New Mexico Child Fatality Review 2023 Report

Findings & Recommendations from Child Deaths Reviewed in 2022

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Executive Summary

The New Mexico Child Fatality Review (NM-CFR) was established in 1998, with the implementation of [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 factors that contribute to the death of children in New Mexico (NM) (see Appendix B). All non-natural child resident deaths in NM are subject to review by NM-CFR. Deaths due to intentional (suicides, homicides) and unintentional injuries (drowning, suffocation, motor vehicle crashes) are preventable and vary by age. These deaths undergo a thorough review process by multidisciplinary review panels, allowing stakeholders to better understand the circumstances surrounding these deaths. Through the review process, panelists identify gaps in systems, as well as risk and protective factors of child fatalities, and develop actionable recommendations to prevent future child fatalities of similar circumstance.

The NM-CFR utilizes the National Center for Fatality Review and Prevention (NCFRP) steps to conduct effective review meetings:

1. Share, question, and clarify all case information
2. Discuss the investigation
3. Discuss the delivery of services
4. Identify risk factors
5. Recommend systems improvements
6. Identify and take action to implement prevention recommendations
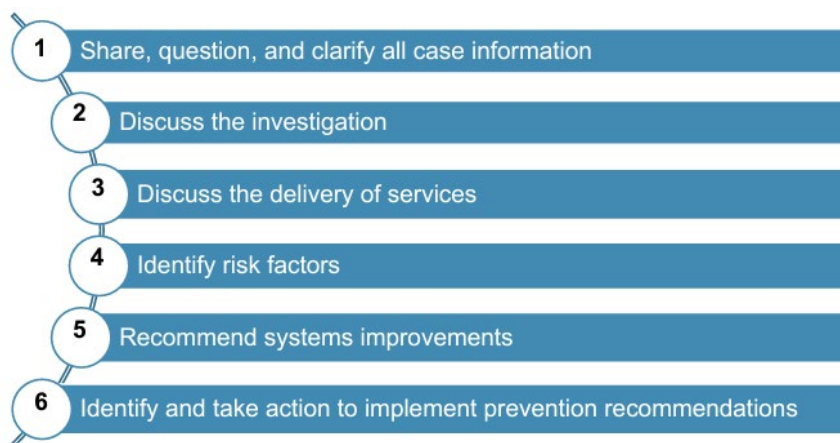
The NM-CFR 2023 Report summarizes and analyzes information about 84 unique injury-related deaths of NM infants, toddlers, children, and youth under the age of 18, which were reviewed in 2022. The child fatalities described in this report occurred between the years 2018 and 2022 and includes: 2 child deaths that occurred in 2018, 7 deaths that occurred in 2019, 29 deaths that occurred in 2021, 43 deaths that occurred in 2021, and 3 deaths that occurred in 2022.

This report should not be used to compare changes over time to previous CFR reports published by the NMDOH Office of Injury and Violence Prevention. Such a comparison would be inaccurate because of the overlap in year of death.

Report Highlights

Causes of Death

Of the 84 unique child fatalities reviewed in 2022 and analyzed in this report, the leading causes of death were: asphyxiation (30%), bodily force or weapon (27%), unknown (20%), and motor vehicle crashes (11%), followed by poisoning (5%), drowning (3%), and other incidents (3%).

Age, Gender and Race

Of the 84 unique child fatalities reviewed in 2022 and analyzed in this report, the age group with the most deaths was infants under the age of one (n=35), child fatalities were markedly higher in males (n=54) and nearly half of cases reviewed (n=41) were of Hispanic or Latino ethnicity.

Location of Death

Of the 84 unique child fatalities reviewed in 2022 and analyzed in this report, the highest number of child deaths were found in Bernalillo County, with 23 cases (27.8%). Following that, seven cases (8.3%) were out of Doña Ana County, and six cases (7.14%) were out of San Juan County.

Preventability

Of the 84 unique child fatalities reviewed in 2022 and analyzed in this report, NM-CFR determined that 80% (n=67) could have been prevented, and 2% of deaths (n=2) couldn't be prevented. Key findings from cases reviewed can be found in the 2023 Report, beginning on page 24.

Recommendation Highlights

In response to the data provided in this report, the NM-CFR makes evidence-based recommendations to prevent future child fatalities of similar circumstances:

- to support program operations and improve the data used for the review,
- to increase awareness of the burden of child fatality and prevention efforts,
- to increase safe home environments, and
- to increase behavioral healthcare and access to resources.

A more detailed list of prevention recommendations can be found in the NM-CFR Recommendations section, beginning on page 49.

The NM-CFR 2023 Report Tear Sheet is a one-page summary resource at the end of this report, beginning on page 65. For optimal use, print in color and on both sides.

Background

Child Fatality Review

Every year, over 37,000 children in the United States die before reaching the age of 18. The death of a child is a great loss to family and community. One indicator of a society's general well-being is the ability to lower child death rates.

Child fatality review is a process in which multidisciplinary teams meet to share and discuss information collected about a child death, also referred to as case information, to understand the circumstances around child deaths. These multidisciplinary committees are made up of representatives from the medical community, public health, law enforcement, child protective services, the office of the coroner/medical examiner, and the prosecuting attorney's office.

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).

The Child Fatality Review process aims to:
- Identify risk and preventable causes of illness or injury
- Develop actionable recommendations to prevent child death
- Disseminate findings and recommendations to partners in prevention

The information included in this report is accessed from the New Mexico Department of Health (NMDOH) BVRHS and from the NCFRP National Fatality Review Case Reporting System database, which is funded by the US Department of Health and Human Services. The state, regional, and local governments, healthcare providers, child-serving and educational groups, communities, and families can use this information to guide decisions to make their communities safer and prevent further child fatalities.

A Framework for 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 and 4) Assure Widespread Adoption.

Figure 1. The Public Health Approach

Similarly, this public health approach to prevent child fatalities seeks to improve the health and wellbeing of all children under 18 years of age. As part of this approach, NM-CFR conducts a review process to identify factors which increase or decrease the risk of injury or violent victimization, also called risk and protective factors. Based on this review, prevention strategies are developed through the recommendation process.

Social-Ecological Model

The Social-Ecological Model (SEM) considers the dynamic interplay of factors which influence health at and across multiple levels of society- individual, relationship, community, and societal.
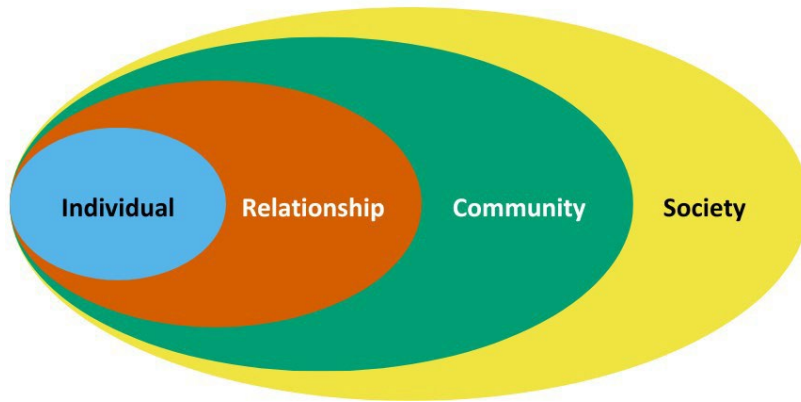
Figure 2. The Social-Ecological Model

To improve health outcomes and to remove the burden of child fatalities, risk and protective factors are identified at each level of the SEM. Findings and recommendations are developed for each case, considering unique characteristics at each level of the SEM.

Shared Risk and Protective Factors

Shared Risk and Protective Factors (SRPF) is a term used in public health to acknowledge factors which either increase or decrease interconnected risks of injury. These risk and protective factors may occur at any singular or on multiple levels of the Social-Ecological Model.

Social Determinants of Health

Social determinants of health (SDOH) are the non-medical factors that have impacts on health outcomes and contribute to a wide range of health disparities (CDC, 2023). SDOH play a crucial role in influencing the overall health and well-being of individuals, regardless of their age.

However, it is especially crucial to consider the influence of SDOH on children and youth. This is because the physical, social, and emotional abilities that develop during early life serve as the building blocks for long-term health and well-being throughout the lifespan. Health disparities exist in the population of NM among different racial, ethnic, and socioeconomic groups due to inequitable differences in SDOH.

Figure 3. Social Determinants of Health

Source: Healthy people 2030, US department of Health and Human Services

The NM-CFR considers various interconnected factors operating at different levels during case reviews. These factors encompass educational attainment, economic stability, social and community dynamics, neighborhood characteristics, access to healthcare, and policy influences.

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) refer to potentially traumatic events that take place during childhood (ages 0-17 years). Neighborhoods lacking resources or experiencing racial segregation have the potential to induce stress which compounds the effect of ACEs on the development of children's brains, immune systems, and stress-response systems. ACEs also disrupt a child's ability to develop healthy attention spans, decision-making processes, and ability to learn, while increasing the risk of injury-related deaths (CDC, 2023), and the risk of future violence victimization and/or perpetration.

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 with excessive use of psychoactive drugs, such as alcohol, pain medications, or illegal drugs that can lead to physical, social or emotional harm.
  - 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.

Emerging research about additional circumstances experienced in childhood which may increase adversity:

- Housing insecurity
  - Emerging research suggests that adults who have experienced housing insecurity are significantly more likely to have encountered adverse experiences during their childhood compared to individuals in the general population who have not experienced housing insecurity (Curry, 2017).
- Community violence
  - Experiencing community violence and physical abuse during childhood can have a significant impact on both externalizing behaviors and academic performance in later years. Furthermore, it is crucial to acknowledge that community violence exposure (CVE) has a distinct and autonomous effect when evaluating the influence of physical abuse (Schneider, 2020).

ACEs and the detrimental effects they cause can be reduced through preventive measures. The establishment and maintenance of secure, stable, and nurturing relationships and environments for children and families can effectively mitigate ACEs and reduce the occurrence of child fatalities. In 2019, the Centers for Disease Control and Prevention issued a resource guide about ACEs, highlighting six strategies to prevent ACEs:

1. Strengthen Economic Supports for Families;
2. Promote Social Norms that Protect Against Violence and Adversity;
3. Ensure a Strong Start for Children;
4. Teach Skills;
5. Connect Youth to Caring Adults and Activities;
6. Intervene to Lessen Immediate and Long-term Harms.

Essentials for Childhood: Preventing Adverse Childhood Experiences through Data to Action is a CDC funded program focused on preventing ACEs and promoting positive childhood experiences (PCEs). Twelve recipient organizations across the nation are building or improving ACEs and PCEs data collection infrastructure and capacity, implementing and sustaining ACEs prevention strategies, focusing on health equity and conducting ongoing data-to-action activities to inform changes to their existing prevention strategies or select additional strategies.

New Mexico Child Fatality Review

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 factors that contribute to the death of children in NM (see Appendix B).

The NM-CFR employs a confidential, comprehensive approach, incorporating both qualitative and quantitative data related to non-natural child deaths, which includes accidental deaths, homicides by parent or caregiver, suicides, and cases where the cause of death cannot be determined. Homicides by a person other than a parent or caregiver are excluded from review. All non-natural child deaths in NM are subject to review by NM-CFR. The objective of this approach is to improve understanding of the complex variables associated with child fatalities in the state of New Mexico.

These deaths undergo a thorough review process by multidisciplinary review panels, allowing stakeholders to better understand the circumstances surrounding these deaths. Through the review process, panelists identify gaps in systems, as well as risk and protective factors of child fatalities, and develop actionable recommendations to prevent future child fatalities of similar circumstance. 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.

For more than 20 years, NM-CFR has been providing prevention recommendations. While some of the recommendations led to enacted legislation, many of the recommendations were adopted by state agencies and community partners. NM-CFR reports from previous years may be found at www.nmhealth.org.

Standard definitions of fatality-related terms, including manner of death (Appendix C), 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 D). The New Mexico Rule for Small Numbers and Public Data Release (Appendix F) guides the suppression of specific data in this report as necessary.

Review Panels

In 2022, NM-CFR maintained four distinct case review panels. Each panel is comprised of a diverse group of experts in child safety, public health, education, behavioral health, medicine, forensic pathology, law enforcement, public safety, juvenile and criminal justice, and other related fields.

Child Abuse, Neglect or Homicide (CAN-H)	This panel reviews child fatalities that result from parent/caregiver abuse, neglect or homicide.
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.
Unintentional Injury	This panel reviews child fatalities in which the manner of death was accidental or undetermined. The causes of death are varied and include motor vehicle crashes, drownings, unintentional overdose or poisonings, fire or environmentally related, and other unintentional injuries.
Youth Suicide	This panel reviews intentional deaths among children and youth that result from self-injury.

Report Narrative

This report analyzes characteristics of child fatalities reviewed in calendar year 2022. A supplemental analysis of cases reviewed by death year(s) is presented in Figures 7, 8 and 9.

This report aims to provide information about child fatality in NM, and to promote the widespread adoption of prevention strategies and recommendations by the NM-CFR. Its primary goal is to advocate for the widespread implementation of prevention strategies and recommendations endorsed by the NM-CFR. The collaborative expertise of multidisciplinary panels enhances the likelihood of formulating pertinent and influential recommendations, ultimately influencing health outcomes within this demographic.

Child Death in New Mexico

Leading Causes of Child Death

The following tables present the primary cause of child mortality in New Mexico from 2011 to 2021. These data represent all child fatalities in NM, including both those due to natural causes and non-natural causes. The table shows that unintentional injury (also referred to as accidents) consistently ranked as the foremost cause of death during this period. Suicide and homicide have been identified as the fourth and fifth leading causes of death in children 0-17 years of age over the course of these years. Upon analysis across various age groups, it was discovered that injury-related deaths consistently ranked among the leading five causes of death for children.

Table 1. Leading Causes of Child Deaths in New Mexico, 2011-2021

Leading Cause-Children 0-17 Years of Age	Number of Deaths	Crude rate per 100,000 population	Percentage of all Child Deaths in NM
Unintentional Injury	589	10.82	35.5%
Congenital Anomalies	432	7.94	26.0%
Short Gestation	276	5.07	16.6%
Suicide	231	4.24	13.9%
Homicide	133	2.81	8.0%

Source: WISQARS™ — Web-based Injury Statistics Query and Reporting System (Last accessed: December 7, 2023)

Analysis of the causes of all childhood deaths in NM from year 2011 to 2021 found that unintentional injuries were the top cause of death across multiple age groups (1 to 4 years, 5 to 9 years, 10 to 14 years, and 15 to 17 years) and the third leading cause of death in infancy (less than one year of age). Suicide was found to be the second leading cause of death in 10 to 14 years and 15 to 17 years age group. Homicide was the third leading cause of death in 1 to 4 years, 5 to 9 years, and 15 to 17 years age groups. In the 5 to 9 years age group, Homicide and congenital anomalies both ranked in the

same position. Homicide was also found to be the fourth leading cause of death in the 10 to 14 years age group (Table 2).

