Child Fatality Task Force

Our Children, Our Future, Our RESPONSIBILITY

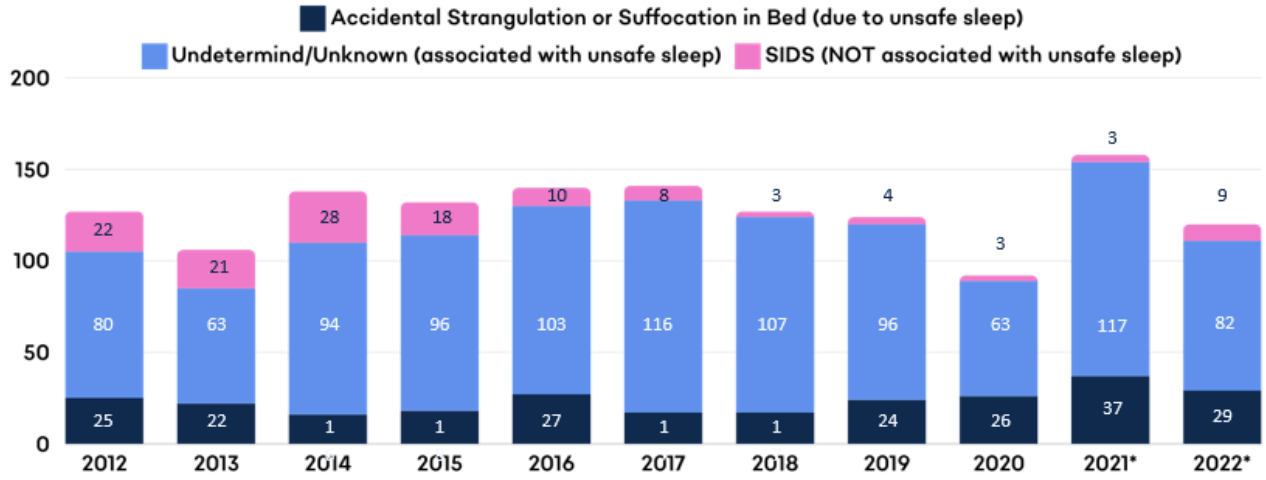
Child Fatality Task Force Recommendation

Support expanded recurring state funding to prevent infant deaths related to unsafe sleep

Each year in North Carolina, more than 100 infants die in unsafe sleep environments. Examples of an unsafe sleep environment include an infant found with his or her face covered by a blanket, found sleeping on a couch with the infant's face to the back of the couch or between cushions, or sharing a sleep space with another individual. In North Carolina, black infants are twice as likely as white infants to die in unsafe sleep environments.

Unsafe sleep is a leading cause of infant death in North Carolina and these deaths are largely preventable. More than 120,000 babies are born each year in North Carolina and sustained funding is essential for an effective statewide initiative to ensure that these babies are not lost to unsafe sleep.

Between 2012 and 2022 in North Carolina, there were over 1,200 infant deaths related to unsafe sleep



