Deaths of children in NSW in 2015: Sudden and Unexpected Death in Infancy


In 2015, 504 children aged from birth to 17 years died in NSW in 2015; a mortality rate of 29.61 deaths per 100,000 children. The majority of the children (294, 58%) were infants under the age of 12 months.

In 2015, 14 per cent of infant deaths (42) were classified as Sudden Unexpected Death in Infancy (SUDI). SUDI is not a cause of death. The term describes the death of an infant aged less than 12 months that is sudden and unexpected, where the cause was not immediately apparent at the time. SUDI includes Sudden Infant Death Syndrome (SIDS).

The reason why an infant dies suddenly and unexpectedly is not always able to be identified. At the time of writing, information regarding cause of death was available for just over half (22) of the 42 infants:

- a cause of death had been identified for 11 infants – this is ‘explained SUDI’. Nine infants died from natural causes, and two infants died as a result of asphyxiation.
- for the other 11 infants, a cause of death was unable to be determined. These deaths remain ‘unexplained SUDI’.

**Trends in SUDI**

The infant mortality rate for SUDI has, overall, declined since 2001, and the rate in 2015 (0.46) is as low as it has been in the last 15 years. However, as illustrated in the figure below, the rate has not changed significantly since 2008.

SUDI is disproportionately evident in disadvantaged and vulnerable families; those residing in areas of low socio-economic advantage; families with a child protection history, and Aboriginal and Torres Strait Islander families.

The CDRT has noted the need to better target initiatives to work effectively with these families to promote safe sleeping and other preventative practices.

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1. Crude mortality rate - deaths per 100,000 people under 18 years of age.
   For children aged less than 12 months, this report uses the Infant Mortality Rate, which is deaths of infants under 12 months per 1,000 live births.
Identified risk factors: SUDI

There are some known risk factors for SUDI that are not modifiable. For example, SUDI is often associated with low birth weight, preterm birth and preceding infectious disease.

There are also well evidenced modifiable risk factors for SUDI. Key risks include:

- placing an infant to sleep prone (on their front)
- sharing a bed with an infant, particularly if drug and/or alcohol affected
- placing an infant to sleep in bedding not designed for them, and/or with loose bedding or other items in the sleep environment
- Exposing infants to tobacco smoke.

All 42 of the infants whose deaths were classified as SUDI in 2015 were found to have at least one known risk factor, and nearly all were exposed to at least one modifiable risk factor. For many of these infants, combinations of a number of modifiable risk factors were present:

- Two-thirds (27) of the 42 infants were bed sharing, either intentionally (21) or unintentionally (6). In most cases, the shared sleep surface was an adult mattress or bed, but sofas and couches were the other main shared surface. Unintentional bed sharing occurred mainly when carers fell asleep while feeding or settling an infant.

- The majority of infants who were bed sharing were exposed to tobacco smoke during pregnancy and/or in the household; a third were born premature and/or of low birth weight; a third had previously been ill with an infectious disease; and five infants were sleeping with alcohol or drug affected adults.

Investigating SUDI

In NSW, on average, a cause of death is not able to be determined after investigation for around three-quarters of infants. This is much lower than best practice.

Determining a cause of death for SUDI is important for a range of reasons, including for the family to explain their loss, and to learn from untimely deaths and help prevent future deaths.

SUDI investigation in NSW involves the NSW Police Force, NSW Health, including forensic services, and the State Coroner. There is no whole-of-government policy to direct the cross-agency coordination of responses to SUDI. The most comprehensive resource is the NSW Health policy directive Death – Management of Sudden Unexpected Death in Infancy (2008), which governs the management of SUDI by NSW Health staff.

Police are responsible for investigation of the death, including death scene investigation. NSW Health is responsible for taking a family medical history, post mortems and coordination of care and follow up for the family. The Coroner examines the death and determines cause.

Investigation of SUDI in 2015

The CDRT has identified significant gaps in investigation of SUDI under existing protocols. In 2015:

- **Triage**: one-quarter of infants and their families were not taken to hospital. This is an important step, to allow for a medical history to be taken.

- **Medical history**: for 26 SUDI, there was no record that a paediatric interview for the purpose of documenting a SUDI medical history took place. A record of the paediatric interview was located for only 14 of the 42 deaths.

- **Post mortem examination**: in a number of cases did not include studies or specialist review that may have assisted in determining a cause of death.

- **Family support and follow-up**: We located no evidence that support was provided to 12 of the 42 families.

Best practice in SUDI investigation

The CDRT has noted that the NSW model – a ‘police-led’ model – is not considered to meet best practice standards. A ‘Joint Agency Approach’ has been show to lead to improved outcomes in identifying a cause of death. A joint agency approach would include:

- expert paediatric assistance in death scene investigation and interviews with the family (with any suspicious deaths being the responsibility of police)

- identified specialists to take the SUDI medical history

- the conduct of SUDI post mortems by specialist paediatric pathologists, or minimally, consultation with paediatric specialists

- multi-disciplinary review following the post mortem, to consider all available information and provide advice to assist the Coroner in determining cause of death, to advise on possible genetic issues and necessary investigations for surviving children and parents.

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Observations and recommendations

The CDRT’s work in 2015, and over recent years, has identified two critical issues:

• The NSW model for SUDI investigation does not comply with best practice standards. It is critical that NSW adopt and ensure adherence to a comprehensive cross-agency approach to investigating SUDI, drawing on contemporary recognised best practice.

• Disadvantaged families are over represented in SUDI. There is a clear need to better target initiatives to work effectively with these families to promote safe sleeping and other preventative practices.

In addition, our reviews have indicated the need for a consistent approach to classifying SUDI. We also consider that further consideration needs to be given to adopting messages to ensure awareness of the risks associated with unintentional bed sharing.

In this context, the CDRT has recommended that:

The NSW government:

• consider a centralised model for SUDI response and investigation in NSW

• devise a joint agency policy and procedure based on best practice to govern the individual and coordinated roles and responsibilities of NSW Health, the NSW Police Force and the NSW Coroner in SUDI investigation.

The State Coroner:

• should consider including specialist review of key information to assist in determining manner and cause of death for SUDI, and establish with the CDRT a consistent approach to classifying SUDI.

NSW Health:

• in consultation with Red Nose, should review current educational strategies, with a view to inclusion of advice and preventive strategies about unintentional bed sharing.

Since 1996, the CDRT has been responsible for reviewing and reporting to the NSW Parliament on all deaths of children aged less than 18 years in NSW. The CDRT maintains a register of child deaths in NSW. The Team consists of experts in child health, child protection and related areas, and representatives of key government agencies. The Convenor of the Team is the NSW Ombudsman, and Ombudsman staff provide support and assistance to the Team.

Contact us for more information

Our business hours are: Monday to Friday, 9am–5pm (Inquiries section closes at 4pm)

If you wish to visit us, we prefer you make an appointment. Please call us first to ensure your complaint is within our jurisdiction and our staff are available to see you.

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