



United States
CONSUMER PRODUCT SAFETY COMMISSION
Washington, D.C. 20207

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MEMORANDUM

DATE: December 5, 2000

TO : ES

Through: Sadye E. Dunn, Secretary, OS

FROM : Martha A. Kosh, OS

SUBJECT: ANPR for Portable Bed Rails, 65 FR Reg.58968,
October 3, 2000

ATTACHED ARE COMMENTS ON THE CH 01-1

<u>COMMENT</u>	<u>DATE</u>	<u>SIGNED BY</u>	<u>AFFILIATION</u>
CH 01-1	12/01/00	Mary E. Fise General Counsel	Consumer Federation of America 1424 16 th St, NW Suite 604 Washington, DC 20036
CH 01-2	12/01/00	Russ Butson Director of Product Safety	Evenflo Company, Inc. 707 Crossroads Court Vandalia, OH 45377
CH 01-3	12/04/00	Eduardo Montorro	<u>Montorro@Bellsouth.net</u>
CH 01-4	12/05/00	Rick Locker	Juvenile Products Manufacturers Assoc. 236 Rte 38 West Suite 100 Moorestown, NJ 08057



Consumer Federation of America

December 1, 2000

Office of Secretary
Consumer Product Safety Commission
Washington, DC 20207-0001

Copy of comments filed by e-mail to cpsc-os@cpsc.gov.

RE: "ANPR for Portable Bed Rails" 65 Fed. Reg. 58968, October 3, 2000

Consumer Federation of America (CFA) strongly supports promulgation by CPSC of a mandatory rule declaring certain portable bed rails to be banned hazardous substances under the Federal Hazardous Substances Act. CFA is a non-profit association of over 270 pro-consumer groups, with a combined membership of over 50 million, that was founded in 1968 to advance the consumer interest through advocacy and education.

Such a rule is necessary to address fatalities due to entrapment of children between portable bed rails and beds or between the rods or bars of the portable bed rail itself. At least 14 children have died as a result of entrapment incidents involving portable bed rails. While the Federal Register notes states that the Commission is aware of 40 non-fatal incidents (nine of which resulted in injury), we believe it is very highly likely that thousands of non-fatal incidents involving partial or temporary entrapments have occurred during the life of these products. We have been told by consumers that it is a common experience for a bed rail to slide away from the bed and for children to slide through the opening (some entrapped for a short time and others not). But for the luck of these children, they too could have died in a portable bed rail entrapment. As a product intended to be used **without adult supervision**, at night or during daytime nap periods, it is imperative that such near miss events be viewed very seriously.

It is appropriate for the Commission to move forward on this rulemaking particularly in light of the industry's failure to develop provisions in a voluntary safety standard to eliminate the entrapment risk. CFA participates in the ASTM/JPMA voluntary safety standard subcommittee for bed rails. Earlier this year, CFA made a motion at a subcommittee meeting to adopt the CPSC staff-

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CFA Comments
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drafted proposed performance requirements. The motion failed to obtain a second on the motion because CFA was the only non-industry voting member of the subcommittee present. The failure of the industry to even second the motion and allow discussion of the proposal is an indicator of the industry's committed unwillingness to address the entrapment risk through a voluntary standard.

Portable bed rails are used by parents as safety devices to keep their children from falling out of bed and injuring themselves. It is unconscionable that, despite their knowledge about the risk of fatal entrapment in their product and consumers' reliance on the product as a safety device, manufacturers have not developed a safety standard to eliminate this risk.

CFA strongly urges the Commission to proceed with this rulemaking and develop a mandatory rule declaring certain portable bed rails to be banned hazardous substances unless the products meet certain physical or performance characteristics (such as those proposed earlier this year by CPSC staff).

Thank you very much for your attention to these comments.

