman, as we look for ways to improve upon these successes, I hope we can find ways to provide the funding and the guidance that will help NHTSA in its mission to improve the safety of children. I look forward to working with the sponsors of the legislation to accomplish this goal. And I yield back.

Mr. ROGAN. I thank my colleague from California. Are there any other opening statements from members of the subcommittee? Hearing none, the subcommittee before we go to the first panel of witnesses is pleased to welcome our friend and colleague from Connecticut, Ms. DeLauro, for a brief statement.

Ms. DELAURO. Thank you very, very much, Mr. Chairman. I want to say thank you to Chairman Tauzin and to Ranking Member Markey for allowing me to come here this morning and to testify on an issue that is very near and dear to my heart and that is children's sleepwear. I also want to say thank you to the committee members. I applaud the work of this committee and what

it does with regard to consumer safety. You really make a difference in the lives of our families. And you are to be congratulated. Twenty-five years ago, the Consumer Product Safety Commission established fire standards for children's pajamas. If the sleepwear caught fire from a small flame, it had to self-extinguish. The reason for the standards is that cotton fibers catch fire easily and they burn quickly. The flames are large, and they move quickly up the body to the face. Children injured in sleepwear burns are hurt horribly. I didn't know this until the burn units at Bridgeport Hospital and Yale-New Haven Hospital, St. Raphael's Hospital, and the fire fighting community in my district invited me to come and to watch a demonstration and to get involved in this issue.

Before the standards, an average of 60 children died every year from burning pajamas. After the standard was adopted, the average dropped to fewer than four per year. The standard worked. It made sense. It kept our children safe. Then something happened which doesn't make sense to me. Four years ago, the Consumer Product Safety Commission changed the flammability standard—the CPSC approved new standards that exempted all sleepwear for infants 9 months or younger from proven fire safety standards. They also exempted tight fitting sleepwear in children's sizes up to 14 from the standards.

I don't understand why the CPSC would move to this weaker standard. The older, stronger standards have proven effective in the past and according to the National Fire Protection Agency estimates, there would have been 10 times as many deaths and substantially more injuries in the past 25 years if these weaker standards had been in place. If you think of the number of children now grown up starting families who may have had their lives cut short or been seriously burned or injured if it not been the tougher sleepwear standards, the number of tragedies that have been prevented, or the number of times firefighters didn't have to answer a call because the stronger standards prevented a terrible tragedy.

I have high regard for the Consumer Product Safety Commission. As so many people have indicated here this morning, on so many issues, standards in baby strollers, toys, as well as hundreds of other products that we have in our homes. And I applaud the baby shower efforts and the making the homes safe in terms of making sure that our kids are safe. The CPSC has done a remarkable job over the years. They keep the public informed, and they help to keep unsafe products off the market. But on the children's sleepwear issue, I believe that they have made a mistake.

You are going to hear from people who object to the legislation that if parents just buy sleepwear that is tight fitting it is more difficult for the flames to spread. That may be true and that may sound reasonable, but I don't know parents who go out and buy tight fitting sleepwear or other kinds of clothing for their children. You normally buy a size bigger; and if you are going to a baby shower, you buy a gift that is a size bigger so that the youngster can grow into it. That is just part of what our culture is all about.

That is why we need the tougher standards, the combination of nonflame resistance and large sizes can be lethal. But with a tougher standard, families can be sure they are getting the safest product that they can get. We must make sure that the labeling

indicates that it is flame resistant or it is nonflame resistant, if that is the case.

I join my colleague, Congressman Rob Andrews of New Jersey, Congressman Curt Weldon of Pennsylvania, as well as the Safe Children's Sleep Coalition, in asking the CPSC for the old standards to be reinstated, probably the simplest legislation my colleagues will ever see in this institution. It is let's just go back to where we were. There is no other change. Several members of this subcommittee, Representatives Shimkus, Luther, Green, and Dr. Ganske, who said that he is supportive of this morning, have joined the effort. I appreciate their support.

This is a bipartisan coalition, that has tried to work with the CPSC. The Commission has indicated that it did not intend to revisit the standards until it saw proof that the number of burned children has increased due to the change. I don't believe they really mean that. I truly don't. We do not need to see and have to wait for children to be burned in this country for us to go back to a standard that was working perfectly well. There are two accounts from the GAO that found that the CPSC data is insufficient to determine whether the number of burns and death for children have risen since the relaxation of the standards in 1996. The CPSC says they don't have the data, so it won't go back to the stronger standard. But I hear from doctors who have seen burned children in their hospitals; they don't need to see the data, they need to see the victims.

I apologize to the chairman. I will conclude. This is not a partisan issue. I am proud to join in a bipartisan way with the cosponsors of this bill. The chairman of the Fire Caucus, Curt Weldon, is an original cosponsor. The Shriners, others have joined forces with the fire fighting community to say let us win an important victory for America's kids. Let's go back to the original standard.

I encourage and I thank the subcommittee for bringing up this issue. Let's make the improvements. We can do this, and we can really do something to help our youngsters. I apologize to the chairman for taking more time.

Mr. ROGAN. The Chair hates to interrupt your passion.

On behalf of the subcommittee, we thank our colleague for joining us this morning. We are now pleased to recognize and invite to the witness table the four witnesses who will make up our first panel of witnesses. First, Ms. Rosalyn G. Millman, deputy administrator of the National Highway Traffic Administration. Our second witness is the Honorable Ann Brown, Chair of the Consumer Product Safety Commission. Our third witness is the Honorable Mary Sheila Gall of the Consumer Product Safety Commission. Our fourth witness is the Honorable Thomas H. Moore, commissioner of the Consumer Product Safety Commission.

Ladies and gentleman, welcome. For your convenience you will notice on the front of the witness table little boxes. When the little amber light goes on, that is the 1-minute warning. If you could please summarize at that point.

Ms. Millman good morning you are recognized.

STATEMENTS OF ROSALYN G. MILLMAN, DEPUTY ADMINISTRATOR, NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION, U.S. DEPARTMENT OF TRANSPORTATION; HON. ANN BROWN, CHAIRMAN; HON. MARY SHEILA GALL, COMMISSIONER; AND HON. THOMAS H. MOORE, COMMISSIONER, CONSUMER PRODUCT SAFETY COMMISSION

Ms. MILLMAN. Thank you, Mr. Chairman. If I could before I start, I would like to introduce my guests that I have brought with me. On my right is a 3-year-old dummy in a child safety seat; and on the other side is our 6-year-old dummy. And that dummy is using a booster seat.

Mr. ROGAN. With their hair lines they look like relatives of mine. Your guests are welcome.

Ms. MILLMAN. I have here a 12-month-old dummy, and it is in a convertible seat which can be used for both infants and toddlers. Thank you for the opportunity to testify on H.R. 2592, an amendment to the Consumer Products Safety Act relating to electric bicycles and H.R. 4145, the Child Passenger Protection Act of 2000. I especially appreciate the opportunity this hearing affords NHTSA to brief you on the agency's comprehensive child passenger protection program. Nothing has a higher priority for us than the safety of children. I want to congratulate and thank Congressman Shimkus and the cosponsors of H.R. 4145 for raising awareness about the leading killer of children in America, motor vehicle crashes. NHTSA welcomes their support in making this country's roads as safe as possible.

For more than 30 years, NHTSA has been a leader in improving motor vehicle safety for all occupants, especially children. We currently have under way a comprehensive program that includes research, rulemaking, and public information and education. The attachment to my written statement describes major activities in our child passenger protection, and with your permission I would like to submit that for the record.

Mr. ROGAN. Without objection.

Ms. MILLMAN. Many initiatives that H.R. 4145 calls for are parts of our program and we look forward to making it even stronger. NHTSA will vigorously pursue these and other initiatives until every child is safe in every vehicle. Working with many public and private organizations, we have greatly improved safety for children. As you can see in the chart on my left, motor vehicle crashes killed 15 percent fewer children ages 4 and younger in 1998 compared to 1994.

The child safety seats now on the market are very effective when used properly. They are saving more than 300 children a year at the current levels of use. And even though these seats are often installed improperly, today's seats are 59 percent effective in preventing fatalities for children ages 4 and under. That statistic can means that 59 percent of the unrestrained children in this age group who died in motor vehicle crashes would be alive if they had been in a child safety seat, even one that was installed improperly.

Sadly, not enough children are riding in appropriate restraints. Of the 575 children ages 4 and under that motor vehicle crashes killed in 1998, half were totally unrestrained. Fewer than 10 percent of children ride unrestrained, up from 78 percent in 1994. Yet

they accounted for half of the fatally injured children in this age group. We must increase the use of child safety seats to 100 percent.

Right now NHTSA is putting the finishing touches on the May 22 kick off for Operation ABC, America Buckles Up Children, our nationwide mobilization with police and other law enforcement officials to educate parents and caregivers and to enforce State child safety seat and seat belt laws. Planning guides for this campaign are in the information packets that NHTSA provided to you. More than 7,100 law enforcement agencies throughout the Nation participated in last year's Thanksgiving operation ABC mobilization. I expect about that same number to join us between May 22 and May 29 this year for outreach, child seat check points, and enforcement waves.

While child safety seat performance can still improve, the most promising improvement is to make seats easier to install and adjust properly. A seat that parents and caregivers use and use properly is by far the best protection we can provide children. To increase proper use of child safety seats, NHTSA issued new requirements in February 1999, for a standardized attachment system, LATCH, Lower Anchors and Tethers for Children, for installing child safety seats in cars, minivans, and light trucks. On September 1, 2002, when the requirements will apply to all new vehicles and seats, properly installing a child restraint will be greatly simplified. NHTSA is currently working with manufacturers and retailers to educate the public about LATCH. This rule will save as many as 50 additional children and prevent 3,000 injuries every year.

In February 2000, NHTSA launched a new nationwide public information campaign, Don't Skip a Step, to educate parents that as their children grow, their restraint needs change. Before children are ready for adult seat belts, they should ride in a belt-positioning booster seat for maximum protection, as our new 6-year-old dummy in the booster seat is doing. That is the one on my left.

Because NHTSA will not rest until every child travels safely, today I am announcing development of a new plan to raise child occupant protection to the next level. This plan, which we will unveil by the end of this summer, will be the successor to the comprehensive plan we issued in 1991 and have been implementing since then. LATCH, the standardized attachment system, is one result of the 1991 plan.

This new strategy will describe priority research and data analysis, rulemaking initiatives, and expanded public information and education opportunities. Since the beginning of April, more than 30 NHTSA staff have been reviewing NHTSA's current and past activities, recommendations from our February public meeting and from the National Transportation Safety Board, and other information to identify the activities most likely to improve child occupant protection over the next 10 years. Today, I am further announcing new plans which include consideration of rulemaking to ensure that child seat test procedures are representative of actual usage conditions.

Also I can state that NHTSA is conducting research that may lead to side impact protection performance standards for child re-

straint systems. Among the outcomes of this plan, I expect to initiate rulemaking to replace the current 9-month-old, 3-year-old, and 6-year-old dummies with the more advanced ones that we included in our recent advanced air bag rule. In addition, NHTSA will evaluate an advanced 18-month-old dummy.

I assure you that NHTSA will follow through with its plans in a manner that will achieve the goals of H.R. 4145. Many NHTSA activities both present and planned correspond to the initiatives that H.R. 4145 proposes. Again, I thank you for your interest in helping parents and caregivers protect children in motor vehicles. NHTSA welcomes the opportunity to work with you further to develop and fund the best possible program to improve child safety on America's roads. We will also be glad to work with you on electric bicycles, to ensure an appropriate transition of authority to the Consumer Product Safety Commission. This concludes my prepared statement, and I will be happy to answer any questions the subcommittee might have.

[The prepared statement of Rosalyn G. Millman follows:]

PREPARED STATEMENT OF ROSALYN G. MILLMAN, DEPUTY ADMINISTRATOR, NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to testify on H.R. 2592, an amendment to the Consumer Products Safety Act relating to electric bicycles, and H.R. 4145, the "Child Passenger Protection Act of 2000." I especially appreciate the opportunity this hearing affords NHTSA to brief you on the agency's comprehensive child passenger protection program. Nothing has a higher priority for us than the safety of children.

I want to congratulate and thank Congressman Shimkus and the co-sponsors of H.R. 4145 for raising awareness about the leading killer of children in America, motor vehicle crashes. NHTSA welcomes their support in making this country's roads as safe as possible.

For more than 30 years, NHTSA has been a leader in improving motor vehicle safety for all occupants, especially children. We currently have underway a comprehensive program that includes research, rulemaking, and public information and education. Attached to my statement is a description of major activities in our child passenger protection program. Many initiatives that H.R. 4145 calls for are parts of our program and we look forward to making it even stronger. NHTSA will vigorously pursue these and other initiatives until every child is safe in every vehicle.

Progress in Child Motor Vehicle Safety

Working with many other public and private organizations, we have made great progress in improving safety for children. Motor vehicle crashes killed 12 percent fewer children ages four and younger in 1998, compared to 1996. Of the 575 children ages four and under that motor vehicle crashes killed in 1998, half were totally unrestrained. Observational studies indicate that fewer than 10 percent of children ride unrestrained, yet they accounted for *half* the fatally injured children in this age group. In 1998, 91 percent of child passengers ages four and under were riding restrained, up from 78 percent in 1994. Our most recent analysis of fatal crashes indicates that child safety seats, even though often installed improperly, are overall 59 percent effective in preventing fatalities for children ages four and under. We must increase the use of child safety seats to 100 percent.

Of the children killed despite being restrained, it is likely that a significant percentage were not *properly* restrained. Either they were in restraints that were not appropriate for their size, they were not properly secured to the restraints, or the restraints were not properly secured to the vehicle. Some of these children would be alive today, if they had been properly restrained. We must ensure that all children are not only restrained, but *properly* restrained.

The child safety seats now on the market are very effective when used properly. While their performance can still improve, the most promising improvement is to make seats easier to install and adjust properly. A seat that parents and caregivers use, and use properly, is by far the best protection we can give children.

Analysis of H.R. 4145

H.R. 4145 contains three major provisions. The first requires NHTSA to consider such new rulemaking actions as dynamic tests of child restraints that simulate an array of crash conditions, using test dummies that simulate a greater variety of child sizes, and improving crash protection for taller and heavier children.

While the actions described in the bill's first provision may improve safety for children, NHTSA's is already planning activities will accomplish the provision's goals. Today, I am announcing a set of rulemaking and research initiatives, including rulemaking to ensure that the test procedures in Federal Motor Vehicle Safety Standard 213 (FMVSS 213)—child safety seat requirements—accurately represent the conditions in which the seats will be used. Further, we are conducting research that may lead to performance standards for child restraint systems in side impact crashes. We plan to evaluate existing data on child restraints involved in both rear-impact and rollover crashes to determine the feasibility of establishing test conditions simulating these crashes.

NHTSA has made, and continues to make, significant progress in improving test dummies to provide more realistic information. NHTSA will initiate rulemaking to replace the current 3-month-old, 9-month-old and 6-year-old dummies with the new, more advanced dummies included in the recent advanced air bag rule. In addition, the agency plans to evaluate an advanced 18-month-old dummy. When the new dummy is validated, NHTSA will consider requiring its use in compliance tests.

NHTSA is engaged in several efforts to improve the protection of older children, those H.R. 4145 designates as children up to 59.2 inches tall and weighing more than 50 pounds. These children have outgrown conventional child safety seats, but are too small for adult lap shoulder belts, unless they use a belt positioning booster seat. NHTSA currently tests booster seats with the dummy that simulates a 6-year-old child. To evaluate the practicability of booster seat performance standards for a broader range of children, the agency plans to study the feasibility of developing a test dummy that would fall between the size and weight of the 6-year-old dummy and the 5th percentile female dummy, which is 14 inches taller and 56.4 pounds heavier than the 6-year-old device. In the interim, NHTSA is considering using an existing 10-year-old European dummy that represents children who weigh up to 100 pounds.

The second major provision of H.R. 4145 mandates that NHTSA (1) issue rules within two years requiring manufacturers to make child restraints that minimize head injuries in side-impact and rollover crashes and that provide side-impact protection; (2) include a child restraint in each vehicle crash-tested under NHTSA's New Car Assessment Program (NCAP); (3) prescribe readily understandable text for any required labels on child restraints; and (4) spend at least $750,000 of its safety funds each fiscal year on crash testing child restraints.

The goals of this provision are laudable, however, at this time legislation should not specify the timing or outcome of the actions. Further research and public comment are needed so that NHTSA can determine their practicability. For example, NHTSA is currently working with the International Standards Organization (ISO) to develop an ISO standard for child restraints. This work will enable us to determine optimum performance criteria for improved head protection in side-impact crashes.

Including child restraints in vehicles crash tested under the NCAP may be feasible, although the information yielded might not be particularly helpful to parents and caregivers trying to choose from the vast array of vehicles and seats now on the market. The resulting data for each test would represent only one particular child safety seat in one particular vehicle and would not help consumers who were considering using a particular child safety seat model in another vehicle. However, NHTSA will include child sized dummies in some NCAP tests to help validate these results to the current FMVSS 213 test.

H.R. 4145's third major provision requires NHTSA to rate child restraint performance. Developing such a rating was the major topic of discussion at NHTSA's February 2000 public meeting at which NHTSA invited comment on such measures as improved labeling, improved test procedures and additional test dummies. Meeting participants, including vehicle and restraint manufacturers and others, actively debated each of these issues. NHTSA is presently reviewing the meeting comments to determine if a rating program is feasible and cost-effective.

Again, I thank you for your interest in helping parents and caregivers protect their children with the introduction of H.R. 4145. NHTSA welcomes the opportunity to work with you further to develop the best possible program to improve child safety on America's roads.

Improvement of NHTSA Standards for Child Restraint Systems

Since NHTSA first proposed to regulate child safety seats in 1969, NHTSA has been raising the minimum required performance standards for motor vehicle child passenger protection. NHTSA's first child safety seat regulation, FMVSS 213, went into effect in 1971, and dealt with seat strength, the width and strength of webbing, the means of attachment to the vehicle, and the use of energy-absorbing materials, but it did not address actual performance of the seats. NHTSA issued a new version, effective in 1981, that required seats to pass dynamic performance requirements simulating the forces of a crash. That version is the basis for today's standard, but NHTSA has since upgraded it.

NHTSA tests every new seat model in the year it is introduced. We also conduct defect investigations to identify safety problems that the standard does not directly address. In the past four years, we have overseen 26 recalls, affecting 4.6 million seats.

We also continue to upgrade our standard in response to new data from the field. One recent upgrade responds to an installation problem that became evident as child safety seat installation rates grew in the late 1980's and early 1990's. During this period, vehicle manufacturers began to install combination lap and shoulder belts in the rear seats of vehicles, rather than lap belts. Combination belts protect adults better, but make installing a child safety seat more difficult.

To address this problem, in 1994, NHTSA formed an internal child safety seat team to formulate ways to ensure the proper installation and use of child safety seats. In 1995, NHTSA convened a panel of experts on the subject. Likely solutions would involve changes to vehicles so the panel included representatives from motor vehicle and child safety seat manufacturers, academic experts, and representatives of a broad range of safety organizations.

These efforts were the framework for the new FMVSS issued in February 1999, requiring a single standardized attachment system, LATCH (Lower Anchors and Tethers for Children), for installing child safety seats in cars, minivans, and light trucks. On September 1, 2002, when the rule applies to all new vehicles and seats, properly installing a child restraint will be greatly simplified. Each child seat will have two standard attachments at the base of the seat, and all new cars, minivans, and light trucks will have standard anchors in the back seat to link to these child seat attachments. NHTSA is currently working with manufacturers and retailers to educate the public about LATCH. The rule will prevent as many as 50 child motor vehicle crash deaths and 3,000 injuries every year.

Along with the FMVSS requiring LATCH, we upgraded child safety seat minimum standards in other respects. In July 1995, NHTSA required a greater array of sizes and weights of test dummies in compliance tests. The new dummies represent an infant, a 9-month-old child and a 6-year-old child. The standard previously required only a dummy representing a 3-year-old child.

We will begin rulemaking later this year to incorporate the dummies in compliance tests for child safety seats the new dummies included in the advanced air bag rule. In February 2000 and March 2000, NHTSA adopted specifications for new, more advanced child test dummies representing 12-month-old, 3-year-old, and 6-year-old children. The improved dummies are more representative of humans than the test dummies previously used and allow the assessment of the potential for more types of crash injuries.

Along with improvements to FMVSS 213, NHTSA encourages manufacturers to exceed the minimum requirements. On September 14, 1999, former Administrator Ricardo Martinez urged all child safety seat manufacturers to increase the margin by which they comply with the standard. A rating system would further identify seats that exceed the minimum standards.

Public Information and Education Initiatives

In addition to rulemaking, NHTSA is continuously developing and implementing public information and education efforts about proper use of child safety seats. In 1996, we began *Patterns for Life,* a national training and educational program to develop and maintain a community infrastructure of child passenger safety professionals. New parents need accurate information and technical assistance concerning child safety seats.[1] The national *Patterns for Life* team consists of about 30 rep-

[1] Every child under age 13 should always ride in the rear seat and follow the four steps for proper restraint for every trip. Infants under one year old and 20 pounds should be in rear-facing child safety seats. Toddlers (children between one year old and 40 pounds) should ride in forward-facing child safety seats. Children weighing between 40 pounds and about 80 pounds

Continued

resentatives from federal agencies and national organizations. It identified public education needs and helped develop NHTSA's standardized Child Passenger Safety Training Program and the American Automobile Association's certification program.

To date, thousands of people have completed this training, and over 6,000 participants from all 50 states have been certified under the program. These certified child passenger safety specialists have checked for the proper installation and use of hundreds of thousands of child safety seats at special clinics and checkpoints in every state and territory.

NHTSA currently is developing a planning guide for states and organizations that wish to establish permanent fitting stations—locations within a community where parents and care givers can learn how to install and use properly their child safety seats. We also are working with states, local communities, and national organizations to conduct child safety seat checkpoints in every state.

In 1997, NHTSA joined with the Air Bag and Seat Belt Safety Campaign, an advocacy organization that some vehicle manufacturers and insurance companies established, to support semi-annual (May and November) mobilizations, *Operation ABC (America Buckles up Children). Operation ABC* mobilizations are high-visibility nationwide efforts that police and other enforcement officials conduct to educate parents and care givers and to enforce state child passenger and seat belt laws. In November 1999, more than 7,100 law enforcement agencies throughout the nation conducted *Operation ABC* mobilizations.

A second "blue ribbon panel" of experts convened in 1998 to recommend better ways to protect children ages 4 to 16 years old, those too large to ride in the child safety seats designed for younger children and who should be either riding in belt positioning booster seats or using adult seat belts. In March 1999, the panel presented recommendations for these children in three areas:

(1) *Marketing and Public Education*—Educate parents and care givers on the importance of booster seats; generate peer programs for increasing seat belt use among older children.

(2) *Legislation and Enforcement*—Close gaps in the child passenger safety and seat belt laws that leave children ages 4 to 16 unprotected; encourage high visibility enforcement of child passenger safety laws.

(3) *Product Design and Implications*—Improve booster seat design for safety and comfort; develop recommendations for the use of after market products.

In February 2000, NHTSA launched a new nationwide public information campaign, *Don't Skip a Step,* that responds to the panel's recommendations. We use it to educate parents that as children grow, their restraint needs change. Before children are ready for adult seat belts, they should ride in a belt positioning booster seat for maximum protection.

Jurisdiction of Low-Speed Motorized Bicycles

Before closing, I want to address H.R. 2592 briefly. NHTSA agrees that Congress should amend the Consumer Product Safety Act to provide that low-speed motorized bicycles are consumer products subject to the jurisdiction of the Consumer Product Safety Commission (CPSC). However, NHTSA recommends that the Subcommittee amend H.R. 2592 to bring all low-speed motorized bicycles within CPSC's jurisdiction, not just electric bicycles. The legislation should focus on the low-speed attribute of these vehicles, not on the energy source that powers them.

Conclusion

Because children cannot protect themselves, adults must make every effort to ensure child safety. With regard to the leading killer of children, NHTSA vigorously pursues a comprehensive program to improve motor vehicle safety for children. Our actions, combined with those of our partners, have saved the lives of many children. When used properly, child safety seats provide excellent protection. But, we need to do more. NHTSA will continue to ensure that seats achieve the highest levels of safety and that every child passenger uses them properly. We welcome the opportunity to work with the Subcommittee to strengthen and fully fund initiatives on this vital issue.

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should use a belt positioning booster seat. At weights above 80 pounds, most children will fit properly into lap shoulder belts.

ATTACHMENT

THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION'S CHILD PASSENGER PROTECTION PROGRAM MAJOR ACTIVITIES

Rulemaking

NHTSA tests and gathers data in support of regulatory initiatives to increase motor vehicle safety.

- In July 1995, NHTSA added a greater array of sizes and weights of test dummies to FMVSS 213 for use in compliance tests. The dummies added included ones representing an infant, a 9-month-old child and a 6-month-old child. The standard retained the use of a dummy representing a 3-year-old child.
- On February 15, 1997, President Clinton announced NHTSA's proposal for a universal child safety seat attachment system. The agency proposed that motor vehicle manufacturers provide a new way of installing child restraints to (1) make them much easier to install properly in motor vehicles; and (2) eliminate incompatibility problems.
- On February 27, 1999, President Clinton announced a new FMVSS requiring a single standardized system, LATCH (Lower Anchors and Tethers for Children), for installing child safety seats in cars, minivans, and light trucks. The first phase of the new system was effective on September 1, 1999. On September 1, 2002, when the rule is fully implemented, properly installing a child restraint will be greatly simplified. All new child seats will have three standard attachments—one on the top and two at the base—and all new cars, minivans, and light trucks will have standard anchors in the back seat designed to link to these child seat attachments. NHTSA is currently working with manufacturers and retailers to educate the public about these improvements. We expect the rule to prevent as many as 50 deaths and 3,000 injuries of children each year.
- On July 7, 1999, NHTSA issued a request for comment to help determine whether to amend FMVSS 213 to permit child restraints to be tethered to meet the limit on head excursion when tested with the 6-year-old child dummy. If such an amendment is adopted, it could facilitate introduction of child restraints for larger children (weighing over 40 pounds) in seating positions that have lap belts. The agency is now evaluating the comments to determine what further action may be appropriate.
- On September 14, 1999, NHTSA sent a letter to all child safety seat manufacturers, urging them to manufacture child seats so that they "perform well beyond the minimum requirements of our standard," and pointing out that, with the safety of our nation's children at issue, mere compliance with the standard's minimum requirements is insufficient. The letter further stated that NHTSA planned to schedule a meeting to discuss ways to maximize the safe transportation of children and the possibility of creating a system to rate the relative performance of child restraints.
- On February 9, 2000, NHTSA convened a public meeting to discuss the issues set out in NHTSA's September 1999 letter. Speakers at the meeting, including manufacturers and other interested parties, and those who commented on the notice that announced the meeting, raised a number of issues and offered varying viewpoints on the merits of a rating for child seats. Also, suggestions were made for future rulemaking, such as improved labeling, new test dummies, and changes to the existing test procedure for child restraints.

  NHTSA is currently reviewing the record of the public meeting and is developing an agency-wide action plan to respond to the issues raised and related matters. We expect to complete this plan by late summer of 2000.
- In February and March 2000, NHTSA adopted new, more advanced child test dummies representing 12-month-old, and 3-year-old and 6-year-old children. The new dummies are more representative of humans than the existing test dummies and allow assessment of the potential for more types of injuries in automotive crashes. NHTSA will initiate rulemaking in the near future to incorporate use of these dummies into child safety seat compliance tests.

Research and Development

NHTSA's research and development program covers the full range of motor vehicle safety issues.

- In 1996, NHTSA published the first national study on the types of misuse of child safety seats. This study showed that about 80 percent of child safety seats are used incorrectly and that only 6 percent of children of booster seat age ride in a booster seat.

- In 1999, NHTSA began its initial evaluation of the interaction of seat-mounted and door-mounted side air bags with various types of child restraint systems.
- In 2000, NHTSA began research to identify potentially effective interventions to address the problem of children moving prematurely from child safety seats to adult seat belts. Also in 2000, the agency plans to assess LATCH.

Enforcement

NHTSA's Vehicle Safety Compliance Program ensures that motor vehicles and motor vehicle equipment, such as child safety seats, provide the safety benefits intended by the agency's federal motor vehicle safety standards. NHTSA's Defects Investigation Program identifies and removes motor vehicles and motor vehicle equipment that contain safety-related defects from interstate commerce.

- From 1996 to the present, NHTSA has conducted compliance tests on 360 models of child safety seats (63 models of booster seats and 238 other safety seat models). Twenty-three recalls have been conducted since 1996, involving about 4.7 million child safety seats. NHTSA has monitored each recall to ensure that consumers were notified, and that the scope and remedy of each recall was adequate and timely.
- Through NHTSA's toll-free Auto Safety Hotline (1-888-DASH-2-DOT) or web site—www.nhtsa.dot.gov/hotline—parents and others report defective child restraints and seat belts to the agency. Through NHTSA's web site, consumers also may access extensive information on the correct use of child restraints.

Public Information, Education and Training

Public information, education and training are integral to all of NHTSA's programs. In particular, NHTSA devotes considerable resources to working with the states and communities and the private sector to promote child safety education and enforcement efforts that increase the correct installation and correct use of these life-saving systems.

- On October 25, 1995, NHTSA issued a public warning that urged parents, in the strongest possible terms, to insist that their children ride in an appropriate restraint in the back seat whenever possible.
- In 1996, NHTSA started *Patterns for Life,* a national training and educational initiative to develop and maintain a community infrastructure of child passenger safety professionals throughout the nation. New parents need accurate information and technical assistance concerning child safety seats.[1] The national *Patterns for Life* team consists of about 30 representatives from federal agencies and national organizations. The Team identified public education needs and assisted in the development of the NHTSA Standardized Child Passenger Safety Training Program and the American Automobile Association (AAA) certification program.

  To date, thousands of people have completed this training and over 6,000 participants from all 50 states have been certified under the program. These certified specialists in child passenger safety have checked for the proper installation and use of hundreds of thousands of child safety seats at special clinics and checkpoints in every state and territory.

  NHTSA currently is developing a planning guide for states and organizations that wish to establish permanent fitting stations—locations within a community where parents and care givers can learn how to install and use properly their child safety seats. We also are working with states, local communities, and national organizations to conduct child safety seat checkpoints in every state.
- On January 23, 1997, President Clinton directed Secretary Slater to prepare a plan to increase the use of seat belts nationwide. To carry out this directive, DOT established the *BuckleUp America* (BUA) campaign. NHTSA coordinates the Department's BUA campaign, which required the agency to implement each of four elements of the President's initiative: partnerships, legislation, enforcement, and education.
- In 1997, as part of NHTSA's comprehensive plan to share vital information directly with the public on correct child safety seat use and positioning, the agency announced a new computer database for parents and care givers to determine whether a particular child safety seat will fit into a particular make and

[1] Every child under age 13 should always ride in the rear seat and follow the four steps for proper restraint for every trip. Infants under one year old should be in rear-facing child safety seats. Toddlers (children between one year old and 40 pounds) should ride in forward-facing child safety seats. Children weighing between 40 pounds and about 80 pounds should use a belt positioning booster seat. At weights above 80 pounds, children will fit properly into lap shoulder belts.

model of vehicle. The database program, launched with the National Automobile Dealers Association (NADA), contains specifications for child seats manufactured since 1989.

- In 1997, NHTSA launched “Safety City,” a web site (www.nhtsa.dot.gov/kids) that provides children with interactive web pages containing sophisticated graphics about all facets of highway safety. Child safety seat information is included on this site.
- Beginning in 1997, NHTSA joined with the Air Bag and Seat Belt Safety Campaign to support the semi-annual (May and November) *Operation America Buckles Up Children (ABC)* mobilizations. *Operation ABC* mobilizations are high-visibility nationwide efforts that police and other enforcement officials conduct to educate parents and care givers and to enforce state child passenger and seat belt laws. In November 1999, more than 7,100 law enforcement agencies throughout the nation conducted *Operation ABC* mobilizations to enforce child safety seat and seat belt laws.
- On November 19, 1998, Secretary Slater, together with NHTSA officials, convened a second “blue ribbon panel” of experts to recommend ways that children ages 4 to16 years old can be better protected in motor vehicles. On March 15, 1999, the panel presented its recommendations for these older children in the following three areas:
  (1) *Marketing and Public Education:* Educate parents and care givers on the importance of booster seats; generate peer programs for increasing seat belt use among older children.
  (2) *Legislation and Enforcement:* Close gaps in child passenger safety laws and seat belt laws, as these laws often leave children ages 4 to 16 unprotected; encourage high visibility enforcement of child passenger safety laws.
  (3) *Product Design and Implications:* Improve booster seat design for safety and comfort; develop recommendations for the use of after market products, some of which currently have no safety performance standards for their use yet are designed to improve safety belt fit.
- In 1999, NHTSA awarded nearly $1 million for 21 cooperative Buckle Up America (BUA) agreements with organizations that support child safety seat education and public information efforts.
- In 1999, in partnership with the Automotive Coalition for Traffic Safety (ACTS), NHTSA initiated a program of periodic meetings with child restraint manufacturers, vehicle manufacturers, and associated retailers to share information and collaborate on the best ways to educate the public about child passenger safety issues.
- In 1999, NHTSA established the Child Passenger Safety Board as an authoritative body to monitor and provide program and technical guidance in matters pertaining to the NHTSA Standardized Child Passenger Safety Training Program and the American Automobile Association’s (AAA) related certification program. Board members include representatives of national organizations that have played a role in standardizing child passenger training.
- In September 1999, to increase booster seat use for children ages 4 to 8 and seat belt use among children ages 8 to 16, NHTSA awarded a total of $500,000 to six states [2] for pilot and demonstration programs.
- On February 14, 2000, NHTSA awarded $7.5 million to 47 states and the territories under the Child Passenger Protection Education Grant Program (section 2003(b) of the Transportation Equity Act for the 21st Century (TEA-21)). The grant program supports state efforts to develop and implement occupant protection educational outreach programs for children up to age 16, to promote proper child restraint use (including booster seats), and to train child passenger safety personnel on proper restraint use. NHTSA has encouraged states to use these funds to target minority and rural populations, and children with special health care needs.
- On February 14, 2000, Secretary Slater launched NHTSA’s *Don’t Skip a Step* national booster seat campaign to educate parents about the risks of improperly positioned adult seat belts and the effectiveness of belt positioning booster seats.

Mr. TAUZIN. Thank you, Ms. Millman.

The Chair wishes also to thank Congressman Rogan for his stewardship of the committee while I was on the floor. I am pleased to report, by the way, to the committee the House has just adopted

[2] Arizona, New York, North Dakota, Rhode Island, Texas, and Washington.

our Internet Access Charge Protection Act, ensuring that per-minute charges for use of the Internet for data services will never be assessed against individuals who use the Internet. And that bill now goes on to the Senate, hopefully, where the Senate will concur in the wisdom of the House.

The Chair is now pleased to welcome the Honorable Ann Brown, the Chair of the Consumer Product Safety Commission, for your testimony. Ms. Brown.

STATEMENT OF HON. ANN BROWN

Ms. BROWN. Thank you, Mr. Chairman. Mr. Chairman and members of the subcommittee, I am Ann Brown, chairman of the U.S. Consumer Product Safety Commission. With me today are Vice Chairman Mary Sheila Gall, Commissioner Thomas H Moore, and members of the commission staff.

Before I begin my statement, I want to call to the subcommittee's attention the amendments to our statutes that President Clinton proposed to the Congress last Friday. Briefly, these amendments would strengthen our enforcement authority by removing the cap on civil penalties when manufacturers fail to report substantial product hazards to us as required by current law, making it a felony rather than a misdemeanor to violate our statutes in a knowing and willful manner, and provide a more effective remedy for consumers when a product contains a substantial hazard. The commission voted two to one to endorse these amendments, and I hope this subcommittee will favorably consider them next year.

There are four subjects for our agenda today, and I will address each of them in turn. The CPSC and the National Highway Traffic and Safety Administration, NHTSA, share jurisdiction over infant car seats which often serve as a carrier for a child when a seat is removed from the car. It is our responsibility to ensure the safety of these products when they are taken from the car and used as an infant carrier.

In the past 2 years, we have recalled more than 2.1 million defective car seat carriers from three different manufacturers. Typically, the defect involved the sudden release of the handle of the carrier, thereby allowing the child to pitch forward onto the ground. I am pleased to tell you that each of these recalls was carried out in a cooperative manner with the NHTSA.

Electric bicycle manufacturers are caught in a regulatory trap between the NHTSA and CPSC. While their products meet the strict definition of motor vehicle under the law, the manufacturers could not comply with the safety regulations that apply to such vehicles. Moreover, NHTSA has no desire to regulate these electric bicycles. CPSC is willing to undertake this responsibility, provided we can do it in an effective and efficient manner.

Mr. Chairman, I believe the best course here is for our staff to work with your staff and interested members to draft legislation that the committee could promptly approve. If that is acceptable to you, I am ready to move forward quickly.

On September 9, 1996, the Commission issued amendments to the standards for children's sleepwear excluding garments sized for infants 9 months or younger and tight fighting garments for young children above that age. I dissented. I believe that the original chil-

dren's sleepwear standard was instrumental in reducing burn-related deaths and injuries related to flammable sleepwear.

The standard was straightforward and simple. It provided a high level of protection for children by requiring fabrics used in children's sleepwear to self-extinguish when exposed to a small open flame. The regulation was working well. The long-standing standard is credited with saving many lives and preventing countless burn-related injuries. As I have said repeatedly, my overriding concern is to keep our children safe. I have seen nothing that has caused me to change my position. Over the past several years, our staff has spent a great deal of time on this issue. Each Commissioner and their personal staffs have done the same.

The situation at the Commission is rigid. There will be no movement. We have heard from thousands of people on both sides of the issue. We have carefully considered all aspects of the issue. The heavy expenditure of resources has been appropriate because this is a very important safety issue. However, this is not the only safety issue confronting the commission. I believe it is now time to move on lest in our vigorous attention to this sleepwear question we begin to spend less time on and pull resources away from other critical safety problems. For now, we turn the issue back to you. If the Congress repeals the current rules and directs us to return to the prior standard, we will carry out your direction faithfully.

I would now like to turn to amusement park rides. The most tragic news the Commission receives is the death of a consumer, especially a child, particularly when that death is preventable. In 1998, seven people died on these rides, the most in any single year in more than a decade. Today, we have no jurisdiction over fixed-site rides. As a result, the amount of consumer protection a rider receives depends on an irrelevant factor, whether it is a fixed site or a mobile ride. Currently, 11 States have no inspection laws, 13 States have no laws requiring operators to report injuries, and others have a patchwork of inconsistent regulations. I believe this is a situation that requires uniform regulatory oversight so that all amusement park riders will receive equal protection, no matter whether the ride is at a fixed or mobile site.

Accordingly, I support Congressman Markey's bill H.R. 3032. Mr. Chairman, this concludes my statement on the four subjects on our agenda today. As always, I am pleased to work with you and the members of your subcommittee; and I am ready to answer any questions you may have.

[The prepared statement of Hon. Ann Brown follows:]

PREPARED STATEMENT OF HON. ANN BROWN, CHAIRMAN, U.S. CONSUMER PRODUCT SAFETY COMMISSION

Mr. Chairman, and members of the Subcommittee, I am Ann Brown, Chairman of the U.S. Consumer Product Safety Commission (CPSC). With me today are Vice Chairman Mary Sheila Gall, Commissioner Thomas H. Moore, and members of the Commission staff.

Before I begin my statement, I want to call the Subcommittee's attention to the amendments to our statutes that President Clinton proposed to the Congress last Friday. Briefly, these amendments would strengthen our enforcement authority by removing the cap on civil penalties when manufacturers fail to report substantial product hazards to us, as required by current law, make it a felony, rather than a misdemeanor, to violate our statutes in a "knowing and willful" manner and provide a more effective remedy for consumers, where a product does contain a sub-

stantial hazard. I support these amendments and hope the Subcommittee will favorably consider them next year.

WHAT WE DO, AND HOW WE DO IT

Since this is my first appearance before you in more than two and a half years, and many members are probably not familiar with our activities, I want to describe briefly who we are, what we do and how we do it.

The Commission was established in 1973, by President Nixon as a five, now three, member independent agency. We enforce five federal statutes: the Consumer Product Safety Act, the Flammable Fabrics Act, the Poison Prevention Packaging Act, the Federal Hazardous Substances Act and the Refrigerator Safety Act. All told, we have jurisdiction over 15,000 different kinds of consumer products, which are found, in and around the home, schools and recreation areas.

Our mission is simple and non-partisan: preventing deaths and injuries to children and families from hazardous consumer products. I prefer to work cooperatively with companies, rather than using compulsory means, whenever possible. I favor market-oriented solutions to product safety problems. The paradigm for the CPSC is the product safety triangle, where business, consumers and government each have an equal role to play.

INFANT CAR SEATS/CARRIERS

The CPSC and the National Highway Traffic Safety Administration (NHTSA) share jurisdiction over infant car seats, which often serve as a carrier for a child, when the seat is removed from the car. It is our responsibility to assure the safety of these products when they are taken from the car and used as an infant carrier. In the past two years, we have recalled more than 2.1 million defective car seats/carriers from three different manufacturers. Typically, the defect involved the sudden release of the handle of the carrier, thereby allowing the child to pitch forward onto the ground. I am pleased to tell you that each of these recalls was carried out in a very cooperative manner with the NHTSA.

ELECTRIC BICYCLES

Electric bicycle manufacturers are caught in a regulatory trap between the NHTSA and CPSC. While their products meet the strict definition of "motor vehicle" under Title 49 Section 30102(a), the manufacturers could not comply with the safety regulations that apply to such vehicles. Moreover, NHTSA has no desire to regulate these electric bicycles. CPSC is willing to undertake this responsibility, provided we can do it in an efficient manner.

Accordingly, I support the intent of Congressman Rogan's bill, but our staff has several technical problems with the provisions of the bill as currently drafted. Last year CPSC and NHTSA staffs developed a bill that I believe is a better approach to resolving this jurisdictional matter. It is modeled on the bicycle helmet standard legislation that this Committee and the Congress enacted as part of the 1994 amendments to the Consumer Product Safety Act.

Mr. Chairman, I believe the best course here is for our staff to work with your staff and interested Members to draft legislation that the Committee could promptly approve. If this is acceptable to you, I am ready to move forward quickly.

CHILDREN'S SLEEPWEAR REGULATION

On September 9, 1996, the Commission issued amendments to the standard for children's sleepwear excluding garments sized for infants nine months or younger, and tight fitting garments for young children above that age. 61 F.R. 47634. I dissented.

Thereafter, certain Members and organizations began urging repeal of the amended rules and a return to the prior standard. They persuaded the conferees on our FY 1999 appropriation to include a provision requiring the CPSC to propose for public comment a revocation of the 1996 amendments, and to promulgate a final rule on the sleepwear standard by July 1, 1999. On June 16, 1999, the Commission voted 2-1 to reaffirm the 1996 amendments. I again dissented. I ask unanimous consent that my statement of June 16, 1999, on this issue be included in the hearing record following my testimony.

I believe that the original children's sleepwear standard was instrumental in reducing burn-related deaths and injuries related to flammable sleepwear. The standard was straightforward and simple. It provided a high level of protection for children by requiring fabrics used in children's sleepwear to self-extinguish when exposed to a small open flame. The regulation was working well. This longstanding

standard is credited with saving many lives and preventing countless burn-related injuries. As I have said repeatedly, my overriding concern is to keep our children safe. I have seen nothing that has caused me to change my position.

I am also not convinced that parents will purchase the correct size of tight-fitting sleepwear so their children will not be at risk. There also is nothing in the record to demonstrate that the availability of this tight-fitting cotton alternative has reduced the use of looser cotton clothing such as cotton T-shirts, for sleepwear. Finally, our enforcement problems continue.

Over the past several years, our staff has spent a great deal of time on this issue. Each Commissioner and their personal staffs have done the same. Our positions are rigidly held. We have heard from thousands of people on both sides of the issue. We have carefully considered all aspects of the issue. This heavy expenditure of resources has been appropriate, because this is a very important safety issue. However, this is not the only safety issue confronting the Commission.

I believe it is now time to move on, lest, in our vigorous attention to this sleepwear question, we begin to spend less time on, and pull resources away from, other critical safety problems.

For now, we turn the issue back to you. If the Congress repeals the current rules and directs us to return to the prior standard, we will carry out your direction faithfully.

I ask unanimous consent to include in the record a copy of the July 27, 1999, letter to all Appropriations Committee Members signed by all three Commissioners asking the Committee not to require further expenditure of resources on this subject.

AMUSEMENT PARK RIDES

I would now like to turn to amusement park rides. The most tragic news the Commission receives is the death of a consumer, especially a child—particularly when that death could have been avoided.

We all know roller coasters, and other amusement park rides, are fun, fast and thrilling. They are supposed to create the illusion of danger, without putting riders at risk.

But the number of deaths tell a different story. In 1998, seven people died on these rides—the most in any single year in a decade.

Until the 1981 amendments to our statute, CPSC had jurisdiction over both fixed site and mobile rides. Now we can obtain a corrective action from a manufacturer, distributor or ride operator only if a mobile ride presents a significant hazard. In fact, last year, CPSC and Reverchon Industries announced the recall of the Himalaya ride that caused two deaths and three injuries.

Today we have no jurisdiction over fixed-site rides. As a result, the amount of consumer protection a rider receives depends on an irrelevant factor, whether it is a fixed site or mobile ride. Currently, 11 states have no inspection laws, 13 states have no laws requiring operators to report injuries, and the others have a patchwork of inconsistent regulations.

I believe this is a situation that requires uniform regulatory oversight, so that all amusement park riders will receive equal protection no matter whether the ride is at a fixed or mobile site. Accordingly, I support Congressman Markey's bill, H.R. 3032.

CONCLUSION

Mr. Chairman, this concludes my statement on the four subjects on our agenda today. As always, I am pleased to work with you and the Members of your Subcommittee. I am ready to answer any questions you may have.

STATEMENT OF CHAIRMAN ANN BROWN

DECISION ON REVOCATION OF AMENDMENTS TO CHILDREN'S SLEEPWEAR STANDARD

June 16, 1999

I regret that I must differ from my fellow Commissioners today in voting against the motion to withdraw the proposal to revoke the 1996 amendments to the Children's sleepwear standard.

I believe that the original children's sleepwear standard was instrumental in reducing burn-related deaths and injuries related to flammable sleepwear. The standard was straightforward and simple. It provided a high level of protection for children by requiring fabrics used in children's sleepwear to self-extinguish when ex-

posed to a small open flame. The regulation was working well. This longstanding standard is credited with saving many lives and preventing countless burn-related injuries.

I voted against the 1996 amendments because I could not agree that the amendments would improve enforcement of the sleepwear standard or that 6-month-old infants were necessarily immobile. I also was skeptical of a promise by the sleepwear industry that it would implement an aggressive information and education program.

