

Broome County Health Department

CHILD FATALITY REVIEW TEAM FINDINGS & RECOMMENDATIONS



Mission: *The mission of the Broome County Child Fatality Review Team is to improve our understanding of how and why children die in our county, develop and promote a countywide system of child death review and response, and to identify systemic and policy issues and clinical and community interventions to improve child health, safety and protection and to prevent other child deaths.*

Claudia A. Edwards, MS, Public Health Director
Debra A. Preston, Broome County Executive

Table of Contents

Introduction	1
Child Death in Broome County	2
Demographics of Cases Reviewed by the CFRT	4
Manner and Cause of Death	6
Findings & Recommendations	7
Finding 1: Infant Sleep Environment – Safe Sleep Practices	7
Finding 2: Substance Use/Abuse	9
Finding 3: Consumer Product Safety	10
Finding 4: Reduce Risk – Use Well Established Safety Devices/Procedures	10
Team Accomplishments	11
Conclusion	12
Appendix A	13
Appendix B	14

Our vision is that all children live in safe and nurturing homes free from abuse, neglect or exploitation

Introduction:

The Broome County Child Fatality Review Team (BC CFRT) is a multidisciplinary team of professionals established in 2008 pursuant to New York State Social Services Law (SSL) to review the death of any child under the age of 18 whose death is unexpected or unexplained. The Team is authorized to review any unexpected or unexplained death, but priority is given to cases:

- for any child for whom Child Protective Services has an open case,
- any child for whom at the time his/her death has an open preventive services case in Broome County,
- any child who at the time of his/her death was in the care and custody or guardianship and custody of DSS or a voluntary authorized agency,
- or any case in which a report was made to the New York Statewide Central Register of Child Abuse and Maltreatment involving the death of a child.

The mission of the BC CFRT is to improve our understanding of how and why children die, develop and promote a countywide system of child death review and response, and to identify systemic and policy issues, and public health interventions to improve child health, safety and protection. Our ultimate goal is to prevent future deaths and to promote child safety through a confidential review process which is thorough, comprehensive, and multidisciplinary. Our tasks include the following:

- Examine the manner, cause and circumstances of a child's death.
- Examine the investigative actions of agencies as applicable.
- Identify risk factors and trends in child deaths.
- Identify specific barriers and systems issues involved in the deaths of children.
- Increase public awareness, through education and advocacy, of the issues identified as affecting the health and safety of children.
- Promote policies, practices, and legislation (when appropriate) and expand efforts in child health and safety to prevent child deaths.
- Improve communication and linkages among local and state agencies and coordination of efforts.

- Develop strategies to improve the accurate identification and uniform consistent reporting of the cause and manner of death, improve the death investigation process; and responses to protect siblings and other children in the homes of deceased children.
- Identify training needs for professionals.

Team membership is defined by New York State Social Services Law which requires the participation of certain agencies as well as allowing for the appointment of professionals from various fields of practice. The multidisciplinary approach is an effective strategy to study the issues related to child death and to move toward solutions. Each case can be reviewed from various perspectives and the collective expertise of the team can engage policy and practice reform. The BC CFRT enjoys membership from community leaders in medicine, law enforcement, child welfare, public health, and behavioral health.

A complete list of team member agencies can be found in *Appendix A*. The BC CFRT has been reviewing cases on a monthly basis since March of 2009. Meetings are highly confidential as dictated by statute and thus are closed to the public. A protocol and procedure manual was developed by the team in 2008 and has been renewed in accordance with New York State Social Services Law and the rules and regulations promulgated by the New York State Office of Children and Family Services.

Between March, 2009 and December, 2012, the team has conducted an in-depth review of 44 cases involving children who died during the years 2007-2012. This summary report provides information regarding the more general findings of this review process and the team's recommendations related to those findings.

