CHILD SAFETY IN PENNSYLVANIA

AN ADVISORY COMMITTEE REPORT WITH RECOMMENDATIONS

JUNE 2008

General Assembly of the Commonwealth of Pennsylvania
JOINT STATE GOVERNMENT COMMISSION
108 Finance Building
Harrisburg, PA 17120

The release of this report should not be interpreted as an endorsement by the members of the Executive Committee of the Joint State Government Commission of all the findings, recommendations and conclusions contained in this report.

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TO MEMBERS OF THE GENERAL ASSEMBLY:

The Joint State Government Commission is pleased to present the report entitled "Child Safety in Pennsylvania – An Advisory Committee Report with Recommendations". House Resolution 357 of 2005 (Printer's Number 4488), directed the Joint State Government Commission to assemble an advisory committee to assist it in preparing a report to "review existing Pennsylvania laws and regulations to determine their impact on preventing unintentional injuries and recommend reforms and policy proposals to strengthen existing laws and regulations to reduce preventable deaths. . . ."

The membership of the advisory committee represented various areas of expertise and interests in the field of child safety. Parents, child safety advocates, industry experts, physicians, attorneys, death review team members, representatives of the Pennsylvania Department of Health and the Pennsylvania Department of Public Welfare, and others participated as members. Their assistance in writing this report was invaluable.

Respectfully submitted,

Roger A. Madigan,
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CONTENTS

INTRODUCTION

House Resolution 357 of 2005 (Printer's Number 4488), sponsored by Representative Josh Shapiro and Representative Jerry Birmelin, begins as follows:

"Sadly and suddenly, the life of three and a half-year old Katie Elise Lambert of Abington, Pennsylvania, was cruelly taken on January 21, 2005, when an unanchored wardrobe cabinet fell on top of her; and whereas, Each year, the lives of many innocent children like Katie Elise Lambert are tragically ended because of unintentional injury-related deaths. . . ."

Subsequently, House Resolution 357 was adopted and provides "that the General Assembly direct the Joint State Government Commission to establish a task force of four members of the Senate and four members of the House of Representatives; and be it further resolved that the Speaker of the House of Representatives, Minority Leader of the House of Representatives, President pro tempore of the Senate and the Minority Leader of the Senate shall each appoint two members to the commission [task force]." In addition, the Resolution authorizes the task force to create an advisory committee to assist it in preparing a report to "review existing Pennsylvania laws and regulations to determine their impact on preventing unintentional injuries and recommend reforms and policy proposals to strengthen existing laws and regulations to reduce preventable deaths. . . ."

On November 20, 2006, the Task Force authorized by the Resolution held its organizational meeting. Rep. Josh Shapiro was appointed Chair of the Task Force. Subsequently, an advisory committee was organized consisting of 24 individuals representing various areas of expertise and interests in the field of child safety. Parents, child safety advocates, industry experts, physicians, death review team members, and representatives of the Pennsylvania Department of Health and the Pennsylvania Department of Public Welfare participated as members of the advisory committee.

The advisory committee first met on March 30, 2007 and then met again on June 13, 2007, October 4, 2007, and December 6, 2007.

The advisory committee and staff of the Joint State Government Commission reviewed applicable existing State law and regulations that pertain to child safety, analyzed data on child injuries and deaths inside and outside of Pennsylvania, and reviewed data and programs of states with lower injury death rates than the Commonwealth's in search of guidance for lowering Pennsylvania's rates of death and injury among children. The advisory committee considered all of the aforementioned and proceeded to discuss funding issues, best practices, public education, and various means

for improving data collection, among other issues, topics, and themes within the expertise of its members and, ultimately, offered the recommendations which appear in this report.

Despite a certain amount of interpretive latitude within the Resolution, the advisory committee limited the scope of its work, including its recommendations, to injuries and deaths of children within the home, and from ages 0 through 14. While there are a plethora of laws and regulations in the Commonwealth which relate to safety generally and child safety specifically (such as bicycle helmet laws and automobile-related child safety seat laws), the advisory committee realized the difficulty in relying on laws and regulations to govern behaviors within the home. Product safety measures are, perhaps, the only means of impacting in-home safety, but these do little, in and of themselves, to alter behavior behind closed doors. Thus, the thread that ultimately ran through the advisory committee's deliberations, and the thread that runs through this report as well, is the need for educating the public about child safety. Given this, the advisory committee determined that the best way to educate the public is to make a commitment, as a State, to make child safety a matter of top priority. Along with this commitment to, and focus on, child safety issues and education, the advisory committee noted that adequate and sustained funding, including federal government funding, is important to the success of any effort to lower unintentional household injuries and deaths among children in Pennsylvania.

The advisory committee initially considered making recommendations per age group and/or type of injury or injury-related death. However, after careful thought and discussion, the committee realized that the same themes, issues, and thus, recommendations, would be replicated among each age category. Therefore, the committee believed it best to settle on a more comprehensive, universal approach to dealing with child safety in the aggregate.

The following chapter offers a summary of the recommendations of the advisory committee. It is followed by a more detailed look at data on child safety and the societal cost of childhood injuries and chapters on some of the other, notable considerations of the advisory committee throughout its deliberations and in the field of child safety generally. This is followed by a more detailed explanation of the recommendations of the advisory committee, with accompanying draft legislation. The report concludes with an appendix of useful child safety resources and other germane information.

SUMMARY OF RECOMMENDATIONS

1) Create a Child Safety Advocate position in the Pennsylvania Department of Health.

2) Create a multidisciplinary commission on child safety (or utilize a currently existing commission such as the Governor's Commission for Children and Families and expand its scope and membership accordingly) to assist the Child Safety Advocate in identifying child safety issues in Pennsylvania.

3) Improve current data collection on child safety related deaths and injuries in Pennsylvania. This may include efforts to secure more reporting on child-related injuries from emergency rooms and physician's offices and collaborating with Child Death Review teams throughout the Commonwealth.

4) Establish a clearinghouse for leading issues in child safety and for issues of immediate concern and disseminate such information to the counties, localities and private health practitioners as practicable.

5) Foster public-private partnerships which will improve child safety in the Commonwealth.

6) Require an annual report on the status of child safety in Pennsylvania to the Children and Youth Committee in the State House of Representatives and the Aging and Youth Committee in the State Senate.

7) Provide the necessary funding to accomplish each of the recommendations of the advisory committee contained in this report.

8) Urge the Pennsylvania Congressional Delegation to support increased federal funding for child safety initiatives and encourage the provision of additional funding to the states.

9) Urge the Pennsylvania Congressional Delegation to support federal legislation which would improve child safety including HR 4266 ("Katie Elise and Meghan Agnes Act").

10) Require child case workers to receive comprehensive training on in-home child safety and to provide information to foster and adoptive families on these issues.

11) Increase funding to the Department of Health to hire additional staff to focus exclusively on injuries to children and improving child safety. In addition, increase funding for the Child Death Review Program.

12) Require labeling of all furniture sold in Pennsylvania to include a warning about the danger of tip over and advocating the use of tethering devices.

UNINTENTIONAL INJURIES AND INJURY DEATHS

From 1999 through 2005, Pennsylvania experienced 1,189 unintentional injury deaths of children aged 14 and under. See table 1. Based on the population during that period, the Commonwealth had a death rate of 7.18 per 100,000 children. Pennsylvania ranked twelfth best among the states, while Massachusetts led all states with the lowest death rate of 3.37. Pennsylvania's rate was slightly better than the 9.01 total death rate of the United States, as a whole, and was nearly three times better than South Dakota's death rate of 19.57. Thus, while the Commonwealth clearly has room to improve, the death rate for children aged 14 and under in Pennsylvania compared well nationally. The advisory committee reviewed this data and considered the programs and efforts of the 11 states with lower death rates than Pennsylvania with an eye toward programs or practices which were likely to improve child safety within the Commonwealth.

Specifically, motor vehicle traffic related deaths were the leading category of unintentional deaths, at 37.8 percent, in the United States for children aged 14 and under in 2005. See table 2. The second through fourth leading causes of unintentional deaths in 2005 were suffocation at 18.9 percent, drowning at 15.7 percent, and fire/burn at 9.0 percent of total deaths. Collectively, these four types accounted for 81.4 percent of the 5,162 unintentional deaths for children aged 14 and under in the United States. Motor vehicle traffic related deaths remained the leading type for individual age groups five through nine (5-9) and ten through fourteen (10-14). However, suffocation was the leading type of unintentional death, at 69.1 percent, for children under the age of one (<1). Drowning was the leading type of unintentional death, at 29.6 percent, for children in the age group one through four (1-4).

The authorizing resolution for the advisory committee's study and this report was prompted by the tragedy involving Katie Elise Lambert and an unanchored wardrobe cabinet. Furniture tip over is likely to be reported in the subcategory "Struck by Thrown, Projected or Falling Object" within the "Struck by or Against" category in the Tables that follow. There were 68 deaths, 1.3 percent, in the "Struck by or Against" category for children aged 14 and under in 2005 throughout the United States. The highest percentage of "Struck by or Against" deaths, 1.9 percent, was in the one through four (1-4) age group.

Pennsylvania's leading types of unintentional deaths for children aged 14 and under were similar to that of the United States in the aggregate in 2005. Motor vehicle traffic related deaths were the highest at 35.3 percent. See table 3. Drowning at 17.6 percent, suffocation at 15.0 percent, and fire/burn at 15.0 percent, complete the top four leading causes of unintentional death. Similar to the United States, these four types of deaths accounted for 82.9 percent of the 153 unintentional deaths in Pennsylvania. Motor vehicle traffic related deaths remained the leading type in the individual age groups with

the exception of children under the age of one (<1). In the group under age one (<1), suffocation was the leading type of unintentional death at 75.0 percent.

Two deaths, which were potentially a direct result of furniture tip over, occurred in the "Struck by or Against" category in Pennsylvania. This represents 1.3 percent of the total number of deaths. No such deaths occurred among children under the age of one (<1) or in the ten through fourteen (10-14) age group. However, a death occurred in both age groups one through four (1-4) and five through nine (5-9).

While deaths due to unintentional injury are well captured in the data, it is difficult to determine the number of injuries that occur, but which do not result in death, within the Commonwealth. The Pennsylvania Health Care Cost Containment Council (PHC4) collects some data on injuries, but only for those that lead to a hospitalization. There is no system in place to collect Statewide emergency room data. However, the Centers for Disease Control and Prevention (CDC) creates national injury estimates based on weighted data from the U.S. Consumer Product Safety Commission's (CPSC) National Electronic Injury Surveillance System (NEISS). These national estimates may provide some insight into the leading types of injuries in Pennsylvania.

Falling was the leading cause of unintentional injury, at 36.3 percent, in the United States for children aged 14 and under in 2005. See table 4. In regard to potential furniture tip over, the "Struck by or Against" category was the second leading type of injury at 21.7 percent. These two types of injuries accounted for 58.0 percent of the 6,196,236 unintentional injuries for children aged 14 and under in the United States. In contrast, the "Fall" and "Struck by or Against" categories accounted for 2.9 percent of all unintentional injury deaths. In addition, of the four leading types of unintentional deaths in the United States for children aged 14 and under in 2005, fire/burn was the only one to appear in the top 20 causes of injury alone, ranking 13th.

Within the individual age groups, falls and "Struck by or Against" remained the top two leading types of unintentional injury respectively, followed by overexertion, which was the third leading type of injury for children ages 10-14, accounting for 12.4 percent of injuries for that age group.

TABLE 1
UNINTENTIONAL INJURY DEATHS
BY STATE, POPULATION AND CRUDE DEATH RATE
AGES 0 THROUGH 14
1999 - 2005

State	Number of Deaths	Population[1]	Crude Death Rate[2]
Massachusetts	293	8,686,453	3.37
Connecticut	205	4,897,534	4.19
New Jersey	554	12,288,904	4.51
New York	1,265	27,021,023	4.68
Rhode Island	71	1,432,986	4.95
New Hampshire	99	1,770,056	5.59
Hawaii	104	1,732,754	6.00
Maryland	490	7,953,800	6.16
California	3,514	55,142,337	6.37
Maine	116	1,671,809	6.94
Virginia	725	10,289,808	7.05
Pennsylvania	1,189	16,560,143	7.18
Vermont	58	807,642	7.18
Illinois	1,415	18,915,601	7.48
Washington	670	8,770,006	7.64
Colorado	518	6,571,369	7.88
Delaware	94	1,150,579	8.17
Minnesota	601	7,349,174	8.18
Ohio	1,402	16,499,892	8.50
Wisconsin	674	7,731,673	8.72
Iowa	362	4,143,930	8.74
Nebraska	240	2,576,086	9.32
Oregon	460	4,899,172	9.39
Utah	406	4,315,521	9.41
North Dakota	83	872,414	9.51
Michigan	1,517	14,872,257	10.20
North Carolina	1,229	11,880,660	10.34
Texas	3,695	35,572,725	10.39
Nevada	344	3,272,255	10.51
West Virginia	241	2,267,828	10.63
Indiana	1,005	9,139,421	11.00
Arizona	965	8,515,515	11.33
Florida	2,517	21,909,473	11.49
New Mexico	336	2,921,619	11.50
Georgia	1,529	13,271,075	11.52
Kansas	475	4,078,453	11.65
Missouri	959	8,205,837	11.69
Montana	157	1,269,611	12.37
Oklahoma	635	5,129,493	12.38
Kentucky	739	5,767,658	12.81
Idaho	277	2,161,063	12.82
Tennessee	1,050	8,190,754	12.82
South Carolina	768	5,902,287	13.01
Alabama	936	6,456,489	14.50
Wyoming	108	708,177	15.25
Louisiana	1,097	6,887,593	15.93
Arkansas	656	3,933,075	16.68
Alaska	200	1,080,636	18.51
Mississippi	845	4,444,520	19.01
South Dakota	222	1,134,300	19.57
Total	38,110	423,023,440	9.01

1. The population figures are a 7 year aggregate of children aged 0 through 14.

2. Crude death rate = 100,000/(population/deaths)

SOURCE: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Web-based Injury Statistics Query and Reporting System (WISQARS), Available at www.cdc.gov/ncipc/wisqars, March 25, 2008.

