Unsafe Sleep Environments and Child Protective Services

by James Marlow

There are many child maltreatment risk factors that caseworkers in Child Protection Services (CPS) encounter. But it may be surprising to realize that the greatest risk related to preventable deaths in children between 29 days and one year of life (the "post-neonatal" period) is an "unsafe sleep environment." It may be difficult, however, to determine how caseworkers will take this important risk factor into account when formulating their assessments and intervention plans.

During the five-year period from 2009 to 2013, there were 836 sleep-related deaths among infants (from birth to 12 months) reviewed by child fatality review boards in Ohio (Ohio Children's Trust Fund & Ohio Department of Health, 2015). Causes of infant sleep-related deaths include medical problems, Sudden Infant Death Syndrome (SIDS), and asphyxia (blockage of the airway). From 2009 to 2013, 32 percent of infant sleep-related deaths were determined to be from asphyxia and 14 percent from SIDS (Ohio Children's Trust Fund & Ohio Department of Health, 2015). When post-neonatal deaths were studied as a sub-group, the number of deaths from SIDS and asphyxia were even more alarming. This post-neonatal period is especially pertinent for prevention of sleep-related deaths.

SIDS is technically considered "unpreventable" because parents can be following every identified risk-reduction practice and their children can still have a diagnosis of SIDS – making it a complex area of study. Even though "unpreventable," there has been a greater than 50 percent reduction in SIDS deaths from the early1990s to the present, attributed mainly to parents placing babies on their backs instead of bellies during sleep(Shapiro-Mendoza, n.d.). Wouldn't this decrease represent prevention? But every SIDS case cannot be prevented currently. Research has identified an abnormality in the vulnerable child's brain stem as a frequently occurring contributor to SIDS (Shapiro-Mendoza, n.d.). As of now, this abnormality can only be confirmed by autopsy, making prevention sometimes impossible. Adhering to a list of risk-reduction practices (e.g., placing the baby on the back instead of stomach or side, preventing overheating of the baby, avoiding exposure to smoke prenatally as well as after birth, and using a pacifier), is important.

Many sleep-related deaths are preventable, especially those due to asphyxia. Children under one year of age who are at some risk of suffering a sleep-related death include children sleeping in adult beds, chairs, couches, or other unsafe areas; children co-sleeping with adults or older children; children sleeping in cribs with extraneous objects like blankets, toys, or even bumper pads; children sleeping in cribs near curtain pulls or other objects that can strangle them; and children sleeping on their bellies or sides instead of their backs. Many children in these unsafe sleep environments do not die; some who do die with these risk factors present are determined to have died from some other cause, perhaps explainable. But the important point is that many children do die because of these unsafe sleep environments! When the death scene investigation reveals that a child was wedged between the wall and an adult mattress, or

that an adult was lying on top of a child found dead, the need to establish preventative measures in each case becomes obvious.

Reasons why unsafe sleep environments are not readily identified as a child protection issue vary. When the author discussed the issue with CPS and other professionals who attended his workshop, several reasons why these scenarios are not viewed as child "neglect" emerged, such as parents' lack of awareness of the potential dangers, parents' lack of access to education about risk factors, inconsistent messages among family members and perhaps even health professionals about what is dangerous and what is not, and lack of malicious intent. Using case examples to stimulate discussion Using case examples to stimulate discussion among workshop participants, the author found that a dramatic case example—for instance, a mother who comes home very intoxicated, falls asleep with the baby in her bed, then ends up lying on top of the baby and smothering the baby to death (by asphyxia)—tended to garner a consensus that neglect had occurred. The majority of other scenarios were deemed to be tragic, accidental situations in which parents certainly did not intend to do harm.

So, what is the role of CPS caseworkers regarding safe sleep environments and practices? Ohio legislation (ORC 3701.66 & ORC 3701.67) makes it mandatory for public children services agencies (PCSAs) to "distribute infant safe sleep education materials…when the agency has initial contact with an infant's parent, guardian, or other person responsible for the infant." Presumably it is the caseworker who most often has this "initial contact" with the family. It will greatly help if caseworkers exceed this minimum standard and embrace the importance of dispersing safe-sleep guidelines whenever and wherever possible to clients, friends, relatives, and the general public. By observing an infant's sleep environment during home visits throughout all phases of the PCSA's involvement with families, caseworkers can identify the risk factors. After establishing the initial family contact and having ongoing discussions with parents and caregivers about sleep-related risk factors and risk-reduction practices, caseworkers can correct caregiver misunderstandings, resolve caregiver challenges in the sleep environment, and reinforce education about safe-sleeping practices. By utilizing all these measures in casework practice, child welfare professionals will make great strides in addressing the issue of sleep-related deaths.

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References

Ohio Children's Trust Fund & Ohio Department of Health. (2015). Ohio Child Fatality Review Fifteenth Annual Report [E-reader version]. Retrieved from: https://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/cfhs/child%20fatality%20review/ohiochildfatalityreviewannualreport2015.pdf

Shapiro-Mendoza, C. (n.d.). Sudden,Unexplained Infant Deaths. Introduction. In U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Sudden Unexplained Infant Death Investigation Training Manual [E-reader version]. Retrieved from http://www.cdc.gov/sids/pdf/suidmanual/chapter1_tag508.pdf