



SEPTEMBER 2008

EDUCATION AND RESEARCH UPDATE



INSIDE THIS ISSUE

1
COMMENTARY ON BEDSHARING

2
DCFS & CHILDCARE LICENSING

3
POLICY & PROCEDURES

INFANT MORTALITY STATISTICS

4
RECOMMENDATION FOR SIDS PREVENTION

COMMENTARY ON BEDSHARING

Pat Tackitt, RN, MS, CDRT Coordinator, Wayne County, Michigan

If bedsharing could be guaranteed as safe, we wouldn't be having this discussion, we'd all be teaching it. But it can't be made SAFE, only safer than it might have been, at it's worst. I see deaths almost weekly, where the family believed they were doing it safely. Doctors who told parents it was okay to bedshare – but be very careful. Safety outside a crib can't be taught. The list of variables is enormous and the situation changes minute by minute; during the time the parents are asleep, unable to supervise their infants safety in response to these changes. Does every bedsharing baby die? No. Did the same babies who died of SUID (Sudden Unexplained Infant Death) often sleep in the same unsafe environment for days or weeks previously before they finally died in it? Yes. Maybe they were just lucky, not safe, the other nights?

When a baby is alive the morning after bedsharing, everyone thinks they slept the baby safely, no matter how many risks were present. When the baby dies, they can suddenly see the risks that were there all along. Unfortunately, the way some people learn they were too tired to sleep bedsharing next to baby, is that their baby is found unresponsive. The cause may not be SIDS, but the baby is still dead.

After 25-30 years of carseat use, we can finally understand the higher level of RISK for any infant who travels without a carseat, even when they returned without being in an accident. But with much higher level of risks present in unsafe infant sleep environments, the bedsharing advocates choose to ignore the risks at which an unsupervised infant is while sleeping outside the added protection a crib offers. The issue is one of RISKS. Bedsharing infants are ALWAYS at a higher level of risk, *even if they didn't die that night or during that nap. It is not simply the risk of dying of SIDS, it is the risk of dying or having an asphyxial event that may cause life long impairment, even if death doesn't occur. It is bigger than just a SIDS issue.*

The public needs answers on how to keep their baby alive from any of the causes of sudden infant death. Parents want help in recognizing any risks that could endanger their infants life. Telling them information based only on the SIDS

cases, is extremely limited and very misleading. If you are only looking at the SIDS cases, wouldn't that mean all the KNOWN overlay deaths, the positional asphyxia deaths, the wedging deaths, covers over the head, etc., were already removed from the bedsharing death subset you used in (the) research? You can't make good public policy on how to stop infant deaths if you discount the other KNOWN causes of SUID that occur in unsafe sleep environments. And many of the KNOWN causes of SUID happen during bedsharing.

Maybe it's the SIDS vs SUID's that is the core of this debate on why we don't see things from the same perspective as those who "advocate bedsharing". They are studying what gets signed out as SIDS and the CDR (child death review) teams are trying to prevent sudden infant deaths from all causes, including all the KNOWN overlays, entrapments, wedgings, positional asphyxias, those with covers over the baby's head and the overheating deaths, all of which would be signed out for a cause other than SIDS.

(Wayne) County's stats show that 5 infants died in the last 5 years in car accidents but 200-250 died during the same 5 year period from unsafe sleep environments. Dying in an unsafe sleep environment is THE LARGEST RISK an infant faces after leaving the hospital as a healthy infant. While not all 250 infants died while bedsharing, the greatest percentage did.

Almost every one of the current SUID deaths have one thing in common. Most deaths would have been prevented if only baby had been sleeping on it's back in a crib following the recommendations released by the AAP. I find the new AAP statement does an excellent job of making the recommendations clear to parents on how to reduce SUID's not just SIDS.

