

OFFICE OF THE INSPECTOR GENERAL
Department of Children and Family Services
2240 West Ogden Avenue
Chicago, Illinois 60612
(312) 433-3000

**Investigating and Indicating Parents for Co-Sleeping
in the Absence of Drug or Alcohol Use With No Other Evidence of Neglect¹**

Introduction

In 2008, the Illinois Child Death Review Teams recommended DCFS develop a protocol for indicating parents whose children die while bed sharing when the parent was under the influence of alcohol or drugs (Illinois Child Death Review Teams, 2010).² In the same year, the Illinois Child Death Review Teams recommended DCFS develop guidelines for SCR (State Central Register/the DCFS hotline) to accept for investigation calls about babies who died while co-sleeping. The practice of bed sharing, also known as co-sleeping, refers to a parent sleeping with an infant in an adult bed, on a mattress, couch, armchair or other “unsafe” sleep environment. “Co-sleeping” can also refer to the practice of “room sharing”—having an infant’s crib in the same bedroom as the parent, but not sharing the adult bed with the infant. In this report, however, “co-sleeping” is meant to be synonymous with “bed sharing.”

A 2009 survey of Illinois parents found that nearly 18% reported their infant “usually” co-slept with another person (Illinois Pregnancy Risk Assessment Monitoring System, 2009, p. 39). Occasional co-sleeping may be even more prevalent: according to a more detailed survey in another state, when parents were asked whether their infant had “ever” co-slept with them during the first three months of life, 65% said “yes.” (See section entitled “*The Prevalence of Co-Sleeping*” *infra*, p. 7).

In 2009 and 2010, the Illinois Child Death Review Teams expanded on their previous position on co-sleeping, including a recommendation that:

If DCFS determines, during the investigation of a child’s death due to unsafe sleep practices, that the caregiver of the child at the time of death or at the time the child was placed in the unsafe sleep environment, has received prior information, education, [or] documentation regarding safe sleep recommendations from hospital staff, schools, [or]

¹ January 9, 2014

² In response to these 2008 recommendations, DCFS stated:

It is important that DCP staff not just accept/rely on a coroner’s report that finds the death to be accidental but look at blatant disregard which is defined as incidents where the risk of harm to the child was so imminent and apparent that it is unlikely that a parent or caretaker would have exposed the child to such obvious danger without exercising precautionary measures to protect the child from harm (Illinois Child Death Review Teams, 2010).

DCFS and knowingly did not follow the safe sleep recommendations, the case shall be indicated for [Allegation] 60 Risk of Harm [Substantial Risk of Physical Injury by Neglect] at a minimum (Illinois Child Death Review Teams, 2012, p. 105).

DCFS responded to the CDRT recommendation, stating that procedures would be amended to instruct investigative staff to indicate for Allegation 60, Substantial Risk of Physical Injury by Neglect, in situations where a child died while in an unsafe sleep environment and the caregivers had received prior education or documentation about safe sleep. The Department also agreed to instruct investigative staff that if the caregiver had consumed alcohol or drugs prior to the child's death in an unsafe sleep environment, the death could be indicated for Allegation 51, Death by Neglect (Illinois Child Death Review Teams, 2012, pp. 96-97, 101-102, 105). Allegation 60, Substantial Risk of Physical Injury by Neglect, has a five year retention; Allegation 51, Death by Neglect, has a 50 year retention.³ To date, the Department has not issued procedures, policy, or rules instructing investigative staff regarding indicating for co-sleeping.

Historically, coroners and the Cook County Medical Examiner called infant deaths into the hotline for record keeping purposes only (though they could also allege abuse or neglect). SCR recorded the deaths as information-only/unusual incident reports. In 2011, the hotline began taking calls involving co-sleeping for investigation of neglect.

In its review and investigation of child deaths, the Office of the Inspector General has noted inconsistencies in investigations in terms of who is indicated or why. Cases in which the cause of death was accidental overlay have been unfounded for Death by Neglect, while cases in which the child's cause of death was undetermined have been indicated for Death by Neglect. This paper will limit its review to the Department's current practice of investigating parents whose child has died while co-sleeping in the absence of drug or alcohol use or other factors suggesting abuse or neglect, and address whether the practice is advisable and whether it is being administered fairly and consistently.

³In 2011, the Illinois Child Death Review Teams again recommended that DCFS:

Have a protocol in place for consistent findings for unsafe sleeping conditions where DCFS previously agreed to indicate for allegation 60 when it was documented that the parents/caregivers have been told of the safety hazards of unsafe sleeping and allegation 51 when the parents/caregiver have been drinking or using drugs" (Illinois Child Death Review Teams, 2013).

The Department responded that it was "re-writing procedure 300 and will include what will be indicated" (Illinois Child Death Review Teams, 2013). The Child Death Review Teams also recommended the Department utilize safe sleep brochures and partner with public health organizations to educate the public about the risks of unsafe sleep practices:

[The] team would like DCFS to send brochures to [the] University of Illinois & Southern Illinois University Pediatric residency programs. The team would like DCFS to work with DHS and IDPH and local health departments to educate on safe sleep (Illinois Child Death Review Teams, 2013).

The Department agreed with the recommendations and stated the Department would work with "DHS, IDPH and local health departments to educate families on safe sleep" and "look at the Public Service Announcement for safe sleep" (Illinois Child Death Review Teams, 2013).

The Shift in Classifying Co-Sleeping Infant Deaths

Until 1969, the sudden and unexpected death of an infant was classified as a crib death. The term Sudden Infant Death Syndrome (SIDS) was introduced at that time to describe the “sudden death of any infant following a post-mortem which fails to adequately identify a cause of death” (Krous, 2010, p. 7). For thirty years, unexplained infant deaths were categorized as SIDS, a natural manner of death.⁴

In 1999, the Centers for Disease Control (CDC), which collects data on infant deaths, began using the term Sudden Unexpected Infant Death (SUID) to describe any death of an infant less than one year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious prior to a coroner or medical examiner’s investigation (Centers for Disease Control and Prevention, 2013). The CDC did this after recognizing in the late 1990s that coroners and medical examiners were attributing different causes of death (e.g., accidental suffocation or unknown) to infant deaths previously categorized as SIDS.

The CDC noted that inconsistent practices in investigations and cause-of-death determinations hamper the ability to monitor national trends, ascertain risk factors, and design and evaluate programs to prevent child deaths. In an effort to standardize practice, the CDC’s Division of Reproductive Health (DRH) launched the Sudden Unexpected Infant Death Initiative (Centers for Disease Control and Prevention, 2011). The goals of the SUID Initiative are to standardize and improve data collected at the death scene; promote consistent classification and reporting of cause of death; improve national reporting of SUID; and reduce SUID by using improved data to identify those at risk. To accomplish these objectives, in 2006 the SUID Initiative revised the existing (1996) CDC Sudden Unexplained Infant Death Investigation Reporting Form; developed a training curriculum and materials for investigators of infant deaths, and; trained medicolegal professionals and child advocates to conduct comprehensive infant death investigations. By 2012, the CDC developed a state-based SUID Case Registry (SUID-CR) pilot program to supplement current vital statistics-based surveillance methods (currently, Arizona, Colorado, Louisiana, Michigan, Minnesota, New Jersey, New Mexico, New Hampshire, and Wisconsin are participating in the pilot).⁵

The term Sudden Unexpected Infant Death (SUID) may be thought of as a cause of death classification used before a thorough investigation assists a coroner or medical examiner in determining a cause of death.

⁴ There are five manners of death: natural, accident, suicide, homicide, and undetermined.

⁵ The CDC’s Funding Opportunity Announcement for the Sudden Death in the Young Registry (formerly SUID-CR) will be released in the spring of 2014. State health departments are encouraged to create teams of child death review experts and apply to participate.