Sincerely,



Mary Ellen R. Fise
General Counsel

evenflo

Evenflo Company, Inc.
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Vandalia, Ohio 45377
(937) 415-3300

*Bed rail comment**CA01-2*

Russ BUTSON
Director of Product Safety
(937) 415-3168
russ.butson@evenflo.com

December 1, 2000

Office of the Secretary
Consumer Product Safety Commission
Room 502
4330 East-West Highway
Bethesda, Maryland 20814

Transmitted via fax to: (301) 504-0127

RE: ANPR for Portable Bed Rails

Dear Sir or Madam:

Having reviewed CPSC's ANPR for Portable Bed Rails (PBR's), Evenflo appreciates this opportunity to provide comments regarding the ANPR.

Evenflo wishes to express its opposition to promulgation of mandatory performance standards for portable bed rails. Reasons for our opposition revolve around both the lack of necessity for separate mandatory standards in addition to voluntary standards now being developed by the American Society for Testing and Materials ("ASTM") as well as CPSC characterization of the safety risks associated with PBR's.

1. First and foremost, the issue of children being injured and killed in incidents where a PBR was present is an issue of children sleeping in inappropriate bedding. Data contained in the CPSC's working group presentation "Options to Address Portable Bed Rail Hazards" to the chair and commissioners indicate a fatality rate from falls for infants and early toddlers sleeping in adult beds as approximately 22 times the fatality rate when a PBR is present and claimed to be related to the fatality. We believe more children will be saved from death and injury if the CPSC, bed rail industry, and other sleep-products manufacturers put their collective efforts into educating caregivers about the hazards of exposing young children to inappropriate sleep practices.
2. The "Options to Address Portable Bed Rail Hazards" presentation includes reference to 8 deaths resulting from falls from windows in the subject 10 year period. These are presumably instances wherein a child rolls off a bed and out a window. No one would reasonably claim the window had a defect which allows these incidents to occur. Rather, the root cause of these incidents must be caregiver inattentiveness or neglect. Yet the number of fatalities involving the presence of a bedrail is not significantly more than those involving windows. Therefore, bedrails do not constitute "an unreasonable risk of injury or death" any more than do windows.

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3. CPSC has characterized in its press release of September 21, 2000 the 40 non-fatal incidents, 31 of which resulted in no injuries to the child, as "near miss" incidents. This characterization was first made during CPSC's working group presentation in the context of "fatalities and near misses". This implies that any incident associated with PBR's that was not a fatality was nearly a fatality. This characterization is misleading, and only serves to inhibit rational discussion, as well as to severely overestimate the risks associated with PBR use which have help to drive the ANPR.
4. The incident data contained in both the ANPR and "Options to Address Portable Bed Rail Hazards" presentation is cursory and does not report adequately the investigation of these incidents. The presentation and subsequent ANPR then associates the presence of a bedrail during the incident as the primary cause of fatalities and injuries. However, without additional detail, in many cases it is impossible to determine if the bedrail was a primary cause, contributing cause, or only peripherally associated with the incidents. As such, it is inappropriate to propose mandatory rulemaking without a sufficient factual basis.
5. The working group presentation and the ANPR appear to fault the ASTM group for the time it has taken in its attempts to promulgate a standard. While this may have taken longer than anticipated, it is more likely than not that this group is struggling with what is appropriate to address in the standard, rather than avoiding a standard as implied during the working group presentation
6. Most of the incidents cited in the working group's presentation indicate children becoming entrapped between the PBR and the mattress resulting in asphyxia. The presentation then goes on to recommend a 50 pound minimum pushout force based on a 95th percentile five year old. However, this does not take into account other, more likely causes of a gap between the PBR and the mattress, such as incorrect installation. Although on the surface CPSC's approach appears to solve a problem, we are extremely concerned that it may take several years to discover that new rulemaking has solved a problem which didn't exist, and didn't solve one that did.
7. Of the 14 fatal incidents, 7 of these resulted strictly from entrapment of the child between the PBR and the bed. Ages of the users are 3, 4, 5, 5, 6, 7, and 15 months. Children of these ages lack sufficient strength to move a PBR out of position, which is what CPSC claims is the primary failure mode. These are more likely instances of incorrect installation. Furthermore, 6 of the 7 were grossly underage for sleeping outside of a crib.
8. Of the remaining 7 incidents, 2 involved portions of the beds the occupants were placed in, namely a bed post to a headboard. This underlines the dangers of putting children in adult-sized beds, not specifically a deficiency in PBR performance. Again, these 2 were under appropriate age for sleeping outside a crib (both 7 months old).