Table 2. Leading Causes of Death and Percentage by Age Group in New Mexico, 2011-2021

Leading cause of Death	‹ 1 year	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
1	Congenital Anomalies 39.7%	Unintentional Injury 59.0%	Unintentional Injury 50.6%	Unintentional Injury 36.5%	Unintentional Injury 40.4%
2	Short Gestation 31.4%	Congenital Anomalies 14.5%	Malignant Neoplasms 18.2%	Suicide 33.3%	Suicide 37.3%
3	Unintentional Injury 12.5%	Homicide 13.3%	Homicide *	Malignant Neoplasms 13.1%	Homicide 13.9%
4	Maternal Pregnancy Complications 9.3%	Malignant Neoplasms *	Congenital Anomalies *	Homicide 9.5%	Malignant Neoplasms *
5	Placenta Cord Membranes 7.1%	Influenza & Pneumonia *	Chronic Low. Respiratory Disease & Septicemia *	Congenital Anomalies *	Congenital Anomalies *

Unintentional Injury   Suicide   Homicide   Non-injury Deaths

Source: WISQARS™ – Web-based Injury Statistics Query and Reporting System Last accessed: December 7, 2023
* Indicates suppressed values (Small Numbers Rule, Appendix F)

The Cost of Child Mortality

Injury-related fatalities not only carry an immeasurable impact on individuals, families, and society, but they also generate economic impacts. The expenses associated with injury-related fatalities encompass medical expenditures linked to deaths caused by injuries and the value of statistical life, which is a monetary assessment of the overall value individuals place on reducing the risk of mortality. Value of statistical life represents the ratio of financial considerations to the risk of death. It functions as an indicator that assesses the marginal cost of improving safety and the population's readiness to pay for preventive and risk reductive measures. The values displayed in Table 3 are estimates based on the age of the child at time of death. For individuals aged 0-17 years, the assigned value was 16.9 million U.S. dollars, which was derived by adjusting the estimate based on life expectancy and baseline quality of life among population (CDC, 2021).

Table 3. Fatal Injuries in Children and Associated Cost in New Mexico, 2021

Year	Number of Injury related deaths (0 to 17 years)	Total Medical Costs	Total Value of Statistical Life	Total Combined cost
2018	97	$906,009	$1.78 B	$1.78 B
2019	102	$865,081	$1.87 B	$1.87 B
2020	85	$837,323	$1.56 B	$1.56 B
2021	110	$1.34 M	$2.01 B	$2.01 B

Source: WISQARS™ — Web-based Injury Statistics Query and Reporting System Last accessed: December 7, 2023

While value of statistical life estimates the economic burden of premature death, there is no manner to quantify the social, psychological, and emotional impacts of the loss of a child's life on their family, friends and community. NM-CFR acknowledges that a statistical life estimate does not represent the complete value of the lives lived.

Child Injury Death Rate

The child injury death rate in NM has consistently been higher than the national rate. Figure 4 shows that the child injury-related death rate in NM was 16.2 per 100,000 population in 2011, while the US rate was 11.8 per 100,000 population. In 2021, the injury related death rate was 23 per 100,000 population in NM compared to 14.4 per 100,000 population in the US.

Figure 4. Crude Rate (per 100,000 population) for All Injury-related Fatalities for Children (ages 0-17) in New Mexico and the United States, 2011-2021
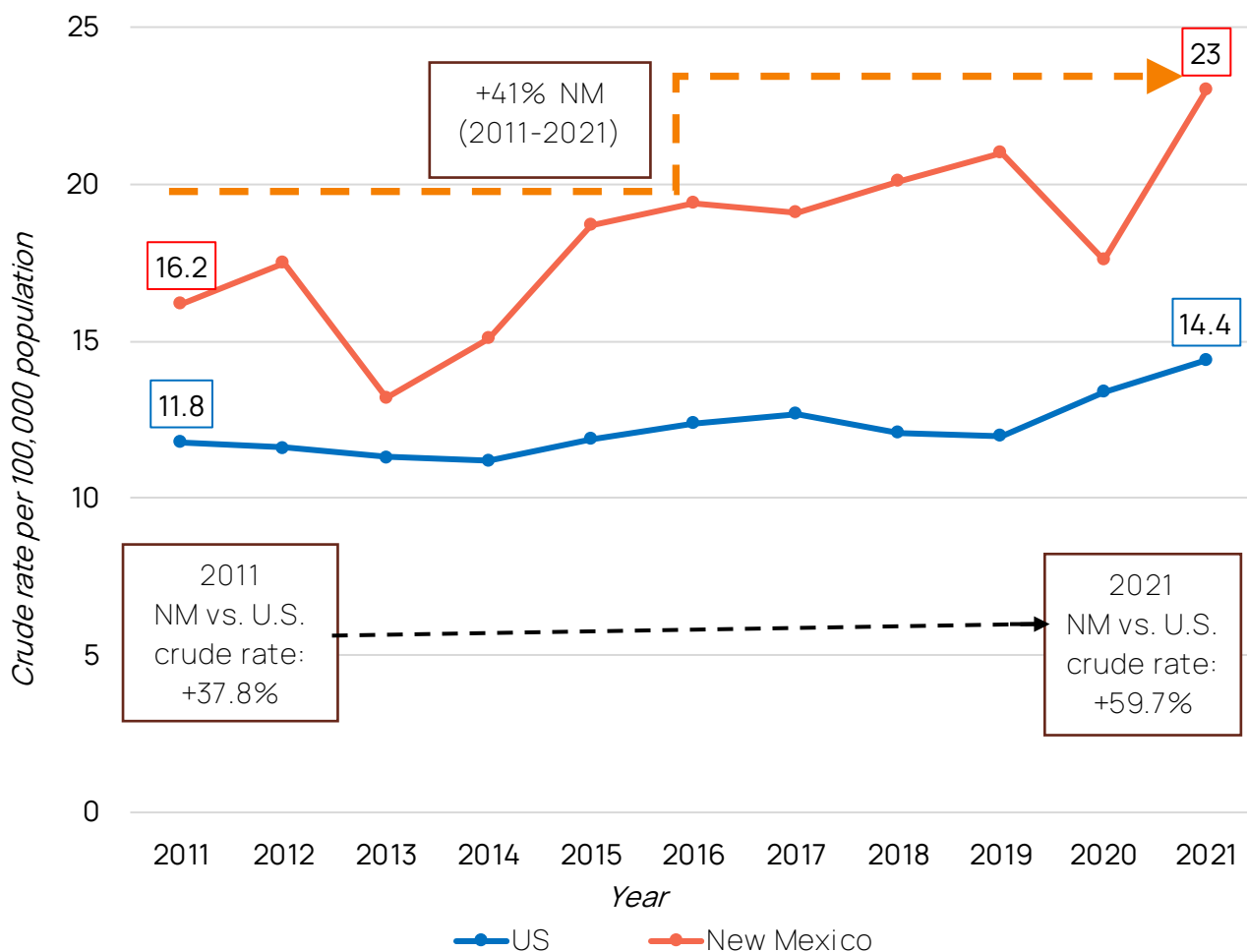

Source: CDC WONDER, Last accessed: October 17, 2023

The percentage difference in rates between NM and the US for child injury related deaths was 37.8% in 2011, and it increased to 59.7% in 2021. From 2011 to 2021, a 41% increase was observed for child injury-related deaths in NM.

Youth Mental Health in New Mexico

According to data captured by the NM Youth Risk & Resiliency Survey (YRRS), in 2021, two out of five NM high school students and three out of five NM female high school students experienced persistent feelings of sadness or hopelessness, an overall increase of 44% since 2011 (YRRS). Figure 5 illustrates an increase in feelings of persistent sadness or hopelessness in New Mexican high schoolers compared to the national average from 2011 to 2021.

Figure 5. Persistently Felt Sad or Hopeless, Grades 9-12, New Mexico, and United States
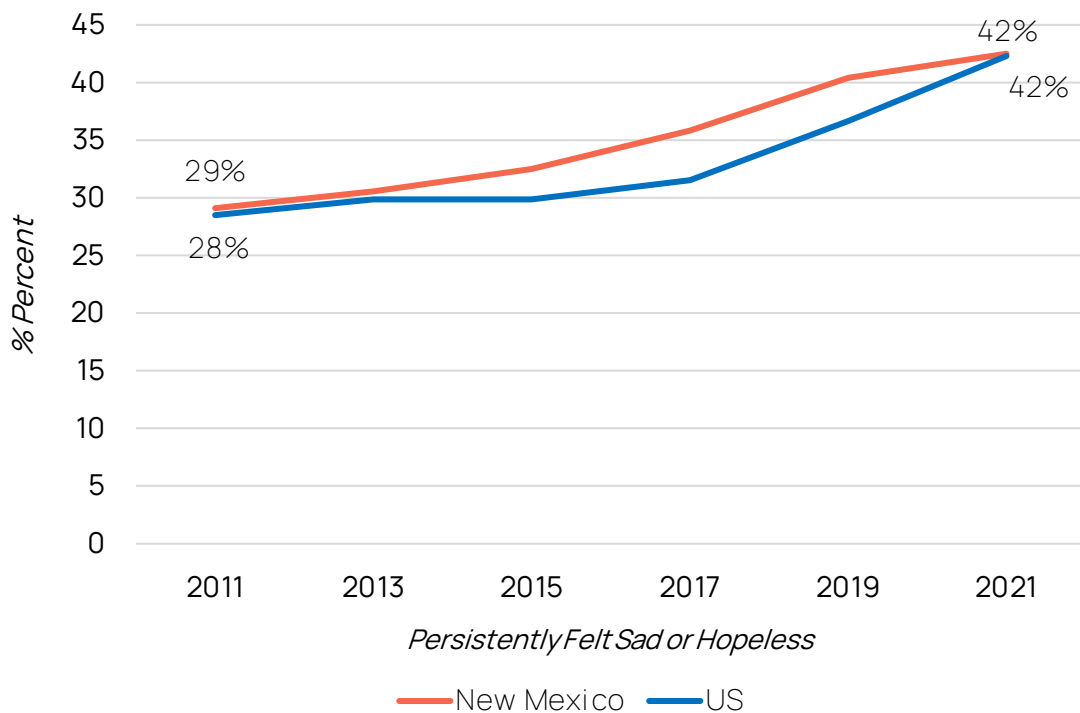
Source: 2011-2021 NM YRRS (NMDOH); and 2011-2021 National YRBS (CDC)

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 years in the United States (CDC, 2023).

In 2021, the Surgeon General, Vivek Murphy, issued a health advisory on youth mental health, writing, "ensuring healthy children and families will take an all-of-society effort, including policy, institutional, and individual changes in how we view and prioritize mental health.

Disparities in Youth Suicide Attempts

Risk for suicide attempts was highest among transgender, genderqueer, genderfluid students as well as students identifying as lesbian, gay, bisexual, or questioning. American Indian or Alaska Native high school students were 56% more likely to have attempted suicide than White peers (Figure 6).

Figure 6. Percent of High School Students Who Attempted Suicide, by Demographics, 2021

% of Suicide attempts
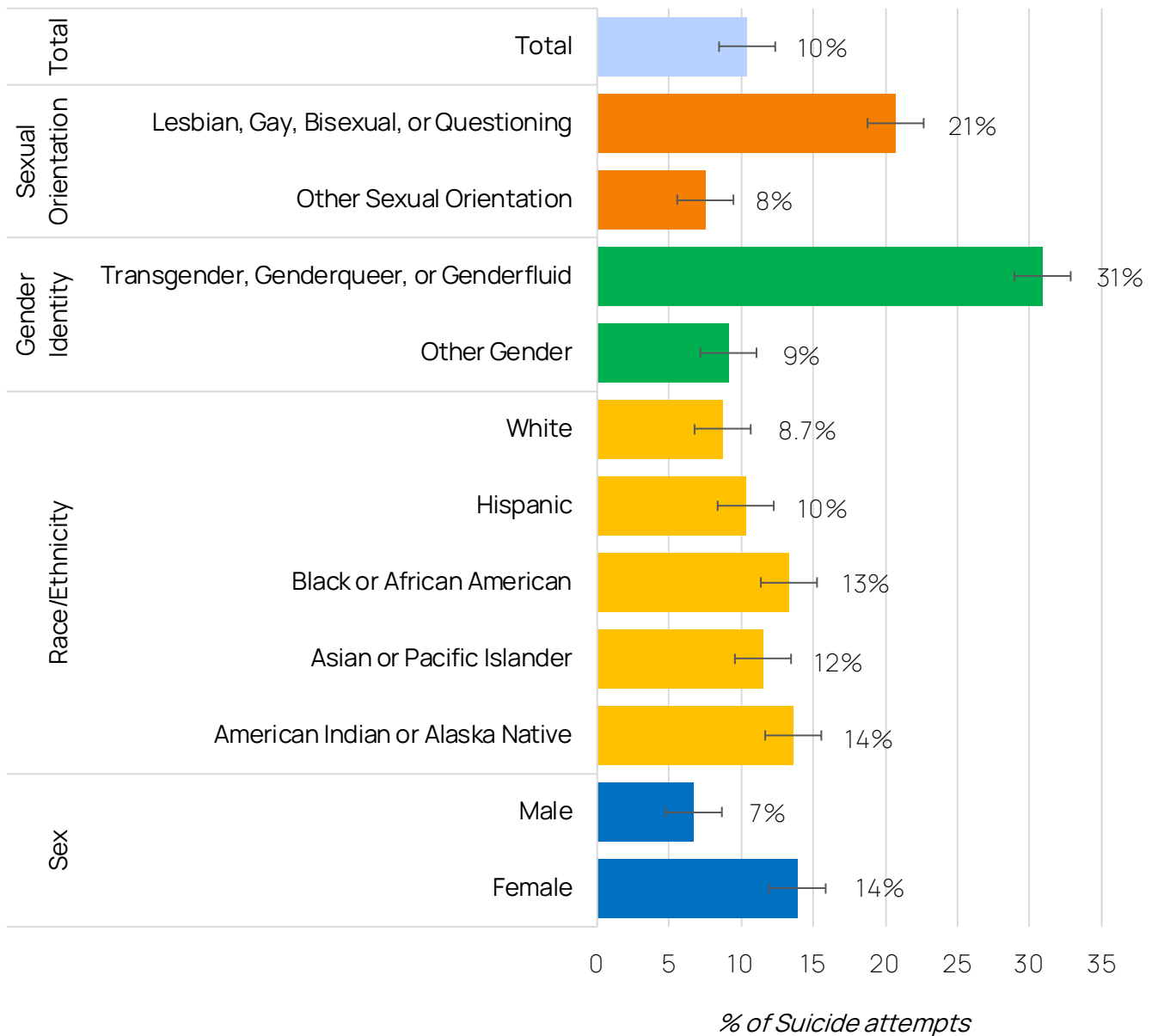
Error Bar indicates 95% confidence interval.

Source: 2021 NMYRRS

Child Fatalities Reviewed by NM-CFR

Figure 7 indicates the distribution of manner of death in the reviewed cases of injury-related deaths among children aged 0-17 years in NM, from 2005 to 2022. Most deaths which were reviewed by NM-CFR were due to unintentional injury, followed by suicide, undetermined deaths, homicide, natural, and deaths with unknown[1] causes.

