Non-Fire Carbon Monoxide Deaths
Associated with the Use of Consumer Products
2011 Annual Estimates

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

This report provides information about the estimated number of unintentional non-fire deaths attributed to carbon monoxide (CO) poisoning that were associated with the use of consumer products in 2011, and companion statistics since 2002. Because U.S. Consumer Product Safety Commission (CPSC) staff continues to receive reports of CO poisoning fatalities for 2011, the 2011 estimates may change in subsequent reports.1

Some of the key findings in this report are:

For 2011:

• There were an estimated 160 unintentional non-fire CO poisoning deaths associated with consumer products under the CPSC’s jurisdiction. The estimated annual average from 2009 to 2011 was 156 deaths.2

• Engine-Driven Tools (EDTs) were associated with the largest percentage of non-fire CO poisoning fatalities at 44 percent (estimated 70 deaths). Heating Systems-related CO fatalities were associated with the second highest percentage 31 percent of non-fire CO poisoning fatalities (49 deaths). Other product categories that comprised 5 percent or greater of the total CO poisoning deaths in 2011 include: Charcoal Grills or Charcoal (8 deaths), Ranges, Ovens (8 deaths), and Water Heaters (8 deaths)—all three categories corresponding to 5 percent, each, of the total number of estimated 160 unintentional non-fire CO poisoning deaths associated with consumer products. The Multiple Products category also comprised 5 percent of the total (8 deaths); however, all deaths were associated with EDTs and/or heating systems.

Generators & Other EDTs3:

• There were an estimated 74 CO fatalities in 2011 associated with EDTs, including five of the eight Multiple Products deaths in which an EDT and another potential CO-producing product was also in use. Sixty-three of the 74 EDT-related deaths (including three of the five multiple product deaths that involved an EDT) involved generators. Since 2005, portable generators have been associated with more non-fire CO fatalities than any other consumer product under CPSC jurisdiction.

1 Note that the estimates for individual categories may not sum to that of the broader category due to rounding effects.

2 Not all of these fatalities are addressable by an action the CPSC could take; however, the purpose of this report was not to evaluate the addressability of the incidents but rather to update the estimates of the number of consumer products associated with CO poisoning deaths.

3 Numbers presented in this document represent national estimates of unintentional non-fire deaths attributed to CO poisoning that were associated with the use of consumer products and not observed counts as presented in the CPSC report Incidents, Deaths, and In-Depth Investigations Associated with Non-Fire Carbon Monoxide from Engine-Driven Generators and Other Engine-Driven Tools, 1999–2012. http://www.cpsc.gov/library/foia/foia12/os/cogenerators.pdf.
Heating Systems:

- Of the estimated 49 Heating systems-related fatalities in 2011, 69 percent (34 deaths) involved gas heating equipment. Natural gas heating equipment accounted for 21 percent (7 deaths) of all fuel types of gas heating system-related fatalities; liquefied petroleum (LP or propane) gas heating accounted for 44 percent (15 deaths); and an additional 35 percent (12 deaths) were identified as unspecified gas heating. Oil- (2 deaths) and kerosene-fueled (2 deaths) heating systems accounted for a combined total of 12 percent of heating system fatalities. Coal- (3 deaths) and wood-fueled (1 death) heating systems accounted for a combined total of 9 percent. Five additional fatalities (11 percent) were associated with heating systems, where the fuel type could not be ascertained from CPSC records.

Location/Demographics:

- CPSC staff is aware of 111 fatal non-fire CO incidents involving consumer products in 2011. Seventy-seven percent of these incidents involved a single fatality.

- Eighty-three percent (estimated 133 deaths) of the estimated 160 CO deaths in 2011 occurred in a home location. Of these 133 estimated fatalities, 10 occurred in an external structure at a residence, such as a shed or detached garage, and 6 occurred in a nonfixed location domicile (e.g., camper trailer or boat used as homes) used as a permanent home, or a structure not designed for habitation used as a home (e.g., sea-land shipping container, metal shed). Additionally, an estimated 10 percent (16 deaths) occurred in tents, camper trailers, and other temporary shelters.

- More CO fatalities occurred in the cold months of the year. In 2011, 51 percent (82 of 160 estimated deaths) occurred during the four cold months of November, December, January, and February.

- In the three most recent years of this report (2009–2011), adults 45 years and older comprised nearly two-thirds (an annual average of 65 percent) of all non-fire, consumer product-related CO deaths, while this age group makes up only about 39 percent of the U.S. population. Conversely, children younger than 15 years of age accounted for an annual average of only 2 percent of the yearly CO poisoning deaths, while this age group makes up about 20 percent of the U.S. population.

- In 2011, 69 percent (an estimated 110 deaths) of CO poisoning victims were males. This percentage is slightly lower than what has been observed over the previous 9 years of the report where an average of 75 percent of the fatalities were males.

- There is some statistical evidence that the proportion of fatalities by race/ethnicity differs from the proportions of race/ethnicity in the U.S. population in the 2009 through 2011 time frame. The proportion of Hispanic victims (irrespective of race) is significantly lower than the proportion of Hispanic Americans in the U.S. population (8% versus 16%), while the proportion of Black or African American victims was significantly greater than the percentage of Black or African Americans in the U.S. population (21% versus 12%) during this time period.
• The proportion of all CO poisoning fatalities that occurred in rural towns or isolated rural locations (21% in 2009 through 2011) is larger than the proportion of the U.S. population living in these areas (11%). The disparity is even higher at rural town or isolated non-home locations, which account for 37 percent of all CO fatalities occurring at non-home locations.
Historical Data:

- Regression models indicate that there is insufficient statistical evidence to support a conclusion that there is a trend in non-fire CO fatalities from 2002 to 2011; although the most recent years’ estimates are below the peak years of this report (2005 through 2007).

- The CO poisoning 3-year average mortality rate for 2009 through 2011 associated with consumer products (5.03 per 10 million population) is approximately 16 percent greater than the 3-year average for 2000 (expressed as the midpoint year of the 3-year period 1999 to 2001) of 4.34 per 10 million population. However, for all consumer products, excluding generators and other EDT products, the 3-year average mortality rate has decreased by 28 percent from 3.44 (the 2000 3-year average) down to a 2.49 3-year average mortality rate in 2010 (the average rate for 2009 through 2011). Conversely, the 3-year average mortality rate of CO poisoning from engine-driven tools during the same time period more than tripled, increasing from 0.72 for 2000, up to 2.18 for 2010. Details are given in Appendix B of this report.

- The data indicate that EDTs and generators, in particular, have had a substantial impact on the CO poisoning mortality rate involving consumer products.
Introduction

Carbon monoxide (CO) is a colorless, odorless, and poisonous gas that results from the incomplete combustion of fuels, such as natural or liquefied petroleum (LP) gas, gasoline, oil, wood, coal, and other fuels. The health effects related to CO depend upon its concentration in blood, which, in turn, depends upon its concentration in air, an individual’s duration of exposure, and an individual’s general health. Carbon monoxide combines with the body’s hemoglobin (Hb) with an affinity about 250 times that of oxygen, forming carboxyhemoglobin (COHb) and interfering with oxygen transport, delivery, and use. Generally, there are no perceptible health effects or symptoms in healthy individuals at COHb levels below 10 percent. Symptoms associated with blood levels at or above 10 percent COHb include: headache, fatigue, nausea, and cognitive impairment. Loss of consciousness, coma, and death can occur at COHb levels greater than 20 percent; although for healthy adults, CO fatalities typically require levels above 50 percent COHb.4

Some symptoms of CO poisoning may mimic common illnesses, such as influenza or colds; thus, there likely is a high incidence of initial misdiagnosis by physicians and victims (Long and Saltzman, 1995). Frequently, patients are unaware of exposures, and health care providers may not always consider CO poisoning a cause of such nonspecific symptoms. COHb formation is reversible, as are some clinical symptoms of CO poisoning. However, some delayed neurological effects that develop following severe poisonings, especially those involving prolonged unconsciousness, may not be reversible. Prompt medical attention is important to reduce the risk of permanent damage.

Any fuel-burning appliance can be a potential source of fatal or hazardous CO levels. Fuels, such as natural and LP gas, kerosene, oil, coal, and wood can produce large amounts of CO when there is insufficient oxygen available for combustion. Consumer products that burn kerosene, oil, coal, or wood (such as wood stoves, oil boilers, and kerosene heaters) produce an irritating smoke that can alert the victim to a potentially hazardous situation. EDTs powered by gasoline engines produce large amounts of CO, even when they are run where there is sufficient oxygen available for combustion; yet EDTs may not emit an irritating exhaust smoke. Other fuels, such as charcoal briquettes and pressed wood-chip logs produce relatively smokeless fires, even at times of inefficient combustion. In these cases, victims receive no obvious sensory warning that high CO levels are present. Another hazard scenario is present when gas appliances are not vented properly or are malfunctioning. Natural and LP gas burn more efficiently and cleanly, compared with other forms of fuel. In circumstances of poor maintenance, inadequate ventilation, or faulty exhaust pathways, natural and LP gas appliances may emit potentially lethal amounts of CO without any irritating fumes. Again, many victims may be unaware of a potential problem.

National Estimates of Non-Fire CO Poisoning Deaths Associated with Consumer Products

The national estimates presented in this report are based on death certificate records obtained from 50 states, the District of Columbia, and New York City directly, augmented by information collected in CPSC’s In-Depth Investigations (IDIs), and to a lesser extent, news articles and medical examiners’ reports contained in the CPSC Injury or Potential Injury Incident (IPII) database. Death certificate data from some states, for a partial year or even an entire year, can lag for months or even years and may not be available in time for use in this report.

The estimates presented in this report are based on reporting as of July 11, 2014, of consumer product-related CO poisoning fatalities that occurred through 2011. The National Center for Health Statistics (NCHS) has records of every death certificate filed in the United States and its territories. A comparison of CPSC records to NCHS records indicates that CPSC records have data on about 91 percent of all the fatal CO poisoning deaths that occurred in 2011, in the United States. By comparison, for the 9 years covered in this report before 2011, CPSC records contain approximately 94 percent of all the fatal CO poisoning deaths that occurred in the United States reported to NCHS. From this comparison, CPSC anticipates that lagged reporting for incidents that occurred in 2011 will continue. Future reports should be based on a higher percentage of the actual number of CO fatalities as lagged data become available to CPSC staff. However, unlike previous reports where lagged reporting was a bigger issue, it is not anticipated that the estimates will change considerably in future reports because it is not anticipated that CPSC will obtain substantially more 2011 data. Appendix A of this report describes the process used to generate the national estimates presented in this report.

