

# Annual Report 2010



May 2011

## New Mexico Child Fatality Review

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## Executive Summary

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The New Mexico Child Fatality Review (NMCFR) was established in 1998 to examine the circumstances that contribute to the deaths of infants, children, and youth in New Mexico. The purpose of the NMCFR is to identify risk reduction, prevention, and systems improvement factors in these deaths and to recommend strategies that can prevent future injury and death.

This report presents information and recommendations from the comprehensive and confidential reviews of child deaths by a multi-disciplinary group of professionals. Death certificate data, provided by the New Mexico Bureau of Vital Records and Health Statistics (NMBVRHS), were used to complete the epidemiologic analysis of child death in New Mexico. The report focuses on deaths of New Mexico residents under 18 years of age who died between 2006 and 2009.

## Key Findings

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- There were 907 deaths (59.1 per 100,000 population) of New Mexico residents, aged 0-17, in the state in 2007-2009.
- The greatest numbers of deaths (N= 487, 54%) occurred in the first year of life and were due to natural causes (e.g. congenital anomalies, prenatal conditions, and Sudden Infant Death Syndrome).
- Injuries of any type, regardless of intent, resulted in a third of all child deaths, but 64% of deaths of children 1-17 years.
- Of the total injury deaths, 56% were unintentional, 17% were homicide, 17% were suicides and approximately 10% of the deaths were undetermined.
- Suicide was the second leading cause of death for children 10-17 years of age after unintentional injury.
  - Approximately 67% of all suicides among children were committed by males (4.6 deaths per 100,000); females accounted for 33% (2.4 deaths per 100,000).
  - American Indian and Alaska Native children had the highest rate of suicide at 10.2 per 100,000 children.
  - The majority of suicide fatalities were caused by hanging (61%), followed by firearms (24%) and poisoning (6%).
- Unintentional injury was the leading cause of death for children 1-17 years of age. It accounted for 175 deaths in 2007-2009.
  - Ninety-one children died in motor vehicle-related incidents; 59% (N=54) of these fatalities were from motor vehicle traffic- occupant deaths and 22% (N=20) were pedestrian deaths.
  - Motor-vehicle pedestrian deaths were the leading cause of unintentional injury deaths among the 1-4 year age group and motor vehicle traffic- occupant death was the leading cause among 5-17 year old children.
  - Twenty-four children died by drowning. Approximately 67% of the drowning victims were under five years of age. Nineteen children died of poisoning and 79% of these children were 15-17 years of age. Seventeen children died as a result of suffocation. Children under one year of age had the greatest risk for suffocation.

## Executive Summary

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### **Child Fatality Review Panels (2006-2009 Data)**

- The Broader Spectrum/SIDS (BSS) Panel reviewed 129 child deaths that occurred in 2006-2009. These included poisoning and drowning deaths that were unintentional in manner. The panel also reviewed 47 deaths that were reported to be due to Sudden Infant Death Syndrome (SIDS).

- The panel found that 44 of the SIDS deaths were in sleep-related circumstances.

Priority Recommendation: Require education on safe sleep guidelines in clinical settings, in spiritual communities, day care centers, shelters, WIC program offices, and social services agencies. Include distribution and showing of DVDs and brochures such as “Back to Sleep”, “Never Shake a Baby” and “SIDS”.

- The Child Abuse and Neglect (CAN) Panel reviewed 23 deaths that resulted from childhood abuse or neglect and occurred in 2006-2009. The panel determined that 21 (91%) of the cases were preventable.
  - Approximately 91% of the deaths were of children younger than five years of age.
  - Biological parents were found to be responsible for most of the cases.

Priority Recommendation: Develop and fund a statewide family safety poster project to report and prevent child abuse and neglect.

- The Suicide Panel reviewed files of 33 children who committed suicide in 2006, 2007, and 2009. The panel determined that 23 (70%) of these cases could have been prevented.
  - In twenty one cases, the child had problems in school.
  - Twelve children had received prior mental health services.
  - Thirteen of the children had a history of substance abuse.
  - Nine children had a history of child maltreatment as victim.

Priority Recommendation: Implement suicide prevention training for school teachers, all staff, coaches and parents of students in Bureau of Indian Education schools, require that all BIE schools have a crisis intervention plan and post-intervention plan and provide related training to all school, staff, parents, and the community on the Question/Persuade/Refer (QPR) model.

- The Transportation Panel reviewed 77 deaths of children that were due to a moving motorized vehicle. The review panel determined that 59 (77%) of these deaths could have been prevented.
  - Motor vehicle (i.e. cars, trucks, SUVs, and vans) occupant deaths accounted for 54 of the reviewed transportation fatalities.
  - Fourteen of the reviewed cases were pedestrian fatalities.
  - Drug/alcohol use and speeding over the limit were the most frequently reported cause for the incidents.

Priority Recommendation: Reduce child deaths by reducing driving while under the influence of alcohol.

## Overview of Child Fatality Review

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The first child fatality review (CFR) was established in 1978 in Los Angeles, California as a result of local efforts to identify child abuse and neglect fatalities. Many states, including New Mexico, now have multidisciplinary, interagency teams that systematically review the deaths of children. From its original concern for victims of child abuse, the scope of death reviews widened to include intentional deaths (by suicide and homicide), unintentional deaths (accidents), and natural deaths.

## Benefits of Child Fatality Review

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The CFR provides a forum to review agency actions and inactions as they relate to child protection and fatality reduction. This is intended to improve interagency communication and coordination of efforts and give agencies information and recommendations to improve prevention efforts. The review process results in increased understanding of risk factors for deaths that help medical and law enforcement personnel identify children at risk. Child fatality review not only alerts the community to emerging patterns of death but also identifies sub-populations most at risk.

## Data Collection and Review Process

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In New Mexico, child fatality review begins when the NMCFR coordinator receives Office of Medical Investigator (OMI) reports of death for children less than 18 years of age. The CFR staff supplements OMI mortality data with reports from other appropriate sources (law enforcement, child protective services, schools, etc.). Individual NMCFR case files are assigned to the appropriate panel for review. A panel member thoroughly reviews a case and presents it to the panel. The panel discusses each case, determines if and how the death might have been prevented through appropriate prevention or intervention measures, and then makes program, system and/or policy recommendations for prevention of future injuries or deaths. All relevant case information is documented on a standard national Child Death Review case form and entered into the confidential National Center for Child Death Review database. Upon completion of child fatality reviews for a given period, review panels compile and evaluate individual case recommendations, and develop formal recommendations for presentation to the NMCFR Advisory Board. The board, which is comprised of chairs of the CFR panels, agency leaders, policymakers, and representatives from various organizations and professions, reviews the recommendations and adopts some or all for use by policymakers and agencies.

Note: The CFR review teams use OMI as the main source for their data because the OMI files contain information surrounding the circumstances of the deaths. However, the OMI is only authorized to investigate child deaths that are of unknown cause or are sudden, violent, suspicious or unattended and that are not on federal or tribal land. As a result, this report also uses data from death certificates provided by the New Mexico Bureau of Vital Records and Health Statistics to complete the analysis of child mortality.

## Population Characteristics

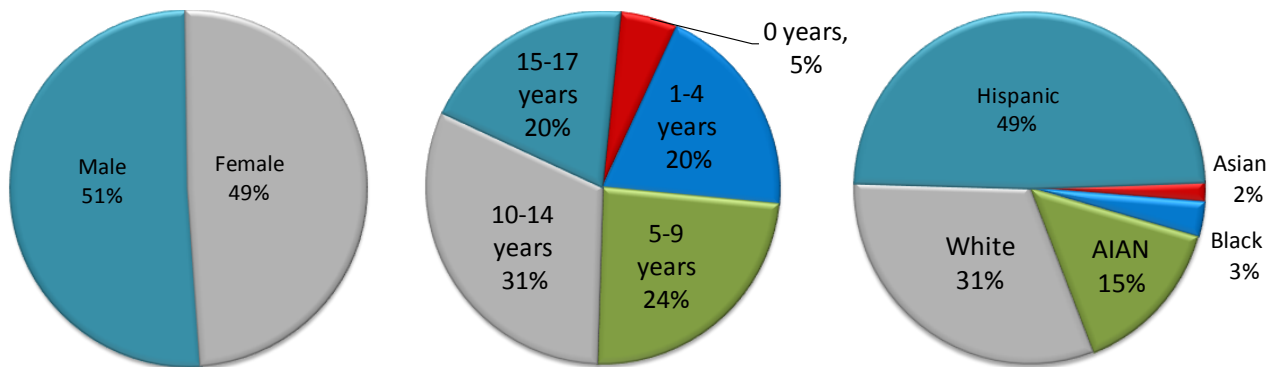
(NM Residents, 0-17 Years of Age, 2007-2009)

The following figures illustrate the population breakdown of New Mexican children by sex, age group, and race/ethnicity according to the Bureau of Business and Economic Research (BBER) population estimates for 2007-2009.

In New Mexico, children under 18 years of age made up a quarter of the state's population. The data show that there were slightly more male children (51%) than female children (49%). The 10-14 year age group was the largest in the state and made up 31% of the population of children. Infants (under one year of age) made up 5% of the population of children. The 1-4 and 15-17 year age groups each constitute 20% of the children's population. According to BBER, 95% of New Mexico's population of children, 0-17 years, was classified as Hispanic, White, or American Indian/Alaska Native. Hispanics (White children of Hispanic origin) made up the largest percentage of children (49%), followed by Whites (31%), and American Indians (15%). Black and Asians comprised 5% of children younger than 18 years of age.

Note: The New Mexico Department of Health combines race and ethnicity for reporting purposes. 'Hispanic' refers to Hispanic Whites and does not include Hispanics of Black, American Indian/Alaska Native (AIAN) or Asian populations and 'White' refers to Non-Hispanic Whites. 'American Indian' is used in this report to refer to the AIAN population in New Mexico.

