STATE REPRESENTATIVE

SAMANTHA KERKMAN

Date: November 20, 2013

To: Members of the Senate Committee on Health and Human Services

From: Rep. Samantha Kerkman

Testimony on SB 357- Intoxicated Cosleeping

Thank you, Chairwoman Vukmir and Committee members for hearing SB 357 today. This bill creates a penalty for intoxicated cosleeping. It also contains an educational component, requiring educational materials to be provided to new parents after a baby is born, and requiring instruction for students at the high school level about safe sleep practices for babies and the dangers of intoxicated cosleeping.

Cosleeping deaths are a problem in Wisconsin. According to the Milwaukee Journal Sentinel, ten infants died in unsafe sleep conditions in 2012. Sadly, that same paper reported that earlier this month, a 2-month-old baby girl died while co-sleeping with her mother. That little girl is the 15th child to die this year in 2013 in unsafe sleep conditions. We as legislators must do something to address this problem. I developed this bill to help prevent these tragic deaths and hold accountable adults who put babies in danger by sharing a bed with them while intoxicated.

I began working on this legislation more than two years ago at the request of my local Kenosha County District Attorney, Robert Zapf, after a tragic case in Kenosha. In that case, a baby was killed while sleeping in the same bed as his father who was heavily intoxicated. DA Zapf informed me that it is very difficult to prosecute a cosleeping death using the current statutes on child neglect. SB 357 will create a specific penalty in statute for harming an infant through intoxicated cosleeping. This is meant to be a tool for District Attorneys to prosecute adults who put babies at risk by choosing to cosleep with them while intoxicated. DA Zapf's written testimony has been distributed to all of you in which he explains the need for this bill from his perspective.

SB 357 does not ban all cosleeping. The decision to cosleep is one that should be made by each family. However, it is generally accepted by medical professionals and child advocates that the safest way for a baby to sleep is alone, on its back, in a crib free of toys or blankets. You'll notice that SB 357 only applies to cases in which harm to an ***infant*** occurs while cosleeping with an adult who is ***intoxicated***. The bill defines an infant as a child less than one year old.

SB 357 will not apply in all cases involving a cosleeping death. But my intent by putting forth this bill is to give District Attorneys the ability to prosecute the most egregious cases in which an adult makes the irresponsible decision to cosleep with their infant while intoxicated.

Thank you, Committee members, and I will now gladly respond to any questions you may have.

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MEMO TO ALL COUNTY LAW ENFORCEMENT AGENGIES

RE: Child Fatality Investigations
FROM: The Kenosha County Child Fatality Review Team
DATE: February 16, 2002

The Kenosha County Child Fatality Review Team (CFRT) was originally formed in 1996 at the request of concerned professionals in the community. It was intended that this team review the deaths of children to ensure these tragic losses were systematically reviewed in the hopes of preventing future accidental deaths and apprehending those responsible for reckless or intentional homicides. Kenosha's CFRT was patterned after other CFRTs created throughout this country. Kenosha's CFRT is comprised of designated representatives from the District Attorney's office, Sheriff's Department, Kenosha Police Department, Medical Examiner's office, Division of Children & Family Services, Division of Health, Kenosha Unified School District and a local pediatrician. Thoroughness and uniformity in the investigation of child deaths in Kenosha County furthers the important goals of the CFRT in the areas of prevention and accountability. A copy of the CFRT's mission statement and team goals is attached.

In furtherance of the CFRT's goals, the CFRT and its members have adopted a policy that all persons conducting child fatality investigations in Kenosha County have specific child fatality investigation training and conduct such investigations utilizing a written protocol. The Kenosha Sheriff and Police Departments currently utilize the "Missouri Model" attached. The Missouri Model is a nine-page written protocol which has successfully inventoried the numerous and critical areas of child death investigations in an organized and chronological outline. The Kenosha District Attorney's office recommends that law enforcement utilize the "Missouri Model" in all child death scene investigations and the CFRT endorses that recommendation.

The CFRT recommends and the District Attorney endorses, that law enforcement adopt an additional specific protocol as part of all child death scene investigations: "Law enforcement shall promptly request a blood sample from any person over the age of 10 years who shared sleeping space with any infant who died in the course of that shared sleep space, for purposes of drug and alcohol screening." Many of these otherwise unexplained infant deaths are caused by an intoxicated adult or youth rolling onto the infant thereby causing asphyxia or "overlay" death situations. While the Missouri Model does not specifically address this issue, it is critical that law enforcement investigating the asphyxia deaths of infants in shared sleep space promptly obtain

blood samples from all persons over the age of 10 in order to determine whether drugs and/or alcohol contributed to the infant's death. These blood samples are critical for purposes of ruling out the possible contributing factor of intoxicants, as well as assisting in the determination of whether criminal charges or child protection issues are indicated.

There is substantial debate in this nation concerning the advisability of parents sleeping with infants. Some groups advocate parents sharing a bed with an infant as a means to strengthen the parent-child bond. However, such sleeping arrangements contribute to avoidable suffocation when an adult rolls on top of the infant. The experience in this community suggests that oftentimes alcohol or drug intoxication is a significant contributing factor in overlay deaths. It is consistent with the mission of the CFRT to investigate all infant deaths in as thorough a manner as possible, in order to isolate contributing factors. A policy of requesting a blood sample from individuals who share sleep space in these situations would provide valuable information and guidance to the CFRT for purposes of child safety and prevention as well as potential criminal accountability.

If you have any questions or concerns, please contact me at your convenience to further discuss this matter. We value your input and would welcome an opportunity to further discuss these issues with your agency.

Melinda Hughes
Chairperson -- Kenosha County CFRT
Kenosha County CO-RE Coordinator

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Alberta Darling
Wisconsin State Senator
Member, Joint Committee on Finance

Testimony on Senate Bill 357
Intoxicated Co-Sleeping

Dear Chairwoman Vukmir and members,

On November 12th, Milwaukee suffered its 16th co-sleeping death this year. Her name was Alexandria and she was only one month and 28 days old. The Milwaukee County Medical Examiner's office says the little girl has died after sharing an adult bed with her mother. Investigators say they found a working crib beside the mother's bed, but the baby was placed to sleep on her back in the mother's bed. Sadly, this is just the latest of many infants to die as a result of unsafe sleeping conditions.