TABLE 2
UNINTENTIONAL INJURY DEATHS
BY RANK, TYPE, AGE AND PERCENTAGE
FOR THE UNITED STATES
AGES 0 THROUGH 14
2005

Total Rank	Unintentional Injury	Age < 1 Deaths	Age < 1 % of Total	Age 1 - 4 Deaths	Age 1 - 4 % of Total	Age 5 - 9 Deaths	Age 5 - 9 % of Total	Age 10 - 14 Deaths	Age 10 - 14 % of Total	Total Deaths	Total % of Total
1	Motor Vehicle Traffic	140	12.9%	489	29.4%	560	52.2%	763	56.8%	1,952	37.8%
2	Suffocation	748	69.1	126	7.6	44	4.1	59	4.4	977	18.9
3	Drowning	64	5.9	493	29.6	121	11.3	132	9.8	810	15.7
4	Fire/burn	36	3.3	208	12.5	138	12.9	85	6.3	467	9.0
5	Pedestrian, Other	3	0.3	129	7.8	25	2.3	22	1.6	179	3.5
6	Other Land Transport	4	0.4	25	1.5	47	4.4	63	4.7	139	2.7
7	Poisoning	20	1.8	21	1.3	17	1.6	34	2.5	92	1.8
8	Natural/Environment	16	1.5	38	2.3	17	1.6	18	1.3	89	1.7
9	Fall	16	1.5	34	2.0	14	1.3	18	1.3	82	1.6
10	Firearm	1	0.1	22	1.3	15	1.4	37	2.8	75	1.5
11	Unspecified	22	2.0	21	1.3	15	1.4	14	1.0	72	1.4
12	Struck by or Against[1]	9	0.8	31	1.9	15	1.4	13	1.0	68	1.3
13	Other Transport	0	0.0	2	0.1	10	0.9	32	2.4	44	0.9
14	Other Specified, classifiable	4	0.4	8	0.5	12	1.1	18	1.3	42	0.8
15	Machinery	0	0.0	7	0.4	10	0.9	12	0.9	29	0.6
16	Other Spec., NEC	0	0.0	6	0.4	7	0.7	10	0.7	23	0.4
17	Pedal cyclist, Other	0	0.0	1	0.1	4	0.4	13	1.0	18	0.3
18	Cut/pierce	0	0.0	3	0.2	1	0.1	0	0.0	4	0.1
	Total	1,083	100.0	1,664	100.0	1,072	100.0	1,343	100.0	5,162	100.0

1. Falling furniture is likely to be reported under the Struck by or Against category.
NEC. Not Elsewhere Classifiable

SOURCE: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Web-based Injury Statistics Query and Reporting System (WISQARS), Available at www.cdc.gov/ncipc/wisqars, March 24, 2008.

TABLE 3
UNINTENTIONAL INJURY DEATHS
BY RANK, TYPE, AGE AND PERCENTAGE
FOR PENNSYLVANIA
AGES 0 THROUGH 14
2005

		Age									
		< 1		1 - 4		5 - 9		10 - 14		Total	
Total Rank	Unintentional Injury	Deaths	% of Total	Deaths	% of Total	Deaths	% of Total	Deaths	% of Total	Deaths	% of Total
1	Motor Vehicle Traffic	3	12.5%	15	28.8%	12	40.0%	24	51.1%	54	35.3%
2	Drowning	0	0.0	13	25.0	5	16.7	9	19.1	27	17.6
3	Suffocation	18	75.0	3	5.8	0	0.0	2	4.3	23	15.0
4	Fire/burn	0	0.0	11	21.2	8	26.7	4	8.5	23	15.0
5	Other Land Transport	0	0.0	1	1.9	0	0.0	4	8.5	5	3.3
6	Poisoning	1	4.2	1	1.9	1	3.3	2	4.3	5	3.3
7	Fall	0	0.0	3	5.8	0	0.0	1	2.1	4	2.6
8	Machinery	0	0.0	2	3.8	1	3.3	1	2.1	4	2.6
9	Unspecified	2	8.3	0	0.0	1	3.3	0	0.0	3	2.0
10	Struck by or Against[1]	0	0.0	1	1.9	1	3.3	0	0.0	2	1.3
11	Pedestrian, Other	0	0.0	1	1.9	0	0.0	0	0.0	1	0.7
12	Firearm	0	0.0	1	1.9	0	0.0	0	0.0	1	0.7
13	Other Spec., NEC	0	0.0	0	0.0	1	3.3	0	0.0	1	0.7
	Total	24	100.0	52	100.0	30	100.0	47	100.0	153	100.0

1. Falling furniture is likely to be reported under the Struck by or Against category.
NEC. Not Elsewhere Classifiable

SOURCE: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Web-based Injury Statistics Query and Reporting System (WISQARS), Available at www.cdc.gov/ncipc/wisqars, March 24, 2008.

TABLE 4
UNINTENTIONAL INJURIES[1]
BY RANK, TYPE, AGE AND PERCENTAGE
FOR THE UNITED STATES
AGES 0 THROUGH 14
2005

		Age									
		< 1		1 - 4		5 - 9		10 - 14		Total	
Total Rank	Unintentional Injury	Injuries	% of Total	Injuries	% of Total	Injuries	% of Total	Injuries	% of Total	Injuries	% of Total
1	Fall	118,292	50.8%	862,993	43.2%	644,546	37.2%	622,613	27.9%	2,248,444	36.3%
2	Struck by or Against[2]	31,293	13.4	365,619	18.3	389,048	22.5	556,822	24.9	1,342,782	21.7
3	Overexertion	6,588	2.8	74,345	3.7	67,774	3.9	276,544	12.4	425,251	6.9
4	Cut/Pierce	6,993	3.0	87,920	4.4	115,980	6.7	145,247	6.5	356,140	5.7
5	Other Bite/Sting	13,996	6.0	138,508	6.9	89,351	5.2	62,219	2.8	304,074	4.9
6	Pedal Cyclist	66[a]	0.0	24,629	1.2	100,203	5.8	126,468	5.7	251,366	4.1
7	Unknown/Unspecified	5,717	2.5	49,152	2.5	44,627	2.6	119,074	5.3	218,570	3.5
8	Foreign Body	9,440	4.1	118,101	5.9	55,405	3.2	24,512	1.1	207,458	3.3
9	Motor Vehicle Occupant	6,547	2.8	38,338	1.9	67,740	3.9	92,902	4.2	205,527	3.3
10	Other Transport	1,111[a]	0.5	28,216	1.4	43,431	2.5	59,209	2.6	131,967	2.1
11	Dog Bite	1,597	0.7	34,827	1.7	46,439	2.7	36,873	1.7	119,736	1.9
12	Other Specified	7,213	3.1	59,059	3.0	15,617	0.9	29,510	1.3	111,399	1.8
13	Fire/Burn	12,003	5.2	59,267	3.0	18,890	1.1	20,327	0.9	110,487	1.8
14	Poisoning	4,872	2.1	39,940	2.0	8,248	0.5	12,729	0.6	65,789	1.1
15	Pedestrian	236[a]	0.1	4,879	0.2	11,781	0.7	16,676	0.7	33,572	0.5
16	Motorcyclist	0	0.0	648[a]	0.0	7,272	0.4	21,223	0.9	29,143	0.5
17	Inhalation/Suffocation	6,611	2.8	6,179	0.3	2,356	0.1	1,295	0.1	16,441	0.3
18	BB/Pellet, Gunshot	0	0.0	355[a]	0.0	1,590	0.1	5,085	0.2	7,030	0.1
19	Machinery	9[a]	0.0	1,251	0.1	969[a]	0.1	1,902	0.1	4,131	0.1
20	Natural/Environment	233[a]	0.1	b	0.0	696[a]	0.0	1,881	0.1	2,810	0.0
21	All Others	197[a]	0.1	1,927	0.1	514	0.0	1,481	0.1	4,119	0.1
	Total	233,014	100.0	1,996,153	100.0	1,732,477	100.0	2,234,592	100.0	6,196,236	100.0

1. The number of nonfatal injuries presented in WISQARS are national estimates based on weighted data from the U.S. Consumer Product Safety Commission's (CPSC) National Electronic Injury Surveillance System (NEISS).

2 . Falling furniture is likely to be reported under the Struck by or Against category.

a. Injury estimates are unstable because of a small sample size.

b. The specific number of Natural/Environment injuries for this age group are unknown, but the injuries are included in the All Others category.

SOURCE: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Web-based Injury Statistics Query and Reporting System (WISQARS), Available at www.cdc.gov/ncipc/wisqars, March 25, 2008.

COST-EFFECTIVENESS OF STRATEGIES TO REDUCE CHILDHOOD INJURIES

House Resolution 357 directed the advisory committee to provide "[i]nformation on the cost-effectiveness of strategies to reduce injuries to children to better inform public debate on the merits of these interventions." It goes without saying that unintentional childhood injuries, particularly those resulting in a child's death, are very traumatic for the family and friends of the child involved. In addition, many of these injuries can also be very expensive to treat and may potentially have a lasting effect on the injured child and his or her family. The financial impact of an unintentional injury may extend well beyond the initial medical expenses. A 2000 study on the cost of childhood unintentional injuries mentions the following potential costs associated with these injuries:

- medical expenses paid for by parents and health insurers;
- loss of work by the parent to care for the injured child affecting both the family's income and the employers' profit;
- future loss of wages and productivity of the child due to a long-term, permanent injury or death;
- diminished quality of life for children who are permanently disabled by the injury; and
- other costs such as police and fire department costs if these public services are needed. [1]

If one knew, on average, how much the treatment of these injuries cost, that data could be utilized to determine how much society would save for every unintentional childhood injury prevented. Unfortunately, the advisory committee did not know of, and could not locate, any recent data source that contained all of this information.

The lack of information stems from the multiple ways in which children receive injury treatment as well as the number of people/organizations that cover the cost for treatment of injuries. Even trying to account for medical expenses only is difficult. Some minor injuries can be treated by a parent using relatively inexpensive first aid supplies such as bandages and ice packs. Other, slightly more severe, injuries may be treated by the child's pediatrician or family doctor in an office setting. Still other severe

[1] Miller, Ted R. et al. *The Cost of childhood Unintentional Injuries and the Value of Prevention.* The Future of Children UNINTENTIONAL INJURIES IN CHILDHOOD. Vol. 10, No. 1. Spring/Summer 2000. p. 139-140. Found at:http://www.futureofchildren.org/usr_doc/vol10no1Art6.pdf (last viewed April 22, 2008).

injuries might be treated at a local hospital emergency room. Finally, the most traumatic injuries may require a child to be hospitalized for a period of time. Payment for the treatment of injuries can be made by any combination of the following groups/individuals: parents or guardians, insurance companies, and doctor's offices and/or hospitals. In short, the diverse and multiple means of treating children's injuries, along with the variations in the funding of such treatment, has made it difficult for Pennsylvania, and the country as a whole, to assemble complete and accurate information on the cost of unintentional childhood injuries.

Using a wide variety of data sources, a 2000 study was able to estimate the average costs of unintentional injuries to children, ages 0 to 19 in the United States in 1996 to be roughly $81.4 billion dollars in total.[2] This same study also calculated the estimated quality-adjusted life years (QALYs)[3] and found that 2,656,000 QALYs were lost in the United States in 1996 due to unintentional injuries to children age 19 and under.[4] The study estimated that the lifetime costs of unintentional injuries per child was a little less than $1,000 for children age four and under, a little less than $1,100 for children age five to nine, and roughly $750 for children age ten to fourteen.[5] While potentially informative, the study data is 12 years old and, thus, somewhat limited in its present day application. The study also contains all unintentional childhood injuries for children age 19 and under, while this report focuses on only childhood injuries occurring within the home to children age 14 and younger. The aforementioned concerns notwithstanding, the study does provide a rough estimate of the magnitude of the cost of unintentional childhood injuries.