Like others, I have the same concern about there being more of an agenda to "promote and protect bedsharing", than to "save lives" and stop sudden infant deaths. The data clearly shows the risks of rollover/suffocation death is far less in a separate baby safe crib, than when bedsharing. Breast-feeding can be totally successful without a sleeping mom ever sharing a bed with her infant,

CONTINUED ON PAGE 2



SIDS OF ILLINOIS, INC.
710 E. OGDEN AVE.
SUITE 550
NAPERVILLE, IL 60563
800-432-SIDS
630-305-7300

www.sidsillinois.org

For more information on any of our articles, contact the SIDS of Illinois office at 630-305-7300 or email nancy@sidsillinois.org

DEPARTMENT OF CHILDREN AND FAMILY SERVICES ADDS SIDS EDUCATION TO CHILDCARE HOMES AND CHILDCARE GROUP HOMES LICENSURE

Sudden Infant Death Services of Illinois has been working with the Department of Children and Family Services for several years to help improve the Childcare Licensing in Illinois. This collaboration has resulted in what may be considered the best Safe Sleep licensing in the country.

Effective June 18, 2008, Childcare Homes and Childcare Group Homes will be required to follow new Safe Sleep requirements. Adding Sudden Infant Death Syndrome (SIDS) education to the third licensure group, Childcare Centers, is still in the process of being adopted and is expected to include the Safe Sleep licensing sometime this fall. SIDS of Illinois will help to spread the word of these changes to all licensed Childcare Providers, Pediatricians and Family Physicians in Illinois.

Every parent with an infant in childcare should make certain that their provider is aware of the changes. In summary:

- 1) When the infant cannot rest or sleep on her/his back due to disability or illness, the caregiver shall have written instructions, signed by a physician, detailing an alternative safe sleep position and/or other special sleeping arrangements for the infant. The caregiver shall sleep the infant in accordance with a physician's written instructions.
- 2) When an infant can easily turn over from the back to tummy position, the infant shall be put down to sleep on his/her back, but allowed to adopt whatever position the infant prefers.
- 3) Infants unable to roll from their stomachs to their backs, and from their backs to their stomachs, when found facedown, shall be placed on their backs.
- 4) No infant shall be put to sleep on a sofa, soft mattress, car seat or swing.
- 5) When an infant is awake, the infant shall be placed on his/her tummy part of the time and observed at all times.

- 6) No positioning device that restricts movement within the child's bed shall be used without written instructions from the child's physician. Soft bedding, bumpers, pillows, quilts, comforters, stuffed toys, laundry and other soft products shall be removed from the crib when children are napping or sleeping. If using a blanket, put the child with feet at the foot of the crib. Tuck a thin blanket around the crib mattress, reaching only as far as the child's chest.

This marks a milestone for SIDS of Illinois as each year in the United States more than 2,200 babies die of Sudden Infant Death Syndrome, a rate of approximately one death every three and one-half hours. In 2006, there were 1301 infant deaths in Illinois, a rate of one death every six hours. Many of these deaths were preventable. The crux of the mission of SIDS of Illinois is educating the population about proven safe sleep tools that parents and caregivers must use to lower the risk of a baby dying. Nationally, nearly 20% of the infants who die of Sudden Infant Death Syndrome die in childcare. SIDS of Illinois works tirelessly with childcare providers and parents to ensure safe sleep for infants. More information on safe sleep practices and SIDS risk reduction can be found at www.sidsillinois.org.

Number of Infant Deaths, Illinois Residents, 2006 Reported to IDPH

<u>Cause of Death</u>	<u>Number of Deaths</u>
All infant deaths, Illinois residents	1,301
SIDS (ICD-10 R95)	83
Accidental Suffocation under age 1 year	33
Undetermined under age 1 year	52

COMMENTARY ON BEDSHARING *continued*

keeping him in a crib instead, close by her bed. *So, why would any group deliberately promote placing infants at a higher level of risk when the same positive outcomes can be achieved without infants bedsharing with a sleeping parent?*

Let's remember that the AAP committee members are the best scientists in this field; they have reviewed all the arguments, slowly and prudently and these are their recommendations. Dr. McKenna had the opportunity to present his findings to them and he was heard. The issue of room sharing and keeping the infant in close proximity was supported; bedsharing was NOT. The AAP recommendations have to be clear; they have to address disparities and their function is to keep the most infants safe from a SUID. They accomplished that.

Let's not continue confusing the public by telling them only about those deaths signed out as SIDS while leaving out the bigger

picture of risk to infants from all kinds of unsafe sleep environments that cause SUID's. When the AAP recommendations are followed, all infants can sleep with the least risks present for sudden death.

