New Mexico Child Fatality Review 2020 Report

New Mexico Department of Health
Epidemiology and Response Division
Injury and Behavioral Epidemiology Bureau
Office of Injury Prevention
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State of New Mexico

The Honorable Governor Michelle Lujan Grisham

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Introduction

In the United States, between 2015 and 2017, there were 119,698 children under 19 years of age who died, according to the Centers for Disease Control and Prevention database CDC WONDER. Nationwide, the deaths of 119,698 children represents a rate of 51 deaths per 100,000 residents. Over 28% of those children (n=33,958) who died in the United States did so from injury-related causes during this time frame. Nationwide, that represents a rate of 14.5 deaths per 100,000 residents in that age group.

The death of a child is a great loss to family and friends. A child's death also serves as a marker of the health and safety of all children living within that community. Understanding the circumstances leading to the death of a child is one way to make sense of the tragedy and may help to prevent deaths of other children from similar circumstances. Child fatality review processes help to:

1) identify risk and preventable causes of illness or injury

2) prioritize prevention

3) promote recommendations and actions to prevent future child deaths.

The New Mexico Child Fatality Review (NM-CFR) Report 2020 summarizes and analyzes circumstances surrounding180 injury-related deaths of resident New Mexico (NM) infants, toddlers, children, and youth through age 17. These deaths were reviewed in depth during confidential processes by multidisciplinary teams of professionals during calendar years 2018 and 2019, regardless of the year of death. This report presents recommendations based on data and panel member input from reviews. Also included in this report are data from the National Center for Fatality Review and Prevention (NCFRP), which is funded by the US Department of

Health and Human Services, and from the New Mexico Department of Health (NMDOH) Bureau of Vital Records and Health Statistics about child deaths in NM.

The NM-CFR was established in 1998, pursuant to the promulgation of NM Regulation 7 NMAC 4.5, Maternal, Fetal, Infant and Child Death Review to examine the circumstances that contribute to the death of children in NM (see appendix). It has thus been making recommendations to its participating members and their agencies for more than two decades. Many of these recommendations have been adopted by these agencies while others have resulted in legislation, some of which has been enacted.

The purpose of NM-CFR is to prevent deaths under similar circumstances seen in prior years from happening in the future. The multidisciplinary review of individual child deaths allows the state to better understand the circumstances surrounding these deaths and utilize this information to prevent future fatalities. This is pursued mainly through policy and systems change at various levels, from clinical care to other parts of the health care system, to local and state governmental including child protective services, and the federal government.

One of the main goals of the NM-CFR is to produce actionable recommendations to further such policy and systems changes. The NM-CFR identifies gaps in systems, risk factors to reduce, and protective factors to increase, and develops recommendations based on these identified factors. The review process results in increased understanding of risk factors for non-medical child fatalities. This increased understanding enables agencies including child protective services, schools, medical, public health, and law enforcement organizations to identify children at risk of life-threatening injury and to make the necessary changes to systems and policies to protect them. The review process can also alert the community to emerging trends in circumstances surrounding injury and sudden unexpected infant deaths. This helps state and

other agencies, health care organizations, child-serving organizations, communities, and families to employ evidence-based actions to prevent child deaths.

This report is dedicated to the memory of the children whose deaths were reviewed through a highly confidential and legally protected process. We continue to dedicate our work to identify modifiable risk factors from these cases and to make recommendations to strengthen our communities to prevent future unexpected child deaths in NM.

Key Recommendations

Based on child fatality data from reviews conducted during calendar years 2018-1029, the most common circumstances surrounding child deaths included risk factors and lack of protective factors in areas of supervision, including home safety, transportation safety, behavioral/mental health care, and access to lethal means.

The NM-CFR makes the following recommendations.

1. The NM Legislature should require the New Mexico Department of Health (NMDOH) to implement a licensing requirement that all hospitals and free-standing birthing centers adopt safe sleep procedures and policies that include effective provision of safe sleep education to parents and caretakers prior to discharge.

2. The Early Childhood Education and Care Department (ECECD) should increase statewide participation in home visiting services by:
    a. Convening focus groups to determine if/why home visiting services are not fully utilized.
    b. Disseminating tailored marketing campaigns designed to increase participation in home visiting services.

3. The NM Legislature should appropriate sufficient funding and personnel to the ECECD for provision of universal home visiting and further expansion of high-quality, affordable, and accessible childcare options to include non-traditional hours of availability for all families.

4. The NM Legislature should mandate suicide prevention gatekeeper training, such as QPR (Question. Persuade. Refer.) ™ or Mental Health First Aid for all personnel in state funded child-serving organizations including public schools and departments such as Public Education, ECECD, and Children, Youth and Families.

5. The NM Legislature should require the Regulation and Licensing Division (RLD) to require lethal means' restriction education for all youth-serving healthcare providers, behavioral/mental healthcare providers, school counselors, gatekeeper personnel, caregivers of high-risk youth, and prevention specialists.

6. NMDOH and the NM Department of Transportation should conduct a public safety campaign regarding transportation safety and seat belt use among teen drivers using mass media (television, radio, billboards) or small media (brochures, posters) and social media (electronic apps). The campaign could include the distribution of incentive items that encourages teens to drive safely and use safety restraints.

New Mexico Department of Health Approach

Public Health Approach

Public health is concerned with the health, safety, and wellbeing of entire populations. Similarly, the child death review process strives to draw conclusions and make recommendations for populations based on the review of individual child fatalities. The CFR process in NM is grounded in the public health approach. This approach draws on a scientific base, seeks input from diverse sectors, and consists of four basic steps: define and monitor the problem, identify risk and protective factors, develop, and test prevention strategies, and assure widespread adoption of indicated interventions.

The NM-CFR seeks input from many sectors and partners including child protective services and other social services, medical/field investigation, education, justice and law enforcement, health care providers, and others. The purpose of this partnership is to increase the potential of the NM-CFR process to address health disparities and inequities, as these are known to be the basis for many of the circumstances that lead to preventable childhood injury and death. Addressing and eliminating these inequities and disparities will lay the groundwork for reduced child injury death rates in the future.

Child fatalities are monitored by various surveillance and database systems, including the Death Investigation Reporting Tool (DIRT) and the Vector Alignment Search Tool (VAST) managed through the NM Office of the Medical Investigator (OMI), NMDOH Bureau of Vital Records and Health Statistics (BVRHS), the NM Violent Death Reporting System (NMVDRS) and the State Unintentional Drug Overdose Reporting System (SUDORS). NM-CFR identifies risk and protective factors as a part of the review process and develops prevention strategies

through the recommendation process. This report is intended to assist with widespread adoption of prevention strategies and recommendations of the Child Fatality Review.

