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OFCO Testimony
HOUSE COMMITTEE ON EARLY LEARNING & HUMAN SERVICES
February 4, 2011
House Hearing Room D, John L. O'Brien Building, 1:30p.m.
Infant Safe Sleep Work Session

Good afternoon Madam Chair and Members of the Committee. My name is Mary Meinig and I am the Director of the Office of the Family & Children's Ombudsman.

The Ombudsman monitors and recommends changes in DSHS Children's Administration (CA) practice with an eye toward ensuring the health and safety of children. In our capacity as oversight of the child protection and welfare system, OFCO conducts independent reviews of all child fatalities in which the family had an open case with CA at the time of death or within a year prior to the death. These reviews include children who die in state licensed care. By these criteria, OFCO reviews about 11% of the total fatalities of children 17 years of age and younger in Washington State. In 2010, OFCO conducted 64 administrative reviews of child fatalities.

Over half of the fatalities that OFCO reviews (66% in 2009) are of children under the age of 2 years. In addition to looking at each fatality individually for missed opportunities, OFCO also identifies factors common to numerous fatalities, such as infant sleep environment. Of the infant fatalities reviewed by OFCO in 2009, the medical examiner or coroner identified sleep environment as the cause of death or a contributing factor in 41% of infant deaths (14 of 34).

OFCO believes many of these infant deaths can be prevented through educating parents and caregivers of safe sleep practices.

Examples of sleep environment related infant fatalities reviewed by OFCO:

- 6 day old infant sleeping on parent's chest, as parent slept on a couch. The deceased infant was found on the side of the parent with a mark on their forehead consistent with a seam on the couch. This death was classified as undetermined death from co-sleeping
- 7 month old wrapped in a receiving blanket sleeping between parents in a n adult bed. One parent awoke to find that they were lying on top of their infant, who was unresponsive. This death was classified as accidental asphyxia.

- 1 month old sleeping with mother in mother's bed. Mother's bed included two adult pillows and a comforter underneath the infant. This death was classified as natural SIDS death noting the risk factor of bed sharing and soft bedding materials.

OFCO Recommendations Regarding Safe Sleep Environment:

- *OFCO 2010 Annual Report:*
  Strengthen efforts such as public education campaigns to promote infant "safe sleep." An unsafe sleep environment was identified as a contributing risk factor in 41 percent of the infant fatalities OFCO reviewed. Through increased public education and awareness, many of these deaths were preventable.
- *OFCO 2009 Annual Report:*
  CPS intake protocol should address common risk factors identified in child death reviews. CA should coordinate with Northwest Infant Survival Alliance, medical examiners and coroners, DOH and other professionals involved with child fatality reviews to improve CPS intake protocol. For example CPS intake workers should gather information about the child's sleeping environment, the parent's substance abuse history and the gestation of the infant to help determine the level of risk.
- *OFCO 2005 Annual Report:*
  Require CA to report on the implementation of OFCO child fatality review recommendations. In the absence of implementation, require CA to provide OFCO with a reasonable basis for the decision not to implement recommendations. (2SSB 6206 requires OFCO to report on the implementation status of CA fatality recommendations)

CA Internal Child Fatality Review Recommendations Regarding Sleep Environment[1]:

- *CA Region 1 review:*
  - Additional training to licensed care providers on issues related to SIDS, safe sleep, drug affected infants, etc.
  - Develop and implement training on care for special needs infants for licensed care providers.
- *CA Region 3 review:*
  - Discussion of a regional protocol for education of selected families related to SIDS risks. This could include professional training in "risk management" of SIDS and how to reduce risk of SIDS in co-sleeping situations.
- *CA Region 4 review:*
  - Safety plans to replace parent-infant bed sharing with a safer alternative.

[1] CA posts summaries of each individual fatality review that include any recommendations made by fatality review team online at: http://www.dshs.wa.gov/ca/pubs/childsafety.asp

In response to both OFCO's and CA's recommendations from child fatality reviews, CA has made efforts to address sleep environment, including:

- "Infant Safe Sleep" has been added to the CA Academy which provides mandatory training to staff.
- Region 3 policy requires intake social workers to ask about sleep environment on calls concerning infants.
- Several regions have cribs available to give to families in need.
- Heightened awareness of safe sleep environment, evidenced by increased documentation in case notes of the child's sleep environment and conversations with the parents about creating a safe sleep environment for infants.

I thank you for the opportunity to discuss this issue and the need for ongoing efforts to prevent child fatalities and particularly those related to a young child's sleep environment.