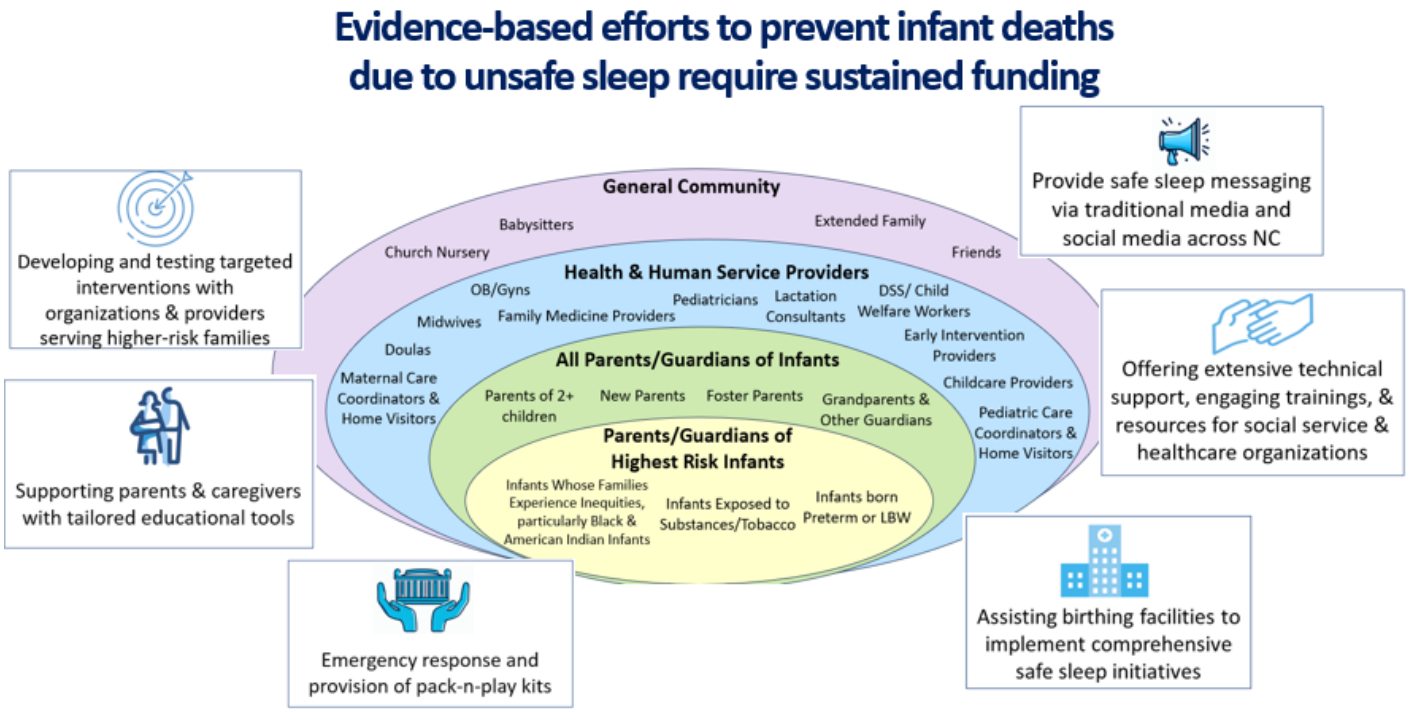
*Cases are still pending, numbers could change. Data sources: NC State Center for Health Statistics and Office of the Chief Medical Examiner, NC Division of Public Health, NCDHHS

Sleep-related infant deaths often involve bed sharing, the intentional or unintentional practice of an infant sharing a sleep space with another individual. In a North Carolina survey, close to half of mothers reported bed sharing with their baby.[1] The common practice of bed sharing is concerning because of the dangers associated with it, and the risks of bed sharing significantly increase for some infants such as those born too soon, too small, or who are in households where tobacco or other substances are used.[2]

Guidelines from the American Academy of Pediatrics to create a safe sleep environment and reduce risk of infant death have evolved during the past decade, with the most recent updates made in 2022. Studies show that unsafe sleep practices are common and that parents and caregivers are not always receiving correct advice from their families, peers, and health and childcare providers. In fact, **one study found that nearly half of caregivers did not receive correct advice on safe sleep practices from healthcare providers**.[3] Outreach and education on safe sleep needs to reach healthcare providers and others who are in a position to educate parents and caregivers.

This Task Force recommendation has been driven by data and recommendations from state and local child death review teams. These teams review infant deaths and repeatedly identify the need for strengthened safe sleep education and expanded outreach and funding for this purpose.

In 2023, a *nonrecurring* appropriation of $250K was added to the $97K of block grant funding for efforts to prevent infant deaths due to unsafe sleep in North Carolina, but funding ends in June of 2025. This funding temporarily enabled a meaningful expansion of efforts targeting multiple levels of prevention and included emergency response in Western NC related to Hurricane Helene. Making this funding recurring would enable a robust and sustained statewide initiative to prevent infant deaths due to unsafe sleep.



Evidence shows that this type of multi-level approach to prevention is essential and effective. For example, Sacramento County California's Safe Babies Initiative reduced their sleep-related infant death rate by 54% and their Black/white disparities rate by 66% over 5 years.[4]

The Child Fatality Task Force is a legislative study commission that recommends policy solutions to prevent child death, prevent abuse and neglect, and support the health and safety of children.
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[1] Pregnancy Risk Assessment Monitoring System, 2020 results for North Carolina survey. The 2020 NC PRAMS survey showed 45% of moms report bed sharing at least sometimes. 2020 is the most recent year that this data is available. https://schs.dph.ncdhhs.gov/data/prams/2020/SLEEPB.html

[2] See: Rachel Y. Moon, Rebecca F. Carlin, Ivan Hand, THE TASK FORCE ON SUDDEN INFANT DEATH SYNDROME AND THE COMMITTEE ON FETUS AND NEWBORN; Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. *Pediatrics* July 2022; 150 (1): e2022057990. 10.1542/peds.2022-057990

[3] Colson ER, Geller NL, Heeren T, et al. Factors Associated With Choice of Infant Sleep Position. Pediatrics. 2017;140(3):e20170596.

[4] First 5 Sacramento Reduction of African American Perinatal & Infant Deaths, Final Evaluation Report, July 1, 2015-June 30, 2018. Microsoft Word - Final Evaluation Report_181128.docx