In addition to the estimations of the 2000 study, the advisory committee also found more recent information collected by the Pennsylvania Health Care Cost Containment Council (PHC4). The PHC4 collects information on hospital charges for various hospital admissions (including unintentional injuries) throughout Pennsylvania. According to PHC4, in 2005 there were 6,122 unintentional injury hospitalizations of children age 14 and younger.[6] In total, hospitals in Pennsylvania billed patients and/or their insurance companies $136,450,894 for these 6,122 hospitalizations, averaging roughly $22,289 per hospitalization.[7] Using this figure as the cost for every unintentional injury which would require hospitalization, but which is otherwise avoided, there would be an average savings of roughly $22,289 per injury avoided. While this information is somewhat helpful, it has four notable limitations with regard to this report as detailed below.

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[2] Ibid at 146.

[3] According to the study, "[e]stimating quality-adjusted life years (QALYS) is one way to value the good health lost to an individual who suffers a health problem, is disabled, or dies prematurely. A QALY is a measure based on individual preferences for states of health that assigns a value of "1" to a year of perfect health and "0" to death." Ibid at 141.

[4] Ibid at 146.

[5] Ibid. at 147.

[6] Pennsylvania Healthcare Cost Containment Council (PHC4), via the Pennsylvania Department of Health, December 2007.

[7] Ibid.

One limitation is that the amount a hospital charges for a procedure is often higher than the amount the hospital eventually receives as final payment from an insurance company or patient. According to *PHC4 Central & Northeastern Hospital Performance Report: Fiscal Year 2006*, "[a]ctual payments to hospitals are imposed by Medicare and Medicaid, or result from negotiations with insurance companies, other third-party payors, and even individual patients."[8] The PHC4 report further explains that, on average, Pennsylvania hospitals received roughly 27 cents for every dollar they charged in Fiscal Year 2006 (7/1/05 – 6/30/06).[9] Using this number as a guide, hospitals, on average, charged $22,289 per unintentional childhood injury hospitalization but received only slightly more than $6,000 for each one of these hospitalizations.

A second limitation to using hospital charges to estimate the financial costs of unintentional childhood injuries is that it only includes immediate medical expenses. It does not include non-related medical costs as well as potential future medical costs such as ongoing, outpatient therapy.

A third limitation is that many injuries are not serious enough to warrant hospitalization. In many cases, children with injuries are treated at home by a parent or by a doctor in a doctor's office or hospital emergency room. None of these cases are included in the hospital charges collected by PHC4.

A fourth limitation to using hospital charges for unintentional childhood injuries reported by PHC4 is that this report's overall focus is on preventing injuries to children *in the home*. PHC4's hospital charges include *all* unintentional childhood injuries such as those resulting from motor vehicle accidents, drowning/submersion and bicycle injuries that may or may not have occurred in the home.

While the PHC4 data is more recent than the 2000 study results, it is missing many of the costs that the advisory committee would have liked to provide in this report in regard to the cost savings attributable to a reduction in unintentional, in-home injuries to children. Overall, the limitations listed above for the 2000 study results, as well as the PHC4 data, underscore the difficulty in attributing an accurate price tag for reducing such injuries. Suffice to say, there is likely considerable societal cost savings for each child injury averted, but of equal and perhaps more importance to the advisory committee is preventing injury to some of the Commonwealth's most vulnerable individuals, thus avoiding the pain and suffering and the concomitant physical and mental trauma which accompanies unintentional injury. In addition, the difficulty in attributing a dollar value per injury highlights the need for better injury reporting. An improved reporting system was a consideration of the advisory committee and is among the recommendations in this report.

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[8] PHC4 Central & Northeaster Hospital Performance Report: Fiscal Year 2006, Oct. 1, 2005 – Sept. 30, 2006. Sept. 2007. Pg 5. http://www.phc4.org/reports/hpr/06/docs/hpr2006centralnortheast.pdf (last viewed, January 23, 2008).

[9] PHC4 Central & Northeaster Hospital Performance Report: Fiscal Year 2006, Oct. 1, 2005 – Sept. 30, 2006. Sept. 2007. Pg 4. http://www.phc4.org/reports/hpr/06/docs/hpr2006centralnortheast.pdf (last viewed, January 23, 2008).

CURRENT FUNDING FOR PENNSYLVANIA'S INJURY PREVENTION EFFORTS

The Bureau of Health Promotion and Risk Reduction of the Pennsylvania Department of Health is responsible for the Commonwealth's Violence and Injury Prevention Program, which seeks to reduce injuries of all types to individuals of all ages. Within this sphere of responsibility is injury prevention to children.

While the Bureau's efforts are not focused solely on childhood injury prevention, there is one full-time position dedicated to such matters. The sources of funding for childhood injury prevention, including the salary of this one employee, are the federal Preventive Health and Health Services Block Grant (PHHSBG) and the federal Maternal and Child Health Block Grant (MCH). No State funds are appropriated.

The PHHSBG has suffered substantial reductions since 2004, but its use is at the discretion of the Department, and the Department, thus far, has chosen to continue to dedicate funding to the non-profit Safe Kids (at a level of $450,000 per year for the last three fiscal years and a recommended $450,000 for FY 2008-09 as well), while other injury prevention programs have been subjected to funding reductions.

Safe Kids Worldwide is a global network of organizations whose mission is to prevent accidental childhood injury, a leading killer of children 14 and under. More than 450 coalitions in 16 countries bring together health and safety experts, educators, corporations, foundations, governments and volunteers to educate and protect families. Safe Kids Worldwide was founded in 1987 as the National SAFE KIDS Campaign by Children's National Medical Center with support from Johnson & Johnson. It is a 501(c)(3) non-profit organization with headquarters in Washington, D.C.[10]

The Department also provides funding to other organizations to conduct a variety of prevention activities for individuals of all ages including children.

The Department cautions that any further reductions in, or elimination of, federal funding will have an adverse affect on funding to organizations such as Safe Kids. The Department points out that every year since 2004 the President has proposed elimination of funding for the PHHSBG. However, each time, Congress has chosen to restore most of these funds to the Federal budget. [11]

[10] Safe Kids USA at http://www.usa.safekids.org/tier2_rl.cfm?folder_id=184
[11] The Pennsylvania Department of Health Bureau of Health Promotion and Risk Reduction, April 2008.

Injury prevention programs, including injury prevention programs focused specifically on children, are administered by a number of Commonwealth agencies: the Department of Education through school curricula, the State's Fire Commissioner's Office through its "Risk Watch" program, and to some degree, the Department of Public Welfare and others. These efforts are supplemented by various local government and private entities as well. Thus, it is difficult to enumerate all of the programs which touch upon child safety and to affix, with certainty, a total dollar amount to child safety efforts/programs Statewide. However, the Department of Health is a logical focal point for injury prevention efforts within the State, as evidenced by the eponymous Violence and Injury Prevention Program, which it administers. Therefore, the advisory committee, which included representation from the Department of Health, focused its recommendations on the Department as the State's current and continuing leader in the realm of child safety.

Although the Department's effort to continue to apply $450,000 of federal funds to child safety programs, such as Safe Kids, has undoubtedly contributed to Pennsylvania's relatively positive national ranking in terms of total deaths and injuries to children 14 and under, it is apparent that it is becoming increasingly difficult to maintain this level of dedicated funding. The advisory committee discussed its concerns in this regard and recommended increased funding for child safety programs and initiatives as an integral part of making child safety a matter of top priority in the Commonwealth. Many of the recommendations of the advisory committee, which appear in this report, require funding, reflecting the need for the State to exert greater effort in persuading the federal government to maintain, and perhaps increase, its support for the State's child safety programs. The advisory committee's recommendations also require the State to assume a greater role itself by supplementing the funds provided by the Federal government or by replacing lost Federal dollars.

CURRENT STATUS OF THE CONSUMER PRODUCT SAFETY COMMISSION

The U.S. Consumer Product Safety Commission was created as an independent federal regulatory agency in 1972 in the Consumer Product Safety Act. It is charged with protecting the public from unreasonable risks of serious injury or death from more than 15,000 types of consumer products under the agency's jurisdiction.

At its inception, the Commission had over 1,000 employees. Budget reductions over the years have decreased staff size to 420 full-time equivalent employees in the agency, with a total field investigative staff of less than 90 people. Of those 90, approximately 15 are assigned to visit ports of entry and inspect imports.[12] Only one employee is assigned to test suspected defective toys.[13] The Consumer Product Safety Commission's annual budget of $63 million is dwarfed by the Food and Drug Administration's $2 billion annual budget.[14] Additionally, testing facilities' physical plants and equipment are outdated and inadequate for the tasks assigned to them.[15]

HR 4040, the proposed Consumer Product Safety Modernization Act is currently before Congress and proposes to increase the agency's budget, raise staffing levels, give the agency additional policing powers, substantially increase maximum penalties, and give state prosecutors the authority to enforce federal consumer safety laws. The acting chairperson of the Commission has expressed opposition to many of these proposals.[16]

Administratively, the agency is currently experiencing a leadership crisis. In July 2006, the then chairman left the agency, creating a vacancy. Normally, all three members are needed for a quorum. A temporary quorum was established upon the chairman's departure, which expired in January 2007. President Bush nominated a new chairman, but the nominee withdrew his name in May 2007 following protest by Senate Democrats and consumer groups. An extension of the temporary quorum was granted in August 2007, but expired at the end of January 2008.[17] HR 4040 would further extend the quorum, but has not yet passed the Senate.

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[12] Statement of Commissioner Thomas H. Moore, U.S. Product Safety Commission, Submitted to the Subcommittee on Commerce, Trade, and Consumer Protection, House Committee on Energy and Commerce, September 19, 2007, p. 5. (Moore Statement)

[13] Eric Lipton, "Safety Agency Faces Scrutiny Amid Changes," *The New York Times*, nytimes.com, September 2, 2007.

[14] *Ibid.*

[15] *Supra,* Moore Statement, pp. 6-7.

[16] Stephen Labaton, "Bigger Budget? No, Responds Safety Agency," *The New York Times*, nytimes.com, October 30, 2007.

[17] Annys Shin, "Consumer Safety Panel Powers to Diminish: Much Authority to Be Lost As Temporary Quorum Ends," *Washington Post,* Washingtonpost.com, February 2, 2008.

Additionally, the acting chairperson and the remaining commission member are at odds over the direction of the commission and have taken opposing stances on the proposed legislative reforms.[18] The lack of a quorum has implications for the commission's ability to act. It will delay the process of adopting new safety standards, and will deprive the agency of the power to push for faster establishment of voluntary standards, according to consumer advocates.[19] Additionally, two resolutions (HR 804 on November 6, 2007 and HR 819 on November 13, 2007) have been introduced in the House expressing a loss of confidence in the acting chairperson's ability to lead the organization, and requesting that the President request her resignation.

Overall, the commission is working under diminished capacity in terms of manpower, technical resources and leadership. Its ability to adequately deal with child safety issues is seriously in question. Such concerns may ultimately put additional pressure on the states to address child safety matters on their own.

[18] *Supra*, note 5.
[19] *Supra*, note 6.

THE ABILITY OF THE COMMONWEALTH TO REGULATE CONSUMER PRODUCT SAFETY: MANDATORY WARNING LABELS ON FURNITURE

In the final resolved clause of House Resolution 357 (2005), which established the Joint State Government Commission's Task Force on Child Safety, the task force was directed as follows:

> RESOLVED, That the final report shall contain findings and recommendations to achieve this goal, including, but not limited to, the following subjects:
>
> * * *
>
> (6) Feasibility of laws making it mandatory that warning labels be applied to all assembled and ready-to-assemble furniture.

For the General Assembly to mandate warning labels on furniture, the legislation must pass two hurdles: (1) the proposed law may not be preempted by the federal Consumer Product Safety Act; and (2) the proposed law may not impose an impermissible burden on interstate commerce in violation of the Commerce Clause found in Article I, Section 8, Clause 3 of the United States Constitution.

Preemption by the federal Consumer Product Safety Act

Section 7 of the Consumer Product Safety Act (CPSA), 15 U.S.C. §2056, authorizes the CPSC to issue consumer product safety standards. It states that a consumer product safety standard may consist of performance requirements and/or requirements that a consumer product be marked with or accompanied by clear and adequate warnings or instructions, or requirements respecting the form of warnings or instructions. It further adds that any requirement must be "reasonably necessary to prevent or reduce an unreasonable risk of injury associated with such product." In addition to being authorized to promulgate its own consumer product safety standards, the CPSC is also authorized to rely upon voluntary consumer product safety standards "whenever compliance with such voluntary standards would eliminate or adequately reduce the risk of injury addressed and it is likely that there will be substantial compliance with such voluntary standards."