Maybe we could focus as much energy on supporting the AAP recommendations as we do in making counter arguments. Let's make sure our recommendations have the same goal theirs had - saving babies from the larger risks of sudden death, including SIDS, but not solely SIDS. It is very misleading when you exclude all the known accidental infant deaths from the subset and then try to set policy with it. Breastfed infants do die in accidents during bedsharing. If all parents followed the AAP recommendations, those deaths would be prevented too.

While being close to baby is good, doing it safely is essential. The AAP statement accomplishes both.

POLICY/PROCEDURE HOSPITAL UNITS HAVING NEWBORNS AND/OR INFANTS

Safe Sleep Practices in Hospitals for Normal Newborns and Young Infants

I. PURPOSE:

To provide guidelines that will ensure a safe sleep environment for all normal newborns and young infants as recommended by The American Academy of Pediatrics (AAP). To ensure modeling behavior that follows these guidelines by hospital staff.

II. POLICY

Safety measures such as positioning the infant on his/her back to sleep and other safe sleep guidelines have been shown to reduce the incidence of Sudden Infant Death Syndrome (SIDS). These same practices will also prevent the risk of asphyxia, entrapment, overlay and accidental suffocation. Parents tend to follow practices that they observe in hospital settings. All staff shall be vigilant about endorsing and modeling the supine sleep position and safe sleep guidelines throughout the infant's hospital stay.

III. PERSONS OR AREAS AFFECTED:

All health care professionals caring for normal newborn and young infants on all hospital units.

IV. DEFINITIONS:

- **Sudden Infant Death Syndrome-** a sudden and unexplained death that usually occurs while the infant is asleep.

V. PROCEDURES:

All full-term newborns and all young infants (unless there are specific doctor orders) will be placed to sleep on their backs.

Blankets used for swaddling should not come up higher than an infant's shoulders.

Soft materials (pillows, quilts, comforters, sheepskin, stuff toys and/or loose bedding) will not be placed in the sleep environment (newborn bassinet, infant crib). Discourage use of these soft materials as well as bumper pads at home as well.

Positioning devices (wedges or rolled up blankets) will not be placed in the sleep environment (newborn bassinet, infant crib).

Bed sharing is acceptable for comforting, feeding, and bonding. However, when the parent and infant are ready for sleep, the infant will be placed in a separate, but proximate sleeping environment (newborn bassinet, infant crib).

Inform parents that offering a pacifier at nap time and bedtime may be helpful in getting the infant to sleep more soundly. Explain why parents should wait one month before offering a pacifier to a breastfeeding baby.

Direct parents to SIDS of IL informational handouts and videos for further information on SIDS.

VI. REFERENCES:

www.SIDSillinois.org

American Academy of Pediatrics Policy Statement 2005: "The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Considering Risk."

INFANT MORTALITY STATISTICS FROM THE 2004 PERIOD LINKED BIRTH/DEATH DATA SET

National Vital Stat Report 2007 May 2

This report presents 2004 period infant mortality statistics from the linked birth/infant death data file by a variety of maternal and infant characteristics. The linked file differs from the mortality file, which is based entirely on death certificate data.

Descriptive tabulations of data are presented and interpreted. Excluding rates by cause of death, the infant mortality rate is now published with two decimal places.

The U.S infant mortality rate was 6.78 infant deaths per 1000 live births in 2004 compared with 6.84 in 2003. Infant mortality rates ranged from 4.67 per 1000 live births for Asian and Pacific Islander mothers to 13.60 for non-Hispanic black mothers. Among Hispanics, rates ranged from 4.55 for Cuban mothers to 7.82 for Puerto Rican mothers. Infant mortality rates were higher for those infants whose mothers were born in the 50 states and the District of Columbia, were unmarried, or were born in multiple births. Infant mortality was also higher for male infants and infants born preterm or at low birth weight. The neonatal mortality rate declined from 4.63 in 2003 to 4.52 in 2004 while the postneonatal mortality rate was essentially unchanged. Infants born at the lowest gestational ages and birth weights have a large impact on overall U.S. infant mortality. More than one half (55%) of all infant deaths in the U.S. in 2004 occurred to the 2% of infants born at less than 32 weeks gestation. Infant mortality rates for later preterm infants were 3 times those for term infants. The three leading causes of infant death – Congenital malformations, low birth weight and SIDS – taken together account for 45% of all infant deaths. Results from a new analysis of preterm related causes of death show that 36.5% of infant deaths in 2004 were due to preterm related causes. The preterm related infant mortality rate for non-Hispanic black mothers was 3.5 times higher, and the rate for Puerto Rican mothers was 75% higher than for non-Hispanic white mothers.

