

# Investigating Co-Sleeping and Unsafe Sleep Deaths:

BEYOND THE SCENE

Tyler Counsil, Ed.D.

Director, Center for Education & Workforce Development  
Zero Abuse Project  
Coroner, Daviess Co.

<https://zeroabuseproject.org/>

# Learning Outcomes

1

## Understand

Understand the importance of comprehensive caregiver interviews

2

## Identify

Identify key areas of inquiry in co-sleeping/unsafe sleep cases

3

## Recognize

Recognize the role of social determinants of health (SDOH)

# Learning Outcomes



## Develop

Develop strategies for  
collecting multi-source  
information



## Understand

Understand how to  
synthesize information for  
a holistic view



## Discuss

Discuss the significance  
of prevention  
opportunities in these  
cases

# The "Beyond the Scene" Imperative

- **Why it's crucial:**
  - Distinguish between accidental vs. undetermined vs. natural
  - Identify chronic risks vs. acute events
  - Inform prevention strategies



SCENE: SNAPSHOT OF THE INCIDENT



INVESTIGATION: UNCOVERS THE HISTORY, CONTEXT, AND CONTRIBUTING FACTORS



COLLABORATION: REQUIRES MULTI-AGENCY COOPERATION

# Comprehensive Caregiver Interviews

Purpose: Understand  
typical routines, incident  
details, contributing  
factors

## Primary Source of Context

Beyond the immediate  
event

## Trauma- Informed Approach

Empathy, patience, non-  
judgment

## Flexible Interviews

Voice & choice in where  
to start conversation can  
empower traumatized  
caregiver

## Separation of Caregivers

Interview separately to  
avoid contamination

# Key Areas of Inquiry:

## Sleep Practices



### Typical Sleep Environment

Where did infant usually sleep?



### Incident Sleep Environment

Where did infant sleep at time of death? (Any deviation?)



### Bedding & Accessories

What was used? Blankets, pillows, sleep positioners.



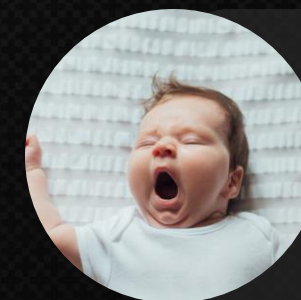
### Caregiver Position/Location

Where were caregivers in relation to infant?



### Feeding Routines

Night feedings, falling asleep during feeding.



### Sleep Routines/Challenges

Infant's sleep patterns, history of sleep issues, illness, etc.

# Key Areas of Inquiry:

## Caregiver Status



### Fatigue/Exhaustion

Sleep deprivation, multiple jobs, other children.



### Medication Use

Prescription, over-the-counter (including sleep aids, sedatives).



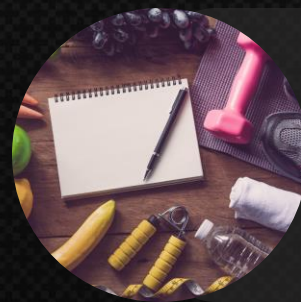
### Substance Use

Alcohol, illicit drugs (recent or chronic).



### Mental Health

Depression, anxiety, stress (especially postpartum).



### Physical Health

Chronic conditions, recent illness.



### Emotional State

Grief, trauma, stress (as it pertains to ability to care).

# Key Areas of Inquiry:

## Infant History



### Medical/Pregnancy History

Prior illnesses, hospitalizations, specific diagnoses.



### Recent Illness/Symptoms

Cold, fever, vomiting, respiratory issues.



### Feeding History

Breastfed/formula, feeding difficulties, recent changes.



### Developmental Milestones

General health and development.



### Previous Unsafe Sleep Exposures

If known or observed.



### Childcare Arrangements

Who typically cared for the infant.