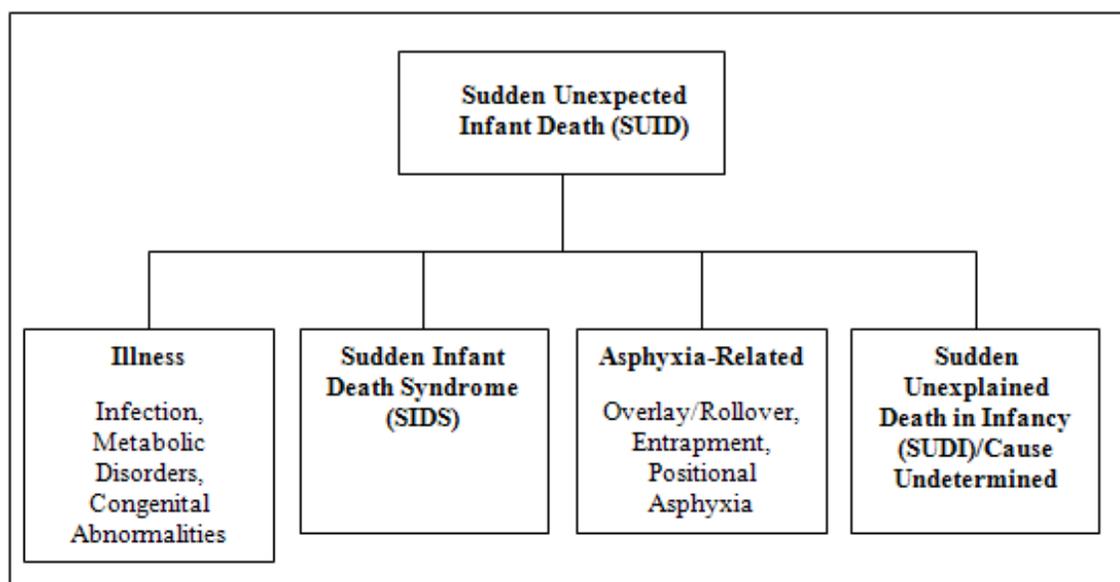


Figure 1: Classification of Infant Deaths

Both Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Death in Infancy (SUDI) are causes of death attributed to the sudden death of an infant less than one year of age in which a thorough investigation, including a complete autopsy, scene investigation, review of the medical/clinical history, and appropriate laboratory testing fails to identify a specific cause of death (Centers for Disease Control and Prevention, 2013; The National Association of Medical Examiners Ad Hoc Committee on Sudden Unexplained Infant Death, 2007, p. 4). A death should be classified as SUDI, not SIDS, when one of the following situations is present:

1. The case meets the criteria for SIDS, but there is evidence of a disease condition whose contribution to the death is unknown or cannot be excluded as a causative or contributing factor.
2. The case meets the criteria for SIDS, but there is evidence of an external condition or risk factor (such as bed sharing with adults, sleeping face down on a soft pillow or sleeping on an adult mattress) whose contribution to the death is unknown or cannot be excluded as a causative or contributing factor.
3. Something in the investigation precludes a diagnosis of SIDS, but the cause and manner of death have not been determined.

A case would be properly classified as SIDS when there is no other cause of death identified after a complete autopsy, including toxicology and other laboratory tests, scene investigation, and review of the medical/clinical history, and there are no unusual scene findings or sleeping conditions identified (The National Association of Medical Examiners, 2002).

The National Association of Medical Examiners (NAME) recommends using the CDC’s Sudden Unexplained Infant Death Investigative Report Form or a similar checklist to conduct a scene investigation, and also recommends that coroners/medical examiners identify and record conditions called “gray zone findings” which may or may not have contributed to the death but

are included on the death certificate because their connection to the death cannot be ruled out (The National Association of Medical Examiners Ad Hoc Committee on Sudden Unexplained Infant Death, 2007, p. 12). In response to these recommendations, the Cook County Medical Examiner and coroners in Illinois began including more conditions such as “bed sharing” or “possible overlay” when officially reporting causes of infant deaths.

When investigating an infant death, the scope of a medical examiner or coroner’s scene investigation should include: determining the original position of the infant when first found unresponsive, conducting interviews, obtaining a medical and social history, and whether the family had any previous unexplained infant or childhood deaths (The National Association of Medical Examiners Ad Hoc Committee on Sudden Unexplained Infant Death, 2007, pp. 4-6, 12). The information that must be obtained before an investigation is considered complete is attached to this report as Appendix A.

Because the criteria for classifying an infant death as SIDS or SUDI are so similar, there is variability within counties in Illinois about what circumstances result in a finding of SIDS (a natural manner of death), versus SUDI (an undetermined manner of death). For example, in some counties the otherwise unremarkable death of an infant co-sleeping in an adult bed might be called a SIDS death. Because SIDS is considered natural, the death would not be indicated by DCFS. In many counties, the same death would be called a SUDI death, an undetermined manner of death. Because the death involved co-sleeping, it would be investigated by the Department, and might be indicated for Substantial Risk of Physical Injury by Neglect or Death by Neglect.

Reasons for the Change in SIDS and SUDI Mortality Rates

Over the past 20 years, the rate of infant mortality attributed to SIDS has decreased while the rate of infant deaths attributed to accidental asphyxiation or unknown causes has increased.⁶ In part, this is due to the reclassification of some unexplained infant deaths that historically would have been classified as SIDS, but whose cause was determined after a thorough investigation (Shapiro-Mendoza, 2009, p. 538). In addition, the national Back to Sleep campaign which promoted education and public awareness of SIDS risk factors is credited with the precipitous drop in SIDS deaths over the past few decades (Kinney, 2009, p. 795).

Success of the Back to Sleep Campaign

The Back to Sleep public education campaign has been credited with significantly reducing the actual incidence of SIDS⁷ while increasing the public’s awareness of unsafe infant sleep environments (Shapiro-Mendoza, 2009, pp. 537-538). One study suggests that if parents were made as aware of the risks of sleeping with their baby as Back to Sleep made them aware of the risks of babies sleeping on their stomachs, a substantial further reduction in infant deaths could be achieved (Carpenter R., 2013, p. 10).

⁶ A 2004 study looked at 20 years of infant mortality data and concluded infant mortality rates attributable to accidental suffocation and strangulation in bed quadrupled between 1984 and 2004 (Shapiro-Mendoza, 2009, p. 536).

⁷ SIDS mortality rates in the United States declined almost 50% between 1992 and 2004 (Shapiro-Mendoza, 2009, p. 535).

Public health campaigns that promote education about safe sleep have been revised several times since the early 1990s to accommodate new information. In 2000, the American Academy of Pediatrics (AAP) amended the Back to Sleep campaign to include information regarding the hazards of bed sharing under certain conditions; in 2005, the AAP amended their recommendations to include a supine sleep position, a firm sleep surface with no loose bedding or blankets, and a separate sleep area for baby (National Institute of Child Health and Human Development, 2013).⁸ Currently, the AAP's Back to Sleep campaign includes the "ABC" campaign to address bed sharing—the campaign educates parents about placing their infant to sleep (A)lone, on their (B)ack, and in a (C)rib (Task Force on Sudden Infant Death Syndrome, 2011).⁹

Although public health organizations like the AAP that championed the Back to Sleep movement have now expanded their safe sleep guidelines and recommend against co-sleeping,¹⁰ public acceptance of this information has not been widespread, and there are barriers that impede widespread acceptance of the recommendation.

Risks Associated With Co-Sleeping

A 2013 British study titled *Bed Sharing When Parents Do Not Smoke: Is There a Risk of SIDS?* found that bedsharing is especially dangerous when combined with known risk factors such as smoking, drug or alcohol use, and low birth weight (Carpenter R., 2013, p. 10).¹¹ The study reported a slightly increased risk of unexplained death for all infants under three months of age who co-slept with an adult, regardless of whether or not the infants were breastfed, exposed to maternal tobacco smoking, or if their mothers consumed "2 or more units of alcohol in the past 24 hours" (Carpenter R., 2013, p. 8). The study also found that bottle feeding increases the risk of unexplained infant death (Carpenter R., 2013, p. 8).

The American Academy of Pediatrics (AAP) does not recommend co-sleeping with infants because of research suggesting it "might increase the risk of overheating, rebreathing or airway obstruction, head covering, and exposure to tobacco smoke, which are all risk factors for SIDS," and because co-sleeping "exposes the infant to additional risks for accidental injury and death, such as suffocation, asphyxia, entrapment, falls, and strangulation" (Task Force on Sudden Infant Death Syndrome, 2011).

⁸ Other Recommendations "warn[ed] against letting baby get too warm during sleep and suggest[ed] using a pacifier to help reduce SIDS risk."

⁹ A 2013 JAMA editorial titled *Bed Sharing per se Is Not Dangerous* questions whether the data used to support the AAP's recommendation against bedsharing is accurate in light of the "nonuniform and unverifiable" data available on causes of infant death (Bergman, 2013).

¹⁰ In 2012, the National Institute of Child Health and Human Development (NICHD) rebranded the "Back to Sleep" campaign as the "Safe to Sleep" campaign, which continues to promote awareness that "safe sleep environments and back sleeping [are] ways to reduce the risk of SIDS and other sleep-related causes of infant death" (National Institute of Child Health and Human Development, 2013).