We will never know what Alexandria would have been as an adult. What her hopes or her dreams were. We will never know because her mother was negligent.

What we do know is that there will be no justice for Alexandria because our current laws fall short.

After reviewing medical examiner records, the Milwaukee Journal Sentinel reported that in the city alone, as of September 25th, at least 55 infants have died after being exposed to unsafe sleep conditions since 2009.

These are entirely preventable and needless deaths. The simple solution is to not sleep with your baby. Despite ad campaigns and news stories, babies continue to die at an alarming rate.

Current law only deals with child negligence and abuse does not give sufficient clarification to provide a jury with the information needed to convict a caregiver of negligence when the crime involved is not co-sleeping, but the act of becoming intoxicated and ignoring the greatly increased risks of co-sleeping with your child.

The bill offered by Representative Kerkman and myself will mirror existing statutes for shaken baby syndrome – bringing awareness and helping to prosecute these cases.

It asks the Child Abuse and Neglect Board to provide educational materials to give to new parents when they leave the hospital with their baby. And each school board to provider or work with a non-profit or hospital to make sure students in grades 10-12 are informed about the potential dangers of co-sleeping.

The practice of co-sleeping is raised to the level of neglect when the caregiver disregards the welfare of the child and becomes intoxicated. The caregiver should have known that becoming intoxicated and getting into bed with an infant would significantly increase the risk that the child would be suffocated and/or injured.

I think it's important to know that our bill doesn't outlaw co-sleeping. We are specifically targeting intoxicated co-sleeping and giving prosecutors the tools they need to get convictions in egregious cases.

In closing, I think it's worth noting that UNICEF has a goal of working for a day when zero children die of preventable causes. If a world-wide organization can set that as a goal, why should we not have the same goal here in Wisconsin? It's my hope that this bill helps us reach that goal and prevent avoidable deaths like Alexandria's.

Testimony on SB 357

About the Alliance

- Good afternoon Chairman Vukmir and members of the committee. Thank you for allowing me this opportunity to testify today. My name is Abby Collier and I am the Injury Prevention and Death Review Project Manager at Children's Health Alliance of Wisconsin (Alliance).
- Children's Health Alliance of Wisconsin is Wisconsin's voice for children's health. We are a statewide organization and our mission is to ensure Wisconsin children are healthy, safe and able to thrive.

Keeping Kids Alive

- The Alliance leads the Keeping Kids Alive in Wisconsin program in partnership with the Wisconsin Department of Health Services, Maternal and Child Health, Title V Program.
- Keeping Kids Alive in Wisconsin is comprised of child death review and fetal infant mortality review teams in each county or region. The teams are multidisciplinary and seek to prevent future injuries and deaths.
- The Alliance assists local communities with establishing local teams and implementing prevention strategies based on recommendations developed from data gathered during child death and fetal infant mortality reviews.
- Currently Wisconsin has child death review teams in 55 counties, covering more than 90 percent of the population. Wisconsin has seven fetal infant mortality review teams. Child death review teams review child deaths occurring to children younger than age 19 in most Wisconsin counties.
- Wisconsin is one of nine states funded by the Centers for Disease Control and Prevention to gain a better understanding of what happens in unexplained infant deaths. The goal of this program is to collect better quality data that will improve knowledge of unexplained infant deaths. As a result of this grant, we have identified unexplained infant deaths in counties across Wisconsin.

Legislation

- The Alliance appreciates policy makers desire to address this issue and understands the intent and goal behind this proposal. However, we believe focusing on community-based solutions and prevention for all co-sleeping injuries is more effective in keeping babies in our community safe.
- Criminalizing co-sleeping under certain conditions, such as when drinking or using drugs, provides parents and caregivers with a false sense of security that co-sleeping is safe as long as you are not under the influence and would be careless public policy.
- In fact, the most common risk factors present in sleep-related deaths reviewed by Wisconsin CDR teams include:
  - Sleeping in an adult bed, couch, recliner or other "non-crib" environment.
  - Fluffy blankets, soft pillows, quilts, clothing or other items present in the sleep environment.
  - Sleeping on the tummy or side.
  - Exposure to smoke during pregnancy and/or after delivery.

- These risk factors are consistent with risk factors noted by the American Academy of Pediatrics. In most sleep-related deaths there is more than one risk factor present.
- Many of the sleep related deaths do not have a known cause of death after a full investigation is completed. We are concerned that this legislation will have an unintended consequence of making these cases even more challenging. Parents and caregivers may delay in reporting a death or provide inaccurate information to investigators.

Closing

- There is much work to be done on this complicated issue. There is not a single solution that will solve this problem. We must collaborate to begin to address the infant deaths.
- A consistent statewide message on all sleep-related risk-factors needs to be developed. This issue is bigger than impaired adults sleeping with infants. Babies are dying sleeping with adults who are not impaired, sleeping with other children, sleeping in cribs filled with soft bedding, at daycare centers in unsafe cribs and in other environments.
- Every social worker, hospital, health provider, clergy member and community leader needs to be sharing the same safe sleep message with families at every opportunity possible.
- We do not believe criminalizing sleep-related deaths that have an intoxicated caregiver will reduce the number of babies dying. At a minimum, this legislation must be amended to require comprehensive education on all sleep-related risk factors that are contributing to these deaths.
- Thank you Chairman and committee for the opportunity to testify today and would be happy to answer any questions.

TO: Chairwoman Vukmir, and Members of the Committee of Health and Human Services
FROM: Dr. Jason Jarzembowski, Chair, Safe Sleep Initiative, and Program Director, Perinatal Pathology, Children's Hospital of Wisconsin
DATE: November 20, 2013
RE: Co-Sleeping Legislation: SB 357

Good morning Chairwoman Vukmir and members of the committee. Thank you for allowing me this opportunity to testify today. My name is Dr. Jason Jarzembowski. I am the Program Director for Perinatal Pathology at Children's Hospital of Wisconsin, and I also chair our hospital system's Safe Sleep Initiative. Children's Hospital of Wisconsin is a nationally recognized, free-standing academic pediatric organization dedicated to the health and well being of children.

