

National Center Quick-Look

Sleep-Related Infant Deaths



Collect

The National Center for Fatality Review and Prevention collects information on sleep-related infant deaths in the National Fatality Review-Case Reporting System (NFR-CRS).



Data

This Quick-Look examines the 26,059 deaths of infants less than 12 months old whose deaths were related to the sleep environment.¹



Learn

To see other Quick-Looks using NFR-CRS data and learn more, visit the National Center's website at ncfrp.org.

National Center's Structural Inequity Statement

Some families lose infants, children and youth to the types of deaths reviewed by fatality review teams not as a result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds can also contribute to a child's death. Segregation impacts access to high-quality education, employment opportunities, healthy foods and healthcare. Combined, the economic injustices associated with residential, educational, and occupational segregation have lasting health impacts that include adverse birth outcomes, infant mortality, high rates of homicide and gun violence and increased motor vehicle deaths.

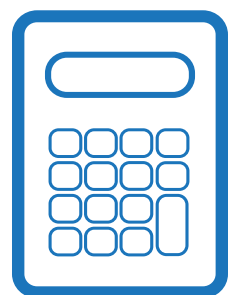
Demographics and Birth History



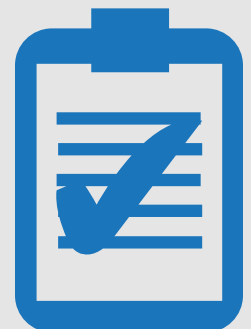
22% of infants were low birth weight—weighing less than 5lbs. 8oz



25% of infants were preterm—born prior to the 37th week of pregnancy



Median age of the infants at time of death was **87 days**



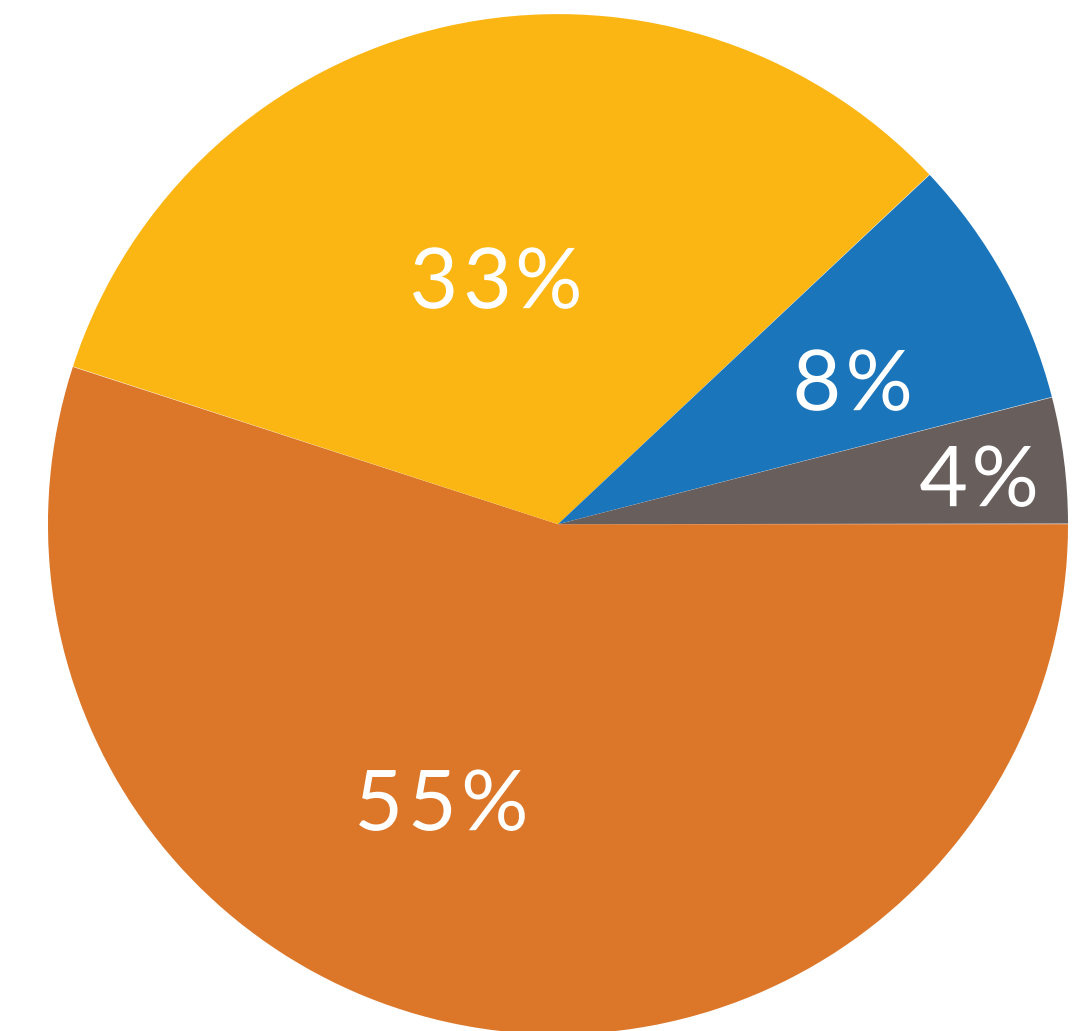
74% of infants were covered by Medicaid insurance



