



United States
Consumer Product Safety Commission

Annual Report on Pediatric Poisoning Fatalities and Injuries

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*This report was prepared by the CPSC staff.
It has not been reviewed or approved by,
and may not necessarily reflect the views of,
the Commission.*

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Executive Summary

Unintentional poisonings from drugs and other household chemical substances pose a hazard to everyone, including children younger than 5 years of age. To address this hazard, Congress passed the [Poison Prevention Packaging Act](#) (PPPA) in 1970. Under the PPPA, the U.S. Consumer Product Safety Commission (CPSC) has issued regulations that require child-resistant packaging for about 30 categories of medicines and hazardous household products.¹ In this report, CPSC staff presents the latest available statistics on pediatric poisoning fatalities and injuries.

Based on mortality data from the National Center for Health Statistics (NCHS), CPSC staff identified that pediatric poisonings involving children under 5 years of age resulted in:

- Forty-three fatalities in 2020, a 26 percent increase from 2019.
- Fifty-nine fatalities in 2021, a 37 percent increase from 2020.

The fatalities in 2020 and 2021 and the increases in fatalities in those years compared to prior years were mostly related to ICD-10 codes X42 (narcotics and psychodysleptics, not elsewhere classified) and X44 (other and unspecified drugs . . . and biological substances).

Based on injury data from the National Electronic Injury Surveillance System (NEISS), staff identified that unintentional pediatric poisonings among children under 5 years of age resulted in:

- An estimated 61,500 emergency department (ED)-treated injuries in 2020, a decrease from the estimated 67,500 injuries in 2019.
- An estimated 62,600 ED-treated injuries in 2021, an increase from the estimated 61,500 injuries in 2020.

Reports from earlier years ([Pediatric Poisoning Fatalities 1972-2018](#) and [Unintentional Pediatric Poisoning Injury Estimates for 2019](#)) present the fatalities from 1972 through 2018, and the estimated injuries treated in emergency departments through the year 2019, for the under 5 age group. The 2022 report ([Annual Report on Pediatric Poisoning Fatalities and Injuries, January 2022](#)) was the first report where the fatality and injury data were combined and published together. This report presents the fatalities from 1972 through 2020, and the estimated injuries treated in emergency departments for 2020, for the under 5 age group.

¹ The Child Nicotine Poisoning Prevention Act of 2015 (CNPPA), Public Law No. 114-116, requires any nicotine provided in a liquid nicotine container, sold, offered for sale, manufactured for sale, distributed in commerce, or imported into the United States shall be packaged in accordance with the standards of the PPPA. Battery ingestions, resulting in exposure to hazardous chemicals, are not in-scope for this report.

Fatality Data

Death counts for 1972 through 1996 are from a previous report prepared by CPSC's Directorate for Health Sciences staff. Death counts for 1997 through 2021 are based on data from the NCHS that are coded using the International Classification of Diseases (ICD).² Population data were obtained from the U.S. Census Bureau. More information on the data sources is available in Appendix A: Methodology.

In 2021, there were 59 fatalities involving unintentional pediatric poisonings. Although 2020 and 2021 show sizeable increases when compared to recent years, the fatalities for children younger than age 5 have declined substantially since Congress founded the CPSC in 1972, from an annual average of about 167 deaths in the 1972 to 1974 timeframe, to an annual average of about 45 deaths in the 2019 to 2021 timeframe. Table 1 and Figure 1 show the detailed death counts by year from 1972 to 2021.

