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Co-sleeping deaths in Riverside County

Christine Leigh Brown

CO-SLEEPING DEATHS IN RIVERSIDE COUNTY

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

The focus of this study was to analyze the characteristics of incidents of infant deaths when the infant was sleeping in the same bed with another adult or child. The study was conducted at Riverside County Child Death Review and Child Protective Services in Riverside County. Data for this study was collected from the Child Death Review Team documents, which included law enforcement documentation, coroner reports, medical records, court records and Child Protective Services records.

The researcher used qualitative data analysis to discover commonalities within cases of co-sleeping deaths. The results of this analysis explained that substance use and abuse contributed to the deaths of several infants in co-sleeping incidents. The results also unveiled a phenomenon about sleeping positions whether they were in bed alone or co-sleeping with someone else.

This study contributes to social work on both a micro and a micro level. It offers micro insight into the families that have already gone through this tragedy; and allows the helping professions on a macro level to learn

from past cases to help prevent future cases from occurring. This study helps provide education to investigators who could potentially have a case that either has already resulted in a co-sleeping death or will result in one.

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Chris

DEDICATION

This study is dedicated to children who suffer abuse and neglect everyday. May an angel, in the form of a social worker, be brought into your life and save you from your despair.

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CHAPTER ONE

ASSESSMENT

Introduction

This chapter discusses the research focus, the paradigm chosen to conduct the research, a review of related research literature and the potential contribution this study will have to micro social work practice.

Research Focus and Question

This research project adopted a post positivist paradigm. It identified the characteristics of families where incidents of infant deaths occurred while the infant was sleeping with another adult or child. These characteristics included ethnicity, age of caretakers, drug issues, domestic violence, criminal history, birth order, and the age of the infant when the death occurred.

The project addressed the following questions:

1. Was the infant sleeping with a biological parent, stepparent or sibling when the death occurred?
2. Was there drug use in the home when the death occurred?

3. Were there incidents of domestic violence in the homes where the death occurred?

4. What age was the child when the death occurred?

The answers to these questions suggested a pattern common to these families. This information offered qualitative data that can now be utilized by social workers who conduct investigations, in the homes, where there is a concern about caretaker's choice to have an infant sleep in the same bed with themselves or siblings.

While this study was being conducted other key elements were formulated based on findings in the cases. It was found that some of the infants were sleeping in the same bed as the adults due to issues of culture biases as well as monetary issues. This suggested that while the adults were aware of the dangers of sleeping with an infant culturally it was unacceptable to not sleep with the infant. Especially in the Hispanic culture it was viewed as nurturing. There were also cases where the infant slept in the bed with the adults simply because there was no crib in the home due to lack of funds.

Paradigm and Rationale for Chosen Paradigm

This research adopted a post positivist paradigm approach. According to Morris (2006) post positivism is defined as a "paradigm that assumes an objective reality governed by laws and mechanisms that can be never be truly understood; that although the observer can never be truly separate from reality, researchers should work to control the influence they might have on reality; and that data gathered in naturalistic settings gives us an accurate understanding of reality" (p. 289-290).

This paradigm is most appropriate for this study because the assumption was made that there are commonalities for cases of identified incidents of infant deaths while co-sleeping. This required certain elements to be present in each of the cases. An example would be that there were a high number of co-sleeping deaths that occurred simply because there was only one "family" bed. This kind of commonality was identified and the researcher remained unbiased in the findings and separate from the reality of the commonalities that were discovered in each case. It was very difficult to look at cases where the deaths were preventable; however the researcher did not allow those personal feelings to

invade the study and remained unbiased when finding the commonalities. The commonalities were then cross referenced and emerging themes and characteristics were identified in homes where infant deaths have occurred.

This study gathered qualitative data. The qualitative data looked at ethnicities, how many family members lived in the home, drug use by the adults in the home; criminal history, domestic violence, as well as poverty and cultural issues to see what emerging themes were presented in homes where co-sleeping deaths were occurring. The data looked at interviews, conducted by law enforcement or Child Protective Services, with the family members when the deaths were being investigated. This data was gathered to see what, if any, similarities were in the stories about the child death. The information that was gathered was not only about the deaths themselves but also about the events that happened in the family preceding the death. This data also included information about who was sleeping with the child when the death occurred, how the child was found, what position the child was found in and if CPR was attempted.

Literature Review

This literature review addresses factors contributing to co-sleeping deaths. It also addresses the debate about the benefits of sleeping with the infant, which suggests that this helps in the development of the relationship between the caretaker and the infant. Several common themes emerged from the literature regarding co-sleeping deaths. The themes were Sudden Infant Death Syndrome (SIDS) and co-sleeping being referred to interchangeably, co-sleeping and Asphyxia, positive findings in co-sleeping, the strong likelihood of death while co-sleeping if the caretaker was overweight, the correlation between drug and alcohol consumption during pregnancy and infant death while co-sleeping, and the possibility of the infant overheating while co-sleeping which then causes death.

Co-Sleeping Infant Deaths

There have been minimal studies of co-sleeping infant deaths. Most of the research focuses on Sudden Infant Death Syndrome (SIDS). According to Alm (2007), Brant (2006), Denton (2008), and Kiechl-Kohlendorfer and Moon (2008), the diagnoses of SIDS was commonly suggested as the cause of death in many deaths where the child died

while the household was asleep regardless of where the infant was sleeping or if the infant was sleeping with another person. A review of this literature found that very few articles talked about infant deaths occurring while the infant was sleeping in the bed with another person. It is estimated that the percentage of co-sleeping deaths is much higher than reported because the cause of death was not properly reported or tracked.

There also seemed to be some disagreement in the articles on whether or not it is good to sleep with your child for nurturing purposes and continued to refer to possible infant deaths occurring while sleeping with another person as SIDS. According to Dr. J. McKenna (2007), from Pomona College, he will continue to encourage mothers to sleep with their infants and states that children tend to die more in cribs by themselves then with a parent in a bed.

