

Butte and Glenn Counties Child Death Review Team

Report 2010-2015

INTRODUCTION

Children are not supposed to die. The death of a child is a profound loss, not only to the child's parents and family, but also to the larger community. In order to reduce the numbers of these tragic losses, we must first understand how and why our children are dying.

In 1978 Los Angeles County began the LA Interagency Council on Child Abuse and Neglect (ICAN). The idea behind ICAN was that if you could bring a multidisciplinary team together to review cases of child deaths due to abuse or neglect, you could discover interventions that could prevent future deaths. This was the starting point for Child Death Review Teams (CDRT) that now exists throughout the nation and the world. Over the years, especially in smaller counties, the scope of the teams broadened to include the examination of all child and infant deaths, the intent being to focus attention on the prevention of intentional and unintentional deaths. The Butte & Glenn Counties CDRT was formed in 1990 from members of the joint Interagency Council and the Child Abuse Prevention Council and has been active for 25 years.

The local Child Death Review Team consists of a multidisciplinary team of government and community agencies that provide services to the families of our communities. Members include representatives from the counties' Coroner and Sheriff's Offices, Forensic Pathologist, local Law Enforcement, Fire and Emergency Services, District Attorney, Public Health, Child Services, Behavioral Health and Office of Education. These government agencies are joined by members representing Child Advocacy groups, the local hospitals and clinics, and community non-profit agencies that work with families. The team meets quarterly to review all fetal deaths and deaths of children 0 up to age 18 that occur in Butte and Glenn counties, regardless of the cause of deaths. Although we review fetal deaths they will not be included in this report. The work of the CDRT is highly confidential and focuses on investigation, system study, service planning, data collection and prevention, with the goal of understanding how children die and taking action to prevent other deaths. It also plays a critical role in improving intervention, while enhancing education and awareness for future prevention of child deaths.

The role of team members can be flexible to meet the needs of particular communities. Each member should:

- Contribute information from his or her records
- Serve as a liaison to respective professional counterparts
- Provide definitions of professional terminology
- Interpret agency procedures and policies
- Explain the legal responsibilities or limitations of his or her profession
- Participate in a respectful manner that is free from judgment or blame

They also assist with referrals for services or provide direct aid to surviving family members. All team members must have a clear understanding of their own and other professional and agency roles and responsibilities in their community's response to child fatalities. The integration of these roles is key to a well-coordinated child death response system.

Scope of the Data

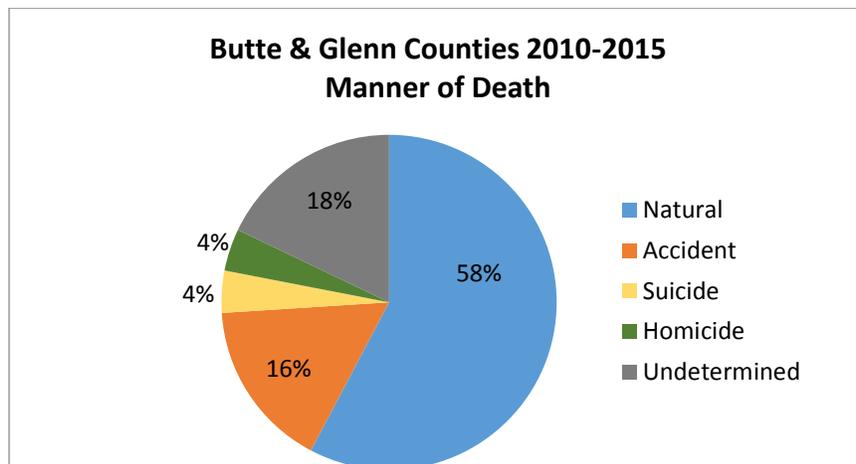
The Butte Glenn Child Death Review Team reviews all fetal and infant deaths that occur in our counties, and deaths of our residents that occur outside our counties. For instance, many severely ill infants will be transferred to Sacramento County where they can receive a higher level of medical care. If the infant succumbs to their illness and we are made aware of the death, our team will review the case. However there are instances when a county resident has died outside of our county and we are unaware of it. For that reason it is important to understand that this report represents all the cases of which the team was aware. The information presented in this report is based on data collected during child death reviews conducted from 2010 to 2015. This data assists in the identification of emerging issues, problematic trends and key factors that can be used to prevent future deaths. A table that shows specific demographics for Butte & Glenn Counties is included as Appendix A.