Table 1: Pediatric Poisoning Fatalities Among Children Under 5, 1972 – 2021

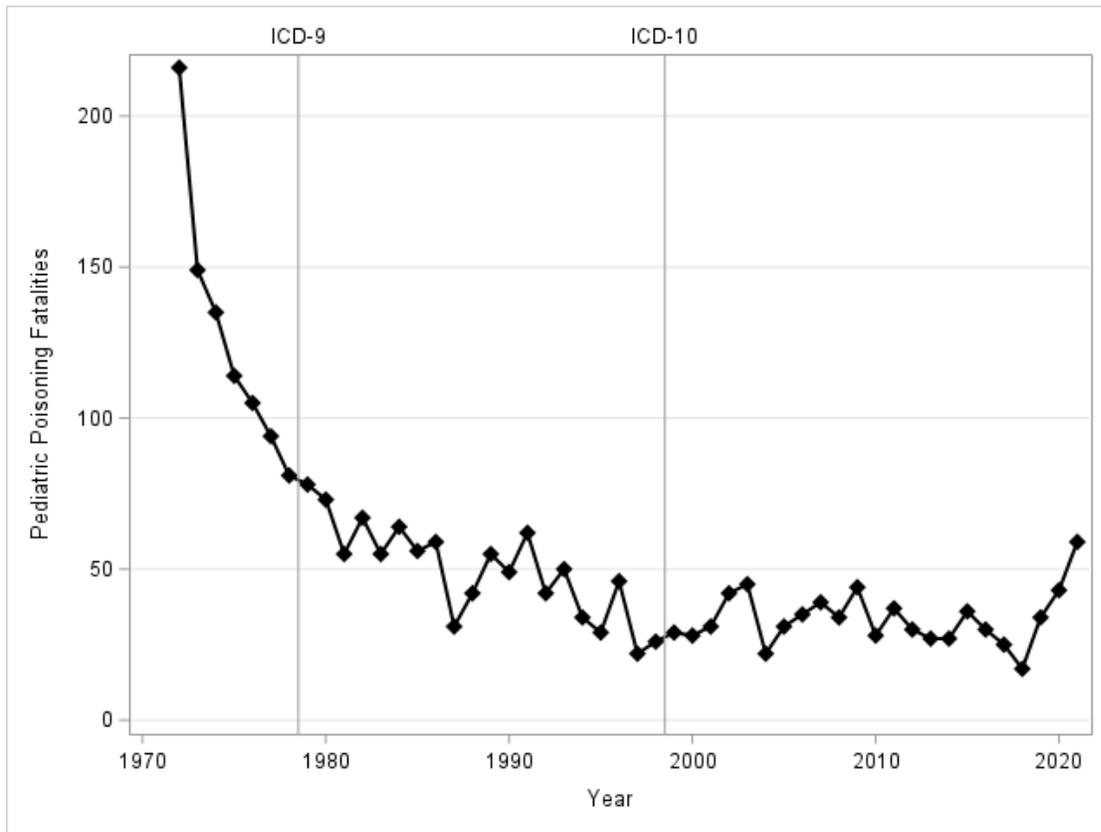
Year	Deaths	Percent Decrease Since 1972
1972	216	0%
1973	149	31%
1974	135	38%
1975	114	47%
1976	105	51%
1977	94	56%
1978	81	63%
1979	78	64%
1980	73	66%
1981	55	75%
1982	67	69%
1983	55	75%
1984	64	70%
1985	56	74%
1986	59	73%
1987	31	86%
1988	42	81%
1989	55	75%
1990	49	77%
1991	62	71%
1992	42	81%
1993	50	77%
1994	34	84%

² Not all these incidents are addressable by an action the CPSC could take. It is not the purpose of this report to evaluate whether the incidents can be addressed, but rather, to update the death counts associated with pediatric poisonings.

Year	Deaths	Percent Decrease Since 1972
1995	29	87%
1996	46	79%
1997	22	90%
1998	26	88%
1999	29	87%
2000	28	87%
2001	31	86%
2002	42	81%
2003	45	79%
2004	22	90%
2005	31	86%
2006	35	84%
2007	39	82%
2008	34	84%
2009	44	80%
2010	28	87%
2011	37	83%
2012	30	86%
2013	27	88%
2014	27	88%
2015	36	83%
2016	30	86%
2017	25	88%
2018	17	92%
2019	34	84%
2020	43	80%
2021	59	73%

Note: The horizontal lines indicate when the World Health Organization switched from using ICD-8 to ICD-9 in 1979, and when it switched from using ICD-9 to ICD-10 in 1999.
Source: National Center for Health Statistics.

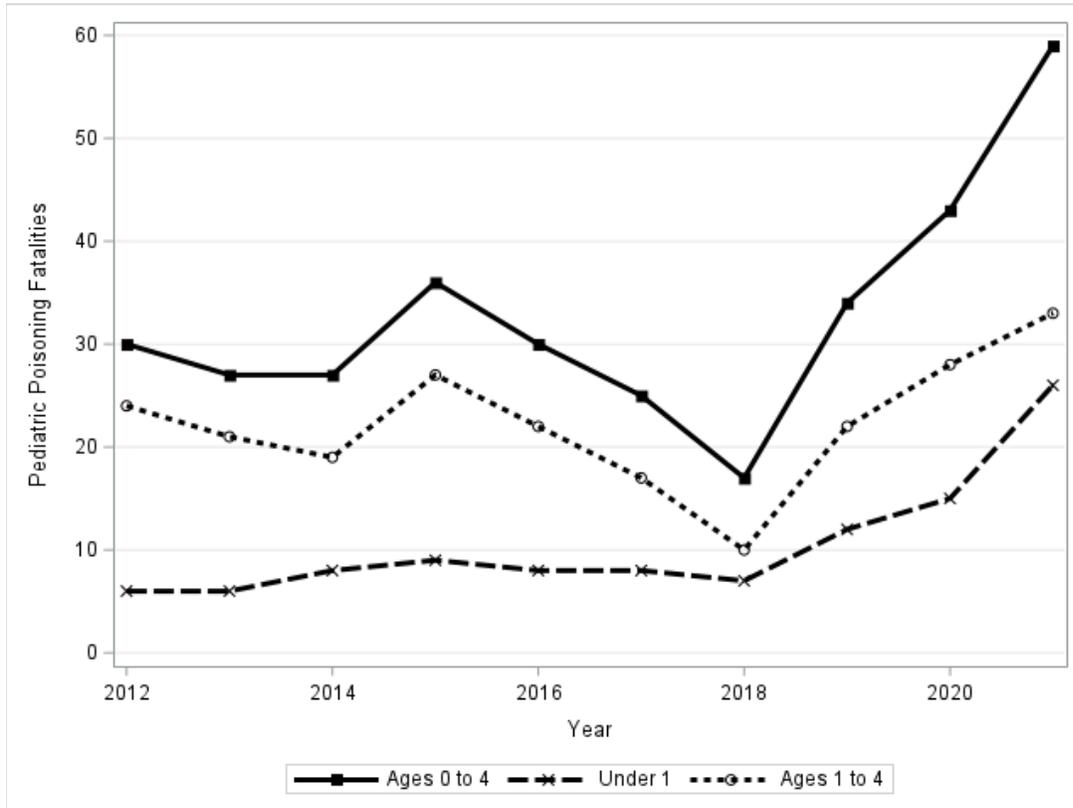
Figure 1: Pediatric Poisoning Fatalities Among Children Under 5, 1972 – 2021