During 2011, an estimated 160 CO poisoning deaths were associated with the use of a consumer product under the jurisdiction of the CPSC. CO poisoning deaths referred to in this report do not include those where the CO gas resulted from a fire or a motor vehicle, were intentional in nature, or were directly work related.

Although multiple factors may contribute to a CO poisoning fatality, the source of CO is virtually always a fuel-burning product. As mentioned earlier, poor product maintenance by professionals or consumers, inadequate ventilation, faulty exhaust pathways, and poor user judgment in operating these products can result in fatal scenarios. CPSC staff produces the CO estimates by associated consumer products to identify product groups involved in fatal CO scenarios and to monitor this distribution over time. Within the individual, product-specific CPSC projects additional analysis is done to consider whether improvements are warranted in the areas of product design, ventilation safeguards, or user information and education.

The annual CO estimates for the years 2002 through 2011 are presented in two formats: by product category (Table 1) and by product within fuel type (Table 2). The data are presented as yearly estimates for each of the 10 years covered by this report and as an average of the most recent 3-year period (2009 through 2011). Data collection was only partially complete for 2011, and estimates for this year may change in the future when additional data become available. Therefore, data for 2011 are reported using italic font in the tables.

Estimated numbers presented in this document represent national estimates of unintentional non-fire deaths attributed to CO poisoning associated with the use of consumer products. Generator and other EDT death estimates would not be expected to match observed fatality counts presented in this report or in the CPSC report, "Incidents, Deaths, and In-Depth
Table 1 (pages 10–11) presents the consumer product distribution of CO poisoning deaths. The estimate for Heating Systems, historically a large percentage of the consumer product estimate, is broken down into heater system subcategories and is further distributed among the various fuel types. Fatality estimates for the Engine-Driven Tools category were further distributed between generators and other engine-driven tools. The consumer product estimate and product distributions were derived using the methodology described in Appendix A.

Of the estimated 160 CO poisoning deaths associated with a consumer product that occurred between January 2011 and December 2011, Heating Systems were associated with 49 deaths (31% of the total consumer product estimate). Of the 49 estimated deaths associated with heating systems, the majority (69% or 34 fatalities) involved gas heating systems. Natural gas heating systems were associated with an estimated seven deaths (14% of all heating system-related deaths). Liquid Petroleum gas (LP gas) heating was associated with an estimated 15 deaths (31% of heating system-related deaths); and unspecified gas heating was associated with an estimated 12 deaths (24% of heating system-related deaths). Oil-fueled heating was associated with an estimated two deaths (4% of heating system-related deaths). There was also an estimated two deaths (4% of heating system-related deaths) associated with a kerosene-burning heater. There were an estimated three deaths associated with coal-fueled heating systems (6% of heating system-related deaths) and one death associated with a wood-fueled heating system (2% of heating system-related deaths). In 2011, there were no reported diesel-fueled heating system fatalities. Additionally, in 2011, there were an estimated five CO deaths (10% of heating system-related deaths) associated with heating systems with unspecified fuel sources. Note that the estimates for individual categories may not sum to that of the broader category due to rounding effects.

Of the estimated seven deaths in 2011 that were associated with natural gas heating systems, six involved installed furnaces. One additional fatality was associated with a natural gas-fueled heater of unknown type. Of the estimated 15 deaths in 2011 that were associated with LP gas heating systems, 11 (73%) involved unvented portable propane heaters. These unvented portable propane heaters were fueled by a propane tank and were not a component of an installed heating system. Unvented portable propane heaters were either camping heaters that used disposable propane tanks, 1-pound propane bottles, or tank top heaters that used bulk tanks larger than 1 pound.

Table 1 indicates that in 2011, an estimated eight CO deaths (5% of the 160 total consumer product estimate) were associated with charcoal or charcoal grills. Additionally, in 2011, an estimated eight deaths (5%) were associated with gas ranges or ovens; an estimated eight deaths (5%) were associated with water heaters; an estimated two deaths (1%) were associated with a fuel-burning lantern; an estimated two deaths were associated with an LP gas-fueled grill or camp stove; and an estimated two deaths were associated with other LP gas-fueled products. Additionally, in 2011, an estimated eight deaths were associated with multiple appliances (5% of the total consumer product estimate). The Multiple Products category includes all incidents where multiple fuel-burning products were used simultaneously, such that a single source of the CO could not be determined.
An estimated 70 CO poisoning deaths (44% of the estimated total for 2011) were associated with the category of Engine-Driven Tools, which includes generators, riding mowers or garden tractors, snow blowers/throwers, and other engine-driven equipment. Additionally, an estimated five of the eight Multiple Product fatalities were associated with some type of engine-driven tool being used in conjunction with another fuel-burning product for an estimated total of 74 CO fatalities associated with the use of an engine-driven tool (46% of the estimated total for 2011). Generator-associated deaths comprised the majority of this category. An estimated 63 CO poisoning deaths were associated with a generator, including 3 of the Multiple Product fatalities involving an engine-driven tool in 2011 (85% of all engine-driven tool fatalities and 39% of the total consumer product estimate).

In recent years, the Engine-Driven Tools category has been associated with more CO fatalities than any other category. The estimated average number of CO fatalities associated with engine-driven tools (67, not including multiple product incidents) for 2009 through 2011, is greater than the average number associated with heating systems (49 deaths). Since 2005, each year a greater number of CO fatalities has been associated with engine-driven tools than with heating systems, primarily due to an increase in generator-related CO fatalities. In 2005, there were more than double the estimated numbers of CO fatalities related to the use of generators from the previous year (88 versus 41, respectively). The higher number of estimated fatalities in 2005 may have been due to the large number of power outages across parts of the country from a number of severe hurricanes (including Hurricanes Katrina, Rita, and Wilma) and a series of snow/ice storms in the Carolinas and the Midwest during that year. The number of generator-related CO fatalities in the subsequent 4 years remained greater than in the years before 2005. An estimated combined total of 569 engine-driven tool-related CO fatalities occurred from 2005 through 2011, compared to 371 deaths combined for heating systems, or 53% more EDT-related fatalities. From 2002 through 2004, there were 49 percent more heating system-related CO fatalities (245) than engine-driven tool-related fatalities (164). (Note: These figures exclude fatalities associated with multiple products because such fatalities possibly could be categorized into both categories.) Stated differently, while heating system-related CO fatalities have dropped by 35 percent from an approximate estimated average of 82 per year from 2002 through 2004, to an average of 53 per year from 2005 through 2011, the estimated annual average number of engine-driven, tool-related CO fatalities has increased by 49 percent over the same time period, from 55 to 81.

Table 1 shows the estimated average annual number of CO poisoning deaths associated with various consumer products for 2009 to 2011. The average yearly total number of CO deaths for this 3-year period is estimated to be 156 (with a standard error of approximately 3.8). The 95 percent confidence interval for this estimated average ranged from 139 to 172 deaths. Appendix B contains a graph and the data point values for the annual estimates of CO poisoning deaths associated with a consumer product for 1980 through 2011.

The availability of detailed information regarding the condition of products associated with CO fatalities varies widely. However, information collected often described conditions regarding compromised vent systems, flue passageways, and chimneys for furnaces, boilers, and other heating systems. Vent systems include the portion of piping that either connects the flue outlet of the appliance and exhausts air to the outside through a ceiling or sidewall, or connects to a chimney. Some products had vents that became detached or were installed or maintained

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6 The confidence interval is based on a t-distribution with two degrees of freedom.
improperly. Vents were also sometimes blocked by soot caused by inefficient combustion, which, in turn, may have been caused by several factors, such as leaky or clogged burners, an over-firing condition, or inadequate combustion air.

Other conditions related to furnaces included compromised heat exchangers or filter doors or covers that were removed or not sealed. Some products were old and apparently poorly maintained, such that there were several factors involved in generating and exacerbating the amount of CO produced. Other incidents mentioned a backdraft condition, large amounts of debris in the chimney, and the use of a product that was later red-tagged by the utility company (taken out of commission by the utility company and designated not to be turned on until repaired).
Table 1: Estimated Non-Fire Carbon Monoxide Poisoning Deaths by Associated Fuel-Burning Consumer Product, 2002-2011

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<tbody>
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<td>156</td>
<td>100%</td>
<td>181</td>
<td>153</td>
<td>168</td>
<td>190</td>
<td>180</td>
<td>186</td>
<td>178</td>
<td>148</td>
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<td>160</td>
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<tr>
<td>Heating Systems</td>
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<td>Furnaces (incl. Boilers)</td>
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<tr>
<td>Liquid Petroleum (LP) Gas</td>
<td>2</td>
<td>1%</td>
<td>16</td>
<td>3</td>
<td>8</td>
<td>1</td>
<td>9</td>
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<td>Oil</td>
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<td>Unspecified Gas</td>
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<td>3%</td>
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<td>2</td>
<td>4</td>
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<td>17</td>
<td>13</td>
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<td>15</td>
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<td>10</td>
<td>14</td>
<td>9</td>
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<tr>
<td>Wall/Floor Furnaces</td>
<td>4</td>
<td>3%</td>
<td>9</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>9</td>
<td>3</td>
<td>6</td>
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<tr>
<td>Liquid Petroleum (LP) Gas</td>
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<td>1%</td>
<td>4</td>
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<td>3</td>
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Charcoal Grills, Charcoal

| 10 | 6% | 11 | 8 | 3 | 6 | 10 | 8 | 7 | 7 | 16 | 8 |
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- Data collection for 2011 is only partially complete and data are shown in italics. Italicized estimates may change in the future if more reports of fatalities are received.
- No reports received by CPSC staff.
- Source: U.S. Consumer Product Safety Commission/EPHA.

Note: Reported annual estimates and estimated averages and percentages may not add to subtotals or totals due to rounding.
Table 2 (beginning on page 14) organizes the estimates by product within fuel type. The three major fuel types include: Gas-Fueled Products (natural gas and liquid petroleum [LP including propane and butane] gas); Solid-Fueled Products (charcoal, coal, and wood); and Liquid-Fueled Products (gasoline, kerosene, and oil). Of these fuel types, Liquid-Fueled Products were associated with 76 of the 160 (48%) estimated CO fatalities in 2011. Gas-Fueled Products were associated with 61 (38%) estimated fatalities and Solid-Fueled Products were associated with 13 (8%) estimated fatalities in the same time period. An additional three (2%) fatalities were associated with multiple products, where there were two or more different categories of fuel used. (Multiproduct cases, where the fuel types were the same, are counted in their respective category summary.) Eight (5%) fatalities in 2011 were associated with consumer products where the fuel type was unknown.