Figure 7. Child Fatalities Reviewed by NM-CFR, by Manner of Death in New Mexico, 2005- 2022

Unknown, 3%

Natural, 9%

Homicide, 11%

Undetermined, 14%

Suicide, 19%

Unintentional, 44%
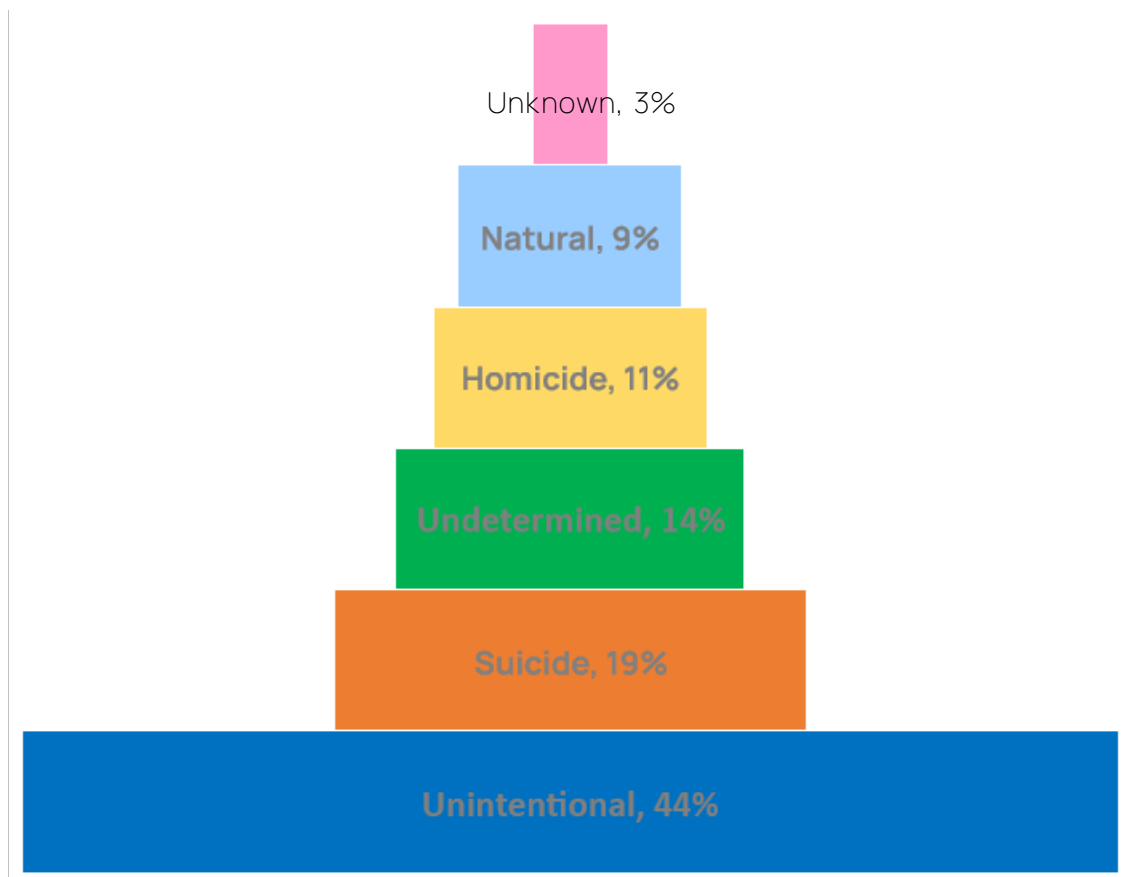
Source: NCFRP, Last accessed: October 3, 2023

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[1] For the purpose of this analysis, "undetermined" cases are a classification by the Office of the Medical Investigator, where the cause of death was not able to be determined, whereas unknown cases are those in which there was limited information or a null value.

By count, the highest number of cases reviewed by NM-CFR in 2022 were from Bernalillo County (n=318), followed by San Juan County (n=100), McKinley County (n=80), Doña Ana County (n=76), and Sandoval County (n=71) (Figure 8).

Figure 8. Child Fatalities Reviewed by NM-CFR, by County in New Mexico, 2005-2022
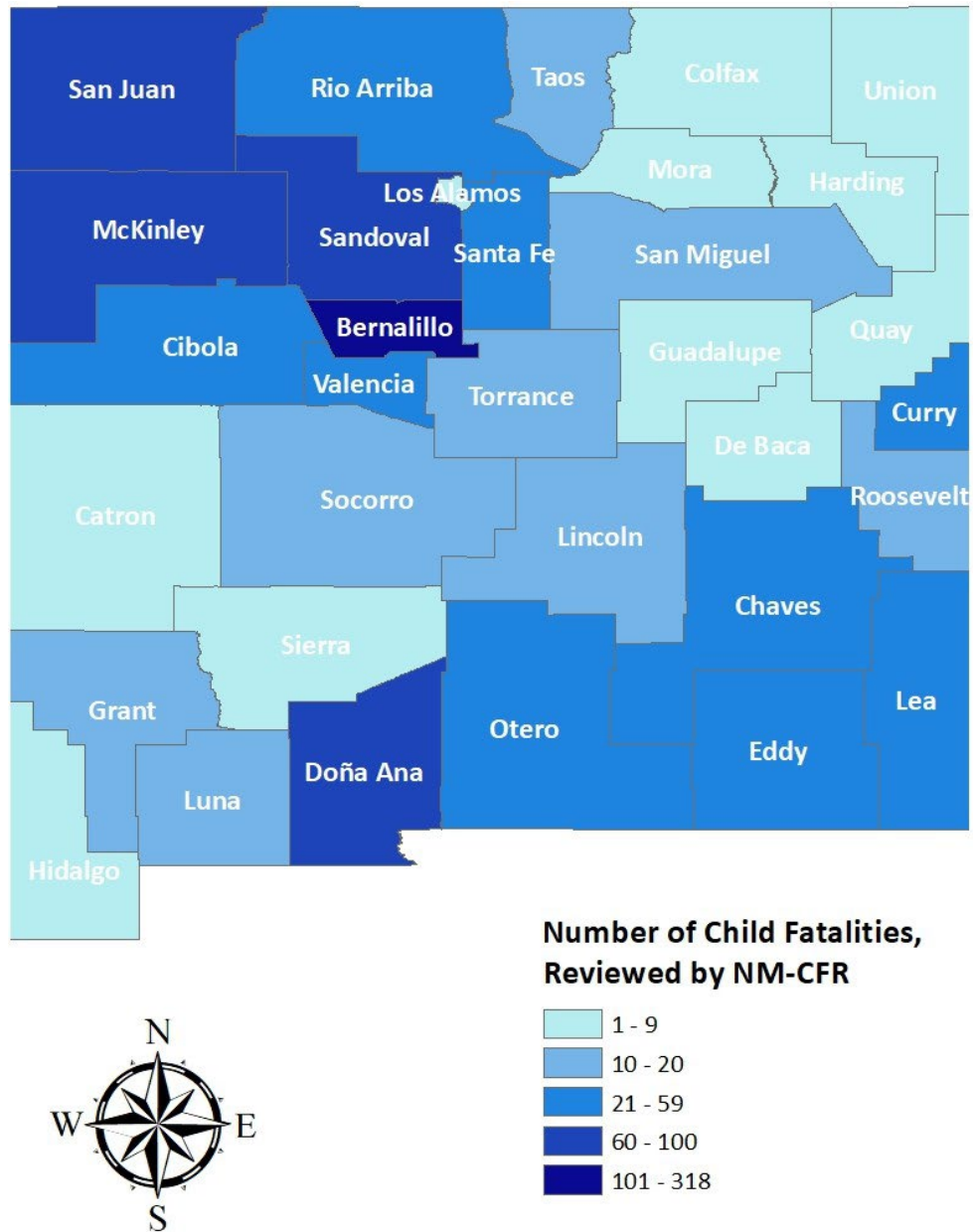
Source: NCFRP, Last accessed: October 3, 2023

The distribution of child fatalities (0 to 17 years) by county was analyzed for calendar year 2021 using a crude rate. A crude rate is the number of cases (or deaths) occurring in a specified population per year, usually expressed as the number of cases per 100,000 population at risk. Sierra County exhibited the highest child fatality rate (11.1), followed by Quay (5.6), Sandoval (3.3), Torrence (3.2), Otero (3.2), Curry (3.0), and Luna (2.9) county (Figure 9).

Figure 9. Crude Rate of Child Fatalities, by County in New Mexico, 2021
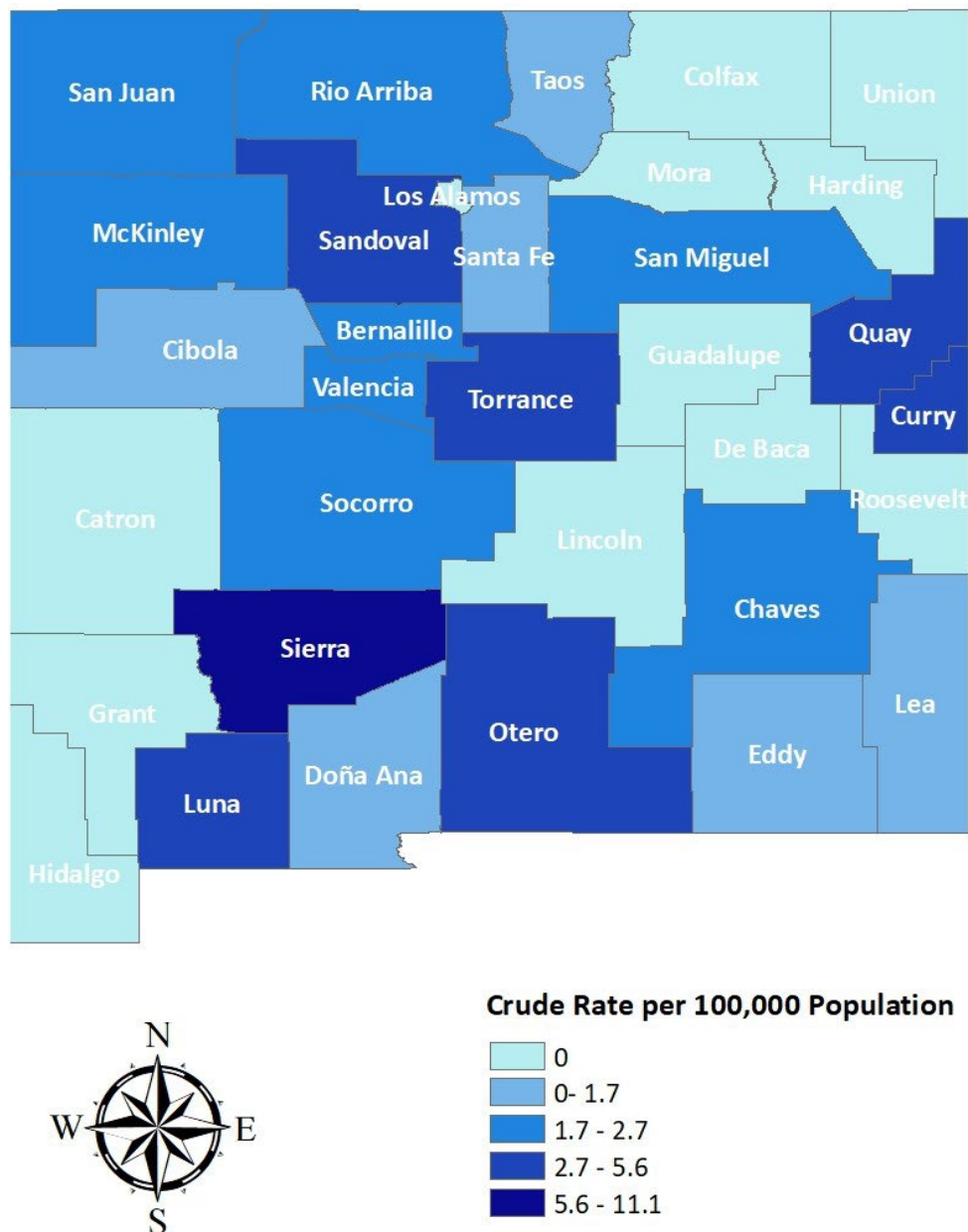
Source: NM Bureau of Vital Records and Health Statistics,
& New Mexico's Health Indicator Data & Statistics (last accessed: November 29, 2023)

2023 Report

Methodology

In 2022, 84 unique cases were reviewed by NM-CFR across its four panels. The NM-CFR 2023 Report summarizes and analyzes information about these 84 injury-related deaths of NM infants, toddlers, children, and youth under the age of 18. The report covers child fatalities resulting from injuries that occurred between the years 2018 and 2022. Each fatality was carefully reviewed in the calendar year 2022.

The data presented in this report are descriptive and not inferential. No analysis was carried out to determine correlations or associations between variables.

This report should not be used to compare changes over time to previous CFR reports published by the NMDOH Office of Injury and Violence Prevention. Such a comparison would be inaccurate because of the overlap in year of death.

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 NM, the birth certificate is also provided. The NM 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 providing 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

From January 1, 2022, through December 31, 2022, 84 unique child deaths were reviewed. The child fatalities reviewed in 2022 comprised deaths that occurred from 2018 to 2022 (Table 4). While an effort is made to review cases in a timely fashion, not all cases receive data in a timely manner. Some cases are criminally prosecuted, and adjudication may be desired by the panel prior to review. For these reasons, some cases are not reviewed until these criteria are met, which may be some years later.

Table 4. Cases Reviewed by NM-CFR, by Year of Death in New Mexico, 2022

Year of Death	Number of reviewed cases
2018	2
2019	7
2020	29
2021	43
2022	3

Each of the 84 unique child deaths were reviewed by at least one of the four panels (Table 5). Occasionally, some child death cases received a second review to gain additional perspective from another panel, which yielded a total of 87 reviews in calendar year 2022. Database entry for the reviewed cases was also completed in the National Fatality Review Case Reporting System.

Table 5. Cases Reviewed by NM-CFR, by Primary Panel of Review in New Mexico, 2022

Review Panel	Frequency	Percent
Child Abuse, Neglect or Homicide	12	13.8%
Sudden Unexpected Infant Death	35	40.2%
Youth Suicide	16	18.4%
Unintentional Injury	24	27.6%
Total	87	100%

According to the National Center for Fatality Review and Prevention (NCFRP), a child's death is considered preventable if there was a reasonable opportunity for an individual or the community to take action that could have altered the circumstances leading to the child's death. Figure 10 shows that out of 84 unique child fatalities analyzed in this report, NM-CFR determined that 67 deaths (80%) could have been prevented, and 2 deaths (2%) couldn't be prevented. In ten cases, there was not information about preventability (12%), and NM-CFR could not determine from the information gathered whether the child's death was preventable in five cases (6%).

Figure 10. Child Fatalities Reviewed by NM-CFR by Preventability in New Mexico, 2022
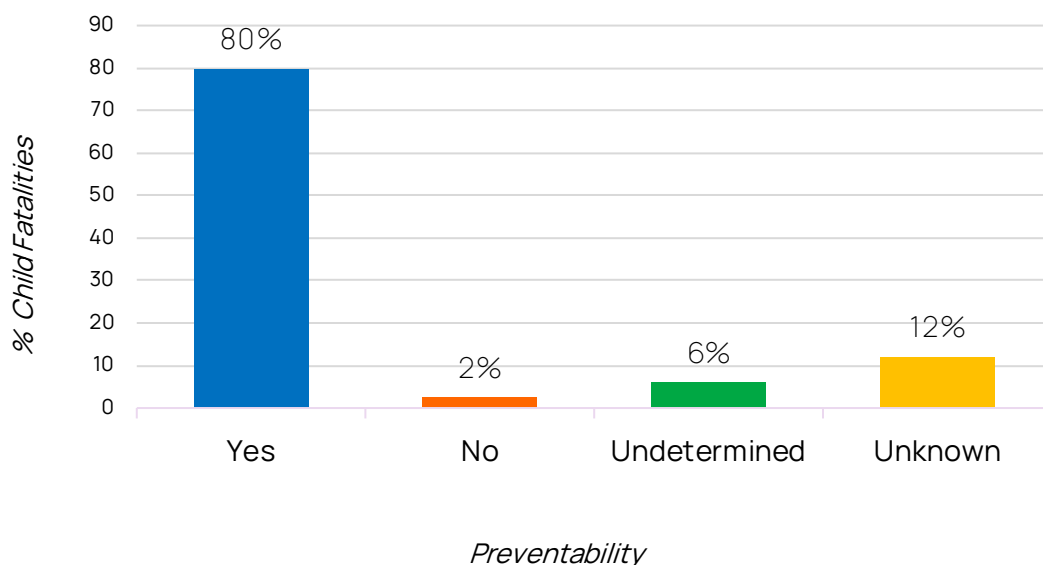
Source: NCFRP, Last accessed: October 3, 2023

To determine preventability, NM-CFR panelists review all available information about a child fatality. Circumstantial information about each case is carefully reviewed, and a robust discussion about risk and protective factors informs the determination of preventability. Each panelist determines if a case was able or unable to be prevented, and the final determination is determined by poll.

