WISCONSIN LEGISLATURE
P.O. BOX 8952 • MADISON, WI 53708

Date: April 1, 2015

To: Members of the Senate Committee on Health and Human Services

From: Rep. Samantha Kerkman

Testimony on SB 46- Intoxicated Cosleeping

Thank you, Chairwoman Vukmir and Committee members for hearing SB 46 today. This bill creates a penalty for intoxicated cosleeping. It also contains an educational component, requiring educational materials to be provided to new parents after before a baby is born regarding all aspects of safe sleep, and, especially, the dangers of intoxicated cosleeping.

Cosleeping deaths are a problem in Wisconsin. On December 17, 2014, Eric Toner of Milwaukee Public Radio was discussing the recent death of a baby who died while sharing a bed with his mother and sibling. In that same broadcast it was mentioned that 18 children died in 2014 in Milwaukee County as a result of unsafe sleep conditions. This is not a new problem. According to the Milwaukee Journal Sentinel, ten infants died in unsafe sleep conditions in 2012. Detective Erik Goth cited that from 2005 – 2010, the City of Janesville suffered 12 infant deaths, 11 of which were related to "unsafe sleep conditions." I developed this bill to help prevent these tragic deaths and to, especially, hold accountable adults who put babies in danger by sharing a bed with them while intoxicated.

I began working on this legislation more than two years ago at the request of my local Kenosha County District Attorney, Robert Zapf, after a tragic case in Kenosha. In that case, a baby was killed while sleeping in the same bed as his father who was heavily intoxicated. DA Zapf informed me that it is very difficult to prosecute a cosleeping death using the current statutes on child neglect. SB 46 will create a specific penalty in statute for harming an infant through intoxicated cosleeping. This is meant to be a tool for District Attorneys to prosecute adults who put babies at risk by choosing to cosleep with them while intoxicated.

SB 46 does not ban all cosleeping. The decision to cosleep is one that should be made by each family. However, it is generally accepted by medical professionals and child advocates that the safest way for a baby to sleep is alone, on its back, in a crib free of toys or blankets. You'll notice that SB 46 only applies to cases in which harm to an ***infant*** occurs while cosleeping with an adult who is ***intoxicated***. The bill defines an infant as a child less than one year old.

SB 46 will not apply in all cases involving a cosleeping death. But my intent by putting forth this bill is to give District Attorneys the ability to prosecute the most egregious cases in which an adult makes the irresponsible decision to cosleep with their infant while intoxicated.

Thank you, Committee members, and I will now gladly respond to any questions you may have.

City of Milwaukee
Health Department

Tom Barrett
Mayor

Bevan K. Baker, FACHE
Commissioner of Health

Joe'Mar Hooper, MPA
Health Operations Administrator

www.milwaukee.gov/health

Frank P. Zeidler Municipal Building, 841 North Broadway, 3rd Floor, Milwaukee, WI 53202-3653 phone (414) 286-3521fax (414) 286-5990
web site: www.milwaukee.gov/health

April 1st, 2015

Senator Leah Vukmir, Chair
Committee on Health and Human Services

Dear Committee Chair and Committee Members,

Thank you for the opportunity to testify on Senate Bill 46, related to "causing harm to a child by co-sleeping while intoxicated, providing information about safe sleep, and providing a penalty." The City of Milwaukee Health Department remains opposed to the felony component of this bill, however we support comprehensive safe sleep education.

The phrase co-sleeping has become all-too-common in our community and one that is full of misunderstanding. Many in the community, seem to imagine that most co-sleeping deaths result from a drunk, incompetent parent rolling onto their baby and suffocating it. For over five years it was my job at the City of Milwaukee Health Department, as part of our Fetal Infant Mortality Review, to compile the stories of each and every infant death in Milwaukee and I can assure you that picture is wildly incorrect.

In an average year, Milwaukee loses approximately 100 babies before their first birthday. Most of those infants, about 60%, never leave the hospital and die from complications due to prematurity. Being born too soon and too small. Twenty percent die from congenital anomalies, commonly called birth defects. The third leading cause of death, on average only 15% of all infant deaths are those that occur in unsafe sleep environments.