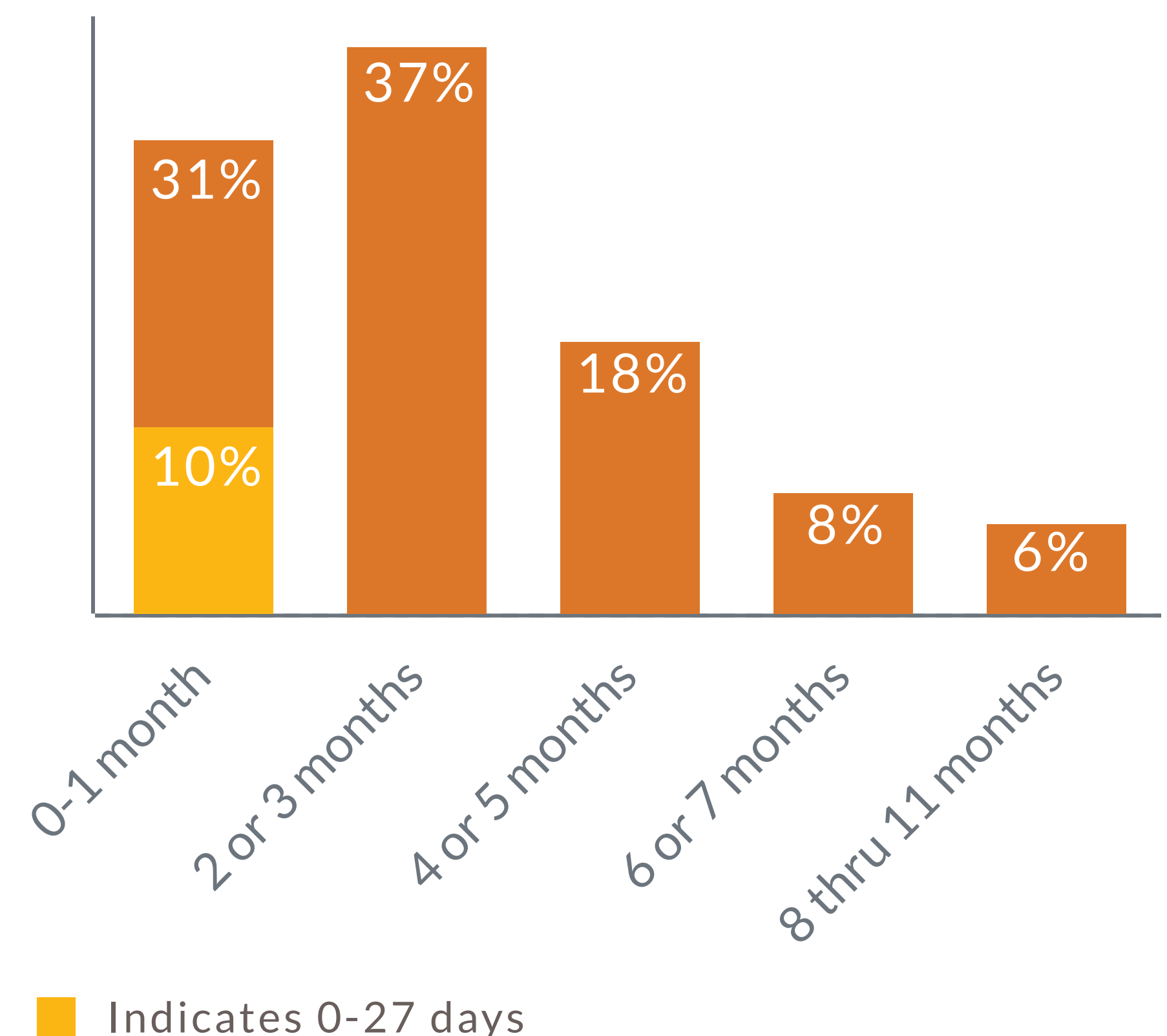
86% of deaths occurred in the first 5 months of life

