



New Mexico Office of the Medical Investigator

# Annual Report 2011



*“Wherever the art of medicine is practiced there is also a love of humanity.” –Hippocrates*

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**2011 Annual Report  
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State of New Mexico**

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**Office of the Medical Investigator (OMI)  
2011 Annual Report**

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## **Introduction**

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The Office of the Medical Investigator (OMI) investigates any death occurring in the State of New Mexico that is sudden, violent, untimely, unexpected or where a person is found dead and the cause of death is unknown. OMI performed services for a total of 5,284 deaths. A detailed breakout of the case distribution can be found in this report.

This report is presented in two sections. The first section of the report summarizes the activity of the OMI. The second presents data routinely collected by the OMI in a manner that answers questions related to mortality and public health from a medical examiner's perspective. The tables and figures included in the report are designed to be self-explanatory, and we hope you find them easy to read and understand. Definitions can be found in the Glossary and may provide assistance with the terminology encountered in the report. Readers with special interests, needs, or whose questions are not answered by this report may contact the Computer and Information Services Section of the OMI. Additionally, we encourage interested researchers to contact the Bureau of Vital Statistics for complete mortality statistics.

Comments or suggestions concerning the content, format or clarity of the report are always welcome.

## **Preparation of the Annual Report**

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The OMI data from which this report was compiled are maintained on a web-based database management system located at the New Mexico Scientific Laboratories in Albuquerque. OMI faculty Sarah Lathrop, DVM, PH.D and, J&J Technical Services staff Greta Freienmuth, using Microsoft Office 2010 Professional, prepared this report. UNM Health Sciences Center – Digital Printing and Document Services printed and bound the final distribution copies. Electronic copies of this report may be downloaded in .PDF format from the OMI website: [omi.unm.edu](http://omi.unm.edu)

## **Overview – Office of the Medical Investigator – 2011**

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The Office of the Medical Investigator (OMI) was created by the New Mexico State Legislature in 1972 and became operational in 1973. Replacing the county coroner system, the OMI was tasked<sup>1</sup> with investigating all reportable deaths occurring in New Mexico, to subsequently determine the cause and manner of death in such cases, and to provide formal death certification.

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<sup>1</sup>NMSA Statute 24-11-1, et seq., and 7-NMAC 3.2.8



## **Reportable Deaths:**

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Those deaths to be reported to the OMI include all deaths occurring in New Mexico as outlined below regardless of where or when the initial injuring event occurred.

- Any death that occurs suddenly and unexpectedly, that is, when the person has not been under medical care for significant, heart, lung or other disease.
- Any death suspected to be due to violence, i.e., suicidal, accidental or homicidal injury, regardless of when or where the injury occurred.
- Any death suspected to be due to alcohol intoxication or the result of exposure to toxic agents.
- Any death of a resident housed in a county or state institution, regardless of where death occurs. This refers to any ward of the state or individual placed in such a facility by legal authorization.
- Any death of a person in the custody of law enforcement officers.
- Any death of a person in a nursing home or other private institution without recent medical attendance.
- Any death that occurs unexpectedly during, in association with, or as a result of diagnostic, therapeutic, surgical or anesthetic procedures.
- Any death alleged to have been caused by an act of malpractice.
- Any death suspected to be involved with the decedent's occupation.
- Any death unattended by physician.
- Any death due to neglect.
- Any stillbirth of 20 or more weeks' gestation unattended by a physician.
- Any maternal death to include death of a pregnant woman regardless of the length of the pregnancy, and up to six weeks post delivery, even where the cause of death is unrelated to the pregnancy.
- Any death of an infant or child where the medical history has not established some pre-existing medical condition.
- Any death, which is possibly, directly or indirectly, attributable to environmental exposure, not otherwise specified.
- Any death suspected to be due to infectious or contagious disease wherein the diagnosis and extent of disease at the time of death are undetermined.
- Any death occurring under suspicious circumstances.
- Any death in which there is doubt as to whether or not it is a medical investigator's case should be reported.

## **Statutory Duty:**

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The OMI Policy Manual, derived from statute, requires the OMI to perform the following duties in all cases of reportable deaths:

- Receive all reports of sudden, unexpected or unexplained deaths.
- Respond to all sudden, unexpected or unexplained deaths.
- In the absence of a physician, pronounce death.
- Take custody of the body and all articles on or near the body.

- Maintain the chain of custody of the body and all articles obtained there from.
- Conduct an investigation leading to the determination of the cause and manner of death.
- Obtain toxicology samples from the body when indicated, and arrange for necessary tests upon those samples that will aid in the determination of cause and manner of death; maintain the proper chain of custody and evidence on those samples; store those samples for an appropriate period of time.
- Certify the cause and manner of death and forward written certification to designated agencies.
- Properly dispose of human remains through release to family or designated and authorized entities.
- Provide accurate identification of all human remains when possible.
- Cooperate with authorized agencies having involvement with death investigation.
- Provide professional, objective testimony in state and local courts of law.
- Define procedures that establish fees for services and material provided by the Office of the Medical Investigator.
- Define procedures to reimburse all parties providing services to the Office of the Medical Investigator.
- Establish and maintain a disaster plan outlining the role of OMI staff.
- Maintain records of each official death investigation and provide reports to official agencies.

The above duties are exclusive of deaths that occur on tribal or federal land. The OMI provides consulting services for requesting agencies such as the Bureau of Indian Affairs (BIA), Federal Bureau of Investigation (FBI), Tribal Law Enforcement or neighboring state jurisdictions.

The OMI is designated as a special program within the Department of Pathology at the University of New Mexico School of Medicine. A Board of Medical Investigations comprised of the Dean of the UNM School of Medicine, the Chief of the New Mexico State Police, the Secretary of Health and Environment Department, the Chairman of the New Mexico Thanatopractice and the Chairman of the New Mexico Indian Affairs Commission was established to oversee and develop policy. The Board appoints the Chief Medical Investigator, a physician licensed in New Mexico, trained in Pathology and Forensic Medicine, who has responsibility for operations.

The program operates out of the Central Office located in the UNM Health Sciences Center in Albuquerque, New Mexico. The Central Office directs all investigative activities statewide. Specially trained and certified Field Deputy Medical Investigators (FDMI) conduct field investigations. Every county in New Mexico has FDMI's who conduct investigations at the scene of death to collect information used to determine jurisdiction, possible cause and manner of death, and in the absence of a physician provide the pronouncement of death. The FDMI's contact the Central Office and present the results of each investigation to Central Office Deputy Medical Investigators who make the ultimate decisions regarding jurisdiction and the need for further medicolegal investigation. All autopsy services are conducted in the Central Office and are performed by forensic pathologists with the assistance of morphology services. The New Mexico State Laboratory provides the majority of toxicology services with some specialized tests sent to other laboratories. All documentation is archived by the Central Office and is available as provided for by public record statutes and regulations.

Such a strongly defined and professionally staffed system provides investigative agencies, the medical community and the citizens of New Mexico with standardized death investigation protocols and a

central repository for the information compiled during those medicolegal investigations. The centralization of these services has proven valuable in many areas of public concern including:

- Criminal investigations such as homicide or child abuse
- Protection of public health from environmental hazards and the spread of infectious disease
- Surveillance and reporting of deaths that may represent bioterrorist activities
- Medical and statistical research contributing to positive preventative measures (Seat Belt Laws)
- Expert testimony in court cases
- Proper certification of death
- Services to families of the deceased persons (Grief Services Program)

## **Program Summary and Highlights for 2011**

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### **Investigative Activity:**

In 2011, New Mexico had 5,284 deaths that met the criteria to become a reportable death. The OMI provided investigative services for each of these 5,284 deaths. Following these investigations, OMI retained jurisdiction of 3,604 deaths and relinquished jurisdiction of 1,480 deaths to private physicians. An additional 200 deaths were investigated as a consultation services resulting in a total caseload of 5,284 medicolegal investigations. A granular examination of the case distribution is presented in the section Overview – Total Cases – 2011 beginning on page 8.

### **“Doe” and/or missing person cases:**

Each year OMI receives 150-200 “Doe” cases, where remains are initially unidentified. 98% of these cases are successfully identified through OMI’s investigative efforts. In 2011 this included 153 postmortem forensic dental examinations (using dental records to help identify remains).

## **Training and Education**

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At the OMI, the activity of training and education is an integral part of day-to-day operations. The OMI is designated as a special program within the Department of Pathology at the University of New Mexico School of Medicine. The staff pathologists are faculty members with the School of Medicine and are expected to participate in training of medical students, residents and fellows, as well as conduct research activity to further advance the science of forensic medicine.

### ***Forensic Pathologist Fellowship Program***

The OMI Forensic Pathology Fellowship Program is considered one of the best in the country. The fellowship is a one-year, in-depth training program in the subspecialty of forensic pathology. Applicants must have completed an accredited pathology residency program. Four positions for this competitive program are available each year and are generally filled two to three years in advance.

### ***Certification Training***

All OMI deputy medical investigators are required to become certified to perform a death investigation. The OMI provides this training for the deputy medical investigators throughout New Mexico and in the past year, 30 individuals successfully completed the training and received certification as new Field Investigators. 69 current Field Investigators participated in training and were recertified. Upon request, OMI will provide the certification training to other medical investigators, coroners and law enforcement agencies for adaptation to the needs of their local systems. (Ex. Native American police officers)

### ***Death Investigation Training***

Death Investigation Training was conducted by the OMI as two training sessions in Albuquerque, in March and October. 64 representatives from the medical examiner, law enforcement and health care professions from throughout the nation participated in the training with a curriculum designed to present the most current facets of death investigations.. Participants were from Washington, DC, Montana, New Jersey, Washington, Arizona, Colorado, Texas, Oklahoma, Idaho, Ohio, Indiana, California, Alabama, Delaware, Tennessee, Illinois and of course, New Mexico. New Mexico personnel included representatives from the New Mexico Department of Public Safety, Bureau of Vital Statistics, Albuquerque Police Department, EMS Academy, and through Career Fairs for Elementary, Middle and High Schools.

### ***Law Enforcement Education***

Death investigation training is provided at the New Mexico State Police Academy, the New Mexico Law Enforcement Academy, the Bernalillo County Sheriff's Office Training Academy, APD Citizen's Police Academy and the Albuquerque Police Academy. In addition, specialized training is provided to individual police departments at their request.

### ***Public Education***

OMI Staff conducts in-service training throughout the state for a wide variety of agencies. Examples of agencies include Department of Health, funeral homes, hospitals, correction facilities, the EMS training site, state search and rescue groups and professional/advanced degree classes at New Mexico Universities.

### ***OMI Newsletter and website***

The OMI Newsletter is published quarterly and sent to OMI field and central office staff, funeral homes and hospice and home health care. The newsletter conveys information regarding updates in legislation and/or investigation and personnel issues.

The OMI website at <http://omi.unm.edu> provides instant access to information concerning OMI, staff, operating procedures and services offered. Through the website, users can download forms needed for requesting OMI documents.

## **Grief Services Program**

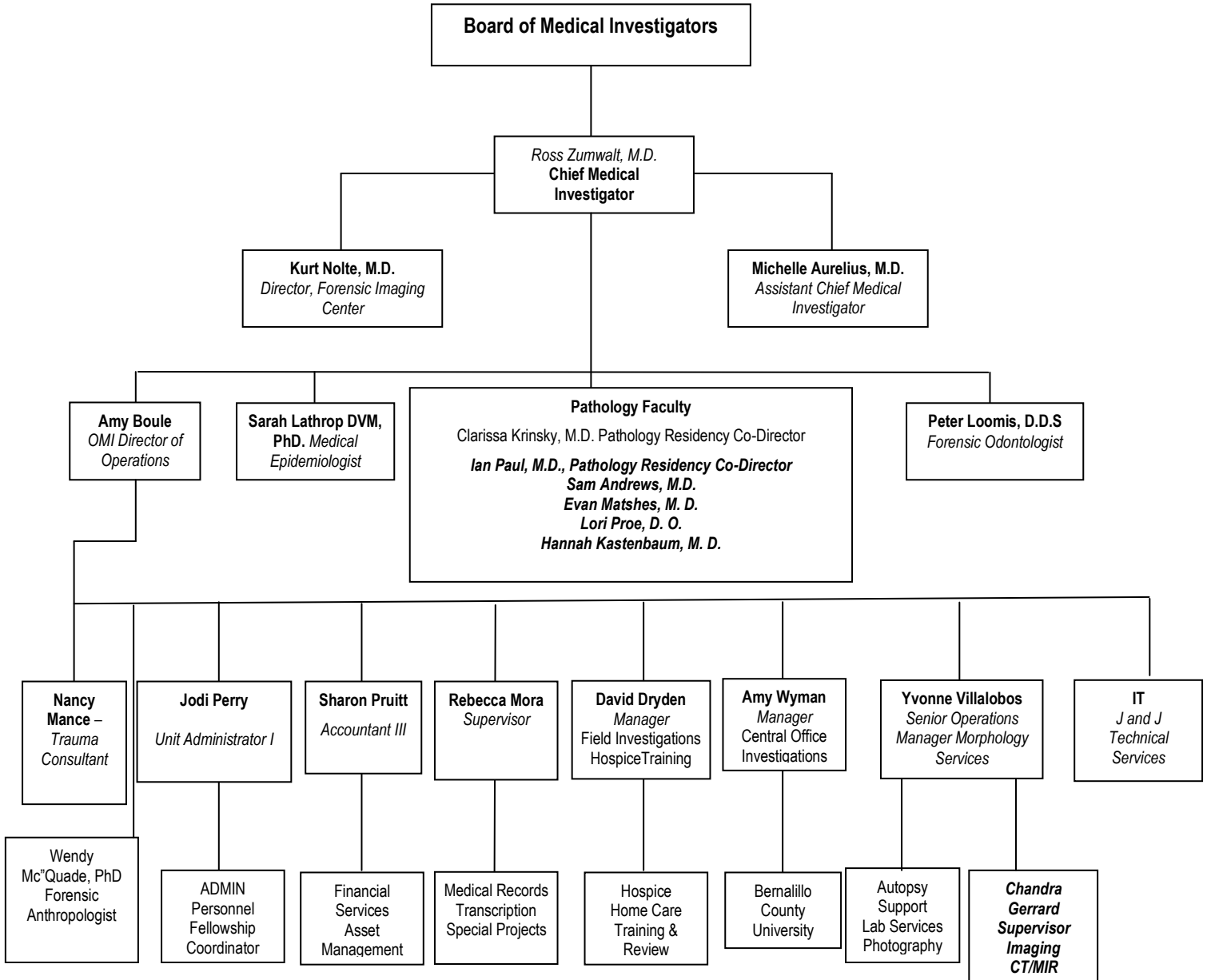
The Grief Services Program (GSP) was established in 1975. Initially, the program provided crisis intervention and education to families whose child died as a result of Sudden Infant Death Syndrome (SIDS). The program has continually expanded its mission and now provides its services to all New Mexico families following the sudden and unexpected death of a family member. These services include: crisis intervention, psychotherapy, education, consultations, and referrals. Additionally, the GSP provides grief education and training throughout New Mexico for agencies such as law enforcement, emergency responders, nurses, mental health providers, teachers and other groups who request such training.

## **Donor Services**

In 2011, OMI ensured that 100% of potential organ donors and their families were allowed to give the gift of life. OMI works closely with Donor Services to provide life-saving organs from transplantation, in New Mexico and across the country. Our thanks to the families whose loved ones became an organ or tissue donor, providing an enhanced quality of life to hundreds of transplant recipients.

## Office of the Medical Investigator Organizational Chart as of December 2011

Figure 1



## **Total Cases**

The remainder of this report will present data routinely collected by the OMI in a manner that answers questions regarding mortality and public health. The tables and charts summarize data collected on every medicolegal investigation, including consultation cases that the OMI conducted for this reporting period. The data, a subset of total mortality figures, represent findings on cases that come to the attention of forensic pathology. Readers who need complete mortality figures are encouraged to contact the State Center for Health Statistics – Office of New Mexico Vital Records and Health Statistics, New Mexico Department of Health.

**Figure 2 – Total Cases – 2002 - 2011**

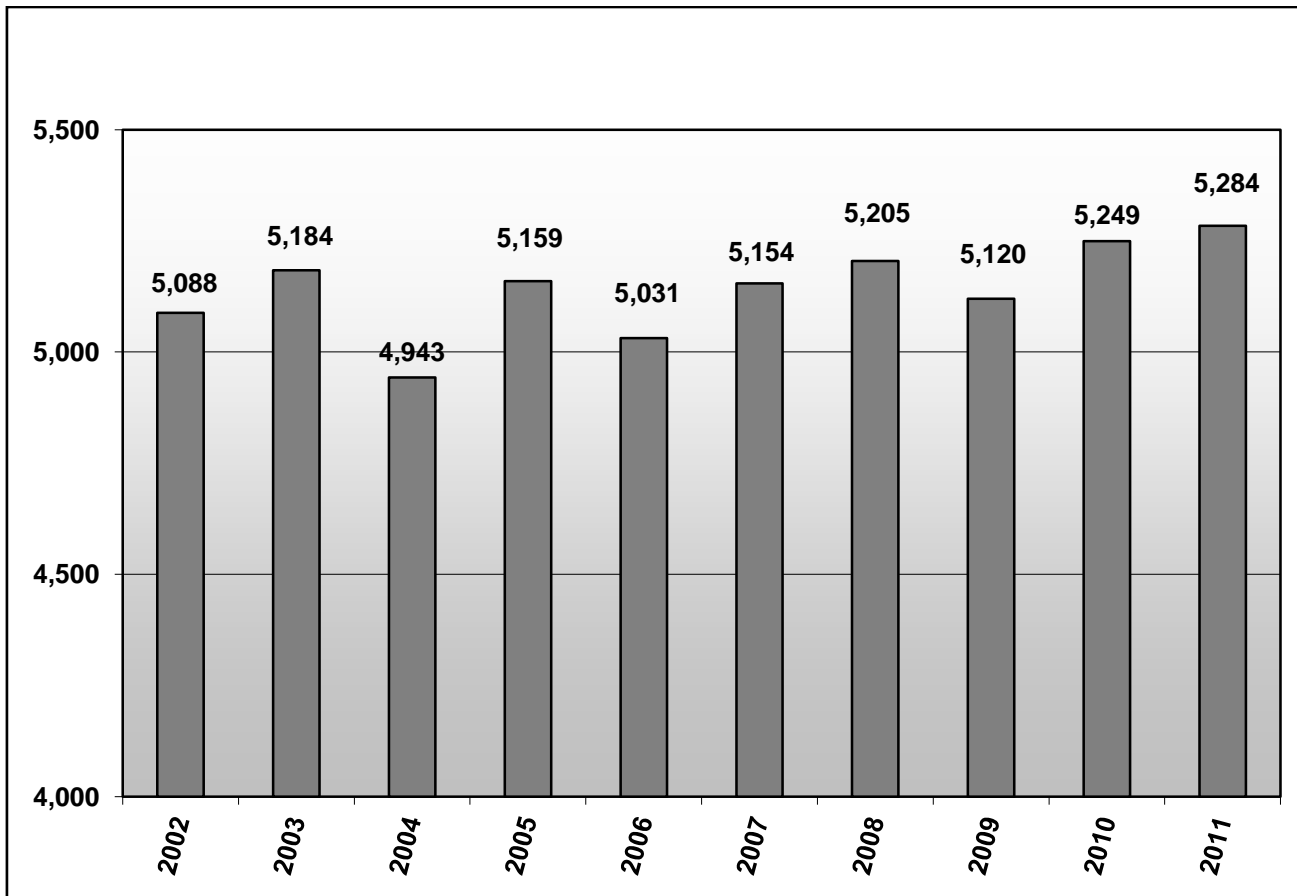


Figure 3 – Total Cases by Month – 2011

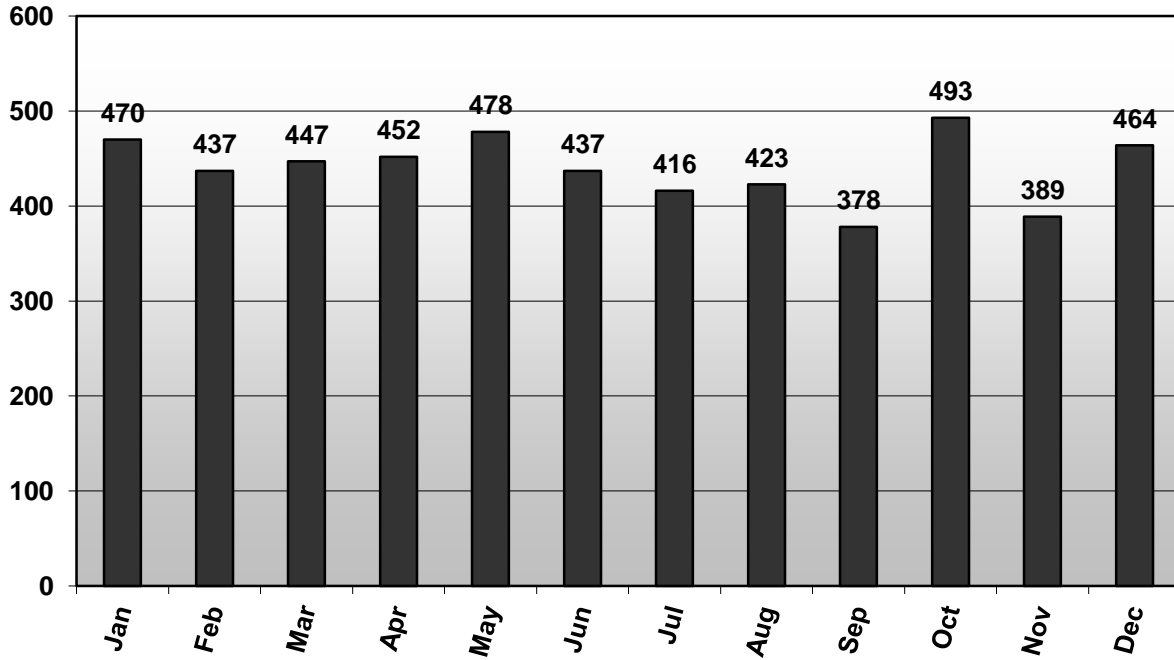


Figure 4 – Total Cases by Day – 2011

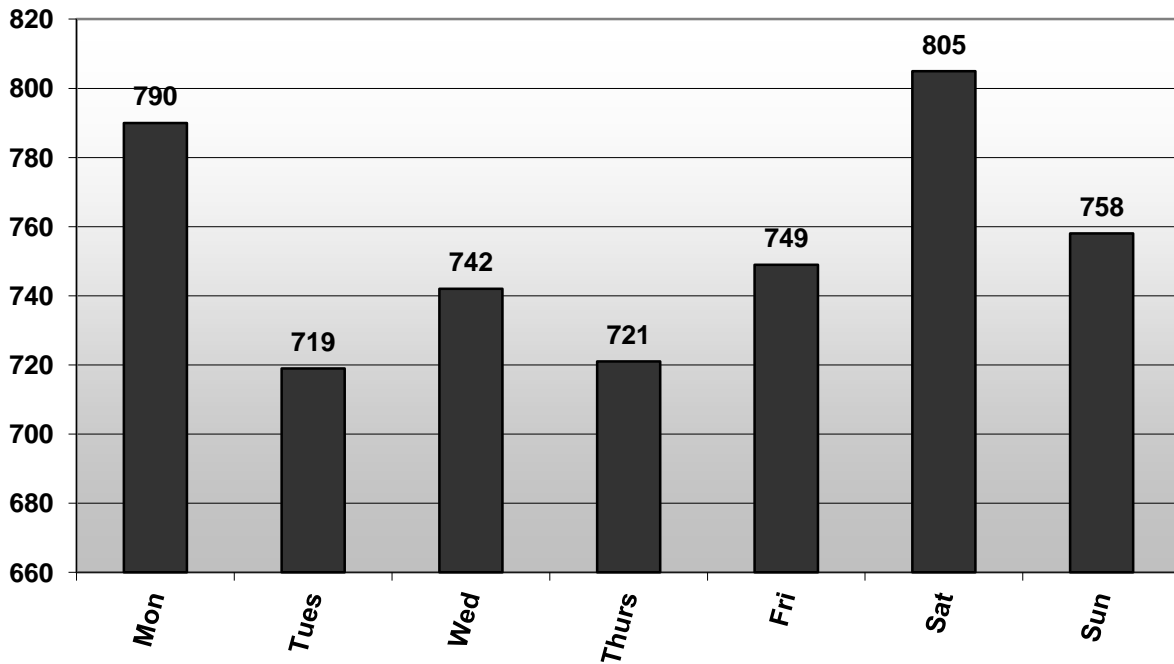
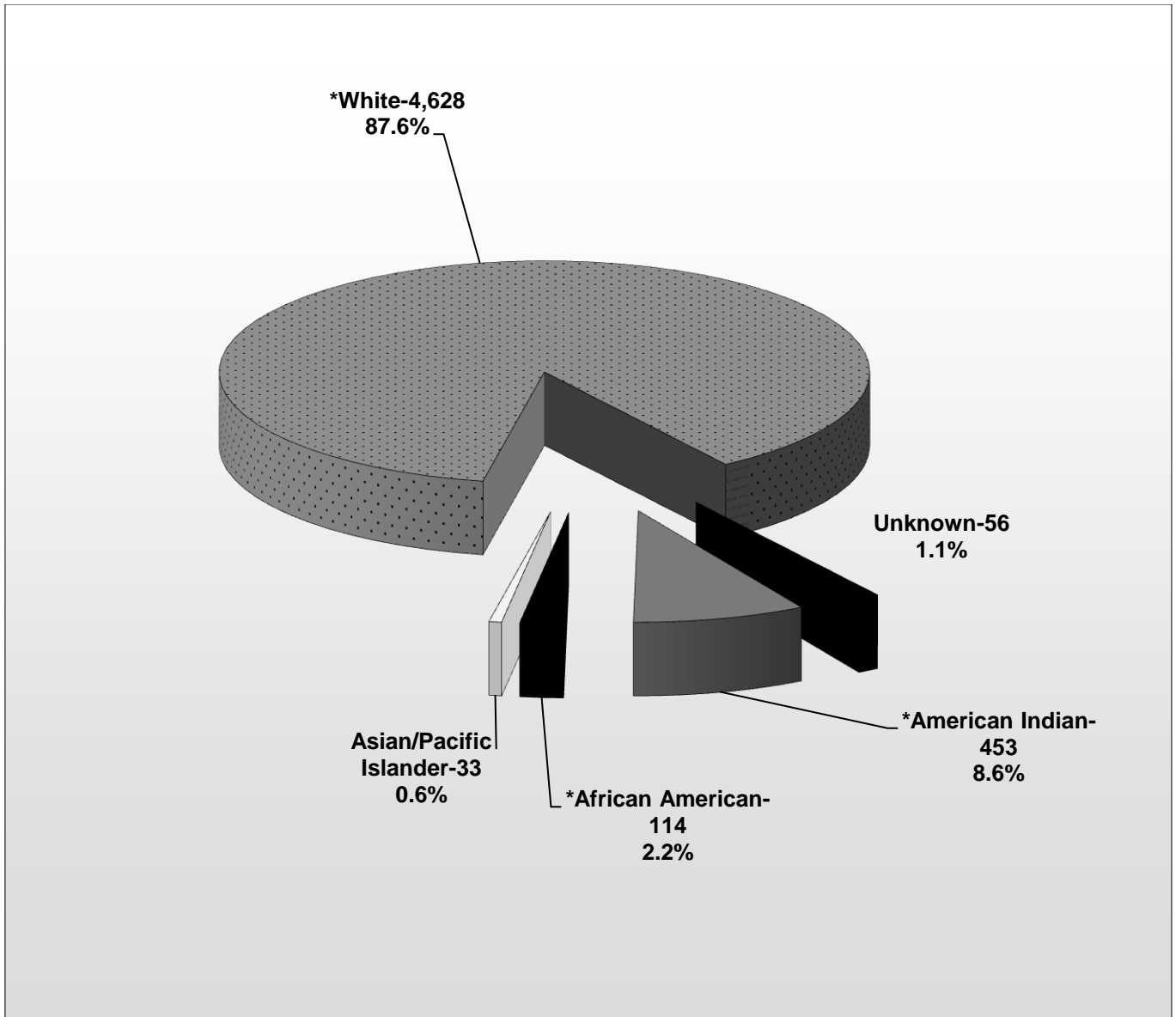