When a federal standard has been established and is in effect, states may not impose any requirements as to performance, composition, contents, design, finish, construction, packaging or labeling of a product unless they are identical to the requirements of the Federal standard.[20]

Exemptions from preemption may be granted on a case-by-case basis to a state or political subdivision under 15 U.S.C. §2075(a) if the standard or regulation (1) provides a significantly higher degree of protection and (2) does not unduly burden interstate commerce. The CPSC must make findings as to whether the proposed standard or regulation unduly burdens interstate commerce based on the following criteria: the technological and economic feasibility of complying with the standard, the cost of complying with the standard, the geographic distribution of the consumer product to which the standard would apply, the probability of other states or political subdivisions applying for an exemption for a similar standard and the need for a national, uniform standard under the CPSA for the consumer product.[21] Regulations governing applications for exemptions are found at 16 CFR Part 1061 and require additional information regarding the burden on interstate commerce.

The CPSC does not currently provide for mandatory or voluntary consumer product safety standards relative to the tip over of children's furniture. Instead, it relies on voluntary industry standards. Currently, three industry standards exist governing some types of furniture. Underwriters Laboratories, Inc. has promulgated two furniture standards that include requirements relative to strength and stability of the products in question:[22]

- *UL 1678, the Standard for Household, Commercial and Professional Use Carts and Stands*[23]. This standard governs carts and stands for use with radio, television and video equipment, information technology equipment, and kitchen appliances and similar loads.

- *UL 1667, Tall Institutional Carts for use with Audio, Video and Television-Type Equipment*[24]. This standard governs carts intended for use with audio-visual products in schools, hospitals and other institutional settings.

[20] 15 U.S.C. §2075(a).
[21] 15 U.S.C. §2075(c).
[22] http://www.ul.com/av/carts.html (July 24, 2006)
[23] http://ulstandardsinfonet.ul.com/scopes/1678.html (July 24, 2006)
[24] http://ulstandardsinfonet.ul.com/scopes/1667.html (July 24, 2006)

ASTM (originally known as the American Society for Testing and Materials) International's *Active Standard F2057-04 Standard Safety Specifications for Chests, Door Chests and Dressers*[25] addresses some, but not all potential tip-overs:

> 1.1 This safety specification is intended to reduce injuries and deaths of children from hazards associated with tip over of clothing storage units.
>
> 1.2 This safety specification covers chests, drawer chests, chests of drawers, dressers, and bureaus only (see Section 2).
>
> 1.3 This safety specification does not cover shelving units, such as bookcases or entertainment centers, night stands, or under-bed drawer storage units.
>
> 1.4 This safety specification does not cover any items 30 in. or less in height.
>
> 1.5 This safety specification is intended to cover children up to and including age five.
>
> 1.6 This safety specification replaces PS 110-98.
>
> 1.7 The following safety hazards caveat pertains only to the test procedure portion, Section 4, of this safety specification: *This standard does not purport to address all of the safety concerns, if any, associated with its use. It is the responsibility of the user of this standard to establish appropriate safety and health practices and determine the applicability of regulatory limitations prior to use.[emphasis supplied*

Thus, in the case of furniture tip over, no federal mandatory standard has been established, and voluntary industry standards cover only a fraction of potential items of furniture that could tip over.

Additionally, Article VI, Clause 2 of the United States Constitution provides that "This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." This provision, known as the Supremacy Clause, reflects the concept

[25] ASTM F2057-04 "Standard Safety Specifications for Chests, Door Chests and Dressers," ASTM International. For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For Annual Book of ASTM Standards volume information, refer to the standard's Document Summary page on the ASTM website. ASTM also has a standard for toy chests, ASTM F834-84 "Consumer Safety Specification for Toy Chests," ASTM International.

of federal preemption whereby state laws are invalidated that interfere with or are contrary to federal law.

State health and safety regulations generally are protected from preemption. The presumption is "that state or local regulation of matters related to health and safety [are] not invalidated under the Supremacy Clause." Additionally, a person challenging a state safety regulation under the Supremacy Clause must "present a showing of implicit pre-emption of the whole field, or of a conflict between a particular local provision and the federal scheme, that is strong enough to overcome the presumption that state and local regulation of health and safety matters can constitutionally exist with federal regulation." *Hillsborough County v. Automated Med. Laboratories, Inc.* 471 U.S. 707, 715, 716 (1985).

Thus, under the preemption provisions of the Consumer Product Safety Act and the Supremacy Clause of the U.S. Constitution, Pennsylvania should be able to proceed with legislation mandating furniture safety labeling without fear of being federally preempted. However, the next hurdle - potentially violating the interstate commerce clause - suggests proceeding with caution.

Interstate Commerce Clause

Article I, Section 8, Clause 3 of the United States Constitution provides that "The Congress shall have power: To regulate Commerce with foreign Nations, and among the several States, . . ."

A negative or "dormant" Commerce Clause has been described as the converse of the power granted in Article I, Section 8, Clause 3, to the effect that it limits the power of states to regulate interstate trade by discriminating against or unjustifiably burdening interstate commerce.

The dormant Commerce Clause uses a strict scrutiny test and a balancing test. Strict scrutiny applies if a statute or regulation facially discriminates against interstate commerce by creating local economic protectionism. Under this test, simple economic protectionism is subject to a virtually per se rule of invalidity under the Commerce Clause, unless the state or local government can prove that the statute or regulation advances a legitimate local public purpose and that there are no discriminatory alternatives available to adequately meet the local need. Under the balancing test, where a statute does not discriminate against interstate commerce on its face or in its practical application, it is intended to effectuate a legitimate local public interest, and its effect on interstate commerce is incidental, the statute will be considered constitutional unless the burden imposed on interstate commerce is clearly excessive in relation to the putative local benefits. Several Pennsylvania cases have summarized this analysis of the dormant Commerce Clause and the strict scrutiny and balancing tests, and their application in particular situations. These include: *Cloverland-Green Spring Dairies v. Pa. Milk Marketing Bd.*, 462 F.3rd 249 (C.A. 3rd, 2006); *Kerbeck Cadillac Pontiac, Inc.v State Bd.*

of Vehicle Manufacturers, Dealers and Salespersons, 854 A.2d 663 (Pa. Commw. Ct. 2004); *Crown, Cork & Seal: in re: Asbestos Litigation*, 2002 WL 1305991 (Pa. Com. Pl.), 59 Pa. D&C 4th 62, *Annenberg v. Commonwealth*, 757 A.2d 333 (Pa. 1998); *Indianapolis Power & Light Co. v. Pennsylvania Public Utility Commn.*, 711 A.2d 1071 (Pa. Commw. Ct. 1998); *Empire Sanitary Landfill, Inc. v. Pennsylvania Dept. of Envtl. Res.*, 684 A. 2d 1047 (Pa. 1996); and *Philadelphia Sch. Dist. v. Pennsylvania Milk Marketing Bd.*, 683 A.2d 972 (Pa. Commw. Ct. 1996).

Additionally, the permissible level of burden will depend on the nature of the local interest and whether it could be accomplished in a different way that would have a lesser impact on interstate commerce.[26]

It seems clear that mandating warning labels on furniture does not create economic protectionism, and thus any such potential legislation should not be subject to the strict scrutiny test. Instead, the balancing test would be applied and any proposed legislation must:

- not be facially discriminatory against interstate commerce;
- not discriminate against interstate commerce in its practical application; and
- effectuate a legitimate local public interest.

A large number of commerce clause challenges to state and local laws involve efforts to promote local health and safety under the police powers of the state. State statutes requiring labels on food products account for the bulk of these cases, with courts approving or invalidating a particular statute based on the purpose, wording and effect of the provision in question.

In general, statutes involving adulterated or imitation food products, or requiring disclosure of weights, measures, or contents have withstood constitutional scrutiny. Laws governing dairy products, in particular, have largely been found constitutional. Conversely, requiring labels as to the origins of a product (domestic or imported) has been regularly struck down.

Statutes purporting to protect the health and safety of a state's citizens usually pass constitutional muster. However, the U.S. Supreme Court has held that "the incantation of a purpose to promote the public health or safety does not insulate a state law from Commerce Clause attack. Regulations designed for that salutary purpose nevertheless may further the purpose so marginally, and interfere with commerce so substantially, as to be invalid under the Commerce Clause." *Kassel v. Consolidated Freightways Corp. of Del.*, 450 U.S. 662, 670 (1981).[27] (Case involved Iowa statute regulating double tractor-trailers). In a case involving regulation of hazardous waste transportation, Pennsylvania Commonwealth Court states "Where, as here, a state's attempt to regulate in the field of health and safety allegedly creates an impact on

[26] 79 A.L.R. Fed. 246, pg. 7.

[27] Cited as recently as 2006 in *U.S. v. Manning*, 434 F.Supp.2nd 988 (E.D. Wash. 2006).

interstate commerce, we must balance the purpose to be served by the regulation against the type and the force of its impact on interstate commerce." *Chemclene Corp. v. Pennyslvania Dept. of Envtl. Res.*, 497 A.2d 268, 274 (Pa. Commw. Ct. 1985).

The interstate commerce clause has been interpreted as deferential to state regulations governing health and safety as a legitimate expression of a state's police power. However, that deference is not absolute. A state statute that does not differentiate between goods produced in Pennsylvania and those produced in other jurisdictions, if challenged, would be subject to the balancing test. Careful drafting to minimize any incidental effect on interstate commerce, and crafting the requirements as narrowly as possible should allow a statute requiring warning labels on furniture to meet any constitutional challenges.

RECOMMENDATIONS

The child safety advisory committee considered many ideas to combat unintentional child injuries and deaths in the home. There was agreement among the members that best efforts necessarily will include educating the public on the issue of child safety, making child safety initiatives a priority at the State level, increasing and maintaining adequate funding for child safety efforts, and delivering succinct messages that will resonate with, and be remembered by, parents and the public at large. After reviewing the data, as well as the programs currently in place in Pennsylvania and in other states and nations, the committee reached consensus on the recommendations that follow.

1) Create a Child Safety Advocate position within the Pennsylvania Department of Health.

The advisory committee considered Sweden's success in the area of child safety and noted Sweden's decision, at the national level, to make child safety a matter of top priority.[28] Realizing that its recommendations in such a regard could best be achieved by urging the General Assembly to adopt a similar approach at the State level, the advisory committee thought it imperative that Pennsylvania make the reduction of unintentional childhood injuries and deaths in the home a State priority. The advisory committee made a series of recommendations to achieve that end. However, in order to spearhead and drive the issue of child safety, the advisory committee sought to mirror Sweden's creation of an Ombudsman for child safety. Again, while Sweden implemented this position at the national level, the advisory committee decided that a similar approach should be taken by Pennsylvania at the state level. The title "Child Safety Advocate," rather then "Ombudsman," was selected for this position so as not to imply that this individual/entity would be limited in function solely to receiving and resolving complaints. The advisory committee further recommends that the Child Safety Advocate be provided with sufficient staff support and that he report directly to the Secretary of the Department. The Child Safety Advocate will also work with other relevant Commonwealth agencies (including the Department of Education and the Department of Public Welfare) and local agencies (as determined by the Child Safety Advocate) to lead and coordinate efforts, as part of a comprehensive child safety strategy for Pennsylvania.

[28] European Environment and Health Committee at http://www.euro.who.int/eehc/implementation/20060713_1, updated July 2006.

The advisory committee envisions the Child Safety Advocate as the entity which will implement many of its other recommendations. However, if the General Assembly does not choose to create a Child Safety Advocate, the advisory committee recommends that the Department of Health's Violence and Injury Prevention Program, in the Bureau of Health Promotion and Risk Reduction, be charged with implementing the recommendations which were otherwise intended to fall within the ambit of the Child Safety Advocate.

2) **Create a multidisciplinary commission on child safety (or utilize a currently existing commission such as the Governor's Commission for Children and Families and expand its scope and membership accordingly) to assist the Child Safety Advocate in identifying child safety issues in Pennsylvania.**

This recommendation is made with the intent of supporting the Child Safety Advocate's overall efforts. The advisory committee envisions this support as a means for supplementing the Child Safety Advocate's day-to-day efforts in responding to emerging child safety issues throughout the Commonwealth. The purpose of the commission would be to identify issues of local concern and to develop a system for rapid notification to healthcare providers and other germane individuals and entities within an affected region so that a new or emerging problem can be addressed as immediately and effectively as possible.

3) **Improve data collection on child safety related deaths and injuries in Pennsylvania. This may include efforts to secure more reporting on childhood injuries from emergency rooms and physicians' offices and collaborating with Child Death Review teams throughout the Commonwealth.**

All 67 counties in Pennsylvania are actively involved in Child Death Review (CDR). This program focuses its efforts on understanding the circumstances surrounding child deaths, through multidisciplinary, systematic, and timely reviews. The teams collect data and work on prevention strategies that help prevent future child injury and death. Each county has a network of professionals in place who are dedicated to issues dealing with the health of children. CDR currently collects aggregate data on circumstances surrounding childhood injury deaths.