**Figure 1. Population of Children (0-17 years of age) by Sex, Age Group, and Race/Ethnicity, NM, 2007-2009**

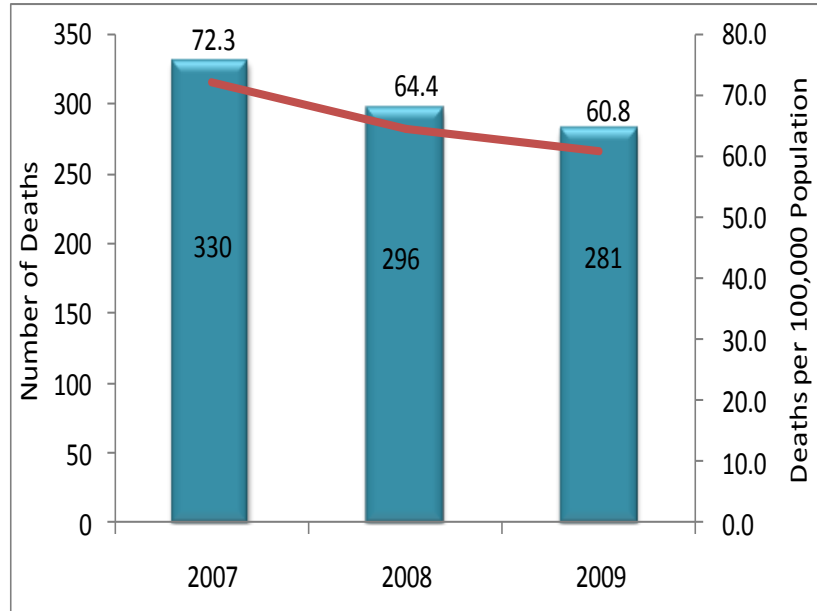


## Deaths among Children

(NM Residents, 0-17 Years of Age, 2007-2009)

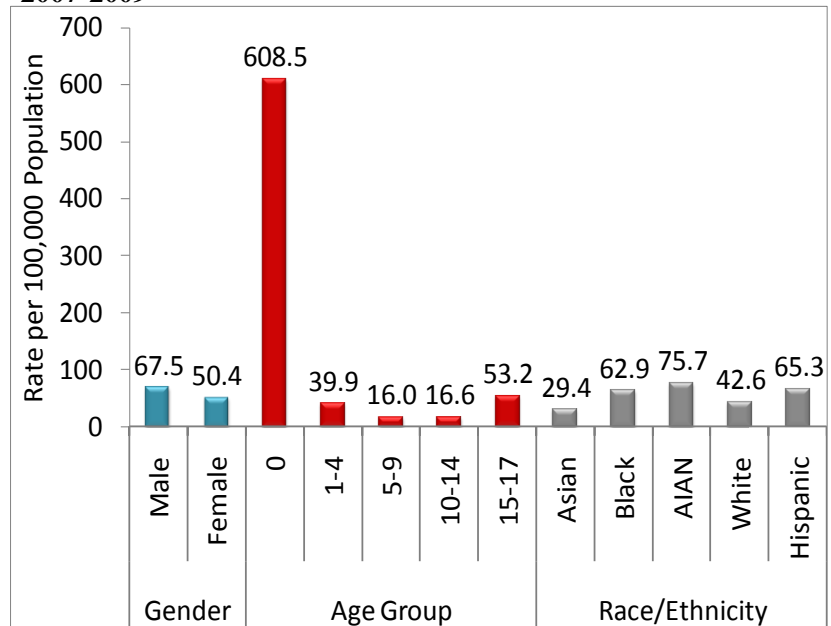
During 2007-2009, there were 907 fatalities of New Mexican children aged 0-17 years. During the three years, the mortality rate decreased by approximately 16% (from 72.3 per 100,000 in 2007 to 60.8 per 100,000 in 2009).

**Figure 2. Numbers and Rates of Deaths among Children, NM, 2007-2009**



A total of 527 male and 380 female children died during the three year period. Males had a higher overall death rate (67.5 deaths per 100,000) than females (50.4 deaths per 100,000). The largest percentage of deaths, at 54%, was among children younger than one year of age (the infant mortality rate was 608.5 per 100,000 population). American Indian, Hispanic, and Black children had higher death rates than White and Asian children.

**Figure 3. Deaths by Gender, Age, and Race/Ethnicity, NM, 2007-2009**



## Deaths among Children

(NM Residents, 0-17 Years of Age, 2007-2009)

### Manner and Cause of Death

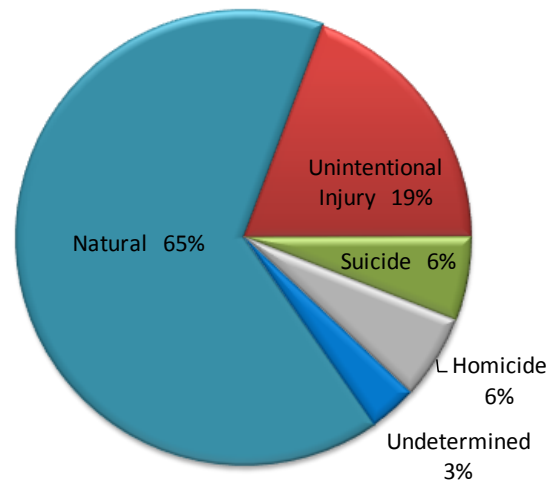
Manner of death is a classification of intentions and circumstances that led to the death. The five categories of manner of death are:

1. Natural – deaths resulting solely from natural causes or disease.
2. Unintentional – refers to the act that resulted in death being one that was not deliberate, willful, or planned.
3. Suicide – intentionally self-inflicted fatal injury.
4. Homicide – death at the hands of another, involving the lack of justification or excuse for the act.
5. Undetermined – death where the manner of death cannot be determined with reasonable certainty.

Of the total child fatalities in NM from 2007-2009, natural deaths accounted for 65% of the 907 child deaths; unintentional injury or accident was the manner in 19% of deaths; and homicides and suicides accounted for approximately 6% of deaths each. Manner could not be determined in approximately 3% of the deaths.

Note: The underlying cause of death was used to determine manner of death in this report.

**Figure 4. Percent of Child Deaths by Manner, NM, 2007-2009**



**N=907**



## Deaths among Children

(NM Residents, 0-17 Years of Age, 2007-2009)

The following charts show the five most common causes of deaths for children. Approximately 64% of deaths among infants were either due to conditions originating in the perinatal period, to congenital disorders or to Sudden Infant Death Syndrome. Unintentional injury was the leading cause of death of children older than one and the third leading cause of death for infants. Suicide was the second leading cause of death for children 10-17 years of age.

**Figure 5. Leading Cause of Child Deaths, NM, 2007-2009**

Leading Cause- Children 0-17 Years of Age	Deaths	Rate	Percent
Certain conditions originating in the perinatal period	213	13.9	23%
Unintentional injuries	175	11.4	19%
Congenital malformations, deformations and chromosomal abnormalities (Congenital disorders)	130	8.5	14%
Homicide	54	3.5	6%
Suicide	54	3.5	6%

**Figure 6. Leading Cause of Child Deaths by Age Group, NM, 2007-2009**

Rank	Age Group				
	0 (N=485, 54%)	1-4 (N=120, 13%)	5-9 (N=59, 7%)	10-14 (N=80, 9%)	15-17 (N=161, 18%)
1	Conditions originating in the perinatal period	Unintentional injuries	Unintentional injuries	Unintentional injuries	Unintentional injuries
2	Congenital malformation, deformation, and chromosomal abnormalities	Congenital malformation, deformation, and chromosomal abnormalities	Neoplasm, malignant	Suicide	Suicide
3	Unintentional injuries	Homicide	Homicide	Neoplasm, malignant	Homicide
4	Homicide	Neoplasm, malignant	Congenital malformation, deformation, and chromosomal abnormalities	Homicide	Neoplasm, malignant
5	Respiratory, Influenza and pneumonia	Respiratory, Influenza and pneumonia	Respiratory, Influenza and pneumonia	Congenital malformation, deformation, and chromosomal abnormalities	Congenital malformation, deformation, and chromosomal abnormalities

## Injury Deaths among Children

(NM Residents, 0-17 Years of Age, 2007-2009)

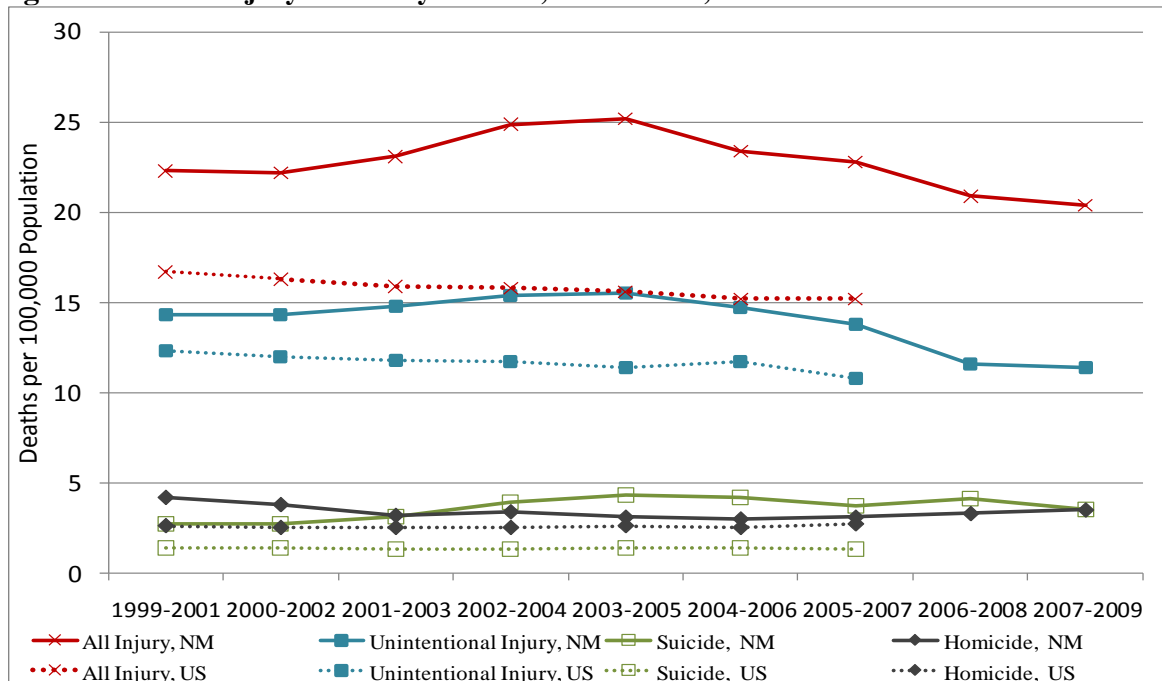
Injury, whether intentional and unintentional, comprised a third of all child deaths in New Mexico in 2007-2009. Suffocation was the leading cause of death accounting for 19% of total injury deaths. Motor vehicle occupant injuries were the second leading cause of death, followed by firearm, poisoning, and drowning.

**Figure 7. Top Five Leading Causes of Child Injury Deaths, NM, 2007-2009**

	Deaths	Rate	Percent
Suffocation	59	3.8	19%
MV - Occupant	54	3.5	17%
Firearm	43	2.8	14%
Poisoning	29	1.9	9%
Drowning	24	1.6	8%

Trend data (1999-2009) indicate that child injury death rates in New Mexico have remained consistently higher than the national rate. In 2005-2007, the injury death rate for New Mexico children was 22.8 per 100,000, approximately 1.5 times higher than the national rate of 15.2 per 100,000. Differences between state and national rates were due to the higher rates of unintentional injury and suicide among children in New Mexico.