# Gathering Collateral Information



Other Household Members

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First Responders

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Medical Professionals

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Social Service Agencies

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Neighbors/Community  
Members/Extended Family

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# The Role of Social Determinants of Health (SDOH)

Reminder: Conditions where people live, learn, work, play, and age

## **Housing Instability/Crowding**

Leads to unsafe sleep surfaces

## **Poverty/Lack of Resources**

Inability to afford adequate provisions

## **Limited Healthcare Access**

Lack of prenatal care, well-child visits, safe sleep education

## **Lack of Social Support**

Increased caregiver stress, fatigue

## **Food Insecurity**

Can lead to infant discomfort, illness

# Documentation Beyond the Scene:

## **Comprehensive**

Detail all questions asked and answers received

## **Verbatim (as much as possible)**

Capture exact phrasing where critical

## **Objective**

Avoid interpretation; record observations of demeanor

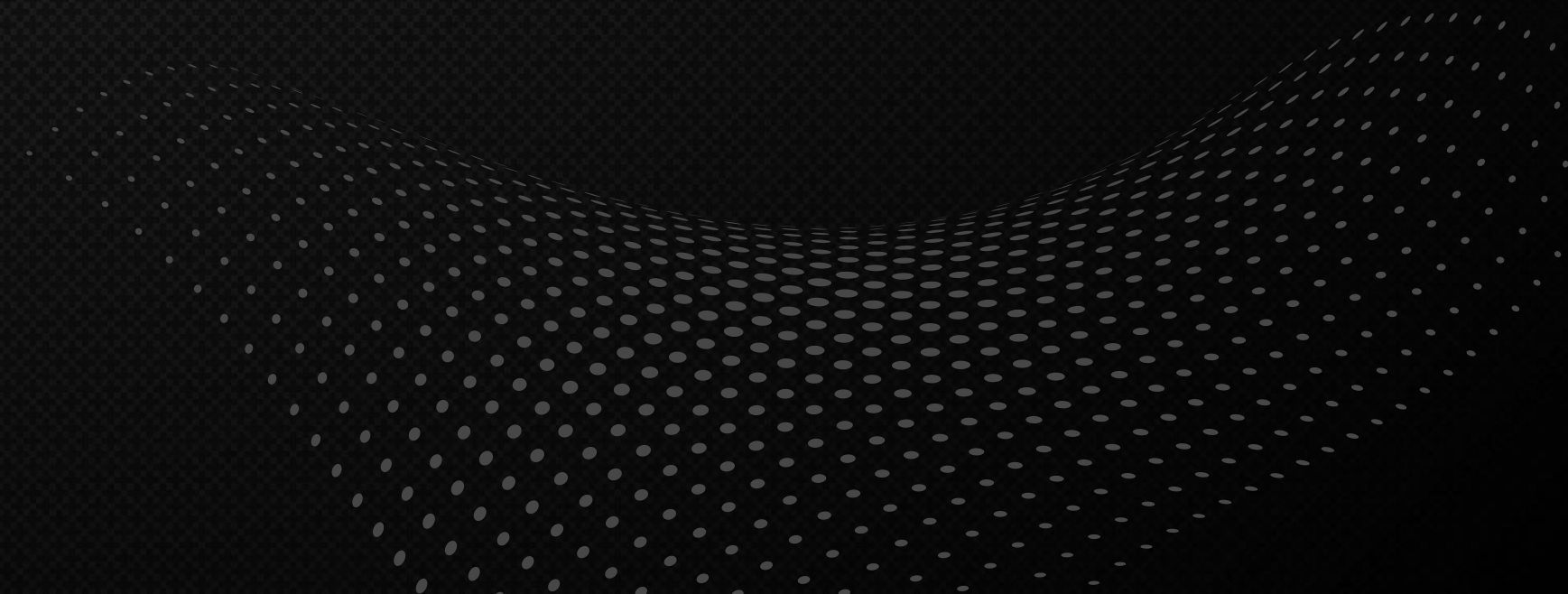
## **Contextual**

Include observations about environment, non-verbal cues

## **Timestamps**

Note start/end times, breaks

Interview Notes



# Documentation Beyond the Scene:

Records Review

## **Medical**

Pre/post-natal, infant's history, ER visits

## **Social Services**

Prior CPS involvement, family support services

## **Law Enforcement**

Prior calls for service, domestic incidents

## **Financial/Housing**

Utility bills, lease agreements (if relevant to SDOH)

## **Communications**

Search history, comms w/ family, friends

# Integrating Information: The Holistic Picture



# Multi-Source Synthesis

## ID Discrepancies

## Corroborate Information

## Contextualize Findings

## Develop a Timeline

Collaborate with MDT: Discuss findings with diverse perspectives

# Accidental" vs. "Undetermined" Manner of Death

- **Importance of Thorough Investigation:**
  - Critical for ruling out other causes and supporting findings