Children's Hospital of Wisconsin serves children from every county in the state. We have inpatient hospitals in Milwaukee and the Fox Valley. We care for every part of a child's health, from critical care at one of our hospitals to routine checkups in our primary care clinics. Children's also provides specialty care, urgent care, emergency care, school health nurses, foster care and adoption services, family resource centers, child health advocacy, health education, pediatric medical research and the statewide poison hotline.

Today I am representing Children's Hospital of Wisconsin in opposition to Senate Bill 357 which calls for criminal penalties in co-sleeping deaths when alcohol or drugs are involved. Children's Hospital of Wisconsin appreciates the desire to address this terrible and tragic issue and understands the good intent and goal behind this proposal and its authors. However, we believe focusing on community-based solutions and prevention for **all** preventable sleep-related deaths is more effective in keeping babies in our community safe. Criminalizing co-sleeping under certain conditions, such as when drinking or using drugs, sends a loud message that co-sleeping is safe when you are sober. It is not. **In fact, according to the Milwaukee County Medical Examiner's Office, drugs or alcohol are a factor in only about 20 percent of co-sleeping deaths and almost uniformly multiple risk factors are involved. Indeed, prevention and education for all areas of safe sleep is critical.** In the past 3 years, there have been 44 sudden unexpected infant deaths occurring in unsafe sleep environments in Milwaukee - 11 in 2011; 18 in 2012; and, to date, 15 in 2013.

In addition, Children's Hospital is concerned that criminalizing intoxicated co-sleeping will not serve as a deterrent to the behavior (which is the goal) but rather encourage delay in reporting and less honest disclosure of the circumstances surrounding the infant death. We are also concerned that this legislation will deter parents or caregivers from calling for help if the child is harmed in a co-sleeping situation. Therefore, what could have been a preventable situation instead leads to the tragic death of a child.

Medical researchers are working hard to better understand the many causes of infant sleep-related deaths. Criminalizing one aspect that is related to some deaths will have a chilling effect on full disclosure of what happened in all sleep-related infant deaths.

Every child's death tugs at the hearts of us all and leaves families fractured. The community, health providers, social workers and policy makers are engaged in discussion about how best to jointly prevent these infant deaths. We all share the same goal – to prevent all sleep-related deaths from ever occurring. But there is no easy answer on how to get us there.

Children's Hospital of Wisconsin has a Safe Sleep Initiative providing education in a variety of settings focused on:

- Ensuring all infants in our hospital and clinics are sleeping safely.
- Teaching parents and caregivers how to put their babies to sleep in a safe environment including the importance of an infant placed alone in a crib and "back to sleep"; avoiding co-sleeping in all circumstances.
- Partnering with other hospitals and clinics to encourage adopting similar policies and practices.

There is much work to be done. The current state of education and prevention efforts is not enough. Focus and resources should be on education about all unsafe sleep risk factors including co-sleeping, soft sleep surfaces, blankets and pillows. Sound research has established these all as serious risks for infants. Community leaders and members, health providers, social workers and policy makers should come together to work on strong community-based education and innovative solutions to promote safe sleep and provide resources for parents and caregivers.

Children's Hospital is engaged in the dialogue around this serious issue at the local and national level and will continue to have discussion with policy makers on ways to address the shared goal of eliminating these preventable tragedies.

Chairwoman Vukmir and committee members, I thank you again for the opportunity to speak on behalf of Children's Hospital Wisconsin and am happy to take any questions at this time.

WISCONSIN HOSPITAL ASSOCIATION, INC.

Date: **November 20, 2013**

To: **Members – Senate Committee on Health and Human Services**

From: **Judy Warmuth, Vice President – Workforce Development**
Kyle O'Brien, Vice President – Government Relations

Re: **SB 357 – Hospital Mandate on Intoxicated Co-sleeping**

Wisconsin hospitals are in agreement with the important goal of this legislation, which aims to prevent harm and avoid the risks of intoxicated co-sleeping. However, the Wisconsin Hospital Association (WHA) would like to express great concern about the legislature establishing the specific actions and requirements for patients and patient care in Wisconsin law. WHA is opposed to mandates on hospitals that establish a particular standard of care in state statutes. These determinations should be made by physicians and other medical professionals, not by the state legislature.

In addition, WHA has serious concern about the bills provision which requires hospitals to provide education during the short hospital stay after a woman has given birth. We believe that creating a new educational requirement during the short inpatient stay when a baby is born will not result in parent learning or behavior change. There are already many demands on the time and attention of new parents. Hospital staff are already hard-pressed to meet these existing needs during the inpatient hospital stay.

While the birth mother and child are in the hospital, staff must assess individual family situations and use their time to educate the parents, but especially new mothers about many things. Parents need to learn how to feed, clothe, bath, change diapers, take temperature, hold, swaddle, etc. WHA believes that it is inappropriate to require that precious teaching time be spent, not on the greatest needs of the patient as assessed by clinical staff, but on other mandated topics that are selected by the legislature.

Wisconsin hospitals are committed to working toward a goal of all children in Wisconsin living in a safe and healthy environment. Although we deal with many vulnerable populations, newborns are of special concern to health care providers. Childbirth is a complicated and busy time for both parents and hospital caregivers. During a usual time period of no more than 48 hours, when a mother and other family members are fatigued by the efforts of labor and delivery, hospitals work to assure that parents are prepared and comfortable caring for a newborn. Simple tasks such as bathing, feeding, comforting, clothing, monitoring temperature and hydration must be demonstrated <u>for</u> parents and then demonstrated <u>by</u> parents.

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Issues around a mother's health must also be addressed in this brief and harried time. Breast feeding, healing, nutrition for the mother, fatigue and possible depression must be addressed. These tasks must be accomplished while both mother and newborn wake, feed, and sleep in 2 hour or less cycles. Physician staff must assess the health of both mother and baby; nursing and social work staff must assess ability to care for the newborn and environmental safety at home.