To understand safe sleep people must understand the difference between "causes" of death and "risk factors." Many times we cannot simply point to one thing that caused an infant to die while in an unsafe sleep environment. There may be numerous, sometimes as many as four or five, risk factors present without clear evidence as to what exactly caused the death. Just because an infant is found dead while sleeping next to an adult, whether intoxicated or not, does not mean that the adult rolled over onto the baby causing the death.

The most common risk factor by far is the presence of soft objects such as pillows, quilts and blankets. These soft objects, which can cause the infant to accidentally suffocate, are present in about 80 percent of all unsafe-sleep-related infant deaths in Milwaukee, and are present in 100 percent of cases when an infant is placed in an adult bed.

While soft objects represent by far the most common risk factor, there are others. The next two most common risk factors are exposure to secondhand smoke (present in 60 percent of cases) and placing an infant to sleep on its side or stomach (present in 40 percent of cases) rather than on its back. By comparison, use of alcohol or drugs by an adult caregiver is noted in about 20 percent of sleep-related infant deaths in Milwaukee. More than 90 percent of

Milwaukee's sleep-related infant deaths have more than one risk factor present.

Because so many risk factors are commonly present it's easy to imagine scenarios where a parent has a glass of wine in the evening, goes to sleep with the infant, and the infant suffocates on a pillow or blanket. In fact, an infant death proven by autopsy to be caused by a parent rolling over on the child is rare (less than once per year in Milwaukee on average). And, if the death was, in fact, *caused* by parental intoxication, we believe that existing Wisconsin law provides ample authority to pursue criminal charges, starting with felony neglect. There have in fact been cases where this has happened. Thus making the penalty component unnecessary.

While well-intended our biggest concern is the limited focus on *intoxicated* bed-sharing, specifically in regards to the education components of the bill. The implication that bed-sharing is safe, unless you are intoxicated, is simply not true. By not providing a comprehensive approach to education we are potentially putting more babies at risk. By far the greatest risk factor for sleep-related infant deaths is the presence of soft objects such as pillows and blankets – and *every* bed-sharing death in Milwaukee has these objects present.

The City of Milwaukee Health Department and our network of community partners have taken a stand on the issue. Through the Lifecourse Initiative for Health Families (LIHF), which our Mayor Tom Barrett co-chairs, and other projects, we work with numerous community agencies and health care providers to optimize the education that mothers and families receive about safe sleep. Our Cribs for Kids program provides a free place for an infant to sleep, along with comprehensive education to promote the proper and consistent use of these cribs.

In conclusion, we would strongly like the bill to be amended to include comprehensive safe sleep education, based on the American Academy of Pediatrics guidelines. Instead of focusing on intoxication, we need your help educating your constituents and the general public about all the ways to ensure a safe sleep environment for our babies.

We need everyone to spread the message that the safest place for an infant to sleep is alone, on his or her back, in a crib that is free of pillows, blankets, bumper pads and toys, and in a smoke-free home.

Thank you Chairwoman and committee members for the opportunity to testify today and I would welcome any questions.

Jessica Gathirimu, MPH, CPH
Director, Family and Community Health
City of Milwaukee Health Department

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Senate Committee on Health and Human Services
Senator Leah Vukmir, Chair

FROM: Mark Grapentine, JD
Senior Vice President - Government and Legal Affairs

DATE: April 1, 2015

RE: **Opposition** to Senate Bill 46 - Intoxicated Co-sleeping

On behalf of more than 12,500 members statewide, the Wisconsin Medical Society thanks the Senate Health and Human Services committee for this opportunity to share our opposition to Senate Bill 46, which criminalizes intoxicated co-sleeping. The Society's Council on Legislation (COL) discussed last session's version of this legislation at its December 5, 2014 meeting, recommending that our Board of Directors oppose the bill. The Board approved that recommendation on January 31, 2015. The COL on February 13, 2015 reviewed the updated bill language that became Senate Bill 46, voting to maintain its opposition.