Sudden Infant Death Syndrome and Co-Sleeping

Until 2006 co-sleeping deaths were referred to as cases of SIDS. It seemed that whenever an infant was found dead either in a crib or in a bed it was considered a case of SIDS. Currently there is an emerging suggestion, in Riverside County, that these cases should

be reviewed individually and identify the differences between a child dying alone in a crib and a child dying in a bed with another person. According to Brant (2006), The American Academy of Pediatrics (AAP) stated that "50 percent of sudden infant deaths occurred when infants shared a bed with adults. They blamed suffocation from fluffy pillows and entrapment between a headboard and mattress, as well as SIDS." She noted that "Parental smoking or drinking and co-sleeping can also be a deadly combination." Because of this revelation the "AAP came out against bed sharing, refusing even to provide safety tips for those who ignore its edict" (p. 3).

This article noted that decades ago it was normal for the infant to sleep alone in its own crib while the caretaker slept in another bed. Between 1993 and 2000 bed sharing with an infant more than doubled. A study that was conducted in 2003 by the National Institute of Health showed that 45 percent of infants were sleeping with their caretakers at some point throughout the night (p. 3) According to Brant (2007), the business of co-sleeping is "booming." She goes on to say that there is "such a growing demand" for products that would allow an infant to sleep in the bed with the caretaker without

rolling on to them that companies can not keep up with the demand (Brant, 2007).

Co-Sleeping and Asphyxia

Unfortunately infants can and do die while sleeping in various locations. Melissa Pasquale-Styles (2007) conducted a study in Detroit, Michigan from 2001 to 2004. This study looked at 209 cases of sudden or unexpected infant deaths. The ages of the 209 infants were between the ages of 3 days to 12 months. These cases were looking at the position of the infant at the time the caretaker realized the child was not breathing and then looked at potential risk factors for asphyxia including wedging, prone position, obstructions on the mouth or nose, bed-sharing, strangulation, blankets or pillows covering the infant and sleeping on couches. Of the 209 cases 178 of them found risk factors which would cause death.

This study helped to open the door to not calling all unexplained sleeping deaths SIDS and taking time to investigate to determine if cases are in fact SIDS cases or co-sleeping cases with other attributes which cause asphyxia. Of the 209 cases studied, 60 infants died in their cribs. One hundred and nine of the infants were placed in adult beds to sleep and of that 109, 92 of

these deaths were noted to be co-sleeping deaths. Twenty-five infants died after being placed on a couch to sleep and of these, 21, were co-sleeping deaths.

This research clearly shows that sleeping with an infant is a dangerous thing to do. It is not undisputed that an infant can accidentally die from other obstructions in a bed which cause asphyxia but it is also undisputed that co-sleeping is overwhelming noted as a cause of death in many of these cases (Styles, 2007).

Positive Findings with Co-Sleeping

According to Bower (1993), "Human babies may have evolved to sleep best-and perhaps most safely-when they snooze next to a parent rather than alone in a crib" (p. 1). In his article, he discusses a pilot study, completed by Dr. McKenna, to make his own argument that babies are better, physiologically, if they co-sleep with their caretaker. According to Bower (1993), Dr. James McKenna from Pomona College in Claremont, California, stated that co-sleeping could prevent infant death. He suggested that by mothers and babies sleeping together the babies can arouse themselves from prolonged breathing pauses that may cause SIDS. He also suggested that the mother and child continued to wake each other up during

the night which helps attribute to the idea of the safety.

Bower (1993) also stated, "SIDS rates rise sharply in societies where babies usually sleep apart from their parents" (p. 1). This, as we know now, is the difference between co-sleeping and SIDS. SIDS happens when a child is sleeping alone, be it in a crib or a bed or a couch, wherever the SIDS occurred the child died inexplicably, alone. This data does not further explain the differences in SIDS and co-sleeping and the alarming rate that infants actually died while in the bed with the parents and not alone which was never originally reported in all or most cases.

Caretaker-infant contact while seeping might be considered normal contact for some parents but it is in the manner in which it is conducted that appears to make co-sleeping safe or not.

Co-Sleeping Deaths and Overweight Caretakers

One interesting finding was that a heavier mother had a higher risk of having an infant die while co-sleeping.

According to Carroll-Pankhurst (2001), "Bed-sharing infants of mothers who weighed more than 79.5 kg (175

pounds) were more likely to die than bed-sharing infants whose mothers weighed less than 79.5 kg" (p. 13). Researchers gathered chart data on 84 infants who had died of SIDS in Ohio between the years 1992 to 1996. They compared age at death, whether the infant was in the bed with one or more caretakers, what the infants gender was, the infant's race, if the infant's mother smoked cigarettes during pregnancy, or if the mother used alcohol or drug during or after pregnancy, as well as the mother's weight. The study had some limitations that could have reduced the strength of the findings such as lack of a control group, being conducted in a single site area that was low income and a lack of direct information from the parents regarding the infant death.

Co-Sleeping Deaths and Sudden Infant Death Syndrome and Drug and Alcohol use and Cigarette Smoking During and After Pregnancy

A study was conducted to determine if there was a higher rate of infant co-sleeping deaths due to mothers using drugs or alcohol during pregnancy. According to Carroll-Pankhurst (2001), twenty five percent of infants that died while co-sleeping were born from mothers that used drugs or alcohol during their pregnancy. This study did not go on explain if the infant had previous

diagnosed or undiagnosed medical conditions which contributed to the deaths but it was a significant number of common findings to report.

Another interesting finding was the correlation between mothers smoking cigarettes and co-sleeping deaths. Joseph DiFranza (1995) stated, "It is surprising that the association between smoking and SIDS is not common knowledge" (p. 6). This article discussed three different groups of mothers that were compared for commonalities related to SIDS deaths. The groups were broken down into mothers who did not smoke, mothers who smoked during and after pregnancy and mothers that only smoked after pregnancy. The comparison found that the mothers who smoked during and after pregnancy were three times more likely to have a child die from SIDS than the other two groups. It was also noted that mothers that exposed infants to smoke after pregnancy had a higher rate of SIDS then the mothers that did not smoke at all.