Parents, who are oftentimes fatigued and overwhelmed after child birth, need to learn necessary information about the care and well being of themselves and their newborn.

We would like to inform the committee of the options already present in the healthcare system to address this issue and to also suggest other primary prevention strategies.

There are many ways in which parents may be informed regarding neonatal safety:

- communication with pre-natal care providers can identify mothers and babies with special need for intervention related to safety and care
- admission processes may trigger consultation with hospital and outside social work staff who can provide or continue contacts with community resources
- routine assessments of mother-baby interaction and all family interactions allow for potential issues to be identified early
- one-on-one teaching and small classes are offered which cover child care, safety, nutrition, and resources available in the community
- discharge planning often creates referrals to outside agencies, sometimes for further in-home evaluation of risk, sometimes for intervention
- post delivery classes, mailing packets and follow up phone calls give new parents the opportunity to ask questions and seek help when the reality of child care become apparent

Healthcare clinicians in every Wisconsin hospital are charged with assessing and evaluating patients, setting priorities, and intervening in the most appropriate way. Although each hospital determines its own strategies for assessing, educating and refereeing parents and their newborns, all are committed to the goal of safe, healthy children in Wisconsin.

Primary prevention is a very valuable strategy for addressing the issue of intoxicated co-sleeping with babies and other conditions or behaviors that may pose risks to newborns and their families. There are many ways, other than a new legislative mandate on hospitals, that parents, caretakers, other family members can be informed about these risks.

This policy applies to the following entity(s):

☒ Children's Hospital of Wisconsin ☐ Children's Hospital of WI-Fox Valley

SUBJECT: Infant Safe Sleep

Definitions

1. An infant (for this policy and procedure) is defined as a child less than one year of age.

2. SIDS is defined as the sudden death of an infant younger than one year of age that remains unexplained even after a complete autopsy, a death scene investigation and a thorough review of the clinical history are conducted (as cited by Esposito, 2007, 158).
   - SIDS is the leading cause of death for infants between 1 month and 12 months of age. SIDS is most common among infants that are 2-4 months old.
   - The risk of SIDS is increased by factors such as premature birth, exposure to tobacco smoke in utero or during infancy, or prone sleeping (as cited by Esposito, 2007).

3. Suffocation refers generally to the death of an infant caused by obstruction of the breathing passages (i.e. the infant who slips down between the crib rail and mattress and has the face pushed against the mattress leading to suffocation). (http://www.sids-network.org/experts/carroll2.htm).

4. Asphyxia is a physiology/pathology term referring to breathing insufficiency leading to inadequate intake of oxygen and inadequate exhalation of carbon dioxide. It can be caused by a variety of factors, some of which may be related to sleeping position and/or bedding materials. (http://www.sids-network.org/experts/carroll2.htm).

5. Three conditions that may lead to the death of the infant with SIDS include:
   a. Vulnerable infant: An underlying defect or brain abnormality makes the baby vulnerable. Defects in parts of the brain that control respiration or heart rate or genetic mutations, confer vulnerability.
   b. Critical Developmental Period: During the infant's first six months of life, rapid growth phases and changes in homeostatic controls occur. These changes may be evident (e.g. sleeping and waking patterns), or they may be subtle (e. g. variations in breathing, heart rate blood pressure and

body temperature). Some of these changes may temporarily or periodically destabilize the infant's internal systems.

c. Outside stressors may influence whether an infant develops SIDS. These factors include sleep environment (bed sharing, soft bedding, stuffed animals, bumper pads, etc. that could increase carbon dioxide retention or overheating, prone positioning, secondhand smoke, and upper respiratory infection. (Filiano, & Kinney, 1994).

Purpose:

1. Implement the American Academy of Pediatrics (AAP) recommendations regarding supine sleeping position. The American Academy of Pediatrics (AAP) recommends supine sleeping as an intervention to decrease the risk of sudden infant death syndrome (SIDS) in healthy, term infants (≥ 37 weeks). Supine sleeping is also recommend for Preterm infants (<37weeks) who have recovered from respiratory distress syndrome (RDS) and who are asymptomatic (without tachypnea, apnea, bradycardia requiring intervention). Refer to **Safe Sleep Practices** on page 3 of this policy.

2. Model and ensure understanding of recommended techniques by parents and caregivers (AAP, 2005).

3. Promote developmentally appropriate care to hospitalized premature infants as well as acutely ill term infants.

4. Identify exclusions to supine positioning.

5. Identify suffocation risks that impact infant mortality.

POLICY

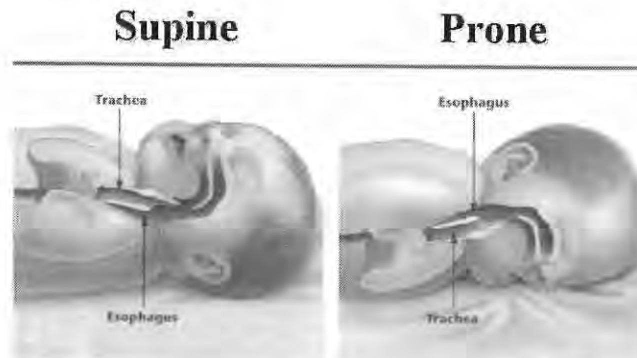
1. All parents, guardians and caregivers of hospitalized infants will be screened for safe sleep practices both at the time of admission and shortly before discharge. Caregivers unable to provide a safe sleep environment for their infant will be referred to social work or other appropriate resources. See Cribs for Kids policy and procedure. NOTE for JCPC: Admission assessment and screening form pending Lauren G updating.
2. **While hospitalized,** infants must be
    a. Placed in the supine position for sleep or must transition to the supine position before discharge (barring any medical contraindications-see exceptions in 1b on page 5).
    b. Offered alternative positions when awake to reduce the risk for developing plagiocephaly include:
        i. Encourage tummy time when awake and supervised.
        ii. Encourage the use of upright cuddle time.
        iii. Shift the direction the infant faces while asleep.
3. Parents or legal guardians of hospitalized infants will be taught rationale for and techniques to support appropriate positioning for sleep including information regarding tummy to play.
4. When sleeping, every infant must be placed alone in the crib (NOTE: ED and PACU do not use cribs for their patients).
5. **No one** may sleep with an infant in a chair or bed. Caregivers must be awake when holding an infant. If the parent/legal guardian or caregiver is noted to be sleeping, the infant must be returned to his or her age appropriate crib and explanation provided to the parent/legal guardian or caregiver as to why this practice is unsafe (i.e. risk of falling, suffocation, entrapment or injury). This does not apply to kangaroo care provided in the NICU or end of life care.
    a. Parents or legal guardians who express concerns or resist complying with this policy should receive additional education about the policy. (See page 8). This education should focus on the benefits of safe sleep and the risks of bed sharing. If the parents or legal guardians continue to be noncompliant with this policy, additional interventions may include; discussion with patient representative, risk management staff or other CHHS representatives, behavioral contracts or supervised visits. Any such interventions should be documented in the medical record.
6. Soft bedding such as pillows, bumper pads and stuffed animals must not be in a sleeping infant's incubator, warmer, bassinet or crib.