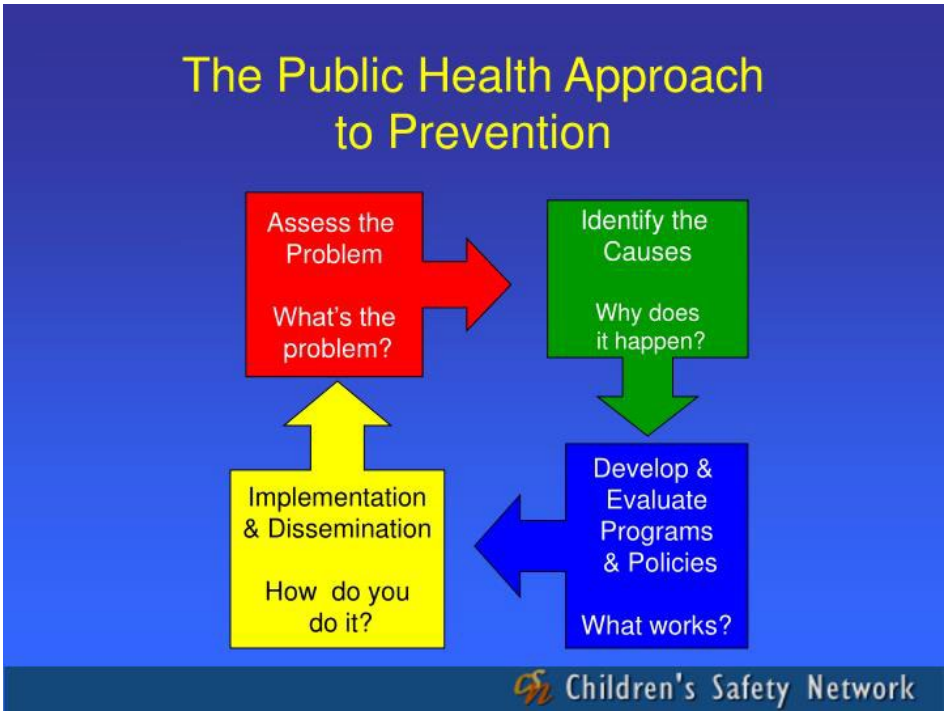


FIGURE 1. The Public Health Approach to Prevention.
Retrieved from the-public-health-approach-to-prevention-n.jpg (720×540) (slideserve.com)

Adverse Childhood Experiences

The NM-CFR process acknowledges certain approaches to child development and wellbeing. It is well-supported in the research literature that the foundations for lifelong health are built in early childhood. The research and literature demonstrate that disruptions in the critical early development period, such as adverse childhood experiences (ACEs), contribute to poor lifelong physical and behavioral health, especially in socially and economically disadvantaged families.

ACEs are traumatic events that occur among children and increase risk for a variety of negative outcomes in adulthood. There are three broad categories of ACEs- abuse, neglect, and household dysfunction, with 10 specific adverse experiences that are typically measured.

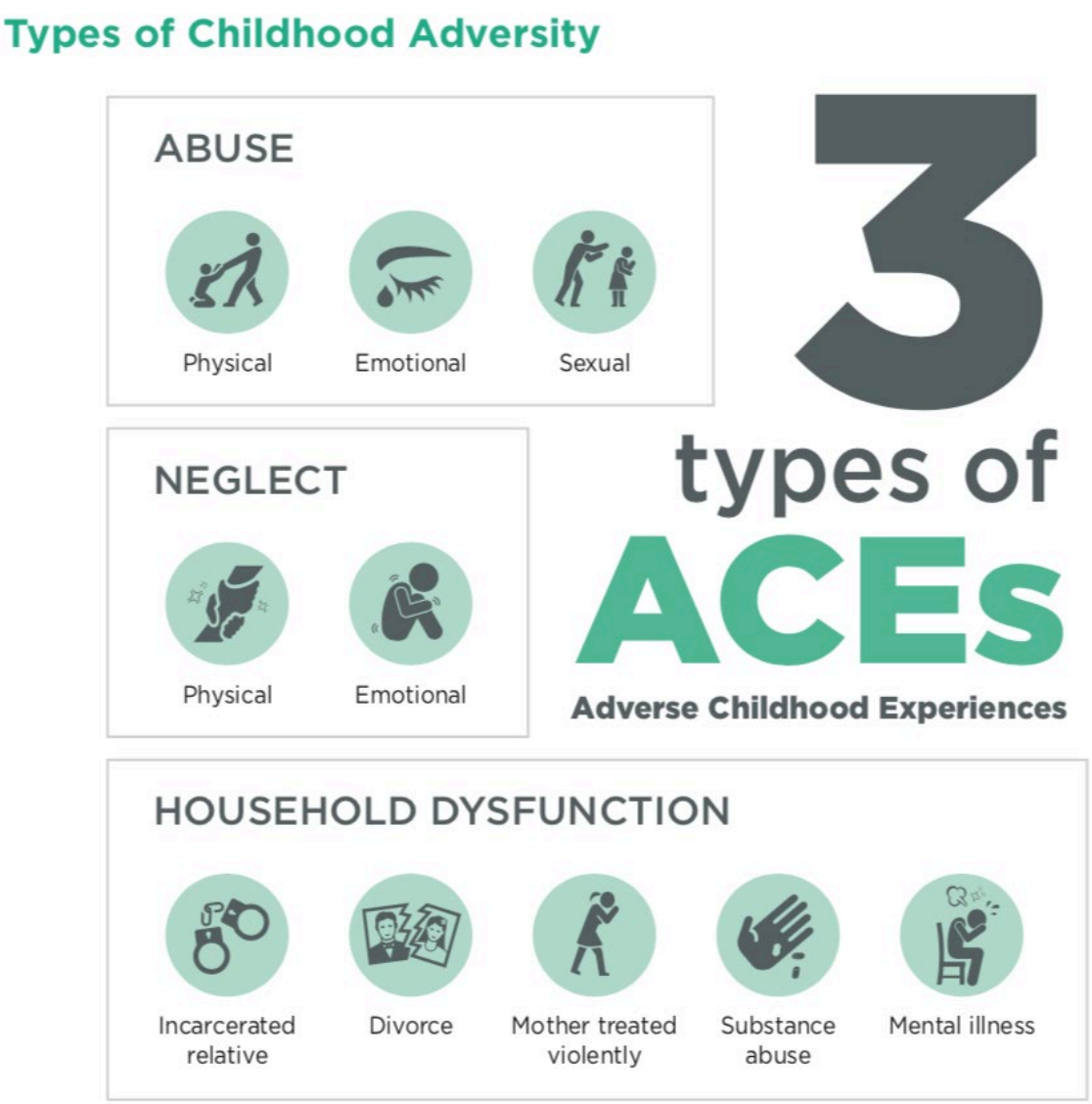


FIGURE 2. Types of Childhood Adversity.
Retrieved from Adverse Childhood Experiences (ACEs) - Napa-Solano (kaiserpermanente.org)

Social Determinants of Health

The individual-level circumstances reviewed by the NM-CFR do not fully explain the disparities observed in sudden unexpected infant deaths and injury-related child deaths. Singh *et al.* found that health disparities in the United States persist because underlying factors (such as healthcare access, poverty, rurality, education, etc.) associated with child mortality impact

health.[1] NM has consistently ranked poorly in indicators associated with childhood wellbeing and early childhood death according to the NM Kids Count data book. There is a need for a system-based approach to prevent child deaths in NM because of the widespread and persistent nature of these inequities.