**ACCIDENTAL:** DEATH RESULTS FROM UNINTENTIONAL INJURY. EVIDENCE CLEARLY SUPPORTS MECHANISM (E.G., SUFFOCATION IN UNSAFE SLEEP ENVIRONMENT)



**UNDETERMINED:** AVAILABLE INFORMATION IS INSUFFICIENT TO CLASSIFY. COMMON IN SUICIDE/UNSAFE SLEEP CASES WHEN A SPECIFIC LETHAL MECHANISM CANNOT BE DEFINITELY IDENTIFIED



**UNSAFE SLEEP AS CONTRIBUTORY:** EVEN IF NOT THE SOLE CAUSE, IT'S A VITAL RISK FACTOR

# Risk Factors for Unsafe Sleep Deaths (Summary)



Infant

Caregiver

Environmental

SDOH

Multifactorial

# Case Study: Beyond the Scene Inquiry

**Scene:** 3-month-old found deceased in an adult bed with mother. Mother reports falling asleep while breastfeeding. Pillows and blankets surround infant.



- **SLEEP HISTORY:** WAS CO-SLEEPING TYPICAL? IF NOT, WHY THIS TIME?



- **MOTHER'S STATUS:** FATIGUE LEVELS, RECENT SLEEP, MEDICATION/SUBSTANCE USE?



- **INFANT'S HISTORY:** ANY FEEDING DIFFICULTIES, RECENT ILLNESS?

- **HOUSEHOLD COMPOSITION:** OTHER CHILDREN, SUPPORT SYSTEMS?

- **SDOH:** HOUSING ADEQUACY, FINANCIAL STRESSORS, ACCESS TO HEALTHCARE/SAFE SLEEP EDUCATION?

- **OTHER WITNESSES:** FATHER, OTHER FAMILY MEMBERS?

# Interviewing Challenges in Unsafe Sleep Cases



## Caregiver Grief & Trauma

Impaired recall, emotional distress.



## Guilt & Shame

Reluctance to disclose unsafe practices.



## Fear of Legal Consequences

Can lead to minimization or dishonesty.



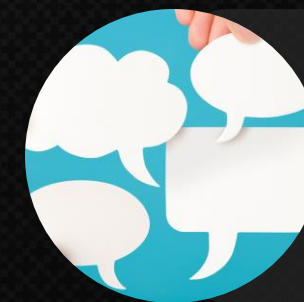
## Sensitivity

Differing views on co-sleeping, privacy.



## Language Barriers

Requires professional, certified interpreters.



## Conflicting Accounts

Between caregivers, or with scene findings.

# Addressing Discrepancies and Inconsistencies



## Acknowledge and Explore

Don't immediately dismiss or accuse.



## Revisit Questions

In subsequent interviews, or with different phrasing.



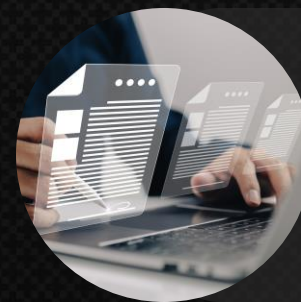
## Corroborate with Evidence

Use scene findings, medical records to inform questions.



## Consider Reasons

Trauma, fear, cultural differences, actual deception.



## Document Thoroughly

Record all attempts to clarify and responses.



## Multidisciplinary Discussion

Team can help interpret discrepancies.

# Collaboration with Child Protective Services

## **Shared Goal**

Child safety and well-being

## **Referral Process**

Understand local protocols for reporting

## **Information Sharing**

Legal frameworks for sharing sensitive data

## **Joint Interviews**

Where appropriate and beneficial

## **Assessment of Risk & Support**

Beyond the incident, for surviving children to uplift, empower

## **Scene Security & Initial Investigation**

LE primary goal

## **Evidence Collection**

Physical evidence, witness identification

## **Interviewing for Criminal Intent**

Distinct from fatality review interviews

## **Legal Standards**

Probable cause, search warrants, arrests

## **Interagency Communication & Training**

Regular updates, shared goals; enhances mutual understanding and best practices

# **Collaboration with Law Enforcement**

# Collaboration with Coroners

## **Cause & Manner of Death**

LE primary goal

## **Scene Reconnaissance**

Death scene investigation  
(walkthrough, photos, reenactments)

## **Medical Context**

Understanding autopsy findings

## **Information Exchange**

Scene findings inform autopsy; autopsy  
findings inform investigation

## **Discussion of Contributing Factors**

Beyond direct cause

# Preventing Future Deaths: The Ultimate Goal



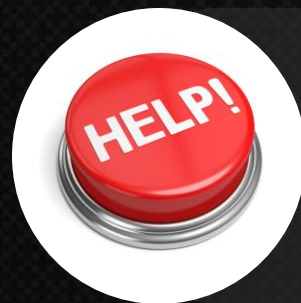
## Beyond the Case

Every investigation informs prevention.



