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THE EXTENDED ROLE OF THE SUDI ADVISER
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Introduction: The role of the SUDI Referral Advisor was piloted by the Ministry of Health, with the enthusiastic support of the Chief Coroner. This envisaged role required the coordination of a SUDI file for the Coroner and a visit to the family to gather information of how/when/where the baby died.

Aim: The vision is to reduce the number of SUDI in New Zealand each year.

Method: Deaths within the scope of the SUDI Referral Advisor Project are: babies between 0-1 years, where death is:
- unexpected and unexplained
- death not resulting from a complication of delivery
- not a result of an accident or injury
- not as a result of a known congenital/genetic condition or disease.

A SUDI form is completed and forwarded to the Ministry and the Child Youth Mortality Review Committee (CYMRC).

The pilot timeframe included deaths occurring on or after 15 December 2008 to 15 December 2009 in the Auckland Region area.

Results: The pilot has contributed valuable data in the search for understanding and prevention, which the Ministry uses to analyse possible trends and identify action areas. Early intervention produces the most significant data, because parents are more likely to provide details as part of their personal grieving process. The quality of the information has improved considerably. A significant gap in family/whanaun support was identified, as were conflicting messages from stakeholders regarding safe sleeping as a preventative measure.

Conclusion: The role is vital, and has identified gaps in bereavement support and conflicting prevention messages which must be addressed. After the initial period, the SRA pilot was extended for a further 6 months, with greater emphasis on data collection, family/whanaun support, education and prevention, and less involvement in the coronial process.

SLOW DOWN; DON'T MOVE TOO FAST. GOT TO MAKE SOME MEMORIES TO LAST
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Baby's Remembered and Wintergreen Press, President ISPID and ISA Member and Committee co-chair

Introduction and Aim: Hopeful, excited expectant parents are given devastating news... their baby will die or has died. Often within minutes or an hour, they drive to the hospital to begin the process of birth. It is any other non-life threatening medical situation, they would be encouraged to go home to deal with the shock... reading material would be given and encouraged to notify work, family, and friends, to pack a bag, speak with staff about what will happen while at the hospital, and other preparation activities. Yet, for decades there has been a rush to the hospital where critical decisions that create the foundation for future healing are mad too quickly while they are in absolute shock.

It is time to slow this down and give parents the time and resources they need to be more prepared. The brand new DVD 'Hardly Know You... What Happens Next?' will be shown and Birth Planning will be introduced focusing on why and the details of how. Compassionate Patient-Centered care will also be addressed.

Method: A short presentation and discussion, a new DVD will be shown, 'Hardly Know You... What Happens Next?' Resources that help parents learn their options and make healthy decisions will be shared. Birth Planning will then be introduced focusing on why it is important and the details of how to help families create a 'Flexible' Birth Plan. Stories of others who have had a loss and a thorough discussion of options will help families have permission to do what is best for them and their families. Participants will work through an actual Birth Plan in small groups.

Conclusion and Results: At the conclusion of the presentation, participants will have learned about the importance of slowing down the process of birth after diagnosis of a loss. They will explore helpful resources for families and also learn about how to create a personalized, written Birth Plan.
Oral Abstracts

caregivers employ incorrect infant care practices which increase the risk of sudden infant death.

Aim: The aim was to design and develop an evidence-based sustainable resource to support health professionals to deliver Safe Sleeping messages to families in Queensland.

Method: This paper will outline a) the process used in developing an electronic resource for health professionals; b) collaborations established in developing a resource suitable for state-wide implementation; c) factors contributing to successful development and implementation.

Results: New and existing collaborations and networks between the project team and SIDS and Kids, the SIDS and Kids National Scientific Advisory Group, expert clinicians, Indigenous representatives, Queensland Health and the Clinical Skills Development Service, were utilized in developing a safe infant sleeping resource suitable for state-wide, and subsequently national, implementation in a variety of clinical and community settings. Factors including information and resource sharing, information consistency, collaboration between key stakeholders, and understanding of change management are integral to the success of an educational resource being evidence-based, user-friendly, accessible to clinicians, and a sustainable model of health professional support.

Conclusion: A collaborative, systematic approach involving amalgamation of current information and resource sharing between all key stakeholder groups, supported at a national level, will facilitate safe sleeping initiatives being delivered and sustained long term.

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IMPROVING UPTAKE OF SAFE INFANT SLEEPING RECOMMENDATIONS: TEACHING TOOLS FOR PARENTS AND HEALTH PROFESSIONALS

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Introduction: Barriers to safe sleeping (SS) recommendation uptake by health professionals and parents include perceptions that babies placed supine to sleep have an increased aspiration risk and are more difficult to settle.

Aim: To develop, implement and evaluate teaching methods that support and promote supine infant sleep positions used by health professionals and parents.

Method: A pre-test/post-test intervention design evaluated knowledge and practices relating to SS recommendations in a sample of nurses and midwives caring for families with infants (n = 539); a pre-test survey and audit (observational and chart); b) educational intervention including safety of supine positioning; c) post-test survey and audit.

