
NEWS RELEASE

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Ministry of Public Safety and Solicitor General
BC Coroners Service

Additional support, awareness needed to prevent infant sleep deaths

VICTORIA – Expanding low-barrier and culturally safe public health services to vulnerable families, improving continuity of care and service co-ordination, and determining the need for a provincial approach for reviewing infant mortality are key recommendations of a death review panel into sudden infant deaths.

Each year, approximately 23 infants under the age of one year die unexpectedly during sleep. This death review panel identified three key areas to reduce the number of these sleep-related sudden infant deaths:

- the need for additional support from trained providers (e.g., public health nurses) for expectant women and families with infants;
- continued, consistent, universally accessible messaging related to infant sleep practices; and
- a provincial approach to the review of infant deaths including expanded investigative protocols.

The review of 141 sleep-related sudden infant deaths between Jan. 1, 2013, and Dec. 31, 2018, found that:

- infants continue to die under the same circumstances as identified by a death review panel examining the same types of deaths occurring between 2008-2012;
- the deaths of infants were disproportionately more common among young families with risk factors (e.g., exposure to tobacco) or other vulnerabilities; and
- sleep position, combined with health issues, may have increased mortality risk for some infants.

Panel members also identified two gaps in service provision — a lack of capacity to deliver universal public health services and insufficient ability to provide enhanced services in situations when a vulnerability is identified.

The death review panel, chaired by Michael Egilson, included 19 panel experts with expertise in youth services, child welfare, maternal health, medicine, nursing, public health, Indigenous health, injury prevention, income support, law enforcement and health research. The panel's recommendations are aimed at preventing death in similar circumstances and improving public safety overall.

“Something that stood out for us is that there are many parallels to the findings from our death review panel into these deaths five years ago,” Egilson said. “That means there is still work to do around sharing messaging about safe sleep practices and associated risk with the right audience; and, there is work to do to better support new parents with identified

vulnerabilities.”

This review builds on the earlier work of a death review panel titled A Review of Unexpected Infant Deaths (2008-2012), published in 2014, which included recommendations aimed at improving investigative practices and data collection for investigators including coroners and first responders, establishing guidelines for genetic testing in coroner investigations and identifying audiences and messaging around safe sleep practices.

Learn More:

Sudden Infant Death Review Panel Report (2013-2018):

https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/child-death-review-unit/reports-publications/sudden_infant_deaths.pdf

A Review of Unexpected Infant Deaths (2008-2012): <https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/child-death-review-unit/reports-publications/unexpected-infant-death.pdf>

Death review panels: <https://www2.gov.bc.ca/gov/content/life-events/death/coroners-service/death-review-panel>

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