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MONTHLY PARENTING JOURNAL

SAFE SLEEP

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SIDS AND OTHER SLEEP RELATED INFANT DEATHS: RECOMMENDATIONS FOR A SAFE INFANT SLEEPING ENVIRONMENT

By the American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome

Approximately 3,500 infants die annually in the United States from sleep-abstract related infant deaths, including sudden infant death syndrome (SIDS;International Classification of Diseases, 10th Revision [ICD-1 O], R95), ill defined deaths (ICD-10 R99), and accidental suffocation and strangulation in bed (ICD-10 W75).

After an initial decrease in the 1990s, the overall death rate attributable to sleep-related infant deaths has not declined in more recent years. Many of the modifiable and non modifiable risk factors for SIDS and other sleep-related infant deaths are strikingly similar. The American Academy of Pediatrics recommends a safe sleep environment that can reduce the risk of all sleep-related infant deaths.

Recommendations for a safe sleep environment include supine positioning, the use of a firm sleep surface, room-sharing without bed sharing, and the avoidance of soft bedding and overheating. Additional recommendations for SIDS reduction include the avoidance of exposure to smoke, alcohol, and illicit drugs; breastfeeding; routine immunization; and use of a pacifier. New evidence is presented for skin-to-skin care for newborn infants, use of bedside and in-bed sleepers, sleeping on couches/armchairs and in sitting devices, and use of soft bedding after 4 months of age. The recommendations and strength of evidence for each recommendation are included in this policy statement.

The rationale for these recommendations is discussed in detail in the accompanying technical report (www.pediatrics.org/cgi/doi/10.1542/peds.2015-3147).

DEFINITIONS

Bed-sharing: Parent(s) and infant sleeping together on any surface (bed, couch, chair).

Caregivers: Throughout the document, “parents” are used, but this term is meant to indicate any infant caregivers.

Co-sleeping: This term is commonly used, but the task force finds it confusing, and it is not used in this document. When used, authors need to make clear whether they are referring to sleeping in close proximity (which does not necessarily entail bed-sharing) or bed-sharing.

Room-sharing: Parent(s) and infant sleeping in the same room on separate surfaces.

Sudden infant death syndrome (SIDS): Cause assigned to infant deaths that cannot be explained after a thorough case investigation, including a scene investigation, autopsy, and review of the clinical history.

Sudden unexpected infant death (SUID), or sudden unexpected death in infancy (SUDI): A sudden and unexpected death, whether explained or unexplained (including SIDS), occurring during infancy.

Sleep-related infant death: SUID that occurs during an observed or unobserved sleep period.

BACKGROUND

Sudden unexpected infant death (SUID), also known as sudden unexpected death in infancy, or SUDI, is a term used to describe any sudden and unexpected death, (including sudden infant death syndrome [SIDS] and ill-defined deaths), occurring during infancy.

After case investigation, SUID can be attributed to suffocation, asphyxia, entrapment, infection, ingestions, metabolic diseases, arrhythmiaassociated cardiac channelopathies, and trauma (unintentional or nonaccidental). SIDS is a subcategory of SUID and is a cause assigned to infant deaths that cannot be explained after a thorough case investigation, including a scene investigation, autopsy, and review of the clinical history. The distinction between SIDS and other whether explained or unexplained SUIDs, particularly those that occur during an unobserved sleep period (sleep-related infant deaths), such as unintentional suffocation, is challenging, cannot be determined by autopsy alone, and may remain unresolved after a full case investigation. Many of the modifiable and non modifiable risk factors for SIDS and suffocation are strikingly similar. This document focuses on the subset of SUIDs that occur during sleep.

The recommendations outlined herein were developed to reduce the risk of SIDS and sleep related suffocation, asphyxia, and entrapment among infants in the general population. As defined by epidemiologists, risk refers to the probability that an outcome will occur given the presence of a particular factor or set of factors. Although all 19 recommendations are intended for all who care for infants, the last 4 recommendations also are directed toward health policy makers, researchers, and professionals who care for or work on behalf of infants. In addition, because certain behaviors, such as smoking, can increase risk for the infant, some recommendations are directed toward women who are pregnant or may become pregnant in the near future.

Table 2 (on the following page) summarizes each recommendation and provides the strength of the recommendation, which is based on the Strength-of-Recommendation Taxonomy. It should be noted that there are no randomized controlled trials with regard to SIDS and other sleep-related deaths; instead, case-control studies are the standard.