**Figure 8. Child Injury Deaths by Manner, NM and US, 1999-2009**



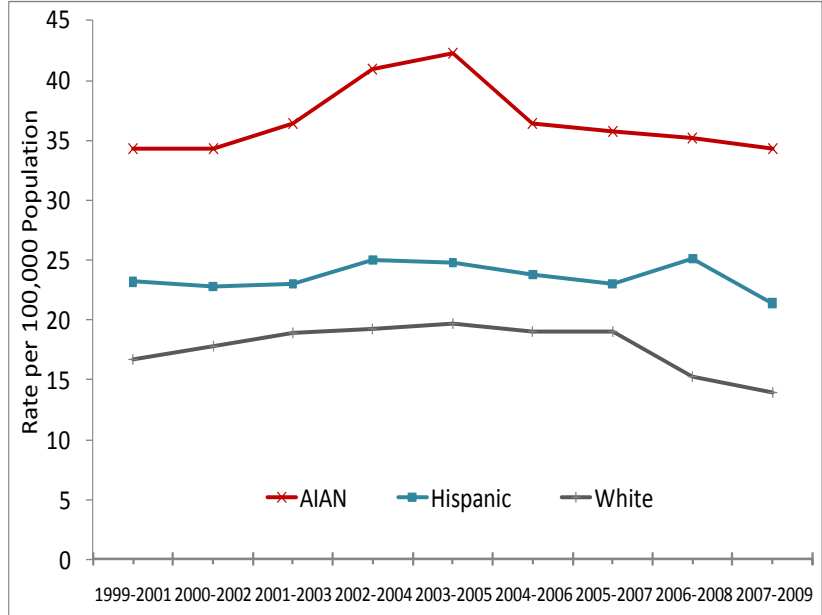
\*Moving average was used to smooth out fluctuation in data.

## Injury Deaths among Children

(NM Residents, 0-17 Years of Age, 2007-2009)

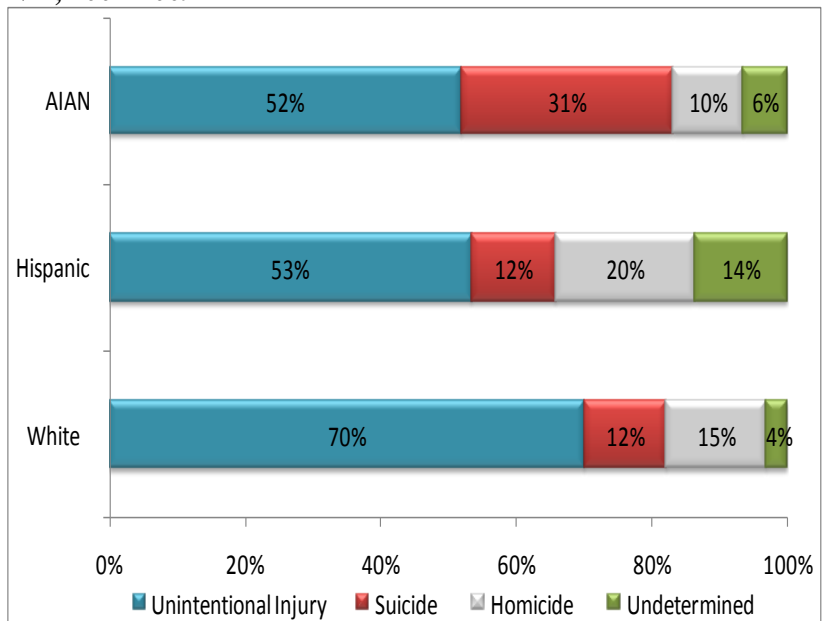
Hispanics, Whites, and American Indians make up approximately 93% of population of children younger than 18 years of age. Among these racial/ethnic groups, injury mortality rates were consistently highest among American Indian children and lowest among White children in the eleven year period (1999-2009).

**Figure 9. Child Injury Deaths by Race/Ethnicity, NM, 1999-2009**



**Figure 10. Child Injury Deaths by Manner and Race/Ethnicity, NM, 2007-2009**

In comparing manner of death, unintentional injury comprised a higher proportion of deaths among White children than among the other racial/ethnic groups in 2007-2009. American Indian children had higher proportion of suicide deaths while Hispanic children had higher proportion of homicides deaths. The injury death rate for American Indian children was 2.5 times higher at 34.3 per 100,000 than for White children at 13.9 per 100,000. The rate for Hispanic children was 21.4 per 100,000.

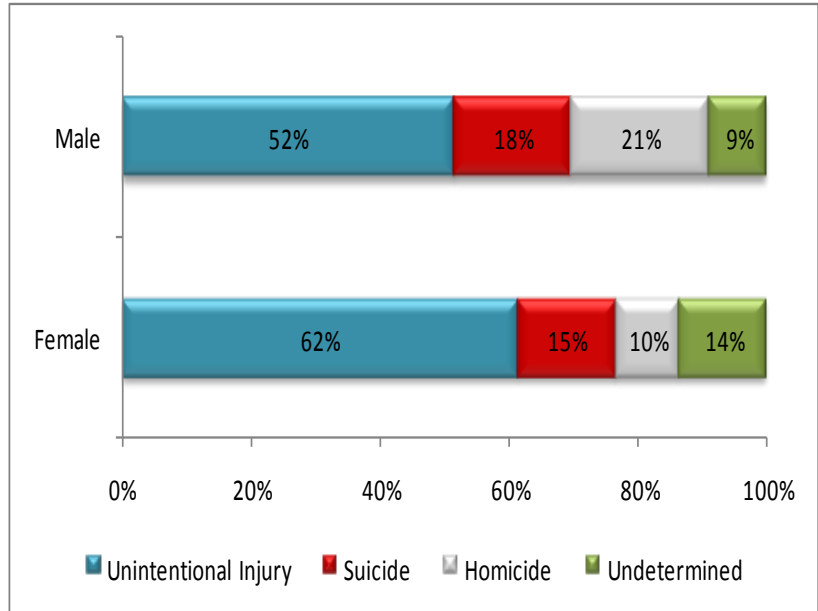


## Injury Deaths among Children

(NM Residents, 0-17 Years of Age, 2007-2009)

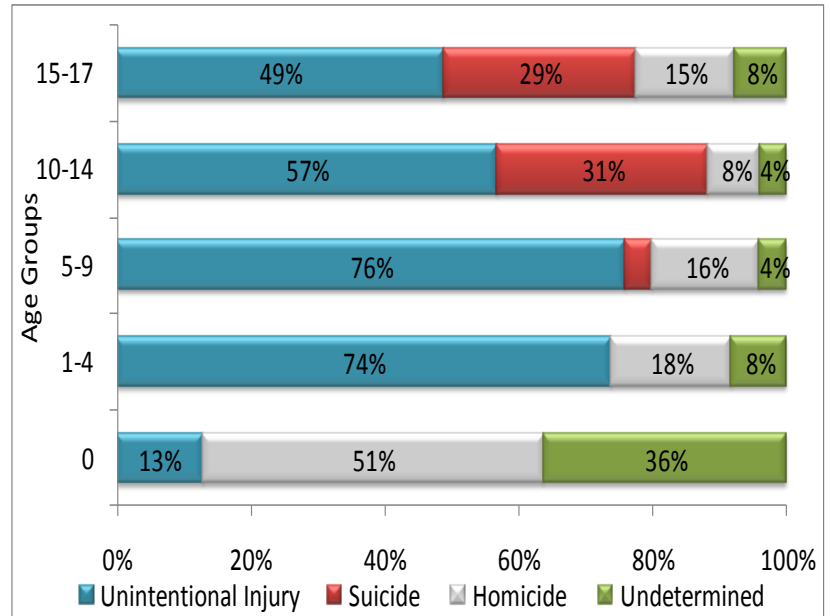
Unintentional injury deaths comprised a higher proportion of total deaths among females while intentional injury deaths (for both homicide and suicide) were higher among males. The injury death rate among male children, aged 0-17 years, was 25.1 per 100,000, approximately 62% higher than the rate among female children (15.5 deaths per 100,000).

**Figure 11. Child Injury Deaths by Manner and Gender, NM, 2007-2009**



Suicides were equal in proportion among the older age groups and homicides (usually resulting from child abuse or neglect) comprised a much higher proportion of total injury deaths among infants than in other age groups. The highest rates of injury deaths were among infants (58.7 per 100,000), followed by children 15-17 years of age (42.6 per 100,000) and children 1-4 years of age (20.3 per 100,000). Children aged 5-9 and 10-14 had the lowest burden of injury death (6.8 and 10.6 per 100,000 respectively).

**Figure 12. Child Injury Deaths by Manner and Age, NM, 2007-2009**

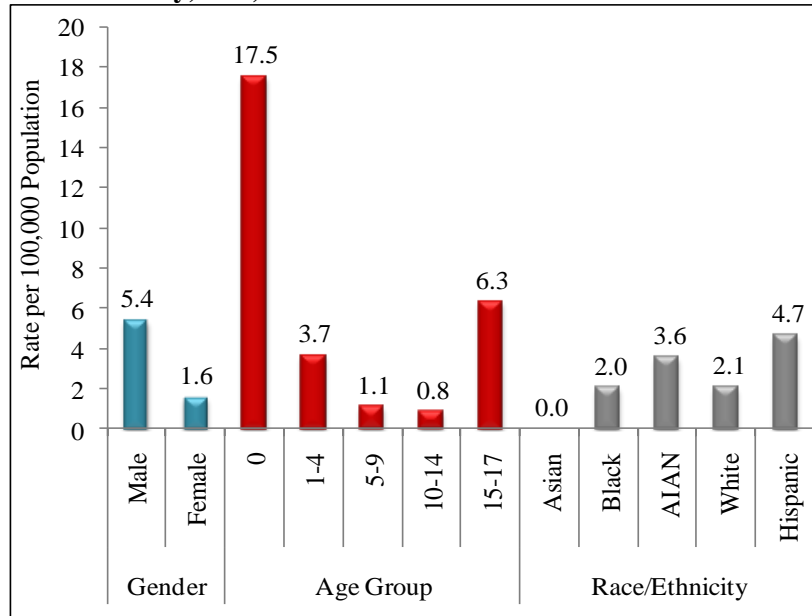


## Intentional Injury Deaths among Children- Homicide

(NM Residents, 0-17 Years of Age, 2007-2009)

**Figure 13. Homicide Deaths by Gender, Age, and Race/Ethnicity, NM, 2007-2009**

During 2007-2009, 54 children died from homicide. Approximately 78% of the fatalities were of male children. At 17.5 deaths per 100,000 population, infants had a significantly higher death rate than did older children. Among infants, males had a slightly higher risk than females. Hispanic children had higher rates of homicide death than children in other racial/ethnic groups. Firearm was the mechanism for homicide in 41% of the cases.