Of the cases reviewed by NM-CFR in 2022, autopsies were performed on 63 (75%) cases. Panelists agreed with the primary cause of death listed on the death certificate and pathology report on 72 (86%) cases. Out of the reviewed cases, a total of 71 investigations (85%) were carried out involving deaths. Furthermore, in 61 cases (73%), the investigation was completed at the location where the child's death took place. The local emergency number or 911 was called in 79 (94%) of the child deaths. Out of the child deaths reviewed, resuscitation was attempted in 54 cases, accounting for 64% of the total; in 31 (57%), of these cases, the resuscitation was attempted by parents, bystanders, friends, or other individuals before emergency medical services (EMS) arrived at the scene (Figure 11).

Figure 11. Review Summary of Child Fatalities Reviewed by NM-CFR, in New Mexico, 2022
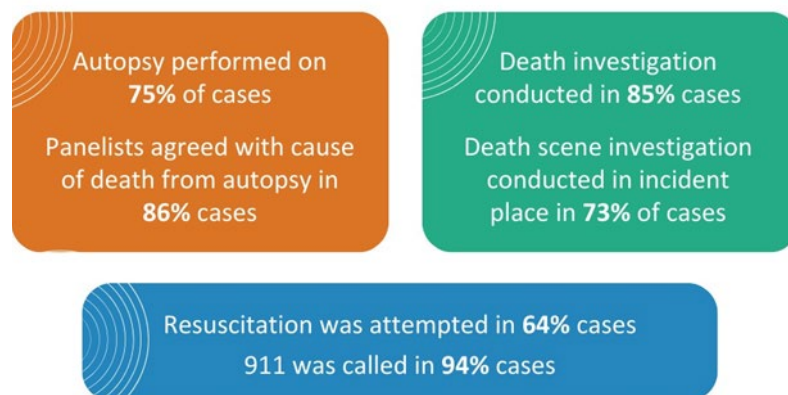
Source: NCFRP, Last accessed: October 3, 2023

Figure 12. Child Fatalities Reviewed by NM-CFR, by Witness Distribution in New Mexico, 2022
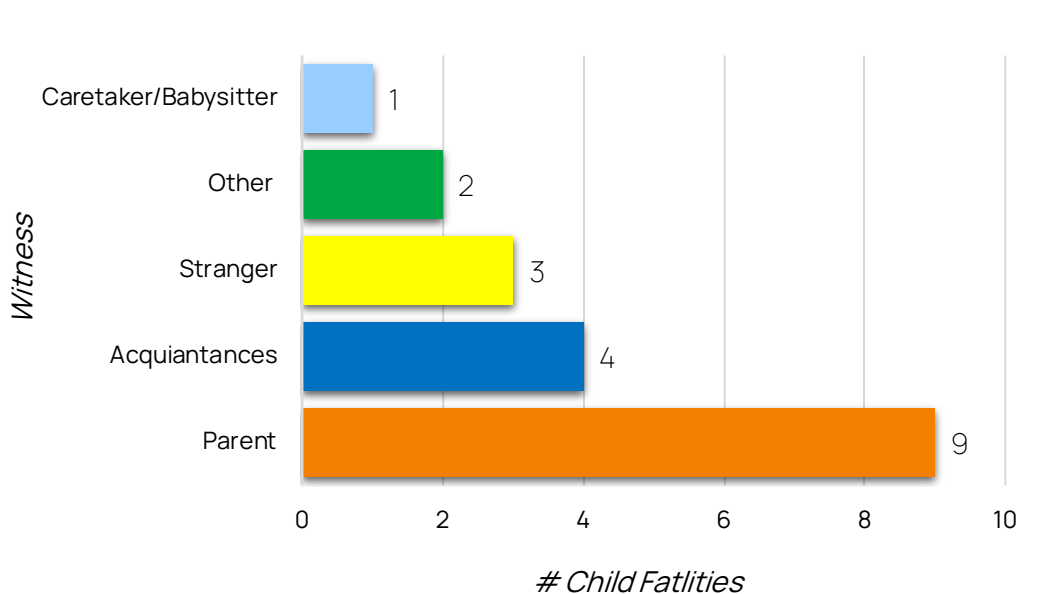
Source: NCFRP, Last accessed: October 3, 2023

The distribution of witnesses in the cases that were reviewed by NM-CFR is shown in Figure 12. A witness to the incident was available at 16 (19%) of the cases reviewed. Among all cases witnessed, most common witnesses at the child's scene of death were a parent (n=9, 56.3%), followed by non-relative/acquaintances (n=4, 25%), stranger (n=3, 18.8%), caretaker/babysitter (n=2, 12.5%) and other (n=1, 6.3%).

Figure 13. Child Fatalities Reviewed by NM-CFR, by Incident Places in New Mexico, 2022
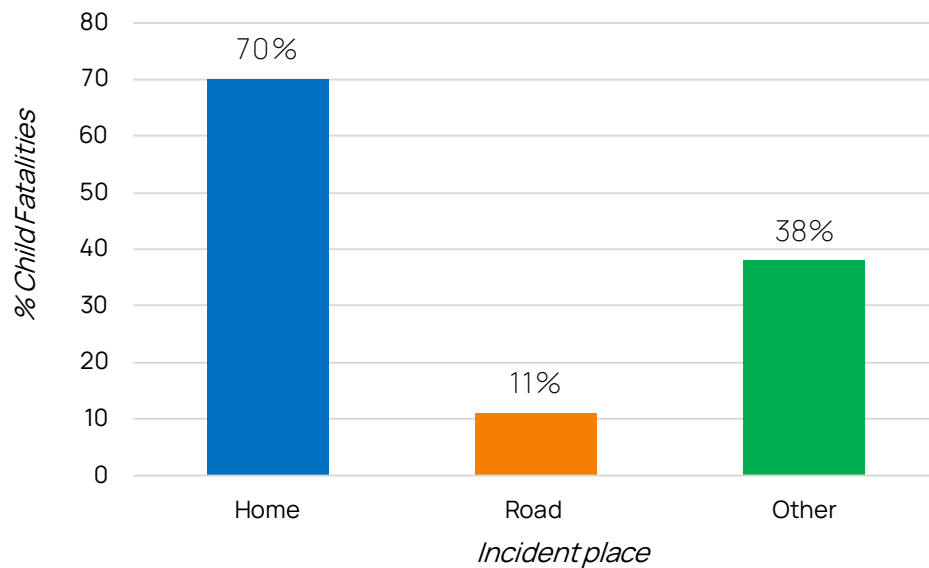
Source: NCFRP, Last accessed: October 3, 2023

The report analyzed a total of 84 cases and found that the circumstances of the children's deaths varied in terms of location. The child's home was the most frequent location for children's deaths, accounting for 59 cases (70%). The second most common location was on or near a roadway, with nine cases (11%) The other location of 32 cases (38%) where incidents occurred included: driveway, other recreational location, other parking area, shed behind a residential home, hotel room, RV trailer, and at another person's home (Figure 13).

To investigate the distribution and occurrence of these child fatalities, the demographic information of the cases, including age, gender, location, race, and ethnicity were also analyzed.

Child fatalities were higher in males (n=54, 64%) than females (n=30, 36%), as shown in Figure 14. The only gender information available for case review was derived from death certificates, which does not denote gender identity of the cases, a limitation of case review.

Figure 14. Child Fatalities Reviewed by NM-CFR by Gender in New Mexico, 2022

Source: NCFRP, Last accessed: October 3, 2023
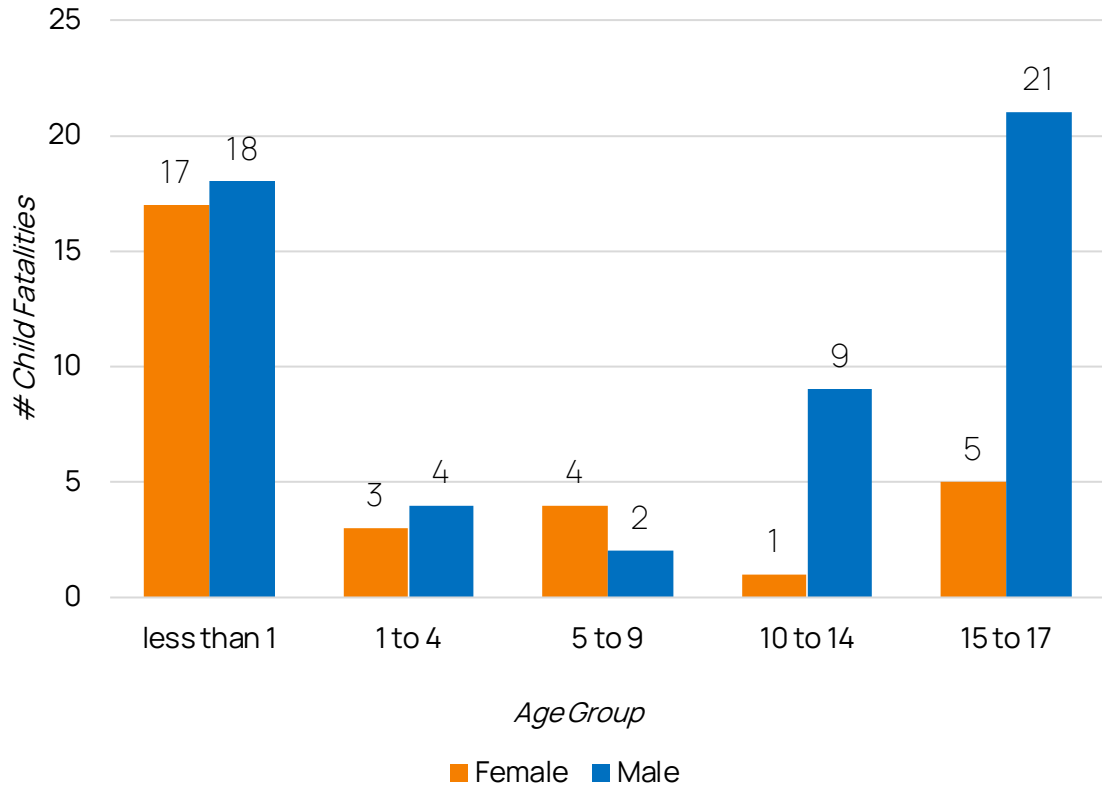
Source: NCFRP, Last accessed: October 3, 2023

Figure 15 illustrates the pattern of males outnumbering females distributed across the different age categories. The age group with the most deaths was infants under the age of one (n=35, 41.6%). This was followed by age group 15 to 17 (n=26, 30.9%), then age group 10 to 14 (n=10, 11.9%), age group 1 to 4 (n=7, 8.3%) and then age group 5 to 9 (n=6, 7.1%).

Figure 16. Child Fatalities Reviewed by NM-CFR, by Race and Ethnicity in New Mexico, 2022
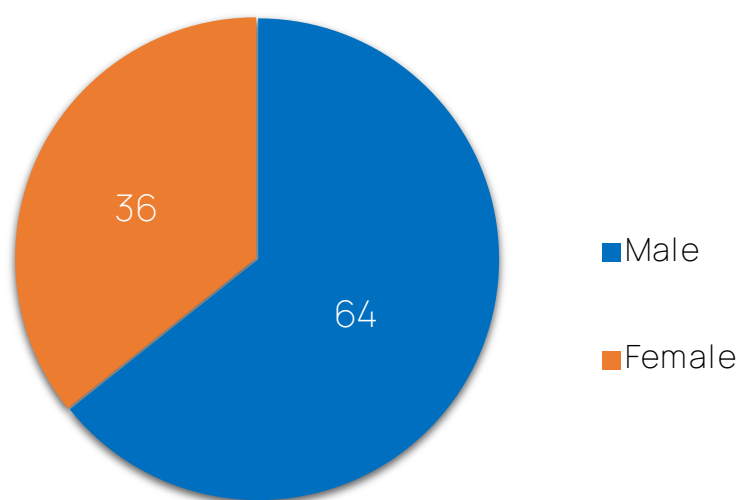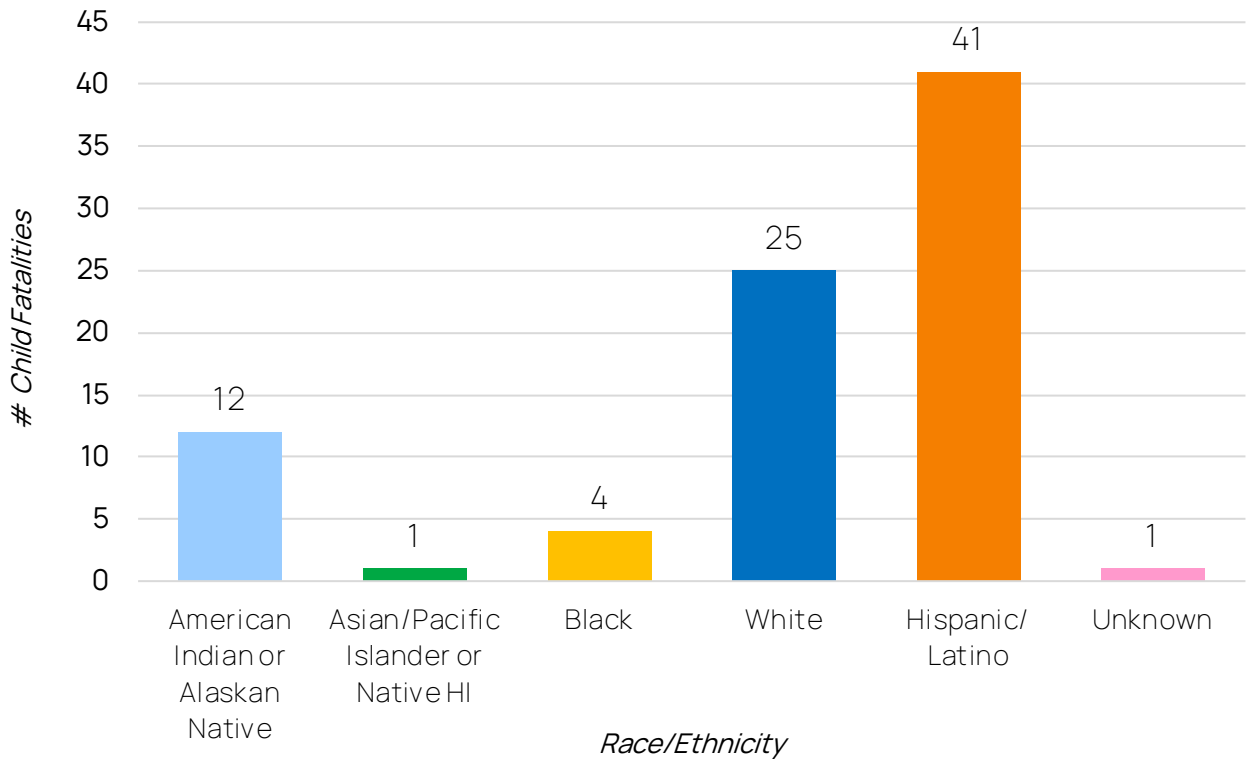

Source: NCFRP, Last accessed: October 3, 2023

Analysis of race and ethnic categorical distribution of reviewed cases found that 41 (49.4%) cases were of Hispanic or Latino ethnicity. Twenty-five (30.1%) cases were non-Hispanic/Latino White. Twelve (14.4%) cases were American Indian or Alaskan Native, four (4.8%) cases were Black or African American, and one (1.2%) case was Asian or Pacific Islander (Figure 16).

The analysis also examined the location of death of cases reviewed in 2022, by county, to explore the distribution of cases across NM. Of the cases reviewed in 2022, the highest number of child deaths were found in Bernalillo County, with 23 cases (27.8%). Following that, seven cases (8.3%) were out of Doña Ana County, and six cases (7.14%) were out of San Juan County.