As I have said time and time again, my overriding concern throughout this entire process is the mission of our agency to keep our children safe. I have seen nothing to date in the oral or written testimony that has changed my original position. A compelling case has not been made to me that infants who are capable of wearing age 9 months sleepwear are not capable of moving to a dangerous ignition source.

I am also not convinced that parents will purchase the correct size of tight-fitting sleepwear so their children will not be at risk. There also is nothing in the record to demonstrate that the availability of this tight-fitting cotton alternative has reduced the use of looser cotton clothing such as cotton T-shirts, for sleepwear. Finally, our enforcement problems continue.

In addition, the industry has not fulfilled its promise to implement an effective information and education campaign. Although about three-fourths of the stores had hangtags, the GAO report evaluating the industry effort concluded that only 16 percent of stores visited displayed either consumer education brochures or signs about sleepwear safety requirements. And now, industry blames the Commission for its own spotty efforts.

In 1996, I said that changing the old standard created an environment that may put our children at greater risk for burn-related injuries and death. Even though our data sources have not disclosed any specific burn cases directly tied to the 1996 standard, I cannot in good conscience support a sleepwear standard that I believe may provide less protection for the Nation's children.

I abstained from voting on the staff proposal to require labeling of tight-fitting garments. While I have supported certain labeling requirements in the past, and will support them on a case-by-case basis in the future, I do not believe labeling is sufficient in this case. I believe that whenever possible, safety should be built into the product—that is, in this case, the garments themselves should inherently resist ignition, rather than relying on the purchasing decisions of parents. While I recognize that the proposed labeling provisions will improve the standard somewhat, they do not go far enough in my view.

I wish to make one other point. Over the past several years, our staff has spent a great deal of time on this issue. Each Commissioner and their personal staffs have done the same. We have heard from thousands of people on both sides of the issue. We have carefully considered all aspects of the issue. This heavy expenditure of resources has been appropriate, because this is a very important safety issue. But this is not the only safety issue confronting the Commission.

And I believe it is now time to move on, lest, in our vigorous attention to this sleepwear question, we begin to spend less time on, and pull resources away from, other critical safety problems. Therefore, while I have not agreed with my fellow Commissioners on this issue, the issue has been decided and we now need to turn our attention to other important safety issues.

U.S. CONSUMER PRODUCT SAFETY COMMISSION
WASHINGTON, D.C.
July 27, 1999

The Honorable JAMES T. WALSH
Chairman
Subcommittee on VA, HUD and Independent Agencies
U.S. House of Representatives
2351 Rayburn House Office Building
Washington, DC 20515

DEAR MR. CHAIRMAN: As you may know, on June 28, 1999, the U.S. Consumer Product Safety Commission (CPSC) voted 2-1 to uphold the 1996 amendments to the children's sleepwear standards. Commissioners Moore and Gall voted to maintain the 1996 amendments and Chairman Brown voted to reinstate the original standard. Despite our continuing difference of opinion on the merits of the changes to the sleepwear standards, we are writing to you to express our unanimous opposition to any amendments to CPSC's appropriations legislation on children's sleepwear.

CPSC has already considered the sleepwear issue twice, spending approximately 7 years altogether on the issue. During the recent reconsideration of the amend-

ments, mandated by our 1999 appropriations legislation, the General Accounting office (GAO), completed two studies on the effect and implementation of the amendments. After carefully considering the GAO studies, additional technical data compiled by CPSC staff, and extensive comments from a public hearing where all views were heard, the Commission's 2-1 vote in favor of the amendments did not change.

Given this thorough review, we do not believe that requiring the Commission to spend more time on this issue will lead to a different decision by the Commission. If the Commission has to allocate any of its limited resources on yet another study of children's sleepwear, the agency will have less time and money to investigate critical safety issues that threaten American children and families.

If you or your staff have any questions about this, please call Bob Wager, Office of Congressional Relations; at 301-504-0515. Thank you for your consideration.

Sincerely,

ANN BROWN
Chairman

MARY SHEILA GALL
Vice Chairman

THOMAS H. MOORE
Commissioner

cc: Appropriations Committee Members

Mr. TAUZIN. Thank you Madam Chair.

The Chair is now pleased to welcome the Honorable Mary Sheila Gall, the vice chairman of the Consumer Product Safety Commission. Ms. Gall.

STATEMENT OF HON. MARY SHEILA GALL

Ms. GALL. Good morning and thank you for the opportunity to be here today. I have a statement for the record, but I will spare all of us the reading of it.

Mr. TAUZIN. Without objection, if it has not been done yet, written statements are automatically a part of our record.

Ms. GALL. There are a number of issues that relate to the Consumer Product Safety Commission, and I will touch upon those just briefly. We have Representative Markey's fixed-site amusement rides proposal, which would give CPSC jurisdiction over fixed-site amusement rides. The commission has not taken a formal position on this legislation as of this date. There are a number of issues that I think we need to address as we look at this legislation from the aspect of Congress as well as the commission.

We have seen in the last year or so, as Chairman Brown has noted, that there has been an increase in injuries and deaths in fixed-site amusement park rides. We don't have the exposure data, however, that will tell us whether or not the increase is due to more people attending amusement parks, and increasing the number of rides that they go on, or if this is an increase in the hazard of the ride itself. So I think that is something we need to take a look at.

The second thing is that we have a number of other factors to study. First of all, we know that we have State regulation in many of the States. We know some States do not have fixed rides. And so obviously they won't have State regulation. I think we really need to take a stronger look at that. We know some legislation or regulation exist, but we need to look at that further. We know there are some voluntary standards through ASTM. We also know that ASTM is looking at the issue over G forces, not only the number of G forces, the increase of the force, but also at the extent of time that an individual is exposed to that G force. So that is being

looked at by the voluntary standards community. We also know that there are tough insurance requirements for these fixed-ride parks. And so we need to look at that further and see what the implications are for safety as far as that is concerned.

I will say this: much as we all like to think that the Federal jurisdiction over an issue gives us a magic bullet to address safety, that isn't always the case. Certainly at CPSC we acknowledge that despite our jurisdiction we do have 22,000 deaths per year associated with products that come under our jurisdiction; and NHTSA, of course, has 40,000 deaths a year associated with motor vehicles despite their best efforts. So it is not necessarily a magic bullet.

The resources issue is something I think we need to address. The bill that we have before us would give the agency $500,000; and I think that is clearly inadequate. If we are going to take on this task, we will need more money to do so. These are very complex rides and would require travel money and so on.

Moving on to electric bikes with Representative Rogan's legislation, I think that bringing electric bikes to the commission is a natural progression and that we already have regulations for bicycles. I note that the Chairman mentioned that she would like to work with the committee to develop a proposal. And I know that CPSC staff has submitted a proposal. I am very much opposed to the CPSC staff proposal. It's not a simple clear cut bill giving us jurisdiction the way Congressman Rogan's bill is. It really takes a dramatic departure and bypasses from the normal rulemaking process, and I disagree with that strongly.

As far as sleepwear is concerned, I know that this is a very controversial issue. The hazard that the sleepwear amendments were designed to address is single-point small open flame ignition such as matches or cigarette lighters. It is not meant to address whole-house fires because there is very little we can do for someone in a whole-house fire. The flame-resistant clothing is really the last line of defense. We have to count on parents and caregivers to make sure that ignition sources are kept away from children as well. And the agency has been very active in designing and regulating child-resistant cigarette lighters and multipurpose lighters toward that goal of increased safety.

I voted for the amendments that were made in 1996. They provided for a tight fitting cotton alternative to flame-resistant sleepwear. It does exempt garments for infants sized under 9 months. There is a great deal of confusion that we face all the time. These are children who are 6 months or under, who are very unlikely to come into contact with cigarette lighters or matches. When we look at the market factors, we realize that there is a very clear desire for consumers to put their children in cotton fabrics; and so what we did was provide a safe alternative. You are given the experience we have. Given the data we looked at and the studies we undertook, we have done a good job in providing that safe alternative.

The Chairman did mention the Consumer Product Safety Commission Enhanced Enforcement Act of 2000 that was announced at the White House last week. Although I realize that is not a matter before the committee today, I would just briefly like to say that I disagree with the provisions of that bill, with one exception, and I

would be happy to comment on that if the opportunity arises and anyone would like to follow up. So I thank you very much for your time.

[The prepared statement of Hon. Mary Sheila Gall follows:]

PREPARED STATEMENT OF HON. MARY SHEILA GALL, COMMISSIONER, CONSUMER PRODUCT SAFETY COMMISSION

I appreciate the opportunity to appear today before the Subcommittee to address three topics: (1) flammability requirements of children's sleepwear; (2) the potential exercise of jurisdiction by the Commission over fixed-site amusement parks; and (3) the potential exercise of jurisdiction by the Commission over bicycles equipped with small electric motors. The hearing today also considers standards for child restraints in motor vehicles, products regulated not by the Commission, but by the National Highway Transportation Safety Administration (NHTSA). I would also like to take this opportunity to state my position on draft legislation, sponsored by Senator Hollings and Congressman Markey, which was the subject of a press event in the White House last Friday, and which amends the enforcement sections of some of the statutes administered by the Commission. I realize that this legislation is not the explicit subject of today's hearing, but it will be referred to this Committee and Subcommittee for consideration.

FLAMMABILITY REQUIREMENTS OF CHILDREN'S SLEEPWEAR

Background

Flammability requirements for children's sleepwear are governed by regulations promulgated under the authority of the Flammable Fabrics Act. The Commission amended the regulations in 1996 to require that sleepwear for children be *either* tight fitting *or* constructed of flame-resistant fabric that passes a burn-rate test in which a small open flame is applied for three seconds. Sleepwear for infants sized under nine months is exempted from the standard. (Such sleepwear is typically worn by infants aged six months and younger.) Before the amendments, *all* children's sleepwear had to be constructed of fabric that passed a burn-rate test that exceeded the general wearing apparel flammability standard.

The Commission based its 1996 amendments to the regulations on an extensive record that documented that the hazard associated with single-point, small open-flame ignition of tight-fitting cotton sleepwear was very low. Tight-fitting cotton sleepwear is less likely to be ignited in the first place, and, if ignited, it burns slowly, since its proximity to the skin retards the flow of air that feeds the fire and the skin acts as a "heat sink" to slow the spread of flame. Infants wearing sleepwear sized nine months or smaller lack the ability to move to ignition sources.

When it acted, the Commission had the benefit of observing the results of a stay of enforcement, in effect for nearly four years, that permitted the sale of tight-fitting children's sleepwear without an increase in burn injuries resulting from single-point ignition. The Commission also observed a Canadian study that proved unable to find incidents of injuries as a result of single-point ignition of tight-fitting cotton sleepwear. Both the stay of enforcement and the Canadian standard permitted the sale of sleepwear that had a looser fit than the requirements of the present regulations. The Commission's record at the time that it acted was well developed and proved that there was no unreasonable risk of injury associated with single-point, small open-flame ignition of tight-fitting cotton sleepwear. There was no challenge to the Commission's decision in court and I have seen no evidence since the time of the decision to indicate that burn injuries associated with single-point ignition of tight-fitting children's cotton sleepwear have increased or represent a significant problem. The opponents of the regulatory changes have, however, sought to overturn them through legislation that falls within the jurisdiction of this Subcommittee.

Reflections on Preventing Fire Injuries

Many of the issues with which I have dealt during my almost nine years of service as a Commissioner have concerned fire: smoke detectors, child-resistant cigarette lighters and multi-purpose lighters, upholstered furniture flammability, and wearing apparel flammability. I believe, therefore, that my observations and reflections on how best to prevent fire injuries, particularly those involving clothing ignition, will be helpful to the Subcommittee as it considers whether to repeal the changes that the Commission made to the regulations on children's sleepwear. My most important point is that clothing flammability resistance represents a *last line of defense.* Preventing fire deaths and injuries *begins* with adequate parental and other caregiver supervision that keeps ignition materials such as matches and cigarette

lighters out of the hands of children, and which keeps children away from other ignition sources such as ranges and fireplaces. A second line of defense involves making certain ignition sources child-resistant. During my service with the Commission it has adopted regulations that require that cigarette lighters and multi-purpose lighters be made child-resistant, and I anticipate that these requirements will result in reduced numbers of deaths and injuries from childplay with fire. Finally, flammability resistance of clothing may reduce the severity of injuries where ignition does occur. But no children's sleepwear is flame*proof*, just as no lighter is child*proof*. Adult caregivers have the primary responsibility to assure that children do not have access to ignition sources that can lead to fires.

Proposed Legislative Changes to Sleepwear Standards

The Commission has been the subject of criticism for adopting the amendments, and was required by the fiscal year 1999 Appropriations Conference Report to reevaluate the advisability of the amendments. The Commission did propose the repeal of the amendments, requested public comments, held a public hearing and gathered data, decided that there was no justification for changing the regulations and sent a letter to the Appropriations Committee stating that conclusion. The Commission retained the amendments, but modified them to require labels and hangtags for tight-fitting garments. Data suggested that the public might not be aware that tight-fitting garments are not flame-resistant and must be worn with a tight fit. This labeling requirement goes into effect June 28, 2000. The Commission is working with the American Apparel Manufacturers Association to develop a national information and education campaign to inform the public about safe sleepwear and why non-flame resistant garments must be tight fitting.

There have been a number of attempts to repeal the amendments legislatively and to reinstitute requirements that all children's sleepwear pass a test that requires that they pass a burn-rate test consisting of the application of a small, open flame for three seconds. Opponents of the Commission's regulatory changes are, of course, free to use the political process. I urge lawmakers, however, in evaluating the case made by proponents of repeal, to ask the question that I have been asking since I started considering these changes. Where are the incidents, or the studies, that demonstrate that single-point ignition of *tight-fitting* cotton sleepwear, or sleepwear used by children sized nine months and under, is an unreasonable hazard?

When the Commission made its decision in 1996 it had before it an extensive record demonstrating very few injuries associated with single-point ignition of tight-fitting children's sleepwear, or any sleepwear at all for children sized under nine months. Proponents of legislative repeal of the amendments frequently cite numbers of burn injuries suffered by children who happen to be in sleepwear at the time of the injury. But the flame-resistance standard was *never* intended to protect children from burn injuries from large-open flames. Clothing would have to be made of highly flame-resistant fabrics, such as that worn by auto racing drivers or military pilots, to protect its wearer from burns in general conflagrations. And even highly flame-resistant fabrics will do nothing to protect children from inhaling smoke and toxic gases.

There have been other criticisms of the data gathering and analysis that the Commission staff performed in developing the record that supported the regulatory changes. These criticisms have been considered, analyzed and responded to by the staff. I urge the Members of the Subcommittee to read the staff response carefully to evaluate the techniques of the data collection and analysis that supported the regulatory change. I believe that you will find that the means used to collect and analyze the data was reasonable.

Other factors that Congress must consider in deciding whether to repeal or to modify the Commission's sleepwear regulation are consumer preference for natural fabrics without chemical treatments, and the difficulty in defining sleepwear. Garments that meet the children's sleepwear flammability standard have been available since the 1970's. These garments have not, however, proved popular, since many consumers do not want chemically treated cotton, and polyester does not "breathe" in the same way that cotton does. Consumers who wish to dress their children in natural fabrics may, therefore, purchase items intended for use as daywear or playwear and use them as sleepwear. The Commission is powerless to alter this behavior without becoming some sort of federal "pajama police."

There have been some changes in the patterns of consumer behavior since the time that the Commission began considering the issue of amendments to the sleepwear standard. When the Commission began the process of considering amendments to the standard, one to two percent of all sleepwear sales were flame-resistant cotton. By 1996, when the amendments were issued, twenty-five percent of the

sleepwear industry was cotton (a combination of flame-resistant cotton and cotton garments whose sale was permitted by the stay of enforcement). As of May 2000, thirty to thirty-five percent of the sleepwear market is cotton, overwhelmingly the tight-fitting cotton sleepwear that the amended sleepwear standard permits.

The Commission can, and does, pursue manufacturers and retailers who market loose-fitting clothing made from non-flame-resistant fabric as children's sleepwear. Determining whether a garment is being marketed as children's sleepwear is often difficult. It depends on such factors as the ornamentation, the position in the store occupied by the garment (e.g., is it in or near the sleepwear section, the underwear section or the playwear section), and the responses of sales persons when asked about the function of a particular garment. Finally, manufacturers and retailers have proved enormously creative in labeling garments as daywear, playwear, beachwear, and loungewear, all of which may have characteristics of sleepwear. The Commission's Compliance staff must deal with these distinctions on a daily basis. New labeling requirements will become effective at the end of next month that should help alleviate the confusion for consumers, industry and our own compliance staff.

In summary, therefore, the present children's sleepwear standards represent a reasonable regulatory response that provides adequate safety from single-point, small open-flame ignition while at the same time accommodating consumer preference for natural fibers and fabrics without chemical treatment. The standards have been the product of extensive data collection and analysis, careful consideration, and full and free debate. Congress should not overturn it without equally careful consideration.

Fixed-Site Amusement Parks

H.R. 3032 would extend the Commission's jurisdiction to fixed-site amusement rides. The decision to exclude the Commission from regulating fixed-site amusement park rides was Congress's in the first place and Congress is free, of course, to change that decision. In July 1999 the Commission staff prepared a report on amusement ride-related injuries and deaths in the U.S. That report showed that the number of non-occupational injuries occurring on fixed-site amusement rides had increased between 1994 and 1998. Additional data collection, specifically including an exposure survey, will be necessary in order to determine whether the risk has actually increased to a point that merits federal intervention.

In considering whether federal regulation is appropriate, I urge Congress to consider the existence of state regulation, the adequacy of voluntary standards recognized by the industry, the extent of compliance with the voluntary standards and the role of insurance companies in requiring safe operation of rides. I do note that federal regulation does not, in and of itself, ensure safety. The Commission estimates that there are over twenty-two thousand deaths and twenty-nine million injuries every year associated with products within CPSC's existing jurisdiction. I note that there are approximately forty thousand deaths each year involving motor vehicles under the jurisdiction of the NHTSA, the agency with which we share the table today.

Finally, I must raise the issue of resources. The Commission staff is already stretched thin to meet its existing regulatory tasks, and there is no "slack" out of which additional regulatory tasks can be paid. Adding the technically complex fixed-site amusement rides to the Commission's jurisdiction would require additional funding, including travel, if regulation is to be effective. I believe that the $500,000 figure set forth in Section 3 of H.R. 3032 would not be adequate to undertake regulation of fixed-site amusement rides. I prefer to wait until the Commission staff has an opportunity to conduct some type of survey and assessment of the fixed-site amusement ride industry before estimating how much would be necessary for adequate federal regulation.

ELECTRIC BICYCLES

H.R. 2592 proposes to extend Commission jurisdiction to bicycles with small auxiliary electric motors. The Commission already has extensive regulations concerning bicycles promulgated under the authority of the Federal Hazardous Substances Act, and H.R. 2592 subjects these electric bicycles to the existing regulations. To the extent that these electric bicycles resemble bicycles in general, I am sure that they will be safer if they comply with the regulations and I support H.R. 2592.

If electric bicycles are placed under the jurisdiction of the Commission, I recommend that any regulations promulgated by the Commission be subject to the three-stage rulemaking procedures and the deferral to voluntary standards required by the Consumer Product Safety Act (CPSA) and the Federal Hazardous Substances Act (FHSA). H.R. 2592 does this, but I have seen a draft of a bill developed by Commission staff that exempts rulemaking for these bicycles from the requirements of

any statute and executive order save the notice and comment requirements of the Administrative Procedures Act. I do not support such a bill. Three-stage rulemaking helps ensure that additional mandatory regulations are given wide exposure to the regulated community, so that the Commission will have the benefit of comments about the nature and desirability of mandatory standards. Deferral to voluntary standards in appropriate circumstances has been a feature of the CPSA and FHSA since the creation of the Commission, and the desirable aspects of such deferral are just as relevant to this type of bicycle as to any other product regulated by the Committee under these statutes. The bicycle regulations to which these vehicles will be subjected were themselves products of three-stage rulemaking and the possibility of deferral to voluntary standards. I do not support exemptions from three-stage rulemaking or deferral to voluntary standards, except in cases where Congress itself specifies a mandatory rule and asks only that the Commission issue implementing regulations.

Child Safety Seats

I have examined H.R. 4145, which pertains to the standards for child safety seats. The Commission does not regulate child safety seats for use in automobiles, although it does regulate child safety seats that double as infant carriers. I find nothing in H.R. 4145 that would affect the Commission's ability to regulate such infant carriers, and I have no further comments on H.R. 4145.

ENFORCEMENT LEGISLATION

Last Friday First Lady Hillary Clinton, Chairman Ann Brown, Senator Ernest Hollings and Congressman Ed Markey announced the introduction of the "Consumer Product Safety Commission Enhanced Enforcement Act of 2000, which amends some of the enforcement powers of the Commission. I would like to address the desirability of those legislative proposals.

Restricting Election of Remedy

Section 2 of the proposed legislation modifies the election of remedy between "repair, replace or refund" that manufacturers, distributors and retailers have under Section 15 of the CPSA and Section 15 of the FHSA. Present law enables the Commission to order a manufacturer, distributor, or retailer to repair, replace, or refund the purchase price of the defective item, at the election of the manufacturer, distributor or retailer. The change would enable the Commission to reject the election made by the manufacturer, distributor or retailer if the Commission found that the election was not in the public interest. I do not support this change, since it would enable the Commission to virtually dictate the terms of any remedy, even if it made no economic sense. It could, for example, order the repair of products with virtually no economic value, or require refunds for products that could be economically repaired.

Under present law the Commission is not helpless if a repair, replace or refund program is not protecting the public. The Commission's order may require the person to whom it applies to submit a plan, satisfactory to the Commission, for carrying out the order. If the Commission concludes that the remedy elected and carried out by the manufacturer, distributor or retailer has not eliminated or adequately reduced the risk from the defective product, the Commission may reopen the case. The present system strikes an adequate balance between product safety and economic rationality and I do not support a change.

Eliminating Civil Penalty Limits

Section 3 of the draft legislation eliminates any limits on civil penalties for violations of the Consumer Product Safety Act or the Federal Hazardous Substances Act. Eliminating limits would obviously increase the stakes of any failure to report. At the same time, there has been no civil penalty during my over eight years of service as a Commissioner that came close to the present limit of 1.6 million dollars. Staff has developed a list of civil penalties assessed in the last five years for failures to report and I am attaching this list to my statement. You can see from this list that most civil penalties are between one hundred thousand and two hundred fifty thousand dollars. It is, therefore, difficult for me to see how eliminating the civil penalty limitation would materially improve our enforcement ability. It is the certainty of a penalty, rather than its theoretical upper limit that serves as a better deterrent to failures to report product hazards.

Criminal Violations

Section 4 of the draft legislation amends the Consumer Product Safety Act to create two tiers of criminal violations. A "knowing" violation of CPSA Section 19 is a

misdemeanor. Under present law, a violation must be *both* knowing and willful to be even a misdemeanor. Section of 4 of the draft legislation further amends the CPSA to make a knowing and willful violation of Section 19 a felony. The legislation eliminates the present requirement that a company be warned that it is not in compliance with the CPSA, and be given an opportunity to correct the noncompliance, prior to a criminal violation of the CPSA. The same section of the draft legislation makes willful violations of the FHSA a felony.

I do not oppose making criminal violations of the CPSA and FHSA felonies, but I firmly oppose removing the requirement that companies be warned that they are in violation of the CPSA, and being given an opportunity to correct the violation, before being prosecuted for criminal violations of the CPSA. While the Commission does deal with many large companies that have staff and counsel who are aware of the Commission and its activities, the Commission also encounters many small companies who have no idea that the Commission even exists and that there are regulations or standards concerning the products that they make. These companies should not be subject to criminal prosecution for violation of the CPSA without receiving at least a notice that they are in violation and an opportunity to correct the violation.

CONCLUSION

I appreciate the opportunity to appear today and to share my views with the Members of the Subcommittee. A dialogue between Congress and regulatory agencies is highly desirable and hearings are a useful aspect of that dialogue. I will do my best to answer any questions that the Members of the Subcommittee may have.

Mr. TAUZIN. I thank the gentlelady.

Speaking of hazardous rides now, Mr. Moore, you survived your tour of duty with Lousiana Senator John Breaux. Some sort of recognition for that. We want to welcome you, the commissioner of the Consumer Product Safety Commission. Mr. Moore.

STATEMENT OF HON. THOMAS H. MOORE

Mr. MOORE. He was one of your buddies. Thank you, Mr. Chairman. And I will briefly summarize my statement. The Commission has taken no position on the bill that would give CPSC jurisdiction over fixed-site amusement park rides. We have a lot of work to do in that area. While I have no view at this time on the substance of Congressman Markey's bill, I do believe it would take much greater resources than the $500,000 which the bill provides if this agency is to undertake this responsibility. Many fixed-site rides are extremely complicated combinations of computer technology and sophisticated engineering. We would very likely have to seek outside contractors with special expertise to evaluate these rides for potential defects. So we are going to need much more than $500,000, I repeat.

Now, I have no objections to the intent of Congressman Rogan's bill. The Commission will need to review it in more detail to make sure the final bill accomplishes its objectives in the most effective manner. The children's sleepwear issue has been before the Commission since I became a Commissioner in 1995. The Commission had a three-step rulemaking proceeding from 1993 to 1996. And then it reexamined the issue at Congress's request during 1998-1999. I have seen nothing, I have seen nothing—and I have two children myself—I have seen nothing that would lead me to believe the commission made the wrong decision to allow a limited cotton alternative in children's sleepwear. There is no data showing the tight fitting cotton creates an unreasonable risk of a fire which would lead to death or injury.

The incidents which led to the creation of the children's sleepwear standard involved looser—and I repeat looser—fitting garments, typically nightgowns and robes. And those types of garments must still meet the flammability test.

So in essence, Mr. Chairman, that is my statement at this point. And I appreciate the opportunity and would be more than happy to respond to any questions that anyone might have. Thank you.

[The prepared statement of Hon. Thomas H. Moore follows:]

PREPARED STATEMENT OF HON. THOMAS H. MOORE, COMMISSIONER, CONSUMER PRODUCT SAFETY COMMISSION

Mr. Chairman and Members of the Subcommittee, I thank you for this opportunity to address several issues of interest to the American consumer.

The Commission has taken no position on the bill that would give CPSC jurisdiction over fixed-site amusement park rides. While I have no view at this time on the substance of Congressman Markey's bill, I do believe it would take much greater resources than the $500,000 which the bill provides, for our agency to undertake this task. Many fixed-site rides are extremely complicated combinations of computer technology and sophisticated engineering. We would very likely have to seek outside contractors with special expertise to evaluate these rides for potential defects. The public should also be aware that the agency would not be able to do more in this area than it does with mobile rides, which is primarily look for defects and seek some redress, after an accident has happened. A federal inspection program that would look for problems before they happened would be very expensive. According to an article in U.S.A. Today, the State of Florida alone spends $1.2 million on its State inspectors and they do not inspect the bigger theme park rides.

I have no objection to the intent of Congressman Rogan's bill, although I am curious about the choice of a 170 pound rider in the definition of what constitutes a "low-speed electric bicycle." The Commission will need to review the proposal in more detail, along with certain changes our staff has proposed (some of which I think need some revision) to make sure the final bill accomplishes its objectives in the most effective manner.

The children's sleepwear issue has been before the Commission twice since I became a Commissioner in 1995. The Commission had a three-step rulemaking proceeding from 1993 to 1996 and then it reexamined the issue at Congress's request during 1998-99. I have seen nothing that would lead me to believe the Commission made the wrong decision to allow a limited cotton alternative in children's sleepwear. There is no data showing that tight-fitting cotton creates an unreasonable risk of a fire which would lead to death or injury. The incidents which led to the creation of the Children's Sleepwear Standards involved looser fitting garments (typically nightgowns and robes) and those garments must still meet the flammability test.

I understand the heart-felt motives that have caused some people to try to overturn the Commission's decision. However, the U.S. Consumer Product Safety Commission would not, and has not, made changes to the Sleepwear Standards that put children at an unreasonable risk.

Mr. TAUZIN. Thank you, Mr. Moore.

The Chair will recognize himself and other members in order for 5 minutes.

Let me first turn to the question of the children's sleepwear issue. Ms. Gall and Ms. Brown, obviously you have different opinions on it. My understanding is that since 1996, Congress has asked the CPSC to review this issue and that you have twice done so and twice sustained the exemption. My understanding also has a lot to do with the problem, at least I would like you to comment on it, that consumers, mothers wanted to have cotton on their children. That they were buying loosely fitting T-shirts instead and that those posed a greater danger than the tight fitting cotton standard that you permitted.

Mr. Moore, also I would like you to comment too, sir. Were you in agreement to educate and advise consumers with any labeling

and some educational effort to make consumers aware of this exemption and why it is in place? Could any one of the three of you comment. Mr. Moore.

Mr. MOORE. In terms of the information education campaign, that industry is to undertake, industry was immediately ready to move forward in that particular area. We, however, have re-examined the problem to make sure of its safety, and we made some design changes that have taken some time. And over that time period, industry has been waiting to go forward with this campaign.

Mr. TAUZIN. But it is the construction of the tight fitting garments.

Mr. MOORE. Precisely. The construction of the garment itself. I think this is an example of the tight fitting garment, as you see. And I might say that that has not been on the market very long, but already it is somewhere between 30 and 35 percent of the market.

Mr. TAUZIN. Am I correct that the concern that drove the commission to this exemption is that parents were choosing loose fitting T-shirts as opposed to tight fitting garments?

Mr. MOORE. Loose fitting cotton garments which are very very susceptible to small open flames. Now, keep in mind—and this is very important—we are not talking about a house fire. We are talking about the initiation of a small open flame.

Mr. TAUZIN. A cigarette lighter or a candle.

Mr. MOORE. That is right. That is what we are talking about. We are talking about that it must meet a standard wherein it goes out in a matter of seconds if it has contact with one of these small open flames.

Mr. TAUZIN. So the commission at least twice now already and continues to take the view that moving with standards on the construction of these tight fitting cotton garments and an educational campaign to go along with it yields a better safety result than not having the exemption and parents choosing loose fitting cotton garments that are not regulated by the commission.

Mr. MOORE. That is right.

Mr. TAUZIN. Is that the essence of the argument?

Mr. MOORE. That is the essence of the argument.

Mr. TAUZIN. Madam Chair, you disagree with that. Would you give us your point of disagreement.

Ms. BROWN. I thought, and continue to think, Mr. Chairman, that the regulation was working very well as it was. And I am a proponent of "if it ain't broke, don't fix it." And I just wanted to say that one of the primary reasons that the staff brought these changes up to the Commission was that they felt that they had a lot of problems with enforcement. And unfortunately those problems with enforcement do still exist. I will say, however, Mr. Chairman, that there is going to be no movement on this at the Commission. The data has been examined. I do think that it is time to move on from this so we can address other very serious safety problems.

Mr. TAUZIN. Quickly, because I have a limited time. Ms. Gall.

Ms. GALL. If I may just add, the reason we selected the tight-fitting cotton alternative was because of market data that showed us that parents are looking to loose fitting cotton sleepwear for chil-

dren and adult T-shirts. People were putting children in adult T-shirts. We wanted to provide a safety cotton alternative. The tight fitting reduces the likelihood of ignition. There is a lack of air to feed the fire and so on. We look at overseas data; we looked at Canadian data. They had a similar, although less stringent, standard and they have not had a series of injuries or deaths with their proposal, as we have not since this went into effect.

Mr. TAUZIN. We have a difference of opinion on the Rogan bill as well on electric bicycles that I want to air real quickly. Madam Chair, you recommend a proposal that would exempt the commission from a whole series of normal regular procedures such as the Consumer Products Safety Act, the Federal Hazardous Substance Act, chapter 6 of the U.S. code of Environmental Policy Act and Small Business Regulatory Enforcement Fairness Act.

Why is it that you disagree with the other commissioners and Mr. Rogan, who believe that if you assume jurisdiction over electric bikes that are you to follow the procedures and adhere to all these acts? Why do you want to exempt all these acts?

Ms. BROWN. Let me have Michael Solender, our general counsel, explain this to you.

Mr. SOLENDER. We have an existing standard for bicycles now. Congress would be asking us to take over jurisdiction of electric bicycles. Now to the extent that they are the same product, the rule would apply. To the extent that these are different—and I know note that they have engines in them so they will have to be different—we will have to be doing some additional modification changes supplementation of the rule. If Congress wants us to pursue this and make this a safe—regulate the safety in the way we have done with bicycles, it will be necessary in order to do that to be able to do it efficiently and effectively. Our current statute will require us to make a series of findings that it would probably, would be unable to make or be very difficult, doubtful we could do them in order to do the regulation we need.

Mr. TAUZIN. My time is up, but my understanding is if the other commissioners have a different view or a——

Ms. GALL. I do.

Mr. TAUZIN. Mr. Moore, do you have a different view as well? If you assume jurisdiction over electric bicycles, do you think you ought to exempt the commission from all of these laws that the chairwoman would like you to exempt the commission from?

Mr. MOORE. At this point I have not taken a position to that extent. No.

Mr. TAUZIN. All right. Ms. Gall you have.

Ms. GALL. I disagree because I do not think that we should remove three-stage rulemaking from CPSA and FHSA, and that would include deferral to voluntary standards. The Congress has given us a clear direction over the history of our agency that we are to look to voluntary standards first. Then, of course, there is getting rid of the Small Business Regulatory Enforcement Fairness Act. It seems to me that that should be retained and there are a number of other issues as well.

Mr. TAUZIN. We will debate that. My time is up. Before I yield to Mr. Markey, I do want to explain that I do have some questions that if they are not asked by other members on the issue of the

amusement rides, I would like to get into that with you and Ms. Millman. On the question of testing of the child seat, the staff has raised some questions that I would like answered regarding how the testing proceeds and whether or not a star rating system might not help consumers understand which are the better systems. But we will get into that, I think, as we move along. The Chair will yield 5 minutes to the ranking minority member, Mr. Markey, for a round of questions.

Mr. MARKEY. Thank you, Mr. Chairman. Chairman Brown, you and your fellow commissioners are appropriately concerned about the level of funding that would be made available for you to be able to discharge your responsibilities under my legislation for you to be able to regulate, monitor the roller coaster industry in the United States. Let's put aside just for a second the question of how much money it might take for you to discharge those responsibilities. Up until 1981, the Consumer Product Safety Commission had jurisdiction over the roller coaster industry. Do you think it was inappropriate for the CPSC to have jurisdiction over the roller coaster industry up to 1981?

Ms. BROWN. I think Congress in its wisdom gave us jurisdiction over it, and I think it was entirely appropriate.

Mr. MARKEY. Do you think it would be appropriate for you to regain authority over the roller coaster industry?

Ms. BROWN. I think it would be appropriate, particularly considering the lives and injuries and deaths and the patchwork of Federal and State regulation. I think Congress was right originally to give it to us, and I hope it can be restored.

Mr. MARKEY. Let me ask the other two commissioners the same question. Either of you may respond.

Ms. GALL. I would just say this——

Mr. MARKEY. Was it appropriate for the commission to have jurisdiction up to 1981?

Ms. GALL. Well, apparently the Congress thought so. I was not at the commission at that time so I am not aware of all the history that was involved at that time. However, I will say this, if we are tasked with this, I think before we even make a decision like that there are a number of factors we do have to look at. We have to look at whether or not the increase in the incidence of injuries and deaths in the past year or 2 is a result of increased attendance, increased use of the rides at the park, or if it is an increase in the hazard of the rides because they are different kinds or whatever. I don't know that we have the exposure data at this point—I believe we do not—to make any sound decision about that right now.

Mr. MARKEY. You won't be able to get that exposure data until you get jurisdiction over the subject material.

Ms. GALL. Well, to move on to my other point, I think we also have to take a look at what the State regulations provide, what ASTM is looking at now and what they provide through voluntary standards and what the insurance company requirements are for these particular rides. I am not saying this is a good idea or a bad idea. I am saying we have work to do before we—all of us have work to do——

Mr. MARKEY. So you are saying, Commissioner, that despite the huge increase in the number of deaths and injuries on fixed-site

roller coasters across the country, despite your own knowledge that we have moved from the model-T era of roller coasters that used to go 50 miles an hour when most of us in this room were children to an era now where they are going 70, 80, 90, 100 miles an hour and you have reservations in your mind that the Consumer Product Safety Commission should have jurisdiction, ensuring that there is some national communication of this information so that an accident in one State would not in fact injure a child in another State with the very same flaw, the very same defect in the roller coaster. But because of the lack of jurisdiction which you have that information would never be shared, you don't think you should have that jurisdiction. You have reservations about that?

Ms. GALL. Congressman Markey, none of us in this room want to see a child or an adult injured or, God forbid, die.

Mr. MARKEY. Do you want jurisdiction over this?

Ms. GALL. May I finish? Thank you.

Mr. MARKEY. The question I want answered is do you want jurisdiction over this, Commissioner. Yes or no.

Ms. GALL. I cannot tell you that yet because I have not looked at——

Mr. MARKEY. Fine.

Ms. GALL. I think that is a fair response.

Mr. MARKEY. It is not a fair response. This is an issue that is so clear in terms of the fatalities, the serious injuries to children across this country. It is a consumer product safety issue which you should have a great deal of concern for right now, Commissioner. And I am very disappointed in your answer. Mr. Moore, what is your answer.

I don't think it is a laughing matter, Commissioner. And I don't think——

Ms. GALL. I would appreciate the opportunity to speak further, but I have been cutoff several times.

Mr. MARKEY. You have not been cutoff. Commissioner Moore.

Mr. MOORE. The jurisdiction question does not bother me at all. I think we ought to have jurisdiction. It is a matter of, if we have jurisdiction, we would need appropriate resources because we don't have the sufficient manpower under $500,000 in order to accomplish it in the number of States that would have these fixed-site rides. But in terms of the jurisdiction, sure. I have no problem with this.

Mr. MARKEY. You have no problem with——

Mr. MOORE. I have no problem with jurisdiction at all.

Mr. MARKEY. My feeling about the amount of money in my bill—I authorize 500,000. Again, it is a number which is equivalent to the amount of money which you have to look at the mobile roller coasters; and if you feel that number is inadequate, you should tell the committee at this time as well. But my feeling is that with $500,000 if you were able to go in and at least in a way that ensured that you understand what happened in each one of these sites and you were able to use that money to share it with the other 49 States all of the other amusement park operators in the rest of the country if we saved just one child's life this coming summer, and I think we would save many more, not only from death but from serious injury—we are now talking thousands who are

being injured on these roller coasters—I think it would be a $500,000 expenditure that would be well spent.

Ms. BROWN. Let me just add at this point we currently spend about $100,000 doing what we do to enforce safety on mobile rides. That means that we investigate the most serious accidents and seek remedial action where appropriate. We serve as a clearing house to State governments and amusement ride operators and owners who are sharing information on mobile amusement rides on safety. And we assist the States in investigating specific defects. That minimal amount, which is what we could begin to do, could be done for $500,000. We are the best buy in government. We turn on a dime and work very well. Certainly more money could be used to do a much more dramatic effort. But as you say, to begin the very act of working with the States, of having a Federal presence, of investigating the most serious incidents and as serving as a clearing house with information is absolutely critical. We could begin the effort with $500,000.

Mr. MARKEY. You would think that it would be appropriate for the CPSC to have that jurisdiction.

Ms. BROWN. Absolutely.

Mr. MOORE. I agree with that. I am concerned as I said before about the sufficiency of our manpower.

Mr. MARKEY. I appreciate that. Thank you, Mr. Chairman.

Mr. TAUZIN. Thank the gentleman. The Chair wishes to note that there is a 15-minute vote on the floor at this time. Mr. Shimkus has gone to vote and is hopefully going to return briefly. In the meantime, the Chair recognizes the gentleman from Ohio.

Mr. SAWYER. I am not sure I can get there that fast. Just go and vote and come back.

Mr. TAUZIN. You can do that. The gentleman will go ahead and vote. I will continue to sit in the Chair until Mr. Shimkus arrives. Let me recognize myself in the meantime. Let me ask some questions about the question of regulations of amusement rides while I have the chance. It is my understanding that most of the fixed amusement rides are relatively unique rides in each one of the States. Is that correct or wrong?

Ms. BROWN. We have Alan Schoem here, who is very succinct, but is an expert in it.

Mr. TAUZIN. Would you identify yourself for the record.

Mr. SCHOEM. I am Alan Schoem, director of the Office of Compliance at the Commission.

Mr. TAUZIN. Let me see if you can answer that question. It is my understanding that the fixed amusement sites around the country each have relatively unique rides, roller coaster rides, what have you. Is that accurate or is that wrong?

Mr. SCHOEM. I don't know precisely. They have rides that I assume are unique, but there are rides that are both mobile and fixed that are used at fixed site parks as fixed rides and at carnivals as mobile rides.

Mr. TAUZIN. Is it true that mobile rides generally tend to look more alike?

Mr. SCHOEM. They tend to?

Mr. TAUZIN. Tend to be more alike.

Mr. SCHOEM. I wouldn't characterize them as more alike. There are so many different mobile rides; there are hundreds of different mobile rides just like there are fixed-site rides.

Mr. TAUZIN. Let me ask this question then in regards to the current administration of State regulations of the fixed sights. Since the law was changed to give the States authority in that area, has any State not accepted that authority where there were fixed amusement sites in the country?

Mr. SCHOEM. I believe there are a number of States that do not have regulations for amusement sites.

Mr. TAUZIN. Even though there are fixed sites in those States?

Mr. SCHOEM. Even though there are fixed sites.

Mr. TAUZIN. Could you identify those?

Mr. SCHOEM. Okay. We can provide that for the record.

Mr. TAUZIN. I would suggest that you do so. If there are States that where there are fixed amusement parks and rides where the States have not accepted the responsibility, I think it is an important part of the record. I will ask that it be submitted by your office for the record.

Ms. BROWN. Let me clarify that in 1981 when the jurisdiction was removed, it was not given to the States. It was just simply that the jurisdiction was removed from the CPSC to have authority over fixed-site amusement rides.

Mr. TAUZIN. My information now is that there are now only eight States without such a law, and that Alabama is currently addressing the issue. In five other States, there are a total of seven parks with rides. The remaining two have no parks. So we are talking basically about a universe of five States with a total of seven parks with rides. Is that close to being accurate?

Mr. SCHOEM. It sounds close to being accurate. I think our numbers are slightly different, but we compiled our list at the end of last year. But there are also different types of regulations within those States. Some may just require an insurance inspection. There are no State regulators that go in and actually inspect the rides.

Mr. TAUZIN. In regard to that point, Mr. Markey asked the question to some of you about whether or not a defect was covered in one State on a ride that is common to another ride in another State which somehow goes unnoticed in the other State. Would any of you like to comment on that or is there in an exchange of that information today, do the insurance companies do that, do the States do that? What is the current status of exchanging information on regulations and discovery of defects?

Mr. SCHOEM. For example, we recently were involved in a ride in Texas where we identified a defect and worked with the manufacturer and operators of those rides to fix all of the mobile rides that were used all throughout the United States. Secondary restraint systems were added and additional inspection procedures were added.

Mr. TAUZIN. How would that occur right now with the fixed sites in terms of a defect occurring? Is there any procedure right now?

Ms. BROWN. There is no requirement to report.

Mr. TAUZIN. No requirement. Does it happen, however, Ms. Gall?

Ms. GALL. There is a private sector organization that is composed of fixed-site amusement park owners and providers, and they do review routinely any accident information.

Mr. TAUZIN. Mr. Shimkus is in the Chair.

Mr. SHIMKUS [presiding]. Thank you. Let me begin my line; and, Ms. Millman, do the tests used by NHTSA to test child restraints accomplish any of the following things: one, do they examine the durability of child restraints for children under 50 pounds in front-impact crashes in bucket-type seats or smaller or modern cars?

Ms. MILLMAN. If I could, I would like to introduce one of the NHTSA staff, Steve Kratzke. He is the head of our rulemaking office, and he can provide more technical information about that.

Mr. SHIMKUS. As much as a yes or no as we can. I understand the bureaucracy.

Mr. KRATZKE. Yes.

Mr. SHIMKUS. Well, okay. How does child restraints perform in rear impact, rollover, side impact, or skidding accidents? Do the bench seats test for roll-overs, rear impacts, and sliding?

Mr. KRATZKE. It does not current——

Mr. SHIMKUS. Thank you. That is commensurate with the first answer. Sir, if your first answer was yes, obviously the second answer is no.

Mr. KRATZKE. No.

Mr. SHIMKUS. Does the bench test how well restraints perform in compact cars?

Mr. KRATZKE. Yes.

Mr. SHIMKUS. Do they test the effect of loose seatbelts or inadequate seat bottom stiffness?

Mr. KRATZKE. Does it test inadequate—it tightens the seat belt. So, no, it does not test that and the second part was?

Mr. SHIMKUS. Inadequate seat bottom stiffness. Obviously, a manufactured seat with the child seat is not cushion enough. Does the bench seat test for the adequate softness of the bottom of the seat?

Mr. KRATZKE. The bench seat that we use now is an older design. It is a more severe test than would be a current seat. So yes, I would say that it tests more than would an updated seat in adequate softness or angle or contour or any of those attributes.

Mr. SHIMKUS. I would venture to guess for—obviously, for folks here the issue that we are addressing is the testing—of one of the issues is the testing of car safety seats. Under the current standards, we use a bench seat from a 1973 Chevrolet Impala down a ramp. So my response would have been the ramp signifies the front-end crash, and really is testing how well that seat adheres to the bench seat of the 1973 Impala. And that is about the only thing you are able to test. I think you correctly stated that you cannot test the side crashes, the roll-overs under that method. Now, I applauded NHTSA in the opening comments and appreciation for some of the lapse areas that we feel that need to be tested, and based upon some of the, unfortunately, real-world cases; but I also applaud the work that we have done before.

Ms. MILLMAN. If I could add a little more information about the testing. One of the things that we try to do is separate the performance of the child seat from the performance of the vehicle. In a test

of the child seat, we want to find out how that particular seat performs and then we can see if it exceeds our minimum standards. But that is only part of the protection that we provide for children in motor vehicles. Things like air bags and bumpers and how the energy flows through the car are also very important determinants of whether that child is going to be injured or not in a crash. So that bench test that you are concerned about is only one part of how we look at protecting children.

Mr. SHIMKUS. As we discussed in our meeting last week, the debate is how do we move to an all inclusive testing in which real life vehicles that are being crashed every day, how do we make an inclusion of the child safety seat aspects. And the real debate over whether we should—while we are testing vehicles today, should we place in various sizes of children dummies in various seats and simultaneously test them as we are doing the other test. And I think some of the provisions that you are going to announce today and move forward with start addressing some of those questions. So we are happy to see movement in that direction.

And you also addressed changing some of the sizes, adding new dummies to, in essence, the lineup. How many currently—how many child test dummies do we have for children under the age of 6?

Mr. KRATZKE. We have a newborn, a 9-month-old, a 12-month-old, a 3-year-old and a 6-year-old.

Mr. SHIMKUS. And how many do the Europeans have?

Mr. KRATZKE. The Europeans that they use in their standard or that they have?

Mr. SHIMKUS. That they use in testing.