Child Death in Broome County:

An important facet to understanding child death is to examine mortality data over a period of time. Since BC CFRT does not review the death of every child, the following data serves as a point of reference for the work of the team. *Table 1* presents data related to the total number of Broome County children who died between the ages of 0-19 and of those children, the total number of infants. It should be noted, as *Table 1* illustrates, about 60 percent of all child deaths in Broome County (2000-2010) involve infants under the age of one. Additionally, although the number of child deaths in Broome County account for a very small percentage of the overall number of child deaths in New York State, the number of children who have died in New York State has been on a steady decline since 2000, whereas Broome County deaths have remained relatively stable.

Table 1

Year of Death	Total # of Child Deaths Broome Aged 0-19¹	Total Number of Infants²	Total Number of Children Aged >1	Total # of Child Deaths NYS Aged 0-19
2000	28	21	7	2,843
2001	28	14	14	2,740
2002	27	17	10	2,701
2003	31	16	15	2,691
2004	28	12	16	2,652
2005	21	11	10	2,529
2006	35	17	18	2,463
2007	35	24	11	2,426
2008	30	19	11	2,371
2009	31	26	5	2,309
2010	16	9	7	2,157
Total	310	186	124	

Closer examination of infant death data provides further definition as to age of infants at the time of their death. *Table 2* presents data on infant mortality within Broome County for the years 2000 – 2010. Included in *Table 2* are infant death rates defined as deaths under the age of 1 year per 1,000 live births; neonatal death rate defined as deaths less than 28 days of age per 1,000 live births; and post neonatal death rate defined at age 28 days and older but less than 1 year per 1,000 live births. It is important to note that of the 186 infant deaths during this ten year time period, 133 involved the death of an infant under the age of 28 days, underscoring the vulnerability of the neonatal period. Deaths in the neonatal period are often due to conditions of being born premature or congenital defects. Similar to Broome, a condition in the perinatal period is the leading cause of death for infants across New York State 2000-2009.³

¹ Source: *Vital Statistics of New York State*, New York State Department of Health

² Infant is defined as less than one year of age.

³ NYS Department of Health, *Leading Causes of Death, Infant Mortality, New York State, 2000-2009*.

Retrieved on 8/21/12 from

http://www.health.ny.gov/statistics/leadingcauses/leadingcauses_death/gender/nys_infants

Table 2

	<u># Infant Deaths < 1 year</u>	<u>Infant Death Rate</u>	<u># Neonatal Deaths < 28 day</u>	<u>Neonatal Death Rate</u>	<u># Post Neonatal Deaths 28 days - < 1 year</u>	<u>Post Neonatal Death Rate</u>
2000	21	9.5 (6.3) *	14	6.3 (4.5)	7	3.2 (1.7)
2001	14	6.5 (5.9)	10	4.7 (4.0)	4	1.9 (1.9)
2002	17	8.2 (6.0)	16	7.8 (4.5)	1	0.5 (1.6)
2003	16	7.7 (5.8)	11	5.3 (4.2)	5	2.4 (1.7)
2004	12	5.9 (6.0)	8	4.0 (4.4)	4	2.0 (1.6)
2005	11	5.4 (5.9)	7	3.4 (4.3)	4	2.0 (1.6)
2006	17	8.0 (5.5)	11	5.2 (3.8)	6	2.8 (1.7)
2007	24	11.3 (5.9)	18	8.5 (4.0)	6	2.8 (1.8)
2008	19	9.2 (5.8)	15	7.2 (4.0)	4	1.9 (1.8)
2009	26	12.6 (5.6)	18	8.7 (4.0)	8	3.9 (1.7)
2010	9	4.4 (5.6)	5	2.4 (4.1)	4	2.0 (1.5)
Total	186		133		53	

* Numbers in () reference values in the Upstate Region.

