Policy Statement—Child Passenger Safety

abstract

Child passenger safety has dramatically evolved over the past decade; however, motor vehicle crashes continue to be the leading cause of death of children 4 years and older. This policy statement provides 4 evidence-based recommendations for best practices in the choice of a child restraint system to optimize safety in passenger vehicles for children from birth through adolescence: (1) rear-facing car safety seats for most infants up to 2 years of age; (2) forward-facing car safety seats for most children through 4 years of age; (3) belt-positioning booster seats for most children through 8 years of age; and (4) lap-and-shoulder seat belts for all who have outgrown booster seats. In addition, a fifth evidence-based recommendation is for all children younger than 13 years to ride in the rear seats of vehicles. It is important to note that every transition is associated with some decrease in protection; therefore, parents should be encouraged to delay these transitions for as long as possible. These recommendations are presented in the form of an algorithm that is intended to facilitate implementation of the recommendations by pediatricians to their patients and families and should cover most situations that pediatricians will encounter in practice. The American Academy of Pediatrics urges all pediatricians to know and promote these recommendations as part of child passenger safety anticipatory guidance at every health-supervision visit. Pediatrics 2011;127:788–793

Improved vehicle crashworthiness and greater use of child restraint systems have significantly affected the safety of children in automobiles. Major shifts in child restraint use, particularly the use of booster seats among older children, have occurred in response to public education programs and enhancements to child restraint laws in nearly every state. In addition, there has been a substantial increase in scientific evidence on which to base recommendations for best practices in child passenger safety. Current estimates of child restraint effectiveness indicate that child safety seats reduce the risk of injury by 71% to 82% and reduce the risk of death by 28% when compared with those for children of similar ages in seat belts. Booster seats reduce the risk of nonfatal injury among 4- to 8-year-olds by 45% compared with seat belts. Despite this progress, approximately 1500 children younger than 16 years die in motor vehicle crashes each year in the United States, nearly half of whom were completely unrestrained.

The American Academy of Pediatrics (AAP) strongly supports optimal safety for children and adolescents of all ages during all forms of travel.
This policy statement provides 5 evidence-based recommendations for best practices to optimize safety in passenger vehicles for all children, from birth through adolescence (a summary of recommendations is listed in Table 1):

1. All infants and toddlers should ride in a rear-facing car safety seat (CSS) until they are 2 years of age.

TABLE 1 Summary of Best-Practice Recommendations

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<th>Best-Practice Recommendation</th>
<th>Complementary Information</th>
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| 1. Best-practice recommendation | Infant-only seats usually have a handle for carrying and can be snapped in and out of a base that is installed in the vehicle. They can only be used rear-facing. Convertible CSSs can be used either forward- or rear-facing and typically have higher rear-facing weight and height limits than infant-only seats. When children using infant-only seats reach the highest weight for their seat, they should continue to ride rear-facing in a convertible seat for as long as possible. Most currently available convertible seats can be used rear-facing to at least 35 lb.

Several models of convertible and combination CSSs can accommodate children up to 65 or 80 lb when used forward-facing. The lowest maximum weight limit for currently available forward-facing CSSs is 40 lb.

There is a safety advantage for young children to remain in CSSs with a harness for as long as possible before transitioning to booster seats.

2. Best-practice recommendation | Several models of convertible and combination CSSs can accommodate children up to 65 or 80 lb when used forward-facing. The lowest maximum weight limit for currently available forward-facing CSSs is 40 lb.

There is a safety advantage for young children to remain in CSSs with a harness for as long as possible before transitioning to booster seats.

3. Best-practice recommendation | Booster seats function by positioning the child so that both the lap and shoulder portions of the vehicle seat belt fit properly, the lap portion of the belt should fit low across the hips and pelvis, and the shoulder portion should fit across the middle of the shoulder and chest. They come in both high-back (a seat back that extends up beyond the child’s head) and backless models. The lap portion of the belt should fit low across the hips and pelvis, and the shoulder portion should fit across the middle of the shoulder and chest when the child sits with his or her back against the vehicle seat back. If they do not, then the child is likely too small to use the vehicle seat belt alone and should continue to use a belt-positioning booster seat.

