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KEEPING AMERICA'S CHILDREN SAFE: PREVENTING CHILDHOOD INJURY

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

ON

EXAMINING PREVENTING CHILDHOOD ACCIDENTAL INJURY

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STATEMENTS

THURSDAY, MAY 1, 2009

ADDITIONAL MATERIAL

KEEPING AMERICA'S CHILDREN SAFE: PREVENTING CHILDHOOD INJURY

THURSDAY, MAY 1, 2008

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:35 a.m. in Room SD–430, Dirksen Senate Office Building, Hon. Edward M. Kennedy, chairman of the committee, presiding.

Present: Senators Kennedy, Dodd, and Isakson.

OPENING STATEMENT OF SENATOR DODD

Senator DODD [presiding]. The committee will come to order, and we welcome all of you here this morning. We are here today to celebrate the victories over the past 20 years of an organization and organizations like Safe Kids USA in protecting America's children from unintentional childhood injury.

First of all, I want to congratulate Safe Kids on their 20th anniversary. I have been fortunate enough to work with this organization for the past 20 years on numerous occasions in various settings, as we have celebrated the work of Safe Kids and their contributions. They deserve a great deal of credit for the progress that has been made in protecting our children from accidental injuries.

On average, the fatality rate from unintentional injuries has dropped by 45 percent over the past 20 years, and that is due to the dedication of all of the organizations we have here today to research the best ways to prevent childhood injury and to get that information out to parents and to caregivers.

But we are also here today to talk about what still needs to be done in this area, and a lot needs to be done, of course. Despite the decrease I mentioned, we still have an average of 430 children dying each month from accidental injuries. It is still the No. 1 killer of American children under the age of 14, regrettably.

I remember a time, and I am sure my colleague does, when there were no car seats, we didn't always buckle up, and it was okay to smoke around your children. We have been able to become far more sophisticated in how we protect our children, but we have got a ways to go. So I am pleased to have all of you here today to discuss that with this committee.

The burden of preventing childhood injury falls on American families and caregivers, and they have so much to worry about. Parents have to be concerned about dangers in the home, at their

childcare provider, at the homes of family and friends, and the potential dangers which arise when children are out of their sight.

The constant concern can be quite an emotional toll on parents, but the financial cost associated with keeping a child safe can be astronomical. Parents and caregivers need to have car seats, helmets, smoke detectors, carbon monoxide detectors, temperature-sensing faucets. The list goes on and on. We need to ensure that families of all income levels have access to the best technology available to keep their children safe.

I have got to take a moment here to brag a little bit. Coming from the State of Connecticut, we recently were named the "Safest State For Kids" by Parents magazine. We are deeply proud of that recognition. It is an honor to be so designated, and there are a lot of people in my State who deserve credit for that, helping us—our mayors, our State legislators, our governors, the State officials, and others who have worked over the years to earn that reputation.

Today, we have with us representatives from the Centers for Disease Control and Prevention, Safe Kids USA, the Home Safety Council, and the State and Territorial Injury Prevention Directors Association, who have all been crucial in the decrease in numbers of injuries over the years.

We also have with us a young man, Justin Bruns, who has a personal story about how he was able to escape permanent injury because of the safety precautions that he took, and the story highlights why it is so important for caregivers to take seriously the issue of injury prevention to protect their children from harm. We are honored to have Justin with us this morning, and we thank him in advance for his testimony. It is very courageous to come forward and talk about a situation that you have been in.

With that, let me turn to my colleague, Senator Isakson, and then we will hear from our witnesses. We thank them for being with us.

STATEMENT OF SENATOR ISAKSON

Senator ISAKSON. Well, thank you very much, Chairman Dodd. It is an honor to be here, and I welcome Safe Kids USA and all our witnesses, in particular young Justin. We are glad to have you here to tell your story today.

I am glad to be a part of this. I am the father of three and the grandfather to eight, six of whom are under 4 years old. We end up keeping them a lot of weekends when I am home. So I have become an expert in child safety restraints and all kinds of things that have been a product of the movement over the last 20 years really to make our homes safer and our children safer.

I was particularly pleased to be the co-sponsor of the Cameron Gulbransen Kids and Cars Safety Act recently, which came out of a personal tragedy in my district, where a young lady by the name of Cindy Donald, who was a cheerleader at Lassiter High School, was sunbathing during the summer between her junior and senior year. Her father, in a hurry, backed his SUV out of the garage and rolled over her legs, severing part of her spine, and she is a quadriplegic today.

I am a part of the Cindy Donald Foundation, where we raise money to help her rehabilitate and recover. But because of this new

act, now we will have the sounds made by cars backing up in reverse so that someone who might be in harm's way has a warning and knows something like that is getting ready to happen.

I think learning the lessons of life, as Justin is going to tell us about in his experience, help us to do those things that make our children safer, and we need to celebrate that. Today is a celebration of child safety, but it is also an awareness that we have to continue to be acutely aware of those challenges that confront us everywhere we can reasonably and responsibly protect our children and make them safe.

Again, I welcome all of our guests who testify today.

Thank you, Mr. Chairman.

Senator DODD. Thank you very much.

I mentioned informally at the outset of the hearing that Senator Kennedy will be here shortly. He has been tied up this morning and asked me to come on in and be a part of this.

But as I mentioned at the outset, I have enjoyed immensely over the years, my involvement with Safe Kids USA. As Chairman of the Subcommittee on Children and Families, we have worked very closely together over the years developing a lot of various ideas that I hope have contributed to exactly the celebration we are enjoying here this morning.

I should also point out, as my friend Johnny, as the father of—well, here he is now. Look at this. The timing—well, very good. I was kind of enjoying this right here.

The Chairman [presiding]. That is what I was afraid of.

[Laughter.]

How many years——

Senator DODD. A lot. I have been waiting a lot.

The CHAIRMAN. How many years have you been waiting?

Senator DODD. I know. I keep on holding his wrist to get a pulse every now and then.

[Laughter.]

I am sad to report it is very strong. Well, I was just saying with two young children as well, we are very conscious in our homes, as all of us are, of safety methods that need to be taken. I have made an opening statement, as has Senator Isakson. We have got our first witness here, but do you want to make some opening comments?

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. Well, I will just put mine in the record.

We want to acknowledge, as we do frequently, that our good chairman today, Senator Dodd, has been the chairman of the Children's Caucus before being chairman of a Children's Caucus was being cool. Years and years, he has chaired that and has been enormously involved in all of the policy issues relating to children and has really made a great difference.

Senator Isakson has also been so involved and active in our committee in terms of the children's issues. So we are very fortunate to have him as well.

I think the really good news is that progress has been made. We are not used to good news around here. It seems that so many of the challenges that we face are so overwhelming and whether we

can really make some progress. But we find out if we really do what these wonderful organizations have recommended and the outreach that they have had in terms of families and parents and urging it in local community levels has really made a very important difference.

We want them to know that we want to be part of that whole process because we think they can continue to make progress.

Second, just very quickly, there is always the issue of the cost of some of these items. Whether they are available, accessible to parents, and whether they can afford them. We are going to hear, I know, this incredible story about this young person's life probably saved because of the use of a helmet, and can people afford it? Particularly these economic ties are things we ought to be able to do or think about some of those issues.

I will put my whole statement in the record, Mr. Chairman. But I thank you, and I thank our witnesses. We have got a really extraordinary group of people who have been on this issue for years and have really been enormously helpful to our committee and very helpful in terms of helping to shape national policy. We are very grateful to all of them.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Our hearing today is on protecting American children more effectively from unintentional childhood injury and death. I'd like to begin by congratulating the organization of Safe Kids USA on its 20th anniversary and on its 20 years of dedication and achievement on this important issue.

First, let me say, I've had the privilege of working with you since the beginning and you deserve great credit for the progress that has been made in protecting children from accidental injury. All of our panelists here today represent organizations that research ways to prevent injury, educate caregivers in creative ways, and help kids learn to keep themselves safe. An important challenge that we face in helping families protect their children is the cost.

As I mentioned, this hearing today focuses on unintentional childhood injury, but I also want to take this opportunity to highlight an important related program up for reauthorization this year—The Child Abuse Prevention and Treatment Act. It was originally enacted in 1974 to identify and address the issues of child abuse and neglect, and to support effective methods of prevention and treatment. It provides grants to States to offer child protective services, funds for research and demonstration projects, assistance to States to investigate and prosecute cases of child maltreatment, and grants for community-based support service. Furthermore, I look forward to working with my colleagues to reauthorize this important program.

It's so important that we do all we can to support safety research and prevention measures. Despite all that we've accomplished over 20 years, 430 children are still dying each month from accidental injury. In Massachusetts alone, there are nearly 43,000 children under the age of 4 who visited the emergency room each year for nonfatal injuries.

It's amazing how times have changed in not only how we behave around our children today, but also take extra care in protecting them. Not long ago, I can remember it was acceptable to place a baby seat in the front of your car and child bike helmets were considered optional. It has been proven that these changes in our behavior, which all of you have been strong advocates and educators in bringing to our attention, save lives. Such examples include that since 1987, we have decreased child motor safety injuries by 49 percent and bike injuries have fallen 49 percent. These statistics demonstrate the success in your work and how sophisticated and aware we have become in protecting our children.

Today unintentional injuries remain the No. 1 killer of American children under the age of 14. The burden of preventing childhood injuries can be a tremendous drain on parent's energy and the worrying can be overwhelming. As a parent, who has raised three children, I have first-hand knowledge of how emotionally draining it can be to protect your children and ensure their safety. It is important for parents to be aware of dangers in not only their home, but their daycare centers, relative's houses, and child's friend's houses. It is only through education and proactive action by parents can we further reduce childhood injuries.

Today, we have with us representatives from the Centers for Disease Control, Safe Kids USA, the Home Safety Council, and the State and Territorial Injury Prevention Director's Association. Also, we have a tremendous example here with us today of how safety precautions prevent childhood injury. A young man, named Justin Bruns, has a personal story of why it's so important for caregivers to take their responsibility of childhood safety precautions seriously.

The CHAIRMAN. I will ask you if you want to——

Senator DODD. Thank you very much.

Dr. Ileana Arias is the Director of the CDC's National Center for Injury Prevention and Control. She is responsible for the expansion of State programs for injury prevention, the development of surveillance for circumstances surrounding violent deaths, and new research in such areas as child maltreatment.

Dr. Arias is a clinical psychologist with a research expertise in family violence, and we are truly honored to have you with us here this morning. I would just say to you, Doctor, and I guess everyone else, all of your statements and supporting documents and materials will be made a part of the record.

So, thank you.

STATEMENT OF ILEANA ARIAS, DIRECTOR, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, ATLANTA, GA

Ms. ARIAS. Thank you very much, Senator Dodd, Chairman Kennedy, and Senator Isakson.

I am delighted to be here to talk to you about this important public health issue and then also join our partners in this endeavor who have been primarily responsible for the advances that you alluded to earlier. It is the case that unintentional injuries is the leading killer of American children, something that continues to be true in spite of the advances that we have made.

Motor vehicle-related crashes and traffic incidents are the primary cause of those deaths, followed very closely by drownings and fires. Of course, the deaths are just the beginning of the story as far as the toll and the burden of injuries among children.

Non-fatal injuries are the leading reason or the main reason why children are brought to the attention of an emergency department. Primarily those are the results of falls. We are talking about kids who are being treated for broken bones, head concussions, and other injuries associated with falls, usually in the home or playgrounds.

Not surprisingly, the costs are astronomical. In 2000, we estimated that the lifetime cost for children between the ages of 1 and 14 of injuries that included both medical expenses and productivity losses over the lifetime is in excess of $51 billion, a significant ticket that we have to then pay on a continuing basis.

That is the bad news. The good news, as you mentioned, is that these are largely preventable, and they are preventable because we know what works. We know how to prevent these injuries, which then accounts for the successes that we have made over the last couple of decades.

At CDC, we are committed to making sure that children are safe. That is, we believe that they are entitled to a safe and healthy life and that every child has the right to live his or her life to the fullest potential. Our contribution to that is by supporting the work that needs to be done in order to decrease that significant challenge to that goal, and that is injuries.

We essentially support research and then, importantly, making sure that that research goes out the door and implemented by communities in order to prevent those injuries. We want to make sure that all caregivers and parents are fully aware of what it is that they have to watch out for as far as their kids are concerned and what kinds of things they can do in order to maximize their safety.

Over the past couple of decades, we have been primarily preoccupied with making sure that people understand what the burden is, that there is a problem, but then very importantly identifying what it is that they can do to prevent it. Where we are now is making sure that those tools get into the hands of individuals who are in a position to actually use them to accomplish the goal of furthering reducing the burden of injury among kids in the United States.

As I said, we know what works. The issue now is making sure that that is widely disseminated and implemented. We recognize that we can't do that on our own. In fact, we can't do much of it on our own. We have to be very cognizant of the partnerships that are crucial to making that happen. Partnering with organizations such as Safe Kids, Home Safety Council, and then Government organizations, both at the State and local levels, as well as to make sure that it happens.

I started off by sort of agreeing with you about the bad news. I agree with you that we do need to concentrate on the fact that there is some good news, that we have made a significant impact over the last two decades. More than that, that we actually do have the tools currently to improve upon that. So that, fortunately, the good news is that nowadays we can do more than cross our fingers

and hope that when our kids leave home, when they get up in the morning, that they will be safe. We actually can ensure that they will be safe.

I thank you for bringing this issue to the attention of the American public and calling attention to it, and I also thank you for the support that you have provided over these last years to make sure that what we are celebrating today actually is possible to celebrate.

So I thank you very much, and then I am happy to answer any questions you may have.

[The prepared statement of Dr. Arias follows:]

PREPARED STATEMENT OF ILEANA ARIAS, PH.D.

Good morning Chairman Kennedy, Ranking Member Enzi, and distinguished members of the committee. It is my privilege to appear before you as Director of the National Center for Injury Prevention and Control (NCIPC) at the Centers for Disease Control and Prevention (CDC). At CDC, we work to ensure that all people achieve their optimal lifespan with the best possible quality of health at every stage of life. We are equally motivated to ensure that individuals get a healthy start in life, and nowhere is this more important than in the lives of children.

Regardless of gender, race, or economic status, injuries remain a leading cause of death for Americans. Unintentional or accidental injury and violence are particularly serious threats to the health and well-being of children and adolescents in the United States. CDC is leading the Nation's efforts in reducing premature death, disability, human suffering and the medical costs associated with injuries and violence. Working with State and local governments, nonprofit organizations, professional societies, academic institutions, private entities, other Federal agencies and international organizations, CDC is documenting the numbers and identifying the causes of injuries, finding and developing effective prevention strategies, and promoting widespread adoption of these solutions.

I will begin today by giving an overview of childhood injury and violence and explaining CDC's unique public health role in their prevention. For many, we know how to prevent injury and death from occurring. I will also give an update on CDC's research findings on specific childhood injuries and give a few examples of CDC efforts that illustrate how we contribute to a healthier nation.

CHILDREN AND INJURIES: OVERVIEW

Infants and young children are at greater risk for many injuries than adults. This increased risk may be attributed to several factors. Children are curious and like to explore their environment, which may lead children to sample pills in the medicine cabinet, play with matches or venture into a family pool. Young children have immature physical coordination and cognitive abilities, and are at greater risk of falls from bicycles and playground equipment. Developing bones and muscles may make them more susceptible to injury in car crashes if they are not properly restrained. As pedestrians, children are particularly vulnerable because developmentally they cannot properly gauge the speed of traffic, and they lack the perceptual motor skills to avoid the path of on-coming traffic when they cross the road.