Demographics of Cases Reviewed by the CFRT:

As noted above, the BC CFRT reviews cases in which a child's death is unexpected or unexplained with priority given to SSL §20 cases. The team does not review the deaths of newborns who die as the result of prematurity or congenital conditions, unless such deaths fall under SSL §20. As a result, about 12 cases are reviewed each year. This report details the findings of a total of 44 cases which were reviewed from March 2009 – December, 2012. *Table #3* presents data about the number of cases reviewed by year of death.

Table 3: Cases Reviewed by Year of Death

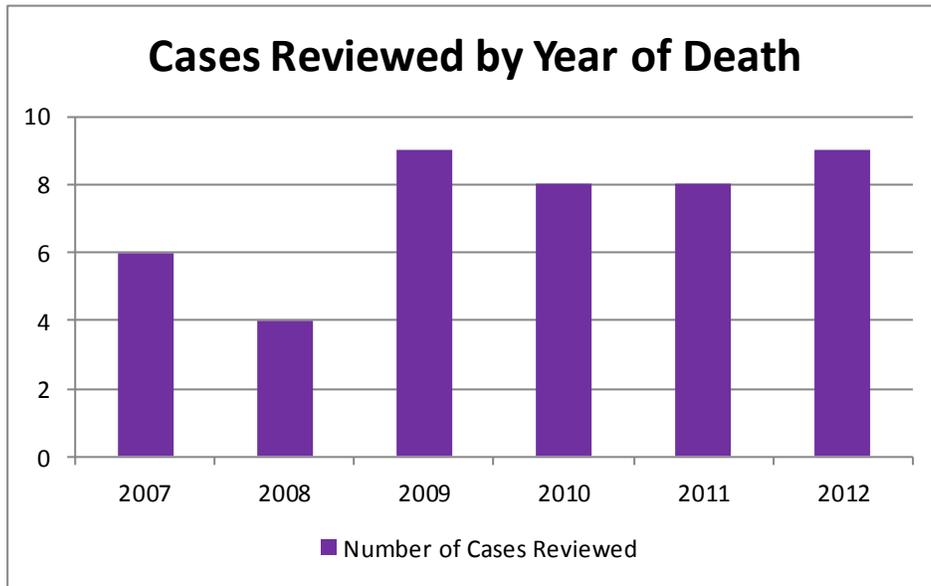
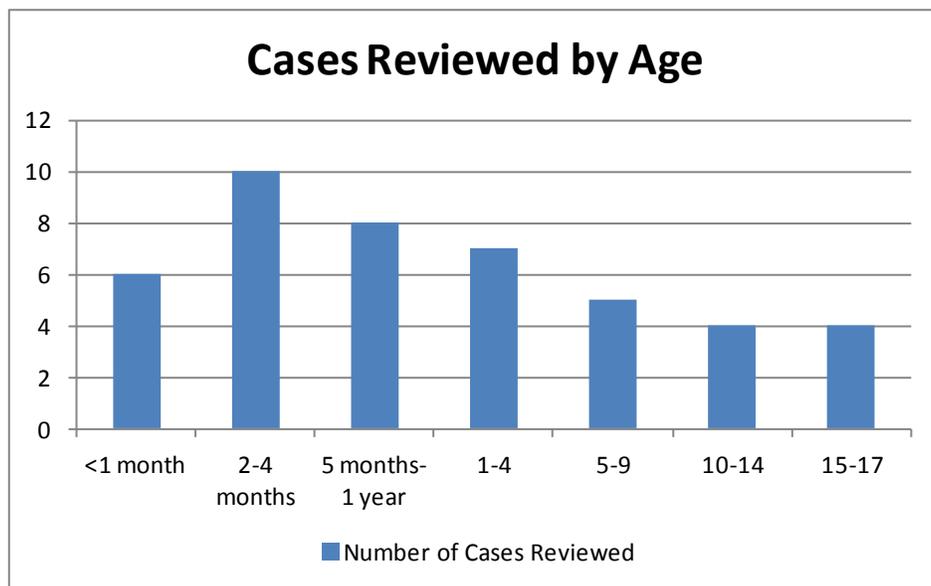


Table 4 lists the age of the children at the time of their death. It is important to note over 50 percent of the cases reviewed involved infants under the age of one year old. All 24 infant deaths reviewed involved babies for whom death was unexpected or unexplained.