### Child Abuse and Neglect Panel Findings:

Source: CFR Child Abuse and Neglect Panel, 2006-2009.

The Child Abuse and Neglect (CAN) Panel reviewed 23 confirmed or suspected child abuse and neglect deaths, which are defined as homicide deaths by a parent/family member/supervisor. Fourteen of the reviewed cases were homicide, eight were undetermined and one was an accident, according to the official manner of death listed on the death certificate. The panel determined that 21 (91%) of the cases were preventable (i.e. an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death).

- Thirteen of the CAN deaths reviewed were male children and ten were female.
- Twenty-one children were under five years of age.
- Thirteen children were reported to be of Hispanic origin.
- In twenty cases, an act(s) of omission or commission directly caused the death.
- In eleven cases, child abuse was reported to have caused the death of the child and in four cases neglect, negligence or poor/absent supervision caused the death.
- Eleven cases were found to be caused by physical abuse.
- A caregiver or supervisor was found to be responsible for eighteen of the fatalities.
  - Six caregivers had a reported history of child maltreatment.

## Intentional Injury Deaths among Children- Homicide

(NM Residents, 0-17 Years of Age, 2007-2009)

### **Child Abuse and Neglect Panel Findings:**

Source: CFR Child Abuse and Neglect Panel, 2006-2009.

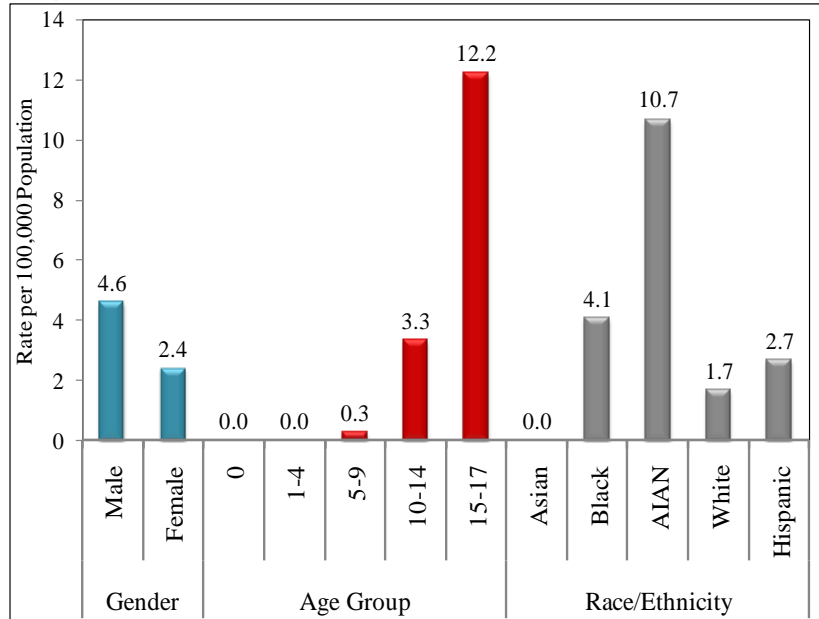
- Biological parents were the largest group of identified perpetrators (12 out of 18 cases).
  - Biological parents who were perpetrators ranged in age from 16 to 33 years.
  - Six were mothers and three were fathers.
  - Four of the parents were either unemployed or stayed at home.
  - An adoptive parent, a step-parent, a mother's partner and two foster parents were found to be responsible for five child deaths.
- In eight cases, the child had a history of prior victimization.
  - Seven were victims of physical abuse and neglect.
  - One child had an open CPS cases at time of death.
- Four children were acutely ill within the two weeks prior to their death.

## Intentional Injury Deaths among Children- Suicide

(NM Residents, 0-17 Years of Age, 2007-2009)

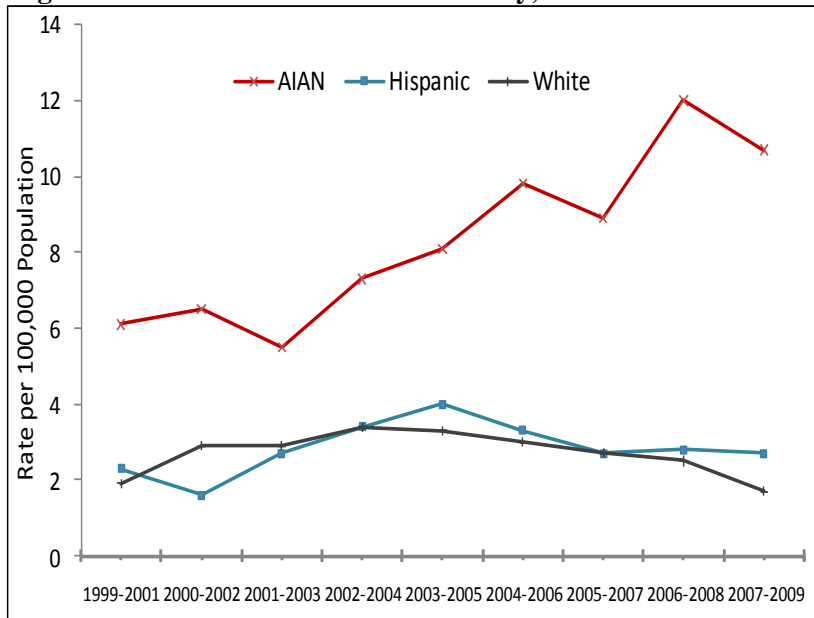
There were 54 suicides of children under 18 years of age. Male children had almost twice the rate at 4.6 per 100,000 than female children at 2.4 per 100,000. Youth from 15 through 17 years of age accounted for 69% of these deaths. American Indian children had the highest suicide rate across all racial/ethnic groups at 10.7 per 100,000. It accounted for approximately 44% of the suicide deaths among children. Hanging (61%) was the leading mechanism for suicide, followed by firearm (24%), and poisoning (6%).

**Figure 14. Suicide Deaths by Gender, Age, and Race/Ethnicity, NM, 2007-2009**



Trend data (1999-2009) for the three major race/ethnic groups in New Mexico reveal that suicide rates among American Indian children have been consistently higher than among Hispanic and White children. This disparity has increased as suicide rates among American Indians have risen while the rates among the other groups have remained fairly constant.

**Figure 15. Suicide Deaths Race/Ethnicity, 1999-2009**



## Intentional Injury Deaths among Children- Suicide

(NM Residents, 0-17 Years of Age, 2007-2009)

### CFR Suicide Panel Findings:

Source: CFR Suicide Panel, 2006, 2007, 2008 and 2009.

The Suicide Panel reviewed 33 records of children less than 18 years of age who died as a result of suicide in 2006-2009. The panel determined that 23 (70%) of the deaths were preventable.

- Twenty-one of the reviewed cases were male children, and twelve were female children.
- Four children were between 12-14 years of age, and twenty nine children were between 15-17 years of age.
- Thirteen children were Hispanic, eleven were White, eight were American Indian children, and one was Black.
- Asphyxia was the leading cause of death (N=20), followed by weapons (N=11) and poisoning (N=2).
- The following chart lists factors associated with the death:

	<b>Deaths</b>
Child talked about suicide	10
Child had history of self-mutilation	8
Suicide was completely unexpected	7
Prior suicide threats were made	7
A note was left	6
Prior suicide attempts were made	5

- Five children had a physical disability or chronic illness that included asthma, seizure disorder, chronic back pain, scoliosis, or hearing problems.
- Ten children had a mental disability such as ADHD, depression or postpartum depression.
- Twelve children had received prior mental health services. Six of these children were still receiving services at the time of death.
- Seven children were on medication for mental illness.
- Thirteen children were known to have a history of substance abuse including alcohol, methamphetamine, opiates, and/or prescription drugs abuse.
  - Eight had a history of alcohol abuse
  - Ten had history of marijuana abuse.
- Nine children had a history of being a victim of child maltreatment (child abuse or neglect) documented in autopsy, law enforcement report or medical records.
  - Three were identified by Child Protective Services as having been a victim of maltreatment.
- Three children had been placed outside of the home prior to the death (i.e. the child had foster parents at a previous time).



## Intentional Injury Deaths among Children- Suicide

(NM Residents, 0-17 Years of Age, 2007-2009)

### CFR Suicide Panel Findings:

Source: CFR Suicide Panel, 2006, 2007, 2008 and 2009.

- Twelve children had a documented history of delinquent or criminal behavior.
  - Nine had a history of assaults and/or drug offences.
- Seven children were known to be home schooled.
- In twenty- one cases, the child was reported to have had problems in school.
  - Seven were known to have academic problems (i.e. where the student’s academic performance was low or declining).
  - Six had behavioral problems such as acting out in class which included disobedience, being disruptive, bullying and/or being bullied.
  - Four had academic and behavioral problems.
  - Four were currently suspended from school or had prior suspensions.
- The following chart lists the frequency of cases a with a recent history of an acute or cumulative personal crisis that may have contributed to the child’s despondency:

	<b>Deaths</b>
School failure	7
Drug/Alcohol use	6
Breakup with boyfriend/girlfriend	5
Argument with parents	4
Argument with boyfriend/girlfriend	3
Suicide by friend/relative	3
Death of friend/relative	3
Move/new school	3
Physical Abuse/Assault	3

- School failure was cited most frequently as a factor that may have contributed to the child’s despondency, followed by drug/alcohol use and then break/up with significant others.

## Unintentional Injury Deaths among Children

(NM Residents, 0-17 Years of Age, 2007-2009)

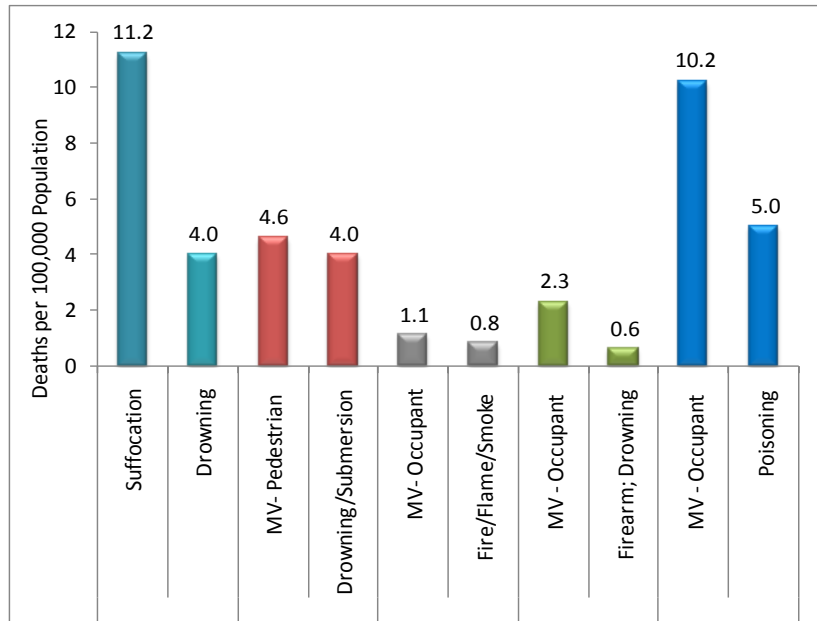
Unintentional injury was the leading cause of death among children 1-17 years of age in New Mexico in 2007-2009. It accounted for 175 child deaths in the three year period. The following charts show the top five leading causes of unintentional injury deaths among children in the three year period. Motor vehicle occupant injuries were the most common cause of unintentional injury deaths in New Mexico and accounted for 31% of the deaths. Drowning, motor vehicle pedestrian, poisoning and suffocation deaths were other major causes of unintentional injury deaths.