In general, injuries are the leading cause of death for Americans aged 1 to 44 years. In 2000, injury death and disability cost an estimated $406 billion in lifetime medical treatment expenses and lost productivity including lost wages and benefits as well as costs that are due to inability to perform household activities for an injury sustained in 2000.[1] Of that total, injuries among children ages 0–14 account for $51 billion). Unintentional or accidental injuries remain the leading cause of death among young Americans, with the exception of Congenital Anomalies for children less than 1 year of age. Overall, motor vehicles and traffic-related accidents are the leading cause of injury by which children are killed, followed closely by drowning and unintentional fires. Additionally, unintentional injuries remain the leading cause of childhood *non-fatal* injuries treated in hospital emergency departments across the Nation.

Below are leading causes of injury deaths by age group:

[1] Injury in the U.S.: 2007 Chartbook, National Center for Health Statistics.

Age Range	Leading Causes of Injury Death, 2005
Less than 1 year	Unintentional suffocation; unintentional motor vehicle crashes; unspecified homicide.
1–3 years	Unintentional drowning; unintentional motor vehicle crashes; unintentional fire/burn.
4–11 years	Unintentional motor vehicle crashes; unintentional fire/burn; unintentional drowning.
12–19 years	Unintentional motor vehicle; homicide (firearm); suicide (firearm).

ROLE OF PUBLIC HEALTH IN CHILDHOOD INJURY PREVENTION

To prevent childhood injuries, CDC uses a systematic public health approach. This approach has four steps: define the problem, identify the risk and protective factors, develop and test prevention strategies and assure widespread adoption of the best interventions. CDC achieves these primarily through surveillance and data sharing; research on possible interventions; community implementation and evaluation of interventions; and widespread adoption of proven interventions.

CDC conducts surveillance to inform efforts in developing effective public health programs. By knowing the magnitude of the problem and the affected populations, resources can be directly applied and capacity adjusted to control or prevent the injury by utilizing and evaluating proven interventions.

BURDEN OF CHILDHOOD INJURIES

CDC studies the burden of injury across the lifespan, but today I will focus on children and the leading causes of childhood injuries.

Child Passenger Safety and Young Drivers

Motor vehicle traffic-related injuries are the leading cause of death among children in the United States. During 2005, the National Highway Traffic Safety Administration (NHTSA) reported that 1,451 children ages 14 years and younger died as occupants in motor vehicle crashes, and approximately 203,000 were injured—an average of 4 deaths and 556 injuries each day. NHTSA also reported that of children ages 0 to 14 years killed in motor vehicle crashes during 2005, nearly half were unrestrained. However, many of these deaths can be prevented. We know that placing children in age- and size-appropriate restraint systems reduces serious and fatal injuries by more than half. CDC is currently evaluating State-based programs to increase booster seat use among children 4 to 8 years of age, in order to inform efforts in other States to address passenger safety issues among children.

Because motor vehicle crashes are the leading cause of death for U.S. teens aged 15–19, accounting for 35 percent of all deaths in this age group, research funded by the AAA Foundation for Traffic Safety suggests that the most strict and comprehensive graduated drivers licensing programs are associated with a 38 percent reduction in fatalities and a 40 percent reduction in injuries of 16-year old drivers due to crashes. CDC is building partnerships to promote and strengthen Graduated Driver Licensing (GDL) Systems in States.

Child Maltreatment

The true number of children who are victims of child maltreatment in the United States is unknown, but in 2006 the Administration on Children & Families (ACF) reported 905,000 cases of confirmed or substantiated cases of non-fatal child maltreatment each year in the United States. Child maltreatment includes physical, sexual, and emotional abuse and neglect, and is believed to be underreported. In 2006, ACF data further showed that 1,530 child deaths were officially attributed to maltreatment. Child maltreatment through blunt trauma to the head or violent shaking (also known as shaken baby syndrome) is the leading cause of head injury among infants and young children.

In addition to injuries and related health issues during childhood, child maltreatment can increase the risk factors for many of the leading causes of death among adults. CDC research shows that children who are maltreated are at an increased risk for a variety of health problems, including heart disease, cancer, chronic lung disease, liver disease, alcoholism, drug abuse and depression; and other forms of violence, such as intimate partner and family violence. Indeed, witnessing or experiencing abuse or neglect as a child can increase the risk factors for becoming a victim or perpetrator of violence. With the other work CDC is doing in violence and injury

prevention, child maltreatment prevention represents an opportunity for CDC to have an impact across the lifespan.

CDC has identified programs that teach parenting skills to promote safe, stable, nurturing relationships as one solution for this problem. These methods aim to motivate positive parent child interaction and teach parents to avoid neglectful and physically abusive behavior.

Water Safety

In 2005, of all children 1-14 years old who died, 6.6 percent died from drowning. Although unintentional drowning rates have slowly declined, fatal drowning remains the second-leading cause of unintentional injury-related death for this age group. In addition, for every child 14 years and younger who died from drowning in 2004, four received emergency department care for non-fatal submersion injuries. Research indicates that lack of supervision and proper barriers (such as pool fencing) are primary risk factors. CDC continues to promote water safety education to caregivers by providing information to parent groups, recreation centers and schools.

Residential Fire-Related Injuries

Pre-school children (age 5 and under) and older adults (age 65 and older) have the highest fire death rates in U.S.-home fires. Deaths from fires and burns are the sixth most common cause of unintentional injury deaths in the United States and the third leading cause of fatal home injury. Residential fires caused nearly $7 billion in property damage in 2006, with fire departments responding to 412,500 home fires in the United States. In that same year the lives of 2,580 people were lost and another 12,925 (not including firefighters) were injured. Approximately half of home fire deaths occur in homes without smoke alarms.

Smoke alarms decrease the risk of death in a home fire by up to 50 percent. However, one-quarter of U.S. households lack working smoke alarms, and those least likely to have an alarm are often at higher risk of being injured in a fire.

The smoke alarm installation and fire safety education programs—funded by CDC in 17 States—provide evidence that smoke alarm installation programs save lives. A review of homes participating in CDC-funded smoke detector installation and fire safety education programs found that nearly 1,600 lives have potentially been saved to date. Program staff have canvassed over 473,000 homes and installed nearly 350,000 long-lasting or lithium-battery powered smoke alarms in high-risk homes, including those with children ages 5 years and younger and adults ages 65 years and older. Technology development, distribution of smoke alarms, and addressing risky behaviors are key to reducing the number of fire-related deaths in the United States.

Recreational Injuries (Playground and Sports Safety)

Children spend a lot of time participating in sports and recreation activities. While participation in sports, recreation, and exercise is an important part of a healthy, physically active lifestyle, the associated injuries present a significant public health problem. Injuries related to playground activities account for many of the injuries to youth aged 0–9. Although the mortality associated with these activities is not high (an average of 13 playground deaths per year from 1999–2001,[2] more than 200,000 children visit emergency departments for treatment of a playground injury each year.

According to the CPSC's Public Playground Safety Handbook, 79 percent of playground injuries are due to falls from playground equipment. Fractures to upper limbs are the most common type of injury. Half of all playground injuries occur in schools and sporting facilities.[3] For sports-related injuries, more than half are sustained by youth between the ages of 5–18, with boys having higher rates of injury than girls.[4] Furthermore, CDC estimates that as many as 3.8 million sports and recreation-related concussions occur every year. A concussion is a brain injury caused by a bump or blow to the head, and can have severe long term consequences for children. According to the Consumer Product Safety Commission's (CPSC) economic data, the medical costs of sports and recreational injuries to children under age 18 years were over $11 billion in 2003. Including parents' work losses, pain and

[2] Tinsworth, D. and McDonald, J. (April 2001). Special Study: Injuries and Deaths Associated with Children's Playground Equipment. Washington, D.C.: U.S. Consumer Product Safety Commission. *http://www.cpsc.gov/LIBRARY/Playgrnd.pdf*.

[3] Conn JM, Annest JL, Gilchrist J. Sports and recreation-related injury episodes in the U.S. population, 1997–1999. *Inj Prev* 2003; 9(2): 117–123.

[4] Non-fatal Traumatic Brain Injuries from Sports and Recreation Activities—United States, 2001–2005; MMWR 2007.

suffering, and product liability and legal fees, this societal cost was approximately $121 billion in 2003.[5]

A CDC-sponsored School Health Taskforce produced recommendations to schools to develop, teach, implement, and enforce safety rules to address recreational injuries. Additionally, CDC has been instrumental in producing appropriate educational materials for parents and youth sports coaches in the assessment, management and prevention of traumatic brain injury or concussions. The "Heads Up: Concussion in Youth Sports" initiative offers information to youth sports coaches and parents to help ensure the health and safety of young athletes. Furthermore, CDC developed the Acute Concussion Evaluation (ACE), a tool for physicians to assess and manage patients with concussions.

CONCLUSION

There is now a strong and growing scientific basis for childhood injury and violence prevention and control. Injuries and violence do not have to be an accepted risk—lives can be saved and injuries can be prevented. Public health can promote the use of effective prevention strategies; yet, where science-based interventions exist, they are too-often not widely disseminated. This is equivalent to developing a life-saving medication but not telling physicians or patients that it is available, not packaging the product for public use, not having skilled pharmacists to dispense the medication, and not providing guidance about the management of its effects. To save lives, consumers and providers need support for adopting and maintaining interventions over time. To effectively address the issue, CDC is developing national initiatives and other large-scale approaches to support and expand current research, improve program evaluation and promote widespread adoption and use of effective preventative measures. Most injuries are completely preventable and thus should never happen.

Thank you for the opportunity to discuss these important public health issues today. Thank you also for your continued interest in and support of CDC's injury prevention activities.

I will be happy to answer any questions.

The CHAIRMAN. Good. Well, thank you very much.

Let me ask you, what do you think would be your estimate if each of the States were to put in an effective kind of program, what are we talking about in terms of sort of resources? What would be just round figures?

Ms. ARIAS. CDC is currently funding 30 States to implement a myriad of intervention programs. One of the things that we are trying to do is focus on those child programs. We would like to be able to extend that to all 50 States and territories and would be happy to then get those numbers to you as a follow-up question.

The CHAIRMAN. OK. Yes, would you? So you are in 36?

Ms. ARIAS. Thirty.

The CHAIRMAN. Thirty now, and if they had—do you have a model? Do you have a model program that you put—

Ms. ARIAS. There are various—yes, we do. The State Territory Program Directors Association has come up with models for how it is that State departments can essentially set up those programs to be as effective not only in surveying and monitoring the issue of injury among kids over time, but also in then disseminating and supporting the implementation of those programs.

We also have, with their help, gathered a number of success stories of States that have done a particularly excellent job and then can be replicated in other States as well.

The CHAIRMAN. Let me ask you, how do you go about—do you get a hold of the States, the States get a hold of you, a mix of both? Do you look at States that haven't been in touch with you recently and recommend that they do? Or how do you proceed?

[5] CPSC Directorate for Economic Analysis 2000; CPSC 2003.

Ms. ARIAS. That is a great question. We do a combination of both. We certainly make information available to all States of the resources that we do have and how those resources can be employed.

Because we are not able to essentially directly support all States, what we do with the States we can't support is reach out to them and find out what are technical assistance or other kinds of resources that we can make available to them. Also how is it that in future competitions, for example, they may be able to then compete more successfully to get that kind of funding.

The CHAIRMAN. Just finally, how are we doing in Massachusetts? I know you never should ask a question you don't know an answer to, but let me hear. How are we doing? What specifically—maybe just specifically, I will ask you for the record, but do you know offhand how we are doing up there and what we ought to be doing better?

Ms. ARIAS. Yes. Massachusetts does quite well, and we can send you specific information about all the programs that we do——

The CHAIRMAN. OK.

Ms. ARIAS [continuing]. Fund across the lifespan and in different settings.

The CHAIRMAN. Yes, if you could, just give me what they are doing and the areas that you think can be strengthened.

Ms. ARIAS. OK.

The CHAIRMAN. I will be glad to get in touch with the Governor, too, and see if we can't make some progress.

Ms. ARIAS. Excellent.

The CHAIRMAN. Thank you.

Senator ISAKSON. Thank you very much, Chairman Kennedy.

Did I hear your testimony correctly that the cost annually is $51 billion?

Ms. ARIAS. Those are lifetime costs.

Senator ISAKSON. Those are lifetime costs?

Ms. ARIAS. Yes. So if we project——

Senator ISAKSON. The results of those injuries, like the young lady I talked about who is a quadriplegic. The cost of her care the rest of her life, that is a part of that number?

Ms. ARIAS. Yes, sir. Even changes in productivity as a result of those injuries.

Senator ISAKSON. Right, and that is incalculable, I guess, in terms of the productivity loss.

What is the most common accident today?

Ms. ARIAS. It usually is motor vehicle crashes. So that really is the leading cause of deaths for sure. For the unintentional, it depends on the age range. For younger kids, it tends to be fall. But really, motor vehicle crashes and traffic-related issues are the primary contributor to those figures.

Senator ISAKSON. Are you in CDC in Atlanta?

Ms. ARIAS. Yes, we are.

Senator ISAKSON. Good, well, welcome. We are neighbors.

On reaching our kids and reaching, in many cases, our adults, when I chaired the State Board of Education in Georgia, we found out the best way to communicate was through the kids, and particularly starting at the elementary school, in terms of good diet, safety practices, even in the enrollment of kids in SCHIP.

When that first started back in 1996, and I chaired the Board of Education, we had a very low enrollment rate until we used the schools to educate the kids to go home and tell mom and dad, "hey, this insurance is available if you will go down and sign up".

So an answer in response to Senator Kennedy's question, I think the single-best conduit to get reinforced safety and good health practices and everything else is through the public schools and through public education. I know in Georgia, we have got Superintendent Kathy Cox, who has done a good job in a number of areas like that. I would recommend any time CDC can or your part of CDC can get that information and use the State centers of education, the better that information will get disseminated.

Ms. ARIAS. Yes. No, that is an excellent point. Both on the unintentional side and even on violence issues related to safety in schools, we have traditionally focused significantly on school programs and how it is that those messages and what kind of tools teachers and other school personnel need in order to deliver those messages.

The other is, of course, trying to deliver them as early as possible. So, if possible, working with elementary school-age kids so that they can then develop those behaviors very early so that by the time they reach high school, where they are a little more autonomous, are engaging in the kinds of behaviors that are going to safeguard them.

Senator ISAKSON. I remember when my youngest son, Kevin, was in some elementary school grade, and he came home with a clay thing that he had made. It was an ashtray, and he gave it to me. At the bottom, he had written on it "don't smoke." You know, one of the great things for kids to do. But this is a very impressionable time in their lives, but also it helps us to make impressions on them that will save them from many dangers in the future.

So we appreciate what you are doing, and thank you for being here.

Ms. ARIAS. Thank you.

Senator DODD. Doctor, just a couple of things. One is to what extent do you work at all with the entertainment industry? We talk about influences on children, and obviously there's programming, cartoons, all sorts of things. To what extent, I mean, is there an awareness that a lot of repetition or imitation of important messages occurs? Obviously, parents have a responsibility to warn their children about what they can and cannot do.