Results: Comparison of paired responses (n = 102) for nurses/midwives who completed both pre and post-tests demonstrated that the intervention significantly improved documentation and practice (P = 0.04); and achieved positive changes in knowledge of risk factors (P = 0.05), parent advice relating to recommended infant sleep position (P = 0.005) particularly for infants with reflux (P = 0.003); and safe wrapping as a strategy to support supine sleep (P = 0.02). Education including bedside teaching tools comprising a flier, card, poster, cart and an online resource developed to facilitate health professional and parent understanding of the importance of supine sleep are included in the resource suite. SS audit indicators have been included in state-wide maternity clinical pathways for ongoing monitoring.

Conclusion: Innovative teaching tools that significantly and positively impact health professional knowledge and practice relating to SS recommendations will directly impact the support parents receive to use infant care practices that reduce risk of sudden unexpected infant death.

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CREATING AN INTERNET RESOURCE FOR PARENTS SEEKING ADVICE DURING PREGNANCY AND AFTER A BABY HAS DIED

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Introduction and Aim: Parents crave information as they seek a healthy pregnancy, but also after their baby has died and when they consider or have a subsequent pregnancy. Having information that is clear, thorough, sensitive, accurate and realistic from a reliable source is important. The ISAs Parent Advisory Committee (PAC) took up the task of testing some of the common questions parents ask in any of these three scenarios and then answered them, with the help of the ISA Scientific Advisory Committee (SAC).

Method: After a brief review of how the project came about, the panel will present the questions and answers which include the most important questions and answers.

Conclusion and Results: Developing a cohesive document from a diverse group of parents from around the world was time consuming but ultimately created a comprehensive guide for parents, seeking advice and guidance after their loss.

At the conclusion of this presentation, participants will be given the opportunity to share their experiences with other parents, to discuss their coping strategies and to ask questions of the panelists.

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"BETTER BEGINNINGS" - COMMUNICATING THE REDUCE THE RISK MESSAGE TO TEENAGE PARENTS

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Introduction: Rate for SIDS is four times greater for teenage compared with older parents.

Aim: To provide more effective resources for teenage parents and the professionals working with them.

Method: FSID developed and launched "Better Beginnings": a) seminars and toolkits for professionals working with teenage parents; b) a social networking website www.bubblicious.co.uk where teenage parents can chat, win prizes, get support, learn about safe sleep. By passing a series of tests they can become "Big Sisters" and themselves give baby care advice to other teenage parents. Teenage parents were consulted in the development of the website through focus group discussions. Six months after the launch the programme was evaluated through questionnaires to professionals, further focus groups with teenage parents, a survey of website users, and analysis of site usage.

Results: 93% of 428 professionals rated the seminars as excellent or very good, 95% rated the booklet highly favourably, and 96% said they would promote Bubblicious. They work with an estimated 20,000 teenage parents annually. In the first 6 months the site had 6002 unique visitors spending on average 8 minutes per visit, and 588 registered users, of whom 33 became Big Sisters. Though the single most
NATIONAL PERINATAL MORTALITY CLINICAL AUDIT DATA COLLECTIONS FOR AUSTRALIA AND NEW ZEALAND

**Conclusion:** This workshop has undergone an iterative process that has resulted in an evidence-based, standardised product that is well accepted, and improves attitudes and knowledge. We are now planning to roll out and comprehensively evaluate this workshop.

- Structured, Clinical, Objective-Focused, Problem-oriented and Organized

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**CLOSING THE GAP – PACIFIC PEOPLE IN NEW ZEALAND**

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**Introduction:** Pacific communities in New Zealand experience high rates of SUDI and stillbirth. During 2003-2007, SUDI rates for Māori (2.34 per 1000) and Pacific (1.31 per 1000) infants were significantly higher than for other (including European) infants (0.52 per 1000). During 1996-2005, late fetal deaths were consistently higher for Pacific babies than for babies from other ethnic groups. Many of the causal factors of Pacific infant and fetal mortality such as SUDI and stillbirth are modifiable, yet research shows that over one third (38%) of mothers of Pacific infants were unable to accurately report a SIDS risk factor.

**AIM:** TAHIA is a new Pacific service based at The University of Auckland, School of Population Health which seeks to improve and protect the health of Pacific pregnant mothers and infants to ensure their babies have the best possible start to life.

**Method:** TAHIA provides a service to equip health professionals to address key modifiable risk factors that are associated with Pacific SUDI and stillbirth (i.e. maternal smoking, safe sleeping, and antenatal care and education). This paper presents the key aspects of the service including findings from a literature review which explores the issues and risk factors with particular reference to Pacific people, indigenous and minority groups.

**Conclusion:** This presentation provides a Pacific approach to improving the health of Pacific mothers and infants and reducing Pacific SUDI and stillbirth rates in New Zealand.

**References**


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**EVALUATION OF BABY HELP, AN ILLNESS ASSESSMENT TOOL FOR INDIGENOUS INFANTS**

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**Introduction:** Indigenous infant death rates are more than double that of the non-Indigenous population. In 2007-08 Maternity Child Health and Safety Branch, Queensland Health, implemented an assessment tool for parents and carers via the Indigenous Health Worker (ICHW) that was aimed at improving the identification and management of illness in Indigenous infants aged 0-2 years. We report on the process used to implement this tool and the effectiveness and value of this tool, as interpreted by the ICHW, for the wider community.