Co-Sleeping Deaths due to Overheating caused by Co-Sleeping

One concern regarding infants sleeping in their parent's bed is the possibility of overheating. According to Ball (2002), an infant sleeping with a parent had a

higher core temperature than infants that slept alone. It is possible that this rise in temperature helped contribute to the demise of the infant. This article speaks about the possibilities of the core temperature of the infant rising while in the bed with the parent and that this is what causes the unexplained death of the infant. This article reported on a study that took 20 pairs of parents and infants and studied their sleeping patterns throughout the night. The infant was studied both with their parent and by themselves. This study lasted three nights and the infants were monitored by rectal temperature, oxygen saturation, pulse rate, and respiratory movements. However, the findings did not support the study's idea. There were no differences in the temperatures of the infants that slept with their parent and those that slept alone. The report stated that the deceased infants were usually found to be unresponsive in the mornings when the adults woke from their sleep. It was difficult to determine the infant's temperature in all cases because the time of death for each infant varied. Some infants died several hours before the adult was aware and therefore Riga mortise would have begun to set in and would make determining the

temperature difficult. This study was only conducted on living infants and appeared to be an idea based purely in theory.

Theoretical Orientation

It is the belief of this researcher that more infant co-sleeping deaths occur in homes where there is drug and alcohol use than in home where these things are not present.

Several theories about infant death when co-sleeping emerged from the literature review such as the weight of a mother, the smoking habits of a parent or the babies' body core temperature. The purpose of the study is not to discuss the emerging theories but to examine and formulate our own theories about these deaths.

Sudden Infant Death Syndrome (SIDS) appears to be a theme that is continuously focused on in these studies. It would appear that SIDS was a label that was given to cases where the infant death was unexplainable. This research project looked for other factors that could be causes of these deaths and not just identify them as SIDS. Throughout the data gathering process the idea that continued to emerge in cases where there were no apparent outward injuries to the child and the child appeared to

have just died while in their sleep, many law enforcement agencies, as well as coroners, were quick to call an otherwise unexplained infant death a case of SIDS. No investigation was conducted as far as measuring other factors that might have attributed to the deaths.

This research looked at several factors associated with these deaths including the age or the parents, birth order of the deceased infant, age of the infant at death as well as domestic violence in the home, criminal history and drug use, alcohol use and cigarette smoking.

The research on this topic proved to be important for Riverside County. There have been many deaths due to co-sleeping in this county and the numbers continue to rise. This research and this study have helped guide investigations in homes where infants are sleeping in the same bed as their caretakers or their siblings. This study also provided a guide for social workers to use when assessing the safety of infants in the home when these aforementioned factors were prevalent.

Potential Contribution of Study to Micro and Macro Social Work Practice

This study contributed to social work practice on a micro and macro level.

On a micro level this study helped provide a more in-depth look at what is happening in the homes where infants are dying in Riverside County. This study was designed to define emerging factors in homes where infants have died while co-sleeping. It provided a checklist of factors that can be assessed in the home with the family prior to an infant dying. This checklist can be utilized in the field by social workers as well as law enforcement officials.

It was anticipated that this study would become a guide to show that there are commonalities in the homes where infant deaths due to co-sleeping have occurred and perhaps intervention services could be provided thus possibly saving the lives of the children in this community. Once the study was complete all of the information was given to both law enforcement agencies as well as child welfare agencies along with a checklist that provided what the study uncovered and what to look for in the homes where an infant death is being investigated. This checklist included both the qualitative and quantitative data collected in this study and outlined the emerging commonalities in each home.

On a macro level this study was presented to the Riverside County Child Death Review Team for review by several of its key members from the District Attorney's Office, to law enforcement officials as well as the Regional Manager of Child Protective Services. Members of each agency were given the opportunity to review their current practices regarding infant deaths and incorporate changes or ideas suggested in this study. This study was able to provide information, otherwise not known, to the members of the agencies. The commonalities identified were a stepping stone for all the agencies involved to change the way they conduct investigations regarding co-sleeping deaths. These deaths are preventable and this study was able to identify how they can be prevented thus guiding agencies to possibly save lives.

Summary

This chapter discussed the research focus of this study. The focus is finding commonalities such as drug use, domestic violence, criminal history, age of parent and age of infant when the death occurs in Riverside County that contribute to incidents of infant death in co-sleeping. The paradigm for this research has also been

discussed in this chapter. This research will take a positivist approach. Last, this chapter discussed previously written literature about infant deaths and co-sleeping as well as why this research is so important to the practice of social work and the protection of infants in the community.

CHAPTER TWO

ENGAGEMENT

Introduction

This chapter covers key aspects of this study such as the engagement strategies and how the researcher prepared for the study. This chapter will also looks at how issues of diversity, ethics and politics were addressed.

Engagement Strategies for Each Stage of Study

Research Site and Study Participants

The research site for this study was the Riverside County Child Death Review Team as well as Riverside County Child Protective Services. The research sites provided unidentified information regarding children that died as a result of co-sleeping from the year 2003 to current. From those records the researcher was able to measure how many commonalties were discovered in each incident.

The researcher first had to engage the Regional Manager at Child Protective Services about the idea of this study. A meeting was held at the Riverside County Child Protective Services office in Moreno Valley. The

researcher engaged the Regional Manager by discussing the increasing amount of co-sleeping deaths reported in Riverside County over the past eight years and the need for the study to discover what was happening in these homes where these deaths were occurring. The study idea was accepted and it was decided that this researcher would become a member of the Riverside County Child Death Review Team in order to gain access to all the data provided by Child Protective Services, The District Attorneys Office as well as The Coroners Office.

This study did not require human study participants. The idea of this study was to look at data and make comparisons with the families where incidents of co-sleeping deaths had occurred. In essence, the study participants were the records and files contained information necessary to conduct this study.

Engagement Strategies

The researcher spoke to several people at both the Child Protective Services study site as well as members of the Child Death Review Team. The engagement process included speaking to the Child Death Review Team and Child Protective Services key stakeholders involved through emails as well as making several telephone calls

to engage the study sites and set up meetings. Then the researcher met with key stakeholders for the study sites and gained access through explanation of the need for this study for Riverside County. The purpose of this study was to provide indicators for social workers to help minimize the incidents of co-sleeping deaths in Riverside County.