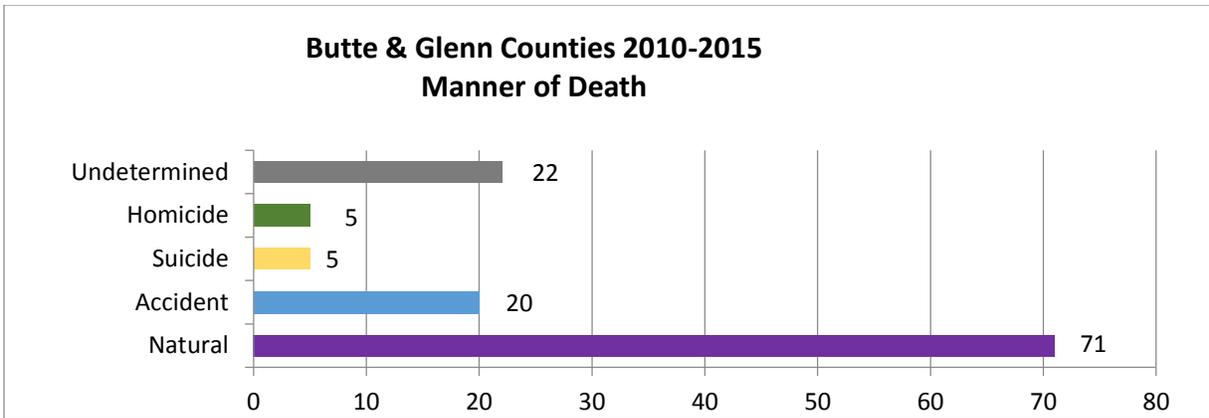
Child Death Review Data Overview

Manner, Age and Race

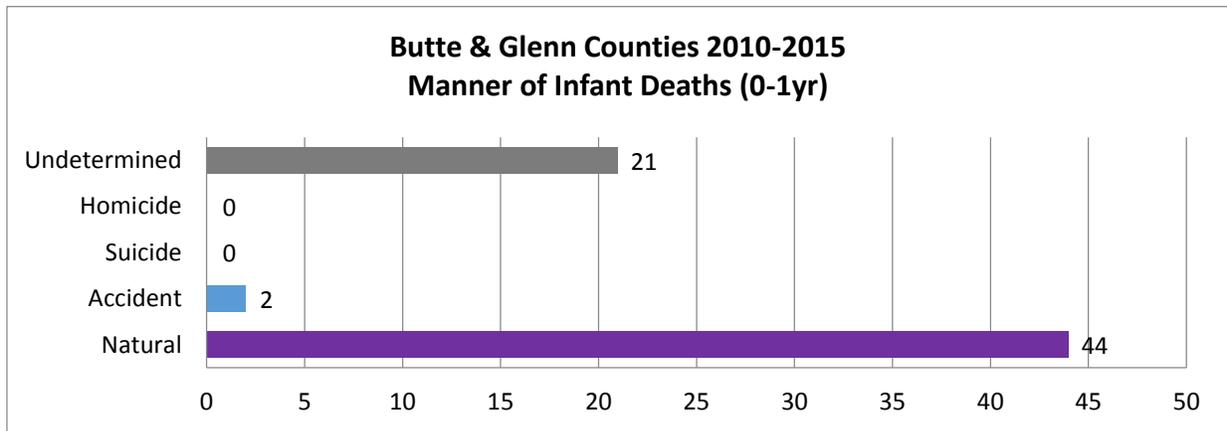
Two types of death determination are reported on death certificates: cause and manner. Cause refers to the actual disease, injury or complications that directly resulted in the death. Manner refers to the circumstances of the death. There are five possible manners: natural, accident, suicide, homicide or undetermined. Within each of the five manners of death, there can be multiple causes of death. For example, natural deaths include causes such as cancer, birth defects and prematurity. Accident is used most often in the case of a death due to an unintentional injury like such as a motor vehicle crash, fall or drowning. Suicide and homicide represents an intentional manner of death at the hands of either the deceased or another person. Its causes could include mechanisms such as hanging, blunt force trauma or multiple gunshot wounds. An undetermined manner of death indicates that the medical examiner felt there was not enough information to assign one of the other manners of death.

Of the 123 child deaths that occurred from 2010-2015, the majority, 58%, were deaths from natural causes such as cancer, chronic or acute medical conditions, and prematurity. Accidents accounted for 16% of undetermined, including, but not limited to drowning, motor vehicle crashes, and unintentional injuries. Eighteen percent of the deaths were recorded as undetermined on the death certificate. This represents 22 of the child deaths, 21 of which were Sudden Unexplained Infant Deaths (SUID). This cause of death will be discussed later in this report.

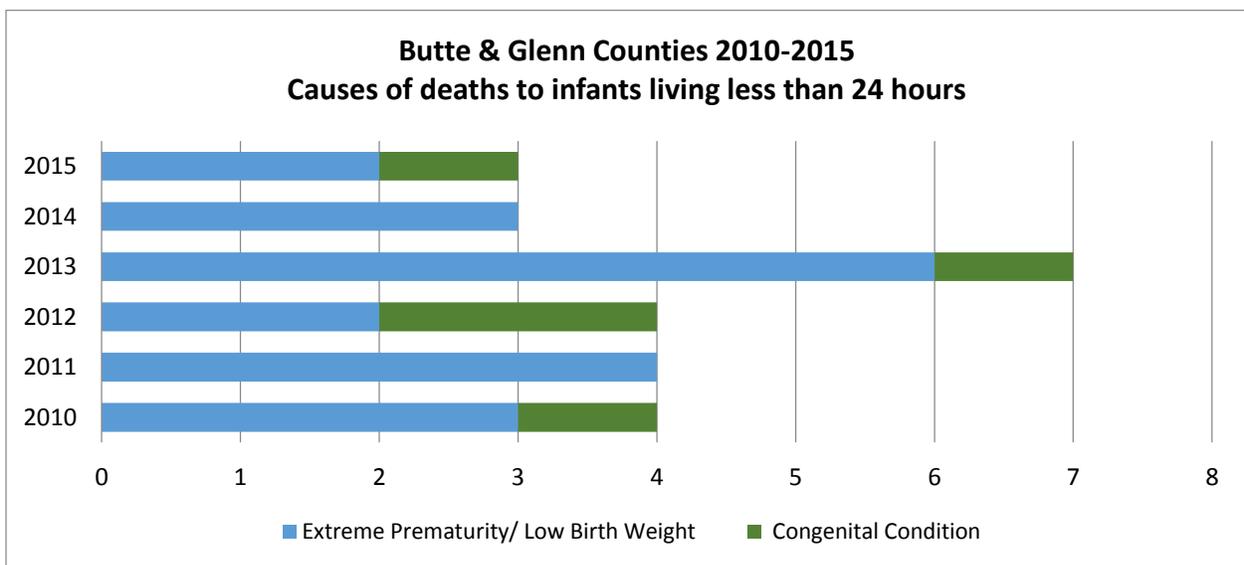




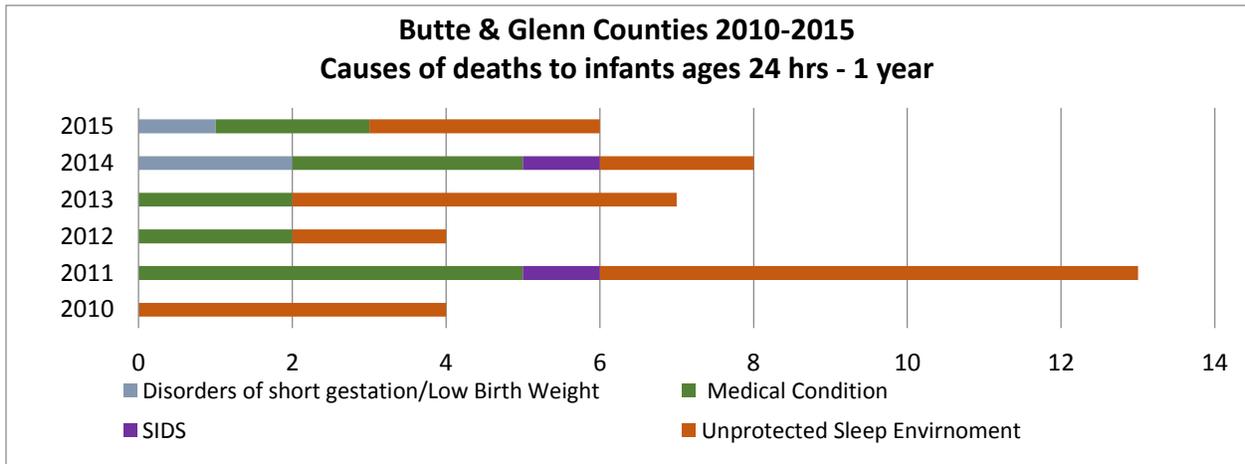
One thing to note is that the manner of death changes as we look at the age of the child who died. The majority of infant deaths are from natural causes.