The Society Opposes Interference with the Patient-Physician Relationship
Ideally patients and physicians build a trusting relationship allowing for full and frank conversations about the full variety of health care topics. This relationship is built on trust often developed over many years, where both parties are comfortable sharing information pertinent with each health care visit. Whenever outside entities - including government - attempt to insert themselves into the patient-physician conversation, that vital trust is threatened.

Senate Bill 46 inserts government mandates into expecting patients' meetings with their physicians. The Society believes the mandates in the bill for physicians to share certain information at certain times unnecessarily intrudes into the patient-physician relationship.

Any sudden unexpected death of an infant is tragic. Harm to an infant due to co-sleeping, intoxicated or otherwise, is avoidable. Physicians join with others in desiring and working toward zero such deaths or injuries every year. The legislation before the committee, while well-intended, creates mandates of questionable efficacy. Pregnant moms, future fathers and their physicians should discuss pregnancy, birthing and post-birth issues on their own terms - not based on an agenda set by a government body.

Physicians often lament that current requirements related to electronic medical records distract from face-to-face interaction with patients. SB 46 exacerbates this problem by not only mandating specific topics of conversation, but requiring a physician to present a form to the patient acknowledging that the forced conversation has occurred. Evidence of the conversation and the presentation of the form must then be entered into the patient's record. These procedural and administrative mandates add to the health care professional's burden with no data or evidence to justify them.

330 East Lakeside Street • PO Box 1109 • Madison, WI 53701-1109 • wisconsinmedicalsociety.org • Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

Criminalization Effects are Not Known - and May Not be Beneficial Overall
It is unclear how creating a new felony for harm due to intoxicated co-sleeping will prevent these tragic injuries and deaths from happening. While the bill may make it easier for district attorneys to bring criminal charges following harm to a child, we have not yet found data supporting how this alone will reduce the number of children harmed or injured by intoxicated co-sleeping.

Instead, the potential unintended consequences of criminalization could offset any gains from deterrence. Fear of arrest could cause adults to delay summoning medical assistance for a child that has been injured. And if an adult brings an injured child to an urgent care clinic or hospital's emergency department, that adult may not be fully forthcoming about how the injuries happened, making diagnosis more difficult and potentially delaying needed treatment.

The Society respectfully opposes Senate Bill 46 for the aforementioned reasons. Thank you for considering our opinions. As always, please feel free to contact the Society on this and other proposed health care policy.

WISCONSIN HOSPITAL ASSOCIATION, INC.

A Valued Voice

To: Senate Committee on Health and Human Services

From: Steven Rush, Vice President Workforce and Clinical Practice SR
Kyle O'Brien, Senior Vice President Government Relations KO

Date: April 1, 2015

Subject: Wisconsin Hospital Association Testimony on Senate Bill 46

While Wisconsin hospitals are in agreement with the important goal of this legislation, which aims to educate parents and caregivers and to keep newborns safe, establishing the practice of medicine and determining hospital operations through a legislative mandate is a policy that WHA opposes. We believe that it is important to leave this determination up to professional health care providers and caregivers. We believe that health care professionals, not stagnant state statutes, should be determining the most effective education methods for the patients our members serve. Providing this additional information to all new mothers may not be the most efficient method for targeting those at highest risk for experiencing this tragic and serious event.

WHA would like to provide information for the Committee on the existing demands for time and attention that are already placed on new parents and hospital staff in a compressed forty-eight hour (at most) hospital stay. According to research published in the Journal of Perinatal Education *the amount of education that is mandated by government and regulatory agencies and recommended by professional organizations for the postpartum mother may be overwhelming, and brief postpartum hospital stays leave insufficient time for nurses to address a new mother's learning needs effectively.*

The vast majority of the responsibility of providing this teaching falls on the nurses in the inpatient, maternity setting. Maternity nurses routinely express concerns about meeting educational needs of new mothers during their brief hospital stays. These concerns are often attributed to the lack of time and the amount of information they are required to provide to prepare new mothers and their families to care for the newborn at home. The literature also suggests that mothers also are overwhelmed with postpartum hospital education.