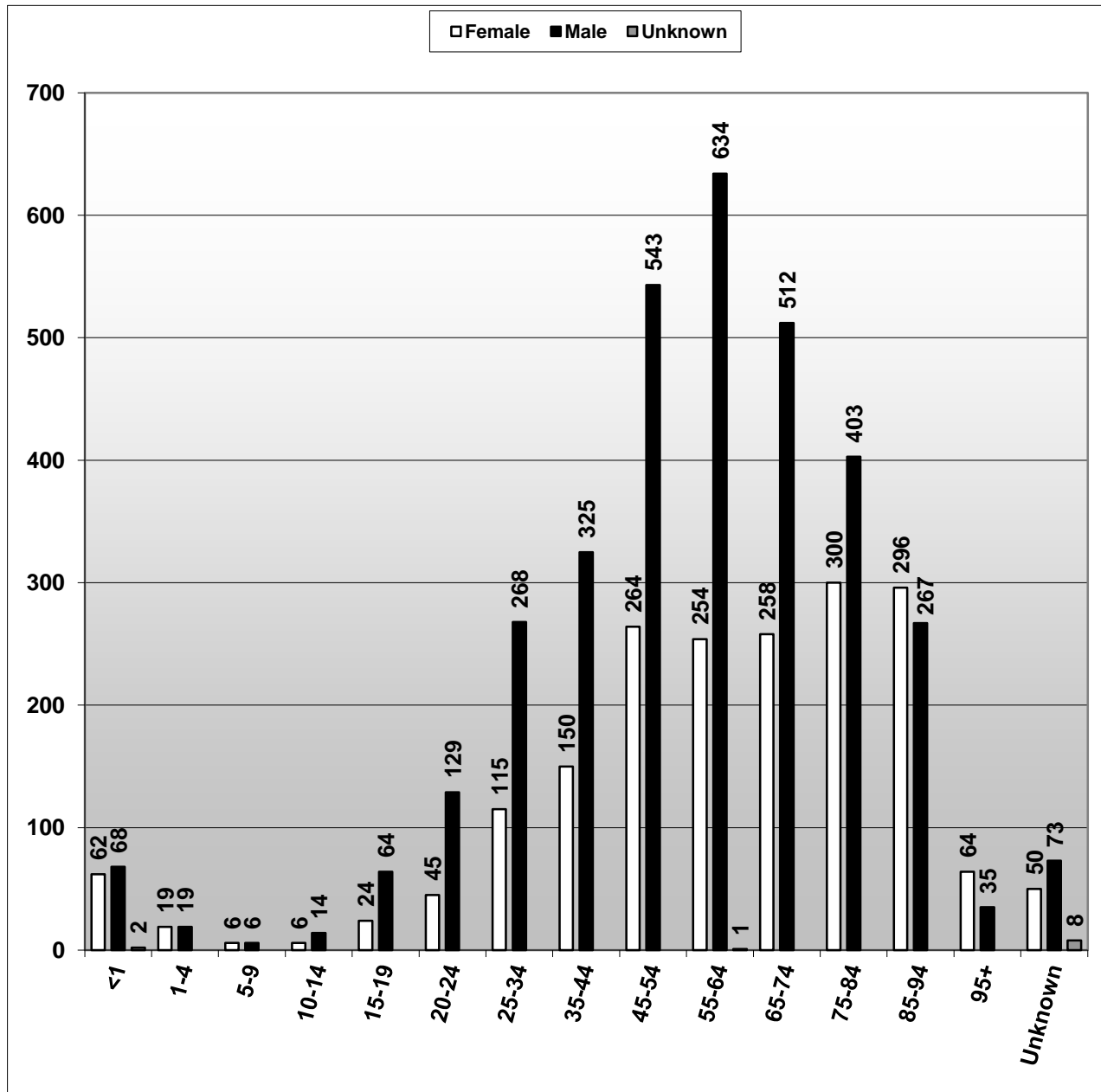


Figure 5 – Total Cases by Race/Ethnicity – 2011



\* White includes 1,645 Hispanic, \* American Indian includes 5 Hispanic, \*African American includes 2 Hispanic

Figure 6 – Total Cases by Age and Gender – 2011



**Table 1 – Total Cases – Autopsy Status – 2011**

Autopsy	Manner of Death					Total
	Natural	Accident	Suicide	Homicide	Undetermined*	
Yes	553	900	363	166	106	<b>2,088</b>
No	2,499	621	54	1	21	<b>3,196</b>
<b>Total</b>	<b>3,052</b>	<b>1,521</b>	<b>417</b>	<b>167</b>	<b>127</b>	<b>5,284</b>

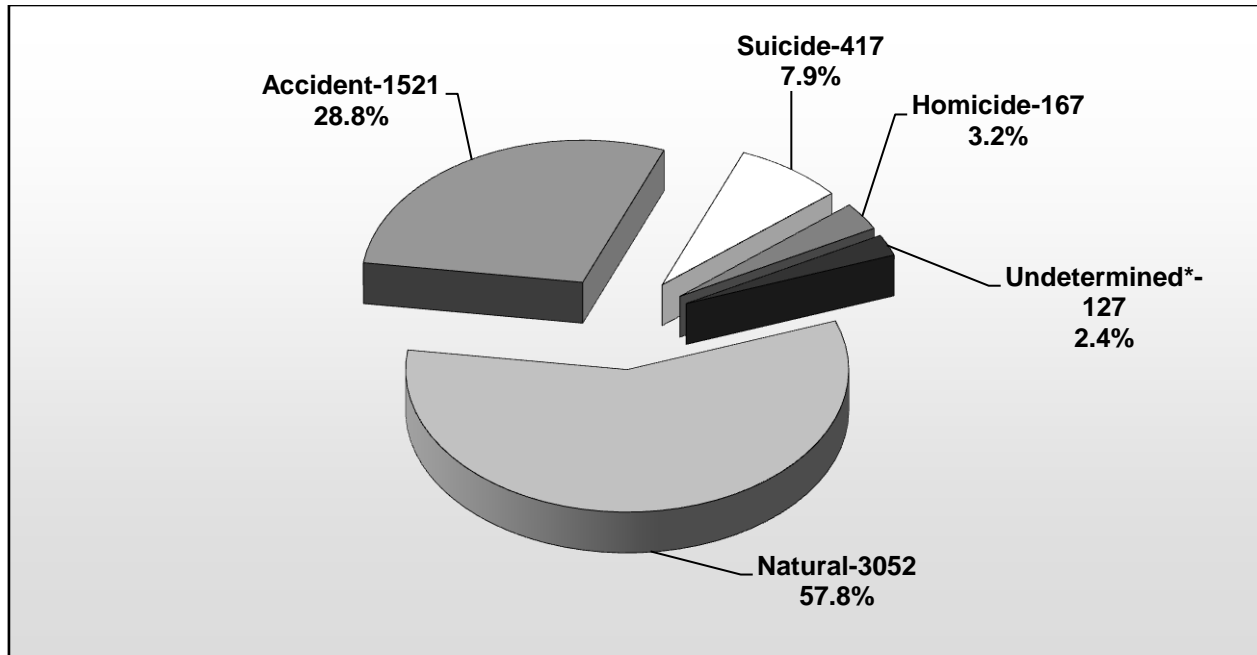
\*18 Other, 21 Pending, 1 Uncoded, 87 Undetermined included in Undetermined

**Table 2 – Total Cases – Case Distribution – 2011**

Type of Case	Manner of Death	Autopsy		Percent Autopsied	Total
		Yes	No		
<b>Medical Investigator</b>	Natural	490	992	33.1%	1,482
	Accident	858	617	58.2%	1,475
	Suicide	349	51	87.3%	400
	Homicide	148	1	99.3%	149
	Undetermined	90	7	92.8%	97
	<b>Subtotal</b>		<b>1,935</b>	<b>1,668</b>	<b>53.7%</b>
<b>Terminated Jurisdiction</b>	Natural	0	1,479	0.0%	1,479
	Accident	0	1	0.0%	1
	Suicide	0	0	0.0%	0
	Homicide	0	0	0.0%	0
	Undetermined	0	1	0.0%	1
	<b>Subtotal</b>		<b>0</b>	<b>1,481</b>	<b>0.0%</b>
<b>Reported Deaths</b>		<b>1,935</b>	<b>3,149</b>	<b>38.1%</b>	<b>5,084</b>
<b>Consultation Cases</b>	Natural	63	28	69.2%	91
	Accident	42	3	93.3%	45
	Suicide	14	3	82.4%	17
	Homicide	18	0	100%	18
	Undetermined	16	13	55.2%	29
	<b>Subtotal</b>		<b>153</b>	<b>47</b>	<b>76.5%</b>
<b>Total</b>		<b>2,088</b>	<b>3,196</b>	<b>76.1%</b>	<b>5,284</b>

## Cause and Manner of Death

Figure 7 – Total Cases – Manner of Death – 2011



\*1 Uncoded, 87 Undetermined, 21 Pending, 18 Other included in Undetermined

In 2011, OMI investigated 5,284 deaths, representing 35% of the estimated total deaths in New Mexico in 2011. Of the deaths investigated by OMI in 2011:

The total number of deaths investigated represents a .7% increase from the 2010 total, and a 3.8% increase since 2002.

The ratio of male to female deaths, when gender was clearly determined, was 1.76. Decedents classified as non-Hispanic white represented 56.4% of the total, Hispanic 31.2%, American Indian 8.6%, African American 2.2% and Asian 0.3%. The racial-ethnic composition of New Mexico was listed in the 2011 census as: 40% non-Hispanic white, 47% Hispanic, 10.1% American Indian, 2.5% African American and 1.6% Asian. (Source: <http://quickfacts.census.gov/qfd/states/35000.html>)

While natural deaths contributed the largest portion of OMI deaths investigated (58%), most natural deaths did not fall under the jurisdiction of the OMI. Data presented regarding natural deaths should not be interpreted as representative of all natural deaths in New Mexico.

Figure 8 – Total Cases – Manner of Death – Ten Year Summary  
2002 - 2011

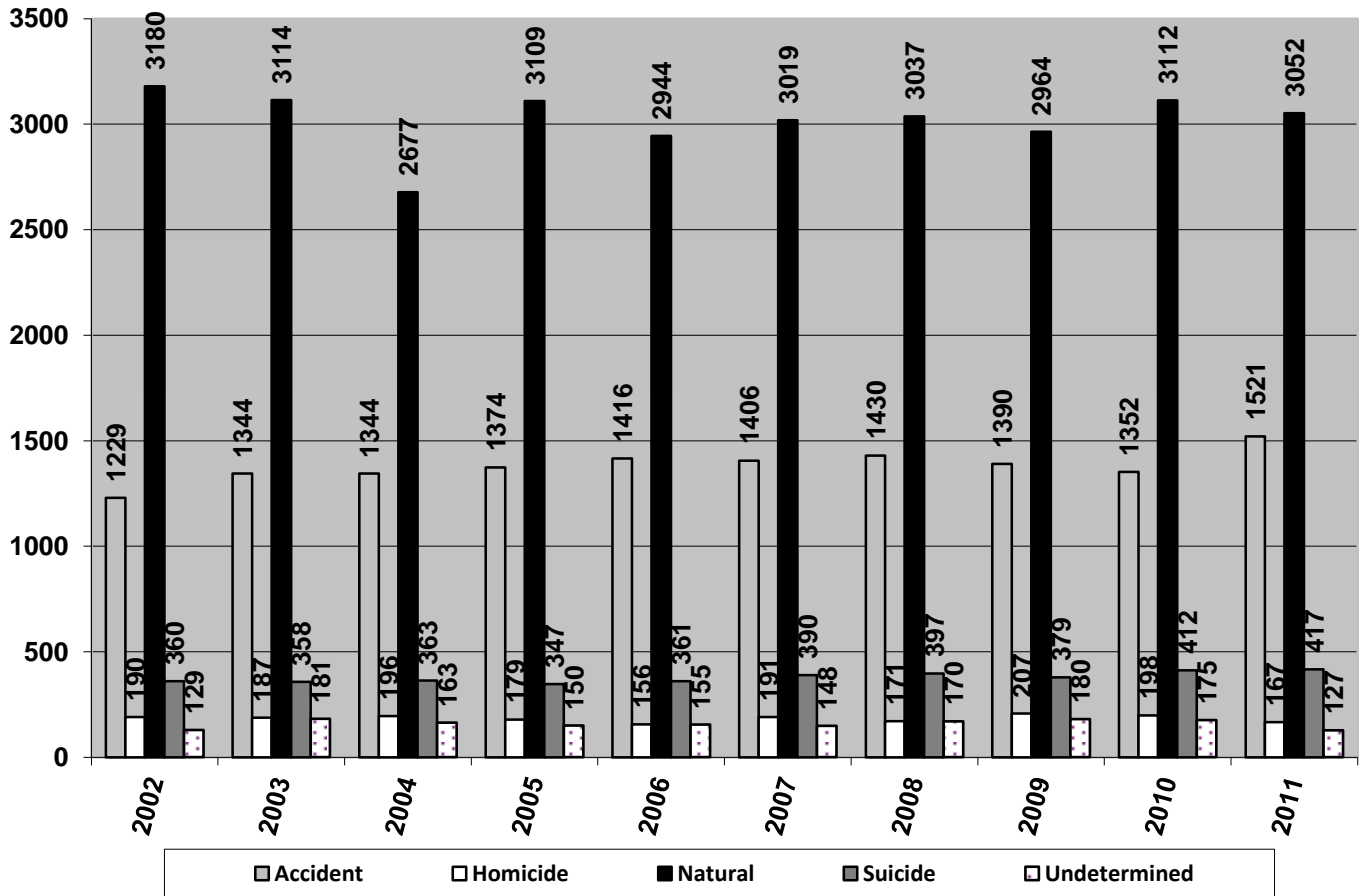


Table 3 - Total Cases – Manner of Death by Gender – 2011

Gender	Accident	Homicide	Natural	Suicide	Undetermined	Total
Female	573	33	1,169	97	41	1,913
Male	948	134	1,881	319	78	3,360
Unknown	0	0	2	1	8	11
<b>Total</b>	<b>1,521</b>	<b>167</b>	<b>3,052</b>	<b>417</b>	<b>127</b>	<b>5,284</b>

Table 4 - Total Cases – Manner of Death by Race/Ethnicity – 2011

Race/Ethnicity	Accident	Homicide	Natural	Suicide	Undetermined	Total
American Indian	161	31	195	37	29	453
Asian /Pacific Islander	10	1	18	3	1	33
African American	19	10	78	5	2	114
White/Hispanic	524	83	936	113	29	1,685
White	790	42	1,800	256	55	2,943
Unknown	17	0	25	3	11	56
<b>Total</b>	<b>1,521</b>	<b>167</b>	<b>3,052</b>	<b>417</b>	<b>127</b>	<b>5,284</b>

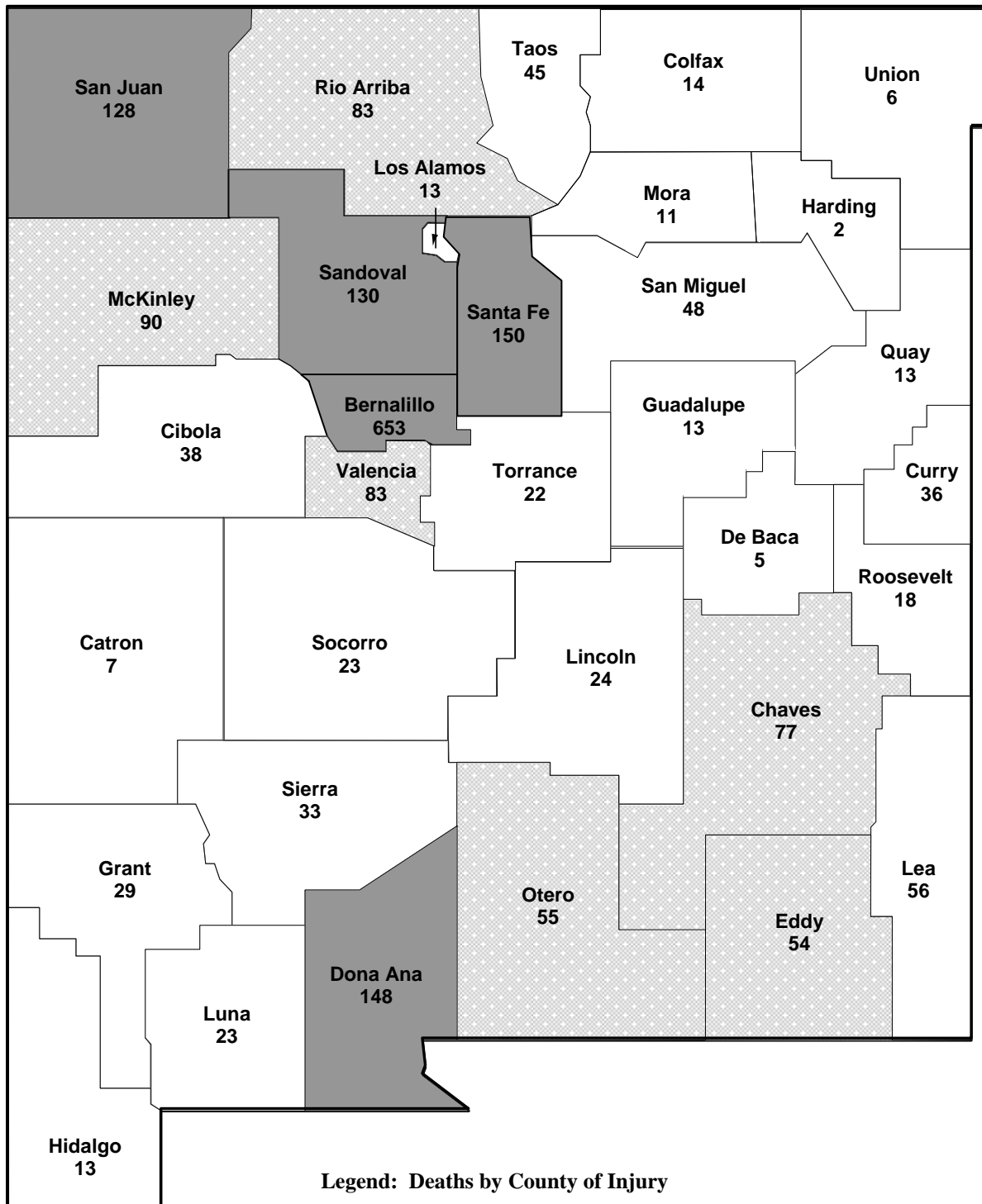
\* American Indian includes 5 Hispanic, African American includes 2 Hispanic

**Table 5 - Total Cases – Manner of Death by Age and Gender 2011**  
**Age at Death**

Gender	Age	Natural	Accidents		Suicide	Homicide	Undetermined	Total
			MVA*	Non-MVA				
<b>Female</b>	<1	47	2	2	0	2	9	62
	1-4	9	8	1	0	1	0	19
	5-9	5	0	1	0	0	0	6
	10-14	2	2	1	1	0	0	6
	15-19	7	7	3	4	2	1	24
	20-24	8	14	12	6	5	0	45
	25-34	25	12	51	18	7	2	115
	35-44	41	9	71	16	5	8	150
	45-54	146	14	62	28	4	10	264
	55-64	195	8	33	12	3	3	254
	65-74	199	10	35	10	2	2	258
	75-84	214	5	77	2	2	0	300
	85-94	185	1	105	0	0	5	296
	95+	38	0	26	0	0	0	64
Unknown	48	0	1	0	0	1	50	
<b>Subtotals</b>		<b>1,169</b>	<b>92</b>	<b>481</b>	<b>97</b>	<b>33</b>	<b>41</b>	<b>1,913</b>
<b>Male</b>	<1	47	0	7	0	1	13	68
	1-4	4	6	5	0	3	1	19
	5-9	1	0	4	0	0	1	6
	10-14	4	4	2	2	0	2	14
	15-19	9	13	12	19	9	2	64
	20-24	12	33	38	26	16	4	129
	25-34	39	44	83	61	34	7	268
	35-44	97	25	106	57	34	6	325
	45-54	268	49	138	55	20	13	543
	55-64	421	24	119	47	11	12	634
	65-74	396	21	62	20	3	10	512
	75-84	307	7	59	23	1	6	403
	85-94	179	7	70	9	1	1	267
	95+	25	0	10	0	0	0	35
Unknown	72	0	0	0	1	0	73	
<b>Subtotals</b>		<b>1,881</b>	<b>233</b>	<b>715</b>	<b>319</b>	<b>134</b>	<b>78</b>	<b>3,360</b>
<b>Unknown</b>	<1	2	0	0	0	0	0	2
	55-64	0	0	0	1	0	0	1
	Unknown	0	0	0	0	0	8	8
<b>Subtotals</b>		<b>2</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>8</b>	<b>11</b>
<b>Total</b>		<b>3,052</b>	<b>325</b>	<b>1,196</b>	<b>417</b>	<b>167</b>	<b>127</b>	<b>5,284</b>

\* MVA = Motor Vehicle Accidents

**Figure 9 - Deaths by County of Injury – 2011**  
Includes Accidents, Suicides, Homicides and Undetermined Deaths

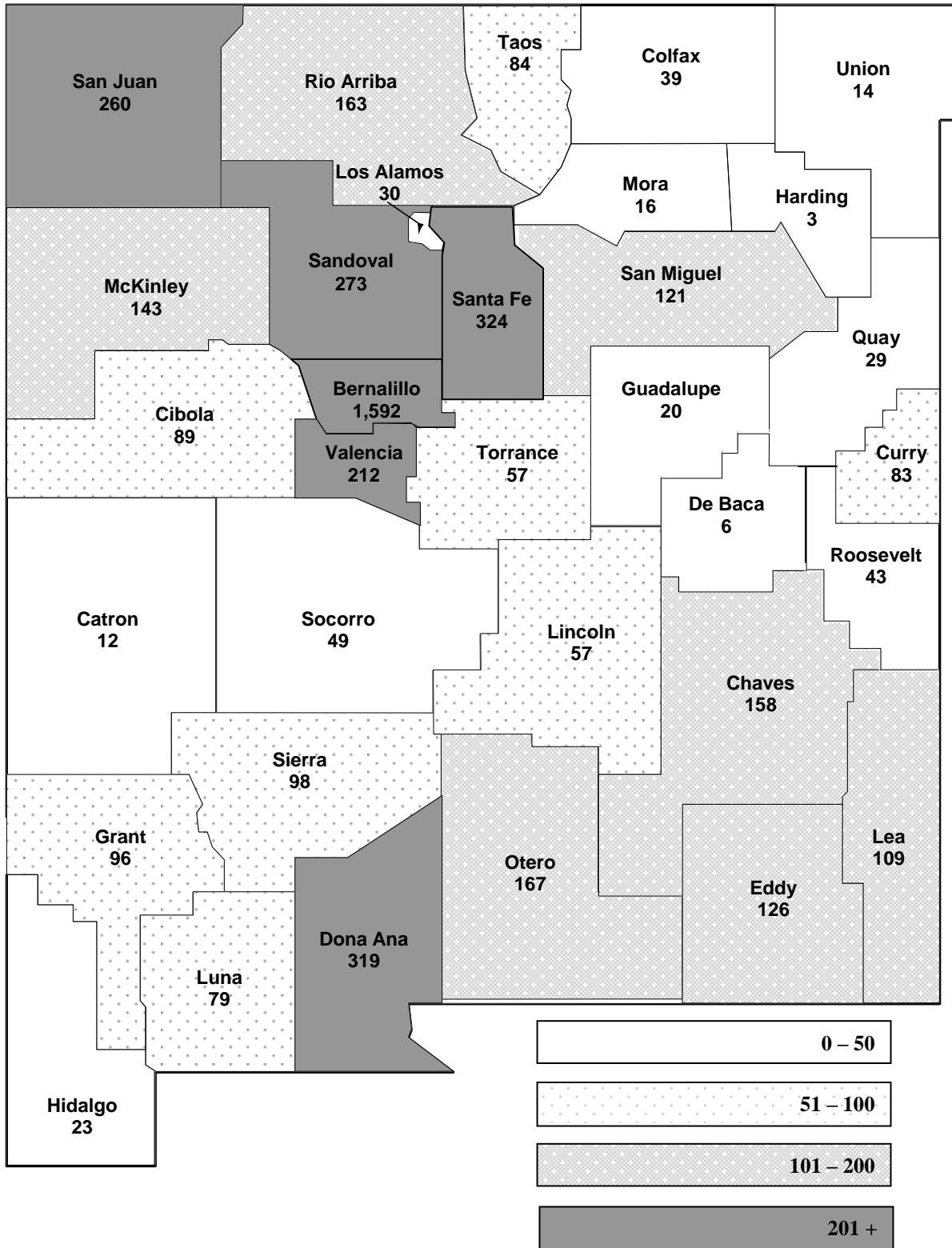


**Table 6 – Total Cases – County of Injury – 2011**

<b>Manner of Death by County of Injury</b>					
<b>County of Injury</b>	<b>Accident</b>	<b>Homicide</b>	<b>Suicide</b>	<b>Undetermined</b>	<b>Total</b>
Bernalillo	466	43	127	17	653
Catron	5	0	1	1	7
Chaves	57	6	12	2	77
Cibola	29	2	6	1	38
Colfax	10	0	3	1	14
Curry	26	5	4	1	36
De Baca	5	0	0	0	5
Dona Ana	98	8	35	7	148
Eddy	38	3	9	4	54
Grant	18	4	7	0	29
Guadalupe	12	0	1	0	13
Harding	2	0	0	0	2
Hidalgo	8	1	2	2	13
Lea	35	12	8	1	56
Lincoln	16	3	3	2	24
Los Alamos	10	0	3	0	13
Luna	14	2	3	4	23
McKinley	51	13	16	10	90
Mora	7	0	2	2	11
Otero	29	3	20	3	55
Quay	9	4	0	0	13
Rio Arriba	60	8	12	3	83
Roosevelt	13	1	3	1	18
San Juan	92	10	20	6	128
San Miguel	36	4	7	1	48
Sandoval	86	4	37	3	130
Santa Fe	107	12	29	2	150
Sierra	22	0	7	4	33
Socorro	18	0	2	3	23
Taos	27	3	13	2	45
Torrance	16	0	4	2	22
Union	4	0	1	1	6
Valencia	60	6	14	3	83
Non-Resident/Unknown	35	10	6	38	89
<b>Subtotals</b>	<b>1,521</b>	<b>167</b>	<b>417</b>	<b>127</b>	<b>2,232</b>
<b>Natural Deaths</b>					<b>3,052</b>
<b>Total</b>					<b>5,284</b>



Figure 10 – Deaths by County of Residence  
All Manners of Death



**Table 7 – Total Cases – County of Residence – 2011**

<b>Manner of Death by County of Residence</b>						
<b>County of Residence</b>	<b>Natural</b>	<b>Accident</b>	<b>Homicide</b>	<b>Suicide</b>	<b>Undetermined</b>	<b>Total</b>
<b>Bernalillo</b>	963	449	35	124	21	<b>1,592</b>
<b>Catron</b>	8	4	0	0	0	<b>12</b>
<b>Chaves</b>	89	49	6	12	2	<b>158</b>
<b>Cibola</b>	59	19	3	6	2	<b>89</b>
<b>Colfax</b>	31	5	0	2	1	<b>39</b>
<b>Curry</b>	47	25	4	4	3	<b>83</b>
<b>De Baca</b>	2	4	0	0	0	<b>6</b>
<b>Dona Ana</b>	184	84	7	36	8	<b>319</b>
<b>Eddy</b>	73	38	3	9	3	<b>126</b>
<b>Grant</b>	68	17	4	7	0	<b>96</b>
<b>Guadalupe</b>	15	4	0	1	0	<b>20</b>
<b>Harding</b>	2	1	0	0	0	<b>3</b>
<b>Hidalgo</b>	16	5	1	1	0	<b>23</b>
<b>Lea</b>	62	30	9	7	1	<b>109</b>
<b>Lincoln</b>	40	10	2	2	3	<b>57</b>
<b>Los Alamos</b>	20	7	0	3	0	<b>30</b>
<b>Luna</b>	53	15	2	3	6	<b>79</b>
<b>McKinley</b>	71	41	9	12	10	<b>143</b>
<b>Mora</b>	10	4	0	2	0	<b>16</b>
<b>Otero</b>	112	30	2	20	3	<b>167</b>
<b>Quay</b>	20	6	3	0	0	<b>29</b>
<b>Rio Arriba</b>	86	59	6	10	2	<b>163</b>
<b>Roosevelt</b>	28	9	1	3	2	<b>43</b>
<b>San Juan</b>	139	85	10	20	6	<b>260</b>
<b>San Miguel</b>	79	30	5	6	1	<b>121</b>
<b>Sandoval</b>	132	89	6	36	10	<b>273</b>
<b>Santa Fe</b>	170	110	11	29	4	<b>324</b>
<b>Sierra</b>	71	18	0	5	4	<b>98</b>
<b>Socorro</b>	32	14	0	2	1	<b>49</b>
<b>Taos</b>	46	24	3	9	2	<b>84</b>
<b>Torrance</b>	41	13	0	2	1	<b>57</b>
<b>Union</b>	9	2	0	2	1	<b>14</b>
<b>Valencia</b>	129	61	6	13	3	<b>212</b>
<b>Out of State/Unknown</b>	145	160	29	29	27	<b>390</b>
<b>Total</b>	<b>3,052</b>	<b>1,521</b>	<b>167</b>	<b>417</b>	<b>127</b>	<b>5,284</b>