**Figure 16. Leading Cause of Unintentional Injury Deaths, NM, 2007-2009**

	Deaths	Rate	Percent
Motor Vehicle- Occupant	54	3.5	31%
Drowning	24	1.6	14%
Motor Vehicle- Pedestrian	20	1.3	11%
Poisoning	19	1.2	11%
Suffocation	17	1.1	10%

**Figure 17. Leading Cause of Death by Age Group, NM, 2007-2009**

Infants under one and 15-17 year olds had the highest rates of unintentional injury. Leading cause of unintentional injury mortality differed by age group. Suffocation was the leading cause of infant mortality while motor-vehicle pedestrian was the principal cause of death among children 1-4 years of age. Motor vehicle occupant deaths were the leading cause of death for children 5-17 years of age. However, adolescents 15-17 years had a much higher motor vehicle occupant death rate than children in other age groups.



## Unintentional Injury Deaths among Children– Transportation (NM Residents, 0-17 Years of Age, 2007-2009)

There were 91 child deaths from unintentional transportation related injuries in New Mexico in 2007-2009. Motor vehicle traffic deaths, which are defined as vehicle fatalities occurring on a public highway, accounted for 92% (N=84) of the transportation fatalities.

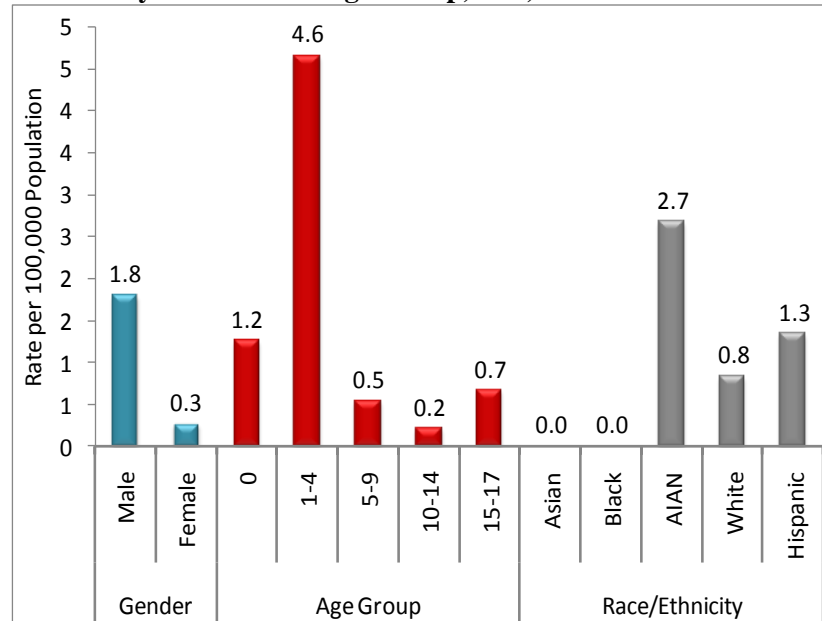
Motor vehicle occupant deaths were the most common and accounted for 59% of transportation deaths and 17% of total injury deaths among children. Nineteen pedestrians died in motor vehicle traffic- related incidents and one died in a non-traffic environment such as a driveway or private property. There were also three deaths resulting from the use of All-Terrain Vehicles (ATVs).

**Figure 18. Motor Vehicle Related Deaths by Type, NM, 2007-2009**

Motor Vehicle Traffic	2007	2008	2009	Total	Rate	Percent
Occupant	20	15	19	54	3.5	59%
Motorcyclist		2		2	0.1	2%
Pedal Cyclist	1			1	0.1	1%
Pedestrian	7	7	5	19	1.2	21%
Other and Unspecified	2	2	4	8	0.5	9%
<b>Motor Vehicle Non-Traffic</b>						
Pedestrian			1	1	0.1	1%
All Terrain Vehicles		2	1	3	0.2	3%
Other and Unspecified	2	1		3	0.2	3%
<b>Total</b>	<b>32</b>	<b>29</b>	<b>30</b>	<b>91</b>	<b>5.9</b>	<b>100%</b>

**Figure 19. Motor Vehicle Pedestrian Traffic and Non-Traffic Deaths by Manner and Age Group, NM, 2007-2009**

Pedestrians accounted for nearly a quarter of all motor vehicle related fatalities among children. Approximately 88% of the pedestrian fatalities were male children. Rates were highest among children 1-4 years of age than among other age groups. The pedestrian fatality rate for American Indians was two times higher than for Hispanics and three times higher than for Whites.

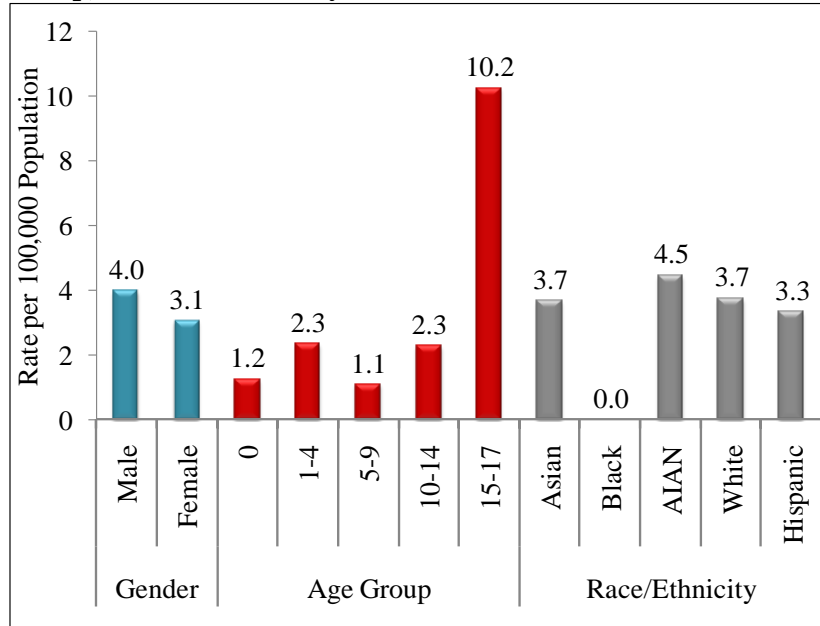


## Unintentional Injury Deaths among Children– Transportation

(NM Residents, 0-17 Years of Age, 2007-2009)

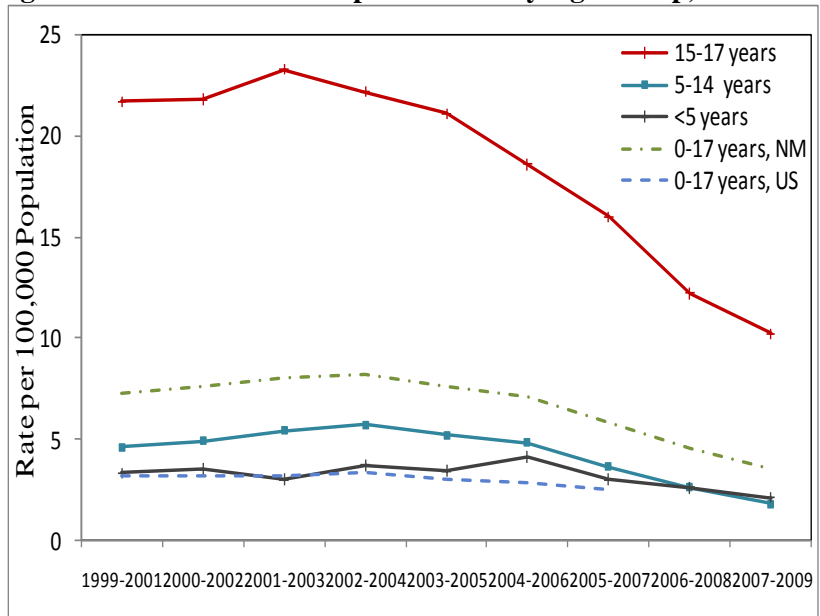
In New Mexico, 54 children died as either passengers or drivers in motor vehicle crashes in 2007-2009. Adolescents aged 15-17 had the highest motor vehicle occupant death rate at 10.2 per 100,000 population.

**Figure 20. MV Traffic Occupant Deaths by Gender, Age Group, and Race/Ethnicity**



Although the MV traffic occupant death rate was five times higher among adolescents 15-17 year of age than among children 0-14 years of age in 2007-2009, trend data show that the rate disparity between the two age groups has decreased significantly in the last eleven years. The reduction in fatalities among 15-17 year olds may be attributable to New Mexico's graduated driver licensing law, which took effect in 2000. Trend data also show that NM rates have been approximately twice as high as national rates.

**Figure 21. MV Traffic Occupant Deaths by Age Group, 1999-2009**



## Unintentional Injury Deaths among Children– Transportation

(NM Residents, 0-17 Years of Age)

### CFR Transportation Panel Key Findings:

Source: CFR Transportation Panel 2006, 2007, and 2008.

The Transportation Panel conducted in-depth case reviews of 77 motor vehicle-related deaths of children that occurred in the state during 2006 through 2008. The panel found that 59 of these deaths were preventable.