SUMMARY OF RECOMMENDATIONS *with strength of recommendation* (TABLE 2)*

A-level Recommendations:

- Back to sleep for every sleep.
- Use a firm sleep surface.
- Breastfeeding is recommended.
- Room-sharing with the infant on a separate sleep surface is recommended.
- Keep soft objects and loose bedding away from the infant's sleep area.
- Consider offering a pacifier at naptime and bedtime.
- Avoid smoke exposure during pregnancy and after birth.
- Avoid alcohol and illicit drug use during pregnancy and after birth.
- Avoid overheating.
- Pregnant women should seek and obtain regular prenatal care.
- Infants should be immunized in accordance with AAP and CDC recommendations.
- Do not use home cardiorespiratory monitors as a strategy to reduce the risk of SIDS.
- Health care providers, staff in newborn nurseries and NICUs, and child care providers should endorse and model the SIDS risk-reduction recommendations from birth.
- Media and manufacturers should follow safe sleep guidelines in their messaging and advertising.
- Continue the "Safe to Sleep" campaign, focusing on ways to reduce the risk of all sleep related infant deaths, including SIDS, suffocation, and other unintentional deaths.
- Pediatricians and other primary care providers should actively participate in this campaign.

B-level Recommendations:

- Avoid the use of commercial devices that are inconsistent with safe sleep recommendations.
- Supervised, awake tummy time is recommended to facilitate development and to minimize development of positional plagiocephaly.

C-level Recommendations:

- Continue research and surveillance on the risk factors, causes, and pathophysiologic mechanisms of SIDS and other sleep-related infant deaths, with the ultimate goal of eliminating these deaths entirely.

There is no evidence to recommend swaddling as a strategy to reduce the risk of SIDS.

The recommendations are based on epidemiologic studies that include infants up to 1 year of age. Therefore, recommendations for sleep position and the sleep environment, unless otherwise specified, are for the first year after birth. The evidence based recommendations that follow are provided to guide health care providers in conversations with parents and others who care for infants. Health care providers are encouraged to have open and nonjudgmental conversations with families about their sleep practices. Individual medical conditions may warrant that a health care provider recommend otherwise after weighing the relative risks and benefits.

RECOMMENDATIONS TO REDUCE THE RISK OF SIDS AND OTHER SLEEP RELATED INFANT DEATHS

1. BACK TO SLEEP FOR EVERY SLEEP.

To reduce the risk of SIDS, infants should be placed for sleep in a supine position (wholly on the back) for every sleep by every caregiver until the child reaches 1 year of age. Side sleeping is not safe and is not advised.

The supine sleep position does not increase the risk of choking and aspiration in infants, even those with gastroesophageal reflux, because infants have airway anatomy and mechanisms that protect against aspiration. The American Academy of Pediatrics (AAP) concurs with the North American Society for Pediatric Gastroenterology and Nutrition that "the risk of SIDS outweighs the benefit of prone or lateral sleep position on GER [gastroesophageal reflux]; therefore, in most infants from birth to 12 months of age, supine positioning during sleep is recommended. Therefore, pronepositioning is acceptable if the infant is observed and awake, particularly in the postprandial period, but prone positioning during sleep can only be considered in infants with certain upper airway disorders in which the risk of death from GERD (gastroesophageal reflux disease) may outweigh the risk of SIDS."

Examples of such upper airway disorders are those in which airway-protective mechanisms are impaired, including infants with anatomic abnormalities, such as type 3 or 4 laryngeal clefts, who have not undergone anti reflux surgery. There is no evidence to suggest that infants receiving nasogastric or orogastric feeds are at an increased risk of aspiration if placed in the supine position.

Elevating the head of the infant's crib is ineffective in reducing gastroesophageal reflux and is not recommended; in addition, elevating the head of the crib may result in the infant sliding to the foot of the crib into a position that may compromise respiration.

Preterm infants should be placed supine as soon as possible. Preterm infants are at increased risk of SIDS, and the association between prone sleep position and SIDS among low birth weight and preterm infants is equal to, or perhaps even stronger than, the association among those born at term. The task force concurs with the AAP Committee on Fetus and Newborn that "preterm infants should be placed supine for sleeping, just as term infants should, and the parents of preterm infants should be counseled about the importance of supine sleeping in preventing SIDS. Hospitalized preterm infants should be kept predominantly in the supine position, at least from the postmenstrual age of 32 weeks onward, so that they become acclimated to supine sleeping before discharge." NICU personnel should endorse safe sleeping guidelines with parents of infants from the time of admission to the NICU.