**Table 8 - Overview – Cause of Death – 2011**

by Highest Value

Natural Cause of Death	Total Cases	Autopsy	Field External	Inv External	Path External
Heart Disease	1,388	173	221	30	52
Carcinoma	226	24	7	1	3
Chronic Obstructive Pulmonary Disease	167	3	11	2	0
Sepsis	139	40	1	0	1
Hypertension	128	36	29	4	6
Ethanolism	112	36	40	3	6
Pneumonia	109	48	1	0	0
Gastrointestinal Hemorrhage	89	26	9	5	6
Cerebrovascular	82	11	3	0	0
Hepatic Failure	64	11	0	0	1
Diabetes	55	10	2	1	2
Renal Failure	47	1	3	0	1
Emboli	42	23	1	0	1
Natural Other	40	6	0	0	0
Spontaneous Hemorrhage	35	10	1	0	0
Congenital Defect	34	7	0	0	0
Alzheimer's	33	2	1	0	0
Prematurity	31	5	0	0	0
Respiratory Distress Syndrome	29	4	0	0	0
Aneurysm	26	7	0	1	0
Epilepsy	21	13	1	0	0
Intrauterine Fetal Death	21	9	0	0	0
Obesity	21	9	4	1	0
Leukemia	17	3	0	0	1
Emphysema	12	0	5	5	5
Asthma	10	5	2	0	0

Parkinson's Disease	10	2	0	0	0
Pancreas	7	4	0	0	0
Pulmonary Edema	7	1	1	0	0
History of Illness or Injury	5	2	0	0	0
Maternal and Fetal Complications of Birth	5	4	0	0	0
Medical Treatment	4	3	0	0	0
Arthritis	3	0	0	0	0
Blood Disorders	3	0	0	0	0
Dehydration	3	2	0	0	0
Sudden Infant Death Syndrome (SIDS)	3	3	0		0
Acquired Immune Deficiency Syndrome (AIDS)	2	1	0	0	0
Amyotrophic Lateral Sclerosis (ALS)	2	0	0	0	0
Aspiration	2	0	0	0	0
C.Difficile Colitis	2	0	0	0	0
Dementia	2	0	0	0	0
Malnutrition	2	2	0	0	0
Multiple Organ Failure	2	0	0	0	0
Obstruction	2	0	0	0	0
Pulmonary Thromboemboli	2	2	0	0	0
Acute Pyelonephritis	1	1	0	0	0
Addison Disease	1	1	0	0	0
Amniotic Fluid Embolism	1	1	0	0	0
Appendicitis	1	1	0	0	0
Cirrhosis	1	0	0	0	0
Meningitis	1	1	0	0	0

<b>Unnatural Cause of Death</b>	<b>Total Cases</b>	<b>Autopsy</b>	<b>Field External</b>	<b>Inv External</b>	<b>Path External</b>
Substance Intoxication	518	502	5	0	3
Multiple Injuries	344	182	109	5	36
Gunshot Wound	303	278	22	0	3
Complications of Fracture	176	2	62	3	6
Head and Neck Injuries	164	79	35	3	22
Hanging	91	69	16	0	5
Complications of Fall	63	8	9	0	4
Unnatural – Other	63	11	24	0	5
Subdural Hematoma	59	4	16	2	16
Asphyxia	51	46	3	0	1
Narcotic Abuse	47	45	1	0	0
Exposure	47	43	2	0	2
Ethanol Intoxication	43	40	3	0	0
Stab Wound	37	37	0	0	0
Drowning	32	31	0	0	1
Thermal Injuries	23	17	0	2	3
Carbon Monoxide Intoxication	20	20	0	0	0
Aspiration	9	3	1	0	2
Exsanguination	8	7	0	0	0
Medical Treatment	7	5	1	0	0

<b>Undetermined Cause of Death</b>	<b>Total Cases</b>	<b>Autopsy</b>	<b>Field External</b>	<b>Inv External</b>	<b>Path External</b>
Undetermined – Other	74	70	0	0	0
Pending Investigation, Histology, Toxicology, Other	21	16	0	0	0
Insufficient Remains for Determination of Death	19	19	0	0	0
Certification for Record Purposes Only	6	1	0	0	0

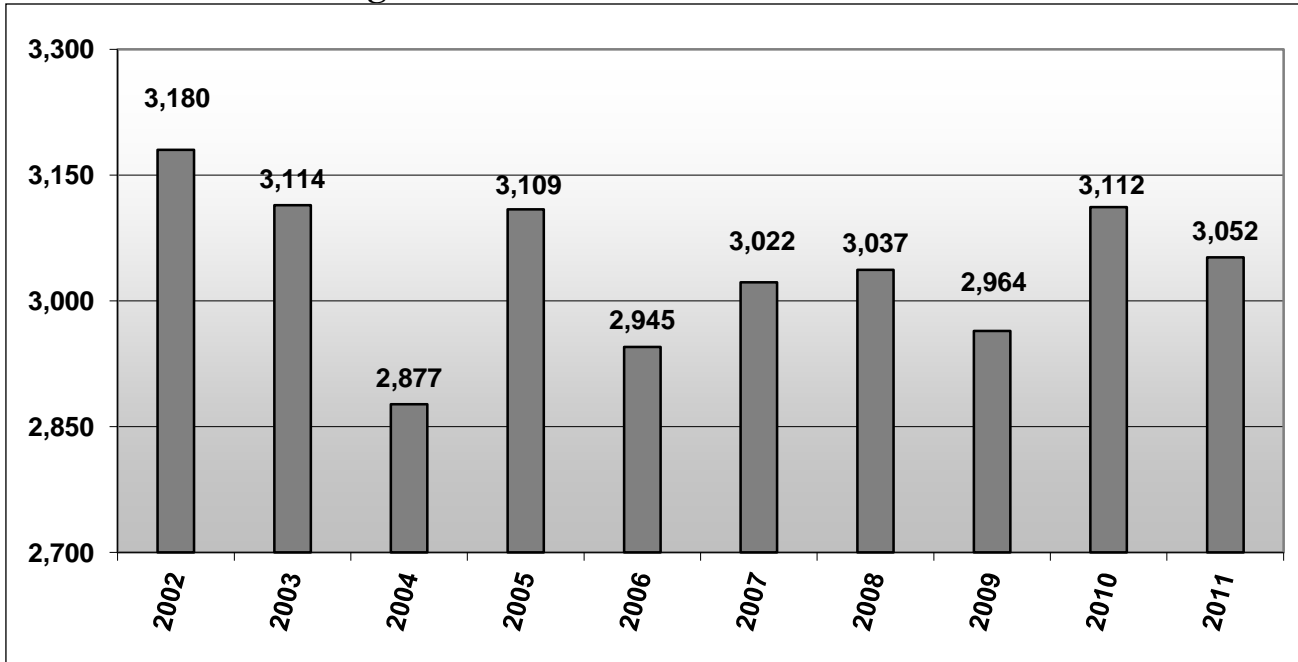
Consult Request Withdrawn	5	0	0	0	0
Donor, No Exam Conducted	1	0	0	0	0
Remains from Burial Site Not of Medico Legal Significance	1	0	0	0	0

## **Summary**

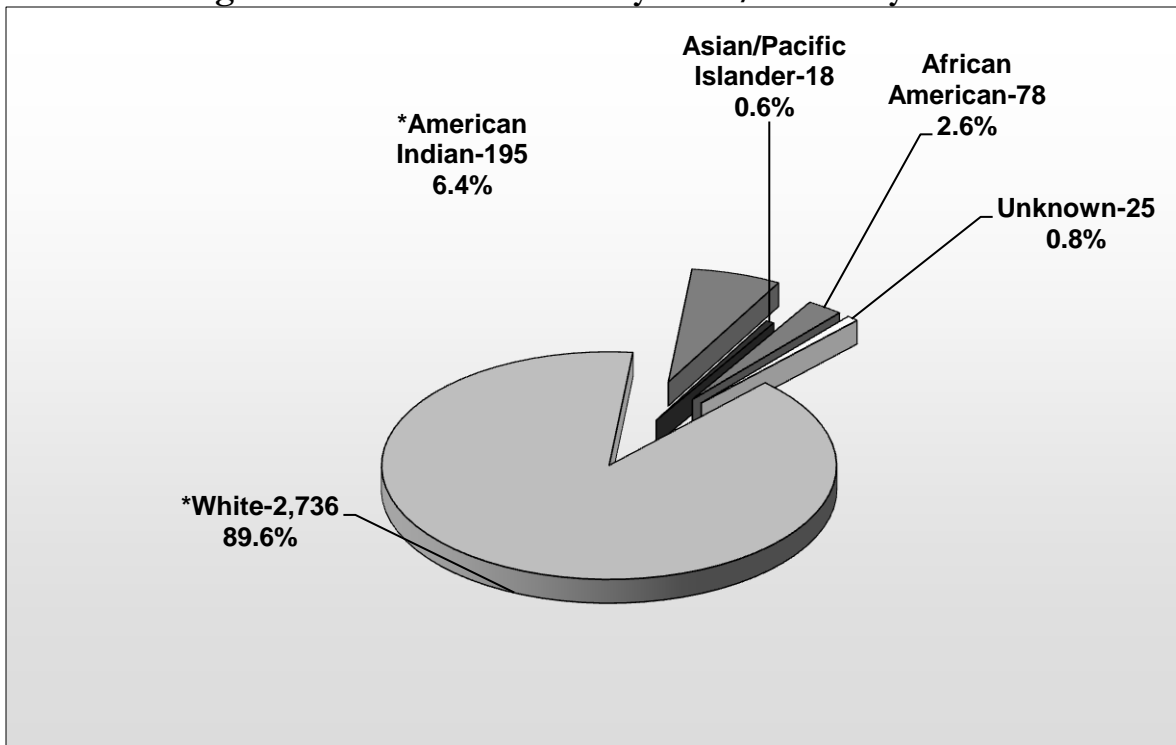
Five manners of death are used to classify deaths at the OMI: natural, accident, suicide, homicide and undetermined. The remainder of the annual report will present information on these specific manners of death, as well as certain categories of deaths investigated by the OMI, including deaths of children, ethanol (alcohol) related deaths, and drug involved deaths. Ten-year summaries will be followed by presentations of the current cases by race/ethnicity, and age/gender, then a breakdown by method of death and county of residence.

**Overview – Manner of Death – Natural Deaths**

**Figure 11 – Natural Deaths – 2002 – 2011**

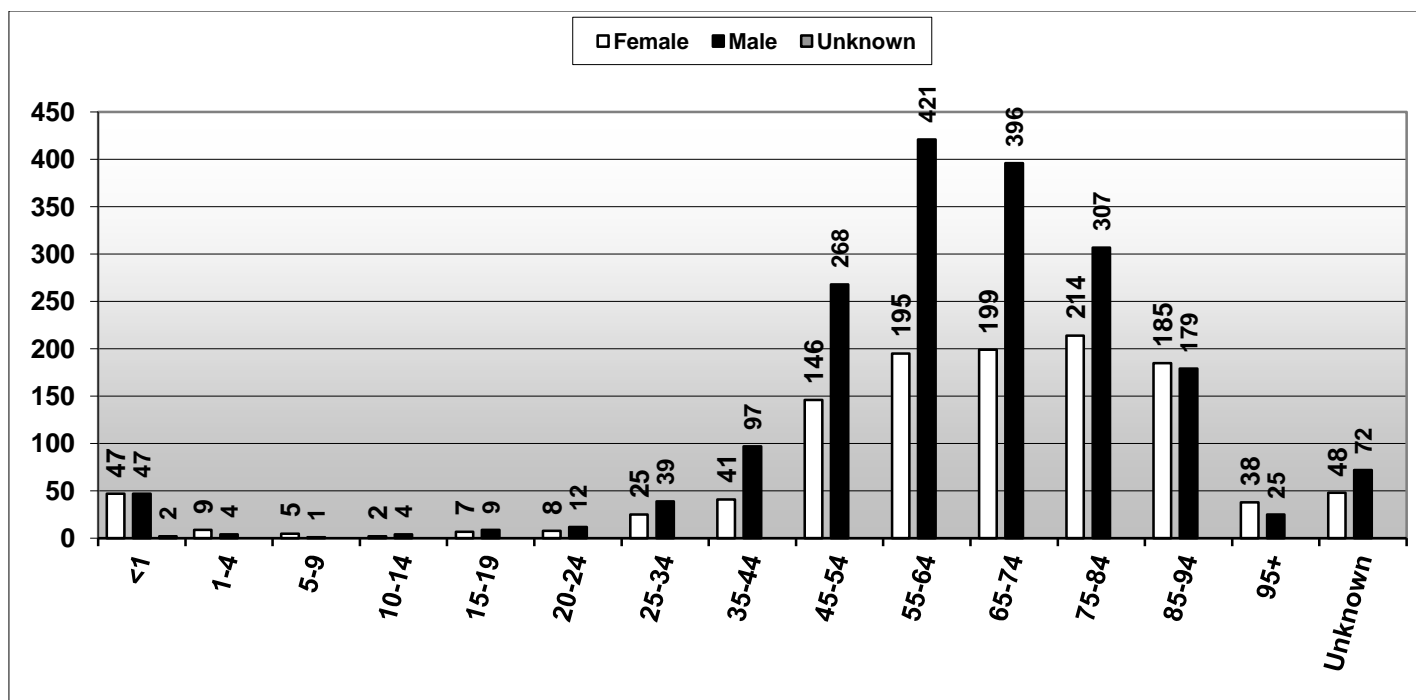


**Figure 12 - Natural Deaths by Race/Ethnicity – 2011**



\* White includes 936 Hispanic, \* American Indian includes 1 Hispanic, African American Includes 1 Hispanic

Figure 13 - Natural Deaths by Age and Gender – 2011



### Natural Deaths – Summary

Deaths classified as a “natural” manner of death, as compared to suicides, homicides, accidents and undetermined manners of death, represent the largest number of deaths investigated by OMI. However, most natural deaths that occur in New Mexico do not fall under the jurisdiction of OMI and are therefore not represented in this report. An excellent resource for all mortality statistics in the state is the publication “New Mexico Selected Health Statistics Annual Report,” published by the State Center for Health Statistics at the Office of New Mexico Vital Records & Health Statistics, Public Health Division, Department of Health, 1105 St. Francis Dr., PO Box 26110, Santa Fe, NM 87502-6110.



## Overview – Manner of Death – Accidental Deaths

Figure 14 - Accidental Deaths – 2002 – 2011

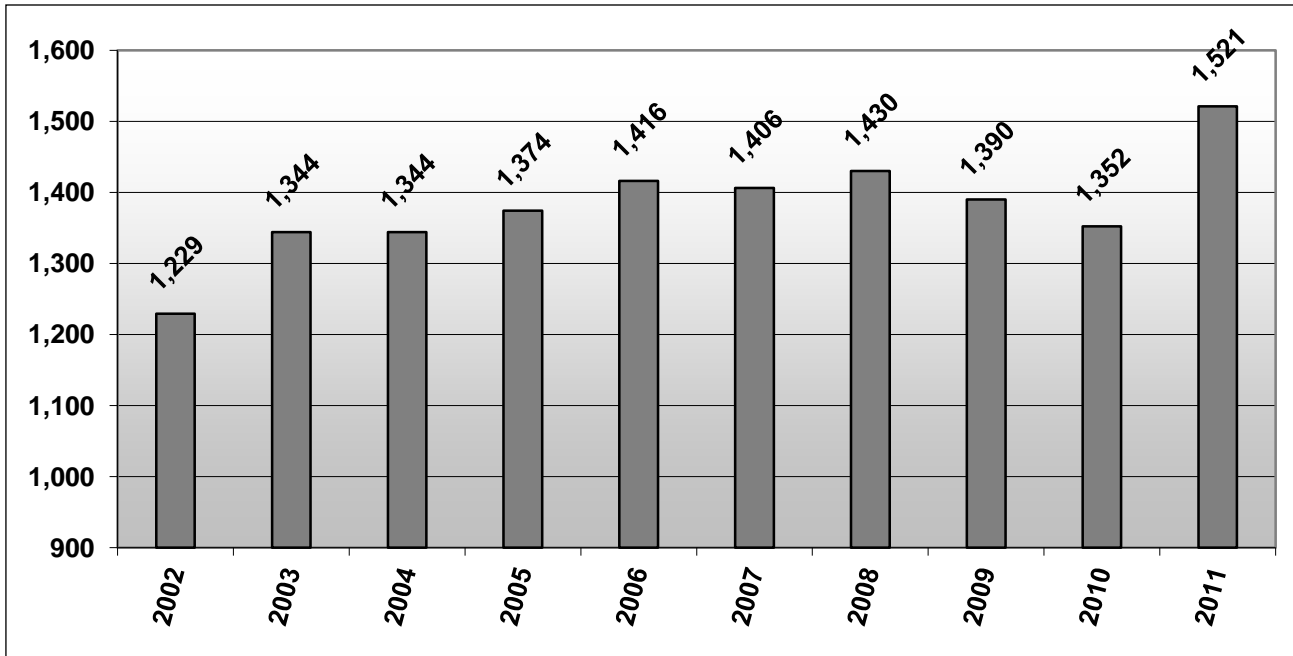
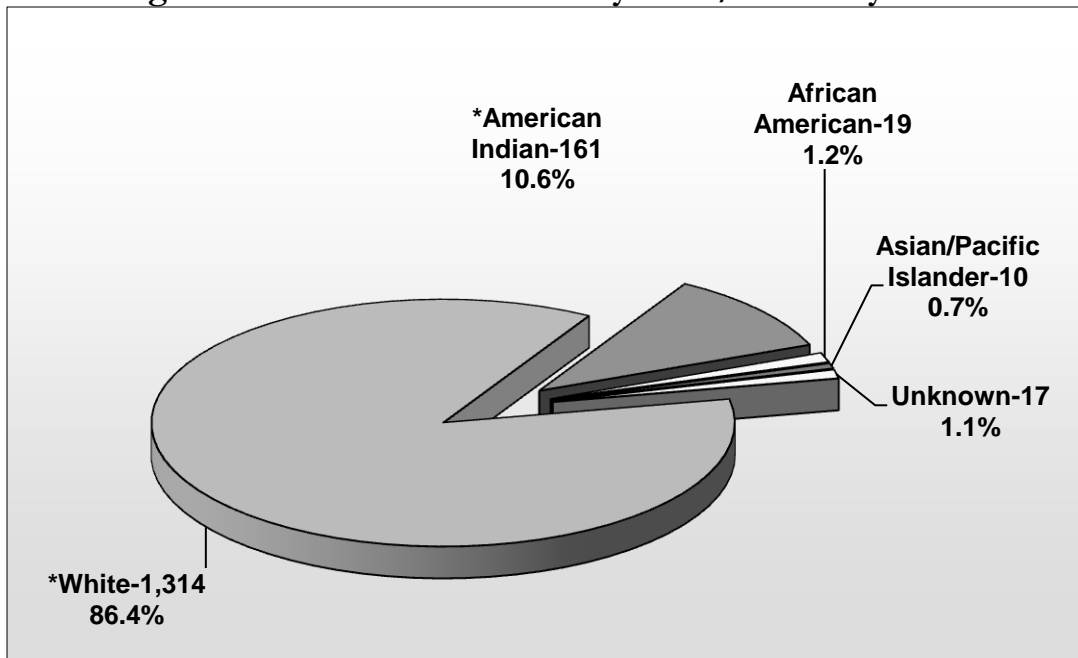


Figure 15 - Accidental Deaths by Race/Ethnicity - 2011



\* White includes 524 Hispanic, African American includes 1 Hispanic, American Indian includes 2 Hispanic

Figure 16 - Accidental Deaths by Age and Gender – 2011

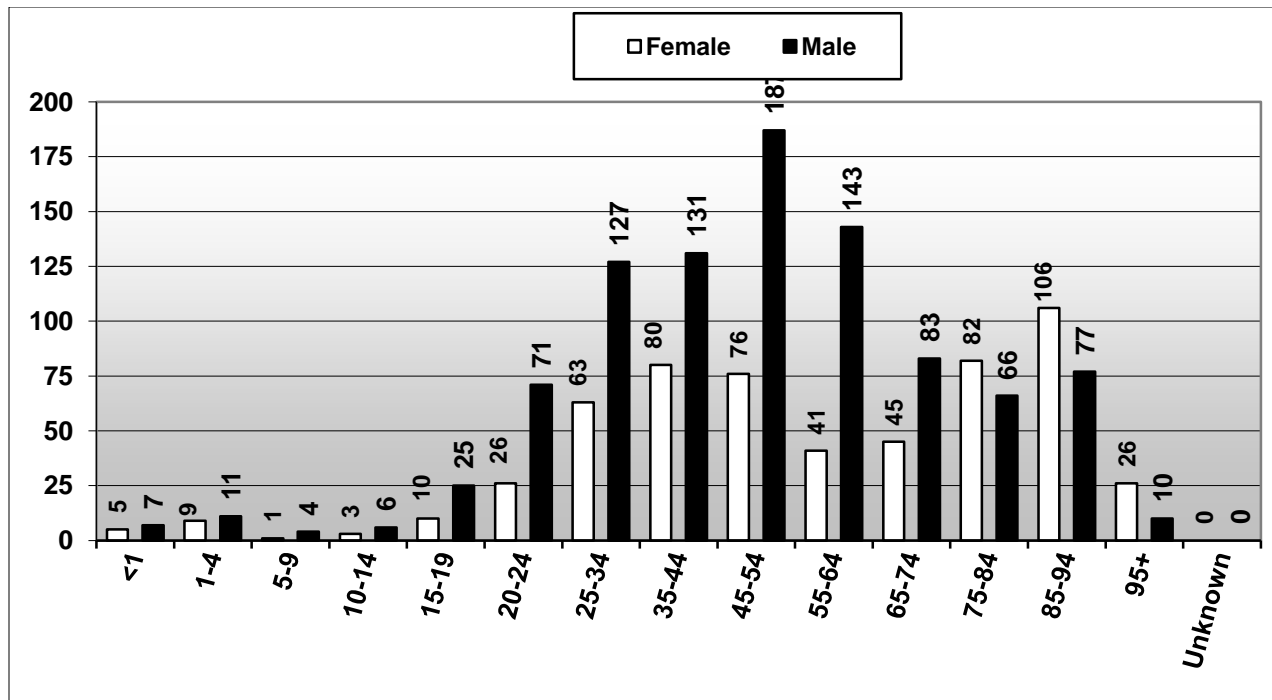


Table 9 - Accidental Deaths - Method – 2011

Manner of Death	Total Cases	Autopsy	Field External	Inv External	Path External
Injuries from Fall	414	30	126	8	40
Ingested and/or injected prescription medication(s)	204	197	1	0	1
Ingested and/or injected illicit drug(s)	144	138	1	0	2
Driver of motor vehicle that left roadway	78	36	32	1	7
Ingested and/or injected prescription medication(s) with alcohol	61	60	1	0	0
Driver of motor vehicle in collision with another motor vehicle	57	31	20	1	5
Ingested and/or injected illicit drug(s) with alcohol	50	48	2	0	0
Exposure	47	43	2	0	2
Ingested alcohol	37	34	3	0	0
Passenger in motor vehicle that left roadway	35	19	10	2	3
Ingested and/or injected illicit and prescription drug(s)	33	0	0	0	0
Pedestrian struck by motor vehicle(s)	26	20	3	0	2

Passenger in motor vehicle in collision with another motor vehicle	25	9	12	0	4
Thermal Injuries	24	19	0	1	3
Passenger in motor vehicle that left roadway and overturned	19	9	7	0	2
Drowned (during recreational activity)	18	18	0	0	0
Driver of motorcycle that left roadway	17	5	8	0	3
Driver of motor vehicle in collision with fixed object	16	5	6	0	4
Asphyxia	15	14	1	0	0
Driver of motorcycle in collision with motor vehicle	15	8	3	0	3
Drowned (non recreational water accident)	15	14	0	0	1
Choked	11	6	1	0	1
Crushed/Suffocated	9	7	1	0	1
Ingested and/or injected illicit and prescription drug(s) with alcohol	9	9	0	0	0
Presumed fall	8	1	1	0	3
Fall from vehicle	7	3	0	0	3
Inhaled toxic Agent (Substance Inhaled Accidentally)	7	7	0	0	0
Driver of ATV that crashed	6	2	3	0	0
Driver of motorcycle in collision with fixed object	6	1	3	0	2
Occupant in motor vehicle in collision with another motor vehicle	6	3	3	0	0
Pedestrian struck by train	6	3	2	1	0
Cyclist Struck by Motor Vehicle	5	3	1	0	1
Farm or Industrial Machinery Accident	5	5	0	0	0
Fall down Stairs	4	0	1	0	2
Medical Treatment	4	3	0	0	0
Pedestrian struck by pickup	4	1	2	0	1
Pilot of aircraft that crashed	4	4	0	0	0
Unknown	4	3	0	0	0
Accident - Other	3	2	0	0	0
Accidental discharge of firearm	3	3	0	0	0
Inhaled toxic agent (Substance Abuse)	3	2	0	1	0
Pedestrian struck by semi	3	3	0	0	0
Accidental Hanging	2	2	0	0	0
Accidental ligature strangulation	2	2	0	0	0
Anaphylaxis	2	2	0	0	0
Driver of motorcycle that struck debris in roadway	2	1	0	0	1

Occupant in motor vehicle that left roadway	3	3	0	0	0
Occupant of airplane that crashed	2	2	0	0	0
Passenger in aircraft that crashed	2	2	0	0	0
Passenger in overturned boat	2	2	0	0	0
Pedestrian struck by truck	2	2	2	0	0
Accidentally ingested Super Algae Guard	1	0	0	0	0
Complications of Mine cave in many decades ago	1	0	1	0	0
Co-Pilot of aircraft that crashed	1	0	0	0	0
Cut self	1	1	0	0	0
Cyclist Non-motor Vehicle Accident	1	1	0	0	0
Driver of auto struck by auto fleeing law enforcement	1	1	0	0	0
Driver of bus in collision with fixed object	1	1	0	0	0
Driver of motor vehicle that overturned	1	1	0	0	0
Driver of motorcycle in collision with another motorcycle	1	1	0	0	0
Driver of motorcycle that caught fire	1	1	0	0	0
Driver of motorcycle that crashed	1	1	0	0	0
Driver of motorcycle that lost control and fell	1	0	1	0	0
Driver of scooter that struck pedestrian, driver ejected	1	0	0	0	1
Exposed to mercury in the workplace	1	0	0	0	0
Fall between a shelf and pallet in warehouse	1	1	0	0	0
Gastric laceration with perforation	1	1	0	0	0
Kicked in chest by horse	1	1	0	0	0
Kicked in head by buffalo	1	0	0	0	0
Mauled by dogs	1	1	0	0	0
Occupant in auto collision with vehicle fire	1	0	0	0	1
Occupant in motor vehicle that overturned	1	1	0	0	0
Occupant in parked vehicle struck by pickup	1	0	0	0	0
Passenger in motor vehicle in collision with fixed object	1	0	1	0	0
Passenger on motorcycle that left roadway	1	1	0	0	0
Pedestrian struck by motorcycle	1	1	0	0	
Pedestrian struck by pickup pulling trailer	1	0	1	0	0
Pedestrian struck by truck that struck building	1	1	0	0	0
Remote hypoxic-ischemic brain injury	1	1	0	0	0
Rode motorized wheelchair into refrigerator	1	0	1	0	0
Struck by a falling tree	1	0	1	0	0
Struck by flying metal debris during wind storm	1	1	0	0	0
Struck on the head by motorcycle falling from stand	1	1	0	0	0
Suffocated by power tack off drive shaft	1	1	0	0	0
Unhelmeted driver of motorcycle that overturned	1	0	0	0	1
Victim of mining explosion	1	1	0	0	0

