New Mexico Child Fatality Review 2022 Report

Findings & Recommendations from Child Deaths Reviewed from 2020-2021

New Mexico Department of Health

Epidemiology and Response Division

Injury and Behavioral Epidemiology Bureau

Office of Injury and Violence Prevention

January 31, 2023

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State of New Mexico

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Special thanks to outgoing panelists Andrea Verswijver (Child Abuse, Neglect or Homicide panelist), Coffee Brown, (Unintentional Injury panelist), and Lucretia Vigil (Child Fatality Review Coordinator), for their dedication to Child Fatality Review and Prevention in New Mexico.

Appreciation and thanks are also extended to the staff at the New Mexico Office of the Medical Investigator, New Mexico Children Youth and Families Department, the New Mexico Bureau of Vital Records and Health Statistics (NM BVRHS), state and federal law enforcement agencies, medical facilities, and school districts across New Mexico who aided in supplying much needed data for the case reviews included in this report.

Most of all, we would like to acknowledge the families and communities affected by child loss in our state. It is with deepest sympathy that we dedicate this report to the children and youth represented in its pages.

New Mexico Child Fatality Review welcomes committed individuals to participate in one or more of the review panels. Those with experience in the fields of mental health, family-focused social services, substance abuse, early childhood services, law enforcement, criminal justice, transportation safety, faith-based initiatives, emergency medical services, and school-based health services are especially encouraged to inquire about taking part in the New Mexico Child Fatality Review.

To get involved, please contact NMCFR@doh.nm.gov.

Background

About Child Fatality Review

The death of a child is a great loss to family and community. Such loss serves as a marker of the health and safety of all children in affected communities; understanding the circumstances leading to the death of a child may help to prevent deaths of other children from similar circumstances.

Child fatality review (also known as child death review) is a process in which multidisciplinary teams meet to share and discuss case information to understand the circumstances around child deaths. Local, regional, and state teams throughout the United States and its territories then submit this information to the National Fatality Review Case Reporting System, a database managed by the National Center for Fatality Review and Prevention (NCFRP).

Included in this report are data from the NCFRP, which is funded by the US Department of Health and Human Services, and from the New Mexico Department of Health (NMDOH) BVRHS about child deaths in NM. Ultimately these data are then used to create a comprehensive picture of the factors that increase risk of child fatalities. This information helps state, regional and local agencies, health care organizations, child-serving and educational organizations, communities, and families to employ evidence-based actions to make their communities safer and prevent child deaths.

New Mexico Child Fatality Review

The New Mexico Child Fatality Review (NM-CFR) was established in 1998, pursuant to the promulgation of rules under Title 7 of the New Mexico Administrative Code (NMAC) Chapter 4- Disease Control, Part 5, Maternal, Fetal, Infant and Child Death Review (NMAC 7.4.5) to examine the circumstances that contribute to the death of children in NM (see Appendix A). It has thus been making recommendations to its participating members and their agencies for more than two decades. Many of the recommendations have been adopted by these agencies while others have resulted in legislation, some of which has been enacted.

The Child Fatality Review process seeks to:

1) identify risk and preventable causes of illness or injury

2) develop actionable recommendations to prevent child death

3) disseminate findings and recommendations to partners in prevention

The multidisciplinary review of individual child deaths allows stakeholders to better understand the circumstances surrounding these deaths and use the information gained in the review process to prevent future fatalities. The NM-CFR identifies gaps in systems, as well as risk and protective factors of child fatalities, to develop actionable recommendations to prevent future child fatalities. The review process can also alert communities and policy makers about emerging trends in circumstances surrounding intentional and unintentional injuries which contribute to child deaths.

Prevention

A Public Health Approach

Public health is "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals." — CEA Winslow

Public health is focused on improving health outcomes for entire populations. It is a science which draws on an evidence-base informed by numerous disciplines, including medicine, epidemiology, social sciences, education, and economics. The New Mexico Department of Health uses a public health approach to:

1. Define and Monitor the Problem
2. Identify Risk and Protective Factors
3. Develop and Test Prevention Strategies
4. Assure Widespread Adoption

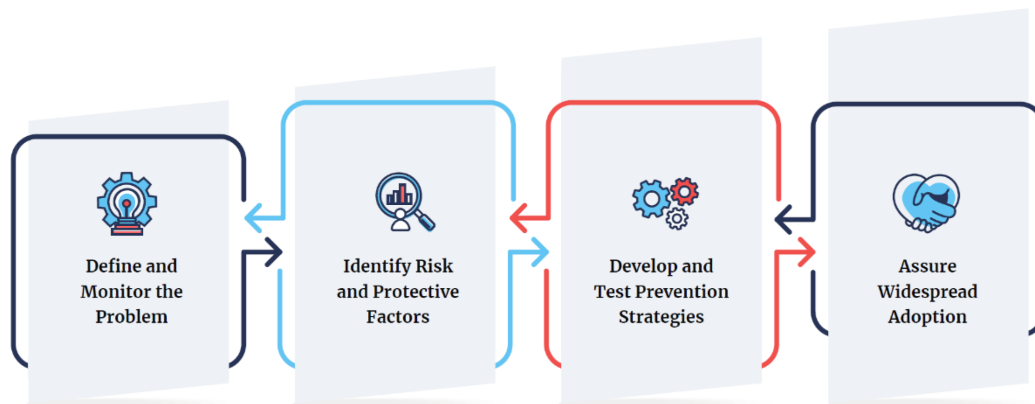

Figure 1. The Public Health Approach

The public health approach seeks to improve the health and wellbeing of entire populations. Collective input and action are key to implement recommendations and impact health outcomes.