¹¹ The Carpenter study was criticized in a 2013 Praeclarus Press White Paper that found the conclusions to be unsubstantiated because the analysis used "faulty and missing data and did not account for confounding criteria used to define bedsharing and risks"—while the Carpenter analysis did include major risk factors associated with SIDS [sleep position, parent smoking, alcohol use, drug use, birthweight and infant age, the study did not discuss other factors that "influence breathing and arousability" like bedding (sleep surface) or temperature (Praeclarus Press White Paper, 2013).

Unsafe sleeping environments, such as an adult bed or couch, increase the likelihood of an overlay suffocation where the person (adult or child) sleeping with the infant rolls over and unintentionally smothers the infant. Unsafe sleeping environments also increase the likelihood of accidental positional asphyxia when an infant's face becomes trapped in soft bedding or wedged in a small space such as between the mattress and a wall or between couch cushions. Excessive or heavy bedding on an adult bed can cause an infant to overheat and increases the likelihood of accidental suffocation, asphyxiation or entrapment in loose bedding materials.

The Consumer Product Safety Commission and the National Institute of Child Health and Human Development now report that infants sleeping in adult beds are 20 times more likely to suffocate than infants who sleep alone in cribs (National Maternal and Child Health Bureau Center for Child Death Review). The National Infant Sleep Position Study found “infants who bed shared were 2.9 times more likely...to usually sleep beneath more than two bed covers, and they were almost twice as likely to be covered with a quilt” regardless of room temperature (Willinger, 2003, p. 46).

The Prevalence of Co-Sleeping

The Pregnancy Risk Assessment Monitoring System (PRAMS)

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. It collects state-specific, population-based data about maternal behaviors and experiences before, during and after pregnancy that may be associated with adverse pregnancy outcomes. Illinois is one of forty states¹² representing approximately 78% of all U.S. live births that currently participate in the PRAMS surveillance project (Centers for Disease Control and Prevention, 2013). Every month in Illinois, approximately 200 mothers who gave birth that month are contacted and asked to complete written surveys.¹³

The PRAMS questionnaire has two parts: a set of core questions asked by all states and a second set of questions from a pretested list of standard questions developed by the CDC or developed by states on their own. As a result, each state's PRAMS questionnaire is unique. Among the second set of questions surveyed by PRAMS are parental behaviors related to their infant's sleep.

Because each state can develop supplemental questions, some states have developed specific questions targeting patterns of co-sleeping. For example, Maryland 2009-2011 PRAMS surveys included the following question:¹⁴

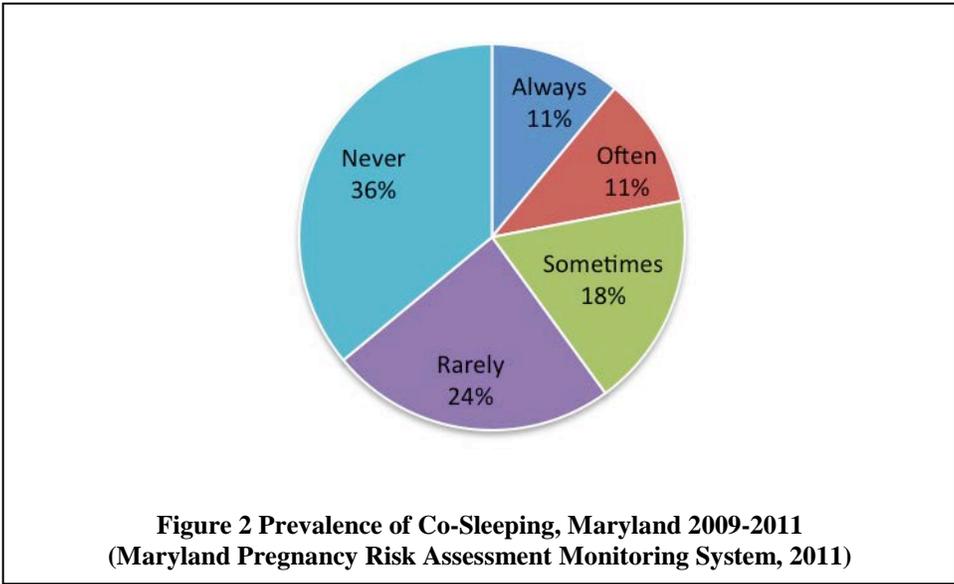
How often does your new baby sleep in the same bed with you or anyone else:

- Always
- Often
- Sometimes
- Rarely
- Never

¹² New York City also participates in the Pregnancy Risk Assessment Monitoring System.

¹³ The 200 mothers represent a “stratified systematic sample” of eligible birth certificates.

¹⁴ Prior to 2009, the Maryland PRAMS survey did not ask this question.



Maryland was able to determine and report on the prevalence of women reporting co-sleeping (see Chart above). PRAMS collects data not available from other sources about pregnancy and the first few months after birth. The data gathered by PRAMS is “used to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants” (Centers for Disease Control and Prevention, 2013).

Maryland used its data to focus on specific campaigns to raise awareness among its minority population to prevent sleep-related deaths. In Baltimore City, most of the infant deaths were not from natural causes but were deaths with risk factors of co-sleeping, objects in the crib, and stomach sleeping.¹⁵ Baltimore’s “B’more for Healthy Babies” Sleep Initiative targeted education about the dangers of co-sleeping to minority communities, and developed a video presentation about safe sleep.¹⁶ In 2012 Baltimore’s infant mortality rate dropped for the third year in a row after the initiation of “B’more for Healthy Babies” in 2009.

Illinois’ 2009 PRAMS infant sleep survey question was limited to a true or false statement:

My new baby sleeps with another person T F

In 2009, 17.9% of the Illinois mothers who participated in the Illinois PRAMS survey reported their infant “usually” sleeps with another person (Illinois Pregnancy Risk Assessment Monitoring System, 2009, p. 39). The Illinois Department of Public Health has not published its PRAMS survey results since 2009.¹⁷

¹⁵ Personal communication with Jana Goins, Epidemiologist, Maternal and Child Health, Baltimore City Health Department, December 11, 2013.

¹⁶The B'more for Healthy Babies Safe Sleep Video can be found online at <http://www.youtube.com/watch?v=yBBiG6e4xRw>.

¹⁷ Staff shortages have limited the ability to produce new reports; personal communication December 2013.

Co-Sleeping and Infant Mortality in Minority and Low Income Families

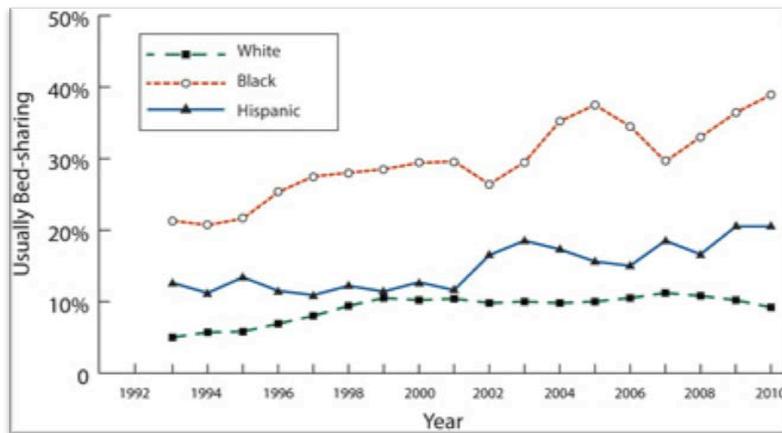
The Illinois Violent Death Reporting System analyzed sleep related deaths in Illinois from 2003 through 2005 and determined that in Cook County, African American infants are 12 times more likely than White infants to die from sleep-related causes (Child Health Data Lab at Children's Memorial Hospital, 2010, p. 1).¹⁸ The incidence of infant deaths due to unsafe sleep is significantly higher in certain parts of Cook County, and “infant deaths are clustered in the middle portion of the south side and on the west side. In the suburbs, the deaths are roughly clustered in the Harvey/Dolton area, the Oak Park/Cicero area and the Streamwood and Des Plaines areas” (Child Health Data Lab at Children's Memorial Hospital, 2010, p. 2). An analysis of “the geographic dispersion of undetermined infant deaths in Chicago strongly suggests an association with race and low income” (Child Health Data Lab at Children's Memorial Hospital, 2010, p. 2).

In her introduction to the 2010 Reduction of Infant Mortality in Illinois Report, Secretary of Illinois Department of Human Services Michelle R.B. Saddler stated, “While we continue to make progress, there is a persistent racial disparity in infant mortality that must be eliminated. An African-American infant born in Illinois is still more than two and a half times as likely as a Caucasian infant to die before reaching one year of age. Our current efforts are commendable, but they are not enough” (Illinois Department of Human Services, 2011, letter). Currently, the rate of infant mortality deaths among Caucasians and Hispanics in Illinois are close to the Healthy People national goal of six deaths per 1,000 live births; the rates among African-Americans, however, are at a high level of 13.4 deaths per 1,000 live births (Illinois Department of Human Services, 2011, p. 23). Illinois will not be successful in reducing its infant mortality rate until the ratio of African-American to Caucasian infant deaths is improved (Illinois Department of Human Services, 2011, p. 25).

