Keeping Kids Alive in Virginia

Unsafe Sleep-Related Infant Death in Virginia:
A Preliminary Overview from the State Child Fatality Review Team
Revised January 2014

The Virginia State Child Fatality Review Team examined the deaths of every infant who died in a sleep environment in 2009 to identify risk factors and develop ideas for intervention and prevention of future infant sleep-related deaths. The Team determined that **95%** of these deaths were **definitely or probably preventable** and that **90%** were **related to an unsafe sleeping environment**. In one case the sleep environment was unrelated to the infant's death. This means that the Team was able to identify **clear threats to infant sleep safety**, which were similar to national risk factors for Sudden Unexpected/Unexplained Infant Death (SUID), in all but one case.

An infant died in a sleep environment every 3 days in 2009

119 infants died in a sleep environment in 2009. This is almost 10 times the number of infants who died as a result of Abusive Head Trauma (12) and almost 30 times the number of infants who died in a motor vehicle collision. **After natural disease, sleep-related death is the leading cause of infant death in Virginia.** The causes of death in these cases were SUID, Sudden Infant Death Syndrome (SIDS), and asphyxia deaths occurring in the sleep environment, such as wedging or smothering.

60% were found on their stomachs or sides

57% were bed-sharing with at least one other person

71% were exposed to secondhand tobacco smoke

Black infants died at a rate almost twice that of white infants

What did these sleep environments look like?

- Though the American Academy of Pediatrics has recommended Back to Sleep since 1994, fewer than half (46%) of the infants were placed for sleep on their backs
- At least 60% were found on their stomachs or sides
- Contrary to current Safe to Sleep recommendations, soft bedding such as blankets or pillows were present in the sleep environment in 95% of cases
- 36% of the infants were found fully or partially obstructed by soft bedding or other objects, including other people
- 27% of infants were sleeping in a crib, bassinet or portable crib (e.g. Pack N Play) at the time of their death; 75%[1] of families had one available in the home
- Of those cases where infants were put in locations recommended for safe sleep, soft bedding was present in 94% of the sleep environments and the infant was found on his or her stomach or side in 75% of cases
- 50% of the infants were placed for sleep in an adult bed at the time of their death; 13% were placed on a couch
- At least one person was bed-sharing with the infant in 57% of cases, and of these, at least one co-sleeper was impaired by drugs or alcohol in 26%

[1]An earlier version of this report cited this figure as 83%. This was an error.

Who are the infants most at risk?

- Black infants died in a sleep environment at a rate of 195.5[2], which is more than twice the rate of white infants (90.3)
- Male infants died at a rate of 135.4, a little more than 1.5 times that of female infants (86.1)
- The rate of infant sleep-related deaths in the Western region of Virginia was 219.9, which was 1.4 times that of the Tidewater region (155.2), more than twice that of the Central region (95.4) and almost five times that of the Northern region (44.4)
- 28% of the infants were born premature and 24% had low birth weights
- 44% of the infants were between two and four months of age
- 71% of decedent children were exposed to secondhand smoke

28% were born premature

50% of mothers smoked while pregnant

Who are the mothers and caregivers of these infants?

- 53% were 23 years old or younger, 17% were 19 or younger
- For 31% of mothers, this was their first live birth. For 28%, this was their second or third
- 50% of the mothers smoked while pregnant with the infant who died and 20% showed evidence of substance use/abuse
- 26% of the mothers had not completed high school
- 54% were unemployed
- Medicaid was the insurance provider for 66% of these mothers
- The mother was noted to be at least one of the caregivers in 89% of cases and the father was noted to be at least one of the caretakers in 54%
- In 24% of cases, at least one caregiver was noted to be impaired by alcohol or drugs

1 in 5 mothers used/abused substances while pregnant

22% of infants were in a new or different environment

Male infants died at a rate greater than 1.5 times that of female infants

Which services were in contact with these infants and/or families?

- 26% of these infants were admitted to the Neonatal Intensive Care Unit (NICU) at birth
- 98% had seen a pediatrician at least once; 72% had seen a pediatrician at least one time in the month preceding their death
- 25% of the families were receiving assistance from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- 15% of the families in these cases had undergone a CPS Family Assessment prior to the infant's death; in 10% of cases, the family was undergoing a current Family Assessment or receiving services

36% were found at least partially obstructed by soft bedding, objects or other people

[2] All rates are per 100,000.

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