**Table 10 - Accidental Deaths – County of Injury – 2002 – 2011**

County of Injury	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Bernalillo	359	406	403	389	433	422	477	430	384	467
Catron	3	6	2	7	2	3	3	1	2	5
Chaves	29	42	41	37	48	30	48	35	53	57
Cibola	19	27	25	41	22	31	20	20	23	29
Colfax	12	23	9	17	9	12	18	8	12	10
Curry	13	15	15	22	20	26	16	21	24	26
De Baca	5	3	1	3	1	3	2	2	0	5
Dona Ana	55	62	80	63	77	87	72	102	82	98
Eddy	27	31	33	39	39	38	41	34	38	38
Grant	18	23	25	17	19	20	31	20	15	18
Guadalupe	17	8	16	10	18	15	18	10	12	12
Harding	2	1	0	0	0	1	0	1	0	2
Hidalgo	10	2	6	14	7	12	4	5	7	8
Lea	20	29	21	30	38	37	36	18	32	35
Lincoln	31	14	14	14	15	24	3	23	13	16
Los Alamos	6	10	6	6	5	6	4	10	11	10
Luna	18	25	22	37	33	27	15	15	14	14
McKinley	71	73	99	80	77	62	58	65	52	51
Mora	4	5	8	7	5	6	5	4	4	7
Otero	25	31	28	30	35	22	30	33	33	29
Quay	18	26	14	10	16	8	16	5	19	9
Rio Arriba	54	46	57	48	49	56	61	50	42	60
Roosevelt	9	8	7	14	7	10	9	5	8	13
San Juan	85	79	76	72	80	90	74	62	62	91
San Miguel	26	30	33	25	23	27	33	23	28	36
Sandoval	33	42	47	52	61	55	71	77	68	86
Santa Fe	89	78	75	101	96	91	102	99	77	107
Sierra	15	16	12	12	9	15	13	22	19	22
Socorro	13	18	21	22	15	19	21	25	11	18
Taos	30	26	30	27	28	36	29	30	33	27
Torrance	12	20	19	18	21	20	16	21	11	16
Union	4	3	4	7	7	4	3	4	5	4
Valencia	34	45	38	41	52	55	46	37	40	60
Out of State/Unknown	63	71	57	62	49	36	35	73	118	35
<b>Totals</b>	<b>1,229</b>	<b>1,344</b>	<b>1,344</b>	<b>1,374</b>	<b>1,416</b>	<b>1,406</b>	<b>1,430</b>	<b>1,390</b>	<b>1,352</b>	<b>1,521</b>

**Table 11 - Accidental Deaths – County of Pronouncement – 2002 – 2011**

County of Pronouncement	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Bernalillo	442	505	503	476	552	512	572	549	532	573
Catron	2	6	2	7	1	3	3	0	1	5
Chaves	27	42	41	34	47	31	48	36	49	56
Cibola	20	20	14	34	12	24	20	18	19	20
Colfax	12	20	9	19	9	12	14	8	9	10
Curry	14	17	18	22	20	27	17	21	24	30
De Baca	5	3	0	2	1	3	2	2	0	3
Dona Ana	53	62	82	61	83	95	75	112	90	96
Eddy	28	30	32	39	39	37	40	34	43	38
Grant	13	24	24	19	18	19	29	19	12	18
Guadalupe	14	6	15	8	14	14	17	8	9	8
Harding	2	1	0	0	0	1	0	1	0	2
Hidalgo	9	2	6	10	7	11	5	4	6	8
Lea	20	29	21	31	40	37	35	18	32	33
Lincoln	23	12	13	13	16	21	5	18	11	15
Los Alamos	4	8	5	5	5	6	5	10	9	8
Luna	17	25	23	37	27	23	14	15	13	12
McKinley	65	73	83	69	67	60	51	58	41	43
Mora	1	4	8	4	3	5	4	1	4	6
Otero	25	30	28	30	33	20	25	33	37	33
Quay	17	24	13	10	16	11	15	4	18	7
Rio Arriba	54	40	53	39	42	52	41	43	35	55
Roosevelt	8	8	6	14	8	11	9	5	9	10
San Juan	89	78	87	79	82	99	79	67	68	92
San Miguel	24	26	26	22	22	24	31	23	25	30
Sandoval	27	24	28	40	33	30	47	58	48	59
Santa Fe	93	87	78	100	97	92	108	94	89	122
Sierra	13	14	9	11	6	11	13	20	19	22
Socorro	11	15	15	22	12	17	17	22	7	13
Taos	24	19	27	25	22	33	26	29	29	22
Torrance	9	9	12	14	17	15	14	14	8	16
Union	4	3	2	6	7	4	3	5	4	4
Valencia	21	34	29	32	37	34	27	24	29	15
Out of State/Unknown	39	44	32	40	21	12	19	17	23	37
<b>Totals</b>	<b>1,229</b>	<b>1,344</b>	<b>1,344</b>	<b>1,374</b>	<b>1,416</b>	<b>1,406</b>	<b>1,430</b>	<b>1,390</b>	<b>1,352</b>	<b>1,521</b>

### Accidental Deaths – Summary

Accidental deaths accounted for 28.8% of the deaths investigated by OMI in 2011, second only to natural deaths (57.8% of OMI-investigated deaths) as a manner of death. The highest number of accidental deaths was in males 45-54 years of age.

## Overview – Manner of Death – Suicide Deaths

Figure 17 - Suicide Deaths – 2002 - 2011

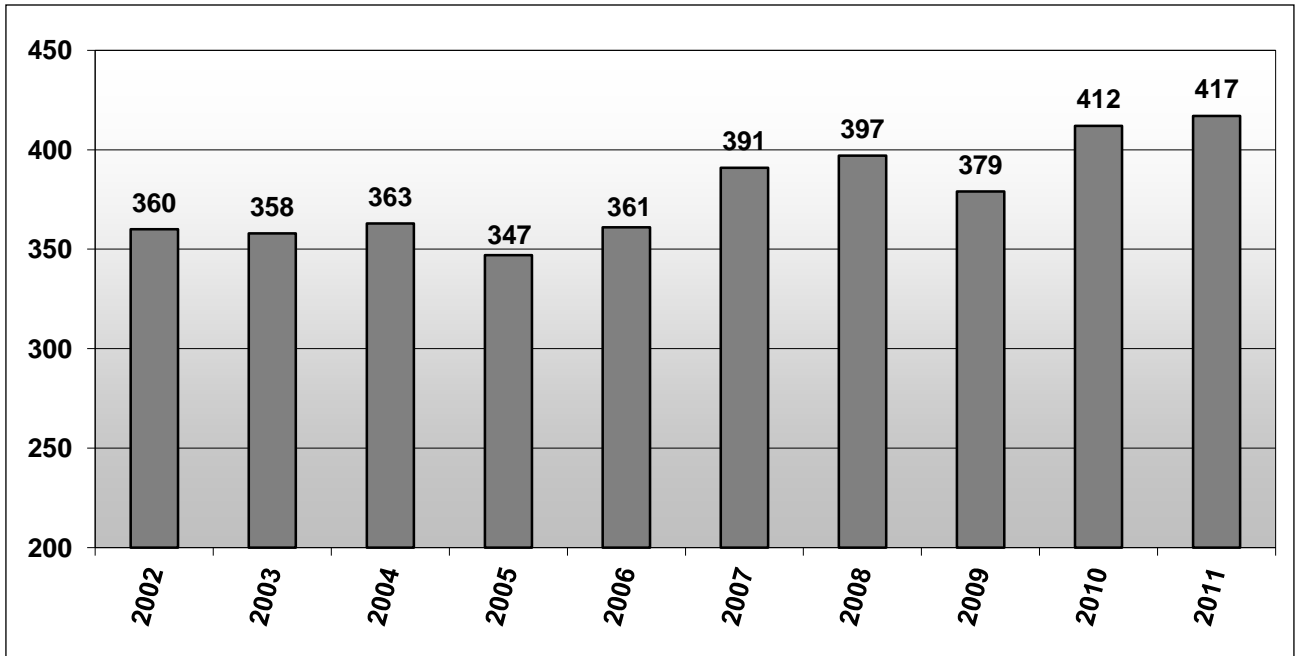
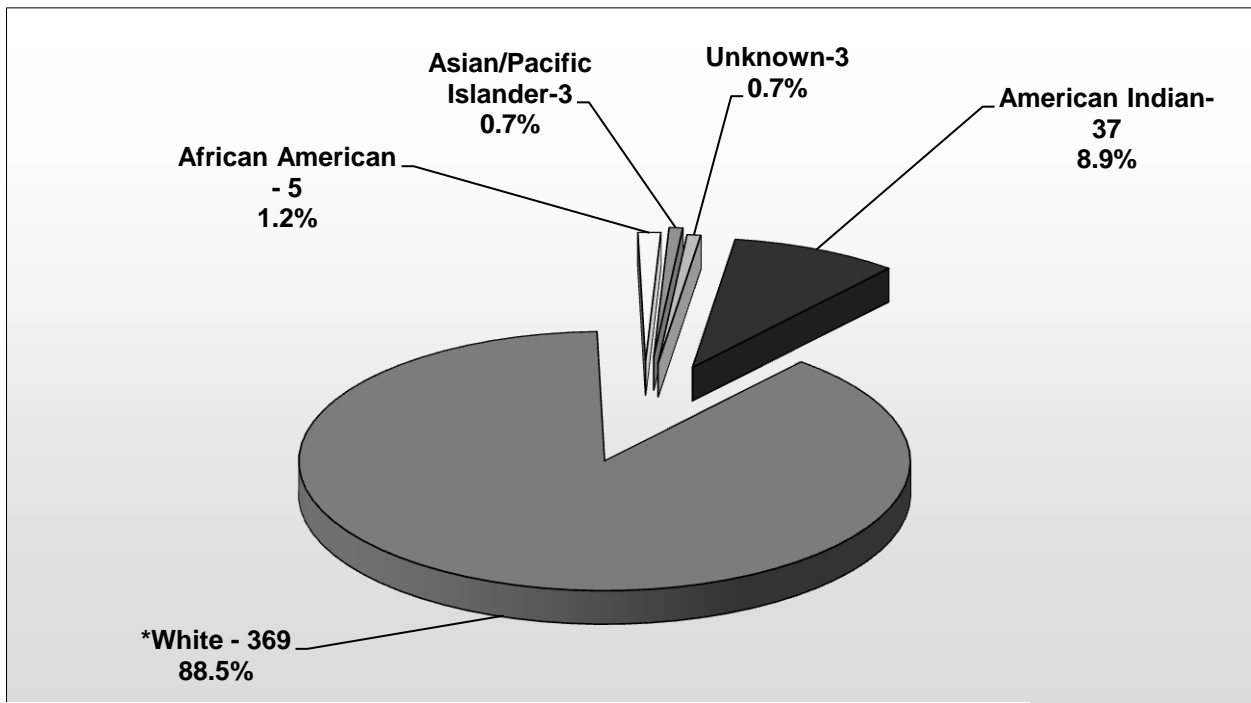


Figure 18 - Suicide Deaths by Race/Ethnicity – 2011



\* White includes 113 Hispanic, American Indian includes 1 Hispanic

Figure 19 - Suicide Deaths by Age and Gender – 2011

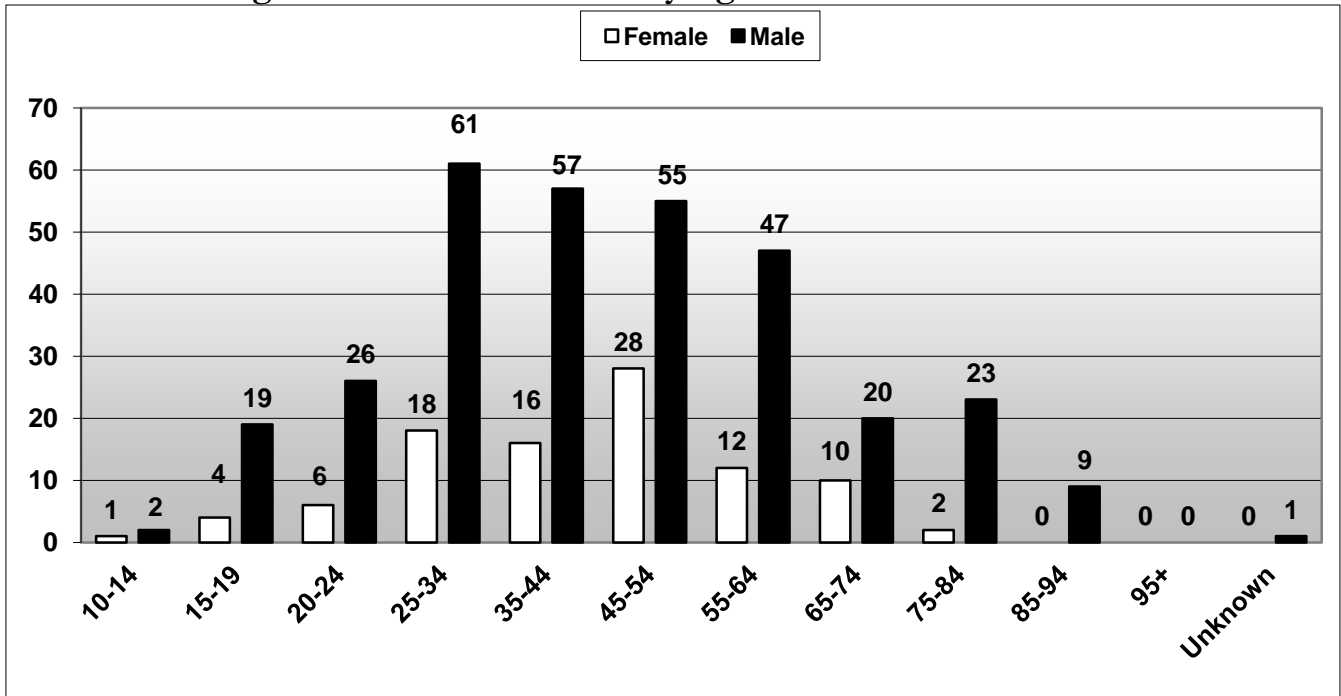


Figure 20 - Suicide Deaths by Month – 2011

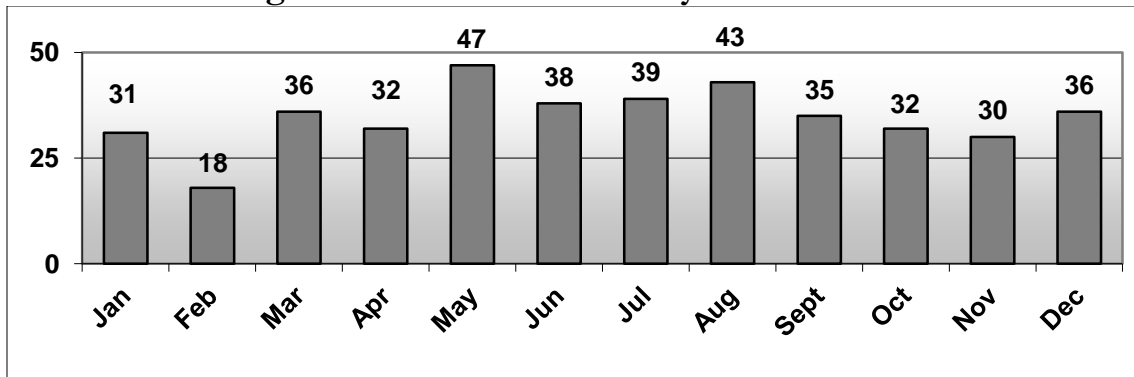
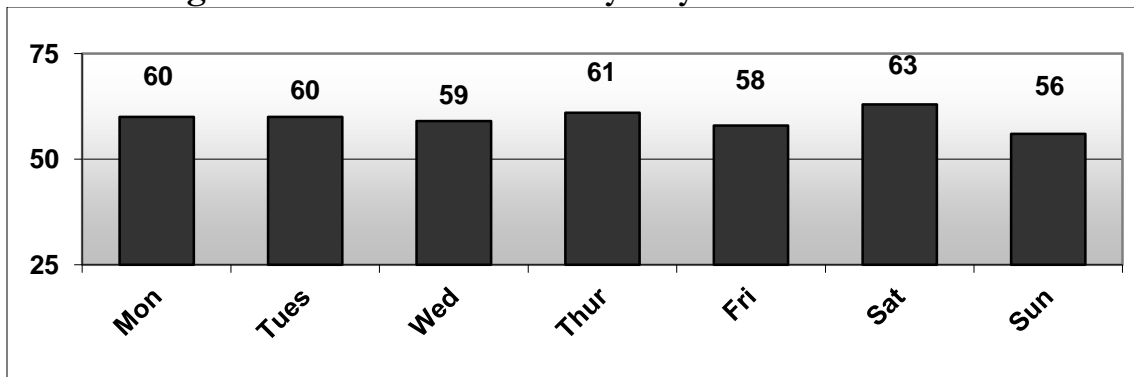


Figure 21 – Suicide Deaths by Day of the Week – 2011





**Table 13 – Suicide Deaths by County of Injury – 2002 - 2011**

County of Injury	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Bernalillo	112	107	102	99	110	120	123	130	114	127
Catron	2	1	3	0	1	3	2	2	2	1
Chaves	10	17	18	8	10	11	11	11	9	12
Cibola	4	5	3	2	5	7	6	10	2	6
Colfax	6	4	7	2	4	6	3	3	4	3
Curry	3	6	5	1	6	3	3	4	6	4
De Baca	2	0	0	1	1	1	0	0	2	0
Dona Ana	27	13	26	36	24	27	35	28	37	35
Eddy	13	9	9	13	10	10	10	7	12	9
Grant	7	9	6	10	9	6	12	10	14	7
Guadalupe	1	0	0	0	2	1	4	0	2	1
Harding	0	0	1	0	0	0	0	2	0	0
Hidalgo	1	0	0	1	0	2	3	2	0	2
Lea	7	11	9	8	12	8	7	5	14	8
Lincoln	10	3	7	6	2	7	5	3	2	3
Los Alamos	0	3	3	4	4	4	2	1	1	3
Luna	11	9	7	3	6	5	5	3	6	3
McKinley	9	16	19	13	16	11	7	14	9	16
Mora	1	4	0	0	2	1	2	4	3	2
Otero	13	14	15	13	13	17	15	11	20	20
Quay	0	3	1	3	2	2	2	2	5	0
Rio Arriba	11	12	9	10	5	15	9	8	8	12
Roosevelt	2	0	3	1	4	1	4	0	1	3
San Juan	19	19	14	20	25	18	24	22	35	20
San Miguel	8	11	9	6	8	6	7	3	7	7
Sandoval	15	7	13	13	16	25	22	17	27	37
Santa Fe	26	35	30	23	23	27	37	24	23	29
Sierra	6	4	4	7	5	2	2	4	2	7
Socorro	5	4	6	3	2	7	3	6	7	2
Taos	9	5	7	20	12	13	6	9	6	13
Torrance	5	3	4	2	7	6	5	4	9	4
Union	0	0	1	2	1	1	0	1	2	1
Valencia	11	11	17	10	11	17	16	10	10	14
Out of State/Unknown	4	13	5	7	3	0	5	19	11	6
<b>Totals</b>	<b>360</b>	<b>358</b>	<b>363</b>	<b>347</b>	<b>361</b>	<b>390</b>	<b>397</b>	<b>379</b>	<b>412</b>	<b>417</b>

**Table 14 – Suicide Deaths by County of Pronouncement – 2002 - 2011**

County of Pronouncement	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Bernalillo	120	119	107	104	118	131	134	142	127	137
Catron	2	1	3	0	1	3	2	2	2	1
Chaves	10	16	18	8	10	11	10	11	9	12
Cibola	3	4	2	3	4	7	6	9	4	5
Colfax	6	3	7	1	4	5	2	3	3	2
Curry	3	6	5	1	6	3	3	4	6	4
De Baca	2	0	0	1	1	1	0	0	2	0
Dona Ana	27	13	26	36	23	27	34	30	38	35
Eddy	13	9	9	13	10	10	9	11	12	9
Grant	6	9	6	8	9	5	12	9	14	7
Guadalupe	1	0	0	0	2	1	4	0	2	1
Harding	0	0	1	0	0	0	0	1	0	0
Hidalgo	1	0	0	1	0	3	3	2	0	2
Lea	7	11	8	8	12	8	7	5	14	8
Lincoln	10	3	7	7	2	7	5	3	2	3
Los Alamos	0	2	3	3	4	4	2	1	1	3
Luna	10	9	7	3	6	4	5	2	6	3
McKinley	9	14	19	12	16	9	7	12	5	16
Mora	1	4	0	0	2	1	1	2	3	2
Otero	13	14	15	12	13	16	16	15	20	20
Quay	0	3	1	3	2	2	2	1	5	0
Rio Arriba	10	11	9	10	4	15	9	9	6	10
Roosevelt	2	0	3	1	4	1	4	0	1	3
San Juan	20	19	14	20	25	19	24	23	36	21
San Miguel	7	10	9	6	8	6	7	3	7	6
Sandoval	15	6	12	11	16	20	20	18	25	30
Santa Fe	26	35	30	22	23	25	38	24	23	31
Sierra	6	4	4	7	5	2	2	4	2	7
Socorro	5	4	6	3	2	7	1	5	6	2
Taos	8	5	6	20	12	12	6	8	6	13
Torrance	5	2	4	2	6	6	4	6	9	3
Union	0	0	1	2	1	1	0	2	2	2
Valencia	7	9	16	9	7	16	15	9	8	14
Out of State/Unknown	5	13	5	10	3	2	3	3	6	5
<b>Totals</b>	<b>360</b>	<b>358</b>	<b>363</b>	<b>347</b>	<b>361</b>	<b>390</b>	<b>397</b>	<b>379</b>	<b>412</b>	<b>417</b>

**Table 15 - Suicide Deaths - Method – 2011**

<b>Manner of Death</b>	<b>Total Cases</b>	<b>Autopsy</b>	<b>Field External</b>	<b>Inv External</b>	<b>Path External</b>
Shot Self with Firearm	218	194	21	0	3
Hanged Self	92	69	17	0	5
Ingested or Injected Medication	61	59	1	0	0
Inhaled	9	9	0	0	0
Jumped	9	8	1	0	0
Suffocated Self	7	7	0	0	0
Cut Self	6	6	0	0	0
Stabbed Self	6	5	0	0	0
Driver of Motor Vehicle	2	1	1	0	0
Ingested, Injected or Inhaled Non-prescription	2	2	1	0	0
Struck by Train	2	0	2	0	0
Burned Self	1	1	0	0	0
Decedent Ate Poisonous Plant	1	1	0	0	0
Suicide as Pedestrian	1	1	0	0	0

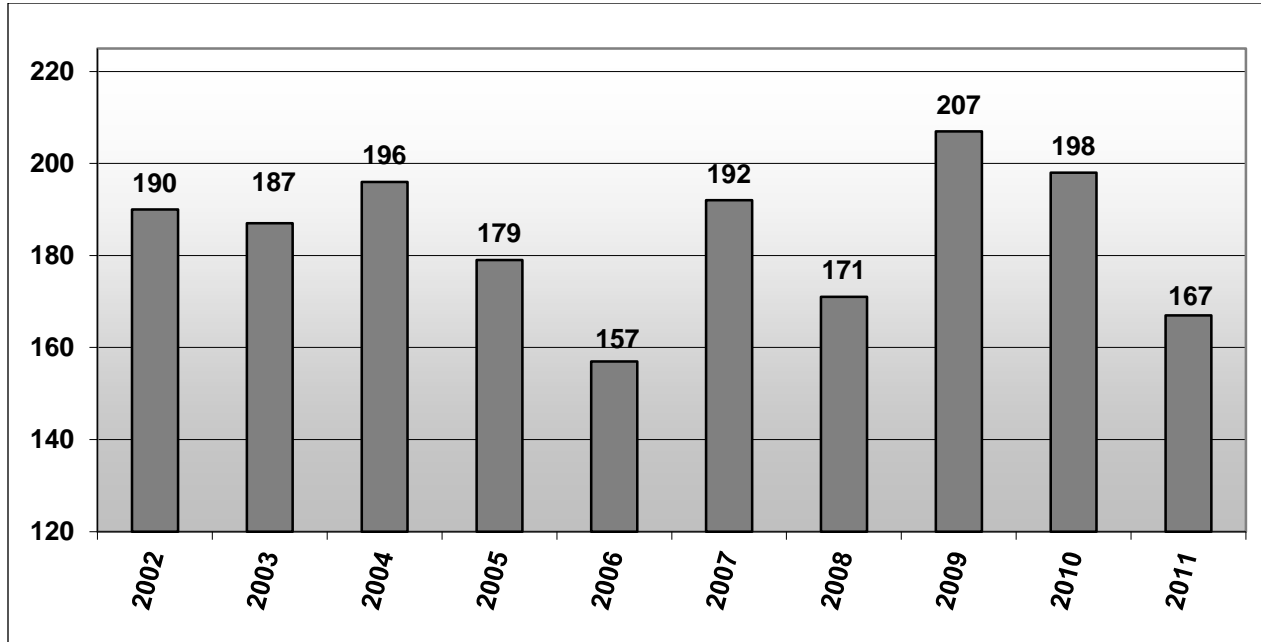
### **Suicide Deaths – Summary**

New Mexico's suicide rate is consistently higher than the national average, comprising 2.4% of all deaths in New Mexico, compared to 1.2% of all deaths in the U.S. The rate in 2009 was 17.4 per 100,000 people, compared to a rate of 11.3 per 100,000 people in the rest of the U.S. (2009 New Mexico Selected Health Statistics, State Center for Health Statistics, Department of Health).

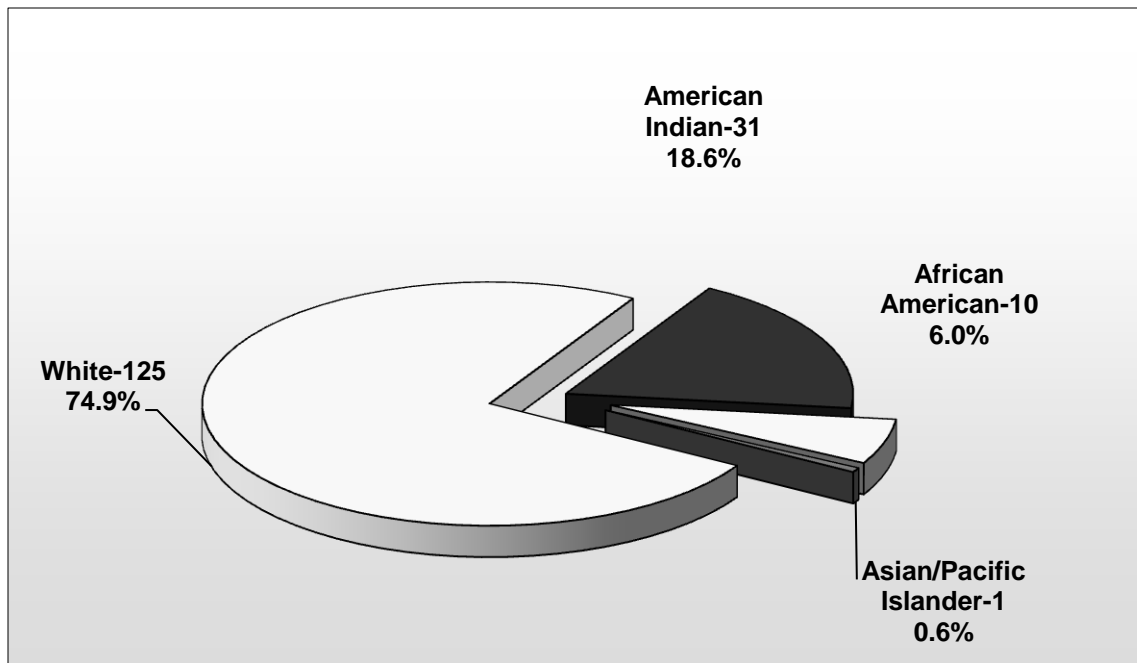
Deaths from suicide in 2011 occurred most frequently among non-Hispanic whites (61.4%) and males (76.7%). More men between the ages of 25 and 34 years (14.6% of all suicides) committed suicide than other age group by gender. More people committed suicide on Saturday (63/417, 15.1%) than any other day of the week. More suicides occurred in May than any other month (47/417, 11.3%). The fewest occurred in February (18/417, 4.3%). The total number of suicides increased from 406 in 2010 to 417 in 2011 (2.7% increase).