Mr. KRATZKE. They use in testing a 3-year-old; they are developing an 18-month-old. They have a 12-month-old and a newborn. They don't have a 9-month-old.

Mr. SHIMKUS. Okay. Will NHTSA have a dummy representing children between newborn and 12 months? I guess you have talked about that in the—the question is what is the gap between newborn and 12 months? How many test dummies are you actively using to test today?

Mr. KRATZKE. A newborn is about 7 pounds. Our 12-month dummy is 22 pounds. We have a 9-month-old dummy.

Mr. SHIMKUS. We don't have one of those here, do we?

Mr. KRATZKE. Yes. Down on the floor.

Ms. MILLMAN. This is the 12-month.

Mr. KRATZKE. This is the new 12-month-old dummy that we use and we just announced in March to assess risk of injury from air bags.

Mr. SHIMKUS. So that is the 12-month. Then there is a smaller size.

Mr. KRATZKE. There is a 9-month and newborn.

Mr. SHIMKUS. Thank you very much. And just to end on this line of questioning and since I am between votes I will be able to continue until other colleagues show up, I applaud the fact—or I wanted to ask one question this is following our discussion again on Friday. And this legislation is very similar to Senator Fitzgerald, my senator from Illinois, who dropped the bill on that side of the legislative branch months ago, maybe a month prior to the dropping of

our legislation here. He also has attempted to address to meet with you and address some of the issues. Can you tell me of your response in working with Senator Fitzgerald on this issue?

Ms. MILLMAN. His staff has indicated, as you did, that the goals are what he is trying to achieve and he is willing to look at the specific language to make sure that we are achieving these goals.

Mr. SHIMKUS. Have you actually met with members of his staff?

Ms. MILLMAN. Members of the NHTSA staff have met with members of his staff.

Mr. SHIMKUS. One question, one last question and I will move to the safety, the sleepwear, child safety sleepwear standards. The Shriners Hospital presented one case to the Consumer Product Safety Commission in which an 8-month-old child was severely burned while wearing the Winnie the Pooh bunny suit. The Consumer Product Safety Commission rejected this case because using a microscope the label says daywear, not sleepwear. Should technicalities be allowed to leave children like this defenseless against fire? I would actually like Ms. Gall and Mr. Moore to respond to that.

Ms. GALL. All right. Thank you. One of the problems that we have had, and why we came up with these amendments to the standard was the difference between some aspects of daywear and some sleepwear. And the confusion that arises out of long underwear and some daywear that can be used as nightwear and so on and so forth. What we have tried to do is provide a safe cotton alternative and——

Mr. SHIMKUS. Keep going.

Ms. GALL. I was hoping you might hold up the child. Oh, how wonderful.

Mr. SHIMKUS. Exhibit A. I told you he was coming.

Ms. GALL. Is he going to bang the gavel?

Mr. SHIMKUS. He might.

Ms. GALL. Well, clearly there is a great deal of confusion between daywear and sleepwear because sometimes it is decorated quite the same and has the same type of materials.

Mr. SHIMKUS. Let me cut to the chase. Really, my son Daniel is here to testify on behalf of all 7-month-olds. And the reality is there is no—there is really no difference for 7-month-old children for daywear and sleepwear. The reality is 7-month-old children sleep. And they sleep at night, hopefully; and they sleep during the day, hopefully. And the question is, you know, does he sleep in this daywear? Well, he is a 7-month-old, the answer is hopefully and hopefully yes, he does. Children can't run from fires. Children cannot learn to drop and roll. Infants I guess is the proper term. So why should we have a separate standard and why should we even be having the debate of sleepwear versus daywear? I mean, if we can't even address that in the sleepwear definition, how do we ever get to daywear, which for infants is sleepwear?

Mr. MOORE. I think it depends on mobility—the age of the child and the child's mobility.

Mr. SHIMKUS. Well, he is 7 months old; and he is not crawling yet.

Mr. MOORE. He is exempt from coverage under our standards because the likelihood of his coming in contact with a small open

flame or bringing himself, for instance, out to use a cigarette lighter or.

Mr. SHIMKUS. It is not——

Mr. MOORE. Or matches.

Mr. SHIMKUS. With all due respect, Mr. Moore, infants aren't going to be playing. We know that these fires come into contact with children because of negligent parents, candles, cigarettes, having children around some small flame. The question is if young children 7 month olds cannot escape the race of the flame, how can we not have this debate for sleepwear when even in daywear they are wearing daywear to sleep in?

Ms. GALL. If I may just say this, we made those amendments based on the data we had available to us. The General Accounting Office looked at that data; and while they would have liked to see additional data, they did not disagree with the conclusion we made. They looked at the years of enforcement relaxation that we had while we were considering this. They looked to the timeframe from when the amendments went into effect until now, and they found that there was no support for amending the amendment that we undertook. And again, our standard is for small open-flame single-point ignition such as matches and cigarette lighters. And obviously caregivers and parents are the first defense for children. And we recognize that is important. But there is no clothing alternative that we can design that would be fireproof under all circumstances, including house fires.

Mr. SHIMKUS. And I will let Ms. Brown finish, and then I will do a quick summation and give it back to the chairman. Ms. Brown.

Ms. BROWN. Congressman Shimkus, I was going to offer a slightly different subjects that we would offer to you at the Consumer Product Safety Commission that we come through and help you and your family babyproof your home for that adorable child.

Mr. SHIMKUS. This is my third, so I think——

Ms. BROWN. And things have changed and developed so we offer that to you and we hope we can work with your staff on that.

Mr. SHIMKUS. Thank you very much. Let me just say again that Daniel, representing all 7-month-olds, wants to make sure that they are safe in their cars from side impacts, roll-overs, rear collisions and they want to be as safe as possible when sleeping. And we appreciate your work actually in protecting our children. But I think we can move forward in trying to protect all 7-month-olds in the future. With that, I will yield back to the chairman of the committee. Thank you.

Mr. TAUZIN. I think John represents the best and safest. Thanks for bringing him, John. The Chair is now pleased today to welcome the gentleman from Ohio for 5 minutes.

Mr. SAWYER. Thank you, Mr. Chairman. My first question—and I don't want it to sound facetious because I don't mean it that way but it goes directly to a point that I have—I don't know whether it has been asked since I left, but how do you know whether sleepwear on any given child is going to be loose fitting or tight fitting? How do you know when you put it out there that someone is not going to buy it in a manner that for one child would have been tight fitting and another would have been loose fitting?

Mr. MOORE. Well, we certainly can't predict that. We can make a recommendation based on the expected age and size of the child, and make recommendations in terms of what tight fitting or snug fitting ought to be. The product itself has a hang tag on it. It is going to have that on it when we are finished with it. It has a label in it that says it needs to be snug fitting. It tells you what snug fitting is.

Mr. SAWYER. It seems to me that relying on that is kind of an illusion and that simply making sure that the fabric is appropriately treated, whether or not the child is of a size that would make it tight fitting seems to me to be the more prudent way of going about assuring that the protection that you seek is actually provided.

Ms. GALL. If I could just add one point here. Even if you buy an extra size up, a larger size of the snug fitting, you still have the cuffs here and here which reduce the flow of air.

Mr. SAWYER. I do appreciate that.

Ms. GALL. It conforms to the body, and so it still provides that measure of protection.

Mr. SAWYER. I understand that.

Mr. MOORE. And my people are telling me that we tested one size up and the product was still snug fitting.

Mr. SAWYER. Let me turn to the question of the amusement park rides. I mentioned the potential at least initially to empower the States perhaps with a mutual recognition standard so that those inspectors who are closest and insufficient in number to inspect amusement park rides would continue to be empowered to act on behalf of the commission. Does that make sense to you?

Ms. BROWN. I think that would be one approach. Having the Federal presence there would of course encourage the States and States inspections to be much more effective. We can work with the States to have a central clearing house, to share data. This would be an enhancement as I would see it to encourage the States and enhance their own protective power. What we need are people on the ground who are keeping these up to date and who know what is going on. So I think what you are talking about is, in the end, State partnership in its best sense with this legislation.

Mr. SAWYER. On another topic, can you tell us a little bit about how low-speed motorized bicycles differ from electric bicycles? Is there a substantial difference?

Ms. BROWN. Mike, could you do this. I have a resident expert on this.

Mr. SAWYER. NHTSA has proposed that you take over the whole field.

Ms. BROWN. It is a good question.

Mr. TAUZIN. Would you identify yourself.

Mr. SOLENDER. My name is Michael Solender. Could you just state the question one more time to make sure I heard.

Mr. SAWYER. I am running out of time. NHTSA has suggested that you all assume the full range of bicycle responsibility and that would include motorized low-power motorized bicycles as well as electric bikes. Could you tell us how these differ and——

Mr. SOLENDER. There are some technical issues as to what is an electric bike, and you can see in the drafts there is 2-wheel, there

is 3-wheel, and there is a speed issue. That was something that was new to us that we saw from NHTSA. We will have to look at that and see what other models are involved. At this point we can't say who would or should or can't take jurisdiction over it. It may well be appropriate. But it is something that we haven't had a chance to consider.

Mr. SAWYER. Director.

Ms. MILLMAN. If we are looking at the safety of the vehicle, then I think the distinguishing factor is the speed and not necessarily the source of the energy.

Mr. SAWYER. Let me turn then finally to the child restraints question. Where would you put child safety seats in terms of the overall spectrum of NHTSA safety programs?

Ms. MILLMAN. Are you asking in terms of our priorities?

Mr. SAWYER. Priorities, yes. Effectiveness and cost.

Ms. MILLMAN. We think that the seats themselves perform well. Where we can make the biggest improvements is getting people to use them for every trip and making sure that they are installed properly. And not to be out done by my colleague, I would like to offer each of you the opportunity to have a certified child safety seat technician inspect your child seats to make sure they are installed properly.

Mr. SAWYER. Let me ask you about the dynamics of child seat testing and the many dimensions including the size of the child, the direction and speed of the impact and so forth. As you undertake this program, would the legislation that is before us limit you or in any way misdirect you in terms of the arenas of research that you undertake?

Ms. MILLMAN. The legislation has very specific requirements. We have our planning effort underway right now that we expect to complete by the end of the summer. I would prefer that we complete that effort, which will identify the most promising areas for us to pursue. Some of those may be the things that the legislation calls for.

The other concern is that the legislation specifies timeframes. Given the state of the research and the test devices that we have available, we have some concerns about being able to meet those timeframes.

Mr. SAWYER. Let me just say in conclusion, Mr. Chairman, I appreciate your flexibility. I very much support the legislation, but I really want to make sure that you all are in the position to do the best technical job that you can do so we get the kind of outcome we want. Thank you.

Mr. TAUZIN. I thank the gentleman. The Chair recognizes the gentleman, Mr. Ganske, for a round of questions.

Mr. GANSKE. Thank you, Mr. Chairman. I think I will direct most of the questions to Ms. Brown. We are going to hear testimony a little later today from the Shriners Hospital for Children that treat over 20 percent of major pediatric burn injuries in the United States. And they have experienced over 150 percent increase in sleepwear-related burn injuries since the commission lowered the safety standards.

In fact, when they compared the years 1995 through 1996 with 1998 and 1999 they had 157 percent increase. In another category

the number of children suffering clothing-related burn injuries increased from 70 to 147 in their institutions, 110 percent increase. 1995, 1996 Shriners Hospital for Children treated three children with sleepwear-related burn injuries under 9 months of age. But in 1998, 1999 the total number of infants with injuries rose to eight, 167 percent.

I am hearing from other burn surgeons who are friends of mine around the country the same story, not just from the Shriners hospitals. And so I was struck by your testimony, which was that you took the position that if it isn't broken why fix it in terms of the rules that CPSC had before. I am interested, what was the push? Who made the push to change the regulations?

Ms. BROWN. I think this originally came from the staff that had problems, two problems that they felt were important. One was there was an enforcement problem, which Congressman Shimkus has given us right away, trying to figure out what is sleepwear and what is daywear. That was one thing. Enforcement was quite difficult. And the other——

Mr. GANSKE. Was there lobbying from the Cotton Council?

Ms. BROWN. This originated without lobbying from the Cotton Council. That has been a misconception. You know I, voted against the change in the regulations originally. There has been plenty of lobbying from the Cotton Council now. But originally from the staff that thought they could help with enforcement.

Mr. GANSKE. So the Cotton Council is weighing in heavily now.

Ms. BROWN. Certainly weighing in now but not before.

Mr. GANSKE. How much does it treat with flame retardant a child's sleepwear?

Ms. BROWN. Alan, can you tell me that. Several dollars is the answer. Several dollars.

Mr. GANSKE. Several dollars per item.

Ms. BROWN. Come on up. This is Ron Medford, who can give you some of the technical information.

Mr. MEDFORD. I am Ron Medford. I am the assistant executive director for hazard identification and reduction at the commission. Our best estimate it is about $2 a garment at wholesale level.

Mr. GANSKE. Is there cotton cloth now available that has fibers woven into it that is flame retardant, and is that significantly less expensive?

Mr. MEDFORD. There are a number of different fire retardant treatments that are available for cotton sleepwear. That is one type. And it is in about the same cost range that I just mentioned. There are a number of types of applications for the fire retardant chemicals.

Mr. GANSKE. Ms. Brown, we have heard from members of the committee that there is sort of an artificial distinction between sleepwear and not because I think that the commission itself has recognized the fact that a lot of kids are sleeping in T-shirts, things like that. Why wouldn't we just move instead of this sort of artificial distinction of tight fighting, loose clothing, why not just move to a clear labeling for consumers that says this item of children's clothing is flame retardant or is not flame retardant?

Mr. MEDFORD. Flame retardant may not be the best phraseology. The current labeling that is going to be required at the end of June

regarding the snug fitting garments is to ensure the parents know these garments have not been treated, but they are relying on the snug fit of the garment to provide the protection to the consumer.

Ms. BROWN. It is a very confusing issue. It is confusing for the people who are selling it in the stores. It is confusing for consumers. That is why originally I didn't want it to change at all. I just wanted it to be straightforward. But we had enough trouble identifying what sleepwear is, because manufacturers wanted to try and make everything daywear, so that we had a big enforcement problem, which by the way, we still have under the changed regulations. But what it should be is very straightforward, that everything, all the sleepwear that is provided to a family would be fire resistant.

Mr. GANSKE. Anything that is marketed as sleepwear should be fire retardant.

Ms. BROWN. Exactly.

Mr. GANSKE. But also, is it correct to say that your position would be that for all children's clothing, that it should be labeled either fire retardant or not?

Ms. BROWN. No. Now children's clothing you are into a larger situation, all children's clothing.

Mr. GANSKE. How about T-shirts?

Ms. BROWN. All of that is a general wearing apparel standard for children's clothing which is not as stringent as it should be. Then the Congress might be talking about an enlarged regulation. But we are just talking right here about sleepwear. Sleepwear is the only one that has this more stringent regulation, either before or after general wearing apparel takes care of all children's clothing.

Mr. GANSKE. Let me just ask a final question, that is, in light of this data that is being provided for us around the country from the institutions that are treating children, the only thing that is significantly changed is the ruling from the commission.

Ms. BROWN. I want to clarify one thing about the data. Because the CPSC has an excellent data system. As you know, I supported the original regulation. But the Shriners who are the most excellent group and we all respect them enormously, are still counting all full house fires. This regulation was only supposed to, even in its original intent, apply to small open flames. In a full house fire, the pajamas really did not protect the infant. It would only—it would only protect it if an infant brushed up—and it has nothing to do with cigarettes by the way, there's been a misconception here. If they brushed up against a candle or a lighter or a match, then the sleepwear was supposed to protect the child and, in fact, it did. We saw the injuries go down. In a full house fire, tragically, there is nothing in a full house fire that will protect a child short of an asbestos suit.

Mr. GANSKE. I think you hit upon it, an asbestos suit. But as a physician who has treated a lot of kids with burns, I find that that distinction is rather artificial too. I think we are going to hear some testimony from the Shriners and that makes, that allows you then to play with your statistics. So when I look at the data, okay, if I am looking at total children burned, 1995, 1996, as to today and I see that we are dealing with 150 percent increase and the most notable thing that has changed in the meantime has been

that we have moved to a weaker standard, in my opinion, for fire retardant children's sleepwear, I think that we need to look seriously at doing something about that. And your point, though, was that in your opinion as chairman, the position of your colleagues is set in stone.

Ms. BROWN. Absolutely.

Mr. GANSKE. And that no amount of additional requests from Congress for the commission to look at this is going to change anybody's opinion.

Ms. BROWN. That is absolutely correct. But the Congress in its wisdom could and this I see as the only out that you could get to have your point of view would be to have the Commission to go back to the old standard. But I see no movement on the Commission whatsoever in doing more work, spending more resources, trying to talk among ourselves. We are a very friendly group on this issue. I think it is rather set in stone.

Mr. GANSKE. I thank you. Thank you, Mr. Chairman.

Mr. TAUZIN. I thank the gentleman. At the request of Congressman Shimkus, the Chair would ask unanimous consent to include in the record a document from the Consumers Union dated May 15, 2000 responding to his request for counsel on the child restraint issue. Without objection that document is offered into the record.

[The information referred to follows:]

CONSUMERS UNION
May 15, 2000

Honorable JOHN SHIMKUS
House Subcommittee on Telecommunications, Trade and Consumer Protection

DEAR CONGRESSMAN SHIMKUS: Consumers Union (CU)[1] commends you for your efforts to improve the safety testing of child restraints and for introducing in the House H.R. 4145, the Child Passenger Protection Act of 2000. CU, the publisher of *Consumr Reports* magazine, has been testing child restraints for over 25 years. We believe we can offer constructive suggestions to improve the effectiveness of testing procedures and recommend effective methods for sharing that information with consumers.

Perhaps more than any other safety concern, consumers worry about the safety and well being of their children. Recognizing this concern, state legislators have enacted laws In all 50 states requiring children to be in child restraints, and many of those laws have been strengthened in recent years. The National Highway Traffic Safety Administration's (NHTSA) estimates that child restraints have saved over 1500 young lives over the past five years. We believe that consumers are more aware now than ever of the need to install child restraint systems properly and to keep children in a restraint well beyond their use of infant seats.

Child Restraint Testing Requirements

CU doesn't believe that a manufacturer ought to be permitted to advertise that a restraint is safe for a child at a specific weight unless the restraint has been tested with a dummy at that weight. In August of 1995, CU petitioned NHTSA, asking that it revise its rules to insure that statements on child restraint product labels and packaging indicating maximum "designed for use" weights not recommend a weight greater than that of the test dummy used in compliance tests. We also asked NHTSA to require restraint manufacturers to test at the 30-mph speed message as specified in the standard, with only minimum variation permitted.

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[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about good, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of *Consumer Reports,* its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports* with approximately 4.5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

The impetus for this petition resulted from CU's testing, in which three child safety seats failed Consumer Reports (CR) crash tests.[2] CU noted in the September 1995 CR article, "In our past reports on child safety seats, we took statements of compliance with the Federal standard as assurance of their safety. This time, we crash-tested the seats ourselves to find out how well they perform in trials that were similar to, but in some cases slightly tougher than, the ones the Government specifies."

Three seats received a "Not Acceptable" rating. Two popular infant seats, certified by the manufacturers as safe based on tests with smaller, lighter dummies, but labeled for use by children up to 20 pounds, performed poorly when tested with the 20-pound dummy. A third convertible seat failed in a forward facing position with a 33 pound dummy—the same sized dummy used by manufacturers to meet current government standards.[3]

CU asked the agency to reconsider its amendments to Standard 213. ". . . [b]ased on our own testing we believe that the amendments are insufficient to assure the safety of many children who will be the users of seats certified and deemed safe in compliance tests conducted in accordance with the provisions of the amended standard. Our tests reported in the *Consumer Reports* rating of child safety seats will appear in the September issue. Three models in that report are rated Not Acceptable for safety reasons."

We asked that NHTSA's rules be revised to reflect the following principles:

- The statements on product labels and packaging indicated maximum "Designed for use" weights should not recommend a weight greater than that of the test dummy specified in certification and compliance tests.
- Testing should match the 30-mph speed specified in the standard, with only minimum variation permitted. Our review of compliance reports in 1995 showed that though the existing standard and the amended standard specified an impact of 30-mph, the tests were regularly being conducted at speeds in a range from 27.6 to 28.7, and that testing at 27 instead of 30 mph generated only 81% as much energy going into the crash. In the case of one car seat, our testimony at 30-30.3 mph showed the product failing in a catastrophic manner. We recommended testing be required at 29.7 to 30.3 mph.
- The standard should require safety for *most* infants who use the product. In particular, NHTSA should revise the amended standard to require that certification and compliance tests specify a test dummy corresponding to the 95th-percentile size when a maximum age user is recommended.
- Product labeling and recommendations for both height and weight should be consistent with size of the dummy used in certification and compliance tests.

Within weeks after CU filed our petition with NHTSA in 1995, then-NHTSA Administrator Dr. Ricardo Martinez issued a press release stating: "Because of Consumers Union's announcement that it had rated three models of child seats as 'not acceptable,' parents across the country understandably are confused and concerned that the safety seat they are using may not be safe. I want to set the record straight—parents should have confidence in any safety seat that meets the federal safety standard. Their safety performance has been validated time and again in real

[2] See *Consumer Reports,* September 1995. 22 of the tested models performed well. The three models that failed were the *Century 590,* the *Evenflo On My Way 206* infant seats, and the *Kolcraft Traveler 700* convertible seat for infants and small children. NHTSA recalled the Kolcraft and Evenflo independently issued a recall of its own seat. Century continued to deny there were safety problems with the seat.

[3] CR found that the *Century 590* used with its base failed in a test with a "9 month-old" 20 pound dummy, the force of the crash causing the carrier to break away from the base. The seat performed well without its base. The *Evenflo On My Way 206* failed in tests without its base, the force of the crash breaking the shell near one of the hook-ups for the vehicle safety belt, leaving one side of the carrier with the dummy strapped inside unsecured from the bench seat. The seat performed well in tests with the "9 month old" dummy when used with its detachable base. The *Kolcraft Traveler 700's* buckle failed in the forward-facing position with the 33 pound dummy, releasing the harness and allowing the dummy to strike the overhead shield. The shield then broke away and, in one test, the dummy was ejected from the seat. In another test, the dummy was left hanging from the seat's harness straps. When tested in the rear facing position, the seat performed safely. The three failing car seats were judged "Not Acceptable" by the magazine.

Consumer Reports crash-tested the seats in a trial that was similar to—but slightly tougher than—the existing government tests. *Consumer Reports* tests closely parallel those used for government certification. Each safety seat is installed securely on an automobile seat attached to a test sled. A crash-test dummy is harnessed snugly into the seat, and the sled then simulates a 30-mph head-on crash into a fixed barrier while high-speed cameras track the movement of the dummy and seat. After the crash, the integrity of the safety seat is examined. We used, where possible, a dummy whose weight matched the manufacturer's claims on the seat.

world crashes. The agency has carefully monitored their test performance for more than a decade."

NHTSA rejected CU's 1995 petition and to our knowledge, it has not to date adopted any of the recommendations CU made in that petition. More recent testing confirms our belief that the concerns CU outlined in 1995 remain as valid today as they were five years ago.

In *Consumer Reports* January 1999 issue, we published results from our most recent tests of 28 child seats. Five seats did not pass our tests, which initially were carried out at the 30mph speed specified by the standard and at the maximum dummy weight recommended by the manufacturers. With four convertible seats the head of the toddler dummy moved forward farther than the government standard allows. We downrated those seats and retested them at 28.5 mph. All but one passed the second test. We rated the seat that did not pass even the second test "poor" for use with a toddler. With another toddler-booster seat combination tested at 30 mph with a 40 pound dummy—the maximum child weight specified for use with its harness—the base cracked and the seatback tore away. We recommended against using the seat with its harness.

Clearly the same problems exist today as did in 1995: in tests of child restraints conducted at the speed specified in the standard and with dummies that weighed the maximum weight specified by the manufacturer, some child restraints failed the tests.

We therefore ask members of this Subcommittee on Telecommunications, Trade and Consumer Protection, in your very worthy efforts to improve safety standards for child restraints, to consider directing NHTSA to make the following changes in its testing requirements:

- Revise the standard to require that statements on products labels and packaging, indicating maximum "Designed for use" weights should not recommend a weight greater than that of the test dummy specified in certification and compliance tests unless weight has been added to the dummy to the level recommended on the car seat. Parents and caregivers have the right to expect such performance for children whose weight is less than or equal to the package claims.
- Revise the certification and compliance programs to require a sled speed specified in NHTSA's Laboratory Procedure for Child Restraint System. Testing should match the 30-mph speed specified in the standard, with only minimum variation.
- Revise the standard to require that certification and compliance tests specify a test dummy corresponding to the 95th percentile size when a maximum age user is recommended.
- Revise labeling requirements to assure that manufacturer-recommended heights and weights for usage of each restraint system are consistent and match certification requirements for that system.

Consumer Information Programs

Section 2 of H.R. 4145, the Child Passenger Protection Act of 2000, calls for a safety rating program for child restraints. We believe that consumer information programs serve two functions: they give consumers reliable and accurate information about the product so they can make rational choices for their families, and they tend to serve as an inducement to manufacturers to improve their product. NHTSA's New Car Assessment Program (NCAP) is a good model of a successful consumer information program. Over a million consumers each year go to NHTSA's website to learn about side and frontal crashworthiness of vehicles they're considering leasing or buying and to compare vehicle crash scores. The NCAP program also rewards manufacturers by allowing them to achieve higher scores for safety improvements in their cars. Many safety experts credit the NCAP program with effectively inducing automakers to build more crashworthy cars. Despite the complaints of the auto industry, the crashworthiness of scores of U.S. cars have improved dramatically in the 20 years since the government started publicizing the test results. We would hope to see similar results for child restraints if NHTSA launches a consumer information program devoted to testing and rating them, and making the results available to consumers.

To our knowledge, CU is the only organization that currently tests and rates child restraints and makes those results available to consumers. We support the establishment of a governmental consumer information program for child restraints, with the caveat that the changes in NHTSA's testing as highlighted above be made a mandatory part of any NHTSA consumer information program. If NHTSA is to test child restraints, the agency must do so at the speed specified in the regulations and

using dummies whose weight is the maximum weight recommended by the manufacturer of the child restraint.

We greatly appreciate the opportunity to share Consumers Union's with members of this Subcommittee and commend you for your work on this issue of critical importance to child safety. We look forward to working with you.

Sincerely,

SALLY GREENBERG
Senior Product Safety Counsel

Mr. TAUZIN. I would also like to, for the record, inform the committee that young Daniel was accompanying our friend Mr. Shimkus today because his wife is attending the first lady's luncheon today. So this is his child duty day. The Chair is now pleased to welcome and recognize for 5 minutes the gentleman from Florida, Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman. I want to thank you again for holding this hearing. I think I'd like to address most of my questions to H.R. 3032. Ms. Gall, if you could answer this question: Since permanent fixed-based amusement sites are unlike carnivals or fairs and never leave the boundaries of their State, would ride safety be better left to those individual States to regulate or the Federal Government?

Ms. GALL. Well, it seems to me most of the States are addressing those issues right now. We would have to look at the other materials. As I have stated before, we have to look at the increased incidents and see whether there is an increased hazard that perhaps is not addressed by the States. There are a host of other factors as well. But certainly from my philosophy and because I haven't seen anything to change my mind about that at this point, it would seem to me that the States would be adequately addressing it.

When you look at the numbers of injuries and deaths on fixed-site amusement rides and compare it with other recreational activities that come under the jurisdiction of CPSC, the incidence of death and injury is much lower on fixed-site amusement rides than it is with other issues that come before the commission with other regulated consumer products.

Mr. STEARNS. Maybe a logical question would be which States are doing a good job of overseeing and regulating fixed amusement and which States are not maybe.

Ms. GALL. And I don't know that we know that at this point. I certainly don't. And I don't think we have sufficient data before the commission to make that determination.

Mr. STEARNS. Ms. Brown, do you have any information to identify which States are?

Ms. BROWN. Yes, I do.

Mr. STEARNS. Do you have that?

Ms. BROWN. We will provide that for you, Mr. Stearns. There is a patchwork of regulations, not only do some States not regulate, but they are different in what they do. I think what we are talking about here is, in effect, a Federal-State partnership. This regulation would provide for people to more thoroughly and better help regulation in their own State. We would be enhancing what the States would do by having a central data source so that they would know about different issues and also know about different kinds of problems and have more standardized kinds of tests that they could perform. It isn't that we are trying to take anything away

from the States, and I may say that in 1981 when the jurisdiction was taken away from us, it was not given to the States. It just meant that there was no Federal regulation at all on fixed-site rides.

[The following was received for the record:]

States with NO Fixed-site Ride Regulations or Statutes*	States with NO Fixed-Site Rides Operating in the States**
District of Columbia	District of Columbia
Montana	Montana
North Dakota	North Dakota
South Dakota	South Dakota
Utah	Utah
Kansas	
Missouri	
Mississippi	
Arizona	
Alabama	

NOTE:
*Per Oct 1999 USCPSC Directory of State Amusement Ride Safety Officials
**Per IAAPA Membership Directory

Mr. STEARNS. I think your idea about data collection is good. I think what some of us are concerned about is a new budget, a new bureaucracy set up. I think the industry itself, they are self-regulation, in many ways might exceed what the Federal Government would provide. And I think this was touched on earlier about the legislation's proposing to spend 500,000 annually. Yet it has been reported by the Consumer Product Safety Commission that it would cost a minimum of $5 million.

Additionally, the State of California alone currently appropriates $24 million for ride safety review. So the bill when it says it is only going to be $500,000 and the State of California is spending $24 million, what we are all worried about is that you would set up not only a data collecting commission but a huge bureaucracy with inspectors, and this would go on and on.

Ms. Gall pointed out that a lot of the States are pointed doing a great job. So if we identify just those few States that are not doing a good job, why don't we talk to those people and let them put in the industry self-regulation, which has been very successful in all these other States without a huge new appropriations of money and also bureaucracy.

Here's another question here. Does the Consumer Product Safety Commission along with ride manufacturers sit on the appropriate American Society for Testing and Materials committee? I guess, Ms., Gall would you say would that possibly be a better review board than the Consumer Product Safety Commission?

Ms. GALL. Certainly the ASTM does have voluntary standards that does address some aspects of fixed-site amusement rides. And they are looking at some additional issues, as I mentioned earlier, the G force issue, the number of Gs that someone would experience and the length of time that they would experience that G force. Congress has told us repeatedly over the years this commission has been in business to look to voluntary standards first whenever possible and then to manditory standards when voluntary standards fail.

Ms. BROWN. We are prevented from sitting on that task force, of the ASTM task force, if it has anything to do with fixed-site amusement rides. We are particularly prohibited by Congress from expending any resources on fixed-site amusement rides.

Mr. STEARNS. Let's say you have 300 to 400 million people riding fixed-base amusement rides. So that is anywhere from a billion rides or more every year. I mean, considering what has occurred in these fixed amusements and that huge numbers and that repetition it seems to me that individual States are doing a remarkably good job. And I think we have got to be careful to go out and propose a whole new appropriation and whole new bureaucracy and regulation when it appears that most of the States are doing it.

So, Mr. Chairman, I urge this committee not look at H.R. 3032 as a panacea here, but I think the chairlady, Ms. Brown, has touched upon possibly something which is a compromise language which would be a data collection that might be helpful. But possibly the States themselves that do not have the State regulation could go ahead and do it. I yield back the balance of my time.

Mr. TAUZIN. I thank the gentleman. Chair is now pleased to recognize the gentlelady, Ms. Cubin, for 5 minutes.

Mrs. CUBIN. Thank you, Mr. Chairman. I just have a couple questions. One for—actually both for Ms. Millman. It is estimated that 80 to 90 percent of children are not properly restrained. Isn't that an area where NHTSA could be more active? Education and those kind of things?

Ms. MILLMAN. Yes, that is the number that we typically use. About 80 percent of the car seats are installed improperly. Now, that can be minor things or it could be major things.

Mrs. CUBIN. What have you done to date to address that problem?

Ms. MILLMAN. Probably the most important thing is that we have developed with partners a standardized curriculum for a certification in child protection. Over 5,000 people have taken that course and achieved the certification. These are people that conduct safety seat checks. They will inspect the seat, make sure it is not a seat that has been recalled, and check the installation of it and also how the parents are putting the child in the seat.

Mrs. CUBIN. Five thousand doesn't seem like very many, since the statistic has been out there for quite a long time, it seems to me. So I would hope that would continue and maybe expand that, maybe do even more.

Ms. MILLMAN. If I could add, that is just one part. The other part of our effort in that area is the uniform attachment system that will be fully implemented by September 1, 2002. This system means that every seat will connect to every car in the same way. That will help eliminate part of the installation problem.

Mrs. CUBIN. In your testimony, you stated that NHTSA tested every new seat and model in the year that it is introduced. So doesn't that mean that for up to 12 months before you even—that the seats could be used for up to 12 months before they have even been tested? Is that right?

Ms. MILLMAN. The general framework that we use in our standards is that the manufacturer certifies to us that their product

meets or exceeds all of the minimums that are laid out in our standards.

Mrs. CUBIN. Would you—I am sorry. Would you repeat that.

Ms. MILLMAN. The framework that we use in general in our regulations is the manufacturer certifies to us that their product meets or exceeds the minimum standards in the regulation.

Mrs. CUBIN. I think it has been widely documented that a significant number of child safety seats fail compliance tests and have to be recalled after they have already appeared in retail stores. So if there is no need for legislative action in this area, how do you explain—I mean, to me it seems like waiting 12 months is waiting too long even though the manufacturer certifies it. Then if your own tests show a significant number to be recalled, it seems like you ought to be more ahead of this problem rather than behind it.

Ms. MILLMAN. Not to quibble but the test is within the year that it is introduced, so 12 months would be the maximum. But we agree that we want to make the program as strong as it can possibly be. That is why we look forward to working with the committee.

Mrs. CUBIN. Ms. Gall, you were referring to G force and the possible injuries or situations resulting from G force. Do you think anywhere near the adequate amount of study has been done on that to be passing regulations that result in——

Ms. GALL. Well, as I said before, it seems to me that not only do we need to look at the number of Gs but also the amount of time that an individual is exposed to that number of Gs.

Mrs. CUBIN. Has that been done?

Ms. GALL. I don't know that that has been explored in any detail as of yet by the ASTM committee. I know they have received data on it and they are taking a look at it. Beyond that I can't really comment.

Ms. BROWN. There is a new study just issued by the National Institute of Neurological Disorders and Strokes, which documented numerous cases of brain injury suffered by riders during normal operation of roller coasters and similar amusement rides. The study reported cases 15 cases, 14 of which occurred in the 1990's where routine roller coaster incidents resulted in brain trauma, internal bleeding, and neurological change.

Mrs. CUBIN. Is that the only study?

Ms. BROWN. That is the only study I know of to date. There may be others.

Mrs. CUBIN. So it wouldn't be unreasonable to say maybe it is too early to make a decision of the effect of G force.

Ms. GALL. I think there are a number of things we have to look at and that is one of them.

Mrs. CUBIN. Would you agree with that, Mr. Moore?

Mr. MOORE. Yes, indeed.

Mrs. CUBIN. Thank you, Mr. Chairman.

Mr. TAUZIN. There are no other members so the Chair recognizes himself quickly for a separate round, then I will recognize any of the members in order. Ms. Millman, I mentioned to you earlier that I wanted to ask you a couple of questions about the child safety restraints.

First, let me thank you as I know other members have for introducing the next generation of the crash test dummies to the scene, because obviously that is a major step forward. We thank you for that. In regard to the testing, however, how do you account for the fact that child safety seats performed differently in various models in motor vehicles? Why does that occur and why—how is that information being, you know, given to consumers, or is it?

Ms. MILLMAN. I would like to have Steve Kratzke answer that for you.

Mr. TAUZIN. Identify yourself for the record, sir.

Mr. KRATZKE. I am Steve Kratzke; I am in charge of our safety standards.

Mr. TAUZIN. If you can, first of all obviously there are different performances by the safety seats in different model vehicles. And I was asking why is that? Can you tell us why that is true, and, second, is that information given to consumers?

Mr. KRATZKE. The first part of it is the safety seat performs in a complex environment. It has the vehicle attributes—if you are in a pickup or sport utility, you will experience different forces in a crash than if you are in a small car. There are parts of the interior that you may or may not contact during that. The seat itself if it is exposed to the same forces will do the same things. That is what we do in our testing. However, it performs differently in different vehicles because the vehicles perform differently. One of the things we are looking at right now in response to the comprehensive plan is if we can develop a way to give information about performance in particular vehicles. So it is not something that we know right now exactly how would you do that.

Mr. TAUZIN. You know there are differences, but you are not yet prepared to advise consumers as to what seat performs better in each vehicle. You want to get there?

Mr. KRATZKE. Yes, we do want to get there.

Mr. TAUZIN. I would suggest that would be a critical important bit of information for consumers. If John Shimkus is buying a car seat for his child, Daniel, and he drives a particular vehicle, it would be incredibly good for him to know that the seat purchased performs best in that vehicle and that perhaps the seat that otherwise is rated well, may not perform as well in that vehicle.

Mr. KRATZKE. One of the things we are really trying to understand is how much of it is just the vehicle performance. What is different about child seats? If we can tell you that this vehicle is exceptional protection in a side impact and average impact in a frontal impact, and it does the same thing where the child seat in there, we are trying to see if we can do that. But the question I thought you were driving at is beyond the vehicle performance differences, and that part we don't know, how to get to, but we are trying to.

Mr. TAUZIN. Regardless of what the causes are for a safety restraint to perform better in one vehicle or another, it just seems to me that is a critical piece of information for consumers not only when they are purchasing a vehicle, but when they are making a decision on which one of the car seats they are going to purchase for their children.

Ms. MILLMAN. We agree. I just want to emphasize that our standards are the minimums. And a seat that is on the market meets or exceeds the minimum standards. So what we are looking at is providing information about by how much a particular seat would exceed the minimum standards.

Mr. TAUZIN. I am sure you know parents probably—given a choice for a seat that protects beyond the minimum—might want to do that. And given information that the car they are driving or the truck they are driving the seat performs better there than somewhere else might be very valuable. We are going to hear testimony from Mr. Baloga later on that roll-overs by their very nature are very difficult to replicate in a scientific action. Is that the reason why you don't have a separate roll-over end cap rating?

Ms. MILLMAN. I am very glad that you asked that because we are about to unveil a proposal that would do just that. We believe that we have come up with a way that we can rate vehicles based on their propensity to roll over and we hope to provide that information along with the star ratings that we provide on our crash tests.

I would also like to draw your attention to the pamphlet in the information packet that we provided, which is called Buying a Safer Car for Child Passengers. This includes the discussion of safety features that parents and caregivers can look for when they are comparing vehicles and includes our crash test ratings.

Mr. TAUZIN. If somebody wants that pamphlet, how do they get it?

Ms. MILLMAN. The information is on our Web site at www.nhtsa.dot.gov and also we have a hotline. They can call, and we will mail the pamphlet to them.

Mr. TAUZIN. That hotline is?

Ms. MILLMAN. 1-800-DASH2DOT.

Mr. TAUZIN. Thank you. Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman, very much. I am going to return again to this issue of roller coasters. And I am going to introduce some startling statistics in terms——

Ms. BROWN. What kinds of statistics?

Mr. MARKEY. Startling.

Mr. TAUZIN. It is Boston for "startling."

Mr. MARKEY. You all sound funny to me. When President Kennedy sounded like this, everybody thought it was charming. When it comes out of my mouth, it doesn't sound quite so.

Mr. TAUZIN. Confusing is the word.

Mr. MARKEY. So the numbers that have been gathered actually by the Consumer Product Safety Commission on the number of injuries requiring emergency room treatment over the last 5 years, gives us all great reason to be concerned about what is happening. In your own survey, looking at mobile sites, mobile roller coasters, over which you do have jurisdiction, the number of emergency room visits related to roller coaster accidents at those sights has risen since 1994 to 1998 from 2000 to 2100. Not that large of an increase.

However, on the fixed-site roller coasters, over which you have no jurisdiction, the number of emergency room visits has risen from 2,400 to 4,500 in just those 5 years. A near doubling of emergency room visits by those who have been injured on these roller

coasters. Now, here is the next interesting fact about it. Who is injured on roller coasters and other amusement park rides? This is the interesting statistic. Children are injured on roller coasters. Children who are 1——

Ms. BROWN. Can you move the water.

Mr. MARKEY. Children who are 1 or under have very few injuries. But beginning at age 2, there is a huge spike. That continues all the way through approximately age 13 or so, related, I think, to a certain extent to more reckless behavior, if there is an absence of already industry provided safety protection and the additional vulnerability that those younger children might have to neurological injury because they are not yet fully developed. So these statistics are a blistering, scalding indictment of the roller coaster industry.

A doubling of the injuries, almost all of them concentrated among children ages 2 to 13, an objection to any coordinated national effort to ensure that information about the flaws about the defects in a roller coaster in one State being shared with all of the other roller coaster operators across the rest of the country. An actual opposition to any Federal role in ensuring that there are proper inspections when an accident has already occurred so that that information can be shared the way we do with buses and trains and planes and other vehicles.

I find this to be something as we head into this vacation summer, very very troubling. We are going to wind up in a situation in which parents again put their kids in a station wagon, head toward States which I am afraid they are going to assume have safety standards in place, but not knowing that an accident that may have occurred in one State has not in fact now been communicated to another State and no requirement that they provide for the safety protections that could prevent a young girl or a young boy from suffering the same injury.

Now, people can say, well, this isn't like handgun control or some other issue or 30,000 people may be harmed in the course of a year. But for every family with every child who is seriously injured it changes the fate, the destiny of that family. It has a profound impact. And we are now talking about 4,500 children for the most part per year. And this just is a survey of 100 hospitals by the Consumer Product Safety Commission. I think it vastly understates the number of children who are visiting hospitals after taking these roller coaster rides. Remember, this is after the amusement park operators have done everything that they can to treat the child onsite with their own nurses, with their own doctors so the family wouldn't have to take the child to an emergency room.

So my hope is that this committee and ultimately the Consumer Product Safety Commission will do what is right for those families as they get in their station wagons or SUVs this summer so that we don't see a continued increase in the number of injuries, which I am afraid we are going to and the number of deaths which are also skyrocketing from numbers of 20 and 30 years ago when we rode on this relatively slow 50-mile-an-hour roller coasters.

So this is, I think, a great opportunity for the Congress. I would be honest with you that I think it is a big mistake for Congress to give up jurisdiction over this subject and to just trust the States

because this is one subject in which the States are letting ordinary families down. Thousands of children are being injured every year as the States turn a blind eye and the Federal Government turns a blind eye to the safety risks for those families across this country. Thank you, Mr. Chairman.

Mr. TAUZIN. The Chair recognizes the gentleman from Mr. Mississippi, Mr. Pickering for 5 minutes.

Mr. PICKERING. Thank you, Mr. Chairman. It is always difficult to compete with my good friend, Mr. Shimkus from Illinois, with his one baby. I started to bring my five today but was concerned it would be too disruptive. It is good to have Commissioner Moore here and the other commissioners, and I appreciate their testimony.

Let me ask Commissioner Moore, having read your statement on the proposed revocation of the children's sleepwear amendments, a few questions. And I realize our time is brief because of votes. I was struck that you stated that there is no data or any baseline figures upon which to base whether there has been a reduction in risk or burns or injuries after the adoption of the original standard. Is that correct?

Mr. MOORE. That is correct because we did not have the system, the emergency room data collection system, in place at that time.

Mr. PICKERING. Are there any other—were there Shriners or consumer groups or outside groups that have any data or information that they have submitted on the increased rate of injury or burn?

Mr. MOORE. They have submitted some data, but I think it is very important, it is critical to understand that many times—and I will have our staff speak to this—that when we are talking about this data, the Shriners and ourselves are not talking in the same direction. They are talking about, in many cases, house fires and we are talking about 3-second small open flame contact by a child. That is what we are trying to protect a child against. Not from a house fire. There is no product out there that can protect a child from a conflagration fire in a home. And many times that is important to understand. It is critical to understand what we are talking about. And I'd like our staff people who have been looking at the data to respond to that question about the data.

Mr. TAUZIN. Again, identify yourself for the record, sir.

Mr. MEDFORD. Ron Medford, Consumer Product Safety Commission. At the time that the original sleepwear standard was promulgated in early 1970, actually by the Department of Commerce, there were no national statistics kept on fire incidents. There is a known statistic that exists for the total number of fires involving clothing of all types, not just sleepwear in 1970, and that was referenced earlier. That number was 60 at the time the sleepwear standards were issued. No one knew then and really not today the number of deaths that are caused or related to sleepwear. We do know that the number is about two or three deaths per year today related to all clothing. That is sleepwear and daywear, general wearing apparel. That is the total number that exists. The biggest confusion——

Mr. PICKERING. Of those two to three, you would not know if it was daywear or sleepwear.

Mr. MEDFORD. That is right, we don't. You do not know. The main confusion revolving around the sleepwear standard has to do with what the standard was initially intended to prevent and what it was not intended to prevent. It was only intended to prevent the application of a very small flame for 3 seconds directly on the sleepwear, which is called the first item ignited. That is the only kind of injury it was intended to prevent. The kinds of cases that have been referred to time and time again by the Shriners and investigated in every instance by the commission staff wherever we get permission from the parents to investigate has shown that those fires are not those that are intended to be addressed by the sleepwear standard. That is really where the confusion lies.

Mr. PICKERING. Let me ask if there is common ground upon which we can all agree. Are there educational initiatives or efforts? When will the labeling requirements take effect? Will that be something where all sides can agree and take part in efforts to reduce the two or three deaths that we are now seeing related whether it is to sleepwear or daywear? And I know with five children, many times my wife and I by the end of the day we just want the easiest thing possible to put our children in. If it is a big T-shirt or a T-shirt that we just throw them if that and put them in bed and thank God that the day is over. But what can we do from an educational initiative and effort and when will the labeling requirements and will that help parents as they try to protect their children, as I try to do that for my own children?

Mr. MOORE. Well, we expect an educational campaign. The industry is willing to participate in an information and education campaign. As I indicated, they are ready to go forward at any time with that. And we expect them to go forward with that at least by I think it is June, I believe, in this year. Yes, by June of this year. We have been making changes in the product. That is one reason why to date there has not been a national information and education campaign. But such a campaign will get under way in June.

Mr. PICKERING. Okay. Mr. Chairman, that is good to hear. I know that we are out of time. I have one question on the amusement park issue that I would like to submit to the record.

Mr. TAUZIN. Without objection the record will stay open for 30 days and members can submit written questions. We hope the witnesses will respond in that time. I thank the gentleman. I am going to dismiss this panel as we go to this vote. But let me make one point by way of advertisement to our viewers, sort of a commercial announcement. When we come back, we will hear from a seven-member panel, one of whom, representing the International Association of Amusement Parks and Attractions, will say as he has said for the record that the Consumer Product Safety Commission staff indicated to them that the enormous increase in accidents reported by Mr. Markey was not the result of an actual increase in the number of accidents, but was a result of a change in methodology at the commission and that an independent analysis produced different results. Before I leave, would the commission like to speak to that allegation?