Social-Ecological Model

The Social-Ecological Model considers the dynamic interplay of factors which influence health at and across multiple levels of society- individual, relationship, community, and societal.

Figure 2. The Social-Ecological Model

Considering unique characteristics at each level of the Social-Ecological Model enables public health practitioners to better understand the shared risk and protective factors which influence health.

Report Narrative

The NM-CFR 2022 Annual Report summarizes and analyzes information about circumstances surrounding 163 injury-related deaths of resident New Mexico infants, toddlers, children, and youth under age 18. The report includes deaths reviewed in calendar years 2020 and 2021.

These deaths were reviewed in-depth during confidential meetings by multidisciplinary teams of professionals. The deaths were fully entered into the National Fatality Review Case Reporting System, regardless of the year of death. This report presents recommendations based on data, and panel member input from these reviews. In some cases, panel members may have drawn from experience in prior year(s) of service on these panels to develop recommendations.

It is important to note that this report includes deaths that occurred from years 2015 to 2021. This report should not be used for comparative purposes to previous CFR reports published by the NMDOH Office of Injury and Violence Prevention to examine change over time. Such comparison would be inaccurate due to the overlap in timeframes.

Methodology

Thematic Review

The NM-CFR uses both qualitative and quantitative data to better understand the complex factors associated with child deaths in New Mexico. Through a process of confidential, comprehensive reviews of individual cases, the NM-CFR makes recommendations. Recommendations can include the development of, or changes to, agency policies and practices; state laws and regulations; media campaigns; prevention programs; strategic partnerships; or further inquiry into troubling trends.

Information obtained through the case review process is input into the National Fatality Review Case Reporting System. Standard definitions of fatality-related terms (Appendix B), provided in the New Mexico Office of the Medical Investigator 2021 Annual Report, describe data points that are referred to in the death certification processes and used by NM-CFR (Appendix C). Select data in this report may be suppressed as needed based on the New Mexico Rule for Small Numbers and Public Data Release (see Appendix E).

During 2020 and 2021, NM-CFR was comprised of four distinct case review panels. Each NM-CFR panel is made up of a diverse group of experts in child safety, public health, education, behavioral health, medicine, forensic pathology, law enforcement, public safety, juvenile justice, criminal justice, and other related fields.

Panel	Description
Child Abuse, Neglect or Homicide (CAN-H)	This panel reviews child fatalities that result from caregiver abuse and/or neglect. This panel also reviews child homicides, regardless of the perpetrator's relationship to the child, as well as other causes of death that involve caregiver abuse or neglect.
Sudden Unexpected Infant Death (SUID)	This panel reviews unexpected deaths of infants less than one year old in which the cause was not obvious before investigation. These deaths often occur during sleep or in the area where the infant was placed to sleep.
Unintentional Injury	This panel reviews child fatalities in which the manner of death was accidental and/or undetermined. The causes of death included in this panel's reviews are varied and include motor vehicle crashes; drowning deaths; unintentional overdose or poisoning; fire- related deaths; and other fatalities due to unintentional injuries.
Youth Suicide	This panel reviews intentional deaths among children and youth that result from self-injury.

Materials Reviewed

Cases are prepared for review when NM BVRHS sends death certificates of individuals under 18 years of age who meet the criteria for inclusion into one of the review panels to the Office of Injury and Violence Prevention. If the child was born in New Mexico, the birth certificate is also provided. The New Mexico Office of the Medical Investigator (OMI)'s database is then utilized to obtain death summaries, any death investigation notes, and any available autopsy and examination notes.

Documents that may provide context for the circumstances leading up to and involving the child's death may be gathered. Additional documents may include, but are not limited to state, local, and/or federal law enforcement records, medical records, court records, school records, obituaries, news media, and social media posts. To supplement the records gathered for the review, panelists from the NM Children, Youth and Families Department (CYFD) and Comprehensive Addiction and Recovery Act (CARA) Program attend panel meetings and are available to provide additional information on the child and family's social history, as well as circumstances around the death.

Panel Reviews

The NM-CFR reviewed 164 unique child deaths from January 1, 2020, through December 31, 2021. The dates of death for these children included calendar years 2015 (n=1), 2017 (n=2), 2018 (n=34), 2019 (n=79), 2020 (n=46), and 2021 (n=2).

Each of the 164 child death cases were reviewed by at least one of the four panels and database entry was completed in the National Fatality Review Case Reporting System.

Occasionally a child death case received a second review to gain perspective from another panel.

One case was excluded from analysis because it did not meet inclusion criteria for the Centers for Disease Control and Prevention Sudden Unexpected Infant Death (SUID) Case Registry, bringing the total unique cases analyzed in this report to 163.

Findings

After NM-CFR review, one case was excluded from analysis because it did not meet inclusion criteria for the Centers for Disease Control and Prevention SUID Case Registry, bringing the total unique cases analyzed in this report to 163.

Table 1. Child Deaths Reviewed by Primary Panel of Review

Panel	Frequency	Percent
Child Abuse, Neglect or Homicide	23	14.1%
Sudden Unexpected Infant Death	37	22.7%
Unintentional Injury	59	36.2%
Youth Suicide	44	27.0%
Total	**163**	**100.00%**

According to the NCFRP, a child's death is determined to be preventable if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death. Of the 163 unique child deaths analyzed for this report, NM-CFR determined that 139 deaths (85%) could have been prevented. NM-CFR could not determine from the information gathered whether the child's death was preventable in 22 cases (13.5%).