The researcher spoke to the key stakeholders about the hopes of this study and gained entry into the study sites. The researcher engaged members of the Child Death Review Team which included District Attorneys, law enforcement officials as well as coroners. The researcher also engaged the Regional Manager for Child Protective Services for this study. This happened by meeting with the team and discussing the reason for the need for this study as well as the benefit Child Protective Services would have from the study. This study provided a multitude of statistical data about the increase in co-sleeping deaths in Riverside County. The Child Death Review discusses deaths cases where the child resided in Riverside County and the researcher was able to be provided a statistical cross reference from the associate members of the Child Death Review Team that had not yet

been studied. The Child Death Review Team conducts a study every year about all the death sin Riverside County but they had not yet conducted a study that crossed several years and focused only on one type of death.

This study did not require engagement of study participants. This study only required the engagement of the study sites (Riverside County Child Protective Services and the Child Death Review Team) and the key stakeholders (members of the Child Death Review Team and the Regional Manager for Child Protective Services).

Self Preparation

This study subject was a very sensitive and disheartening thing to read about. These are people who knowingly or unknowingly put their children at risk of death by sleeping with them in the same bed. The researcher had to prepare herself for reading and researching children's deaths. The researcher was able to process the information and then speak to the key stakeholder about the information to debrief. The Child Protection Regional Manager as well as past members of The Child Death Review Team were available to process and

discuss findings as well as answer questions about unclear data.

There were several cases where the caretakers were under the influence of controlled substances when the children were sleeping with them and it was possible those children could still be alive today. It was also noted that some of the cases were accidental and the loss suffered by the family was unbearable. This was very difficult to read about and the researcher had to be able to speak to someone to process the information.

Diversity Issues

The researcher in this study was looking for diversity issues. The study compared ethnicity, culture, gender, age and other characteristics. Because the researcher was looking at data there was no face to face diversity issues the researcher had to deal with.

It was anticipated that there would be many diversity issues the researcher would find. It was those issues that were compared in this study so diversity was anticipated, expected and welcomed. It was anticipated that several old cases that were determined to be SIDS cases would in fact be co-sleeping cases. This then would

possible lead to the potential of re-opening previously closed cases to determine if the children were in fact sleeping alone or sleeping with someone at the time of their death. Once this was resolved then it could possibly mean re-opening the case to distinguish if negligence actually played a roll in the child's demise.

Another anticipated issue was that of a cultural one. For example the Latino/Hispanic culture tends to co-sleep with their children more than any other culture. This is a generational practice and is done to promote the closeness of the family and the bond of the infant with their new family. The researcher was able to speak to several different women with infants from various cultures and the reoccurring theme within the Latino/Hispanic culture was that the family sleeps with the infant to encourage bonding.

Ethical Issues

This study used secondary data therefore ethical issues associated with face to face interviews were not an issue in this study. The identity of the subjects remained confidential and the information was more of a

statistical procedure rather than a personal journey by a study participant.

The other ethical issues were associated with the people that were involved with the investigations. Most of the cases in the early 2003 and 2004 subjects were thought to have been quickly investigated by both law enforcement as well as Child Protective Services. It was understood throughout the course of this study that there was very little information about co-sleeping in those years and so an unexplained infant death was acceptable due to the sensitive nature of the investigation alone. First, the investigation was about a dead infant, which that alone caused, and still causes, people to have a skewed judgment. Then you add to that the grieving family and it is easier to label the case as SIDS and move on. As the study progressed investigations became a little more intrusive and some even resulted in arrests for negligence on the part of the parent. This was not seen in the earlier cases.

The morality issue of this study was to not do the study at all. There are a multitude of these cases in Riverside County and it would not have be morally correct to not try to find the similarities in these homes and

report on them to help prevent future child co-sleeping deaths.

These issues were dealt with by the researcher, key holders as well as the faculty supervisor from the University. The researcher had to continue to check in with not only themselves but with key holders and the faculty supervisor.

An example was the researcher found that a higher percentage of child co-sleeping deaths happen in a certain ethnic group. The researcher had to make sure to not hold onto to this information and turn it into a bias against that particular ethnic group. It was important to discuss this information with all involved in the study and then to remember that only one county is being sampled which is not an accurate representation of an entire ethnic group. This study was designed to find the similarities in this county to help prevent future co-sleeping deaths not to single out an entire ethnic group and blame them for all the cases. It was not the purpose of the study to label any particular ethnic group. It was the purpose of the study to gather the information and report in an unbiased manner.

Political Issues

Political issues were not anticipated for this study. The "gate keepers" were the only people interacting with the researcher. The study participants were only documents and written historical facts. So, as long as the researcher did not divulge any identifying information about the families and reported correct information there were not any political issues within the study. One issue that came up when the information was present to individuals associated with the Child Death Review Team was the mislabeled cases of SIDS and how law enforcement agencies would not be happy to hear that they made mistakes when investigating deaths in the earlier cases. It was recommended that the researcher present the information in a way that was not abrasive or judgmental but more informative so the same errors would not be repeated. The researcher was cautioned about approaching the group by presenting old mislabeled cases as wrong but rather to present them as cases with possible alternatives for finality of the case rather then to just have labeled it SIDS when other evidence clearly stated that is was not a SIDS case. The researcher felt that presenting the information found in

the study in a positive way would be more beneficial to not only the team but to the researcher herself. Most of the law enforcement officials that investigated these earlier cases are now hold positions of authority and have aspirations for political gain. This was made clear and the researcher thus followed the advice the information was taken well and open dialogue happened once the information from the study was provided.

Summary

This chapter discussed key aspects of this study such as the engagement strategies and how the researcher prepared for the study. This chapter also discussed how issues of diversity, ethical issues and political issues were addressed.

CHAPTER THREE

IMPLEMENTATION

Introduction

This chapter describes the implementation of the study. It includes descriptions of the research site and study participants, selection of participants, data gathering, phases of data collection and data recording.

Research Site and Study Participants

The research site for this study was the Riverside County Child Death Review Team, which meets once a month to discuss all child deaths in Riverside County. The study participants chosen for this study were from cases discussed at these meetings.

Research Site

The research site for this study was the Riverside County Child Death Review Team, which is located in the Coroner's office in the city of Perris, as well as Riverside County Child Protective Services, located in the city of Moreno Valley. Each site holds information related to child deaths in Riverside County. Both of these sites have a vested interest in the safety and well-being of children in Riverside County because both

sites have noted an increase of co-sleeping deaths beginning in 2003.