Table 4: Cases Reviewed by Age



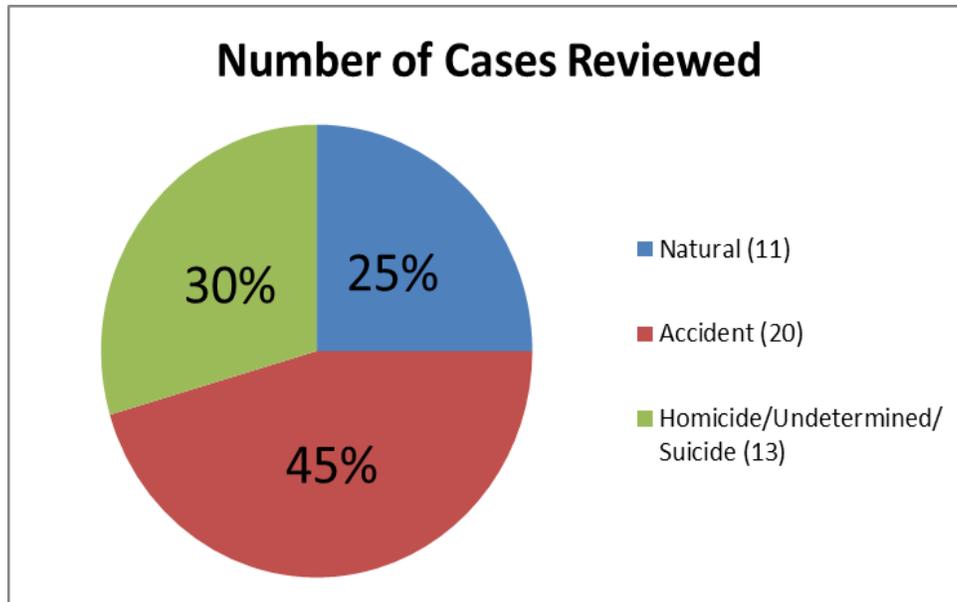
Additionally, 25 cases involved males and 19 involved females. The racial categories are those identified on the New York State Death Certificate; however, due to the low numbers of those children in the non-White categories, they are presented here as Non-White to protect confidentiality. Of the 44 cases reviewed, 38 children were White and 6 were Non-White.

Manner and Cause of Death:

All death certificates involve a determination of the manner of death, as well as the cause of death. The manner of death is characterized into different categories: natural, accident, homicide, suicide, or undetermined/pending. The cause of death relates specifically to physical condition that led to an individual's death. Deaths in New York State are certified by physicians, coroners, or medical examiners. State law was recently amended to also include licensed nurse practitioners. Most of the deaths that come under the purview of the BC CFRT were certified by a Broome County Coroner. All four coroners in Broome County are physicians, as dictated by Broome County's Charter. Several BC CFRT cases were certified by the Onondaga County Medical Examiner's office and several were certified by an attending physician.

Certifying death is a complex process that generally involves an autopsy, a death scene investigation if relevant, and a review of the decedent's medical records. Autopsies are performed by physicians who are specially trained as general pathologists, pediatric pathologists, or forensic pathologists. *Table 5* presents the BC CFRT cases by manner of death as determined by the death certificate. Categories are condensed to protect confidentiality. Further detail regarding the cause of the death is not provided in this document in order to protect individual confidentiality.

Table 5: Deaths Reviewed 2007-2012: Children aged 0-17



Natural Deaths: Twenty-five percent of cases were determined to be natural deaths. Some of these cases involved acute illnesses or conditions suffered by children with chronic medical concerns, whereas other cases involved an undiagnosed congenital condition or an illness of unknown origin. Some cases were certified as Sudden Infant Death Syndrome (SIDS).