Data Overview

Autopsies were performed on 139 (85%) of the child deaths reviewed by the NM-CFR. The primary cause of death listed on the death certificate agreed with the pathology report on 160 (98%) child deaths that were reviewed. 135 (83%) death scene investigations were conducted at the place where the child's death occurred.

A witness to the incident was available at 152 (93%) of the child deaths reviewed by the NM-CFR. The most common witnesses at the child's scene of death were a stranger (n =17, 10%), followed by non-relative/acquaintances (n=12, 7%), parent/relative (n=8, 5%), and caretaker/babysitter (n=5, 3%). The local emergency number or 911 was called in 157 (96%) of the child deaths. Resuscitation of the child was attempted in 101 (62%) of the child deaths reviewed. Of these, resuscitation was attempted by parents, bystanders, or friends in 73 (45%) prior to EMS arrival to the scene.

The circumstances of the children's deaths varied widely in terms of location for the 163 cases analyzed in this report. The most common place where children's deaths occurred was at the child's home (n=88, 54%) followed by a location on or near a roadway (n=34, 21%).

Case Demographic Information

Child fatalities were more often male (n=109, 67%) than female (n=54, 33%), with this pattern of males outnumbering females distributed across the different age groups (Figure 3). The age group with the most deaths was 15 to 17-year-olds (n=58, 36%). This was followed by infants under the age of one (n=42, 26%).

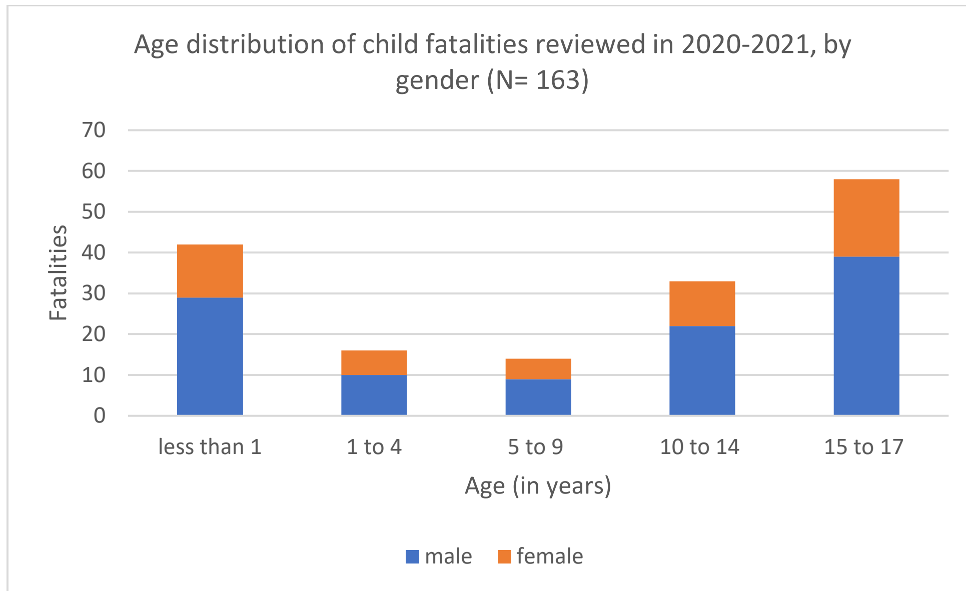

Figure 3. Age distribution of child fatalities reviewed in 2020-2021, by gender (N= 163)

Eighty (49%) of the cases reviewed were of Hispanic or Latino ethnicity. Sixty-one (37%) cases were non-Hispanic/Latino White. Thirty-six (22%) cases were Native American, 12 (7%) cases were Black or African American, eight (5%) cases were bi/multi-racial, and three (2%) cases were Asian.

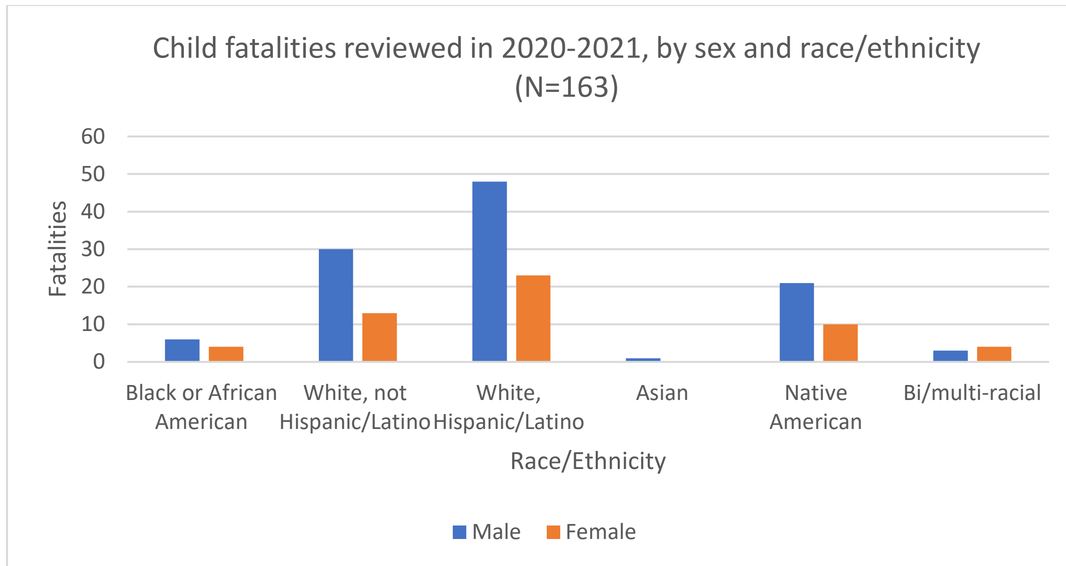

Figure 4. Child fatalities reviewed in 2020-2021, by sex and race/ethnicity (N=163)

Most children died in Bernalillo County (n= 55, 34%), followed by Santa Fe (n=12, 7%), Sandoval (n=11, 7%), McKinley (n=10, 6%), and San Juan County (n=9, 6%).