Note: The vertical lines indicate when the World Health Organization switched from using ICD-8 to ICD-9 in 1979, and when it switched from using ICD-9 to ICD-10 in 1999.
Source: National Center for Health Statistics.

Poisoning death counts for children younger than age 5 were categorized into two age subcategories: children younger than 1 year of age, and children from 1 year through 4 years of age. The death counts for each age subcategory from 2012 through 2021, along with the total death counts for children under 5, are shown in Figure 2.

Figure 2: Pediatric Poisoning Fatalities Among Children Under 5, 2012– 2021 By Age Categories



Source: National Center for Health Statistics.

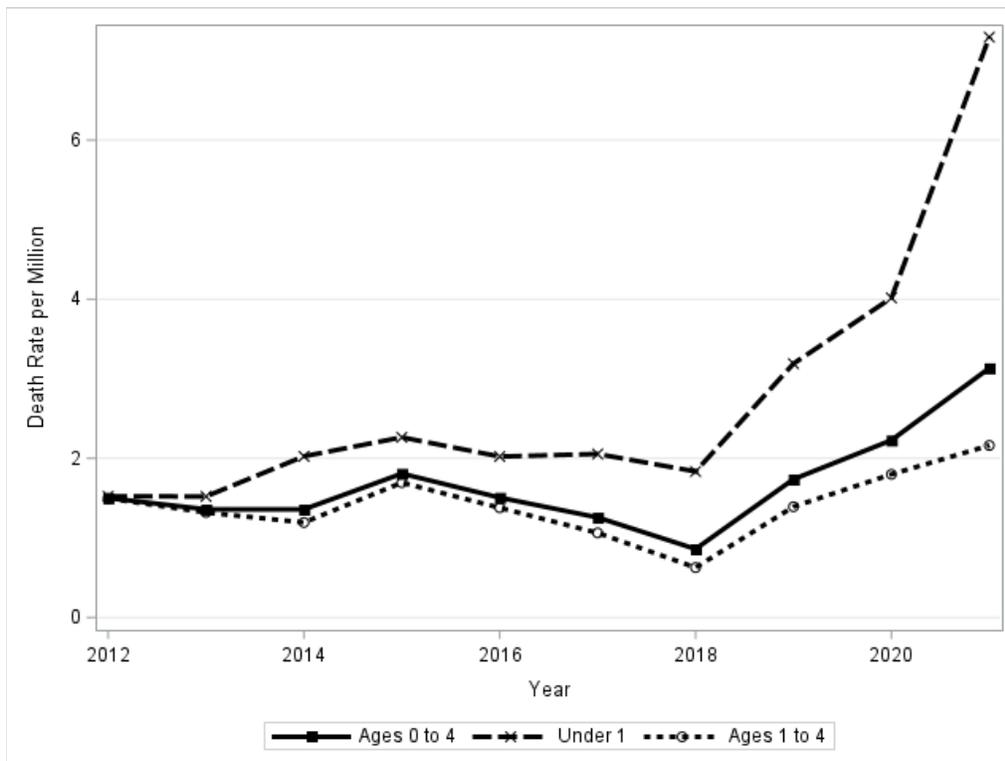
The death rates were calculated using population estimates from the U.S. Census Bureau. The death rates for each age subcategory from 2012 through 2021, along with the total death rates, are shown in Table 2 and Figure 3. It should be noted that the death rates may change slightly, depending on the release year of the population data used in the calculation.

Table 2: Pediatric Poisoning Death Rates Among Children Under 5, 2012 – 2021 By Age Categories*

Year	Under 1	Ages 1 to 4	Ages 0 to 4
2012	1.52	1.50	1.50
2013	1.52	1.32	1.36
2014	2.03	1.19	1.36
2015	2.26	1.69	1.81
2016	2.02	1.38	1.51
2017	2.05	1.06	1.26
2018	1.83	0.63	0.86
2019	3.19	1.39	1.74
2020	4.02	1.80	2.23
2021	7.29	2.16	3.13

*Rates are per million population of the specified age group.
Source: National Center for Health Statistics and U.S. Census Bureau.