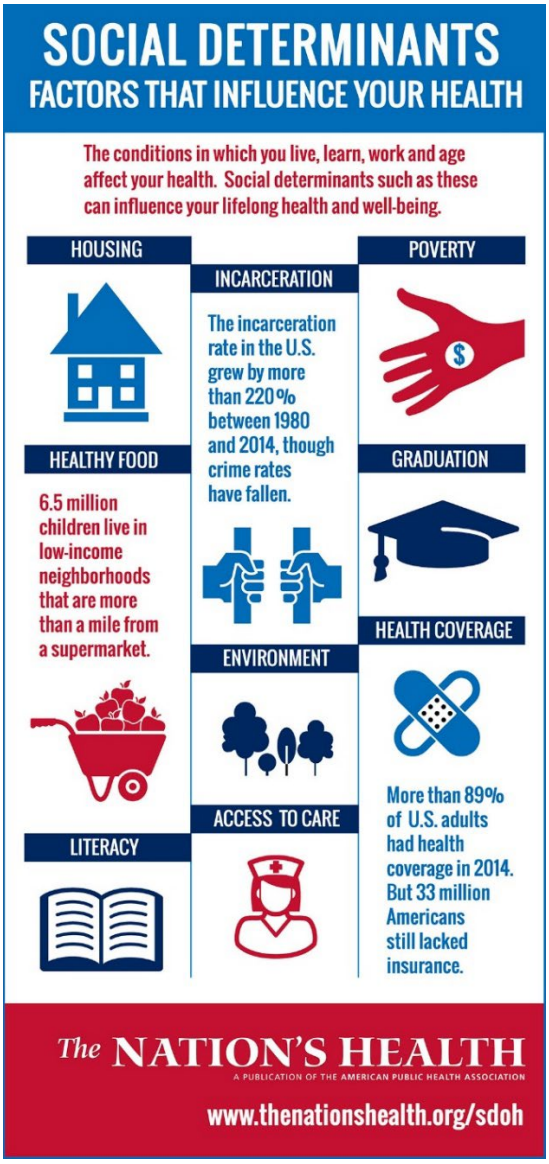


FIGURE 3. Social Determinant.

Retrieved from Infographics: Social determinants of health | The Nation's Health (thenationshealth.org)

NM has ranked below the national rate in several areas strongly associated with infant and child mortality.[1,2] According to the Annie E. Casey Foundation's Kids Count 2021 report, NM's families fared worse than their national counterparts in 2021 for: children living in poverty (25%); children whose parents lack secure employment (35%); children in single-parent families (44%); high school students not graduating on time (25%); fourth graders who are not proficient in reading (76%); and eighth graders who are not proficient in math (79%).[2] Children born into household poverty or neighborhood poverty have a higher risk of negative outcomes including an increased risk of having a mental condition or being hospitalized for an injury than children not born in poverty.[3]

According to NM-IBIS during 2019[4] about four percent of New Mexican children lived in counties that are considered rural (less than 10,000 inhabitants) and 31% of New Mexican children lived in counties considered to be mixed urban/rural (between 10,000 and 50,000 inhabitants). Rural communities are less likely to have access to quality health care and more likely to have difficulty accessing and obtaining goods and services.[1] Residents of rural and mixed urban/rural communities in NM suffer from injury deaths from all causes at much higher rates than residents of small metro and metropolitan counties.[5] Residents of rural communities are also more likely to have access to firearms, which contributes to both intentional and unintentional injury deaths from firearms.[3] In 2019, the firearm-related age-adjusted injury death rate for all ages in rural NM counties was 46% higher than the rate in metropolitan counties.[5]

Factors associated with early child death disproportionately affect minority populations.[1] In 2019, over seventy-five percent of NM's parents identified their children as non-Hispanic white according to NM-IBIS.[4] According to the U.S. Census, 28% of NM children aged 5-17 speak a language other than English at home.[6] Along with possible language differences,

minority communities in NM tend to have higher rates of poverty and possibly less economic opportunities than non-Hispanic whites, in keeping with national trends.[7]

Below is a chart, Figure 4, depicting the percentage of children under age 18 who were living in poverty in NM during 2012 to 2017. The chart also shows poverty rates for children by race/ethnicity, along with a comparison between NM and the United States rates of child poverty.

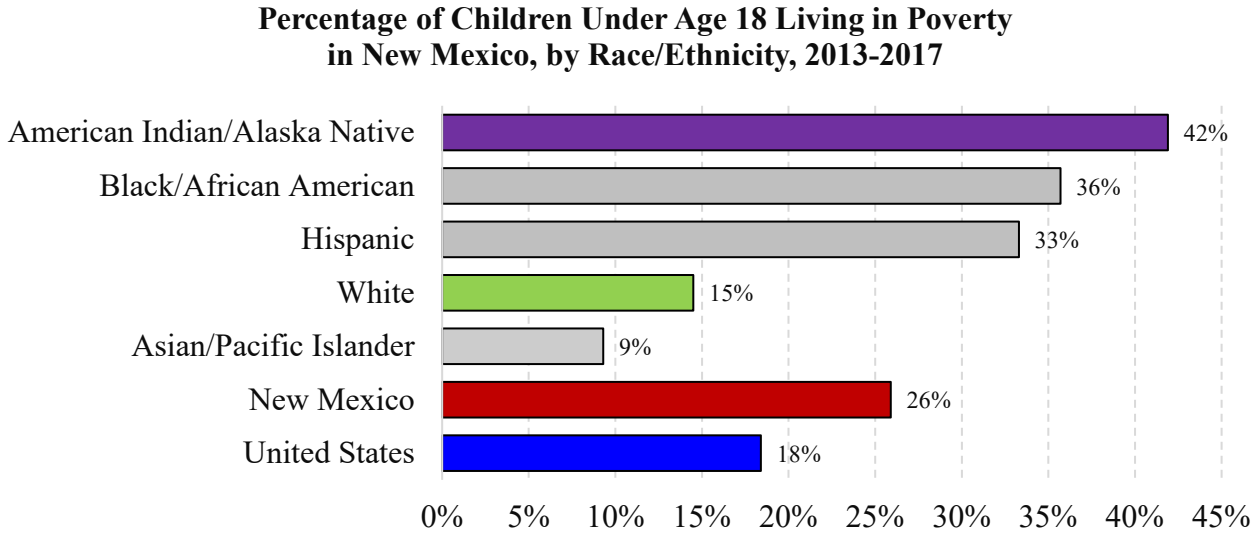


FIGURE 4. Poverty Among Children in NM. Figure retrieved from NM-IBIS - Complete Health Indicator Report - NM Population - Poverty Among Children Under Age 18 (https://ibis.health.state.nm.us/indicator/complete_profile/NMPopDemoChildPov.html#:%7E:text=In%202017%2C%20the%20New%20Mexico,Hampshire%20to%2027.7%25%20in%20Louisiana.)

Together, the public health approach and knowledge of current research and literature in child development and wellbeing provide a practical and theoretical basis for the CFR process in NM.

New Mexico Child Fatality

The NM-CFR uses both qualitative and quantitative data to better understand the complex factors associated with child deaths in NM. It is authorized by the NM Public Health Act and the applicable regulation and administered by the NMDOH (Title 7- Health, Chapter 4- Disease Control (Epidemiology), Part 5- Maternal, Fetal, Infant and Child Death Review, (see appendix).

Through a process of confidential, comprehensive reviews of individual cases, the NM-CFR makes recommendations for development of, or changes to, agency policies and practices; state laws and regulations; media campaigns; prevention programs; strategic partnerships; or further inquiry into troubling trends.

Information obtained through the case review process is supplemented by aggregate data from state vital records and then inputted into the National Center for Fatality Review and Prevention (NCFRP) Case Reporting System. The following definitions of fatality-related terms, provided in the New Mexico Office of the Medical Investigator 2020 Annual Report, describe data points that are referred to in death certification processes and used by NM-CFR (see appendix).

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 in which death results from intentional self-harm.
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."