Manner and Cause of Death

The most common manner of child death reviewed by the NM-CFR was unintentional injury (also referred to as accidental) (n=73, 44.8%), followed by suicide (n=44, 27%), undetermined (n=23, 14.1%), homicide (n=18, 11%), and natural (n=5, 3.1%).

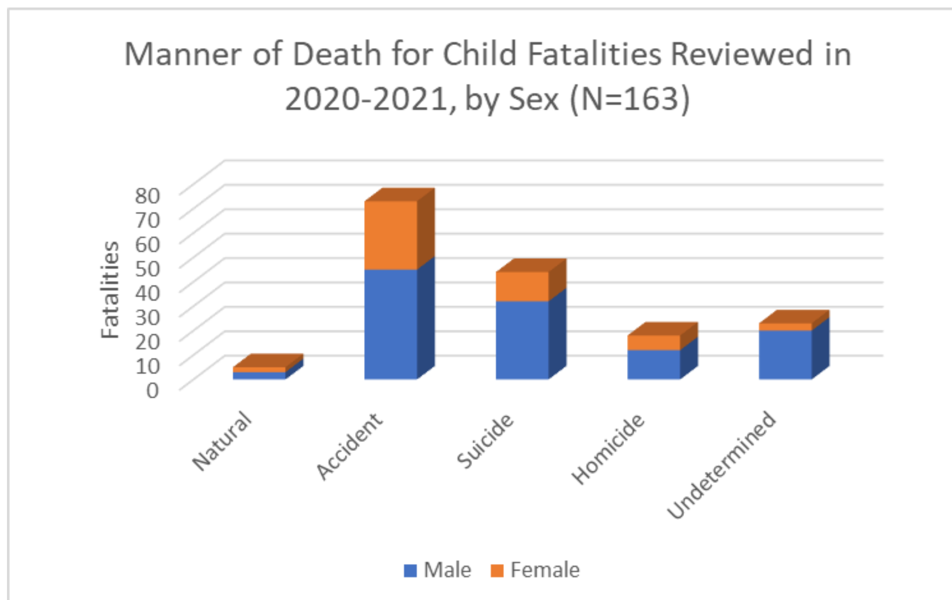

Figure 5. Manner of death for child fatalities reviewed in 2020-2021, by sex (N=163)

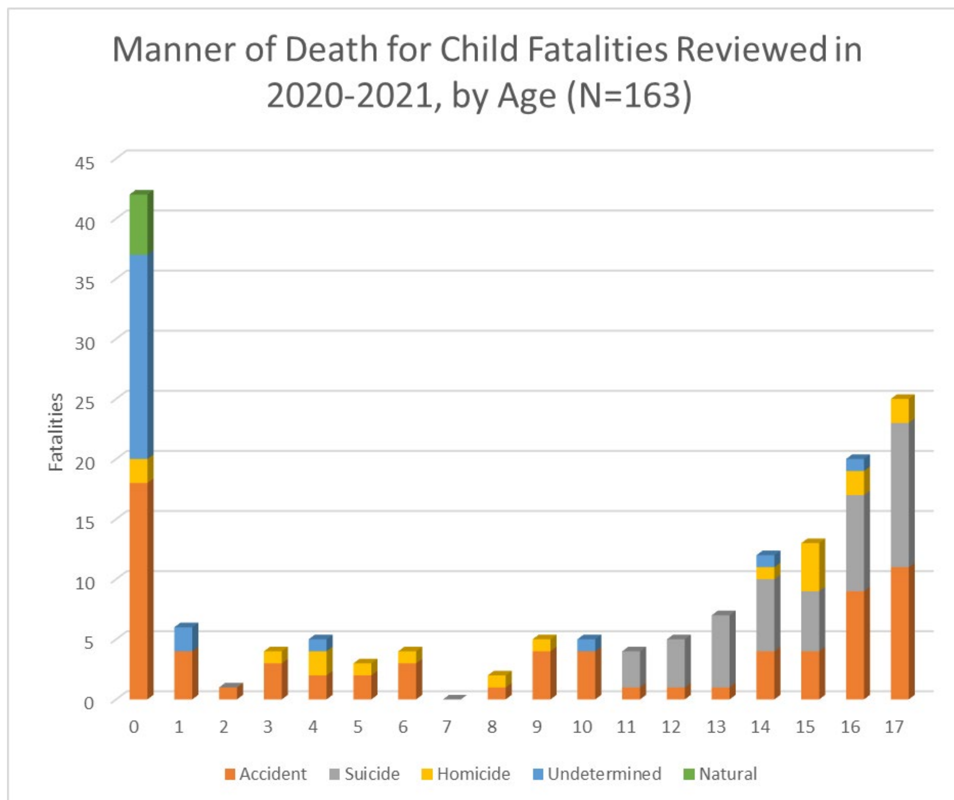

Figure 6. Manner of death for child fatalities reviewed in 2020-2021, by age (N=163)

The leading cause of death of the 73 unintentional injury deaths was motor vehicle related (n=34, 47%), followed by asphyxia (n=15, 21%), poisoning (n=8, 11%), drowning (n=6, 8%), other or not classified (n=4, 5%), fall/crush (n=3, 4%), fire/burn/electrical (n=2, 3%), and finally bodily force or weapon (n=1, 1%). Of the 42 suicide cases, 19 (45%) had the cause listed as bodily force or weapon, 20 (48%) were classified as asphyxia, and the three other cases fell under fall/crush, other, or poison.