Co-Sleeping – Statistics Gathered From Available Studies

77% of mothers in Oregon bedshare at least sometimes. 35% bedshare usually or always. (Lahr M et al, Oct 2005)

41% of African American infants in St. Louis bedshare. (Unger B et al, Feb 2003)

13% of U.S. infants bedshare usually or always. 20% bedshare 50% of the time or more and almost 50% were bedsharing sometime during the two weeks before the survey. (National Infant Sleep Position Study, Willinger et al, Jan 2003)

75% of Alaskan infants bedshare sometimes or always. 35% always bedshare. (Perham-Hester K, PRAMS, Dec 1999)

50% of infants in Chicago were bedsharing on a reference night. (Hauck F, CIMS, May 2003)

46% of infants in England bedshare for at least sometime during the night. 30% were found to bedshare on any given night. (Blair P, Ball H, Dec 2004)

20% of infants in Scotland were bedsharing during a reference sleep. The number of infants bedsharing at least parttime would be greater. (Tappin D, Jul 2005)

12% of infants are regularly bedsharing in Canterbury, New Zealand. (Ford R, et al, Jan 2000)

23% of infants bedshare in Sweden. (Lindgren C, et al, Oct 1998)



710 East Ogden Avenue
Suite 550
Naperville, IL 60563

ADDRESS SERVICE REQUESTED

NON-PROFIT ORG.
U.S. POSTAGE
PAID
GLENVIEW, IL 60025
PERMIT NO. 238

MISSION STATEMENT

Sudden Infant Death Services of Illinois, Inc. is a not-for-profit organization dedicated to the elimination of Sudden Infant Death Syndrome (SIDS) and other infant deaths, serving the State of Illinois since 1968.

VISION STATEMENT

Sudden Infant Death Services of Illinois, Inc. is a statewide not-for-profit organization dedicated to:

- Supporting family members and others who have been touched by the tragedy of Sudden Infant Death Syndrome (SIDS) or other infant death;
- Educating both the public and professionals about bereavement support and infant mortality reduction;
- Creating community awareness on the subject of SIDS and other infant death; and
- Eliminating SIDS and other infant death through the support and implementation of appropriate research.

RECOMMENDATIONS FOR SUDDEN INFANT DEATH SYNDROME PREVENTION: A DISCUSSION DOCUMENT

EA Mitchell, Arch Dis Child 2007; 92; 155-159

Bed Sharing

This remains controversial although the epidemiological evidence is clear. Bed sharing increases the risk of SIDS. Most, but not all studies show that the increased risk of SIDS with bed sharing is predominantly among infants of mothers who smoke. The major controversy is whether infants of non-smoking mothers are at increased risk. Individually, only some studies have shown an effect, but a meta-analysis has shown an increased risk. More recently, however, the European Concerted Action on SIDS Study has shown an interaction among infant age, (parental) smoking and bed sharing. Infants aged 12 weeks born of non-smokers are at increased risk of SIDS with bed sharing compared with infants of non-smoking mothers not bed sharing. However, this increased risk is quite small compared with infants of maternal smokers who bed share. Some have argued that it is the type of families that share beds that increases the risk rather than bed sharing itself, but this is unlikely. The fact that infants who are placed back in the cot after breastfeeding or cuddles are not at increased risk, and that the risk increases with the duration of bed sharing, suggests that the problem is related to bed sharing rather than other factors.

Sleeping with older siblings is especially dangerous. No data are available on whether twins sleeping together are at similar high risk. The mechanism by which co-sleeping increases the risk of SIDS is unknown. Postulated mechanisms include airway obstruction, thermal stress, head covering and hypoxia due to rebreathing of expired gases. Co-sleeping promotes infant arousals (Mosko S, Richard C, McKenna J, 1997) which does not support the hypothesis that arousal defects may be part of the causal pathway for SIDS. (Phillipson EA, Sullivan CE, 1978)