In the Gas-Fueled Products category, the majority of CO fatalities in 2011 were associated with heating-related products. Of the estimated 61 gas-fueled appliance fatalities in 2011, 36 (59%) were associated with heating systems or heaters, including furnaces, portable heaters, wall or floor heaters, room or space heaters, or fireplaces. Additionally, all of the estimated three fatalities in the Multiple Gas-Fueled Products category involved some type of gas heater. Of the estimated 76 liquid-fueled appliance-related fatalities in 2011, 70 (92%) were associated with engine-driven tools (e.g., generators, lawn mowers/garden tractors, power washers). Generators accounted for 60 of the estimated 76 fatalities (79%) in the Liquid-Fueled Products category for 2011. Additionally, all three of the CO fatalities associated with multiple products of different fuel types involved portable generators.

In 2011, an estimated 13 fatalities occurred in the Solid-Fueled Products category. Eight of these were associated with charcoal or charcoal grills; three with some type of coal-fueled heater; and one with a wood-burning space heater.
Table 2: Estimated Non-Fire Carbon Monoxide Poisoning Deaths Associated with Consumer Products Organized by Fuel Type, 2002–2011

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+ Data collection for 2011 is only partially complete. Italicized estimates may change in the future if more reports of fatalities are received.
* No reports received by CPSC staff.
# In 2011, there were an estimated three CO fatalities associated with an LP-fueled-welder/generator being used as a generator.

Source: U.S. Consumer Product Safety Commission/EPHA.
CPSC Death Certificate File, CPSC Injury or Potential Injury Incident File, CPSC In-Depth Investigation File,
National Center for Health Statistics Mortality File, 2002-2011.

Note: Reported annual estimates and estimated averages and percents may not add to subtotals or totals due to rounding.
Table 3 (below) shows a breakdown of the fatality estimates for the 10-year period from 2002 through 2011 in the Engine-Driven Tools category. During 2011, engine-driven tools were associated with an estimated 74 carbon monoxide poisoning deaths (46% of the total consumer product estimate). Table 3 totals differ from those in Tables 1 and 2 in that they also include fatalities associated with multiple potential CO-producing products, where at least one product was an engine-driven tool. In 2011, there were five such deaths—three of which were associated with a generator and some other product (in all cases, some type of heater). An estimated 63 of the 74 engine-driven tool-related CO poisoning deaths (85%) were associated with generators, or generators in conjunction with another fuel-burning product. In 2011, the other engine-driven, tool-related CO fatalities included an estimated three deaths that were associated with some type of lawn mower; two with an ATV, two with a power washer; and one with a paint sprayer.

Table 3: Estimated Non-Fire Carbon Monoxide Poisoning Deaths Associated with Engine-Driven Tools, 2002–2011

<table>
<thead>
<tr>
<th>Engine-Driven Tools (OEDTs)</th>
<th>2009–2011(^*) Average Estimate</th>
<th>Average Percentage</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008(^*)</th>
<th>2009</th>
<th>2010</th>
<th>2011(^*)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>71</td>
<td>100%</td>
<td>59</td>
<td>63</td>
<td>59</td>
<td>110</td>
<td>106</td>
<td>85</td>
<td>92</td>
<td>78</td>
<td>62</td>
<td>74</td>
</tr>
<tr>
<td><strong>Generators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gasoline-fueled</td>
<td>55</td>
<td>77%</td>
<td>41</td>
<td>50</td>
<td>41</td>
<td>88</td>
<td>85</td>
<td>68</td>
<td>76</td>
<td>64</td>
<td>42</td>
<td>60</td>
</tr>
<tr>
<td>LP-fueled</td>
<td>1</td>
<td>1%</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>2</td>
</tr>
<tr>
<td><strong>Other Engine-Driven Tools (OEDTs)</strong></td>
<td>12</td>
<td>17%</td>
<td>10</td>
<td>7</td>
<td>15</td>
<td>13</td>
<td>18</td>
<td>11</td>
<td>6</td>
<td>12</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Lawn Mowers</td>
<td>6</td>
<td>8%</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>9</td>
<td>11</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Riding Mowers</td>
<td>5</td>
<td>7%</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>8</td>
<td>9</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Walk Behind Mowers</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>2</td>
</tr>
<tr>
<td>Unspecified Mowers</td>
<td>1</td>
<td>1%</td>
<td>*</td>
<td>*</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>*</td>
<td>*</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paint Sprayer</td>
<td>&lt;1</td>
<td>&lt;1%</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>1</td>
</tr>
<tr>
<td>Power Washer</td>
<td>1</td>
<td>1%</td>
<td>*</td>
<td>*</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>*</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Snow Blower/Thrower</td>
<td>1</td>
<td>1%</td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>1</td>
<td>2</td>
<td>*</td>
<td>3</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>ATV</td>
<td>2</td>
<td>3%</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>*</td>
<td>2</td>
<td>*</td>
<td>4</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Water Pump</td>
<td>&lt;1</td>
<td>&lt;1%</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>*</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Welder</td>
<td>*</td>
<td></td>
<td>2</td>
<td>1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Air Compressor</td>
<td>*</td>
<td></td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Concrete Saw</td>
<td>*</td>
<td></td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Tiller</td>
<td>&lt;1</td>
<td>&lt;1%</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Go-Cart</td>
<td>&lt;1</td>
<td>&lt;1%</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Small Engine</td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Snowmobile</td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td><strong>Multiple Product: Engine-Driven Tools Involved</strong></td>
<td>4</td>
<td>6%</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>6</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Generator + OEDT</td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Generator + other Product</td>
<td>4</td>
<td>6%</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>9</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Multiple OEDT</td>
<td>&lt;1</td>
<td>&lt;1%</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>2</td>
<td>*</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>OEDT + other product</td>
<td>*</td>
<td></td>
<td>*</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
</tbody>
</table>

\(\text{Note}: \text{Reported annual estimates and estimated averages and percentages may not add to subtotals or totals due to rounding.}\)

\(\text{+ Data collection for 2011 is only partially complete, and data are shown in italics. Italicized estimates may change in the future if more reports of fatalities are received.}\)

\(\text{+ No reports received by CPSC staff.}\)

\(\text{Source: U.S. Consumer Product Safety Commission/EPHA.}\)

\(\text{CPSC Death Certificate File, CPSC Injury or Potential Injury Incident File, CPSC In-Depth Investigation File, National Center for Health Statistics Mortality File, 2002–2011.}\)
Figure 1 provides a graphic representation of the CO fatality trends related to: (1) all consumer products; (2) engine-driven tools, and (3) non-generator products. A regression analysis of the estimated number of all non-fire, consumer product-related CO poisoning fatalities from 2002 to 2011, indicates that there is insufficient evidence to conclude that there is a trend in the data (p-value = 0.3269). Due to reporting delays, national estimates for recent years, especially 2011, most likely will change in subsequent reports; although the estimates are not expected to change noticeably. As can be seen in Figure 1, the estimated number of non-generator CO fatalities fluctuates from year-to-year, but appears to be fairly steady across time. Conversely, the estimated number of generator CO fatalities has shown a steady rise, to peak levels in 2005 and 2006. The estimated number of generator CO fatalities in 2007 through 2011 is below the peak 2005 and 2006 levels, but, with the exception of 2010, all years had a greater number of generator-related fatalities than the average number of fatalities (44) for the three years before 2005. Data from recent years, especially 2011, should be considered incomplete, and the numbers are expected to change.

Figure 1: Comparison of Trends in Consumer Product-Related Carbon Monoxide Deaths–2002 to 2011
Lawnmowers were associated with 54 percent (63 of 116) of the deaths in the *Other Engine-Driven Tools* category for the 10-year period. There were four other fatalities associated with a lawnmower and another product in this time period. There was an estimated average of six lawnmower-related CO fatalities per year in 2009 to 2011 (17 deaths). CO fatalities related to ATV exhaust were in the next largest subcategory with an estimated 11 deaths from 2002 to 2011, and eight occurred from 2008 through 2011. Additionally, power washers were associated with 10 deaths and snow blowers/throwers associated with nine CO fatalities over the 10-year period.

Table 4 shows that in 2011, 86 CO incidents (77 percent of fatal CO incidents reported to the CPSC) involved a single death. Table 4 accounts for only the fatally injured victims in each CO poisoning incident. It is not uncommon for CO incidents involving one or more fatalities also to result in one or more nonfatal CO poisoning injuries, but they were not quantified for analysis in this report. These are the incidents reported in CPSC databases and do not represent the national estimates of fatalities per CO incident. Death certificates do not include information about other fatalities for the same incident. The number of fatalities for a particular incident is based on CPSC IDI files and may include fatalities for which CPSC staff does not have death certificates. Some additional multiple fatality incidents were identified by matching date of death and location of death on death certificates, while others were identified from news articles contained in the CPSC Injury or Potential Injury Incident (IPII) database. Over the 10-year period covered by this report, CPSC records indicate that 19 percent (237 of 1,273 incidents) resulted in multiple fatalities, including 16 incidents resulting in four or more CO fatalities.

<table>
<thead>
<tr>
<th>Number of Deaths Reported in Incident</th>
<th>Total Incidents</th>
<th>2009–2011†</th>
<th>Annual Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>113</td>
<td>100%</td>
<td>130</td>
</tr>
<tr>
<td>1</td>
<td>91</td>
<td>81%</td>
<td>101</td>
</tr>
<tr>
<td>2</td>
<td>18</td>
<td>16%</td>
<td>24</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1%</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>&lt;1</td>
<td>&lt;1%</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

† Data collection for 2011 is only partially complete, and data are shown in italics. Italicized counts may change in the future if more reports of fatalities are received.

Note: Percentages do not add to 100% due to rounding.
Source: U.S. Consumer Product Safety Commission/EPHA.

Table 5 shows that in 2011, an estimated 133 CO poisoning deaths occurred in home locations, including an estimated 10 deaths in detached structures at residential locations (*i.e.*, sheds, detached garages) and six in structures not intended originally as a permanent residence (*i.e.*, camper trailers, sea-land shipping containers). From 2009 to 2011, an annual average of 128 CO poisoning deaths (82% of all CO fatalities) occurred at home locations. In 2011, an estimated 16 deaths took place in temporary shelters, such as campers, tents, and ice fishing sheds. For 2009 to 2011, an annual average of 17 CO poisoning deaths (11%) took place in temporary shelters. Carbon monoxide deaths in temporary shelters were most commonly
associated with heating sources, generators, or lanterns. In 2011, more than half (an estimated 9 of 17) CO deaths in temporary shelters were associated with generators including an incident in a parked camper/RV with five fatalities.

A consistently small percentage of deaths due to CO poisoning involving a consumer product occurred in vehicles, such as passenger vans, trucks, automobiles, or boats. In 2011, there were an estimated nine (6%) CO fatalities in this category—an estimated six deaths were associated with generators, and three with the burning of charcoal inside the vehicle. For 2009 to 2011, an annual average of nine CO poisoning deaths (6%) took place in vehicles.