**Method:** A pre-test post-test survey design was used in a sample of ICHW's and CHW's across Queensland to evaluate current knowledge...
and practice relating to infant illness management. Focus groups were conducted to obtain further practice information and identify support systems and resources that existed within work environments.

Results: Comparison of paired responses to surveys (n = 21 paired) for Health Workers was conducted to determine the impact of the tool on knowledge. Evaluation of strategies used to educate and disseminate the 'Baby Help' tool demonstrated issues relating to distribution and support. The importance of education and support amongst health workers, as well as within the community, were highlighted for the tools success.

Conclusion: CHWs and CWs have a key role in the implementation of health promotion initiatives. Identification of health promotion tools that are appropriate and effective support for their roles will ultimately assist the indigenous community overall. Elements relating to the implementation of the 'Baby Help' tool will inform future health promotion activities within this population.

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PERINATAL DEATH AUDITS AT NSAMBYA HOSPITAL, KAMPALA, UGANDA

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Introduction: Maternal and neonatal conditions in Uganda contribute 20.4% of the total burden of ill health and avoidable deaths. Perinatal death audits significantly reduce perinatal mortality.

Aim: To assess the quality of maternal and newborn care and the effect of perinatal death audit on perinatal mortality.

Methods: Over a nineteen months period (March 2008-December 2009), weekly perinatal death reviews were conducted by a team consisting of midwives, paediatricians, administrators and obstetricians for a total of 279 perinatal deaths. Each case was discussed in detail, identifying gaps in care and cause of death. The quality offered to the mother was classified into four categories: 1. Optimum 2. Probable acceptable 3. Probably suboptimal and 4. Suboptimal. Solutions were implemented according to the gaps identified. Descriptive analysis of data was made.

Results: Of 279 deaths, 98 (35.1%) were macerated stillbirths, fresh Stillbirths 69 (24.7%), and neonatal deaths 97 (34.8%). A total of 134 (48%) of the mothers received optimal care, 56 (20%) probably acceptable care, 56 (20%) probably suboptimal care, 46 (16.5%) Suboptimal care 28 (19.7%). The major causes of death were birth asphyxia 83 (29.4%), respiratory distress syndrome 22 (7.9%), and meconium aspiration pneumonia 9 (3.3%). Perinatal mortality rate was 50 and 45 per 1000 live births in 2008 and 2009 respectively after introduction of the audits compared to 62.5 per 1000 total births in 2007.

Conclusion: Perinatal audits have potential to significantly contribute to maternal and newborn quality of care and to reduce health facility related perinatal mortality.

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EPISTOMILOGY

EVOLUTION OF RISKS FACTORS IN SIDS CASES IN LYON AREA

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Introduction: The highest risk period for SIDS has been shown to be between the age of 2 and 4 months in many countries. As we started to receive younger patients (<1 month) in our SIDS Center, we speculated that there might be different risk factors in this younger population.

Aim: To document the evolution of risk factors in our SIDS population in the Lyon area, especially age of occurrence, prematurity and dysmaturity, and to try to explain these changes.

Method: We compared the age of occurrence in our SIDS population between two different periods: 1993-2002 and 2003-2009, and with the national data established in 1995 by INSEM. Between 1993 and 2002, 4.5% died before 1 month and 17% between 1 and 2 months. These data are similar to the 1995 national data. Between 2003 and 2009, 12% died before 1 month and 21% between 1 and 2 months. In this latter group, babies who died before 1 month were in their parents' bed at the time of death in 75% of cases, had a small birth weight for GA in 61% of the cases and 23% were born preterm. Between 1 and 2 months 33% were in a bed-sharing setting, 33% were preterm and 26% had SWB for GA.

Result: Bed-sharing, prematurity and dysmaturity are major risk factors in SIDS cases before the age of 2 months.

Conclusion: The recent increase of SIDS cases before 2 months of age may be related to the increase of bed-sharing in the Lyon area.

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USING COCHRANE REVIEW TO HELP REDUCE STILLBIRTH IN HIGH INCOME COUNTRIES

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Introduction: In high income countries, stillbirths make up about 70% of perinatal deaths. Currently, several interlinked international groups are examining the epidemiology of stillbirth, potential interventions to reduce stillbirth rates, and research gaps and priorities in low, middle and high income countries.

Objectives: To outline the contribution of Cochrane reviews to stillbirth policy and research priority development.

Methods: We assessed all relevant Cochrane reviews (254 reviews from Cochrane Library Issue 4, 2009) for their ability to identify interventions with the potential to reduce stillbirths or to reduce factors known to be associated with stillbirth in high-income countries.

Results: Only 11 (4.3%) of the 254 Cochrane reviews reported a significant reduction in stillbirth. While we judged that a further 139 (54.7%) were unable to confirm or refute stillbirth reductions due to insufficient trials or participants, they helped indicate which interventions might affect modifiable factors (such as smoking cessation