Figure 3: Pediatric Poisoning Death Rates Among Children Under 5, 2012 – 2021 By Age Categories*



*Rates are per million population of the specified age group.
Source: National Center for Health Statistics and U.S. Census Bureau.

Overall, the total poisoning death counts and rates for children under age 5 increased from 2018 to 2021. The death rate for the under-1-year age category was higher than the rate for ages 0 to 4 and ages 1 to 4 categories throughout the years 2012 to 2021.

Yearly poisoning death counts of children under age 5 from 2019 to 2021, by ICD-10 codes, are shown in Table 3.

Table 3: Pediatric Poisoning Death Counts Among Children Under 5, 2019 – 2021 by ICD-10 Code³

ICD-10 Code	2019	2020	2021
X40 (non-opioid analgesics, antipyretics, and antirheumatics)	0	1	1
X41 (antiepileptic, sedative- hypnotic, . . . and psychotropic)	8	8	9
X42 (narcotics and psychodysleptics, not elsewhere classified)	17	21	33
X43 (drugs acting on the autonomic nervous system)	0	0	0
X44 (other and unspecified drugs . . . and biological substances)	7	11	16
X45 (alcohol)	0	0	0
X46 (organic solvents and halogenated hydrocarbons)	0	0	0
X48 (pesticides)	1	2	0
X49 (other and unspecified chemicals and noxious substances)	1	0	0
Total	34	43	59

Source: National Center for Health Statistics.

³ The code definitions were abbreviated due to space considerations. Please see the full list of codes and definitions on page 14.

Estimated Injury Data

In 2021, staff found 2,563 cases involving unintentional pediatric poisonings for children younger than age 5 in the NEISS.⁴ Based on these cases, staff computed a national estimate of 62,600 ED-treated injuries, with a coefficient of variance (C.V.) of 16.54 percent. The 95 percent confidence interval (C.I.) for this estimate was 42,300 to 82,900. A breakdown of the estimated injuries by diagnosis is shown in Table 4.

Table 4: 2021 ED-Treated Unintentional Pediatric Poisoning Estimates by Diagnosis*

Diagnosis (Code)	Estimate	Cases	C.V.	95% C.I.
Poisoning (68)	58,400	2,432	15.09%	41,100-75,700
Chemical Burn (49)	N/A**	148	42.36%	N/A**
Total ⁵	62,600	2,563	16.54%	42,300-82,900

Source: National Electronic Injury Surveillance System

*Adjusted to exclude adverse reactions, therapeutic errors, and exposures beyond the victim's control.⁶

**Estimates are unstable as C.V. is above the threshold of 33%.

From 2019 to 2021, there was an estimated annual average of 63,900 ED-treated injuries involving unintentional pediatric poisonings for children younger than age 5. The estimated injuries decreased from 2019 to 2021, but the trend was not statistically significant (the lowest p-value for all year-to-year changes, for the entire time frame, was 0.17, with an overall long-term trend p-value of 0.71). Table 5 gives a breakdown of the estimated injuries by year and diagnosis code.

Table 5: 2019–2021 ED-Treated Unintentional Pediatric Poisoning Estimates by Year*

Diagnosis (Code)	2019	2020	2021	Average
Poisoning (68)	64,500	58,200	58,400	60,400
Chemical Burn (49)	N/A**	N/A**	N/A**	N/A**
Total	67,500	61,500	62,600	63,900

Source: National Electronic Injury Surveillance System

*Adjusted to exclude adverse reactions, therapeutic errors, and exposures beyond the victim's control.⁶

**Estimates are unstable as C.V. is above the threshold of 33%.

An estimated 49,500 (79 percent of the total 62,600) poisonings occurred at home. An estimated 12,100 (19 percent) poisonings occurred at an unknown location. The remaining injuries occurred at other locations, such as streets, schools, playgrounds, and other public property.

⁴ In October 2018, NEISS was upgraded. An ED visit is allowed to contain up to two codes for the diagnoses. Data were extracted if either of the two codes listed poisoning or chemical burn. Note that it is possible for some incidents to have both poisoning and chemical burn diagnoses.

⁵ Columns may not sum to totals due to rounding and the diagnosis categories not being mutually exclusive.

⁶ See examples of the out-of-scope cases in Methodology section on page 16.

Table 6 presents a breakdown, by the product involved, for the estimated ED-treated unintentional pediatric poisonings. Note that the product categories are not mutually exclusive because it is possible for two different products to be associated with the same poisoning incident.

Table 6: 2021 ED-Treated Unintentional Pediatric Poisoning Estimates by Top 10 Products^{7*}

Product	Estimate ⁸	C.V.	95% C.I.
Blood Pressure Medications	5,800	20.29%	3,500-8,100
Acetaminophen	4,700	20.31%	2,800-6,500
Antidepressants	3,100	21.77%	1,800-4,400
Laundry Packets	3,000	21.89%	1,700-4,200
Bleach	3,000	22.16%	1,700-4,200
Dietary Supplements	2,500	23.21%	1,400-3,700
Ibuprofen	2,000	19.64%	1,300-2,800
Illegal drugs	2,000	27.88%	900-3,100
Attention Deficit Disorder Medications	2,000	23.75%	1,100-2,900
Unknown	1,700	16.31%	1,200-2,200

Source: National Electronic Injury Surveillance System

*Adjusted to exclude adverse reactions, therapeutic errors, and exposures beyond the victim's control.