Table 5: Estimated Non-Fire Carbon Monoxide Poisoning Deaths by Location of Death, 2002–2011

<table>
<thead>
<tr>
<th>Location of Death</th>
<th>2009–2011*</th>
<th>Average Estimate</th>
<th>Average Percent</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home1</td>
<td>117</td>
<td>75%</td>
<td></td>
<td>117</td>
<td>156</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home – External Structure2</td>
<td>7</td>
<td>4%</td>
<td></td>
<td>7</td>
<td>15</td>
<td>11</td>
<td>10</td>
<td>16</td>
<td>14</td>
<td>11</td>
<td>13</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Home – But Not House3</td>
<td>4</td>
<td>3%</td>
<td></td>
<td>4</td>
<td>8</td>
<td>2</td>
<td>*</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Temporary Shelter</td>
<td>17</td>
<td>11%</td>
<td></td>
<td>17</td>
<td>32</td>
<td>22</td>
<td>22</td>
<td>32</td>
<td>36</td>
<td>22</td>
<td>20</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Vehicles (including boats)</td>
<td>9</td>
<td>6%</td>
<td></td>
<td>9</td>
<td>4</td>
<td>9</td>
<td>8</td>
<td>14</td>
<td>6</td>
<td>8</td>
<td>9</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1%</td>
<td></td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>&lt; 1</td>
<td>&lt; 1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+ Data collection for 2011 is only partially complete, and data are shown in italics. Italicized estimates may change in the future if more reports of fatalities are received.
* No reports received by CPSC staff.

Note: Percentages do not add to 100% due to rounding.
1 Traditional home (e.g., detached house, townhouse, apartment, mobile home)
2 External structure at residential locations (e.g., detached garage, shed)
3 Non-fixed structure or structure not originally designed for permanent occupation (e.g., camper trailer, van, converted sea-land shipping container).

Source: U.S. Consumer Product Safety Commission/EPHA.

CPSC data indicate that there were more CO fatalities attributable to incidents that occurred in the cold months than in the warm months. This is most likely because of the use of furnaces and portable heaters in the cold months. Additionally, generators are often used in the cold months because of power outages due to snow and ice storms. Table 6 shows the annual estimated CO fatalities categorized by month of death for the 10 years covered by this report. In 2011, slightly more than half of the 160 estimated CO fatalities (82) are attributable to incidents that occurred during the four cold months of November, December, January, and February. An estimated 55 fatalities (34%) are attributable to incidents that occurred during the transition months of March, April, September, and October; and an estimated 22 fatalities (14%) in the warm months of May, June, July, and August. Over the 10 years this report spans, an estimated 59 percent of CO fatalities are attributable to incidents that occurred during the cold months; an estimated 27 percent are attributable to incidents that occurred during the transition months; and an estimated 13 percent of fatalities occurred in the warm months.
Table 6: Estimated Non-Fire Carbon Monoxide Poisoning Deaths by Month and Year of the Fatality, 2002–2011

<table>
<thead>
<tr>
<th>Month of Death</th>
<th>2009-2011*</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
<td>Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Estimate</td>
<td>Percent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td>100%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cold Months</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>November</td>
<td>91</td>
<td>58%</td>
<td>94</td>
<td>96</td>
<td>107</td>
<td>98</td>
<td>95</td>
<td>109</td>
<td>110</td>
<td>85</td>
<td>107</td>
</tr>
<tr>
<td>December</td>
<td>25</td>
<td>16%</td>
<td>26</td>
<td>30</td>
<td>27</td>
<td>33</td>
<td>38</td>
<td>25</td>
<td>25</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>January</td>
<td>31</td>
<td>20%</td>
<td>20</td>
<td>22</td>
<td>34</td>
<td>37</td>
<td>14</td>
<td>43</td>
<td>31</td>
<td>29</td>
<td>39</td>
</tr>
<tr>
<td>February</td>
<td>16</td>
<td>10%</td>
<td>21</td>
<td>12</td>
<td>20</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td>26</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td>Transition</td>
<td></td>
<td></td>
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<td>March</td>
<td>15</td>
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<td>28</td>
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<td>September</td>
<td>7</td>
<td>4%</td>
<td>5</td>
<td>9</td>
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<td>October</td>
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<td>14</td>
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<tr>
<td>May</td>
<td>7</td>
<td>4%</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>9</td>
<td>16</td>
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<tr>
<td>June</td>
<td>6</td>
<td>4%</td>
<td>5</td>
<td>7</td>
<td>6</td>
<td>9</td>
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<tr>
<td>July</td>
<td>3</td>
<td>2%</td>
<td>2</td>
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<td>4</td>
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<td>3</td>
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<tr>
<td>August</td>
<td>4</td>
<td>3%</td>
<td>8</td>
<td>3</td>
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<td>13</td>
<td>11</td>
<td>5</td>
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</tbody>
</table>

* Data collection for 2011 is only partially complete. Italicsized estimates may change in the future if more reports of fatalities are received.
* No reports received by CPSC staff.
Source: U.S. Consumer Product Safety Commission / EPHA.
Note: Reported annual estimates and estimated averages and percentages may not add to subtotals or totals due to rounding.

Figure 2 illustrates the relationship between the time of year and the estimated number of CO poisoning fatalities. The total estimated number of CO poisoning fatalities is presented on the radar graph by month of death. The shaded area represents the estimated total number of fatalities for 2002 through 2011, for each month. Notably, more CO deaths occur in the cold months, particularly, November, December, and January, than in warm months. Additionally, as the months after the summer get colder, the number of CO fatalities increases. Conversely, as the months after the winter get warmer, the number of fatalities decreases.
Figure 2: Estimated Number of Consumer Product-Related Carbon Monoxide Deaths by Month of Death, 2002–2011

Deaths

Jan
Dec
Nov
Oct
Sep
Aug
Jul
Jun
May
Apr
Mar
Demographics of Fatalities from Non-Fire Carbon Monoxide Poisoning Associated with the Use of Consumer Products

Table 7 shows the estimated number of CO poisoning fatalities categorized by victim age for the 10 most recent years of data (2002-2011). From the data, it appears that consumer product-related CO fatalities are skewed toward older individuals. For the three most recent years (2009-2011), children younger than 15 years of age accounted for an annual average of 2 percent (an estimated 3 of 156) of the yearly CO poisoning deaths, while this age group represents an average of about 20 percent of the U.S. population. The annual average percentage of deaths represented by adults 45 years and older was 65 percent (101 of 156) in 2009 to 2011, while only about 39 percent of the U.S. population is over 45 years old. In 2009 to 2011, adults age 65 years and older accounted for an annual average percentage of 24 percent of CO poisoning fatalities, nearly double the age group’s percentage of the U.S. population (13 percent). Chi-Square goodness-of-fit test results indicate that there is a statistically significant difference (p-value = < 0.0001) between the proportion of CO victims in each age group from that of the general U.S. population. Each age group was analyzed separately, versus the expected proportion of the respective age group, based on U.S. population figures, assuming there was no age group effect on the CO poisoning fatality rate, to determine which age group proportions were significantly different from expectation. For the Chi-Square statistical analysis, the two younger groups (“Under 5” and “5-14”) were combined due to their small estimated averages. Binomial tests indicate that all individual groups, with the exception of the “25-44” group, were found to be significantly different than what would be expected if there was no population group effect:
1. The “Under 15” group9 was significantly lower (< 0.0001);
2. The “15-24” group was significantly lower (0.0124);
3. The “45-64” group was significantly higher (< 0.0001); and
4. The “65 and older” group was significantly higher (< 0.0001).

Table 7: Estimated Non-Fire Carbon Monoxide Poisoning Deaths by Age of Victim, 2002-2011

<table>
<thead>
<tr>
<th>Age</th>
<th>2009-2011*</th>
<th>Estimated Percentage of U.S. Population</th>
<th>Annual Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average Estimate</td>
<td>Average Percent</td>
<td>2002</td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Under 5</td>
<td>1</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>5-14</td>
<td>2</td>
<td>1%</td>
<td>13%</td>
</tr>
<tr>
<td>15-24</td>
<td>11</td>
<td>7%</td>
<td>14%</td>
</tr>
<tr>
<td>25-44</td>
<td>39</td>
<td>25%</td>
<td>27%</td>
</tr>
<tr>
<td>45-64</td>
<td>64</td>
<td>41%</td>
<td>26%</td>
</tr>
<tr>
<td>65 and over</td>
<td>37</td>
<td>24%</td>
<td>13%</td>
</tr>
</tbody>
</table>

* Data collection for 2011 is only partially complete. Italicized estimates may change in the future if more reports of fatalities are received.

# No reports received by CPSC staff.

8 Based on estimated U.S. population statistics for the mid-range year 2010.

Source: U.S. Consumer Product Safety Commission/EPHA.


8 "Under 5" and "5-14" groups were combined due to small sample sizes.
Table 8 presents the distribution of estimated CO fatalities categorized by gender. In 2011, 69 percent of CO poisoning victims were males, and 31 percent were females. These percentages varied slightly from year to year over the 10 years of this report, but every year there are many more male CO fatalities than female. Over the years, 2009 through 2011, the average percentage of male CO victims was 72 percent, and the average percentage of female victims was 27 percent. By contrast, about 49 percent of the U.S. population is male, and 51 percent are female. Chi-square goodness-of-fit test results indicate that there is a statistically significant difference (p-value = < 0.0001) between the proportion of CO victims by gender group and that of the general U.S. population.

Table 8: Estimated Non-Fire Carbon Monoxide Poisoning Deaths by Gender of Victim, 2002-2011

<table>
<thead>
<tr>
<th>Gender</th>
<th>2009-2011*</th>
<th>Estimated Percentage of U.S. Populationa</th>
<th>Annual Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
<td>Average Percent</td>
<td>2002</td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>113</td>
<td>72%</td>
<td>49%</td>
</tr>
<tr>
<td>Female</td>
<td>42</td>
<td>27%</td>
<td>51%</td>
</tr>
</tbody>
</table>

* Data collection for 2011 is only partially complete. Italicized estimates may change in the future if more reports of fatalities are received.
# Based on estimated U.S. population statistics for the mid-range year 2010.
Source: U.S. Consumer Product Safety Commission/EPHA.
CPSC Death Certificate File, CPSC In-Depth Investigation File, CPSC Injury or Potential Injury Incident File, National Center for Health Statistics
Mortality File, 2002-2011.
Note: Reported annual estimates and estimated averages and percentages may not add to subtotals or totals due to rounding.