Child Abuse, Neglect or Homicide

In 2020 and 2021, 26 child fatalities were reviewed by the CAN-H Panel, 23 of which were unique cases. Five cases reviewed in 2020 or 2021 were either a re-review by this panel or a secondary review following primary review by another panel.

Of the 23 cases of child abuse, neglect, and homicide included in this report, 13 (56.5%) were males, and 10 (43.5%) were female. Seventeen (73.9%) of the 23 children were White, 12 of which identified as Hispanic. Six (26.1%) were Native American.

Table 2. CAN-H deaths reviewed in 2020 and 2021, by age (N=23)

Age	Count	Percent
Less than 1 year	3	13.0%
1-4 years	7	30.4%
5-9 years	4	17.4%
10-14 years	1	4.4%
15-17 years	8	34.8%
Total	**23**	**100.00%**

The reviews of these fatalities highlighted several risk factors, including significant Adverse Childhood Experiences (see Shared Risk and Protective Factors section, p.19). The family economic background for 10 (43.5%) of these children was classified as low and was unknown for the other 13 cases reviewed.* Eighteen (78.3%) had at least one parent with a history of being charged and/or convicted with a crime. Thirteen (56.5%) of the children had a history of being the victim of violence and neglect. Eight (34.8%) of the children had a prior referral to a child welfare service (ranging from 1 to 11 referrals). Eight (34.8%) of the children had been the victim of intimate partner violence. Eight (34.8%) had a personal history of drug abuse. Documentation in six (26.1%) cases indicated the child had multiple challenges in school (such as academic, truancy, suspensions, and behavioral issues).

*According to the National Center for Fatality Review and Prevention, "Income level is an estimate based on economic indicators such as caregiver education, social service enrollment, and health insurance type; can assist in determining the child's household income level. If no concrete evidence exists regarding income, unknown is selected" (NCFRP, 2022).

Sudden Unexpected Infant Death (SUID)

In 2020 and 2021, 37 unique child fatalities were reviewed by the SUID Panel. One case reviewed in these years was a re-review by this panel. One child fatality was excluded from final analysis because the case characteristics did not meet inclusion criteria for the Centers for Disease Control and Prevention's SUID Case Registry. More information about the SUID Case Registry can be found at https://www.cdc.gov/sids/case-registry.htm

Of the 37 cases of SUID included in this report, 26 (70%) were male and 11 (30%) were female. Twenty-four (65%) of the infants were white, 13 of which were identified as Hispanic or Latino; seven (19%) were Black or African American, five (14%) were Native American, and one (3%) was Asian or Pacific Islander. With an estimated statewide population of only 2.7% (all ages), Black and African American infants were significantly overrepresented in this analysis.

Table 3. SUID deaths reviewed in 2020 and 2021, by age (N=37)

Age	Count	Percent
Sudden unexpected early neonatal deaths (SUEND), 0-6 days of life		
0-6 days old	1	2.7%
Post-perinatal SUID, 7-364 days of life		
< 1 month old	8	21.6%
1-4 months old	19	51.4%
5-8 months old	8	21.6%
9-12 months old	1	2.7%
Total	**37**	**100.00%**

Unintentional Injury

In 2020 and 2021, 59 unique child fatalities were reviewed by the Unintentional Injury Panel. Forty-two percent of the cases reviewed were 15-17 years old. Fifty-three (90%) of the cases were identified as preventable by the NM-CFR; the team could not determine preventability for the remaining 6 (10%) cases.

Thirty-eight (64%) were males and 21 (36%) were female. Forty (68%) of the 59 children were White, 28 of which identified as Hispanic. Nineteen (32%) were Native American.

Table 4. Unintentional Injury deaths reviewed in 2020 and 2021, by age (N=59)

Age	Count	Percent
Less than 1 year	2	3.39%
1-4 years	9	15.25%
5-9 years	10	16.95%
10-14 years	13	22.03%
15-17 years	25	42.37%
Total	**59**	**100.00%**

Youth Suicide

Of the 44 unique cases of child suicide included in this report, 32 (72.7%) were males and 12 (27.3%) were female. Twenty–two (50%) were Hispanic or Latino, 16 (36.4%) were white, and six (13.6%) were Native American.

Thirty-five (80%) of the cases were identified as preventable by the NM-CFR; the team could not determine preventability for the remaining nine (20%) cases.

Table 5. Suicide deaths reviewed in 2020 and 2021, by age (N=44)

Age	Count	Percent
11-13 years	13	29.6%
14-15 years	11	25.00%
16-17 years	20	45.5%
Total	**44**	**100.00%**

Mental Health

Less than half of the children that died by suicide had received prior mental health services (n=19, 43.2%). Thirteen (29.5%) were actively receiving mental health services around the time of death. In the year prior to death, 10 (23%) children had been seen in the emergency department for a mental health emergency, yet only half of them (n=5) were scheduled for a follow up appointment within 30 days.