Ms. BROWN. Mr. Chairman, what happens is that we have 101 hospitals in our system. That gives us statistically significant results.

Mr. TAUZIN. But you added 30 hospitals, didn't you?

Ms. BROWN. Which doesn't change, except in one way which I will explain. What happens is if there is a hospital that is near an amusement park, it may get the more injuries and others less. Therefore, under this system the number of injuries are underreported, they are not overreported.

Mr. TAUZIN. It is not the question of the number of injuries that the gentleman will complain about. It is the fact that statistically there may not have been a jump of 54 percent in the year 1995, 1996; that that increase may have been the result of simply a change in the methodology. At least that is what he is going to say. The staff of your own agency informed his association.

Ms. BROWN. I think he may have misunderstood.

Mr. MEDFORD. Every few years the commission redraws a new sample of hospitals to update the most current population of emergency room-based hospitals in the country. And when you do that, some hospitals that are in your system move out and some new ones come in.

Mr. TAUZIN. So you move 30 in in that period; and his claim is that by moving the hospitals around, it artificially changed the results. But the bottom line is I have to go vote.

Ms. BROWN. We disagree.

Mr. TAUZIN. It will be interesting to hear. So as a commercial announcement, please come back after we resume after this vote. We are voting on my military construction final passage. Let me thank this panel. Please respond in writing. You have 30 days to do so if you have additional comments, and the record will stay open for additional written comments. Thanks a great deal. You have added immeasurably to our store of knowledge. The committee stands in recess for 15 minutes.

[Brief recess.]

Mr. TAUZIN. The subcommittee will please come back in order. Let me ask our guests to take seats and to cease conversations. I have a very important announcement to make and that is that I think we gave you the wrong phone number to get that wonderful pamphlet on how to find a safe car with the right safety features for your children. I wanted to give the correct number out.

The correct number for the hotline to receive those nice pamphlets and help consumers make good decisions about child safety in the car is 1-888-347-4236. So it is 1-888-347-4236. And if you are on the Internet, and you want to contact the National Highway and Traffic Administration for this information, it is www.NHTSA.DOT.gov. Again, it is www.NHTSA.DOT.gov for that same information on the Internet.

We are pleased to welcome now our second panel, which consists of seven folks, beginning with Ms. Judith Lee Stone, president of Advocates for Highway and Auto Safety; Tom Baloga, president of Britax Child Safety Incorporated; Dr. Malcolm Currie of Currie Technologies; Dr. David Herndon of the Shriners Burns Hospital in Galveston Texas; Dr. Phillip Wakelyn, the senior scientist, National Cotton Council; Mrs. Kathy Fackler of La Jolla California; and Mr. John Graff, president and CEO of International Association of Amusement Parks and Attractions, the gentleman I mentioned earlier.

We will start with Ms. Judith Stone, president of Advocates for Highway and Auto Safety. Ladies and gentlemen, the rules of our committee are that your testimony has by unanimous consent been made a part of the record. So you needn't read it all to us. We would like you to use the 5 minutes allotted to you to highlight the chief points you want to make in your oral testimony for us today so as members rejoin us we can get into a good Q&A session with you. Ms. Stone.

STATEMENTS OF JUDITH LEE STONE, PRESIDENT, ADVOCATES FOR HIGHWAY AND AUTO SAFETY; TOM BALOGA, PRESIDENT, BRITAX CHILD SAFETY, INC.; MALCOLM R. CURRIE, PRESIDENT AND CEO, CURRIE TECHNOLOGIES; DAVID N. HERNDON, CHIEF OF STAFF AND DIRECTOR OF RESEARCH, SHRINERS BURNS HOSPITAL; PHILLIP J. WAKELYN, PHD, SENIOR SCIENTIST, ENVIRONMENTAL HEALTH AND SAFETY, NATIONAL COTTON COUNCIL; KATHY FACKLER; AND JOHN GRAFF, PRESIDENT AND CEO, INTERNATIONAL ASSOCIATION OF AMUSEMENT PARKS AND ATTRACTIONS

Ms. STONE. Thank you, Mr. Chairman. I am Judith Lee Stone, and president of Advocates for Highway and Auto Safety. We call our self Advocates, so you may hear that in the testimony. I am testifying today in support of the Child Passenger Protection Act of 2000 because it is an important first step in attempting to address areas that need to be improved.

If enacted into law, H.R. 4145 would require NHTSA to consider the need for more comprehensive testing procedures including dynamic testing that simulates different crash modes and the need to use additional child test dummies. The bill would require the resulting regulations to minimize child head injuries, inside impact and in roll-over crashes and to require in vehicle testing as part of a the New Car Assessment Program. We support most of these proposals. Child restraint performance is tested on a laboratory sled, not in a full vehicle crash test. Add-on child restraints, the most prevalent restraints purchased in the U.S. Are secured to old- style 1950's standard bench seats and for built in-child restraints the seat is placed in a partial vehicle shell. Both are mounted on the sled for testing.

Although this is referred to as dynamic testing, sled testing merely simulates crash forces when the sled is suddenly decelerated. Since it does not involve a full vehicle in an actual crash, the sled test does not provide information on the interaction between the child, the child restraint and the vehicle interior under real-world crash conditions. Such testing should include consideration of an array of crash modes as provided in the bill geared toward minimizing head injuries to children, especially side impact crashes. Current sled testing only simulates head-on full frontal crashes. Head and neck injuries also occur in side impact crashes and roll-overs.

The side impact aspect is particularly important as child restraints have no current injury requirement for side impact protection. This is a problem because child restraints that are now secured with vehicle seat belts are frequently placed in the rear out-

board seating positions in order to take advantage of the 3-point lap shoulder belts which are typically provided in the outboard but not the center seating position. In the future, child restraints will be secured in the rear outboard seating positions because NHTSA recently adopted a uniform anchorage system for child restraints which goes into effect in the year 2001. The NHTSA rule requires two sets of lower anchorages in the rear set which will most likely only permit child restraints to be secured in the outboard seating positions.

Advocates also supports the need to update and improve the child test dummies currently available for child restraint testing. Each type of child restraint should be tested with instrumented dummies at the high and low end of each size and weight range recommended by the manufacturer. NHTSA is adopting a new set of more advanced test dummies, the hybrid 3 for use in evaluating performance requirements in connection with seat belts and air bags under the occupant protection standard. This set of better-instrumented, more advanced test devices should quickly be made part of the testing requirements under the child restraint standard.

The agency should as part of the rulemaking revise standard 213, the child restraint standard, to comport with the injury criteria adopted for child dummy testing for air bags and consider the need to add a neck injury criterion similar to that adopted in the standard 208.

While Advocates supports real-world dynamic testing in vehicles to ensure safety, we are not sure what approach is best to achieve this purpose. Using vehicles crash tested as part of NCAP is appealing because NHTSA already conducts both frontal and side impact crash testing in this program. However, we perceive several pitfalls with using NCAP. Only about 40 or so crash tests are conducted under NCAP in a given year, limiting the number of child restraints that could be tested in this manner. NCAP is a consumer information program which conducts crash testing at 35 miles per hour, higher than the current 30-mile-per-hour maximum test speed. This would not be appropriate for compliance testing conducted to determine whether child restraints meet performance requirements in safety standard 213.

Finally, NCAP testing is conducted with no seat in the back of the vehicle which is where the instrumentation to report the crash is placed, posing both logistical and financial problems for NHTSA. Alternatively, child restraint manufacturers could contract either with private crash test centers or with the vehicle manufacturers to place child restraints in the rear seats of vehicles that are going to be crash tested.

At a minimum a limited testing program to validate child restraint performance in the sled test should be conducted. NHTSA should evaluate which option promotes child restraint safety.

I want to move to booster seats. Advocates wholeheartedly supports the language in this bill that would require consideration of protection for children who weigh more than 50 pounds. Children roughly between the ages of 4 and 8 years and older are disenfranchised under both State restraint laws and Federal occupant protection requirements. I see the red light. I will try to move as quickly as I can.

As regards consumer information, which is a very important area, we think that labels for child restraints should be written in a language that is readily understandable. We also believe that the ratings system, a child restraint rating system, is another important step in the bill that Advocates does support. There are several elements about that that we could discuss perhaps later on. I would like to close by just saying that it is important for child restraint manufacturers to inform the public about which vehicle models are not compatible with their child restraints. Each child restraint package should be clearly labeled with this information so the consumers do not mistakenly purchase restraints that are incompatible with their vehicle. I really believe also that child restraint manufacturers could share that information with NHTSA, who in turn could publish it for consumers. Thank you.

[The prepared statement of Judith Lee Stone follows:]

PREPARED STATEMENT OF JUDITH LEE STONE, PRESIDENT, ADVOCATES FOR HIGHWAY AND AUTO SAFETY

INTRODUCTION

Good morning Mr. Chairman and members of the Subcommittee on Telecommunications, Trade and Consumer Protection. My name is Judith Lee Stone, I am President of Advocates for Highway and Auto Safety (Advocates), a coalition of consumer, health and safety groups and insurance organizations working together to reduce motor vehicle deaths and injuries.

Since its inception in 1989, Advocates has been involved in all aspects of child safety and protection issues in motor vehicles. Advocates has conducted campaigns to promote child safety and child restraint use including the "Children At Risk" campaign in 1993 and the "Kids, Cars and Crashes" campaign launched in 1996. Advocates has been in the forefront of efforts to enact state laws to improve child safety in motor vehicles including amendments to close the gaps in existing state child restraint laws. Despite many efforts, there remains a long list of states whose occupant protection laws do not cover all ages of children in every seating position. (See attached chart). We have filed regulatory comments with the National highway Traffic Safety Administration (NHTSA) on a wide variety of important child safety rules issued by that agency. Advocates has also worked to include child safety protection provisions in federal legislation such as the Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA) and the Transportation Efficiency Act for the 21st Century (TEA-21). Most recently, I personally participated as a member of the Department of Transportation's Blue Ribbon Panel—Protecting Our Older Child Passengers—which issued a set of recommendations one year ago. I also serve as a member of the Advisory Board of "Partners for Child Passenger Safety," a ground breaking research project at Children's Hospital of Philadelphia supported by State Farm Insurance.

Advocates is well aware of the need for child safety and we have documented that this concern is shared by the American public. In a 1999 poll commissioned by Advocates, the eminent pollster Lou Harris found that 93% of the American public overwhelmingly supports the federal government in their quest to set highway and auto safety standards, including standards for child safety. A 1998 Lou Harris poll showed that 90% of the public want better enforcement of child safety seat laws.

PAST IS PRELUDE

In the last 20 years there has been extraordinary progress in motor vehicle child safety, with improved child safety seat protection and adoption of state laws requiring their use. But the more we know, the more we are compelled to act in order to ensure maximum protection for all children of all ages, on every ride in a motor vehicle. NHTSA has been in the lead on improving child safety in a number of ways. For example, several years ago, the agency required child restraint manufacturers to determine the recommended use of their restraints in ranges of height and weight based on testing with different sizes of child dummies. More recently, NHTSA issued a rule to require a new system of child restraint anchorages in order to reduce the chances of incorrect installation of child restraints. New vehicles are already being produced with ready-to-use upper tether anchorages that will secure

the top of the child restraint to the vehicle chasis. By 2002, all new vehicles will be required to have the new set of lower anchorages that will allow child restraints to be installed without the use of the adult lap belt or lap/shoulder belt.

While the record of NHTSA is commendable in certain respects, and Advocates has supported them, there are areas of child safety in which the agency has not taken action. First, the testing of child restraints should be upgraded. Second, little has been done to provide protection for the so-called "forgotten child," between approximately 4 and 8 years old, who is too old or large for child restraints and too young or small for adult seat belts. In this respect, Section 2503 of ISTEA, which Advocates lobbied Congress to adopt, required that the agency address in regulation the "safety of child booster seats used in passenger cars and other appropriate motor vehicles." In response, NHTSA made a change in the rules to permit the use of belt-adjusting booster seats without an overhead tether, but has taken no other regulatory action to address the need for booster seat performance and use. Finally, the agency has not adequately addressed the need for consumer information on child restraints and child safety. I would point out that the lack of adequate resources to pursue safety in all areas is one of the major reasons for this deficiency.

Advocates addressed several aspects of the child restraint issue in our 1999 safety report entitled "Stuck In Neutral—Recommendations For Shifting The Highway And Auto Safety Agenda Into High Gear," which I would like to submit for the record. I have provided the committee with several copies of the report. With respect to child restraints the report concluded that NHTSA should take action on the following four recommendations:

1) expand the scope of the child restraint standard to children who weigh 80 pounds;
2) establish minimum requirements for child booster seats and belt-adjusting devices;
3) develop a child test dummy that is representative of a 10-year-old child; and,
4) require that child restraints be dynamically [crash] tested.

Provisions in H.R. 4145 would require NHTSA to address these recommendations.

CHILD PASSENGER PROTECTION ACT OF 2000—H.R. 4145

I am testifying before you today in support of the Child Passenger Protection Act of 2000, H.R. 4145, because it is an important first step in attempting to address the three areas mentioned above that need to be improved. The bill would direct NHTSA to conduct rulemaking to improve child restraint testing and performance, address the protection of children who weigh more than the 50 pound limit in the current child restraint safety standard, and require understandable labels and safety ratings for child restraints. Advocates supports the effort to put these issues on the front burner of the agency's rulemaking agenda.

TESTING REQUIREMENTS

If enacted into law, H.R. 4145 would require the NHTSA to consider the need for more comprehensive testing procedures including dynamic testing that simulates different crash modes and the need to use additional child test dummies. The bill would require the resulting regulations to minimize child head injuries in side-impact and in rollover crashes and to require in-vehicle testing as part of the New Car Assessment Program (NCAP). We support most of these proposals.

There is no doubt that there is room for improvement when it comes to the current methods of child restraint testing. Child restraint performance is tested on a laboratory sled, not in a full vehicle crash test. Add-on (after-market) child restraints, the most prevalent restraints purchased in the U.S. are secured to old style, 1950s standard bench seats, and for built-in child restraints the seat is placed in a partial vehicle shell. Both are mounted on the sled for testing. Although this is referred to as dynamic testing, sled testing merely simulates crash forces when the sled is suddenly decelerated. Since it does not involve a full vehicle in an actual crash, the sled test does not provide information on the interaction between the child, the child restraint, and the vehicle interior under real-world crash conditions. Advocates supports the provision in H.R.4145 that requires consideration of the need to conduct more comprehensive and real-world dynamic testing of child restraints.

Such testing should include consideration of an array of crash modes, as provided in the bill, geared toward minimizing head injuries to children, especially in side-impact crashes. The current sled testing only simulates head-on, full frontal crashes. Head and neck injuries also occur in side-impact crashes and rollovers. The side-impact aspect is particularly important as child restraints have no current injury requirement for side impact protection. This is a problem because child restraints that are now secured with vehicle seat belts are frequently placed in the rear out-

board seating positions in order to take advantage of the three-point, lap/shoulder belts which are typically provided in the outboard, but not the center, seating positions. In the future, child restraints will be secured in the rear outboard seating positions because NHTSA recently adopted a uniform anchorage system for child restraints, which goes into effect in 2001. The NHTSA rule requires two sets of lower anchorages in the rear seat which will most likely only permit child restraints to be secured in the outboard seating positions.

Dynamic side-impact testing is also necessary to ensure that interactions between side-impact air bags, now being introduced in the market, and children placed in outboard seating positions, are safe and compatible for children secured in child restraints, in seat belts, as well as for unrestrained child passengers.

Advocates also supports the need to update and improve the child test dummies currently available for child restraint testing. Each type of child restraint—rear facing infant, adjustable, forward facing toddler and booster seats—should be tested with instrumented dummies at the high and low end of each size and weight range recommended by the manufacturer. In general, NHTSA is adopting a new set of more advanced test dummies, the Hybrid-III test dummies, for use in evaluating performance requirements in connection with seat belts and air bags under the *Occupant Protection Standard* (Safety Standard 208). This set of better instrumented, more advanced test devices should quickly be made part of the testing requirements under the *Child Restraint Standard* (Safety Standard 213). In addition, the existing 9-month-old child test dummy should only be used for testing infant restraints, but it is not large enough to be used to test forward facing child restraints. A slightly larger 12-month-old test dummy should be used for testing forward facing child restraints. The Child Restraint Air Bag Interaction, or CRABI-12 test dummy representing a one-year-old child was recently added to the test dummies listed in Part 572, *Anthropomorphic Test Dummies*, of Title 49 Code of Federal Regulations. NHTSA should evaluate the use of the CRABI-12 for testing rear facing infant restraints or, possibly, forward facing toddler seats. The need to add at least one other test dummy, representing children over six years of age and 50 pounds, is discussed below in the section on booster seats.

With respect to performance requirements for injury, NHTSA recently issued a final rule on advanced air bag systems that includes newly revised injury criteria performance levels for head, chest and neck injury. For example, the agency adopted a head injury criterion of 700 HIC for the 6-year-old child test dummy and 530 HIC for the 3-year-old child dummy. The agency should, as part of the rulemaking, revise Standard 213 to comport with the injury criteria adopted for child dummy testing in Standard 208 and consider the need to add a neck injury criterion similar to that adopted in Standard 208.

While Advocates supports real-world dynamic testing in vehicles to ensure safety, we are not sure what approach is best to achieve this purpose. Using vehicles crash-tested as part of the New Car Assessment Program (NCAP) is appealing because NHTSA already conducts both frontal- and side-impact crash testing in this program. However, we perceive several pitfalls with using NCAP. First, usually only about 40 or so crash tests are conducted under the auspices of NCAP in a given year. This limits the number of child restraints that could be tested in this manner. Second, NCAP is a consumer information program which conducts crash testing at 35 miles-per-hour (mph), higher than the current 30 mph maximum test speed required for testing child restraints. This would not be appropriate for compliance testing conducted to determine whether child restraints meet performance requirements in Safety Standard 213. Finally, NCAP testing is conducted with no seat in the back of the vehicle, which is where the instrumentation to record the crash is placed. Thus, requiring child restraint tests in NCAP vehicle back seats would pose both logistical and financial problems for NHTSA. Alternatively, child restraint manufacturers could contract either with private crash test centers or with the vehicle manufacturers to place child restraints in the rear seats of vehicles that are going to be crash tested. At a minimum, a limited testing program to validate child restraint performance in the sled test should be conducted. NHTSA should evaluate which option best promotes child restraint safety.

Advocates also believes that H.R. 4145 should direct that any rulemaking also specifically consider the need to update the design of the standard bench seat used in child restraint testing under Safety Standard 213. A more realistic seat, or array of seats, including possibly contoured, angled and bucket seat designs, should be used to appraise child restraint performance in current, real-world vehicle models.

BOOSTER SEATS

Advocates whole heartedly supports the language in H.R. 4145 that would require consideration of protection for children who weigh more than 50 pounds. Advocates has on many occasions stated that children roughly between the ages of 4 and 8 years old and older are disenfranchised under both state restraint laws and federal occupant protection requirements. We firmly believe that the current 50 pound weight limit in Standard 213 should be raised to 80 pounds and that booster seat performance requirements should be regulated by NHTSA. It is essential that minimum performance requirements be established for booster seats in order to assure parents that their use is safe for older children who no longer fit comfortably in child restraints. NHTSA should also undertake an education and publicity campaign to disseminate information about the need for, and to promote the use of, child booster seats. Adult seat belts, either lap belt only or lap/shoulder systems, do not afford adequate fit and protection to children who are too short or small to use them properly.

In addition, the agency should develop and adopt a crash test dummy representative of a 10-year-old child that can be used in testing booster seats. This was among the recommendations of the Blue Ribbon Panel on Protecting Our Older Child Passengers, and Advocates fully endorses this recommendation. While we understand there may be an effort to develop such a test dummy already underway, efforts should be made to ensure that it is ready for use in the next two to four years.

CONSUMER INFORMATION

Advocates agrees that labels for child restraints, as well as all other safety and warning labels, should be written in language that is readily understandable. NHTSA has already made efforts to revise air bag labels using clear and concise language and unambiguous depictions to communicate information and warnings. The same effort should be made to ensure that all child restraint labels are equally effective in communicating information and instructions to the public.

A child restraint rating system is another important step included in H.R. 4145 that Advocates supports. The current information available to consumers, whether child restraints pass or fail the minimum federal requirements, is not sufficient to provide the public with accurate information about the comparative safety of child restraints. A rating system should be devised to provide information about how well child restraints perform above the federal requirements. Ratings could individually address several aspects of child restraint safety including structural integrity and durability, head, chest and possibly neck injury protection in both frontal- and side-impact crashes, the degree to which the restraint limits head and knee excursion, and the flammability (burn rate) of the material used in the seat covering. A child restraint rating system could be modeled on NCAP, in which crash tests are conducted above the minimum level for compliance, or restraints could be subjected to a test-to-failure approach in order to determine maximum performance levels. Regardless of the method chosen, a rating system should provide consumers with practical and readily understandable information that can be used as the basis for comparisons when shopping for child restraints. Advocates will work with NHTSA to develop a comprehensive rating system that will be informative and useful to consumers.

As written, H.R. 4145 requires the substantive rulemaking to improve child restraint testing standards be completed in two years, at the same time the rule establishes the safety rating system. While the agency can work on both issues simultaneously, it would be logical to require that the improved testing requirements be implemented before the rating system takes effect, so that the rating system will reflect information on child restraints designed to the improved standards and requirements.

In addition, it is important for child restraint manufacturers to inform the public about which vehicle models are not compatible with their child restraints. Each child restraint package should be clearly labeled with this information so that consumers do not mistakenly purchase restraints that are incompatible with their vehicle. This type of information is provided by vehicle equipment suppliers for items such as windshield wipers and headlamps. There is no reason why this could not be accomplished for child restraints, and it would eliminate a frustrating and potentially dangerous concern for many parents. Child restraint manufacturers could also be required to report this information to NHTSA who, in turn, could publish it for consumers.

Thank you, Mr. Chairman, for the opportunity to address these important issues. Advocates is prepared to work with the committee in its evaluation of H.R. 4145, and I will answer any questions you and the committee may have.

Children Not Covered By Safety Belt Or Child Restraint Laws

Alabama	Younger than 6-yrs. In out-of-state vehicle, 6+ yrs. in rear seat
Alaska	all children covered
Arizona	all children covered
Arkansas	5+ yrs. in rear seat
California	all children covered
Colorado	all children covered
Connecticut	all children covered
Delaware	all children covered
District of Columbia	all children covered
Florida	all children covered
Georgia	all children covered
Hawaii	4+ yrs. in rear seat
Idaho	4+ yrs. or 40+ lbs. in rear seat
Illinois	6+ yrs. in rear seat if driver is 18+ yrs.; all children if driver is other than parent/guardian unless parent provides child restraint
Indiana	younger than 4 yrs. in out-of-state vehicle; 12+ yrs. in rear seat
Iowa	6+ yrs. in rear seat
Kansas	14+ yrs. in rear seat
Kentucky	all children covered
Louisiana	younger than 13 yrs. in out-of-state vehicle; 13+ yrs. in rear seat
Maine	all children covered
Maryland	all children covered
Massachusetts	all children covered
Michigan	all children covered
Minnesota	11+ yrs. in rear seat
Mississippi	8+ yrs. in rear seat
Missouri	all children covered
Montana	all children covered
Nebraska	all children covered
Nevada	all children covered
New Hampshire	all children covered
New Jersey	5+ yrs. in rear seat or pickup truck
New Mexico	11+ yrs. in rear seat
New York	10+ yrs. in rear seat
North Carolina	all children covered
North Dakota	all children covered
Ohio	4+ yrs. & more than 40 lbs. in rear seat
Oklahoma	13+ yrs. in rear seat; younger than 13 yrs. if driver is nonresident of state
Oregon	all children covered
Pennsylvania	4+ yrs. in rear seat
Rhode Island	all children covered
South Carolina	younger than 6 yrs. in out-of-state vehicle; 6+ yrs. in rear seat without shoulder belt
South Dakota	5+ yrs. in rear seat
Tennessee	13+ yrs. in rear seat
Texas	15+ yrs. in rear seat
Utah	all children covered
Vermont	all children covered
Virginia	all children covered
Washington	all children covered
West Virginia	all children covered
Wisconsin	8+ yrs. in rear seat without shoulder belt
Wyoming	all children covered

Mr. TAUZIN. By the way, as a consumer who just bought a universal remote for his television set that doesn't work, and I called the manufacturer he said oh, yeah it won't work for your set. I said why do you call it universal? I understand your point. Thank you. Mr. Tom Baloga, president of Britax Child Safety Incorporated, on behalf of Juvenile Products Manufacturers Association. Mr. Baloga.

STATEMENT OF TOM BALOGA

Mr. BALOGA. Thank you, Mr. Chairman. I am Tom Baloga. President of Britax Child Safety. I was formerly with Mercedes Benz of

North America, manager of safety engineering; and I am the proud father of four children, and I am pleased to provide comments here today on behalf the Juvenile Product Manufacturers Association. The JPMA is a not-for-profit trade association whose 200 members manufacture and produce a variety of children's products. Our membership includes all of the domestic manufacturers of child restraint systems.

Clearly, children are unsafe at any speed if not in a car seat. The need for child seats is clear. It is essential to understand the important function that these seats perform. It is clear that unrestrained small children are unsafe at any speed. It is extremely dangerous for children to ride without proper protection in a motor vehicle at any time under any circumstances.

Children have been killed or seriously injured on what parents may perceive as routine trips. Unrestrained children are more likely to be killed or to suffer severe injuries if they are being held in the arms of an adult or if they are ejected from the vehicle. Almost all fatal and serious unjuries to unrestrained children result from head or spinal injuries, which are particularly debilitating. Unrestrained children being held in the arms of an adult are crushed or released and ejected from the vehicle. An unrestrained child is also in danger of being injured in certain common every day driving incidents even if the crash is not severe. Additionally, unrestrained children cause accidents which endanger not only the children but every other person on the road.

Child car seats are specifically designed to decelerate children in a controlled manner and restrain them to prevent as much as possible their striking the vehicle interior during a collision. They are designed to provide more protection for small children than a standard vehicle safety belt in a vehicle which is designed for adults. They work by using a safety harness or shield to distribute crash forces over a large area of the child's fragile body and very importantly they link the child to the vehicle's crumple zone. The vehicle plays a very important role in this process.

Manufacturers are required to certify compliance before they market these seats. Every child seat must bear the manufacturer's certification by way of a label that they are certified and the testing, sufficient testing has been done prior to say sale on the market. Manufacturers conduct these tests with their own laboratory test sleds or by using the same laboratory sleds used by the NHTSA.

Child car seats are probably the single most effective safety device ever developed for use in motor vehicles. When correctly used, the car seat reduces a child's risk of death or serious injury in a crash by 70 percent. With 100 percent correct usage, even greater reductions could be achieved. In comparison, adult lap and shoulder belts are 40 to 50 percent effective in preventing fatalities and 45 to 55 percent effective in preventing seriour injuries. This is impressive real-world experience and an indication of the effectiveness of child car seats. That is even more impressive when one considers that this is being achieved in a truly violent environment. Given this violent environment, there is no doubt that fatalities do occur. Unfortunately, children continue to die in automobile acci-

dents. Most of the deaths involve unrestrained children. In fact, in 1998 half the fatalities were unrestrained children.

It would be nice to think that every life could be saved, but the answer to the question is clearly no. Vehicle crashes involve force that can be catastrophic. Lap and shoulder belts, child care seats, and even air bags provide a certain degree of protection but cannot provide absolute protection. Misuse is a significant problem that, while showing signs for improvement, has not been truly abated. We believe that misuse must be addressed very aggressively.

The good news is that in the real world even partially misused child seats continue to provide good crash protection.

And in closing, I would just like to say that we believe that we have gone a long way with the NHTSA working together toward coming up with the LATCH system, which is lower anchors and tethers for children that was an initiative between industry and government; and we think that the results are very impressive and we will continue to improve as time goes on with the system. Thank you very much.

[The prepared statement of Tom Bologa follows:]

PREPARED STATEMENT OF TOM BALOGA, PRESIDENT, BRITAX CHILD SAFETY, ON BEHALF OF JUVENILE PRODUCTS MANUFACTURERS ASSOCIATION

The Juvenile Product Manufacturers Association is a not-for-profit trade association whose 200 members manufacture and produce a variety of children's products. These products range from cribs, high chairs, strollers, playpens, bedding, decorations, to an immensely diverse range of products designed to help parents care for their children. Our membership includes all of the domestic manufacturers of child restraint systems. Currently, there are seven major manufacturers or distributors of child restraint systems who account for more than 95% of the market.

CHILDREN ARE UNSAFE AT ANY SPEED IF NOT IN A CAR SEAT

The need for child car seats is clear. I am here today to report on our industry's view of the State of the Union with regard to the use and effectiveness of child car seats. First, it is essential to understand the important function that these seats perform. It is clear that *unrestrained* small children are unsafe at any speed. Too many accident investigations conducted by the National Transportation Safety Board (NTSB) show that it is extremely dangerous for children to ride without proper protection in a motor vehicle at any time, under any circumstances. Children have been killed or seriously injured on what parents may perceive as routine trips; within yards of the family home or while going to or returning from shopping, a baby-sitter, a relative, a local restaurant or a family trip to the ice cream store. Unrestrained children are more likely to be killed or to suffer severe injuries if they are being held in the arms of an adult or if they are ejected from the vehicle. Almost all fatal and serious injuries to unrestrained children result from head or spinal injuries when they are propelled into the instrument panel, windshield or other interior surfaces, or from the vehicle or into other restrained articles or persons in the vehicle. Unrestrained children being held in the arms of an adult are often crushed into the instrument panel or other interior surfaces by the weight and acceleration of the adult holding them or ejected from the vehicle and crushed when they collide with exterior surfaces such as another vehicle or the pavement. An unrestrained child is also in danger of being injured in certain common everyday driving incidents, even if the vehicle is not involved in a crash, such as sudden stops, swerves, turns and falling out of the vehicle. Additionally, unrestrained children can cause accidents which endanger not only the children involved, but every other passenger in that vehicle.

HOW CHILD CAR SEATS WORK

Child car seats are specially designed to decelerate children in a controlled manner and restrain them to prevent, as much as possible, their striking the vehicle interior during a head-on collision or sudden stop. They are designed to provide more protection for small children than a standard vehicle safety belt. They work

by using a safety harness or protection shield, or both, to distribute the crash forces over a larger area of the child's fragile body.

These seats are required to comply with the Federal Motor Vehicle Safety Standard 213, *Child Restraints,* which require the seats to be configured to certain dimensions, to be labeled and provide important instructions on correct usage, to be fire-resistant, and to conform to certain dynamic performance criteria to ensure proper force distribution and restraint of the child. Compliance with FMVSS 213 is administered by the National Highway Traffic Safety Administration (NHTSA), whose test programs extensively check for compliance by conducting large scale compliance testing of actual child car seats produced and available in the marketplace. This represents testing of hundreds of various car seat models annually. Manufacturers are required to certify compliance before they market these seats. Manufacturers conduct pre-market dynamic tests with the same independent laboratories used by the National Highway Traffic Safety Administration in its compliance program.

CHILD CAR SEATS ARE A RELATIVELY SAFE HARBOR IN A VIOLENT ENVIRONMENT

Child car seats are probably the single most effective safety device ever developed for use with a motor vehicle. When correctly used, a car seat reduces a child's risk of death or serious injury in a crash by 70%. With 100% correct usage, even greater reductions in risk of death could be achieved. In comparison, adult lap and shoulder belts are 40-50% effective in preventing fatalities and 45-55% effective in preventing serious injuries for the population as a whole. This is an impressive, real world indication of the effectiveness of child car seats. It is even more impressive when one considers that this is being achieved in a truly violent environment.

NON-USE IS A PROBLEM

Given this violent environment, there is no doubt that fatalities do occur. Unfortunately, children continue to die in automobile accidents. *Most of the deaths involved unrestrained children.*

As might be expected, the number of fatalities among restrained children has risen as child car seat and adult belt usage increases. Our analysis indicates that the incidence of fatalities involving child car seats in use is extremely low and shows relatively little deviation from year to year.

It would be nice to think that every life could be saved but the answer to the question—Can all lives be saved?—is clearly no. Automobile crashes involve forces that are beyond our ability to cope with. Lap and shoulder belts, child car seats and even air bags can only provide a certain degree of protection. Fatalities and injuries do occur.

Consider that the use of child car seats increased significantly over the last two decades, when it was estimated that child car seat use was only about 15%. These figures indicate significant and substantial progress in getting parents to use child car seats during the last two decades. This increase in usage, in large part, can be attributed to intensive efforts by child passenger groups and the enactment in all fifty states and Washington, D.C. of child passenger protection laws, which in varying degrees require use of a child restraint system in vehicles.

MISUSE IS A PROBLEM

Misuse is another significant problem that, while showing signs of improvement, has not been truly abated. We believe that misuse by almost a quarter of the users of child car seats is still not satisfactory. Failure to properly anchor the child car seat to the vehicle with the adult seat belt, improper seat belt routing and failure to use the child's harness and/or shield properly are the major types of misuse that is prevalent. User apathy plays the largest part of this misuse. It is not enough for a parent to own a car seat. It is not enough for a parent to place that car seat in their car if it is not properly belted and used. Unfortunately, studies have shown that users often are not attentive enough, or worse yet, realize they are not properly using a car seat (i.e., facing the child in the wrong direction or not using the harness properly).

The good news is that in the real world it is apparent that even partially misused child car seats continue to provide some crash protection in real-life crash situations. However, grossly misused car seats provide little or no protection.

Child restraint system manufacturers have attempted to combat misuse by making their designs easier to use and more resistant to misuse. For instance, child safety seat models are now made to easily tether to the vehicle anchorage points which all vehicles produced since September 1999 are required to have installed. We believe the Lower Anchor Tethers for Children ("LATCH") system requirements will prove very effective in combating misuse. All cars and seats now contain the easier

to use LATCH system. Some models of seats contain automatic locking straps, similar to the types used on adult safety belts. We applaud recent collaborative efforts aimed at promoting proper use of car seats, however, in the final analysis, only the user—the parent of the child—can make sure that the seat is used and securely attached in their vehicle.

COMMENTS ON S. 2070 AND HR 4145

The proposed legislation suggests that NHTSA should refine and add testing requirements to existing standards for child car seats. While we agree that test conditions employed to test the FMVSS 213 should reflect "real world" conditions, we have to be careful to avoid an overly simplistic approach. We certainly support standardized labeling where possible. As to the other provisions of the proposed bills, please note the following:

(1) Side impact and rollover testing does not add to the benefits provided by car seats. Because rollovers are generally considered non-repeatable events, it would be extremely difficult, if not impossible, to establish a test protocol which is, by definition, repeatable. Moreover, rollover testing is destructive in nature, as such, the tests costs could be prohibitively expensive and would likely price some consumers out of the market. There is no protocol for side-impact testing, and we are unsure what, if anything, side impact testing would teach us.

Child restraints are currently designed to minimize these types of injuries. It is our position that NHTSA needs to address this issue carefully because in many instances providing additional protection for potential head strikes could have an overall negative effect on the performance of the car seat. For example, in many situations head excursion may be reduced but the result is also a significant increase in neck loads which may result in very serious injury to the occupant. As for side-impact protection, most restraints manufactured by the industry today do provide side-impact protection. Although we would examine this issue with NHTSA, it is well accepted that the vehicle itself provides the greatest protection in side-impact collisions. However, we are willing to work with NHTSA to discuss whether rollover or side impact testing standards could be useful.

(2) NHTSA should consider the use of test hardware that reflects the designs of passenger motor vehicles. JPMA members have encouraged NHTSA for some time to update the sled test bench to a more contemporary design. Test equipment which reflects an artificial laboratory environment should be modified. We believe that the current sled bench used may actually result in a more severe simulated crash environment than is actually present in the real world.

(3) JPMA would support use of a greater variety of anthropometric dummies for testing, provided they are available for testing by industry and the cost of such testing does not increase the cost of products to consumers. Most of our member companies would consider testing with additional anthropometric dummies. However, the dummies will need to first be specified by NHTSA, and then will need to be built by dummy manufacturers. These products would then have to be widely available at the same cost as current dummy testing.

(4) JPMA would support NHTSA's regulation of restraints (boosters) for children above fifty pounds. We agree with this recommendation. Per the NTSB's recommendation, boosters should be regulated to 80 pounds.

(5) A rating system is only valuable if everyone understands what is being rated. Child restraints provide proven benefits to children involved in crashes. Child restraint manufacturers acknowledge and understand that some people may want a rating system for child restraints. However, due to the complexity and variety of real-world crashes, the wide variety of vehicle configurations, and differences among child occupants, a simple rating system based on the current Standard 213 and without an up-to-date real-world analysis of crashes would be premature and flawed. A flawed rating system is far worse than no rating system because consumers would be deceived.

Based on years of experience, child restraints have proven to do an excellent job in real-world crashes, but no child restraint can do its job when it is not used, when misused, when involved in a catastrophic crash and/or when excessive vehicle structural intrusion occurs. How would you rate these possibilities?

The issue of proper installation is already substantially addressed with the new LATCH system. Before a rating system is initiated, it is critically important for NHTSA to evaluate real-world crashes involving children restrained in child restraints and determine what aspects of lab test performance are actually relevant to a rating system.

CHILD PASSENGER SAFETY IS A CONTINUING OBLIGATION

As an association dedicated to children, we also believe that it is important not to overlook the importance of continued public education about the importance of seatbelt use among children past the toddler stage, that is to say, over four years of age. Parents who have a child who has graduated from a child car seat or booster seat should be urged to use the vehicle's lap and shoulder belts.

Belts should never be shared, and the common misuse of placing the shoulder strap behind the child's back should be avoided. Two children sharing the same seatbelt in a collision can result in a tremendous increase in the injury severity to both children as they collide violently into one another. The heads and shoulders of the children can strike one another. Failing to use the shoulder belt places the child in a lap-only belt situation. A lap belt can cause serious spinal, head or abdominal injuries to a child. A recent review of fatality data by the Children's Hospital of Philadelphia found that car seats are currently 95+% effective, even when misused. Lap shoulder belts should be used correctly, just as a child safety car seat must be used correctly to receive full crash protection. Keep in mind that physiology and anatomy of children is not the same as adults. There is a greater need to distribute the force of a crash impact more evenly over a child's body. This is aided by the use of both the lap and shoulder belts. Obviously, when using the shoulder belts, parents should make sure the child is old and large enough so that the shoulder belt fits correctly. The good news is that it seems that children are much more attuned to wearing lap and shoulder belts than were their parents. This rise in usage continues.

The JPMA recommends, however, that children be kept in child restraint systems as long as possible. A restraint especially designed for a child's body is always to be preferred over a seat belt which is designed for an adult's body.

RECOMMENDATIONS AND COMMENTS

The most serious problem continues to be the non-use and misuse of child car seats. Significant strides have been made to improve the use and minimize the misuse of child car seats over the last seven years. There is much to be done. It is still not satisfactory when millions of children are not receiving the benefits of child car seats, despite child passenger protection laws in all fifty states. The industry has made significant improvements in designing child car seats that are easier to use and which afford significant protection to children in the violent world of vehicle collisions and accidents.

The greatest enemy in this battle for wider proper usage of child car seats (and it is a battle) is apathy. The primary goal of all of us should be to increase use of child car seats. They are effective in saving children's lives and preventing serious injury to children. It is important that the public be reminded of their usage as often and through as many means as possible. Even when partially misused, child car seats offer significant protection to children in vehicles. If the premises of the proponents of this Act is that properly used child restraints are not working, then I would suggest they are mistaken. While we should always strive for improved standards, we should acknowledge how extraordinarily effective currently produced child restraints are in saving lives and preventing serious injury.

The media must and can play an important role in educating the public. Reporters have themselves conceded that it is unfortunate that all too often the media only understands the value of a story if is it sensationalized. Nothing is more tragic than the scene of an accident where a child has been killed needlessly because that child was not placed in a child car seat; it would help tremendously if the next time a reporter reports on a traffic accident (whether it be by television, radio or newspaper), he or she indicated whether the occupants of the vehicles involved in that accident were wearing seatbelts or whether children were placed properly in a child car seat or not. If made a general practice, something as simple as that could have a profound long-term beneficial effect with the public.

The existence of child passenger protection laws in all fifty states was a significant step forward in increasing use rates for child car seats. But a law in and of itself does not save lives. In order for such laws to continue to have an effect, they must be vigorously enforced with the active support of local law enforcement officials. Loopholes and exemptions which exist in a variety of state laws must be eliminated. It is not sufficient for a law to allow an infant or small child to be removed from that seat for the purpose of changing its diaper or feeding when the car is in motion. Local police officers should be rewarded for issuing citations. Next time you have a few minutes at home, call you local police department and ask them how many citations they have issued in the past year to drivers who have failed to place

small children in their cars in child car seats. Also, fines should be increased for failure to abide by these laws.

To the public, I say the next time you see someone in a car with a small child who is not in a car seat, don't be embarrassed—say something. It is important to constantly publicize and provide funding for the education of the public on this important issue. I know industry will work with consumers and government in trying to get the message out and remind users of child car seats to use them consistently. When you get in that car with your child it should be second nature to you to buckle your child up and then to buckle yourself up and make a point of telling the child that it is important. Take a few minutes out periodically just to check and make sure the child car seat is securely anchored to your vehicle and make sure the harness or shield is used properly and don't cave in to the crying and wiggling of a child who wants to get out of their seat. The momentary inconvenience to you and your child might one day mean the difference between life and death.

Mr. TAUZIN. Thank you, Mr. Baloga.

Now, Dr. Malcolm Currie, president, CEO, Currie Technologies of Agoura Hills, California. Mr. Currie.

STATEMENT OF MALCOLM R. CURRIE

Mr. CURRIE. Thank you, Mr. Chairman. I am president and CEO of Currie Technologies. My name is Malcolm Currie. I am going to submit a statement which outlines the gratitude we have for James Rogan for sponsoring the bill, Lois Capps on the other side. It is a noncontroversial but yet extremely important bill and also the many staff members who worked with us.

Let me tell you a little bit about our industry. The electric bicycle industry is comprised of a growing number of companies, both domestic and overseas, who have made great strides in the last few years to develop affordable and accessible electric-powered vehicles for mass distribution. Electric bicycles comprise a new product category of the products we make, such as the bicycle you see in front of you here today. And the pictures on the poster are, in essence, regular bicycles with small electric motors attached and batteries to drive them. The purpose of the motors is to provide a clean nonpolluting power-assist to the rider. This allows more people to use more bikes in more situations.

Mr. TAUZIN. Dr. Currie for the sake of our audience, what is the difference between that bike and a moped.

Mr. CURRIE. A moped is generally higher. These are fairly lightweight, regular bicycles. Moped you will see much heavier plastic around it. It is more like a light-motor cycle. A typical moped is gasoline operated. And you use the pedal only to get it started, then it just runs on the gasoline engine. The gasoline engine has many times the power of these little electric motors.

Mr. TAUZIN. So the basic difference is that this is a regular bike with a battery-powered assist motor.

Mr. CURRIE. Yes, sir.

Mr. TAUZIN. As the moped, which is generally a much larger, heavier unit with a gasoline or some other powered engine attached.

Mr. CURRIE. That is correct. These bicycles, their top speed is 16 to 18 miles an hour. That is the fastest they can go, even if you are pedaling with them. A typical moped and within the NHTSA regulations that can go up to 30 miles an hour for extended periods.

Mr. TAUZIN. Thank you, sir.

Mr. CURRIE. The customers include older riders and those with disabilities, who may be otherwise unable to travel by bicycles. They include law enforcement agencies. Well over 200 of them are using them regularly on patrol today; and numerous other constituencies nationwide will find that electric bicycles increase the practicality of bicycles. And in fact, many and a growing population are using them for commuting when they cannot afford automobile transportation.

The electric bikes all have something in common. They are essentially regular bicycles, as I mentioned, using typical bicycle frames and bicycle components. The motors are very low powered, low speed. The top speed of all of our products is 16 to 18 miles an hour. They all produce zero air pollution.

To put the electric bicycle in further perspective, it is easy for us all to visualize an average person can produce roughly 140 or 150 watts of power for perhaps 1½ or 2 hours before they get exhausted. A top athlete like Lance Johnson, of course, and it is in one of those upper corners on the poster, can maintain a speed of 25 miles an hour for many hours using a very lightweight racing bike. By contrast, a typical electric bike without pedaling can go at 12 miles an hour or so for 90 minutes at which time the battery will need recharging. The simultaneous pedaling while using the motor as an assist it can go longer at low speed because battery power is thereby conserved.

Mr. TAUZIN. About how much longer?

Mr. CURRIE. It depends upon how much energy the rider wants to put in. Typically a bicycle like that without pedaling for an average weight will go 15 to 20 miles. You can extend it to 30 miles on the level if you put in just a little bit of energy; and it really doesn't require your pulse rate to go up very much.

By comparison, and this gets back to your question of the moped, in even the smallest gasoline-powered moped has at least 5 horsepower compared to 1 or less here and can sustain a speed of 30 miles an hour or more for several hours without refueling. The electric bike, therefore, maintains what we call human equivalency. And the purpose of the motor is mainly to help climb hills at very low speeds. And for night operation, there is a plethora of small after-market bicycle lights that can handle night riding.

Now, why is H.R. 2592 necessary? The purpose of the bill is very simple. It is to provide a uniform national definition of electric bikes and to ensure that the Consumer Product Safety Commission regulates these products as they do all other bicycles. The legislative remedy is necessary because NHTSA currently interprets the statutory definition of motor vehicle as applying to bicycles with low-power motors that cannot operate independently of pedaling, thereby subjecting them to motor vehicle requirements.

This means the addition of a large array of costly and unnecessary equipment, brake lights, turn signals, automotive-grade headlights, fairly large headlights, powerful headlights, et cetera. This increases the cost tremendously, and the additional cost and waste and power drain of these devices would effectively kill the growing market for electric bikes.

NHTSA has taken this position only because it is the only position they could take within the current law. And the electric bike,

as I mentioned, is defined in this proposed legislation as a new product category. I would like to make it absolutely clear at this point that our industry is firmly in favor of safety standards. In fact, we believe very strongly that safety standards are essential to the long-term success of our industry. And we introduce new improvements all the time adding to safety.

Our point is merely that these vehicles should be subject to bicycle safety standards, since they are indeed bicycles, and should not be subjected to motorcycle-type safety standards since they are clearly not even light motorcycles or mopeds. H.R. 2592 would ensure that this would be the case. Not only is this legislation noncontroversial and much needed, but it is also pro Americans with disabilities, pro elderly, pro safety, and pro environment. A lot of good stuff there.

Many disabled riders are able to employ electric bicycles to provide them freedom of mobility without the cost or stigma of an electric wheelchair. Because of electric bicycles, older Americans are now reaping the benefits of increased exercise and life-style flexibility enjoyment of the outdoors. Electric bicycles provide effective low-cost transportation and particularly for those who cannot afford automobiles. Law enforcement operators, a large and crucial segment of our market, are finding electric bikes extremely practical in patrolling neighborhoods and downtowns. Electric bicycles preserve our environment, reduce air pollution, reduce congestion, conserve energy, and enhance the quality of life for all Americans.