**Overview – Manner of Death – Homicide Deaths**

**Figure 22 - Homicide Deaths – 2002 – 2011**



**Figure 23 - Homicide Deaths by Race/Ethnicity – 2011**



\* White includes 83 Hispanic

Figure 24 - Homicide Deaths by Age and Gender – 2011

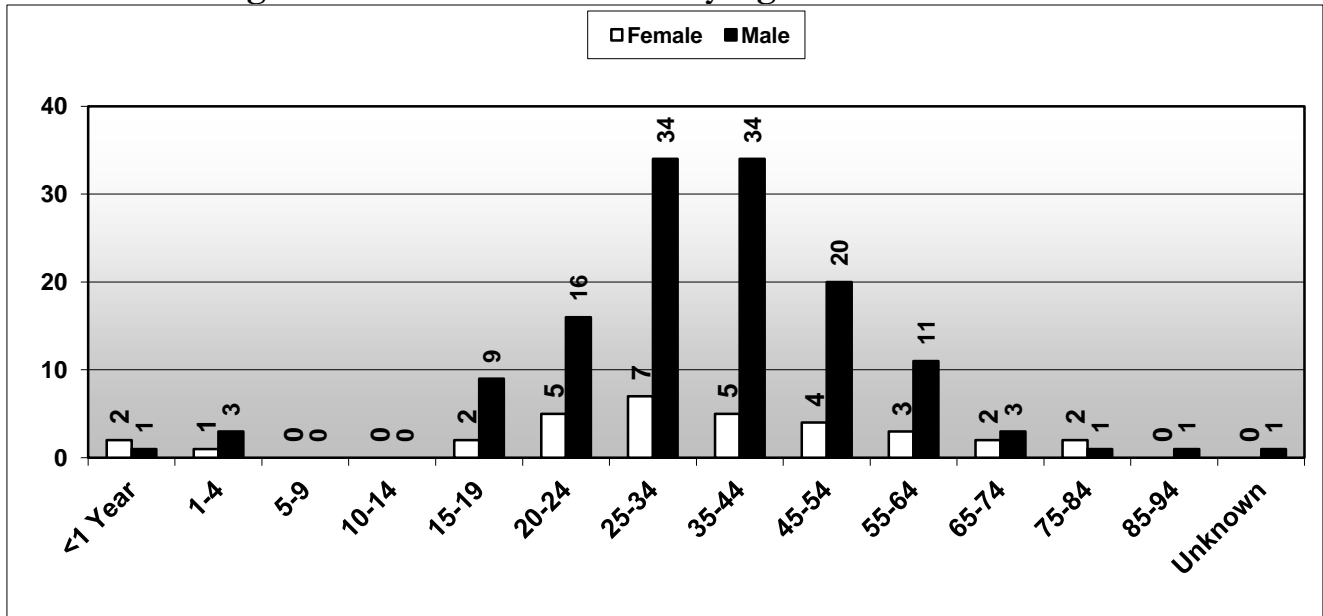


Table 16 - Homicide Deaths - Method – 2011

Manner of Death	Total		Field External	Inv External	Path External
	Cases	Autopsy			
Shot by Assailant(s) with Firearm	74	73	1	0	0
Beaten by Assailant(s)	40	40	0	0	0
Stabbed by Assailant(s)	32	32	0	0	0
Shot by On-duty Enforcement Officer(s)	8	8	0	0	0
Beaten and Stabbed by Assailant(s)	5	5	0	0	0
Victim of Intentionally Set Fire	1	1	0	0	0
Sustained Injuries During Sexual Assault	1	1	0	0	0
Suffocated by Assailant(s)	1	1	0	0	0
Strangled, Beaten, and Bound by Assailant(s)	1	1	0	0	0
Pedestrian Stuck by Auto	1	1	0	0	0
Passenger in Auto in Collision with Auto	1	1	0	0	0
Neglect/Starvation	1	1	0	0	0
Driver of Auto Forced off Roadway	1	1	0	0	0

**Table 17 - Homicide Deaths – County of Injury – 2002 - 2011**

County of Injury	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Bernalillo	66	64	62	69	52	60	53	51	64	43
Catron	2	1	0	0	0	1	0	0	0	0
Chaves	9	6	8	15	6	9	9	10	6	6
Cibola	2	4	2	1	2	1	0	2	3	2
Colfax	2	3	0	0	2	2	0	1	1	0
Curry	5	5	11	4	4	2	4	2	2	5
De Baca	0	0	1	1	0	0	0	0	0	0
Dona Ana	9	6	9	8	6	9	11	11	14	8
Eddy	6	4	5	3	3	4	2	6	3	3
Grant	2	3	1	1	3	4	3	1	1	4
Guadalupe	0	2	0	0	0	2	0	0	0	0
Harding	0	0	1	0	0	0	0	0	0	0
Hidalgo	0	0	1	0	0	1	0	0	0	1
Lea	5	7	6	7	6	7	4	6	12	12
Lincoln	1	0	5	2	1	1	1	0	1	3
Los Alamos	0	0	1	0	0	0	1	0	0	0
Luna	5	3	4	0	1	2	3	1	1	2
McKinley	11	8	7	7	7	11	8	10	9	13
Mora	1	0	0	0	1	0	0	2	0	0
Otero	4	5	9	0	4	3	4	8	4	3
Quay	0	0	1	0	0	4	1	1	1	4
Rio Arriba	4	8	8	8	2	6	5	2	7	8
Roosevelt	1	0	2	3	0	2	1	1	2	1
San Juan	6	8	7	11	11	19	12	7	13	10
San Miguel	6	7	2	4	1	8	2	5	3	4
Sandoval	6	5	8	4	3	3	7	7	5	4
Santa Fe	6	5	6	4	9	4	9	8	11	12
Sierra	1	1	1	3	2	1	0	1	0	0
Socorro	2	3	1	1	1	1	4	2	0	0
Taos	4	7	6	2	3	2	2	0	6	3
Torrance	1	2	0	2	1	2	3	0	3	0
Union	0	2	1	0	0	0	0	0	0	0
Valencia	3	4	12	8	6	6	11	7	1	6
Out of State/Unknown	20	14	8	11	19	14	11	55	25	10
<b>Totals</b>	<b>190</b>	<b>187</b>	<b>196</b>	<b>179</b>	<b>156</b>	<b>192</b>	<b>171</b>	<b>207</b>	<b>198</b>	<b>167</b>

**Table 18 - Homicide Deaths – County of Pronouncement – 2002 – 2011**

County of Pronouncement	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Bernalillo	72	72	74	73	62	70	61	81	74	50
Catron	1	1	0	0	0	0	0	0	0	0
Chaves	9	6	9	14	5	9	8	10	6	6
Cibola	2	3	1	1	2	1	0	3	5	3
Colfax	2	3	0	0	2	2	0	1	1	0
Curry	6	5	11	3	3	2	3	4	2	3
De Baca	0	0	1	1	0	0	0	0	0	0
Dona Ana	7	5	6	7	6	10	9	9	13	6
Eddy	6	4	4	3	0	3	2	6	3	3
Grant	2	3	1	1	2	3	2	1	1	4
Guadalupe	0	2	0	0	0	2	0	0	2	0
Harding	0	0	1	0	0	0	0	0	0	0
Hidalgo	0	0	1	0	0	0	0	0	0	1
Lea	4	7	5	6	6	6	4	8	10	10
Lincoln	3	0	6	1	1	1	1	1	0	3
Los Alamos	0	0	1	0	0	0	1	0	0	0
Luna	6	3	2	1	2	4	4	2	1	1
McKinley	11	7	6	5	6	8	7	10	8	9
Mora	1	0	0	0	0	0	0	2	0	0
Otero	3	4	8	0	3	3	4	5	4	3
Quay	0	0	1	0	0	4	1	0	1	4
Rio Arriba	4	8	7	8	2	5	0	4	8	8
Roosevelt	0	0	2	3	0	1	5	1	1	1
San Juan	7	9	7	13	15	20	0	10	11	11
San Miguel	6	7	2	3	1	6	11	5	2	4
Sandoval	4	5	7	4	4	3	2	11	3	5
Santa Fe	5	5	7	4	9	5	7	8	12	12
Sierra	1	0	1	2	1	1	10	0	1	0
Socorro	1	2	1	1	1	1	0	2	0	0
Taos	4	7	5	2	3	2	2	1	6	2
Torrance	1	1	0	2	1	2	1	0	2	0
Union	0	1	1	0	0	0	2	0	0	0
Valencia	3	5	7	6	4	4	0	4	1	6
Out of State/Unknown	19	12	11	15	15	13	9	18	20	12
<b>Totals</b>	<b>190</b>	<b>187</b>	<b>196</b>	<b>179</b>	<b>156</b>	<b>192</b>	<b>171</b>	<b>207</b>	<b>198</b>	<b>167</b>

## **Homicide Deaths – Summary**

Homicides decreased by 13.5% from 2010 to 2011. Homicide victims were most frequently male (80%) and Hispanic (49.7%). As with suicide rates, homicide rates in New Mexico tend to be higher than the national rate, 8.0 per 100,000 in 2011 compared to a national rate of 6.1 per 100,000 (2011 New Mexico Selected Health Statistics, State Center for Health Statistics, Department of Health).

## **New Mexico Violent Death<sup>†</sup> Reporting System (NM-VDRS) Update**

New Mexico is one of 18 states currently participating in the National Violent Death Reporting System (NVDRS) in cooperation with the Centers for Disease Control and Prevention. The primary purpose of this surveillance system is to increase the understanding of circumstances that contribute to violent deaths in order to encourage the development and implementation of more effective violence prevention strategies. Violent deaths include suicides, homicides, legal intervention deaths (excluding executions), deaths of undetermined intent, unintentional firearm-related deaths, and terrorism-related deaths.

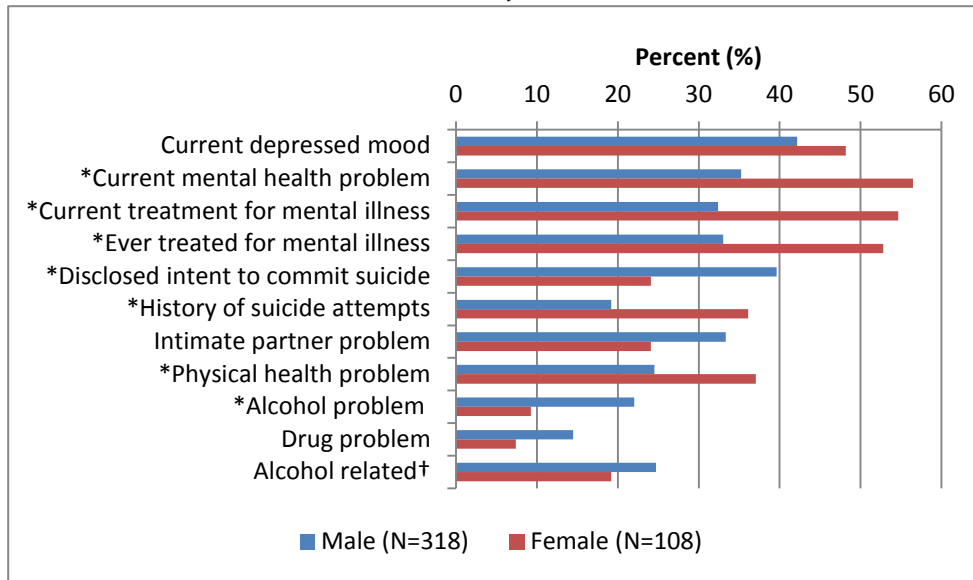
The Office of the Medical Investigator has been part of the New Mexico Violent Death Reporting System (NM-VDRS) at the New Mexico Department of Health since its inception in 2004. Data collection began on January 1, 2005, and is ongoing. NM-VDRS personnel at OMI collect information from numerous sources, including medical examiner records, police reports, death certificates, and the state crime laboratory, and abstract data on all victims, suspects, circumstances, relationships, and weapons for each violent death incident. Collecting information from numerous sources allows for more certainty in the identification of deaths due to violence and improves the reliability and completeness of the information collected.

In 2010, 683 violent deaths occurred in New Mexico; of these, 94.7% were residents of NM. The majority of all violent deaths were due to suicide (62.4%), and three quarters (74.6%) of suicide victims were male. Males generally have a higher rate of completed suicide rate because they use more lethal means, plan the suicide attempt more carefully, and avoid detection. The crude suicide rate among male residents (29.6 per 100,000) was approximately three times higher than the female suicide rate (10.0 per 100,000).

Circumstance data collected on suicide incidents highlights important differences in risk factors reported for male vs. female suicide victims (Figure). Male victims were more likely than females to disclose suicidal feelings or intent to another person and to have an alcohol problem. Female victims were more likely to have a mental health problem; to have received treatment for a mental health problem in the past 2 months or at any time in the past; to have made previous suicide attempts; and to have a physical health problem that contributed to their deaths. More than a third (37.2%) of suicide victims who were tested for blood alcohol tested positive; and almost one quarter (23.2%) of suicides were alcohol related, or had a blood alcohol concentration (BAC) greater than or equal to 100 mg/dl or 0.10%. Alcohol related suicide deaths were more common among males (24.7%) compared to females (19.2%) (Figure). These data may be used to inform the development and implementation of suicide prevention strategies, focusing on the differences in circumstances reported for male and female suicide victims.



**Figure 25 - Prevalence of Reported Circumstances‡ for all Suicide Victims by Gender - 2010, NM-VDRS**



\* $\chi^2$  significant at p value <0.05

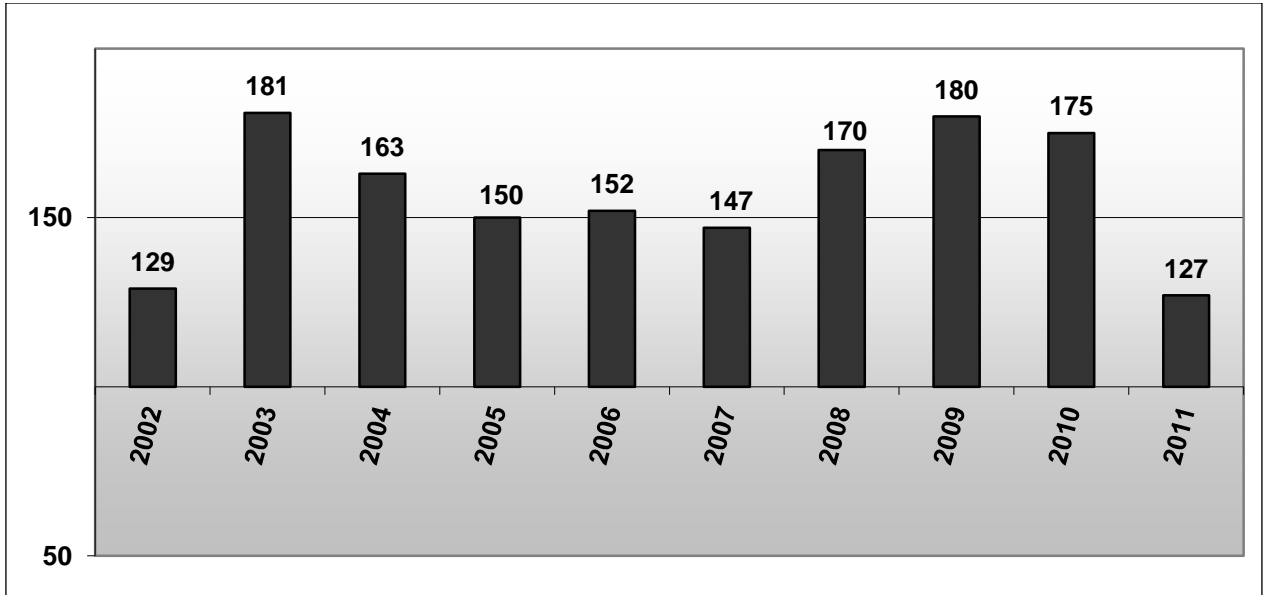
†BAC level  $\geq$  100 mg/dl, or 0.10% among victims tested for blood alcohol

‡One or more circumstances were known for 298 male and 103 female suicide victims

The New Mexico Violent Death Reporting System is supported by Cooperative Agreement 5U17CE001696-04 from the Centers for Disease Control and Prevention (CDC).

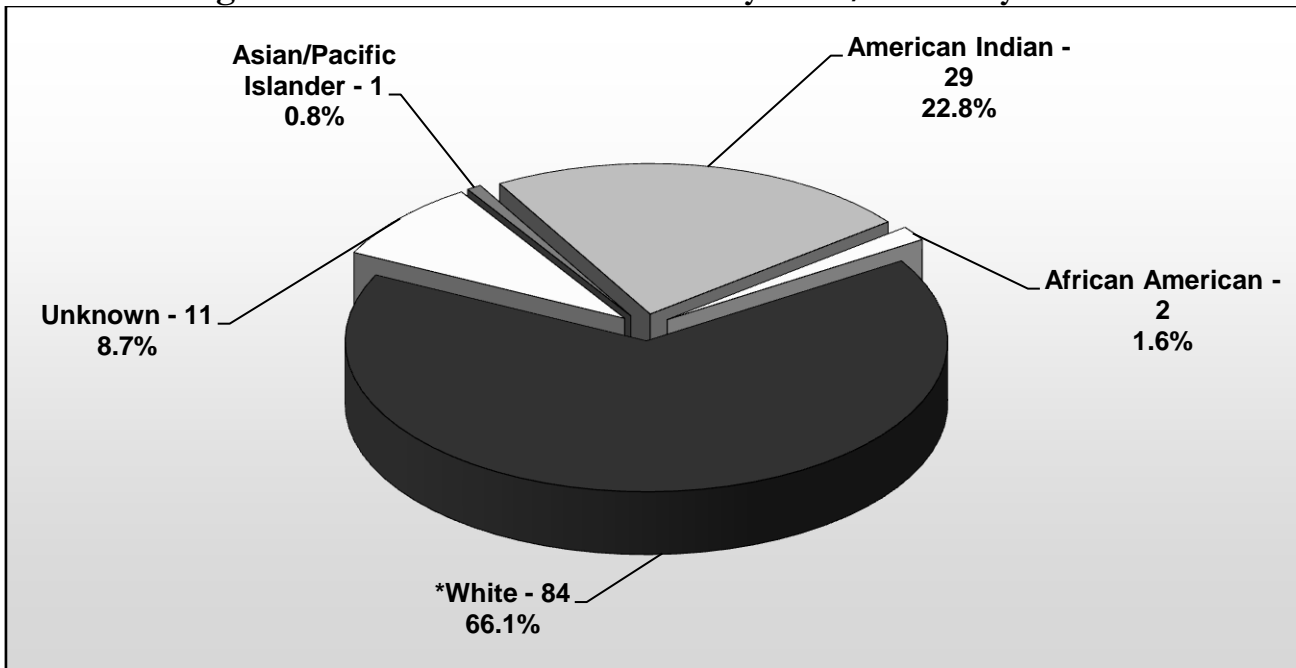
## Overview – Manner of Death – Undetermined Deaths

Figure 26 - Undetermined Deaths – 2002 – 2011



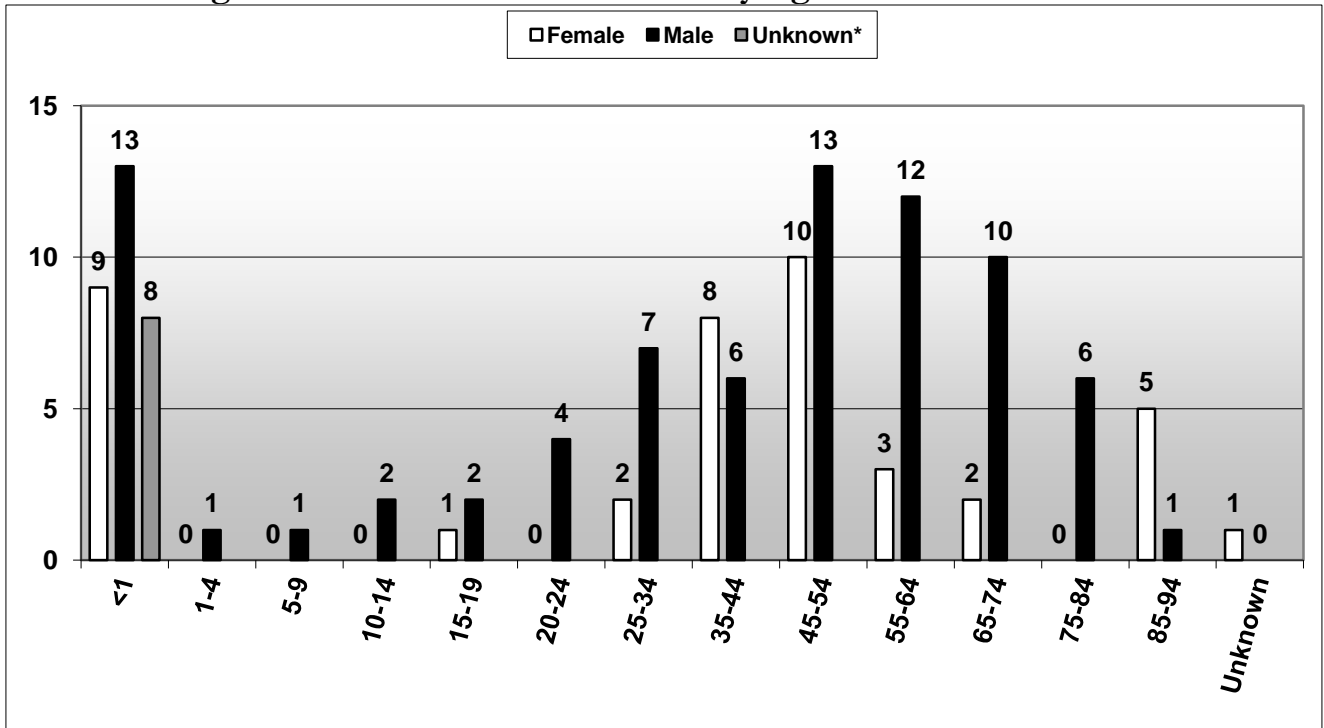
18 Other, 1 Uncoded, 87 Undetermined, , 21 Pending included in Undetermined

Figure 27 - Undetermined Deaths by Race/Ethnicity – 2011



\* White includes 29 Hispanic, African American includes 1 Hispanic

Figure 28 - Undetermined Deaths by Age and Gender – 2011

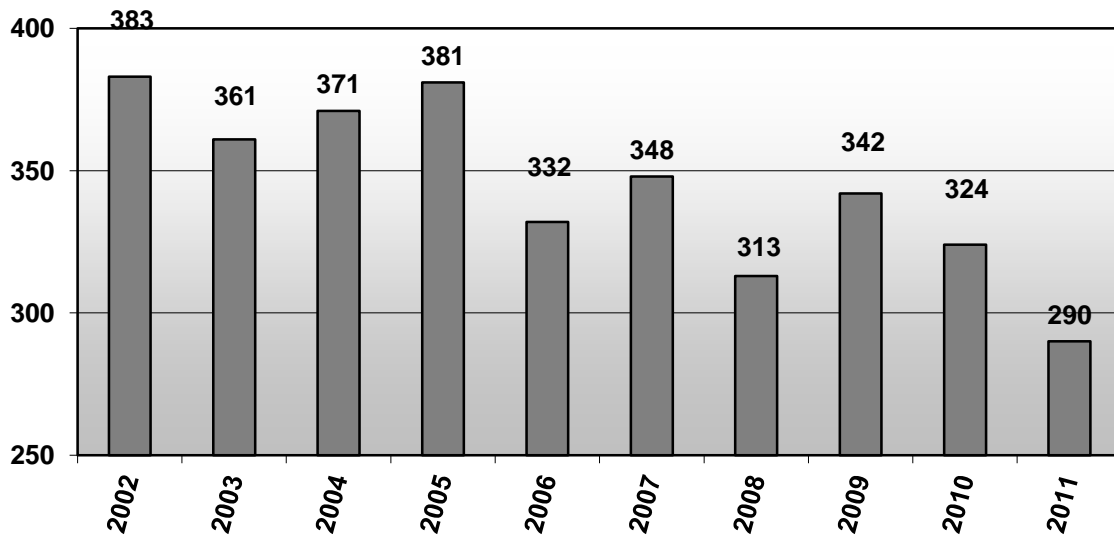


### Undetermined Deaths – Summary

All possible efforts are made to determine both a manner (accident, suicide, homicide, natural) and a cause of death for all deaths investigated by OMI. In a very small percentage of cases (between 0.4% and 0.9% most years) neither the manner nor cause of death can be determined, even with a complete autopsy, scene investigation, and laboratory testing. In other cases only skeletal or mummified remains were found, or a request for an autopsy was withdrawn.

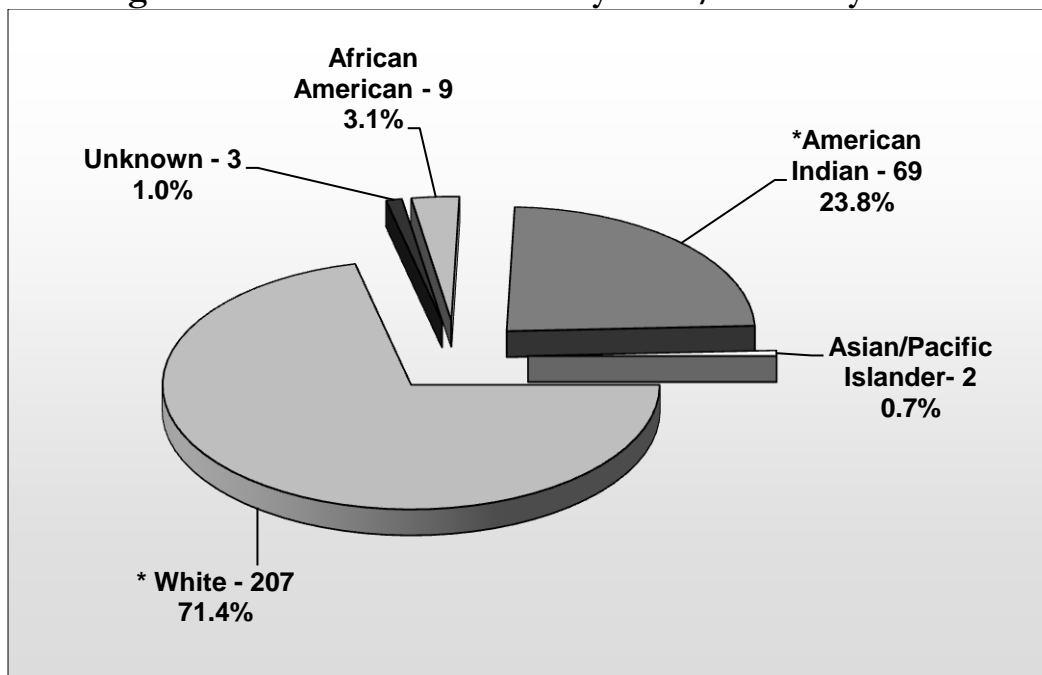
## Deaths of Children (19 Years of Age and Younger)

Figure 29 – Children\* – Deaths – 2002 – 2011



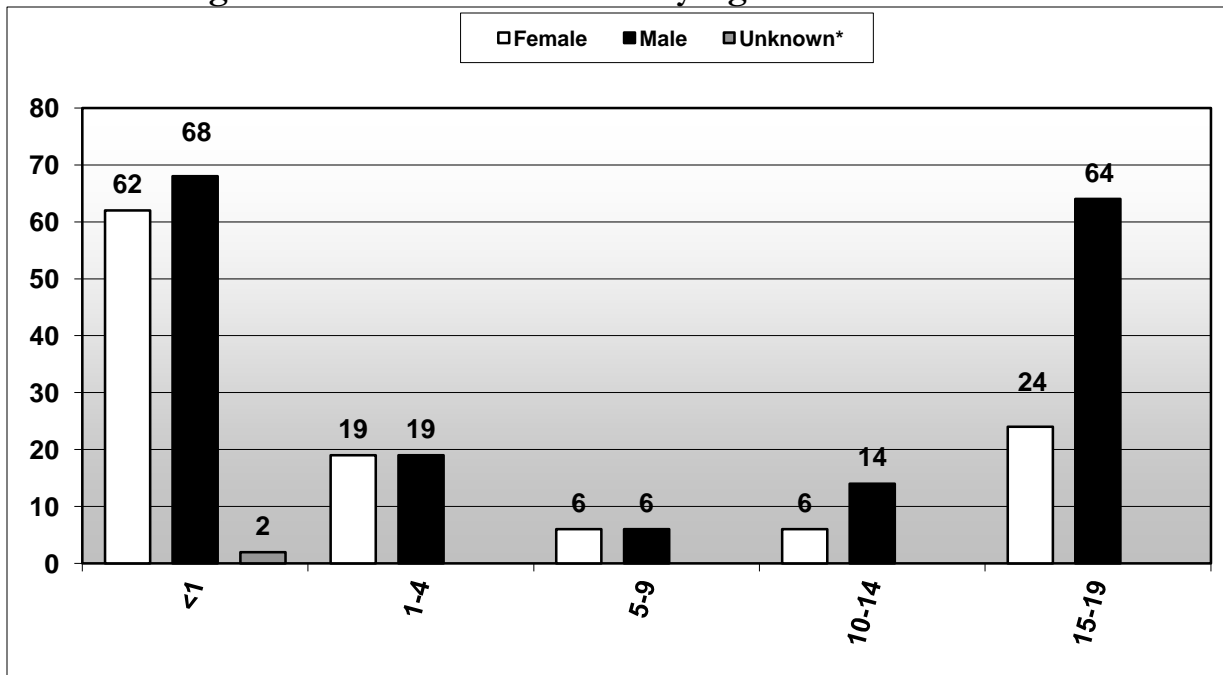
\* 19 Years old and younger.