Cases reviewed were found to have one or more of the following:

- Twenty-two (50%) communicated their thoughts or intentions of suicide to another individual
- Twenty (45.5%) experienced a major life stressor within 30 days prior to death
- Twenty (45.5%) experienced a sense of isolation
- Eighteen (40.9%) experienced a life stressor in terms of failure in school
- Fifteen (34.1%) experienced the death of a loved one
- Fourteen (31.8%) exhibited a recent change in behavior
- Thirteen (29.5%) recently had an argument with their parents
- Twelve (27.3%) had parents who were divorced or separated
- Twelve (27.3%) experienced housing insecurity
- Twelve (27.3%) had been the victim of bullying
- Twelve (27.3%) were diagnosed with depression
- Eleven (25%) had a history of self-harm
- Eight (18.2%) had recently gone through a breakup with a significant other
- Eight (18.2%) had a history of being raised in a home with domestic violence
- Seven (15.9%) were diagnosed with anxiety
- Five (11.4%) had previously attempted suicide, yet none of the records reviewed indicated a safety plan was in place.

Shared Risk and Protective Factors

Shared Risk and Protective Factors is a term used in public health which seeks to acknowledge that risk and protective factors- that is, factors which either increase or decrease risk of injury,

are interconnected. These risk and protective factors may occur at any singular or multiple levels of the Social-Ecological Model. In this analysis, some themes emerged across the panels of review.

Life Stressors & Mental Health as a Risk Factor for Child Fatality

Through the cases reviewed in 2020 and 2021, some shared risk factors were identified: life stressors such as failure in school, death of a loved one, argument with parents, bullying, parents divorced/separated, recent breakups, and mental health challenges (thoughts or intentions of suicide, depression or anxiety, self-harm, prior suicide attempt).

Youth Suicide

With regard to youth suicide, 11 of the 44 suicide cases were identified as having a number of issues leading to non-utilization or underutilization of mental health services. These issues included: lack of providers in rural areas, refusal of parents or child to participate or utilize referrals, stigmas around mental health or about receiving mental health supportive services, and travel distance to services.

Access to Lethal Means as a Risk Factor for Child Fatality

Access to lethal means such as firearms, medication and other instruments or objects which may result in intentional injury increases the risk of deaths by homicide and suicide, as well as other unintentional injuries such as accidental gun deaths and accidental overdose. Reducing access to lethal means through safe firearm and medication storage saves lives.

Youth Suicide

Suicide is the second leading cause of death for 10 to 14-year-olds and the third leading cause of death among individuals between the ages of 15 to 24-year-olds in the United States, and the in the United States (CDC, 2022).

Lack of Supervision as a Risk Factor for Child Fatality

According to the NCFRP, lack of supervision is defined as a child who did not have supervision but needed it, with children less than age six requiring constant supervision most of the time. In addition, if the supervisor of a child younger than age six could not see or hear the child at the time of need, this would be considered lack of supervision. For the children included in this report, at the time of the child's death there were 57 children and youth (35%) who were of sufficient developmental age and circumstances to supervise themselves. Sixty-seven children (41%) were supervised at the time of death and 68 children (42%) did not have supervision and needed it. In four cases, the NM-CFR was not able to determine their supervisory need and one case did not have a response entered into the database.

Regardless of supervision status at time of incident leading to death, 66 of the 163 cases analyzed contained information about the last time a primary person responsible for supervision at time of incident saw the child: In 33 (50%) of those cases, the deaths occurred when the child was in sight of the supervising individual; 18 deaths (27%) occurred when the child was out of sight of the supervising individual for less than an hour; 15 deaths (23%) occurred when the child was out of sight of the supervising individual for more than an hour.

A range of risk factors were identified from the available records of 101 children who were identified as needing supervision or who were under parents/caregiver(s) supervision at the time of their death. Nineteen (19%) child deaths occurred in situations where the supervising individual had a disability or chronic illness. Twenty-one (21%) child deaths occurred in situations where the supervising adult was impaired (defined by the NCFRP as being "distracted or absent, drug or alcohol impaired, and/or impaired by disease or disability"). Twenty-five children (25%) were supervised by an individual who had a known history of maltreating a child. Thirty-six children (36%) were supervised by an individual with a known history of substance use disorder. Twenty-five children (25%) were supervised by an individual who was convicted of a crime.

Adverse Childhood Experiences as a Risk Factor for Child Fatality

Adverse Childhood Experiences (ACEs) are stressful or traumatic events which are experienced in children and youth under the age of 18. ACEs increase the risk of future violence victimization and/or perpetration and have a significant impact on multiple lifelong measures of health and wellbeing.

The Centers for Disease Control and Prevention (CDC) categorizes ten ACEs into three groups: abuse, neglect, and household challenges (CDC, 2021). The ten ACEs are:

- Abuse
  - **Emotional abuse:** A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.
  - **Physical abuse:** A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
  - **Sexual abuse:** An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.
- Household Challenges
  - **Mother treated violently:** Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.
  - **Substance abuse in the household:** A household member was a problem drinker or alcoholic or a household member used street drugs.
  - **Mental illness in the household:** A household member was depressed or mentally ill or a household member attempted suicide.
  - **Parental separation or divorce:** Your parents were ever separated or divorced.
  - **Incarcerated household member:** A household member went to prison.
- Neglect

- **Emotional neglect:** Someone in your family never or rarely helped you feel important or special, you never or rarely felt loved, people in your family never or rarely looked out for each other and felt close to each other, or your family was never or rarely a source of strength and support.
- **Physical neglect:** There was never or rarely someone to take care of you, protect you, or take you to the doctor if you needed it, you didn't have enough to eat, your parents were too drunk or too high to take care of you, or you had to wear dirty clothes.