The National Infant Sleep Position Study found the number of infants “routinely sharing an adult bed or mattress” more than doubled, from 5.5% to 12.8%, between 1993 and 2010. (Willinger, 2003, pp. 44-45) The 17-year National Infant Sleep Position Study conducted annual telephone interviews with families of infants less than eight months of age in order to “examine trends in bed sharing...and the factors that influence this behavior” (Willinger, 2003, p. 43). The study found that bed sharing with infants was more common than researchers predicted: 13% of infants usually slept in adult beds; about 20% of infants slept in an adult bed at least half of the time; and almost 50% of infants slept in an adult bed at some point during the two weeks before being surveyed (Willinger, 2003, pp. 46-48).

The study used a “three-year moving average calculation” to determine whether the rates of bed sharing rose across all ethnic groups. This study found “it was more common for infants of nonwhite mothers to sleep on an adult bed for half or more of the time than infants of white mothers” (Willinger, 2003, p. 44). Between 1993 and 2010, the percentage of white families bed sharing increased from 4.9% to 9.1%; during the same period, the percentage of Hispanic families bed sharing increased from 12.5% to 20.5% and the percentage of African-American families bed sharing increased from 21.2% to 38.7% (National Institutes of Health, 2013).

¹⁸ Only data from Cook County was analyzed for this report. There is only one Medical Examiner system in the State of Illinois; the Cook County Medical Examiner’s jurisdiction includes ½ the State’s population.



Trends in Infant Bed Sharing in the United States, 1993-2010

<http://www.nih.gov/news/health/sep2013/nichd-30.htm>

The National Infant Sleep Position Study also found an increased likelihood of an infant routinely bed sharing when there is a low household income (Willinger, 2003, p. 45).¹⁹ A 2008 study in *Pediatrics* found 14% of women surveyed who bed shared “felt the practice was safer than not bringing the infant to bed with them” (Hauck, 2008, p. s113). A 2006 study surveyed 671 mothers of infants at Women, Infants, and Children (WIC) program centers²⁰ and found 29% of the mothers believed that having their infant sleep with an adult helped to prevent SIDS (Colson, 2006, p. e248).

The incidence of bed sharing in low income households has not been extensively researched, although data from a study of low-income families living in the District of Columbia between 1995 and 1997 concluded “bed sharing was normative behavior” in that community, with “almost 50% of 3 to 7-month-old-infants, predominantly low-income, inner city infants routinely sharing a bed with a parent or other adult” (Brenner, 2003, p. 39). The data also suggested that bed sharing occasionally occurred even in families where the infant usually slept alone.²¹

Some Literature Supports Co-Sleeping

Co-sleeping is championed by some academics because it is perceived as increasing parent-child bonding and the likelihood of breastfeeding, both of which are associated with more positive outcomes for children. There is disagreement in the scientific and medical communities about whether bed sharing, in the absence of increased risk factors—such as intoxication, smoking, use of illegal drugs or obesity—does in fact increase the risk of infant death. Because studies have found “little or no independent association between bed sharing and SIDS,” proponents of co-sleeping like James J. McKenna²² take the stance that “among parents who do not use tobacco,

¹⁹ The study also found a higher incidence of co-sleeping when a mother is less than 18 years old.

²⁰ WIC program centers in Boston, Massachusetts, Dallas, Texas, Los Angeles, California, and New Haven, Connecticut were included in this study

²¹ 4% of the families who responded their infant usually slept alone admitted their infant did not sleep alone the night prior to the interview.

²² Professor of Biological Anthropology and Director of the Mother-Baby Sleep Laboratory at the University of Notre Dame.

alcohol, or other drugs, sleeping with their infant is a perfectly reasonable and potentially beneficial option” (Gessner, 2006, p. 990).

Proponents of bed sharing fear an anti-co-sleeping campaign for non-smoking mothers “would seemingly have little if any effect on the SIDS rates but could deny these mothers and infants any potential advantages in co-sleeping, including accessibility to the breast” (P. Flemming, 2006, p. 1). They point to its cultural and historical acceptability, and note that co-sleeping (including skin-to-skin care, or “kangaroo care”) is “accepted as normal human practice by anthropologists and infant physiologists,” and there are “consistently low rates of unexpected infant deaths in some societies in which bed sharing is a routine cultural practice” (P. Flemming, 2006, p. 2). In addition, proponents claim that co-sleeping with infants can lead to “improved breastfeeding, less infant crying, improved parent and child sleep, and improved parent-child bonding,” all of which “may relate directly to a decreased risk of child abuse” (Gessner, 2006, p. 990).

Breastfeeding advocates fear recommendations against co-sleeping could place more infants at risk for unexplained death by causing a decrease in the number of infants that are breastfed—some experts worry “any action leading to reduced rates or duration of breastfeeding may increase infant mortality” (P. Flemming, 2006, p. 2).

Reasons Parents Choose to Bed Share

A 2003 study in *Clinical Pediatrics* examined the way parents are educated about safe sleep practices and concluded a parent’s knowledge about safe sleep practices does not predict whether or not they will choose to co-sleep, and found many parents chose to bed share because of a “parental preference” (Forlwer, 2003, p. 1049). In this study, 60% of parents practiced bed sharing regularly—these parents reported they “‘feel safer with the baby in bed with me’ and that it is ‘better for the baby to be closer to me’” (Forlwer, 2003, p. 1049). Although the majority of parents co-slept because of parental preference, 16% of the parents who practiced bed sharing in this study did so because they did not have a crib (Forlwer, 2003, p. 1049). The study also found that some parents who regularly use a crib “revert to bed sharing” if their infant wakes up in the middle of the night (Forlwer, 2003, p. 1049).

The rates of bed-sharing are highest when an infant is youngest: one study found 59% to 65% of mothers lay down or slept with their infant at night during the first three months after birth (Hauck, 2008, p. s113). Rates of co-sleeping declined as infants aged, with 42% of infants bed sharing at two weeks, 34% bed sharing at three months, and 27% bed sharing at 12 months (Hauck, 2008, p. s115). The three most common reasons given for bed sharing were to “calm a fussy infant, to help the infant and/or the mother sleep and to facilitate breastfeeding” (Hauck, 2008, p. s115).

Pop culture may reinforce beliefs that sleeping with an infant is an acceptable practice. A 2013 Christmas Pandora TV commercial portrayed a caring husband leaning over his wife, who was sleeping in bed with their infant. A 2011 episode of *Parenthood*, a fictional TV series, showed a father falling asleep on a couch while holding and bonding with his newborn daughter (see Appendix B). These portrayals are intended to convey tender or empathetic moments of parents sleeping with or nodding off from exhaustion while holding their newborn infants.

What or How Much Education About Safe Sleep Works?

After giving birth at a hospital, new parents “receive a folder with a variety of information about caring for a newborn,” however, studies have found “infant sleep position was not affected by receiving or reading a Back to Sleep brochure” (Forlwer, 2003, pp. 1049-1050). To better educate new parents, it has been suggested that “instruction, reinforcement and demonstration” of safe sleep practices should be done “in the presence of both parents and other potential caregivers,” and that education about safe sleep should be more direct and interactive (Forlwer, 2003, p. 1050). It is also recommended that “pediatricians, family physicians, and other clinicians who care for infants need to be comfortable bringing up bed sharing with parents...especially in the early months of life, in a way that is nonjudgmental...but that conveys the evidence about the risks associated with this practice” (Forlwer, 2003, p. 1049).

Research has shown parents’ attitudes about safe sleep practices are strongly influenced by the information they receive from nurses and physicians, and “the personal education parents receive regarding SIDS prior to discharge is highly nurse and physician dependent” (Forlwer, 2003, p. 1049). Despite how influential physicians can be in helping parents learn about safe sleep practices, one study that analyzed parents’ education about safe sleep practices found that only “10%-15% of mothers [surveyed] responded that a doctor or nurse had advised them not to take the infant to bed with them” (Hauck, 2008, p. s118).

The Illinois Child Death Review Teams recommended that parents or caregivers be indicated for Substantial Risk of Physical Injury by Neglect if before their baby died in an unsafe sleep environment they had received information about safe sleep and chose not to follow it. Child protection investigators seek to determine whether parents or caregivers of an infant who died while co-sleeping have been “educated” about the dangers of co-sleeping. It is thought if parents know about the risks of co-sleeping and decide to co-sleep anyway, they are consciously disregarding a substantial and unjustifiable risk that their child will suffer death or serious injury.

