HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
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20 June 2012

David Meates
Chief Executive Officer
Canterbury DHB
PO Box 1600
Christchurch 8140

Dear David,

Re: Safe sleep policies and SUDI prevention

The Health Quality & Safety Commission (the Commission) would like to encourage all District Health Boards (DHBs) to prioritise the prevention of Sudden Unexpected Death in Infancy (SUDI).

Sixty infants die of SUDI each year in New Zealand. Among industrialised nations, New Zealand has the highest rate of death from SUDI with 1.1 deaths per 1000 live births. The rate for Māori is 2.3 deaths per 1000 live births, nearly four and a half times higher than the rate for infants of "other" ethnicity. Many of these SUDI deaths are preventable.

A significant portion of SUDI deaths result from suffocation in the place of sleep. Ensuring that *every sleep is a safe sleep* for infants both in and out of hospital, along with a continuing reduction in maternal smoking, can lead to a reduction in SUDI.

Some DHBs already have a safe infant sleeping policy[33], which aims to ensure:

- staff who support families caring for infants receive mandatory training and updates about prevention of SUDI and ways of communicating risks to families
- the modelling of safe sleeping practices for **all infants**[34] within DHB facilities
- safe sleeping arrangements are available for all infants after they are discharged home
- families are provided with education and supports tailored to their level of need about the hazards that arise in some sleeping situations
- advice on safe strategies for night feeds and settling of infants is provided to parents.

If you have not already done so, we encourage you to develop and implement such a policy as a matter of priority. It is also important that all services and staff encourage safe sleep practices in ways that are inclusive of Māori and Pacific cultures and values.

In many cases, infants who die of SUDI come from families where complex needs exist and vulnerability to a number of adverse outcomes can be recognised before death. Early identification of vulnerable infants and families provides an opportunity to implement intersectoral interventions and supports. Systems to ensure the ongoing assessment of needs from before birth, followed by planning and action to provide additional supports and interventions, are recommended.

The Perinatal and Maternal Mortality Review Committee (PMMRC) and the Child and Youth Mortality Review Committee (CYMRC) are statutory committees of the Commission, collectively mandated to

[33] For a sample of a DHB safe sleep policy, see the CYMRC website at: http://www.hqsc.govt.nz/our-programmes/mrc/cymrc/publications-and-resources/sudi/.

[34] It is important to ensure this work extends beyond maternity services to include paediatric medical and surgical services and other services where infants may be admitted with a parent such as adult medical, surgical and mental health services.

report on all perinatal, infant and child deaths in New Zealand. Both committees have made clear, evidence-based recommendations about the prevention of SUDI (see Appendix 1). I am enclosing a copy of the CYMRC's special report on SUDI from its *Fifth Report to the Minister of Health* (2009).

I would like to take this opportunity to thank you for considering what your DHB can do to contribute to SUDI prevention and also for your ongoing input into the PMMRC and CYMRC mortality review systems. In addition, we would appreciate a reply to this letter outlining what you are doing to prevent SUDI so we may acknowledge progress, offer support to DHBs that may encounter difficulties, and support the sharing of good practice and innovation across the DHBs.

More information about SUDI is available on the Commission website at http://www.hqsc.govt.nz/our-programmes/mrc/cymrc/publications-and-resources/sudi/. We will continue to add resources to this website, including any provided in response to this letter if we are granted permission by the DHB to do so. If you wish to discuss SUDI prevention further, please do not hesitate to contact us at info@hqsc.govt.nz or 04 901 6040.

Yours sincerely

Professor Alan Merry ONZM
Chair
Health Quality & Safety Commission

Dr Nick Baker
Chair
Child & Youth Mortality Review Committee

Enc: CYMRC's special report on SUDI from its *Fifth Report to the Minister of Health* (2009)

cc: Bruce Matheson, Chair, Canterbury DHB
Dr Nigel Millar, Chief Medical Officer, Canterbury DHB
Child Health Manager
Child Health Funding and Planning Portfolio Manager