Mr. Chairman, this bill enjoys widespread support in our industry, and in this statement is a list of a number of the companies involved. One again, I thank the subcommittee for its time and urge favorable consideration of this bill. And a couple of my colleagues are in the audience, we are available to answer any questions that you may have.

[The prepared statement of Malcom R. Currie follows:]

PREPARED STATEMENT OF MALCOLM R. CURRIE, PRESIDENT AND CEO, CURRIE TECHNOLOGIES, INC.

Mr. Chairman, Members of the Subcommittee, my name is Dr. Malcolm Currie. I am President and CEO of Currie Technologies, Inc., and am here today on behalf of the entire domestic electric bicycle industry. With me are representatives from two of the other largest companies in the U.S. electric bicycle industry: Mr. Warren Dennis of the Electric Transportation Company, and Mr. Doron Amiran of ZAPWORLD.COM.

Mr. Chairman, I would like to begin by thanking you not only for holding this hearing, but also for the interest you have shown in this non-controversial, yet extremely important legislation. I would also like to thank Full Committee Chairman Bliley and Ranking Minority Member Dingell for their bipartisan support of Committee action on this bill. Most importantly however, I want to pay special recognition to Congressman James Rogan who is not only the sponsor of this legislation, but whose dedication, perseverance, and commitment made today possible. And, as a further affirmation of the bipartisan support for their bill, a word of appreciation for Congresswoman Lois Capps who has also worked tirelessly on behalf of our cause.

Industry Overview

Mr. Chairman, before explaining the details of the bill you have before you, and the reasons why it is so crucial to our young industry, I would like to take just a few moments to outline who we are.

The electric bicycle industry is comprised of a growing number of companies—both domestic and overseas—who have made great strides in the past few years to develop affordable and accessible electric powered vehicles for mass distribution. Elec-

tric bicycles comprise a new product category. The products we make, such as the bicycle you see before you here today, are bicycles, with small, low-powered motors attached. The purpose of the motors is to provide a clean, non-polluting power-assist to the rider. This allows more people to use bikes in more situations.

To date over 40,000 electric bikes have been sold in the U.S. alone, and we believe this represents just the tip of the iceberg. Customers include older riders, and those with disabilities who may be otherwise unable to travel by bicycle; law enforcement agencies—well over 200 of whom are using electric bikes on patrol—who use electric bikes in their community policing programs; and numerous other constituencies nationwide who find that electric bicycles increase the practicality of a bicycle. Many are now being used for commuting to work, often by people who cannot afford automobile transportation.

Although electric bikes come in many styles and designs, they all share a few common features:

- They are essentially bikes, using typical bicycle frames and components.
- The motors are low speed—the top speed of all our products is 16-18 mph.
- They all produce zero air pollution.

To put the electric bicycle in further perspective that is easy for us to visualize, an average person can produce roughly 150 watts of power for perhaps a couple of hours before exhaustion. This is sufficient to pedal a regular bicycle at a speed of about 15 mph for perhaps 90 minutes. (Of course, a top athlete like Lance Armstrong could maintain a speed of 25 mph for many hours.) By contrast, a typical electric bicycle without pedaling can go at 12 mph for about 90 minutes at which time the battery will need recharging. With simultaneous pedaling while using the motor as an assist, it can go longer because battery power is thereby conserved.

By comparison, even the smallest gasoline-powered moped has at least 5 horsepower and can sustain a speed of 30 mph or more for several hours without refueling.

The electric bike therefore maintains what we call "human equivalency" and the purpose of the motor is mainly to help climb hills at very low speeds. For night operation, a number of powerful after-market lights are adequate (same as for a regular bicycle).

HR 2592

What is HR 2592 and why is it necessary?

HR 2592's purpose is simple: to provide a uniform national definition of electric bikes, and to ensure that the Consumer Product Safety Commission regulates these products, as they do all other bicycles.

A legislative remedy is necessary because the National Highway Traffic Safety Administration currently interprets the statutory definition of "motor vehicle" as applying to bicycles with low powered motors that can operate independently of pedaling, thereby subjecting them to motor vehicle requirements. Subjecting electric bicycles to motor vehicle requirements would mean the addition of a large array of costly and unnecessary equipment—brake lights, turn signals, automotive grade headlights, rear view mirrors, and more. These additions would raise the cost of an electric bicycle by hundreds of dollars, in many cases doubling the cost of the bike. This would effectively kill the growing market for electric bikes.

NHTSA has never indicated that they have taken this position because it is good policy. Rather they have claimed that existing law requires them to do so.

I would like to make it clear at this point that our industry is firmly in favor of safety standards. In fact, we believe very strongly that safety standards are essential to the long-term success of our industry. Our point is merely that these vehicles should be subjected to bicycle safety standards, since they are indeed bicycles, and should not be subjected to motorcycle safety standards, since they are clearly not even light motorcycles or mopeds. HR 2592 would ensure that this would be the case.

Not only is this legislation non-controversial and much needed, but it is also pro-Americans with disabilities, pro-elderly, pro-safety, and pro-environment.

- Many disabled riders are able to employ electric bicycles to provide them freedom of mobility without the cost or stigma of an electric wheelchair.
- Because of electric bicycles, older Americans are now reaping the benefits of increased exercise and lifestyle flexibility.
- Electric bicycles provide effective low-cost transportation, and particularly for those who cannot afford automobiles.
- Law enforcement officers, a large and crucial segment of our market, are finding electric bikes extremely practical in patrolling neighborhoods and downtowns in a manner consistent with the highly successful emphasis on "Community Policing", and,

- Electric bicycles preserve our environment, reduce air pollution, reduce congestion, conserve energy, and enhance the quality of life for all Americans.

Mr. Chairman, this bill enjoys widespread support in our industry. The list of organizations supporting HR 2592 includes: Electric Cycle Association; Diamondback Bicycles; ZAPWORLD.COM; EV Global Motors; Electric Transportation Company; Total EV (subsidiary of CSW Utilities); Currie Technologies Incorporated; and Raleigh Cycle USA

Once again, I thank the Subcommittee for its time and urge favorable consideration of this bill. My colleagues and I are available to answer any questions you may have.

Mr. TAUZIN. Thank you, Dr. Currie.

We are now going to switch gears again and hear a little bit about burn safety, and we hear from Dr. David Herndon of the Shriners Burn Hospital in Galveston, Texas. On behalf of the American Burn Association and the Shriners Hospitals for Children, Dr. Herndon.

STATEMENT OF DAVID N. HERNDON

Mr. HERNDON. Thank you, Mr. Chairman. It is a great honor to be able to testify today. I have with me today the chairman of the board of the Shriners Hospital, John VerMaas; the chairman of the board emeritus, Mr. Gene Bracewell; and the chief of staff of the Shriners Burns Hospital in Boston, Ron Tompkins, who is also president of the American Burn Association. There are also members of the Safe Environment for Children Fire Coalition here today.

What we would like to testify for is expansion of flammability standards for children, not restrictions. Since the Commission withdrew requirements for protection of children between the ages of 0 and 9 months of age and for close-fitting clothing in the year that began in 1997, we have compared the incidents of flame injury at the Shriners Hospitals, at our four different hospitals between the years 1995 and 1996 and the years after the regulations were decreased, 1998 to 1999. As is present after page 23 in the written testimony that I provided, the number of burn patients in which sleepwear of the first thing ignited in the accident increased from 14 pre-reduction in regulation to 36, 157 percent increase between those 2 periods.

We also saw 110 percent increase in clothing-related injuries and a 43 percent increase from 218 to 311 in burns that were caused by fire that we could not isolate the cause of burning injury precisely. Many of those probably did involve sleepwear. But we, as health care individuals, are not gathering labels in the emergency room. We are thinking more about saving the patients. The data that was used by the Commission to determine that there has been no increase in incidence of injury since the withdrawal of regulations draws upon a hundred sample of emergency rooms from around the country. Only four burn units are represented there in that sample, and three of those do not admit children. One is the Massachusetts General, run by Dr. Tompkins who is here with us today. Children are admitted directly to the Pediatric Burns Institute of the Shriners in Boston. Kings County in Brooklyn, pediatric burn patients are admitted to the New York Hospital in the city of New York. Kansas City Children's Hospital, patients in that district are admitted to the Galveston Burn Unit for treatment of burns.

So a sampling error has been made in data collection that has allowed us to let go unrecognized the fact that children under 9 months of age who are no longer protected by having fire retardant placed in their sleepwear have had an increase of 167 percent in sleepwear-related injuries between the period when the protections were present and the current era when the protections are not present. Detailed data are available in my testimony that has been submitted, but I want to share with you a couple of examples.

LT, a 5-month-old whose sleepwear was caught on fire, sustained an 18 percent total body surface burn. LT no longer has a foot.

JD, a 9-month-old child who was sleeping in bed when one of his siblings came and lit his clothing on fire with a cigarette lighter, sustained a 45 percent total body surface burn. He is still rehabilitating.

A child in her mother's arms is depicted. And then we go to tight-fitting clothing. JF, a 4-year-old who was wearing close-fitting long underwear, a bunny suit, brushed against a candle in his family's dining room. He sustained a 15 percent total body surface burn, burning the surface of his back rather seriously.

A 2-year-old child on whom a candle fell on top of his sleepwear. The sleepwear caught fire, and the flames went to his face. His face is now scarred for life.

Another case of a 50 percent total body surface burn in tight-fitting clothing.

I would like to describe another child, Dorian Morales, one that was briefly alluded to before, who is in a bunny suit such as this one which, if you use a microscope, the label says it is not intended for sleepwear. But mothers frequently use this kind of fabric for sleepwear. A halogen lamp fell upon that garment, the clothing lit on fire, then the bed subsequently lit on fire, and he sustained an 80 percent total body surface burn.

We are led to believe that any burn that is greater than a small circumscribed burn is not contributed to by burning clothing. We are also led to believe that clothing itself does not protect. RO is a 2-year-old child who was wearing a flame-resistant pajamas top and diaper when he ran through a house that was burning. He was totally unburned where the fire-resistant clothing was present. He was burned everywhere else, his face, his legs his feet where the fire-resistant clothing was not present.

We would submit, Mr. Chairman, that you should expand fire-safe clothing laws not restrict them. We believe, since the restriction, the incidents of injury has truly gone up. We believe that the limited definition of what an injury is that is caused by flame that the CPSC is using is misleading. We believe new legislation is required so that there is no longer any misleading possible.

We think that clearly labeled sleepwear that says it is fire resistant or not fire resistant, rather than this tight-fitting fabric which currently says sleepwear should be flame resistant or snug fitting to meet U.S. Consumer Product Safety Commission sleepwear requirements. And then a little bit further down, if you bother to keep going, this garment should be worn snug fitting. Fire engine, rescue. Is that always going to be snug fitting? Thank you very much, Mr. Chairman.

[The prepared statement of David N. Herndon follows:]

PREPARED STATEMENT OF DAVID N. HERNDON, SHRINERS HOSPITALS FOR CHILDREN, AMERICAN BURN ASSOCIATION, TASK FORCE FOR FIRE SAFE ENVIRONMENTS FOR CHILDREN [1]

I. INTRODUCTION

Mr. Chairman and Members of the Subcommittee, thank you for holding this hearing today. A burn injury is one of the most devastating of the accidental injuries that can occur to an individual. Health care professionals consider burn injuries to be one of the most intensely painful injuries the body can sustain. If a child survives a burn injury, it often leaves a legacy of years of painful reconstructive surgery, permanent scarring, disfigurement and severe functional disabilities. These injuries, terrible for an adult, are particularly cruel for children, who rely on adults to protect them.

We come here today representing organizations that have all too much experience with traumatic burn injuries, the Shriners Hospitals for Children, the American Burn Association and the Task Force for Fire Safe Environments for Children. I am the chief of staff of the Shriners Hospitals for Children Burns hospital in Galveston, Texas, a Professor of Surgery at the University of Texas and a past President of the American Burn Association. Accompanying me is Dr. Ron Tompkins, Chief of Staff of the Shriners Hospitals for Children Burns Hospital in Boston, Professor of Surgery at the Harvard Medical School and current President of the American Burn Association, the primary association of health care professionals working in burn care, prevention, research, rehabilitation and teaching in this country.

I would also like to acknowledge the presence of Mr. John VerMaas, Chairman of the Board of Trustees of Shriners Hospitals for Children, and Mr. Gene Bracewell, Chairman Emeritus of the Shriners Hospitals Board of Trustees. It is through the support of Shriners such as John VerMaas and Gene Bracewell that Dr. Tompkins and I are able to carry on our work on behalf of the children who suffer these horrible burn injuries. Shriners Hospitals have been in existence for over seventy-five years. The 20 Shriners Hospitals in the United States provide 100 percent free care to hundreds of thousands of children, accepting neither government, insurance or parental reimbursement for the care provided.

Dr. Tompkins and I everyday see terrible burn injuries that could have been prevented or minimized. Sadly, the government agency charged with protecting children from burn injuries, the Consumer Product Safety Commission ("Commission" or "CPSC") has dropped the ball. An agency with many strengths, the Commission has a weak link when it comes to protecting infants and children from fire related injuries sustained while wearing sleepwear and certain types of daywear used as sleepwear.

II. SHRINERS HOSPITALS TREAT OVER TWENTY PERCENT OF ALL MAJOR PEDIATRIC BURN INJURIES IN THE UNITED STATES. SINCE THE CONSUMER PRODUCT SAFETY COMMISSION LOWERED THE SAFETY STANDARDS BEGINNING IN 1997, THE NUMBER OF SLEEPWEAR-RELATED BURN INJURIES TO CHILDREN HAS INCREASED OVER 150 PERCENT AT SHRINERS HOSPITALS.

Originally, Shriners Hospitals focused on pediatric orthopaedic work, but in 1966 Shriners Hospitals decided to provide care for the thousands of children burned across the country every year and started the first of its four burn units in Galveston, Texas. Today, Shriners Hospitals operate four burn units in Galveston, Boston, Cincinnati and Sacramento, which together treat over 20 percent of all major pediatric burn injuries in the United States. As such, the experience at Shriners Hospitals provides a unique database for assessing the impact of the Consumer Product Safety Commission's actions on the safety of our nation's children.

The CPSC's actions took effect in 1997. To determine whether these actions resulted in any increases in pediatric burn cases (U.S. citizens only), we compared 1995 and 1996 with 1998 and 1999. We did not include 1997 because it was a transition year. We knew, instinctively, that we were seeing more children with sleepwear and clothing-related burn injuries, but until we performed this analysis, we did not realize the magnitude of the increase. For 1995-1996, Shriners Hospitals treated 14 children for sleepwear-related burn injuries; the number of children suf-

[1] The Task Force for Fire Safe Environments for Children is comprised of the following organizations: American Burn Association, Burn Foundation, Coalition for American Trauma Care, Congressional Fire Services Institute, Fairfax County Fire & Rescue Department, National Fire Protection Association, National Volunteer Fire Council, Prince William County Fire & Rescue Department, Shriners Hospitals for Children, Trauma Foundation, and Washington Metropolitan Regional Fire & Rescue Departments/ Aluminum Cans for Burned Children.

fering these sleepwear-related burns has increased to 36 for the 1998-1999 period, a 157 percent increase.

We also looked at two other categories. Clothing-related burn injuries and undefined flame injuries. With respect to the clothing category, in some cases we were able to determine that clothes were involved, but not the exact type of clothing. In other situations, we knew that the clothing was not technically sleepwear, but the child may have been using the clothing to sleep in. In this category, the number of children suffering clothing-related burn injuries increased from 70 to 147, a 110 percent increase.

Finally, we have the undefined flame category. These are situations in which the we don't know anything about the clothing the children were wearing, except to say that it is likely that the children were wearing clothes because of the severity of the burn injuries. For example, the clothing might have been totally burned away. Without a doubt, some of these children were wearing sleepwear. In this category, the number of injuries went from 218 in 1995-1996 to 311 in 1998-1999, a 43 percent increase.

If one totals all these categories, the number of burned children treated at Shriners Hospitals increased from 302 in 1995-1996 to 494 in 1998-1999, a 64 percent increase.

The data regarding infants age 0-9 months, the most defenseless of our citizens, whom the Commission stripped of all protection, is also revealing. In 1995-1996 Shriners Hospitals treated 3 children with sleepwear-related burn injuries under nine months of age. For 1998-1999 the total number of infants suffering such injuries has risen to 8, a 167 percent increase! For flame injuries, the figures go from 8 to 19, a 138 percent increase.

There really is only one variable between these two time periods. In 1995-1996 the CPSC had not yet lowered the safety standards for children's sleepwear. In 1998-1999, the Commission's lowered standards were in full effect, and the results have been a major increase in the number of children suffering sleepwear-related burn injuries.

We will hear a lot of discussion from the CPSC and others regarding whether these children that we care for really suffered "sleepwear-related" burn injuries. All we as physicians who care for burned children can say to you is that we are seeing more burn injuries involving sleepwear and what should be categorized as sleepwear than ever before. The saying in Latin is "Res Ipsa Loquitur," the thing speaks for itself.

We are attaching an appendix, which includes several cases studies regarding these children who have suffered sleepwear-related burn injuries since the Commission changed the regulations. In some instances, these cases fit even the artificially narrow definition the Commission has adopted to justify its actions. In other instances, the cases will illustrate the benefits of flame resistant sleepwear can provide, even in larger household or bedding fires. Finally, these cases will show why Congress must seriously consider broadening the definition of sleepwear to cover those items of clothing that are commonly used by young children as sleepwear.

III. THE PRE-1997 CHILDREN'S SLEEPWEAR SAFETY STANDARDS PLAYED A MAJOR ROLE IN REDUCING THE NUMBER OF CHILDREN'S BURN INJURIES.

I have personally been involved in the surgical and medical care of burned children for over 25 years. I have seen first-hand the horrific reality of sleepwear and other burn injuries. Over this period, as a result of intensive research and state of the art clinical care, a burned child's chance of survival has now more than doubled. In the late 1960's, shortly after the Galveston Burn unit opened its doors, Shriners burn physicians realized that the most effective cure for burn injuries was prevention.

Historically, Shrine doctors have been particularly concerned about the number of children being treated for burn injuries resulting from their sleepwear igniting. They found that many people warmed their homes with open gas fires, and that children, while warming themselves next to the fire, sustained burn injuries when their sleepwear ignited from the open flames. A lobbying effort commenced in Texas, and that state's legislature became the first in the country to pass a law requiring sleepwear to be flame resistant.

As you all know, Congress followed suit, and in 1971 national flammability standards for children's sleepwear were adopted. These standards had a profound and positive impact for kids. The average number of clothing-related burn deaths for children under the age of 14 dropped from 60 per year to 4.

While these figures represent all clothing-related burn injuries, not just those involving sleepwear, we believe that the sleepwear standards were primarily respon-

sible for this development. According to one classic epidemiological study regarding the decline in sleepwear-related burn injuries following enactment of the national standards, the authors concluded that "[I]t is probable that the single factor most important to the decline . . . is lower fabric flammability." Indeed, during the nine-year period between 1980 and 1988, only 7.9 percent of all reported children's burn injuries resulted from the ignition of sleepwear that complied with the standards. The National Fire Protection Association has also estimated a tenfold decrease in the number of deaths associated with children's sleepwear since enactment of the standards.

Estimates vary regarding the number of sleepwear-related burn injuries today. The CPSC has estimated that the annual average number of sleepwear-related burn cases is around 90, plus or minus 59 and the average number of clothing-related burn injuries 1,045, again plus or minus 256. What is commendable is that in the years following enactment of the standards in 1971 until 1996, kids slept more safely. Despite this progress, we find the CPSC's methodology for determining sleepwear-related burn injuries flawed and unsound, overlooking the continued danger, particularly for children who wear non-flame resistant clothing as sleepwear. We need to raise the overall standards for children's sleepwear and daywear to protect our most vulnerable citizens—our infants and children.

IV. THE CONSUMER PRODUCT SAFETY COMMISSION'S 1996 DECISION TO RELAX THE SAFE SLEEPWEAR STANDARDS WAS ILL ADVISED.

Notwithstanding the great success of children's safe sleepwear standards between 1971 and 1996, the Consumer Product Safety Commission voted in 1996 to make two critical modifications, which placed children at greater risk. The two changes were as follows: first, sleepwear for infants age 0-9 months no longer has to meet the flammability requirements; and, second, so-called "snug" or "tight-fitting" sleepwear for children of all ages was exempted from the safety standards.

As we understand it, the Commission was concerned that the sleepwear regulations were being ignored, evaded or circumvented. Parents were using non-sleepwear garments such as long underwear or t-shirts in lieu of sleepwear that met the safety requirements. Moreover, manufacturers were exploiting the subjective definition of sleepwear by labeling garments as "daywear," thus avoiding the regulations.

The Commission's regulations define sleepwear as clothing that is "intended to be worn primarily for sleeping or activities related to sleeping." The regulations state that whether wearing apparel is "intended to be worn primarily for sleeping" depends on the facts and circumstances present in each case. Section 1615.649(c)(2) of the Commission's regulations defines relevant factors to include the nature of the product and its suitability for use by children for sleeping, the manner in which the product is distributed and promoted and the likelihood that the product will be used by children "primarily for sleeping or activities related to sleeping in a substantial number of cases."

Despite the facts and circumstances test permitted by the regulation, the use of an intent and primary use standard made it extremely difficult for the Commission to enforce the standards. The Commission does not seem to be following its own standards. For example, it admits that kids are sleeping more and more in t-shirts. If this is true, as the CPSC suggests, it should find that t-shirts are "sleepwear" because they are being used by a substantial number of children for sleeping.

It is not just t-shirts where the regulations are not working. I would like to show you some examples of exactly what I mean. I have with me a so-called "Winnie the Poo" bunny suit which was worn by one of my eight-month old patients when she was severely burned. The suit instantly ignited, and the child suffered 90 percent body burn. You may need a magnifying glass, but if you read the label, you will discover that these bunny pajamas are not sleepwear but daywear. You may also be interested to know that the CPSC rejected this case as outside the scope of its regulations because it involved daywear, not sleepwear.

In any event, faced with these enforcement problems, the Commission made two key decisions, which actually made the situation significantly worse. H.R. 329 attempts to reverse these two exemptions created by the Commission. This is a step in the right direction, but it does not go far enough. Congress must direct the Commission to close the loopholes, which enable manufacturers to label Winnie the Poo or similar outfits as daywear. To protect our children, we need a functional definition of sleepwear.

We also want to make policing by the CPSC easier and more effective. This means requiring clothing like all in one bunny suits with enclosed feet, togs, onesies, body suits with snaps at the bottom for easy access to a diaper, garments with cartoon

characters or symbols that are particularly attractive to children, t-shirts and other garments to be fire resistant. If a child, particularly one under the age of reason, sleeps in these types of garments, they should have to meet the safety standards. The CPSC chose to go in another direction, one that put a greater number of children at risk.

Since we all want kids to have the most fire safe environment possible, it will be up to Congress to act.

V. THE COMMISSION'S DECISION TO EXEMPT INFANT GARMENTS FROM THE SAFETY STANDARDS WAS BASED ON THE FAULTY ASSUMPTION THAT INFANTS ARE IMMOBILE AND THEREFORE NOT AT RISK.

The first major change made by the Commission was to exempt garments for infants age 0-9 months from any sleepwear standards. According to the Commission, the risk of burn injury or death from all clothing, including sleepwear remains low. Of course, the reason for this was the standards that were put in place in 1971. In particular, the CPSC argued that infants are immobile and could not expose themselves to ignition sources as could older children and therefore would not be endangered by eliminating the protections for this most vulnerable group. The CPSC further claimed to have analyzed over 150 burn injuries involving infants age 0 to 9 months from 1990 "1999 and found "insufficient information to conclude there is an increased risk of sleepwear-related burn injuries for pre-ambulatory infants."

This is a matter of pure common sense. Not only can infants below the age of nine months crawl to flame sources, the flame source can come to them. Children can be very mobile and are at a great safety risk as early as five months of age. At five months, infants may start crawling towards objects of interest. It is not possible to teach an infant safety, so it is our responsibility to provide a safe environment for them. Infants between 0-5 months are totally unable to protect themselves from injury or even to escape heat or flame by crawling or rolling away. If you have any doubt regarding whether infants are vulnerable to sleepwear-related burn injuries, you can talk to Dave Borowski, a coalition member here today, who was burned at age six weeks. Had Dave been wearing fire resistant sleepwear, his injuries would have been far less severe.

Candles, which are used in many homes for decoration, lighting or aromatherapy, have caused many burn injuries to children. Space heaters, which are frequently used for heating homes, have been responsible for many burn injuries to children. Infants may be laid next to the heat source for warmth and either get radiant heat burns or the clothing may accidentally catch on fire.

Infants 0-9 months are also at the greatest risk for morbidity and mortality. An infant's skin is thinner than an adult's, often resulting in a much deeper burn. Relatively immature organs such as kidneys make recovery more difficult for infants sustaining traumatic burn injuries. Functional and cosmetic disability affects infants much more than adults, and infants are at higher risk for loosing fingers, toes, hands, feet, ears and noses from burn injuries. Infants also scar more easily and these scars are permanent.

We have observed many cases in which infants, the group that needs the most protection but receives the least from the CPSC have suffered horrible sleepwear-related burn injuries. For example, in one case the mother was holding the child in her arms when a candle tipped over and landed on the infant's sleeve. The sleeve caught fire and severely burned the infant's arm and hand before the parents could extinguish the flames. Far from being a benefit, immobility also traps a child who cannot move away from the flame source that comes to them.

As discussed earlier, the number of infants suffering sleepwear-related burn injuries at Shriners Hospitals have increased from 5 in 1995-1996, the two years prior to the Commission's decision to exempt infant garments from the sleepwear standards, to 19 in 1998-1999, after the safety standards were lowered. *A 280 percent increase cannot be ignored!* Although we have not included 1997 in our comparisons because it was the first year the lowered standards were in effect, Shriners Hospitals experienced a 200 percent increased in the number of infants suffering sleepwear-related burn injuries in that year alone.

Mr. Chairman and Members of the Subcommittee, we will discuss the types of injuries the standards were designed to guard against and the clinical evidence of injuries that we have assembled, but a major policy decision based on the faulty assumption that an infant's immobility protects him or her from exposure to fire should not be allowed to stand.

VI. THE COMMISSION'S DECISION TO EXEMPT TIGHT-FITTING SLEEPWEAR FROM THE SAFETY STANDARDS WAS BASED ON THE FAULTY AND SCIENTIFICALLY INCORRECT ASSUMPTION THAT TIGHT-FITTING SLEEPWEAR IS MORE DIFFICULT TO IGNITE.

The second exemption put into place by the Commission relates to snug or tight-fitting sleepwear. First, I would like to observe that if the Commission were having trouble enforcing the standards because of the confusion between daywear and sleepwear, it certainly would have trouble determining what is or is not tight-fitting. Second, parents buy oversized garments for children, who then grow into them. With growing children, tight-fitting is an illusory concept. Third, the Commission believes that tight-fitting garments are not easily ignited because the body acts to absorb heat from the ignition source and thus slows the heating of the fabric to the point at which ignition can begin. And, if the sleepwear is ignited, it tends to burn slowly because only one side of the fabric receives sufficient oxygen to support combustion. Even if we assume that children will be wearing sleepwear that actually fits tightly, there is no scientific evidence to support the theory that tight-fitting sleepwear will not ignite. The Commission most likely relied on mannequin data in coming to such conclusions. Before endorsing such a significant policy change, the CPSC should have relied on studies utilizing patient data before acting. Like the assumption that governed the decision to exempt infants' sleepwear, the Commission's assumption that tight-fitting sleepwear will not ignite is horribly flawed.

Again, Mr. Chairman and Members of the Subcommittee, we will review many cases that we have actually treated where tight-fitting clothing has ignited.

VII. THE COMMISSION USED A HIGHLY FLAWED DATABASE TO DETERMINE THE EXTENT OF SLEEPWEAR-RELATED INJURIES.

The Commission has refused to concede that the assumptions underlying its decisions are flawed. They ultimately resort to just denying the reality we see every day in our hospitals. According to their briefing documents the "CPSC knows of no burn incidents involving the types of children's sleepwear that the amendments affected." In making this statement, the CPSC relied on data accumulated by the CPSC's National Electronic Injury Surveillance System (NEISS). According to the NEISS sample, only 13 cases involving sleepwear-related burn injuries were reported from 1990-1998, including a maximum of 4 in any one year. The CPSC extrapolates these figures to a national estimate of 90 sleepwear-related burn injuries, plus or minus 59.

Our first reaction regarding this statistic is, "how can this be?" We treat many more children with sleepwear-related burn injuries in just our own hospitals.

The first problem with the CPSC's reliance on NEISS is that its database is seriously flawed. NEISS samples 101 hospital emergency rooms around the country, including 4 burn centers, less than 4 percent of the 139 hospitals that are self-identified burn treatment centers. The four burn centers included in the NEISS sample are the Massachusetts General Hospital in Boston, Kings County Hospital in Brooklyn, Children's Mercy Hospital in Kansas City, Missouri and Children's Hospital in Columbus, Ohio.

The CPSC's reliance on NEISS data, particularly emergency room data, creates severe reliability problems. The NEISS methodology does not provide for actual investigations of product injuries. Only if the doctor in the emergency room identifies a specific case as the cause of the injury is the product entered into the NEISS database. The doctor's notes must be legible and identify the product by name. Most of the time, doctors don't mention the product in their clinical treatment documentation. According one experienced NEISS data collector, the individuals collecting this data can't even read the doctor's notes over 40 percent of the time.

Identification of the product is particularly problematic in the burn area. In the case of a burn injury, the first thing that the paramedics do is to remove whatever remnants of burned clothing might remain on the child to stop the burning process. Of course, often there is no clothing left to examine. And, the last thing one should be thinking of in an emergency room is "what was the baby wearing?" The priority is to save the child's life, not investigate the labels of the charred remains of the clothing.

As the GAO stated, "national data on burn injuries must be interpreted cautiously because these data necessarily provide only limited detail about the circumstances surrounding each individual case." NEISS also does not identify or separately report non-sleepwear garments that children commonly use for sleeping. The emergency room environment is simply not conducive to the accumulation of accurate data on sleepwear-related burn injuries. *All this is to say that the NEISS methodology produces an inordinate number of false negatives, and therefore it was completely inappropriate for the CPSC to rely upon this flawed methodology when it decided to lower*

the children's sleepwear safety standards, presumably because of a lack of reported sleepwear injuries.

Looking at the four burn centers included in the NEISS sample also reveals much about the CPSC's flawed approach towards this issue. Dr. Tompkins, who is with me today, heads up the Shriners Burns Hospital in Boston, which is directly adjacent to Massachusetts General Hospital. Dr. Tompkins also is in charge of burn treatment at MGH. He can tell you that MGH does not admit any pediatric burn patients. They are immediately sent to the Shriners Hospital right next door. Similarly, Kings Country Hospital in Brooklyn admits all pediatric burn patients to New York Hospital at Cornell Medical Center; Children's Mercy Hospital in Kansas City sends all major pediatric burn injuries to the Shriners Hospital in Galveston; and, Children's Hospital in Columbus has a limited referral network for pediatric burn injuries because of the Shriners Hospital in Cincinnati.

I can't say it any more directly than this. The CPSC is basing its conclusions regarding the lack of sleepwear-related burn injuries on the experience of hospitals that do not treat pediatric burn injuries. These burned kids are sent to hospitals that the CPSC did not even bother to call. Interestingly, the Shriners Hospitals for Children, which treat over 20 percent of all major pediatric burn injuries in the United States, were never even contacted by the CPSC before deciding to relax the safety standards. And, when we contacted them, the Commission dismissed our clinical data out-of-hand because it did not support its conclusions.

VIII. THE COMMISSION HAS ADOPTED AN OVERLY NARROW AND ARTIFICIAL DEFINITION OF BURN INJURIES TO DISCREDIT THE HUNDREDS OF DOCUMENTED CASES INVOLVING CHILDREN BURNED AS A RESULT OF THEIR ACTIONS.

Realizing that the CPSC was utilizing a highly flawed database that underestimated the number of pediatric burn injuries, Shriners Hospitals provided several case studies of children treated at our own facilities for burn injuries involving sleepwear. The CPSC uniformly rejected every one of these cases. To do otherwise would have destroyed the rationale for their actions. We cannot let bureaucratic bungling win the day on this issue.

The Commission stated as follows:

> "The children's sleepwear standards were never intended to address the risk of death and injury from exposure to a whole house or bedding fire. The intent of the sleepwear standards is to eliminate the risk of serious personal injury or death from fire as a result of contact between the sleepwear garment and a small ignition source such as a match or lighter flame."

The Commission has further explained that the standards are performance based, and that if the garment self-extinguishes after the administration of a one and one-half inch flame for three seconds, it passes the test. Simply put, the CPSC has confused the standard by which the sleepwear is tested with the intent of the regulations. The three-second test was the standard used to prevent ignition and did not purport to describe the types of burns involved. In so doing, the Commission has virtually defined sleepwear-related injuries out of existence. This gross oversimplification defeats the original intent of the legislation and eliminates more common injuries, which also involve ignition of other materials. This fact pattern occurs at least 100 times more frequently than the CPSC's highly unusual scenario in which an open flame, match or lighter is placed on a small part of a child's clothing, which ignites and there is nothing else burning in the environment.

We will show you cases in which precisely what the CPSC claims never to happen has in fact occurred. However, the sad truth is that the CPSC is ignoring real life fire scenarios in favor of most uncommon types of injuries, all in an effort to deny the harsh consequences of their actions.

IX. FLAME RETARDANT SLEEPWEAR CAN PROTECT CHILDREN FROM MORE SERIOUS INJURY OR DEATH IN LARGER HOUSEHOLD OR BEDDING FIRES.

What is particularly unfortunate about the CPSC's semantics is that flame resistant sleepwear can be highly effective in reducing the extent and severity of burn injuries resulting from larger fires. The Cotton Council has argued that the sleepwear standards were never intended to protect children from anything other than brief contact with a small flame, and that "in all cases on record involving fire accidents with pre-ambulatory children, the accidents would have occurred no matter what type of clothing the child was wearing." Similarly, the CPSC claims there are no substantial benefits associated with the standards beyond those represented by the test method.

In 1972 the Department of Health, Education and Welfare ("HEW") published a study, which reviewed over 1,500 sleepwear-related injuries. *The study concluded*

that children in fires whose clothing ignited had a four to six-fold increase in mortality and associated morbidity and more than $70,000 in increased hospital costs compared to those whose clothing did not ignite. Preventing ignition of the clothing also decreases the extent and severity of the burn injury. For example, in a larger fire, if the clothing ignites, the total burn usually doubles and there is nearly six times the amount of full-thickness injury.

Let me posit just one scenario that makes this point quite clearly. A house is on fire and a parent picks up her infant and flees the burning house. Sparks are flying, but the infant's garments do not ignite because they are flame resistant. However, if the sleepwear is not flame resistant, the sparks catch the clothing, which virtually explodes into flames.

The Commission and its supporters also ignore one other rather logical point. For example, the Commission ignores cases involving crib fires. The sheets, they say, caught fire first, and then the sleepwear. How do they know? We have cases where we believe the flame dropped first onto the sleepwear, and then the bedding ignited thereafter. If the infant had been wearing flame resistant sleepwear, the bedding fire would not have occurred. Perhaps what Congress should do if we really want to protect helpless infants is to not only eliminate the infant exemption for sleepwear but recognize that regardless of what infants are wearing, they sleep virtually all the time. We should also consider requiring crib sheets to be flame resistant as well.

X. THE COMMISSION'S STATEMENTS CLAIMING THAT THE SAFETY STANDARDS WERE ONLY INTENDED TO COVER BURN INJURIES RESULTING FROM SMALL LOCALIZED IGNITION SOURCES ARE WITHOUT ANY LEGAL OR LOGICAL SUPPORT.

One last legal point. There is no basis in law for the Commission's assertion that the standards were not designed to protect children from just the uncommon type of injury we have been discussing. The Flammability Fabrics Act, 15 USC section 1193, et seq does not restrict the Commission to such a contorted definition of sleepwear-related injury, nor do the implementing regulations. Indeed, section 1193(a) of the Flammability Fabrics Act charges the Commission with developing standards that "may be needed to protect the public against unreasonable risk of the occurrence of fire leading to death or personal injury..." Congress gave the Commission latitude to determine exactly how children should be protected, not the discretion to so circumscribe the protections as to make them meaningless.

XI. CONGRESS NOT ONLY SHOULD REPEAL THE COMMISSION'S TWO EXEMPTIONS TO THE SAFETY STANDARDS, BUT SHOULD BROADEN THE DEFINITION OF SLEEPWEAR FOR CHILDREN BELOW THE AGE OF REASON WHOM OTHERWISE REMAIN AT SERIOUS RISK OF BURN INJURIES.

A CPSC Memorandum regarding the Enforcement History of Children's Sleepwear Standards, dated May 12, 1999, did at least acknowledge some of the difficulties inherent in determining what is or is not a sleepwear-related injury:

> "In-scope classification of sleepwear-related burn incidents is complicated by inherent difficulties in defining sleepwear, especially for infants, and in determining the size of the flame intended to be addressed by the children's sleepwear standard. Identifying sleepwear-related cases for infants is difficult because infants sleep frequently and for long periods of time and are likely to do so regardless of the clothing they happen to be wearing at any given time. Identifying sleepwear-related cases for older children is also difficult because they frequently use certain garments as both daywear and nightwear (e.g., t-shirts, long underwear)."

We agree with the Commission regarding the complicated nature of determining what is or is not a sleepwear-related injury and the attendant confusion over what is daywear and what is sleepwear. As the Commission noted, "[A] primary problem in enforcing the children's sleepwear standards is that "children's sleepwear" is a moving target." Congress needs to make it clear that the sleepwear standards are not designed to deal just with the rare situation in which a small open flame ignites the sleepwear and nothing else. It also needs to adopt a more functional definition of what is sleepwear.

Just recently, Australia broadened the definition of sleepwear to include some types of daywear that children use as sleepwear. If a child sleeps in a particular type of clothing, then it should be flame resistant. Congress should list certain types of garments, which function as sleepwear and require that they meet the flammability standards. These types of garments could include underwear, t-shirts, bunny suits, garments with cartoon characters particularly attractive to children and more.

We recognize that it is not practical to recommend that all clothing be treated, but we believe that this broader, functional definition of sleepwear should apply to children age 0-7. The age of seven is sometimes referred to as the age of reason, a time when, hopefully, a child will appreciate the danger of fire. This age grouping also happens to account for well over half of sleepwear or clothing-related burn injuries. Congress might even consider simply requiring that all clothing for infants age 0-9 months be flame resistant, since infants sleep virtually all the time. In other words, Congress should go in 180 degrees the opposite direction as the Commission.

XII. CONGRESS SHOULD STRENGTHEN AND BROADEN THE CHILDREN'S SLEEPWEAR STANDARDS BECAUSE THE TECHNOLOGY NOW EXISTS TO MAKE COTTON FIRE RESISTANT.

Finally, we are encouraged that the Congress may direct the Commission to take these steps to provide broader protection for our children without excluding cotton products from the marketplace. Many consumers prefer cotton products, but there have been concerns regarding the desirability and feasibility of making such cotton products flame resistant. We now know that the technology exists to make cotton safe for children, without sacrificing the product's other attributes. A new type of children's sleepwear called "Skivvydoodles" is on the market. Skivvydoodles are made with flame resistant cotton. You can get them at Target or other stores. The flame retardant doesn't wash out because it cannot be separated from the cotton fiber itself. There is no reason why those of us representing children at risk from serious burn injury cannot join with groups such as the Cotton Council to ensure that this new technology becomes the standard in the industry.

XIII. CONCLUSION

Mr. Chairman, the Consumer Product Safety Commission made a very dubious assumption when they concluded that immobile infants were not at risk from fire. The Commission also made a very dubious scientific decision when it concluded that tight-fitting garments really wouldn't burn. The Commission then compounded these errors by relying on a highly flawed database, and then using semantic maneuvering to define a real world problem out of existence. Finally, the Commission ignored the medical data regarding the benefits of preventing clothing ignition in its attempt to further justify a discredited and dangerous interpretation of what is or is not a "sleepwear-related burn injury."

The Commission's actions in 1996 cannot be justified, either logically or empirically. However, the Commission was right when it identified the difficulty in determining what is or is not sleepwear. Congress needs to broaden this definition to include the clothing that young children actually sleep in, no matter what it may be called by the manufacturer. In fact, the Commission should have moved long ago to broaden, not narrow the safety standards. When the agency charged with protecting our children takes steps that leave them vulnerable to horrible burn injuries, Congress should step in and fill the breach. Please think of the children whom we have discussed who have suffered through these horrible burn injuries and ensure that others like them do not have to go through the same thing.

Increase in Flame Injuries to US Children admitted to Shriners Hospitals Comparing 1995 & 1996 to 1998 & 1999

	1995/1996	1998/1999	% Increase
Sleepwear Related	14	36	157%
Clothing Related	70	147	110%
Undefined Flame	218	311	43%
Total	302	494	64%
Flame < 9 mo. old	8	19	138%
Sleepwear Related < 9 months	3	8	167%

Regulation Reduction

Flame Injuries to US Children Admitted to Shriners Hospitals in the Last 5 Years

	1995	1996	1997	1998	1999
Sleepwear Related	9	5	12	15	21
Clothing Related	25	45	41	59	88
Undefined Flame	79	139	186	165	146
Total Flame	113	189	239	239	255
Children < 9 months	3	5	6	8	11

↓ Regulation Reduction

Mr. TAUZIN. Thank you Dr. Herndon.

Next, Dr. Phillip Wakelyn. Ph.D., senior scientist, Environmental Health and Safety of the National Cotton Council, Washington, DC. Dr. Wakelyn.

STATEMENT OF PHILLIP J. WAKELYN

Mr. WAKELYN. I am Phillip Wakelyn, senior scientist for the National Cotton Council. With me today is Bruce Navarro who is a former CPSC employee.

Mr. TAUZIN. Dr. Wakelyn, would you please take the mike sir.

Mr. WAKELYN. With me today is Bruce Navarro, a former CPSC employee and consultant. I am also testifying today on behalf of Apparel and Retail Associations, the Apparel Manufacturers Association, and the National Retail Federation and the International Mass Retailers Association. All of these groups are very much concerned about children and have a long history of deep commitment to consumer safety and safety of children.

As you mentioned earlier, you have my complete statement for the record, I will just raise a few points. The 1996 amendments are not the cause of burn injuries seen in burn hospitals, and the amendments have nothing to do with the concern raised by the opposition. The children's sleepwear standards are doing what they were intended to do in 1971 when they were first issued, and what was considered then the unreasonable risk that they were set to address. This is not a weaker standard.

While all burn injuries are troubling and the images they present very disturbing, nobody wants to see a burned child. CPSC doesn't, we don't, and we would not support anything that would lessen the standard. The fact remains that snug-fitting cotton and infant-sized sleepwear are safe. Since 1991, the Consumer Product Safety Commission has thoroughly and sufficiently reviewed and re-reviewed the children's sleepwear flammability standards. No further action is necessary on these standards at this time.

There is no basis from all the burn incidents data since 1965, and I have personally gone back and looked at everything in all the records, there is no source or other data that would say that these 1996 amendments diminish the safety of the standard. CPSC made the correct decisions for the correct reasons.

Those opposed to the amendments believe the CPSC analysis was flawed, but they have never presented any substantive data that show that the data in the various data bases used by CPSC are incorrect. In fact, in their own comments in testimony to CPSC, these parties state that in the data they have given to CPSC they do not know whether the child was wearing sleepwear at the time of the incident or whether the sleepwear was or was not in compliance with the standards. They also do not know what the flame source was that ignited these garments or the whole fire scenario.

All of their data were given to CPSC for investigation, but none of it showed that snug-fitting or infant sleepwear or any sleepwear was the first item to ignite or caused the incident. You realize that the CPSC has been under an extreme microscope because of all the pressure and because this is such an emotional issue, and they have looked at every piece of information that has been submitted

to them by the Shriners, none of it supports that this standard has been diminished in any way.

Surely if burn injuries were occurring with the garments affected by the amendments, data from the U.S., Canada, and other countries would show some incidences. The original standards were promulgated in 1971 and 1974. They were designed to protect against burn injury or death caused by small open-flame ignitions, that is matches, lighters, and candles, to children when they were up moving around.

This was the unreasonable risk that they were designed to prevent. Testing involved a 3-second ignition with a small open flame. This has been in effect since 1971. The amendments had nothing to do with changing that test method. The standards never were intended to protect against large flame sources such as burning mattresses or house fires. No apparel except perhaps heat-protective clothing worn by firefighters will do that.

The standards are doing what they were intended to do. The standards, the original standards, were justified on data collected from 1965 to 1972 by Health, Education and Welfare. That is the F facts data base and the standard for zero to 6x sizes was for children 0 to 5 years. There were 580 cases in that data base, 37 of them involved sleepwear.

None of the garments in the data used to justify the original standards were snug-fitting garments. In all cases on record involving a fire incident with preambulatory children, the accident would have occurred no matter what type of clothing the child was wearing. All data indicate that loose-fitting garments are the types of garments involved with the burn instances.

Mannequin studies and actual experience in the U.S., the UK, Canada, Australia, New Zealand the only countries who have such a standard and that have the same sort of amendments to their standard, and only our standard is more severe than any other standard in the world, continue to show that tight-fitting garments and infant-size garments are not the type of garments that are involved in burn injures.

The standards have been amended several times. In February 1978, CPSC amended the standards because of Tris which was a fire-retardant agent that was used to make polyester flame resistant. Nothing is fire retardant. The term is flame resistant. The amendments removed residual flame time which is also referred to as melt drip from the standard so that meant that polyester and nylon would pass the test without any treatment.

So since that time, 1978, virtually no garments in the marketplace have been treated with fire retardant chemicals to make them flame resistant. I also might add that cotton and polyester ignite at about the same temperature and both burn similarly in tests. I have actually published articles on this. I can provide much more information if you like.

Human burns occur when skin temperature exceeds 110 degrees farenheit which may explain how a child can be burned on exposed skin and protected in areas covered by sleepwear or other garments, flame resistant or not. And these 1978 amendments did not diminish the protection of the standard. We have not heard anybody raise that issue. We also feel that the 1996 amendments to

exclude snug-fitting and infant garments do not diminish the standard.

I would also mention that Canada originally had our standard, but in 1987, adopted a standard based with fit characteristics and removed and exempted infant garments. The reason for amending their standards, they had extensive mannequin testing of garments, I had video tapes of it which produced a thick final report. There is a Canadian Medical Association paper which describes all of this. There are many papers in the literature that describe how a design affects flammability. Even the classical work in the 1970's called America Burning referred to the design having an effect on preventing burns.

We also got a letter from the head of Health Canada which states that since the regulations have come into effect, injury due to the ignition of children's sleepwear are no longer a problem in Canada. The standards in Australia and New Zealand and UK are all also working.

Mr. TAUZIN. Would the gentleman please conclude.

Mr. WAKELYN. There is no basis in documented fact to overturn the CPSC decision to amend the children's sleepwear standards. We urge the Congress to uphold the amendments to these standards and to refrain from further legislative action on these standards.