Manner of Death

The NM-CFR reviewed the manner of death, the way in which a death occurs, across different demographics. The most common manner of child death reviewed by the NM-CFR in 2022 was unintentional injury (classified as accidental by the OMI) accounting for 39 cases (46%). This was followed by suicide with 16 cases (19%), homicide with 12 cases (14%), undetermined with 14 cases (17%), and natural causes with three cases (4%) (Figure 17).

Figure 17. Child Fatalities Reviewed by NM-CFR, by Manner of Death in New Mexico, 2022

Source: NCFRP, Last accessed: October 3, 2023

An analysis of cases reviewed in 2022 by manner of death and gender (Figure 18) illustrates that most cases reviewed, across various manners, were male. Twenty-six (30.9%) male children died by accident compared to the female death count of 13 (15.5%). The number of male suicides (n=15, 17.8%) was significantly greater than that of females (n=1, 1.2%). In cases of homicide, the number of male fatalities (n=7, 8.3%) was found to be higher compared to the number of female fatalities (n=5, 5.9%).

Figure 18. Child Fatalities Reviewed by NM-CFR, by Manner of Death and Gender in New Mexico, 2022

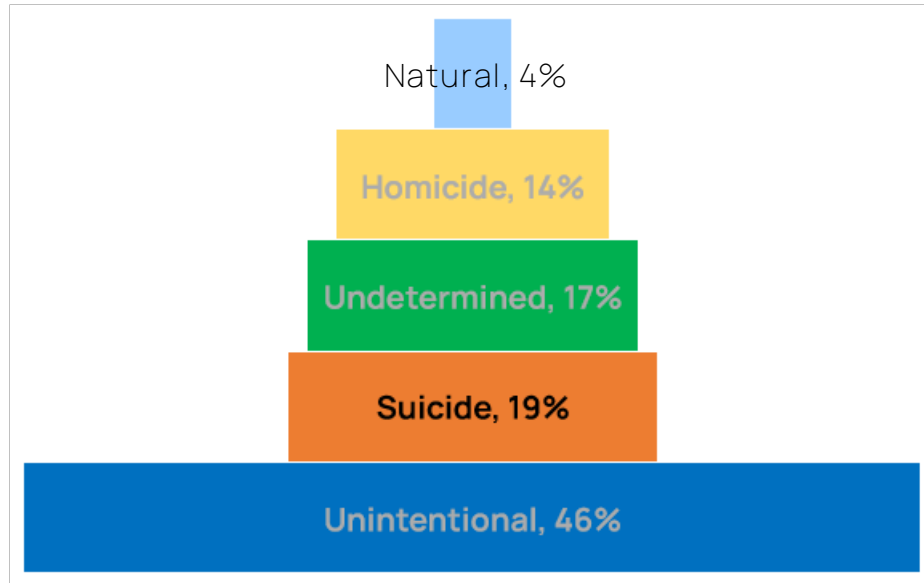*Source: NCFRP, Last accessed: October 3, 2023*

Among 84 unique cases reviewed, the most frequent manner found was unintentional, which was present in all age groups. The unintentional death count was highest for infants, accounting for 17 cases (20.2%), followed by the 15 to 18 age group with 12 cases (14.3%). Suicide was highest in the 15 to 18 age group with nine cases (10.7%) followed by the 10 to 14 age group with seven cases (8.3%). Homicide was greatest in the 15 to 18 age group, with five cases (5.9%) (Figure 19).

Figure 19. Child Fatalities Reviewed by NM-CFR, by Manner of Death and Age in New Mexico, 2022
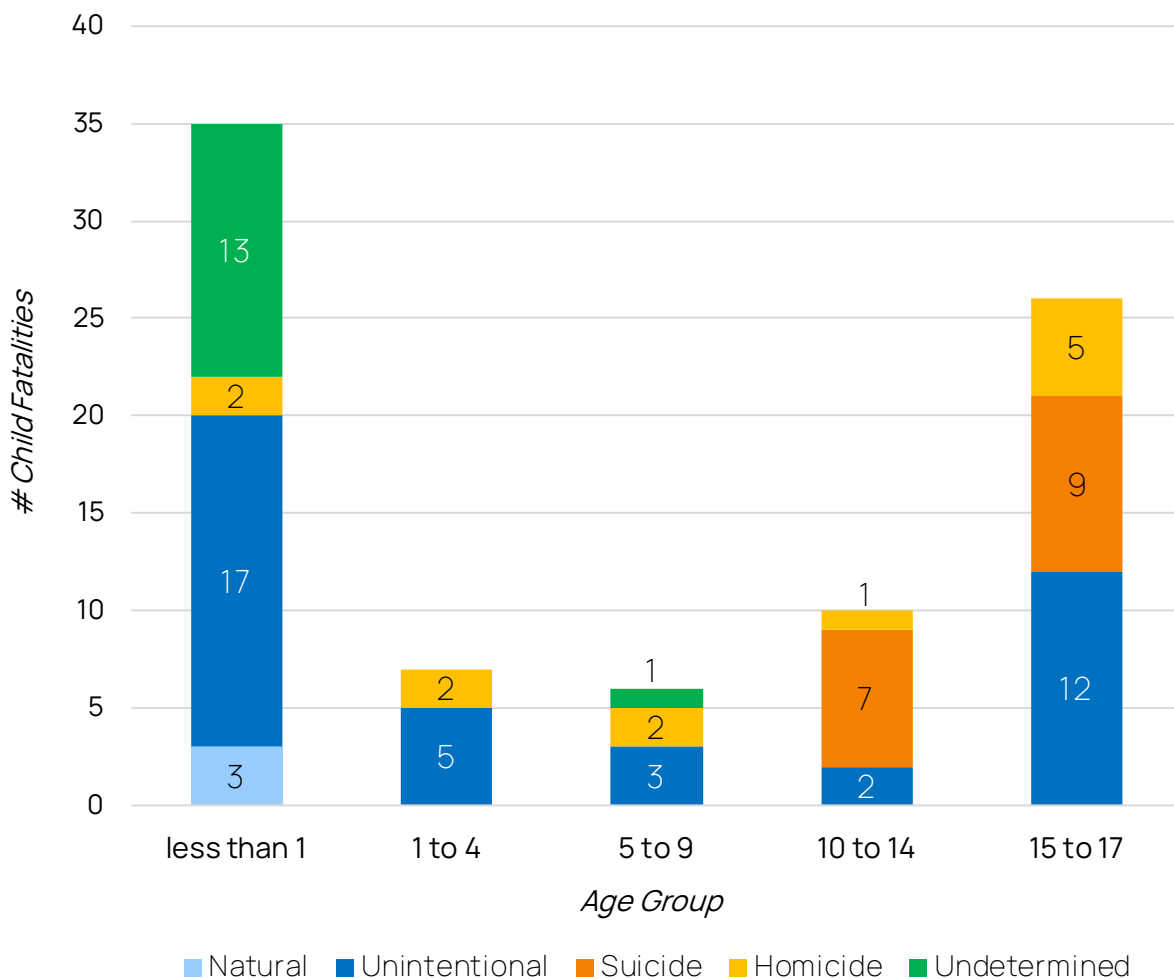
Source: NCFRP, Last accessed: October 3, 2023

Figure 20 illustrates the causes and manners of death for cases reviewed in 2022. Of the 39 unintentional injury deaths, asphyxia was the leading cause, accounting for 18 deaths (21.4%). This was followed by motor vehicle-related incidents, which caused nine deaths (10.7%). Other causes of death included poisoning (n=4, 4.8%), drowning (n=3, 3.6%), and various other or unclassified causes (n=1, 1.2%). Additionally, there was one death each resulting from fall/crush, fire/burn/electrical incidents, and bodily force or weapon use, each accounting for 1.2% of the total deaths. Of the 16 suicide cases, nine (10.7%) were attributed to bodily force or weapon, while seven (8.3%) were classified as asphyxia.
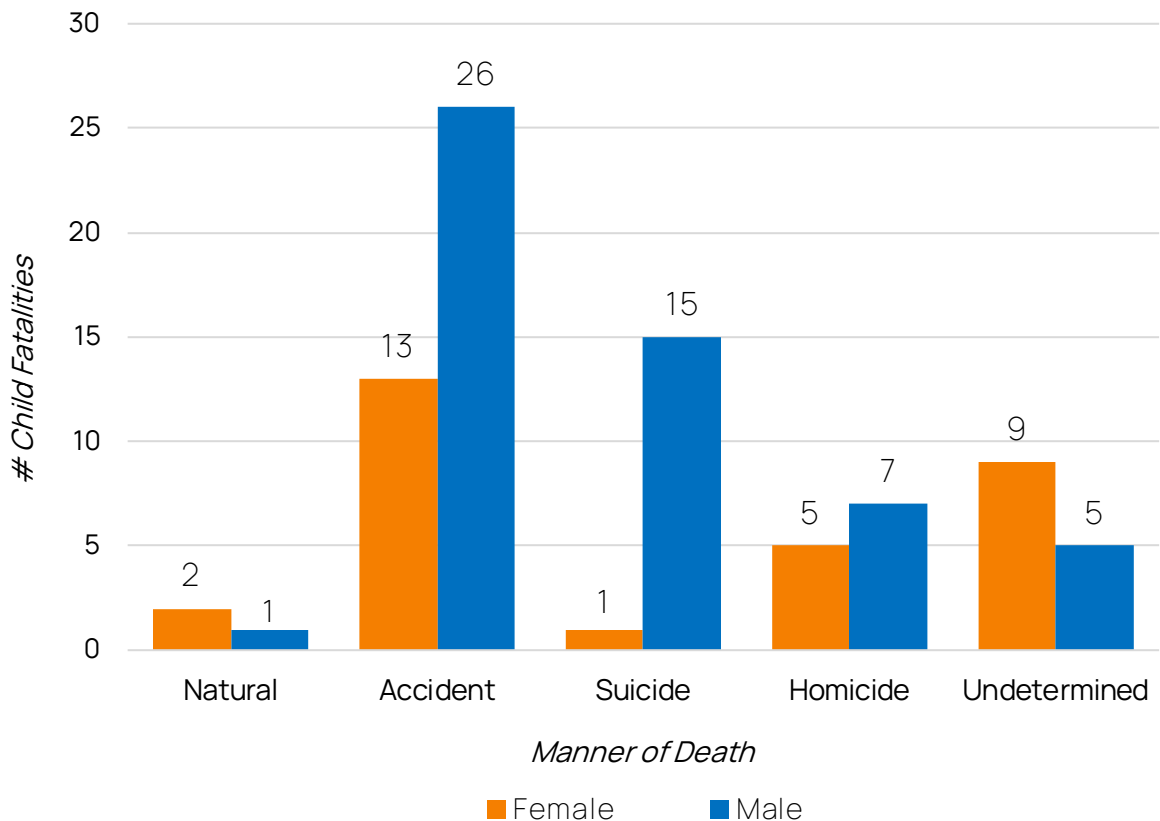
Figure 20. Child Fatalities Reviewed by NM-CFR, by Cause and Manner of Death in New Mexico, 2022
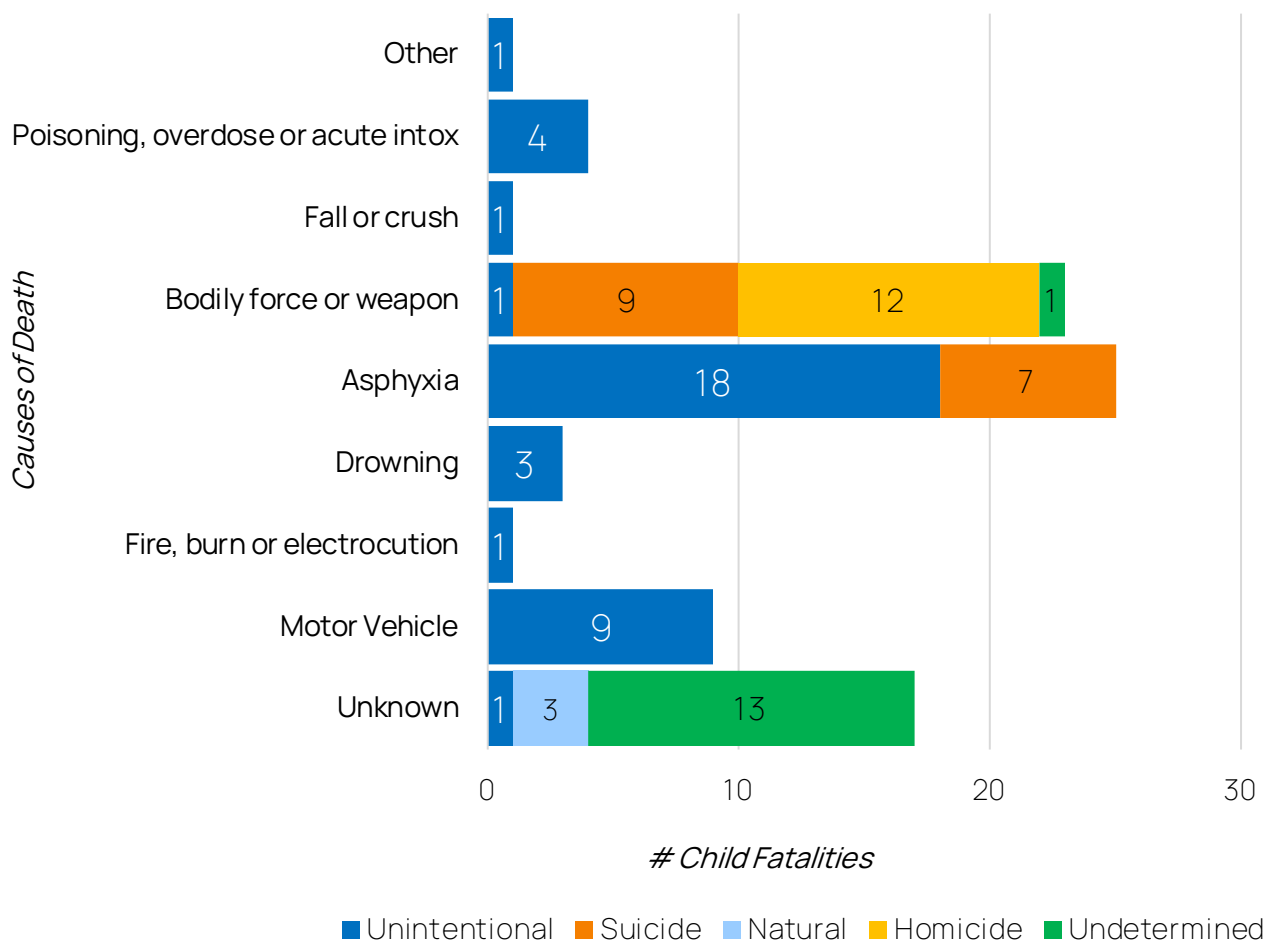
Source: NCFRP, Last accessed: October 3, 2023

Child Abuse, Neglect or Homicide (CAN-H)

In 2022, 12 child fatalities were reviewed by the CAN-H Panel, each of which was a unique case. Of the 12 cases of child abuse, neglect, or homicide included in this report, eight (66.7%) were males, and four (33.3%) were female. Eight (66.7%) of the children were Hispanic or Latino, three (25%) children were White, one (8.3%) child was Black or African American. Out of 12 cases reviewed in this panel, six cases (50%) were reported in the age group of 15 to 17 years. There were two cases (16.6%) each in the age group of one to four years and five to nine years. Additionally, there was one case (8.3%) in each age group of less than one year and 10 to 14 years (Figure 21).