PROCEDURE

NOTE: For infants <37 weeks gestation or physiologically compromised monitored infants, see Addendum A for developmentally supportive positioning.

Infants who have not been home from the hospital will start transitioning to back to sleep without supportive devices as soon as the infant is medically stable. Babies should be transitioned to back position early enough (ideally 1-2 weeks) before discharge to adjust to the supine position.

1. **Sleep Position:** Position all healthy infants, including asymptomatic premature infants that have recovered from RDS, supine (back to sleep) during sleep with the head of bed (HOB) flat.
   NOTE: Side sleeping is not as safe as supine sleeping and is not advised.
   a. Continue supine positioning during sleep until infants are developmentally able to roll out of supine by themselves. At this point, put infants to sleep in a supine position but allow them to assume a preferred sleep position.
      i. Infants who are prone and cannot roll out of supine by themselves need to be on a medically provided physiologic monitor.
      ii. Rationale for supine sleep:
         1. When a baby is supine, the trachea lies on top of the esophagus. Anything regurgitated or refluxed from the esophagus must work against gravity to be aspirated into the trachea.
         2. Conversely, when baby is in the stomach sleeping position, anything regurgitated or refluxed will pool at the opening of the trachea, making it easier to aspirate.



SIDS Risk Reduction: Curriculum for Nurses, NICHD, 2006. NIH Publication No. 06-6005.

   b. **Exceptions to supine (NOTE: Monitor required):**

i. Some infants may benefit clinically from prone positioning during sleep. These include but are not limited to:
   1. Supine position causes medical or neurobehavioral instability.
   2. Any symptomatic preterm infant with signs of respiratory distress (increased work of breathing, apnea or tachypnea) for whom prone positioning is clearly beneficial clinically.
   3. Asymptomatic, very low birth weight preterm infants (<1250 grams) for whom prone positioning provides a respiratory and developmental advantage.
   4. Infants with known or suspected airway obstruction.
   5. Infants on assisted ventilation who benefit from prone positioning.
   6. Infants with severe gastroesophageal reflux who respond positively to prone positioning.
   7. Infants with birth defects for whom the supine position would be contraindicated (such as children with neural tube defects or Pierre Robin sequence).
   8. Other infants as deemed necessary by the licensed independent practitioner (LIP).

2. **Sleep Environment**
   a. **Alone in the crib:** Infants will be placed alone in the crib. No one may sleep with the infant in a chair or bed. Mom may breastfeed awake infants in a bed but cannot sleep with the infant in the bed. (See Visiting and Guest Policy and Procedure).
   b. **Prevent overheating:** Dress infant for sleep to provide warmth but prevent overheating.
      i. Dress infant when medically stable.
      ii. Fleece bedding or blankets or sacks should not be used. Fleece blankets may be used to cover an incubator or warmer.
      iii. Swaddling with a cotton blanket is recommended for infants who do not demonstrate physiologic flexion.
      iv. Sleep sacs, if used in the hospital, are recommended to be cotton (L'Hoir).
         1. Fleece sleep sacs can be considered in the community as long as the infant does not overheat.
         2. Fleece is susceptible to damage from high temperature washing, tumble drying or ironing (as occurs with hospital laundering). Lower quality fleece is prone to pilling.
         3. Velcro sleep sacks should be adjusted to allow the arms to be midline in order to promote self regulation.
      v. Room temperature should feel comfortable to a lightly clothed adult.
      vi. Use hats only as infant condition warrants. Hats should not be used in the home environment due to the risks of overheating and suffocation (potential loose object in the bed).

c. **Firm Sleep Surface:** Position infant on a firm flat mattress covered only with a single sheet tucked securely around the mattress and a single blanket can be put on top of the sheet if it can be securely tucked under the mattress.

- Sheepskin should not be used under a sleeping infant.
- Quilts should not be used in the bed.

i. Exceptions

1. If an infant is monitored, a cloth diaper can be placed under the head.
2. Sheepskin can be used for low birth weight infants < 1500 grams or immobilized patients as an intervention to prevent skin breakdown. Sheep skin can be used with dermatologic conditions (e. g. Epidermolysis bullosa, hemiangiomas).
3. Quilts can be used over an incubator to shield light. Quilts can be used for tummy time on the floor after discharge home.
4. Gel pillows and gel mattresses can be used for in the hospital for monitored infants, ventilated infants, infants with plagiocephaly, or dolichocephaly and infants with limited mobility. These devices are not to be used in the home environment.

d. **Keep soft objects and loose bedding out of the crib:**

i. Soft bedding such as pillows, bumper pads and stuffed animals must not be in a sleeping infant's incubator, warmer, bassinet or crib. NOTE: Seizure pads are an exception.