The Child Death Review team meets to talk about every child death in Riverside County. This is where a discussion happens to determine if there was negligence on anyone's part when the death happened. The Child Death Review Team leader has a list of all deaths for each month and each case is discussed. Child Protective Services is notified about every child death in Riverside County. The purpose of the team meetings is to ensure that those responsible for the non-accidental death of a child are prosecuted to the fullest extent of the law.

Co-sleeping deaths are discussed at the meetings and each of the disciplines in attendance, provides additional information if additional information is available.

Study Participants

The research sites provided a secondary data set with unidentified information on children that died as a result of co-sleeping from the year 2003 to 2008. The data included family information, age of the child, ethnicity, drug history, criminal history, household composition, and verbal accounts of what happened in the

home at the time of the death from both the investigating law enforcement official as well as the family. From those records the researcher was able to measure how many similarities were discovered in each death. The study also looked at cases that were determined to be SIDS to see if the labeling of SIDS was correct or if elements of co-sleeping were present when the death occurred. It was determined that several cases previous, were in fact, co-sleeping cases. The data clearly gave descriptive details about not only where the child was sleeping in the house but where the child was sleeping in the bed.

The cases that were studied were cases where law enforcement was notified about a child death and it was then determined by all the members of the team, including the coroner, that the death was a result of co-sleeping or SIDS. Looking at the documentation was a key element in determining what the differences were between the co-sleeping cases and the SIDS cases.

This study looked at data and extracted information from the files. In essence, the study participants were the records and the files, and those records and files contained information necessary to conduct this study.

The Child Death Review Team meets and shares information under the California Penal Code Section 11174.32-11174.35 which allows information about child deaths, accidental or otherwise to be public information for members of the Child Death Review Team. In order for this information to be considered public information there must be a review team that comes together to discuss the cases. It was because of this penal code this researcher was able to become a member of the team and allowed access to the data.

Selection of Participants

The focus of the study was to look at cases of co-sleeping deaths and find the similarities between them and determine if these deaths were preventable. The researcher used a qualitative approach to data gathering. The researcher used Maximum Variation Sampling as a sampling strategy for this study. According to Morris, "This sampling strategy identifies the diversity of experiences with a social phenomenon and gives in-depth descriptions of unique cases as well as any important shared patterns that are common to diverse cases" (p. 92). The cases for this study were selected from the

Riverside Child Death Review Team from the year 2003 to the year 2008. The cases chosen were based on a medical professional stating the child in the home was a victim of a co-sleeping or SIDS death. There were 63 cases from 2003 to 2008 where the child's cause of death was listed as co-sleeping or SIDS. The researcher did not intend to look at SIDS cases, however, when selecting the cases for the study the researcher came across several cases listed as SIDS where the child was clearly described as sleeping in the bed with someone else at the time of their demise. Therefore, this study included children that died as a result of co-sleeping as well as SIDS.

According to the U.S. Census Bureau, there are 2,100,516 people living in Riverside County. 566,040 of these people are children under the age of 18. There have been over 600 child deaths since 2003. This study looked at 63 cases involving the death of a child labeled co-sleeping or SIDS deaths. Of these 63 cases, 33 identified themselves as Hispanic, 21 identified themselves as Caucasian, 6 identified themselves African American, and 3 identified themselves as other. Of the 63 cases studied 55 of the children that died were under the age of 2 months. There did not seem to be a distinction

on gender. There were a total of 63 SIDS and co sleeping deaths, 31 were males and 32 were females.

The following table displays the demographic information about the cases that were used for this study.

Table 1. Demographics of Families

Variables N = 63	Percentages
Ethnicity:	
Caucasian	33%
African American	10%
Hispanic	52%
Other	5%
Gender:	
Male	49%
Female	51%
Age of Child:	
0-2 months	87%
2-4 months	7%
4-6 months	3%
6-8 months	3%
8-10 months	
10-12 months	
CPS HX:	
Yes	76%
No	24%
Other children in home:	
Yes	79%
No	21%

Data Gathering

The researcher used law enforcement records, CPS records, and district attorney records for this study. The information in the records was collected by reviewing each co-sleeping and SIDS death. The researcher used "historical comparative research" and "narrative case studies" (Morris 2006, p. 53). For this study the researcher looked at medical records, death record, police reports and Child Protective Service reports to find data to compare each case of co-sleeping or SIDS deaths. The Child Death Review Team is notified of every child death in the county. The team is also informed when a child that resides within the county is killed in a different county or state. The information about a child death is received and in most cases, CPS as well as law enforcement will go to the home to investigate. The information is then passed on to the District Attorney's office for further investigation. Part of the D.A.'s investigation includes gathering at the Child Death Review Team meeting and discussing the cases. A representative from each agency keeps notes, records, and all of the information about each death. Usually the Deputy District Attorney has the master list of cases and

a notebook of police reports, medical reports, witness statements, and anything else considered important to the case. The documents are shared with the other agencies so everyone has the same information. This researcher was allowed to view the information contained in both the Deputy District Attorney's files as well as the Regional Manager's files from Child Protective Services.

While the researcher was examining the data about co-sleeping deaths, several cases of Sudden Infant Death Syndrome (SIDS) emerged. SIDS is different from co-sleeping in that SIDS happens when a child is sleeping alone, and he or she dies in his or her sleep. Several of the cases studied listed the child's death as SIDS even though the child was found in the same bed with a parent or other family member. This researcher sees co-sleeping deaths and SIDS deaths as two different categories. While SIDS remains an unexplainable phenomenon, and no concrete instructions have been formulated to prevent SIDS from happening, co-sleeping deaths are preventable. To prevent co-sleeping deaths, a child must sleep alone in the bed or crib.

Once the qualitative data about the co-sleeping deaths and SIDS cases were collected, it was used to

determine what similarities were happening in the homes where children had died. This data looked at conversations between law enforcement and family members about the death of the child. These conversations were coded and then examined to determine the similarities in the homes where the deaths occurred.

Phases of Data Collection

Since this was secondary data, the researcher began the data collection using open coding to determine the common themes or similarities in the data. The data collection began with cases of co-sleeping deaths. The next phase was to look at cases where children were killed as a result of co-sleeping and the involvement of drugs or alcohol. The researcher also examined sleeping positions. Another area studied was the number of children living in the home. The information about other children would help establish historical or familial reasons of why the parent slept in the bed with the child. The researcher was looking for data on whether parents co-slept with other siblings in the home; if so, what was different about this child that it did not survive while its siblings did?