But do you get any cooperation? Are they helpful at all in this?

Ms. ARIAS. They are very helpful, both in terms of working with us directly and then working through our partners as well, whether it is print media or television or others, trying to look for opportunities to deliver those safety messages. For example, a partnership with *Parents* magazine potentially this coming year on safety issues across the lifespan.

We are now in the process of also reaching out to Sesame Street Workshop. Walt Disney, who has done an excellent job of addressing the issue, for example, of residential fires and the prevention of fires in the home. So that the entertainment industry has a significant and strong interest in being helpful in that way.

Senator DODD. It is an average of 430 deaths a month from accidental injury. Tell me about how those numbers have changed in the last few years. And do me a favor as well, break down that number. It seems like there is an inordinate amount of reporting lately on violence, gun violence and the like. Please share with us your thoughts on that and what CDC is doing about it and how cooperative are States being in some of the issues where you are trying to reduce the level of gun violence in our schools.

Ms. ARIAS. The focus today was on unintentional injuries primarily because it is by far the most significant contributor to injuries and deaths among kids. However, violence is a significant issue for children and adolescents and young adults. For example, we know that homicide is the fourth-leading cause of death for kids between ages——

Senator DODD. Is what? I am sorry?

Ms. ARIAS. Homicide is the fourth-leading cause of death——

Senator DODD. Fourth leading.

Ms. ARIAS [continuing]. For children between the ages of 1 and 9. So that is a pretty startling statistic. Most of that, of course, is the result of child maltreatment, which includes anything from physical abuse, sexual abuse, and then neglect.

What we are doing, very similar to what we do with injuries, is trying to identify who are the kids who are at high risk for that or who are the families that are at high risks for those kinds of issues, and then what are the most effective ways of preventing those issues from happening?

We know from the research and the science that we have supported at CDC and that others have conducted that parenting programs are significant in order to prevent child maltreatment and also to prevent a number of negative health outcomes for kids. That is, programs that essentially teach parents not only how to discipline their children, but also how to interact in a positive way with their children and sort of help them develop in the way that they want.

In addition to those parenting programs, early home visitation programs have also been shown to be incredibly successful, looking at a reduction of about 40 percent in child maltreatment among families who have been enrolled in those programs. So that very similar to unintentional injuries, it is a big problem, but fortunately, we know what can be done. Currently, it is then a matter of making sure that communities are equipped to be able to address the issue by having those things available to them.

Senator DODD. Yes. I wonder if you might address as well the current state of collaboration between the Federal agencies on coordinated injury prevention approaches, particularly between the CDC and HRSA. How is that working?

Ms. ARIAS. It is working quite well. Usually, it winds up being topic specific, so that if we have an issue that we are pursuing—for example, whether it is shaken baby syndrome or car seats—finding other Federal agencies, either within the Department of Health or other Federal agencies who have a role in making sure that that happens.

One of the things we do in public health is recognize that everything we do is multisectorial. It is not just about public health.

Usually there are a number of other sectors that have to essentially coordinate with what we are doing in order to be effective. From the very beginning, we reach out to them, make sure that we do coordinate. Otherwise, we are going to essentially hamper our chances of success in addition to then maybe getting in their way.

Senator DODD. Is your general conclusion that they are receptive, the various Federal agencies?

Ms. ARIAS. Yes, they are. What we try to do is be very clear about what is the value added that each of us brings to the table. In the case of CDC, we know that there are certain things that we do that usually are not replicated in other agencies and that we have particular expertise.

Primarily, that has to do with the surveillance issues, making sure that we support the systems to collect the information to find out what the problem is, where the problem exists and, therefore, where we should be investing our resources. The other is in the evaluation of those programs. So that other agencies are ideally equipped and suited to be able to disseminate programs, but not necessarily support the evaluation of those programs once they are implemented in a community.

Of course, we are very interested in making sure that we document the effect of those programs when they are implemented to make sure that we want to continue with that investment and not have to change it in order to improve success.

Senator DODD. Yes. And last, let me just mention that Senator Kennedy raised this and I think Senator Isakson did as well, touched on it, and that is cost. We are looking—as a parent of these young children, just going out and buying car seats and other safety equipment, it is expensive. And if you are a family that is struggling, those costs can be astronomical and can become prohibitive in some cases.

I know there are places you can go to get secondhand and used equipment, good equipment, by the way. It doesn't mean it is faulty in any way. What recommendations and thoughts do you have? Because so many people today are struggling to make these ends meet. They want to keep their children safe, and yet these objects are——

Ms. ARIAS. Yes. We have explored various options for reducing those costs, again to make sure that everybody does have the benefit of the tools that are available to protect their children. Most of what we have looked at and actually have done is building those partnerships.

So whatever resources we can bring to the table and then really focusing on the private sector as well so that we have supported programs, for example, where a Wal-Mart or a Target may actually donate the equipment. Health departments then basically take charge of distributing those and educating individuals about how to use that equipment.

The other is to the extent to which medical services can actually cover the cost of that equipment. So we are looking at those models as a way of then making sure that these things are accessible to all families.

Senator DODD. Thank you very much.

Senator ISAKSON. Mr. Chairman, can I add something?

The CHAIRMAN. Please.

Senator ISAKSON. Senator Dodd asked a question, I know, Dr. Arias, I believe you would be aware of this. But last year, there was an attempt by a member of the Senate to delete in the appropriations act for CDC a line item for what I call the Hollywood Help Desk at CDC.

But CDC has, under Dr. Gerberding, established a working group that works with television writers and screenwriters to make sure that when they put health-related, safety-related, any type incident like that that is depicted in a film, to try and get them to depict it in the proper way, both negatively, if it is a bad thing for someone to do, as well as positively, if it is the right way to handle it.

So CDC has been a leader in trying to communicate with Hollywood and television to make sure that what people are seeing and influenced by so much at least has credible information in it and that hopefully depict the type of outcome we would all want to have.

The CHAIRMAN. That is good. That is useful.

Let me just ask a final question, do you look at the Advertising Council, too? Have you tried the Advertising Council to get them sort of involved? They take on various projects, and they are—when they get behind it, they have got enormous resources and interests. But it seems to me there may very well be interest in the Ad Council. See if they would take on something like this, you might take a look.

And we might inquire. Maybe that is a job for us to inquire of the Ad Council, and we might be back in touch with you about how that might be suggested, recommended. But if we could get them involved in it, too, it might be of value and use to all of the different groups that are doing a lot of good work.

So I guess we will follow up. I am just rambling along here. But we will follow up with you and see if there is something that makes some sense.

Ms. ARIAS. Most definitely.

The CHAIRMAN. OK. Thank you very much.

Senator DODD. Thank you, Doctor.

The CHAIRMAN. Go ahead. You have got the second panel there.

Senator DODD. Alan Korn, I want to welcome you. Alan, thank you for being here. He is the Director of Public Policy for Safe Kids Worldwide.

We invite Justin to come on up and join us as well. Justin, come on up here. Justin is a student from The Boys Latin School in Baltimore, MD, and we thank Justin for joining us.

Meri-K Appy, did I pronounce that correctly? Meri-K is President of Home Safety Council, and we thank you for being with us.

Amber Williams is the Executive Director of State and Territorial Injury Prevention Directors Association in Atlanta, GA. You have got a lot of constituents here.

Senator ISAKSON. Absolutely. We are on top of this.

Senator DODD. I know. Justin, how are you? You doing okay? Good man. Good to have you with us. Got off school today. So we can keep you talking all day. You don't have to go to school today.

[Laughter.]

The CHAIRMAN. We have got some young observers here, back here. Do they want to stand up? Some young children, I see them in the second row. Are they your sisters? You are going to introduce them for us? Good morning.

Senator DODD. Good morning.

The CHAIRMAN. Thank you for being here.

Senator DODD. Well, we will begin, Alan, with you. Thank you for being with us this morning.

STATEMENT OF ALAN KORN, DIRECTOR OF PUBLIC POLICY, SAFE KIDS USA INTERNATIONAL, WASHINGTON, DC

Mr. KORN. Sure. Thank you very much.

There we go. Safe Kids appreciates the attention this committee has thrown toward this issue over the past 20 years. I would be remiss if I did not point out that this committee helped us at our launch 20 years ago—Senator Dodd, you were chair of that subcommittee when we did it—at our 10th, 15th, and now 20th anniversary.

This committee has played a tremendous role in helping us with the good news that we reported earlier this week, with the help of a lot of groups and the Federal Government. It has been quite remarkable.

Let me just say one other thing, if I didn't point out—with your permission, Chairman Kennedy and Senator Isakson—point out Senator Dodd individually. Senator Dodd, you have been thinking about and acting on these issues for 20-plus years. It is, if I were to spend the time drawing down the list of things that you have done on behalf of injury prevention, we would eat up our entire time of the hearing.

This committee in particular and Senator Dodd specifically, so we really do appreciate—

The CHAIRMAN. Is this your witness, Senator Dodd?

[Laughter.]

Senator DODD. But he is going to be at every hearing that I——

Mr. KORN. You always risk pointing out one particular Senator, but it is well deserved.

The CHAIRMAN. It is well deserved.

Mr. KORN. I should say now to rebuild my reputation here a little bit, Senator Kennedy, no one has done more, too, for public health also. I mean, really.

The CHAIRMAN. There you go. Something nice about Johnny Isakson over here, and he will——

[Laughter.]

We can say the same about you, Mr. Korn.

Mr. KORN. Thank you very much.

The CHAIRMAN. Well known. So thank you.

Mr. KORN. We are smack-dab in the middle of Safe Kids Week, which Congress has helped us celebrate for many, many years, and I will be very brief. I am not going to read my statement. I am just going to make a few points and try to make it as informal as possible.

We released this report earlier this week on Monday here in Washington, DC. It has got absolutely, we believe, tremendous news in it. It is success that all of us here and all of our partners

can be very proud of, including the CDC, the CPSC, NHTSA, the U.S. Fire Administration, and this committee—and we can talk about some of the things that this committee has done under your leadership, Chairman Kennedy.

Over the past 20 years, in two decades, we have seen a decrease of 45 percent in the death rate to children. We think that is remarkable. In fact, I can't think of—there might be, but there is very few of a public health issue that has had that kind of success over that really short period of time. I mean, it seems like a long time, but two decades, and it is remarkable.

It says to us that we know how to prevent these injuries. I brought a lot of visuals. If we get to them, I will be happy to talk about them. But we know how to prevent these injuries, and every single one of them is preventable, in our view. Always with the glass half full, there is a little space yet to go and it is half empty. For some reason, it is still the leading cause of death in this country. Unintentional injury is 5,200 deaths a year.

In fact, is today May 1st? I think it is. We are starting trauma season in this country, which is May 1st to the end of August. Seventeen children a day will die in this country because of an accidental injury during that time period. The CDC and public health groups call it the trauma season, and it is for a reason. They are all preventable.

We are celebrating Safe Kids Week this week with activities around the country, with our support of our founding sponsor, Johnson & Johnson, who, as you know, Senator Kennedy and Dodd, have been with us for so long in our efforts. Doing events in Massachusetts, in Connecticut, and Georgia—and here is my shout-out to Georgia.

We have State and local offices all around the country. I think a lot of our staff here is in the audience, our very best ones are in Georgia. They really know how to do the job there. They are doing child safety seat——

The CHAIRMAN. Have you ever thought of running for office?

[Laughter.]

Senator DODD. As a Democrat.

Mr. KORN. I see what happens, and I am not so sure I want to expose myself to that. But they are doing child safety seat checkup events. They are doing bicycle helmet checks this week and giveaways, personal flotation device giveaways, and they are very good.

That is the type of thing that Dr. Arias was mentioning, about that collaboration, that partnership to get the job done. I will defer to my other colleagues here.

[The prepared statement of Mr. Korn follows:]

PREPARED STATEMENT OF ALAN KORN

My name is Alan Korn, and I am the Director of Public Policy and General Counsel for Safe Kids USA, a member country of Safe Kids Worldwide. Safe Kids thanks the Senate Health, Education, Labor, and Pensions Committee, and in particular Chairman Kennedy and Ranking Member Enzi for holding a hearing on childhood injury prevention. We have all come a long way over the past 20 years in protecting children from unintentional injuries and deaths. Despite the many successes, "accidents" are still the No. 1 killer of children ages 1–14 in the United States. Clearly there is so much more to do. Safe Kids hopes that the attention fostered by both the roundtable and the activities surrounding Safe Kids Week 2008 will prove to be the catalyst we all need to redouble those efforts that we know work, improve

upon others that missed the mark and try new initiatives, both government-based and otherwise, that hold the promise of saving children's lives.

I. HISTORY OF SAFE KIDS WORLDWIDE

Safe Kids Worldwide is the first and only international organization dedicated solely to addressing an often under recognized problem: *More children ages 1–14 in the United States are being killed by what people call "accidents" (motor vehicle crashes, fires, drownings and other injuries) than by any other cause*. Formerly known as the National SAFE KIDS Campaign, Safe Kids Worldwide unites more than 450 coalitions in 16 countries, bringing together health and safety experts, educators, corporations, foundations, policymakers and volunteers to educate and protect families against the dangers of accidental injuries. Our USA network includes coalitions in all 50 States and the District of Columbia, including outstanding programs in both Massachusetts and Wyoming.

Founded in 1987 by the Children's National Medical Center and with support from Johnson & Johnson, Safe Kids Worldwide and its member country, Safe Kids USA, relies on developing injury prevention strategies that work in the real world—conducting public outreach and awareness campaigns, organizing and implementing hands-on grassroots events, and working to make injury prevention a public policy priority.

This year marks our 20th anniversary of our efforts, which has resulted in the significant reduction of accidental childhood injury-related deaths in the United States. We have, over the years, reinforced the ways that parents, caregivers, State and Federal policymakers, and communities can continue to promote children's safety. We have released a comprehensive report to the Nation demonstrating how far we have come in 20 years, and how far we still have to go. In addition, the week of April 26–May 4, is Safe Kids Week and Safe Kids coalitions across the country will be holding local community outreach events to spread awareness about child safety, such as bike helmet rodeos, health fairs and car seat check up events.

The ongoing work of Safe Kids coalitions reaching out to local communities with injury prevention messages has contributed to a decline in the childhood unintentional injury death rate since 1987. However, with more children dying from accidental injury than from cancer, heart disease and birth defects, Safe Kids Worldwide and its member countries remain committed to reducing unintentional injury by implementing prevention strategies and increasing public awareness of the problem and its solutions.

Safe Kids has been proud to work with the Senate Health, Education, Labor, and Pensions Committee over the years to increase the knowledge and understanding of proper child safety practices. This committee has addressed childhood accidental injury through hearings and media outreach events for Safe Kids' other milestones, such as our launch in 1988 and our 10th and 15th anniversary celebrations. We thank the committee once again for being a part of Safe Kids' history and most importantly, for helping us to promote programmatic, educational and legislative interventions to ensure that every child in this country is protected from their most serious public health problem—accidental injury.