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9. Of the remaining 5 incidents, 1 involved a 19 month old hung by his neck from the top bed of a bunk bed with the back of his head on the PBR. Had the PBR not been present, the child would at least have fallen between the bed and the wall either to the bed below or to the floor and possibly still have been hung between the wall and the bed frame. Not only was this child too young to be outside of a crib, placing this young of a child in the top of a bunk bed may be considered gross neglect.
10. Of the remaining 4 incidents, 1 suffocation was likely exacerbated by and possibly caused by the presence of a plastic sheet covering much of the child's face.
11. Of the remaining 3 incidents, 1 was a strangulation resulting from catching a portion of the child's collar on a protrusion. This is an item which is simple to address in ASTM's performance standard.
12. The remaining two incidents both involve appropriately aged children, though both mentally impaired in some way, which may have had their injuries mitigated by some performance standard. However, without additional information about the incidents, it is difficult to determine how the PBR contributed to the fatalities.
13. Fourteen fatalities over a 10 year period assuming a production rate of 733,000 units per year yields a fatality rate of 0.0000019 fatalities per unit per year. Adding in injuries yields a rate of 0.0000031 fatalities/injuries per unit per year. This is an exceedingly low incident rate, particularly considering the majority of these could have easily been prevented through proper use. It also belies the sentiment expressed during the working group presentation that "this is a safety product that is killing people".

Evenflo applauds CPSC's continuing efforts to reduce the risk of injury to consumers, especially children. Evenflo shares this commitment, and as such, is compelled to voice its belief that this goal can be better served outside of the context of mandatory rulemaking.

Thank you for your time and consideration.

Sincerely,



Russ Butson

evenflo

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Number of pages including cover sheet:

4

DATE: December 1, 2000

FAX TO: Office of the Secretary
Consumer Product Safety Commission
(301) 504-0127

FROM: Russ Butson
Director of Product Safety
Extension: 3168

SUBJECT: ANPR for Portable Bed Rails

Please see the attached letter.

Bed Rail
comment

CH 01-3

December 4, 2000

Office of the Secretary
Consumer Product Safety Commission
Washington, DC 20207-0001

Re: ANPR for Portable Bed Rails

To Whom It May Concern:

I am writing to you regarding the proposed rulemaking for the banning of portable bed rails that present a risk of injury. I believe that the Labeling Rule should be put into effect. The Commission should issue a rule banning PBRs that do not contain specific warning and instructions.

After reading about the fourteen instances in which a PBR was associated with a loss of life, it is obvious that something needs to be done. PBRs should not be banned altogether, but the labeling and instructions need to be improved upon. Without PBRs, children will fall out of beds, and will still result in serious injury.

PBRs definitely need to be improved upon, and hopefully there will be a rule issued to improve this situation and stop these tragic losses.

Sincerely,

Eduardo Montorro
Robert Garnett
Harold Gomez
Amy Rodriguez

Stevenson, Todd A.

From: Eddie Montorro [Montorro@Bellsouth.net]

Sent: Monday, December 04, 2000 11:20 PM

To: cpsc-os@cpsc.gov

Cc: Garnett@bfgbc.org; Gomez_Harold@Hotmail.com

Subject: ANPR for Portable Bed Rails

Attached, please find my comment on the proposed rule for portable bed rails.