1. **Exception:** If mom of a premature infant is unable to visit immediately post-partum, a small blanket that mom has had with her may be placed in the monitored infant's incubator or warmer to promote bonding (Nishitani et al, 2009, 66).

ii. A lightweight preferably cotton blanket can be used to bundle the infant as long as the blanket is not above the shoulders and the arms are free. Swaddling must be discontinued once the infant can roll in order to prevent any suffocation risk.

1. Blankets can be used for nesting, bundling and positioning for infants with a corrected gestational age of less than 37 weeks or medically compromised infants who are monitored (e.g. to promote a flexed, tucked, midline, symmetrical position of trunk and extremities for developmental support).
    a. Monitored infants in the NICU/NPCU who cannot turn may need an additional blanket to maintain temperature in the hospital environment (if the room temperature cannot be well controlled). Hyperthermia should be avoided.

b. The blanket should be tucked at the foot of the mattress and not reach beyond the infant's chest so that the infant's face is protected from being covered. <u>Do not use this method if the infant has the ability to move under the blanket.</u>

2. Premature infants will need developmentally supportive positioning devices. (van Sleuwen, 2007)
    a. Positioning devices (snuggly, bendy bumpers and frogs) may be used in the hospital to support developmental care and prevent muscular skeletal problems.

    b. Positioning devices from the hospital or commercially made products are not to be used in the home environment unless medically indicated.

iii. A covered face, even in the supine position is considered a risk factor for SIDS.

e. **Pacifiers:** Pacifiers may reduce the risk of SIDS and are recommended for all sleep time. Pacifier should be offered at time of sleep and not reinserted if the pacifier falls out during sleep. Non-nutritive sucking is used for calming as part of the Cue-based feeding guideline at CHW. AAP states that pacifiers should not be introduced until breastfeeding is established (approximately 3-4 weeks). (AAP, 2005, 1248). However, hospitalized patient's need or diagnosis may not align with this recommendation.
f. Evidence does not support the use of **commercial devices** marketed to decrease the risk of SIDS.
g. Evidence does not support the use of **home monitors** to decrease the risk of SIDS (AAP, 2005, 1250). Medically fragile infants sent home in the prone position require medically provided home physiologic monitoring.

3. Parent/Guardian Teaching
    a. During the hospital stay:
        i. Educate on Safe Sleep practices and deviations from Safe Sleep including principles of developmental care.
        ii. Explain use of monitors when applicable.
        iii. Incorporate all sleep environment practices during the hospital stay and explain any exclusion.
        iv. Explain goal of supine sleep without assistive devices within 1-2 weeks of discharge (depending on developmental and medical needs).
    b. Prior to discharge:
        i. Safe Sleep materials available include:
            1. Handout "Safe Sleep for your Baby" (National Institute of Child Health and Human Development NIH Pub. No. 05-7040).
            2. "Sleep Position for Infants" (Health facts for you #2010).
            3. TIPS to prevent flatheads in infants (#1220)
            4. ABCs of Safe Sleep (# pending)
            5. WAPC crib card
        ii. Discuss the importance that parents/guardians will need to remind every caregiver of their child to use the Back to Sleep position and sleep environment during every sleep period, especially when the infant is accustomed to the supine sleep position.
        iii. **Positioning devices cannot go home with the infant (unless a medical necessity).**
        iv. Discuss any medical positioning requirements.
        v. If a sleep sacs will be used at home review:
            1. Cotton versus fleece indications
            2. How to place infant in the sleep sac
            3. Developmental milestones to monitor related to the supine position.
            4. How to encourage tummy time.
    c. All CHHS-affiliated educational courses, lectures, handouts, and other materials, whether targeted at medical personnel, parents/caregivers, or other audiences, must be compliant with this policy although the exact content and focus may vary. All materials should be approved by the Safe Sleep Working Group and Educational Services.
    d. Document education and materials provided on the Interdisciplinary teaching sheet.

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Addendum A

Developmentally Supportive Positioning: for infants < 37weeks gestation or physiologically compromised monitored infants

1. Monitored infants requiring intensive care should be positioned with appropriate developmental and positional support in supine, side lying or prone position depending on gestational age, acuity of illness and medical diagnosis.
   a. All immobilized, sedated, or paralyzed, infants need to be repositioned to prevent skin breakdown.
2. Principles of developmental supportive positioning:
   a. Neonatal positioning is used to position high risk, preterm or medically unstable neonates in a manner that promotes physiologic, neuromuscular and neurobehavioral development.
   b. Premature infants have an inability to change static posture which may result in muscle imbalance and positional deformities.
   c. In addition, medically unstable near-term and full-term neonates with hypotonia caused by illness severity or sedation are at risk for positioning deformities, muscle shortening, and contractures of the muscles.
   d. Possible complications stemming from developmental immaturity and restricted movement include frog legs, W position of the arms, neck extension, arching postures, head molding and torticollis. (Kenner & McGrath, 2004, McManus & Capistran 2008).
   e. All positioning (correct and incorrect) has an ongoing impact on the developing neuromotor, physiologic, and neurological status of the preterm and/or compromised infant (Sweeney & Gutierrez, 2002).
   f. Every positioning option (supine, prone, side lying) has both medical and developmental advantages and disadvantages.
   g. Always turn head and entire body as a unit.
   h. To avoid neck flexion use small neck roll under the shoulders.
   i. Handle infant gently, avoiding sudden changes in posture.
   j. Developmentally supportive positioning:
      i. Promotes physiologic flexion through positioning of infant and provision of supportive equipment and boundaries. Containment touch- boundaries are provided using positional devices and support such as bendy bumper, snuggly, and frogs.
      ii. Maintains head, trunk and pelvic alignment in all positions.
      iii. Promotes midline forward positioning of arms and legs. Arms, legs and feet are flexed and tucked toward midline of trunk in all positions.
      iv. Promotes infant's self regulatory efforts (to stay calm and steady) such as hands to mouth, flexed and tucked trunk and extremities.
      v. Supports respiratory stability.