Table 9 provides a summary of CO fatality victims characterized by race/ethnicity for the years 2002 through 2011. Because of the growing proportion of the U.S. population of Hispanic descent, Hispanic victims were categorized separately, irrespective of their race. Estimates of the percentage of the U.S. population categorized into the various race/ethnicity groupings were based on single-race characterizations, as represented in the U.S. Census Bureau reports. Individuals reported as multirace are included in the Unknown/Other category.

The estimated percentage of the 2009-2011 annual average of non-Hispanic white CO fatalities closely mirrors the percentage of the U.S. population at 60 percent and 64 percent, respectively. However, there appears to be a disproportionate number of Black or African American victims of CO poisoning, comprising 21 percent of all CO poisoning fatalities, even though Blacks or African Americans represent only about 12 percent of the U.S. population. By contrast, the proportion of the CO poisoning fatality victims who were of Hispanic ethnicity (8%) is below the percentage of Hispanics in the U.S. population (16%). Chi-square goodness-of-fit test results indicate that there is a significant statistical difference (p-value = 0.0003) between the proportion of CO victims categorized by race/ethnicity from that of the general U.S. population.

10 The "percentage of the U.S. population" is defined here as the mid-range of 2009 to 2011 (2010) of the 2013 U.S. Census estimates of the U.S. population.
population. Each race/ethnicity group was analyzed separately, versus the expected proportion of the respective race/ethnicity group based on U.S. population figures, assuming there was no race/ethnicity group effect on the CO poisoning fatality rate, to determine which race/ethnicity group proportions were significantly greater than or less than the expectation. For the Chi-Square statistical analysis, the three smaller groups ("Asian/Pacific," "American Indian," and "Unknown/Other") were combined due to their relative small proportion of the U.S. population. Binomial tests indicate that two race/ethnicity groups were statistically significantly different from the expected proportion based on the U.S. population. The observed proportion of Hispanic CO fatalities was significantly lower (p-value of 0.0046) than the proportion of Hispanics in the U.S. population. Additionally, the observed proportion of Black or African American CO fatalities was significantly higher (p-value < 0.0004) than the proportion of Black or African Americans in the U.S. population.

Table 9: Estimated Non-Fire Carbon Monoxide Poisoning Deaths by Race/Ethnicity, 2002–2011

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</thead>
<tbody>
<tr>
<td>Total</td>
<td>156</td>
<td>100%</td>
<td>153</td>
<td>168</td>
<td>190</td>
<td>180</td>
<td>186</td>
<td>178</td>
<td>148</td>
<td>159</td>
<td>160</td>
<td></td>
</tr>
<tr>
<td>White (non-Hispanic)</td>
<td>94</td>
<td>60%</td>
<td>138</td>
<td>116</td>
<td>134</td>
<td>107</td>
<td>122</td>
<td>122</td>
<td>93</td>
<td>81</td>
<td>107</td>
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</tr>
<tr>
<td>Black or African American</td>
<td>33</td>
<td>21%</td>
<td>12%</td>
<td>26</td>
<td>27</td>
<td>36</td>
<td>35</td>
<td>30</td>
<td>20</td>
<td>44</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Hispanic (All races)</td>
<td>12</td>
<td>8%</td>
<td>16%</td>
<td>14</td>
<td>14</td>
<td>15</td>
<td>19</td>
<td>23</td>
<td>14</td>
<td>11</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>Asian / Pacific(^1)</td>
<td>3</td>
<td>2%</td>
<td>5%</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>13</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>American Indian(^2)</td>
<td>2</td>
<td>1%</td>
<td>1%</td>
<td>2</td>
<td>2</td>
<td>*</td>
<td>6</td>
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<td>5</td>
<td>1</td>
<td>5</td>
<td>1</td>
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<tr>
<td>Unknown / Other(^3)</td>
<td>11</td>
<td>7%</td>
<td>2%</td>
<td>1</td>
<td>*</td>
<td>2</td>
<td>2</td>
<td>*</td>
<td>2</td>
<td>4</td>
<td>19</td>
<td>7</td>
</tr>
</tbody>
</table>

+ Data collection for 2011 is only partially complete. Italicized estimates may change in the future if more reports of fatalities are received.
+ No reports received by CPSC staff.
\(b\) Based on estimated U.S. population statistics for the mid-range year 2010.
\(^1\) Includes Asian, Pacific Islander, and Native Hawaiian
\(^2\) Includes American Indian, Native American, and Native Alaskan
\(^3\) Includes Unknown race, Other race, and Multiple races
Source: U.S. Consumer Product Safety Commission / EPHA.
CPSC Death Certificate File, CPSC In-Depth Investigation File, CPSC Injury or Potential Injury Incident File, National Center for Health Statistics
U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties:
April 1, 2010 to July 1, 2013. June 2014.
Note: Reported annual estimates and estimated averages and percentages may not add to subtotals or totals due to rounding.

Table 10 provides a breakout of the CO poisoning fatalities characterized by population density of the incident location. The table is presented as three sections: (1) incidents occurring at all incident locations; (2) incidents occurring in locations identified as a permanent home (e.g., house, apartment, mobile home); and (3) incidents occurring only in non-home locations (e.g., camper trailer, tent, motel room). Please note that “Home Locations” and “Non-Home Locations” sum to “All Locations.”

All fatal incidents were designated as occurring in one of four rural/urban categories based on the Rural-Urban Commuting Area (RUCA) codes developed by the Economic Research Service (ERS) of the U.S. Department of Agriculture (USDA) in conjunction with the Center for Rural Health, School of Medicine and Health Sciences, University of North Dakota. The categories are based on theoretical concepts used by the U.S. Office of Management and
Budget (OMB) to define county-level metropolitan and micropolitan areas.\textsuperscript{11} This 21-category classification system is based on measures of population density, urbanization, and daily commuting. The OMB methodology is based on a county-level delineation. ERS refined the methodology by applying it to smaller census tracts. ERS further delineated the characterization by cross-referencing each zip code in the United States to its RUCA code classification.\textsuperscript{12} The development of the new update of the RUCAs to version 3.1 was developed by Center for Rural Health, School of Medicine and Health Sciences, University of North Dakota and ERS and is funded by the federal Office of Rural Health Policy (of HRSA, HHS) and the Economic Research Service (of Department of Agriculture). The zip code cross-reference was used to characterize each of the CO fatalities into one of four broad categories: Urban Core, Sub-Urban, Large Rural Town, and Small Town/Rural Isolated.

Table 10 also includes the estimated percentage of the U.S. population, per population density designation category. As can be seen in the All Locations section, the estimated average percentage of CO fatalities during the 3-year period 2009 through 2011, in urban locations (56%), is smaller than the percentage of the U.S. population living in urban core locations (74%). The difference is offset by the larger percentages the other three categories: sub-urban locations (23% versus 14% of the U.S. population), large rural town locations (12% versus 6%), and small town/rural isolated locations (9% versus 5%). A look at the section, Non-Home Locations, helps to identify some of the disparity. An average of 26 percent of all non-home CO fatalities occurred in small town/rural isolated locations, even though the U.S. population living in isolated locations is only 5 percent. In 2009 through 2011, an estimated average of seven of 27 CO poisoning fatalities in non-home locations occurred in small town/rural isolated locations. Two factors may help to explain the relatively high proportion of small town/isolated rural location CO fatalities. Many non-home locations where CO fatalities occurred were tents, camper trailers, or cabins in isolated locations, used during hunting or camping activities where no local power utility is available. In these cases, individuals often resort to generators for power and use portable LP heaters, lanterns, and stoves.

Due to changes in the RUCA classification system from Version 2 used in prior reports and the current Version 3.1 used in this report, the percentage of the U.S. population designated in the four different categories have changed slightly. The “Urban Core” designation now encompasses 74 percent of the U.S. population, up from 72 percent in prior versions. The “Sub-Urban” designation increased from 9 percent to 14 percent under RUCA 3.1. “Large Rural Town” decreased from 10% to 6%, and “Small Town/Rural Isolated” decreased from 9 percent to 5 percent. Incident counts were correspondingly reclassified using these newer geographic definitions, and thus Table 10 counts differ from prior published versions.


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<tbody>
<tr>
<td>All Locations</td>
<td>156</td>
<td>100%</td>
<td>181</td>
<td>153</td>
<td>168</td>
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<td>186</td>
<td>178</td>
<td>148</td>
<td>159</td>
<td>160</td>
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<tr>
<td>Urban Core</td>
<td>87</td>
<td>56%</td>
<td>76</td>
<td>88</td>
<td>95</td>
<td>91</td>
<td>112</td>
<td>114</td>
<td>105</td>
<td>78</td>
<td>93</td>
<td>90</td>
</tr>
<tr>
<td>Sub-Urban</td>
<td>36</td>
<td>23%</td>
<td>49</td>
<td>31</td>
<td>36</td>
<td>53</td>
<td>28</td>
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<td>32</td>
<td>42</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Large Rural Town</td>
<td>18</td>
<td>12%</td>
<td>14</td>
<td>8</td>
<td>20</td>
<td>15</td>
<td>17</td>
<td>12</td>
<td>23</td>
<td>10</td>
<td>26</td>
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<tr>
<td>Small Town/Rural Isolated</td>
<td>14</td>
<td>9%</td>
<td>41</td>
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<td>23</td>
<td>38</td>
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### Home Location

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</thead>
<tbody>
<tr>
<td>All Locations</td>
<td>128</td>
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<td>144</td>
<td>120</td>
<td>130</td>
<td>140</td>
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<td>152</td>
<td>136</td>
<td>116</td>
<td>134</td>
<td>133</td>
</tr>
<tr>
<td>Urban Core</td>
<td>75</td>
<td>59%</td>
<td>63</td>
<td>77</td>
<td>79</td>
<td>73</td>
<td>98</td>
<td>95</td>
<td>84</td>
<td>65</td>
<td>88</td>
<td>72</td>
</tr>
<tr>
<td>Sub-Urban</td>
<td>28</td>
<td>22%</td>
<td>42</td>
<td>22</td>
<td>23</td>
<td>32</td>
<td>19</td>
<td>22</td>
<td>27</td>
<td>30</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Large Rural Town</td>
<td>15</td>
<td>12%</td>
<td>12</td>
<td>8</td>
<td>16</td>
<td>14</td>
<td>13</td>
<td>11</td>
<td>14</td>
<td>10</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Small Town/Rural Isolated</td>
<td>10</td>
<td>8%</td>
<td>27</td>
<td>13</td>
<td>12</td>
<td>21</td>
<td>7</td>
<td>24</td>
<td>11</td>
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### Non-Home Locations

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</thead>
<tbody>
<tr>
<td>All Locations</td>
<td>27</td>
<td>100%</td>
<td>37</td>
<td>31</td>
<td>36</td>
<td>49</td>
<td>42</td>
<td>33</td>
<td>40</td>
<td>32</td>
<td>23</td>
<td>27</td>
</tr>
<tr>
<td>Urban Core</td>
<td>10</td>
<td>41%</td>
<td>13</td>
<td>10</td>
<td>15</td>
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<td>19</td>
<td>21</td>
<td>13</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Sub-Urban</td>
<td>6</td>
<td>22%</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>21</td>
<td>9</td>
<td>9</td>
<td>5</td>
<td>12</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Large Rural Town</td>
<td>3</td>
<td>11%</td>
<td>2</td>
<td>*</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>*</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Small Town/Rural Isolated</td>
<td>7</td>
<td>26%</td>
<td>14</td>
<td>13</td>
<td>9</td>
<td>10</td>
<td>17</td>
<td>14</td>
<td>6</td>
<td>7</td>
<td>9</td>
<td>5</td>
</tr>
</tbody>
</table>

* Data collection for 2011 is only partially complete. Italicized estimates may change in the future if more reports of fatalities are received.