Although there is currently significant data available, there are some gaps in the effort to collect information on child injuries, especially in regard to injuries treated in hospital emergency rooms and in physicians' offices. The advisory committee noted that there would be a challenge associated with developing a more comprehensive data collection system, in part due to the cost of collecting this additional data and the risk that State requirements to track and report this information could result in an unfunded mandate on hospitals and other affected healthcare providers. However, the committee reached consensus on the value of attempting to gather such information and

recommends that the Department of Health develop the means for doing so. The advisory committee envisions this task as one of the duties of the Child Safety Advocate and recommends that the Child Safety Advocate be charged with carrying out this recommendation and with identifying, and advocating for, the funding source(s) for it. Regardless of whether a Child Safety Advocate or the Department's Bureau of Health Promotion and Risk Reduction is ultimately charged with this responsibility, the advisory committee intends that the designated individual/entity be cognizant of the burden of imposing additional requirements on healthcare providers and recommends that said entity/individual refrain from recommending or promoting a system which would represent an unfunded mandate.

In addition, the advisory committee noted the potential concern about privacy, which may be attached to this additional information, and acknowledges that the Child Safety Advocate, or entity ultimately charged with this task, will need to be cognizant of legal and ethical concerns which may limit the gathering of certain types of information.

4) Establish a clearinghouse for leading issues in child safety and for issues of immediate concern and disseminate such information to the counties, localities, and private health practitioners as practicable.

The advisory committee recommends that the Department of Health serve as a clearinghouse for child safety information and emerging issues in Pennsylvania and that it lead the effort to communicate new and emerging issues to affected localities as expeditiously as possible. Again, the advisory committee envisions the Child Safety Advocate leading this effort and envisions the Child Safety Advocate and his staff serving as first responders in regard to new and emerging child safety issues throughout the Commonwealth. As in-home threats to child safety begin to be identified by healthcare providers in a particular area and reported to the Child Safety Advocate's office directly or through members of the child safety commission recommended above, it is expected that the Child Safety Advocate will work with the affected region on tactics to mitigate the problem before it becomes widespread. The committee believed that the Child Safety Advocate's approach in establishing this function could take many possible forms but that rapid communication of a problem that has developed, or is developing, is critical. Ultimately, the advisory committee defers to the Child Safety Advocate on the best approach in such situations and notes that the Child Safety Advocate should be engaged in ongoing communication and public relations efforts to thwart unintentional, household child deaths and injuries Statewide. The advisory committee noted that public education and communication are key components of any safety campaign, as well as any continuing safety efforts, and sees the Child Safety Advocate, with the assistance of the child safety commission, as the cornerstone of these initiatives.

Just as the issue of in-home furniture tip over led to the formation of this advisory committee, a number of committee members pointed out that other issues will arise which will benefit from rapid communication and response. One such example noted by the committee is the continuing concern over unsafe sleep practices for children under one year of age. As the statistics in this report reflect, suffocation is the leading cause of

death among children under one. This is a highly avoidable cause of death which may be better addressed through focused and targeted communication and education campaigns. This sort of focus and rapid attention could be achieved by taking the first step of establishing an information clearinghouse within the Department.

In addition, the Child Safety Advocate/Department could issue reminders from time-to-time to underscore important safety messages that may re-emerge. One such example may be a reminder to parents that they should not only be aware of safety concerns in their own homes but that they should also be cognizant of potential hazards and safety concerns in other locations in which their child/children may play or otherwise spend time.

5) Foster public-private partnerships which will improve child safety in the Commonwealth.

The Department of Health currently works with various private entities to provide child safety programs in Pennsylvania. The Department and/or Child Safety Advocate is expected to continue to work with private organizations (both non-profit and for-profit) to foster opportunities for more public-private, child injury prevention efforts. The advisory committee views such partnerships to be necessary in the effort to disseminate the child safety message to as much of the public as possible. These partnerships also represent a cost effective way to extend the message when there are many competing demands for a limited pool of available public funds. Further, many "for-profit," private entities are engaged in the sale of household products which, when used incorrectly, or without proper precautions or supervision, can be dangerous to children. Thus, the advisory committee believes it is critical that public-private partnerships be fostered and utilized to the maximum extent possible.

One specific example of a possible public-private partnership that was discussed by the advisory committee was to have the Child Safety Advocate/Department work with the Pennsylvania Department of State (as the licensing entity for real estate agents) in distributing the Katie Elise Lambert Foundation's safety checklist, which appears as an appendix to this report, to real estate agents for dissemination to their clients as part of the purchase of a new home. The intent of this recommendation is to encourage new home owners to inspect their property for potential child safety hazards and to make safety improvements as necessary.

6) Require an annual report on the status of child safety in Pennsylvania to the Children and Youth Committee in the State House of Representatives and the Aging and Youth Committee in the State Senate.

As a means of assessing the Commonwealth's level of success in reducing unintentional, household injuries to, and deaths of, children, the advisory committee recommends that the Department (or Child Safety Advocate) be required to publish an annual report and provide oral testimony on the status of child safety efforts in

Pennsylvania. This report will be a public document directed to the Children and Youth Committee of the Pennsylvania House of Representatives and to the Aging and Youth Committee of the Pennsylvania Senate and be supported by oral testimony to both of these committees. This report should include relevant data on childhood deaths and injuries as well as a comparison of Pennsylvania's data to all other states so that the General Assembly is adequately apprised of Pennsylvania's child safety ranking at the national level. The report should also include a summation of ongoing efforts by the Department/Child Safety Advocate as well as information on new programs and initiatives implemented during the prior year and projected for the coming fiscal year. This report, and the accompanying oral testimony to the House and Senate, should be made in September of each year, prior to the development and submission of the Governor's Budget for the coming fiscal year. The advisory committee recommends that the Department/Child Safety Advocate include additional information which may be useful to the General Assembly and important in the effort to achieve improved child safety as it relates to reducing unintentional household injuries and deaths.

7) Provide the necessary funding to accomplish each of the recommendations of the advisory committee contained in this report.

Throughout its deliberations, the members of the advisory committee noted that the issue of funding, including diminishing funds from the federal government, to support child safety efforts is making it more difficult to sustain good child safety programs which, in turn, brings with it the risk that there will be an increase in child injuries and deaths. While some advisory committee members pointed out that there may be creative ways to effectuate child safety programs which depend less on public funds, it was also noted that sustained, adequate funding is critical to support the various recommendations of the advisory committee which are included in this report. The advisory committee understands that funding alone is not a panacea. However, the committee believes that child safety should be a priority of the Commonwealth, and a commitment to reduce unintentional childhood injuries and deaths in the home will necessarily require a certain financial commitment. Funding must be both adequate and sustained over time. This will require a commitment from the Commonwealth to provide funding itself and to urge the federal government to increase its funding for child safety programs and initiatives. Additionally, it was not the intent of the advisory committee to propose recommendations which would result in unfunded mandates on the individual and/or entity charged with carrying out a particular recommendation or set of recommendations.

8) Urge the Pennsylvania Congressional Delegation to support increased federal funding for child safety initiatives and encourage the provision of additional funding to the states.

This recommendation is a stand alone recommendation of the advisory committee. However, the impetus for it follows the reasoning of recommendation number seven, above. Essentially, the advisory committee considers this

recommendation to be an integral part of recommendation seven above (i.e., adequate funding should be provided through a mix of state and federal dollars).

9) Urge the Pennsylvania Congressional Delegation to support federal legislation which would improve child safety, including HR 4266 ("Katie Elise and Meghan Agnes Act").

The advisory committee recommends that the General Assembly urge the Pennsylvania Congressional Delegation to support, generally, legislation to advance child safety at the federal, state and/or local levels. This would include supporting additional funding for child safety programs and initiatives as enunciated in recommendation eight above. Specifically, the advisory committee recommends that the General Assembly urge the Pennsylvania Congressional Delegation to support passage of HR 4266 introduced in the United States House of Representatives by Representative Alyson Schwartz, of Pennsylvania's 13th Congressional District, on December 4, 2007. This legislation is entitled the "Katie Elise and Meghan Agnes Act" and directs the federal Consumer Product Safety Commission to issue regulations concerning the safety and labeling of certain furniture.

10) Require child case workers to receive comprehensive training on in-home child safety and to provide information to foster and adoptive families on these issues.

The advisory committee discussed current gaps in child safety efforts and opportunities to educate parents and caretakers in order to address such gaps. As a result of this discussion, the advisory committee recommends that child case workers involved in foster care placements and adoptions receive comprehensive training on hazards in the home and ways to improve the safety of children in the home. In addition, the advisory committee recommends that these individuals be required to inform and educate prospective foster and adoptive families on in-home child safety. Appropriate supporting literature should also be developed for easy reference by these families. This recommendation should be accomplished through a joint effort of the Department of Public Welfare and the Department of Health. Assuming the creation of a Child Safety Advocate, the advisory committee envisions the Child Safety Advocate to be an integral part of any such effort.

11) Increase funding to the Department of Health to hire additional staff to focus exclusively on injuries to children and improving child safety. In addition, increase funding for the Child Death Review Program.

The advisory committee recommends that additional staffing occur with or without the creation of a Child Safety Advocate. Currently, the Department of Health is focused on preventing injuries of all kinds for all age groups. There is only one staff person devoted entirely to the issue of preventing children's injuries. In keeping with its

goal of making child safety a priority for the Commonwealth, the advisory committee recommends adding staff (appropriate level to be determined by the Department, in conjunction with the Child Safety Advocate - assuming the creation of such a position as recommended above) so that greater attention and focus can be brought to the issue of children's safety relative to the causes of accidental injury and death.

In addition, Child Death Review (CDR) currently is funded through grant monies from the Departments of Health and Public Welfare and administered by the Pennsylvania chapter of the American Academy of Pediatrics. When CDR started in Pennsylvania, there were no local teams involved with the program. Over the past ten years, CDR has been able to achieve participation from all 67 counties in Pennsylvania. Currently there are 1.2 full-time equivalent staff devoted to coordinating CDR in Pennsylvania. The advisory committee recommends that, in order to reach its full potential, CDR receive increased funding and staff to provide support for all 67 counties in Pennsylvania so that it is able to improve its reviews and provide recommendations to local agencies to reduce childhood injuries and deaths. In addition, the advisory committee supports additional funding so that the CDR State team is able to coordinate meetings and prevention activities at the State level and is able to network with other states involved with CDR. Further, if a Child Safety Advocate is created by the General Assembly, he too should serve as a member of the CDR State team.

12) Require labeling of all furniture sold in Pennsylvania to include a warning about the danger of tip over and advocating the use of tethering devices.

The advisory committee recognizes the challenges which can come from a labeling requirement at the state level (as addressed previously in this report). However, the committee recommends that the General Assembly require manufacturers of household furniture to label their products with warnings about the dangers of tip over and that manufacturers also be required to warn consumers that tethering devices should be used to secure furniture in order to reduce the potential for such injury. Currently, ASTM has established voluntary standards relative to the danger of furniture tip over. However, this advisory committee was created in response to a death due to furniture tip over, and part of the specific charge of the advisory committee was to examine the issue of warning labels on furniture and to make a recommendation in this regard. The advisory committee supports voluntary efforts by manufacturers to warn their customers about tip over and to provide tethering devices to customers, but the advisory committee recommends that Pennsylvania pass legislation requiring manufacturers to affix labels to their products to warn consumers about the danger of tip over and encourage consumers to use appropriate tethering devices. The advisory committee reached consensus on the requirement of warning labels but did not offer specific language for legislation to accomplish this because it believes that the Constitutional intricacies addressed previously in this report would be best resolved in the legislative drafting process by staff with expertise in this area. However, the advisory committee urges the General Assembly to craft a bill, which can pass Constitutional muster, to carry out this recommendation.

AN ACT

Creating the office of Child Safety Advocate in the Pennsylvania Department of Health.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Creation of Child Safety Advocate.

The General Assembly hereby creates the position of Child Safety Advocate within the Pennsylvania Department of Health. The Child Safety Advocate shall report directly to the Secretary of the Department.

Section 2. Duties and Responsibilities of Child Safety Advocate.

The Child Safety Advocate is hereby charged with the duty of assessing the status of child safety efforts in Pennsylvania and working with other relevant State, local and private entities to develop programs and initiatives to improve child safety in Pennsylvania.

Section 3. Staffing and Funding.

The Child Safety Advocate is charged with working with the Secretary of the Department of Health to determine the appropriate staffing and funding levels necessary within the Department for addressing child safety and reducing child injuries and deaths in Pennsylvania.

Section 4. Data Collection and Reporting Requirements.

The Child Safety Advocate shall gather and maintain data on child injuries and death in Pennsylvania and data relative to Pennsylvania's ranking, among the fifty states and the District of Columbia, as it relates to child injuries and deaths. The Child Safety Advocate shall, annually, make a report of this data to the appropriate committees of the General Assembly prior to the preparation of the Governor's budget for the next fiscal year. The Child Safety Advocate shall also report on the efforts of his office, funding requirements, and on planned programs and initiatives for the subsequent fiscal year.