Bed rails
CH 01-4

TO: OS@CPSC.GOV

**In The Matter of the Advance Notice of Proposed Rulemaking (ANPR)
For Portable Bed Rails**

**COMMENTS BY THE JUVENILE PRODUCTS MANUFACTURERS ASSOCIATION
("JPMA") IN THE MATTER OF THE ANPR PORTABLE BED RAILS**

The Juvenile Products Manufacturers Association ("JPMA" or "the Association") is a not-for-profit trade association comprised of more than 400 manufacturers, importers and distributors of juvenile products, which are used in the care of infants. The Association is dedicated to the promotion of the safe responsible use of such products for infants. JPMA promotes public information and safety campaigns, such as Baby Safety Month, adherence to voluntary and mandatory safety standards, and distributes millions of safety brochures and product inserts to the public, promoting sound infant care practices.

The Association is submitting these comments in response to the Advanced Notice of Proposed Rulemaking ("ANPR") stating the intention of the U.S. Consumer Product Safety Commission ("CPSC" or "Commission") to consider promulgating rules for a category of products generally recognized as portable bed rails. JPMA is concerned that the proposed rulemaking could result in adoption of a scheme of regulation that encourages "risk-taking behavior" by care givers by promoting use of products in a manner not reasonably intended. Use of these products is generally associated with aiding toddlers to transition from a crib to an adult bed. They are not and have never been intended to be a substitute for a crib for infants. Additionally, the Association is gravely concerned that, in a rush to create standards that address hazards associated with the unreasonable misuse of the product with infants on adult beds, such standards not create a serious risk of injury to the toddlers for whom such products are intended. JPMA believes that various proposals submitted by the CPSC staff could result in performance requirements that pose a significantly increased risk of serious injury or death to toddlers with whom such products are intended for use. To date, intended users of these products have not been subject to a risk of serious injury or death. The data collected by the CPSC Staff indicate that children in the 2-5 year age range are not subject to any serious risk of injury in connection

with product currently marketed. We note that the development of a bed rail designed to eliminate or reduce the entrapment hazard for infants for whom the product is not intended, could create an entrapment hazard for older children for whom the product is intended. While there have been a handful of deaths associated with infants placed in adult beds in the past decade, during the same time period entrapments between the mattress and walls on adult beds resulted in approximately 271 deaths of children age 5 and under. All advocates for children's safety generally agree that the public needs to be better educated about the risk of death from suffocation or entrapment when infants are inappropriately placed to sleep on adult beds. The American public finds these products useful and relatively safe in aiding the transition from cribs to adult beds. The Government has a responsibility to the public to develop standards in a way that does not increase the risk of injury to children.

I. The Product Category

A portable bed rail is an after-market device intended to be installed on adult or youth beds to assist a child transitioning from sleeping in a crib to sleeping in such beds. The products are generally recognized as intended for use by children who can get in and out of bed unassisted. Manufacturers generally recommend use of these products only for children who have outgrown their cribs. A typical portable bed rail contains a partial barrier designed to attach to the adult bed. These products usually clamp onto the side of the bed or contain perpendicular horizontal arms that are inserted between the mattress support or box springs and the mattress. There is a significant variety of designs and methods of attaching the products to the adult beds. The public generally recognizes this products as a transitional aid for children old enough to move from a crib to an adult bed. The bed rail's purpose is to prevent the toddler from accidentally rolling out of bed while sleeping. It generally provides a positive tactile reinforcement to the sleeping child. When confronted, most children usually roll away from the barrier back towards the center of the bed. A bed rail is not a substitute for a crib. They are not designed nor intended for use with infants. Most parents follow the manufacturer's instructions for age and weight recommendations and do not use the product with infants, who should not be placed to sleep in an adult bed.

II. Background

The CPSC commissioners voted on September 21, 2000 to issue an Advance Notice of Proposed Rulemaking on portable bed rails, following dissension in a voluntary standards group on how to address an alleged hazard with infants for whom the products were not intended to be used.