⁷ Liquid nicotine poisoning injuries did not appear in the top 10 products in 2021, or any prior years. The CNPPA requires any nicotine provided in a liquid nicotine container, sold, offered for sale, manufactured for sale, distributed in commerce, or imported into the United States shall be packaged in accordance with the standards of the PPPA.

⁸ Please refer to the appendix on page 20 for estimates for the previous year.

Table 7 and Table 8 provide breakdowns by gender and ethnicity/race, respectively, for the estimated ED-treated unintentional pediatric poisonings for the injured and U.S. population under the age of 5. The population data are from the U.S. Census Bureau.

Table 7: 2021 ED-Treated Unintentional Pediatric Poisoning Estimates by Victims' Gender

Gender	Estimated Total Number of ED-Treated Injuries	Percent of Estimated ED-Treated Injuries	Percent of U.S. Population
Male	34,000	54%	51%
Female	28,600	46%	49%

Source: National Electronic Injury Surveillance System and U.S. Census Bureau.

Table 8: 2021 ED-Treated Unintentional Pediatric Poisoning Estimates by Victims' Ethnicity and Race*

Ethnicity	Race	Injured Population	U.S. Population
Hispanic Origin		14.8%	26.0%
	White	10.4%	21.3%
	Black/African American	0.4%	1.8%
	Asian	<0.1%	0.4%
	American Indian/Alaska Native	-	1.1%
	Native Hawaiian/Pacific Islander	-	0.1%
	Other ⁹	4.0%	1.3%
Non-Hispanic Origin		85.2%	74.0%
	White	58.6%	48.2%
	Black/African American	21.0%	14.0%
	Asian	1.5%	5.6%
	American Indian/Alaska Native	1.4%	0.8%
	Native Hawaiian/Pacific Islander	<0.1%	0.2%
	Other ⁹	2.7%	5.2%
All		100%	100%
	White	69.0%	69.4%
	Black/African American	21.4%	15.8%
	Asian	1.5%	6.0%
	American Indian/Alaska Native	1.4%	1.9%
	Native Hawaiian/Pacific Islander	<0.1%	0.4%
	Other ⁹	6.7%	6.5%

Source: National Electronic Injury Surveillance System and U.S. Census Bureau.

*Excludes any incidents where either Race was "Not Stated" or Ethnicity was "Not Stated", which comprised 44 percent of the estimated injuries.

⁹ This category includes two or more races.

Appendix A

Methodology

Fatalities Data

The data for 1972 through 1996 are from a previous report prepared by CPSC's Directorate for Health Sciences staff.¹⁰ Counts of deaths for 1997 through 2002 were obtained from the NCHS website, using data in the under-1-year age group and the 1- to 4-year age group. Counts of deaths for 2003 through 2006 for children under the age of 5 years were determined from data obtained in CD-ROMs from NCHS. Counts of deaths for 2007 through 2021 for children under the age of 5 years were determined from data downloaded from the NCHS website. Population data were obtained from the U.S. Census Bureau website.

The download of the NCHS data for 2021 was from:

- U.S. Department of Health and Human Services. National Center for Health Statistics. Mortality Multiple Cause File. Downloaded from:
https://ftp.cdc.gov/pub/health_statistics/nchs/datasets/dvs/mortality/mort2021us.zip

The download of the population data for 2021 was from:

- Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States: April 1, 2020 to July 1, 2021 (NC-EST2021-ASR6H). Release Date: June 2022: <https://www2.census.gov/programs-surveys/popest/tables/2020-2021/national/asrh/nc-est2021-asr6h.xlsx>

Staff used the NCHS mortality data file, as downloaded from the Internet. The data are provided in a column-format text file, with documentation on the table layout. CPSC staff wrote SAS Studio® v3.81 code to subset the data provided by the ICD-10 cause of death code, age, and resident status.

Staff used ICD-10 codes X40 through X49, excluding X47. Traditionally, we collected the X47 code for analysis, but we excluded it from the report because it covers carbon monoxide poisonings not relevant to the PPPA. We included incidents in the subset only if a relevant ICD-10 code was listed as the underlying cause of death.

The NCHS data use two-variable age encoding with a unit and a value. Included in the subset are all incidents with a unit of years and a value less than five. It also includes all incidents with a unit shorter than 1 year, which is used for children younger than 1 year old. There is an "unknown" age unit that is not included in the subset.

The data are arranged in the subset by resident status to exclude foreign nationals.

¹⁰ Memorandum from Susan Aitken, Ph.D., to Kenneth P. Giles, dated 29 Jan 1999: "National Center for Health Statistics (NCHS) Data on Pediatric Fatalities for 1996." U.S. Consumer Product Safety Commission, Washington, D.C.