The routine education process is to distribute a folder containing several informational handouts to mothers upon arrival in the mother–baby unit following childbirth. (According the Journal of Perinatal Education, many hospitals include 25-35 different handouts. Breastfeeding mothers often receive a second folder containing as many as 10 additional handouts about breastfeeding.) If individual education needs are identified, additional teaching and handouts are given. Mothers are also often required to view several videos about newborn care before leaving the hospital. Additionally, nurses assigned to mother–baby dyads provide mothers with one-on-one education based on standard teaching checklists.

5510 Research Park Drive P.O. Box 259038 Madison, WI 53725-9038 P (608.274.1820) F (608.274.8554) wha.org

Data from the National Research Corporation reveals that despite the overabundance of educational materials and teaching provided during the immediate post-partum period, mothers are dissatisfied with the experience. Mothers report they either do not receive the information they need or receive irrelevant information.

During a very brief hospital stay, hospital staff need to assess individual family situations and use their time to educate parents. This necessary education includes instruction to new mothers about many topics including how to feed, clothe, bath, change diapers, take temperature, hold, swaddle, etc. To require teaching time be spent, not on the greatest needs as assessed by clinical staff, but on other government mandated topics, risks that necessary teaching might be compromised or missed entirely. We would like to inform the committee of the options already present in the healthcare system to address this issue and to highlight other primary prevention strategies.

Hospitals have many ways in which they already address concerns which might be identified regarding neonatal safety:

- communication with pre-natal care providers can identify mothers and babies with special need for intervention related to safety and care
- admission processes may trigger consultation with hospital and outside social work staff who can provide or continue contacts with community resources
- routine assessments of mother-baby interaction and all family interactions allow for potential issues to be identified early
- one-on-one teaching and small classes are offered which cover child care, safety, nutrition, and resources available in the community.
- discharge planning often creates referrals to outside agencies, sometimes for further in-home evaluation of risk, sometimes for intervention
- post-delivery classes, mailing packets and follow up phone calls give new parents the opportunity to ask questions and seek help when the reality of child care becomes apparent
- public health campaigns that promote safe sleeping practices

Healthcare clinicians in hospitals are charged with assessing/evaluating patients, setting priorities, and intervening in the most appropriate way. That is done for every birth in Wisconsin hospitals. Although each hospital determines its own strategies for assessing, educating and referring parents and their newborns, all are committed to the goal of safe, healthy children in Wisconsin.

Buchko, B. L., Gutshall, C. H., & Jordan, E. T. (2012). Improving Quality and Efficiency of Postpartum Hospital Education. *The Journal of Perinatal Education, 21*(4), 238–247. doi:10.1891/1058-1243.21.4.238

Testimony on SB 46

About the Alliance

- Good morning Chairwoman Vukmir and members of the committee. Thank you for allowing me this opportunity to testify today. My name is Abby Collier and I am the Injury Prevention and Death Review Project Manager at Children's Health Alliance of Wisconsin (Alliance).
- Children's Health Alliance of Wisconsin is Wisconsin's voice for children's health. We are a statewide organization and our mission is to ensure Wisconsin children are healthy, safe and able to thrive.
- We would support the education component of this bill if it is amended to require that all education is consistent with the American Academy of Pediatrics guidelines. We believe a consistent, evidence-based message is necessary to prevent these deaths.
- However, we oppose the criminal penalty proposed in this legislation. We believe it provides caregivers with a false sense of security that sleeping with an infant is safe as long as the caregiver is not intoxicated.