II. FINDINGS FROM SAFE KIDS' REPORT TO THE NATION: TRENDS IN UNINTENTIONAL CHILDHOOD INJURY MORTALITY AND PARENTAL VIEWS ON CHILD SAFETY

A. Safe Kids USA's 2008 Report

Safe Kids marked our anniversary by releasing a comprehensive report to the Nation demonstrating how far we have come in 20 years, and how far we still have to go. Entitled, *Report to the Nation: Trends in Unintentional Childhood Injury Mortality and Parental Views on Child Safety*, the report examines accidental injury in the United States and its impact on children by age, gender and race, and reviews the changes in unintentional injury fatality rates for children ages 14 and under in areas such as motor vehicle occupant injuries, drownings and suffocation (which includes strangulation and choking).

B. Major Findings

Major findings from the report include:

1. The unintentional childhood injury fatality rate among children ages 14 and under has decreased in the United States by 45 percent since 1987.

2. Despite this decline, unintentional injury remains the leading cause of death among children ages 1 to 14 in the United States. In 2005, 5,162 children ages 14 and under died from an unintentional injury, and 6,253,661 emergency room visits for unintentional injuries in this age group occurred in 2006.

3. The unintentional injury fatality rate has declined in most risk areas. Some of the greatest improvements have been made in prevention of bicycle injuries (down 73 percent), fire/burn injuries (down 68 percent) and pedestrian injuries (down 62 percent). The four leading causes of death from accidental injuries to children 14 and under are suffocation (19 percent), motor vehicle occupant injuries (16 percent), drownings (16 percent) and pedestrian incidents (11 percent).

4. Unfortunately, the suffocation rate has a documented increase of 21 percent. This is largely the result of a re-categorization of the cause of death driven by an improvement in the quality of death scene investigations that is occurring at various levels across the country. Previously, many of these deaths were categorized as Sudden Infant Death Syndrome (SIDS). With the improved investigations, more cases are being seen where a child suffocates from soft pillows, mattresses, or mattress coverings in his/her crib or from bed-sharing with a parent.

5. Children ages 4 and under have the highest fatality rate as well as the highest number of deaths (2,747 in 2005). Between 1987 and 2005 there has been a 35 percent decrease in fatal unintentional injuries in this group.

6. The fatality rate from unintentional injury is higher among males than females, as is the actual number of deaths. In 2005, approximately 3,000 boys and 2,000 girls ages 14 and under died from unintentional injury.

7. There are large disparities between the fatality rates among children of different races and ethnicities. American Indian/Alaskan Native children have the highest fatality rate from unintentional injury at 15.3 per 100,000, and Asian/Pacific Islander children have the lowest fatality rate at 4.24 per 100,000. These disparities have been consistent since 1987.

8. Fatality rates from unintentional injury declined in each of the four regions of the United States between 1987 and 2005. The largest decrease, almost 60 percent, was in the Northeast, while the Midwest had the smallest decrease, 40 percent. Since 1987, the South has consistently had the highest rate of fatality, 10 per 100,000 in 2005, and the Northeast has had the lowest, 4.56 per 100,000.

III. ADVANCEMENTS IN CHILD SAFETY OVER THE YEARS

While the fatality rate in the United States from unintentional injury in children ages 14 and under has declined by 45 percent since 1987, and significant progress has been made in most risk areas, there is still a long way to go. Every year, more than 5,000 American children ages 14 and under die from unintentional injury. Deaths from suffocation, motor vehicle crashes and drowning still represent a majority of these deaths—and the vast majority of these deaths could have been prevented.

A. Motor Vehicle Occupant Safety

1. **Problem:** Car crashes pose a significant risk for injuries and death to children. Although the motor vehicle occupant death rate among children ages 14 and under declined 49 percent from 1987 to 2005, motor vehicle crashes remain the leading cause of death among children ages 3 to 14 in the United States. In 2005, an estimated 842 children ages 14 and under died unintentionally as motor vehicle traffic occupants. Additionally, in 2006 an estimated 190,346 emergency room visits were for motor vehicle traffic occupant injuries to children ages 14 and under.

In addition to motor vehicle crashes, children are also at risk of injury or death from being left unattended in closed vehicles. Each year from 1998 to 2004, an estimated 33 children died from heat stroke after being left unattended in a vehicle. Between 1987 and 1998 there were 19 reported deaths to children under age 7 due to car trunk entrapments, where children were playing in the trunk and closed the door. Children can also be backed over by unknowing drivers; from 2001 to 2003 approximately 7,475 children (2,492 per year) aged 1 to 14 years were treated for non-fatal motor vehicle backover injuries in emergency departments. Most backovers occurred at either home or in driveways or parking lots; 47 percent occurred at home, and 40 percent occurred in driveways or parking lots.

2. **Solution:** The increased use of car seats has contributed to the reduction in injury and death rates from motor vehicle accidents. Adult seat belts do not adequately protect children under age 8 from a crash injury so car seats, when used appropriately, are the most effective safety devices to protect children. Research demonstrates that correctly installed car seats can reduce fatal injury by 71 percent for infants less than 1 year of age and by 54 percent for toddlers ages 1 to 4. Booster seats for older children reduce the risk of injury by 59 percent. It is recommended that children ride on booster seats, in the rear seats of a vehicle, until they reach 4′9″ in height and weigh between 80–100 pounds. Many children are moved prematurely to seat belts when they should still ride on booster seats.

a. **Education:** The nationwide proliferation of car seat education and distribution programs—and in particular, increased availability of child restraint inspection/installation opportunities utilizing certified technicians—has increased the prevalence and proper usage of these vital safety devices.

Safe Kids has a national program sponsored by General Motors to educate parents and caregivers about the importance of properly restraining children on every ride. Since 1996, the General Motors Corporation has served as Safe Kids Buckle Up's exclusive funding source and helped build Safe Kids Buckle Up into a multifaceted national initiative, bringing motor vehicle safety messages to children and families through community and dealer partnerships. In October 2004, Chevrolet became the lead partner of Safe Kids Buckle Up, bringing an added dimension to the promotion of Safe Kids Buckle Up activities.

Since the program's inception, more than 13 million people have been exposed to Safe Kids Buckle Up events and community outreach efforts, and child passenger safety specialists have examined more than 915,250 seats and donated 365,000 seats to families in need. The program includes car seat check up events, mobile car seat check up vans, child safety seat inspection stations, child safety seat distribution programs, technical child passenger safety trainings, educational workshops, legislative and enforcement efforts to enact or publicize child restraint laws and a toll-free hotline for parents and caregivers to access child safety information.

b. **Enactment and Enforcement:** Over the years improvements in child occupant protection and safety belt laws have proven effective at increasing restraint use and protecting children. The first child occupant protection law was passed in Tennessee in 1978. Since then, all States have passed laws requiring young children be restrained in car seats in motor vehicles. The first booster seat law to protect older children went into effect in California on January 1, 2002. Since then, 43 States, including Washington, DC, have improved upon their restraint law to require some older child passengers to ride properly restrained in a booster seat. Significantly, Massachusetts became the last State in the Northeast to pass a booster seat law. Governor Deval Patrick signed the bill into law on April 11, 2008. Wyoming passed their law in 2003 and has one of the strongest child passenger safety laws in the Nation.

Primary enforcement of seat belt laws is also important. Currently, seat belt use laws in only 26 States and the District of Columbia are subject to primary enforcement. These laws allow a citation to be issued if a police officer simply observes an adult or child riding improperly without a safety belt. Primary enforcement has proven effective in increasing restraint use for both adults and children. In 2007, seat belt use was 87 percent in primary law States versus 73 percent in secondary law States.

In addition, several States have enacted safety laws that protect children in and around cars, including 14 States that prohibit leaving children unattended in a motor vehicle.

The National Highway Traffic Safety Administration has also contributed greatly to the success. Improvements to the Federal Motor Vehicle Safety Standard Number 213, the LATCH system of car seat installation, ease of use ratings for child safety seats—along with their many government-funded public education campaigns supported by the 2005 Federal SAFETEA-LU (Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users) law—have made child safety seats more effective, user-friendly and has helped Safe Kids spread the important message of consistent and correct car seat usage.

In addition, the National Transportation Safety Board has helped promote this vital message. Their Most Wanted List of Traffic Safety Improvements has consistently included the recommendation for State governments to upgrade their child passenger safety laws. The Board has taken a strong role in encouraging these changes through their Advocacy Center.

B. Bicycle and Wheeled Sports Safety

1. **Problem:** Although the bicycle unintentional injury death rate among children ages 14 and under declined by 73 percent from 1987 to 2005, bicycle injury remains a major cause of child mortality and morbidity. In 2005, an estimated 121 children ages 14 and under died from unintentional bicycle injuries. Additionally, in 2006 an estimated 226,409 emergency room visits by children 14 and under were for unintentional bicycle-related injuries.

Other wheeled sports such as skateboarding and skating continue to grow in popularity, and a significant rate of child injury is associated with these activities. According to the U.S. Consumer Product Safety Commission (CPSC), in 2004, more than 46,200 emergency room visits by children 5 to 14 years old were for injuries from inline skating and roller skating. In the same year, more than 43,100 emer-

gency room visits by children 14 and under were for injuries involving non-powered scooters. Nearly 60,300 emergency room visits by children 5 to 14 years old were for skateboarding injuries. The most serious injuries and many of the deaths are due to head injuries.

Quite simply, not enough children are wearing helmets and other protective gear when using bikes, scooters, in-line skates or skateboards.

2. **Solution:** Public health interventions such as education about the proper use of a bicycle helmet, safety campaigns, and environmental changes, have likely helped reduce the child injury death rate from bicycle and other wheeled sports. Bicycle helmets can help protect children from head injuries while participating in bicycle and wheeled sports. In fact, bicycle helmets are 88 percent effective in preventing serious brain injury, yet fewer than half of bicycle riders wear one.

a. **Education:** In addition to promoting helmet use, advocates and researchers recommend creating a comprehensive bicycle safety campaign that includes education about safe riding practices and provides helmets at a discounted cost to those in need. Community-based interventions that include making environmental changes, educating children about helmets and safe riding practices, and enforcing bicycle helmet laws, have proven to increase helmet use and decrease bicycle injuries.

Environmental changes that make streets safer also protect children when they are biking, skateboarding, or skating. A nationwide coalition of diverse members and organizations is currently pushing for States, cities and towns to build road networks that include safety improvements. This coalition stated that a recent survey found 71 percent of adults walked or rode their bicycles to school as a child, but only 17 percent of their own children currently do so. Although decreased biking also decreases a child's risk of injury, the goal is to increase participation in these activities among children in a safe way. More children are likely to bike to school when there are sidewalks or footpaths, safe street crossings, and when there are enforced school zones of vehicle speed.

b. **Enactment and Enforcement:** Legislation requiring helmet use and strict enforcement has positively impacted bicycle helmet use among children. California had the first State helmet law, which became effective in 1987. The enactment and enforcement of mandatory helmet legislation for children (in 21 States, the District of Columbia and over 150 localities across the United States) has likely contributed to the decline in bicycle-related injuries and deaths from 1987 to 2000.

Various studies have shown bicycle helmet legislation to be effective at increasing bicycle helmet use and reducing bicycle-related death and injury among children covered under the law. One study showed that in the 5 years following the passage of a State-mandatory bicycle helmet law for children ages 13 and under, bicycle-related fatalities decreased by 60 percent. Police enforcement increases the effectiveness of these laws. In addition, eight States and Washington, DC now require children to wear a helmet while participating in a wheeled sport (e.g., scooters, inline skates, skateboards). Other States should follow suit.

Over the years, helmets used by children and required by State and local laws have become much more effective. In 1994, Congress required the CPSC to establish performance standards for bike helmets. These better engineered helmets have contributed to our success in lowering the injury death rate.

In addition, the enactment of SAFETEA-LU included the establishment of Safe Routes to Schools, a federally funded program designed to make it safer for children to walk or bike to school. Through this program and with grant monies, States can fix sidewalks, execute traffic-calming and speed-reduction measures, improve pedestrian and bicycle crossings, and conduct public education campaigns to encourage children to walk or bike to school.

C. Poisoning Prevention

1. **Problem:** The childhood unintentional poisoning death rate among children ages 14 and under declined 42 percent from 1981 to 1987 and has continued to decline by 21 percent since 1987. However, unintentional poisoning is still a serious threat to young children. In 2005, an estimated 92 children ages 14 and under died from unintentional poisonings. Additionally, in 2006 an estimated—71,649 emergency room visits were for unintentional poisoning injuries to children 14 and under. In 2005 nearly 63,000 children under age 5 were treated for unintentional medication poisoning. More than 1.2 million unintentional poisonings among children ages 5 and under are reported to U.S. poison control centers. In addition, according to the Centers for Disease Control and Prevention, from 1999–2004, 135 children ages 14 and under died from unintentional, non-fire related CO poisoning.

Carbon monoxide is a hidden hazard for children and families. CO is produced when any fuel is incompletely burned—potentially resulting in flu-like illnesses,

such as dizziness, fatigue, headaches, nausea, and irregular breathing. Common fuel-burning appliances, like furnaces, stoves, fireplaces, clothes dryers, water heaters, and space heaters can produce lethal amounts of CO under certain conditions. Carbon monoxide poisoning mimics other illnesses so it can sometimes be difficult to diagnose. CO poisoning symptoms include headache, dizziness, weakness, nausea, vomiting, chest pain, confusion, loss of consciousness and death to unborn babies. Infants are more susceptible to the effects of CO. Carbon monoxide detectors are essential to have in homes and are effective in preventing deaths from carbon monoxide exposure.

Lead paint poisoning is an additional danger to children. In children, lead poisoning can cause brain damage, impair mental functioning, retard mental and physical development and reduce attention span. Because the early symptoms of lead poisoning are easy to confuse with other illnesses, it is difficult to diagnose lead poisoning without medical testing. Early symptoms may include persistent tiredness, irritability, loss of appetite, stomach discomfort, reduced attention span, insomnia, and constipation. Failure to treat children in the early stages can cause long-term or permanent health damage.

2. **Solution:** A multitude of factors have contributed to the reduced number of deaths from poisonings, including child-resistant packaging for medications and household cleaning products, educational programs, increased accessibility of poisoning prevention information, and treatment/care advances. For unintentional medication exposures, manufacturers are being encouraged to further improve container designs, allowing more convenient access for the user, especially seniors, while also serving as a barrier to children gaining entry.

Intensive efforts to reduce lead in consumer products such as gasoline and paint have helped to protect children from lead poisoning. However, lead paint continues to be an issue in older homes, especially in low-income apartment buildings, where children can ingest paint chips or inhale paint dust. Children also can be poisoned by lead if they lick their fingers after they interact with products that are coated with lead paint. Recently, lead paint in toys has posed a risk to children. Significant news coverage and outreach by nonprofits about lead in toys has likely increased awareness of this issue.

a. **Education:** The Nation's 70 poison control centers historically operated with distinct phone numbers for each center. A big advancement has been the creation of a new nationwide toll-free number for poison control centers. The hotline (1–800–222–1222) was established through the passage of the Poison Control Center Enhancement and Awareness Act of 2000, a law which originated in the Senate HELP Committee with the leadership of Senators Kennedy and DeWine, among others. The hotline is available 24 hours a day and 7 days a week to provide assistance with poisoning emergencies, questions about a specific poison, or information about poison prevention, no matter where the caller is from.