Figure 30 – Children - Deaths by Race/Ethnicity – 2011



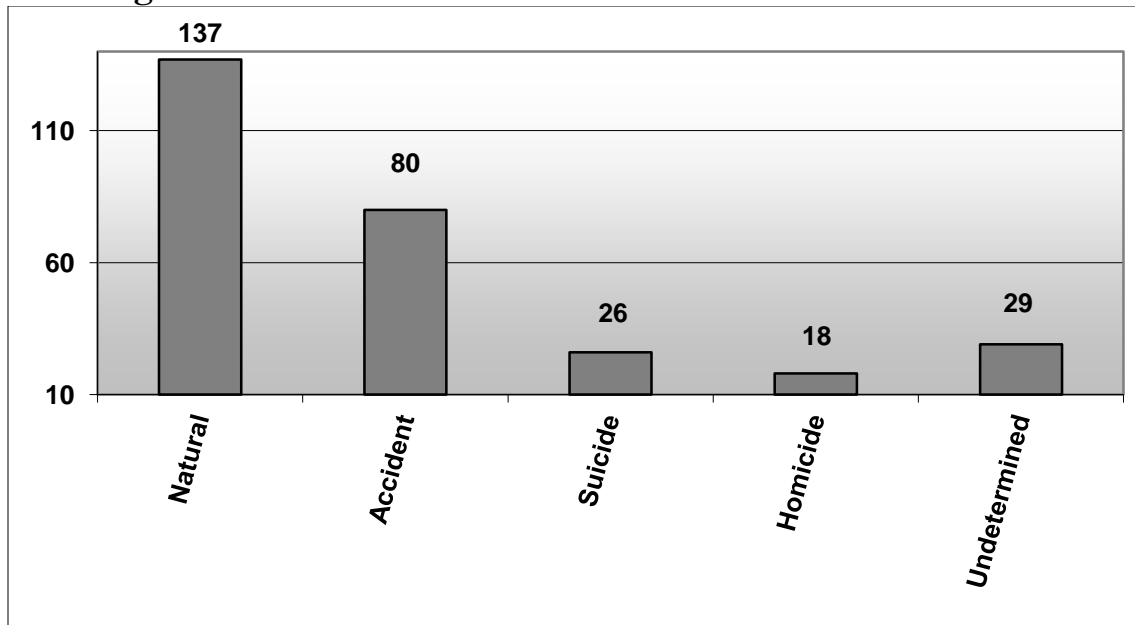
\* White includes 118 Hispanic, American Indian includes 1 Hispanic

Figure 31 – Children – Deaths by Age and Gender – 2011



\* Gender unknown

Figure 32 – Children – Total Cases - Manner of Death – 2011



**Table 19 – Children – Cause of Death- Method – 2011**

<b>Natural Causes</b>	<b>Total Cases</b>	<b>Autopsy</b>	<b>Field External</b>	<b>Inv External</b>	<b>Path External</b>
Prematurity	31	5	0	0	0
Congenital defect	28	5	0	0	0
Intrauterine fetal death	20	9	0	0	0
Carcinoma	6	0	0	0	0
Heart disease	6	2	0	0	0
Pneumonia	6	5	0	0	0
Respiratory Distress Syndrome	6	3	0	0	0
Epilepsy	5	3	0	0	0
Sepsis	5	3	0	0	0
Maternal and fetal complications of birth	4	3	0	0	0
History of illness or injury	3	2	0	0	0
Sudden Infant Death Syndrome (SIDS)	3	3	0	0	0
Cerebrovascular	2	2	0	0	0
Chronic obstructive pulmonary disease (COPD)	2	2	0	0	0
Gastrointestinal hemorrhage	2	2	0	0	0
Natural Other	2	1	0	0	0
Asthma	1	1	0	0	0
Blood disorders	1	0	0	0	0
Diabetes	1	1	0	0	0
Leukemia	1	1	0	0	0
Multiple organ failure	1	0	0	0	0
Pancreas	1	0	0	0	0

Unnatural Causes	Total Cases	Autopsy	Field External	Inv External	Path External
Shot Self with Firearm	14	12	2	0	0
Passenger in motor vehicle that left roadway	12	8	3	0	1
Asphyxia	10	10	0	0	0
Beaten by Assailant(s)	9	9	0	0	0
Hanged Self	9	7	1	0	1
Shot by Assailant(s) with Firearm	8	8	0	0	0
Passenger in motor vehicle in collision with another motor vehicle	6	3	2	0	1
Passenger in motor vehicle that left roadway and overturned	6	1	3	0	2
Ingested and/or injected prescription medication(s)	5	5	0	0	0
Ingested and/or injected illicit drug(s)	4	4	0	0	0
Pedestrian struck by motor vehicle(s)	4	4	0	0	0
Driver of motor vehicle in collision with another motor vehicle	3	3	0	0	0
Driver of motor vehicle that left roadway	3	2	1	0	0
Drowned (during recreational activity)	3	3	0	0	0
Drowned (non recreational water accident)	3	3	0	0	0
Driver of ATV that crashed	2	1	1	0	0
Injuries from Fall	2	2	0	0	0
Occupant in motor vehicle in collision with another motor vehicle	2	0	2	0	0
Pedestrian struck by pickup	2	0	1	0	1
Accidental discharge of firearm	1	1	0	0	0
Accidental Hanging	1	1	0	0	0
Choked	1	1	0	0	0
Cyclist Struck by Motor Vehicle	1	1	0	0	0
Driver of motorcycle that caught fire	1	1	0	0	0
Ingested alcohol	1	1	0	0	0
Ingested and/or injected illicit and prescription drug(s)	1	1	0	0	0

Inhaled toxic Agent (Substance Inhaled Accidentally)	1	1	0	0	0
Jumped	1	1	0	0	0
Occupant in motor vehicle that overturned	1	1	0	0	0
Passenger in overturned boat	1	1	0	0	0
Pedestrian struck by pickup pulling trailer	1	0	1	0	0
Pedestrian struck by train	1	1	0	0	0
Stabbed by Assailant(s)	1	1	0	0	0
Stabbed Self	1	1	0	0	0
Struck by Train	1	0	1	0	0
Thermal Injuries	1	1	0	0	0



## Overview – Children – Manner of Death – Natural Deaths

Figure 33 – Children – Natural Deaths – 2002 – 2011

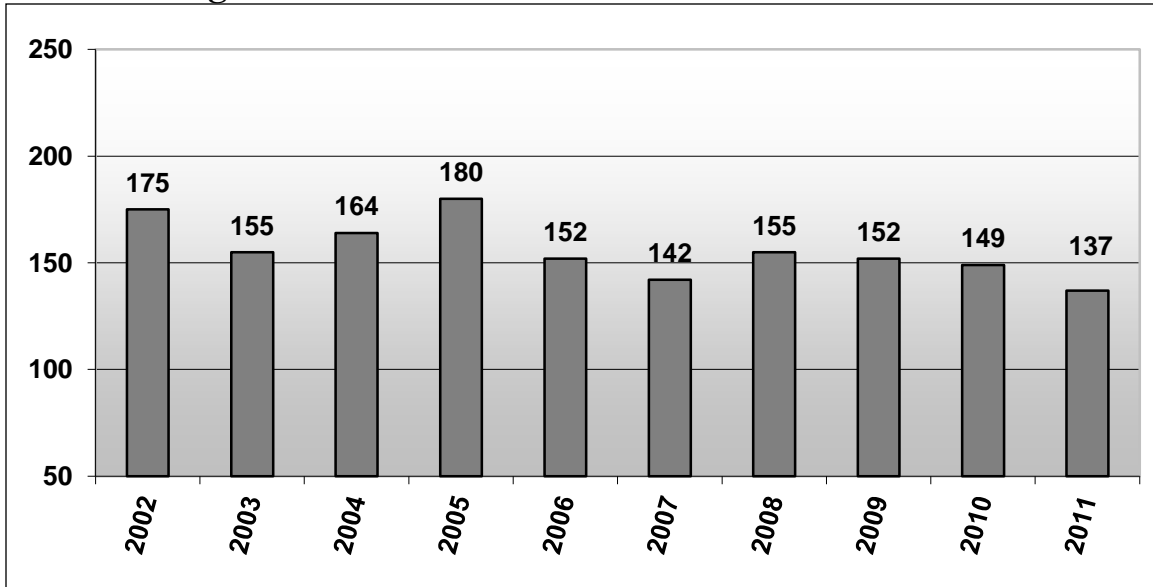
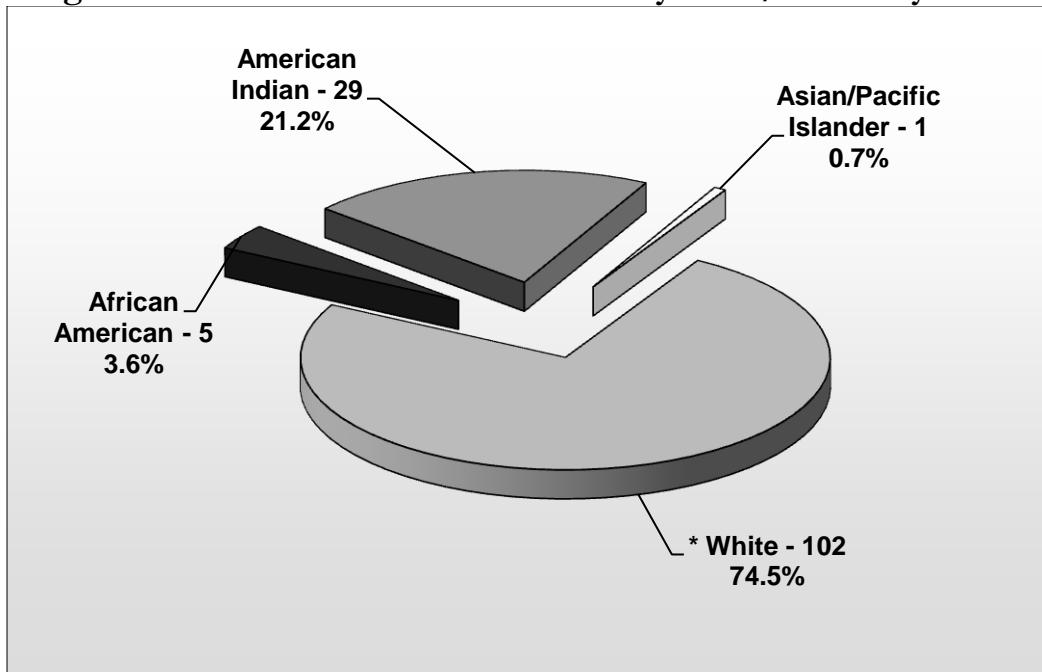
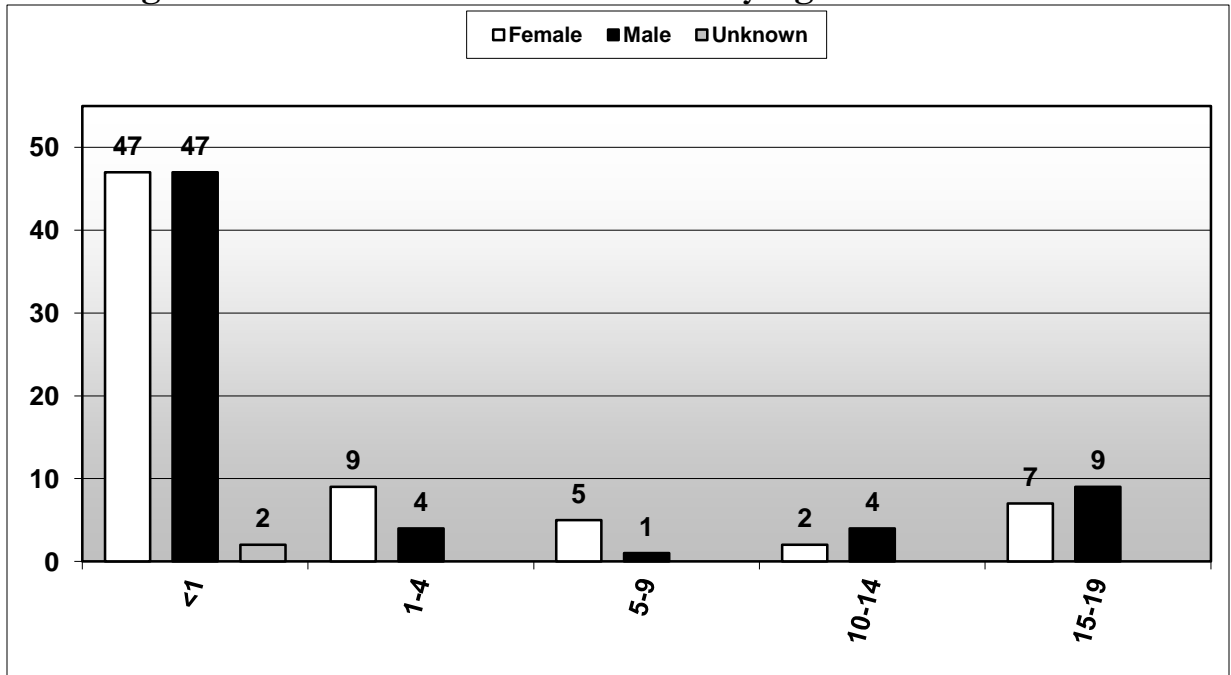


Figure 34– Children – Natural Deaths by Race/Ethnicity – 2011



\* White includes 56 Hispanic

Figure 35 – Children – Natural Deaths by Age and Gender – 2011



## Overview – Children – Manner of Death – Accidental Deaths

Figure 36 – Children – Accidental Deaths – 2002 – 2011

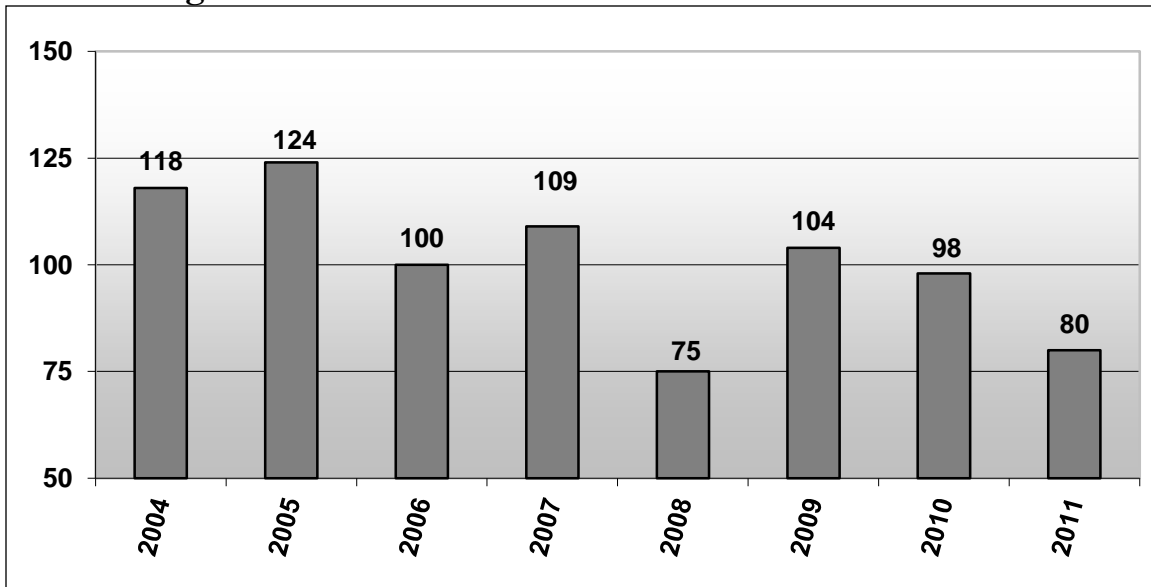
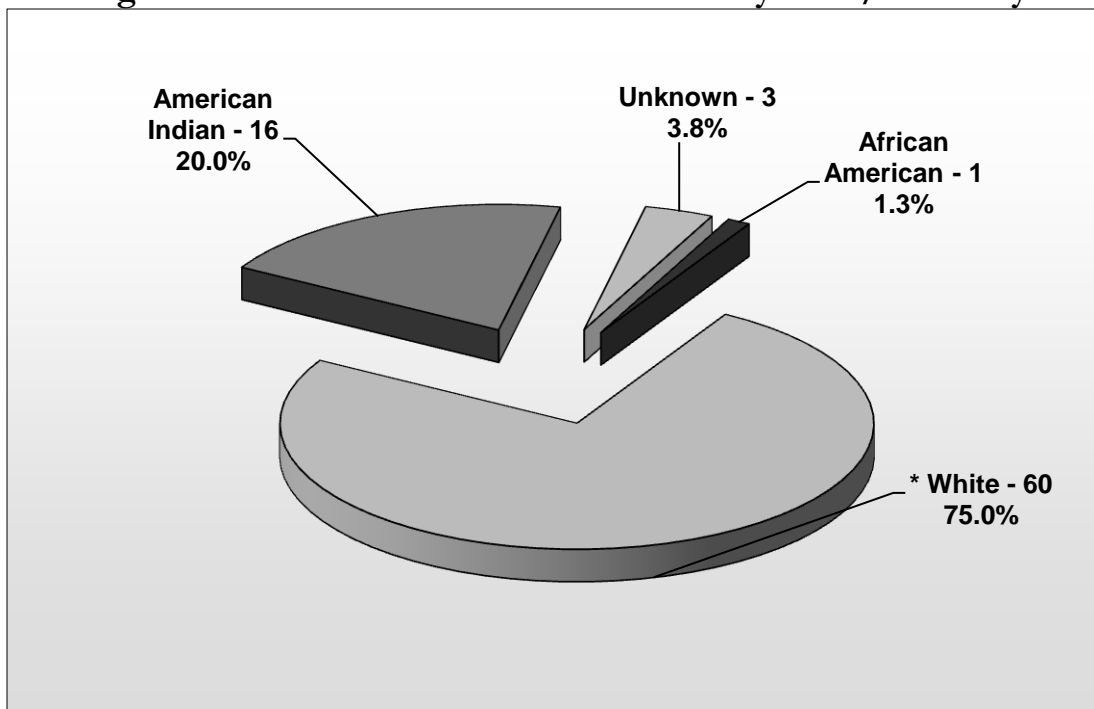
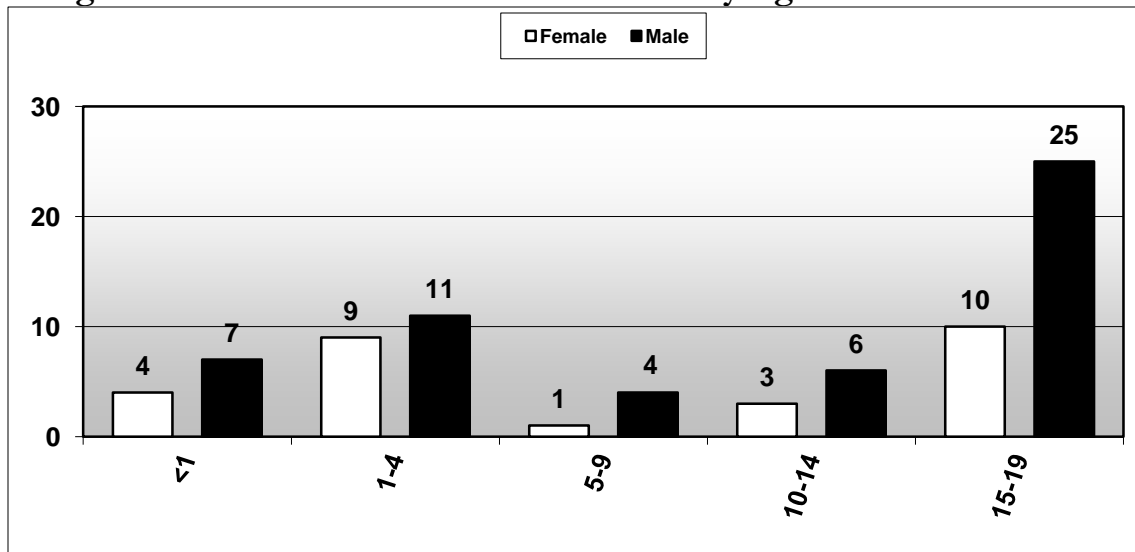


Figure 37– Children – Accidental Deaths by Race/Ethnicity



\* White includes 39 Hispanic

**Figure 38 – Children – Accidental Deaths by Age and Gender – 2011**



**Table 20 – Children – Accidental Deaths – Cause of Death -- 2011**

Cause of Death	Total Cases
Asphyxia	10
Difluoroethane Toxicity	1
Drowning	6
Ethanol Intoxication	1
Gunshot Wound	1
Head and Neck Injuries	14
Hypothermia	1
Multiple Injuries	32
Narcotic Abuse	7
Smoke Inhalation	2
Suffocation	1
Other	4
<b>Total</b>	<b>80</b>

**Table 21 - Children – Accidental Deaths - Method – 2011**

Manner of Death	Total Cases	Autopsy	Field External	Inv External	Path External
Passenger in motor vehicle that left roadway	12	8	3	0	1
Asphyxia	10	10	0	0	0
Passenger in motor vehicle in collision with another motor vehicle	6	3	2	0	1
Passenger in motor vehicle that left roadway and overturned	6	1	3	0	2
Ingested and/or injected prescription medication(s)	5	5	0	0	0
Ingested and/or injected illicit drug(s)	4	4	0	0	0
Pedestrian struck by motor vehicle(s)	4	4	0	0	0
Driver of motor vehicle in collision with another motor vehicle	3	3	0	0	0
Driver of motor vehicle that left roadway	3	2	0	0	0
Drowned (during recreational activity)	3	3	0	0	0
Drowned (non recreational water accident)	3	3	0	0	0
Driver of ATV	2	1	1	0	0
Injuries from Fall	2	2	0	0	0
Occupant in motor vehicle in collision with another motor vehicle	2	0	2	0	0
Pedestrian struck by pickup	2	0	1	0	1
Accidental discharge of firearm	1	1	0	0	0
Accidental Hanging	1	1	0	0	0
Choked	1	1	0	0	0
Cyclist Struck by Motor Vehicle	1	1	0	0	0
Driver of motorcycle that caught fire	1	1	0	0	0
Ingested alcohol	1	1	0	0	0
Ingested and/or injected illicit and prescription drug(s)	1	1	0	0	0
Inhaled toxic Agent (Substance Inhaled Accidentally)	1	1	0	0	0
Occupant in motor vehicle that overturned	1	1	0	0	0
Passenger in overturned boat	1	1	0	0	0
Pedestrian struck by pickup pulling trailer	1	0	1	0	0
Pedestrian struck by train	1	1	0	0	0
Thermal Injuries	1	1	0	0	0

## Overview – Children – Manner of Death – Suicide Deaths

Figure 39 – Children – Suicide Deaths – 2002 – 2011

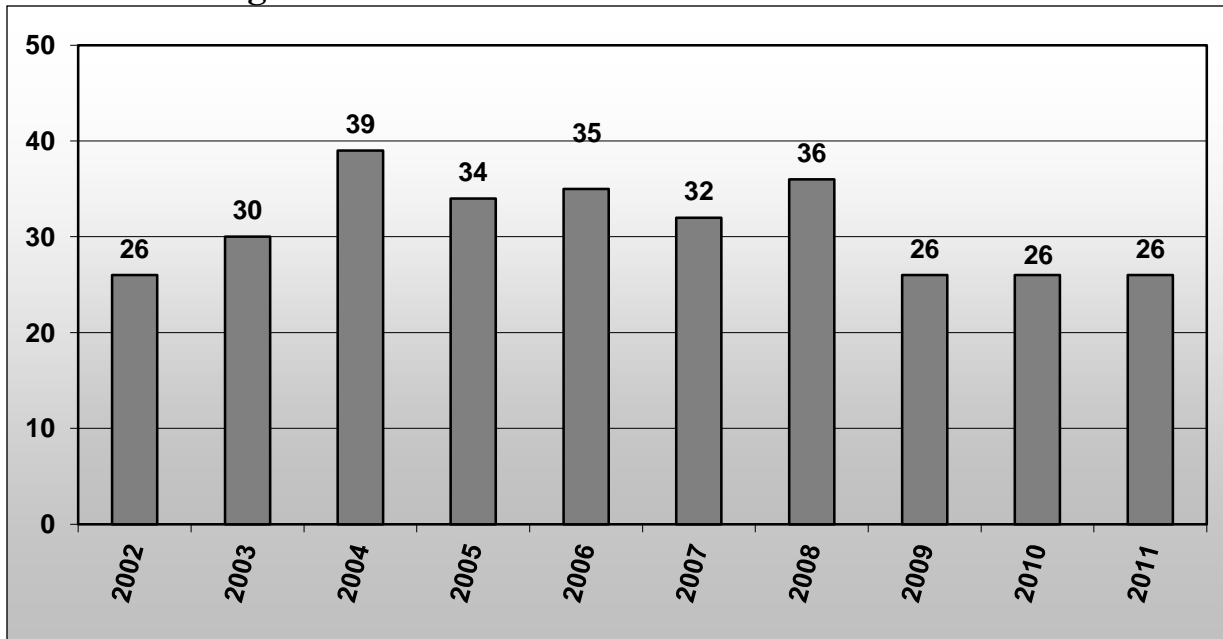
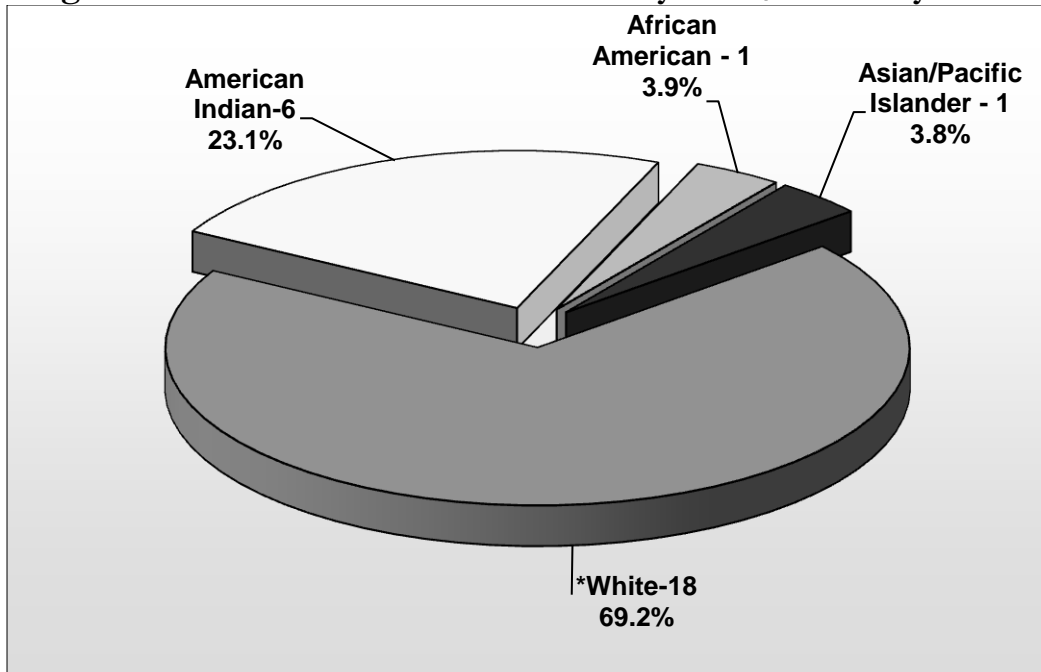