Once this data was collected, the researcher looked at different categories in each of the above mentioned cases. The categories included gender, ethnicity, criminal history, prior child abuse reports, the number of children in the home, income level (if applicable), drug use, domestic violence, education, employment status, family support, and marital status.

This study randomly picked numbers to assign to each category of data. The numbers, in no way, represented a numerical value to the category being studied.

A data extraction instrument was used to collect data in this study. The researcher used a grid type of diary to keep a numeric tally of each of the categories. There were six separate extraction sheets categorized by the year the death occurred (See Appendix).

Data Recording

All of the data was recorded into a chart as well as a notebook. These were used to store information so the researcher could look for similarities between cases. The researcher read each case and wrote down specific information about the case in columns. A column was identified as ethnicity. Another column was listed as

gender and so on. The researcher then continued to read through the cases using the columns to identify information pertinent to the study.

Analysis Methods

In order to understand the interpretation of the study, one must understand the use of open and axial coding and the significance of using these forms of coding as a source of data examination. Open coding is, "the first stage of qualitative analysis for grounded theory in which narratives are grouped into categories of information" (Morris, p. 289). This means the researcher looked at the data and extracted common statements about the co-sleeping death. These statements were then connected to one another using axial coding. Axial coding is, "the second stage in qualitative analysis for grounded theory in which relationships between themes or categories are proposed; these relationships are tested in further rounds of data gathering" (Morris, p. 285).

Summary

This chapter covered several aspects of the study such as the research site and study participants,

selection of participants, data gathering, phases of data collection and data recording.

CHAPTER FOUR

EVALUATION

Introduction

This chapter reports and interprets the findings of the study. These coding procedures are explained as well as the process of theory development and understanding the implications of this theory for micro and macro social work practice.

Data Analysis

This study used a post positivist qualitative data analysis. The researcher used codes to develop themes in the data. Open codes were used to identify words and responses documented from interviews. After the open codes were constructed, the researcher used axial coding to develop connections and link together commonalities in the language or words used in the interviews. These connections were used to construct the theory of co sleeping deaths.

Open Coding

According to Morris (2006), "In the early stages of analysis, grounded theory researchers carry out

microanalysis. This initial process is used to develop a routine practice analysis data with a frame of mind that is open to all potential interpretations. The researcher may scan a narrative of an interview, for example, and pick an interesting segment" (p. 113).

The interpretation of the data for this study revealed that ongoing substance use in the home by the caretakers, caretakers being under the influence of substances the night of the child's death, and sleeping positions were reoccurring open codes.

Ongoing Substance Use

This study defines ongoing substance use as the continual and habitual use of illegal substances throughout the life of the child by the caretaker of the child. There were 63 cases of child deaths studied from the year 2003 to the year 2008 in Riverside County. These 63 cases included identified cases of SIDS and co-sleeping deaths. Of the 63 cases studied, 18 admitted to ongoing substance use in the home with the child. Case number 22 stated, "mother used methamphetamines throughout the pregnancy and the father had a continual and habitual issue with the use of methamphetamines." Case number 13 stated, "father continually tested

positive for methamphetamine throughout the investigation." Case number 42 stated the mother admitted to, "using marijuana daily and drug paraphernalia was found in her apartment."

This code emerged because it was continually talked about in the interviews and appeared to be an ongoing issue for the caretakers.

Under the Influence at the Time of the Child's Death

This study defines under the influence at the time of the child's death as simply the caretaker of the child being under the influence of illegal substances at the time of the child's death. This category is different from ongoing substance use in that in this category the caretaker was administered a drug test on the night of the death and the test revealed positive findings. Some of the individuals in the ongoing substance abuse category were not defined as being under the influence as they were not administered a drug test and they did not reveal substance use at the time of the child's death.

Each case examined by the researcher, the caretaker either admitted to being under the influence of a substance or had a positive drug screening. Case number

11 stated, "The mother was under the influence of drugs and while coming down off the methamphetamines she fell asleep and rolled over on her son." Case number 46 stated, "The father lay on top of the child while coming down off methamphetamines and tested positive for methamphetamines." Case number four, "the mother admitted to lying down with the baby while under the influence of methamphetamine, drug test revealed methamphetamines in the mother's system." Case number 22 stated, "Mother and father were under the influence of methamphetamines at the time of the child's death."

This code was significant in that it revealed to the researcher the deaths that occurred while the caretaker was under the influence could have been prevented. This code emerged as a major open code in the theory of why these deaths happen.

Sleeping Positions

As mentioned previously, there was also the emerging theory of SIDS. The researcher has clearly defined the difference between co-sleeping and SIDS; however, there were many reported cases of SIDS and co-sleeping deaths with overwhelming data about sleeping positions. This

data could not be ignored and warranted further investigation.

The similarities in sleeping positions of the child in both types of deaths were remarkable. The researcher continued to see the same description of the sleeping position and felt it was a strong enough piece of data to become a third open code.

Of the 63 cases studied, 36 described the sleeping position of the child. Of the 36 cases, 20 stated the child was placed facedown, 8 laid the child on their back and 8 laid the child on the left side. There was not a single report of a child in any of the cases studied being laid to sleep on their right side.

The findings about sleeping positions lead to the question of whether sleeping positions contribute to the death of a child. Unfortunately, there did not appear to be enough evidence to say concretely that sleeping positions contribute to the death. It was, however, significant to report the fact that not one child death interview reported the child was laid to sleep on their right side. The researcher does not believe this is enough proof to say that sleeping a child on their right

side will prevent a co-sleeping or SIDS death, but it is definitely significant enough to report on.

Axial Coding

Axial coding is the "procedure for linking emergent categories and making statements about the relationship between categories and their dimensions" (Morris, 2006, p. 115). Ongoing substance use, substance use the night of the death of the child and sleeping positions all emerged as theories of why co-sleeping deaths and SIDS happen in homes. Once these theories were identified, the researcher used axial coding to connect the theories to formulate concepts of why these deaths occurred.

