

INFANT SAFE SLEEP

Dayton's Story

Canton, OH



I was first advised to bed share, or sleep with my baby, when I was pregnant with my first child, Malayah. I was told by the pediatrician that it promoted bonding and breast feeding. I bed shared every night with Dayton, just as I had done with Malayah. I used a firm mattress on the floor with no excessive bedding or pillows. I was not obese, drunk, high, or under the influence of medication. I was simply asleep. But on the morning of October 27, 2002, I awoke to the screams of my mother-in-law, "You're laying on top of the baby!"

I close my eyes for a moment and that morning comes rushing back, as if it were yesterday. I was lying on top of my baby. My shoulder was pressed against Dayton's face. His lips were slightly blue. I immediately picked my baby up and began CPR, while chaos erupted in my home. I shut down emotionally in order to focus on breathing existence back into my child. I tried so very hard to save this little life to no avail. The ambulance arrived and in a flash my son was gone. How could this happen to me? To my son? How could this happen?!?

We arrived at the hospital and were told that our son, Dayton, could not be resuscitated. In the blink of an eye we were thrown into a nightmare. I had to do things that I always thought my children would have to do for me, years down the road. Choose a casket, decide what my precious little one would wear to be buried in, and somehow figure out what cemetery plot would be the appropriate place to bury my first born son, along with all of the hopes and dreams I had for his life. I was left standing next to his tiny grave, and with each shovel of earth that was tossed upon his casket I felt a stabbing pain in my chest, as if someone was cutting my heart out with a jagged knife and burying it with my child.

Along with the grief that comes with the loss of a child, I am also burdened with the knowledge that my son's death was 100% preventable, and that he suffocated under MY shoulder. I have said to myself and others countless times, "If only I had heard about this happening. I wish someone would have told me."

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I share my story of the loss of my precious Dayton in the hopes of saving another baby. If I can save one baby, just one, from death, save one other family from going through this hell, then to me it is more than worth the criticism and reluctance that I am met with at times. I don't ever want another parent to have to say "I wish someone would have told me."

Story told by Dayton's mother, Lisa.

Infant deaths due to suffocation result when the child is in a place or position where he or she is unable to breathe. The majority of these suffocations happen to infants while they are in unsafe sleeping environments.¹

HOW DOES IT IMPACT THE U.S.?

- In 2010, 977 infants² died as a result of unintentional suffocation.³
- More than 105,000 infants sustained injuries as a result of unintentional suffocation between 2001 and 2011.⁴
- In a single year, infant suffocation injuries and deaths cost the U.S. more than \$936 million dollars in medical costs and lost productivity.⁵

HOW DOES IT IMPACT OHIO?

- Suffocation is the leading cause of injury death for infants in Ohio. In 2010, there were three sleep-related infant deaths every week.⁶ Infant sleep-related deaths accounted for 14 percent of the 1,044 total reviews of infant deaths by Ohio's Child Fatality Review Boards in 2010, more than any single cause of death except prematurity. Most of these sleep-related deaths were deemed preventable.⁷
- From 2006-2010, sixty percent (499) of sleep-related infant deaths occurred in adult beds, on couches or on chairs. Bedsharing was a commonly reported circumstance for sleep-related deaths. Sixty-two percent (514) of sleep-related deaths occurred to infants who were sharing a sleep surface with another person at the time of death.⁸
- In one year, infant sleep-related fatalities cost Ohioans more than \$51 million in medical care and productivity loss.⁹

HOW DO WE ADDRESS THIS PROBLEM?

- Most infant suffocation occurs in the sleeping environment. Infants should be placed on their backs to sleep in bare cribs that meet safety standards of the Consumer Product Safety Commission (CPSC) and the Juvenile Products Manufacturers Association (JPMA).¹⁰
- Lack of education regarding safe infant sleep practices is an important risk factor in infant sleep-related death. Receiving this information early is especially important because 87 percent of Ohio sleep-related infant deaths in 2010 occurred before six months of age.¹¹ To address this lack of uniform education, five states have laws requiring the distribution of infant safe sleep educational materials to parents or caregivers upon discharge from the hospital following their infant's birth.^{12 13}
- Often parents do not realize that products such as crib bumper pads, which attach inside the slats of cribs, create a potentially deadly environment for infants. Researchers reviewed data from 1985-2005 and found 27 deaths of children, ages one month to two years old, attributed to suffocation or strangulation by bumper pads or their ties. The researchers concluded that all retail bumpers had hazardous properties and should not be placed in cribs or bassinets.¹⁴ In October 2011, the American Academy of Pediatrics recommended that parents refrain from using crib bumper pads because of the increased risk of suffocation, strangulation and entrapment.¹⁵ In June 2013, Maryland became the first state to ban the sale of these unsafe products and a similar ban is currently in effect for the city of Chicago.¹⁶

ADDITIONAL RESOURCES

Ohio Injury Prevention Partnership, Child Injury Action Group:

www.healthyohiprogram.org/vipp/ciag/ciag.aspx

Ohio Department of Health, Child Fatality Review:

www.odh.ohio.gov/odhprograms/cfhs/cfr/cfr1.aspx

Safe Kids USA: www.safekids.org

Consumer Product Safety Commission: www.cpsc.gov

American Academy of Pediatrics: www.healthychildren.org

SID Network of Ohio: <http://sidsohio.org/>

REFERENCES

1 National MCH Center for Child Death Review. Suffocation Fact Sheet. <http://www.childdeathreview.org/causesSUF.htm>. Accessed October 11, 2012.

2 Ages 0-1

3 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). www.cdc.gov/injury/wisqars/index.html

4 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). www.cdc.gov/injury/wisqars/index.html

5 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). www.cdc.gov/injury/wisqars/index.html

6 2012 Ohio Child Fatality Review Annual Report.

7 2012 Ohio Child Fatality Review Annual Report.

8 2012 Ohio Child Fatality Review Annual Report.

9 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). www.cdc.gov/injury/wisqars/index.html

10 Safe Kids USA. Suffocation Prevention Tips. www.safekids.org/safety-basics/safety-resources-by-risk-area/choking-suffocation-and-strangulation/suffocation-prevention-tips.html. Accessed September 2, 2012.

11 2012 Ohio Child Fatality Review Annual Report.

12 NCSL Sudden Infant Death Laws. November 2010. <http://www.ncsl.org/issues-research/health/sudden-infant-death-syndrome-laws.aspx>

13 Pennsylvania HB 47 (2009 Session). <http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2009&sessInd=0&billBody=H&billTyp=B&billNbr=0047&pn=3776>

14 Thach, B.T., Rutherford Jr., G.W., Harris, K. (2007) Deaths and injuries attributed to infant crib bumper pads. *Journal of Pediatrics*, 151 (3), 271-274;

15 American Academy of Pediatrics, Taskforce on Sudden Infant Death Syndrome. (2011). Policy statement. SIDS and other sleep-related infant deaths: expansion of recommendations for safe infant sleeping environment. *Pediatrics*, 128(5), 1030-9.

16 Final Regulations Banning Crib Bumper Sales in Maryland. Maryland Department of Health and Mental Hygiene. Accessed: February 13, 2013. <http://dhmh.maryland.gov/SitePages/crib-bumper.aspx>