Determining whether parents received sufficient education about safe sleep can be difficult to assess. Literature about adult learning suggests an adult’s ability to learn and retain new information is limited, and is especially compromised during periods of stress, exhaustion, anxiety, or depression. Merely talking to a new parent one time about the risks of co-sleeping (or providing them with a brochure about safe sleep practices) does not necessarily equate to educating that parent, and it is important to consider barriers that prevent a parent from fully understanding the risks of co-sleeping when they are presented. In addition, differences in language and culture, as well as the “use of jargon and scientific language” can make it difficult for new information to be absorbed (Rzepnicki, 2004, pp. 273-290).

New information must be processed and not merely “accepted.” Specific barriers to effective communication and “accurate understanding” can “include information overload, stress and illness, and language differences,” and there are limits to how much new information can be processed—research suggests “people can only retain about seven ‘chunks’ of new information at any one time” (Rzepnicki, 2004, pp. 273-290). The stress new parents experience and their exposure to an overwhelming amount of new information undoubtedly impedes their ability to retain and process new information.

Furthermore, it is hard to measure how much a person understands the many ways in which they must change their daily behavior as a result of new information (Rzepnicki, 2004, pp. 273-290). This means that while a parent might truthfully tell a doctor or nurse they will not co-sleep with their infant, they may not consider the numerous actual changes they must make in their daily routines to adhere to this standard. A person's ability to truly change their daily behavior in response to new information can be compromised by "stress, depression, or anxiety," all of which can be common emotions for new parents (Rzepnicki, 2004, pp. 273-290). Newborn infants may need to be fed every hour and a half to two hours, and that combined with the increased stress of parents being sleep-deprived during the first weeks of adjusting to a new infant leads to parental exhaustion.

DCFS Investigation of Co-Sleeping Deaths

Prior to the Illinois Child Death Review Teams' recommendations, the Department did not accept infant deaths for investigation unless abuse or neglect in the death was specifically alleged. After the Department began taking for investigation calls that were previously reported for information-only purposes, the number of infant deaths investigated and indicated by the Department increased. The Department has not yet promulgated rules and procedures regarding the investigation of sleep-related deaths which would include requirements for investigation and what evidence is needed to support a finding. Consequently, investigative tasks performed and the rationales for findings are inconsistent among child protection investigators.

Definitions of Neglect

An indicated finding for Allegation 51, Death by Neglect, requires a determination that a perpetrator exercised a "*blatant disregard of parental (or other person responsible for the child's welfare) responsibilities*" which resulted in a death (89 Ill. Admin. Code §300 Appendix B). Under the Abused and Neglected Child Reporting Act, a parent or caretaker exercises "blatant disregard" when a "*real, significant, and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm*" (325 ILCS 5/3).

An indicated finding for Allegation 60, Substantial Risk of Physical Injury by Neglect, requires a determination that "*the child's environment creates a likelihood of harm to the child's health, physical well-being, or welfare and the likely harm to the child is the result of a blatant disregard of parent or caretaker responsibilities*" (325 ILCS 5/3).

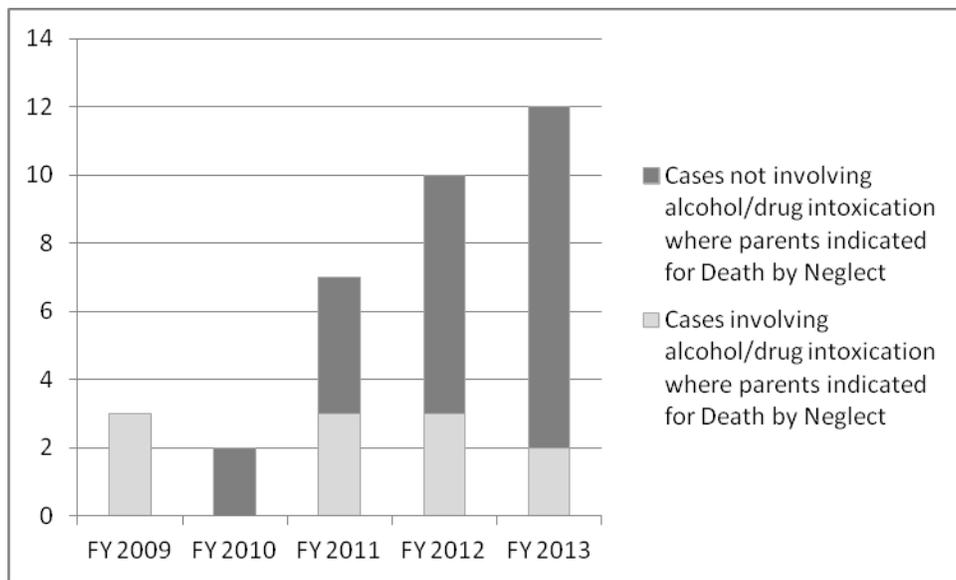
Inconsistent Investigation and Findings in Co-Sleeping Deaths

The Office of the Inspector General has noted in its death reviews and investigations that the practice of indicating parents for neglect allegations based on a co-sleeping death is inconsistent. In FY 2009, the Office of the Inspector General reviewed three death cases in which a parent was indicated for Death by Neglect because an infant died in an unsafe sleep situation; all three cases involved parents drinking or using drugs. In FY 2010, the Office of the Inspector General reviewed two cases in which a parent was indicated for Death by Neglect but neither case involved parental alcohol or drug use. In FY 2011, there were seven cases in which a parent was indicated for Death by Neglect; only three of those cases involved parental alcohol or drug use.

In FY 2012, there were ten cases where a parent was indicated for Death by Neglect; only three of those cases involved parental alcohol or drug use.

In FY 2013 the Office of the Inspector General reviewed 93 child deaths that fit its criteria of children whose families were involved in the child welfare system within the preceding twelve months. Of the 93 child deaths reviewed, 25 (27%) of the deaths involved unsafe sleeping arrangements. Twenty-two of the unsafe sleeping arrangements involved co-sleeping. In 15 (68%) of the 22 investigations, the caretaker was indicated. Twelve of the caretakers were indicated for Death by Neglect, a finding which is retained for 50 years and three were indicated for Substantial Risk of Physical Injury by Neglect, which carries a five year retention. Only 2 of the 12 cases indicated for Death by Neglect involved the caretaker being under the influence of drugs or alcohol at the time of death. Six (27%) of the co-sleeping investigations were unfounded.²³

Number of Parents Indicated After Co-Sleeping Infant Death



The following case descriptions illustrate the inconsistent findings being made in investigations involving co-sleeping:

- A two-month-old infant was discovered unresponsive in bed after being put to sleep in an adult bed with her mother and two siblings (aged 2-1/2 years and 1-1/2 years). The family had a play pen, but the mother stated the infant liked to sleep with her. At the time the infant died, the play pen was not full of clothing or anything else that would pose a barrier to its use. The two older children did not want to sleep in their own beds where they normally slept^{24, 25}—the mother and

²³ One investigation was still pending at the time of review.

²⁴ The Department had contact with this family less than one year before the infant's death due to an unfounded allegation of inadequate supervision against the mother. Despite the fact the allegation was unfounded, the family was referred for Norman Services to purchase toddler beds.²⁴ Although the investigation aftercare plan documented

infant slept on the right side of the bed and the two other children laid across the foot of the bed. A substance abuse screen was conducted and neither alcohol nor drug use was disclosed. The hotline was contacted by police, who reported there were no signs of abuse, trauma or medical issues, and that the doctor believed the death was caused by rollover. The family was maintained in a safety plan for nine months, where the mother was not allowed to live with her children. The children stayed with their grandmother, who lived in the apartment below the mother. As a result of a backlog in the medical examiner's office, the official autopsy results were not available until nine months after the infant's death. The medical examiner ruled the manner of death was accident and the cause was asphyxia resulting from probable overlay. Once the Department received the autopsy, the mother was indicated for Death by Neglect, which carries a 50 year retention. As the mother is in school to become a nurse, the indicated finding threatens her future career (J.S., Cook County, 2013).