The NM-CFR is comprised of four distinct case review panels: child abuse and neglect, youth suicide, sudden unexpected infant death (SUID), and other unintentional injury. Each NM-CFR panel is made up of experts in child safety, public health, education, behavioral health, medicine, forensic pathology, law enforcement, public safety, juvenile justice, criminal justice, and other related fields.

The Child Abuse and Neglect Panel reviews child fatalities that result from caregiver abuse and/or neglect. This panel also reviews child homicides, regardless of the perpetrator's relationship to the child, as well as cases in which the manner of death is something other than homicide, yet in which circumstances indicate that caregiver abuse or neglect is a factor in the case, whether directly or indirectly.

The Unintentional Injury Panel reviews child fatalities in which the manner of death was accidental and/or undetermined. The causes of death included in this panel's reviews are varied and include motor vehicle crashes; drowning deaths; unintentional overdose or poisoning; fire-related deaths; and other fatalities due to unintentional injuries.

The Youth Suicide Panel reviews intentional deaths among children and youth that result from self-injury.

The Sudden Unexpected Infant Death Panel (SUID) reviews unexpected deaths of infants less than one year old in which the cause was not obvious before investigation. These deaths often occur during sleep or in the area where the infant was placed to sleep, such as an adult bed or living room furniture. The SUID panel reviews manner of death classifications including accident, undetermined, homicide, pending, and some natural (when circumstances involve an aspect of sleep and/or sleep setting). Sudden and unexpected deaths of children older than one year may be reviewed at one of the other panels noted above, if the circumstances point

to a possible injury-related cause, or they are reviewed by the Sudden Death in the Young (SDY) Panel conducted by the New Mexico Office of the Medical Investigator. More information about SDY is available at the Sudden Death in the Young Case Registry at https://sdyregistry.org/.

Report Narrative

The NM-CFR reviewed 180 unique child deaths from January 1, 2018, through December 31, 2019. As different circumstances led to reviews with time frames different from occurrences, the date of deaths for these children included some from calendar years 2014/15 and a majority from 2016/17, with only a few from 2018/19. The data show that most children died in the metro area (Bernalillo, Torrance, and Valencia counties), were more often male, and were predominately infants, and youth aged 15-17 years. The most common manner of child death reviewed by the NM-CFR were unintended accidental deaths, 63 out of 180 (35%) and suicides, 61 out of 180 (34%).

Each of the 180 child death cases were reviewed by at least one of the four panels; occasionally a child death case received a second review to gain perspective from another panel. During calendar years 2018 and 2019, a total of 205 reviews of the 180 unique child fatalities were completed by these distinct panels:

Panel	**Reviews**	**Included**
Child Abuse and Neglect	20	Homicides: six by non-parent/caregiver and 14 by the parent/ caregiver
Unintentional Injury	50	Accidents: motor vehicle and other transportation fatalities, accidental drownings, deaths caused by fire or other thermal injuries, unintentional poisonings/overdoses, along with other accidental causes
Youth Suicide	67	Suicides: by mechanisms including firearm, hanging, poisoning/overdosing, jumping, and other

SUID	68	Sudden Unexpected Infant Deaths: non-medical deaths of infants aged up to 364 days old, where a sleep-related circumstance may have contributed to the cause of death, such as accidental suffocation or strangulation that occurred where an infant was placed for sleep, possibly caused by soft bedding, soft furniture, wedging, and/or a person's body part.

According to the NCFRP, a child's death is determined to be preventable if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death. Of the 180 unique child deaths reviewed, NM-CFR determined that 149 deaths (83%) could have been prevented. NM-CFR could not determine from the information provided whether the child's death was preventable in 25 deaths (14%).

Autopsies were performed on 171 (95%) of the child deaths reviewed by the NM-CFR. The primary cause of death listed on the death certificate agreed with the pathology report on 171 (95%) child deaths that were reviewed. One hundred fifty-six (87%) death scene investigations were conducted at the place where the child's death occurred. A witness to the incident was available at 57 (31%) of the child deaths reviewed by the NM-CFR. The most common witnesses at the child's scene of death were the child's parents in 26 (14%) of the child deaths, followed by strangers in 16 (8%) child deaths. The local emergency number or 911 was called in 167 (93%) of the child deaths and resuscitation of the child was attempted in 113 (63%) of the child deaths reviewed.

The circumstances of the children's deaths varied widely in the 180 unique cases reviewed by NM-CFR during calendar years 2018 and 2019. As previously noted, each death was reviewed at least once, while others received multiple reviews to solicit feedback from different perspectives. Unless otherwise noted, the following data are shown with the letter "n"

to equal the numerator out of a total denominator of 180 unique cases. The most common place children's deaths occurred was in their home n=113 (63%) followed by roadways n=21 (12%).

At the time of the child's death, there were 82 children (46%) who were of sufficient developmental age and circumstances to supervise themselves; 81 children (45%) were being supervised; 14 children (7%) did not have supervision but needed it; and in the cases of three children (2%), the NM-CFR was not able to determine their supervisory need. 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 less than age six was out of visual or auditory proximity, they could not see or hear the child at the time of need, this would be considered lack of supervision.

Of the 180 unique child deaths reviewed, 97 were identified as having been associated with inadequate supervision (54%). The following section uses a denominator of 97 to reflect the percentage pertaining only to child deaths identified as needing supervision. The most common reported supervisor at the time of the incident was the child's biological mother n=54 (56%) followed by their biological father n=18 (19%). Twenty-six deaths (27%) occurred where the supervising individual was in sight of the child; 17 deaths (18%) occurred where the child was out of sight of their supervisor for 30 minutes or less; 19 deaths (20%) occurred where the child was out of sight of their supervisor between one to three hours' time; 11 deaths (11%) occurred where the child was out of sight of their supervisor from four to seven hours, and one death occurred in situation where the time of last supervision was not known.

Many of the individuals supervising the child at the time of their death did not have any known prior risk factors or histories that would increase the risk of the child dying. However, this may be due in part to a lack of available records to identify such risk factors. From what was

identified in the records, of the 97 children needing supervision, 14 child deaths (22%) occurred in situations where the supervising individual had a disability or chronic illness. Twenty-one child deaths (22%) occurred in situations where the supervising individual was impaired, (defined by the NCFRP as being "distracted or absent, drug or alcohol impaired, and/or impaired by disease or disability"). Eighteen children (19%) were supervised by an individual who had a known history of maltreating a child.

A remarkably similar finding related to the known prior factors that may have contributed to an increased risk of death is that 40 of the 180 children (22%) had a history of being a victim of child maltreatment. The next set of instances shown by count and percentage, reflect all 180 unique child deaths reviewed. There are other social/system factors that were known prior to these fatalities including reports that 18 children (10%) were ever placed in foster care. Eighteen children (10%) were ever placed in foster care and another 40 children (22%) had a history of being a victim of child maltreatment. Twenty-nine children (16%) had a known prior disability or chronic illness. Fifteen children (8%) were receiving mental health services prior to their death and another 22 children (12%) had ever received mental health services in their past. Twenty-five children (14%) had used alcohol or drugs prior to their death and another 12 children (7%) had a history of substance abuse. Fifty-five children (31%) were the only child living in the household.

The next section of this report presents data tables illustrating various demographics of these same deaths that were discussed in this section.

Data Overview

The tables on the following pages provide information regarding the 180 unique child deaths that were reviewed by NM-CFR from January 1, 2018, through December 31, 2019.