In or about early 1998, the CPSC staff requested the American Society for Testing and Materials ("ASTM") to consider convening a work group to develop a safety standard for portable bed rails. The ASTM F-15 Executive Committee agreed to convene such a work group. In or about the middle of 1999, the CPSC staff submitted ideas for a proposed standard to the ASTM work group. Participants of the work group reviewed and tested various proposals. By September 1999, the ASTM Portable Bed Rail Subcommittee voted to form two Task Groups - one group would develop labeling and instructional requirements and submit these requirements to ballot as soon as possible; the second Task Group focused on performance requirements.

In February 2000, the Subcommittee attendees voted to withdraw a ballot containing CPSC staff proposed performance requirements. The reasons given for withdrawing the standard were that it would receive several negative votes and that certain issues should be resolved before performance requirements are balloted.

In April 2000, the Subcommittee met again, with CPSC staff in attendance. The proposed standard, its rationale and proposed design changes were discussed. Several manufacturer members of the Subcommittee believed that the proposed CPSC requirements were too severe and lacked adequate rationale. Some manufacturers contended that incidents involving infants represent a misuse of the product and that standard requirements should not be based on these cases. Further, some Subcommittee members contended that the resulting performance criteria were unreasonably severe when the anthropometric data of infants and the strength data for five-year-olds are combined. The CPSC staff agreed that portable bed rails should not be used in place of a crib when placing infants down to sleep.

One of the primary concerns expressed by manufacturer members of the Subcommittee was that the adoption of the CPSC staff proposed standard could result in bed rail designs that

present an equal or greater risk of entrapment than current bed rails on the market. The basis for their concern was that new bed rails designed to meet the CPSC staff draft requirements would be more complex than current designs. The increased complexity could increase the possibility that consumers would install them incorrectly or perhaps make modifications to the bed rails. Either action could defeat the safety features on the bed rail, and possibly even increase the possibility of entrapment.¹ Given the known data on entrapments against walls and fitted barriers, there was also concern that such a standard not create greater risks for the intended user.

¹ These concerns were noted in the "*Options to Address Portable Bed Rail Hazards*", Briefing Memorandum of Patricia L. Hackett, CPSC Director for Engineering Sciences, dated June 2000; additionally, these concerns were referenced in "*Statement of Honorable Mary Sheila Gall in Support of Issuance of an ANPR on Portable Bed Rails*" dated September 21, 2000.

It must be stressed that the ASTM Work Group has always indicated its willingness to develop standards to reduce the risk associated with misuse of the product with infants, while at the same time acknowledging that such products should not be used with infants. It appears that a genuine difference of view developed with some CPSC staff participants. The ASTM Work Group was concerned about efforts to impose unrealistic requirements that would have the effect of creating a new generation of bed rails with "wall-like" characteristics. Additionally, participants were concerned about efforts to promote singular designs which might prove to be design restrictive in the marketplace. With the abundance of data that clearly indicates serious injuries and deaths occurring because of entrapment between adult beds and walls, a legitimate concern existed that complicated fixed, immovable partial barriers on the other side of the bed could create a pattern of serious risk and injury to intended users of the product. Historically, children in the 2-5 age range have not experienced serious injuries on the non-wall side of the bed where such barriers are traditionally used. As recently as October 2000, the ASTM Work Group continued to indicate its willingness to develop a standard to reduce risk to the unintended infant user. Upon information and belief, a concerted effort is underway to develop a performance standard based upon suggested reasonable physiological characteristics of infants at risk.²

Additionally, it should be noted that the work of the ASTM Subcommittee has thus far resulted in a standard that addresses labeling, as well as performance criteria related to openings and protrusions. It was inaccurate of the CPSC staff to characterize the standard as only dealing with minor insignificant labeling issues. Indeed, two of the incidents cited in the ANPR involved protrusions or openings which the standard seeks to address and which are not reflective of current designs on the marketplace.³

² Statement based upon attendance and observation of October ASTM Portable Bed Rail Subcommittee.