Children's Hospital and Health System, Inc.
Patient Care Policy and Procedure

This policy applies to the following entity(s):

☒ Children's Hospital of Wisconsin ☐ Children's Hospital of WI-Fox Valley

SUBJECT: Infant Safe Sleep

Definitions

1. An infant (for this policy and procedure) is defined as a child less than one year of age.

2. SIDS is defined as the sudden death of an infant younger than one year of age that remains unexplained even after a complete autopsy, a death scene investigation and a thorough review of the clinical history are conducted (as cited by Esposito, 2007, 158).
   - SIDS is the leading cause of death for infants between 1 month and 12 months of age. SIDS is most common among infants that are 2-4 months old.
   - The risk of SIDS is increased by factors such as premature birth, exposure to tobacco smoke in utero or during infancy, or prone sleeping (as cited by Esposito, 2007).

3. Suffocation refers generally to the death of an infant caused by obstruction of the breathing passages (i.e. the infant who slips down between the crib rail and mattress and has the face pushed against the mattress leading to suffocation). (http://www.sids-network.org/experts/carroll2.htm).

4. Asphyxia is a physiology/pathology term referring to breathing insufficiency leading to inadequate intake of oxygen and inadequate exhalation of carbon dioxide. It can be caused by a variety of factors, some of which may be related to sleeping position and/or bedding materials. (http://www.sids-network.org/experts/carroll2.htm).

5. Three conditions that may lead to the death of the infant with SIDS include:
   a. Vulnerable infant: An underlying defect or brain abnormality makes the baby vulnerable. Defects in parts of the brain that control respiration or heart rate or genetic mutations, confer vulnerability.
   b. Critical Developmental Period: During the infant's first six months of life, rapid growth phases and changes in homeostatic controls occur. These changes may be evident (e.g. sleeping and waking patterns), or they may be subtle (e. g. variations in breathing, heart rate blood pressure and

body temperature). Some of these changes may temporarily or periodically destabilize the infant's internal systems.

c. Outside stressors may influence whether an infant develops SIDS. These factors include sleep environment (bed sharing, soft bedding, stuffed animals, bumper pads, etc. that could increase carbon dioxide retention or overheating, prone positioning, secondhand smoke, and upper respiratory infection. (Filiano, & Kinney, 1994).

Purpose:

1. Implement the American Academy of Pediatrics (AAP) recommendations regarding supine sleeping position. The American Academy of Pediatrics (AAP) recommends supine sleeping as an intervention to decrease the risk of sudden infant death syndrome (SIDS) in healthy, term infants (≥ 37 weeks). Supine sleeping is also recommend for Preterm infants (<37weeks) who have recovered from respiratory distress syndrome (RDS) and who are asymptomatic (without tachypnea, apnea, bradycardia requiring intervention). Refer to **Safe Sleep Practices** on page 3 of this policy.

2. Model and ensure understanding of recommended techniques by parents and caregivers (AAP, 2005).

3. Promote developmentally appropriate care to hospitalized premature infants as well as acutely ill term infants.

4. Identify exclusions to supine positioning.

5. Identify suffocation risks that impact infant mortality.

POLICY

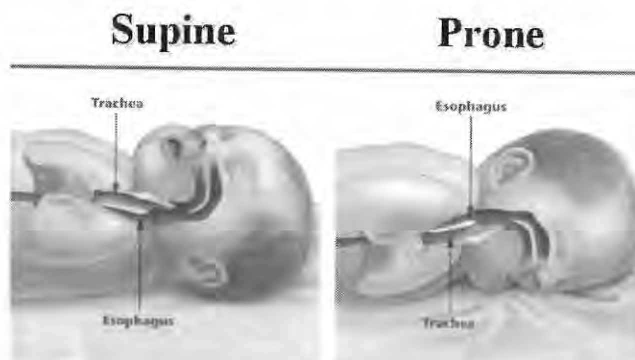
1. All parents, guardians and caregivers of hospitalized infants will be screened for safe sleep practices both at the time of admission and shortly before discharge. Caregivers unable to provide a safe sleep environment for their infant will be referred to social work or other appropriate resources. See Cribs for Kids policy and procedure. NOTE for JCPC: Admission assessment and screening form pending Lauren G updating.
2. **While hospitalized,** infants must be
    a. Placed in the supine position for sleep or must transition to the supine position before discharge (barring any medical contraindications-see exceptions in 1b on page 5).
    b. Offered alternative positions when awake to reduce the risk for developing plagiocephaly include:
        i. Encourage tummy time when awake and supervised.
        ii. Encourage the use of upright cuddle time.
        iii. Shift the direction the infant faces while asleep.
3. Parents or legal guardians of hospitalized infants will be taught rationale for and techniques to support appropriate positioning for sleep including information regarding tummy to play.
4. When sleeping, every infant must be placed alone in the crib (NOTE: ED and PACU do not use cribs for their patients).
5. **No one** may sleep with an infant in a chair or bed. Caregivers must be awake when holding an infant. If the parent/legal guardian or caregiver is noted to be sleeping, the infant must be returned to his or her age appropriate crib and explanation provided to the parent/legal guardian or caregiver as to why this practice is unsafe (i.e. risk of falling, suffocation, entrapment or injury). This does not apply to kangaroo care provided in the NICU or end of life care.
    a. Parents or legal guardians who express concerns or resist complying with this policy should receive additional education about the policy. (See page 8). This education should focus on the benefits of safe sleep and the risks of bed sharing. If the parents or legal guardians continue to be noncompliant with this policy, additional interventions may include; discussion with patient representative, risk management staff or other CHHS representatives, behavioral contracts or supervised visits. Any such interventions should be documented in the medical record.
6. Soft bedding such as pillows, bumper pads and stuffed animals must not be in a sleeping infant's incubator, warmer, bassinet or crib.

PROCEDURE

NOTE: For infants <37 weeks gestation or physiologically compromised monitored infants, see Addendum A for developmentally supportive positioning.

Infants who have not been home from the hospital will start transitioning to back to sleep without supportive devices as soon as the infant is medically stable. Babies should be transitioned to back position early enough (ideally 1-2 weeks) before discharge to adjust to the supine position.