In addition, groups concerned with fire safety and children should be encouraged to focus their resources and efforts with those of CPSC and the industry on an information educational campaign to inform American consumers about the current sleepwear standards and the importance of teaching fire safety to children.

[The prepared statement of Phillip J. Wakelyn follows:]

PREPARED STATEMENT OF PHILLIP J. WAKELYN, NATIONAL COTTON COUNCIL

I am Phillip Wakelyn, Senior Scientist with the National Cotton Council. I have been involved with flammability issues since 1963. The National Cotton Council (NCC) is the central trade association of the American cotton industry. Our members include producers of over 75% of the US cotton and cotton processing industries.

Today I am also testifying on behalf of several apparel and retail association, the American Apparel Manufacturers Association, the National Retail Federation and the International Mass Retailers Association who support this statement. NCC, the US cotton industry, and all of these associations have a long history of deep commitment to the safety of consumers.

We appreciates the opportunity to testify at this hearing in support of the 1996 CPSC amendments to the Children's Sleepwear Flammability Standards (that exclude infant garments, sized 9 months of age or younger, and snug-fitting garments), because there is no indication from technical data (mannequin research, etc.), and burn injury and fatality incidence data, from all sources (the US, Canada, and other countries) that these garments present an unreasonable risk or that these amendments diminish the protection provided by the standards. An examination of the original data sources show there never have been data to support the coverage of these garments under the Children's Sleepwear Flammability Standards.

I. INTRODUCTION

At the outset I would like to say that it is unfair and untrue for anyone to suggest that the Consumer Product Safety Commission (CPSC) would do anything that would cause children harm. Or that Canada and the three other countries in the world that have standards and that also do not cover infant sizes and snug-fitting garments are not concerned about children's safety. Or that the cotton, apparel, and retail industries would support anything that would harm children. Indeed, while

all burn injuries are troubling, and the images they present disturbing, *the fact remains that snug-fitting cotton and infant-sized sleepwear are safe.*

CPSC is a regulatory agency that is committed to the safety of children and all consumers. Those opposed to the amendments believe the CPSC analysis was flawed but they have never presented substantive data that show that the data in the various databases [Flammable Fabrics Accident Case and Testing System (FFACTS), National Electronic Injury Surveilance System (NEISS), In-Depth Investigations(IDIs), National Fire Incidence Reporting System (NFIRS), Institute for Textile Technology, Charolottesville, VA (ITT)] used by CPSC are incorrect. In fact, in their own comments (CF99-1-108) to CPSC these parties state that in the data they have given to CPSC they do not know whether the child was wearing sleepwear at the time of the incident or even "whether the sleepwear was or was not in compliance with flammability standards". All of their data was given to CPSC for investigation but none of it show that snug-fitting or infant sleepwear or any sleepwear was the first item to ignite or the cause of the incident. CPSC sometimes finds that other wearing apparel (e.g., shirts, t-shirts) are involved. However, the burn injuries are usually the result of a house or other large flame fire in which the clothing is not the first item to ignite or even a contributing factor.

For children under 15 years old (about 50 million children), there were 2 or 3 clothing-related thermal burn fatalities (for all clothing) each year in the US from 1993 through 1998. The portion of these cases involving sleepwear is unknown, because no data system in the US specifically identifies sleepwear. Estimated thermal burn injuries involving sleepwear and other clothing among children under 15 years old remained low and showed no statistically reliable annual trends from 1990 to 1998. (C.C. Morris, "Sleepwear-Related Thermal Burns in Children under 15 Years Old," CPSC June 1999) Therefore, it is not really known if sleepwear of any kind or small open flame ignitions are involved in any of these incidents.

The databases could always be improved, but they are much better today than when the standards were first promulgated in 1971 and 1974. Available data do not support the notion that the 1996 amendments have caused burn injuries to children. Surely, if burn injuries were occurring with the garments affected by the amendments, data from the US, Canada and other countries would show some incidences.

A. CPSC has Extensively Reviewed the Standards

From Nov. 1991 to July 1996 and again in 1999, CPSC thoroughly and sufficiently reviewed and re-reviewed the Children's Sleepwear Flammability Standards. In the process, the CPSC twice conducted complete notice and comment rulemaking, received comments and testimony from thousands of witnesses, held hearings and exhaustively analyzed burn incidence and other data. The CPSC, in four separate extensive briefing packages, explained the rationale for all decisions at all steps and the Commissioners voted at each step. Over $7 million was spent on this effort, which continues to review all pertinent data. All data since 1965 indicate that CPSC made the correct decision for the correct reasons.

II. THE STANDARDS WERE DESIGNED TO PREVENT BURN INJURIES FROM SMALL OPEN FLAME IGNITION AND COVER ONLY SLEEPWEAR

Some seem confused about the purpose of the sleepwear standards, including the burn scenario and unreasonable risk these standards were designed to prevent. Let me explain. The *original standards* promulgated in 1971 and 1974 were designed to provide protection against serious personal burn injury or death, caused by small open flame ignition sources (e.g., matches, lighters, and candles), to children in sleepwear when they were up moving around. (This was the unreasonable risk the standards were designed to prevent.) Testing involves a 3 second ignition with a small open flame. The standards never were intended to protect against large flame sources, such as a burning mattress or house fire. No apparel except heat-protective clothing worn by firefighters (only protective clothing that resists burning, melting, or disintegration on exposure to high heat or flame) will do that.

These standards were justified on data collected from 1965 to about 1972 (FFACTS: 580 cases by Nov. 1971; 1964 cases by Dec. 1972; Cases were investigated in the Denver area, the Boston area, the state of Iowa and 99 from other areas by FDA.) All data since 1965 indicate that *loose fitting* garments, loose nightgowns, robes, nightshirts, loose pajamas, etc., are the garments involved in burn incidence cases. There were no data to justify including infant garments sized 9 months of age or younger and snug-fitting garments. None of the garments in the database used to justify the original standards were snug-fitting garments. In all cases on record involving fire accidents with pre-ambulatory children, the accidents would have occurred no matter what type of clothing the child was wearing. There was a house fire, or a crib fire, or some other general conflagration in which the

sleepwear garment was not the first to ignite, but instead became involved in a larger, external fire situation. The infant plays a passive role in the ignition sequence, according to NBS reports. Details on the 22 cases involving children under three are given in NBS Technical Note 815 by Elaine Tyrrell published in Feb. 1974.

Mannequin studies and actual experience in the UK, Canada, Australia, New Zealand and the US (since 1993) continue to show that tight-fitting garments and infant sized garments are *not* the types of garments that are involved in burn injuries and fatalities.

The philosophy of the DOC (CPSC took over in 1974) at the time when the original standards were promulgated was to cover everything—even those products that were not shown to be a risk. Therefore, in the original 0-6x standard (1971) and 7-14 standard (1974), all sleepwear products, including 100% polyester and nylon, had to be treated with fire retardant chemicals to make them flame resistant to meet the standard, because the standard applied to all products, even those that were not part of the problem the standards were designed to address.

A. 1978 Amendment to the Standards

The standard has now been amended several times. In February 1978, CPSC amended the standard because "tris" (tris 2,3-dibromo propyl phosphate), a *fire-retardant* agent used on polyester and other synthetics to make those garments *flame resistant,* was shown to be a carcinogen. Tris was never used on cotton garments, only on polyester and nylon garments. This amendment removed the "residual flame time" (also referred as "melt drip") requirements from the test method of the standard. As a result, since 1978 essentially no sleepwear in the marketplace was treated with FR-agents to make them *flame resistant,* until the last 1-2 years. Consumers appeared to be more concerned about potential toxicity (real or imagined) of FR-treatments to their children, than the risk of burn injuries in sleepwear. The cotton FR-treatments have been shown to be safe by the National Cancer Institute. Nevertheless, essentially every time FR-cotton sleepwear was put on the market until recently, it has not sold well and was removed from the market.

Cotton (700-1560 F) and polyester (840-1290 F) ignite at about the same temperature and both burn. Polyester fibers generally begin to melt between 480 and 570 F. Human burns occur when the skin temperature exceeds 110 F, which may explain how a child can be burned on exposed skin and "protected" in areas covered by sleepwear or other garments, flame resistant or not. The 1978 amendments allow untreated polyesters and other synthetic fibers that melt and drip away from the flame to pass the test. Cotton, a char former, which does not melt and drip, will not pass the test [(which requires the tested material to be bone dry (0% moisture)] without a FR-treatment. Since the 1978 amendments, virtually no garments in the marketplace have been treated with fire retardant chemicals to make them flame resistant.

The 1978 amendments appear not to have diminished the safety provided by the standards.

B. 1996 Amendments to the Standards

In 1996, CPSC amended the standards again. This time, snug-fitting and infant garments (sized 9 months of age or younger) were removed from coverage, since these products were never part of the problem. *Contrary to the impression conveyed by some, these amendments did not affect loose pajamas, nightgowns, and robes.* These items still must meet the requirements of the Children's Sleepwear Flammability Standards and be flame resistant.

In data from 1994 and before, CPSC has found virtually no injuries associated with snug-fitting garments or long underwear worn as sleepwear, or sleepwear worn by infants under one year. And along with data from Canada and other countries these data strongly support and reinforce the CPSC finding that the amendments do not diminish the safety provided by the Children's Sleepwear Flammability Standards. Burn injuries that have been reported are usually the result of a house fire or other large fire tragedy in which *sleepwear is not the first item ignited or even a contributing factor.*

Therefore, the 1996 amendments to exclude snug-fitting and infant garments do not diminish the safety provided by the standards.

III. SNUG-FITTING GARMENTS SHOULD REMAIN EXEMPT FROM THE CHILDREN'S SLEEPWEAR FLAMMABILITY STANDARDS (16 CFR 1615 AND 1616).

CPSC has very strong data indicating that the exemption of tight fitting garments does not diminish the protection provided by the standards. All currently available data strongly demonstrate that loose and flowing nightwear garments are the kind of nightwear involved in burn injuries and fatalities (59 FR 53620; Oct. 25, 1994,

ref. 8, 10, 11 and 61 FR 47634; Sep. 9, 1996); that tight-fitting garments are less likely to contact an ignition source and less likely to be ignited and if ignited burn less rapidly than loose fitting garments; and that tight-fitting sleepwear does not present an unreasonable risk of fire leading to burn injury or death to children.

These amendments did not affect loose pajamas, nightgowns, and robes. Those items still must meet the requirements of the Children's Sleepwear Flammability Standards and be flame resistant. In addition, tight-fitting garments must comply with the Standard for the Flammability of Clothing Textiles, 16 CFR 1610.

A. Snug fitting garments are one of the safest types of garments because: (1) they are not easily ignited because the body acts to absorb heat from the ignition source and thus helps to slow the heating of the fabric to the point at which ignition can start; (2) they make the wearer immediately aware of an ignition source, since the heat of a match or lighter flame is transferred through the fabric directly to the skin; and (3) if they are ignited, they tend to burn slowly, because only one side of the fabric receives sufficient oxygen to support combustion. Using mannequins and video-tape recordings, the safety of tight-fitting garments has been demonstrated and illustrates why those garments do not represent an unreasonable flammability hazard.

B. Canada originally adopted the US Children's Sleepwear Flammability Standards but modified them in 1987. The major reasons for amending their standard were results from mannequin testing of garments that were described in a Final Report to the Consumer and Corporate Affairs Canada by E.M. Crown, U. of Alberta, July 1985 and a *Canadian Medical Association* paper (J.R.S. Stanwick, *CMAJ* 132, 1143, 1985).

Since promulgation of the amended Canadian sleepwear standards in 1987, no burn injuries or deaths associated with children's sleepwear have been reported in Canada (61 FR 47634; Sep. 9, 1996). A December 18, 1995, letter from Therese Gagnon, Acting Chief, Mechanical and Electrical Hazards Division, Health Canada, Health Protection Branch, Product Safety Bureau, to NCC concerning the Children's Sleepwear Flammability Standards and the Canadian experience, states:

> "Since the Regulations have come into effect, injuries due to the ignition of children's sleepwear are no longer an issue in Canada."

Australia and New Zealand also have standards that include fit characteristics that exempt tight-fitting garments. The burn injury and fatality data in these countries show that these standards are working (59 FR 52620; Oct. 25, 1994 and 61 FR 47634; Sep. 9, 1996).

D. Other than the United Kingdom, no other European country has legislation or standards specifically to control the fire safety of children's sleepwear. The UK Nightwear (Safety) Regulations 1985 (finalized December 20, 1985) came into effect March 1, 1987. Since 1987 the UK has allowed children's nightwear that does not meet strict vertical flame test requirements in the marketplace (if it is labeled). The UK burn incidence data indicates that their standard is working.

IV. INFANT GARMENTS, SIZED 9 MONTHS OF AGE OR YOUNGER, SHOULD REMAIN EXEMPT FROM THE CHILDREN'S SLEEPWEAR FLAMMABILITY STANDARD SIZES 0 THROUGH 6X (16 CFR 1615).

Infant sleepwear should never have been covered in the original standard. The determined unreasonable risk that the Children's Sleepwear Flammability Standards are designed to protect the child against is when the child is up and ambulatory and can obtain matches, cigarette lighters, candles, or be exposed to other sources of flame, including stoves, fireplaces, and space heaters, not when the child is in bed. These exposures are not encountered by pre-ambulatory children.

The Canadian and other countries' experiences for burn injuries and fatalities for infant sleepwear sizes are similar to the US as reviewed by CPSC—there are no cases under 15 months. These infant items are not included in the Canadian, Australian, and New Zealand Children's Sleepwear Flammability Standards, all of which are effectively protective standards (59 FR 52620 and 61 FR 47634).

The rare or exceptional accidents for infants lying in their cribs still occur. In exposures to large flame source such as a burning mattress or crib or house fire, or if something burning is tossed on the bed and over the child, none of the products on the market, flame resistant or not under 16 CFR 1615 and 1616, will provide protection from injury. Complying flame resistant garments provide no protection from injury under these circumstances. No general wearing apparel will. If anything cotton sleepwear may be slightly more protective than untreated polyester garments (1977 memo/report from J. Krasny, NBS, to M. Neily, CPSC).

V. OTHER

Some also argue that a more severe Children's Sleepwear Flammability Standard is required in the US because we have more *residential fires* than almost any other country. This argument is without merit since *in the US the number of residential fires where "all wearing apparel worn" was the form of material first ignited was less than 0.2%* (CPSC Report, 1993 Residential Fire Loss Estimates, Nov. 1995). Therefore, sleepwear is not a risk factor in residential fires.

Changes in lifestyle in the US, as in other countries, e.g., in smoking habits, elimination or reduction in use of space heaters, and other socio-economic changes, also provide additional reasons that these amendments to the Children's Sleepwear Flammability Standards were the justifiably correct thing to do.

VI. CONCLUSIONS

We agree that CPSC is correct in its determination that these amendments afford the consumer a wider selection of sleepwear garments without reducing the protection provided by the standards.

There is no basis in documented fact to overturn the CPSC decision to amend the Children's Sleepwear Flammability Standards. All available burn injury and fatality incidence data from the US and all other countries, as well as technical studies with mannequins, support the CPSC conclusions that the amendments to the Standards for Flammability of Children's Sleepwear (sizes 0 through 6x and 7 through 14, 16 CFR 1615 and 1616) which exclude tight-fitting sleepwear garments and garments sized for infants 9 months of age or younger do *not* diminish the protection to the public from unreasonable risk of fire provided by these standards. The CPSC's conclusions to amend and reaffirm the standards were arrived at after many years of intense and thorough study and two full notice and comment rulemakings, which included extensive briefing packages outlining the rationale for the staff recommendations.

We appreciate the opportunity to testify at this hearing. We urge the Congress to uphold the amendments to the Children's Sleepwear Flammability Standards that exclude infant garments (sized 9 months of age or younger) and snug-fitting garments and refrain from further legislative actions on these standards. In addition, groups concerned with fire safety and children should be encouraged to focus their resources and efforts, with those of CPSC and industry, on educational campaigns to inform American consumers about the current sleepwear standards and the importance of teaching fire safety to children.

Mr. TAUZIN. Thank you is very much, sir.

We will now switch to the issue of the amusement park bill, and we will hear from, first, Mrs. Kathy Fackler of La Jolla, California.

STATEMENT OF KATHY FACKLER

Ms. FACKLER. Thank you, Congressman Tauzin, and thank you, Congressman Markey, wherever you are for introducing this bill.

Mr. TAUZIN. If you will allow me, the problem we are experiencing today is that another subcommittee of our full committee is engaged in a very controversial markup. So Members are required to cast votes in that controversial markup; and, therefore, they are not with us and apologize for Mr. Markey and Mr. Rogan and others who are part of that markup.

Ms. FACKLER. I know you are busy. I am going to summarize what is in my statement then I would like to move actually and comment on what I have been hearing around here. On March 10, 1998, my 5-year-old son David's foot was torn in half on a roller coaster ride at Disneyland. The accident occurred while he was sitting next to me with my arm around his shoulder and the safety bar in place across his lap.

He became confused when the car made a temporary stop before the platform, thought it was time to get off and tried to get out of the car. And my arm and the bar kept his body in, but his foot came out the open side of the car. The operator wasn't able to see

it in time, people yelled on the platform. But it was just crazy at that time, and his foot was pinned in between the car and platform as the ride came into the station.

In the wake of that, what I was more surprised at, frankly, than the accident itself was the lack of any kind of outside oversight surrounding this accident. The fact that Disneyland did not have to report the accident to anybody. They didn't have to have anybody come in from outside the company to investigate the accident. The police weren't called in. The press never found out about it. Even though my son screamed for an hour in the middle of Frontierland during business hours no one knew about this accident for a year after it happened. It passed unnoticed, as do the vast majority of amusement-park accidents.

So my concern with the industry actually has little to do with their technical capacity. I have nothing but admiration for the technical arm of the industry. But what bothers me, frankly, is that David's accident is typical of the 65 to 85 percent of amusement-ride accidents that industry attributes to patron misconduct. And yet none of that data is out there where it needs to be.

I find it doesn't make any sense to me that consumers are considered fully responsible for up to 85 percent of accidents, and yet those same accidents are considered none of our business. And so since David's accident, I have learned more and more about the problem and learned that it is a child-safety issue. These preschoolers are at highest risk. I think that those issues need to be addressed. There are no mandatory Federal safety standards for these rides. The restraints can range from anything that can sell. Many kiddie rides have no restraints at all. Some have a piece of clothes line that is clamped off across.

No one is looking at this stuff, and the data is not out there where it needs to be.

So as I have listened here to the panel, the things that come up that surprise me the most, frankly, was the mistaken impression that we are looking to Federal regulation to set G-force limits or to provide, you know, yearly inspections of these rides. And to my knowledge all I am looking for is more data, more public access to data, and to have some agency that can take a broader view of this. The State agencies do a marvelous job of looking at individual accidents. But they can't connect the dots between an accident that happens on a Tilt-a-Whirl in one State and another State. Only a Federal agency can do that. They also can't disseminate that data nationwide.

I would like this added to the record if I could. It is a copy of a letter that I wrote to Senator Feinstein's office. It recounts a conversation that I had with Bob Johnson who is the executive director of the Outdoor Amusement Business Association. He is the counterpart to Mr. Graff in the traveling carnival world. He talked about how the CPSC oversight complements the State programs, and he felt actually that it was anything but intrusive and that their industry gets some benefit mostly having to do with the collection and dissemination of data.

I have another letter that I would like to have introduced as well, it actually was an excerpt of a letter that I wrote to some of

the California Park representatives outlining what it is like as a consumer to try to track down this injury data.

I went through this exercise last fall. And again, I was appalled not only by how difficult it is, I mean that is all right, but the fact that this data just doesn't exist. The NEISS data from the Consumer Product Safety Commission is far and above the best data and it isn't technical at all. It comes from hospital room records. So there is nothing in there that oftentimes they don't even sight what ride it was on, and they certainly don't say what happened to cause the accident. So while it gives you a good overview of the age data which is important and a good overview of the kinds of physical problems that are caused or injuries that can are caused by these rides, it doesn't help to highlight where we need to go to solve the problem.

I heard several people mention that one representative said that the 12 most tragic deaths happen at traveling carnivals, and I am not sure where they got that impression. First of all, every death is tragic to the parent. But second of all, last year all of the deaths happened at permanent parks. I agreed with Representative Eshoo about the need for more data. I mean it makes sense. You cannot possibly understand the problem without more data. I have heard that from the Consumer Products Safety Commission commissioners as well, even though they may differ on what the Consumer Products Safety Commission ought to do. They all say, well we just don't know because we don't have the data.

What I would like to do here, and this is what I have been lobbying for in California as well, is to give the consumers the information that empowers them to keep their own families safe. And if most of these accidents are, in fact, caused by rider errors such as my son made, the only possible solution is public education. And the industry is not in the business of public education. They are great in technology and they are great in selling tickets, but the one thing that they don't do is put that information out where it needs to be.

In my son's case, when Disneyland went through their investigation they didn't talk to me or either of my two children who were riding with me. They didn't interview any of the eye witnesses, that were not Disneyland employees. They conducted their whole investigation and the changes to the ride while we were still in the hospital. And the changes, they never did anything to keep a child's foot from coming out of the side of the ride. They never did anything to warn parents that they need to watch their children's feet. Again there are simple solutions to these problems, but not if you stop the free flow of data.

I have heard their ride designers; I have heard from people in the industry, inspectors, they all want more data because it helps them do their job. A ride designer can't pull up a list of all of the accidents that have hurt children if he is designing restraints for a kiddie ride. Many of those restraints are the same restraints that they have used for, in the case of ferris wheels, for 100 years, and no one has looked at this to see whether possibly we could upgrade the standard.

The newer roller coasters, the wild rides, actually the safety technology has improved along the same rate as the thrill technology.

So, frankly, I am way less worried about, you know, a super coaster that uses an over-the-shoulder harness to retrain an adult than I am a kiddie train that uses a piece of clothesline to restrain a toddler. So I think again we need to look at the problem itself.

There was a question asked about State programs, and I have looked. Again this is another subject I have researched extensively and while some States, Ohio for one, New Jersey for another, have excellent programs, some States don't necessarily have great programs. I will tell you there are some States like Florida that exempt the large parks. In that State, 20 percent of the amusement park business operates out of the Orlando area in the large theme parks. They are exempt from the State law.

Those parks like Disney World, Universal Studios Florida, they don't have to report injuries or deaths even if a death happens. They need to report it to the coroner, but they are not allowed to have the safety regulators come in and take a look at that from a technical standpoint. There was, oh gosh, I know I am going through my time. I am so sorry. There has been bickering over the NEISS system and whether the data is valid or not valid. Why don't we come up with better data? Then if the data is inadequate, I think we ought to come up with better data.

Just to say California, that was the first news I ever heard that California has allocated $24 million for ride safety review. The last figure I heard was 1.6 and it was being negotiated down by the industry.

So to sum up, all the available data indicates that amusement ride accidents are a child-safety issue. The Consumer Products Safety Commission has an established track record in this area. It is foolish to exclude certain amusement rides from their jurisdiction simply because the rides aren't being regularly transported. Children aren't hurt because the rides are moved from place to place. Children are hurt because the rides are heavy machinery and because the injury data is hidden from the public.

I have seen first hand the kind of damage that an amusement ride can do to a small child. My 5-year-old son's foot was torn in half while he was sitting next to me with my arm around his shoulder and the safety bar in place across his lap. When we boarded that ride, I assumed it was subject to the same oversight and protections that apply to all other children's products. I was wrong.

My son will live the rest of his life paying the price for my misplaced trust. It is time for Congress to stop protecting theme parks and start protecting children who visit them. I urge the committee to move H.R. 3032 forward as soon as possible so that the safety lessons we learn through personal tragedies, like David's, can be shared nationwide.

Mr. TAUZIN. I believe you brought your sons with you. You want to introduce them to the audience.

Ms. FACKLER. This is my husband, Mark, over on the end. He is a conservative Republican, by the way. This is David.

Mr. TAUZIN. This is David.

Ms. FACKLER. I am so proud of David. He has been just the hero through all of this. He has really done a fine job. This is my older son, Steven, who has been a giant help as well.

[The prepared statement of Kathy Fackler follows:]

PREPARED STATEMENT OF KATHY FACLKER

On March 10, 1998, my five-year-old son's foot was torn in half on a roller coaster ride at Disneyland. The accident occurred while he was sitting next to me, with my arm around his shoulders and the safety bar locked in place across our laps. David mistook a temporary stop for the final stop, and tried to get off the ride. In doing so, his foot came out the open side of the car, and was crushed between the car's edge and the loading platform.

David's accident is typical of the 65%-85% of amusement ride accidents which the park industry attributes to patron misconduct. Hospital emergency room data provided by the Consumer Product Safety Commission shows that ⅔ of all ride-related accidents involve children. Preschoolers are at higher risk than any other age group.

Yet there are no mandatory federal safety standards for amusement rides. Restraints on kiddie rides range from seatbelts and lap bars to pieces of clothesline or, in many cases, nothing at all. Permanent amusement rides are the only consumer product marketed to children that are specifically exempt from federal safety oversight. Although many states have *some* form of regulatory law governing *some* amusement rides, the largest theme parks are almost entirely self-regulated. Parks like Disney World and Universal Studios Florida are not required to report injuries to any outside agency, or allow ride safety officials to investigate serious accidents—not even if a rider dies.

Disneyland is also self-regulated, and will be until California's new regulations have been finalized. The maiming of my child was not reported to anybody. The police weren't called in. No one from the press found out about the tragedy, despite the fact that David screamed for an hour in the middle of Frontierland during business hours. The incident passed without notice—as the vast majority of amusement ride accidents do.

Disneyland conducted their own investigation and made changes to the ride while David was still in the hospital. No one from Disneyland's technical staff contacted me as part of that process. Nor did the company interview the three best eye-witnesses: a man riding directly behind us, and a couple waiting on the platform.

Disneyland did not modify the ride to guard against young children sticking their feet out the open sides of the cars. Nor did they do anything to warn parents about the platform entrapment hazard. Instead they added the word "feet" to the warning sign that David was too young to read. And they built a ramp on the facing edge of the platform in the hopes that a child's foot would be more likely to "bounce off" a ramped approach, and not be caught in the one-inch gap that still exists between the cars and the platform.

Thanks to self-regulation, the thousands of visitors who line up every day for a turn on Big Thunder have no way of knowing that they're loading their own children onto a ride that once tore a 5-year-old boy's foot in half.

Congressman Markey's bill is a model of brevity. In four sentences, it returns consumer rights to a heavily protected industry. The Consumer Product Safety Commission has been regulating traveling carnival rides for more than 20 years. They are the only agency that has authority to "connect the dots" between related accidents in different states, and develop a plan of action to address product hazards. Sometimes this involves a modification to the design, operation, or maintenance of the ride, information which the CPSC disseminates to ride owners/operators across the country.

Product safety also involves public education. The amusement park industry attributes the majority of accidents to rider error. Given that amusement parks are in the business of loading children onto heavy machinery, their claim makes perfect sense. Yet the industry, which claims safety as it's number one priority, does very little to constructively address what they readily admit is the primary cause of accidents. In a recent USA Today article ("Park Safety Rules Lax", April 7, 2000), John Graff of the International Association of Amusement Parks and Attractions (IAAPA) claimed that "that kind of thing is largely beyond our control."

Unlike the IAAPA, the CPSC is both willing and able to raise public awareness about child safety issues. They're the people who issue safety bulletins about bike helmets and window cord strangulation and keeping kids away from rider mowers. Those bulletins are picked up and published by parenting and women's magazines, so that parents learn how to keep their children safer.

The amusement park industry deserves high praise for their technical achievements. They put enormous effort into constructing, testing, and maintaining safe equipment. They are not, however, in the business of disseminating safety information to the public. Although they consider 65%-85% of accidents to be wholly the consumer's responsibility, they also consider those same accidents to be none of our business.

In fact, the CPSC is the only source of nationwide injury data on amusement park accidents. The agency has been monitoring the safety of traveling carnival rides for more than 20 years. I see no logical reason why permanent rides should be exempt.

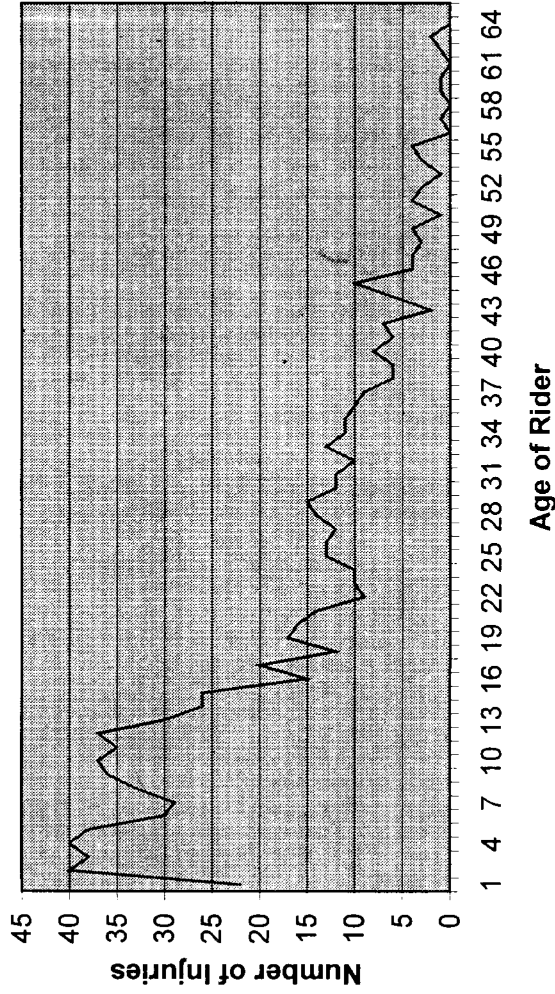
It's important to understand that, with the exception of giant roller coasters and a handful of custom-built rides found at parks like Universal Studios, there is no difference between traveling carnival rides and amusement park rides. In fact, it's quite common for an amusement park to sell a used ride to a carnival, or vice versa. So a Ferris wheel or Tilt-a-Whirl can be subject to consumer protection regulation one day and exempt the next, following a change in ownership. The 1981 exemption didn't eliminate a product from CPSC oversight, it created a loophole by which a select class of business is allowed to operate without governmental oversight.

CONCLUSION

All the available data indicates that amusement ride accidents are a child safety issue. The Consumer Product Safety Commission has an established track record in this area. It seems foolish to exclude certain amusement rides from their jurisdiction, simply because the rides aren't being regularly transported. Children aren't hurt because the rides are moved from place to place. They're hurt because the rides are heavy machinery, and because injury data is hidden from the public.

I have seen, first hand, the kind of damage an amusement ride can do to a small child. My 5-year-old son's foot was torn in half while he was sitting next to me with my arm around his shoulders and the safety bar in place across his lap. When we boarded that ride, I assumed it was subject to the same oversight and protections that apply to all other children's products. I was wrong. My son will live the rest of his life paying the price for my misplaced trust.

It's time for Congress to stop protecting theme parks, and start protecting the children who visit them. I urge the committee to move HR 3032 forward as soon as possible, so that the safety lessons we learn through personal tragedies like David's can be shared nationwide.



Amusement Ride-Related Injuries
(Source: CPSC sampling of 100 U.S. hospital emergency rooms 1997-1999)
Number of Injuries
45
40
35
30
25
20
15
10
5
0
1 4 7 10 13 16 19 22 25 28 31 34 37 40 43 46 49 52 55 58 61 64
Age of Rider

Mr. TAUZIN. Glad to have you here. Thank you, Kathy.

Now we will hear from John Graff, president and CEO of International Association of Amusement Parks and Attractions here in Alexandria, Virginia. Mr. Graff.

STATEMENT OF JOHN R. GRAFF

Mr. GRAFF. Good afternoon. My name is John Graff. I am president and CEO of the International Association of Amusement Parks and Attractions. Our parks have as their No. 1 priority the safety of our guests. We have in place extensive training programs for our employees and systems to check and recheck the safety of our rides. We are safety oriented out of a concern for our guests, but we are also highly motivated to promote safety because any accident, certainly any large number of accidents, can threaten our business and put us out of business. We are in the amusement business, and we know that people expect their amusement and leisure-time activities to be as free as possible from potential harm. The full text of my remarks make three points that I believe should be central to your examination of this issue. These are: First, amusement rides are an exceptionally safe form of recreation and entertainment, probably the safest available.

Second point, the industry is highly regulated and adequately regulated by various government and private entities at the present time.

Third, the industry has demonstrated its capacity for effective self-regulation and constant adaptation to new technology that is improving the way we provide safe fun to our guests.

The annual CPSC report that has been referred to often this morning have consistently shown for over 20 years that there are very few new activities or products of any kind that produce fewer injuries than our park rides. Three hundred nine million visitors annually visit our parks, and they take a conservatively estimated 900 million rides. The incidents of those of serious injuries, injuries serious enough to require hospitalization is 1 in 25 million rides. Fatalities have averaged 2 a year for some 20 years, and that is a rate of incidence of 1 in every 450 million rides.

We regard 36 accidents which is the number of serious accidents last year and 2 fatalities or even one accident as too many. We recognize the human pain and grief that attend each of them. But the question you must confront is whether there is a realistic possibility that another layer of regulation will further reduce those incidents and whether the resources that would have to be spent trying should be diverted from other critical national needs.

The media has reported that the incidents of ride injuries increased 54 percent between 1995 and 1996 and 24 percent over the past 4 years. These numbers appear to be inaccurate. When they first appeared in the agency report, we contacted CPSC to discuss these reports. And we are told on three different occasions that they were not an increase in the number of actual injuries but that the method of collecting and reporting data had been changed which was the reason for that jump in 1955, 1956. Ms. Brown suggested there was a misunderstanding. I say again, we were told that on at least three occasions to three different people on my staff over a period of years. But to double-check the statement, we

hired an independent expert, a former CPSC employee, the director of strategic planning for the agency to analyze the numbers. Using the data supplied by the CPSC and the CPSC's own analytical methods, this expert found that the figures on which these claims are based are not accurate. In fact, he found there was a substantial decrease in the incidence of accidents between 1995 and 1996.

Our expert confirmed that the CPSC changed its methodology in 1997 and suggested that this change could account for the increase that took place during this period of time. That is exactly what we were told on three occasions by the staff of the Commission. In other words, the accident increase justification being cited for this legislation simply does not exist.

My second point is that the industry is already highly and effectively regulated by a number of agencies. All but a handful of parts are subject to State regulation. Only eight States do not have ride laws, Alabama is one of them, but is currently considering legislation. Of the remaining seven states, two have no parks and therefore no need for regulation. The remaining five have a total of seven parks between them. Whatever your personal opinion may be. I would suggest that it is a legitimate issue of public policy that States with so few parks need to set up an agency to oversee them, especially in the absence of a demonstration of need.

My final point is that our industry has proven its capacity for leadership in the area of safety and for constant adaptation to new technology. Great concern has been expressed that technology is out of control in our industry. For years, there has been an independent committee that has produced a set of standards dealing with issues of safety raised by technology, the ASTM standards that have been adopted by many States as law and would serve as the standard that manufacturers and parks must operate to even if it has not formally adopted them into law.

I was quite puzzled by Mrs. Brown's comment that CPSC is prohibited from participating in this process because they deal with fixed-location rides. The agency was represented for years on the ASTM committee by a Mr. David Caplan who eventually retired, and now there is a Thomas Cayton who represents the agency on the ASTM committee. There is nothing that I know of in either the rules or the methods of operation of ASTM that would prohibit them from being there because fixed-location rides are discussed along with mobile rides. There is no distinction made in the presentations that are the discussions that are made there.

Let me address just very briefly, the issue of G-forces. G-forces were under discussion by both the German agency responsible for ride standards and by the ASTM before the issue was ever raised in this Congress. There is a great deal of exchange of that kind of information between all of the policy and standards writing organizations, amusement ride safety standards organizations that stand in the world. I am confident that these groups which cooperate extensively, as I just said, will reach a consensus on appropriate action with respect to that subject. That this multitiered system of private and public regulation works and works well is again best evidenced by the success the industry has enjoyed worldwide in keeping the number of accidents very low.

I would also point out that the chart that Mr. Markey used is a chart of all amusement park accidents not just ride-related accidents. And children from 2 years old up to 7 or 8 or 9 are not allowed on roller coasters because they can't meet the height requirements. So we have to be sure what we are looking at and what we are talking about here.

I mention in my statement there are other organizations such as the AIMS organization, the Amusement Industry Manufacturers and Suppliers organization, which is involved in all of this and works closely with the operators, and the National Association of Amusement and Recreational Officers. These people provide very important information sharing function which is a matter of some concern here. They also conduct regular teaching seminars for operators and for public inspectors. All of this taken together is why the accident rate is as low as it is. The effort goes on ceaselessly to improve it even further. We are at least as concerned about this as anyone in this room and perhaps more so because of the acute interest that I mentioned. So I thank you for the opportunity to be here today, Mr. Chairman, and to discuss this with you and obviously like everyone else here am here to respond to questions.

[The prepared statement of John R. Graff follows:]

PREPARED STATEMENT OF JOHN R. GRAFF, PRESIDENT/CEO, INTERNATIONAL ASSOCIATION OF AMUSEMENT PARKS AND ATTRACTIONS

Good morning, my name is John Graff. I am President and CEO of the International Association of Amusement Parks and Attractions (IAAPA). IAAPA is a trade association for fixed location amusement parks and attractions with 5600 members in 91 countries. About 1,500 of those members are amusement parks and other facilities. The remainder is suppliers to the industry.

Thank you for the opportunity to appear here today to discuss with you the amusement park industry's number one priority, the safety and well being of our guests and patrons.

Our amusement parks have as their number one priority the safety of our guests. We have in place extensive training programs for our employees and systems to check and recheck the safety of our rides. We are safety oriented out of concern for our guests, but we are also highly motivated to promote safety because any accident can threaten our business. We are in the amusement business and we know that people expect their amusement and leisure time activities to be as free from potential harm as is humanly possible.

This is the reason we are constantly striving to ensure the safest possible attractions and rides through a variety of programs and activities and through our cooperation with public and private regulatory and standards setting organizations. When an accident does occur, and accidents are rare, we take whatever steps are needed to assure that our guests receive prompt care and attention. We want to be measured not just by the steps we take to prevent accidents, but also on the actions we take when there is that rare accident. Our staff is trained to handle medical emergencies that are inevitable whenever people congregate, as well as for accidents. We are sensitive to the needs of our guests, and for their care from the time they enter our gates until they leave.

I intend here to very briefly discuss three points that should be central to your examination of this issue. They are highly relevant to the decision you must make concerning the wisest use of limited federal resources. That is, the critical element of every public policy debate of this type is whether a realistically perceived benefit to be realized from some action justifies the diversion of resources from other priority items.

My points are these:

1. Amusement rides are an exceptionally safe form of recreation and entertainment—perhaps the safest available;
2. The industry is highly and adequately regulated at the present time; and
3. The industry has demonstrated its own capacity for effective self-regulation and constant adaptation to new technology and new challenges in the area of safety.

IAAPA strongly and with ample justification believes that our industry is exceptionally safe. This belief is supported by the government's statistics. While attendance at fixed-site U.S. parks and attractions has grown to 309 million annually, the CPSC estimates that of the 4,500 injuries nationwide in 1998 involving rides at these venues, only 36 resulted in hospitalization. Again, according to CPSC statistics, fatalities related to fixed-site amusement rides have averaged just 2 per year over the past two decades.

Assuming each guest takes only three rides (for a conservative total estimate of 900 million rides in the U.S. yearly), the odds of being injured seriously enough to require hospitalization are therefore 1 in 25 million, and the odds of being fatally injured are 1 in 450 million. I invite you to look at the entire list of products and modes of conveyance regulated by CPSC and other federal agencies and see which, if any, come even close to our record in terms of the number of injuries.

Year after year, rides have remained at the low end of the CPSC's figures on product-related injuries. In fact, the latest statistics estimate that more people were injured in 1998 while fishing (77,643), dancing (38,427), golfing (46,019), and bicycling (597,284) than were injured on or in fixed-site amusement rides (4,500). Please remember, too, that in each of these instances we are talking about injuries serious enough to require the individual involved to be examined or treated in a hospital emergency room—the same threshold as is used for counting amusement ride injuries.

I know that some question the relevance of these comparisons. They are nonetheless relevant and informing. They demonstrate that there are risks in life, sometimes from everyday activities. Yet, we in the amusement park industry have minimized these risks well below these other, some seemingly innocuous, activities.

Let me add that it seems clear that the public is very confident of our ability to provide safe entertainment. As already noted, amusement park attendance is currently at 309 million visits. Despite the occasional accidents that do occur and the tremendous amount of media coverage they generate, that attendance number has been increasing steadily for years.

If you will permit me a further, personal, note, I can state truthfully that I have visited hundreds of amusement parks all over the world. My employment provided me the opportunity to take my children to many parks of all types and sizes. We are all enthusiastic riders and to this day there is not a ride I would be afraid to get on alone at age 64 or with my children.

It has been said that there is a loophole in the law for fixed site rides. There is no such loophole. In 1981, Congress examined the issue of ride safety and the jurisdiction of CPSC. That review was not a Reagan administration initiative to take away CPSC jurisdiction over our parks. For several years CPSC had been exercising a jurisdiction it did not have.

Prior to 1981 there had been a number of court cases asking the court to decide whether the definition of the term "consumer product" in Consumer Product Safety Act was intended to cover amusement rides. The decisions had split. Congress was urged, by our organization among others, to clarify the law. It did. After hearings and much discussion, including a review of the safety numbers and our industry practices, it concluded that our rides were not consumer products and not in need of regulation by CPSC. Several times over the intervening years the issue has been presented again. Congress has never seen fit to change its mind.

The safety record to which I refer doesn't just happen. It is the result of concerted effort. IAAPA members have in place a variety of procedures and protocols to minimize the chance of an accident and to evaluate accidents that do occur in order to take appropriate action. IAAPA members do all they can to maximize safety.

Although there is some disagreement as to the exact number of accidents that are caused by rider action or inaction, it is widely agreed that the majority of the accidents that do occur are unrelated to design, manufacturing, maintenance defects or defaults or operator error. I mention this because it means that of the already very small number of serious accidents that occur, an even smaller number are due to the kind of things that might be, and usually are, found by inspection.

While it is impossible to control all human behavior, IAAPA members review every accident case, including those cases where rider horseplay or other patron negligence is shown to have caused the accident, in an attempt to develop operations and security methods to minimize the potential risk of harm to all of our patrons.

Proponents of this legislation maintain that there has been a dramatic increase in the number of ride-related accidents in the last five years, particularly during the period 1995-96. I would invite you to take a very careful look at that claim before relying on it as justification for a new federal program. IAAPA undertook to check this out as soon as we saw the increase reported for 1995-96. We were told by the

CPSC staff that the increase did not reflect an actual increase in the number of accidents but was, rather, the result of a change in the methodology used to collect and analyze the results.

That explanation seemed more plausible than that all of a sudden, and for one year only, there was a 54% increase in accidents.

To further satisfy ourselves on that point, we recently commissioned an independent analysis of the years in question by a company thoroughly familiar with the CPSC reporting system. Working with the data supplied to them by CPSC and using the same methods followed by the agency, our independent analysts found that the CPSC conclusion that injuries had substantially increased for 1995-96, was not supported by the agency's data.

Further, this independent analysis reveals that in 1997 CPSC significantly redesigned its injury data collection sample, adding approximately 30 new hospitals to that sample. The analysis indicated that this significant redesign of the sample raised questions about the statistical representativeness and year-to-year comparability of the data for a product like fixed site amusement rides, with their non-uniform geographic distribution across the nation. The modifications in methodology could also account for an increase that is revealed for the following and subsequent years. This is precisely what we were told when we contacted the Commission.

It would seem important that you proceed with extreme caution and diligence so as to base sound policy decisions on valid and accurate data.

For our part, we believe that even if the agency's numbers are correct, they show a leveling off after 1996 and, in fact, a decrease for the years 1997-98. There is simply no basis for believing that there has suddenly been a sharp, systemic, increase in ride injuries in recent years. Some variation is almost inevitable as total park attendance increases (or, as is happens quite rarely, decreases) each year.

Efforts have been made to cast our safety claims in terms of accidents per mile and other comparisons; but the simple fact remains-and it is confirmed by the public record—that what is at issue here is an annual average of 36 injuries serious enough to require over-night hospitalization and two fatalities in the entire country.

The second of my three main points is that the industry is already highly and effectively regulated.

In addition to the thorough set of internal protocols and procedures followed by member parks, all facilities are subject to one or more layers of outside, independent examination.

Almost all parks are subject to compliance with various governmental codes and requirements. State and/or local officials perform a range of ride-inspection tests, and often assist park personnel with accident prevention programs.

Much is being made of the fact that only 41 of 50 states regulate parks. Again, I invite you to look carefully at this. A critical factor is the distribution of parks among the states and whether they have any rides. More than a dozen years ago we surveyed and discovered that at that time 85% of all the parks in the country were subject to some, in almost all instances State, jurisdiction. Since that time, a number of additional states, including California which has a great many parks, have enacted ride regulation statutes. Since the figure 41 was published, the State of Missouri has enacted a law. So, there are now 8 states without such a law. Of those, the legislature in Alabama is currently addressing the issue, and five states have a total of only 7 parks with rides (AZ, KS, MS, SD, UT). The remaining two states have no parks (ND, MT).

I might add parenthetically that I was surprised to find South Dakota, my home state, among those having an amusement park. I visit there constantly and have never been aware of such. In investigating, I found that an indoor swimming pool that has been in the Black Hills for nearly a century recently added a Ferris wheel to its property and thus became, by somebody's definition, an amusement park.

I think it is a fair question of public policy with respect to which reasonable people can disagree as to whether a state with no parks or even only one or two should set up an agency to regulate parks. I would note, however, that as an organization we have never opposed state regulation.

One has only to look again at the number of serious accidents occurring to be reassured that this system of regulation is working very well. But it is not the only safeguard.

Amusement parks must pass rigorous "risk control" inspections carried out by representatives of insurance companies. Other outside specialists are also used to inspect rides. All these various government agencies, organizations and specialists work together effectively to provide the public with a very high level of assurance that their day in the park will be a safe one.

Finally, I point with pride to the fact that the industry has proved its capacity for leadership in the area of safety and for constant adaptation to new technology and the changes that affect our industry.

Years ago we took the leadership in getting the industry involved in the development of comprehensive amusement ride standards, under the auspices of the American Society for Testing and Materials. ASTM is an independent standards-writing organization that requires broadly based committees, including representatives of the public interest, in setting their standards. CPSC has participated in that process for many years.

That ASTM committee exists precisely to analyze the uses of technology and to provide standards to both manufacturers and operators concerning safe design, manufacture and practices.

The ASTM standards are in place. They are, however, constantly subject to review and revision as new technology and new experience dictates. The committee meets twice a year for this purpose.

The ASTM standards are voluntary as drawn but many states have incorporated them in their regulatory schemes, thereby giving them the force of law. Where they are not encoded, the standards still provide an effective shield for the public. The nature of our legal system is such that no one operating in the industry could afford to ignore the standards.