Section 5. Effective Date.

This act shall take effect in 60 days.

APPENDICES

The following pages contain a copy of House Resolution 357 of 2005 (Printer's Number 4488) that authorized the advisory committee and task force which produced this report. In addition, there is a copy of the household child safety checklist which appears on the website of the Katie Elise Lambert Foundation at www.katieeliselambert.org. Finally, there appears a chart of internet resources regarding child safety and child safety-related matters. This is provided for informational purposes only, with the hope that it is useful to those who read this report.

SENATE AMENDED

PRIOR PRINTER'S NO. 2246 PRINTER'S NO. **4488**

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 357 Session of 2005

INTRODUCED BY SHAPIRO AND BIRMELIN, JUNE 21, 2005

SENATOR WENGER, APPROPRIATIONS, IN SENATE, RE-REPORTED AS AMENDED, JUNE 30, 2005

A CONCURRENT RESOLUTION

~~Establishing the Katie Elise Lambert Commission on Child Safety in this Commonwealth.~~ <—

DIRECTING THE JOINT STATE GOVERNMENT COMMISSION TO ESTABLISH A TASK FORCE ON CHILD SAFETY. <—

WHEREAS, Sadly and suddenly, the life of three and a half-year old Katie Elise Lambert of Abington, Pennsylvania, was cruelly taken on January 21, 2005, when an unanchored wardrobe cabinet fell on top of her; and

WHEREAS, Each year, the lives of many innocent children like Katie Elise Lambert are tragically ended because of unintentional injury-related deaths; and

WHEREAS, Unintentional injuries are a major public health problem in the United States, causing an estimated 91,000 deaths each year; and

WHEREAS, In 2001, the National Center for Health Statistics placed unintentional injuries as the leading cause of death for all individuals between the ages of 1 and 34; and

WHEREAS, Unintentional injuries are responsible for more child deaths in one year than homicide, suicide, congenital anomalies, cancer, heart disease, respiratory illness and HIV combined; and

WHEREAS, The National SAFE KIDS Campaign reported that 5,526 children in the United States died from unintentional injuries in 2001. Shockingly, 45% of these deaths occurred in the home; and

WHEREAS, Unintentional injuries disproportionately affect poor children and children under the age of four; and

~~WHEREAS, The leading cause of unintentional injury-related death and disabilities, including motor vehicle crashes, residential fires, alcohol-impaired driving and falls, with very young children primarily at risk for injuries and death in the home caused by suffocation, drowning, firearms, choking, poisoning, fallen furniture and improperly secured major appliances; and~~ <--

WHEREAS, The American Association of Poison Control Centers reports that accidental death from exposure to hazardous household substances occurs mainly among children and youth; and

WHEREAS, The Consumer Product Safety Commission estimates that 8,000 to 10,000 people, predominantly children, are injured each year as the result of tipping furniture, often occurring when children climb onto, fall against or pull themselves up on items such as shelves, bookcases, dressers, bureaus, desks, chests, television stands and television sets; and

WHEREAS, It is estimated that the incidence and severity of unintentional injury-related death and disability can be reduced through a combination of education, enactment and enforcement of legislation and regulations and program evaluation; and

WHEREAS, To reduce further tragedy and lessen unintentional injury-related death and disability in this Commonwealth, current laws must be strengthened, proven strategies that have an impact on reducing unintentional injuries must be implemented in all communities, and research on this topic must continue; ~~therefore be it~~ AND <—

WHEREAS, IT IS THE INTENTION OF THE GENERAL ASSEMBLY THAT THIS TASK FORCE BE REFERRED TO AS THE KATIE ELISE LAMBERT TASK FORCE ON CHILD SAFETY; THEREFORE BE IT

~~RESOLVED, (the Senate concurring), That the General Assembly establish the Katie Elise Lambert Commission on Child Safety; and be it further~~ <—

~~RESOLVED, That the commission consist of 18 members who shall be residents of this Commonwealth; and be it further~~

RESOLVED, (THE HOUSE OF REPRESENTATIVES CONCURRING), THAT THE GENERAL ASSEMBLY DIRECT THE JOINT STATE GOVERNMENT COMMISSION TO ESTABLISH A TASK FORCE OF FOUR MEMBERS OF THE SENATE AND FOUR MEMBERS OF THE HOUSE OF REPRESENTATIVES; AND BE IT FURTHER <—

RESOLVED, That the Speaker of the House of Representatives, Minority Leader of the House of Representatives, President pro tempore of the Senate and the Minority Leader of the Senate shall each appoint ~~four~~ TWO members to the commission; and be it further <—

~~RESOLVED, That of the members to the commission appointed by the Speaker of the House of Representatives, one shall be the Chairman of the Children and Youth Committee of the House of Representatives or the chairman's designee; and be it further~~ <—

~~RESOLVED, That of the members to the commission appointed by the Minority Leader of the House of Representatives, one shall be the Minority Chairman of the Children and Youth Committee of~~

~~the House of Representatives or the chairman's designee; and be it further~~

~~RESOLVED, That of the members to the commission appointed by the President pro tempore of the Senate, one shall be the Chairman of the Aging and Youth Committee of the Senate or the chairman's designee; and be it further~~

~~RESOLVED, That of the members to the commission appointed by the Minority Leader of the Senate, one shall be the Minority Chairman of the Aging and Youth Committee of the Senate or the chairman's designee; and be it further~~

~~RESOLVED, That the members of the commission appointed by the Speaker of the House of Representatives, Minority Leader of the House of Representatives, President pro tempore of the Senate and the Minority Leader of the Senate shall include, if possible,~~

RESOLVED, THAT THE TASK FORCE BE AUTHORIZED TO CREATE AN <—
ADVISORY COMMITTEE TO ASSIST THE TASK FORCE, TO INCLUDE a parent or representative of a child severely injured or deceased due to an unintentional injury-related death or disability; a board-certified pediatrician acquainted in matters regarding unintentional injury; a member of a county child death review team; a child safety advocate whose work promotes the prevention of childhood injury; and a product and safety expert in the manufacturing industry; and be it further

~~RESOLVED, That the Governor shall appoint two members to the~~ <—
~~commission who have an interest in child safety and one of the members shall be the Secretary of Health or the Secretary's designee; and be it further~~

~~RESOLVED, That the members of the commission be appointed within 15 days of the date of the adoption of this resolution;~~

~~and be it further~~

~~RESOLVED, That the Speaker of the House of Representatives call the initial meeting of the commission within ten days of the appointment of the members, at which meeting the members of~~

RESOLVED, THAT THE MEMBERS OF the commission shall elect from <—
their membership a chairman; and be it further

RESOLVED, That the commission may hold hearings, take testimony and make its investigations at such places as it deems necessary within this Commonwealth and that each member of the commission shall have the power to administer oaths and affirmations to witnesses appearing before the commission; and be it further

RESOLVED, That the members of the commission shall receive no compensation for their services but shall be allowed their actual and necessary expenses incurred in their capacity with the commission; and be it further

~~RESOLVED, That the commission be provided staff support by the Joint State Government Commission; and be it further~~ <—

RESOLVED, That the commission prepare and submit to the House of Representatives, the Senate and the Governor a report of its findings no later than ~~November 30, 2006~~ MARCH 31, 2007; and be <—
it further

RESOLVED, That the purpose of the final report shall be to review existing Pennsylvania laws and regulations to determine their impact on preventing unintentional injuries and recommend reforms and policy proposals to strengthen existing laws and regulations to reduce preventable deaths; and be it further

RESOLVED, That the final report shall contain findings and recommendations to achieve this goal, including, but not limited to, the following subjects:

(1) Statistics outlining the primary causes of unintentional injury-related deaths and disabilities to children.

(2) Individual behaviors and practices that can reduce the risk of childhood injuries and make others aware of possible injury hazards in the home.

(3) Recommendations to raise the awareness to parents and other concerned citizens of the looming threat of unintentional injuries to their children.

(4) Suggestions pediatricians and other health care providers can provide to patients during routine health visits regarding safety practices in their homes to prevent unintentional injuries.

(5) Information on the cost-effectiveness of strategies to reduce injuries to children to better inform public debate on the merits of these interventions.

(6) Feasibility of laws making it mandatory that warning labels be applied to all assembled and ready-to-assemble furniture.

In Memory of Katie Elise Lambert
A Child Safety Check List
www.katieeliselambert.org

	Ok	Repair	Replace
Bedrooms			
Furniture; No matter what size, anchor to wall. All anchors should be into a stud. Furniture of all heights can tip over.			
Window guards to prevent child from falling out window.			
Electrical outlets should have protective covers to prevent children from inserting objects into outlets.			
Blind and curtain cords shortened so they can not be reached when open and used to hang from.			
Doors with locks MUST have key near by or install door handle without lock.			
Electric cords plugged into outlets should have protective covers over them.			
Window locks present and working.			
Never sleep with children or infants in your bed (or sofa.			
Infants Room in addition to above			
Up to date safe furniture (no recalls, yards sales etc.).			
Crib slats not more then 2 3/8 inches maximum gap.			
Old furniture should be tested for lead paint.			
Changing tables should have guard rails and safety straps for securing infants in place.			
Adjustable crib mattress to get lowered as children can stand.			
Firm mattresses recommend so child can not get face trapped between mattress and crib.			
Flame retardant sleepwear, blanks etc.			
Check all objects for choking hazard. If they can fit into a toilet paper core then child can choke on it.			

	Ok	Repair	Replace
Soft bedding materials such as pillows and comforters and other objects should not be used in the crib.			
Furniture: No matter what size furniture anchor it to the wall. Anchors should be into a stud.			
Remove crib bumpers when children can pull themselves up in the crib.			
Bathrooms			
Toilet locks to prevent small children from falling in the toilet and drowning.			
Lock all medicines.			
Cabinet lock where cleaners are stored.			
Hot water controls (105-125 degrees): anti scalding devices on tubs, showers etc.			
GFIC (Ground Fault Intercept Circuits) in all outlets in bathrooms.			
If door has lock, key must be close by or change door handle not to have a lock.			
Blind and curtain cords shortened.			
Never leave children alone in the tub, not even to answer the phone.			
Never leave children in tub rings devices alone in the tub.			
Tub spout covers.			
Tub slip mat.			
Bathroom floor mat to prevent slipping on wet floors.			
ALWAYS test bath water first with wrists or elbow in several areas. Temperatures are different throughout.			
Keep children away from hot blow dryers, curling irons etc.			

	Ok	Repair	Replace
Halls, Railings and Steps			
All outlets with covers to prevent objects from being inserted.			
Railings properly secured.			
Balusters on railings not more then 4-5 inches apart.			
Baluster netting to prevent small children from fitting between the balusters.			
No objects on steps.			
Stair guards (gates) to prevent access to steps.			
Kitchen			
Drawer and cabinet locks.			
Locks on knife drawers.			
Knifes and sharp objects ALWAYS pointing down in dishwasher.			
Lock on refrigerators and freezers doors.			
GFIC (Ground Fault Intercept Circuits) on all outlets.			
Oven door locks.			
Never leave hot ovens or stove tops unattended.			
Pot handles always facing in so children can not pull them down.			
Anti-tipping devices on stoves/ovens.			
Corner guards on tables.			
Window locks.			
Phone cords shortened so they can not be used to hang from.			
High chairs with proper straps so children do not slip down and get their necks caught on the lower strap.			
Never leave children alone in a high chair			
Never let children play with or use toasters, heaters etc.			
Never let children eat alone.			
Keep plastic bags locked and away from children.			

	Ok	Repair	Replace
Living Rooms and Dinning Rooms			
Furniture anchored to a stud in the wall no matter what height of furniture.			
Corner guards on all tables.			
Glass inserts on tables should be tempered glass.			
Objects on table tops can be pulled down by children.			
Keep TV's pushed as far back on the stand/cabinet as possible.			
Outlets with covers to prevent objects from being inserted.			
Laundry Rooms, Utility Rooms			
Hot irons never left unattended.			
Irons never left (even if cool) on ironing board.			
Laundry detergent and chemicals locked away.			
Children should not have access to the washer and dryer. Could get locked inside.			
Buckets: can be used to climb and if children fall into buckets they might not be able to get themselves out. It takes approximately 2 inches of water to cause a child to drown.			
Playrooms			
Toy chest should have a safety latch to keep the lid from falling on the children.			
Check all toys for proper age and chocking hazards.			
Outlets with covers to prevent objects from being inserted.			
Ensure that older children's toys are not accessible to smaller children.			