* No reports received by CPSC staff.

\* Estimated 2010 U.S. population categorized by Rural Urban Commuting Area (RUCA 3.1) designation. U.S. population estimates by RUCA classification were determined by cross-referencing the Center for Rural Health, School of Medicine and Health Sciences, University of North Dakota/Economic Research Service, Department of Agriculture RUCA3.1 zip code table with the 2010 U.S. Census population estimates by zip code area.

Source: U.S. Consumer Product Safety Commission/EPHA.


Table 11 provides a breakout of the CO poisoning fatalities characterized by geographic region where the incident occurred. As can be seen in the table, for the most part, the percentage of CO fatalities in each of the regions reflects the percentage of the U.S. population living in these regions. This would indicate that geographic location has little effect on the likelihood of fatal CO poisoning incidents. There are, however, a few exceptions that should be pointed out. The Midwest region, as a whole, exhibited a greater than expected number of CO deaths. Twenty-nine percent of the estimated CO fatalities in 2009 through 2011 occurred in Midwest states where only 22 percent of the U.S. population lives. Conversely, the South Atlantic states of the South region accounted for 13 percent of the CO deaths where 19 percent of the U.S. population lives. And the Pacific states of the West region also accounted for fewer CO deaths than expected (12% of the deaths, 16% of the population).
Table 11: Estimated Non-Fire Carbon Monoxide Poisoning Deaths by Geographical Region of Incident, 2002–2011

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>156</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Northeast</td>
<td>24</td>
<td>15%</td>
<td>18%</td>
<td>24%</td>
<td>16%</td>
<td>33%</td>
<td>24%</td>
<td>44%</td>
<td>28%</td>
<td>14%</td>
<td>20%</td>
<td>37%</td>
</tr>
<tr>
<td>New England</td>
<td>7</td>
<td>4%</td>
<td>5%</td>
<td>6%</td>
<td>3%</td>
<td>7%</td>
<td>8%</td>
<td>10%</td>
<td>12%</td>
<td>5%</td>
<td>5%</td>
<td>11%</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>17</td>
<td>11%</td>
<td>13%</td>
<td>12%</td>
<td>21%</td>
<td>10%</td>
<td>26%</td>
<td>34%</td>
<td>16%</td>
<td>9%</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>South</td>
<td>57</td>
<td>37%</td>
<td>37%</td>
<td>69%</td>
<td>53%</td>
<td>58%</td>
<td>74%</td>
<td>57%</td>
<td>61%</td>
<td>51%</td>
<td>55%</td>
<td>58%</td>
</tr>
<tr>
<td>East South Central</td>
<td>16</td>
<td>10%</td>
<td>6%</td>
<td>12%</td>
<td>15%</td>
<td>16%</td>
<td>9%</td>
<td>10%</td>
<td>9%</td>
<td>10%</td>
<td>19%</td>
<td>13%</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>21</td>
<td>13%</td>
<td>19%</td>
<td>38%</td>
<td>25%</td>
<td>21%</td>
<td>41%</td>
<td>26%</td>
<td>25%</td>
<td>21%</td>
<td>13%</td>
<td>28%</td>
</tr>
<tr>
<td>West South Central</td>
<td>20</td>
<td>13%</td>
<td>12%</td>
<td>19%</td>
<td>12%</td>
<td>21%</td>
<td>24%</td>
<td>21%</td>
<td>27%</td>
<td>23%</td>
<td>17%</td>
<td>20%</td>
</tr>
<tr>
<td>Midwest</td>
<td>65</td>
<td>29%</td>
<td>22%</td>
<td>58%</td>
<td>41%</td>
<td>40%</td>
<td>46%</td>
<td>54%</td>
<td>47%</td>
<td>58%</td>
<td>48%</td>
<td>51%</td>
</tr>
<tr>
<td>East North Central</td>
<td>32</td>
<td>21%</td>
<td>15%</td>
<td>38%</td>
<td>34%</td>
<td>30%</td>
<td>31%</td>
<td>40%</td>
<td>25%</td>
<td>39%</td>
<td>28%</td>
<td>41%</td>
</tr>
<tr>
<td>West North Central</td>
<td>12</td>
<td>8%</td>
<td>7%</td>
<td>20%</td>
<td>7%</td>
<td>19%</td>
<td>15%</td>
<td>14%</td>
<td>22%</td>
<td>18%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>West</td>
<td>30</td>
<td>19%</td>
<td>23%</td>
<td>33%</td>
<td>33%</td>
<td>37%</td>
<td>33%</td>
<td>46%</td>
<td>33%</td>
<td>40%</td>
<td>31%</td>
<td>28%</td>
</tr>
<tr>
<td>Mountain</td>
<td>11</td>
<td>7%</td>
<td>7%</td>
<td>21%</td>
<td>12%</td>
<td>20%</td>
<td>18%</td>
<td>21%</td>
<td>17%</td>
<td>25%</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>Pacific</td>
<td>18</td>
<td>12%</td>
<td>16%</td>
<td>12%</td>
<td>20%</td>
<td>16%</td>
<td>15%</td>
<td>24%</td>
<td>17%</td>
<td>15%</td>
<td>14%</td>
<td>21%</td>
</tr>
</tbody>
</table>

† Region designation is based on U.S. Census Bureau reporting practices. See Appendix C for identification of specific regional designation of state of occurrence.

+ Data collection for 2011 is only partially complete. Italicized estimates may change in the future if more reports of fatalities are received.

* Based on estimated U.S. population statistics for the mid-range year 2010.

Source: U.S. Consumer Product Safety Commission/EPHA.
CPSC Death Certificate File, CPSC In-Depth Investigation File, CPSC Injury or Potential Injury Incident File, National Center for Health Statistics

Note: Reported annual estimates and estimated averages and percentages may not add to subtotals or totals due to rounding.
Appendix A: Methodology

This appendix describes the data sources and methodology used to compute the national estimate of non-fire carbon monoxide (CO) poisoning deaths associated with the use of consumer products and the estimates by product, victim age, and incident location.

All death certificates filed in the United States are compiled by the National Center for Health Statistics (NCHS) into a multiple cause of mortality data file. The NCHS Mortality File contains demographic and geographic information, as well as the International Statistical Classification of Diseases and Related Health Problems codes for the underlying cause of death. Data are compiled in accordance with the World Health Organization instructions, which request that member nations classify causes of death by the current Manual of the International Statistical Classification of Diseases and Related Health Problems. The International Classification of Diseases, Tenth Revision (ICD-10) was implemented in 1999. Although the NCHS data contain cause of death codes that are helpful in identifying deaths due to CO poisoning, the records do not contain any narrative information that might indicate the involvement of a consumer product.

To complement the NCHS mortality data, CPSC staff purchases death certificates from the 50 states, the District of Columbia, and New York City. Specifically, CPSC staff purchases death certificates with certain cause-of-death codes for which there is a high probability that consumer products are involved. In addition to the cause-of-death codes and demographic and geographic information, the death certificate contains information about the incident location and a brief narrative describing the incident. Any references to consumer products are usually found in these narratives. As resources allow, CPSC staff conducts follow-up In-Depth Investigations (IDIs) on selected deaths to confirm and expand upon the involvement of consumer products.

ICD-10 classifies deaths associated with CO poisoning with the codes listed below. The focus of this report is accidental CO poisoning deaths and concentrates on deaths coded as X47 and Y17. That is, code X67—records of intentional CO poisonings—are excluded from this analysis.

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>X47</td>
<td>Accidental—Poisoning by and exposure to other gases and vapors. Includes: carbon monoxide, lacrimogenic gas, motor (vehicle) exhaust gas, nitrogen oxides, sulfur dioxide, utility gas.</td>
</tr>
<tr>
<td>X67</td>
<td>Intentional—Poisoning by and exposure to other gases and vapors. Includes: carbon monoxide, lacrimogenic gas, motor (vehicle) exhaust gas, nitrogen oxides, sulfur dioxide, utility gas.</td>
</tr>
<tr>
<td>Y17</td>
<td>Undetermined intent—Poisoning by and exposure to other gases and vapors. Includes: carbon monoxide, lacrimogenic gas, motor (vehicle) exhaust gas, nitrogen oxides, sulfur dioxide, utility gas.</td>
</tr>
</tbody>
</table>

The first step in compiling the annual estimates is computing the total estimates of CO poisoning deaths associated with consumer products. The CPSC’s Death Certificate (DTHS)
File and the CPSC’s Abbreviated Death Certificate (ABDT) File were searched for cases associated with ICD-10 codes X47 and Y17.

Each death found in the CPSC’s DTHS File and coded as X47 or Y17 was reviewed by an analyst and categorized as in scope, out of scope, or whether the source of the CO was unknown or questionable. In-scope cases are unintentional, non-fire CO poisoning deaths associated with a consumer product under the jurisdiction of the CPSC. Out-of-scope cases are cases that involve CO sources that are not under the jurisdiction of the CPSC (including motor vehicle exhaust cases), fire or smoke-related exposures, or intentional CO poisonings. Examples of out-of-scope cases include: poisonings due to gases other than CO (i.e., natural gas, ammonia, butane); motor vehicle exhaust- or boat exhaust-related poisonings; and work-related exposures. The source of CO was classified as unknown or questionable in cases where a consumer product was possibly associated with the incident, but the exact source of CO was unknown.