Figure 21. Child Fatalities Reviewed by NM-CFR (CAN-H panel) by Demographics in New Mexico, 2022
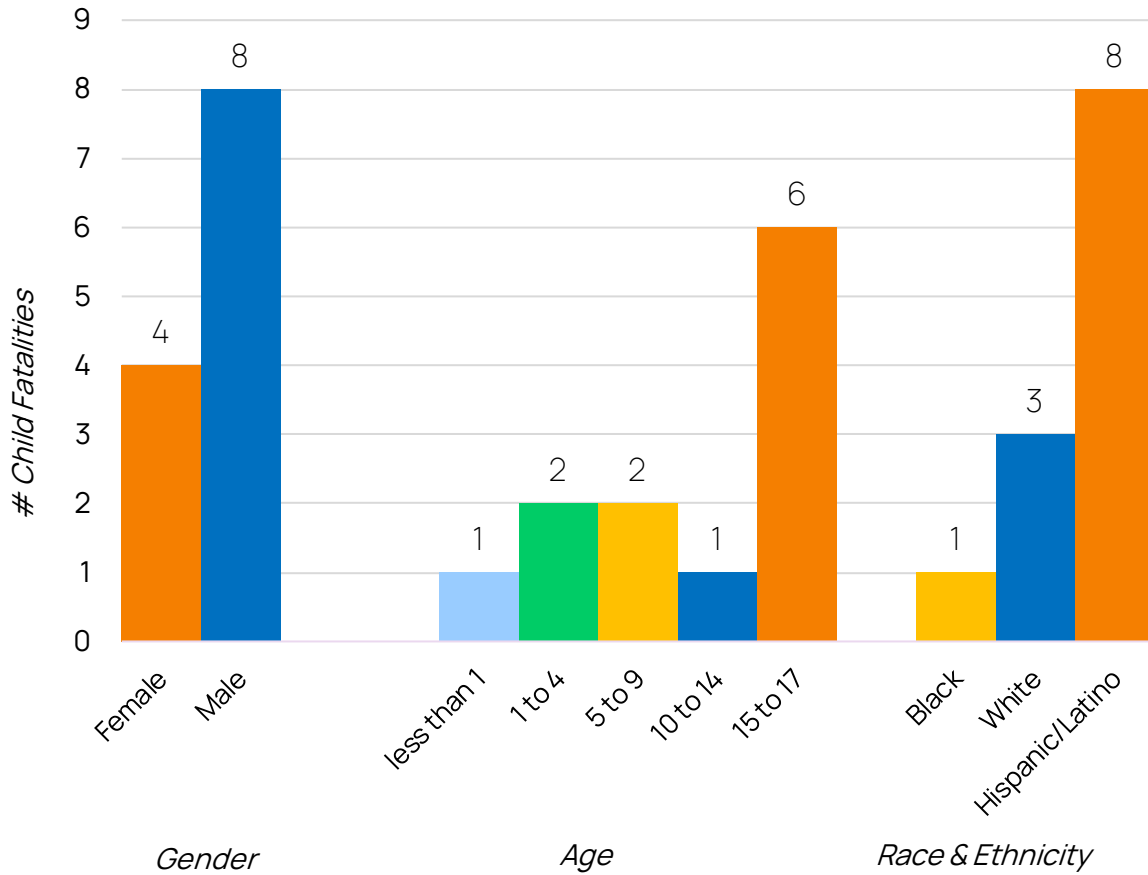
Source: NCFRP, Last accessed: October 3, 2023

Of the 12 child fatality cases reviewed in CAN-H panel in 2022, 75% (n= 9) were identified as having a history of maltreatment with a parent as a perpetrator. A quarter of children (n=3, 25%) had a prior referral to child welfare services. More than half of the children (n=7, 59%) had at least one parent with a history of being charged and/or convicted of a crime.

Half of the children (n=6, 50%) had a history of victimization of violence or neglect, had a personal history of substance misuse, or faced multiple challenges in school such as academics, truancy, suspensions, or behavioral issues. Seven (59%) children were also victims of intimate partner violence (Figure 22).

Figure 22. Summary of Adverse Childhood Experiences in Child Fatalities Reviewed by NMCFR (CAN-H panel) in New Mexico, 2022

Adverse Childhood Experiences

75%
had biological parent with a history of maltreatment as perpetrator

59%
had been the victim of intimate partner violence

59%
had at least one parent with a history of being charged and/or convicted with a crime

50%
had a history of being the victim of violence and neglect

50% indicated the child had multiple challenges in school: academic, truancy, suspensions, and behavioral issues

50% had a personal history of drug abuse

25% had a prior referral to a child welfare service
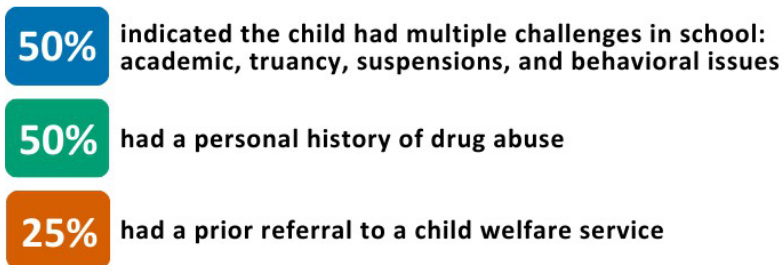
Source: NCFRP, Last accessed: October 3, 2023

The socioeconomic background[2] of six (50%) of these 12 children was categorized as low, while the economic background of the remaining six cases reviewed was unknown. The evaluations of these fatalities brought attention to several risk factors, one of which was the presence of notable Adverse Childhood Experiences (refer to the Shared Risk and Protective Factors for Child Fatality in NM section, page 45).

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[2] 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) is a term used to describe the sudden and unexpected death of a baby 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.

Three commonly reported types of SUID include: sudden infant death syndrome (SIDS), accidental suffocation and strangulation in bed and unknown cause.
In 2022, 34 reviews of infant fatalities were conducted by the Sudden Unexpected Infant Death (SUID) Panel. One case was reviewed twice by this panel. Three were ultimately excluded from final analysis as the case characteristics did not meet inclusion criteria for the Centers for Disease Control and Prevention's SUID Case Registry. The three excluded cases are described further in the Exclusions subsection. More information about the SUID Case Registry can be found at https://www.cdc.gov/sids/case-registry.htm

Of the 30 unique cases which met inclusion criteria and were analyzed in this report, 16 (53.3%) were male and 14 (46.7%) were female, 14 (46.7%) were Hispanic or Latino, nine (30%) were White, five (16.7%) were Native American, and two (6.7%) were Black or African American. In terms of age, most were between 1-8 months of age. Three (10%) were less than one month old, and one (3.3%) was more than nine months old. Table 6 displays counts and percentages of cases by age.

Table 6. Child Fatalities Reviewed by NM-CFR (SUID Panel) by Age Group in New Mexico, 2022

Age	Count	Percent
Sudden unexpected early neonatal deaths (SUEND), 0-6 days of life		
0-6 days old	0	0%
Post-perinatal SUID, 7-364 days of life		
‹ 1 month old	3	10%
1-4 months old	13	43.3%
5-8 months old	13	43.3%
9-12 months old	1	3.3%
Total	30	100%

Selected Risk Factors for SUID

Sleep and caregiver characteristics such as infant sleep position, surface and location which increase the risk of SUID, as well as exposures and other risk factors, are described in the 2022 AAP Technical Report on SUID (Moon, et al. 2023).

Of note, while surface sharing (adult or other person sleeping on the same surface, such as adult bed, couch, recliner or futon) alone poses an increased risk of SUID, some additional characteristics significantly increase the risk of accidental strangulation or suffocation in bed and wedging or entrapment. Bed sharing with someone who is impaired in their alertness or ability to arouse because of fatigue or use of sedating medications (e.g., certain antidepressants, pain medications) or substances (e.g., alcohol, illicit drugs), bed sharing with a current smoker (even if the smoker does not smoke in bed) or smoking during pregnancy can increase the risk of SUID by more than 10 times the baseline risk of parent-infant bed sharing.

The following sections describe characteristics of NM SUID cases reviewed by NM-CFR in 2022:

Sleeping environment and place

In 20 cases (67%), the death was identified as related to an unsafe sleep environment. In three cases, the infant was placed to sleep in a bassinet and in another two cases, the infant was placed to sleep in a crib (Figure 23). Although cribs and bassinets meet safe sleep recommendations, the presence of other items are not recommended. Items such as soft objects, like pillows, pillow-like toys, quilts, comforters, mattress toppers, fur-like materials, and loose bedding (blankets and nonfitted sheets) increase the risk of suffocation, entrapment/wedging, and strangulation.

In fifteen (50%) cases, the infant was placed to sleep on an adult bed. In 17 cases (57%), the infant was placed to sleep sharing a sleep surface with another person or animal. Of the 17 cases related to surface sharing, eight (27%) were noted to have no infant crib or safe sleep space in the home. In one case (3%), the family was noted to be experiencing housing insecurity and/or homelessness.

Figure 23. Child Fatalities Reviewed by NM-CFR (SUID Panel), by Sleeping Place in New Mexico, 2022
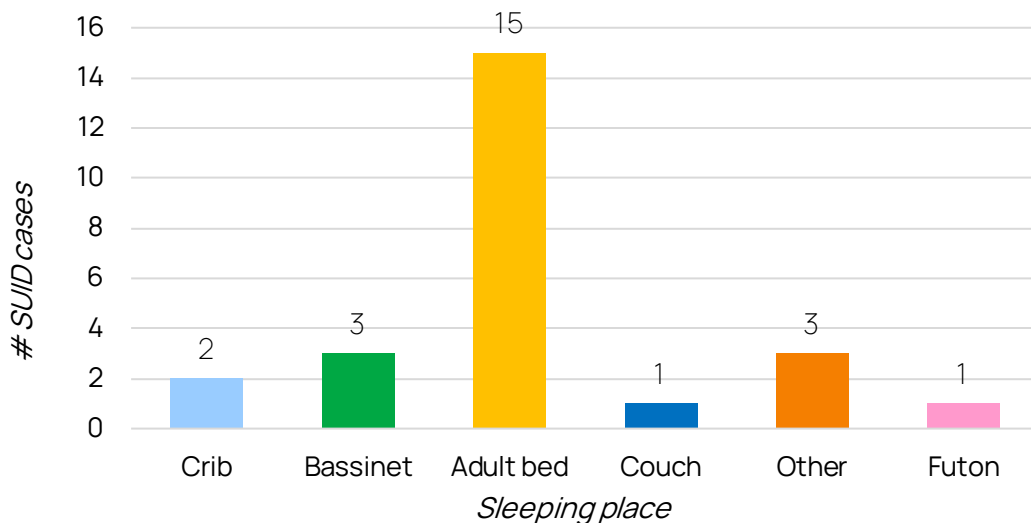
Source: NCFRP, Last accessed: October 3, 2023

Caregiver Impairment

Caregiver impairment is defined broadly by the NCFRP and includes being distracted or absent, impaired by illness or disability, and impaired by substances such as medications, alcohol or other substances.

An analysis of adult caregivers who were intoxicated by alcohol, medication or other substances (prescribed or illicit) at the time of the incident was conducted. Of the 30 unique SUID cases reviewed in 2022, six cases (20%) in which the adult caregiver was impaired were identified, which may be an underrepresentation of the actual proportion. There were five cases (17%) identified in which the adult caregiver was intoxicated by alcohol, and one (3%) in which the adult caregiver was impaired by other substances.

SUID Categorization

Cases were categorized using the CDC SUID Registry Case Categorization Algorithm. Of the 30 unique cases reviewed in 2022, 13 (43%) were categorized as explained and determined to be due to suffocation with unsafe sleep factors; 11 (37%) were categorized as unexplained with unsafe sleep factors present; two cases (7%) were categorized as unexplained, possible suffocation with unsafe sleep factors present and one case (3%) was categorized as unexplained due to incomplete case information available.

Primary Mechanism of Injury

The primary mechanism of injury in eight cases (27%) was identified as soft bedding. In six cases (20%), the primary mechanism of injury was overlay, and in one case (3%), it was wedging.

Exclusions

Out of the 34 cases reviewed by the SUID panel, three cases were ultimately excluded because they did not meet the criteria for SUID as described by the CDC, as their cause of death was determined to be natural. Two (66.6%) of these cases were female and one (33.3%) was male. All three were Hispanic or Latino. Among them, two cases fall into the one to four months age category, while one case falls into the five to eight months age category.

Unintentional Injury

Unintentional injuries can be caused by poisoning, inhalation or ingestion, motor vehicle crashes, falls, drowning, and structural fire or thermal injuries, firearms, or other mechanisms. In 2022, 24 unique child fatalities were reviewed by the Unintentional Injury Panel. Twelve (50%) of the cases reviewed were of children 15-17 years old (Figure 24). Twenty-three cases (96%) were identified as preventable; only one (4%) case was identified not to be preventable. Fifteen (62%) cases were males, and nine (37.5%) cases were female. Twelve (50%) of the 24 children were Hispanic or Latino, five (20.8%) of which identified as White, and six (25%) were Native American. The leading causes were asphyxiation (n=11, 46%), motor vehicle crashes (n=6, 25%), poisoning (n=3, 13%), falls (n=1, 4%), drowning (n=1, 4%), bodily force or weapon (n=1, 4%), and other incidents (n=1, 4%).

Figure 24. Child Fatalities Reviewed by NM-CFR (Unintentional Injury Panel), by Age Group in New Mexico, 2022
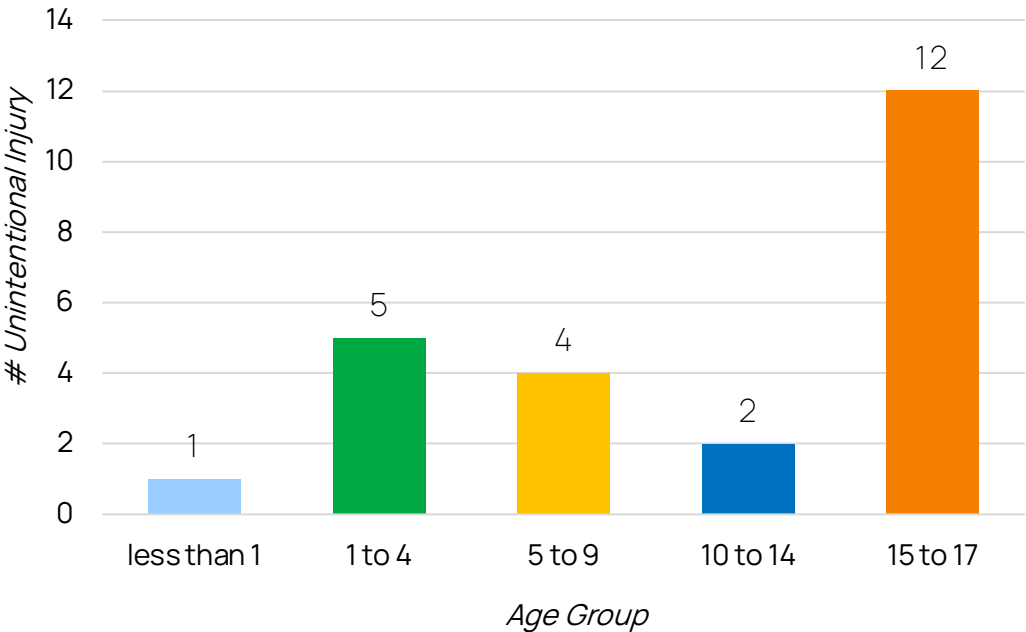
Source: NCFRP, Last accessed: October 3, 2023

Of the 16 unique cases of child suicide included in this report, fifteen (93.8%) were males and one (6.3%) was female. Nine (60%) were white, four (26.7%) were Hispanic or Latino. Of the reviewed cases, nine (56%) were in the 15 to 17 age group and seven (44%) were in the 10 to 14 age group (Figure 25).

Fifteen (93.8%) of the cases were identified as preventable by the NM-CFR; the team could not determine preventability for one (6.3%) case.