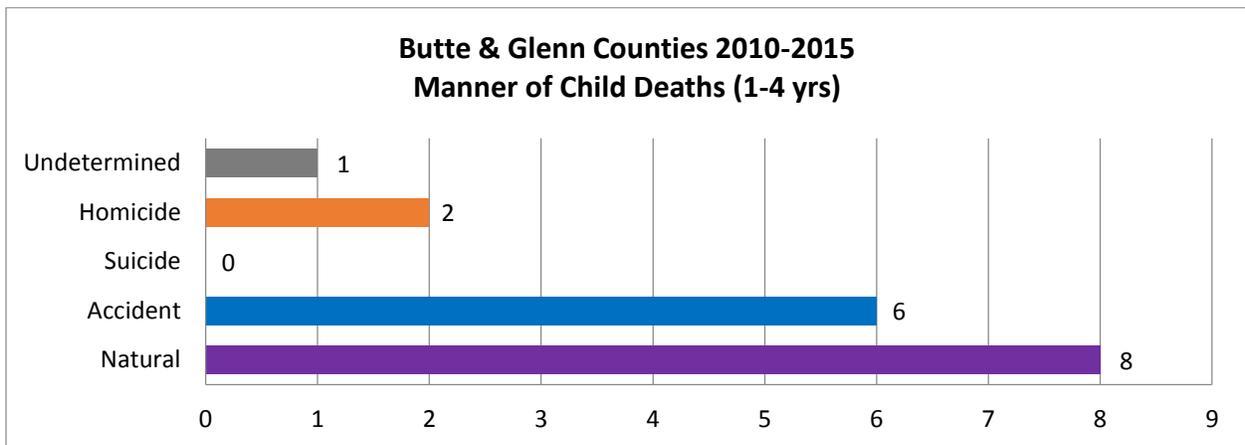
Twenty-five of these deaths occurred in the infant's first 24 hours of life, dying due to extreme prematurity (20) or a congenital condition (5) that was incompatible with life.



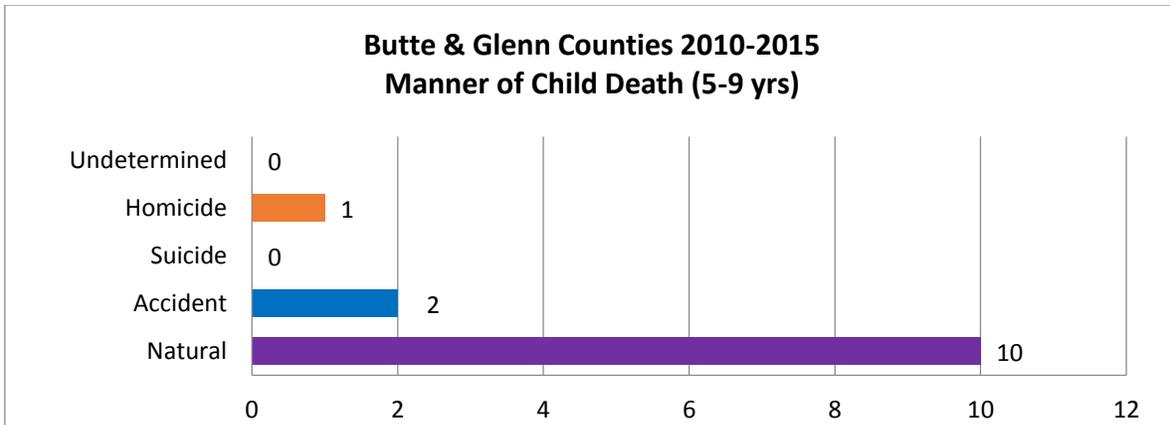
For the 42 infants that lived longer than 24 hours, 40% (17) died due to medical causes and 60 % (25) of the deaths were sleep related. The non-medical cases included two SIDS deaths, 21 deaths listed as undetermined which occurred while the infant was sleeping, and two were determined to be accidental suffocations. Additional information regarding sleep related deaths will be presented later in this report.



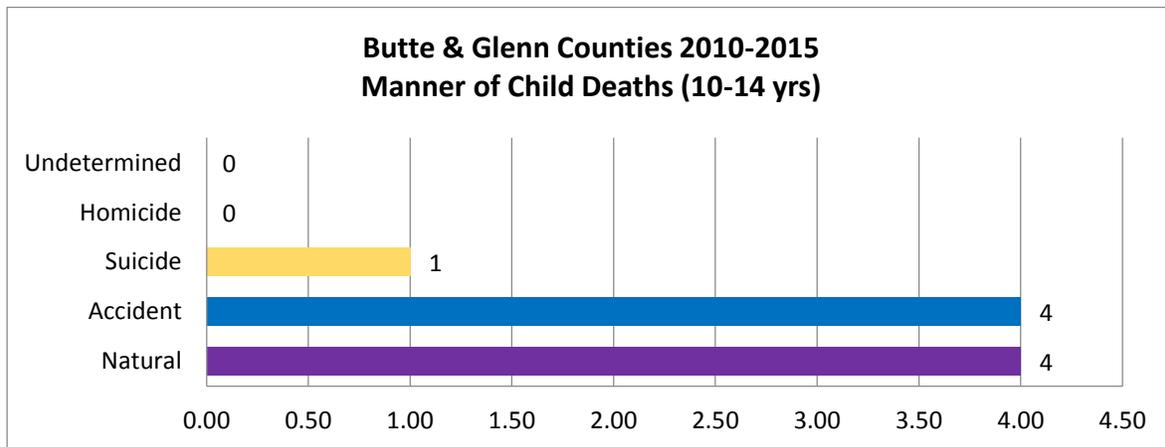
As an infant develops into a toddler and becomes more mobile, the causes of death reflect that mobility. There were 17 deaths in children ages 1-4 and six of those were due to drowning. Sadly, two of the children were victims of abuse. The drowning and abuse cases will be discussed later in this report.



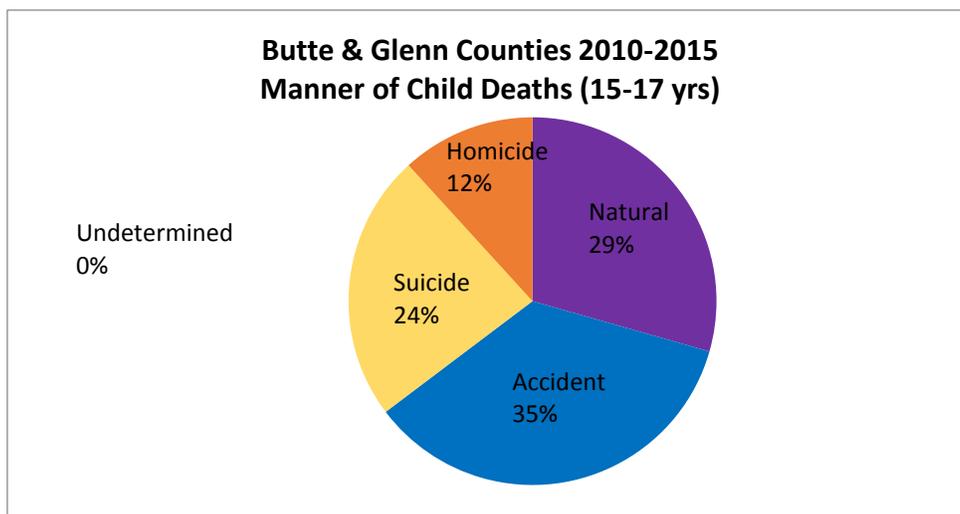
Moving through the ages there is a shift from a high of 77% of deaths attributed to natural causes in children ages 5-9 years to a low of 29% of the deaths to children 15-17 being from natural causes.