Table 1:

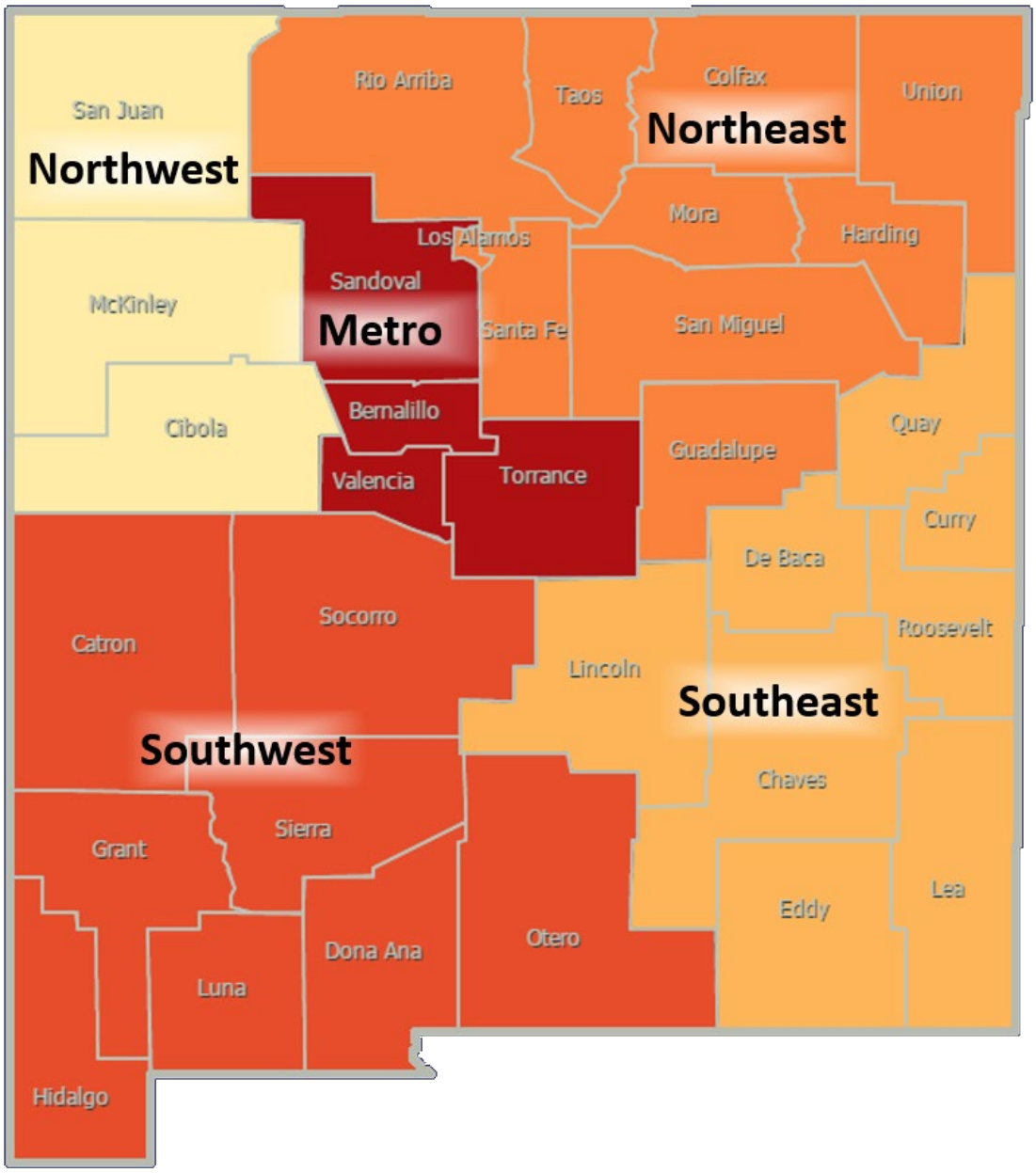
Number of Live Births* by Public Health Region, New Mexico, 2018 and 2019

New Mexico Public Health Region	Total Number of Live Births in 2018	Total Number of Live Births in 2019
Northwest	2,589	2,648
Northeast	2,487	2,481
Metro	9,430	9,312
Southeast	4,147	4,098
Southwest	4,385	4,426
Statewide	**23,038**	**22,965**

** The number of live births registered in NM provides a population count to refer to when analyzing population health issues for different age ranges. NM has five public health regions designated to specific geographic locations aggregated by counties. The public health region designation is also referred to when analyzing population health issues to distinguish characteristics by location. In the following data tables, information is broken into these five health regions shown on the map in Figure 1a.*

Figure 1a:

New Mexico Public Health Regions and Counties



Retrieved from https://ibistest.health.state.nm.us/view/image/RegionRed.png

Table 2:

Manner of death* (n=180)

Accident (Unintentional)	63
Suicide	61
Undetermined	25
Homicide	21
Other	10
Total	180

** The manner of death is determined by a pathologist based on the circumstances that resulted in the death and is listed on the death certificate. The categories are accident, suicide, homicide, undetermined, pending, or natural. Typically, deaths classified as natural are not reviewed by NM-CFR. Occasionally NM-CFR conducts a review of a natural manner of death case. Definitions from OMI 2020 Annual Report can be found on page 14 of this report.*

Approximately one-third of the child deaths were accidents, and another third were suicides according to categories listed on death certificates. Just over ten percent of the child deaths were classified as homicides. Classifications of undetermined and other may have resulted from injuries described in the Cause of Death Table 3.

Table 3:

Cause of Death* (n=180)

Other	1
Undetermined	1
Fire, burn, or electrocution	5
Drowning	7
Fall or crush	11
Unintentional asphyxia	13
Poisoning, overdoes or acute intoxication	13
Motor vehicle and other transport	24
No apparent external injury	33
Assault, weapon, or person's body part	72
Total	180

**Cause of death, unlike manner of death, is the type of injury that led to the death and includes a wide range of specific injuries. The definitions from OMI 2020 Annual Report can be found on page 11 of this report.*

Table 3a:

Type of weapon (assault, weapon, or persons body part) (n=72)

Person's body part	9
Rope	20
Firearm	32
Other	11
Total	72

Most external injuries involved in child deaths were related to assault, weapon, or 'person's body part'. The type of weapon used in about half of these deaths was a firearm, while another 27 percent used a rope. The term "person's body part" is used to describe injuries caused either intentionally when an individual uses their hands and feet to beat or kick a child, or accidentally when an individual's body or limb suffocates an infant during sleep. About half of the child suicides in New Mexico are caused by some type of rope ("Rope" is the term used for all types of ligatures including belts, ties, sheets. and pet leashes), while the other half involve firearms.

Table 3b:

Cause / Type of Fatal Childhood Injuries by Age Group (n=180)

	< 1 year	1-4 years	5-9 years	10-14 years	15-17 years	Total
Fire, burn, electrocution, or other	**	**	**	**	**	**7**
Drowning	**	6	**	**	**	**7**
Fall or crush	**	**	**	**	6	**11**
Poisoning, overdose, or acute intoxication	**	**	**	**	10	**13**
Unintentional asphyxia	11	**	**	**	**	**13**
Motor vehicle and other motorized transport	**	**	6	5	11	**24**
Internal Causes (physiological)	32	**	**	**	**	**33**
Assault, weapon, or person's body part	6	**	**	19	42	**72**
Total	**53**	**19**	**10**	**29**	**69**	**180**

Note: *** The estimate has been suppressed based on the New Mexico Rule for Small Numbers and Public Data Release, see appendix. NM Indicator Based Indicator System (https://ibis.health.state.nm.us/view/docs/Standards/NMSmallNumbersRule2006.pdf)*

Certain types of fatal childhood injuries result in death at significantly different ages. Infants (birth to one year old) are disposed to three causes including: physiological internal causes (or unknown/unseen causes), unintentional asphyxia, and death caused by an assault, weapon, or person's body part. Deaths of children ages one to four years were fewer in number and scattered among all causes. Motor vehicle-related fatality was the most common cause of death for children ages five to nine years old. Although the total number of child deaths caused by motor vehicles is very similar for the next age group of ten to 14 years old, the leading cause of death for this age jumps significantly in the category of assault, weapon, or person's body part.