1. **Sleep Position:** Position all healthy infants, including asymptomatic premature infants that have recovered from RDS, supine (back to sleep) during sleep with the head of bed (HOB) flat.
   NOTE: Side sleeping is not as safe as supine sleeping and is not advised.
   a. Continue supine positioning during sleep until infants are developmentally able to roll out of supine by themselves. At this point, put infants to sleep in a supine position but allow them to assume a preferred sleep position.
      i. Infants who are prone and cannot roll out of supine by themselves need to be on a medically provided physiologic monitor.
      ii. Rationale for supine sleep:
         1. When a baby is supine, the trachea lies on top of the esophagus. Anything regurgitated or refluxed from the esophagus must work against gravity to be aspirated into the trachea.
         2. Conversely, when baby is in the stomach sleeping position, anything regurgitated or refluxed will pool at the opening of the trachea, making it easier to aspirate.



SIDS Risk Reduction: Curriculum for Nurses, NICHD, 2006. NIH Publication No. 06-6005.

   b. **Exceptions to supine (NOTE: Monitor required):**

i. Some infants may benefit clinically from prone positioning during sleep. These include but are not limited to:
    1. Supine position causes medical or neurobehavioral instability.
    2. Any symptomatic preterm infant with signs of respiratory distress (increased work of breathing, apnea or tachypnea) for whom prone positioning is clearly beneficial clinically.
    3. Asymptomatic, very low birth weight preterm infants (<1250 grams) for whom prone positioning provides a respiratory and developmental advantage.
    4. Infants with known or suspected airway obstruction.
    5. Infants on assisted ventilation who benefit from prone positioning.
    6. Infants with severe gastroesophageal reflux who respond positively to prone positioning.
    7. Infants with birth defects for whom the supine position would be contraindicated (such as children with neural tube defects or Pierre Robin sequence).
    8. Other infants as deemed necessary by the licensed independent practitioner (LIP).

2. **Sleep Environment**
    a. **Alone in the crib:** Infants will be placed alone in the crib. No one may sleep with the infant in a chair or bed. Mom may breastfeed awake infants in a bed but cannot sleep with the infant in the bed. (See Visiting and Guest Policy and Procedure).
    b. **Prevent overheating:** Dress infant for sleep to provide warmth but prevent overheating.
        i. Dress infant when medically stable.
        ii. Fleece bedding or blankets or sacks should not be used. Fleece blankets may be used to cover an incubator or warmer.
        iii. Swaddling with a cotton blanket is recommended for infants who do not demonstrate physiologic flexion.
        iv. Sleep sacs, if used in the hospital, are recommended to be cotton (L'Hoir).
            1. Fleece sleep sacs can be considered in the community as long as the infant does not overheat.
            2. Fleece is susceptible to damage from high temperature washing, tumble drying or ironing (as occurs with hospital laundering). Lower quality fleece is prone to pilling.
            3. Velcro sleep sacks should be adjusted to allow the arms to be midline in order to promote self regulation.
        v. Room temperature should feel comfortable to a lightly clothed adult.
        vi. Use hats only as infant condition warrants. Hats should not be used in the home environment due to the risks of overheating and suffocation (potential loose object in the bed).

c. **Firm Sleep Surface:** Position infant on a firm flat mattress covered only with a single sheet tucked securely around the mattress and a single blanket can be put on top of the sheet if it can be securely tucked under the mattress.
   - Sheepskin should not be used under a sleeping infant.
   - Quilts should not be used in the bed.

   i. Exceptions
      1. If an infant is monitored, a cloth diaper can be placed under the head.
      2. Sheepskin can be used for low birth weight infants < 1500 grams or immobilized patients as an intervention to prevent skin breakdown. Sheep skin can be used with dermatologic conditions (e. g. Epidermolysis bullosa, hemiangiomas).
      3. Quilts can be used over an incubator to shield light. Quilts can be used for tummy time on the floor after discharge home.
      4. Gel pillows and gel mattresses can be used for in the hospital for monitored infants, ventilated infants, infants with plagiocephaly, or dolichocephaly and infants with limited mobility. These devices are not to be used in the home environment.

d. **Keep soft objects and loose bedding out of the crib:**
   i. Soft bedding such as pillows, bumper pads and stuffed animals must not be in a sleeping infant's incubator, warmer, bassinet or crib. NOTE: Seizure pads are an exception.
      1. **Exception:** If mom of a premature infant is unable to visit immediately post-partum, a small blanket that mom has had with her may be placed in the monitored infant's incubator or warmer to promote bonding (Nishitani et al, 2009, 66).

   ii. A lightweight preferably cotton blanket can be used to bundle the infant as long as the blanket is not above the shoulders and the arms are free. Swaddling must be discontinued once the infant can roll in order to prevent any suffocation risk.
      1. Blankets can be used for nesting, bundling and positioning for infants with a corrected gestational age of less than 37 weeks or medically compromised infants who are monitored (e.g. to promote a flexed, tucked, midline, symmetrical position of trunk and extremities for developmental support).
         a. Monitored infants in the NICU/NPCU who cannot turn may need an additional blanket to maintain temperature in the hospital environment (if the room temperature cannot be well controlled). Hyperthermia should be avoided.

b. The blanket should be tucked at the foot of the mattress and not reach beyond the infant's chest so that the infant's face is protected from being covered. <u>Do not use this method if the infant has the ability to move under the blanket.</u>

2. Premature infants will need developmentally supportive positioning devices. (van Sleuwen, 2007)
   a. Positioning devices (snuggly, bendy bumpers and frogs) may be used in the hospital to support developmental care and prevent muscular skeletal problems.

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            3. TIPS to prevent flatheads in infants (#1220)
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            5. WAPC crib card
        ii. Discuss the importance that parents/guardians will need to remind every caregiver of their child to use the Back to Sleep position and sleep environment during every sleep period, especially when the infant is accustomed to the supine sleep position.
        iii. **Positioning devices cannot go home with the infant (unless a medical necessity).**
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        v. If a sleep sacs will be used at home review:
            1. Cotton versus fleece indications
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        v. Supports respiratory stability.