Keeping Kids Alive

- The Alliance leads the child death review program known as Keeping Kids Alive in Wisconsin. Child death review teams are multi-disciplinary groups of professionals who come together to understand the "who, what, where, when, why and how" surrounding a death.
- Currently, Wisconsin has death review teams in 57 counties, covering more than 90 percent of the population.
- The Alliance is funded by the Centers for Disease Control and Prevention to gain a better understanding of what happens in unexplained infant deaths, which includes sleep-related deaths. The goal of this program is to collect better quality data that will improve knowledge of unexplained infant deaths. As a result of this grant, 2013 was the first year in which population-based data was collected on deaths occurring in a sleep environment.

Data

- In 2013, 56 Wisconsin infants died in a sleep environment. Of the 56, 98 percent (n=55) had some component of an unsafe sleep environment as defined by the American Academy of Pediatrics.
- More than one-fifth (n=20) of Wisconsin counties experienced a sleep-related infant death. These deaths occurred in all five public health regions.
- 58 percent (n=32) were placed in an adult bed. Whereas only 22 (n=12) percent of these infants were placed in a crib or bassinette.
- 62 percent (n=34) of the infants were sleeping on the same surface as an adult, child or animal at the time of death.
- 87 percent (n=48) of these infants were in a sleep environment containing soft bedding, loose blankets, pillows, etc.
- 43 percent (n=24) of women experiencing a sleep-related death in 2013 smoked before pregnancy and 45 percent (n=25) smoked at least once during pregnancy.
- 53 percent (n=29) of infants who died in a sleep environment were exposed to secondhand smoke.

- Of the 56 sleep-related infant deaths, death scene investigators noted caregiver intoxication in 9 percent (n=5) of the deaths.
- 86 percent (n=48) of sleep-related deaths had at least three risk factors as defined by the American Academy of Pediatrics.

Closing

- As you can see, intoxicated co-sleeping is one piece of a much bigger issue requiring comprehensive education on how to sleep babies safely. Education based solely on the risks of intoxicated co-sleeping is not consistent with what risk factors we see in the data.
- Consistent education on infant safe sleep is critical. Education needs to stress that babies sleep safest alone, on their back, in a crib.
- We respectfully ask that the bill be amended to ensure any educational materials created be consistent with the American Academy of Pediatrics guidelines.
- Thank you Chairwoman and committee members for the opportunity to testify today and I would welcome any questions.

Wisconsin Alliance for Women's Health
www.supportwomenshealth.org

TO: Senate Committee on Health and Human Services
FROM: Sara Finger, Executive Director, Wisconsin Alliance for Women's Health
RE: Opposition to SB 46 – Criminalization of Co-sleeping that Results in Injury or Death to a Child
Date: April 1, 2015

My name is Sara Finger and I am the Executive Director of the Wisconsin Alliance for Women's Health (WAWH). I am submitting this written testimony to express WAWH's opposition to the criminalization provisions of SB 46. WAWH's vision for Wisconsin is to be an environment in which all women at every stage of life can realize their optimal health and well-being. We believe that such an environment will promote healthy families and communities in our state.

While WAWH supports the laudable intent of SB 46 to reduce the number of sleep-related infant deaths in Wisconsin, we do not believe that the criminalization of intoxicated co-sleeping is the most effective or humane way to achieve this goal. Instead, the Legislature should address all sleep-related infant deaths as a public health issue, not a crime.

According to medical experts who submitted testimony regarding this legislation last legislative session, intoxicated co-sleeping is a risk factor for sleep-related infant death, but is certainly not the primary risk factor. For example, in Milwaukee, 80 percent of such deaths do not involve alcohol or drug use by the responsible adult caretaker. According the City of Milwaukee Health Department, of the approximately 15 sleep-related infant deaths that occur annually in Milwaukee, other risk factors are far more prevalent than intoxicated co-sleeping: 80 percent include the presence of soft objects, such as pillows and blankets; 60 percent include exposure to second-hand smoke; and, 40 percent involve placing the infant to sleep on his or her side or stomach.

To my knowledge, there are no legislative proposals to criminalize parental or caretaker behavior that involves any of the other risk factor listed above, nor should there be. The reason why most of us would not even consider criminalizing such behavior is because we recognize that these behaviors are best addressed through community-based education efforts to help parents and adult caretakers better understand how follow best practices for safe infant sleep, not through significant criminal sanctions.