	Ok	Repair	Replace
Miscellaneous			
Smoke detectors present and working.			
Carbon monoxide detectors present and working.			
Home fire drills.			
Door Alarms.			
Lower water temperature on hot water heater if anti-scalding devices are not in place.			
Rodent poisons out of reach of children in any area of the house.			
Never leave children unattended in highchairs, swings, playpen, play yard, etc.			
Ensure that children can not get behind radiators.			
Check the type of plants that are in the house to ensure they are not poisonous if eaten.			
Bikes, skate boards, roller blades etc: Ensure that children have proper helmets, wrist guards, knee and elbow pads.			
Never leave ladders unattended around children.			
Never let children into unfinished attics. Children can step off of the floored areas and fall through the ceilings. Roofing nails protrude through the roof sheathing and can cause puncture wounds to the head.			
Firearms and Hunting Equipment			
Firearms: trigger locks or proper locking devices to prevent children from being able to operate.			
Firearms stored separate from ammunition.			
Hunting knifes stored out of reach of children.			
Fishing hooks and knifes stored out of reach of children.			
Pools and Hot tubs			
Pools gates locked.			
Pool covered with proper protective covers.			

	Ok	Repair	Replace
Children never left alone in or near any size pool			
Proper life vest for children in pools.			
Pool water movement alarms. (see local pool store)			
Pool ladders locked or raised when not in use.			
Keep hot tubs covered and secured.			
Garages			
Locked so children can not wonder unattended.			
Power tools out of reach.			
Power tools with safety keys.			
Chemicals, gas, paint etc. out of reach of children.			
Cutting tools out of reach of children.			
Electric garage door openers should have emergency reversing systems.			
Cars			
Proper child safety seats.			
No children under 12 years old and 100 lbs in front seat.			
No child safety seat in front seat. Air bags hitting car seat can seriously injure children.			
Never leave children alone in the car.			
Always have children in car seats or seat belts.			
Before backing up a car or moving a car in a driveway WALK around and check the location for children and their toys. Children can not be seen in mirrors.			
Fireplaces			
Never leave children alone by a hot fireplace.			
Have safety screens to prevent small children from touching the hot glass doors or fire.			
Keep fireplace tools out of reach of children.			

	Ok	Repair	Replace
General Information and Concerns.			
Never let children plug in appliances or turn appliances on or off.			
Never leave children unattended.			
Learn CPR			
Remember children don't understand danger, they are curious and fast.			
Never let children play or use lights, matches etc.			
Ensure babysitters know and understand dangers to children.			
Ensure babysitters know CPR and what to do in case of an emergency.			
Phone Numbers.			
Police:			
Fire:			
Ambulance:			
Poison Control:			
Doctor:			

This is only a basic list for child safety. Not every possible situation is covered. Please add to or modify this list to fit your family needs. Practicing for emergencies is not always something you have time for. But will be something you will be thankful for if ever needed. Any question or suggestions please contact the Katie Elise Lamberts web site at www.katieeliselambert.org or call M.E.D. Home Inspection Company at 215-632-4220

Copying and reproducing this list is **ENCOURAGED.**

Tables of Internet Resources for Child Safety Information and Education[29]

TABLE I – PENNSYLVANIA ORGANIZATIONS

Organization Name	Website	Comments
Katie Elise Lambert Foundation	www.katieeliselambert.org	Furniture safety
Children's Hospital of Philadelphia, Health and Wellness Center	www.chop.edu/consumer/your_child/index.jsp	Injury prevention tips. One of seven pediatric trauma centers in Pennsylvania. Trauma Center is a Regional Resource Center, Pediatric Level I.
The Center for Injury Research and Prevention, The Joseph Stokes, Jr. Research Institute, Children's Hospital of Philadelphia	http://stokes.chop.edu/programs/injury	
The International Society for Child and Adolescent Injury Prevention (ISCAIP)	www.iscaip.net	Based at the Children's Hospital of Philadelphia, to improve the global dialogue and action for preventing and controlling child and adolescent injuries. Publishes the Injury Prevention Journal.
Children's Hospital of Pittsburgh, University of Pittsburgh Medical Center	www.chp.edu/besafe/	Injury prevention tips; printable Home Safety Handbook. One of seven pediatric trauma centers in Pennsylvania. Trauma Center is a Regional Resource Center, Pediatric Level I.
University of Pittsburgh Center of Injury Research and Control	www.circl.pitt.edu	One of the national injury centers funded by the NCIPC. Sponsors the Injury Control Resource Information Network (www.injurycontrol.com/icrin)
Geisinger Health System, Janet Weis Children's Hospital at Geisinger Medical Center	www.geisinger.org/consumers/services/emergency/trauma.html	Provides community injury prevention programs. One of seven pediatric trauma centers in Pennsylvania. Trauma Center is a Regional Resource Center with Additional Qualifications in Pediatric Trauma, Level I AQ. Located in Danville.
Milton S. Hershey Medical Center, Penn State University, Injury Prevention Program	www.hmc.psu.edu/pediatrictrama/injury	Safety tips and community education programs. Offers child safety tips. One of seven pediatric trauma centers in Pennsylvania. Trauma Center is a Regional Resource Center with Additional Qualifications in Pediatric Trauma, Level I AQ. Located in Hershey.
Lehigh Valley Hospital and Health Network	www.lvh.org/healthyyou/Raising_a_Family	Offers child safety tips. One of seven pediatric trauma centers in Pennsylvania. Trauma Center is a Regional Resource Center with Additional Qualifications in Pediatric Trauma, Level I AQ. Located in Allentown.
St. Christopher's Hospital for Children	www.stchristophershospital.com/CWS/ChildrenHealthInfo.aspx	Household safety checklist and other information relating to safety and injury prevention. One of seven pediatric trauma centers in Pennsylvania. Trauma Center is a Regional Resource Center, Pediatric Level I. Located in Philadelphia.

[29] The National Center for Injury Prevention and Control, under the administration of the U.S. Department of Health and Human Services' Centers for Disease Control and Prevention provides educational materials and information relating to unintentional injuries through the Division of Unintentional Injury Prevention which tracks trends, conducts research to better understand risk factors, and evaluates interventions to prevent these injuries. Research and prevention programs focus on two categories of unintentional injury: motor vehicle-related injuries and home and recreation related injuries. One valuable resource of this agency is a list of injury-related websites, from which many of these websites referenced in these tables were drawn. See http://www.cdc.gov/ncipc/injweb/websites.htm The NCIPC also publishes the Journal of Injury Prevention.

Table I – continued

Organization Name	Website	Comments
Temple University Health System, Temple University Hospital	www.health.temple.edu/tuh	Trauma Center is a Regional Resource Center with Additional Qualifications in Pediatric Trauma, Level I AQ. Located in Philadelphia.
Pennsylvania Department of Health, Injury Prevention Program	www.dsf.health.state.pa.us/health/cwp/view.asp?a=174&Q=197949&healthPNavCtr	
American Trauma Society, Pennsylvania Division	www.atspa.org/programs.htm	Provides numerous free community safety programs, including Neighborhood Safety Day Camps. Located in Mechanicsburg.
Pennsylvania Chapter of American College of Emergency Physicians	www.paacep.org/Healthcare.htm	Health and safety tips. Located in Harrisburg.
Pennsylvania Chapter of American Academy of Pediatrics	www.paaap.org/index.php	Several programs- Child Death Review Project, Traffic Injury Prevention Project (TIPP)

TABLE II – FAMILY AND CONSUMER-DRIVEN ADVOCACY GROUPS

Organization Name	Website	Comments
American Red Cross, Health and Safety Services	www.redcross.org/services/hss/lifeline	
Bicycle Helmet Safety Institute	www.bhsi.org	The institute is the helmet advocacy program of the Washington (D.C.) Area Bicyclist Association. This website provides links to standards, recalls and laws relating to bike helmets.
Brain Injury Association of America	www.biausa.org	
Center for Environmental Health	www.cehca.org	Advocacy group providing information about toxic chemicals.
Crash Survivors Network	www.crashsurvivorsnetwork.org	Provides information about vehicle safety and injury prevention. Affiliated with the Crash Safety Center at Kettering University (Flint, Michigan).
Consumer Federation of America	www.consumerfed.org	Advocacy group lobbying Congress on numerous issues. Opposed the appointment of Michael Baroody as chairman of CPSC (Press release dated April 26, 2007
Consumers Union	www.consumersunion.org	Independent, nonprofit testing and information organization serving only consumers. Frequent testimony before Congress on product safety issues. Publishes Consumer Reports magazine and www.ConsumerReports.org
Family Caregiver Alliance, National Center on Caregiving	www.caregiver.org	
Foundation for Spinal Cord Injury Prevention, Care & Cure	www.fscip.org	
International Consumer Product Health and Safety Organization	www.icphso.org	Advocacy organization dedicated to the health and safety issues related to consumer products manufactured and marketed in the global marketplace. ICPHSO sponsors both annual and regional workshops. These workshops serve as training programs to inform and educate manufacturers, importers, distributors, retailers, and others of their product safety responsibilities.
Kids In Danger	www.kidsindanger.org	Advocacy group - resources about children's product safety including information on recalled products, descriptions and pictures of dangerous products, child advocacy, federal and state legislative activities.
Meghan's Hope	www.meghanshope.org	Furniture safety
Mikey's Furniture Safety Foundation	www.mikeysfoundation.org	Furniture safety
National Organizations for Youth Safety	www.noys.org	Coalition of 40+ nonprofit organizations and federal agencies.

TABLE II – continued

Organization Name	Website	Comments
National Program for Playground Safety	www.uni.edu/playground	Based at the University of Northern Iowa – receives funding from the CDC
National Safe Kids Campaign	www.safekids.org	Based at Children's National Medical Center, Washington, D.C. Most states have a statewide SafeKids organization.
National Safety Council	www.nsc.org	
National Youth Sports Safety Foundation	www.nyssf.org	
Prevent Blindness America	www.preventblindness.org	
Public Citizen	www.citizen.org	Founded by Ralph Nader – primarily concerned with child safety in automobiles
SafeAmerica Foundation	www.safeamerica.org	Safety tips found at www.safeamerica.org/st_kids.htm
Saferparks	www.saferparks.org	Amusement park and carnival ride safety. In July, 2006, the organization issued a proposal for National Child Safety Standards for Amusement Rides.
SafeUSA	www.safeusa.org	Located at the Johns Hopkins Center for Injury Research and Policy
U.S.PIRG – state affiliate PennPIRG	www.pennpirg.org	Association of public interest research groups (PIRG). Information about product safety, including toy safety and playground safety.

TABLE III– INDUSTRY-BASED GROUPS

Organization Name	Website	Comments
American Home Furnishings Alliance	www.findyourfurniture.com/caresafety.html	
American National Standards Institute	www.ansi.org	Coordinates development and use of voluntary consensus standards.
ASTM International	www.astm.org	Product standards
Farm Safety 4 Kids	www.fs4jk.org	Based in Iowa, primarily supported by agri-business related companies.
Home Safety Council	www.homesafetycouncil.org	Provides safety tips for all types of home products, and a child safety checklist at www.homesafetycouncil.org/safety_guide/safetyguide.aspx
International Association for Child Safety	www.iafsc.org	Childproofing industry
International Organization for Standardization	www.iso.org	The ISO is a federation of national standards organizations of over 150 countries that develops international standards for business and government. The ISO's revised Guide 50, Safety aspects – Guidelines for child safety, provides guidance on preventing child injuries. A description of the Guide can be found at http://www.iso.org/iso/en/commcentre/isobulletin/articles/2002/pdf/childinjury02-12.pdf
Juvenile Products Manufacturers Association	www.jpma.org	Dedicated to promoting the industry and the safe use of juvenile products.
National Fire Protection Association	www.nfpa.org	Fire, electrical and building safety – develops safety codes and standards
National Home Furnishings Association	www.nhfa.org	Home furnishing retailers group
Toy Industry Association	www.toy-tia.org	
Underwriters Laboratories	www.ul.com	The UL website offers numerous safety tips for families. Some can be found at http://www.ul.com/consumers/child.html (Child Safety), http://www.ul.com/consumers/home.html (Room-by-Room Safety Tips), and http://www.ul.com/media/newsrel/nr051004.html (Make Your Home a Safe Haven for Young Children).