New Mexico Behavioral Risk Factors Surveillance System data indicate that an estimated 67% of adults have experienced at least one ACE, and nearly one in four adults (23.8%) have experienced four or more ACEs (Whiteside, 2021).

Child Maltreatment & Child Health as Risk Factors for Child Fatality

A history of child maltreatment has been identified as a risk factor for preventable child fatality (Jonson-Reed, et al., 2022). Forty-six of the 163 children (28%) had a history of child maltreatment, and 10 (6%) had open investigations at the time of their death.

Eighteen children (11%) had a history of being placed into foster care at any time prior to their death.

Child health status can also be a stressor for families that increases the risk of child fatality. Forty-three (26%) children had a known prior disability or chronic illness. Twenty-three children (14%) were receiving mental health services prior to their death and another 33 children (20%) had ever received mental health services in their past. Thirty-two children (20%) had used alcohol or drugs just prior to their death, while one child (1%) had a documented history of substance abuse.

Socioeconomic Status (SES) as a Risk Factor for Child Fatality

Social determinants of health, the conditions in which people live, work and play, have a significant effect on health and well-being. Socioeconomic status (SES) is a notable finding in this analysis. One child (1%) was classified as having high household income, 10 (6%) were classified as having medium household income, 58 (36%) were classified as having low household income, and 92 (56%) were unknown/unable to classify. Although the largest group is unknown, known health insurance information gives further insight into the SES of these children. 124 cases (76%) had Medicaid as their insurance coverage, while seven (4%) had no medical coverage. Only 38 (23%) of case records indicate that their mothers received prenatal care (a known preventive factor of child fatality).

In the cases reviewed and analyzed in this report, social determinants such as household income, geographic location, or education level may have prevented these children or their parents/caregivers from equitable access to and use of healthcare services.

Conclusions

Child deaths due to injury and violence are preventable. Of the unique 163 child fatalities analyzed in this report, NM-CFR determined that 139 (85%) deaths may have been prevented. In most cases, there was sufficient data for the NM-CFR to determine preventability, but in 22 (13.5%) cases, the information provided was insufficient to determine whether the child's death was preventable.

Based on child fatality data from reviews conducted during the calendar years 2020-2021, the most common circumstances surrounding child deaths included risk factors and a lack of protective factors in areas of access to lethal means, behavioral and mental health care, supervision, transportation safety, and home safety. The next section describes key prevention recommendations made by NM-CFR.

Recommendations

Recommendations to reduce access to lethal means:

1. The NM Legislature, as well as regional and local municipalities, should enact legislation requiring gun owners to obtain a license and attend a gun safety class as part of the licensing process. Sufficient funding should also be appropriated to provide lock boxes and/or trigger locks as an incentive for current gun owners to obtain a license.
2. In collaboration with OMI, Regulation and Licensing Division (RLD), NM Public Education Department (PED), Children, Youth and Families Department (CYFD), as well as state and local police departments, NMDOH should create a joint public safety media campaign on the lethality of firearms in the state of New Mexico.

Recommendations to increase behavioral and mental health care and access to resources:

3. Legislation should be passed in NM that allows for greater access to mental health professionals from other states via telehealth by joining a multistate compact such as PSYPACT, an interstate agreement which allows psychologists in participating jurisdictions to practice across state lines, which includes provisions for tele-practice.
4. Legislation in NM should be passed to mandate suicide prevention gatekeeper training, such as QPR (Question. Persuade. Refer.) ™ or Mental Health First Aid for appropriate personnel in state-funded child-serving organizations, including public schools and departments such as PED, ECECD, and CYFD.
5. NM-CFR supports the implementation of a centralized reporting and referral database that can be utilized by state agencies, police departments, medical providers, and other partners in order to flag and assist children who are being exposed to violence and are in need of referrals, especially mental health.

Recommendation to increase access to appropriate supervision:

6. State general funds should be appropriated to increase access to high quality childcare that is free or low-cost through ECECD. The review panels highlighted the need for these facilities to have childcare availability outside of traditional business hours due to individuals working alternate shifts.

Recommendations to increase safe home environments:

7. State general funds should be appropriated for Sudden Unexpected Infant Death Education and Prevention, including funding for the purchase and provision of safe sleep spaces such as bassinets and cribs.

Appendix

Appendix A: State of New Mexico Child Death Review Legislation

As outlined in 7 NMAC 4.5, which can be found at https://www.ncfrp.org/wp-content/uploads/State-Docs/NM_leg.pdf, the New Mexico Department of Health has the regulatory authority to operate a child fatality review program. The Department of Health Act, Section 9-7-6. E. NMSA 1978 and the Public Health Act, Section 24-1-3.F NMSA 1978 specifically, states "The department has authority to: investigate, control and abate the causes of disease, especially epidemics, sources of mortality and other conditions of public health; and Section 24-1-3. F. NMSA 1978, which states: "The department has authority to: establish programs and adopt regulations to prevent infant mortality, birth defects and morbidity". 7.4.5.2 thru 7.4.5.15 in Title 7 outline this statutory authority as well as the program administration, oversight, membership, case identification, data collection, confidentiality and security of records, proceedings, and findings.