Figure 25. Child Fatalities Reviewed by NM-CFR (Suicide Panel), by Age in New Mexico, 2022

- 10 to 14
- 15 to 17
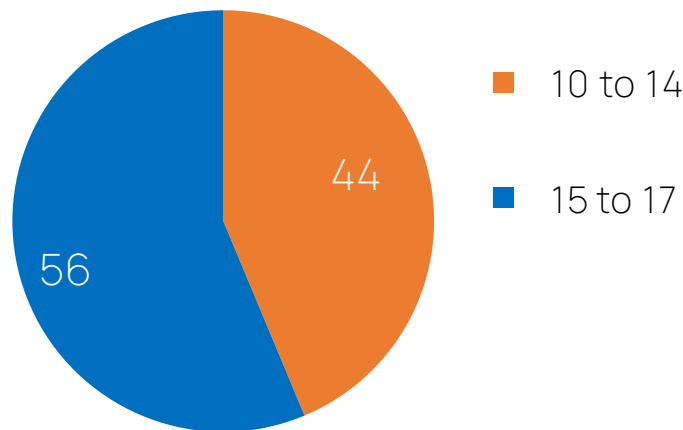
Source: NCFRP, Last accessed: October 3, 2023

Mental Health Status and Suicide Ideation

Of the youth suicide cases reviewed in 2022, fourteen (88%) were identified as having experienced a sense of isolation. Eleven (69%) had experienced a major life stressor or crisis within the 30 days before their death. Prior to their death, seven (44%) children had communicated thoughts or intention of suicide to someone else, and 69% had a history of self- harm. Four (25%) experienced a change in behavior prior to their death. Three (19%) were diagnosed with depression; two (13%) were diagnosed with anxiety. Two cases (13%) had previously attempted suicide, yet none of the records reviewed indicated that a safety plan was in place at the time of their death.

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

88% experienced a sense of isolation

69% experienced a major life stressor or crisis within 30 days prior to death

44% communicated their thoughts or intentions of suicide to someone

25% exhibited a recent change in behavior

69% had a history of self-harm   **19%** were diagnosed with depression   **13%** were diagnosed with anxiety

13% had previously attempted suicide, yet **none** of the records reviewed indicated a safety plan was in place.

Half of the children (n=8, 50%) that died by suicide had received prior mental health services. Six (37.5%) were actively receiving mental health services around the time of death. Two (12.5%) children had been seen in the emergency department for a mental health emergency within the last 12 months; however, no information was found about follow-up appointments within 30 days.

Social Characteristics

Of the youth suicide cases reviewed in 2022, half (n=8, 50%) had parents who were divorced or separated. Before their death, six (38%) had recently argued with their parents, experienced a life stressor in terms of failure in school, or had been raised in a home with domestic violence. Four (25%) had experienced housing insecurity; four (25%) had been the victim of bullying. Two (13%) had experienced the death of a loved one, and two (13%) had recently gone through a breakup with a significant other.

50%
had parents who were divorced or separated

37.5%
had a history of being raised in a home with domestic violence

38%
recently argued with their parents

25%
experienced housing insecurity

38%
experienced a life stressor in terms of failure in school

25%
had been the victim of bullying

13%
experienced the death of a loved one

13%
had recently gone through a breakup with a significant other
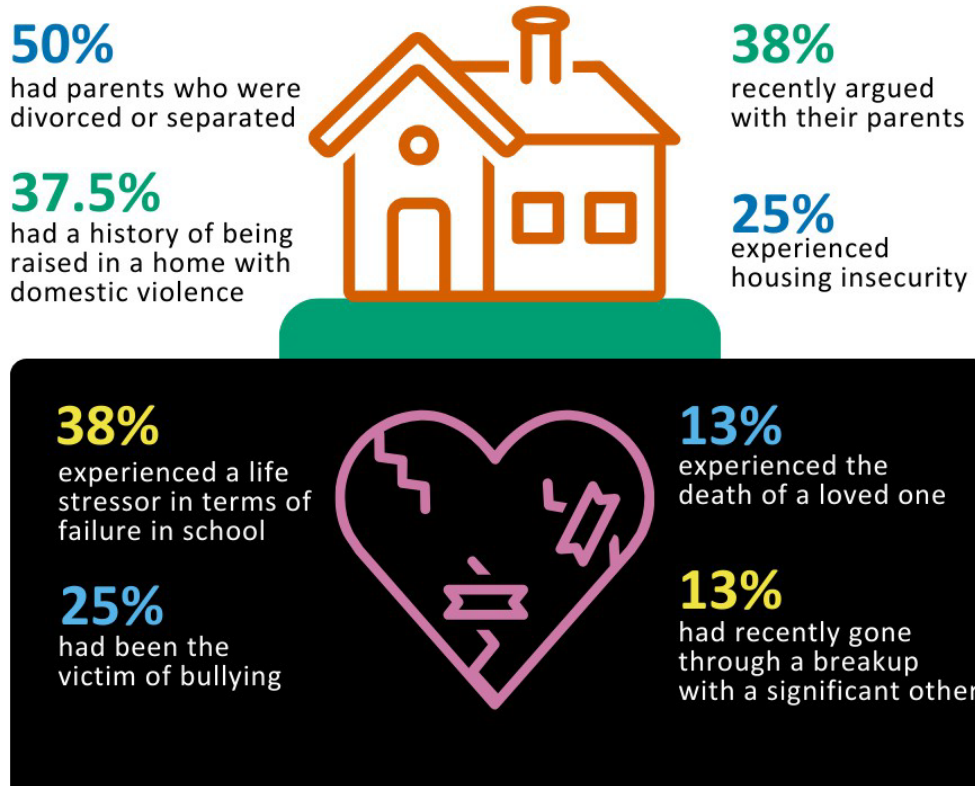
Source: NCFRP, Last accessed: October 3, 2023

Shared Risk and Protective Factors for Child Fatality in NM

In this analysis, some themes about risk and protective factors emerged across the review panels:

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

Through the cases reviewed in 2022, 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).

Lack of Mental Health Services as Risk Factors

According to the National Alliance on Mental Illness (NAMI), New Mexicans are 1.5 times more likely to be forced out-of-network for mental health care than for primary health care. More than 59% of New Mexicans aged 12–17 who have depression did not receive any care in the last year.

In the analysis of youth suicide cases reviewed, four (25%) of 16 cases were identified as having several 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 death by homicide and suicide, as well as other unintentional injuries such as accidental gun deaths and accidental overdose.

Eighteen percent (n=15, 17.8%) of all 84 cases reviewed in 2022 were due to firearm injury. Nine (56%) suicide deaths were due to firearm injury. Five (41.7%) of the 12 cases reviewed by the CAN-H panel were due to firearm injury. One unintentional injury death reviewed in 2022 was by firearm. Four (16.7%) cases reviewed by the Unintentional Injury panel were due to accidental overdose.

A 2023 report by the NMDOH, Comprehensive Report on Gunshot Victims Presenting at Hospitals in New Mexico, identified lack of safe storage as risk factor for firearm injury and death. Reducing access to lethal means through safe storage of firearms and medication could save lives in the future.

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 84 children included in this report, at the time of the incident which led to the child's death, less than half of children (n=38, 45.2%) were supervised at the time of death and 17 children (20.2%) did not have supervision and needed it. In 15 (17.9%) cases, the child who died was of sufficient developmental age and circumstances to supervise themselves. In one case, the NM-CFR was not able to determine the child's supervisory need. Thirteen (15%) cases did not have any response entered in the database.

Regardless of supervision status at time of incident leading to death, 38 of the 84 (45%) cases analyzed contained information about the last time a primary person responsible for supervision at time of incident saw the child: in 26 (30.5%) of those cases, the deaths occurred when the child was in sight of the supervising individual; two deaths (2.3%) occurred when the child was out of sight of the supervising individual for less than an hour; nine deaths (10.7%) 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 55 children who were noted as needing supervision or who were under parents/caregiver(s) supervision at the time of their death. In 21 (38.1%) cases, the individual responsible for supervising the child was asleep at the time of the child's death. Seventeen children (30.9%) were supervised by an individual who had a known history of child maltreatment. Thirteen children (23.6%) were supervised by an individual with a known history of substance use disorder. Ten children (18.2%) were supervised by an individual who was convicted of a crime. Nine children (16.3%) were supervised by an individual who had a history of intimate partner violence victimization. Six (10.9%) 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"). Five (9%) child deaths occurred in situations where the supervising individual had a disability or chronic illness.

Adverse Childhood Experiences as a Risk Factor for Child Fatality

NM Behavioral Risk Factors Surveillance System data indicate that an estimated 68% of adults residing in NM experienced at least one ACE, and nearly one in four (23.8%) experienced four or more ACEs (Whiteside, 2021). As a person's number of ACEs increases, so does the risk for negative health and life outcomes.

Among the 84 cases reviewed in 2022, 30 children (35.7%) had a history of maltreatment with a perpetrator parent. Eighteen children (21.4%) had lived with at least one parent who

was convicted of a crime. A history of referral to child welfare services was found in 10 cases (12.4%). Thirteen children (15.5%) experienced multiple challenges in school such as academics, truancy, suspension, or behavioral issues. Eighteen (21.4%) had history of intimate partner violence, and 19 (22.6%) had history of substance misuse.

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). Twenty-seven (32.1%) of the 84 cases reviewed by NM-CFR in 2022 had a history of child maltreatment, and four (4.7%) had open investigations at the time of their death. Eight children (9.5%) 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. Twenty-one (25%) children had a known prior disability or chronic illness. Nine children (10.7%) were receiving mental health services prior to their death and another 15 children (17.9%) had received mental health services in the past. Nineteen children (22.6%) had a history of substance use prior to their death.

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. Two children (2.4%) were classified as having high household income, 11 children (13.1%) were classified as having medium household income, 30 cases (35.7%) were classified as having low household income, and 29 (34.5%) cases were unknown or unable to classify.

Health insurance information gives further insight into the SES of these children. A 2021 factsheet by NAMI indicated that 9.8% of people in NM are uninsured. In the analysis of insurance status for the 84 unique child fatalities reviewed by NM-CFR in 2022, 48 cases (57.1%) had Medicaid as their insurance coverage, 30 cases (35.1%) had private insurance coverage, and one child (1.2 %) had no medical coverage. Twenty-two (26.2%) 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.

Limitations

A limitation of this report is that data were missing for several variables. During the comprehensive review of these cases, certain information was unavailable due to various factors, such as records requests which were not received by the agency. In cases where there were difficulties in accessing data, it was necessary to classify certain values as 'unknown'. This lack of comprehensive data may contribute to underrepresentation of some variables in this report.

Conclusions

Child deaths due to injury and violence are predictable and preventable. Of the unique 84 child fatalities reviewed in 2022 and described in this report, NM-CFR determined that 67 (79.76%) deaths could have been prevented. In most cases, there was sufficient data for the NM-CFR to determine preventability, however, in five (5.6%) cases, the information provided was insufficient to determine whether the child's death was preventable. Based on child fatality data from reviews conducted during calendar year 2022 and analyzed in this report, the leading causes of death were: asphyxiation (30%), bodily force or weapon (27%), unknown (20%), and motor vehicle crashes (11%), followed by poisoning (5%), drowning (3%), and other incidents (3%). The most common circumstances surrounding child deaths in NM included risk factors and a lack of protective factors in areas of access to lethal means, behavioral and mental health care, supervision, income level in family, maltreatment, and violence.

A broad evidence base demonstrates that social determinants of health, such as educational attainment, economic stability, social and community dynamics, neighborhood characteristics, and access to quality healthcare, as well as discriminatory policies, systemic violence and historical trauma contribute to the manifestation of complex and interconnected risk factors for children and families. Enacting preventative measures can reduce risk factors such as adverse childhood experiences, mitigating trauma and creating a protective environment to reduce the occurrence of child fatalities.

Recommendations to prevent adverse childhood experiences and promote positive childhood experiences to increase protective factors include strengthening economic supports for families; promoting social norms that protect against violence and adversity; ensuring a strong start for children; teaching skills; connecting youth to caring adults and activities; and intervening to lessen immediate and long-term harms.

The next section describes key prevention recommendations made by NM-CFR.

NM-CFR Recommendations

Previous Recommendations

Although some recommendations from previous years have not yet been implemented, and may not be included in this report, the NM-CFR recognizes the continued need for adoption. Exclusion from this report should not be interpreted as a discontinued need. The key recommendations were selected and included in this report based on current public health and social conditions, as well as alignment with departmental priorities.

Some recommendations that were made by NM-CFR panelists in 2022 have since been implemented, and thus excluded from the Key Recommendations. The following actions have been taken based on previous recommendations of the NM-CFR:

A long-standing infant injury prevention recommendation of the NM-CFR included shaken baby syndrome (SBS) prevention. In 2017, the Shaken Baby Syndrome Educational Materials Act was enacted in NM, which requires hospitals and freestanding birth centers to provide training and education to prevent SBS to every parent of every newborn before discharge.

One recommendation made in 2022 was for the NM-CFR to develop a panel to address violence affecting youth, oftentimes, but not limited to causes by firearm injury. In 2023, the NM-CFR created a new panel to review cases related to community and/or peer violence.

Another recommendation which was made in previous years as well as in 2022 was for a legislative mandate for the safe storage of firearms in homes with children. In 2023, [House Bill 9, the Bennie Hargrove Gun Safety Act](#) was enacted, which prevents gun violence by requiring gun owners to keep firearms safely stored.

A recommendation that funds 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, was realized in 2023 when the Early Childhood, Education and Care Department (ECECD) was allocated funds for safe sleep in the Thriving Families Prenatal to Three (PN-3) Prevention Plan. However, recurring funding is needed to sustain these activities.

Discussion of Recommendations

Qualitative assessment and analysis of responses by NM-CFR panelists across its four panels revealed themes related to safe infant sleep, firearm safety and storage, motor vehicle and pedestrian safety, and behavioral health care, including mental health and substance use needs.

NM-CFR panelists highlighted significant challenges faced by children and families, including poverty, lack of access, or barriers to engagement with social services, trauma informed and culturally appropriate care:

"When a high count of CYFD reports [and] refusal of help by family, this is a sign of high-risk of abuse and neglect."
NM-CFR CAN-H Panelist

"Resources for culturally sensitive safe sleep education for parents that reside on tribal land."
NM-CFR SUID Panelist

The key recommendations included in the next section include recommendations to strengthen the NM-Child Fatality Review for improved data and recommendations for preventing child deaths, recommendations to increase safe home environments and recommendations to increase behavioral healthcare and access to resources.

With regard to the recommendations to strengthen the NM-Child Fatality Review for improved data and recommendations for preventing child deaths, the NM-CFR was created with the passing of an unfunded mandate. At the time of publication of the first NM-CFR Annual Report in 2000, NM-CFR staff consisted of one full-time equivalent (FTE) Epidemiologist and one 0.5 FTE Coordinator. Currently, the statewide program is operated by 1.0 FTE, the Child Fatality Review Coordinator, of which the salary is funded through state general funds. To date, there is no budget to support program operations, such as data collection and management, nor for salaries, office supplies, or other items. Recurring funding to support program operations would improve program capacity. Dissemination of this report as well as other publications by NM-CFR or the Office of Injury & Violence Prevention would increase awareness of the program, increase statewide knowledge of prevention recommendations, and may contribute to increases in prevention programming and coordination across sectors to prevent child fatalities in NM.

Key Recommendations

Recommendations to strengthen the NM-Child Fatality Review for improved data and recommendations for preventing child deaths:

1. The NM Legislature should appropriate recurring funding to support the NM Child Fatality Review in its programmatic operations and activities.
2. State agencies, NM-CFR Panelists, policymakers, the media, and the public should disseminate this report and its findings widely, in remembrance of those it describes, and to increase awareness of the burden of child fatality in New Mexico, as well as prevention efforts.