Table 4:

Demographics of All Child Deaths (n=180)

Demographics	Number	Percent
Gender		
Male	116	64%
Female	64	36%
Age Group		
Infant (< 1 year)	53	29%
1 - 4 years	19	11%
5 - 9 years	10	6%
10 - 14 years	29	16%
15 - 17 years	69	38%
Race and Ethnicity		
Hispanic (All Races)	77	43%
White	63	35%
Black or African American	8	4%
American Indian or Alaskan Native	29	16%
Asian or Pacific Islander	3	2%
Health Region		
Northwest	31	17%
Northeast	27	15%
Metro	73	41%
Southwest	21	12%
Southeast	28	16%

Of the 180 deaths reviewed by NM-CFR during 2018-2019, regardless of the date of death, males were approximately two-thirds of the decedents (n=116), while females were about one-third (n=64). Boys died at nearly twice the rate of girls.

Table 5:

Unintentional / Accidental Child Deaths (n=53)

Demographic		Number	Percent
Gender			
	Male	36	68%
	Female	17	32%
Age Group			
	Infant - 4 years	18	34%
	5 - 9 years	8	15%
	10 - 14 years	7	13%
	15 - 17 years	20	38%
Race and Ethnicity			
	Hispanic (All Races)	20	38%
	White	22	42%
	American Indian or Alaskan Native	8	15%
	Other	3	6%
Health Region			
	Northwest	10	19%
	Northeast	9	17%
	Metro	21	40%
	Southwest	6	11%
	Southeast	7	13%

Of the 53 unintentional/accidental child deaths, decedents were predominantly male (68%), were mainly infants aged up to four-years old (34%) or in their late teenage years (38%). Most were White (42%) and Hispanic (38%) and residing in the Metro Public Health region (40%).

Table 5a

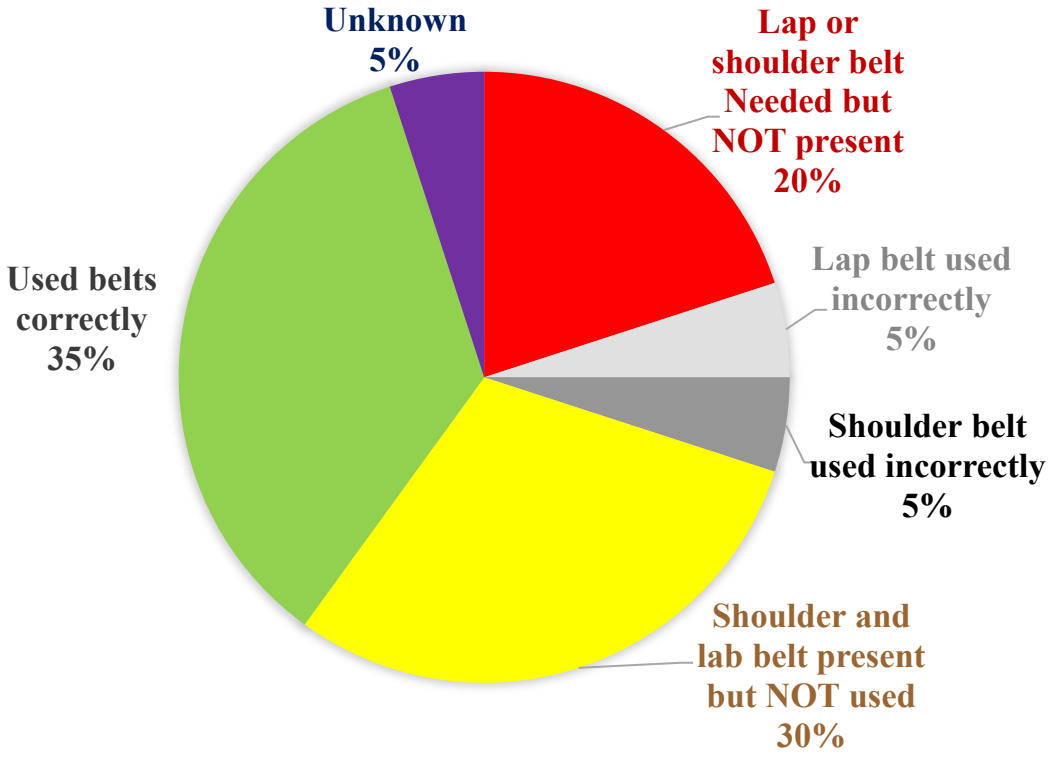
Motor Vehicle and Other Transport-related Child Deaths (n=24)

Demographic		Number	Percent
Gender			
	Male	19	79%
	Female	5	21%
Age Group			
	0 - 9 years	8	33%
	10 - 14 years	5	21%
	15 - 17 years	11	46%
Race and Ethnicity			
	Hispanic (All Races)	9	38%
	White	10	41%
	Other	5	21%
Health Region			
	Northwest and Northeast	7	30%
	Metro	11	45%
	Southwest and Southeast	6	25%

Of the 24 motor-vehicle and other transport-related child deaths, more than three in four were males (70%) and nearly half were in their late teenage years (46%). Although many of these deaths occurred in the Metro Public Heath region (45%), more than half of them occurred in the other public health regions (55%).

Figure 5b

Safety Restraint (Seatbelt) Use in Motor Vehicle Child Deaths (n=20)



Of the 20 motor vehicle child deaths where the deceased was a driver or passenger, roughly a third of the decedents (35%) were properly using seatbelts. Sixty-five percent were not properly using seatbelts. In one-third of the child deaths, the seatbelts were present (available in the vehicle) but not used, in 20% of the deaths, seatbelts were not available yet were needed, and in 10% of the deaths, seatbelts were not used properly.

Table 6

Sudden Unexpected Infant Deaths (SUIDs) (n=47)

Demographic		Number	Percent
Gender			
	Male	26	55%
	Female	21	45%
Age Group			
	0 - 1 Month	14	30%
	2 - 3 Months	20	43%
	4 - 6 months	5	11%
	7 months - 1 year	8	17%
Race and Ethnicity			
	Hispanic (All Races)	21	45%
	White	15	32%
	American Indian or Alaskan Native	8	17%
	Other	3	6%
Health Region			
	Northwest (NW)	8	17%
	Northeast (NE)	4	9%
	Metro	14	30%
	Southwest (SW)	6	13%
	Southeast (SE)	13	28%

Of the 47 sudden unexpected infant deaths (SUID) reviewed by the NM-CFR during 2018-2019, over two-thirds were infants under four months of age (73%). Just over 10% of the SUIDs were aged four to six months, while 17% were between seven months to one year. As for race and ethnicity, 32% of these infants were White and 45% were Hispanic. Notably, nearly one-third of these infants resided in the Southeast region (third smallest region by life birth population count) and almost one-fifth of them were in the Northwest region (second smallest region by life birth population count). These geographical locations are rural and small-metro areas of the state that lack significant infrastructure and healthcare services which are contributing risk factors to early deaths.