Deaths found in the CPSC’s ABT File are categorized as out-of-scope cases. The ABDT File contains death certificates for CO poisonings (X47 and Y17) that involve motor vehicle exhaust, cases where the source of the CO is unknown, or where the death certificate does not mention a consumer product. Other examples of out-of-scope cases that may appear in the abbreviated file are cases associated with farm accidents, smoke inhalation from a structural fire, or other gas poisonings. Occasionally, newer information from CPSC IDIs may be matched with ABDT cases that were classified as having no known source or did not mention a consumer product. In the cases where the CPSC IDIs indicate the CO source was from a consumer product and should be considered in scope, it was assumed that the death certificate was misclassified, and the subject cases in the ABDT File were included with the DTHS database files.

In previous years, a small number of cases in the ABDT File were identified as in scope, based on further information collected during IDIs. The method used to identify three deaths in 1999, and two deaths in 2000, is found in Appendix A of the 1999 and 2000 Annual Estimate Report (Vagts, 2003). For 2001 data, no ABDT File cases were reclassified as in scope, based on additional information. For the 2002 data, additional information on one incident in the ABDT File resulted in the incident being reclassified as in scope. This fatality was not included in the NCHS file. Because the incident was not included in the NCHS data, it was also removed from the ABDT File; thus, the incident was not used in calculations for the weights. For the 2003 data, there were seven reclassified in-scope cases in the ABDT File and five in 2004. For the 2005 data, one case from the ABDT File was reclassified as an in-scope case. For the 2006 data, three cases from the ABDT were reclassified. And for 2007, three more cases were reclassified. For 2008, 2009, 2010, and 2011 no ABDT records were reclassified as in scope.

Since the release of the previous annual report, additional records have been entered into the CPSC databases, and therefore, the resultant initial categorization for 2010 through 2011 has been recalculated and is presented in Tables A.1.a through A.1.b.
The proportion of death certificates found in the CPSC database associated with non-fire unintentional X47 or Y17 deaths and associated with consumer products was applied to the NCHS totals to calculate the total estimated number of non-fire CO poisoning deaths associated with consumer products. In theory, the NCHS totals comprise all death certificates in the United States, and the same proportion of in-scope cases should exist in the death certificates that are missing from the combined CPSC Death Certificate and Abbreviated Death Certificate files or are from an unknown source. Applying the proportion of in-scope cases to the NCHS database totals, therefore, should provide an estimate of in-scope cases nationwide. This was done in the following way and was done for ICD-10 codes X47 and Y17, separately:

1. The number of in-scope deaths in the CPSC’s Death Certificate File coded as X47 or Y17 separately that were associated with an accidental non-fire CO poisoning and a consumer product were identified \( n_1 \).

2. The total number of deaths in the CPSC’s Death Certificate File and the Abbreviated Death Certificate File coded as X47 or Y17 were summmed separately, excluding cases with an unknown or highly questionable source \( n_2 \).

3. The total number of deaths in the NCHS data associated with X47 and Y17 was counted \( n_3 \).

The proportion of death certificates found in the CPSC database associated with non-fire unintentional X47 or Y17 deaths and associated with consumer products was applied to the NCHS totals to calculate the total estimated number of non-fire CO poisoning deaths associated with consumer products. In theory, the NCHS totals comprise all death certificates in the United States, and the same proportion of in-scope cases should exist in the death certificates that are missing from the combined CPSC Death Certificate and Abbreviated Death Certificate files or are from an unknown source. Applying the proportion of in-scope cases to the NCHS database totals, therefore, should provide an estimate of in-scope cases nationwide. This was done in the following way and was done for ICD-10 codes X47 and Y17, separately:

1. The number of in-scope deaths in the CPSC’s Death Certificate File coded as X47 or Y17 separately that were associated with an accidental non-fire CO poisoning and a consumer product were identified \( n_1 \).

2. The total number of deaths in the CPSC’s Death Certificate File and the Abbreviated Death Certificate File coded as X47 or Y17 were summmed separately, excluding cases with an unknown or highly questionable source \( n_2 \).

3. The total number of deaths in the NCHS data associated with X47 and Y17 was counted \( n_3 \).
4. The estimate of the number of non-fire CO poisoning deaths associated with consumer products in codes X47 and Y17 was calculated separately, using the formula:

\[ N = \frac{n_1}{n_2} \times n_3 \]

The proportion \(\frac{n_1}{n_2}\) represents the number of in-scope cases found in the CPSC’s files, divided by the total of in-scope and out-of-scope cases.

5. The estimates of the number of non-fire CO poisoning deaths associated with consumer products in codes X47 and Y17 were summed to calculate the total estimate of non-fire CO poisoning deaths.

\[ \text{Total Estimate} = N_{X47} + N_{Y17} \]

The ratio \(\frac{n_3}{n_2}\) represents the weighting factor used to calculate the annual estimates. The CPSC’s Death Certificate File does not contain death certificates for all deaths listed in the NCHS file; therefore a weighting factor was calculated to account for death certificates that are missing. The weighting factor allows the computation of national estimates of CO deaths by consumer products and by other characteristics collected by CPSC about each death.

Table A.2 contains the values for the variables used in the calculation, as well as the final computed 2010 and 2011 estimates of CO poisoning deaths.

<table>
<thead>
<tr>
<th>Table A.2.a: Calculation Detail of the Final Computed 2010 Estimate of Non-Fire CO Poisoning Deaths Associated with Consumer Products</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>(n_1)</td>
</tr>
<tr>
<td>(n_2)</td>
</tr>
<tr>
<td>(n_3)</td>
</tr>
<tr>
<td><strong>Weighting Factor (\frac{n_3}{n_2})</strong></td>
</tr>
<tr>
<td><strong>Total Estimate</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table A.2.b: Calculation Detail of the Final Computed 2011 Estimate of Non-Fire CO Poisoning Deaths Associated with Consumer Products</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>(n_1)</td>
</tr>
<tr>
<td>(n_2)</td>
</tr>
<tr>
<td>(n_3)</td>
</tr>
<tr>
<td><strong>Weighting Factor (\frac{n_3}{n_2})</strong></td>
</tr>
<tr>
<td><strong>Total Estimate</strong></td>
</tr>
</tbody>
</table>

Death certificates received by NCHS are routinely checked for accuracy of state personnel identified ICD-10 coding. On occasion, NCHS staff will correct codes before entering the data into their databases. The death certificate facsimiles or electronic death certificates that CPSC receives are direct from the states, and therefore, have not been corrected per NCHS procedures. As a consequence, there may be slight discrepancies between final NCHS counts and CPSC records, which are not due to CPSC simply not having the records, but instead, may be due to corrections made at NCHS. Because CPSC receives the death certificates directly from the states, CPSC records do not contain information from NCHS when an ICD-10 code changed for a specific death certificate; so CPSC staff has no way of correcting CPSC records to come into accord with NCHS records. For this report, CPSC staff has made the assumption that, over time, the number of death certificates with ICD-10 codes changed by NCHS staff to the codes of interest (X47 and Y17) would approximately equal those changed from the code of interest.

Table A.3 shows the weighting factors used to calculate the estimates for the years 2002–2011, based on the information available to CPSC staff.
Table A.3: CO Fatality Cases and Weighting Factors Used to Calculate the Estimates for the Years 2002–2011

<table>
<thead>
<tr>
<th>Year</th>
<th>NCHS Total</th>
<th>Total in CPSC Databases*</th>
<th>In-Scope Cases*</th>
<th>Weighting Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>X47</td>
<td>642</td>
<td>599</td>
<td>168</td>
</tr>
<tr>
<td></td>
<td>Y17</td>
<td>71</td>
<td>61</td>
<td>1</td>
</tr>
<tr>
<td>2003</td>
<td>X47</td>
<td>633</td>
<td>625</td>
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<td></td>
<td>Y17</td>
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</tr>
<tr>
<td>2004</td>
<td>X47</td>
<td>566</td>
<td>527</td>
<td>154</td>
</tr>
<tr>
<td></td>
<td>Y17</td>
<td>86</td>
<td>72</td>
<td>2</td>
</tr>
<tr>
<td>2005</td>
<td>X47</td>
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<td>590</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>Y17</td>
<td>92</td>
<td>70</td>
<td>1</td>
</tr>
<tr>
<td>2006</td>
<td>X47</td>
<td>585</td>
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<td>161</td>
</tr>
<tr>
<td></td>
<td>Y17</td>
<td>74</td>
<td>53</td>
<td>1</td>
</tr>
<tr>
<td>2007</td>
<td>X47</td>
<td>605</td>
<td>580</td>
<td>173</td>
</tr>
<tr>
<td></td>
<td>Y17</td>
<td>89</td>
<td>68</td>
<td>4</td>
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<tr>
<td>2008</td>
<td>X47</td>
<td>677</td>
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<td>166</td>
</tr>
<tr>
<td></td>
<td>Y17</td>
<td>68</td>
<td>54</td>
<td>6</td>
</tr>
<tr>
<td>2009</td>
<td>X47</td>
<td>734</td>
<td>769</td>
<td>145</td>
</tr>
<tr>
<td></td>
<td>Y17</td>
<td>72</td>
<td>52</td>
<td>2</td>
</tr>
<tr>
<td>2010</td>
<td>X47</td>
<td>675</td>
<td>554</td>
<td>122</td>
</tr>
<tr>
<td></td>
<td>Y17</td>
<td>98</td>
<td>66</td>
<td>7</td>
</tr>
<tr>
<td>2011</td>
<td>X47</td>
<td>786</td>
<td>700</td>
<td>134</td>
</tr>
<tr>
<td></td>
<td>Y17</td>
<td>89</td>
<td>74</td>
<td>8</td>
</tr>
</tbody>
</table>

For some years, the number of in-scope cases has changed slightly from the previous report, due to either newly obtained information or a recharacterization of a few cases.

* This is the total number of deaths in the Death Certificate File and Abbreviated Death Certificate File, excluding deaths associated with an unknown or questionable source of CO.

Source: U.S. Consumer Product Safety Commission/EPHA
Incidents with unknown or highly questionable CO sources were excluded from the denominator (the number of fatalities in the CPSC databases) of the weighting factor. The group of cases with unknown or highly questionable sources was assumed to contain the same proportion of cases associated with a consumer product as the group of cases within the CPSC database with known CO sources (this is the same assumption that is made for those cases where the death certificate is missing). To include these cases within the denominator assumes that these cases can be classified as in-scope or out-of-scope cases, when actually their scope status is unknown. Therefore, for weighting purposes, cases where the source was unknown, or highly questionable, were treated in the same way as missing cases were treated.

In-scope cases were examined further to determine which product was associated with the incident. Further information on the CO deaths was obtained from review of the CPSC’s IDI File.