Figure 40 – Children – Suicide Deaths by Race/Ethnicity – 2011



\* White includes 6 Hispanic

Figure 41 – Children – Suicide Deaths by Age and Gender – 2011

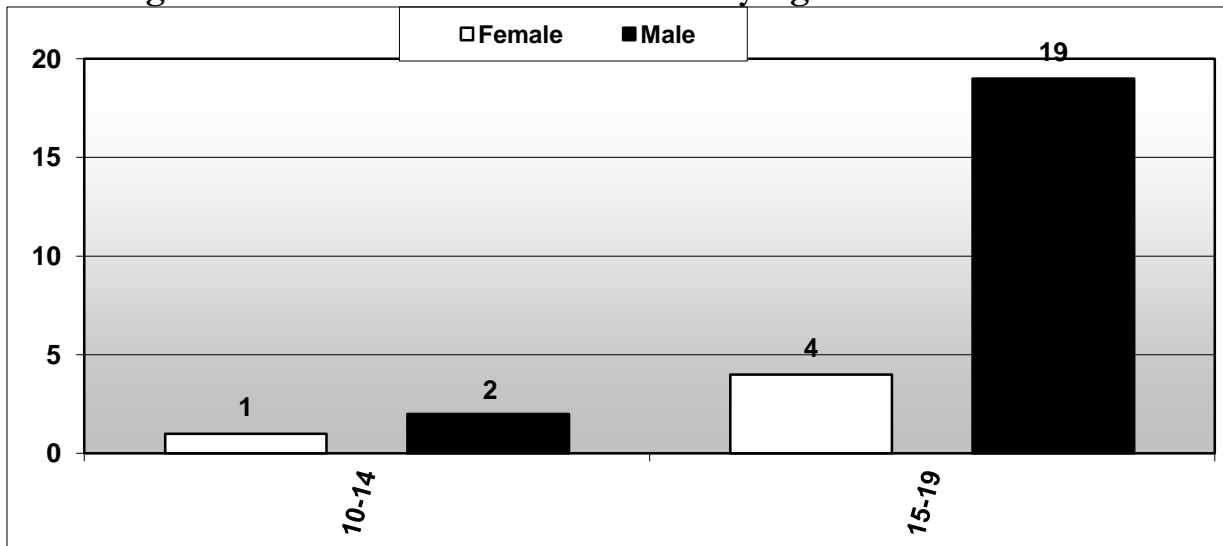


Figure 42 – Children – Suicide Deaths by Month – 2011

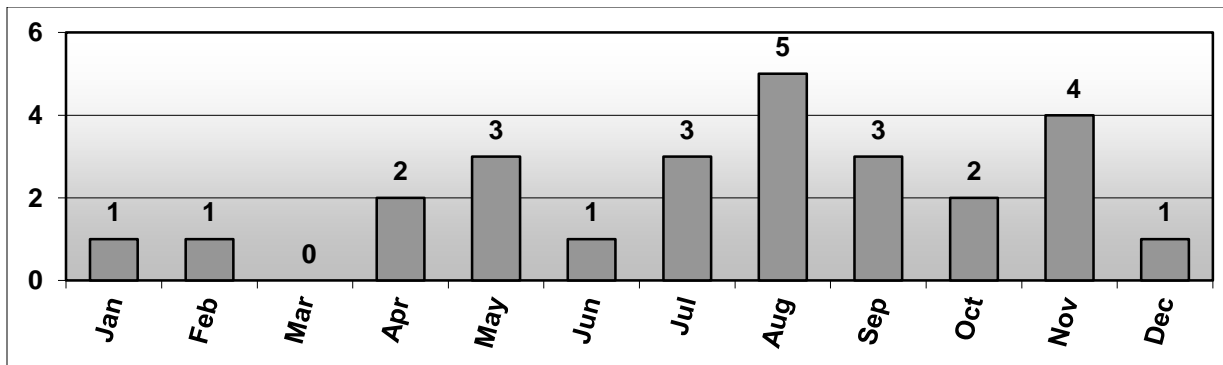
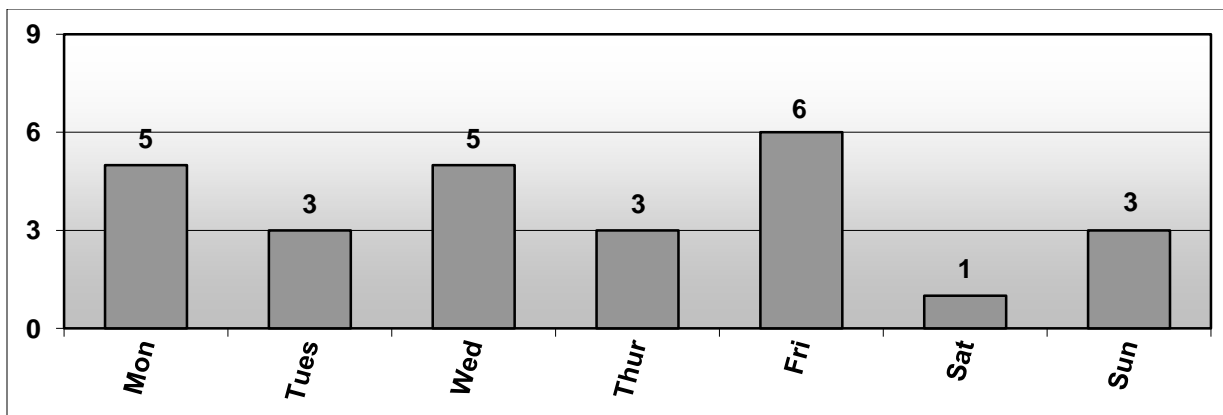


Figure 43 – Children – Suicide Deaths by Day of the Week – 2011



**Table 22 – Children – Suicide Deaths – Cause of Death – 2011**

<b>Cause</b>	<b>Total Cases</b>
Hanging	8
Gunshot Wound	14
Multiple Injuries	2
Stab Wound	1
Hypoxic-ischemic Brain Injury	1
<b>Total</b>	<b>26</b>

**Table 23 - Children – Suicide Deaths - Method – 2011**

<b>Manner of Death</b>	<b>Total Cases</b>	<b>Autopsy</b>	<b>Field External</b>	<b>Inv External</b>	<b>Path External</b>
Shot Self with Firearm	14	12	2	0	0
Hanged Self	9	7	1	0	1
Jumped	1	1	0	0	0
Stabbed Self	1	1	0	0	0
Struck By Train	1	0	1	0	0

### **Suicide in Children – Summary**

The 10-year summaries presented in this report for childhood deaths all include ages 19 and younger. There were 26 suicides in children in 2011. Suicide deaths were more common among young males (81%) than females (19%). Self-inflicted gunshot wounds and hanging were the most common method of suicide in children. More suicides were committed by youth during August when compared with other months, and Fridays were the most common day for youth suicides.



## Overview – Children – Manner of Death – Homicide Deaths

Figure 44 – Children – Homicide Deaths – 2002 – 2011

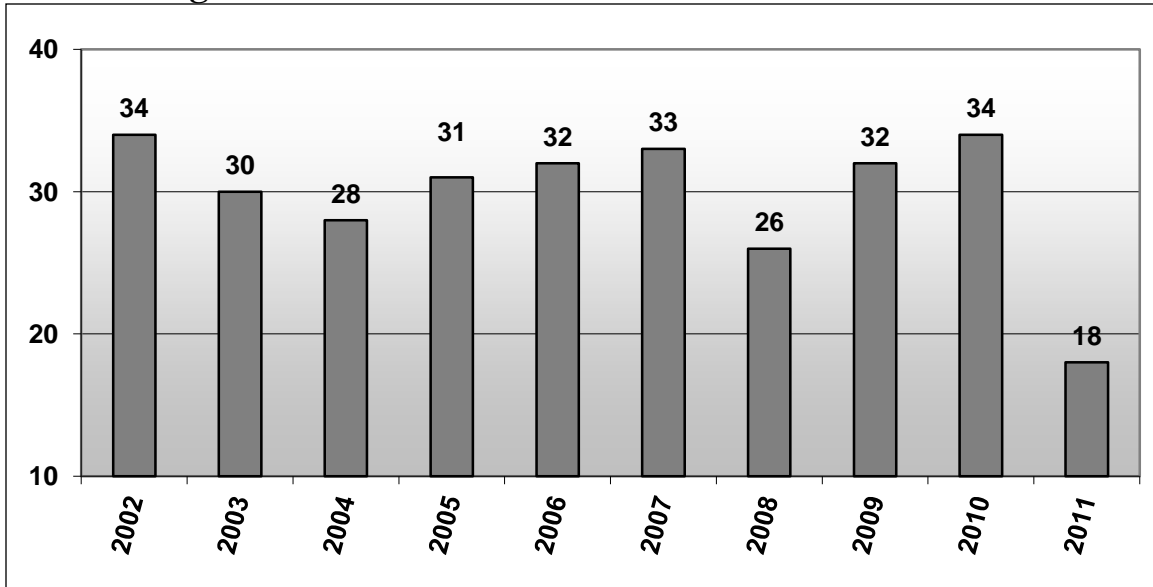
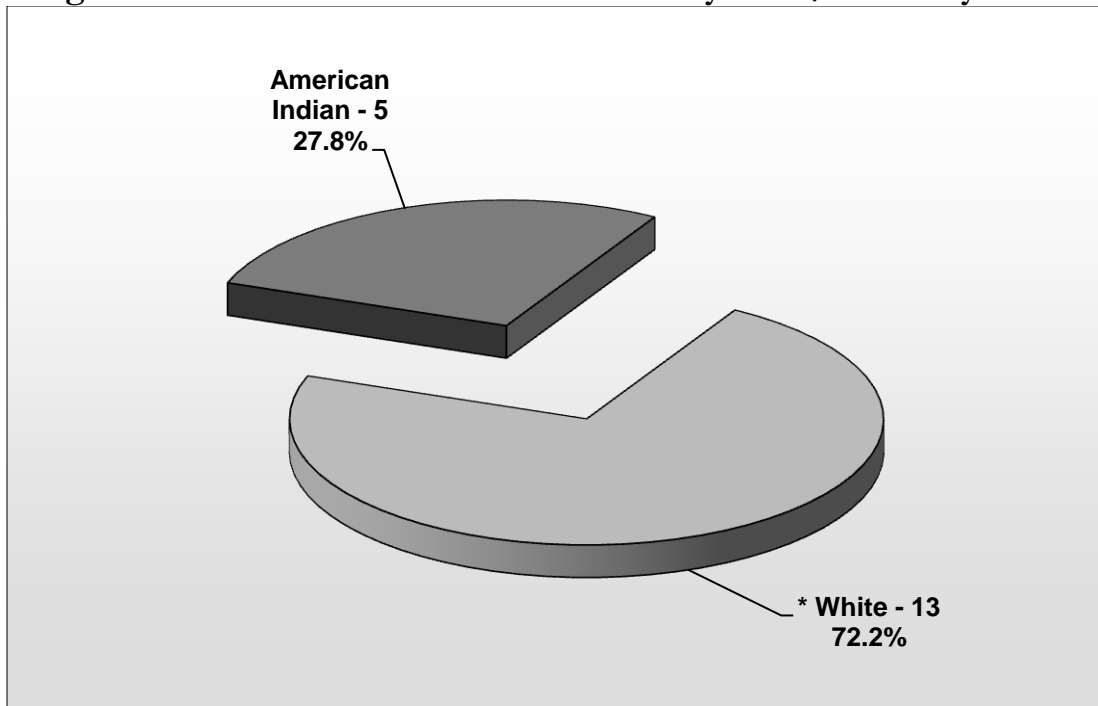
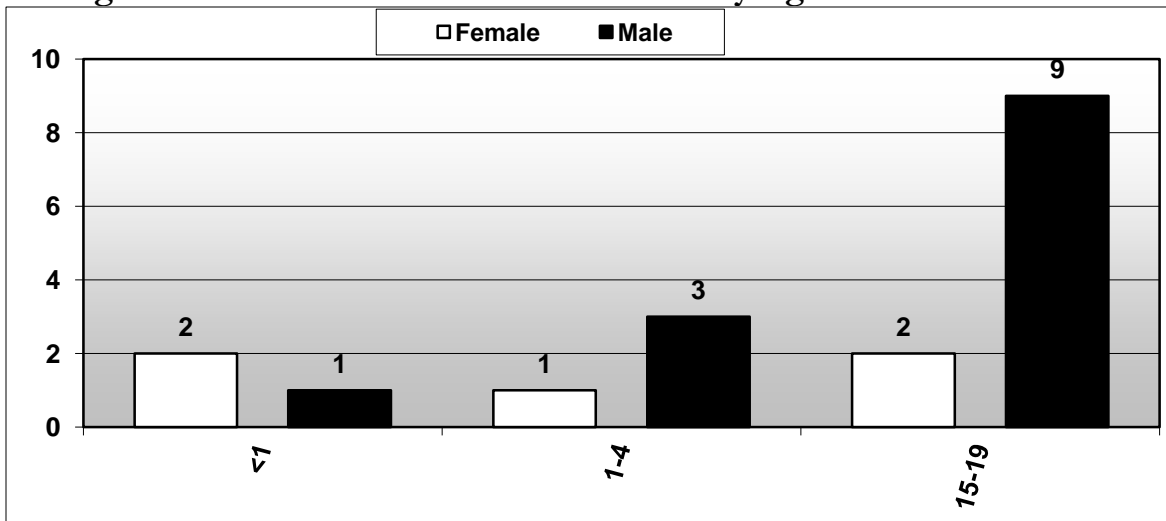


Figure 45 – Children – Homicide Deaths by Race/Ethnicity – 2011



\* White includes 11 Hispanic

**Figure 46 – Children – Homicide Deaths by Age and Gender – 2011**



**Table 24 – Children – Homicide Deaths – Cause of Death – 2011**

Cause of Death	Total Cases
Gunshot wound	8
Head and Neck Injuries	6
Multiple Injuries	3
Stab Wound	1
<b>Total</b>	<b>18</b>

**Table 25 - Children – Homicide Deaths - Method – 2011**

Manner of Death	Total Cases	Autopsy	Field External	Inv External	Path External
Beaten by Assailant(s)	9	9	0	0	0
Shot by Assailant(s) with Firearm	8	8	0	0	0
Stabbed by Assailant(s)	1	1	0	0	0

## **Homicide Deaths of Children – Summary**

As with the suicides, the total number of childhood homicides, both for this year's cases and in the 10-year summaries, now includes anyone aged 19 years or younger. Childhood homicides decrease by 45% from 2010. Murdered children tended to be male (72%), Hispanic (61%) and killed by a firearm (44%). The majority of childhood murder victims (61%) were between the ages of 15 and 19.

## **Overview – Children – Manner of Death – Undetermined Deaths**

During 2011, 29 people 19 years old or younger were classified as Undetermined manner of death.

## **Deaths of Children in New Mexico – 2011 Summary**

The 290 deaths of people aged 19 and younger represented 5.5% of all deaths investigated by the OMI in 2011. Male decedents comprised 59% of the total deaths in children. The most common manner of death among children was natural, contributing 47.2% of the total. Firearms played a role in 14 suicides (47.2% of total child suicides) and 8 homicides (44.4% of child homicides), 17.7% of all unnatural deaths in children.

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

## Overview – Children – SIDS Deaths

Figure 47 – Children – SIDS (Natural) Deaths – 2002 – 2011

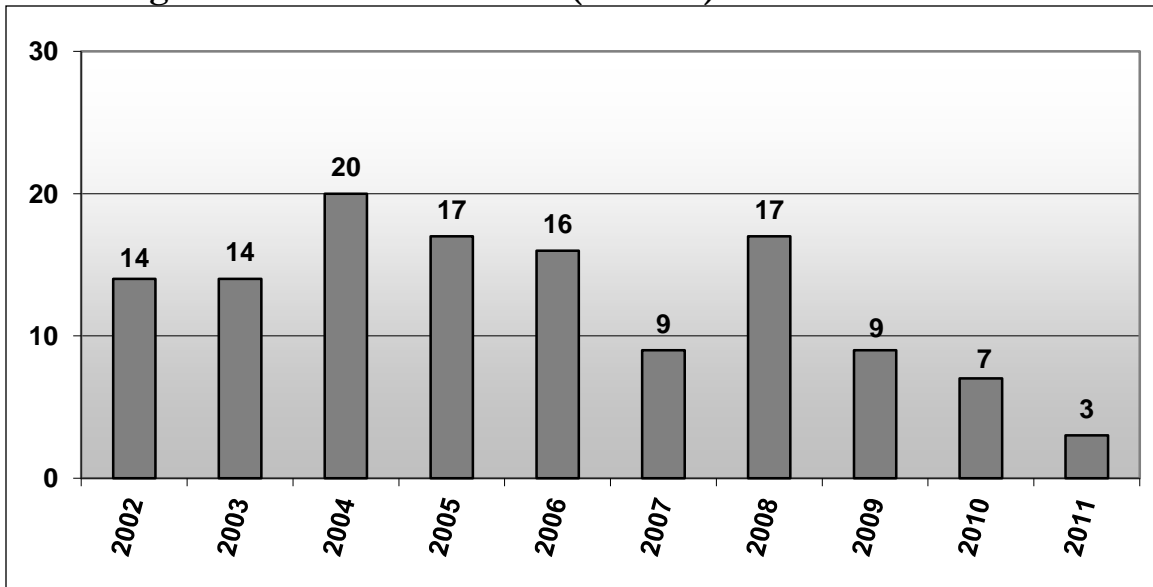
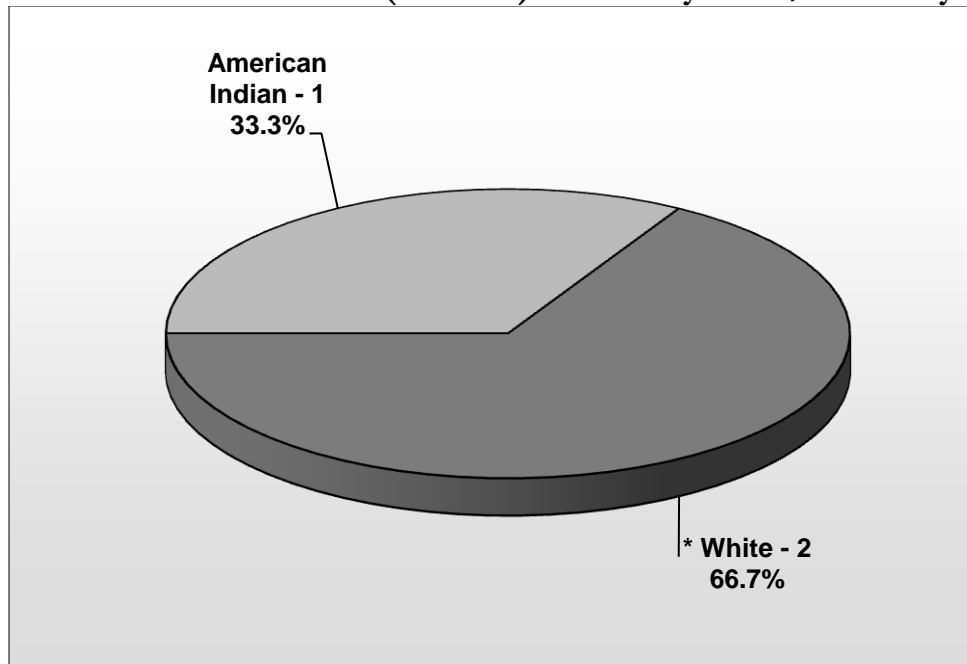


Figure 48 – Children – SIDS (Natural) Deaths by Race/Ethnicity – 2011



\* White includes 2 Hispanic

## Overview – Ethanol Related Deaths

Figure 49 – Ethanol Related Deaths – 2002 – 2011  
Ethanol Present in Decedent (> 0.005%)

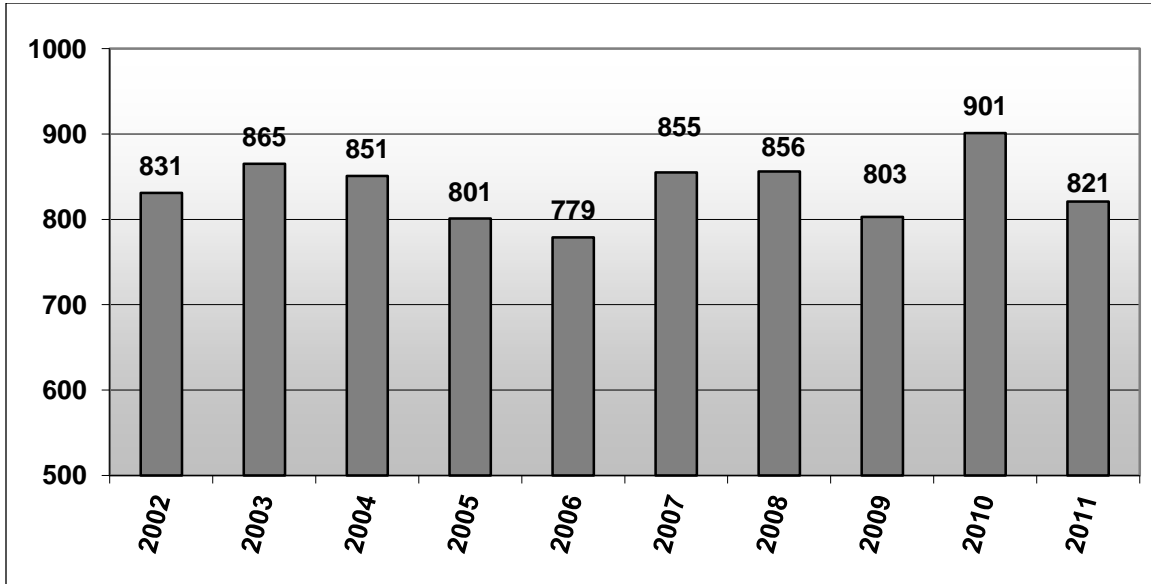
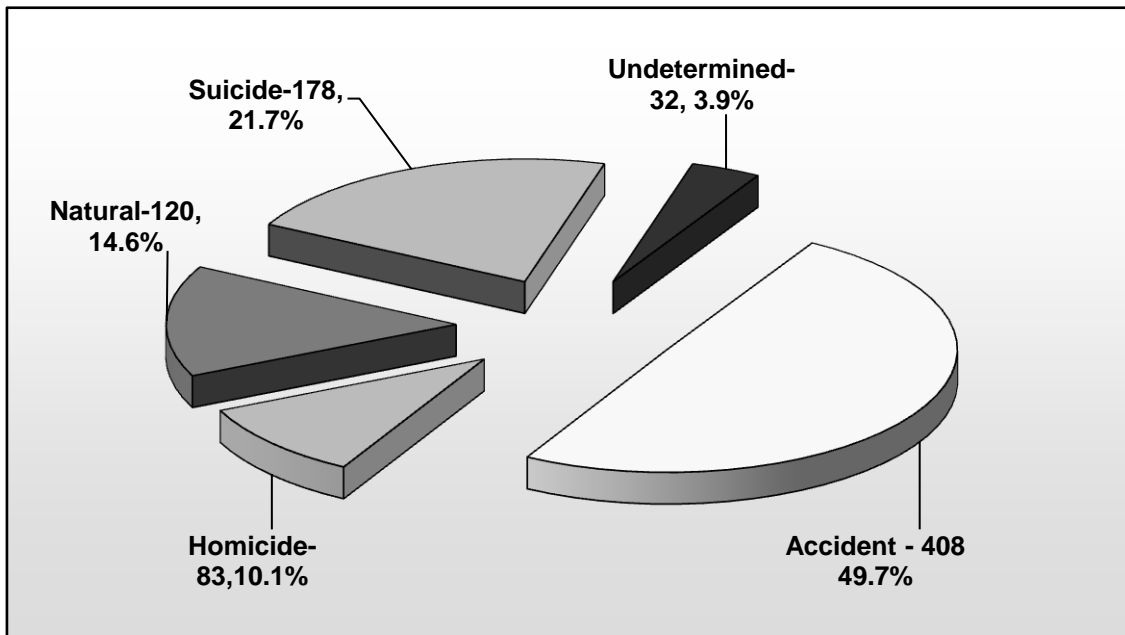
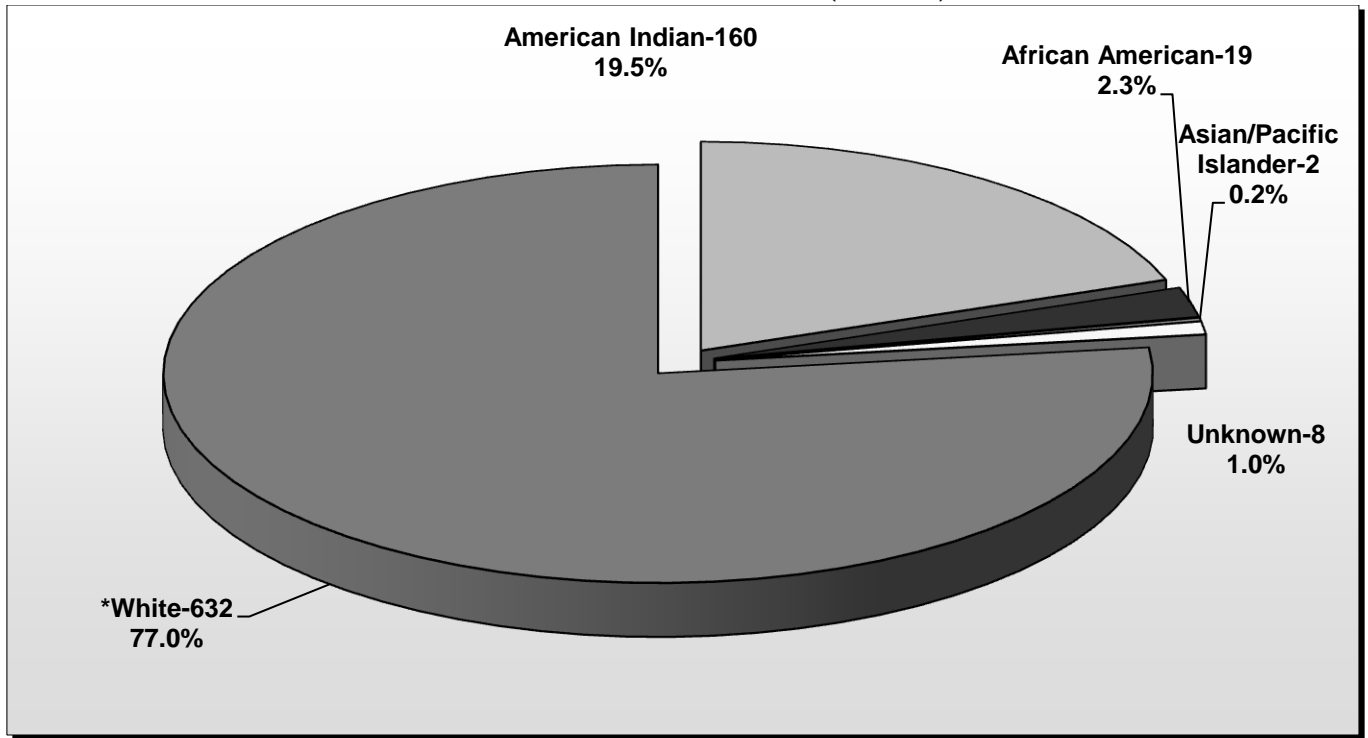


Figure 50 – Ethanol Related Deaths – Manner of Death – 2011  
Ethanol Present in Decedent (> 0.005%)

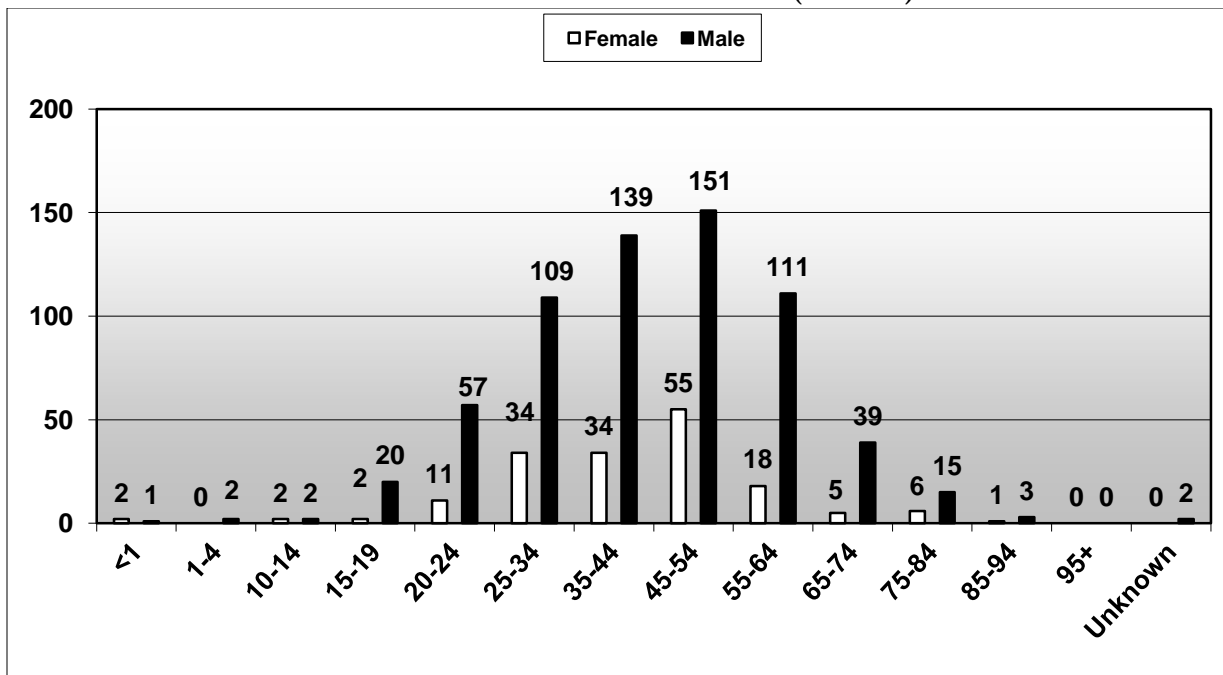


**Figure 51 – Ethanol Related Deaths by Race/Ethnicity – 2011**  
Ethanol Present in Decedent (> 0.005%)



\* White includes 279 Hispanic

**Figure 52 – Ethanol Related Deaths by Age and Gender – 2011**  
Ethanol Present in Decedent (> 0.005%)



**Table 26 – Ethanol Related Deaths – Accidental Deaths - Method – 2011  
Ethanol Present in Decedent**

	Presence of Ethanol>0.005%		
	Total Cases	Yes	No/Not Tested
Injuries from Fall	414	10	404
Ingested and/or injected prescription medication(s)	204	24	180
Ingested and/or injected illicit drug(s)	144	27	117
Driver of motor vehicle that left roadway	78	33	45
Ingested and/or injected prescription medication(s) with alcohol	61	59	2
Driver of motor vehicle in collision with another motor vehicle	57	7	50
Ingested and/or injected illicit drug(s) with alcohol	50	47	3
Exposure	47	28	19
Ingested alcohol	37	34	3
Passenger in motor vehicle that left roadway	35	13	22
Ingested and/or injected illicit and prescription drug(s)	33	2	31
Pedestrian struck by motor vehicle(s)	26	12	14
Passenger in motor vehicle in collision with another motor vehicle	25	5	20
Thermal Injuries	24	9	15
Passenger in motor vehicle that left roadway and overturned	19	10	9
Drowned (during recreational activity)	18	9	9
Driver of motorcycle that left roadway	17	8	9
Driver of motor vehicle in collision with fixed object	16	6	10
Asphyxia	15	3	12
Driver of motorcycle in collision with motor vehicle	15	6	9
Drowned (non recreational water accident)	15	8	7
Choked	11	2	9
Crushed/Suffocated	9	2	7
Ingested and/or injected illicit and prescription drug(s) with alcohol	9	9	0
Presumed fall	8	0	8
Fall from vehicle	7	3	4
Inhaled toxic Agent (Substance Inhaled Accidentally)	7	1	6
Driver of ATV that crashed	6	1	5