- Forty-four reviewed cases were male, and thirty three were female.
- Thirteen deaths were children less than five years of age, twenty-four deaths were children 5-14 years of age, and forty deaths were 15-17 years of age.
- Thirty-three of the reviewed deaths were White, twenty-nine were Hispanic, and eleven were American Indian. Four children’s race/ethnicity was not reported.
- The following chart lists the type of vehicle the child was riding in or on at time of the incident:

	<b>Deaths</b>	<b>Percent</b>
Car	22	29%
Truck	17	22%
Sports Utility Vehicle (SUV)	14	18%
Van	4	5%
Semi/tractor trailer	1	1%
Motorcycle	1	1%
All terrain vehicle	3	4%
Bicycle	1	1%
Pedestrian	14	18%
Total	77	100%

- Of the fourteen pedestrian fatalities that were reviewed by the panel, six occurred on city streets and four occurred on driveways.
- Motor vehicle occupants (car, trucks, SUV, and van) accounted for 57 deaths.
  - Nineteen MV occupant fatalities occurred on NM highways.
  - Twenty-three occurred on rural roads; five of which were reported as highways.
  - Forty-three of the deaths occurred under normal driving conditions.
  - Inadequate lighting, wet conditions, and/or snow were also listed as factors in seven fatalities.
  - Of the thirty cases in which number of vehicles in the crash were reported, the majority (N=17) were single car crashes. Ten fatalities involved two cars, and three fatalities involved three or more cars.
  - In twenty-three cases, the shoulder belt was reported as being present but was not being used.
  - In three cases, a child seat was needed but was not present, and in two cases the child seat was present but was not being used or was being used incorrectly.
  - A booster seat was reported to be needed but was not present in one fatality.

## Unintentional Injury Deaths among Children– Transportation (NM Residents, 0-17 Years of Age)

### CFR Transportation Panel Key Findings:

Source: CFR Transportation Panel 2006, 2007, and 2008.

- The following chart lists the most frequently reported causes for all of the reviewed transportation fatalities as well as causes of death for child drivers of cars, trucks, SUVs, or vans:

Cause*	All Child Deaths* <sup>1</sup>	Percent	Child Driver Deaths* <sup>2</sup>	Percent
Drug or alcohol use	25	32%	6	46%
Speeding over limit	24	31%	7	54%
Recklessness	21	27%	3	23%
Rollover	16	21%	5	38%
Driver distraction/inattentions	9	12%	1	8%
Driver inexperience	8	10%	1	8%
Total Deaths	77		13	

Note: \*<sup>1</sup> Several factors could have contributed to cause of incident; \*<sup>2</sup> Drivers of cars, trucks, SUVs or vans.

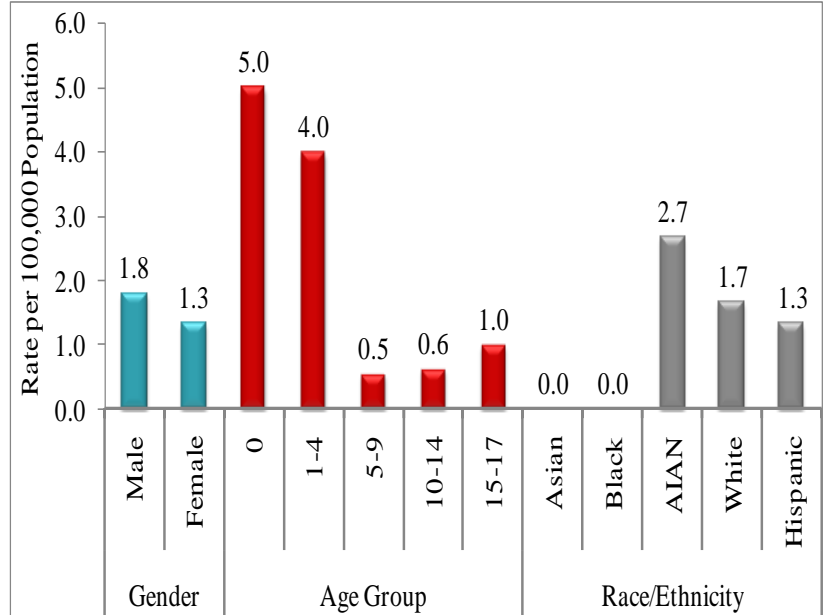
- Among all transportation related child deaths, drug and alcohol use, speeding over the limit, and recklessness were most frequently reported as the contributing causes of the incidents.
- Speeding over the limit and drug/alcohol use were noted as a contributing factor in 54% and 46% respectively, of the deaths that involved child drivers.
- In 32 cases, the child's driver was responsible for causing the incident.
  - In 11 cases, the child's driver was alcohol/drug impaired.
- In 11 of the 13 cases involving child drivers (of cars, trucks, SUVs and vans) the child was responsible for causing the incident.

## Unintentional Injury Deaths among Children– Drownings

(NM Residents, 0-17 Years of Age)

There were 24 unintentional drowning deaths among New Mexican children in 2007-2009. Males accounted for a slightly higher rate than females. Children younger than five years of age and American Indian children were most at risk of drowning.

**Figure 22. Drowning Deaths by Gender, Age, and Race/Ethnicity**



Among children under one year of age, three of the four fatalities occurred in bathtubs. Swimming pools and natural waters (such as rivers and lakes) were the setting for a majority of drowning cases for children 1-17 years of age.

**Figure 23. Drowning Deaths by Place of Occurrence**

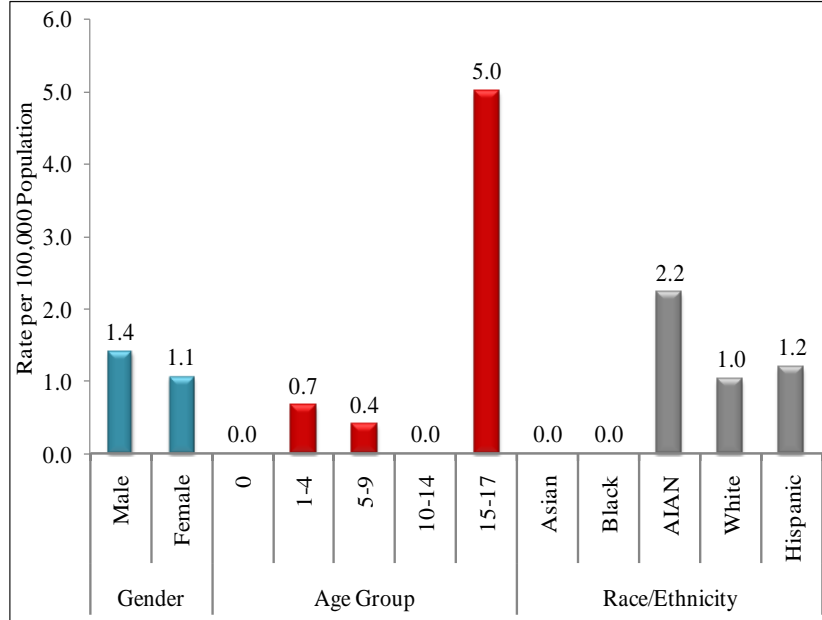
	Age 0 (Infants)	Ages 1-17	Total	Percent
While in bathtub	3	1	4	17%
While in swimming pool	1	5	6	25%
Following fall into swimming pool		1	1	4%
While in natural water		6	6	25%
Other specified		2	2	8%
Other unspecified		5	5	21%
<b>Total</b>	4	20	24	100%

## Unintentional Injury Deaths among Children– Poisoning

(NM Residents, 0-17 Years of Age, 2007-2009)

Nineteen children, including eleven males and eight females, died from unintentional poisoning. Approximately 80% of the deaths were among 15-17 year olds. Unintentional poisoning was higher among the American Indian population than among other racial/ethnic groups.

**Figure 24. Poisoning Deaths by Gender, Age, and Race/Ethnicity**



The majority of unintentional poisoning deaths among children were due to prescription, over-the-counter, or illegal drugs. Narcotics and psychodysleptics including heroin, methadone, cocaine, and cannabis accounted for almost half of the poisoning deaths among 15-17 year olds.

**Figure 25. Unintentional Poisoning Deaths by Primary Cause**

	Ages 1-9	Ages 15-17	Total	Percent
Antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs	1	1	2	11%
Narcotics and psychodysleptics		7	7	37%
Other and unspecified drugs, medicaments and biological substances	1	4	5	26%
Alcohol		3	3	16%
Organic solvent and hydrocarbons	1		1	5%
Other gases and vapors	1		1	5%
<b>Total</b>	<b>4</b>	<b>15</b>	<b>19</b>	<b>100%</b>

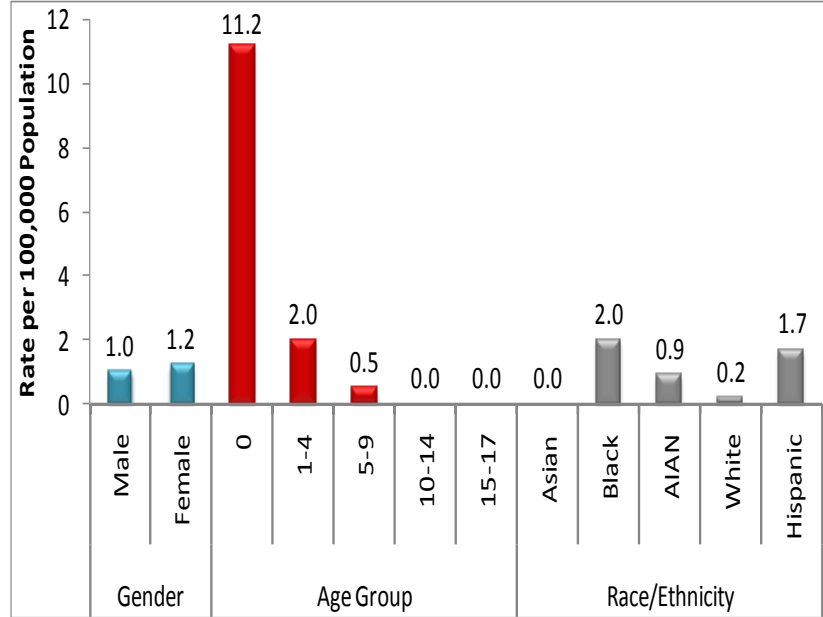


## Unintentional Injury Deaths among Children– Suffocation

(NM Residents, 0-17 Years of Age, 2007-2009)

Seventeen children died from unintentional suffocation in 2007-2009. More than half of the deaths were children under one year of age. Among the infant deaths, approximately 67% were considered ‘accidental suffocations in bed’ (i.e. suffocation by a mother’s body or by linen or pillow). Inhalation and ingestion of food/object causing obstruction of respiratory tract resulted in two infant deaths and three deaths among children 1-9 years of age.

**Figure 26. Suffocation by Gender, Age, and Race/Ethnicity**



## Natural Deaths among Infants– Sudden Unexpected Infant Deaths

(NM Residents, Under One Year of Age, 2007-2009)

### CFR BSS Panel Findings:

Source: CFR Transportation Panel 2006, 2007, 2008, and 2009.

The Broader Spectrum Panel reviewed 47 infant deaths that were reported by the OMI as due to Sudden Infant Death Syndrome (SIDS).