As stated in the AAP clinical report, "skin-to-skin care is recommended for all mothers and newborns, regardless of feeding or delivery method, immediately following birth (as soon as the mother is medically stable, awake, and able to respond to her newborn), and to continue for at least an hour." Thereafter, or when the mother needs to sleep or take care of other needs, infants should be placed supine in a bassinet. There is no evidence that placing infants on their side during the first few hours after delivery promotes clearance of amniotic fluid and decreases the risk of aspiration. Infants in the newborn nursery and infants who are rooming in with their parents should be placed in the supine position as soon as they are ready to be placed in the bassinet.

Although data to make specific recommendations as to when it is safe for infants to sleep in the prone or side position are lacking, studies establishing prone and side sleeping as risk factors for SIDS include infants up to 1 year of age. Therefore, the best evidence suggests that infants should continue to be placed supine until 1 year of age.

Once an infant can roll from supine to prone and from prone to supine, the infant can be allowed to remain in the sleep position that he or she assumes. Because rolling into soft bedding is an important risk factor for SUID after 3 months of age, parents and caregivers should continue to keep the infant's sleep environment clear of soft or loose bedding.

2. USE A FIRM SLEEP SURFACE.

Infants should be placed on a firm sleep surface (eg, mattress in a safety approved crib) covered by a fitted sheet with no other bedding or soft objects to reduce the risk of SIDS and suffocation. A firm surface maintains its shape and will not indent or conform to the shape of the infant's head when the infant is placed on the surface. Soft mattresses, including those made from memory foam, could create a pocket (or indentation) and increase the chance of rebreathing or suffocation if the infant is placed in or rolls over to the prone position.

A crib, bassinet, portable crib, or play yard that conforms to the safety standards of the Consumer Product Safety Commission (CPSC), including those for slat spacing less than 2-3/8 inches, snugly fitting and firm mattresses, and no drop sides, is recommended. In addition, parents and providers should check to make sure that the product has not been recalled. This is particularly important for used cribs. Cribs with missing hardware should not be used, nor should the parent or provider attempt to fix broken components of a crib, because many deaths are associated with cribs that are broken or with missing parts (including those that have presumably been fixed). Local organizations throughout the United States can help to provide low-cost or free cribs or play yards for families with financial constraints.

Bedside sleepers are attached to the side of the parental bed. The CPSC has published safety standards for these products, and they may be considered by some parents as an option. However, there are no CPSC safety standards for in-bed sleepers. The task force can not make a recommendation for or against the use of either bedside sleepers or inbed sleepers, because there have been no studies examining the association between these products and SIDS or unintentional injury and death, including suffocation.

Only mattresses designed for the specific product should be used. Mattresses should be firm and should maintain their shape even when the fitted sheet designated for that model is used, such that there are no gaps between the mattress and the wall of the crib, bassinet, portable crib, or play yard. Pillows or cushions should not be used as substitutes for mattresses or in addition to a mattress. Mattress toppers, designed to make the sleep surface softer, should not be used for infants younger than 1 year.

There is no evidence that special crib mattresses and sleep surfaces that claim to reduce the chance of rebreathing carbon dioxide when the infant is in the prone position reduce the risk of SIDS. However, there is no disadvantage to the use of these mattresses if they meet the safety standards as described previously.

Soft materials or objects, such as pillows, quilts, comforters, or sheepskins, even if covered by a sheet, should not be placed under a sleeping infant. If a mattress cover to protect against wetness is used, it should be tightly fitting and thin.

Infants should not be placed for sleep on beds, because of the risk of entrapment and suffocation. In addition, portable bed rails should not be used with infants, because of the risk of entrapment and strangulation.

The infant should sleep in an area free of hazards, such as dangling cords, electric wires, and window covering cords, because these may present a strangulation risk.

Sitting devices, such as car seats, strollers, swings, infant carriers, and infant slings, are not recommended for routine sleep in the hospital or at home, particularly for young infants. Infants who are younger than 4 months are particularly at risk, because they may assume positions that can create a risk of suffocation or airway obstruction or may not be able to move out of a potentially asphyxiating situation. When infant slings and cloth carriers are used for carrying, it is important to ensure that the infant's head is up and above the fabric, the face is visible, and the nose and mouth are clear of obstructions. After nursing, the infant should be repositioned in the sling so that the head is up, is clear of fabric, and is not against the adult's body or the sling.

If an infant falls asleep in a sitting device, he or she should be removed from the product and moved to a crib or other appropriate flat surface as soon as is safe and practical. Car seats and similar products are not stable on a crib mattress or other elevated surfaces. Infants should not be left unattended in car seats and similar products, nor should they be placed or left in car seats and similar products with the straps unbuckled or partially buckled.

What does a safe sleep environment look like?

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death

Use a firm sleep surface, such as a mattress in a safety-approved* crib, covered by a fitted sheet.