Over all, in child deaths over the age of one, accidental is the second leading manner of death with a high of 44% being seen in children ages 10-14.

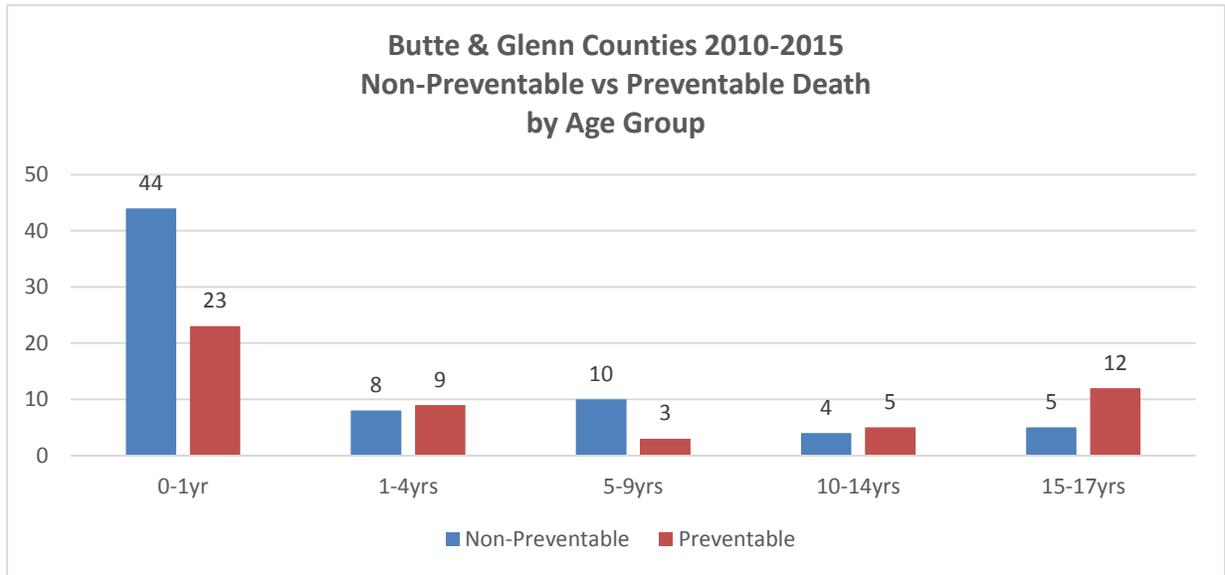


In children aged 15-17, 35% (n=6) of the deaths were due to accidents and 35% (n=6) were intentional deaths, either suicide (n=4) or homicide (n=2). The causes of these accidental and intentional deaths will be discussed later in this report.

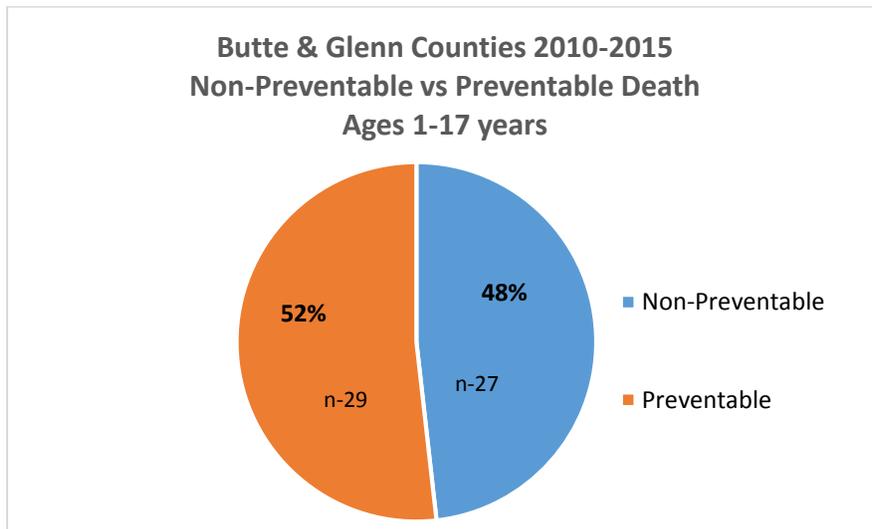


Preventable versus Non-Preventable

Another way that CDRTs categorize child deaths is by determining the preventability of the death. A death is considered preventable “if the community or an individual could reasonably have changed the circumstances that led to the death.” Using this definition, nearly all accidents, suicide/homicide, and undetermined deaths were considered preventable. Non-preventable deaths are those that were signed out on the death certificates as being of a natural manner and most often had a medical cause of death. It is difficult to determine how many of these deaths, especially those affecting infants, could have been prevented through improved access to medical care, enhanced social services or health education. For instance, deaths due to prematurity accounted for 52.3% (n=23) of our deaths of a natural manner in infants. The infants that died from causes that the CDRT considered preventable were all sleep related, with infants sleeping in an environment that was not specifically intended for an infant.



Consistent with the prior ten years, preventable deaths accounted for slightly more deaths in children over the age of one.



These deaths included unintentional and intentional injuries more typically seen in unsupervised toddlers, inquisitive children and risk taking youth. Drowning (n=8) and motor vehicle (n=7) deaths accounted for the greatest number of deaths that were considered to be preventable in children over the age of one.

SELECTED CAUSES OF DEATH

As the team examined the data over the last 6 years there were causes of death that deserved closer examination. This is especially true in causes that were determined to be preventable. In this section of the report we will look more closely at the causes of preventable deaths that have the highest rate of incidence.