Race

White (55%)
Black (33%)
Other (8%)
Missing (4%)



Age



Incident Details



51% occurred in an adult bed



56% of sleep environments contained soft objects like pillows, blankets, or bumper pads



21% were found in a new or different sleeping environment



66% were surface-sharing with another person at the time of the incident



24% occurred in a crib or bassinette



37% were found on their back

48% were found on their stomach

16% were found on their side



When their status was known, 79% of supervisors were not impaired at the time of incident*

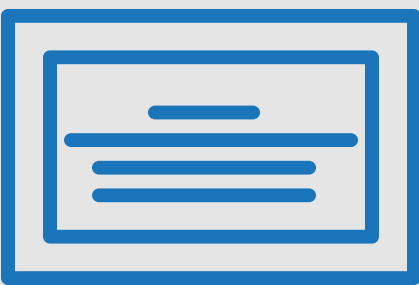
*Whether a supervisor was impaired was unknown in 14% of these cases

Investigation and Community Response



Death scene investigation

- conducted in 97% of deaths



Primary cause of death

- 36% injury
 - Of *injuries*, 87% were determined to be asphyxia
- 25% medical condition
 - Of *medical* causes, 68% were determined to be SIDS
- 36% undetermined if injury or medical condition
 - Of *undetermined* causes, 88% were undetermined manner

Community Response Site-Specific Recommendations...

1

Delaware

Launched an infant safe sleep media campaign to increase community awareness about unsafe sleep risk factors

2

Michigan

Passed the Infant Safe Sleep Awareness and Education Act, requiring hospitals to provide infant safe sleep education and materials before post-birth hospital discharge

3

Tennessee

Implemented the Direct On Scene Education (DOSE) program, training first responders to identify unsafe infant sleep conditions and provide a safe sleep kit and education to pregnant women or families when called out to homes

Prevention Resources



Safe Sleep for Babies,
Centers for Disease
Control and
Prevention



<https://www.cdc.gov/vitalsigns/safesleep/index.html>



Safe to Sleep, National
Institute for Child
Health and Human
Development



<https://safetosleep.nichd.nih.gov/>



Safe Sleep, American
Academy of Pediatrics



<https://www.aap.org/en-us/about-the-aap/aap-press-room/campaigns/Safe-Sleep/Pages/default.aspx>

National Center for Fatality Review & Prevention Supporting Fetal and Infant Mortality Review and Child Death Review Teams

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1. These deaths have been reviewed and recorded into the NFR-CRS by participating fatality review teams. Some percentages may not add up to 100% due to rounding.

These data represent a smaller percent of the cases entered into the NFR-CRS. For more information about the data contained in this Quick-Look, please visit https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/NCFRP_Quick_Looks_Analysis.pdf