³ IDI 920310HCC1596 involved an incident on 8/2/91 involving a 3-month-old entrapped between the opening created by the bottom of the bed rail on one side and the mattress on the other, and IDI920302HCC0122 dated 11/10/91 involved a child hanging by a shirt collar, which caught on a metal tab protruding from the exterior of a bed rail. It is worth noting that these incidents were not the subject of standards proposed by the CPSC staff.

III. There Is No Risk of Serious Injury in Evidence for Intended Users of the Product

An analysis of the data cited in the ANPR indicates that the children involved in the fatal incidents were primarily children significantly under two years of age. Only 3 of the deaths cited involved older children and appear to involve individuals who were disabled in some capacity and incidents where the products themselves may not have caused the death. Since 1990, when aberrant incidents are excluded, there are no incidents or evidence of serious injury or death involving children over 2 years of age associated with use of this product.⁴ Furthermore, a review of the incident data cited in the ANPR leads us to believe that the incidents of bed rail fatalities from 1988 to November 2000 are extremely limited and rare. An analysis of the data indicates that the incidents cited as a justification for the rule are misleading.⁵ There appears to be only a handful of fatalities in more than a decade involving misuse of the product and placement of infants under 7 months of age in adult beds. Many of the incidents cited would also not have been prevented by the standard previously proposed by the CPSC staff.

This data must be contrasted to the high number of incidents of death involving children 1 month to 5 years of age during the same period involving incidents on the wall side of the bed.

⁴ Refer to IDIs listed in Portable Bed Rails ANPR, FR Vol. 65, No. 192, October 3, 2000, cited at p. 58969

⁵ IDI 911112HCC1470 involved a 15 month old hanging from a bunk bed, a situation in which bed rails were not intended to be applied; IDI920302HCC0122 involved a 15 month old hanging by a shirt on an exterior protrusion; IDI950815HCC4107 involved a 7 month old who became entrapped between the end of the bed rail and the end structure of a bed (even with an immovable fixed bed rail, this incident could have occurred); IDI960215HCC5012 involved a 2 ½ year old developmentally impaired child who suffocated on a plastic rubber sheet; IDI970127CCN0290 involved a 19 month old who became entrapped on the upper bunk of a bunk bed on the wall side of the bunk bed. IDI980327HCC3723 involved a mentally impaired 4 year old; IDI990317HCC0349 involved a 7 month old boy whose neck became wedged not between the bed rail and mattress, but between the headboard and a fixed bed rail installed on the side of the bed. None of the foregoing incidents would have been addressed or prevented by the CPSC staff's proposed standard. In many instances, it is unclear whether the bed rail was truly portable and in some of the instances the bed rail may have been fixed or modified as a fixed barrier.

The CPSC's own data indicate that there were 271 deaths between January 1, 1990 and May 17, 2000 involving an incident on the wall side of the bed. The deaths on the wall side included entrapments between the wall and the bed/mattress, incidents with no entrapment indicated, and incidents involving falls from the bed out of windows. A majority of incidents (232) involved children under one year of age. With the exception of falls out of windows, almost all of the wall-side deaths involved asphyxia in adult beds of varying sizes.⁶ Additionally, there were 47 deaths of children 1 month to 2 years old during the same period involving a fall from beds (exclusive of bunk beds) with most of them (38) involving children under 1 year old. Most of the children died when they fell into or onto an object (a bucket or bag of clothes, for example). Approximately 70% of the children died from asphyxia/suffocation/drowning.⁷

⁶ Memorandum re "Portable Youth Bed Rail Entrapments and Hangings" from Joyce McDonald to Patricia Hackett dated June 7, 2000.

⁷ Ibid, Appendix C.