Table 6a

Manner of Sudden Unexpected Infant Deaths (SUIDs) (n=47)

Manner	Number
Homicide	5
Natural	8
Accident	10
Undetermined	24

Roughly half of the sudden unexpected infant deaths were classified as "undetermined" on the infant's death certificate. A manner of "undetermined" is reported by a pathologist when the cause of death remains pending and/or questionable without a clearly noticeable reason leading to the death. In some of the undetermined cases more investigations, interviews, and tests may reveal additional circumstances, while some cases remain undeterminable and are filed as such.

Ten infant deaths were classified as unintentional accidents, while five were caused by a parent or caregiver with manner of death classified as homicide. Eight cases classified as natural were reviewed by the SUID panel due to the possibility that the death was related to the sleep environment and may have been preventable.

Table 6b

Method and/or Means of Sudden Unexpected Infant Deaths (n=47)

Method/Means	Number
Non-Injury	32
Unintentional asphyxia	9
Person's body part	3
Undetermined/Other	3

Most sudden unexpected infant deaths (n=32) did not have external injuries. About one fifth of the infants died from suffocation (unintentional asphyxia).

Table 7

Suicide (n=61)

Demographics		Number	Percent
Gender			
	Male	43	70%
	Female	18	30%
Age Group			
	10 - 14 years	17	28%
	15 - 17 years	43	70%
Race and Ethnicity			
	Hispanic (All Races)	23	38%
	White	24	39%
	American Indian or Alaskan Native	9	15%
	Other	5	8%
Health Region			
	Northwest (NW)	10	16%
	Northeast (NE)	11	18%
	Metro	28	46%
	Southwest (SW)	6	10%
	Southeast (SE)	6	10%

Nearly three in four child suicides were youth in their late teens, 43 out of 61 (70%). More than two-thirds of the decedents were male, 43 out of 61 (70%). Slightly over one third were White and another third were Hispanic. Notably, both Southern Public Health regions of the state suffered far fewer child suicides than the Metro and Northern Public Health regions.

Table 7a

Method and/or Means of Suicides (n=61)

Method/Means	Number	Percent
Firearm	23	38%
Rope	20	33%
Fall or crush	5	8%
Poisoning, overdose, or acute intoxication	3	5%
Other	10	16%

About one third of youth suicides involved firearms and another third involved rope. Using rope as a means for suicide is also referred to as fatal hanging caused by intentional asphyxia. There are several household items that children used to hang themselves with, including articles of clothing such as neck ties, belts and shoelaces, bed sheets, garden hoses, utility and climbing rope, and pet leashes.

Firearms are the most lethal weapon used for both suicides and homicides, whereas self-inflicted poisoning and/or drug overdosing and alcohol intoxication are not often ruled as suicides due to the reduced lethality compared to firearm use. Only a few of the youth suicides involved a child who jumped (fall or crush) from a significant height.

Table 8:

Homicide, Abuse, and Neglect-Related Deaths (n=21)

Demographics		Number	Percent
Gender			
	Male	14	67%
	Female	7	33%
Age Group			
	Infant (<1 year)	7	33%
	1 - 9 years	5	24%
	10 - 14 years	5	24%
	15 - 17 years	4	19%
Race and Ethnicity			
	Hispanic (All Races)	13	62%
	American Indian or Alaskan Native	6	29%
	Other	2	10%
Health Region			
	Northwest and Northeast (NW+NE)	5	24%
	Metro	12	57%
	Southwest and Southeast (SW+SE)	4	19%

About one third of the 21 child homicides, abuse, and neglect deaths were infants (under one-year old). Most significantly, over two-thirds of these child deaths were males (67%). Male children were twice as likely to die as the result of these causes as females.

Table 8a:

Method and/or Means of Homicide, Abuse, and Neglect-related Deaths

Method/Means	Total
Person's body part	8
Firearm	7
Other/Undetermined	6

About one third of the 21 child homicide, abuse, and neglect deaths reviewed by the NM-CFR during 2018-2019 involved a person's body part (hitting, kicking, strangling) and another third involved a firearm according to Table 8a.

Conclusion

Male children (n=116) were nearly twice as likely (64%) to be victims of preventable deaths than female children (n=64, 36%) in every manner of the injury-related deaths.

Circumstance	Total	Male		Female	
	Count	Count	Percent	Count	Percent
Injury-related (all)	180	116	64%	64	36%
Accidental/Unintentional	53	36	68%	17	32%
Motor vehicle	24	19	79%	5	21%
Suicide	61	43	70%	18	30%
Homicide, Abuse/Neglect	21	14	67%	7	33%
SUID	47	26	55%	21	45%

Of the 53 unintentional/accidental deaths, 36 of them were boys. Seventy-nine percent of the motor vehicle and other transport-related cause of child deaths were males. Almost three-fourths (70%) of youth suicide in NM were males compared to females (30%). Male children were twice as likely (67%) to die because of child abuse and neglect homicides as females (33%). However, in the deaths of children under one year of age, with a cause of death reviewed at the SUIDs

panel, male infants made up close to half (55%) of the deaths compared to females (45%). Boys in NM are far more likely than their female peers to die in accidents, be murdered, or take their own lives.

In infants (birth to one years old) there were three main injury-related causes leading to death: physiological internal causes (or unknown/unseen causes), unintentional asphyxia, and death caused by an assault, weapon, or person's body part. Deaths of children ages one to four years old were scattered among all causes including accidents, homicides, and suicides, yet were fewer in number than other age groups. Motor vehicle-related fatality was the most common cause of death for children ages five to nine years old. Intentional self-harm resulting in suicide and violence resulting in homicide increase in likelihood with a child's age, compared to accidental deaths of younger children. Although the total number of child deaths caused by motor vehicles for children ages five to nine years old was very similar for ten to 14 years old, the leading cause of death for ten to 14 years old jumps significantly in the category of assault, weapon, or person's body part. Refer to Table 3b on page 22 of this report for details.

Of the 180 unique child deaths reviewed, the NM-CFR determined that 149 deaths (83%) could have been prevented. In most case reviews there was sufficient quality of data to determine whether the child's death could have been prevented. Among the deaths reviewed by the NM-CFR in 2018 and 2019, most children died in their home environments under the supervision of their biological parent(s) and on roadways regardless of supervision. Many of the supervising adults were reported as having been distracted or absent, drug or alcohol impaired, and/or impaired by disease or disability; and some of those adult supervisors had a known history of being charged with perpetrating a crime of maltreatment against a child. Firearms were the means for over one-third of youth suicides and almost all the adolescent homicides in NM.

Based on these findings, demographics, and circumstances, the key recommendations made by NM-CFR focus on supports to increase parent/caregiver knowledge, understanding, and use of effective supervision for children and youth; healthcare system-based provision of safe-sleep education/training for parents/caregivers of newborns and infants; safe driving improvement efforts and education for teens; along with recommendations to mandate training for educators and behavioral health care providers in suicide prevention strategies and counseling on reduction of access to lethal means. NM-CFR recommends interventions aimed to increase protective factors and decrease risk factors for many of the above-mentioned circumstances that will need to be appropriately tailored to specific age ranges for the different types of injuries, with an emphasis on male children.