Recommendations to increase safe home environments:

3. The NM Legislature should pass legislation that requires hospitals, birthing facilities, midwives and birth workers to provide education to parents and caregivers about safe infant sleep practices, as prescribed by the American Academy of Pediatrics, and training for appropriate personnel in state-funded infant-serving organizations, including childcare facilities and departments such as the Early Childhood, Education and Care Department and the Children, Youth and Families Department.
4. Child-serving agencies and organizations should implement policy and make available resources to improve safe home environments for families, such as gun locks, baby gates and products to encourage safe infant sleep practices, smoke and carbon monoxide detectors and airway clearing devices.

Recommendations to increase behavioral healthcare and access to resources:

5. The NM Legislature should pass legislation that provides increased access to mental health professionals from other states via telehealth by joining a multistate compact such as Psychology Interjurisdictional Compact (PSYPACT), an interstate agreement which allows psychologists in participating jurisdictions to practice across state lines and includes provisions for tele-practice.
6. The Children, Youth and Families Department, Early Childhood, Education and Care Department, Department of Health, and Public Education Department should require suicide prevention gatekeeper training, such as QPR (Question. Persuade. Refer.™) or Mental Health First Aid for appropriate personnel. These trainings are also recommended for personnel in state-funded child-serving organizations, including public schools, behavioral health care settings, medical and childcare settings (i.e. YMCA, Boys and Girls Club etc.).
7. The 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 to flag and assist children who are being exposed to violence and need referrals, especially mental health.

Appendix

Appendix A: Acknowledgements

The NMDOH would like to express appreciation to all the members of the 2022 NM-CFR panels: Child Abuse, Neglect or Homicide, Sudden Unexpected Infant Death, Unintentional Injury and Youth Suicide. Individuals on these panels include state and local experts in diverse fields as well as occasional attendees brought to specific case reviews. Thank you for your dedicated time, expertise, and feedback to aid in reducing child fatalities and injuries in New Mexico.

Name	Organization
Abby Turner	Western New Mexico University
Aidan Kerr	Office of the Medical Investigator
Alberto Aldana	Roswell Police Department
Alexis Grasse	Guest
Alina Potrzebowski	Department of Health
Allie Heredia	Bernalillo County Sheriff's Office
Anelle Brand	Office of the Medical Investigator
Angela Baca	Children, Youth and Families Department
Arthur Malone	Pojoaque Pueblo Social Services
Ashley Anaya	Children, Youth and Families Department
Barbara Salazar	Children, Youth and Families Department
Bella White	Breaking the Silence NM
Benjamin Vickers	Department of Health
Benny Chen	University of New Mexico Hospital
Catherine Small	Bernalillo County Sheriff's Office
Chloe Stoffel	University of New Mexico Hospital
Christopher Trujillo	Department of Health
CL Kieffer Nail	Department of Health
Clarie Miller	Department of Health
Clarissa Krinsky	Office of the Medical Investigator
Colinda Vallo	Children, Youth and Families Department
Ross Daugherty	Bernalillo County Sheriff's Department
Doug Parson	Chaves County CASA
Dylan Pell	Department of Health
Edith Lewis	Children, Youth and Families Department
Erika Myers	University of New Mexico Hospital
Fahad Hussain	University of New Mexico Hospital
Garry Kelly	Department of Health
Harley Schainost	Office of the Medical Investigator
Hayley Peterson	Department of Health
Heather Carrica	Children, Youth and Families Department

Holly Burks	Department of Health
Jacalyn Dougherty	Department of Health
Jeanne Masterson	Children, Youth and Families Department
Jeffrey Bullard-Berent	University of New Mexico Hospital
Jennifer Hart	Albuquerque Public Schools
Jennifer Padgett-Macias	Santa Fe County District Attorney's Office
Jessi Fuchs	Department of Health
Jimmy Gibson	Public Education Department
Joshua Lopez	University of New Mexico/Albuquerque Ambulance Service
Karen Campbell	University of New Mexico Hospital/Children, Youth and Families Department
Katherine Schafer	University of New Mexico
Kathleen Maese	Department of Health
Kathryn Lowerre	Department of Health
Keisuke Abe	University of New Mexico
Kelly Hynes	Office of the Medical Investigator
Kimberly Pruett	University of New Mexico
Kylie Diver	Children, Youth and Families Department
Laura Geiger	University of New Mexico Hospital
Laura Migliaccio	University of New Mexico Hospital
Lauren Dvorscak	Office of the Medical Investigator
Leslie Kelly	Public Education Department
Leslie Strickler	University of New Mexico Hospital
Lidia Bachechi	Children, Youth and Families Department
Lisa Rohleder	Children, Youth and Families Department
Liza Suzanne	Department of Health
Lori Proe	Office of the Medical Investigator
Lori Zigich	Office of the Medical Investigator
Lucretia Vigil	Department of Health
Maggie Edmiston	Cibola Hospital
Maryanne Chavez	University of New Mexico Hospital and Para Los Niños
Matt Cottle	City of Santa Fe
Melissa Ewer	NM Coalition of Sexual Assault Programs
Mercedes Barr	Children, Youth and Families Department
Michael Harrell	Office of the Medical Investigator
Natasha Sing	Chaves County CASA/Child Advocacy Center
Nicholas Marshall	United States Attorney's Office – District of NM
Nicholas Sharp	Department of Health
Nicole Urrea	University of New Mexico Hospital
Rachel Ralya	Department of Health
Rachel Wexler	Department of Health

Rebecca Girardet	University of New Mexico Hospital
Rebecca Tarin	Office of the Medical Investigator
Ronaldo Chavira	Court Appointed Special Advocate
Ruth Golar	Albuquerque Public Schools
Samantha Medeiros	Department of Health
Sarah Johnson	Chaves County CASA/Child Advocacy Center
Scott Patterson	Administrative Office of the Courts
Sean Thomas	Albuquerque Public Schools
Shayna Klassen	Department of Health
Shelly Bucher	Substitute Care Advisory Council
Sophie Rodriguez	Office of the Medical Investigator
Stephanie McGovern	University of New Mexico Hospital
Susan Merrill	Department of Health
Teri Cotter	Department of Health
Theresa Yazzie	Indian Health Service
Toby Rosenblatt	Department of Health
Travis Hardy	Chaves County Sheriff Office
Wendy Linebrink-Allison	NM Crisis and Access Line

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

NM-CFR 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 participate. To get involved, please contact NMCFR@doh.nm.gov.

Appendix B: 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 C: Glossary Terms from OMI 2021 Annual Report

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 D: 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/Latino (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.

Appendix E: Suicide Awareness, Prevention and Training Organizations

Breaking the Silence New Mexico http://www.breakingthesilencenm.org
Campaign Against Living Miserably (CALM) https://www.thecalmzone.net
Child Mind Institute https://childmind.org/topics/trauma-grief
Coalition to Support Grieving Students https://grievingstudents.org
Herald Alliance, The K-12 Toolkit for Mental Health Promotion and Suicide Prevention
http://www.heardalliance.org/wp-content/uploads/HEARDToolkit2017.pdf
Mental Health America https://mhanational.org/sites/default/files/B2S%202021%20-%20Full%20Toolkit.pdf
Model School District Policy on Suicide Prevention https://afsp.org/model-school-policy-on-suicide-prevention
National School Mental Health Curriculum and Best Practices for States, Districts, and Schools https://mhttcnetwork.org/centers/mhttc-network-coordinating-office/national-school-mental-health-projects
National Child Traumatic Stress Network's Trauma-Informed School Strategies During Covid-19 https://www.nctsn.org/resources/trauma-informed-school-strategies-during-covid-19
NM Connect https://nmcrisisline.com/nmconnect-app
Protecting Youth Mental Health, U.S. Surgeon General's Advisory
https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf
Psychological First Aid for Schools (PFA-S) https://rems.ed.gov/K12PFAS.aspx
Suicide Prevention Resource Center https://www.sprc.org
The Sky Center's Adolescent Hugs Program https://skycenter.nmsip.org/our-programs/adolescent-hugs
US Department of Health and Human Services, Stop Bullying Campaign
https://www.stopbullying.gov

Appendix F: 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 G: Related Resources

2022 Data Book | New Mexico Human Services Department
https://www.hsd.state.nm.us/2022-data-book

Centers for Disease Control and Prevention https://www.cdc.gov

    Adverse Childhood Experiences (ACEs)
    https://www.cdc.gov/violenceprevention/aces/index.html

    Child Abuse and Neglect Prevention
    https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html

    Firearm Violence Prevention
    https://www.cdc.gov/violenceprevention/firearms/index.html

    National Center for Injury Prevention & Control https://www.cdc.gov/injury

    Sudden Unexpected Infant Death and Sudden Infant Death Syndrome
    https://www.cdc.gov/sids/index.htm

    Suicide Prevention https://www.cdc.gov/suicide

    The Public Health Approach to Violence Prevention
    https://www.cdc.gov/violenceprevention/about/publichealthapproach.html

    The Social-Ecological Model: A Framework for Prevention
    https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

Comprehensive Report on Gunshot Victims Presenting at Hospitals in New Mexico, 2023
https://www.nmhealth.org/publication/view/report/8463

Connect New Mexico https://connect.nm.gov

Kids Count (Annie E Casey Foundation) https://www.aecf.org/resources/2022-kids-count-data-book

National Center for Fatality Review and Prevention https://ncfrp.org

New Mexico Indicator Based Information System (NM-IBIS) https://ibis.doh.nm.gov

New Mexico Maternal Mortality Review Report, 2022
https://www.nmhealth.org/data/view/maternal/2684

New Mexico Office of the Medical Investigator https://hsc.unm.edu/omi

New Mexico Office of the Medical Investigator, 2021 Annual Report
https://hsc.unm.edu/omi/_docs/pdfs/ar2021.pdf

New Mexico Pregnancy Risk Assessment and Monitoring System (NM PRAMS)
https://www.nmhealth.org/about/phd/fhb/prams

New Mexico Voices for Children Kids Count Data Book https://www.nmvoices.org/wp-content/uploads/2022/01/KidsCount-DataBook2021-FINAL.pdf

New Mexico Youth Risk & Resiliency Survey https://youthrisk.org

Safe Sleep NM https://www.safesleepnm.org

Safe Storage NM http://www.safestoragenm.org

State of Mental Health in New Mexico, 2022
https://www.nmhealth.org/data/view/report/2650

Substance Use and Mental Health Services Administration https://www.samhsa.gov

988 Suicide & Crisis Lifeline https://www.samhsa.gov/find-help/988

QPR (Question, Persuade, Refer) Suicide Prevention Training
https://www.samhsa.gov/resource/dbhis/qpr-question-persuade-refer-suicide-prevention-training
Share Information Center, New Mexico https://www.share.state.nm.us

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NM-CFR 2023 Report Tear Sheet

The following two pages are intended to be used as a one-page summary resource. Whether this document is printed in its entirety or pages 65 and 66 are printed alone, print on both sides for optimal use.

NM-CHILD FATALITY REVIEW 2023 ANNUAL REPORT
SELECTED FINDINGS

NM VS US TRENDS

The child injury death rate in New Mexico has consistently been higher than the national rate. In 2021, the injury related child death rate in NM was 23 per 100,000 population, compared to 14.4 per 100,000 population in the US.

MOST CHILD DEATHS IN NM ARE UNINTENTIONAL

More than 35% of all child deaths (0-17) were by Unintentional Injury. From 2011-2021, 589 child fatalities in NM were unintentional injuries. These deaths are due to motor vehicle crashes, drownings, unintentional overdose or poisonings, fire or environmentally related, and other unintentional injuries.

PREVENTABILITY

If an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death.
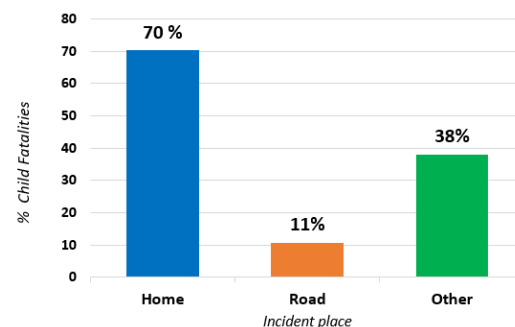
Of the 84 unique child deaths reviewed in 2022, NM-CFR determined:
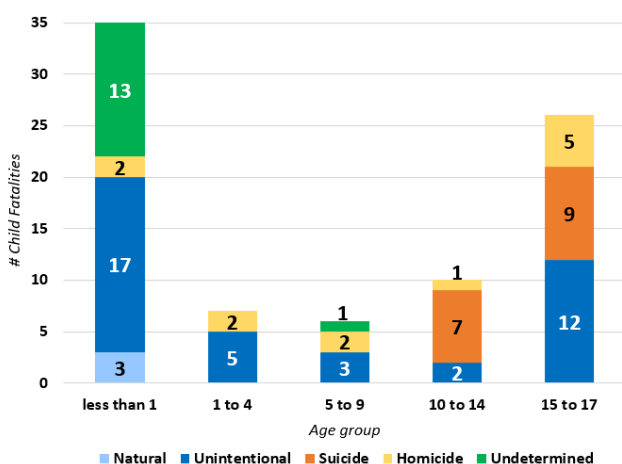
79.76%
could have been prevented

2.38%
could not be prevented

5.95%
unable to determine

PLACE OF INCIDENT

Bar chart — % Child Fatalities by Incident place: Home 70%, Road 11%, Other 38%.

MANNER OF DEATH BY AGE

Stacked bar chart — # Child Fatalities by Age group (Natural, Unintentional, Suicide, Homicide, Undetermined):
- less than 1: Natural 3, Unintentional 17, Homicide 2, Undetermined 13
- 1 to 4: Unintentional 5, Homicide 2
- 5 to 9: Unintentional 3, Homicide 2, Undetermined 1
- 10 to 14: Unintentional 2, Suicide 7, Homicide 1
- 15 to 17: Unintentional 12, Suicide 9, Homicide 5

RISK & PROTECTIVE FACTORS

Across its' panels, the following risk and protective factors were observed:

- *Access to Lethal Means*
- *Adverse Childhood Experiences, Life Stressors*
- *Child and Mental Health*
- *Lack of Supervision, Child Maltreatment*
- *Socioeconomic Status*

NM-CHILD FATALITY REVIEW 2023 ANNUAL REPORT
SELECTED RECOMMENDATIONS

TO STRENGTHEN THE NM-CFR FOR IMPROVED DATA &RECOMMENDATIONS:

- The NM Legislature should appropriate recurring funding to support the NM Child Fatality Review in its programmatic operations and activities.
- State agencies, NM-CFR Panelists, policymakers, the media, and the public should disseminate this report and its findings widely, in remembrance of those it describes, and to increase awareness of the burden of child fatality in New Mexico, as well as prevention efforts.

TO INCREASE SAFE HOME ENVIRONMENTS:

- The NM Legislature should pass legislation that requires hospitals, birthing facilities, midwives & birth workers to provide education to parents/caregivers about safe infant sleep practices, as prescribed by the American Academy of Pediatrics, & training for appropriate personnel in state-funded infant-serving organizations, including childcare facilities & departments such as ECECD and CYFD.
- Child-serving agencies and organizations should implement policy and make available resources to improve safe home environments for families, such as gun locks, baby gates and products to encourage safe infant sleep practices, smoke and carbon monoxide detectors and airway clearing devices.

TO INCREASE BEHAVIORAL HEALTHCARE & ACCESS TO RESOURCES:

- CYFD, ECECD, DOH & PED should require suicide prevention gatekeeper training, such as QPR (Question. Persuade. Refer.) ™ or Mental Health First Aid for appropriate personnel, as well as personnel in state-funded child-serving organizations, including public schools, behavioral health care settings, medical care settings & childcare settings.
- The 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 to flag and assist children who are being exposed to violence and need referrals, especially mental health.

Read the full report

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