Accident: A significant number of deaths, or 45%, were certified as accidental deaths. These cases involved accidental asphyxiation, drowning, smoke inhalation, injuries due to a fall, prescription drug overdose, and transportation-related deaths.

Homicide, Suicide, and Undetermined: Thirty percent of the deaths reviewed were certified in one of these categories. As noted above, this category condenses homicide, suicide and undetermined. Of these, the majority (or 62%) were undetermined. These cases involved a manner of death that could not be firmly established by the Coroner MD or the Pathologist after an investigation was completed.

It is important to note, the CFRT process resulted in the recommendation that two death certificates be changed. The recommendations were considered and in one instance the death certificate was changed to reflect team findings.

Findings and Recommendations:

The BC CFRT reviews cases individually in a manner that is as comprehensive as possible. As referenced above, priority is given to review cases with DSS involvement. Regarding DSS involvement, it is important to note what the team did NOT find. There were no cases where DSS or any other local agency involvement could have prevented any of the 44 cases reviewed. DSS consistently conducted thorough investigations; appropriately provided protection for surviving children, when necessary; and provided families with significant services and referrals.

The following findings presented in this report represent the major themes that have emerged from reviewing cases over the course of several years. The BC CFRT is most concerned with identifying patterns of risk that exist in the community, which if changed, could result in preventing some child deaths in the future. It is important to note that it is not possible to prevent all deaths from occurring; however, much has been learned about child health and safety by examining the risk factors that exist in child fatalities. The team offers the following findings with corresponding community recommendations:

Finding 1: Infant Sleep Environment – Safe Sleep Practices

There has been much discussion in recent years about the role of safe sleep practices in reducing sudden infant death. As has been found by child fatality review teams around

the county, the BC CFRT found that sleep environment is a very important element to be considered in understanding how and why some infants die. This report provides the opportunity to re-iterate the importance of the infant sleep environment.

The team recommends caregivers follow the recommendations provided by the American Academy of Pediatrics⁴. Infants should be placed on their back, in an empty crib. The crib should meet current safety standards and have a firm mattress sized appropriately for the crib, with a tight fitting sheet. The crib should be free from bumper pads, pillows, blankets, stuffed animals, etc. Additionally, newborns can benefit by being in close proximity to their parents, so if possible the crib should be positioned in the same room as the parents. Room-sharing can facilitate breast feeding and bonding.

Of the cases reviewed by the BC CFRT, regardless of death certification, the team determined 17 cases involved hazardous sleep environments. Hazardous sleep environments involve infants placed to sleep in environments that place them at significant risk of suffocation or asphyxiation. Such environments include presence of pillows, cushions, blankets, comforters, stuffed animals, pets, siblings, and include instances in which a child is placed to sleep on their stomach. In addition, infants are at risk when placed to sleep in products not meant for such purpose (such as a couch, chair, boppy pillow or car seat), when an infant's size has exceeded the limit set for product safety, or if the product has not been assembled properly.

Most notable, in 10 cases an infant was co-sleeping with or sharing a sleep surface with at least one adult. At some point during the sleep episode the adult(s) and/or the bedding created a situation in which the infant was asphyxiated or suffocated. Co-sleeping between an infant and other individuals or pets is dangerous. All of these co-sleeping deaths may have been preventable.

As a result of BC CFRT's above findings that unsafe sleep caused children's deaths, the BC CFRT reviewed various educational opportunities parents and caregivers have to learn about safe sleep within our Broome County community. The BC CFRT determined the safe sleep message is routinely given at local hospitals, through family care and pediatric physicians, and community agencies. To strengthen this important message, the team sponsored a television commercial, purchased educational materials, and team members participated in several local news reports. Further, organizations such as Mothers and Babies Perinatal Network, Broome County's Health Department and Family Violence Prevention Council reaffirmed their commitment to continue to educate our community about the importance of safe sleep.