Reports of non-fire CO poisoning deaths were retrieved from the DTHS and ABDT files based on the following criteria: date of death between 1/1/2002 and 12/31/2011, and ICD-10 code of X47 or Y17. Death certificates entered into the CPSC’s database prior to July 11, 2014, were included in this analysis. Whenever possible, each CO death was reviewed and coded by the author, according to the consumer product and type of fuel involved, incident location, and whether multiple deaths resulted in the same incident. If information about the product’s condition, venting system, or installation environment was provided in the IDI report, then this information was coded for informational purposes.

In Table 1 of this report, the Heating Systems category includes CO poisoning fatalities from subcategories for furnaces and boilers (combined under the heading of Furnaces), vented floor and wall heaters, unvented room/space heaters, unvented portable heaters, and other miscellaneous heating systems. Each subcategory is further delineated by fuel type used. Deaths associated with charcoal being burned alone and in the absence of an appliance (e.g., in a pail or in the sink) were presented with Charcoal Grills, even though this practice usually was done for heating purposes. Examples of products historically included in the Other Products category include LP gas refrigerators and gas pool heaters. LP gas grill, LP fish cooker, and other LP gas portable cooking appliance incidents are classified in the Grills, Camp Stoves category. Deaths where multiple fuel-burning products were used simultaneously, such that a single source of the fatal CO could not be determined, were classified under Multiple Products. Engine-Driven Tools included generators and power gardening equipment, such as power lawn mowers, garden tractors, concrete cutters, gasoline-powered water pumps, and snow blowers. Generators that were original equipment installed on a recreational vehicle (RV), trailer, camper, or boat were considered out of scope, as they are outside the jurisdiction of the CPSC.

Figure B.1 below graphically suggests a trend of the estimated CO fatalities from 1980 to 2011. Before the implementation of the ICD-10 coding in 1999, the estimated number of non-fire, consumer product-related CO poisoning deaths decreased from the early 1980s to the late 1990s, from a high of 340 in 1982, to a low of 180 in both 1997 and 1998. In 1999, there were an estimated 108 consumer product-related CO fatalities, well below the estimated 180 deaths in each of the two previous years. The difference may be due, in part, to the change from ICD-9 coding to ICD-10 coding, where product identification could be assessed more accurately.

Table B.1 presents the annual estimates from 1980 to 2011, and the 3-year average mortality rates associated with each year, where 3 years of data were available. The 3-year average mortality rate is presented in the table for the mid-point year. The estimated 3-year average mortality rate decreased from the 1982 high of 14.02 per 10 million population, to a 3-year average rate of 4.34 per 10 million in 2000, a reduction of 69 percent. Subsequently, the 3-year average rate has been increasing annually through 2006, to a rate of 6.21. Since 2006, the rate has been slowly dropping to the current 2010 estimate of 5.03. But the 2010 estimate is still 16 percent above the 2000 low average. The year 2010 is the last year for which data are available to calculate a 3-year average.
Table B.1: Estimated Non-Fire Carbon Monoxide Poisoning Deaths Associated with Consumer Products, 1980–2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimate</th>
<th>U.S. Population Estimates (thousands)</th>
<th>3-Year Average Mortality Rate per 10 Million Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
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<td>227,225</td>
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</tr>
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<td>1982</td>
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<td>231,664</td>
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</tr>
<tr>
<td>1983</td>
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<tr>
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<tr>
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<td>180</td>
<td>275,854</td>
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<td>5.81</td>
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<td>5.23</td>
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<td>309,326</td>
<td>5.03</td>
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<tr>
<td>2011</td>
<td>160</td>
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</tr>
</tbody>
</table>

Note: The 3-year average mortality rate is reported at the mid-point year.

* The Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) was implemented.


Before implementation of ICD-10 in 1999, generation of estimates for an important category of products: generators and other engine-driven tools was not possible. With the advent of ICD-10 coding, generation of estimates of fatalities associated with generators and other engine-driven tools is now possible. This category has been observed to have a statistically

13 See Appendix B of Mah (2001) for details.
significant upward trend in the estimated number of associated CO poisoning fatalities since 1999 (pages 13–14). This increasing trend appears to be having an impact on the mortality rate of consumer product-related CO poisoning fatalities. Table B.2 shows that the 2010, 3-year average mortality rate (1.79) for generators alone was more than three times greater than for the 2000, 3-year average rate (0.54), and the estimated 3-year average rate has increased each year from 2000 through 2006, before slowly decreasing each year through 2010. Over the 6-year period 2005 through 2011, more CO fatalities were associated with engine-driven tools than with heating systems. These are the only years since the implementation of ICD-10 with more EDT-associated CO deaths than heating system-associated CO deaths.

Table B.2: Estimated Non-Fire Carbon Monoxide Poisoning Deaths Associated with Generators*, 1999–2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimate</th>
<th>U.S. Population (thousands)</th>
<th>3-Year Average Mortality Rate per 10 Million Population</th>
</tr>
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<tbody>
<tr>
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<td>0.95</td>
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<td>2001</td>
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<td>2010</td>
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<td>309,326</td>
<td>1.79</td>
</tr>
<tr>
<td>2011</td>
<td>60</td>
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</tr>
</tbody>
</table>

* Estimates are based on single source product incidents as multiple source incidents could be included in multiple categories.
* Estimates in this table do not include multiple product-related deaths because a generator was not the sole product associated with the fatality.

Note 1: The 3-year average mortality rate is reported at the mid-year population estimates.
Note 2: Mortality rate changes from last year’s report are due to changes in CPSC CO death estimates and changes in U.S. Census population estimates.
Table B.3 shows the CO poisoning mortality rates associated with all consumer products, excluding generators. The data indicate that, when generators are excluded, there does not appear to be a trend in the mortality rate for consumer products. The 2000, 3-year annual average mortality rate was 3.60. The 2010, 3-year average mortality rate was 2.88, a decrease of 20 percent. In fact, the 3-year averages have dropped slightly each year since the 2003 high point. With generators included, the mortality rate increased from 4.34 per 10 million to 5.03 in the same time span, an increase of 16 percent.

Table B.3: Estimated Non-Fire Carbon Monoxide Poisoning Deaths Associated with Consumer Products, 1999–2011 (Excluding Generator-Related Deaths)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimate</th>
<th>U.S. Population (thousands)</th>
<th>3-Year Average Mortality Rate per 10 Million Population</th>
</tr>
</thead>
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<td>2003</td>
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<td>3.93</td>
</tr>
<tr>
<td>2004</td>
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<td>3.48</td>
</tr>
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<td>2005</td>
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<td>2.90</td>
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<td>2010</td>
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<td>2.88</td>
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<tr>
<td>2011</td>
<td>92</td>
<td>311,583</td>
<td></td>
</tr>
</tbody>
</table>

* Estimates are based on single source product incidents as multiple source incidents could be included in multiple categories.
+ Excludes estimates of deaths associated with a generator only.

Note 1: The 3-year average mortality rate is reported at the mid-year population estimates.
Note 2: Mortality rate changes from last year's report are due to changes in CPSC CO death estimates and changes in U.S. Census population estimates.
Table B.4 shows the 3-year average mortality rates of all engine-driven tools, including generators, through 2010. Even though the average mortality rates for 2007 through 2010 have dropped since the 2006 high (3.18), the table shows that the average mortality rate has more than tripled from the 2000, 3-year average rate (0.72), to the average rate for 2010 (2.18).

Table B.4: Estimated Non-Fire Carbon Monoxide Poisoning Deaths Associated with Generators and Other Engine-Driven Tools, 1999–2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimate</th>
<th>U.S. Population (thousands)</th>
<th>3-Year Average Mortality Rate per 10 Million Population</th>
</tr>
</thead>
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<td>1.51</td>
</tr>
<tr>
<td>2003</td>
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<td>290,326</td>
<td>1.88</td>
</tr>
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<td>2.43</td>
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<td>2006</td>
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<td>3.18</td>
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<td>2007</td>
<td>79</td>
<td>301,580</td>
<td>2.62</td>
</tr>
<tr>
<td>2008</td>
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<td>307,007</td>
<td>2.31</td>
</tr>
<tr>
<td>2010</td>
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<td>2.18</td>
</tr>
<tr>
<td>2011</td>
<td>70</td>
<td>311,583</td>
<td></td>
</tr>
</tbody>
</table>

* Estimates are based on single source product incidents as multiple source incidents could be included in multiple categories.

Note 1: The 3-year average mortality rate is reported at the mid-year population estimates.

Note 2: Mortality rate changes from last year's report are due to changes in CPSC CO death estimates and changes in U.S. Census population estimates.
Table B.5 shows the CO mortality rates associated with all consumer products, excluding generators and other engine-driven tools. The data indicate that the annual average, 3-year mortality rate decreased by 28 percent of non-engine-driven tool consumer products (i.e., excluding generator and other engine-driven tools), with the 2000 average mortality rate of 3.44 and 2.49 in 2010. When all consumer products are included, there has been a 16 percent increase in the CO mortality rate from the 2000 average rate, increasing from 3-year average mortality rate of 4.34 in 2000, to 5.03 in 2010, as shown in Table B.1. Engine-driven tools and generators, in particular, have had a substantial impact on the CO poisoning mortality rate involving consumer products.

Table B.5: Estimated Non-Fire Carbon Monoxide Poisoning Deaths Associated with Consumer Products, 1999–2011* (Excluding Generator- and Other Engine-Driven Tool-Related Deaths)

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimate</th>
<th>U.S. Population (thousands)</th>
<th>3-Year Average Mortality Rate per 10 Million Population</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>2011</td>
<td>82</td>
<td>311,583</td>
<td></td>
</tr>
</tbody>
</table>

* Estimates are based on single-source product incidents, as multiple-source incidents could be included in multiple categories.
+ Excludes estimates of deaths associated with EDTs only. Multiproduct-associated incidents are included here because an EDT could not be identified as the only product involved. The one exception to this is the 2001 estimate, which excludes one estimated death associated with a generator and another EDT.

Note 1: The 3-year average mortality rate is reported at the mid-year population estimates.
Note 2: Mortality rate changes from last year's report are due to changes in CPSC CO death estimates and changes to U.S. Census estimates.
Appendix C: Regional Definitions

1) Northeast comprises New England and Middle Atlantic states.

2) Midwest comprises East North Central and West North Central states.
   a) East North Central: Ohio, Indiana, Illinois, Michigan, and Wisconsin.
   b) West North Central: Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas.

3) South comprises South Atlantic, East South Central, and West South Central states.
   a) South Atlantic: Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, and Florida.
   b) East South Central: Kentucky, Tennessee, Alabama, and Mississippi.
   c) West South Central: Arkansas, Louisiana, Oklahoma, and Texas.

4) West comprises Mountain and Pacific states.

Source: U.S. Census Bureau 2012 Statistical Abstract
http://www.census.gov/compendia/statab/cats/population.html
References


<https://www.cpsc.gov/library/co03.pdf>