It is telling that no mainstream medical organization or health care entity has registered in support of this legislation. That is because criminalization of intoxicated co-sleeping is highly unlikely to reduce sleep-related infant deaths. Most medical experts who have weighed in on this issue would argue that any co-sleeping—not just intoxicated co-sleeping—is dangerous. According to the Wisconsin Perinatal Depression Task Force, 60 percent of U.S. parents will sleep with their infants at some point in the first year after birth, either on purpose or an accident. Parents co-sleep for a variety of reasons, ranging from family tradition to accidentally falling asleep with an infant during breastfeeding[1]. Again, even though such co-sleeping is a risk factor for sleep-related infant death, most people certainly would not support any attempt to criminalize behavior in which research indicates the majority of parents engage.

Most parents simply want what is best for their children. After having an infant, many parents are often overwhelmed by exhaustion, stress and sometimes mental health issues like Postpartum Depression. Instead of focusing on criminalizing parental behavior that is often based in ignorance, we should focus on providing families the support and information they need to properly care for their infant. The provisions of SB 46 that focus on comprehensive education regarding safe sleep practices for infants would be a far more welcome approach to this issue than criminalization. While WAWH does not have an opinion regarding the specific content or mechanics of the education provisions contained in SB 46, we believe that an evidence-based, educational approach would be a far more effective way to prevent these tragic infant deaths.

[1] http://uwm.edu/nursing-app/wp-content/uploads/sites/159/2013/09/Doering_Infant-sleep-talking-points_8.28.13-pswmp3.pdf

P.O. Box 1726, Madison, WI 53701-1726 608-251-0139 toll free: 866-399-9294 fax: 608-256-3004 info@wiawh.org

Children's Hospital of Wisconsin

TO: **Chairwoman Vukmir & Members of the Senate Health and Human Services Committee**

FROM: **Michelle Mettner, VP of Government Relations, Children's Hospital of Wisconsin**

DATE: **April 1, 2015**

RE: **Senate Bill 46**

Thank you for the opportunity to provide written testimony on Senate Bill 46.

Children's Hospital of Wisconsin serves children from every county in the state. We have inpatient hospitals in Milwaukee and the Fox Valley and a network of dozens of pediatric primary and specialty care clinics. Children's provides specialty care, urgent care, emergency care, routine checkups, school health nurses, child welfare, foster care and adoption services, family resource centers, child health advocacy, health education, pediatric medical research and the statewide poison hotline. Children's also operates the state's largest Medicaid health plan in SE Wisconsin, serving more than 140,000 lives. In addition, Children's engages in injury prevention advocacy and policy that impacts the health and well being of infants and children.

I share that background, which many of you already know, to illustrate that Children's mission is much more than a medical facility. We believe it is our responsibility to advocate for the health, safety and well-being of infants and children in our state. Because of our holistic mission, Children's Hospital of Wisconsin applauds the authors of SB46 and AB 94 for including a provision in the legislation that will increase educational opportunities for mothers and fathers to learn about safe sleep for infants. Because we know the vast majority of co-sleeping deaths do not involve an intoxicant, it is critical that the education component include all aspects of safe sleep.

Making sure all parents and caregivers know the only truly safe method of sleep for a baby is alone, on his or her back and in a crib is the key to stopping the tragedies that we all want prevent. We at Children's want to see an end to all sleep-related infant deaths, regardless of whether an intoxicant is involved or not.

That's why the education component of this bill is so important and the educational materials must include messaging about all sleep risks. Without this education, we would be sending a message that sober co-sleeping is safe and we know from the data that infants are dying in sober co-sleeping situations.

I want to again thank the authors for their work on this bill and their passion for and commitment to protecting vulnerable infants. It is truly a tragedy every single time a baby dies from an unsafe sleeping situation. We strongly encourage the committee to keep the education component of this legislation as it provides a real opportunity to prevent infant sleep-related death.