The BC CFRT recommends the community continue to invest in educating all types of caregivers regarding safe sleep of infants, including; parents, grandparents, intimate partners, daycare providers, and babysitters. The community should also continue to

⁴ American Academy of Pediatrics, Retrieved on 3/18/13 from <http://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Expands-Guidelines-for-Infant-Sleep-Safety-and-SIDS-Risk-Reduction.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token>.

invest in the training of professionals, such as health care professionals and others who work with families. See *Appendix B* for a complete list of safe sleep recommendations.

Finding #2: Substance Use/Abuse

Another finding of the BC CRFT is the relationship between use of substances and child death. In at least 7 cases, use of prescription drugs, alcohol, or illicit drugs by a primary caretaker was determined to be a contributing factor in the events that led to a child's death. In other cases, impairment of a caretaker was suspected. Tragically, several children died as a result of accidental prescription drug poisoning/overdose.

The BC CRFT found the prescription of opiate drugs the most problematic. The following community recommendations are made:

- Caretakers be better advised by their physicians and pharmacists about the impact various prescriptions may have on their ability to properly attend to and supervise young children.
- Drivers should be advised by their physicians and pharmacists about the impact various medications may have on their ability to drive and respond to dangers in the road.
- All prescription drugs and over-the-counter drugs should be kept out of the reach of children, and certain drugs should be kept in a locked box.
- As improper disposal can cause child death, community education regarding proper disposal of various prescription medications.
- Increase the number of opportunities and continue to emphasize the availability for unused pharmaceuticals to be properly disposed of within the drop off disposal program provided by the Broome County Sheriff's Office.

It should also be noted, many children whose cases were reviewed were exposed to secondhand tobacco smoke, although such exposure was not directly linked to their death. Secondhand smoke exposure is a concern for the overall health and well-being of children and is well established in research literature as a risk factor specifically related to Sudden Unexpected Infant Death. The risk for Sudden Unexpected Infant Death increases for babies whose mothers smoked while they were pregnant and for those infants exposed after birth. Chemicals in secondhand smoke appear to affect an infant's brain in ways that interfere with the regulation of breathing. In fact, the Surgeon General has concluded that there is no risk-free level of exposure to secondhand smoke for children, as even brief exposure can be harmful.⁵

⁵ U.S. Department of Health and Human Services. 2006, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Retrieved 12/28/12.

Finding #3: Consumer Product Safety

Several cases reviewed by the team involved use/misuse of a consumer product. The team concluded the community would greatly benefit from a heightened awareness of possible dangers that could exist in consumer products, particularly those designed for young children. The following recommendations are made:

- Promote community notification of recalled child products.
- Consumers should not modify products from their original design.
- Consumers/caretakers should use products as they are recommended by the manufacturer.
- Since there is no way to assure that second-hand products meet current safety standards, it is recommended that caregivers not use products which are second-hand, found, or of unknown history. It is important that all products be assembled with proper parts as directed by manufacturer instruction.
- Encourage consumers to maintain a file for instructions on the products they purchase ...paying particular attention to when they should stop using the product because of weight/age restrictions. Consumers should flag dates to periodically read instructions. Store these essential documents for use with future children.
- Educate consumers that just because a product is sold in the store it does not mean it is safe or necessary. For instance, crib bumper pads are NOT NECESSARY; yet do present a potential hazard. The American Academy of Pediatrics states “Bumper pads should not be used in cribs. There is no evidence that bumper pads prevent injuries, and there is a potential risk of suffocation, strangulation or entrapment.”⁶ When shopping for products for babies or children, consumers should carefully inspect product for potential hazards, even if product has not been recalled.
- Children should be supervised when using products/toys.

