

GOVERNMENT OF THE DISTRICT OF COLUMBIA OFFICE OF THE CHIEF MEDICAL EXAMINER 401 E. Street, SW – 6<sup>th</sup> Floor Washington, D.C. 20024

Overview of Infant Sleeping Deaths that Occurred in the District of Columbia January 2016 to December 2016<sup>1</sup>

Report Date: February 15, 2017

Although a death of an infant may occur in the District of Columbia, the infant's place of residence can be anywhere in the world. For the purpose of this report, infant deaths are defined as babies that are age one year old or less at the time of death. This report will identify the residential jurisdiction of the infant by using the parental residence at the time of the infant's death.

## **Overall Infant Sleeping Fatalities**

There were a total of **17** infant fatalities due to co-sleeping, bed-sharing or unsafe sleeping environments during the reporting period (January 2016 to December 2016). The cause of death includes Asphyxia, Sudden Unexplained Infant Death (SUID), and Undetermined. The information below presents the decedent information by cause and manner of death, parental residence, yearly trends, race/ethnicity and gender.

## Co-sleeping/Bedsharing

There were a total of **4** co-sleeping/bed-sharing infant fatalities that were certified with a manner of death as "*Undetermined*" in calendar year 2016 (Table 1), of which, three had parents that were residents of the District of Columbia, and one had parents that lived in Maryland. In addition, there were **4** cases were certifed with a manner of death as "*Accident*" (Table 1). These accidential infant fatalities were caused by Asphyxia due to overlay (as the result of a co-sleeping environment). Two had parents that were residents of the District of Columbia and two had parents that lived in Maryland (Table 2).

## Unsafe sleeping environment or Inappropriate bedding

Although "*Unsafe sleeping environment*" and "*Inappropriate bedding*" are classified independently in the circumstances and cause of death, these classifications are very similar as it relates to the sleeping environment of the infant. For example, an <u>adult bed</u> is identified by the Office of the Chief Medical Examiner (OCME) as an unsafe sleeping environment, yet it is also known as inappropriate bedding for an infant.

There were **7** cases in 2016 where the infant died as a result of unsafe sleeping or inappropriate bedding, yet was NOT attributed to co-sleeping or bed-sharing based on the investigation (Table 1). **All** of these cases had a manner of death of "Undetermined".

## Undetermined/Crib Death

Based on the investigation by the OCME, there were 2 deaths where the sleeping environment of the

<sup>&</sup>lt;sup>1</sup> Data for 2016 is inconclusive and subject to change, due to cases where cause and manner of death is "Pending Further Investigation".

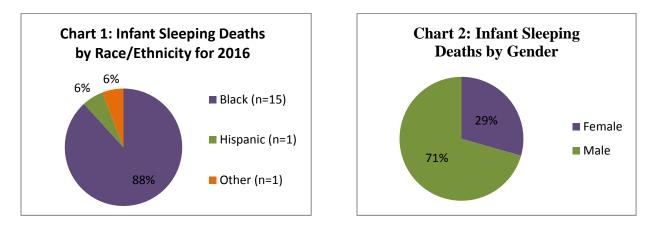


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infant was a crib and therefore the cause and manner of death were classified as either "SUID/Undetermined" or "Undetermined/Undetermined" (Table 1).

Table 1: Infant Deaths by Cause of Death, Manner of Death andContributing Factors						
2016					Table 2: Infant Deaths	
Cause of Death	Manner	Co-sleeping/ Bed- sharing	Unsafe Sleep Environment/ Inappropriate Bedding	Total	by Parental Residence	
Asphyxia	Accident		nappi opi fate bedding 0	4		Total
SUID	Undetermined	2	0	2	DC	7
Undetermine	Undetermined	4	7	11	MD	10
Total		10	7	17	Total	17

Of the 17 infant fatalities due to unsafe sleeping environments or co-sleeping, **41%** of the fatalities were DC residents (Table 2) and the majority (57%) of residents from Ward 8 (residency based on parental address). There were no fatalities among residents in Ward 1, 2, 3, 5, and 7. In addition, **88%** of infant sleeping deaths occurred among black infants in 2016 (Chart 1). Overall, infant sleeping deaths were more prevalent among **males** (n=12) in 2016 (Chart 2).



Over the last three years (2014-2016), a total of **48** infant deaths due to co-sleeping/bedsharing or unsafe sleeping/inappropriate bedding have occurred (Graph 1).