- Seventeen infants who were found to have died of SIDS were exposed to second hand smoke either frequently or occasionally.
- Two infants had a history of seizures and two others had a history of apnea.
- The panel found that 44 deaths were related to sleeping or the sleep environment.
- In four cases the room where the infant was sleeping was reported as too hot and in one case there was too much bedding.
- The following chart lists the place where the infant was asleep at the time of incident:

Incident Sleep Place	Deaths	Percent
Adult bed	22	47%
Crib	12	26%
Bassinette	5	11%
Floor	2	4%
Other	3	6%
Unknown	3	6%
Total	47	100%

- Adult bed was the reported most frequently as the incident sleep place.
- The following chart lists the position in which an infant was put to sleep in and the position the infant was found in at time of the incident:

Position	Child put to sleep:	Child found:
On back	15	9
On stomach	15	19
On side	8	5
Unknown	9	14
Total	47	47

- Infants were most frequently reported to be put to sleep on their backs or on their stomachs.
- Infants were most frequently found to be sleeping on their stomach at time of incident.
- In nine cases, the child's airway was reported to be partially or fully obstructed.
- Seventeen children were sleeping on the same surface with an adult at the time of incident.

## Conclusion

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The goal of the child fatality review process is to understand how children are dying in New Mexico and to make recommendations for program, system and policy improvements to prevent future child injuries and deaths. With this goal in mind, in 2010 the CFR panels (BSS, CAN, Suicide, and Transportation) reviewed 262 deaths of children and young people between 0 through 17 years of age that occurred in New Mexico in 2006-2009. With information garnered in the reviews, the panels determined that many of these deaths could have been prevented and made recommendations for preventive measures. The prevention recommendations were presented to the NM Child Fatality Review Advisory Board in December, 2010.

The New Mexico Department of Health Epidemiology and Response Division will continue to collect, analyze and disseminate information about child deaths and injuries in various publications and studies. The Child Fatality Review program will monitor progress on implementation of the Advisory Board's recommendations and other initiatives to reduce child deaths. It will also continue to collaborate with various state agencies and other organizations to help reduce the number of child deaths through prevention, risk reduction, and identification of protective factors, and system improvements.

## Child Fatality Review Panel Recommendations

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### Priority Recommendations

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(The following is the top priority because of the evidence and the number of lives lost and injuries. It is also one of the top priorities of the Advisory Board)

1. Reduce child deaths by reducing driving while under the influence of alcohol:
  - Enact legislation to strengthen New Mexico's zero tolerance limits for driving while intoxicated (e.g., lower the threshold from 0.02 g/dL to the 0.00 g/dL threshold used in neighboring states Arizona, Oklahoma, Texas, and Utah).
  - Expand the use of evidence-based underage drinking prevention programs that educate youth about the dangers of riding with a driver who is drinking or under the influence of alcohol.
  - Implement and enforce local social host ordinances to reduce social availability of alcohol to youth. This emerging and promising strategy can reduce social provision of alcohol to minors, particularly in the context of underage drinking parties. In 2009, almost 60% of underage drinkers in New Mexico reported usually receiving their alcohol from a social source; and 60% reported 'another person's home' as their usual drinking location (YRRS).
  - Increase the price of alcohol. According to the latest available estimates (Community Guide), a 10% increase in price results in a 7% decrease in consumption; and there is evidence that such price increases disproportionately impact young drinkers. Reducing binge drinking by youth can be expected to reduce not only alcohol-related motor vehicle crash injury and death, but a range of other negative outcomes of binge drinking, including suicide, homicide, assaults, and fighting, and high-risk sexual activity. Of the 49,318 crashes in New Mexico in 2006, 2,698 (5.5%) involved alcohol.
  - Of the 49,318 crashes in New Mexico in 2006, 2,698 (5.5%) involved alcohol. However, among fatal crashes, alcohol was involved 42% of the time. Among fatalities involving child drivers in the 2006-2008 cases studies, 36% were impaired by alcohol or other drugs; 50% did not use shoulder belts or used them incorrectly; and 22% were violating graduated drivers licensing laws.

## Child Fatality Review Panel Recommendations

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2. Require education on safe sleep guidelines in clinical settings, in spiritual communities, day care centers, shelters, WIC program offices, and social services agencies. Include distribution and showing of DVDs and brochures such as “Back to Sleep”, “Never Shake a Baby” and “Safe Sleep”.
  - Known risk factors for SIDS include: (Mayo Clinic web site).
    - i. Boy babies are more likely to die of SIDS than girl babies.
    - ii. Infants are most vulnerable during the second and third months of life.
    - iii. Premature and low-birth-weight infants are more susceptible to SIDS than full-term, normal-weight babies.
    - iv. Black and American Indian infants are at greater risk of SIDS.
    - v. Babies who are not placed on their backs to sleep are at higher risk.
    - vi. Babies with drug-using mothers (including tobacco) are at increased risk of SIDS death.
    - vii. Presence of environmental tobacco smoke contributes to risk.
    - viii. Most SIDS deaths occur when the weather is cooler.
    - ix. Evidence suggests that babies who are too warm are at higher risk of SIDS
  - Risk factors for other Sudden Unexpected Infant deaths include sharing sleep surfaces with adults and having soft objects and loose bedding in beds with infants. (Mayo Clinic web site)
  - Case reviews and death data show that babies died due to traumatic brain injury from being shaken.

*Level of evidence - the above recommendation is considered to be promising.*

3. Develop and fund a statewide safety poster project to report and prevent child abuse and neglect.
  - These posters would have pull-off tabs with telephone numbers for the following organizations:
    - i. Child Protective Services to report suspected abuse/neglect, a Child Abuse Crisis line organization for parents to call if they can't cope and need to talk to someone, from a domestic violence organization.
  - These posters would be posted in places that are frequented by young mothers, families, and non-related caretakers.

*Level of evidence – the above recommendation is considered to be promising.*

## Child Fatality Review Panel Recommendations

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4. Implement suicide prevention training for school teachers, all staff, coaches and parents of students in Bureau of Indian Education schools, require that all BIE schools have a crisis intervention plan and post-intervention plan and provide related training to all school, staff, parents, and the community on the QPR (Question/Persuade/Refer) model.
  - From 2007 through 2009, the suicide death rate for Americans Indians in New Mexico was more than 2.5 times higher than for the second highest racial/ethnic group, and more than six times higher than the suicide death rate for Non-Hispanic Whites.
  - At least a third of youth suicides are preceded by warnings of possible suicide attempts.

*Level of evidence - the above recommendation is considered to be promising.*

5. Enact a statewide law prohibiting use of hand-held cell phone use and texting while driving.
  - Crash deaths due to distractions have increased with the increase in the use of cell phones. Legislation enacting texting bans should be paired with effective enforcement to deter drivers from the use of handheld devices while driving. (American Journal of Public Health, Vol. 100, No.11, 2010)
  - Inexperienced drivers are especially vulnerable to distraction such as use of cell phones for talking and texting.
  - A study conducted in 2006 concluded that "...the impairments associated with using a cell phone while driving can be as profound as those associated with driving drunk." ( Human Factors, Vol. 48,No.2, 2006)
  - The use of hand-held phones by drivers is illegal in most European Union countries, in all Australian states, and in the Canadian province of Newfoundland. In the US, use of hand-held phones is not permitted in Connecticut, New Jersey, New York, and the District of Columbia. (Driver Distraction: A review of the Current State of Knowledge, National Highway Traffic Safety Administration, April, 2008)
  - The National Safety Council estimated in January, 2010 that at least 1.6 million crashes are caused each year by drivers using cell phones and texting. In addition, it found that 28% of crashes are caused by drivers using their cell phones. (National Safety Council)

*Level of evidence- the above recommendation is considered to be evidence-based.*

## Child Fatality Review Panel Recommendations

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6. Base Infant Home Visiting Programs contracted by the Children, Youth, and Families Department on models that have been demonstrated to be effective, and conduct professional fidelity and outcome evaluation of those programs. Ensure that these include comprehensive injury prevention.
  - Home Visiting Programs, especially models based on nurse visits to homes of young mothers, have been demonstrated to improve health and social outcomes of infants.

*Level of evidence- the above recommendation is considered to be evidence-based.*

7. Provide mandated professional reporters of child abuse/neglect opportunity to discuss their referrals with a Child Protective Services supervisor prior to the “screen-out” process.
  - Some reporters are concerned that their cases are screened out without sufficient investigation to fully determine whether it is appropriate to screen them out. More communication may result in more cases being investigated more fully, thereby preventing more incidents of abuse and neglect.

*Level of evidence - the above recommendation is considered to be promising.*

8. Encourage high schools with a 30% or more population of American Indian students to provide suicide prevention activities and training that are culturally appropriate to students, staff, and parents.

*Level of evidence - the above recommendation is considered to be promising.*

## Additional Recommendations

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### **Broader Spectrum Panel**

1. Expand substance abuse prevention efforts.
2. Promote gun safety to prevent accidental child deaths involving firearms.
  - Promote use of trigger locks and provide associated training.
  - Promote use of gun safes and provide associated training.
  - Several studies found that keeping a gun locked, unloaded, storing ammunition locked, and in a separate location each had a protective effect. (JAMA, 2005, Feb 9; 293(6):707-14).

## Child Fatality Review Panel Recommendations

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3. Establish a program to ensure that all families with infants have access to cribs and appropriate training in safe child sleep practices.
  - A promising model of Cribs for Kids has demonstrated that the rate of deaths occurring in sleep settings can be reduced through the use of cribs and associated training.

### **Child Abuse and Neglect Panel**

4. In cases of “non-accidental trauma” to children, involve medical professionals and law enforcement personnel in the review of safety plans.
  - Some medical professionals believe that safety plans would be improved, and additional abuse would be prevented if more professionals were involved in finalizing safety plans.
5. Increase taxes on firearms and ammunition to help fund a statewide safety campaign addressing gun safety in homes where children may be present.
6. Establish a state registry of convicted child abusers, similar to the registry of child sex offenders. Require that gun locks be provided with all guns sold in NM.

### **Suicide Panel**

7. Establish school-based programs for the lesbian, gay, bisexual and transgender population.
8. Encourage New Mexico news organizations to use guidelines provided by the Suicide Prevention Resource Center when reporting suicides and reporting about issues related to suicide.
9. Develop culturally appropriate crisis teams to attempt to prevent suicide clusters through grief counseling.



## Child Fatality Review Panel Recommendations

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### **Transportation Panel**

10. Strengthen New Mexico's graduated licensing law to bring it into full compliance with standards recommended by the Insurance Institute for Highway Safety (e.g., increase the minimum "learner stage" age from 15 to 16; increase the minimum "intermediate stage" age for driving while unsupervised from 15 years, 6 months to 16 years, 6 months; expand the hours during which unsupervised driving is prohibited, from midnight-5 am to 9/10 pm-5 am; and increase the minimum age at which nighttime driving and passenger restrictions can be lifted, from 16 years, 6 months to 18 years).
11. Increase enforcement of traffic laws, including speeding laws, reckless driving laws, minimum legal drinking age laws and laws requiring use of adult and child occupant restraints.
12. Conduct child passenger safety training in the police, fire, and emergency medical services academies.
13. Improve primary care physicians', pediatricians', and other health care providers' advice to parents about the proper selection and use of care seats and booster seats.