Finding #4: Reduce Risk - Use Well Established Safety Devices/Procedures

Many deaths reviewed by the team were deemed preventable. The review process identified issues regarding child health and safety that could apply to the broader community, even if a particular child’s death could not reasonably have been prevented. Children’s health and safety can be maximized by utilizing devices or processes and procedures intended to protect the health and safety of children. Examples include:

⁶ American Academy of Pediatrics. Retrieved on 3/18/13 from <http://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Expands-Guidelines-for-Infant-Sleep-Safety-and-SIDS-Risk-Reduction.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token>.

- Caretakers should have a general understanding of the various developmental milestones of babies and young children. Knowledge of children’s developmental ability will enable caretakers to adhere to **safety guidelines appropriate for the age of the child**.
- **Proper adult supervision** is critical to children’s health and safety.
- **Use smoke and carbon monoxide detectors.** Ensure batteries are routinely changed.
- **Pools and other bodies of water should be fenced off and locked. Children should always be supervised around bodies of water.**
- **Prevent fatal automobile accidents; use, booster seats, car seats, and seat belts** in the appropriate manner based on weight and age of the child.
- **Baby monitors** can alert caretakers that a baby is having difficulty during sleep; however, monitors need to be placed in a safe location away from the baby as the **electrical cord can cause hazards**.
- **Medications should be disposed of and stored properly. Medications must be kept** out of reach of children. Some medications may be better stored in a locked box.
- **Window locks/guards should be used** to prevent fatal falls. Windows should be free of window treatments with cords.
- **Practice gun safety/keep guns and ammunition locked.**
- **Children should be breast-fed; as it is associated with a reduced risk of Sudden Infant Death Syndrome. Breast-feeding improves mother-child bonding; and promotes positive health,** psycho-social, economic, and environmental effects.⁷
- **Promote preventive healthcare:** pre-natal care; pediatric health, dental, and vision care. Promote immunizations.

Team Accomplishments:

The BC CFRT, in partnership with other local organizations and agencies, accomplished a number of important endeavors since its 2008 inception. These achievements are a reflection of the work of a dedicated group of professionals in Broome County who care very deeply about the well-being of our children. The following summarizes some of the more significant accomplishments and outcomes of the BC CFRT process.

- **Professional Education:** The CFRT sponsored two trainings for law enforcement and child protective workers regarding infant death investigation. Team members also participated in a number of trainings involving a wide range of topics that relate to child health/safety and child death investigation.

⁷ U.S. Department of Health and Human Services. *The Surgeon General’s Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. This publication is available at <http://www.surgeongeneral.gov>.

- ***Safe Sleep Message Strengthened:*** Two newspaper articles were published to address the issue and the team sponsored a television commercial. The team corresponded with national media/corporations to reinforce the safe sleep message. The team also partnered with other organizations to assist in purchasing educational materials for community distribution. Community partners continue to strengthen safe sleep message.
- ***Consumer Product Safety:*** Three reports involving questionable products were made to the Consumer Product Safety Commission.
- ***Traffic Safety:*** Transportation officials installed new signs on a busy road, after the team recommended officials' review the roadway after a fatality to warn drivers of a potential safety concern.
- ***Child Abuse Prevention:*** In partnership with Broome County's Family Violence Prevention Council, the team supported the "*Choose your Partner Wisely*" prevention campaign.
- ***Prescription Drug Safety:*** In partnership with Broome County's Sheriff's Office, additional "drug drop off" sites were added in the county.
- ***Professional Development:*** The CFRT process has been instrumental in increasing our understanding of how and why children die. Each of the professionals involved has developed many new insights that can improve their own professional practice and knowledge base across multiple disciplines.
- ***Building a Library:*** The team is staying updated on recent research related to child death.
- ***Improved Process/Communication:*** The BC CFRT also acknowledges improvements have been made in the death investigation and certification process as well as improved communication between agencies as a result of the review process.
- ***Broome's Child Fatality Review Team used as Model:*** Upon recommendation of State officials and other professionals, child fatality review team members from other communities and communities without review teams have observed team meetings to determine how their community may benefit from Broome's experience.