Key Recommendations

Based on child fatality data from reviews conducted during calendar years 2018-1029, the most common circumstances surrounding child deaths included risk factors and lack of protective factors in areas of supervision, including home safety, transportation safety, behavioral/mental health care, and access to lethal means.

The NM-CFR makes the following recommendations.

1. The NM Legislature should require the New Mexico Department of Health (NMDOH) to implement a licensing requirement that all hospitals and free-standing birthing centers adopt safe sleep procedures and policies that include effective provision of safe sleep education to parents and caretakers prior to discharge.

2. The Early Childhood Education and Care Department (ECECD) should increase statewide participation in home visiting services by:
    a. Convening focus groups to determine if/why home visiting services are not fully utilized.
    b. Disseminating tailored marketing campaigns designed to increase participation in home visiting services.

3. The NM Legislature should appropriate sufficient funding and personnel to the ECECD for provision of universal home visiting and further expansion of high-quality, affordable, and accessible childcare options to include non-traditional hours of availability for all families.

4. The NM Legislature should mandate suicide prevention gatekeeper training, such as QPR (Question. Persuade. Refer.) ™ or Mental Health First Aid for all personnel in state funded child-serving organizations including public schools and departments such as Public Education, ECECD, and Children, Youth and Families.

5. The NM Legislature should require the Regulation and Licensing Division (RLD) to require lethal means' restriction education for all youth-serving healthcare providers, behavioral/mental healthcare providers, school counselors, gatekeeper personnel, caregivers of high-risk youth, and prevention specialists.

6. NMDOH and the NM Department of Transportation should conduct a public safety campaign regarding transportation safety and seat belt use among teen drivers using mass media (television, radio, billboards) or small media (brochures, posters) and social media (electronic apps). The campaign could include the distribution of incentive items that encourages teens to drive safely and use safety restraints.

Acknowledgements

NMDOH wishes to acknowledge and express appreciation to the members of the NM-CFR Child Abuse & Neglect, Sudden Unexpected Infant Death, Youth Suicide and Unintentional Injury panels who contributed their time and expertise to reduce child fatalities and childhood injury in NM. Appreciation is also extended to the NM Office of the Medical Investigator, the NM Bureau of Vital Records and Health Statistics, law enforcement agencies, hospitals, and schools across New Mexico.

NM-CFR Panel Membership – Panel members of the NM-CFR teams are state and local experts in diverse fields. Representation from indigenous populations is strongly sought. Guests or one-time attendees also take part on team reviews for educational purposes or specific case reviews.

NM-CFR 2018-2019 Panel Members

Panel Participant Name	Organization
Alejandra Rebolledo Rea	NM Children, Youth and Families Department
Amy Dudewicz	Bernalillo County Sheriff Office
Angela Baca	NM Children, Youth and Families Department
Andrea Verswijver	Christus St. Vincent Regional Medical Center
Ashley Cochran	University of NM Hospital
Ashley Garcia	NM Public Education Department
Bella White	Breaking the Silence NM
Benny Chen	University of NM Hospital
Brittney Primmer	University of NM Hospital
Carol Moss	NM Department of Health
Carla Gandara	Albuquerque Public Schools Police Department
Christina Brigance	NM Department of Health
Coffee Brown	University of NM Emergency Medical Services Academy
Daniel Portell	Bernalillo County Sheriff Office
Eddie Sandoval	Albuquerque Public Schools
Edith Lewis	NM Children, Youth and Families Department
Elizabeth Hamilton	NM Children, Youth and Families Department
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Heather Jarrell	NM Office of the Medical Investigator
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Jeff Wright	Federal Bureau of Investigations
Jefferson Joe	Navajo Nation/Shiprock Tribal Police
Jennifer Garcia	University of NM Hospital
Jennifer Hart	Albuquerque Public Schools
Jennifer Pak	Indian Health Service
Jerry Lee	Indian Health Service
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Karen Campbell	University of NM Hospital Child Abuse Response Team and NM Children, Youth and Families Department
Katrina Montano White	NM Children, Youth and Families Department
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Kylie Diver	NM Children, Youth and Families Department
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Lee Hood	District Attorney's Office
Leslie Kelly	NM Public Education Department
Leslie Strickler	University of NM Children's Hospital
Lhadze Bosiljevac	University of NM
Lidia Bachechi	NM Children, Youth and Families Department
Linsday Eakes	University of NM Emergency Medical Services Academy
Lisa Hecker	NM Public Education Department
Lisa Trabaudo	District Attorney's Office, NM Second Judicial District
Liz Bearzi	NM Children, Youth and Families Department
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Nicholas Sharp	NM Department of Health

Nicole Urrea	University of NM Hospital
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Rachel Ochoa	Albuquerque Public Schools
Rachel Baeza	Pojoaque Pueblo
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Rebecca Tarin	NM Office of the Medical Investigator
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Sean Healy	NM Department of Public Safety
Scott Patterson	NM Administrative Office of the Courts
Shayna Klassen	NM Department of Health
Shelly Bucher	Substitute Care Advisory Council
Shinenn Nair	NM Children, Youth, and Families Department
Steven Diamond	Second Judicial District Attorney's Office
Susan Casias	Native American Suicide Prevention Council
Theresa Yazzie	Indian Health Service
Travis Bowser	Indian Health Service
Toby Rosenblatt	NM Department of Health
Troy Gray	Office of the Second Judicial District Attorney
Victoria Lehrmann	University of New Mexico
Victoria Waugh-Reed	NM Department of Health
Wendy Allison-Linebrink	NM Crisis and Access Line
Wendy Vu	University of NM Hospital
Zachary Wesley	Albuquerque Police Department

Ways to Get Involved

Although data only tell part of the story, they do show us how much work remains to be done. NM-CFR is always looking for 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, and school-based health services are especially encouraged to inquire about taking part in NM-CFR. To get involved please contact Lucretia Vigil, Child Fatality Review Coordinator at Lucretia.Vigil@state.nm.us or by phone at (505) 827-5146.

Appendix

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.

Office of the Medical Investigator Annual Report 2020 - Excerpt

"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 3.8% of all deaths investigated by the OMI in 2020. Male decedents comprised 72.0% of the total deaths in children. The most common manner of death among children was natural, contributing 25.2% of the total. There were 38 suicides among children in 2020. Suicide deaths were more common among young males (79.0%) than females (21.0%), and gunshot wounds and hanging were the most common method of suicide in children. The total number of childhood homicides decreased from 30 homicides in 2019 to 24 in 2020. Homicide deaths among children tended to be male

(87.5%), White Hispanic (66.7%) and killed by a firearm (79.2%). Most childhood homicide victims (75.0%) were between the ages of 15 and 19. Firearms played a role in 21 suicides (55.3%) and 21 homicides (79.2% of child homicides). Homicide rates decreased by 20.0% from 2019 to 2020 with the largest homicide population impacting the age group 15–19 years."

The full report from the New Mexico Office of the Medical Investigator, Annual Report 2020, can be found at this link 2020-annualreport-.pdf (unm.edu).

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.

This rule can be found at

https://ibis.health.state.nm.us/view/docs/Standards/NMSmallNumbersRule2006.pdf

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Resources

National Center for Fatality Review and Prevention
The National Center for Fatality Review and Prevention – Keeping Kids Alive (ncfrp.org)

New Mexico Office of the Medical Investigator
Office of the Medical Investigator (unm.edu)