- A six-week-old infant died and the mother self-reported that she had found the infant dead in her arms after falling asleep with the child. The Department indicated the mother for Allegation #60, Substantial Risk of Physical Injury by Neglect, after an investigation showed that the mother had been educated about safe sleep practices and the need to place the child in a crib to sleep. The mother appealed the finding which was overturned on administrative appeal because the administrative law judge found that the Department failed to show that the mother intended to fall asleep with the child. At the hearing, the mother admitted that she knew better than to sleep with the infant, but claimed that she had not intended to fall asleep, but was apparently more exhausted than she realized when she laid down with the baby. Under these conditions, the administrative review determined that she could not be indicated for Allegation # 60, Substantial Risk of Physical Injury by Neglect (A.G., Lake County, 2011).
- A one-month-old infant was found unresponsive after sleeping with his father on a couch and being placed face-down on the father's chest. Prior to the death, the family was given information about not co-sleeping with their infant; the family had a crib and bassinet, and the infant usually slept in the bassinet unless not feeling well. The father reported he had been sleeping with the infant on the couch for two weeks because the infant was not feeling well and would not sleep unless someone was holding him. The father drank two beers on the evening the infant died, but did not report feeling intoxicated or buzzed. When the mother discovered the infant positioned between the father and a couch cushion, she began performing CPR. The father was unfounded for Allegation #51, Death by

that the family was referred for Norman services, further investigation revealed that they may not have received these funds.

²⁵ In May 2006 the Office of the Inspector General began distributing portable cribs to child protection workers throughout Illinois. The Office of the Inspector General started purchasing the cribs from the non-profit organization Cribs for Kids in May 2010—prior to that time, portable cribs were obtained from a variety of other sources. In FY 2011, the Department assumed responsibility for the purchase and distribution of portable cribs.

Neglect, and Allegation #60, Substantial Risk of Physical Injury by Neglect with the rationale that the infant died of SUDI due to co-sleeping; there were no reported concerns of trauma or evidence of blatant disregard; although the parents were educated about co-sleeping, it is culturally common for this type of co-sleeping to occur; and the father was sleeping with the child on the couch for several days because the child would not sleep without being held (M.F., Crawford County, 2012).

- A two-month-old infant was discovered unresponsive around 7:00 a.m. by her father. The infant had slept between her parents in two twin beds pushed together. The family resided in a shelter, and there was no crib or bassinet in their room. The father reported smoking marijuana and staying awake until 4:00 a.m. playing video games. The infant, who had a cold and was congested, was last seen alive at that time. No signs of abuse or neglect were observed on any of the other five children residing at the shelter, who were removed under a safety plan. The medical examiner ruled the cause and manner of death undetermined, and noted the infant “was found by the father on a bed, unresponsive, and face up.” Both parents were indicated for allegation #51 Death by Neglect, and unfounded for Allegation #60, Substantial Risk of Physical Injury by Neglect (H.J., Cook County, 2013).
- A two-month-old infant was found unresponsive in an adult bed. The previous evening, the infant had slept in the same bed as her mother. In the morning, the mother awoke and left to pick up the infant’s father from work. The mother believed the infant was sleeping when she left the home; while she was gone, her brother checked on the infant and found her sleeping on her back in the bed. When the mother returned, she discovered the baby unresponsive in the bed. The mother had found a bug in the infant’s crib, and that was why she had placed her infant to sleep with her in bed. The mother was indicated for Allegation #51, Death by Neglect and for Allegation #60, Substantial Risk of Physical Injury by Neglect, to her two surviving children. The father was indicated for Allegation #60, Substantial Risk of Physical Injury by Neglect, because he allowed the mother to sleep with the infant (M.R., LaSalle County, 2012).
- A seven-month-old infant, who was born two months prematurely and needed a feeding tube, was discovered unresponsive in an adult bed after her mother fell asleep while feeding her and accidentally left the feeding tube running. There was a crib/bassinet in the corner of the bedroom. No signs of abuse or neglect were observed on any of the four other children living in the home, who were removed under a safety plan. The medical examiner ruled the cause and manner of death undetermined, “in consideration of the circumstances surround[ing] her death, autopsy examination, ancillary studies and scene investigation which indicate an unsafe sleep environment (co-sleeping/bed sharing).” Allegations #51, Death by Neglect, and #60, Substantial Risk of Physical Injury by Neglect, against the infant’s mother were unfounded. In making this decision, the investigator noted the medical examiner did not classify the death as a rollover; the parents

responded immediately upon noticing their child was in distress; and no arrests or criminal charges were filed against either parent (S.A., Cook County, 2013).

Review of Indicated Findings

The Office of the Inspector General reviewed all first sequence allegations of Death by Neglect related to unsafe sleep practices in FY 2011, FY 2012, and FY 2013. Some of the unfounded investigations were unavailable for review because they have been expunged. Between FY 2011 and FY 2013, the number of cases indicated for Death by Neglect based on co-sleeping alone, with no evidence of other neglect, increased four-fold.

In FY 2011, the Department investigated 41 allegations of Death by Neglect related to unsafe sleep practices.²⁶ Eleven (27%) of the 41 investigations were indicated. In six of the 11 indicated reports, the parent(s) had abused alcohol or drugs prior to the co-sleeping death. In another, the investigation disclosed a chaotic household. In the four remaining indicated investigations, the parents were indicated for Death by Neglect based on co-sleeping alone, with no evidence of other neglect.

In FY 2012 the Department investigated 66 allegations of death by neglect related to unsafe sleep practices. Twenty-one (32%) of the sixty-six investigations were indicated. In six of the indicated reports the parents(s) had used drugs or alcohol prior to the co-sleeping death. Another six investigations had other identified risk factors including chaotic household, environmental neglect, physical abuse and a prior death of another child. In nine investigations the parents were indicated for death by neglect based on co-sleeping with no evidence of other neglect.

In FY 2013 the Department investigated 65 allegations of death by neglect related to unsafe sleep practices²⁷. Thirty-three (51%) of the investigations were indicated. In eight of the indicated reports the parent(s) had used drugs or alcohol prior to the co-sleeping deaths. Another three reports involved other identified risk factors. Six investigations involved accidental positional asphyxia or entrapment with no other identified risk factors. In sixteen investigations the parents were indicated for death by neglect based on co-sleeping with no evidence of other neglect.

The Office of the Inspector General's review of indicated reports for sleep-related death by neglect reports found only one report where protective custody was taken of a surviving sibling. A 28-year-old mother was indicated after she co-slept with her three month old twins and one of the twins died. There was no indication during the investigation that the mother used drugs or alcohol, nor any other reports of neglect. The mother reported that she was not sure if she had rolled over on the baby or not but she was indicated for death by neglect. The mother's surviving three month old twin was taken into custody and placed with a relative. During an extended shelter care hearing, the judge found that the State failed to meet its burden of proof to substantiate risk of harm to the surviving sibling. The judge returned custody to the mother and dismissed the case.

²⁶ This number does not include investigations that were overturned on appeal.

²⁷ Three investigations are pending, two of those pending are sleep related deaths.

Safety Plans

Once a child death is accepted for investigation, a mandatory safety plan is put into place until the autopsy report is obtained. Most of the surviving siblings that are separated from their families through a safety plan are of an age where they are no longer at risk of harm from co-sleeping. Because it can take several months to obtain an autopsy report, parents who already lost one child and children who have lost a sibling may be separated for long periods of time, adding to the grief they are already experiencing.²⁸ In its review and investigation of child deaths in FY 2013, the Office of the Inspector General found that in three of the co-sleeping child protection death investigations with surviving siblings, the surviving children were placed in safety plans outside the care of their parents during the pendency of the investigations for seven, eight and nine months, while the Department awaited completion of the infants' autopsy reports. A parent was indicated for Death by Neglect in only one of the investigations (see J.S. case example above).

Case Law Involving Co-Sleeping Infant Deaths

The Office of the Inspector General has reviewed case law to identify cases where parents have been held criminally liable for the death of a child due to bed sharing or have had an indicated finding of child abuse or neglect upheld in court. Nine states, including Illinois, have cases in which parents were held liable for co-sleeping deaths.

In 1997, the Illinois courts addressed whether risk of harm to surviving siblings was demonstrated after an infant died while co-sleeping with his mother on a couch, after she had "two shots" of eggnog with brandy. The appellate court affirmed the trial court's finding that the State had failed to prove the child died from negligence or that the mother had failed to exercise a reasonable degree of care. In support of its finding, the court noted that the medical examiner had determined that the infant's death was accidental and that an expert had testified that co-sleeping was "not detrimental and, in some cases, was beneficial to an infant" In re K.G., D.G., 288 Ill.App.3d 728, 682 N.E.2d 95 (Ill.App.1997).

In two cases in Utah, families were held criminally responsible because the co-sleeping death was the second co-sleeping infant death in the same family. Georgia, Florida, Tennessee, Arizona, Minnesota, Indiana and California have found liability because of parental misuse of drugs or alcohol.