Conclusion:

This *Community Report* provides general findings of Broome County's Child Fatality Review Team from 44 cases reviewed. These reviews occurred between March, 2009 and December, 2012. These reviews involved child deaths occurring from 2007 - 2012. Case specific findings have also been identified. Those specific findings are currently being followed-up on in a variety of ways by BC CFRT members and community partners.

This *Community Report* is the first of its kind. This *Report* will be updated periodically to reflect team findings and recommendations as the team continues its work into 2013.

APPENDIX A

**BROOME COUNTY CHILD FATALITY REVIEW TEAM
REPRESENTED AGENCIES
MARCH 2013**

Broome County Health Department

Public Health Director
Director of Maternal Child Health & Development
Medical Director
Associate Professor, Department of Public Justice

Broome County Mental Health

Commissioner
Director of Clinic Services

Broome County Office of Emergency Services

Emergency Medical Services Coordinator

Broome County Social Services

Commissioner
Director of Adult and Child Protective Services
DSS Attorney

County Attorney's Office

Deputy County Attorney
Coroner

District Attorney's Office

District Attorney

Family Violence Prevention Council

Coordinator

Lourdes Hospital

Forensic Pathologist
Emergency Room Director
Director of Social Work

Mothers & Babies Perinatal Network

Executive Director

New York State Police

Senior Investigator, Kirkwood
Lieutenant, Sidney

NYS Office of Children & Family Services

Designated Representative

Office of the Sheriff

Sheriff
Captain of Law Enforcement Division

United Health Services Hospital

Neonatologist
Addiction Medicine Specialist

What does a safe sleep environment look like?

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death



Use a firm sleep surface, such as a mattress in a safety-approved* crib, covered by a fitted sheet.

Do not use pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area.

Keep soft objects, toys, and loose bedding out of your baby's sleep area.

Do not smoke or let anyone smoke around your baby.

Make sure nothing covers the baby's head.

Always place your baby on his or her back to sleep, for naps and at night.

Dress your baby in light sleep clothing, such as a one-piece sleeper, and do not use a blanket.

Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.

*For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or <http://www.cpsc.gov>.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
Eunice Kennedy Shriver National Institute of Child Health and Human Development



Safe Sleep For Your Baby



- Always place your baby on his or her back to sleep, for naps and at night, to reduce the risk of SIDS.
- Use a firm sleep surface, covered by a fitted sheet, to reduce the risk of SIDS and other sleep-related causes of infant death.
- Your baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.
- Keep soft objects, toys, and loose bedding out of your baby's sleep area to reduce the risk of SIDS and other sleep-related causes of infant death.
- To reduce the risk of SIDS, women should:
 - Get regular health care during pregnancy, and
 - Not smoke, drink alcohol, or use illegal drugs during pregnancy or after the baby is born.
- To reduce the risk of SIDS, do not smoke during pregnancy, and do not smoke or allow smoking around your baby.
- Breastfeed your baby to reduce the risk of SIDS.
- Give your baby a dry pacifier that is not attached to a string for naps and at night to reduce the risk of SIDS.
- Do not let your baby get too hot during sleep.
- Follow health care provider guidance on your baby's vaccines and regular health checkups.
- Avoid products that claim to reduce the risk of SIDS and other sleep-related causes of infant death.
- Do not use home heart or breathing monitors to reduce the risk of SIDS.
- Give your baby plenty of Tummy Time when he or she is awake and when someone is watching.



Remember Tummy Time!

Place babies on their stomachs when they are awake and when someone is watching. Tummy Time helps your baby's head, neck, and shoulder muscles get stronger and helps to prevent flat spots on the head.

For more information about SIDS and the Safe to Sleep campaign:

Mail: 31 Center Drive, 31/2A32, Bethesda, MD 20892-2425

Phone: 1-800-505-CRIB (2742)

Fax: 1-866-760-5947

Website: <http://www.nichd.nih.gov/SIDS>

NIH Pub. No. 12-5759

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