Fatalities from 1994 through 1998 were coded in 17 E-codes (850 through 866) from the ninth revision of the International Classification of Diseases (ICD-9). Fatalities for 1999 through 2021 are identified under the nine codes from X40 through X49, excluding X47, from the tenth revision of the International Classification of Diseases (ICD-10). These codes are:

- X40 Accidental poisoning by and exposure to nonopioid analgesics, antipyretics, and antirheumatics.
- X41 Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism, and psychotropic drugs, not elsewhere classified.
- X42 Accidental poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified.
- X43 Accidental poisoning by and exposure to other drugs acting on the autonomic nervous system.
- X44 Accidental poisoning by and exposure to other and unspecified drugs, medicaments, and biological substances.
- X45 Accidental poisoning by and exposure to alcohol.
- X46 Accidental poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapors.
- X48 Accidental poisoning by and exposure to pesticides.
- X49 Accidental poisoning by and exposure to other and unspecified chemicals and noxious substances.

The excluded code, X47, is for accidental poisoning by and exposure to other gases and vapors, a code that includes carbon monoxide poisoning.

The United States began using ICD-10 codes for deaths occurring in 1999, replacing ICD-9, which had been adopted in 1979. The revision of ICD-9 into ICD-10 involved increasing the number of categories from about 5,000 to about 8,000, changing from numeric to alphanumeric codes, and changing some rules for selecting the underlying cause of death.¹¹ Because ICD-10 codes are not directly comparable to ICD-9 codes, discontinuities can appear in trend analyses

¹¹ Anderson, RN, Minino, AM, Hoyert, DL, Rosenberg, HM. Comparability of Cause of Death Between ICD-9 and ICD-10: Preliminary Estimates. National Vital Statistics Report; vol 49 no 2. Hyattsville, Maryland: National Center for Health Statistics. 2001.

that use data on deaths occurring before 1999. Year-to-year variability is also evident in the data.

Comparability ratios can be used to adjust past NCHS counts to reflect how many deaths would have been coded in certain groupings had ICD-10 been in effect during a given year. However, NCHS has not released a comparability ratio for poisonings as of this writing. NCHS released preliminary estimates of comparability ratios for the transition from ICD-9 to ICD-10 in May 2001. The estimates were based on a sample of double-coded death certificates from 1996.¹² For most cause-of-death groupings, the NCHS researchers provided ratios. For the poisoning group, however, the preliminary ratio estimate was deemed unreliable. This may have been for several possible reasons, including a paucity of deaths in the poisoning codes; a lack of inclusion of deaths from the poisoning grouping in the preliminary study; or an increase or decrease in deaths due to poisoning, which was determined by the researchers to be both large-scale and erroneous.

In the absence of a ratio for poisoning, the ratio for nontransport accidents was considered for use by CPSC staff in this analysis. Nontransport accidents include all accidental deaths that do not involve a vehicle. Because of the possibility that the comparability ratio for the poisoning group could differ significantly from that for all nontransport accidents for any one of the reasons above, CPSC staff ultimately chose to postpone the use of an NCHS comparability ratio. Comparisons between pre-1999 and post-1999 data should be made with caution.

The ICD-10 categories included in this report were chosen to present comprehensive statistics on childhood poisonings, with a particular interest in including any death that may have been prevented using child-resistant packaging. Some of the deaths included may involve situations or products that fall outside of the CPSC's jurisdiction. For example, the category X44 may include deaths due to food poisoning (e.g., salmonella, botulism toxin) or due to exposure to wild mushrooms; and category X42 may include deaths due to exposure to illegal drugs.

In the absence of a detailed analysis of the full complement of death certificates in the given categories, it is not possible to determine what percentage of the deaths included in these codes may have been preventable using child-resistant packaging. A detailed analysis might be helpful. It is noted that the true number of deaths due to household products or the drug packaging within the CPSC's jurisdiction is likely close to and is a subset of the number presented in this report in any given year.

¹² Memorandum from Susan Aitken, Ph.D. to Kenneth P. Giles dated 29 Jan 1999: "National Center for Health Statistics (NCHS) Data on Pediatric Fatalities for 1996." CPSC, Washington, D.C.

Estimated Injury Data

NEISS is a probability sample of approximately 100 U.S. hospitals, each operating 24-hour EDs and providing more than six beds. Staff in each hospital input and code consumer product-related data from the ED record, and then the data are transmitted electronically to the CPSC. Because NEISS is a probability sample, each case collected represents several cases (the case's weight) in the total estimate of injuries in the United States. Different hospitals carry different weights, based on stratification by their annual number of ED visits (Kessler and Schroeder, 1999).