Do not use pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area.

Keep soft objects, toys, and loose bedding out of your baby's sleep area.

Do not smoke or let anyone smoke around your baby.

Make sure nothing covers the baby's head.

Always place your baby on his or her back to sleep, for naps and at night.

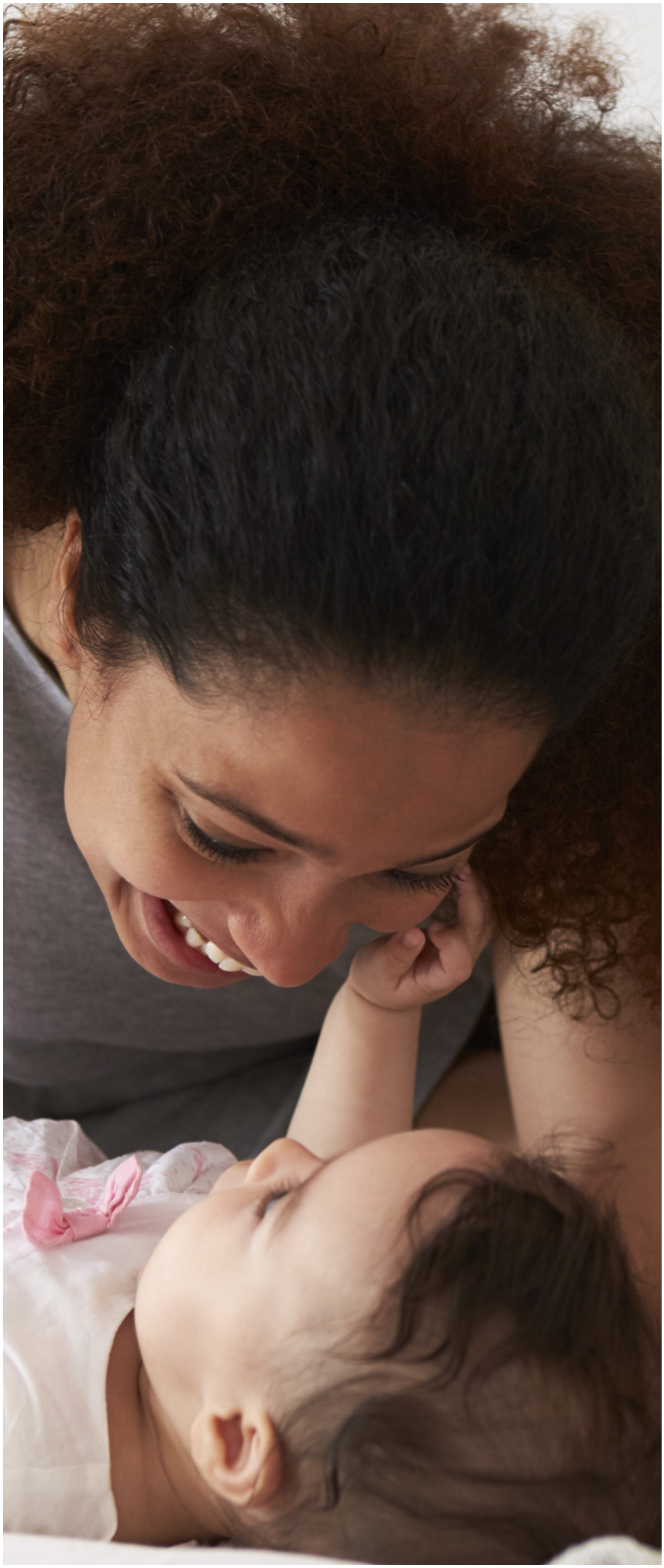
Dress your baby in light sleep clothing, such as a one-piece sleeper, and do not use a blanket.

Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.

*For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or http://www.cpsc.gov.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
Eunice Kennedy Shriver National Institute of Child Health and Human Development

SAFE TO SLEEP



3. BREASTFEEDING IS RECOMMENDED.

Breastfeeding is associated with a reduced risk of SIDS. Unless contraindicated, mothers should breastfeed exclusively or feed with expressed milk (ie, not offer any formula or other nonhuman milk based supplements) for 6 months, in alignment with recommendations of the AAP. The protective effect of breastfeeding increases with exclusivity. However, any breastfeeding has been shown to be more protective against SIDS than no breastfeeding.

4. IT IS RECOMMENDED THAT INFANTS SLEEP IN THE PARENTS' ROOM, CLOSE TO THE PARENTS' BED, BUT ON A SEPARATE SURFACE DESIGNED FOR INFANTS, IDEALLY FOR THE FIRST YEAR OF LIFE, BUT AT LEAST FOR THE FIRST 6 MONTHS.