The issue of g-forces and ride design has been raised. This, too, needs to be looked at objectively. The designers and manufacturers of rides have been designing rides for years in accordance with the best knowledge available concerning the effect of such forces on our guests. The same modern technology that makes higher and faster rides possible also makes it possible to much more accurately assess these forces and accommodate them in design and manufacturing processes.

Proposals relating to g-force analysis and safety are under discussion in both the German organization responsible for ride safety and the ASTM committee in the U.S.

Furthermore, for years there has been a high level of communication and cooperation between those involved in writing ride standards in the U.S. and the various standards writing bodies in Europe. I am confident that this process of international sharing of information and ideas in the standards area will continue.

The maintaining of the industry's excellent safety record also involves an assurance that information concerning safety matters be communicated effectively throughout the industry. There are many protocols involving the parks, manufacturers and government agencies that result in the reporting of incipient or actual problems involving ride safety. The ASTM ride standards also require reporting of both accidents and ride-related defects.

The existing regulatory system which helps insure the extraordinary safety record of the industry is capable of making whatever adjustments are necessary to produce and make available vital information.

The industry has long opposed being subject to the reporting requirements contained in Section 15 b of the Consumer Product Safety Act. Those provisions may be quite adequate for most general consumer products but they are not at all appropriate for something like an amusement ride.

It is the conclusion of all legal experts in the industry that I have spoken to over the years that the language of Section 15 b is ambiguous at best when applied to rides and could very well require every ride in every park to be reported to CPSC as a potentially dangerous product. That would include such things as carousels and kiddie cars.

Let me conclude by stressing once again that the safety and well being of our guests and patrons is our number one priority. Anyone in the business who had had to deal with an serious accident knows the anguish and anxiety that results—certainly for the injured guest and his or her family, which is our first concern, but also for the people on staff. IAAPA members recognize and accept that full responsibility for providing a safe environment rests squarely with the parks themselves. We strongly believe that the current scheme of voluntary and state-based regulation is working and that adding another layer of federal regulatory oversight will not improve safety in our parks.

Thank you for the opportunity to testify. I stand ready to answer any questions that you might have.

Mr. TAUZIN. Thank you very much. The Chair recognizes himself and other members in order. Let me first of all, Mr. Graff, ask you with reference to the statistics compiled by CPSC on accidents and amusement parks, you quarrel with the statistical finding that that

was a dramatic increase in injuries in the year 1995, 1996, but you don't quarrel with the number of injuries reported do you?

Mr. GRAFF. We have accepted the number of injuries reported by the agency for years. Mr. Hyden, the CPSC expert I talked to, suggests that because of the reporting system, because of the NEISS reporting system the number of accidents in our parks is probably overestimated. Mrs. Brown said underestimated. Mr. Hyden says that because of the way the NEISS system works with these 100 sample hospitals from which they determine a statistical average which is then multiplied times all the hospitals in America. There is a severe distortion in what he called location specific. There are 450 parks in the country, and there are 5,000 hospitals.

Mr. TAUZIN. Ms. Fackler makes a point that there are some parks which don't report to anyone, exempted. In the cases where parks do report to State inspectors or ride manufacturers, that information never reaches a central clearing house so that it can be distributed to other parks and other manufacturers or other operators so that they might make the changes that might protect a child from the foot injury her own son suffered. In terms of improving the ride safety or advices to those who are going to be riding the ride, what is wrong with a minimum requirement for centralized reporting and distribution of that information?

Mr. GRAFF. Let me say first with respect to that, then I will get after the question. There is a great deal of communication of that type of information within the industry.

Mr. TAUZIN. I suspect there is, but I am asking you what is wrong with a mandatory requirement that everyone report these accidents and the defects that may be related to them so that everybody can fix them?

Mr. GRAFF. Our basic objection to this process was the same one that was made in 1981, when you were still—I mean we were, you were involved in this committee, and again in 1987 that and that has to do with the specific language of the Consumer Products Safety Act as it applies to amusement rides and devices. On of the greatest things that was discussed in Congress in 1981 and 1987 was whether the NEISS language could be reasonably applied to amusement parks and it was decided that it couldn't. The act would require——

Mr. TAUZIN. But look I am going to have to move on. I want to ask you specifically regardless of the legalities of what the law says today, what it might say if we pass a different bill, what is wrong with the simple notion of all amusement parks whether fixed or mobile reporting to a central data bank from which—managed by CPSC or anyone, would mandatorily report any incidents of defects and accidents so that everybody can share that information and act accordingly.

Mr. GRAFF. Reserving my objection to the precise language of the statute, I would say anything that will facilitate the exchange of useful information in a way that is protective of everybody's legitimate interest is certainly something that we will look at.

Mr. TAUZIN. Ms. Fackler, let me go to you and commend you for your efforts following your son's injury. By the way, I came within a week of having my own foot amputated as a child from a roller accident, you know, just roller skates. And so you know, accidents

like that are just awful. That is the foot I love the most because I always put it in my mouth. So I am glad to still have it. But the bottom line is that kids have accidents, kids make mistakes.

What you are saying in effect is that these things are going to happen by the nature of children making mistakes. They are asking simply that there be some systems by which when those things happen people know about them, people generally share that information. And hopefully rides can continually be improved so that there are fewer of those mistakes that lead to the accidents like your son suffered. Is that about the substance?

Ms. FACKLER. That is about it. And it is not just that the rides be improved. There has been a lot talk about product defects. I am not sure that the vast majority of the problems here has to do with a defective product, but it is the fact that children are being loaded on to heavy machinery. There is an expectation gap. We have heard a lot about car seats today. It is so interesting. Today we talk about restraining children in cars. We restrain children everywhere else in high speed vehicles, and then you get to an amusement park and those same protections don't apply. But oftentimes parents don't understand that when they go on.

You know those hard metal lap bars that come down across your lap are not considered restraints by the designers I have talked to. They are considered something to hold on to. They help keep someone from being thrown bodily out of the car. But there is a chronic problem with those lap bars fitting closely against only the largest person in the car, and the children slip out either through the motion of the ride or if they are young enough they will just stand up. So having an adequate data base allows someone like me maybe to go out and help educate the public to the problem so that parents know when they go on those rides that they need to watch more closely than in a car.

Mr. TAUZIN. Let's talk about restraints quickly. Ms. Stone, you made the observation that in fact there ought to be better information to consumers about whether or not in particular a child restraint will work well in a particular car they own. I want to turn to your Britax seat, Mr. Baloga. It may perform very well in a Chevy Blazer but not so well in a Ford Taurus is what we are told. Can you answer that criticism on whether that is true and whether parents ought to be told whether a seat performs better in a given vehicle.

Mr. BALOGA. It is a very complicated issue and to answer that the engineers would need to know what kind of crash is it going to be, which is virtually impossible to answer. The characteristics of the vehicles are so much different because the seats are designed for adults and therefore vehicle seats need a child restraint. So there is such a variety of performance that it is really impossible to answer that.

Mr. TAUZIN. For example, just the simple question of whether the seat will fit in the car, shouldn't you give consumers information as to whether the seat you are selling them the seat for the child will actually fit in the car that the parents own?

Mr. BALOGA. There is a factor where the seat belt location is dictated by the vehicle manufacturers to fit adults and the child seat manufacturers have no influence on that whatsoever.

Mr. TAUZIN. I am not questioning whether you have influence, I am just saying consumer information. Wouldn't it be useful for you to put on your seats, in fact, all manufacturers whether or not it will fit in a car? I just made the case for my remote, you know, I was pretty upset when I called last night and found out this universal remote didn't work on my television. Just how much worse it is when you go buy an expensive car seat for your child and find out it doesn't fit in your car.

Mr. BALOGA. This is a good point. That is why we recommend try before you buy in terms of the child seat.

Mr. TAUZIN. But do you know as a manufacturer which cars your seat won't fit in.

Mr. BALOGA. In some cases where there are extreme problems, yes.

Mr. TAUZIN. I would just suggest, you know, maybe we have some need for some good consumer education information here. Because apparently the agency is not yet ready to report to consumers about which seats work better in which cars, but you certainly can tell at least whether they fit in a car. We probably ought to know that. I want to quickly turn to the other point with you that is the LATCH system. My understanding is that new cars do not need to be equipped with anchors until the year 2002. If that is correct, how much more do you think it will cost to equip car seats with the LATCH hardware?

Mr. BALOGA. Are you talking about vehicles or child seats.

Mr. TAUZIN. I am talking about vehicles that do not need to be equipped with the anchors that are critical to a LATCH system as I understand it.

Mr. BALOGA. So how much would it cost?

Mr. TAUZIN. To equip cars that don't have it. What are we talking about?

Mr. BALOGA. I am not really the right one to answer that. If it means a redesign, serious redesign of the whole vehicle it could be 10's of millions of dollars to retool.

Mr. TAUZIN. How much would it cost to make a change in the seat?

Mr. BALOGA. We are doing that right now, the industry. It can be $15 to $75 depending on the complexity of the attachment.

Mr. TAUZIN. You are in the business of doing that right now.

Mr. BALOGA. Absolutely, yes.

Mr. TAUZIN. Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman. When I was 5, I was chasing Bobby Olson and Charlie Kiddaro across the street. They were 9. In retrospect, I was way up where I should have been up there on the corner of Welsh Street, and I was run over by a car. There were two things my mother always told me, if I got run over by a car and was taken to an emergency room. One was my telephone number is M840815. Your name is Eddy Markey. And second make sure you change your underwear every day because I will be totally embarrassed if you ever go into your emergency room and they found out you didn't change your underwear.

There is another lesson I learned too because I carry it with me for my whole life, which is this huge bump up here on the top of my head, which is—unlike other kids when they were 15 or 16

back in the 1960's, I put my seat belt on. These cars can hurt you if they hit you.

Now better to learn that lesson vicariously than in person. Huh?

So now we look at the roller coaster industry, and they are over here kind of in this separate world where you are putting a whole bunch of kids into a ride which we know is very dangerous but without any Federal and in many States any State regulation. And we have got this huge increase now in the number of kids who will have a memory of the injury which they suffered.

And I think that it again is much better for people to learn this lesson vicariously. The injury really isn't necessary and hundreds of millions of kids learn how to buckle up now or protect themselves without having to learn it in person. But there were no laws, obviously, when I was a kid that dealt with those kind of issues.

So Mr. Graff, here is the problem for your industry. Your industry has—if we can put up the chart—your industry has a higher fatality rate per distance traveled than scheduled airlines, passenger trains, buses. In 1997, 42 passengers died on scheduled airlines at a rate of .01 per 100 million miles traveled. Roller coaster rides are much shorter than plane rides, but even so people are dying on roller coasters on a much higher rate than on airplanes. Now, do you think the airline industry is not sensitive to safety concerns? No, I don't think the answer is no to that. They are concerned. But do you think it makes sense for us not to regulate them at the Federal level to make sure that there are safety precautions built in for the public? I think obviously the answer to that is no as well.

So your industry may be concerned, but there is no other industry that has such a high rate of accidents and fatalities for a million miles travelled that we allow to escape some form of Federal regulation. So the information is shared. If there is a plane accident in one State, the information is then shared with every other airline so that every other passenger, every other child getting on a plane any place else in the United States is given the opportunity to be given the protections which they need.

Do you think, sir, Mr. Graff, that your industry should be exempt while the bus, plane, train, automobile industries are not except from some form of Federal regulation?

Mr. GRAFF. Yes, I do. First place, I take issue with your characterization that you say these are really dangerous instruments, these roller coasters. They are not. And again I point to our public safety record. You characterize it, sir, in this manner, and that is fine and that is an interesting way to do it. The fact remains that there are 41,967 people killed in motor vehicles in 1997. From 1994 to 1996, the average number of airline deaths was 262. Our average for 20 years has been 2. Now, I suggest that the regulatory system that is out there and plus the industry activities that go on are producing an extraordinary safety record.

Mr. MARKEY. Well, I think I am going to have to disagree with you. Because obviously every American for the most part is in an automobile every day. Every American is not on a roller coaster every day. Americans only go on a roller coaster once a year, and it is a very small percentage of all Americans that do and it is

mostly families with small children for that 1 day they are going to go to the amusement park.

So the absolute numbers may be smaller, but the percentage per mile traveled in the vehicle is higher in terms of the actual risk. And that is the only way there which you can have a fair comparison in terms of the rate of injuries and deaths on these competing modes of transportation.

Mr. GRAFF. I would suggest that a more meaningful one would be the number of times the number of incidences that you get in your car as compared to the number of times you get in a coaster and how many times you have an accident.

Mr. MARKEY. Let me move on. I know the Chairman wants me to wrap up. The industry has moved to adopt G-force limits, the amount of stress that these children should be placed under. At least one ride in the United States, Texas Tornado boasts of G-force standards that exceed the German industry standard. Does that concern you that there are no standards in the United States, that other countries have standards, and we have yet to adopt one?

Mr. GRAFF. First of all, you point out the Germans have not adopted a standard. They have a standard pending. There is a standard related to G-forces pending before the ASTM, the American Society of Testing Materials. So both of these organizations have that issue under consideration. There is a European Union committee working on amusement right standard. The issue is relevant to them. This is not anything new.

Mr. MARKEY. When will your industry adopt a standard? Are you going to adopt a standard, Mr. Graff, on G-forces?

Mr. GRAFF. The ASTM's committee of experts will look at that and determine what standards, if any need, to be adopted. That is what the process is about. And the CPSC has been involved over the years in that. I said again today, I don't know why they said they can't because they have been.

Mr. MARKEY. We need a G-force standard, Mr. Graff.

Mr. GRAFF. It is being considered by the committee.

Mr. MARKEY. I don't know how many children have to die or be injured before G-force standard is put in place, but we are long past the time where your industry should ensure that every child is safe going on a roller coaster.

Mr. GRAFF. We have exchanged that information with the Germans. I talked to Mr. Leitensdorfer this week about this very subject. I have known him for years. They come back and forth to our meetings. We go to theirs. This information is traded. I think you can assume that the industry across national boundaries will be arriving at some point of a consensus about what happens to G-forces.

Mr. MARKEY. Mr. Graff, as long as the consensus is that you are going to have a standard then it is a good consensus. But it would be just plain wrong for us to go through another summer without having you built in the safety precautions for families with small children heading toward amusement parks in America.

Mr. TAUZIN. Thank you Mr. Markey. We have another vote on the floor. Let me just say for the record, Mr. Currie, you have sold me on your bikes. I am going to pass on you. But the other two of you that spoke on the children's sleepwear issue there are some

questions I would like you to respond in writing. I will send them to you, but they basically have to do with the three commissioners testifying that there is not a single incident of a child wearing tight-fitting cotton sleepwear and receiving burn injuries. I would like to get your comments on that whether it is true or not.

Second, that we have heard that there has been some real problems with consumers buying clothes that have been treated because of their fear of the toxicity of the chemicals involved in treating the sleepwear. I would like to get your comments on that.

And finally whether or not you think the CPSC burn data information itself is flawed. Because obviously we have got a spotty record when it comes to Congress telling them what to do. You remember the first time we told them what to do with seat belts, some at least claim may have cost a lot of children their lives in the way—not seat belts, rather the air bags, by the way those air bags operate.

And our record is spotty in that regard. We want to be very careful here to make the right decisions. Please respond in writing. We will issue the questions to you. The record will stay open for 30 days.

Thank you all very much for the information you provided us today and the time you spent with us. The hearing stands adjourned.

[Whereupon, at 2:20 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

JOINT PREPARED STATEMENT OF THE ALLIANCE OF AUTOMOBILE MANUFACTURERS AND THE AUTOMOTIVE COALITION FOR TRAFFIC SAFETY

We are pleased to offer our comments on H.R. 4145, the Child Passenger Safety Act of 2000 and welcome the opportunity to work with the Subcommittee on Telecommunications, Trade, and Consumer Protection, along with the bill's sponsors and the sponsors of S. 2070, the Senate version of this legislation. Our section-by-section comments are as follows:

We suggest expanding **Section 2, Findings** to include language noting that, notwithstanding the need to update test standards for child restraints, most children who are killed or seriously injured in motor vehicle crashes are completely unrestrained or are in child restraints which are either grossly misused or inappropriate for their age or size. In addition to upgrading test standards, NHTSA should expand programs that encourage parents and caregivers to properly secure children in child restraints, and in the rear seat, whenever possible. Additional funding for programs addressing these problems should be authorized.

While we prefer to leave the specifics of regulatory matters in the hands of executive branch agencies, to provide flexibility to address changing situations, we agree that Congressional encouragement for NHTSA to review and update FMVSS 213 may be warranted. In addition, given the complexity of the issue of child safety in motor vehicles, we suggest that the Subcommittee consider requiring NHTSA to both initiate and complete actions by specified dates, and allow the agency to terminate rulemaking, or conduct additional research, should the record lead NHTSA to those conclusions. Mandating revised rules in so complex an area could lead to unintended consequences and we believe NHTSA should have the flexibility we suggest. Such a course of action would be similar to directions that Congress gave NHTSA in the 1991 ISTEA legislation.

We support new side impact test requirements as described in **Section 4(b)(1)(A)** (except for belt positioning booster seats), but believe that rear impact and rollover test requirements may not be necessary. Few children in child restraints are seriously injured in rear impact crashes. We believe that a child restraint that performs well in frontal and side impact tests will also provide protection in rollovers. Updating child restraint test platforms to reflect contemporary motor vehicle designs is appropriate; however, we hope that when doing so NHTSA would consider harmonizing with the current ECE R44-03 standard, which has been recently updated.

With respect to the use of additional anthropomorphic test dummies as specified in **Section 4(b)(2)**, we believe that switching to the updated, more biofidelic test dummies (including an instrumented infant dummy) is as important as is adding more dummy sizes. However, as the world's technical community develops additional child dummy sizes, particularly representing children above age six, NHTSA should consider adding them to FMVSS 213.

It is important to note that the new LATCH uniform attachment point requirements will, as of September 1, 2002, require many child restraints to be tested both forward-facing and rear-facing with lap belt, lap belt and tether, and LATCH attachments with several dummy sizes. The resulting matrix may involve approximately one dozen certification tests for a single child seat. Adding side, rear and rollover tests would expand the matrix to approximately fifty tests per convertible child restraint model. In view of the fact that affordability is already an issue with many families, Congress should direct NHTSA to carefully consider increased child restraint costs as it formulates its revised standards.

Section 4(b)(3) appears to require that FMVSS 213 be extended to cover belt positioning booster seats. This issue is not easily resolved. A number of safety groups and the Blue Ribbon Panel II—Protecting Our Older Child Passengers—have supported such a measure. However, belt-positioning booster seats rely on vehicle lap/shoulder belts, the geometry of which varies among vehicle models, to restrain the child. Since lap/shoulder belts are designed to restrain heavier adults, the strength of such belts is adequate to protect children in booster seats. In addition, current booster seats appear to be performing well in the field and booster seats rated for children up to eighty pounds are now being manufactured. The safety need for the existing dynamic test of belt positioning booster is highly questionable. While we are willing to work with child restraint manufacturers and NHTSA to explore possible testing protocols, we are not certain that an additional test for belt-positioning booster seats would necessarily improve child safety. NHTSA should carefully weigh the benefits and costs of such a test as it could have a negative effect on the cost and availability of booster seats, and, thus, on the fledgling booster seat market. **Section 4(c)(1)** should be redrafted to exempt belt-positioning booster seats. Side impact head restraint requirements are not practicable for booster seats because they utilize the lap/shoulder belt to restrain the child.

Due to the large number of vehicle models, seat and seat belt configurations and the number of child restraint models in the marketplace, the inclusion of a limited number of specific child restraints in NHTSA's New Car Assessment Program protocol each year would appear unlikely to provide useful information for consumers. For example, inclusion of a certain child restraint in a specific vehicle NCAP test would provide information only for that child restraint-vehicle combination. It would provide no information about other child restraints in that vehicle or that child restraint in other vehicles. In addition, even placing the child seat in a different seating position in that vehicle might yield different results. As discussed with regard to **Section 5**, below, we believe the use of a child seat that "fits" the vehicle seat is a more important criterion. Also, LATCH system attachments, as required by FMVSS 225, will help alleviate past child restraint and vehicle compatibility problems.

We support changes to FMVSS 213 to make labeling text more readable and note that the Blue Ribbon Panel on Child Restraint and Vehicle Compatibility also recommended improved labeling.

As an added objective for NHTSA, any updated U.S. standards issued under the directive of **Section 4** should be harmonized with international standards and test procedures to the extent possible.

Section 5 requires the Secretary to develop and implement a safety-rating program for child restraints. Because of child restraint and vehicle compatibility issues, the current widely accepted definition of the "safest" child restraint is the one that will fit a person's vehicle and child and will be used consistently and properly. Many child restraints that fit securely on NHTSA's test seat may fit with varying degrees of security in different seating positions in different vehicles, depending on variations in seat and seat belt design. Thus, there can be no single best or safest child restraint for all seats in all vehicles. Many of these compatibility issues will be resolved with the implementation of LATCH system uniform attachments. In addition, NHTSA is developing a database which, when completed, will identify which child restraint models can be securely installed in different model vehicles.

Because all vehicles and all child restraints manufactured after September 1, 2002 must be equipped with LATCH attachments, we suggest that any child restraint ratings program promulgated under the requirements of **Section 5** rate child restraints as installed with LATCH system attachments. Such ratings could be based on the results of the updated compliance tests developed under Section

4(b)(1). In keeping with the NCAP practice of using all available restraint systems, the ratings should also utilize any standard equipment top tether straps or other standard safety features. Attempting to rate child restraints installed with the lap belt on the NHTSA standard test could unintentionally confuse consumers and could induce them to purchase child restraints that are not the best for the seats and seat belts in their vehicles.

In closing, we reiterate that while this bill can have a positive impact on child passenger safety, the most common causes of death and serious injuries are riding unrestrained or in a child restraint that is being grossly misused. We urge the Congress to also address these important issues.

PREPARED STATEMENT OF AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics (AAP) is an organization of 55,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

We are pleased to submit this testimony for the record of the May 16, 2000, subcommittee hearing on "Consumer Safety Initiatives: Protecting the Vulnerable." Specifically, our testimony addresses the "Child Passenger Protection Act of 2000" (H.R. 4145), introduced by Representative John Shimkus and others, and the issue of regulations regarding the flammability of children's sleepwear.

Child Passenger Protection

Every day, infants and children are injured and killed in motor vehicle accidents because they are not well restrained. In fact, more children are killed and injured in car crashes than from any other type of injury. As pediatricians, we see the terrible results of motor vehicle injuries in children.

Using a child restraint that is well-designed and used correctly can prevent many of these injuries. However, we know that children are not always adequately restrained. Larger, older children are often transitioned to adult seat belts too soon. Booster seats are essential to keeping these kids safe. By using an adult seat belt too early, children are at risk for serious head injuries, which are the most common injuries in car crashes, as well as damage to the liver, spleen, intestine and spinal cord. These types of injuries can be prevented through widespread use of booster seats.

Pediatricians strive to ensure that parents have up-to-date, appropriate information about car safety seat choices and use. A safety rating program to provide parents with clear, easy to understand information about choosing a child safety seat will help us spread that important message.

By addressing these issues, we can help ensure that children are better protected in the car. We commend the sponsors of this legislation for their efforts to address the safety needs of our nation's youth.

Flammability Standards for Children's Sleepwear

Injury is the leading cause of death and disability in childhood and early adult life-more school-age children die of injuries than all other diseases combined. Yet most of these major injuries are preventable.

As pediatricians, there is nothing more tragic than seeing a child suffering from an injury that could have been prevented. This is true whether it is a severe burn treated at a burn center or a minor burn that is seen in a pediatrician's office. In many cases, the best way to prevent an injury is by altering the environment. The CPSC made the right decision years ago when it issued a standard to ensure that children's sleepwear would not cause burn injuries to children.

Considerable progress has been made in the development of ways to understand and control childhood injury. The most notable successes have been in the reduction of poison and flame burns as causes of death and disability in childhood.

Since the CPSC issued the children's sleepwear standards approximately 20 years ago, there has been a substantial decrease in the number of burn injuries and deaths to children. This includes an estimated tenfold decrease in the number of deaths associated with children's sleepwear. This strong association leaves little doubt that the sleepwear standard has had a major impact on children's safety. That is why the CPSC's decision to relax the children's sleepwear flammability standards is so disturbing.

The American Academy of Pediatrics has had a long history of working successfully with the CPSC to prevent injuries to America's children. We have urged to reinstate the more stringent flammability standards for children's sleepwear in order to ensure maximum protection for children.

PREPARED STATEMENT OF DAVID M. BOROWSKI, MANAGER OF REPORTING AND INFORMATION, CORPORATE FINANCE DIVISION, FREDDIE MAC

Mr. Chairman, members of the Committee. My name is David Borowski. I'm the manager of reporting and information in the Corporate Finance Division of Freddie Mac. I'm also a counselor for young burn survivors at the Mid-Atlantic Burn Camp. There we help children from the Washington, Baltimore and Philadelphia areas adjust to living as normally as possible with the emotional and physical scars caused by fire.

Proponents for the 1996 relaxation of the safe children's sleepwear standard say children are not likely to be involved in fire situations if they are younger than nine months. They say we should keep the relaxed standard and monitor statistics to see if further adjustments are necessary. And they seem to have decided that the risk of fire injury to children does not justify the added cost of making infants' sleepwear with fire-resistant materials. This is my response.

First, I am a burn survivor. The fire occurred in 1954, years before the safe sleepwear standard was enacted. I was six weeks old. Now, I was a precocious child, but trust me, even I wasn't playing with matches at that age. In my case, a puppy chewed an electrical cord causing sparks that flew to me and the bassinet in which I lay, starting the fire. I sustained second and third degree burns over eighty percent of my body, and lost, most significantly, my entire right hand and part of my left hand. Much of my face, ears, scalp and feet have been reconstructed.

The Consumer Product Safety Commission's statement relaxing the safe sleepwear standard says, "infants under nine months are insufficiently mobile to expose themselves to sources of fire." I am living proof that lack of mobility does not protect children from the danger of fire. Fires can and do make their way to infants, who have no means of escape. And the younger they are, the more vulnerable they are.

Second. Monitoring. Does anyone really want to wait for statistics to prove the previous standard was working? Let me tell you something. These statistics will not be neatly typed numbers on tidy white paper. They will be bodies: young, burned, in unimaginable pain and some horribly disfigured. Worst of all, they will be the same "statistics" that established the standard in the first place, twenty-nine years ago. Some lessons should not have to be re-learned.

Finally, clothing manufacturers appear to be concerned about costs. Whatever that cost is, there is a far greater cost if the fabric is not flame resistant.

There was a cost for me to be in the hospital for months. There was a cost to my insurance company for more than fifty surgeries. There was a cost to the Government as I continued my efforts to look more normal. And I was only one child.

I'm sure you're aware that there is an even greater cost than money. There was the cost to my parents who, to their credit, magnificently adjusted to my limitations and helped me overcome them. And there was the cost to me, which I was able to pay because I had the emotional resources and family encouragement to do so.

But I am not the norm. Many disfigured burn survivors choose not to engage in a society that places so much emphasis on traditional, physical beauty. I'm very aware that without my support system, I might not have accomplished what I have.

Now, I know that we won't prevent every fire. But shouldn't we do what we can to minimize their effects on children? Today, you have the opportunity to do this. By re-establishing the safe sleepwear standard, you can, once again, help protect children from the physical and emotional scars brought on by fire.

Each child at the Mid-Atlantic Burn Camp has his or her own sad story. Yet, in a way, the emotional results are the same. Even when the physical pain is gone and the children are declared physically recovered and are released from the hospital, the long, truly hard road is just beginning for the seriously injured and disfigured ones.

Every time we prevent a child from being burned, we keep one more little person from ever having to set foot on that road. In light of the failure of the CPSC to fulfill its role as public protector, you are now charged with the responsibility of being the vigilant guardians at that gate.

PREPARED STATEMENT OF EASTER SEALS

Easter Seals national headquarters appreciates the opportunity to submit a statement for Subcommittee consideration that supports the "Child Passenger Protection Act," H.R. 4145. Please include our statement in the record for the legislative hearing, titled "Consumer Protection Initiatives: Protecting the Vulnerable," held by the Subcommittee on Telecommunications, Trade & Consumer Protection on May 16, 2000,

Easter Seals strongly supports efforts to reduce the number of children who are injured or killed in car accidents. The Child Passenger Protection Act, H.R. 4145, includes provisions that will improve the accuracy of safety testing methods and ensure that parents have greater access to information about car seats, including proper installation and use.

Easter Seals has partnered with the National Highway Traffic Safety Administration to improve access to child passenger safety information and car seating for all families. Easter Seals is concerned that child passenger safety information and seating does not adequately provide for the needs of families with children v4th disabilities. It is our hope that passage of this legislation will enhance testing, information and support to increase passenger safety for children with disabilities and special needs.

Easter Seals is a community-based nonprofit organization dedicated to promoting independence for people with disabilities. Through a nationwide network of 105 affiliates, Easter Seals provides early intervention and special education, vocational rehabilitation, training and employment, medical rehabilitation, and an array of other home and community services to more than one million children and adults each year.

Easter Seals appreciates the Subcommittee's interest in this legislation and encourages passage of this legislation as an effective means of promoting child passenger safety.

U.S. CONSUMER PRODUCT SAFETY COMMISSION
WASHINGTON, DC 20207
May 22, 2000

Mr. W.J. TAUZIN
Chairman
Subcommittee on Telecommunications, Trade and Consumer Protection
House Committee on Commerce
2125 Rayburn House Office Building
Washington DC 20515-6115

DEAR MR. TAUZIN: During the hearing on May 17, 2000 before the Telecommunications, Trade and Consumer Protection Subcommittee, a number of statements were made by Members and witnesses that indicate to me that the reasons for the Commission's amendments to the children's sleepwear standards have been misinterpreted and misconstrued. I ask that this letter be included in the hearing record.

The Commission changed the sleepwear regulations to permit the sale of snug-fitting, non-flame resistant cotton sleepwear to give consumers who preferred non-flame resistant sleepwear a safe choice for their children. When the Commission began its consideration of amending the children's sleepwear regulations only one to two percent of all children's sleepwear sales consisted of chemically-treated flame-resistant cotton. The market for flame resistant cotton sleepwear remains very small. Sales figures indicate that consumer acceptance of flame-resistant sleepwear was and is low. While more advanced chemical treatments or other methods of flame-resistance may increase consumer acceptance of flame-resistant sleepwear, the Commission was, and continues to be faced with the fact that consumers prefer natural fibers for children's sleepwear.

With low consumer acceptance of flame-resistant sleepwear, the Commission amended its regulations to provide consumers with a safe cotton alternative for children's sleepwear. The Commission developed a careful record documenting why snug-fitting cotton sleepwear was reasonably safe. The testimony that I delivered at the hearing shows why snug-fitting cotton sleepwear is safe and I will not repeat those arguments here.

Dr. David N. Herndon, MD testified during the hearing on behalf of the Shriners Burn Centers. Dr. Herndon's testimony proceeds from the premise that children are virtually safe from burn injuries if they are dressed in flame-resistant sleepwear. He even claims that such clothing will protect its wearers from burn injuries in house fires (pages 9 and 10 of his testimony,) a claim that not even the manufacturers of flame-retardant sleepwear will make. The Commission staff has conducted over 200 investigations of combustion incidents involving children's clothing since 1993. About 70 of those incidents involved clothing that the children used for sleeping. While the majority of the incidents involved the ignition of garments not intended for use as sleepwear (e.g., T-shirts, sweatshirts, etc.), fifteen completed investigations *involved burn injuries to children in sleepwear covered by the flammability standard, in other words, made of flame-resistant fabrics.* Flame-resistant sleepwear

is designed to protect its wearers from small open-flame, single-point ignition. It is not intended, designed or manufactured to protect a child in a house fire, and it will not do so.

An objective that appeared to receive little attention at the hearing was consumers' freedom to choose among *safe* sleepwear alternatives. Consumers who wish to do so may purchase chemically-treated flame-resistant traditional sleepwear (e.g., nightgowns, nightshirts, and traditional pajamas). Consumers who prefer untreated natural fibers may now purchase safe alternatives in the form of snug-fitting sleepwear. I hope that the availability of safe sleepwear made from natural fibers will prompt consumers to reject unsafe alternatives such as oversize cotton T-shirts. The action taken by the Commission provides a *greater net safety* because it permits the sale of additional safe sleepwear options. Congress should not overturn the Commission's action legislatively and reduce this net increase in safety.

Sincerely,

MARY SHEILA GALL
Vice Chairman and Commissioner

cc: Members, Subcommittee on Telecommunications, Trade and Consumer Protection

The Honorable Greg Ganske
The Honorable Ann Brown, Chairman, CPSC
The Honorable Thomas Moore, Commissioner, CPSC

SHRINERS HOSPITAL FOR CHILDREN
June 2, 2000

W.J. "BILLY" TAUZIN
Chairman
Subcommittee on Telecommunications, Trade, and Consumer Protection

DEAR MR. TAUZIN, thank you for the opportunity to speak to the Subcommittee on Telecommunications, Trade and Consumer Protection. I appreciate the opportunity to clarity any issues before the hearing record is printed. Please find below my responses to each question.

Question 1 All three CPSC Commissioners have testified that there has not been a single serious incident of a child wearing tight-fitting cotton sleepwear and receiving burn injuries resulting from single point ignition. Is this true?

Answer: No, this is not true. We produced three examples in the testimony that was submitted to Congress. The patients are: a) J.F. burned 12-1-99 (page 36-36). The four-year-old child from California was wearing close fitting, long underwear like bunny suit sleepwear when he brushed against a candle in the family's dining room. b) U.S. burned 1-20-98 (page 37-38). The two-year-old child from California was sleeping when a candle fell over and caught her close fitting pajamas on fire. c) D.S. burned 4-16-97 (page 39-40). The seven-year-old child from Florida was involved in a house fire when he was wearing tight fitting pajamas.

Question 2. In the past, haven't some parents been concerned about the toxicity of the chemicals used to treat children's sleepwear, and have been less willing to buy those garments?

Answer: Yes. The substance used to treat sleepwear in the 70's was called "Tris" which had potential difficulties and was withdrawn, Today, technology is available to treat sleepwear so it is flame resistant but that treatment does not alter the quality of sleepwear in any way. It feels and looks the same as normal cotton, The product is being marketed under the brand name "Skivvydoodles" which meets all these characteristics and consumer acceptance has been excellent.

Question 3. Has the CPSC been basing their analysis on faulty burn data?

Answer: Yes, their data was flawed, as already stated in the testimony. It was based on a random sampling of 101 emergency rooms in the United States, which included only 4 burn centers. Those burn centers do not admit pediatric burn patients at a rate that would be demonstrative of national statistics. In fact, three of those refer pediatric burns in their area to other hospitals. The Massachusetts General Hospital in Boston refers all pediatric burn patients for direct admission to the Shriners Hospitals for Children in Boston. Children's Hospital in Kansas City Missouri refers their patients to Shriners Hospitals for Children in Galveston and King's County Brooklyn emergency room preferentially diverts patients with large pediatric burns to the New York Hospital Burn Center in New York. This leaves only one burn center in their sample, the Columbus Children's Hospital that routinely does admit children with burn injuries. Their referral area, however, is lim-

ited by proximity to Cincinnati where the Cincinnati Shriners Hospitals for Children admits pediatric patients for burn care.

Sincerely,

DAVID N. HERNDON
Chief of Staff, Shriners Burns Hospital
Professor of Surgery
Jesse H. Jones Distinguished Chair in Burn Surgery
University of Texas Medical Branch

PREPARED STATEMENT OF THE NATIONAL FIRE PROTECTION ASSOCIATION

Thank you for the opportunity to submit this statement. The National Fire Protection Association (NFPA) commends the Chairman and the members of the Telecommunications, Trade and Consumer Protection Subcommitteefor holding this important hearing on child safety.

NFPA is the premier source worldwide for the development and dissemination of knowledge about fire and life safety. Our mission is to reduce the worldwide burden of fire and other hazards on the quality of life by providing and advocating scientifically-based consensus codes and standards, research, training, and education.

NFPA is an independent, voluntary membership, nonprofit organization. Our membership totals over 68,000 individuals and our activities fall into two broad, interrelated areas: technical and educational. The basic technical activity involves the development, publication and dissemination of state-of-the-art consensus codes and standards intended to minimize the possibility and effects of fire in all aspects of life.

For over 90 years, NFPA has been teaching how to be fire safe. Our public education materials include school-based programs such as the *Learn Not to Burn Curriculum®*, and Risk Watch™. The Association's Fire Analysis and Research Division maintains the world's most extensive fire experience databases.

In 1996 the NFPA opposed the decision made by the U.S. Consumer Product Safety Commission (CPSC) to amend the children's sleepwear flammability standards. NFPA's disagreement with CPSC over standards for children's safety is an anomaly. Our two organizations have a long history of concurrence on the needs of a nation that values safety.

NFPA has contended throughout the debate that CPSC abandoned the mandatory flame resistant children's standards without appropriate analysis or sufficient facts or data.

The pre 1996 sleepwear flammability standards were successful in preventing injuries and deaths to children by fire. The relaxation of the standards purported to address CPSC's concern with parents putting children to bed in loose fitting T-shirts or underwear. We do not believe these amendments eliminated any risks. To the contrary, we believe the amendments placed children at higher risk by compromising the mandatory flame resistant requirements.

The old standards for flammability of children's sleepwear served for decades to protect America's children from fatal or disfiguring burns due to clothing ignitions. Children under the age of five are among America's population at highest fire risk. Current fire death rates for preschool children is more than twice the average of people of all ages and four times the rate for young youths. They also suffer a substantially higher rate of fire injuries.

The leading cause of fatal fires in this age group is children playing with matches and lighters, a scenario in which the ignition heat source is very close to the children's clothing from the beginning of the fire. Children's sleepwear must be able to stand up to these exposures.

The arguments we used to oppose the 1996 decision have been reinforced and validated over the past 3 years. The difficulty in achieving compliance with the flame resistant sleepwear standards led to the CPSC conclusion that "snug fitting" cotton garments could deliver an equivalent level of safety. NFPA questioned whether skin tight was achievable. There is an American tradition of hand-me-downs and the common practice of buying clothing large enough for the child to grow into. Parents do not buy age-appropriate garments.

The revised standards also added a new concern, an exemption for infants up to 9 months of age. The theory was that infants are not mobile and therefore are not exposed to fire. This was asserted without supporting data and in the face of data showing that many infants are mobile and that fire play by older siblings and playmates can and does bring fire near younger children.

For the old standards, the problem was non-use of compliant sleepwear. For the revised standards, the problems are non-use of compliant sleepwear, compliant

sleepwear that is not snug enough to assure protection, compliant sleepwear in age-inappropriate use, and the lack of protection for infants.

In June 1999 GAO issued the report "Consumer Education Efforts for Revised Children's Sleepwear Safety Sandard". GAO's conclusion reaffirmed NFPA's position that "while consumers often have some information on children's sleepwear safety available at the point-of-sale, it is not to the extent envisioned by CPSC. The effectiveness of this consumer education effort is unknown . . . neither CPSC nor the industry has assessed whether consumers use this information to select the proper size of snug-fitting garments". The old standards protected children even if families had no idea how they worked. The revised standards are much more dependent on the level of knowledge and the consistency of safe usage by customers. There is no evidence that the revised standards will achieve a high rate of proper usage, and little evidence that industry is doing much to raise the rate of proper usage. And, there is no evidence that families previously using daywear as sleepwear are returning to sleepwear.

After three years, we still fail to see the logic behind the 1997 amendments. Why weaken the standards that for over twenty-five years worked to reduce the number of burn injuries and deaths suffered by children? We recommend a return to safer standards.

This is not an industry versus safety advocate issue, or a political issue. As the Subcommittee recognized by including it in today's hearing, it is a child's safety issue.

PREPARED STATEMENT OF ROSEMARY SHAHAN, PRESIDENT, CONSUMERS FOR AUTO RELIABILITY AND SAFETY

Mr. Chairman and Members, I am Rosemary Shahan, President of Consumers for Auto Reliability and Safety (CARS), a national auto safety and consumer advocacy organization based in Sacramento, California. CARS is affiliated with the CARS Foundation, formerly named Motor Voters, which for over 20 years has been active in promoting auto safety and preventing vehicle-related deaths and injuries.

The CARS Foundation helped form the National Coalition to Reduce Car Crash Injuries, which worked to promote seat belt use and ensure the availability of more advanced occupant restraint technologies, including improved seat belt systems and air bags.

On behalf of the members of CARS and the motoring public which benefits from our work, I offer this testimony in support of the Child Passenger Protection Act of 2000, H.R. 4145, because it is an important step in improving protection for America's children from preventable deaths and injuries.

Car crashes remain the leading cause of death among children ages 6 to 14. Despite progress in the enactment of child safety seat laws, there is much more that needs to be done, particularly as new technologies become available. The advent of side impact air bags, which may offer increased protection to some occupants but not necessarily to children, poses a special set of challenges.

CARS is particularly pleased to support H.R. 4145's provisions for better protection for older children, addressing the "forgotten child" problem, which persists. For decades, NHTSA has been in the forefront of efforts to improve child safety, in a number of ways. However, the agency and the public can still benefit from direction from Congress.

In 1990, the CARS Foundation petitioned the National Highway Traffic Safety Administration to require auto manufacturers to provide height adjusters for seat belt shoulder harnesses, allowing seat belts to be easily adjusted to properly fit smaller or taller children and adults. The efficacy of properly worn seat belts in reducing deaths and injuries is well-documented, and was not in dispute.

The CARS Foundation was particularly concerned about the lack of comfortable, properly fitting restraints for older children and smaller adults, many of them women and older citizens. It had also come to our attention, through consumer complaints and real-world observation, that children who are too large to fit into child safety seats but too small for seat belts designed to meet standards set for adult-sized dummies, are at risk. It was common to see children ages 5-16 riding either unrestrained or with the shoulder portion of the belt under their arms or behind their backs, compromising the benefits of the restraint system and posing new risks, including the threat of devastating internal injuries, spinal cord injuries, and head injuries.

The petition was supported by many respected organizations, including the Insurance Institute for Highway Safety and the National Coalition for Consumer Health and Safety, including leading physicians organizations, consumer and public safety

groups, and insurers. The petition also attracted support from many individuals including parents and smaller adults. However, it was opposed by a number of auto manufacturers, although some of them at the time were installing height adjusters, mostly in the front seats of luxury models.

In 1991, NHTSA denied the petition, citing a lack of evidence the height adjusters were needed, and their cost, which the agency estimated to be approximately $2 per seating position, or a total of $8 per typical passenger car.

The CARS Foundation then worked with the National SAFE KIDS Campaign and Congress, and succeeded in gaining enactment of a provision in ISTEA requiring the agency to revisit the issue. In 1994, NHTSA issued a rule requiring that auto manufacturers install the height adjusters beginning in the 1998 model year, but only for seating positions in the front.

H.R. 4145 may help spur NHTSA to take the long-overdue step of mandating seat belt height adjusters in rear seats. This is an important step, particularly since the entire safety community urges children to ride in the rear seats, rather than in the front. Belt-positioning child booster seats offer greatly enhanced protection. However, many children will remain dependent upon the systems available as original equipment, particularly as the vehicles age and are resold to families that may be less likely to provide the additional protection of a booster, due to cost constraints or other factors.

CARS also is pleased to support the provision in H.R. 4145 that requires consideration of the need to conduct more comprehensive and real-world dynamic testing of child restraints. Dynamic side-impact testing is necessary to fully evaluate the effect of existing technologies on safety. With increasing numbers of new vehicle models equipped with side impact air bags, dynamic tests are also needed to ensure that new air bag designs are compatible with child safety restraints and do not jeopardize the safety of children riding in outboard seating positions.

For purposes of testing child restraints, CARS is concerned about the limitations inherent in the NCAP program, which tests only about 40 vehicles each year. There may be other more comprehensive, yet cost-effective approaches available which NHTSA should explore.

The consumer information provisions of H.R. 4145 are also worthy of support, in CARS' estimation. The child safety seat rating system promises to provide valuable information for parents and caregivers, allowing market forces to encourage innovation and superior designs. We would also urge that NHTSA continue to expand upon its outreach efforts in multiple languages, as we are a diverse nation, and all our children need protection from vehicle crashes.

Thank you for this opportunity to present our views. Should you or your staff have any questions, please do not hesitate to contact me directly via phone at 530-759-9440 or via e-mail at Error! Bookmark not defined.

PREPARED STATEMENT OF STEPHANIE M. TOMBRELLO, L.C.S.W., EXECUTIVE DIRECTOR, SAFETYBELTSAFE U.S.A.

It is our privilege to share ideas about beneficial outcomes expected from passage of H.R. 4145 which has been introduced to increase statutory protection for youngsters across the United States. Our goal is to demonstrate the importance of assisting parents and other caregivers in finding the best protection from injury and even death as motor vehicle passengers for the youngsters for whom they are deeply concerned. By increasing the testing approaches to better simulate the multiple conditions to which children are exposed in motor vehicle crashes, particular characteristics of safety seats will be enhanced by their producers, providing a level playing field for all and assuming that even the least expensive safety seat will offer more protection.

Safety seats already do a good job in most circumstances. However, the position of SafetyBeltSafe U.S.A. (SBS USA) is that in any area in which parents cannot modify the performance of the product by being more assiduous themselves in "getting it right", the changes must be regulatory. The other differences for which parents can compensate by overcoming, for example, less convenient systems can be left to the companies.

Therefore, we believe that in the following areas, regulatory change is needed.

These aspects fall under the first three provisions of H.R. 4145, enumerated below:

1)[1] require that some car seats and boosters seat be crash-tested in actual vehicles (under NHTSA's existing, annual "New Car Assessment Program");

2)[1] require the National Highway Traffic Safety Administration, or NHTSA, to revisit its current standard for child safety seats within the next two years (to improve outdated crash testing methods);

3)[1] require that child safety seats have side-impact padding to better protect against head injuries in rollovers and side-impact crashes, as they do in Europe.

The six areas SBS USA has identified for regulatory action are:

1. Recalls: Investigations of possible child restraint system [CRS] defects which affect crashworthiness, as opposed to less dangerous non-compliance problems, should be handled very quickly. SBS USA has identified at least eight persistent, repetitive problems with safety restraints that need to generate recalls so all owners can become aware of the resolutions available. [If it is determined that there is a defect and a recall campaign cannot be carried out because the manufacturer is out of business, NHTSA should notify the public about the problem. Currently, consumers who own products which have failed NHTSA testing and have no manufacturer support, such as the Safe Rider Harness, receive no warning that their children are at risk.]

2. Padding: Specifications for the quality and placement of padding protecting the child's head should be revised to require energy-absorbing material.

3. All convertible CRS should be tested forward facing with an **instrumented 12-month dummy,** not the uninstrumented 9-month dummy, to better judge the effect of particular designs on the well being especially of tiny babies. [(Convertibles are tested with rear-facing newborn, rear- and forward-facing 9-month, and forward-facing 3-year dummies; the 9-month dummy cannot measure head contact.) There is a concern that shields may cause increased head and neck injuries for smaller children; at least one death was caused by interaction of a 9-month-old with a shield.]