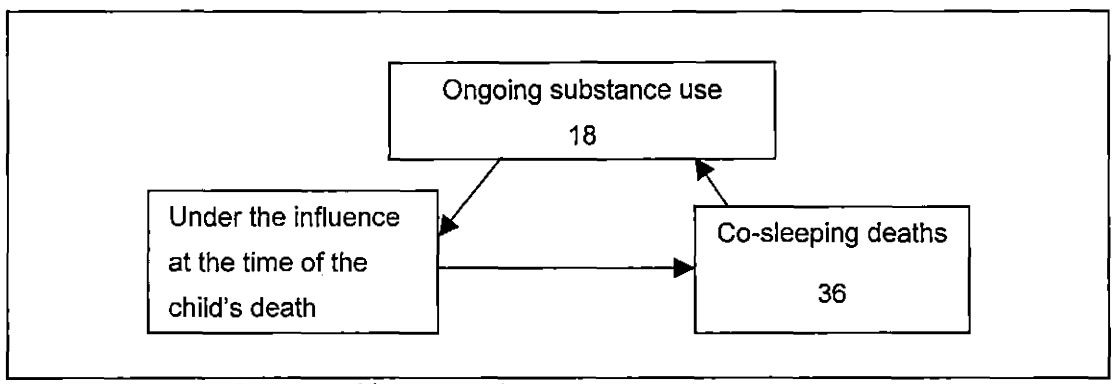

Figure 1. Axial Coding: Substances

The chart in Figure 1 demonstrates the connections between ongoing substance use, substance use the night of

the child death and the death of the child in co-sleeping cases. Once the data was examined and the axial codes were developed, it was easy to see at least 18 of these cases were clearly preventable deaths. The use and abuse of substances directly related to the deaths of those children.

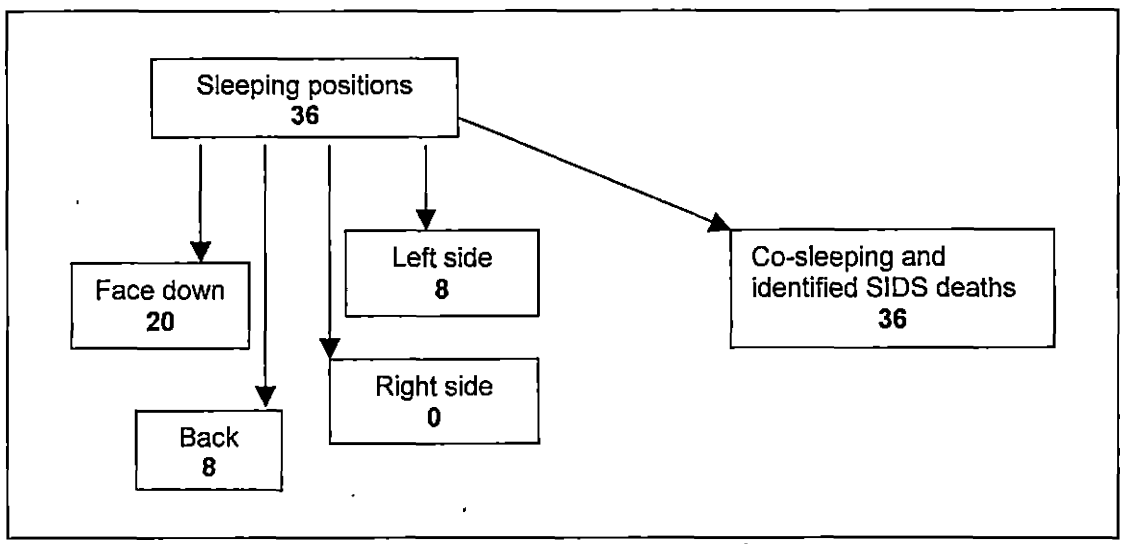

Figure 2. Axial Coding: Sleeping Positions

The chart in Figure 2 demonstrates the connections between sleeping positions the night of the child's death. The chart clearly shows lying a child face down has a higher rate of death than any other position. The chart also demonstrates not one child was reported lying on their right side at the time of death. While the face

down sleeping position emerges as a strong indicator of child death, adversely, it does not appear to be a strong indicator a child will not die if they are placed on their right side as the data might suggest. This suggestion would have to conduct an independent study about sleeping positions to clearly state if less deaths occur when the child is placed to sleep on their right side.