Recent data collected by the U.S. Food & Drug Administration (“FDA”) also indicates that, according to the FDA’s medical device reporting system, 371 patients became trapped in hospital bed rails from 1985 to 1999. Most of the entrapments involved frail, elderly or confused patients or a category of patients categorized as “high risk” patients. According to the FDA, they routinely send out safety alerts to help prevent entrapment injuries, but still receive more than 2 dozen reports of deaths and injuries annually.⁸

The foregoing data is illustrative of the scope of the problem that could be faced by the agency and the public if it were to require that portable bed rails be designed in such a way that would make it unlikely that an entrapped child would be able to extricate themselves. We believe that the advantage of the portable bed rails currently on the marketplace is that the products themselves do not create entrapment or entanglement risks that can result in serious injury or death to their intended users. Children over 2 years of age generally possess cognitive and physiological abilities that enable them to extricate themselves from problematic situations. The ability of the older child to dislodge the product and remove him/herself from a situation of danger should not be compromised by the agency’s effort to develop rules for portable bed rails. The above data illustrates that there is a greater risk in creating fixed, immovable partial barriers. Additionally, we would note that even if portable bed rails were to be subject to a standard that made them “fixed”, since these products are not integrated and designed as original equipment with adult beds, the movement of the bed from the wall or the mismatching of mattresses to underlying box springs could in and of itself create dangerous gaps. We are concerned that any standard developed to address the relatively rare risk to infants, who are not the intended users of the product, never create an increased risk of injury for the primary intended users of the product.

CONCLUSION

Existing data indicates that portable bed rails as exist on the marketplace today do not necessarily present an unreasonable risk of injury. It is questionable whether portable bed rails

⁸ Telephone inquiry with FDA

can reasonably be determined to even be a “hazardous substance”, as that term is defined under the Federal Hazardous Substances Act (“FHSA”), 15 U.S.C. §1261 et seq. We do not believe that portable bed rails present a mechanical hazard pursuant to the requirements of 15 U.S.C. §1261(f)(1)(D) or a mechanical hazard sufficient to be banned pursuant to Section 2(q)(1)(A) of the FHSA.

The ANPR issued offers a variety of regulatory alternatives in an attempt to reduce a statistically minimal identified risk to infants for whom the products are not intended to be used. On average, it appears that the handful of incidents involving serious injury or death have occurred to children that are, on average, under 7 months of age. The ASTM Section F15.11 Portable Bed Rail Subcommittee has evidenced an intention to try to reduce this remote risk, while recognizing that the paramount message to consumers should be to keep infants in cribs and not place them in adult beds with portable bed rails. This is a message that all parties should consistently reinforce. At the same time, the Commission should proceed cautiously to ensure that it does not implement a performance standard that has the unintended effect of increasing the risk of serious injury or death to older children for whom the product is intended to be used.

Based on the foregoing, please note the following:

1. JPMA supports the development of an ASTM voluntary standard addressing labeling and certain performance criteria of portable bed rails.
2. JPMA is opposed to a mandatory rule declaring portable bed rails to be banned hazardous substances.
3. If the ASTM voluntary standard is not developed and implemented, the Association would support a rule banning portable bed rails that did not contain specified warnings and instructions.

Thank you for the opportunity to provide these preliminary comments on the ANPR.

Respectfully submitted,

JUVENILE PRODUCTS
MANUFACTURERS ASSOCIATION
236 Route 38 West, Suite 100

Moorestown, N.J. 08057
(856) 231-8500



From: Rick Locker [fblocker@lockerlaw.com]
Sent: Tuesday, December 05, 2000 5:25 PM
To: cpsc-os@cpsc.gov.
Subject: ANPR PORTABLE BED RAILS


JPMA Bed Rail
Comments.wpd

Enclosed please find Comments on the ANPR submitted by the Juvenile Products Manufacturers Association ("JPMA"). Thank you for allowing us to file these Comments. If you have any questions or require additional information please don't hesitate to contact the Association.