## ID Risk Factors

Specific, modifiable risks observed.



## Tailoring Interventions

Targeted education, resource allocation.



## Public Health Messaging

Based on real-world data.



## Policy & Advocacy

System-level changes informed by trends.



## CFR Team Meetings

Key for aggregate data analysis.

# Case Study Revisited: Prevention Opportunities

**Scene:** 3-month-old found deceased in an adult bed with mother. Mother reports falling asleep while breastfeeding. Pillows and blankets surround infant.



- **TARGETED EDUCATION:** ON SAFE ALTERNATIVES TO CO-SLEEPING, ESPECIALLY FOR BREASTFEEDING MOTHERS.
- **FATIGUE MANAGEMENT:** RESOURCES FOR NEW PARENTS (SLEEP SUPPORT, MENTAL HEALTH).
- **SAFE CRIB/BASSINET PROVISION:** COMMUNITY PROGRAMS TO PROVIDE SAFE SLEEP SPACES.
- **SDOH ADVOCACY:** ADDRESSING HOUSING OR FINANCIAL INSECURITY, ACCESS TO RESOURCES.
- **UNIVERSAL SAFE SLEEP MESSAGING:** CONSISTENT, REPEATED MESSAGING IN HEALTHCARE.

# Key Takeaways



- **BEYOND THE SCENE:** CRUCIAL FOR UNDERSTANDING CONTEXT AND CAUSE.
- **COMPREHENSIVE INTERVIEWS:** PRIMARY SOURCE FOR HISTORY, PATTERNS, AND FACTORS.
- **SDOH:** DEEPLY INFLUENCE UNSAFE SLEEP PRACTICES.
- **MULTI-SOURCE DATA:** INTEGRATE INTERVIEWS, RECORDS, COLLATERAL FOR HOLISTIC VIEW.
- **COLLABORATION:** ESSENTIAL WITH DCS, LE, CORONER.
- **PREVENTION FOCUS:** EVERY CASE INFORMS FUTURE SAFETY.

# Resources for Further Learning



- **NATIONAL CENTER FOR FATALITY REVIEW AND PREVENTION (NCFRP):**  
[HTTPS://WWW.NCFRP.ORG/WP-CONTENT/UPLOADS/SLEEP-RELATED-QUICK-LOOK\\_PRINT.PDF](https://www.ncfrp.org/wp-content/uploads/sleep-related-quick-look_print.pdf)
- **CRIBS FOR KIDS® NATIONAL SAFE SLEEP HOSPITAL INITIATIVE:**  
[HTTPS://CRIBSFORKIDS.ORG/HOSPITALCERTIFICATION/](https://cribsforkids.org/hospitalcertification/)
- **AMERICAN ACADEMY OF PEDIATRICS (AAP):**  
[HTTPS://WWW.AAP.ORG/EN/PATIENT-CARE/SAFE-SLEEP/SUDDEN-UNEXPECTED-INFANT-DEATH-SUID-PREVENTION-PROGRAM/](https://www.aap.org/en/patient-care/safe-sleep/sudden-unexpected-infant-death-suid-prevention-program/)
- **LOCAL CFR TEAM**
- **NATIONAL ASSOCIATION OF MEDICAL EXAMINERS (NAME) POSITION PAPERS ON INFANT DEATHS:**  
[HTTPS://PMC.NCBI.NLM.NIH.GOV/ARTICLES/PMC6474526/](https://pmc.ncbi.nlm.nih.gov/articles/PMC6474526/)

# Thank You

[HTTPS://ZEROABUSEPROJECT  
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Tyler Counsil, Ed.D

[tyler@zeroabuseproject.org](mailto:tyler@zeroabuseproject.org)