In addition to emergency response, these centers perform public education, professional education, data collection and referral resources—services which are all supported by the Federal Act.

b. **Enactment and Enforcement:** The enactment of laws has protected children from unintentional poisoning. The Poison Control Center Enhancement and Awareness Act of 2000 also provided much needed funding to the centers which were on the verge of having their doors shut due to budget shortfalls. In addition, the issuance of the U.S. Food and Drug Administration regulation requiring iron-containing products to carry a warning about the acute poisoning risk to children has been important in protecting kids from poisoning.

The Federal Government has also banned paint that contains a certain amount of lead. The ban protects children from lead poisoning that can occur by ingesting paint chips or inhaling paint dust. The regulation also includes toys or other children's products as well as furniture with lead paint.

The Poison Prevention Packaging Act of 1970, administered by the CPSC, mandated child resistant packaging for hazardous products such as drugs, certain household cleaners, and some residential use portable fuels. The purpose of the act is to protect children under age 5 from poisonings and deaths that occur when they open containers of hazardous products, and eat or drink the contents. The act has been credited with reducing prescription medication deaths in children less than 4 years of age by 45 percent from 1974 to 1992.

In addition, 14 States and some local jurisdictions have passed legislation requiring the use of carbon monoxide detectors in some homes. However, most State carbon monoxide detector laws only apply to newly constructed residences, reinforcing the need for legislation that applies to all homes.

D. Fire and Burn Safety

1. **Problem:** The unintentional fire/burn death rate among children ages 14 and under declined by 68 percent from 1987 to 2005, yet fire and burn injury remains the fifth leading cause of child unintentional injury-related death. In 2005, an estimated 467 children ages 14 and under died from unintentional fire/burn injuries. Fire and flames accounted for 460, or 99 percent, of these deaths. Additionally, in 2006 an estimated 98,760 emergency room visits were for unintentional fire/burn injuries to children ages 14 and under including scald, thermal, chemical and electrical burns. Scald burns, caused by hot liquids or steam, are more common types of burn-related injuries among young children, compared to contact burns, caused by direct contact with fire, which is more prevalent among older children.

The majority of scald burns children experience, especially in ages 6 months to 2 years, are from hot foods and liquids spilled in the kitchen or wherever food is prepared and served. Hot tap water accounts for nearly 1 in 4 of all scald burns among children and is associated with more deaths and hospitalizations than any other hot liquid burns. Because younger children have thinner skin, their skin burns at lower temperatures and more quickly than adult skin does.

2. **Solution:** There are many factors likely involved in the downward trend of the child death rate from fire and burn injuries. Most home fires started by children begin with playing with lighters or matches and the most common items ignited are mattresses, bedding, clothing, upholstered furniture, trash or papers. Fortunately, there has been a decline in the number of fires set by children playing with lighters and matches, most likely as a result of lighters being subject to a consumer product safety standard that requires them to be child resistant. However, parents still need to be educated to store matches and lighters out of children's reach, preferably in a locked cabinet.

a. **Education:** In addition, smoke alarms, which cut the chances of dying in a residential fire nearly in half, have been promoted as an invaluable tool for preventing fire and burn injury. According to data from the National Fire Incident Reporting System (NFIRS) and the National Fire Protection Association's (NFPA) annual fire department experience survey, 96 percent of U.S. homes report having at least one smoke alarm. However, 47 percent of fire deaths in one- and two-family dwellings and 15 percent of apartment fire deaths resulted from fires with no smoke alarms present, reinforcing the need for continued promotion of smoke alarms in homes.

Another factor involved in the downward trend of reduced fire and burn-related deaths include intensive public education campaigns by Federal agencies such as the CPSC and U.S. Fire Administration, non-profit advocacy groups like Safe Kids, the National Fire Protection Association, the Home Safety Council and the thousands of committed fire departments that promote residential fire safety and burn prevention. Efforts to educate parents about the importance of checking smoke alarm batteries monthly as well as grassroots activities that distribute smoke alarms have made a difference. These efforts must be continued, with the help of the Federal Government, since most of the deaths and injuries to children happen in residential fires in homes with *no* smoke alarms.

Methods to reduce scald burns include lowering hot water temperatures to 120 degrees and keeping hot fluids and liquids away from children, especially when cooking. Educational efforts around these messages to parents may have contributed to a decline in burn-related deaths.

b. **Enactment and Enforcement:** The 1994 child-resistant lighter standard established by the CPSC and the agency's regulations requiring that children's sleepwear be flame resistant and self-extinguish if a flame causes it to catch fire have reduced fire-related deaths. Since the lighter standard has been in effect, the number of child-play lighter fires has declined 58 percent and the number of deaths and injuries associated with these fires has declined by 31 percent and 26 percent, respectively.

For smoke alarms, all States and the District of Columbia have laws that require smoke alarms to be used in both new and existing dwellings.

E. Drowning Prevention

1. **Problem:** Although the childhood drowning death rate declined by 49 percent from 1987 to 2005, fatal drowning remains the second-leading cause of unintentional injury-related death for children ages 1 to 14 years. In 2005, 810 children ages 14 and under died from unintentional drowning, and in 2006, an estimated 3,771 emergency room visits were for unintentional drowning injuries to children ages 14 and under. As many as 20 percent of near-drowning survivors suffer severe, permanent neurological disability. Infants less than 1-year-old drown in bathtubs, buckets, or toilets most often, while the majority of child drownings between ages

1 to 4 occur in residential swimming pools. Older children drown more often in open bodies of water.

In swimming pools and spas, the suction from drain outlets is strong enough to cause entrapment of hair or body parts, and children cannot free themselves. From 1985 to 2004, at least 33 children ages 14 and under died as a result of entrapment in a pool or spa drain, and nearly 100 children ages 14 and under were injured. However, because entrapment is generally a little-known risk for drowning, it is possible that many drowning deaths have not been classified as entrapment and as a result, the number of fatalities could be much higher than reported.

2. **Solution:** Many factors have contributed to the decrease in the childhood drowning rate, including water safety public education efforts, the passage of critical pool/spa and boating safety laws and the decreased use of alcohol in and around water. Advances in emergency medical services and increased training of the public in cardiopulmonary resuscitation (CPR) for drowning incidents also have likely contributed to the downward trend.

a. **Education:** Despite successes in reducing the death rate from drowning, there is still much that can be done to protect children. Nearly 9 out of 10 fatal drowning events occur during a brief lapse in supervision. Most children who drown in swimming pools were last seen in the home, had been missing from sight for less than 5 minutes and were in the care of one or both parents at the time of the drowning. Very young children can drown when they wander outside and fall into their own or other's backyard pools. These research results emphasize the need for pool fencing, swimming lessons for children, and active supervision by parents and caregivers. The installation and proper use of four-sided fencing could prevent 50 to 90 percent of residential swimming pool drownings and near drownings of children.

A specific type of pool/spa drowning known as entrapment cannot be prevented with supervision as the force of the drain's suction is too strong for many adults to remove a child. Entrapments can be prevented by using proper devices, such as anti-entrapment drain covers, a safety vacuum release system, and a multiple drain or no-drain system.

For children ages 10 to 14, recreational or open water settings (such as lakes, rivers, or the ocean) pose a higher risk representing the majority of drownings for this age group. From 1999 to 2003, it is estimated that 85 percent of boating-related drownings could have been prevented if the victim had been wearing a life jacket, however a Safe Kids 2007 Parent Survey showed that only 76 percent of parents consistently have their child wear a life jacket when they are in or near a lake, river or ocean. These statistics emphasize the need for educating parents and caregivers on the importance of consistent use of life jackets when children are boating or playing in or near open bodies of water.

Life jacket loaner stations are an effective way for communities to provide education and safety devices to parents and children. The stations consist of life-jacket loaner boards from which families can borrow a life jacket for their child before heading out on the open water. In Alaska, 75 percent of children under 18 used life jackets at loaner sites compared to 50 percent at non-loaner sites and have reported 12 lives saved.

b. **Enactment and Enforcement:** There have been laws passed in many States to protect children from unintentional drowning. Ten States have safety laws requiring fencing around residential swimming pools and many local jurisdictions also have fencing or barrier ordinances. Five States have laws designed to prevent entrapment-related incidents for residential swimming pools. These generally consist of requiring anti-entrapment safeguards, such as the installation of drain covers or multiple drains. The Virginia Graeme Baker Pool and Spa Safety Act, a Federal law passed in December 2007, provides an incentive for States to pass comprehensive laws requiring safeguards for pools and spas, such as barriers/fences and anti-entrapment devices. The law also requires the establishment of a safety standard for anti-entrapment drain covers; public pools and spas to be equipped with anti-entrapment drain covers and other layers of protection, such as safety vacuum release systems; and a Federal Government-implemented national drowning prevention education program.

Forty-seven States and the District of Columbia have enacted boating safety laws that require children to wear life jackets while participating in recreational boating and in 2002, the U.S. Coast Guard issued a rule requiring children under 13 wear life jackets while aboard recreational vessels in Coast Guard waters.

IV. SAFE KIDS USA'S CALL TO ACTION

Despite the reduction in the child injury death rate, more work still needs to be done in order to address the leading killer of children ages 1–14 in this country.

Safe Kids USA is calling on national and State governmental leaders to recognize that accidental injury is the #1 threat to the Nation's children, and in response, to marshal a multi-faceted effort (similar to what the Nation has done to address drunk driving and smoking cessation) to eliminate this serious public health threat.

A. Federal Efforts Needed

Specifically, Safe Kids is urging the Federal Government to implement a number of steps to keep kids safe:

1. Congress and the President should continue and increase efforts to modernize the operations and facilities of the U.S. Consumer Product Safety Commission (CPSC) so that it can better fulfill its critical mission of protecting consumers, especially children, from dangerous products. This includes swift passage and enactment of the CPSC's pending reauthorization legislation (H.R. 4040/S. 2663).

2. Congress and the President should target increased funding to the several Federal agency programs charged with promoting and improving child safety. These include programs housed at agencies, such as the National Highway Traffic Safety Administration (NHTSA), the United States Fire Administration (USFA) and the National Center for Injury Prevention and Control (NCIPC) at the Centers for Disease Control (CDC).

3. Congress should continue its aggressive oversight of the Federal agencies charged with protecting children from unintentional injury to ensure each agency is properly meeting its mission.

4. Congress and the President should support full funding to the programs recently authorized by the Virginia Graeme Baker Pool and Spa Safety Act (P.L. 110–140). This would allow the CPSC to properly and fully implement the State law advocacy grant program that is designed to motivate States to pass or improve pool and spa safety laws by requiring "layers of protection" that prevent drowning and entrapments (i.e., four-sided isolation fencing, anti-entrapment drain covers, safety vacuum release systems, among other safety devices). Congress and the President should also provide the necessary funds to implement the critical pool and spa safety education program required by the law.

5. Congress and the President should fully fund, and Federal agencies should continue to support, incentive grants programs that are designed to encourage States to pass child safety laws, such as primary safety belt enforcement, booster seat and pool/spa safety legislation.

6. Congress and the President should, through existing programs and the creation of new authorities, ensure that life-saving child safety devices (car seats, carbon monoxide detectors, smoke alarms, pool/spa anti-entrapment drain covers, for example) are available at no cost (or low cost) to disadvantaged families that could not otherwise afford them.

7. Congress, Federal agencies and injury prevention stakeholders should work together to improve consumer product recall effectiveness so that dangerous products are quickly removed from retail store shelves, homes, day care centers and re-sale shops.

8. The U.S. Surgeon General, America's chief health educator, should focus the Nation's attention on childhood accidental injury by issuing an official public health report on unintentional injuries and deaths and how, collectively, we can prevent them. This report should be a catalyst to generate a major public health initiative in the Office of the U.S. Surgeon General.

B. State Efforts Needed

Safe Kids also believes that there is a role for State government officials to promote proper child safety practices:

1. Safe Kids calls on State legislatures and governors to enact:

a. Laws that require all children to be appropriately buckled in a child safety seat (infant seat, forward facing child safety seat or booster seat) or seat belt in the back seat of motor vehicles; and

b. Laws that make it unlawful to leave a child unattended in a motor vehicle even for a short period of time.

2. State legislatures should address bike crashes by passing or improving child helmet use laws in all 50 States for all wheeled activities (i.e., bicycles, scooters, skateboards and in-line skates).

3. State legislatures should address carbon monoxide poisoning by passing carbon monoxide detector use laws in all 50 States that require detectors in all residences, day care centers, hotels/motels and schools.

**Please note that the penalties for violations of these safety device use laws (items 1–3) should be high enough to provide an economic disincentive for non-compliance.*

4. State governors and legislatures should ensure that their respective State public health agencies have adequate funding streams to support the country's injury prevention departments. For the last several years, funding has been reduced for State agencies to address unintentional injury prevention. An adequately funded State public health agency is the cornerstone of a State government's commitment to preventing accidental childhood injury.

V. CONCLUSION

As childhood unintentional injuries and deaths still exist and can be prevented, parents, caregivers, State and Federal policymakers, and communities must make children's safety a priority. Safe Kids commends Chairman Kennedy and Ranking Member Enzi, along with the other members of this committee, for their support of child safety and safer environments for children. We look forward to working with this committee on any efforts designed to protect children from accidental injury and death.

Senator DODD. Terrific. Great work. Good.

Justin, welcome.

STATEMENT OF JUSTIN BRUNS, STUDENT, THE BOYS LATIN SCHOOL OF MARYLAND, BALTIMORE, MD

Mr. BRUNS. Good morning. My story starts, I was in Breckenridge with our friends the Mulroys. Shawn and I woke up early one morning, and we went to go get our lift tickets for the day. It was a beautiful day, and everything was going great. We were doing the terrain park all day, no problem.

So our last run of the day, we decided that we wanted my dad to film us so we could put it on YouTube or something. So we were all tired, and it probably wasn't a good idea to do one more run.

We did the first two rails fine, and the last rail was the kinked rail, which is one of the toughest rails there. When you're going up to a kinked rail, you have to be leaning forward, and I was leaning back, and the board slipped out from under me, and I nailed my head on the packed snow.

I got knocked unconscious and woke up a few minutes later with all of the people around me, not really sure what was going on. They took me to the hospital, and they found trace blood in the left side of my brain. I was in the hospital for 3 days, not really feeling any pain because I was on morphine and all of these painkillers, luckily.

But when I got out, all I could have was Tylenol, and I had headaches for at least 2½ weeks after, and it was probably the worst couple weeks of my life. The pain was crazy, and in school, I only could go 2 to 4 hours a day because the doctor said the more you concentrate, the worse you can make the injury.

So that was hard catching up. But the teachers, luckily, I have a good relationship with them, and they made it really easy for me to get back. My grades didn't drop too much. So that was good.

Excuse me, I was out of sports for 8 weeks and anything active. I am an athlete, and I like to go full all the time. So it was hard to stop doing that for 8 weeks.

Luckily, I am back now, and I haven't had a headache or anything in at least 5 weeks, or any symptoms. So I am happy I was wearing a helmet because it saved my life.

[The prepared statement of Mr. Bruns follows:]

PREPARED STATEMENT OF JUSTIN BRUNS

Good Morning, my name is Justin Bruns. I am an eighth grader from Baltimore, MD. I want to thank Chairman Kennedy, Senator Enzi and other distinguished members of the HELP Committee for inviting me to testify about this important topic and tell my story of how a helmet saved my life in a snowboarding accident.