TABLE IV– MEDICAL/HEALTH PROFESSIONAL GROUPS[30]

Organization Name	Website	Comments
American Academy of Family Physicians	www.aafp.org, www.familydoctor.org	The AAFP website is geared toward practitioners, while the family doctor website is for consumers. The family doctor website provides links for parents to obtain information regarding various aspects of child safety. The American Family Physician, the journal of the AAFP, printed an article dated December 1, 2006, at pp. 1864-1869, entitled "Prevention of Unintentional Childhood Injuries."
American Academy of Neurology	www.aan.com	This website addresses brain injuries.
American Academy of Orthopaedic Surgeons and the Orthopedic Trauma Association	www.orthoinfo.aaos.org, www.ota.org	Injury prevention program. The OTA website uses the same information as the AAOS website.
American Academy of Pediatrics	www.aap.org	The AAP maintains TIPP, The Injury Prevention Program, which is an educational program for parents. Age-related safety sheets are found at www.aap.org/family/tippmain.htm. Safety related information is found under the "Health Topics" link, and seasonal safety tips can be found at http://www.aap.org/pressroom/aappr-tips.htm
American Association for the Surgery of Trauma	www.aast.org/prevent.html	
American Association of Poison Control Centers	www.aapcc.org	This website provides links for poison prevention and education, which can be found at www.aapcc.org/educatio.htm
American Burn Association	www.ameriburn.org	This website provides burn prevention information.
American College of Emergency Physicians	www.acep.org/webportal/PatientsConsumers/HealthSubjectsByTopic	Provides seasonal safety tips.
American College of Surgeons, Subcommittee on Injury Prevention and Control	www.facs.org/trauma/injmenu.html	
American Paraplegia Society	www.apssci.org	This website addresses spinal cord impairment.
American Psychological Association	www.apa.org	This website addresses mental health issues.
The American Pediatric Surgical Association	www.eapsa.org/parents/injury.cfm	
American Spinal Injury Association	www.asia-spinalinjury.org	
American Trauma Society	www.amtrauma.org	An organization of trauma teams, this group promotes prevention of trauma and improvement of trauma care.
Association for the Advancement of Automotive Medicine	www.carcrash.org	Founded by the Medical Advisory Committee to the Sports Car Club of America, this website provides information relative to motor vehicle crash injury prevention control.
Association of American Medical Colleges	www.aamc.org	An article entitled "Teaching Future Doctors About Injury Needs Integrated Approach, AAMC Report Says" can be found in the December 2005 AAMC Reporter, at http://www.aamc.org/newsroom/reporter/dec05/injury.htm

[30] Some of these organizations are included in the NCIPC list of websites, although they appear to be geared toward dealing with the aftermath of all types of childhood injuries.

TABLE IV– continued

Organization Name	Website	Comments
Association of Schools of Public Health	www.asph.org	The ASPH Injury Advisory Work Group Recommendations, finalized in March 2003, present recommendations to promote injury research and training. The can be found at http://www.asph.org/UserFiles/FINAL.doc
Child Neurology Society	www.childneurologysociety.org	
Emergency Nurses Association, Injury Prevention Institute	www.ena.org/ipinstitute	
Injury Free Coalition for Kids	www.injuryfree.org	A program of the Robert Wood Johnson Foundation, hospital-based in 37 cities, all housed in the trauma centers of their participating institutions.
Injury Prevention	http://ip.bmj.com	An international peer review journal for health professionals and others in injury prevention.
The Institute for Preventative Sports Medicine	www.ipsm.org	
KidsHealth	www.kidshealth.org/parent/firstaid_safe/ index.html	Sponsored by the Nemours Foundation Center for Children's Health Media, this link provides links to dozens of articles and information sheets relating to child safety and the prevention of unintentional injuries that has been review by physicians and other health experts.
National Association of School Nurses	www.nasn.org	
Society for Advancement of Violence and Injury Research (SAVIR)	www.savirweb.org	Membership primarily consists of the national injury centers sponsored by the CDC and representatives of various medical academic institutions.
Society for Public Health Education (SOPHE)	www.sophe.org	For health education professionals and students.
Trauma.org	www.trauma.org	TRAUMA.ORG is an independent, non-profit □rganization providing global education, information and communication resources for professionals in trauma and critical care.
ThinkFirst: National Injury Prevention Foundation	www.thinkfirst.org	A joint program of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), this website addresses brain and spinal cord injury prevention.

TABLE V – FEDERAL GOVERNMENT AGENCIES[31]

Organization Name	Website	Comments
Consumer Product Safety Commission	www.cpsc.gov	See also www.recalls.gov
National Center for Child Death Review Policy and Practice	www.childdeathreview.org	Supported by grants from the Maternal and Child Health Bureau (U.S. Department of Health and Human Services); located at the Michigan Public Health Institute. Provides services to state and local CDR teams.
U.S. Department of Health and Human Services, Administration for Children and Families	www.acf.hhs.gov	Primarily concerned with child care and child abuse and neglect.
U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Injury Data and Resources	www.cdc.gov/nchs/injury.htm	
U.S. Department of Health and Human Services, (CDC), National Center for Injury Prevention and Control	www.cdc.gov/ncipc	The regional centers for injury research are described in Table V. Additionally, there are currently 30 states participating in the Public Health Injury Surveillance and Prevention Program.
U.S. Department of Health and Human Services, Health Resources and Services Administration, Emergency Medical Services for Children	http://bolivia.hrsa.gov/emsc	
U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Child Health and Human Development	www.nichd.nih.gov	
U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion	www.healthfinder.gov/kids/	Links to various child safety sites.
U.S. Fire Administration for Kids	www.usfa.dhs.gov/kids	
U.S. National Highway Traffic Safety Administration Safety City – kids' page	www.nhtsa.dot.gov/kids	

[31] The U.S. Food and Drug Administration, the U.S. Department of Agriculture, the U.S. Environmental Protection Agency, the National Highway Transportation and Safety Administration, and the U.S. Coast Guard affect consumer safety issues.

TABLE VI – REGIONAL/STATE/LOCAL PROGRAMS

Organization Name	Website	Comments
California Department of Health Services	www.dhs.ca.gov/cdic/epic	Epidemiology and Prevention for Injury Control Branch
Center for Rural Emergency Medicine, Injury Control Research Center	www.hsc.wvu.edu/crem, www.hsc.wvu.edu/icrc	Based at West Virginia University, it is one of the national injury centers funded by the NCIPC.
Colorado Injury Control Research Center	http://psy.psych.colostate.edu/CICRC	Based at Colorado State University, it is one of the national injury centers funded by the NCIPC. It covers the Rocky Mountain Region.
Columbus Children's Research Institute, Center for Injury Prevention and Policy	www.columbuschildrens.com/ccri	Columbus, Ohio
Commonwealth of Massachusetts, Department of Public Health, Bureau of Family and Community Health, Injury Prevention and Control Program	www.mass.gov/dph/fch/injury	
Connecticut Childhood Injury Prevention Center	www.ccmckids.org/ipc	Connecticut Children's Medical Center program.
Governors Highway Safety Association	www.naghsr.org/html/stateinfo/index.html	State highway safety laws.
Harborview Injury Prevention and Research Center	http://depts.washington.edu/hiprc	Based at the University of Washington, Northwest Regional Trauma Center, Harborview Medical Center, Seattle. One of the national injury centers funded by the NCIPC.
Harvard Injury Control Research Center	www.hsph.harvard.edu/hicrc	One of the national injury centers funded by the NCIPC.
The Injury Prevention Center at Rhode Island Hospital	www.lifespan.org/services/emergency/ipc/	
The Injury Research Center at the Medical College of Wisconsin (IRC-MCW)	www.mcw.edu	One of the national injury centers funded by the NCIPC. It covers the Great Lakes Region.
Iowa Injury Prevention Research Center	www.public-health.uiowa.edu/iprc	Located at the University of Iowa. One of the national injury centers funded by the NCIPC.
The Center for Injury Research and Policy at the Johns Hopkins Bloomberg School of Public Health and the Children's Safety Center at Johns Hopkins Hospital	www.jhsph.edu//InjuryCenter	One of the national injury centers funded by the NCIPC. Home to the Children's Safety Center, a homelike environment at the children's center (hospital) where families can try a variety of home safety products, receive free personalized safety education and purchase low cost safety products such as smoke alarms and batteries, cabinet locks and latches and stair gates. Produces a replication guide entitle "The Johns Hopkins Children's Safety Center: A Replication Guide" and a promotional video, "Prescription for Safety: The Johns Hopkins Children's Safety Center" which are used to promote the center to all children's hospitals in the U.S.
The Kansas Department of Health and Environment, Injury and Disability Prevention Programs	www.kdheks.gov/idp	Produces a booklet "Preventable Childhood Injuries," accessible from the website.
Minnesota Department of Health, Injury and Violence Prevention Unit	www.health.state.mn.us/injury	

TABLE VI – continued

Organization Name	Website	Comments
National Farm Medicine Center, National Children's Center for Rural and Agricultural Health and Safety	www.marshfieldclinic.org/nfmc	Based at the Marshfield Clinic, Marshfield, Wisconsin. Designed to address injury prevention, health promotion and agricultural safety. The NCCRAHS receives funding from the National Institute for Occupational Safety and Health (NIOSH). Provides the North American Guidelines for Children's Agricultural Tasks (NAGCAT).
Nebraska Health and Human Services System, Injury Prevention Program	www.hhs.state.ne.us/hpe/injury.htm	
New York Online Access to Health	www.noah-health.org	This is an information guide, the joint product of several New York City library organizations, which provides links to resources regarding various topics, including accident prevention.
New York State Department of Health, Bureau of Injury Prevention	www.health.state.ny.us/nysdoh/research/injury/injury.htm	Injury statistics for New York State.
Oklahoma State Department of Health, Injury Prevention Service	www.health.state.ok.us/program/injury	
The San Francisco Injury Center	www.surgery.ucsf.edu/sfic	Located at San Francisco General Hospital, University of California San Francisco School of Medicine. One of the national injury centers funded by the NCIPC.
Southern California Injury Prevention Research Center	www.ph.ucla.edu/sciprc	Located at the UCLA School of Public Health. One of the national injury centers funded by the NCIPC.
State and Territorial Injury Prevention Directors' Association	www.stipda.org	
Texas Department of State Health Services Environmental EPI and Injury Surveillance Group	www.dshs.state.tx.us/injury	
UNC Injury Prevention Research Center	www.iprc.unc.edu	Located at the University of North Carolina. One of the national injury centers funded by the NCIPC.
University of Alabama, Birmingham Injury Control Research Center	www.uab.edu/icrc	One of the national injury centers funded by the NCIPC.
Virginia Department of Health, Division of Injury and Violence Prevention	www.vahealth.org/civp	
Washington State Department of Health, Office of Emergency Medical Services and Trauma System, Injury and Violence Prevention Program	www.doh.wa.gov/hsqa/emstrauma/injury	
Washington State Drowning Prevention Network	www.chmc.org/dp	Washington State Department of Health, Office of Emergency Medical Trauma and Prevention. Supported in part through grants from U.S. Department of Health and Human Services, Health Resources Administration, Emergency Medical Services for Children.

TABLE VII – U.S. EDUCATIONAL INSTITUTIONS

Organization Name	Website	Comments
Burn and Shock Trauma Institute Injury Prevention Program	www.luhs.org/depts/injprev	Loyola University. Addresses all types of injuries, not just burns and shocks.
The Center for Injury Control	www.em.emory.edu/research_public.html	Emory University
The George Washington University Center for Injury Prevention and Control	www.gwemed.edu/reagan/initiatives/cip.html	
Kentucky Injury Prevention and Research Center	www.kiprc.uky.edu	University of Kentucky
Los Angeles County Department of Health Services, Injury and Violence Prevention Program	http://phps.dhs.co.la.ca.us/ivpp	
Pedestrian and Bicycle Information Center	www.pedbikeinfo.org	University of North Carolina Highway Safety Research Center, in cooperation with the Association of Pedestrian and Bicycle Professionals. Funded by the U.S. Department of Transportation.
SafetyLit: Injury Prevention literature update	www.safetylit.org	San Diego State University Graduate School of Public Health, College of Health and Human Services.
Center for Injury Prevention Policy and Practice	www.cippp.org	San Diego State University Graduate School of Public Health, College of Health and Human Services.
SafetyPolicy	www.safetypolicy.org	San Diego State University Graduate School of Public Health, College of Health and Human Services. Information on injury prevention policy.
South Texas Injury Prevention and Research Center	http://sthrc.uthscsa.edu/stiprc/	South Texas Health Research Center, University of Texas Health Science Center at San Antonio.
University of Michigan Injury Research Center	www.med.umich.edu/em/injuryresearch/InjuryResearch.htm	
William Lehman Injury Research Center	http://surgery.med.miami.edu/williamlehman	University of Miami,/Jackson Medical Center, Ryder Trauma Center.

TABLE VIII– INTERNATIONAL/FOREIGN ORGANIZATIONS

Organization Name	Website	Comments
Alberta Centre for Injury Control and Research	www.acicr.ualberta.ca	
Australian Institute of Health and Welfare, National Injury Surveillance Unit	www.nisu.flinders.edu.au	
European Child Safety Alliance	www.childsafetyeurope.org	A program of the European Consumer Safety Association.
HealthCanada	www.hc-sc.gc.ca/cps-spc/index_e.html	Consumer product safety information.
Safe Communities Foundation	www.safecommunities.ca	
University of Otago Injury Prevention Research Unit	www.otago.ac.nz/ipru	New Zealand
Working Party on Accidents and Injuries	www.actiononinjuries.org	European Commission
World Health Organization, Department of Injuries and Violence Prevention	www.who.int/violence_injury_prevention/en	
World Health Organization Helmet Initiative	www.whohelmets.org	