CSSs should be installed tightly either with the vehicle seat belt or with the LATCH system, if available. LATCH is a system of attaching a CSS to the vehicle that does not use the seat belt. It was designed to ease installation of the CSS. Whether parents use LATCH or the seat belt, they should always ensure a tight installation of the CSS into the vehicle.

4. Best-practice recommendation | Booster seats function by positioning the child so that both the lap and shoulder portions of the vehicle seat belt fit properly, the lap portion of the belt should fit low across the hips and pelvis, and the shoulder portion should fit across the middle of the shoulder and chest. They come in both high-back (a seat back that extends up beyond the child’s head) and backless models. The lap portion of the belt should fit low across the hips and pelvis, and the shoulder portion should fit across the middle of the shoulder and chest when the child sits with his or her back against the vehicle seat back. If they do not, then the child is likely too small to use the vehicle seat belt alone and should continue to use a belt-positioning booster seat.

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or until they reach the highest weight or height allowed by the manufacturer of their CSS.

2. All children 2 years or older, or those younger than 2 years who have outgrown the rear-facing weight or height limit for their CSS, should use a forward-facing CSS with a harness for as long as possible, up to the highest weight or height allowed by the manufacturer of their CSS.

3. All children whose weight or height is above the forward-facing limit for their CSS should use a belt-positioning booster seat until the vehicle lap-and-shoulder seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are between 8 and 12 years of age.

4. When children are old enough and large enough to use the vehicle seat belt alone, they should always use lap-and-shoulder seat belts for optimal protection.

5. All children younger than 13 years should be restrained in the rear seats of vehicles for optimal protection.

FIGURE 1
Algorithm to guide the implementation of best-practice recommendations for optimal child passenger safety (see Table 1 for a summary of recommendations and Table 2 for definitions and explanations).
It should be noted that the recommendation that all children younger than 2 years be restrained in an infant-only or convertible CSS used rear-facing represents a significant change from previous AAP policy and is based on new data from the United States as well as extensive experience in Sweden. It is important to note that most currently available CSSs have weight limits for rear-facing use that can accommodate the new recommendations. Certain considerations contained in this policy statement are relevant to commercial airline travel as well and are noted in the accompanying technical report. Other AAP policy statements provide specific recommendations to optimize safety for preterm and low birth weight infants, children in school buses, and children using other forms of travel and recreational vehicles. In addition, complementary AAP policy statements provide recommendations for teenaged drivers and the safe transport of newborn infants and children with special health care needs.
Pediatricians play a critical role in promoting child passenger safety. To facilitate their widespread implementation in practice, evidence-based recommendations for optimal protection of children of all ages in passenger vehicles are presented in the form of an algorithm (Fig 1) with an accompanying table of explanations and definitions (Table 2). A summary of the evidence in support of these recommendations is provided in the accompanying technical report. Because pediatricians are a trusted source of information to parents, every pediatrician must maintain a basic level of knowledge of these best-practice recommendations and familiarize themselves with additional resources to address unique situations for their patients that may not be covered by the algorithm and to maintain current knowledge. In particular, many communities have child passenger safety technicians who have completed a standardized National Highway Traffic Safety Administration (NHTSA) course and who can provide hands-on advice and guidance to families. In most communities, child passenger safety technicians work at formal inspection stations; a list of these stations is available at www.seatcheck.org. If your community does not have an inspection station, you can find a child passenger safety technician in your area on the National Child Passenger Safety Certification Web site (http://cert.safekids.org/) or the NHTSA child safety seat inspection station locator (www.nhtsa.dot.gov/cps/cpsfitting/index.cfm). Car seat checkup events are updated at www.safekidsweb.org/events/events.asp. In addition, additional resources for pediatricians and families can be found at www.aap.org or www.healthychildren.org.

REFERENCES


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