This past winter my family and I went to Colorado for President's Day weekend. We went to visit friends and family and go skiing/snowboarding. On Saturday, February 16, I got up early to go snowboarding with my friend Shawn. We were having a great day and the runs were amazing. As the end of the day neared we decided to film ourselves while boarding in the terrain park. My dad came along and offered to film the two of us. It was to be the last run of the day on probably the toughest rail of the day. It was a kinked downhill rail and it was very long. It was a little intimidating and I was a little freaked out. I guess I wasn't leaning forward enough and the board slipped out from under me and I nailed my head on the snow.

I don't remember the fall or going up the rail for that matter. A few minutes later I came to and I was on a backboard with a neckbrace on being taken down the mountain by ski patrol. They took me to the local Medic Center. They did a CT scan and found traces of blood. The doctors decided I needed to go to the hospital in Denver—St. Anthony's. I was admitted to the Trauma unit. I had to stay in the unit for 3 days and 2 nights. I was happy when I finally got released Monday afternoon.

I went back to Baltimore the next day—Tuesday. My parents were really worried about how I was doing/feeling. I had headaches and was tired for the next couple of weeks. I was only allowed to take Tylenol to relieve the pain. My parents told my teachers about my accident. School was helpful and accommodating about how I was feeling. I had trouble with reading and taking notes. Doing both of these almost always gave me a headache in the first couple of weeks after the concussion.

I had to see a couple of doctors over the next 4–5 weeks. I had to stay out of all sports until my doctor in Baltimore said it was okay to play sports. After 7½ weeks I was finally told it was okay to play lacrosse. This was the worst time of my life but I am sure glad I had my helmet on. I can't imagine what things would be like for me if I hadn't.

Senator DODD. Terrific. Well, that is great. Thank you very much.

The CHAIRMAN. What do you think would have happened to you if you weren't wearing your helmet?

Mr. BRUNS. I probably wouldn't be the same person, or the doctor said I could have died.

The CHAIRMAN. Have you always worn your helmet?

Mr. BRUNS. I have. My parents are "helmet Nazis."

[Laughter.]

Senator DODD. Clean up that record here.

[Laughter.]

The CHAIRMAN. Good for them, I guess. OK, thanks.

Do most of your friends wear helmets?

Mr. BRUNS. No. Only one of them, who I just met like this school year. But besides that, none of my other friends wear them.

The CHAIRMAN. What do they say? It is not cool, or what do they——

Mr. BRUNS. They don't really say anything to me, but I just don't like wearing one, I guess. I feel kind of weird wearing one. But now I do because I know what can happen.

The CHAIRMAN. Do you feel now, do you ever suggest to any of these other kids that they might think about it, too?

Mr. BRUNS. I don't want to nag them about it, but I told them what happened, and I think they are a little more afraid.

The CHAIRMAN. There you go. That is a nice way of doing it, too. You get the example that you set, and they see that you are having a good time and a safe time. It may make a difference to them. It certainly does.

We have your mom here.

Mr. BRUNS. Yes.

The CHAIRMAN. We want to thank you. You wrote a statement as well, and we are going to put that in the record. It is a wonderful, wonderful statement. Very, very appreciative of spelling this out. It was very powerful and very moving, and we are very, very grateful. It will be very helpful to the people.

[The prepared statement of Ms. Bruns follows:]

STATEMENT OF KATHLEEN BRUNS, MOTHER OF JUSTIN BRUNS

On February 16 of this year my husband and I experienced a situation I hope very few parents ever go through. Our 14-year-old son, Justin, had a snowboarding accident while boarding with his father and his friend Shawn. Justin took a hard spill off of a rail in a terrain park while boarding in Breckenridge, CO. Bob and I are adamant about helmet use and thankfully for Justin, he had his on.

Justin suffered a stage 3 concussion. This means he was knocked unconscious and had some memory loss. In Justin's case it was about 3–5 minutes. This stage is the highest degree of severity. As a result of this injury Justin had to spend 2 nights in the hospital, the first being spent in the trauma unit. The hospital performed CT scans that showed blood, which is one of the reasons they wanted to keep him for 2 nights. The speech pathologist also gave Justin a cognitive test to test his brain function. The first time he took this test he missed passing by just a few points. The hospital decided to follow up with a second test Monday morning, which Justin passed. An MRI was also done Monday. Dr. Nichols, the Neurological Surgeon informed us it was clear and Justin was discharged in the early afternoon.

Justin was told he would have headaches for some time and that he should take it easy. He had to be honest with how he was feeling since there were no clear outward signs of injury. Doctors had told him, if you had broken a bone everyone would immediately know because you would have a cast. In his case there was no outward sign to let others know what had happened.

We contacted Justin's teachers at school to let them know what had happened. We made it clear to them the symptoms that would be troubling Justin. The biggest indicator in his recovery was going to be how he was doing cognitively. Was he able to read, study, complete homework and class assignments and take tests. The first couple of weeks after the concussion Justin only went to school for about 4½ hrs because he tired very easily and developed regular headaches. He was given some leeway by teachers, who allowed him to skip on some of the class work. Within about 3 weeks after the concussion Justin was reporting that he was headache free. By the end of the third week Justin was able to start exerting some energy on the elliptical at home for 15–20 minutes. Dr. Andy Tucker, our doctor in Baltimore, allowed Justin to slowly increase his workouts over the next 3 weeks. On the school/cognitive front, by the 6th week after the accident Justin was finally caught up on all assignments and tests.

During the time, immediately after the head trauma, Justin was not allowed to participate in any physical activities. He was not even allowed to be in the same vicinity as kids who were playing catch with a football, playing basketball, or roughhousing in any way. He was not allowed to risk having any kind of trauma to his head, so soon after the accident, or it could have very disastrous repercussions to the level of his brain function. As a member of 2 lacrosse teams he was not even to be near the field to watch his teams practice for fear of an errant ball coming his way and hitting him in the head.

It took 7½ weeks for Justin to be cleared for full contact physical activity. This seemed like much longer to all of us and was very difficult to get through. Justin will continue with the activities he has always done, but with a greater understanding of how a $70 helmet kept him "the Justin we know and love." His helmet truly saved his life!

The CHAIRMAN. OK. Meri-K, please.

STATEMENT OF MERI-K APPY, PRESIDENT, HOME SAFETY COUNCIL, WASHINGTON, DC

Ms. APPY. Good morning. I feel very fortunate. I grew up in Connecticut. My children were born and raised in Massachusetts.

The CHAIRMAN. There you go.

Ms. APPY. Henry will graduate from U-Mass next month. My dear oldest brother lives in Georgia. So, I feel—How do you like that, Alan?

[Laughter.]

Thank you so much for letting me be here today, and congratulations to Safe Kids for their 20 years of service to our shared purpose.

I am Meri-K Appy, President of the nonprofit Home Safety Council. HSC's mission is to prevent accidental injuries in and around the home. This is a serious public health problem, resulting in nearly 20,000 deaths and more than 21 million medical visits in America every year.

Far too many of these tragic events involve children, and we believe, as does Safe Kids, almost all of them could be prevented. Our dream is to help kids learn safety lessons today so they grow up being safer parents and caregivers in the future.

We make safety fun, hands on, and high impact. For example, our Great Safety Adventure, or GSA, is an incredible field trip on wheels. We have two 1,000-square foot vehicles that travel across America, visiting schools and communities free of charge at events throughout the year. More than 1 million kids, family members, and teachers have experienced GSA with proven results.

Our Safety Ranger Classroom program—Senator Isakson, I loved what you said earlier—developed through a partnership with Weekly Reader, have reached more than 75 million teachers, students, and family members. Our method is to engage teachers, local safety experts, and parents to help children develop positive safety habits.

CodeRedRover.org is the Home Safety Council's educational Web site for kids, and it was recognized by USA Today as an Education Best Bet Award winner.

The Home Safety Council loves teaching children about safety. But when you think about it, family safety is really an adult responsibility. Unfortunately, many parents and caregivers are missing this message. HSC is convinced that part of the problem lies in how we have all been communicating that message.

Here is a shocking statistic I would like to share with you. More than 93 million adults in America read at or below basic levels. This has huge implications when we think about educating the caregivers about how to take care of their children.

The Home Safety Council and our partner, Pro Literacy Worldwide, has launched an award-winning home safety literacy project in 2005. It teams up local literacy tutors and teachers with firefighters and other safety experts. They use our specially designed materials to teach basic safety lessons and even install devices such as smoke alarms as the adults are learning to read in English. So it is taking care of two huge societal issues at the same time.

I would like to thank you so much. We were thrilled to be included in this August lineup this morning. We are thrilled to be contributing to the safety of our children, particularly in the place we all would like them to be safest—their homes.

[The prepared statement of Ms. Appy follows:]

PREPARED STATEMENT OF MERI-K APPY

Chairman Kennedy, Ranking Member Enzi, and members of the committee, I very much appreciate the opportunity to share my comments on keeping children safe by preventing childhood injuries. I am Meri-K Appy, president of the Home Safety Council.

Good morning and congratulations to SAFE KIDS for their 20 years of service to the safety of our Nation's children.

The Home Safety Council's mission is to prevent accidents in and around the home. This is a serious problem, resulting in nearly 20,000 deaths and 21 million medical visits on average each year in America. Far too many of these tragic events involve children, and most can be prevented.

Our dream is to help kids learn injury prevention lessons early in life so they can grow into a future generation of safer adults and caregivers. We make safety fun, hands-on, and high-impact. For example:

Our **Great Safety Adventure (GSA)** is an incredible "safety field trip on wheels." Two 1,000-square foot traveling exhibits visit schools and community events across America. More than 1 million kids and family members have toured GSA since the tour began in 1999, with proven success.

HSC's **"Safety Ranger"** classroom programs, developed through a partnership with Weekly Reader, have reached more than **75 million teachers, students, and family members** with documented results. We engage teachers, local safety partners, and parents to help children develop positive safety habits that will last a lifetime.

CodeRedRover.org, the Home Safety Council's Web site for children, is an interactive, educational site offering games, activities, home safety checklists, and tips for children and the adults who care for them. The site was recognized by USA Today as an "Education Best Bet" award winner.

The Home Safety Council loves teaching children about safety. But it's really the responsibility of *adults* to create a safe environment for our kids. HSC learned something that frankly shocked us: **more than 93 million adults in America read at or below basic levels**.

So HSC and our partner, ProLiteracy Worldwide, launched the Home Safety Literacy Project. This program teams local literacy tutors and teachers with firefighters and emergency managers who use our specially-designed educational materials to teach basic safety lessons and even install free smoke alarms.

These are just a few of the programs of the Home Safety Council we've implemented to help prevent injuries to our children.

Thank you for inviting me to be here today. On behalf of the Home Safety Council, here's to another 20 years of progress for SAFE KIDS and all of us in the injury prevention world.

The CHAIRMAN. Great.

Ms. Williams.

STATEMENT OF AMBER N. WILLIAMS, EXECUTIVE DIRECTOR, STATE AND TERRITORIAL INJURY PREVENTION DIRECTORS, ATLANTA, GA

Ms. WILLIAMS. Thank you, Mr. Chairman, for the opportunity to be here today.

My name is Amber Williams, and I am the Executive Director of the State and Territorial Injury Prevention Directors Association, which is also known as STIPDA. We are based out of Atlanta, but we represent State public health injury and violence prevention programs across the United States.

We are also pleased to celebrate with our colleagues and partners the tremendous advances that have been made in preventing unintentional injuries to children, or what are commonly referred to as accidents. And I am pleased to tell you about the role that State health departments have played in those reductions.

They have, first, helped us to truly understand what has been going on, how children have been injured, who is at risk for certain

injury types, and have been involved in developing effective interventions and disseminating those widely to those at the local level.

One example of State leadership in this area has been in preventing residential fire-related injuries and deaths. In the State of Oklahoma, the injury prevention program identified an area that had a much higher than average rate of fire-related injury death. They went in, did a smoke alarm distribution program and educated the residents and, following that, saw an 81 percent decrease in the rate of residential injury and fire-related death.

That is incredible. At the same time in Oklahoma, there was only a 7 percent decline.

The CHAIRMAN. Can you give that to me again? I missed the significance.

Ms. WILLIAMS. They saw an 81 percent decline in residential injury/fire-related deaths, while in the rest of Oklahoma there was only a 7 percent decline.

The CHAIRMAN. What is that, why—what is that attributed to?

Ms. WILLIAMS. They distributed and installed smoke alarms.

The CHAIRMAN. Smoke alarms, good.

Ms. WILLIAMS. This program has since been replicated across the United States with support from the Centers for Disease Control, and we have had similar successes, and the program has been credited with saving 1,500 lives. We have seen similar progress, obviously, in the areas of child passenger safety and bicycle safety.

Today, our economy is uncertain. We are facing growing healthcare rates—healthcare crisis, and the cost of injuries are one of the top 10 most expensive medical conditions, along with cancer and heart disease. But injuries are predictable, they are preventable, and our prevention efforts are cost-effective. Most of all, children deserve our help in keeping them safe.

So I thank you again for the opportunity to be here, and I look forward to any questions you may have.

[The prepared statement of Ms. Williams follows:]

PREPARED STATEMENT OF AMBER N. WILLIAMS

SUMMARY

Thank you, Mr. Chairman, for the opportunity to participate in this hearing on childhood injury prevention along with our colleagues and partners at the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention, Safe Kids Worldwide, and the Home Safety Council. My name is Amber Williams and I am the Executive Director of the State and Territorial Injury Prevention Directors Association, also known as STIPDA. STIPDA is the only membership association representing State public health injury and violence prevention programs and has more than 300 members who are professionals working at the State, territorial and local levels to prevent injuries and violence. During this hearing, I will share examples of how State public health departments have contributed to the declines we have seen in deaths due to unintentional injuries among America's children, as well as offer our perspective on future opportunities to keep our children safe.

If those of us working in the field of injury and violence prevention had been asked to share our progress regarding childhood injury prevention 20 years ago, we would have only been able to tell you that we know children were dying unnecessarily in car crashes, falling off bikes, in residential fires and other unintentional or "accidental" ways. At the time, however, we didn't understand enough about the problem. Fortunately, today my colleagues and I can sit before you and share the tremendous progress we have made collectively in reducing deaths related to unintentional childhood injuries. This progress is partly through the efforts of State health departments which have helped us better understand how children are being

injured, what children are at greatest risk for injuries, what interventions are best to prevent these injuries, and ensure the widespread adoption of these interventions. State health departments have also been strong allies of Safe Kids coalitions, and often serve as the lead agency for State coalitions. Through these relationships, State health departments provide data, technical assistance, training, and often financial and in-kind support.

Today I would like to share with you some of the specific ways State injury and violence prevention programs are preventing unintentional childhood injuries. The Georgia State Injury and Violence Prevention Program has been able to document at least 56 lives potentially saved since 2006 through a child safety seat distribution program and unique partnership with the Emergency Medical Services (EMS). The New York Injury and Violence Prevention Program was able to document reductions in bicycle-related injuries and traumatic brain injuries following the implementation of a statewide comprehensive bicycle helmet program that culminated in a bicycle helmet law passing easily through the State legislature. Finally, the Oklahoma Injury Prevention Service was able to identify a high-risk area in Oklahoma City for house-related fire injuries. In response, they conducted a smoke alarm distribution program. After the program, Oklahoma saw an 81 percent decline in residential fire injury-related deaths in the target population while rates declined only 7 percent in the rest of Oklahoma during the same time period.