There is evidence that sleeping in the parents' room but on a separate surface decreases the risk of SIDS by as much as 50%. In addition, this arrangement is most likely to prevent suffocation, strangulation, and entrapment that may occur when the infant is sleeping in the adult bed. The infant's crib, portable crib, play yard, or bassinet should be placed in the parents' bedroom until the child's first birthday. Although there is no specific evidence for moving an infant to his or her own room before 1 year of age, the first 6 months are particularly critical, because the rates of SIDS and other sleep-related deaths, particularly those occurring in bed-sharing situations, are highest in the first 6 months. Placing the crib close to the parents' bed so that the infant is within view and reach can facilitate feeding, comforting, and monitoring of the infant. Room-sharing reduces SIDS risk and removes the possibility of suffocation, strangulation, and entrapment that may occur when the infant is sleeping in the adult bed.

There is insufficient evidence to recommend for or against the use of devices promoted to make bed-sharing "safe." There is no evidence that these devices reduce the risk of SIDS or suffocation or are safe. Some products designed for in-bed use (in-bed sleepers) are currently under study but results are

Recommendation #4 continued

not yet available. Bedside sleepers, which attach to the side of the parental bed and for which the CPSC has published standards, may be considered by some parents as an option. There are no CPSC safety standards for in-bed sleepers. The task force cannot make a recommendation for or against the use of either bedside sleepers or in-bed sleepers, because there have been no studies examining the association between these products and SIDS or unintentional injury and death, including suffocation.

Infants who are brought into the bed for feeding or comforting should be returned to their own crib or bassinet when the parent is ready to return to sleep.

Couches and armchairs are extremely dangerous places for infants. Sleeping on couches and armchairs places infants at extraordinarily high risk of infant death, including SIDS, suffocation through entrapment or wedging between seat cushions, or overlay if another person is also sharing this surface. Therefore, parents and other caregivers should be especially vigilant as to their wakefulness when feeding infants or lying with infants on these surfaces. Infants should never be placed on a couch or armchair for sleep.

The safest place for an infant to sleep is on a separate sleep surface designed for infants close to the parents' bed. However, the AAP acknowledges that parents frequently fall asleep while feeding the infant. Evidence suggests that it is less hazardous to fall asleep with the infant in the adult bed than on a sofa or armchair, should the parent fall asleep. It is important to note that a large percentage of infants who die of SIDS are found with their head covered by bedding. Therefore, no pillows, sheets, blankets, or any other items that could obstruct infant breathing or cause overheating should be in the bed. Parents should also follow safe sleep recommendations outlined elsewhere in this statement. Because there is evidence that the risk of bed-sharing is higher with longer duration, if the parent falls asleep while feeding the infant in bed, the infant should be placed back on a separate sleep surface as soon as the parent awakens.

There are specific circumstances that, in case-control studies and case series, have been shown to substantially increase the risk of SIDS or unintentional injury or death while bed-sharing, and these should be avoided at all times:

- Bed-sharing with a term normal weight infant younger than 4 months and infants born preterm and/or with low birth weight, regardless of parental smoking status. Even for breastfed infants, there is an increased risk of SIDS when bed-sharing if younger than 4 months. This appears to be a particularly vulnerable time, so if parents choose to feed their infants younger than 4 months in bed, they should be especially vigilant to not fall asleep.
- Bed-sharing with a current smoker (even if he or she does not smoke in bed) or if the mother smoked during pregnancy.
- Bed-sharing with someone who is impaired in his or her alertness or ability to arouse because of fatigue or use of sedating medications (eg, certain antidepressants, pain medications) or substances (eg, alcohol, illicit drugs).
- Bed-sharing with anyone who is not the infant's parent, including non-parental caregivers and other children.
- Bed-sharing on a soft surface, such as a waterbed, old mattress, sofa, couch, or armchair.
- Bed-sharing with soft bedding accessories, such as pillows or blankets.
- The safety and benefits of cobedding for twins and higher-order multiples have not been established. It is prudent to provide separate sleep surfaces and avoid co bedding for twins and higher-order multiples in the hospital and at home.

5. KEEP SOFT OBJECTS AND LOOSE BEDDING AWAY FROM THE INFANT'S SLEEP AREA TO REDUCE THE RISK OF SIDS, SUFFOCATION, ENTRAPMENT, AND STRANGULATION.