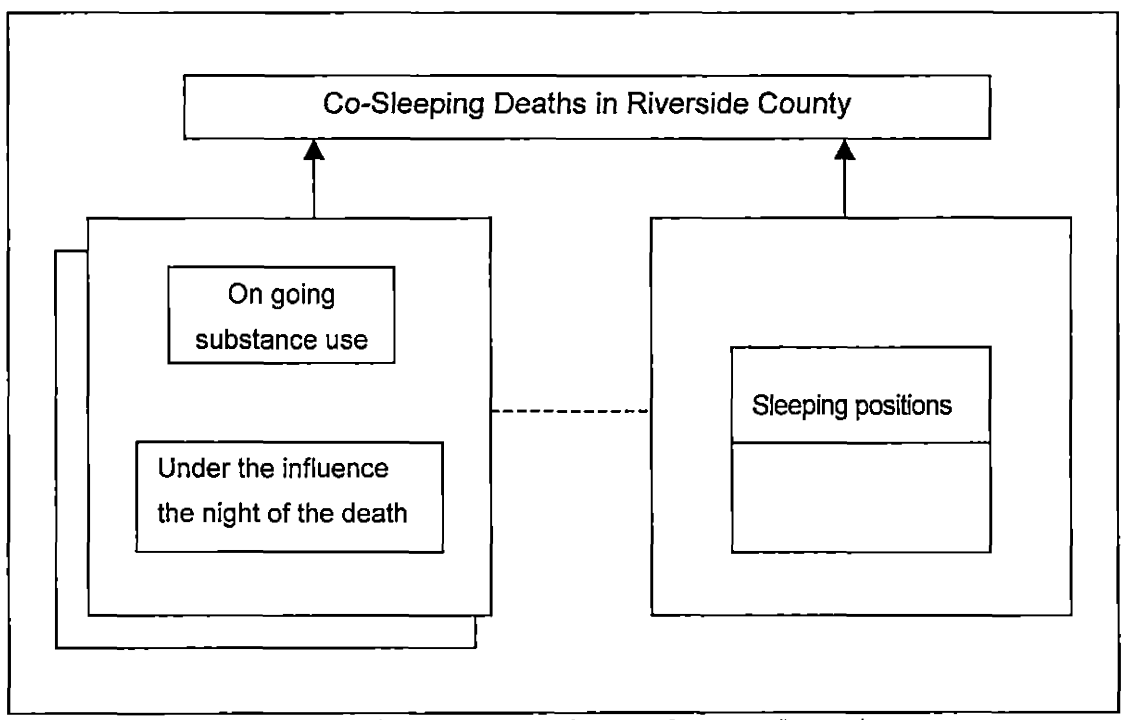

Figure 3. Axial Coding: Theories of Co-Sleeping

Theories

This data revealed three emerging theories that developed with the open codes in the co-sleeping category. One theory was ongoing substance use contributed to the co-sleeping death, the second was substance use the night of the death of the child contributed to the co-sleeping death, and the third was the sleeping position of the child while in the bed contributed to the co-sleeping death. These three theories help one understand what happens in a home where a co-sleeping death has occurred. This research clearly defines two processes that can lead to co-sleeping deaths are ongoing substance abuse and substance abuse the night of the child death.

Sleeping positions continued to emerge in this study. While nothing definite can be said about the connection of sleeping positions in these cases to the deaths of the children, it is still important to list the sleeping positions as a possible theory of why these deaths occur. Further research in this area would be necessary to determine if the sleeping position of the child in the bed with the parent makes a difference to the child's survival.

Research still indicates sleeping with your child is a healthy and nurturing practice; however, the theories revealed in this study show that this is an unhealthy and detrimental practice when the caretaker is an ongoing and habitual substance user or if they are under the influence of substances at the time of the child's death. The emergence of these two theories can argue that co-sleeping deaths are preventable when and if substance use or abuse is an issue in the home.

Implications of Findings for Micro and Macro Practice

From a micro social work perspective, this study will contribute to more thorough investigations in homes where there are infants with bed-sharing and drug use happening. If a social worker can see these factors in a home and recognize them as dangerous combinations for the child's health and well being, then perhaps on a micro perspective this study can help prevent another senseless co-sleeping death. With regard to the information about the sleeping positions, perhaps a social worker could educate the caretakers with this information so the caretakers could make informed decision about how and where to put their child when it comes time to sleep.

This study could also help formulate interventions and strategies so the social worker can uncover all the factors within the family dynamics, including ethnicity, cultural, class, and other relevant information discussed in chapter three about the selective participants. This information can then be used so a child death could be prevented by using the family strengths and cultural values.

On a macro level, the Child Death Review Team reviewed the study and perhaps will use the information mentioned above to better train first responders. These responders need to be educated to not move the child's body when they arrive at the home. If for some reason the body is moved, they must properly document all information relevant to the case including where the child was sleeping, who the child was sleeping with and if the caretaker was under the influence of any substances. On a macro level, Riverside County needs to have correct information about co-sleeping, so it can continue to be filtered to the public as being a dangerous practice. The researcher spoke to several people about this study that openly said they do not

believe co-sleeping to be dangerous, and they sleep with their children now and will continue to sleep with them.

Co-sleeping deaths are a phenomenon that are increasing monthly and the public needs to be made aware that co-sleeping with a child can be fatal and these fatalities are preventable.

Summary

This chapter discussed the data and the analysis of that data. The researcher used data from cases of child deaths from 2003 to 2008. These cases were labeled co-sleeping deaths and upon further review they were also listed as SIDS cases. The researcher discovered substance use and abuse contributed to the deaths of 18 children. The researcher discovered data within the context of the cases about sleeping positions of the infant, whether they were placed in a bed by themselves or if they were in a bed with someone else.

Finally, this chapter discussed the macro and micro social work implications when working directly with these families and when training to work with these families. Both the macro and the micro implications are important

to help prevent these senseless deaths from continuing in Riverside County.

CHAPTER FIVE

TERMINATION AND FOLLOW UP

Introduction

This chapter will discuss how the researcher communicated the findings of the study to the participants, the termination of the study, and the ongoing relationship with the study participants.

Communicating Findings to Study Site and Study Participants

The researcher communicated the findings of the study to the members of the Riverside Child Death Review Team which included law enforcement officials, Deputy District Attorney's, the county coroner, and the Regional Manager for Child Protective Services. The meeting took place at the Riverside County Coroners office in Perris. Copies of the findings were distributed to all members and a question and answer session took place during the meeting. At the meeting the members were given an opportunity to speak to the researcher in a public or private setting if necessary. None of the members felt it necessary to speak to the researcher further and

commented that the data and findings were explained and detailed in the handouts and the meeting was adjourned.

Termination of Study

The termination of the study took place at the aforementioned meeting. The study participants were files and reports and not live participants therefore termination of the study took place with the members of the Riverside Child Death Review Team. The study was conducted to find the similarities in cases of co-sleeping deaths. The study was completed and the information was documented as well as verbally conveyed to the agencies involved in the study. Once those tasks were completed the study was terminated and the agencies involved were informed of the conclusion of the study.

Ongoing Relationship with Study Participants

The study participants were files and documentation therefore there was no ongoing relationship with the study participants. There was, however, an ongoing relationship with the agencies involved with the study. The information about the study was conveyed to the different agencies throughout the study and the researcher continued to provide updates to the agency

members. When the study was completed there was no ongoing relationship with the study participants or the agency members. The information gathered in the study was conveyed to the members and once the members finished with their questions about the study the relationship was terminated.

Summary

This chapter discussed how the researcher communicated the findings of the study to the participants, the termination of the study, and the ongoing relationship with the study participants.

APPENDIX

DATA COLLECTION INSTRUMENT

	Gender	Ethnicity	Crime HX	Abuse rep	# of child	Income	Drug HX	DV	Education	Employ	Family sp	Marital
#1												
#2												
#3												
#4												
#5												
#6												
#7												
#8												
#9												
#10												
#11												
#12												
#13												
#14												
#15												
#16												
#17												
#18												
#19												
#20												
#21												
#22												
#23												

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