INVESTIGATION INTO SLEEP-RELATED INFANT DEATHS

The Western Australian Ombudsman has today tabled in Parliament an own motion investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths.

1. Background

The Western Australian Ombudsman reviews certain child deaths, identifies patterns and trends arising from these reviews and makes recommendations designed to prevent or reduce investigable child deaths.

“In undertaking my child death review function I identified a need to undertake an investigation into the number of deaths that have occurred after infants have been placed to sleep,” said Western Australian Ombudsman Chris Field.

2. What is a sleep-related infant death?

A sleep-related infant death is defined in the report as a death that has occurred after an infant has been placed to sleep. An infant is defined as a child under the age of 12 months.

3. Objectives of the investigation

The objectives of the investigation were to:

- analyse all sleep-related infant deaths notified to the Ombudsman between 1 July 2009 and 31 December 2011;
- undertake research, including a comprehensive literature and practice review, in relation to sleep-related infant deaths;
- undertake consultation with key stakeholders;
- identify patterns and trends specifically in relation to sleep-related infant deaths; and
- from this analysis, pattern and trend identification, research and consultation, identify opportunities for State Government departments to prevent or reduce sleep-related infant deaths, and make recommendations to these departments accordingly.

4. Child deaths included in investigation

Over the period 1 July 2009 to 31 December 2011, the Chief Executive Officer of the Department for Child Protection notified the Ombudsman of 242 child deaths. Ninety one (38%) of these deaths concerned infants and in 54 (59%) of these cases, the information provided in the notification indicated that the infant appeared to die during their sleep.

-FOLLOWS-

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5. Agencies included in investigation

The investigation principally involved the Department of Health, but also involved the Department for Child Protection and the Department for Communities.

6. What are infant death risk factors?

The most frequent cause of sleep-related infant deaths is likely to be Sudden Infant Death Syndrome (SIDS). Certain factors increase the risk of SIDS. It is important to note that these risk factors are correlative, not necessarily causal.

The infant risk factors are: infant is aged older than one month and less than four months; infant is male; infant was born prematurely; infant had low birth weight; and infant's mother smoked during pregnancy. These infant risk factors for SIDS have also been found to be relevant to other types of sleep-related infant deaths. Our analysis found that these infant risk factors were also prominent among the sleep-related infant deaths notified to the Ombudsman.

Other identified risk factors for SIDS concern characteristics of the infant's sleeping environment (environmental risk factors). These environmental risk factors are: prone sleeping position; unsafe sleeping surface; unsafe bedding; and environmental tobacco smoke (within the infant's sleeping environment). These environmental risk factors for SIDS have also been found to be relevant to other types of sleep-related infant deaths. Our analysis found that these environmental risk factors were also prominent among the sleep-related infant deaths notified to the Ombudsman.

7. Findings

The investigation found that the Department of Health has undertaken a range of work to contribute to safe sleeping practices in Western Australia, however, there is still important work to be done.

"This work particularly includes establishing a comprehensive statement on safe sleeping that will form the basis for safe sleeping advice to parents, including advice on modifiable risk factors, that is sensitive and appropriate to both Indigenous and culturally and linguistically diverse communities and is consistently applied state-wide by health care professionals and non-government organisations at the antenatal, hospital-care and post-hospital stages," said Mr Field.

"This statement and concomitant policies and practices should also be adopted, as relevant, by the Department for Child Protection and the Department for Communities."

The investigation also found that a range of risk factors were prominent in sleep-related infant deaths reported to the Ombudsman's office.

"Most of these risk factors are potentially modifiable and therefore present opportunities for the departments to assist parents, grandparents and carers to modify these risk factors and reduce or prevent sleep-related infant deaths," said Mr Field.

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8. Recommendations

Arising from this investigation, the report makes 23 recommendations about ways to prevent or reduce sleep-related infant deaths.

“I am very pleased that each department has agreed to these recommendations and has, more generally, been highly co-operative and positively engaged with our investigation,” said Mr Field.

“Each of these recommendations will be monitored by our office to ensure their implementation and effectiveness in relation to the observations made in the investigation,” Mr Field said.

The report titled *Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths* is available from the Ombudsman’s website at **www.ombudsman.wa.gov.au/infantdeathsreport**

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