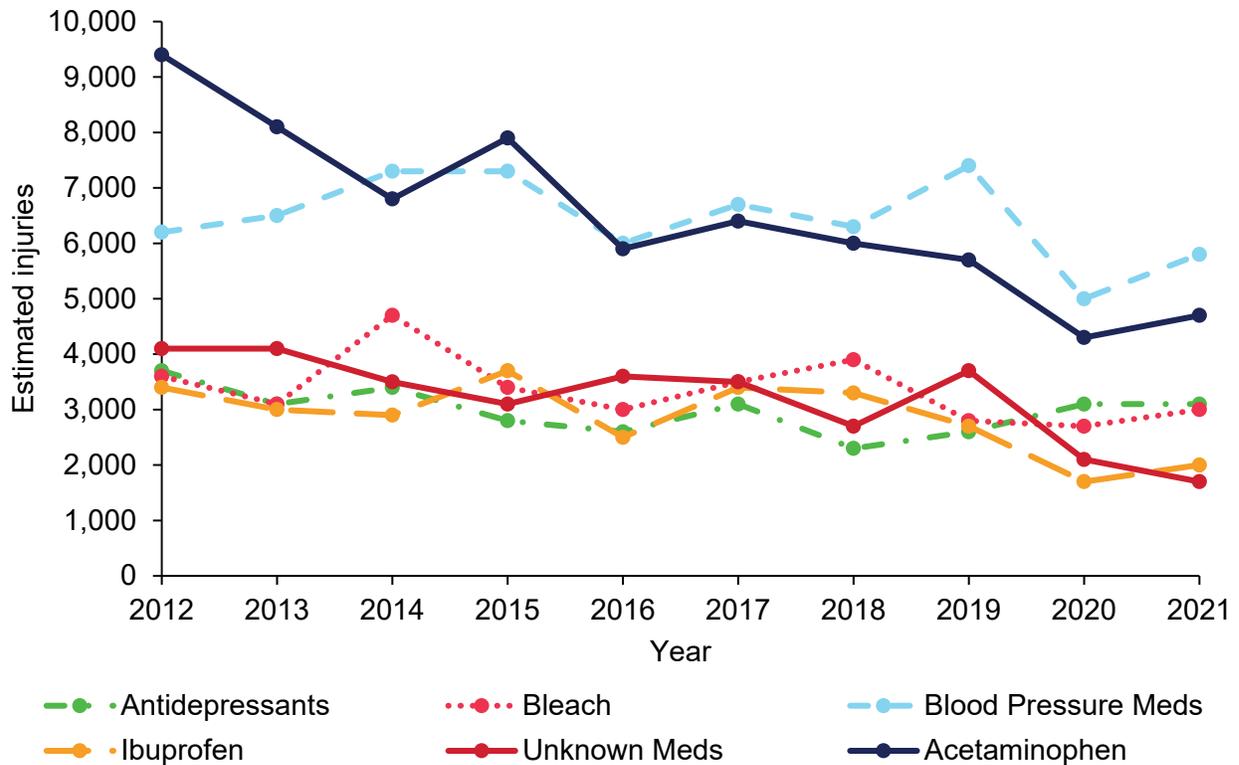
Hazard Analysis staff searched NEISS databases for all incidents with a poisoning diagnosis (code 68) or chemical burn diagnosis (code 49) involving children under the age of 5. Health Sciences staff examined all incidents to identify cases that were not unintentional exposures, but were deemed generally associated with a prescribed therapeutic regimen, or an unforeseen incidental exposure from a situation beyond the victim's control. These types of cases, delineated below, are out-of-scope cases because they do not directly involve a child independently accessing a poison.

1. *Adverse Reactions*: This includes undesirable effects that occur with the proper use of a substance (e.g., drowsiness after administration of an antihistamine). Allergic, hypersensitivity, or idiosyncratic reactions to recommended doses of vaccines, antibiotics, or other medications are also included in this category.
2. *Therapeutic Errors*: Unintentional mistakes made during a prescribed or recommended course of treatment, such as: (1) a caregiver administering the wrong substance or an overdose (e.g., two tablespoons instead of two teaspoons) to the patient; (2) a pharmacist mislabeling the dosage instructions on a prescription; or (3) a caregiver giving medication to the wrong child.
3. *Incidental Exposures*: This category refers to exposures resulting from a situation beyond the control of the victim. Examples include exposures to: (1) chlorine fumes from a pool; (2) gas fumes while in a dwelling or an automobile; (3) gasoline while it is being pumped into an automobile; or (4) illicit drugs (e.g., cocaine, methamphetamine, marijuana) while the caregiver is using or producing them.

Hazard Analysis staff used SAS® software program (SAS Studio® v3.81) to manage and retrieve data and to compute estimates and the associated C.V. for the number of unintentional pediatric poisoning injuries. A C.V. is the ratio of the standard error of the estimate (i.e., variability) to the estimate itself. This is generally expressed as a percent. A C.V. of 10 percent means the standard error of the estimate equals 0.1 times the estimate.

NEISS data do not typically identify all of the contributing factors to unintentional pediatric poisoning injuries. CPSC continues public outreach efforts to help manufacturers comply with the PPPA and to remind consumers about the need to keep products in their original child-resistant packaging and out of the reach of children.

Figure A.1: Estimated ED-Treated Injuries for Products in the Top 10 Every Year from 2012 – 2021*



*Due to limited variance in the population of children under 5, the pattern remains the same when normalized per 100,000 children.