Sleep-Related Infant Deaths

During the past several decades, the diagnosis of Sudden Infant Death Syndrome (SIDS) was often made when an infant died suddenly and unexpectedly in his or her sleep, and where no medical cause could be identified. In the past 10 years, there have been statewide and national efforts to improve the quality of death scene investigations in these types of cases. As a result, better information is now available on the circumstances surrounding these deaths, including details about the infant's sleep environment. Medical examiners, now equipped with this additional information from the scene investigations, are determining that it is probable that these sleep-related infant deaths were caused by asphyxia (suffocation) secondary to sleep position or location. In many jurisdictions, including ours, a determination of SIDS is being reserved for an infant that slept on their back in a protected sleep environment as defined by the American Academy of Pediatrics (AAP). The AAP has defined a safe infant sleep location as a safety-approved crib, bassinet or portable crib with a firm mattress and tight-fitting sheet. In addition the environment should be free of soft objects or loose bedding including stuffed animals, pillows, blankets, and bumper pads (see full AAP guidelines in Appendix B).



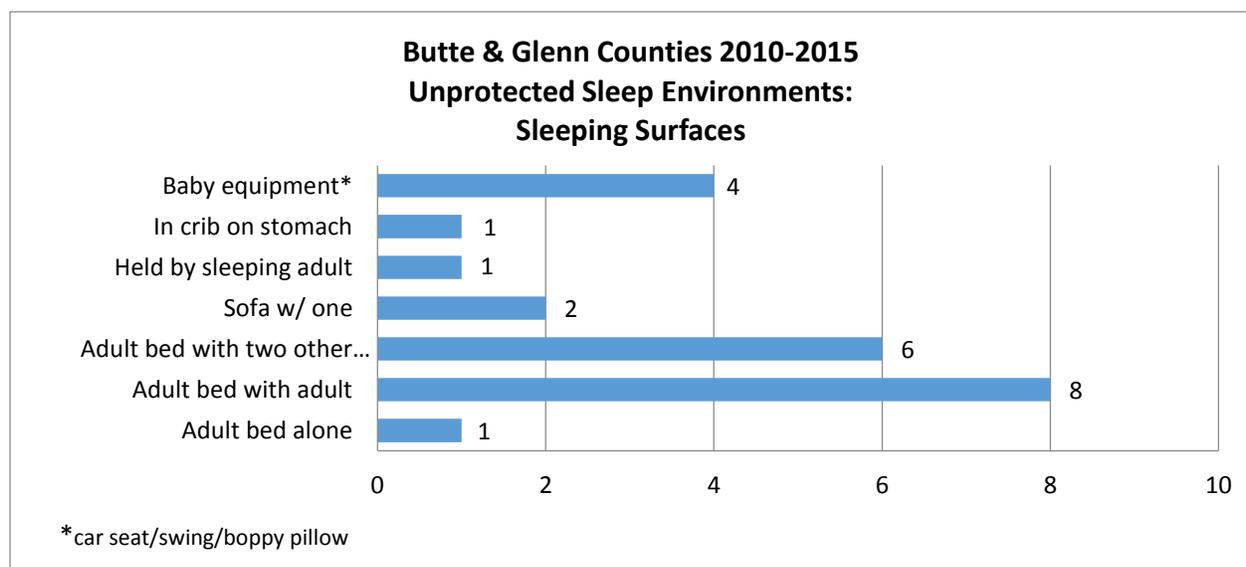
There are many ways that an infant's airway can become blocked during sleep: by suffocation hazards such as pillows, thick blankets, stuffed toys and bumper pads; by being face down on soft bedding; by sleeping on couch cushions and other inappropriate sleep surfaces; by becoming wedged between an adult bed mattress and the wall or headboard; and in many cases, by another's body if they are co-sleeping on the same surface with the infant.

If the medical examiner believes that there is any evidence that could suggest asphyxia was possible, they are using the term "Sudden Unexpected Infant Death" (SUID), rather than SIDS. For this reason the

diagnosis of SIDS has decreased and may lead some to believe that infant deaths are no longer a concern. On the contrary, the number of Infant deaths due to unsafe sleep environments / practices continues to be an issue in our community.

From 2010-2015 there were 23 infants who died of an undetermined cause while sleeping. The cause of death (COD) in two of those deaths was SIDS, the remaining were SUID. It is interesting to note that the two infant deaths that were determined to be caused by SIDS died in a county other than Butte or Glenn. The CDRT did not have access to a death scene investigation or autopsy to determine if there was sufficient information to make the distinction between SIDS and SUID. In addition to the 21 cases that were assigned as SUID, there were two sleep related infant deaths that showed clear evidence of suffocation.

There were 23 infants that died in our counties while sleeping in such a manner that put them at risk for suffocation. As the CDRT reviewed the death scene investigations, there were several factors that stood out. First of all there were a variety of sleep locations. The most commonly found sleep location was in an adult bed or couch, 74% (n=17), in all but one occasion with one or more other people. Four infants were put or left asleep in infant equip that was not designed for sleeping. One infant was being held by a sleeping parent. Only one of the infants was sleeping alone in a crib but was found unresponsive on their stomach; it is unknown if there were other items in the crib with the infant.



A variety of other factors may have increased the risk of death while co-sleeping with an adult or adults including use of alcohol, prescription or illicit drugs by the adult(s), second-hand smoke, adult obesity, the infant being placed between two adults or between an adult and the wall or blankets covering the infant's face.

The infant mortality rate is a statistic that is often cited to show the health of a nation, state or county. In 2013 the national infant mortality rate was 6 deaths per 1000 live births and in California the rate was 4.8. In Butte County the rate in the same year was 4.9 and in Glenn County it was 5. It is important to note that when you are looking at counties with a small number of births like Glenn County, 399 in 2013, it is difficult to determine a reliable rate because one incident can change the rate dramatically. For this reason it is more reliable for an area like ours to look at an average rate for this report's six year study

period (2010-2015). Combining the births and deaths from Butte and Glenn Counties there were 16,946 births and 67 deaths between 2010 and 2015 for an infant mortality rate of 3.95. This includes non-preventable deaths and preventable deaths. If we, as a community, could have prevented all sleep related deaths (25) during this time period our mortality rate would have dropped to 2.48.