Two recent cases in California examined parental culpability when infants died while co-sleeping and their mothers were intoxicated at the time. In one case, the mother was found guilty of felony child endangerment and sentenced to eight years in prison based on the facts that she habitually co-slept and habitually abused alcohol. In the other case, the court found that the State had not proven that the mother presented a risk of harm to surviving siblings when an infant died while co-sleeping with her while she was intoxicated. The court found that risk of harm could

²⁸ The prolonged separation of children from their parents seems to contradict the legislative intent of the statute that requires the Cook County Medical Examiner and Illinois coroners to provide preliminary reports of autopsy within 5 days of a child's death, when the child is under 2 and has died suddenly and unexpectedly (55 ILCS 5/3-3016).

not be shown unless the State established that she had a habit or pattern of alcohol or other drug abuse.²⁹

Analysis of Findings of Administrative Appeals of Indicated Findings for Co-Sleeping

The Office of the Inspector General reviewed available Illinois administrative appeals involving co-sleeping or other unsafe sleep practice. There were three in FY 12, two in FY 13 and one in FY 14. The six appeals were decided by six different administrative law judges (ALJs).

Findings Overturned Based on Failure to Sustain Burden of Proof

Five of the cases examined whether the Department had sustained its burden of proof to indicate the appellant for Death by Neglect (Allegation #51 – 50 year retention) in cases of co-sleeping or other unsafe sleep practice. In all five cases, the ALJ determined that a finding of Death by Neglect was not supported. In four of the five cases, the ALJ found that the autopsy finding of “Undetermined” created a barrier to indicating an alleged perpetrator for Death by Neglect. In the fifth case, the ALJ simply determined that although the child died of asphyxia and the parents were aware that co-sleeping presented risks, the parents did not act with blatant disregard for the infant’s safety, because they only co-slept “when the child needed extra care or comfort.”

In the other four appeals, the ALJ found that the act of lying down with the infant to nurse or comfort the child did not create an environment injurious or demonstrate blatant disregard for the infant’s safety. One appeal involved a family with nine children. The parents had received recommendations about safe sleep but chose not to use a crib because a younger child had gotten caught in the slats and injured. The ALJ determined that the parents’ decision was based on their experience and culture, and did not demonstrate blatant disregard for the infant’s safety.

Finding Overturned Based on Failure to Show Substantial Impairment

In two of the appeals that were overturned, the co-sleeping parent had consumed several alcoholic drinks but there was no showing of substantial impairment.

The Relevance of Safe Sleep Education

Five of the six appeals addressed whether the parents had received education about safe sleep. In three of the appeals, the finding was overturned despite the parents’ admission to having been educated about safe sleep. In one case, a parent’s indicated finding of Inadequate Supervision was upheld for placing the infant in a bed and co-sleeping with knowledge that the practice was risky.³⁰ In the fifth case, the indicated finding was overturned after the parent denied having received education about the risks of co-sleeping and testified that the lactation specialist at the hospital had told her about the benefits of breast-feeding in bed.

Expungement Based on Exhaustion and the Failure to Show Blatant Disregard

²⁹ Arizona, Florida, Georgia, Indiana and Tennessee have sustained criminal findings against parents after co-sleeping deaths where the parents abused drugs or alcohol prior to engaging in co-sleeping. Utah, in two separate cases, upheld criminal liability to parents whose infants died while co-sleeping when each family had lost a previous child to co-sleeping.

³⁰ Although not cited as the basis for upholding the finding, the ALJ noted that on the evening in question, the father had consumed ten alcoholic “shooters.”

In one appeal, the ALJ noted that the mother was tired after a full day of work. The ALJ examined whether the mother's decision to lay down in bed to breastfeed her infant created either an environment injurious to the child's safety or demonstrated blatant disregard for the child's safety. The ALJ determined that it did neither. The ALJ's determination was similar to the unpublished determination of the court in Ramos and Gonzalez v. DCFS (12 MR 251 Lake County Circuit Court 2012). In Ramos, the Department indicated a mother whose infant had died while in bed with her. The indicated finding was based on the mother's admission that she had received information that co-sleeping was dangerous for infants. The mother filed an administrative appeal in which her indicated finding was upheld. The mother appealed her indicated finding to the circuit court. The circuit court overturned the administrative finding. The mother testified that she misjudged how exhausted she was and had laid down with the child, not intending to fall asleep. The court noted that the Department had failed to show that the act of lying down with an infant—without sleeping—showed a blatant disregard for the child's safety. The court found that even assuming the mother knew that the practice of sleeping with her child was dangerous, the Department had not shown that by lying down with the infant, the mother had *intended* to fall asleep and overturned the Department's indicated finding as *clearly erroneous*.³¹

Diversion of Investigative Resources

Intensive investigative resources and training will need to accompany any attempt to consistently indicate parents for co-sleeping. Even then, the Department may lose an administrative or judicial appeal because the parent may successfully argue that there is insufficient scientific proof that co-sleeping—in the absence of alcohol or drug use—is blatantly dangerous.

In order to support an indicated finding for Allegation 60, Substantial Risk of Physical Injury by Neglect, for co-sleeping, the Investigator will have to be able to prove the following facts:

³¹ Child welfare systems in Louisiana and Wisconsin will not substantiate a finding against the parents unless there is suspected or actual abuse/neglect that exists apart from the bed sharing (Telephone conversations with Linda Hale, Wisconsin Department of Health Services and Linda Carter, LCSW-BACS, ACSW, CPI Section Administrator, Louisiana Department of Children & Family Services). If the death is attributable purely to co-sleeping, including death attributable to possible overlay, and cause undetermined, they do not substantiate findings against the parents for neglect.

Louisiana's child welfare policy states:

If the child was co-sleeping with another child or an adult at the time of death and the initial suspicion/diagnosis is SIDS, the information is not a report unless there is also a suspicion of abuse/neglect. An example of a suspicious circumstance is an impaired adult sleeping with a child. If at a later date there is toxicology or other evidence indicating a cause of death other than SIDS, the report may need to be accepted at that time. The reporter shall be advised to contact the department, if any later evidence indicates a possibility of abuse/neglect

(11/27/13 email from Linda Carter, LCSW-BACS, ACSW, CPI Section Administrator, Louisiana Department of Children & Family Services).

Both Louisiana and Wisconsin have public education programs that address co-sleeping, and have adopted strong public health campaigns that work to reduce co-sleeping within minority populations.

1. That the caregivers were *sufficiently* educated about the dangers of co-sleeping;
2. That the caregiver *intended* to ignore the risks of co-sleeping;
3. That the practice of co-sleeping, in the absence of ingestion of drugs or alcohol by the caretaker, presents a significant risk of harm to an infant.

In addition, while awaiting receipt of the infant's autopsy report, the family will be subject to a safety plan and the Department will have to monitor that safety plan. Autopsy reports, including toxicology results, may take several months or more to be completed.

Conclusion

Infants should sleep alone, on their backs, and in cribs. Sleep-related deaths are a preventable public health issue that should be addressed as such. Indicating parents for co-sleeping with infants is ill-advised until such time as either the legislature recognizes it as negligent or the scientific community is less divided on the question. Illinois law defines negligence as acting with blatant disregard for a child's safety or well-being. Blatant disregard is defined as an action which is so inherently dangerous that a reasonable parent would not subject their child to it. When surveys disclose that as many as 65% of parents admit to co-sleeping with their infant at some time, a single act of co-sleeping cannot meet the definition of blatant disregard in the absence of other complicating factors suggesting negligence – such as substance abuse, or a child whose medical needs make co-sleeping extraordinarily dangerous (assuming the parents have been adequately advised).

The Department's decision to begin investigating and indicating co-sleeping deaths in the absence of allegations of neglect or abuse (such as intoxicated parents) is a departure from existing statute and rule. Mandated reporters are not currently instructed that a parent's disclosure of co-sleeping requires a call to the hotline. Administrative law judges have recognized the dissonance and have refused to uphold indicated findings for parents who co-slept in a misguided effort to comfort or nurse their child.

In addition, the decision to indicate for co-sleeping ignores other sleep-related risks – such as parents smoking, and placing the child to sleep on their stomach. Whether the decision to co-sleep with an infant demonstrates blatant disregard for a child's safety is an issue for public debate, and should therefore go through rule-making and review by the Joint Committee on Administrative Rules.

The Department's current practice is especially ill-advised because it unfairly burdens poor families. Low quality adult bedding (sagging mattresses and couches with gaps) may result in accidental asphyxiation more frequently than new bedding – suggesting that poorer families will more frequently be indicated. Studies have shown that minorities are more likely to co-sleep – also contributing to the disparate impact on already vulnerable families that indicated findings may have.