Soft objects, such as pillows and pillow-like toys, quilts, comforters, sheepskins, and loose bedding, such as blankets and nonfitted sheets, can obstruct an infant's nose and mouth. An obstructed airway can pose a risk of suffocation, entrapment, or SIDS. Infant sleep clothing, such as a wearable blanket, is preferable to blankets and other coverings to keep the infant warm while reducing the chance of head covering or entrapment that could result from blanket use.

Bumper pads or similar products that attach to crib slats or sides were originally intended to prevent injury or death attributable to head entrapment. Cribs manufactured to newer standards have a narrower distance between slats to prevent head entrapment. Because bumper pads have been implicated as a factor contributing to deaths from suffocation, entrapment, and strangulation and because they are not necessary to prevent head entrapment with new safety standards for crib slats, they are not recommended for infants.

6. CONSIDER OFFERING A PACIFIER AT NAP TIME AND BEDTIME.

Although the mechanism is yet unclear, studies have reported a protective effect of pacifiers on the incidence of SIDS. The protective effect of the pacifier is observed even if the pacifier falls out of the infant's mouth.

The pacifier should be used when placing the infant for sleep. It does not need to be reinserted once the infant falls asleep. If the infant refuses the pacifier, he or she should not be forced to take it In those cases, parents can try to offer the pacifier again when the infant is a little older.

Because of the risk of strangulation, pacifiers should not be hung around the infant's neck. Pacifiers that attach to infant clothing should not be used with sleeping infants.

Objects, such as stuffed toys and other items that may present a suffocation or choking risk, should not be attached to pacifiers. For breastfed infants, pacifier introduction should be delayed until breastfeeding is firmly established. Infants who are not being directly breastfed can begin pacifier use as soon as desired. There is insufficient evidence that finger sucking is protective against SIDS.

7. AVOID SMOKE EXPOSURE DURING PREGNANCY AND AFTER BIRTH.

Both maternal smoking during pregnancy and smoke in the infant's environment after birth are major risk factors for SIDS. Mothers should not smoke during pregnancy or after the infant's birth.

There should be no smoking near pregnant women or infants. Encourage families to set strict rules for smoke-free homes and cars and to eliminate secondhand tobacco smoke from all places in which children and other nonsmokers spend time. The risk of SIDS is particularly high when the infant bed-shares with an adult smoker, even when the adult does not smoke in bed.

8. AVOID ALCOHOL AND ILLICIT DRUG USE DURING PREGNANCY AND AFTER BIRTH.

There is an increased risk of SIDS with prenatal and postnatal exposure to alcohol or illicit drug use. Mothers should avoid alcohol and illicit drugs periconceptionally and during pregnancy. Parental alcohol and/or illicit drug use in combination with bed-sharing places the infant at particularly high risk of SIDS.

9. AVOID OVERHEATING AND HEAD COVERING IN INFANTS.

Although studies have shown an increased risk of SIDS with overheating, the definition of overheating in these studies varies. Therefore, it is difficult to provide specific room temperature guidelines to avoid overheating.

In general, infants should be dressed appropriately for the environment, with no greater than one layer more than an adult would wear to be comfortable in that environment. Parents and caregivers should evaluate the infant for signs of overheating, such as sweating or the infant's chest feeling hot to the touch.

Overbundling and covering of the face and head should be avoided. There is currently insufficient evidence to recommend the use of a fan as a SIDS risk-reduction strategy. There is currently insufficient evidence to recommend the use of a fan as a SIDS risk-reduction strategy.

10. PREGNANT WOMEN SHOULD OBTAIN REGULAR PRENATAL CARE.

There is substantial epidemiologic evidence linking a lower risk of SIDS for infants whose mothers obtain regular prenatal care. Pregnant women should follow guidelines for frequency of prenatal visits.

U.S. Consumer Product Safety Commission

A SAFER GENERATION OF CRIBS

New Federal Requirements

5 New Federal Requirements:

- Traditional drop-side cribs cannot be made or sold; immobilizers and repair kits not allowed
- Wood slats must be made of stronger woods to prevent breakage
- Crib hardware must have anti-loosening devices to keep it from coming loose or falling off
- Mattress supports must be more durable
- Safety testing must be more rigorous

Beginning June 28, 2011 all cribs sold in the United States must meet new federal requirements for overall crib safety.

SafeSleep is a campaign of the U.S. Consumer Product Safety Commission.

www.cpsc.gov

NEIGHBORHOOD SAFETY NETWORK
A PROJECT OF THE U.S. CONSUMER PRODUCT SAFETY COMMISSION

NSN 11-2

11. INFANTS SHOULD BE IMMUNIZED IN ACCORDANCE WITH RECOMMENDATIONS OF THE AAP AND CENTERS FOR DISEASE CONTROL AND PREVENTION.