Actions taken by the CDRT include:

- Presentations to Pediatric Grand Rounds for local hospitals
- Presentation to Butte Glenn Medical Society
- Education for Foster Care parents
- Sheriff Dept. training for infant death scene investigations
- Safe Sleep education at all birthing hospitals & home visiting agencies
- Educational programs at WIC & safety seat trainings
- Providing Pack & Play beds for low income parents
- Safe Sleep Campaign Brochure

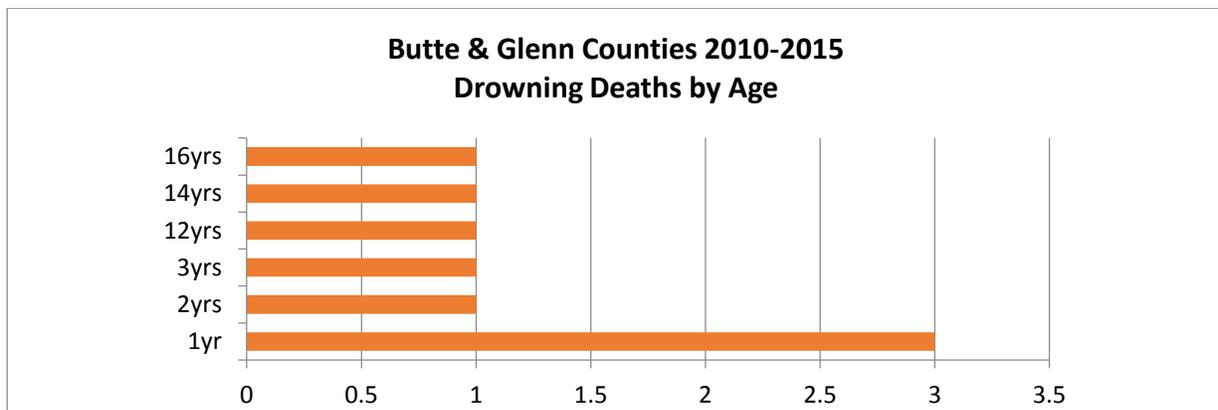
Recommendations for future trainings and projects:

- Education for child care providers
- Education for private child care locations like churches
- Nursing/Health Educator student project providing community Safe Sleep education
- Presentation to Butte College Law Enforcement & Fire Academies
- Presentation for all local Law Enforcement agencies on the importance of the scene investigation

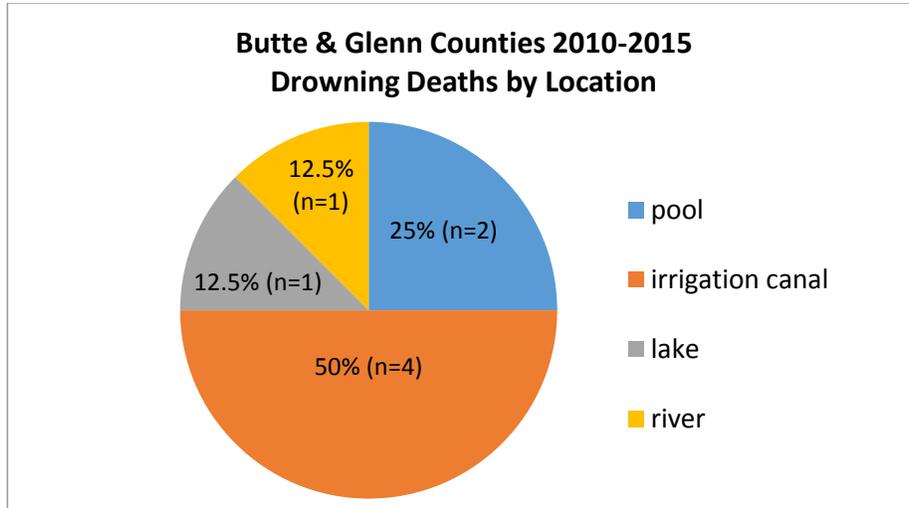
Drownings

Drowning is the leading cause of accidental death for children ages 1-17 in Butte and Glenn Counties. Drowning is often referred to as “the silent death” because parents do not hear a scream or splashing. The child slips quickly and silently under the water without warning. There is no cry for help. Drowning is a highly fatal injury, with most incidents resulting in the death of the child.

Drowning deaths represented 47% (n=8) of all accidental deaths (n=17) to children over one year of age. All of the drowning-related deaths were unintentional and considered preventable. Five of the eight drowning deaths occurred to children ages 1-3 years.



The location where the drowning deaths occurred is different than one might expect and are indicative of the rural nature of our counties. Only 2 of the drownings occurred in a swimming pool, and those occurred out of our counties while the child was visiting a relative or friend. The locations of the remaining deaths were irrigation canals (4), a lake (1) and a river (1).



This is a historical problem in this area because of the agricultural environment in the valley. In this region there is a network of irrigation canals & ditches that run through the counties. The majority of these bodies of water has no restricted access and may be located very close to a family home or housing development. Young children have wandered away while an adult was not watching and been found hours later in the ditches. Older children have been swimming in the canals and sucked into drains.



In years past, others had drown because their car had gone off the highway and ended up in a large canal from which there was no escape. These deaths are tragic, but it is not possible to fence or cover the irrigation ways throughout the counties. The key to prevention in most of these situations is supervision of younger children and education of older children regarding the dangers of being in unregulated bodies of water. As for the motor vehicle related drownings, there has been a recommendation that ladders be built into the sides of the canal so that someone could climb out but it

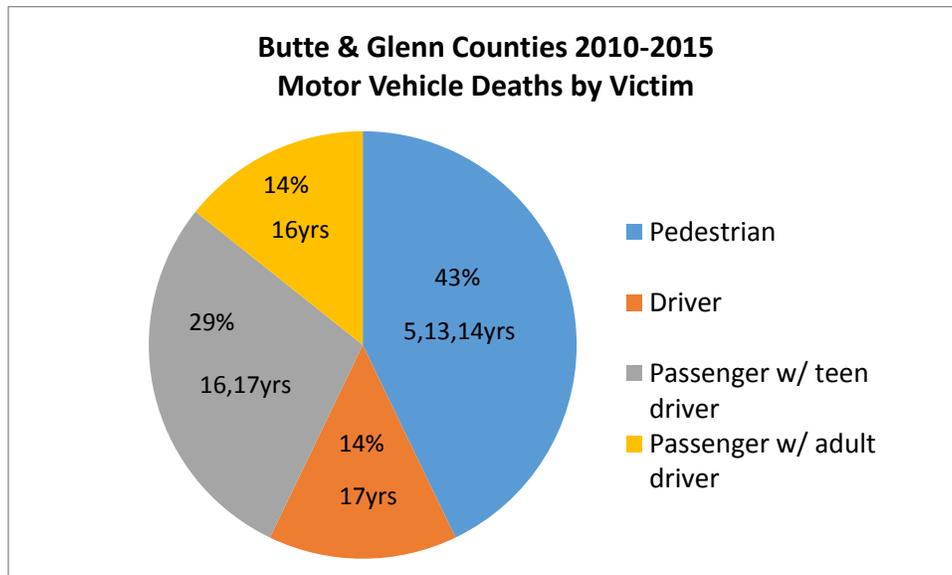
is unlikely that would prevent all deaths. The CDRT also learned that many children, especially those from immigrant families, did not know how to swim. Another issue was children not wearing life jackets in boats or while swimming at lakes.