In addition, lack of sleep and exhaustion can result in unintended co-sleeping; the exhaustion factor also affects the ability of new parents to process the quantity of information they receive after birth – especially when that information is contradicted by loved ones.

An indicated finding of Death by Neglect remains in the State Central Register for 50 years. One reason the State Central Register exists is to flag individuals who are unsuitable to care for or work with children (e.g., daycare workers, teachers, nurses). It is inconceivable that the legislature intended to bar individuals from such employment because they unintentionally fell asleep with their baby or slept with their child in an effort to feed or comfort them.

Recommendations

1. This Report will be shared with the Secretary of the Illinois Department of Human Services and the Director of the Illinois Department of Public Health to address co-sleeping as a public health issue, including a focus on the reduction of infant mortality rates among minority populations.
2. The Department of Children and Family Services should reinstate its historical practice of investigating co-sleeping deaths only when the report discloses circumstances suggesting possible abuse or neglect, such as an intoxicated parent or a previous co-sleeping death in the same family. In the alternative, the Department should immediately convene public hearings toward adopting Rules governing investigating and indicating co-sleeping deaths.
3. The Inspector General will share this Report with the Senate Human Services Subcommittee.
4. The Inspector General will share this Report with the Illinois Child Death Review Teams' Safe Sleep Subcommittee.

Appendix A

It is recommended that the following conditions, if present in a specific case, be reported on the death certificate:

- Bedsharing
- Unsafe or soft sleep surface (if found face down)
- Previous unexplained infant death of sibling
- Excessive blanketing or wrapping
- Face down position when found
- Intoxication (defined as detection of a substance in infant's system)
- Prenatal exposure to tobacco smoke
- Abrupt change in sleep position
- Abrupt change in sleep location
- Abrupt change in sleep surface
- Injuries of unknown significance (specifying the type)

(The National Association of Medical Examiners Ad Hoc Committee on Sudden Unexplained Infant Death, 2007, p. 12)

Appendix B



Works Cited

- Bergman, A. B. (2013 . November). Editorial: Bed Sharing per se Is Not Dangerous. *JAMA Pediatrics Volume 167, Number 11*, 998-999.
- Brenner, R. e. (2003). Infant-Parent Bed Sharing in an Inner-City Population. *Arch Pediatr Adolesc Med.*, 157, 33-39.
- Carpenter R., M. C. (2013). Bed Sharing When Parents Do Not Smoke: Is There a Risk of SIDS? An Individual Level Analysis of Five Major Case-Control Studies. *BMJ Open*, 8-10.
- Centers for Disease Control and Prevention. (2011). Retrieved 2013 12-December from CDC's Sudden Unexpected Infant Death Initiative: <http://www.cdc.gov/sids/SUIDAbout.htm>.
- Centers for Disease Control and Prevention. (2013). Retrieved 2013 12-December from Sudden Unexpected Infant Death (SUID): <http://www.cdc.gov/sids/>.
- Centers for Disease Control and Prevention. (2013). *About PRAMS*. Retrieved 2013 12-December from Centers for Disease Control and Prevention: <http://www.cdc.gov/prams/AboutPRAMS.htm>.
- Centers for Disease Control and Prevention. (2013). *About the SUID Initiative*. Retrieved 2013 12-December from <http://www.cdc.gov>: <http://www.cdc.gov/sids/SUIDAbout.htm>
- Centers for Disease Control and Prevention. (2013). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome*. Retrieved 2013 12-December from www.cdc.gov: <http://www.cdc.gov/SIDS/index.htm>.
- Child Health Data Lab at Children's Memorial Hospital. (2010). Understanding Sleep-Related Infant Deaths. *Illinois violent Death Reporting System, Volume 1, Issue 4*, 1-4.
- Colson, E. e. (2006). Barriers to Following the Supine Sleep Recommendation Among Mothers at Four Centers for the Women, Infants, and Children Program. *Pediatrics, Volume 118, Number 2*, e243-e250.
- Forlwer, A. J. (2003). Safe Sleep Practices and Sudden Infant Death Syndrome Risk Reduction: NICU and Well-Baby Nursery Graduates. *Clinical Pediatrics 52*, 1044-1050.
- Fu, L. Y. (2010). Bed Sharing Among Black Infants and Sudden Infant Death Syndrome: Interactions with Other Known Risk Factors. *Academic Pediatrics Vol. 10 Number 6*, 376-382 at 381.
- Gessner, B. (2006). Letter to the Editor. *Archives of Disease in Childhood*, 990-991.
- Hauck, F. R. (2008). Infant Sleeping Arrangements and Practices During the First Year of Life. *Pediatrics, Volume 122, Supplement 2*, s113-s120.
- Illinois Child Death Review Teams. (2010). *Annual Report on Child Deaths in 2007 and 2008*.

- Illinois Child Death Review Teams. (2012). *Annual Report on Child Deaths in 2009 and 2010*.
- Illinois Child Death Review Teams. (2013). *Annual Report on Child Deaths in 2011*.
- Illinois Department of Children and Family Services. (2011). *Administrative Procedures 300, Appendix K*.
- Illinois Department of Human Services. (2011 . 18-March). *The Reduction of Infant Mortality in Illinois - Fiscal Year 2010*. Retrieved 2014 . 2-January from Illinois Department of Human Services:
http://www.dhs.state.il.us/OneNetLibrary/27897/documents/CHP/Reports/AnnualReports/FY10_Annual_IMR_report_WIC_and_FCM_Final.pdf.
- Illinois Pregnancy Risk Assessment Monitoring System. (2009). *2009 Report: Illinois Pregnancy Risk Assessment Monitoring System*. Retrieved 2013 . 12-December from <http://www.idph.state.il.us/>: http://www.idph.state.il.us/health/prams_rpt_09.pdf.
- Kinney, H. a. (2009). The Sudden Infant Death Syndrome. *N Engl J Med* 361(8) , 795-805.
- Krous, H. F. (2010). Sudden Unexpected Death in Infancy and the Dilemma of Defining the Sudden Infant Death Syndrome. *Current Pediatric Review Vol. 6, No. 1*, 5-12.
- National Institute of Child Health and Human Development. (2013). *Key Moments in Safe to Sleep History: 1994-2003*. Retrieved 2013 . 12-December from <http://www.nichd.nih.gov/sts/campaign/moments/Pages/1994-2003.aspx>.
- National Institute of Child Health and Human Development. (2013). *Key Moments in Safe to Sleep History: 2004–2013*. Retrieved 2013 . 12-December from National Institute of Child Health and Human Development: <http://www.nichd.nih.gov/sts/campaign/moments/Pages/2004-2013.aspx>.
- National Institutes of Health. (2013 . 30-9). *Roughly 14 Percent of Infants Share Bed With Adult or Child*. Retrieved 2013 . 12-December from <http://www.nih.gov>: <http://www.nih.gov/news/health/sep2013/nichd-30.htm>.
- P. Flemming, P. B. (2006). Infant Death: New Knowledge, New Insights and New Recommendations. *Archives of Disease in Childhood* , 1-3.
- Praeclarus Press White Paper. (2013). *SIDS: Risks and Realities, A Response to Recent Findings on Bedsharing and SIDS Risk*. Amarillo: Praeclarus Press, LLC.
- Rzepnicki, T. (2004). Informed Consent and Practice Evaluation: Making the Decision to Participate Meaningful. In H. a. Briggs, *Using Evidence for Social Work Practice: Behavioral Perspectives* (pp. 273-290). Chicago: Lyceum Books, Inc.
- Schnitzer, P. C. (2012). Sudden Unexpected Infant Deaths: Sleep Environment and Circumstances. *Am J Public Health* 102(6) , e1-e9.

Shapiro-Mendoza, C. K. (2009). US Infant Mortality Trends Attributable to Accidental Suffocation and Strangulation in Bed from 1984 Through 2004: Are Rates Increasing? *Pediatrics* 123 (2) , 533-539.

SIDS Fact Sheet. (n.d.). Retrieved 2013 . 12-December from <http://www.idph.state.il.us>: http://www.idph.state.il.us/sids/sids_factsheet.htm.

Task Force on Sudden Infant Death Syndrome. (2011). SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment. *Pediatrics*, 128 , e1349-e1351.

The National Association of Medical Examiners Ad Hoc Committee on Sudden Unexplained Infant Death. (2007). *A Functional Approach to Sudden Unexplained Infant Deaths*.

The National Association of Medical Examiners. (2002). *A Guide For Manner of Death Classification*.

Willinger, R. e. (2003). Trends in Infant Bed Sharing in the United States, 1993-2010:The National Infant Sleep Position Study. *Arch Pediatr Adolesc Med.*, 157 , 43-49.