*There has been an overall reduction in Acetaminophen since 2012, which may be due to several Acetaminophen child safety cap recalls.

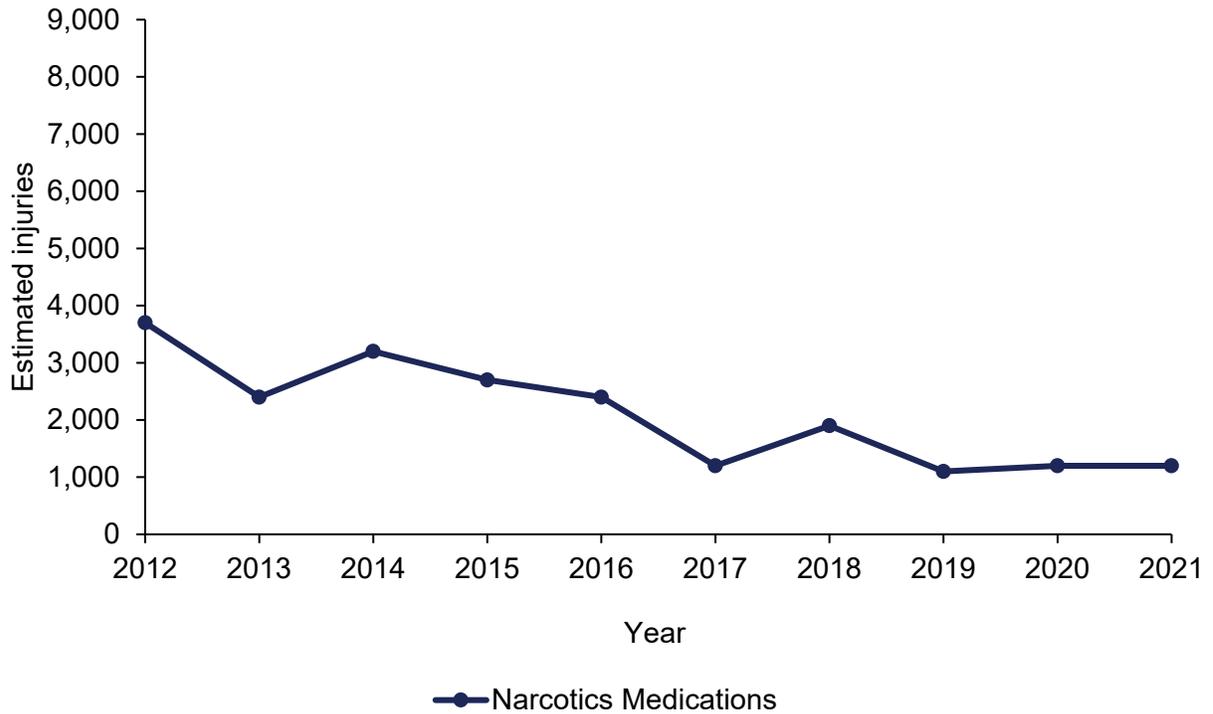
Source: National Electronic Injury Surveillance System.

Figure A.2: Estimated ED-Treated Injuries for Laundry Packets from 2012 – 2021*



*Laundry Packets were introduced in 2012 and have been in the top 10 products every year since 2013. The increase in estimated injuries from 2020 to 2021 was not significant. Source: National Electronic Injury Surveillance System.

Figure A.3: Estimated ED-Treated Injuries for Narcotics Medications from 2012 – 2021*



*Although Narcotics medications deaths increased 57% from 2020 to 2021, Narcotics medications injuries remained stable from 2020 to 2021.
Source: National Electronic Injury Surveillance System.

Estimated ED-treated injuries for the top 10 products for each year from 2012 through 2018 are provided in <https://www.cpsc.gov/content/Unintentional-Pediatric-Poisoning-Injury-Estimates-for-2019>, pp 7-9. Data for the year 2019 are provided in <https://www.cpsc.gov/content/Annual-Report-on-Pediatric-Poisoning-Fatalities-and-Injuries>, pp 20.

Shown below is the tabulation for the 2020 top 10 products involved in unintentional pediatric poisoning injuries.

Table A.1: 2020 ED-Treated Unintentional Pediatric Poisoning Estimates by Top 10 Products*

Product	Estimate	C.V.	95% C.I.
Blood Pressure Medications	5,000	19.82%	3,100-6,900
Acetaminophen	4,300	16.41%	2,900-5,700
Antidepressants	3,100	21.77%	1,800-4,400
Dietary Supplements	3,000	18.98%	1,900-4,100
Bleach	2,700	19.94%	1,700-3,700
Diphenhydramine	2,200	21.35%	1,300-3,100
Laundry Packets	2,200	22.66%	1,200-3,200
Attention Deficit Disorder Medications	1,800	25.47%	900-2,700
Ibuprofen	1,700	18.26%	1,100-2,300
Unknown	2,100	22.76%	1,200-3,000

Source: National Electronic Injury Surveillance System.

* Adjusted to exclude adverse reactions, therapeutic errors, and exposures beyond the victim's control.