There is no evidence that there is a causal relationship between immunizations and SIDS. Indeed, recent evidence suggests that vaccination may have a protective effect against SIDS.

12. AVOID THE USE OF COMMERCIAL DEVICES THAT ARE INCONSISTENT WITH SAFE SLEEP RECOMMENDATIONS.

Be particularly wary of devices that claim to reduce the risk of SIDS. Examples include, but are not limited to, wedges and positioners and other devices placed in the adult bed for the purpose of positioning or separating the infant from others in the bed. Crib mattresses also have been developed to improve the dispersion of carbon dioxide in the event that the infant ends up in the prone position during sleep. Although data do not support the claim of carbon dioxide dispersion unless there is an active dispersal component, there is no harm in using these mattresses if they meet standard safety requirements. However, there is no evidence that any of these devices reduce the risk of SIDS. Importantly, the use of products claiming to increase sleep safety does not diminish the importance of following recommended safe sleep practices. Information about a specific product can be found on the CPSC Web site (www.cpsc.gov). The AAP concurs with the US Food and Drug Administration and the CPSC that manufacturers should not claim that a product or device protects against SIDS unless there is scientific evidence to that effect.

13. DO NOT USE HOME CARDIORESPIRATORY MONITORS AS A STRATEGY TO REDUCE THE RISK OF SIDS.

The use of cardiorespiratory monitors has not been documented to decrease the incidence of SIDS. These devices are sometimes prescribed for use at home to detect apnea or bradycardia and, when pulse oximetry is used, decreases in oxyhemoglobin saturation for infants at risk of these conditions. In addition, routine in-hospital cardiorespiratory monitoring before discharge from the hospital has not been shown to detect infants at risk of SIDS. There are no data that other commercial devices that are designed to monitor infant vital signs reduce the risk of SIDS.

14. SUPERVISED, AWAKE TUMMY TIME IS RECOMMENDED TO FACILITATE DEVELOPMENT AND TO MINIMIZE DEVELOPMENT OF POSITIONAL PLAGIOCEPHALY.

Although there are no data to make specific recommendations as to how often and how long it should be undertaken, the task force concurs with the AAP Committee on Practice and Ambulatory Medicine and Section on Neurologic Surgery that "a certain amount of prone positioning, or 'tummy time,' while the infant is awake and being observed is recommended to help prevent the development of flattening of the occiput and to facilitate development of the upper shoulder girdle strength necessary for timely attainment of certain motor milestones."

Diagnosis, management, and other prevention strategies for positional plagiocephaly, such as avoidance of excessive time in car seats and changing the infant's orientation in the crib, are discussed in detail in the AAP clinical report on positional skull deformities.

15. THERE IS NO EVIDENCE TO RECOMMEND SWADDLING AS A STRATEGY TO REDUCE THE RISK OF SIDS.

Swaddling, or wrapping the infant in a light blanket, is often used as a strategy to calm the infant and encourage the use of the supine position. There is a high risk of death if a swaddled infant is placed in or rolls to the prone position. If infants are swaddled, they should always be placed on the back. Swaddling should be snug around the chest but allow for ample room at the hips and knees to avoid exacerbation of hip dysplasia. When an infant exhibits signs of attempting to roll, swaddling should no longer be used. There is no evidence with regard to SIDS risk related to the arms swaddled in or out. These decisions about swaddling should be made on an individual basis, depending on the physiologic needs of the infant.

16. HEALTH CARE PROFESSIONALS, STAFF IN NEWBORN NURSERIES AND NICUS, AND CHILD CARE PROVIDERS SHOULD ENDORSE AND MODEL THE SIDS RISK REDUCTION RECOMMENDATIONS FROM BIRTH.

Staff in NICUs should model and implement all SIDS risk-reduction recommendations as soon as the infant is medically stable and well before anticipated discharge. Staff in newborn nurseries should model and implement these recommendations beginning at birth and well before anticipated discharge.

All physicians, nurses, and other health care providers should receive education on safe infant sleep. Health care providers should screen for and recommend safe sleep practices at each visit for infants up to 1 year old. Families who do not have a safe sleep space for their infant should be provided with information about low-cost or free cribs or play yards.

Hospitals should ensure that hospital policies are consistent with updated safe sleep recommendations and that infant sleep spaces (bassinets, cribs) meet safe sleep standards. All state regulatory agencies should require that child care providers receive education on safe infant sleep and implement safe sleep practices. It is preferable that they have written policies.