The following community programs were a response to these tragic drownings:

- Vouchers for free swim lessons available through the Butte County Public Health Department
- Water Watcher Programs: teaching parents the importance of supervision
- Kids Don't Float provided life vests for children at lakes/ivers

Motor Vehicle

The second greatest number of deaths of an accidental manner was related to motor vehicles. There were seven child deaths that resulted from either being struck by a vehicle or being in a motor vehicle crash. Three of the seven (43%) were vehicle versus pedestrian incidents. These were younger victims ages 5, 13, and 14 years that were struck by a moving vehicle. The 13 and 14 year old children were in crosswalks at the time. The other four deaths were in vehicle crashes. One was a teenager in the car with an adult driver, the other three involved teen drivers and/or their passengers. Although teen drivers did not play the greatest role in the motor vehicle deaths during these years, it has been a greater issue in the past and remains a concern for our communities.



Motor Vehicles deaths on highways

Three major highways run through Butte and Glenn counties: Interstate 5, Highway 70 and Highway 99. For this reason there are motor vehicle crashes that have occurred on those highways which have resulted in the death of children who reside in other California counties or states. Most notable were four Los Angeles County youth who died in a horrible bus crash that occurred in 2014. These four

students were on a school sponsored trip to visit Humboldt State University in Northern California. While traveling through Glenn County on Interstate 5, their bus was struck by a truck trailer which came across the center median. Both were engulfed in flames. There were 10 fatalities including the four minors. An extensive study by the National Institute of Traffic Safety failed to determine what caused the truck to suddenly come across the median into the northbound lane and strike the bus.



The CDRT would like to commend those agencies involved in the rapid response to this horrific bus accident. Local sheriff and police departments that assisted included Glenn County Sheriff/OES, CHP, Orland Police and Willows Police departments. Also CDPH-EPO, Cal-OES provided assistance. Response from 9 local fire departments including Willows Fire, Orland Fire, Artois Fire, Bayliss Fire, Hamilton City Fire, Capay Valley Fire, Corning Fire, Cal-Fire and Tehama County Fire departments. There were 7 hospitals that assisted in the Northern Region including Glenn Medical Center, Enloe Medical Center, Oroville Hospital, St. Elizabeth Hospital, Mercy Medical Center, Shasta Regional Medical Center and UC Davis Medical Center. There were 17 ambulances and 7 Helicopters that assisted on site including Westside Ambulance, Butte EMS, Dignity Healthcare EMS, Enloe Flightcare, Reach Air Medical Services, Cal-Star, Sierra-Sac Valley EMS, Nor-Cal EMS and EMSA. Equally important, the ongoing and other support services following this bus accident including Glenn County Health and Human Services Agency, American Red Cross, Salvation Army, LA Unified School District, CSU Humboldt and Sweets Mortuary (Willows and Orland). What our CDRT has learned from this incident is how wonderful rural communities are at working as a team and pulling existing resources together to respond to an emergency in a timely manner when needed.



Activities that have taken place in Butte and Glenn Counties related to vehicle and pedestrian safety:

- Walkable Neighborhood Grants
- Walk Your Child to School Days
- Annual Office of Traffic Safety Grants
- California Kids Plate Grants
- Safe Routes to School



- Every 15 Minutes – drunk driving prevention high school presentation
- Parents of Teen Drivers informational forums
- Traffic calming measures around schools
- Paradise crosswalk modifications-relocating & pedestrian flashing lights
- Infant & Child Safety Seat Classes and Low Cost distribution
- Butte County Safe Kids Coalition
- Safe Kids Helmet distribution



INTENTIONAL INJURY DEATHS

Intentional injury deaths are deaths that occur at the decedent's own hand or at the hand of another person. The manner of death is listed as suicide or homicide on the death certificate. The cause of death is varied. There were ten intentional deaths in Butte and Glenn Counties from 2010-2015.

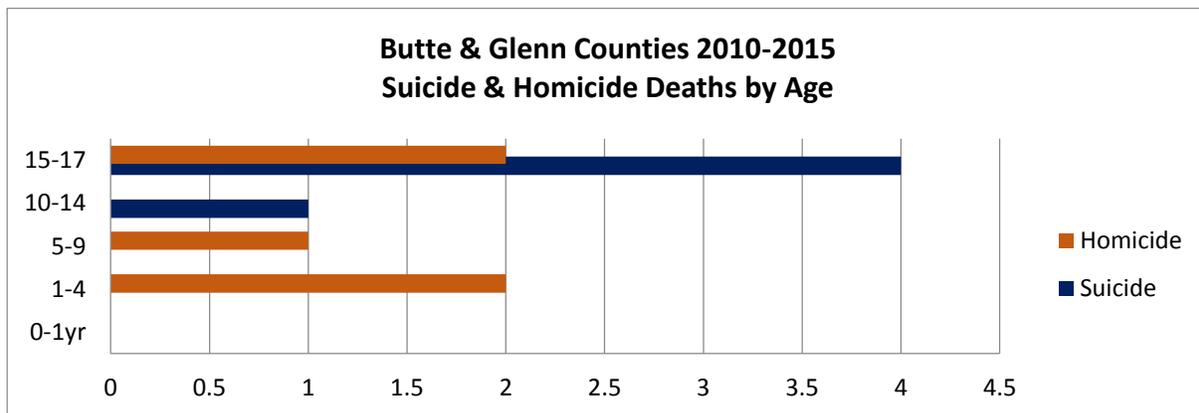
Can we study these deaths of innocent young lives and say that they were preventable? In some cases yes, there were red flags seen by various people or agencies but unfortunately the entire picture of abuse was never seen by one entity. In other cases there were no signs that would have alerted the community to a child in danger or an adult(s) out of control.

Only 3.3% of the deaths that the CDRT reviewed during these years were the direct result of abuse or neglect. As part of the review of a child death case the CDRT determines if there were any reports of abuse or neglect in the family. There have been cases in which the child was known to public or private social services agencies for various reasons, and although their death was not directly related, it was an indication that their life was a troubled one.

Suicide

Of all the types of child death highlighted in this report, one category stands apart, those in which the child had a deliberate hand in producing the sad statistic. As communities, agencies and individuals, we all do what we can to keep children safe and alive. When it is the child who makes the decision to end his or her young life it affects not only their family and friends but the whole community. In some cases, young people have had a long history with mental health services, substance abuse and school issues, family discord and/or run-ins with the law. In others, there is very little in the way of red flags before the fatal event occurs. According to the CDC, for ages 10-24, suicide is the third leading cause of death in the U.S.

Over the last 24 years (1991-2015) there have been 17 suicides ranging in age from 9-17. All of these tragic deaths were discussed and the members of the CDRT have worked within their agencies and the community to strengthen youth services in an effort to prevent future incidents. During this reporting period there were 5 suicides in children ages 14, 15, 16 (2) and 17 years. It is interesting to note that all suicide deaths were to Butte County residents residing in Chico. There were 3 White males and a White and Hispanic female. The mechanism of death was hanging in all but one case in which the death resulted from a gunshot wound.