As we look to the future, we see that so many childhood health issues are interrelated and that really what truly is needed is an investment in healthy communities. In healthy communities, children can walk to school without fear of being hit by a car, or becoming the target of bullies or other violence; they have access to safe equipment that will allow them to participate in sports and other recreational activities while being protected from a variety of injuries, including head and brain injuries. We need to expand our focus to building communities where American families can live active, safe and healthy lives.

ABOUT STIPDA

Good morning Mr. Chairman, Senator Enzi, and other distinguished members of the committee. It is my pleasure to appear before you as the Executive Director of the State and Territorial Injury Prevention Directors Association (STIPDA). We appreciate the opportunity to participate in this hearing and to share the stories of the success we've seen in preventing unintentional injuries and deaths among America's children from the perspective of State public health injury and violence prevention programs. Formed in 1992, STIPDA is the only organization that represents public health injury prevention professionals in the United States and has a membership of more than 300 professionals committed to strengthening the ability of State, territorial and local health departments to reduce death and disability associated with injuries and violence. To accomplish this, STIPDA engages in activities to increase awareness of injury, including violence, as a public health problem; provides training and technical assistance; supports policies designed to advance injury and violence prevention; and works to enhance the capacity of public health agencies to conduct injuries and violence.

THE ROLE OF STATE PUBLIC HEALTH INJURY AND VIOLENCE PREVENTION PROGRAMS IN REDUCING CHILDHOOD UNINTENTIONAL INJURIES AND DEATHS

State governments have a responsibility to protect the public's health and safety. A comprehensive injury and violence prevention program at the State health department provides focus and direction, coordinates and finds common ground among the many prevention partners, and makes the best use of limited injury and violence prevention resources. State public health injury and violence prevention programs apply the public health approach to help understand, predict and prevent injuries and use a population-based approach to extend the benefits of prevention beyond individuals.

State injury and violence prevention programs use surveillance data to determine how injuries occur, who is most at risk, and what other factors contribute to whether or not an individual will be injured and to what degree. We have also come a long way in our understanding of how to prevent injuries and look beyond just the personal behaviors that lead to an injury to also investigate to the products that people use, the physical and social environment, and the organizational and governmental policies that affect the safety of our environments.

State programs have also contributed to the dissemination of effective practices through partnerships with injury control research centers, local health departments, local coalitions and other organizations. State programs provide training and technical assistance to local injury prevention efforts every day.

Although we have seen successes in many areas of childhood unintentional injury prevention, three areas that stand out include improvements in child passenger safety, bike and wheeled sports injury prevention, and residential fire-related injury prevention.

CHILD PASSENGER SAFETY

When you get into your car, do you automatically secure your children (or grandchildren) in car seats before buckling up yourself? Chances are, like most Americans, you do. However, just a few short decades ago this wasn't the case. Today it is more the exception than the rule for Americans not to buckle up—or to not use car seats for their children. In fact, when a celebrity recently drove with her infant in her lap, the public was outraged. Motor vehicle crashes are the leading cause of death for children and by putting a child in an appropriate restraint—whether it's a car seat turned to the rear of the vehicle for an infant or a belt-positioning booster seat for a young child—you can reduce serious and fatal injuries by more than half. However, there is still work that must be done to ensure everyone is restrained properly for every ride in the car and that car seats and boosters seats are used correctly.

It's evident that collectively, we have made incredible strides in reducing the number of children who die or are injured in car crashes by increasing the number of children who are restrained properly in car seats until they are able to properly fit in a car's seat belt. In fact deaths have decreased 32 percent during the last two decades. This success have been achieved using a number of strategies including: by strengthening laws that require children to be properly restrained and enforcing those laws, training child passenger safety technicians to work with parents and help them to use car seats properly, distributing car seats to low-income families, and increasing awareness of the need for car seats. We have changed the "norm" for riding in cars so that today there is an outcry when anyone is found driving with infants in their laps or turning their child's car seat to face the front of the car before the child's first birthday.

State injury and violence prevention programs are often involved in efforts to raise awareness, distribute car seats, conduct car seat checkpoints, and strengthen organizational policies:

• Over the last several years, the Georgia Injury and Violence Prevention Program has conducted a car seat distribution program to low-income families in 109 of the 159 counties in Georgia in partnership with local health departments, Safe Kids coalitions, and other organizations. Each seat distributed through the program has a teddy bear sticker that EMS personnel look for on the scene of car crashes. The State health department has documented at least 56 potential lives saved through this program so far between 2006 and March 2008.

• In New York State, the Bureau of Injury Prevention conducted a program called "Gimme a Boost" in three counties to determine the barriers to booster seat use and how to best increase use among 4–8 year olds. Through interviews with parents and guardians of 4–8 year olds, the Bureau was able to determine that reasons for non-use included: New York State law does not require use by 4–8 year olds, the belief that their child was too big or old for a booster seat, lack of knowledge about the need for booster seats and the injury risks associated with only using safety belts, and child resistance to using a booster seat. Booster seat distribution, public awareness campaigns, and school-based programs were implemented in the three counties to determine which combination(s) might be associated with increase booster seat use. Comparison to a control county that received none of the interventions found that the combination of all three interventions led to the largest increase in booster seat use from 21 percent to 53 percent. Using this information, as well as injury hospitalization and death data, communities educated their policymakers in support of legislation requiring the use of booster seats for children 4–6 years of age. The booster seat law was enacted in 2005.

• The Michigan Injury Prevention Program was able to identify that because the child passenger safety law did not include older children, parents were not using booster seats. Through a targeted educational effort, the Michigan Injury Prevention Program was able to demonstrate an increase in booster seat usage by 300 percent. These efforts and many others have translated into the support needed to strengthen the child passenger safety law to include older children and was signed by the Governor just this year. In fact, there are four new booster seat laws this year—bringing the total to 43 States—which now protect older children in some form through child passenger safety laws.

• The Utah Department of Health conducted a statewide program to increase booster seat usage among children ages 4–8 years from 2002–2005. Through part-

nerships with local health districts, the Utah Department of Health conducted awareness and media activities, distributed more than 2,000 child safety seats, conducted more than 120 car seat checkpoints to ensure families were using car seats correctly, and implemented booster seat policies in pre-schools and daycare centers. As a result, an estimated 44 Utahans are alive today and the death rate decreased 6 percent from 2002 to 2004 while booster seat usage increased by 10 percent from 2002–2005. Every $1 spent on child safety seats saves $41. In 2005, distributing 2,000 child safety seats in Utah saved approximately $3.3 million.

• In Colorado, the Injury and Violence Prevention Program conducted a booster seat program between 2001 and 2004. During this program, booster seat use by children ages 4–8 increased significantly in Colorado from 2001–2004. In 2001, adults reported that 86 percent of the 4- to 8-year-olds in their household always used a restraint while riding in a vehicle. Of those who always used a restraint, 15 percent used a booster seat. In 2004, the percentage of children who always used a restraint remained high at 89 percent, but booster seat use increased to 45 percent.

Today, motor vehicle crashes remain the leading cause of injury death for children, but the collective efforts of those working has lead to a 32 percent decrease in this rate over the last two decades. Future efforts should continue to focus on older children ages 4–8 who are still not ready for a vehicle's lap and shoulder belt as well as effort to ensure all States have laws that appropriately protect our youngest riders.

BICYCLE AND OTHER WHEELED SPORTS

Bicycling and participating in other wheeled sports, such as skateboarding, riding scooters and in-line skating, are excellent ways to increase physical activity and combat obesity and other chronic health conditions. Although these activities provide healthy exercise, they are not without risk of injury, with head injuries accounting for 60 percent of bicycle-related deaths and more than two-thirds of bicycle-related hospital admissions. Extensive research has shown that use of helmets can reduce the risk of head and brain injury by 70 percent to 88 percent. Survivors of head injuries can have severe physical, emotional or cognitive problems that result in a long-term disabilities including difficulties with learning and activities of daily living.

Universal use of bicycle helmets by children ages 4 to 15 could prevent between 135 and 155 deaths, between 39,000 and 45,000 head injuries, and between 18,000 and 55,000 scalp and face injuries annually. If 85 percent of all child cyclists wore helmets every time they rode bikes for 1 year, the lifetime medical cost savings could total between $134 million and $174 million.

Over the last two decades, deaths have declined from 389 deaths to 132 deaths in 2004. State injury and violence prevention programs have contributed to the reduction in these injuries and deaths by providing data to partners, raising awareness, distributing bicycle helmets and supporting efforts to require the use of bicycle helmets by law. Today 21 States, the District of Columbia and over 140 localities have enacted some form of mandatory child bicycle helmet legislation. Efforts of State injury and violence prevention programs have included:

• From 1991–1995, the New York State Injury Prevention Program conducted a statewide multifaceted bicycle helmet safety program featuring a Teenage Mutant Ninja Turtle character. The program included a public service campaign, prescription pads for New York State pediatricians and family practice physicians to prescribe helmet use for children seen in the practice, and the development of 77 community-based programs. Community coalitions distributed more than 30,000 bicycle helmets to children from families and need. With so much public attention and support, in 1994, State legislation was enacted requiring all bicyclists under the age of 14 to wear a bicycle helmet. School-based and observational surveys documented an increase in helmet ownership and usage between 1989 and 1993, and the New York State injury and violence prevention program has found a steady decline in bicycle-related deaths since the implementation of the program.

• The Louisiana Injury Prevention Program has provided information to advocates such as Safe Kids, Think First, the Governor's Highway Safety Commission, and other public and professional groups. These advocates have used the information to educate State legislators, inform their constituencies, and promote appropriate injury prevention behaviors. These activities led to establishment of a law requiring the use of bicycle helmets, and re-establishing a law requiring the use of motorcycle helmets.

• After learning that children ages 5–14 have the highest rate of bicycle-related hospitalization and 32 percent of these hospitalized children sustain a brain injury, the Colorado Injury and Violence Prevention Program implemented a bicycle helmet

program. Survey results indicate that the percent of Colorado children ages 5–14 who were reported as always wearing a helmet when bicycling increased slightly, from 40 percent in 1999 to 49 percent in 2005.

• In California, bicycle helmet legislation, which led to an increase in helmet use, resulted in an 18 percent reduction in the proportion of traumatic brain injuries among young bicyclists.

• The Florida Injury and Violence Prevention Program provided data on bicycle-related injuries comparing one county with the rest of the State of Florida upon request in January 2006 to the administrator of local health department. The administrator used the data to present to county commissioners, who finally opted to enforce the State's bike helmet law for riders under age 16—the last county in the State to do so.

• From 1993–2000, the Oklahoma Injury Prevention Service collaborated with numerous national, State, and community partners and with funding provided by the National Center for Injury Prevention and Control, implemented bicycle helmet programs in several Oklahoma communities. These comprehensive, community-based efforts targeted children at greatest risk of bicycle-related TBIs, those 5–12 years of age. Mini-grants were awarded to county health departments, schools, police departments, civic organizations, and injury prevention coalitions to implement bicycle helmet distribution and education programs throughout the State. These bicycle helmet programs have been conducted in more than 90 communities and more than 100,000 bicycle helmets have been distributed. According to the OSDH Behavioral Risk Factor Surveillance System (BRFSS), from 1992 to 1998, reported bicycle helmet use among children increased from 6 percent to 25 percent.

RESIDENTIAL FIRE

Finally, we have seen a lot of progress in preventing injuries and deaths due to residential fires through smoke alarm distribution programs. Children, especially those in rural areas, are at high risk for injuries and deaths due to residential fires—partly due to their greater likelihood of starting fires as well as their greater need for assistance in escaping fires. It is well established that smoke alarms are extremely effective at preventing fire-related injuries and deaths. An individual's chance of dying in a residential fire is reduced by half when a smoke alarm is present.

In the late eighties and early nineties, the Oklahoma Injury Prevention Service led the way in establishing the best practices for preventing fire-related injuries and deaths through an innovative smoke alarm distribution program that involved developing a strong partnership with local firefighters, identifying areas at highest risk for fires, canvassing these areas and installing smoke alarms outside sleeping areas and on each floor of high-risk homes.

The work in Oklahoma led to the development of a residential fire injury prevention program through the National Center for Injury Prevention and Control to provide funding to State health department injury and violence prevention programs to conduct smoke alarm distribution and installation programs. Through this funding, State health departments, in partnership with local firefighters, have been able to reach 185,000 high risk families, install more than 348,000 smoke alarms and potentially save more than 1,500 lives. Overall, deaths related to fires and burns have decreased nearly 60 percent over the last 20 years.

State successes have included:

• In Washington State, firefighters installed a smoke alarm in the mobile home of a Shoreline mother and her 3-year-old son. Weeks later the alarm woke the mother, who found a portion of her home ablaze. She woke her sleeping child and escaped before the home became fully engulfed. She was treated for smoke inhalation and released; her son was unharmed.

• In Georgia, firefighters visited a home in Moultrie, installed smoke alarms in the proper places, and educated the family about a fire escape plan. When wires shorted and ignited the old wood home, a teenage boy awoke in the night to the alarm, alerted his mother and two younger siblings, and followed the fire escape plan. Although the fire damage was extensive, no injuries occurred.

• Between 1998 and 2006 in New York, the Bureau of Injury Prevention canvassed approximately 39,732 homes in communities across New York State, installed more than 21,000 smoke alarms, and documented 379 lives saved in 165 fire and severe smoke incidents.

OPPORTUNITIES FOR THE FUTURE

We must continue to invest in the prevention efforts that have demonstrated so much success over the last 20 years, such as child passenger safety, residential fire

injury prevention, and bicycling and other wheeled sports. Additionally, State injury and violence prevention programs must continue to study the patterns of injuries to identify new injury concerns—such as the recent rise in unintentional poisonings/drug overdoses, as well as translate new research into community-based practices.

As we learn more about what puts children at risk for injury, we must also consider the reality that children today are less active, more likely to be overweight or obese, and at increased risk for chronic diseases in adulthood. Yet parents are fearful of allowing their children to walk to and from school or to play outside due to the dangers of traffic and crime. America's children deserve to live in communities where they can be healthy and active without the fear of violence or "accidental" injury. Investments in healthy communities and smart growth initiatives are one of the strongest ways we can work together to improve the overall health and safety of America's children.

We believe that with appropriate investments for continued and new injury prevention efforts, we will be able to see even more dramatic declines when we meet again to celebrate 25, 30 and 40 years of preventing unintentional injuries to children.

The CHAIRMAN. Very good.

Let me, if I could, just a few—do you have to go, Chris? Do you have questions?

Senator DODD. No, just this, and I thank all of you—I apologize slipping out a little early. I just can't thank you enough, and we will just keep working. Give us more ideas on how we can deal with these issues.

Just one question, you mentioned how you—that last run, you wanted your father to film you on that run. Did he film you on that run?

Mr. BRUNS. He did, yes.

Senator DODD. Well, that is not a bad idea. Have you shown that to your pals?

Mr. BRUNS. Ah, yes. They all laughed.

Senator DODD. That is not a bad way maybe of convincing them of what can go wrong. Maybe put it on YouTube.

Mr. BRUNS. I already put a song with it. So——

Senator DODD. Did you? Put a song to it, too.