See overhead of baby in a convertible safety seat labeled inappropriately as fitting an infant.

4. The plastic shell of convertible CRS should be strong enough to hold a harnessed 40-lb. child at 30 mph, even if the parents fail to use the proper slots. Of 15,482 convertible CRS checked by the Family Safety in the Car program from 1992-1998, **37% had straps in the wrong slots.** At least two cases are known in which children were ejected and died when the harness ripped through non-reinforced slots in the shell

See the consequence of choosing the wrong strap slots; the youngster died.

5. Indelible identifying information: Labels with identifying information and manufacture date should be marked indelibly on the CRS, not on paper stickers which can peel off or be washed off inadvertently. **Twenty-six percent of 19,725 CRS checked by the Family Safety in the Car program from 1992-1998 had no readable date. Transport Canada is using these data as part of their study of improvements; we invite US regulators to review them as well.**

See the label coming off 3 weeks after manufacture—when the photo was taken.

The model name should be on the CRS (some manufacturers leave it off) so consumers can identify their restraints easily in case of a recall or if they need to order an instruction booklet or other parts.

6. Height ranges for certification should not be based on total height, which does not accurately address CRS fit. For rear-facing seats, the child's head should be no higher than a specified point on the back of the CRS. For forward-facing CRS, the child's shoulders should be at or below the highest set of strap slots. Ideally, a mark on the CRS cover would indicate the height limit; one manufacturer already provides height indicator lines on the CRS cover.

Two other areas covered by the bill cover the areas in which reporting of the features of the product would allow parents to make informed decisions about the facets where they can increase their personal efforts or choose a more convenient product.

4)[1] call for NHTSA to furnish crash test results information that is reliable and easy to understand, for parents' use in deciding which car seats to purchase and install;

5)[1] require that warning labels and instructions on child safety seats be written in plain English.

Any rating system developed should be based on real-world conditions and behavior, not just crash testing with dummies secured properly in brand-new CRS. Children are not dummies. Developmental and behavioral issues must be taken into consideration in any evaluation of child restraints. Crash test results, alone, cannot accurately predict the performance of a child restraint in the real world. For example, a two-year-old who meets size criteria to ride in a belt-positioning booster generally is not mature enough to sit still with the lap/shoulder belt properly posi-

[1] Summary comments on S. 2070 from Senator Fitzgerald's office.

tioned. Or parents may not tighten harness systems as children change their clothing if the adjustment mechanisms are hard to reach or balky. These factors can have enormous effects on the real-world protection of children. Parents do not know enough about the way the systems operate BEFORE they use them; a grid listing such factors along with the most critical aspects of crash-test performance will make it possible for parents to make intelligent choices.

The specific areas in which SafetyBeltSafe U.S.A. sees the effect of the bill are enumerated below:

1) Crash test results. To help parents evaluate performance, provide one or two of the most important measures, such as head excursion and HIC (head injury criteria). **Today, most parents and many professionals believe that the federal government tests and certifies safety seats BEFORE they are placed on the market, not understanding the self-certification system.**

2) Frequently updated information about ongoing investigations of CRS for alleged defects with extremely dangerous potential consequences, such as ejection or severe head injury.

3) Characteristics of the safety seat that can affect correct use. Bringing these inconvenient designs to parents' attention may encourage their improvement without regulatory mandate, AND parents can strive to equalize the outcomes with both inconvenient and convenient features.

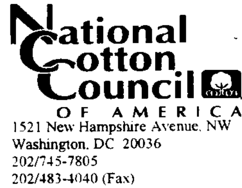
a) Ease of harness adjustment. Parents have a tendency to leave the straps loose if they cannot adjust the harness without unbuckling the CRS from the car every time the child puts on or takes off a jacket. Although SAFE KIDS found 33% of the seats evaluated at checkups had loose harnesses, random review of safety seat checkup data gathered by SBS USA indicates an even higher level of failure. **Once the situations evaluated that do not include harness snugness tabulations (no kids, boosters, etc.) were omitted, in a series of three checkup events, SBS USA found that 69% of the cases in which harness snugness was evaluated were too loose!!**

[The adjuster strap and release lever on some rear-facing CRS cannot be reached when the CRS are securely installed. Some forward-facing CRS are adjusted behind the shell which prevents tightening of the harness without unbuckling the vehicle belt.] HOWEVER, bringing these inconvenient designs to parents' attention may encourage their improvement without regulatory mandate, AND parents can strive to equalize the outcomes with both inconvenient and convenient adjustment mechanisms.

b. Width, thickness, and material of harness straps. Thinner straps are more likely to become twisted and ropy, which may cause injuries in a crash. The harness may not be adjusted snugly because the child complains that the straps hurt. However, parents can make extra efforts to keep straps clean and flat.

4) A number of critical measurements/features of the products should be listed since they affect the proper selection and use of the products. Among them are the I) Height of bottom and top harness strap slots; II) Distance from back of CRS to crotch strap and availability of two crotch strap positions. III) Width of the CRS at the base to compare to distance between vehicle belt anchor points; also will assist in selecting seats for use on aircraft. IV) Vehicle belt path, especially if it is unusual and could help or hinder installation in certain vehicles. V) Color-coding of the belt paths, strap slots, and other features appropriate for use with babies and older children.

The most common question asked of SafetyBeltSafe U.S.A. volunteers and staff has not changed since our founding in 1980. It is, "Which car seat is the best?" Our response has always been, "The best seat is the one that fits your child, fits your vehicle, and fits the needs of your family." It is essential that any rating system include all of these essential factors so that parents do not inadvertently ignore the impact of features of the products which contribute mightily to the protection of their children.



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June 15, 2000

The Honorable W.J. Tauzin, Chairman
Subcommittee on Telecommunications, Trade, and Consumer Protection, Room 2125
Rayburn House Office Building
Washington, DC 20515-6115

Re: May 16, 2000 Hearing on Consumer Safety Initiatives; Post Hearing Response to Questions

Dear Chairman Tauzin:

I testified at your May 16, 2000 hearing on Consumer Safety Initiatives: Protecting the Vulnerable on the CPSC Children's Sleepwear Flammability Standard representing the National Cotton Council (NCC), the American Apparel Manufacturers Association, the National Retail Federation and the International Mass Retail Association.

During the oral hearing and in a letter from you on May 25, 2000, I was specifically asked to respond to several questions for the record and other questions were raised that we would like to address. Attachments to this letter contain more details on the various points.

1. **Why was the original flammability standard for children's sleepwear established in the first place? Was the burn data different back then?**

Basis for original standards: The original Children's Sleepwear Flammability standards for garments sized 0-6x [for children 0-5 years of age; July 29, 1971 (36 FR 14062); effective date July 29, 1973] and 7-14 [for children 6-12 years of age; May 1, 1974 (39 FR 15210); effective date May 1, 1975] were based on analysis of data collected by HEW, which indicated that children in these age groups were injured relatively more frequently from apparel fires than were most other groups (see Attachment). The HEW data (collected starting in 1965) is the Flammable Fabrics Accident Case and Testing System (FFACT) database, which was used as the basis for the 0-6x and 7-14 standards. For the 0-6x standard it contained 580 cases, 37 of these involved sleepwear for children under five (proposed standard: 35 FR 17670; Nov. 17, 1970). None of these involved

infant garments or snug-fitting garments as the first to ignite. Elaine Tyrrell in *NBS Technical Note 815* (U.S. DOC Feb 1974) reviewed the 22 cases for children under three in the expanded FFACTS data base (there were 1964 cases by Dec. 1972). None of these involved snugger fitting garments or infant garments as the first to ignite; any incidences involved the crib/bed catching on fire.

There is no indication from burn incidence data since 1965 from the US, Canada and other countries that infant garments sized 9 months of age or younger and snug-fitting garments present an unreasonable risk or that the 1996 CPSC amendments diminish the protection provided by the Children's Sleepwear Flammability Standards. This includes data from the National Bureau of Standards Flammable Fabrics Accident Case and Testing System (FFACTS) which started in 1965; the ITT data for 1972-90, which is from NEISS and the CPSC IDI's; and National Bureau of Standards publications (*NBS Technical Notes* 815 and 810). None of the CPSC data sources indicate any increase in injuries or deaths with children's sleepwear, including data submitted by the Shriners Burn Hospitals for Children.

Purpose of original standards: The standards were designed to provide protection against burn injuries caused by small open flame ignition sources (e.g., matches, lighters) to children in sleepwear when they were up moving around. The test method uses a 1.5 inch natural gas flame with a 3 second ignition time to simulate a match. The standards never were intended to protect against large open flame sources (e.g., house fires, mattress/crib fires, flammable liquids, explosions). Because of their melting and ignition temperatures and high temperatures and sustained fire growth that occurs in these larger fire scenarios, and the many other factors affecting the outcome of an incident, flame resistant sleepwear garments can not be counted on to provide enough protection to prevent life-threatening burn injuries from occurring. No apparel except heat-protective clothing worn by firefighters will do that. Prevention of and protection from large fires is a subject wholly different from those addressed by the successful sleepwear standards (16 CFR 1615, 1616), which are doing what they were intended to do, and is best dealt with by fire safety programs

The examples/data presented at your hearing and elsewhere by those opposed to the amendments do not distinguish those incidents involving children's sleepwear from other types of fire scenarios that resulted in children being treated at burn hospitals, including burn incidents caused by flammable liquids, explosions, house fires and other large, open-flame fires nor is the garment type and whether they are fire resistant known. Their own earlier testimony to CPSC states that in the data they have given to CPSC, they do not know whether the child was wearing sleepwear at the time of the incident or even "whether the sleepwear was or was not in compliance with flammability standards" (CF99-1-108; 1999 Comments by Dr. Herndon, Shriners Burn Hospitals to CPSC). Nevertheless, they now suggest that the amendments are the cause for an increased incidence of burn injuries for all clothing even though the standards only cover sleepwear. Since 1993 CPSC has exhaustively investigated all of the data presented to them by those opposed to the 1996 amendments as well as all other clothing-related thermal burn incidents in their databases and determined that there are no incidents

within the scope and intent of the children's sleepwear standard caused by the 1996 amendments (C.C. Morris, *Sleepwear Thermal Burns in Children under 15 Years Old*, CPSC June 1999).

Amendments to the standards: The standard has been amended several times. The 1978 amendments were in response to the finding that the fire retardant chemical "Tris" (used on polyester and and other synthetic fibers that melt) was a carcinogen. The 1978 amendments removed the "residual flame time"/"melt drip" requirements from the test method for the 0-6x standard but did not diminish the safety provided by the standard; and neither did the 1996 amendments. "Residual flame time" is the requirement in the original test method that no sample could have flaming material on the bottom of the test cabinet 10 seconds after the ignition source was removed (i.e., material that melts and drips away from the flame must extinguish in 10 seconds).

The removal of this requirement allows polyester and nylon garments to pass the flame test without being treated with fire retardant chemicals. Cotton and wool garments (which do not melt) have to be treated to pass the test, which requires the fabric to be bone dry (0% relative humidity). The 1978 amendments resulted in virtually no garments in the marketplace being treated with flame retardant chemicals to make them flame resistant (see *CPSC Product Safety Fact Sheet* No.96: Children's Sleepwear, Aug. 1981). It appears that consumers still are concerned about potential toxicity from FR-treatments to their children's sleepwear, since essentially every time FR-cotton sleepwear has been put on the market the customer has not purchased it. So it has been removed from the market. Presently, there is some FR-cotton sleepwear in stores but the amount being sold is very small. There have been commercial, effective FR-treatments for cotton since the 1970's, but they are complicated and expensive [P. J. Wakelyn, W. Rearick, and J. Turner "Cotton and Flammability", *Am. Dyestuff Reporter 87(2)*, 13-21(1998)].

Cotton (700-1560 °F) and polyester (840-1290 °F) ignite at close to the same temperature and all fibers will burn. Polyester fibers generally begin to melt between 480 and 570 °F and would provide no reliable protection from serious burn injury in larger fires, such as if the infant was in a crib and the crib caught on fire or there was a house fire. Human burns occur when the skin temperature exceeds 110 °F, which may explain how a child can be burned on exposed skin and "protected" in areas covered by sleepwear or other garments -- flame resistant or not.

Garment fit/ Infant sizes: In the 1995 briefing package, CPSC addressed the question of the degree of snugness and burn injury-potential (CPSC Memorandum, L. Fansler, *Technical Rationale Supporting "Tight Fitting" Children's Sleepwear Garments and Tight Fitting Children's Sleepwear*, Appendix D, p. 67-81). In addition, it has long been known that snugger fitting/body-conforming garments are safer than loose fitting garments. The reason snugger fitting garments are safer are these fabrics are less easy to ignite, slower burning, earlier recognition if the garment has been ignited, and easier to extinguish (see Attachment). Snug-fitting garments should never have been covered in the original standards because there never was information in the databases to justify their coverage.

Infant sleepwear should never have been covered in the original standard, since the determined unreasonable risk that the standards are designed to protect the child against is when the child is up and ambulatory and can play with or be exposed to small fire sources, not when the child is in bed. Children wearing sleepwear sized 9 months and less are pre-ambulatory. For further information see CPSC Memorandum, C. Meires to M. Neily, ***Human Factors Issues in Children's Sleepwear***, Issue 1, May 27, 1999.

The Standard does not need additional review: Since 1991, the CPSC has thoroughly and sufficiently reviewed these standards, including the Congressionally mandated review in 1999. No further action is necessary on these standards at this time. The three CPSC Commissioners all stated this in their testimony at this hearing.

The CPSC conclusions were arrived at after years of intense and thorough study and full notice and comment rulemaking. In four separate extensive briefing packages, CPSC explained the rationale for their decisions. CPSC made the correct decisions for the correct reasons. The 1996 amendments are not the cause of burn injuries seen in burn hospitals and the amendments have nothing to do with the concerns raised by those who oppose the amendments. The standards are doing what they were intended to do in 1971, when first issued.

Commissioner Thomas Hill Moore in his 1999 statement justifying his vote not to revoke the 1996 amendments stated:

"The Commission has gone through what amounts to four-step rulemaking on this issue. It is clear from their comments that many of the opponents of the Commission's action in 1996 have never read the three previous briefing packages of the staff on this issue. I would hope before any member of Congress contemplates taking further action in this area that they would read those three packages, along with the most recent one, and not be guided by the misconceptions that have obscured this issue." *(Statement of Thomas Hill Moore on the Proposed Revocation of the Children's Sleepwear Amendments, June 16, 1999)*

2. What have other countries used as their flammability standards for children's sleepwear?

The only other countries in the world besides the U.S. that have children's sleepwear flammability standards are Canada, Australia, and New Zealand, who exempt infant garments and snug-fitting garments and the UK, who allow garments that do meet their standard, if they are labeled to say they do not meet the standard. The U.S. standards are more severe than any of these standards because of the stricter definition of snug-fitting and the stricter test method. Foreign flammability standards for children's sleepwear are reviewed by CPSC in several of their "briefing packages".

Canada originally adopted the US Children's Sleepwear Flammability Standards but modified them in 1987. The major reasons for amending their standard were results from

mannequin testing of garments that were described in a Final Report to the Consumer and Corporate Affairs Canada by E.M. Crown, U. of Alberta, July 1985 and a *Canadian Medical Association* paper (J.R.S. Stanwick, *CMAJ* 132, 1143, 1985).

Since promulgation of the amended Canadian sleepwear standards in 1987, no burn deaths associated with children's sleepwear have been reported in Canada (61 FR 47634; Sep. 9, 1996). A December 18, 1995, letter from Therese Gagnon, Acting Chief, Mechanical and Electrical Hazards Division, Health Canada, Health Protection Branch, Product Safety Bureau, to NCC concerning the Children's Sleepwear Flammability Standards and the Canadian experience states:

> **"Since the Regulations have come into effect, injuries due to the ignition of children's sleepwear are no longer an issue in Canada."**

Australia and **New Zealand** also have standards that include fit characteristics that exempt snug-fitting garments. The burn injury and fatality data in these countries show that these standards are working (59 FR 52620; Oct. 25, 1994 and 61 FR 47634; Sep. 9, 1996).

Other than the **United Kingdom**, no other European country has legislation or standards specifically to control the fire safety of children's sleepwear. The UK Nightwear (Safety) Regulations 1985 (finalized December 20, 1985) came into effect March 1, 1987. Since 1987 the UK has allowed children's nightwear that does not meet strict vertical flame test requirements in the marketplace, if it is labeled to say it does not meet the standard and is not flame resistant. Burn injuries involving sleepwear in the UK are a rare occurrence. When burn injuries do occur, they are when children are wearing loose flowing garments (a class that has to comply with a vertical flame test).

3. Request

We appreciate the opportunity to provide additional information for your May 16 hearing, "Consumer Safety Initiatives: Protecting Vulnerable Children". We urge this committee and the Congress to uphold the amendments to the sleepwear flammability standards that exclude infant garments sized 9 months of age or younger and snug-fitting garments and reframe from further legislative actions on these standards. If there are questions, please contact me at 202/745-7805

Sincerely,

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Attachments

1. Children's Sleepwear Flammability Timeline
2. Basis for the Children's Sleepwear Flammability Standard for Garments Sized 0-6x (for children 0-5 years of age)
3. Children's Sleepwear Flammability Standard 7-14 (for children 6-12)
4. Brief History of Data Collection for the Purpose of Justifying Regulation of the Flammability of Children's Sleepwear
5. Fire Deaths are Down

   Clothing-Related Thermal Burn Fatalities in the United States: Children Under 15
6. Garment Fit
7. Statement of Commissioner Thomas Hill Moore on the Proposed Revocation of the Children's Sleepwear Amendments

Children's Sleepwear Flammability Standards Timeline

- **1953**: Flammable Fabrics Act of 1953 passed (and amended 1954)
  Prohibits sale of highly flammable articles of wearing apparel and fabrics
  Standard for flammability of clothing textiles (CS 191-53, effective 1/30/53; now 16 CFR 1610)

- **1967**: Flammable Fabrics Act amended and revised
  It was amended to recognize the flammability hazard in the use of textiles. It gives authority to CPSC to promulgate and enforce flammability standards for clothing and textiles that present an unreasonable flammability risk to consumers

- **1971**: Children's Sleepwear Sizes 0 to 6x (for children 0-5 years of age)
  16 CFR 1615
  Final standard: July 29, 1971 (36 FR 14062-73)
  Effective date: July 29, 1973
  (Test method: 1.5 in. natural gas flame, 3 sec. ignition; "melt drip" requirement)

- **1973**: CPSC took over administration of the FFA from DOC May 14, 1973

- **1974**: Children's Sleepwear Sizes 7 to 14
  16 CFR 1616
  Final Standard: May 1, 1974 (39 FR 15210)
  Effective date: May 1, 1975
  (Test method same as 0-6x, except no test requirement for "residual flame time")

- **1977**: [On April 8, 1977, CPSC under the Federal Hazardous Substances Act (FHSA) banned the sale of children's sleepwear treated with the FR-agent "Tris"]

- **1978**: Amendment to eliminate "residual flame time" ("melt drip") requirements from 16 CFR 1615 (0-6x standard)
  Final Standard: July 21, 1978 (43 FR 31348)
  (The requirement that no single sample could have flaming material on the bottom of the test cabinet 10 seconds after the ignition source was removed.)

- **1996**: Amendments to exempt infant garments and snug-fitting garments, Sept. 9, 1996 (effective 1/1/97)

- **1999**: 1996 Amendments upheld and mandatory labeling added

- Canadian standard amended 1987
  To add exemptions for infant garments and snug-fitting garments

- Australian standard 1972
  Contains exemption for infant garments and snug-fitting garments

Basis for the Children's Sleepwear Flammability Standard for Garments Sized 0-6x (for Children 0-5 years of age)

❖ **Notice of Need for a Children's Sleepwear Flammability Standard:**

Jan. 21, 1970, a notice of need for a flammability standard was published based on analysis of 254 cases (from FFACTS). "This analysis indicated to us that children in the 0 to 5 year-age group were injured relatively more frequently from apparel fires than were numbers of most other groups. Based on this analysis, we concluded there was sufficient evidence for us to publish a notice that a standard may be needed..." (*Statement of James H. Wakelin, Jr., Asst. Sec. For Science and Technology, U.S. Dept. of Commerce, Before the Committee on Commerce, U.S. Senate, July 30, 1971*)

❖ **Proposed Flammability Standard (0-6x): November 17, 1970 (35 FR 17670):**

• 580 cases investigated by HEW (FDA) were analyzed by DOC as the basis for the 0-6x standard (for children 0-5 years of age); this is the FFACT database. [FFACTS: From 1965 to Nov. 71, 580 cases were collected in the Denver, CO area (221); in Boston, MA area (163); in the state of Iowa (97); and 99 from other areas. By Dec. '72 there were 1964 cases collected. CPSC took over in May 1973.]

• 174 cases (of the 580 cases) involved flammable liquids. This leaves 406 cases (involving 713 garments) for analysis. (Only breakdown was garment category not fit or fiber content.)

• 86 cases (21.2% of the 406 cases) involved children in the 0-5 age group (girls were 1.6x and boys 3.9x as often as would be expected on the basis of their percent of total population.); 37 of these cases (43%) involved sleepwear. A breakdown of the 37 cases: 28 were known not to be cotton knits or other body-conforming cotton garments (i.e., not snug-fitting); the 9 other cases attributed to garment ignition were worn under another garment (e.g., a robe), which ignited first or the ignition was caused by some large flame source (e.g., crib or house fire) (i.e., these 9 fabrics were either not the first to ignite or not caused by a small open flame source).

• **NBS Technical Note 815** ("*Fire Accidents Involving the Ignition of Sleepwear Worn by Children Under the Age of Three", Elaine A. Tyrrell, US DOC Feb. 1974*) gives details on 22 cases for children under 3 years in the larger FFACT database (as of Jan. 1973) of 1964 cases. In the 3 incidents involving children under one, the infant was sleeping in a crib that caught fire; in the 3 cases involving snugger-fitting garments, the bed caught on fire while the child was sleeping.

• 11 fabrics were tested by NBS and all failed the new "vertical test" of proposed standard (no details given on fabrics tested).

❖ **Final Rule 36 FR 14062, July 29, 1971 (effective date July 29, 1973):**

It contains no data or discussion of data to justify the standard, unlike preambles to standards issued today. Test method: 1.5 in. natural gas flame, 3 sec. ignition (to simulate a match; i.e., small open flame); vertical test with bottom ignition; "residual flame time"/"melt drip" requirement.

Children's Sleepwear Flammability Standard 7-14 (for Children 6-12)

- **Finding of Need (37 FR 11896, June 15, 1972)**

Most frequent victims of fire involving sleepwear are between ages 1-12 and of those 40% are between ages 6-12.

- **Proposed Standard (38 FR 6700; Mar. 12, 1973)**:

1964 cases in FFACT; 413 total sleepwear; 389 non-contaminated (with flammable liquids); 316 of 389 sleepwear first to ignite; 77 are ages 6-12; all but 3 cellulosic fibers

- **Final Rule (39 FR 15210; May 1, 1974) (effective May 1, 1975):**

No data given. One comment requested exclusion of "close-fitting pajamas". CPSC decided these can burn and can be oversized so these were not excluded.

- **NBS Technical Note 810, "Fire Incidents Involving Sleepwear Worn by Children Ages 6-12," Dec. 1973, J.A. Slater**

• In the FFACT database, there were 1964 cases. Sleepwear items were ignited in 413 fire incidents. 485 separate items of sleepwear were involved in the 413 incidents, 316 involved non-contaminated (without flammable liquid) sleepwear that was first to ignite; about one-fourth (101, 23%) involved children 0-5 years old and about one-fourth (80, 19%) children 6-12 years old. So they said about 50% of the incidents involved children 12 and under. No data given on garment construction (i.e., whether snug-fitting).

• 6-12 age group represents 15% of the FFACT database and 14% of the US population. Since 14% of the population is ages 6-12, one would expect 44 cases (14% of 316) but found 77 (40 were pajamas, 31 nightgowns, 6 robes) or 1.8 times as frequent. Females were more frequently involved.

• 38 of the 77 were kitchen range ignitions; 32 were female (22 with pajamas, 9 with nightgowns).

• Females outnumbered males 4-to-1 in the 6-12 age group, due mostly to the involvement of nightgowns and kitchen ranges. Most of the garments (all but 3) were cotton (mostly cotton flannel). One of the fabrics was a cotton knit and no information is given on how this was involved in the fire injury.

• FFACTS database increased from 580 cases in Nov. '71 to 1964 cases as of Dec. '72.

• Data from the Shriner Burn Institute and Nat. Burn Information Exchange (NBIE) were reviewed. These include all items involved in incidents, not only first item to ignite. There is no information given on how or what garment was involved in the burn incident.

• In discussion it was recognized that: "A primary factor is garment construction and its relationship to various ignition sources and activity patterns of persons involved in incidents." Pajamas are generally in two pieces – a loose shirt top and a pants bottom – while nightgowns are one-piece and by nature loose and flowing (p. 13).

BRIEF HISTORY OF DATA COLLECTION FOR THE PURPOSE OF JUSTIFYING REGULATION OF THE FLAMMABILITY OF CHILDREN'S SLEEPWEAR

In the 1960's and early 1970's, the implementation of the Flammable Fabrics Act was a joint responsibility of the Food and Drug Administration (FDA) in the Dept. of Health, Education and Welfare (HEW) and the Dept. of Commerce up until the establishment of the Consumer Product Safety Commission in 1974. Flammable fabric inflicted burns were within the scope of HEW while DOC had some fabric expertise. In 1965 the Secretary's of HEW and DOC became concerned that flammable fabric inflicted burns were and issue to be address particularly with respect to sleepwear, underwear and little girls dresses. For this reason a study was undertaken by HEW to investigate as many flammable fabric burn incidents as practical in a few areas. FDA offices in Boston and Denver were selected as the main incident collection and investigation points. Cases were investigating in the Denver area, the Boston area, the state of Iowa and 99 from other areas. Whenever possible these offices collected garments which had inflicted burns and sent them to the Nation Bureau of Standards for analysis. This was the National Bureau of Standards Flammable Fabrics Accident Case and Testing System **(FFACTS)**

FFACTS was comprised of reports of fire incidents involving fabric products and laboratory test results of any fabric remains which may accompany these reports (E.A.Tyrrell, NBS Technical Note 815, Feb. 1974, p. 10, ref. 1). These accident reports, along with any available fabric remnants, were forwarded to the NBS Fire Technology Division by field investigators and other participating organizations for testing and evaluation. Processing of the reports and fabric samples accepted for FFACTS included the analysis of fabric samples for fabric weight, construction, composition and flammability characteristics, and the coding and computerization of up to 130 different data elements for each incident. Incidents chosen for FFACTS were not selected on a statistical basis, and therefore did not constitute a statistically representative sample of all fabric fire accidents in the United States at the time (J.A. Slater, NBS Technical Report 810, Dec.1973, p.2, ref. 2). However, they did represent events investigated without known preference and therefore, may be roughly representative of incidents reported to the agencies from which the DOC and then the CPSC and others obtained accident data before the NEISS system was established.

According to the Nov. 1970 proposed standard for children's sleepwear sized 0-6x (35 FR 17670; Nov. 17, 1970), 580 cases (1,059 separate garments) had been collected and analyzed at NBS. Of these 174 cases involved flammable liquids and were therefore not considered. The remaining 406 cases involving 713 garments were analyzed further. There were 37 sleepwear cases in the age group 0-5, sizes 0-6x, that involved 41 garments. This was the data base for the Children's Sleepwear Flammability Standard 0-6x. The staff at NBS reported that a more substantial basis for regulation as well as measuring the effectiveness of a standard would require an order of magnitude greater number of garments. The data from the FDA offices was combined with the NBS analytical results to produce a database which was developed, controlled and analyzed in detail by several people at NBS, including Henry Tovey, Laura Bookbinder and Elaine Tyrrell.

According to Elaine Tyrrell who transferred to the CPSC office of Epidemiology from NBS, there are a number of reports written at NBS which were used by the DOC and HEW and later CPSC as the basis for regulating the flammability of Children's Sleepwear. See for example, NBS Technical Note 815, "Fire Accidents Involving the Ignition of Sleepwear Worn by Children Under the Age of Three" (Elaine A. Tyrrell, U.S. DOC, Feb. 1974) and NBS Technical Note 810 "Fire Incidents Involving Sleepwear Worn by Children Ages 6-12" (J.A Slater, U.S. DOC,Feb 1973). Tyrrell's report in 1974 gives details on 22 cases (in the FFACTS database of 1964 cases) for children under 3, which shows that in the three incidents involving children under one the infant was sleeping in a crib that caught on fire; in the three cases that involved sugger-fitting garments the bed caught on fire while the child was sleeping.

When the CPSC was established in May 1973, the data collection effort was turned over to the CPSC to be used as a basis for a much broader database including all products within the jurisdiction of the CPSC. The CPSC National Electronic Injury Surveillance System (**NEISS**) was established to obtain burn incidents and other injury incident data. The CPSC maintains two pertinent databases relative to flammable fabrics. One is based on information submitted by selected (over 100) hospital emergency rooms (NEISS) and the other is the collections of results of In-Depth Investigations (**IDI's**) of specific incidents. The NEISS system comes the closest to being a statistically valid data collection system. It includes some detailed information about specific garments involved in burn incidents. The IDI's contain more specific details. However, much of the information can be unreliable because of the long delay between the incident and the initiation of the investigation (averaging approximately 50 days). The CPSC collection of IDI's includes all of the incident reports recorded by NBS (now NIST) as well as all those collected by CPSC and it's contractors since CPSC was established in 1973. The total number of fabric flammability burn incidents is now approaching 4000 with over half of those originating prior to 1975. The CPSC IDI's are since 1973 part of the Institute for Textile Technology, Charlottesville, VA (**ITT**) database.

Statistics on clothing-related thermal burn fatalities in the U.S. for children under 15 years old (0-14) come from the National Center for Health Statistics (**NCHS**).

The National Fire Incident Reporting System (**NFIRS**) operated by the U.S. Fire Administration scope covers only fires attended by a sample of fire departments, and only a few fabric burn injuries ever come to the attention of a fire department.

1. **NBS Technical Note 815**, E A. Tyrrell, "Fire Accidents Involving the Ignition of Sleepwear Worn by Children Under the Age of Three," US DOC, Feb. 1974
2. **NBS Technical Note 810**, J.A. Slater, "Fire Incidents Involving Sleepwear Worn by Children Ages 6-12," US DOC, Dec. 1973.
3. **Children's Sleepwear 7-14**: *Finding of Need*, 37 FR 11896, June 15, 1972; *NPR*, 38 FR 6700, Mar. 12, 1973; *Final Rule*, 39 FR 15210, May 1, 1974, effective May 1, 1975.
4. **Children's sleepwear 0-6x**: *Finding of Need*, Jan. 1970; *NPR*, 35 FR 17670, Nov. 17, 1970; *Final Rule*, 36 FR 14602, July 29,1971, effective July 29, 1973.

Fire Deaths are Down

Canada amended their standard for fit characteristics in 1987 and "since the regulations have come into effect, injuries due to the ignition of sleepwear are no longer an issue in Canada "(Dec. 18, 1995 letter from Health Canada. Since most of Canada's population lives near its southern border, the environmental conditions are not dramatically different from those northernmost US states. Recent fire data indicate that the number of fires in Canada and the US are about the same once an adjustment is made for the difference in population and outdoor brush and trash fires and vehicle fires are excluded. Civilian fire death rates per million population in the USA and Canada have always been very close. The principal difference is that vehicle fires are higher in the USA. (J.R. Hall, Jr., Fire in the USA and Canada, International Fire Comparison Report #2, NFPA, Nov. 1995).

The CPSC report "1993 Residential Fire Loss Estimates" provides trends and data on fire-related deaths, injuries and property loss for 1993. Trend data for the previous five years (1989 to 1993) are presented along with estimates for the benchmark year 1980. These estimates were derived from data provided by the US Fire Administration and the National Fire Protection Association (NFPA). An examination of the data shows a 38% decrease in residential fires from 1980 to 1993. This decrease was attributed to greater public awareness of ignition sources such as cigarettes and matches and the CPSC Match Standard. Trends in Estimated Residential Structure Fires by Selected Product Involved, 1980 and 1989-1993, shows a 63% decrease in matches as the form of heat ignition. Of residential fires ignited by matches, there has been a 64% decrease in fires started by children playing with matches.

In addition, an article on the March 17, 1999, Washington Post front page stated that "Fire Deaths Decline Sharply," thanks to safety improvements such as smoke detectors, sprinklers and childproof lighters and also people smoking less. In 1997, US fire deaths totaled 4,050, down from 6,215 in 1988 according to the National Fire Protection Association.

Changes in lifestyle in the US, e.g., in smoking habits, elimination or reduction in use of space heaters, the CPSC Match and Lighter Standards and other socioeconomic changes, all have helped reduce fire incidences in the U.S.

Clothing-related thermal burn fatalities in the U.S.: children under 15 years old. Clothing-related thermal burn fatalities in the U.S. for all children under 15 for all clothing are 2 or 3 each year since 1993 (see Table 1). The portion of these cases involving sleepwear is unknown, because on data system in the U.S. specifically identifies sleepwear (C.C. Morris, "*Sleepwear Related Thermal Burns in Children under 15 Years Old*", CPSC, June 1999). There were 15 clothing-related thermal burn fatalities in 1975, the first year reliable data were available; and essentially before any complying 0-6x would have had a chance to have had any impact (became in effect July 29,1973) and before the 7-14 standard was in effect (May 1, 1975). The figure of 60 for 1970 is often used but this number is likely based on HEW estimates that are very doubtful (see footnote 3 to Table 1 and *Report from the Commissioners*, CPSC 1975) and were revised by a factor of 10 in 1974-75 when more accurate data became available.

Table 1. Clothing-related thermal burn fatalities in the United States: Children under 15 years old (0 to 14 years old)[1]

YEAR	DEATHS[2]
1970	60(?)[3]
1975	15[4]
1980	7[4]
1981-92	6 or fewer[4]
1993-96	2 or 3[4]
1996-99	2 or 3[4]

[1] C.C Morris, "Sleepwear-related Thermal; Burns in Children under the age of 15 Years Old ", USCPSC, June 1999

[2] It is not known if any of these are sleepwear of any kind

[3] From HEW estimate 1968. At the time sleepwear standards were promulgated, the information being relied on was supplied by the Department of HEW in 1968, which reported that there were 150,000-250-000 injuries and 3.000-5,000 deaths a year attributable to burning clothing (see *Report from the Commissioners*, CPSC 1975, attached). This is likely where the 60 death estimate for children sleepwear deaths came from. It is doubtful that this was ever a real figure and could ever have been supported. These figures for total deaths and injuries remained the official estimate until about 1974-75. In 1974-75, information from NEISS (National Electronic Injury Surveillance System) indicated that 15,600 persons annually receive medical treatment for textile-related burns: 9,700 involve articles of clothing, including 2,600 specifically in the nightwear; and in 1974-75 according to the National Center for Healthy Statistics (NCHS), 517 deaths a year are caused by ignition of clothing (see article attached). In 1975 NCHS indicated 15 clothing-related thermal burn fatalities.

[4] National Center for Health Statistics

Report from the Commissioners

Despite the viable alternatives for future flammability regulation that will soon be presented before the five commissioners of the Consumer Product Safety Commission, they have all indicated that they plan to proceed very cautiously. In the back of most of their minds seems to be at least the idea that it might be advantageous for the industry to resolve the situation on its own — without further governmental interference.

Of the five commissioners, Richard Simpson, chairman, has the most hands-off view: "I personally question whether there is a need for additional government regulations, because of the extensive voluntary efforts being made by the industry, and because of the new injury data which has just been presented to us."

Simpson refers to the recently released information from NEISS (National Electronic Injury Surveillance System), which indicates that 15,600 persons annually receive medical treatment for textile-related burns; 9,700 involve articles of clothing, including 2,600 specifically in the nightwear area. And according to the National Center for Health Statistics, 517 deaths a year are caused by ignition of clothing.

Heretofore, the CPSC had been relying on information supplied by the Department of Health, Education and Welfare in 1968, which reported that there are 150,000-250,000 injuries and 3,000-5,000 deaths a year attributable to burning clothing.

"The new information," says Simpson, "indicates that although the problem is severe, the order or magnitude is less than we previously thought. And it is an indication that flammable fabrics ought not to be as high on our list of priorities."

Vice Chairman Constance Newman stresses the need for more information about voluntary marketing of flame-retardant apparel. She said that she "generally prefers product safety matters to be solved by the industry" and that she would "demand much more information about industry efforts before I vote for any more mandatory standards.

As a result, Newman said, the presentation of the proposals — for a new general flammability standard and the extension of PFF-7 to additional apparel categories — is likely to "raise new questions and provoke new requests for information."

Commissioner David Pittle emphasizes the legal framework within which the Commission works. Section 4A of the Flammable Fabrics Acts empowers the Commission to issue regulations only when there is a need to reduce an unreasonable risk. Therefore, he said, if the industry reduces the risk of its own, the CPSC loses it statutory right to issue standards.

CPSC CHAIRMAN RICHARD SIMPSON

Of course, Pittle points out, it devolves on the Commission to determine the point at which a substantial risk is reduced. "For example, if all of a sudden 85-90 per cent of the industry was complying voluntarily, that might obviate the need for mandatory standards. However, if only 10 per cent are complying, there might still be a serious hazard."

Cost seems to be uppermost on the mind of Commissioner Barbara Franklin: "Our experience with sleepwear shows us that there has been a cost increase of at least 25 per cent. And the consumer is the one who ultimately pays."

Outlining her thinking, Franklin says: "I have not made up my mind yet which way to go. I am not persuaded that a general standard is needed. I am not decided if PFF-7 is needed in one category or six categories, if at all. I will question what any additional standard will cost the consumer. And I will make my next move based on a determination of where this is all going, and whether it is worth it."

Finally, Commissioner Lawrence Kushner proposes an original approach to future flammability regulations based on public disclosure. It would require mandatory testing and labeling but not mandatory compliance. "The consumer would have a choice. Cost increases would be minimized. And more fabrics would be available," he said.

Kushner said that the Commission ought to consider mandatory compliance for high risk items; mandatory disclosure/voluntary compliance for products in the intermediate area; and a totally voluntary program for low risk categories of apparel."

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Garment Fit

CPSC has addressed the question of garment fit and snugness (L. Fansler, *Technical Rationale Supporting "Tight Fitting" Children's Sleepwear Garments and Tight Fitting Children's Sleepwear*, 1995 CPSC briefing package, Appendix D, p. 67-81). In addition, it has long been known that snugger fitting/body-conforming garments are safer than loose fitting garments. This was recognized in America Burning and other technical papers.

The reason snugger fitting garments are safer are: (a) garments which fit the body closely are not easily ignited because the body acts to absorb heat from the ignition source and thus helps to slow the heating of the fabric to the point at which ignition can start; (b) close-fitting garments make the wearer immediately aware of an ignition source since the heat of a match or lighter flame is transferred through the fabric directly to the skin; (c) if such a garment can be ignited, it tends to burn slowly, again because of the heat absorbed by the body, and more importantly, because only one side of the fabric receives sufficient oxygen to support combustion; and (d) therefore, these fabrics are less easy to ignite, slower burning, earlier recognition if the garment has been ignited and easier to extinguish. With regard to extinguishment, the burning of such garments can be terminated in the early stages very quickly just by slapping the area where the ignition has taken place. If injuries do occur with snug-fitting/body conforming garments, there is only minor injury or no injury generally resulting from the ignition (i.e., a much lower level of injury compared to looser fitting garments).

The burning of garments of this type have been studied with mannequins and video-tape recording to illustrate why body conforming knits do not represent an unreasonable flammability hazard. One of the most compelling statistics on the lack of hazard in more body conforming garments is found in data bases in the FFACTS and in the NEISS records. Examination of the detailed records from these programs confirms the infrequency of cases involving body conforming knits. The data used to support the original Children's Sleepwear Standard tell the same story about knits.

STATEMENT OF COMMISSIONER THOMAS HILL MOORE ON THE PROPOSED REVOCATION OF THE CHILDREN'S SLEEPWEAR AMENDMENTS

June 16, 1999

I voted today: to approve the withdrawal of the proposed revocation of the amendments to the children's sleepwear flammability standards; to issue a labeling requirement for tight-fitting sleepwear; and to correct several references in the sleepwear standards.

Throughout this process there have been many misconceptions about the provisions of the original Sleepwear Standards and about the changes the Commission has made to them. The staff has done an excellent job of analyzing and responding to the public comments and in presenting their recommendations. I would particularly like to thank Margaret Neily, the current project manager. And Terry Karels who was the project manager during the original amendment process upon which much of today's decision still rests.

There are a few issues staff addressed in their most recent briefing package to the Commission that I think are worth reiterating.

Some people think that there are no longer any sleepwear standards. Nothing could be further from the truth. For most children--the ones found to be at greatest risk from small open flame ignition--only one specific style of garment, tight-fitting is exempt from the sleepwear flammability requirements. All of the styles of sleepwear that were the cause of burns to children in the past--robes, nightgowns and loose-fitting pajamas--must still meet the sleepwear flammability requirements. Those styles of sleepwear will not disappear.

Many people think that prior to the Commission's changes in 1996, most sleepwear garments were treated with chemicals to make them flame retardant. Again, this is not true. Less than one percent of either polyester or cotton sleepwear garments are treated with flame retardant chemicals. The vast majority of children's sleepwear garments are made from untreated polyester or untreated cotton. Both of which, under the right circumstances, can be ignited and both of which, depending upon the weight, finish and weave of the fabric and the fit of the garment can afford a degree of protection from a small open flame.

Nearly all commenters who spoke in favor of revocation, based their remarks on the belief that there are solid statistics that

show the sleepwear standards had a dramatic effect in reducing the deaths and injuries to children from sleepwear ignition. In fact, we have no baseline data from which to measure the performance of the standards. No national injury database existed prior to the promulgation of the standards and the death data on clothing ignition can not distinguish between deaths related to sleepwear and deaths related to other types of clothing. Clothing-related deaths, for all age groups, have declined dramatically over the last twenty-five years. The dramatic declines in age groups over age 15 could not have had anything to do with the children's sleepwear standard. A number of other factors had to come into play to cause this across-the-board reduction in deaths in all age groups.
While I am sure the standards played some role in reducing deaths and injuries to children, we cannot measure it, nor can we separate out its effect from the many other societal factors that have reduced fire deaths and injuries in this country.

Certain proponents of revocation continue to insist that the Commission take into account burn incidents that are beyond the scope of the Children's Sleepwear Standards because those are the burn incidents that they have found. The original sleepwear standards were never intended to protect children from anything other than brief contact with a small flame, such as a match, cigarette lighter or candle. The three-second test with a one and one-half inch flame was meant to duplicate the most common fire scenarios that were identified in the incidents. We make no claim and we have no data to support the notion that any garment that passes the children's sleepwear standards' flammability test will protect a child from any larger flame or one of any longer duration. So to include burn incidents which involve bigger flames with longer exposure times would be, in effect, to require the cotton garments to pass a test that the flame resistant garments were never required to meet in the first place.

What factors led to the Amendments? The impetus for the change in the sleepwear standards was that some manufacturers, capitalizing on consumers' preference for cotton, were making long underwear that looked suspiciously like sleepwear and perhaps engaging in other activity to encourage parents to move to underwear as a cotton alternative to the traditional polyester sleepwear. Our enforcement staff tried to take action against these manufacturers, but as long as the garments were labeled "underwear," enforcement action was extremely difficult.

Once the staff began looking at the incidents of children being burned while wearing clothing they were put to sleep in, it became clear that oversized T-shirts were a dangerous choice for children's nightwear. However, staff never based its recommendation to the Commission, and I certainly did not base my vote, on any assumption that parents who permitted loose-fitting

cotton T-shirts to be used for their children's sleepwear would switch to tight-fitting cotton sleepwear. What we did believe would happen was that the same parents who went out of their way to buy form-fitting cotton underwear would buy slightly more form-fitting cotton sleepwear and that manufacturers, now having a legal cotton alternative, would stop skirting the sleepwear standards and make complying cotton sleepwear garments. Since the adoption of the amendments, sales of polyester sleepwear garments have grown, as have sales of the new cotton sleepwear garments, whereas cotton underwear sales, after years of marked growth are showing signs of flattening out. This may be an early indication that our strategy is working.

Some commenters say there has not been enough time to tell what effect the amendments to the standards have had. People focus on the effective date of the amendments (January 1, 1997), but ignore that the Commission, as early as 1979, had notice of consumers crossing over and buying long underwear to be used as pajamas. As that trend increased throughout the 1980's and 1990's, when the Commission was actively trying to enforce against these garments, the injury rate to children in clothing used for sleeping did not change. In other words, even though more children were being put to sleep in form-fitting cotton underwear garments, these garments were not involved in burn injuries or deaths from small open flames. Thus we have a much longer history without incidents--at least twenty years--not just back to the effective date of the amendments.

Now I would like to address the new labeling requirements. A number of people who testified or submitted comments attacked the lack of a uniform, nationwide information and education campaign on the part of industry to help consumers make an informed choice on children's sleepwear. I agree that there should be more uniformity in the message and that the level of conformance with the voluntary program is not nearly as high as it should be (although I am grateful to those manufacturers and retailers who did take their commitment seriously).

There are a number of reasons why industry never launched the full campaign, not the least of which was the uncertainty about the content and the future of the cotton exemptions. The Commission is also at fault for not taking a more aggressive posture in getting out the message about the changes in the sleepwear standard and reminding consumers about why the standards were promulgated in the first place. The Commission will take a more active role in the future. The mandatory hangtag and permanent neck label we have adopted today should make it easier for consumers to select the type of sleepwear they want for their children and for secondhand users to know the garment is not flame resistant and must fit their child snugly.

Our new message is 'look for the yellow tag' if you want to determine which garments are the snug-fitting cotton sleepwear. I imagine that makers of flame-resistant sleepwear will find a similar way to make their garments more readily identifiable to the consumer.

While we have no mandatory requirements for hangtags and labels to be printed in Spanish (and we were supplied with no data to support the need for this) I would certainly hope that manufacturers who sell in regions of the country with a high Spanish-speaking population would consider the need for this.

We have given manufacturers a year to switch over to the new hangtag and label, but I would encourage manufacturers who are able to do so, to make the switch sooner. We want to be able to tell consumers about this new labeling and the sooner it appears, the sooner we can get our message out.

The mandatory labels will replace part of the voluntary information and education campaign, but retailers, manufacturers and the Commission need to get the story out about tight-fitting cotton sleepwear. Retailers, in particular, need to do their part in segregating non-sleepwear from sleepwear garments and in educating their sales personnel about what can and what can not be characterized as "sleepwear."

The Commission has now gone through what amounts to four-step rulemaking on this issue. It is clear from their comments that many of the opponents of the Commission's action in 1996 have never read the three previous briefing packages of the staff on this issue. I would hope before any Members of Congress contemplate taking further action in this area that they would read those three packages, along with the most recent one, and not be guided by the misconceptions that have obscured this issue.

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