## Acknowledgments

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The New Mexico Department of Health wishes to acknowledge and express appreciation to the members of the Broader Spectrum/SIDS panel, Child Abuse and Neglect panel, Suicide Panel, Transportation panel, and the CFR Advisory Board who have volunteered their time and expertise to reduce the incidence and severity of child injury in New Mexico. Appreciation is also extended to the New Mexico Office of Medical Investigator, the New Mexico Bureau of Vital Records and Health Statistics, and the New Mexico's Indicator-Based Information System (NM-IBIS) for death data used in the CFR investigations and in this report.

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- Sarah Lathrop, Associate Professor of Pathology, UMNHSC & OMI Epidemiologist
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- Michelle Garcia, Chief of Staff, NM Attorney General's Office
- Renee Ornelas, Medical Director of Para Los Ninos, UNM School of Medicine

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- Leslie Strickler, Physician, Child Abuse Response Team, University of New Mexico Hospital
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- Rena Brown, Executive Director, NM Family Network

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- Lisa Trabaldo, Deputy District Attorney, Crimes against Children, Office of the District Attorney, 2<sup>nd</sup> District
- Terese Yanan, Executive Director, Dine Protection and Advocacy, Native American Disabilities Law Center

## Appendix A

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Note: Rate = Injury Death Rates based on 100,000 population.  
 Rates based on small numbers of deaths may not be statistically reliable.

### 1. Deaths by Gender, Age Group, and Race/Ethnicity, NM, 2007-2009

<b>N=907</b>		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	527	67.5
	Female	380	50.4
<b>Age Group</b>	0	487	608.5
	1-4	120	39.9
	5-9	59	16.0
	10-14	80	16.6
	15-17	161	53.2
<b>Race/Ethnicity</b>	Asian	8	29.4
	Black	31	62.9
	AIAN	170	75.7
	White	205	42.6
	Hispanic	491	65.3

(Figure 3)

### 2. Homicide Deaths by Gender, Age Group, and Race/Ethnicity, NM, 2007-2009

<b>N=54</b>		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	42	5.4
	Female	12	1.6
<b>Age Group</b>	0	14	17.5
	1-4	11	3.7
	5-9	4	1.1
	10-14	4	0.8
	15-17	19	6.3
<b>Race/Ethnicity</b>	Asian	0	0.0
	Black	1	2.0
	AIAN	8	3.6
	White	10	2.1
	Hispanic	35	4.7

(Figure 13)

Appendix A

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**3. Homicide Deaths by County, NM, 2007-2009**

<b>County</b>	<b>Deaths</b>	<b>Rate</b>
<b>Bernalillo</b>	14	3.2
<b>Colfax</b>	1	10.4
<b>Dona Ana</b>	5	3.1
<b>Eddy</b>	1	2.5
<b>Grant</b>	2	9.0
<b>Lea</b>	3	6.3
<b>Luna</b>	2	8.0
<b>McKinley</b>	3	3.6
<b>Otero</b>	3	5.4
<b>Quay</b>	1	16.1
<b>Rio Arriba</b>	2	5.8
<b>Roosevelt</b>	2	13.8
<b>Sandoval</b>	2	1.9
<b>San Juan</b>	5	5.1
<b>San Miguel</b>	1	4.4
<b>Santa Fe</b>	1	1.1
<b>Socorro</b>	2	13.5
<b>Valencia</b>	4	5.9

**4. Suicide Deaths by Gender, Age Group, and Race/Ethnicity, NM, 2007-2009**

<b>N=54</b>		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	36	4.6
	Female	18	2.4
<b>Age Group</b>	0	0	0.0
	1-4	0	0.0
	5-9	1	0.3
	10-14	16	3.3
	15-17	37	12.2
<b>Race/Ethnicity</b>	Asian	0	0.0
	Black	2	4.1
	AIAN	24	10.7
	White	8	1.7
	Hispanic	20	2.7

(Figure 14)

Appendix A

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**5. Suicide Deaths by County, NM, 2007-2009**

<b>County</b>	<b>Deaths</b>	<b>Rate</b>
<b>Bernalillo</b>	15	3.5
<b>Chaves</b>	3	6.1
<b>Cibola</b>	2	9.4
<b>Dona Ana</b>	4	2.5
<b>Eddy</b>	1	2.5
<b>Lincoln</b>	1	6.8
<b>McKinley</b>	6	7.1
<b>Otero</b>	3	5.4
<b>Rio Arriba</b>	4	11.5
<b>Sandoval</b>	1	1.0
<b>San Juan</b>	12	12.3
<b>Santa Fe</b>	1	1.1
<b>Valencia</b>	1	1.5

**6. Unintentional Injury Deaths: Leading Cause by Age Group, NM, 2007-2009**

<b>Age Groups</b>	<b>Cause</b>	<b>Deaths</b>	<b>Rate</b>
<b>0</b>	Suffocation	9	11.2
	Drowning	5	4
<b>1-4</b>	MV- Pedestrian	14	4.6
	Drowning/Submersion	12	4.0
<b>5-9</b>	MV- Occupant	4	1.1
	Fire/Flame/Smoke	3	0.8
<b>10-14</b>	MV - Occupant	11	2.3
	Firearm; Drowning	9	0.6
<b>15-17</b>	MV - Occupant	31	10.2
	Poisoning	15	5.0

(Figure 17)

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**7. Unintentional Injury Deaths: Motor Vehicle Pedestrian Traffic and Non-Traffic Deaths by Gender, Age Group, and Race/Ethnicity, NM, 2007-2009**

<b>N=20</b>		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	14	1.8
	Female	2	0.3
<b>Age Group</b>	0	1	1.2
	1-4	14	4.6
	5-9	2	0.5
	10-14	1	0.2
	15-17	2	0.7
<b>Race/Ethnicity</b>	Asian	0	0.0
	Black	0	0.0
	AIAN	6	2.7
	White	4	0.8
	Hispanic	10	1.3

(Figure 19)

**8. Unintentional Injury Deaths: MV Traffic Occupant Deaths by Gender, Age Group, and Race/Ethnicity, NM, 2007-2009**

<b>N=54</b>		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	31	4.0
	Female	23	3.1
<b>Age Group</b>	0	1	1.2
	1-4	7	2.3
	5-9	4	1.1
	10-14	11	2.3
	15-17	31	10.2
<b>Race/Ethnicity</b>	Asian	1	3.7
	Black	0	0.0
	AIAN	10	4.5
	White	18	3.7
	Hispanic	25	3.3

(Figure 20)



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**9. Unintentional Injury Deaths: Drowning Deaths by Gender, Age Group, and Race/Ethnicity, NM, 2007-2009**

<b>N=24</b>		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	8	1.8
	Female	4	1.3
<b>Age Group</b>	0	4	5.0
	1-4	12	4.0
	5-9	2	0.5
	10-14	3	0.6
	15-17	3	1.0
<b>Race/Ethnicity</b>	Asian	0	0.0
	Black	0	0.0
	AIAN	6	2.7
	White	8	1.7
	Hispanic	10	1.3

(Figure 22)

**10. Unintentional Injury Deaths: Poisoning Deaths by Gender, Age Group, and Race/Ethnicity, NM, 2007-2009**

<b>N=19</b>		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	11	1.4
	Female	8	1.1
<b>Age Group</b>	0	0	0.0
	1-4	2	0.7
	5-9	2	0.4
	10-14	0	0.0
	15-17	15	5.0
<b>Race/Ethnicity</b>	Asian	0	0.0
	Black	0	0.0
	AIAN	5	2.2
	White	5	1.0
	Hispanic	9	1.2

(Figure 24)

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**11. Unintentional Injury Deaths: Suffocation by Gender, Age Group, and Race/Ethnicity, NM, 2007-2009**

<b>N=17</b>		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	8	1.0
	Female	9	1.2
<b>Age Group</b>	0	9	11.2
	1-4	6	2.0
	5-9	2	0.5
	10-14	0	0.0
	15-17	0	0.0
<b>Race/Ethnicity</b>	Asian	0	0.0
	Black	1	2.0
	AIAN	2	0.9
	White	1	0.2
	Hispanic	13	1.7

(Figure 26)

**12. Unintentional Injury Deaths: Fire Deaths by Gender, Age Group and Race/Ethnicity, NM, 2007-2009**

<b>N=5</b>		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	3	0.4
	Female	2	0.3
<b>Age Group</b>	0	1	1.2
	1-4	1	0.3
	5-9	3	0.8
	10-14	0	0.0
	15-17	0	0.0
<b>Race/Ethnicity</b>	Asian	1	1.2
	Black	0	0.0
	AIAN	0	0.0
	White	2	0.8
	Hispanic	2	1.3

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**13. Unintentional Injury Deaths: Firearm Deaths by Gender, Age Group and Race/Ethnicity, NM, 2007-2009**

		<b>Deaths</b>	<b>Rate</b>
<b>Gender</b>	Male	4	0.5
	Female	1	0.1
<b>Age Group</b>	0	0	0.0
	1-4	1	0.3
	5-9	1	0.3
	10-14	3	0.6
	15-17	0	0.0
<b>Race/Ethnicity</b>	AIAN	2	0.9
	White	1	0.2
	Hispanic	3	0.3

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## 14. Unintentional Injury Deaths by County

<b>County</b>	<b>Deaths</b>	<b>Rate</b>
<b>Bernalillo</b>	31	7.2
<b>Chaves</b>	7	14.2
<b>Cibola</b>	4	18.8
<b>Colfax</b>	2	20.8
<b>Curry</b>	4	11.0
<b>De Baca</b>	1	72.7
<b>Dona Ana</b>	15	9.3
<b>Eddy</b>	7	17.2
<b>Grant</b>	2	9.0
<b>Lea</b>	9	19.0
<b>Lincoln</b>	2	13.6
<b>Los Alamos</b>	2	15.5
<b>Luna</b>	4	16.1
<b>McKinley</b>	11	13.0
<b>Mora</b>	1	27.8
<b>Otero</b>	2	3.6
<b>Quay</b>	2	32.2
<b>Rio Arriba</b>	5	14.4
<b>Roosevelt</b>	1	6.9
<b>Sandoval</b>	9	8.7
<b>San Juan</b>	26	26.7
<b>San Miguel</b>	3	13.1
<b>Santa Fe</b>	13	13.8
<b>Sierra</b>	1	11.8
<b>Socorro</b>	1	6.8
<b>Taos</b>	4	18.7
<b>Torrance</b>	3	18.7
<b>Valencia</b>	3	4.5