Appendix B: Glossary Terms from OMI 2021 Annual Report

Term	Definition
Cause of Death	“The agent of effect that results in a physiological derangement or biochemical disturbance that is incompatible with life. The results of postmortem examination, including autopsy and toxicological findings, combined with information about the medical history of the decedent serves to establish the cause of death. The cause of death can result from different circumstances and manner of death. For example, the same cause of death, drowning, can result from the accidental immersion of a child in a swimming pool or from the homicidal immersion of a child in a bathtub.”
Manner of Death	“The general category of the condition, circumstances or event, which causes the death. The categories are natural, accident, homicide, suicide and undetermined.”
Natural	“The manner of death used when solely a disease causes death. If death is hastened by an injury, the manner of death is not considered natural.”
Accident	“The manner of death used when, in other than natural deaths, there is no evidence of intent.”
Homicide	“The manner of death in which death results from the intentional harm of one person by another.”
Suicide	The manner of death which results from intentional self-injury.
Undetermined	“The manner of death for deaths in which there is insufficient information to assign another manner.”
Pending	“The cause of death and manner of death are to be determined pending further investigation and/or toxicological, histological and/or neuropathological testing at the time of publication”

Appendix C: Office of the Medical Investigator Annual Report 2021 – Excerpt (page 44)

Deaths of Children in New Mexico – Summary

The 10-year summaries presented in this report for childhood deaths all include ages 19 and younger. The 361 deaths of people aged 19 and younger represented 3.51% of all deaths investigated by the OMI in 2021. Male decedents comprised 58.27% of the total deaths in children. The most common manner of death among children was natural, contributing 21.95% of the total. There were 32 suicides among children in 2021. Suicide deaths were more common among young males (78.12%) than females (21.88%). The total number of childhood homicides increased from 24 homicides in 2020 to 29 in 2021. Homicide deaths among children tended to be male (82.76%), White Hispanic (44.83%). The majority of childhood homicide victims (68.97%) were between the ages of 15 and 19. Homicide rates increased by 20.83% from 2020 to 2021 with the largest homicide population impacting the age group 15–19 years.

An excellent resource for additional information about the deaths of children in New Mexico, their circumstances, risk factors, and opportunities for prevention is the Annual Report of the New Mexico Child Fatality Review (NMCFR), published by the New Mexico Department of Health Public Health Division, Maternal and Child Health Epidemiology Program. NMCFR consists of volunteers from many state and local agencies organized into four panels: Suicide, Sudden Unexplained Infant Death (SUID), Unintentional Injury, and Child Abuse and Neglect. The experts on these panels review the circumstances of childhood deaths in order to identify risk factors and develop prevention strategies, and their findings are presented in their annual report.

Appendix D: Suicide Awareness, Prevention and Training Organizations

American Foundation for Suicide Prevention (AFSP), American School Counselor Association (ASCA), the National Association of School Psychologists (NASP), and The Trevor Project advocacy group for Lesbian, Gay, Bisexual, Transgender, Questioning/Queer (LGBTQ) youth. Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources, 2nd edition.

Breaking the Silence New Mexico

Campaign Against Living Miserably (CALM)

Child Mind Institute

Coalition to Support Grieving Students

Herald Alliance, The K-12 Toolkit for Mental Health Promotion and Suicide Prevention

Mental Health AmericaThe Mental Health Technology Transfer Center Network Coordinating Office (MHTTC) National School Mental Health Curriculum and Best Practices for States, Districts, and SchoolsNational Child Traumatic Stress Network's Trauma-Informed School Strategies During Covid-19

NM ConnectReadiness and Emergency Management for Schools (REMS), Psychological First Aid for Schools (PFA-A)The Sky Center's Adolescent Hugs ProgramSuicide Prevention Resource CenterUS Department of Health and Human Services, Stop Bullying CampaignThe U.S. Surgeon General's Advisory's Protecting Youth Mental Health

Appendix E: New Mexico Rule for Small Numbers and Public Data Release

New Mexico Rule for Small Numbers and Public Data Release

Specified population/ Event set*		**Numerator**	**Action**
<20	AND	1-3	Suppress (and suppress other cells allowing calculation of 1-3)
>=20		all	Release

*Event set – the set of which the numerator is an immediate subset

Percentages or rates that can be used to determine the value of suppressed cells must also be suppressed.

These guidelines do not relieve the data user of the responsibility to be aware of the confidentiality issues regarding the data and to appropriately present data.

Do not suppress the number of births or deaths at the state, district, or county levels presented by standard racial/ethnic groups, standard age groups, sex, prenatal care, birth weight categories, birth order, plurality, total anomalies, marital status, or NCHS standard 113 cause of death categories.

Survey Data

If the number of persons surveyed in a given population or subpopulation is 50 or greater then estimates based on this surveyed population or subpopulation will not be suppressed. It is recommended that confidence intervals for the estimate be presented.

Appendix F: Related Resources

2022 Data Book | New Mexico Human Services Department

Centers for Disease Control and Prevention

- Adverse Childhood Experiences (ACEs)
- Child Abuse and Neglect Prevention
- Firearm Violence Prevention
- National Center for Injury Prevention & Control
- Sudden Unexpected Infant Death and Sudden Infant Death Syndrome
- Suicide Prevention
- The Public Health Approach to Violence Prevention
- The Social-Ecological Model: A Framework for Prevention

Kids Count (Annie E Casey Foundation)

National Center for Fatality Review and Prevention

New Mexico Indicator Based Information System (NM-IBIS)

New Mexico Maternal Mortality Review Report, 2022

New Mexico Office of the Medical Investigator

New Mexico Office of the Medical Investigator, 2021 Annual Report

New Mexico Pregnancy Risk Assessment and Monitoring System (NM PRAMS)

New Mexico Voices for Children Kids Count Data Book

New Mexico Youth Risk & Resiliency Survey

State of Mental Health in New Mexico, 2022

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