Suicide Prevention Activities

There has been several suicide prevention / education endeavors that have occurred in Butte County over the last 6 years. The Suicide Prevention Task Force called CETA (Care Enough to Act), is made up of individuals and representatives from various agencies, groups and communities from Butte, Glenn and Tehama County. The CETA group was started with the intent to provide hope and care for people affected by suicide and educate people on suicide. The goal of CETA is to reduce suicide attempts and deaths in the Butte County and northern region and increase understanding of Mental Health issues. CETA promotes Know the Signs, Mental Health Awareness month in May and an Out of the Darkness Walk is held In October during Suicide Prevention Week.

The Butte County Office of Education (BCOE) has completed suicide prevention activities at local high schools. This included Safe Talk presentations to students at Paradise High School in 2014-15 and a Safe Talk training held at Butte College in 2014. BCOE has a Safe Talk and an Applied Suicide Intervention Skills Trainer (ASIST) on staff. This year BCOE and Special Education Local Plan Area (SELPA) will be sponsoring MH First Aid trainings for school staff on May 20, 2016.

Behavioral Health at Northern Valley Indian Health Clinic provided Suicide Awareness trainings to all their staff in response to the local child deaths related to suicide.

Homicide

The reason that Child Death Review Teams were started back in the seventies was to determine if a child's death was the result of child abuse. Was this death an intentional homicide or the result of ongoing abuse or neglect? Fortunately Butte and Glenn counties have a low number of homicides but in any year one is too many. There have been 17 homicides of children ages newborn to 17 years since 1991. In the past 6 years, 5 homicide deaths to children ages 1-16 were reviewed by the CDRT. These intentional deaths have not been the result of neglect but have been an intentional violent act, some the end result of years of abuse. In the majority of the cases (60%) the perpetrator was a parent(s) of the victim. In one case it was a sibling and the last was a male adult who was known by the young victim. There were 2 male and 3 female victims and from various ethnic groups and county locations. In all five cases the perpetrator(s) have been persecuted or are awaiting persecution.

CONCLUSION

The Butte Glenn Child Death Review Team has been carefully reviewing the deaths of children in our communities since 1991 with the overriding goal of preventing future deaths of innocent lives. We grieve for the loss of these children but are determined that they will not have died in vain. It has been a sobering but rewarding process as county agencies have put aside their own agendas and openly discussed this sensitive information. Many lessons have been learned, services improved and new programs developed as a result of this work. This productive working relationship has led to the implementation of innovative strategies to better protect children and prevent deaths.

This effort would not have been possible without the dedicated and consistent participation of many people. On behalf of Butte and Glenn County families, a heartfelt appreciation is extended to the following agencies.

Butte County Departments:

Sheriff/Coroner
District Attorney
Public Health
Behavioral Health
Child Protective Services
Probation
Fire

Glenn County Departments:

Sheriff/Coroner
Fire
Public Health
Child Protective Services
Mental Health

Law Enforcement:

Chico Police Department
Oroville Police Department
Gridley/Biggs Police Department
Paradise Police Department
Willows Police Department
Orland Police Department
Chico California Highway Patrol
Oroville California Highway Patrol

Hospitals/Medical Clinics:

Enloe Medical Center
Oroville Hospital
Feather River Hospital
Northern Valley Indian Health Children's Health Center
Feather River Tribal Health

Education:

Butte County Office of Education
Glenn County Office of Education

Community Agencies/Organizations:

Northern Valley Catholic Social Services
Catalyst: Domestic Violence Prevention
Valley Oaks Children's Services
Glenn County Child Abuse Prevention Council
Butte County Child Abuse Prevention Council
Butte Glenn Medical Society

Appendix A

Butte & Glenn Counties: Child Deaths* of Residents: 2010-2015											
Demographics											
		County		Gender		Ethnicity					
Ages	Deaths	Butte	Glenn	Male	Female	White	Hispanic	Black	Asian	Nat. Amer.	Unk
Infant deaths: Birth-12 mos.											
Birth-< 24 hrs.	25	21	4	13	12	15	3	3	4	0	0
1 day-<1 mo.	16	14	2	10	6	10	3	2	0	0	1
1-3 mos.	18	16	2	10	8	13	3	1	0	1	0
4-6 mos.	4	4	0	3	1	2	1	1	0	0	0
7-9 mos.	4	3	1	3	1	3	0	0	0	0	1
10-12 mos.	0	0	0	0	0	0	0	0	0	0	0
Total Infant	67	58	9	39	28	43	10	7	4	1	2
Child Deaths: 1 - 17 yrs.											
1 yrs.	11	7	4	8	3	9	0	0	1	1	0
2 yrs.	4	3	1	3	1	1	1	0	1	0	1
3 yrs.	2	2	0	1	1	0	1	0	0	1	0
4 yrs.	0	0	0	0	0	0	0	0	0	0	0
5 yrs.	4	3	1	2	2	3	0	0	0	0	1
6 yrs.	1	1	0	0	1	0	1	0	0	0	0
7 yrs.	2	2	0	0	2	0	1	1	0	0	0
8 yrs.	3	2	1	2	1	1	0	0	2	0	0
9 yrs.	3	3	0	1	2	1	0	0	0	1	1
10 yrs.	0	0	0	0	0	0	0	0	0	0	0
11 yrs.	1	0	1	1	0	1	0	0	0	0	0
12 yrs.	2	2	0	1	1	1	0	0	0	0	1
13 yrs.	3	2	1	1	2	1	1	0	1	0	0
14 yrs.	3	2	1	1	2	0	2	0	0	1	0
15 yrs.	1	1	0	0	1	1	0	0	0	0	0
16 yrs.	11	9	2	7	4	8	2	0	1	0	0
17 yrs.	5	4	1	4	1	5	0	0	0	0	0
Total Child	56	43	13	32	24	32	9	1	6	4	4
Total Deaths	123	101	22	71	52	75	19	8	10	5	6

*Cases Reviewed by the Child Death Review Team of Butte & Glenn Counties

Appendix B

American Academy of Pediatrics expanded its guidelines to focus not only on SIDS, but on safe infant sleep environments and reducing overall risk of death.

Expanded Recommendation, 2011 (www.onondagachildfatalityreview.com/pdf/AAP-guidelines.pdf)

- Supine positioning (back to sleep) for every sleep
- Firm sleep surface
- Room sharing, without bed sharing
- Keep soft objects, loose bedding, bumpers out of crib
- Breastfeeding
- Routine immunizations
- Consideration of use of a pacifier at sleep times
- Avoidance of:
 - soft (squishy/deep) bedding
 - overheating
 - exposure to tobacco smoke, alcohol, illicit drugs

What Does a Safe Sleep Environment Look Like?

You can reduce your baby's risk of SIDS and other sleep-related causes of infant death in the following ways. <https://www.nichd.nih.gov/sts/Pages/default.aspx>