This is the father here, too. I am getting him in a lot more trouble. You are not from Connecticut, are you?

[Laughter.]

Well, thank you very, very much, and I apologize again for leaving early. Appreciate your testimony. Thanks.

The CHAIRMAN. Mr. Korn, let me ask you, Safe Kids attribute 45 percent decline in the unintentional death rate for children over the last 20 years. Do you want to tell us, what do you attribute that to?

Mr. KORN. Well, 20 years ago—I am 43 years old and rode a bike and never wore a bike helmet. When I used to ride in my father's car, I used to stand up. He had a convertible. I used to stand up in the center between my mother and father. There was no car seats.

So the devices that you hear about today, that I brought with me today, have made a real difference. Twenty years ago, these type of things didn't exist. Or if they did, they weren't nearly as good as they are today. So we have seen the consciousness of parents raised quite remarkably. Second, they have had the devices that they need—smoke alarms, carbon monoxide detectors, personal flotation devices—to use when out doing their winter or summer activities.

The other thing I will mention just real quickly. Twenty years ago, there was no such thing as a bicycle helmet law. Georgia has a bicycle helmet law now. So does Massachusetts. Twenty years ago, there was no such thing as a State child safety seat law. Massachusetts, I think it was April 11th, just improved their child restraint law to include booster seats. Georgia has had one for a while.

Twenty years ago, those didn't exist, which is a good motivation to get parents to not only use the devices, but use them as a custom pattern and practice over time.

The CHAIRMAN. Well, what is your answer to those that would say we are just coddling our children on these?

Mr. KORN. Yes. You know, Safe Kids—and I know STIPDA and the Home Safety Council are the same way on this. We are not suggesting that you need to wrap kids in bubble paper every time they go out. You want them out there enjoying the summer, swimming, biking. You are even going to fall off your bike and scrape your knee, a little stitch in your elbow. Those are badges of honor. Maybe his small concussion is a badge of honor, maybe.

But we are talking about serious traumatic injuries here. We want the kids out there enjoying summer. So my response to those people is, these are the things that are preventable. These are the things that we know how to take charge of and prevent from happening in the first place. It is not preventing the little scratch. It is preventing the concussion that will kill you or the drowning that will happen when 100 parents are standing around a pool. A kid goes under, that is the end of it.

Or a smoke alarm. When there is smoke, it rings, and you are out of the house. These are serious injuries, not those smaller injuries.

The CHAIRMAN. Your report points out that accidental injuries disproportionately affect minority children. Can you tell us why that is the case and what suggestions you have to do something about it?

Mr. KORN. I think Senator Isakson and Dodd both referenced to it. One of the reasons is the cost associated with these items. A bike helmet is now $15, down a lot over the past 10 years. But still, when you are choosing between a gallon of milk, which is increasing now, and a bicycle helmet, a family—and I, quite frankly, don't blame them—choose the gallon of milk.

So it is incumbent upon groups like ours and the Federal Government to make sure that we are giving away free bicycle helmets, which we do each year, or that we are giving away free smoke alarms, which I know the Home Safety Council does each year. So these are the types of things that we need to do to reach those underserved populations.

The other thing is maybe getting additional funding through the CDC, the U.S. Fire Administration, the National Highway Traffic Safety Administration, to buy these devices, to make sure we can give them away without charge to those families.

The CHAIRMAN. Amber, what are the biggest barriers at the State and local level to implementing programs to address childhood injury?

Ms. WILLIAMS. I think, first of all, it is a resource issue. As Ileana said at the beginning, CDC funds 30 States to do basic injury prevention for the entire State, and that figure is about—just over $100,000 for a State to do coordinated injury prevention.

So when you take that and you are trying to do surveillance, you are trying to do interventions, you are trying to distribute safety products to folks, it doesn't go very far. So, we really have to do a lot to engage States and private industries to help us in getting those devices into the hands of the public.

I think the other part of it is that from a State perspective, they are really charged with truly understanding what is going on because it does vary from State to State and from community to community. Our ability to do the surveillance that we need to is limited by the quality of the external cost coding and hospital discharge data.

So that is another challenge, and just one further challenge is overall the public health workforce. There is a shortage of workers in the public health workforce, and I am sure you are familiar with that issue as well.

So there are a number of challenges from the workforce to resource issues to be able to take what is known about preventing injuries and doing that at the State and community levels.

The CHAIRMAN. OK. Senator Isakson.

Senator ISAKSON. Thank you, Mr. Chairman.

Mr. Korn, I remember in the 1970s or 1980s, when I was in the State legislature, we passed a mandatory helmet law for motorcycle operation in Georgia. There was a tremendous lobby against mandatory helmet law. Do those lobbies still exist today?

Mr. KORN. They sure do. In fact, there has been a retraction in the helmet use laws in some States around the country. The childhood injury prevention movement doesn't quite have the organized opposition that the motorcycle helmet law has, but we do run into that same issue like kind of Government's role is overstepping its bounds a little bit.

My response to that, when it comes to the children, we always have to keep the best interest of children in mind, and there are so many examples of that, adoption and child abuse. You always keep the best interest of the children in mind.

When it comes to these types of State laws that happen, the bicycle helmet laws, the personal flotation device laws, the smoke alarm laws, we are talking about children. That helps us cross that hurdle that the motorcycle helmet efforts and advocates run across from that very organized lobby that does still exist today.

Senator ISAKSON. I remember my predecessor, Senator Coverdell from Georgia, who was in the Senate before Zell Miller was here in the seat I hold, he actually was the driving force behind the mandatory seatbelt law in Georgia, which also was taking place in that same time period. The compelling argument that finally broke the opposition in terms of intervention versus freedom was the impact, cost impact to society on the lost productivity, which was testified to earlier, as well as the medical cost and the treatment cost and the rehabilitation cost.

That was the argument that finally broke the opposition on those two pieces of legislation.

Mr. KORN. Thankfully, Justin is with us here today. I mean, if he had been seriously injured, the medical costs would have been astronomical, and we all would have paid that. The family couldn't have afforded that. Instead, it was a $15 helmet that saved his life.

So those costs, as if protecting and saving the child's life isn't enough—I think it is—but now we can also make the cost effectiveness argument in addition to that, and that helps us combat what little opposition there is. We do have opposition, but it helps us get over that hurdle.

Senator ISAKSON. Justin, I am not a snowboarder. So you are going to have to—you were snowboarding, right?

Mr. BRUNS. Yes.

Senator ISAKSON. What is a rail?

Mr. BRUNS. A rail, it is like something that you grind on with your board.

Senator ISAKSON. That you grind?

[Laughter.]

Mr. BRUNS. Yes. I can't really explain it. But go to YouTube.

Senator ISAKSON. Well, I know the Summer Olympics are coming up, and this is a Winter Olympic example. But snowboarding has become a huge part of Olympic sports. The Olympics do a good job of mandatory helmet requirements of all participants, don't they?

Mr. BRUNS. Yes, everyone has to wear a helmet.

Senator ISAKSON. Snowboarding looks particularly—to somebody my age, snowboarding looks particularly dangerous to start with. So I want all the protection that I could get. But your testimony is outstanding. I want to encourage you to be an advocate and use your personal story because kids influence kids more than anybody else.

When you can tell your story and tell them that you got to come to the U.S. Senate and advocate on behalf of what a helmet did for you, you can save somebody else's life. So what you are doing today is very important, and we commend you for being here and what you are doing.

I commend all of you for your advocacy on behalf of safety for kids.

The CHAIRMAN. Good. Thank you.

Just a final couple of questions, and I join—thanking Senator Isakson for making that point and just underline it. Your example is key in terms of the future. It will make a real difference to other children's safety. So good for you.

Let me ask Meri-K about hidden hazards in the home that parents should know about. Do you want to just talk about that for a minute?

Ms. APPY. I would love to. The Home Safety Council has done a number of studies, including the most definitive one, the State of Home Safety in America, followed up by a series of smaller studies to get an idea about what parents are thinking about out there.

About 90-plus of the caregivers we surveyed indicated that they do think about safety quite a bit, but they are not acting really. We wanted to know why. Many of them said they don't know what actions to take, or they don't have enough time to do it, or home improvements are too expensive.

I think our challenge here is to really help make it very clear what the hazards are that you may not know about. I will give you one specific example. Hot water tap burns, scalding burns. When we surveyed parents, we found that hardly any of them knew what the temperature of the water coming out of the tap really is. Yet at temperatures of 140, 150 degrees, a child can be devastatingly scalded in just seconds.

We worked with a mother actually from Georgia, come to think of it, Shelly McCammon, who has been helping us raise awareness of the dangers of hot water tap burns. Her story actually inspired the private sector to create a tool that can prevent that. It is called Hot Stop. It has got sensing devices in the tub spout and shower head so that if the water reaches a dangerously high level, it shuts it off to just a trickle. It only costs $25 to replace this tub spout.

When I talked with Shelly, this mother, she looked me right in the eye and said, "Meri-K, I am a conscientious mom. David and I baby-proofed everything. Nobody ever told us that hot water could do this to Leah." Her baby died of third-degree burns.

So I think part of what we have to do without scaring the parents too much, we have to kind of point out these are the things that can happen, these are the things you can do to prevent it from happening, and if you do these things, you know what, it will work.

Once we complete that circle, thinking always about the ones who may not be able to read that brochure. They may not see the notice that there is a free smoke alarm distribution. They may be falling through the cracks. So working harder to get into those homes, I really believe we can make a tremendous difference.

The CHAIRMAN. That is an enormously interesting. I think all of us have had over our life experience that same sort of situation where that just scalding hot water comes out of the taps.

Ms. APPY. Exactly.

The CHAIRMAN. Could I ask you just about the key elements of the Home Safety Council, home safety, the literacy project? Do you want to just tell us, could you speak to that for a minute?

Ms. APPY. Yes, you see me smiling. I have been a safety educator for more than 25 years. I don't know if you know, Senator, I spent 13 years at the National Fire Protection Association in Massachusetts, in fact. So I have really devoted my life to safety education programs, particularly school-based programs for children, which I love.

However, in thinking about who makes safety changes at home, it became clear it is really the adults. When we did some research on most of the information going home to families, we learned that much of it, if not most of it, is written at a level the parents can't—many parents cannot read.

So the idea behind the Home Safety Literacy Project is to identify adults in the community who come forward to learn to read as they are adults. As they are learning to read in English, we integrate basic safety lessons into that process. So you join forces with literacy experts and safety experts to really get into some of the homes where families are of lower income levels and education levels. Those tend to be families at highest risk.

So it is very efficient. Thread the needle into some of those homes we really can't reach any other way.

The CHAIRMAN. Good. Alan, finally, just on those props that you have there, do you want to give us one, a little visual there?

Mr. KORN. Sure. Your question of hidden hazards, one of which we are concerned with is carbon monoxide. This is a carbon monoxide detector that you put up in your home. The sources of carbon monoxide are your car, gas heaters, anything—a combustible natural source of fuel in the home, a fireplace.

If you don't have a carbon monoxide detector in your home, there is no way you can detect that it exists. It is odorless. It is tasteless. It doesn't have any smell, unlike fire.

So this is a newer, relatively newer device out there, and we could use the help, maybe through your Poison Control Enhancement Act, which I know you have passed out of this committee and I think is up for some reauthorization. This is a hidden hazard in the home that we are actually taking an extra look at and making some more efforts at.

We are starting the summer season and drownings are of particular concern to me. Notwithstanding what I do for a living, I am not that tightly wound as a parent. I want my child out there playing. But when it comes to pools, when it comes to hot tubs, watching your children every step of the way when they are in the water makes such a big difference because drowning does not happen like it does in the movies.

There isn't a "help, help, I'm drowning" and plenty of time to react. A 2-year-old or 4-year-old goes under, that is the last you see of them. So we kind of work with a water watcher program, where you assign a parent to a pool to watch. You want to avoid the situation where everybody is watching the pool, but nobody is watching the pool. It is this type of device and those types of hidden hazards that we are going to work toward preventing.

The CHAIRMAN. OK. I want to thank—Senator Isakson, anything further?

Senator ISAKSON. I would just thank the panelists for being here.

The CHAIRMAN. Panelists, very helpful. We will want to hear from you another time, another year or so, find out the progress that is being made. We are always interested in any suggestions you have for us about what we can do to help.

Where we stand ready, we can do both sort of legislatively or if you have some suggestions about things that we ought to know about and that we ought to be involved in, I hope you will feel free to let us know. We congratulate all of you for the difference that you make.

The committee will stand in recess.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR ENZI

Good morning and thank you for joining us today to discuss preventing childhood injuries. Our Nation has come a long way in reducing childhood injuries and making parents and others aware of ways they can help keep their kids safe. Today, we will take a look at where our Nation has been, where we are today, and where we need to be in the future for child injury prevention.

Unintentional injuries are the leading cause of death among children in the United States with nearly 100,000 deaths a year. Those injuries include motor vehicle accidents, bicycle accidents, fires, poisonings, burns, falls, and playground injuries, among many others. While the number of deaths is startling, we also need to put that into perspective.

Twenty years ago, parents generally didn't secure an infant or young child in a safety seat when driving. Today, all 50 States and the District of Columbia require infants and toddlers to be in a child safety seat, and 43 States have child booster laws. The child-safety seat campaign has proven to be one of the most successful campaigns in child injury prevention. We also have requirements that motor vehicles are designed to make child-safety seats more effective and to allow for installation to be much easier. These efforts, accomplished by a partnership with State governments and the Federal Government, have significantly decreased the number of unintentional deaths caused by car accidents. Since 1975, deaths among children aged less than 5 years have decreased 30 percent to 3.1 per 100,000 population.

We've not only taken action in our cars but also in our homes. Through city ordinances requiring fire and carbon monoxide detectors to additional Federal standards for safer pools to increased use of bicycle helmets, we have significantly reduced the number of childhood injuries. As each of these cases demonstrates, the public health actions are not simply those made by the Federal Government. In fact, States and localities have traditionally had the most successful efforts.

Sometimes, what the Federal Government can do is simply ensure that we have the right information to parents. Last year, as part of the FDA Amendments Act, we reauthorized the Best Pharmaceuticals for Children Act (BPCA) and the Pediatric Research Improvement Act (PRIA). BPCA and PRIA act as a "carrot and stick" to ensure that parents have the right information about the drugs kids take. Kids aren't little adults. They metabolize drugs differently than adults. Because of BPCA, over 300 studies have been performed to see how drugs affect kids.

The local police and fire fighters play a large role in preventing and responding to unintentional child injuries and are much more effective because of their relationship with the community and ability to react more quickly than any program the Federal Government could create. Child injury prevention must continue to be the responsibility of the State first and, when needed, the Federal Government may support their efforts.

Between 1987 and 2000 we have seen a 40 percent decline in the injury death rate. The decline is a result of successful prevention

campaigns with child-safety seats, a reduction in alcohol-related motor vehicle deaths and many other child injury prevention efforts. All 50 States have come a long way in injury prevention yet we still see over 100,000 deaths per year caused by unintentional injuries. We must continue to reduce these numbers through public education and messaging, new devices to eliminate risk and continued support for prevention programs across the country.

I look forward to hearing from our witnesses today to better understand how far we have come to reduce the number of deaths, where we need to be in the future and how to address the challenges we see ahead.

[Whereupon, at 11:37 a.m., the hearing was adjourned.]

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