17. MEDIA AND MANUFACTURERS SHOULD FOLLOW SAFE SLEEP GUIDELINES IN THEIR MESSAGING AND ADVERTISING.

Media exposures (including movie, television, magazines, newspapers, and web sites), manufacturer advertisements, and store displays affect individual behavior by influencing beliefs and attitudes. Media and advertising messages contrary to safe sleep recommendations may create misinformation about safe sleep practices.

12. CONTINUE THE "SAFE TO SLEEP" CAMPAIGN, FOCUSING ON WAYS TO REDUCE THE RISK OF ALL SLEEP RELATED INFANT DEATHS...

...including SIDS, suffocation, and other unintentional deaths. Pediatricians and other primary care providers should actively participate in this campaign.

Public education should continue for all who care for infants, including parents, child care providers, grandparents, foster parents, and babysitters, and should include strategies for overcoming barriers to behavior change.

The campaign should continue to have a special focus on the black and American Indian/Alaskan Native populations because of the higher incidence of SIDS and other sleep related infant deaths in these groups. The campaign should specifically include strategies to increase breastfeeding while decreasing bed-sharing, and eliminating tobacco smoke exposure. The campaign should also highlight the circumstances that substantially increase the risk of SIDS or unintentional injury or death while bed-sharing, as listed previously.

These recommendations should be introduced before pregnancy and ideally in secondary school curricula to both males and females and incorporated into courses developed to train teenaged and adult babysitters. The importance of maternal preconceptional health, infant breastfeeding, and the avoidance of substance use (including alcohol and smoking) should be included in this training.

Safe sleep messages should be reviewed, revised, and reissued at least every 5 years to address the next generation of new parents and products on the market.

19. CONTINUE RESEARCH AND SURVEILLANCE ON THE RISK FACTORS, CAUSES, AND PATHOPHYSIOLOGIC MECHANISMS OF SIDS AND OTHER SLEEP RELATED INFANT DEATHS, WITH THE ULTIMATE GOAL OF ELIMINATING THESE DEATHS ALTOGETHER.

Education campaigns need to be evaluated, and innovative intervention methods need to be encouraged and funded. Continued research and improved surveillance on the etiology and pathophysiologic basis of SIDS should be funded.

Standardized protocols for death scene investigations, as per Centers for Disease Control and Prevention protocol, should continue to be implemented. Comprehensive autopsies, including full external and internal examination of all major organs and tissues including the brain; complete radiographs; metabolic testing; and toxicology screening should be performed.

Training about how to conduct a comprehensive death scene investigation offered to medical examiners, coroners, death scene investigators, first responders, and law enforcement should continue; and resources to maintain training and conduct of these investigations need to be allocated. In addition, child death reviews, with involvement of pediatricians and other primary care providers, should be supported and funded.

Improved and widespread surveillance of SIDS and SUID cases should be implemented and funded. Federal and private funding agencies should remain committed to all aspects of the aforementioned research.

Rest Easy When You Know the ABC's of Safe Sleep

A is for Alone

The safest place for babies is in the same room as their parents, but alone in a separate sleep area.

B is for Back

Always place babies on their back to sleep at night and at nap time.

C is for Crib

Babies need their own safe space to sleep. Keep all loose objects, soft toys and bedding out of baby's sleep area.

American Academy of Pediatrics

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AAP TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. Pediatrics. 2016;138(5):e20162938

To view complete article, please visit: http://pediatrics.aappublications.org/content/early/2016/10/20/peds.2016-2938

* The following levels are based on the Strength-of-Recommendation Taxonomy (SORT) for the assignment of letter grades to each of its recommendations (A, B, or C). 2 Level A: There is good-quality patient-oriented evidence. Level B: There is inconsistent or limited-quality patient-oriented evidence. Level C: The recommendation is based on consensus, disease-oriented evidence, usual practice, expert opinion, or case series for studies of diagnosis, treatment, prevention, or screening. Note: "patient-oriented evidence" measures outcomes that matter to patients: morbidity, mortality, symptom improvement, cost reduction, and quality of life; "disease-oriented evidence" measures immediate, physiologic, or surrogate end points that may or may not reflect improvements in patient outcomes (eg, blood pressure, blood chemistry, physiologic/unction, pathologic findings). CDC, Centers for Disease Control and Prevention. For the background literature review and data analyses on which this policy statement and recommendations are based, refer to the accompanying technical report, "SIDS and Other Sleep-Related Infant Deaths: Evidence Base for 2016 Updated Recommendations for a Safe Infant Sleeping Environment," available in the electronic pages of this issue (www.pediatrics.org/ cgi/doi/ 10. 1542/ peds. 2016- 2940).

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