Driver of motorcycle in collision with fixed object	6	3	3
Occupant in motor vehicle in collision with another motor vehicle	6	4	2
Pedestrian struck by train	6	3	3
Cyclist Struck by Motor Vehicle	5	0	5
Farm or Industrial Machinery Accident	5	2	3
Fall down Stairs	4	0	4
Medical Treatment	4	0	4
Pedestrian struck by pickup	4	0	4
Pilot of aircraft that crashed	4	1	3
Unknown	4	1	3
Accident - Other	3	1	2
Accidental discharge of firearm	3	2	1
Inhaled toxic agent (Substance Abuse)	3	1	2
Pedestrian struck by semi	3	3	0
Accidental Hanging	2	1	1
Accidental ligature strangulation	2	1	1
Anaphylaxis	2	0	2
Driver of motorcycle that struck debris in roadway	2	0	2
Occupant in motor vehicle that left roadway	3	2	1
Occupant of airplane that crashed	2	0	2
Passenger in aircraft that crashed	2	0	2
Passenger in overturned boat	2	0	2
Pedestrian struck by truck	2	1	1
Accidentally ingested Super Algae Guard	1	0	1
Complications of Mine cave in many decades ago	1	0	1
Co-Pilot of aircraft that crashed	1	0	1
Cut self	1	0	1
Cyclist Non-motor Vehicle Accident	1	0	1
Driver of auto struck by auto fleeing law enforcement	1	0	1
Driver of bus in collision with fixed object	1	0	1



Driver of motor vehicle that overturned	1	0	1
Driver of motorcycle in collision with another motorcycle	1	1	0
Driver of motorcycle that caught fire	1	0	1
Driver of motorcycle that crashed	1	0	1
Driver of motorcycle that lost control and fell	1	0	1
Driver of scooter that struck pedestrian, driver ejected	1	0	1
Exposed to mercury in the workplace	1	0	1
Fall between a shelf and pallet in warehouse	1	0	1
Gastric laceration with perforation	1	0	1
Kicked in chest by horse	1	0	1
Kicked in head by buffalo	1	0	1
Mauled by dogs	1	0	1
Occupant in auto collision with vehicle fire	1	0	1
Occupant in motor vehicle that overturned	1	0	1
Occupant in parked vehicle struck by pickup	1	0	1
Passenger in motor vehicle in collision with fixed object	1	1	0
Passenger on motorcycle that left roadway	1	1	0
Pedestrian struck by motorcycle	1	1	0
Pedestrian struck by pickup pulling trailer	1	0	1
Pedestrian struck by truck that struck building	1	0	1
Remote hypoxic-ischemic brain injury	1	0	1
Rode motorized wheelchair into refrigerator	1	0	1
Struck by a falling tree	1	0	1
Struck by flying metal debris during wind storm	1	0	1
Struck on the head by motorcycle falling from stand	1	0	1
Suffocated by power tack off drive shaft	1	0	1
Unhelmeted driver of motorcycle that overturned	1	0	1
Victim of mining explosion	1	0	1

**Table 27 - Suicide Deaths - Method – 2011  
Ethanol Present in Decedent**

<b>Manner of Death</b>	<b>Total Cases</b>	<b>Presence of Ethanol&gt;0.005%</b>	
		<b>Yes</b>	<b>No/Not Tested</b>
Shot Self with Firearm	218	102	116
Hanged Self	92	42	50
Ingested or Injected Medication	61	24	37
Inhaled	9	3	6
Jumped	9	2	7
Suffocated Self	7	0	7
Cut Self	6	0	6
Stabbed Self	6	0	6
Driver of Motor Vehicle	2	1	1
Ingested, Injected or Inhaled Non-prescription	2	1	1
Struck by Train	2	2	0
Burned Self	1	0	1
Decedent Ate Poisonous Plant	1	0	1
Suicide as Pedestrian	1	1	0

**Table 28 - Homicide Deaths - Method – 2011  
Ethanol Present in Decedent**

<b>Manner of Death</b>	<b>Total Cases</b>	<b>Presence of Ethanol&gt;0.005%</b>	
		<b>Yes</b>	<b>No/Not Tested</b>
Shot by Assailant(s) with Firearm	74	32	42
Beaten by Assailant(s)	40	16	24
Stabbed by Assailant(s)	32	24	8
Shot by On-duty Enforcement Officer(s)	8	4	4
Beaten and Stabbed by Assailant(s)	5	3	2
Victim of Intentionally Set Fire	1	0	1

Sustained Injuries During Sexual Assault	1	1	0
Suffocated by Assailant(s)	1	1	0
Strangled, Beaten, and Bound by Assailant(s)	1	0	1
Pedestrian Stuck by Auto	1	1	0
Passenger in Auto in Collision with Auto	1	0	1
Neglect/Starvation	1	0	1
Driver of Auto Forced off Roadway	1	1	0

### **Ethanol Related Deaths – Undetermined - 2011**

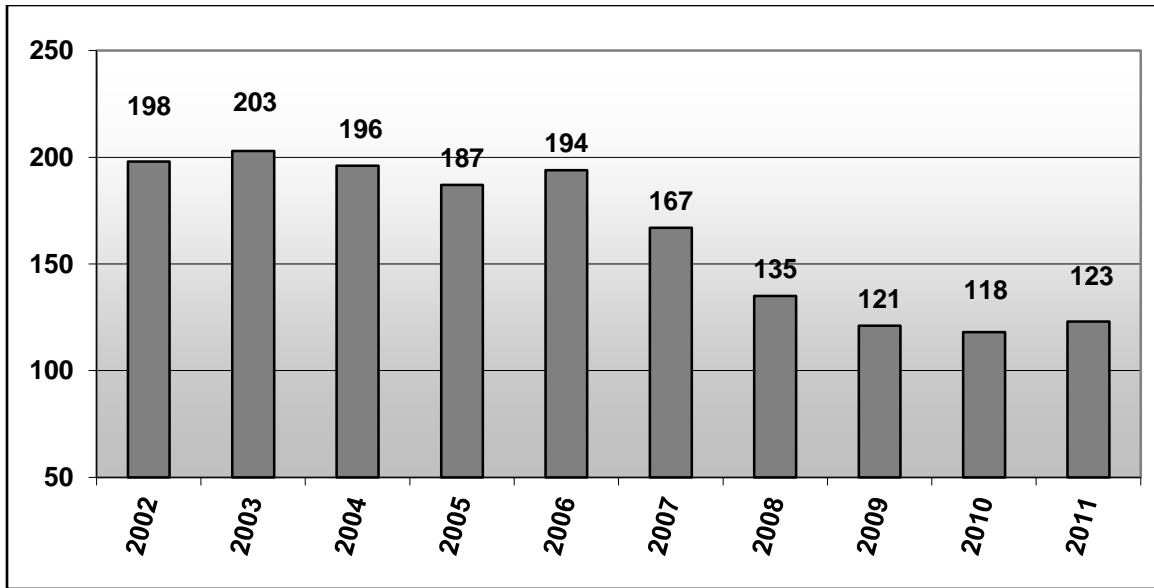
There were 32 Undetermined Deaths where Ethanol was present in the decedent in amounts greater than 0.005%.

### **Ethanol Related Deaths – Summary – 2011**

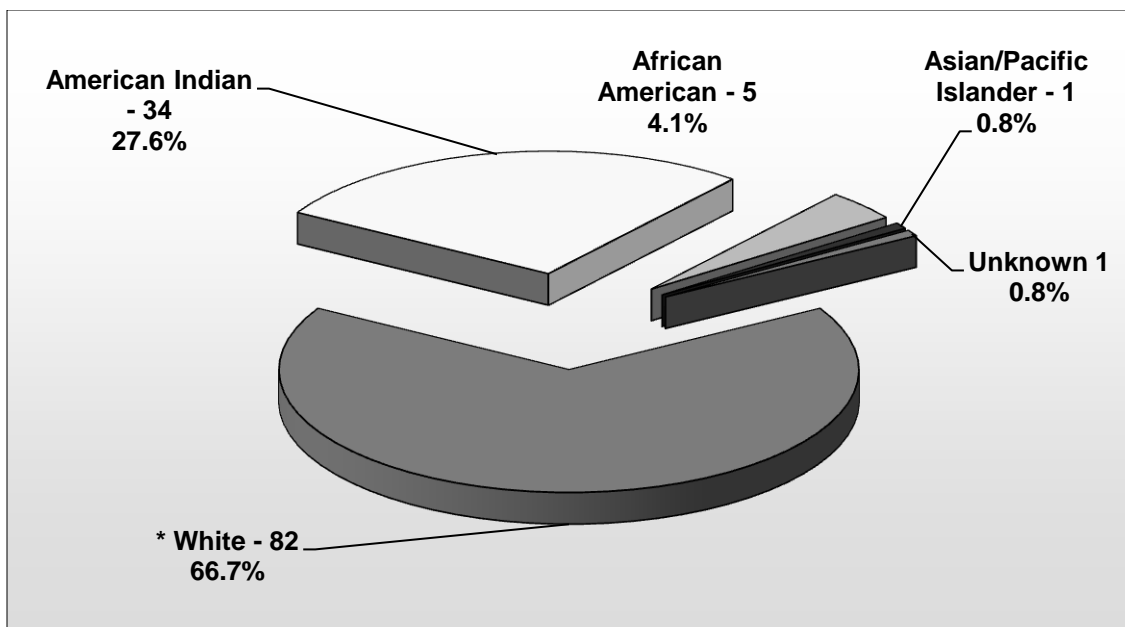
There were 821 alcohol (ethanol) related deaths investigated by OMI in 2011, 15.5% of the total and a 8.9% decrease from 2010. Alcohol was most frequently related to accidental deaths (49.7% of all alcohol-related deaths) but was found in people dying from all manners of death. Alcohol was present in 42.6% of all suicide fatalities and 49.7% of all homicide victims. The most alcohol related deaths were seen in males ranging in age from 45 to 54 years.

## Motor Vehicle Related Deaths

**Figure 53 – Motor Vehicle Deaths – 2002– 2011  
Ethanol Present in Decedent (> 0.005%)**

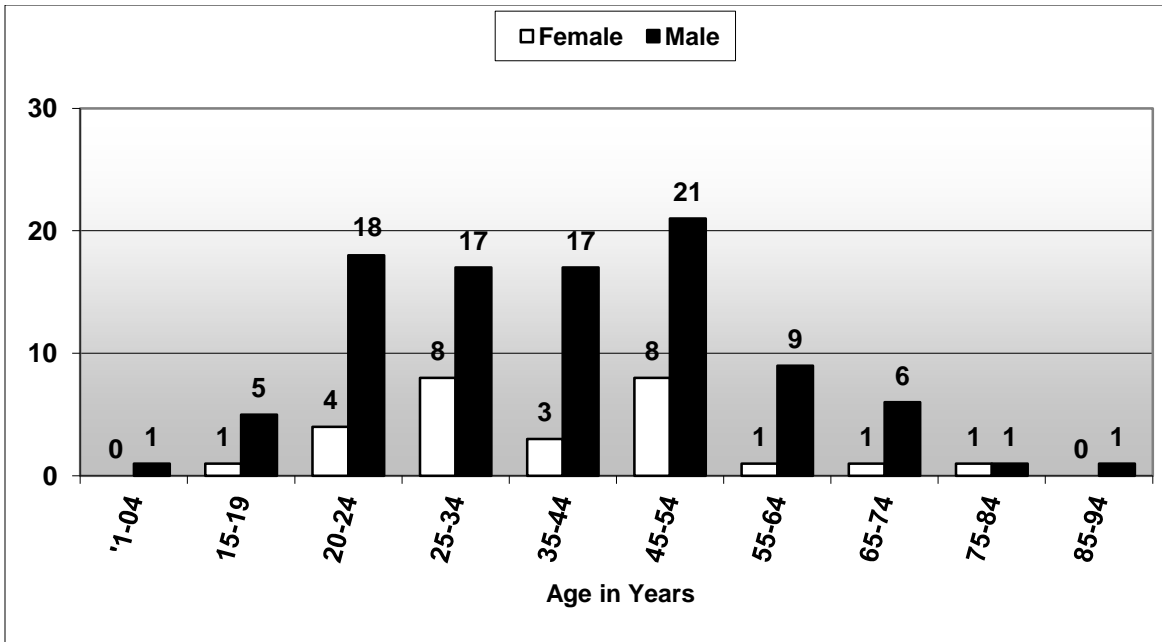


**Figure 54 – Motor Vehicle Deaths by Race/Ethnicity – 2011  
Ethanol Present in Decedent (> 0.005%)**



\* White includes 45 Hispanic

**Figure 55 – Motor Vehicle Deaths by Age and Gender – 2011  
Ethanol Present in Decedent (> 0.005%)**



**Table 29 – Motor Vehicle Related Deaths – Method 2011  
Ethanol Present in Decedent**

Circumstances	Total Cases	Presence of Ethanol > 0.005%	
		Yes	No/Not Tested
Driver	201	65	136
Passenger	82	30	52
Pedestrian	42	20	22
Occupant	13	8	5
Cyclist	5	0	5
Unknown	1	0	1
<b>Totals</b>	<b>344</b>	<b>123</b>	<b>221</b>

**Table 30 – Motor Vehicle Related Deaths – Seat Belt Use  
Ethanol Present in Decedent**

	Ethanol >0.005%	Seat Belt Use			Unknown	Total
		Belt Used	Belt Not Used	Not Installed		
<b>Motor Vehicle Driver</b>	Yes	9	31	0	25	65
	No	50	41	0	45	136
	<b>Subtotal</b>	<b>59</b>	<b>72</b>	<b>0</b>	<b>70</b>	<b>201</b>
<b>Motor Vehicle Passenger</b>	Yes	5	23	0	2	30
	No	16	30	0	6	52
	<b>Subtotal</b>	<b>21</b>	<b>53</b>	<b>0</b>	<b>8</b>	<b>82</b>
<b>Motor Vehicle Occupant*</b>	Yes	0	8	0	0	8
	No	2	1	0	2	5
	<b>Subtotal</b>	<b>2</b>	<b>9</b>	<b>0</b>	<b>2</b>	<b>13</b>
<b>Totals</b>		<b>82</b>	<b>134</b>	<b>0</b>	<b>80</b>	<b>296</b>

\*Occupant means the person was either the driver or a passenger, but was not confirmed.

**Table 31 – Motor Vehicle Related Deaths – Air Bag Use  
Ethanol Present in Decedent**

	Ethanol >0.005%	Air Bag Use			Unknown	Total
		Inflated	Not In Use	Not Installed		
<b>Motor Vehicle Driver</b>	Yes	13	6	0	43	62
	No	27	13	6	90	136
	Not Tested	0	0	0	0	0
	<b>Subtotal</b>	<b>40</b>	<b>19</b>	<b>6</b>	<b>133</b>	<b>198</b>
<b>Motor Vehicle Passenger</b>	Yes	3	4	3	20	30
	No	10	3	1	38	52
	Not Tested	0	0	0	0	0
	<b>Subtotal</b>	<b>13</b>	<b>7</b>	<b>4</b>	<b>58</b>	<b>82</b>
<b>Motor Vehicle Occupant*</b>	Yes	0	2	2	4	8
	No	2	0	0	3	5
	Not Tested	0	0	0	0	0
	<b>Subtotal</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>7</b>	<b>13</b>
<b>Totals</b>		<b>55</b>	<b>28</b>	<b>12</b>	<b>198</b>	<b>293</b>

\*Occupant means the person was either the driver or a passenger, but was not confirmed.

## Drug Caused Deaths

Figure 56 – Drug Caused Deaths – 2002 – 2011

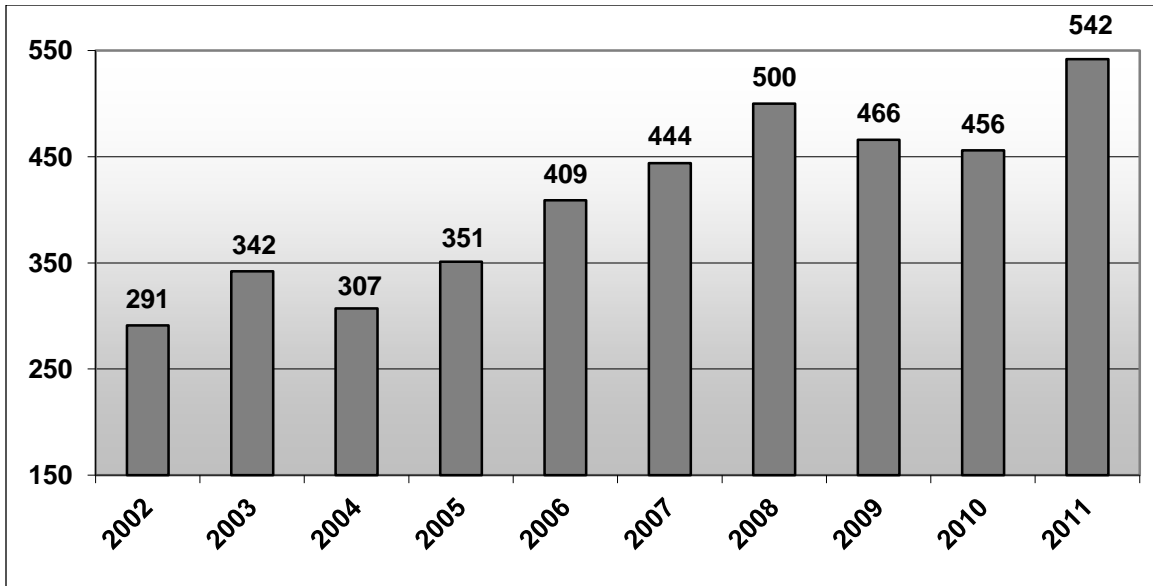
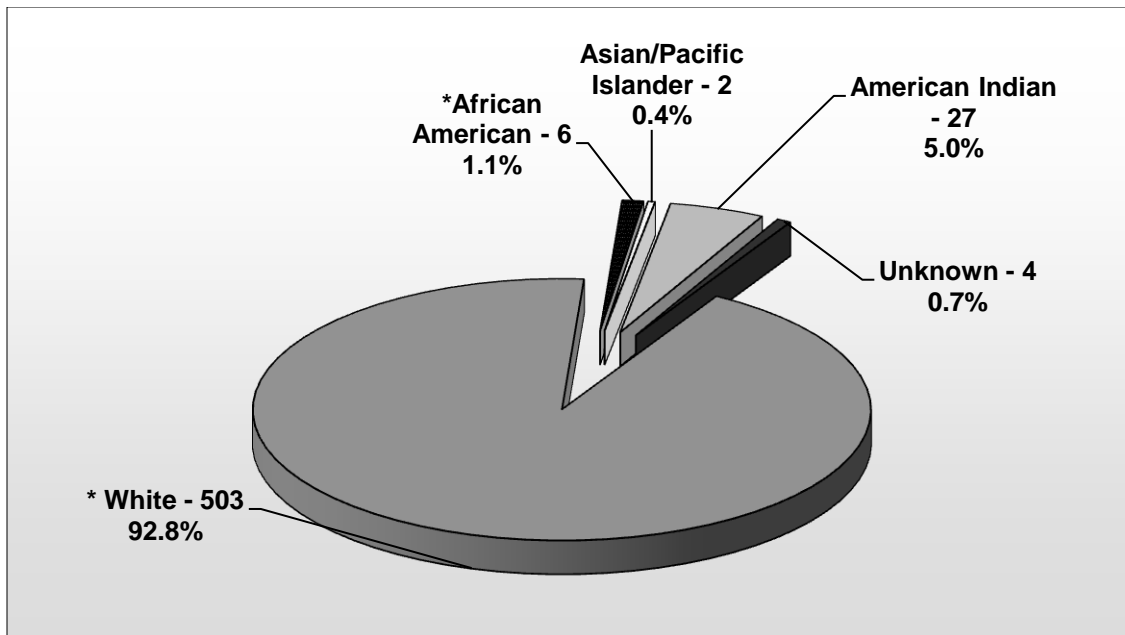
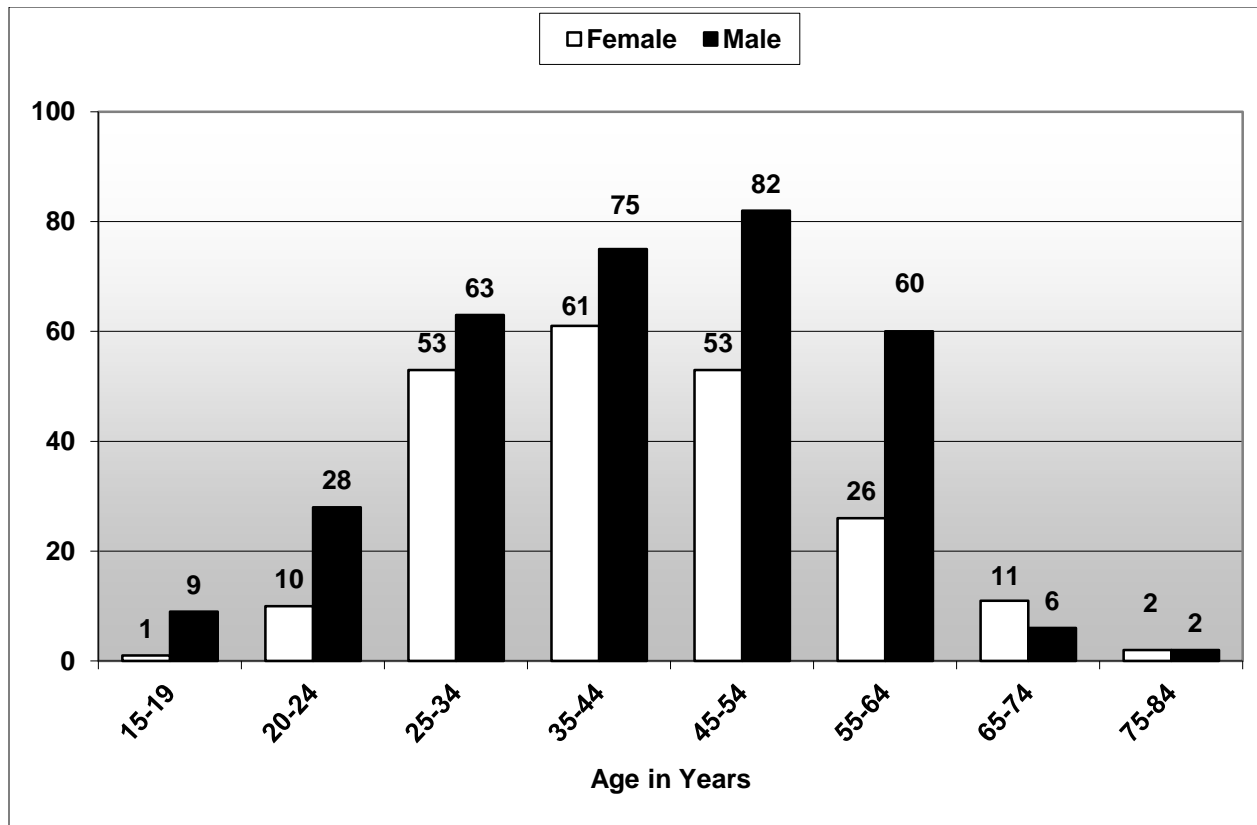


Figure 57 – Drug Caused Deaths by Race/Ethnicity – 2011



\* White includes 223 Hispanic, African American includes 1 Hispanic

Figure 58 – Drug Caused Deaths by Age and Gender – 2011





**Table 32 – Drug Caused Deaths – Counties of Injury and Pronouncement– 2011**

County	County of Injury	County of Pronouncement
Bernalillo	208	218
Catron	3	3
Chaves	21	21
Cibola	4	2
Colfax	1	1
Curry	5	5
De Baca	0	0
Dona Ana	39	38
Eddy	7	8
Grant	5	5
Guadalupe	0	0
Harding	0	0
Hidalgo	4	4
Lea	13	13
Lincoln	6	5
Los Alamos	3	3
Luna	4	2
McKinley	8	9
Mora	5	5
Otero	13	16
Quay	3	3
Rio Arriba	29	26
Roosevelt	0	0
San Juan	22	22
San Miguel	12	12
Sandoval	27	28
Santa Fe	45	45
Sierra	8	8
Socorro	3	3
Taos	10	10
Torrance	6	7
Union	0	0
Valencia	24	19
Out of State/Unknown	4	1
<b>Totals</b>	<b>542</b>	<b>542</b>

## **Drug Caused Deaths – Summary – 2011**

Drug overdose deaths continue to be a problem in New Mexico. A wide variety of drugs, both illegal and prescription, contributed to the 542 drug-caused deaths, with the most commonly involved being narcotics, with approximately 800 isolations of a narcotic substance. Many decedents had more than one drug present at the time of death. The most drug-caused deaths being seen in males ages 45-54 years. The OMI designation of ‘drug-caused deaths’ includes both intentional (suicide, homicide) and unintentional (accidental) drug overdoses.

Additional information regarding unintentional drug overdose deaths in New Mexico is available annually in the newsletter *New Mexico Epidemiology*, published by the New Mexico Department of Health. An issue containing detailed information on unintentional drug overdose deaths will be available from NMDOH this fall.

## **Glossary**

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**Accident** – The *manner of death* used when, in other than *natural deaths*, there is no evidence of intent.

**Autopsy** – A detailed postmortem external and internal examination of a body to determine cause of death.

**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.

**Children** – Individuals 19 years of age or younger. (Normally this is 18 years of age or younger, but to keep with industry standard age divisions, 19 year-olds are included in our tables.)

**Circumstances of Death** – The situation, setting, or condition present at the time of injury or death.

**County of Injury** – The county where the injury leading to death occurred.

**County of Pronouncement** – The county where the decedent was pronounced dead.

**County of Residence** – The county where the decedent resided. If not a legal resident of New Mexico, the decedent is listed as “out of state.” A single case may have all three county definitions applied. For example, a decedent may be a resident of Rio Arriba county and be injured in an automobile accident in San Juan county (County of Injury) where, upon transfer to a hospital in Albuquerque, be pronounced in Bernalillo county.

**Deputy Medical Investigator** – An investigator, not necessarily a physician, appointed by the *State Medical Investigator* to assist in the investigation of deaths in the *jurisdiction* of the OMI. There is at least one deputy medical investigator in each county in New Mexico.

**Dictated External** – A detailed postmortem external examination of a body.

**Drug Caused Death** – A death caused by a drug or combination of drugs. Deaths caused by *ethanol*, poisons and volatile substances are excluded.

**Ethanol** – An alcohol, which is the principal intoxicant in liquor, beer and wine. A person with an alcohol concentration in blood of 0.08 grams percent (0.08g%) is legally intoxicated in New Mexico.

**Ethanol Present** – Deaths in which toxicological tests reveal a reportable level of *ethanol* (0.005% or greater) at the time of death.

**Homicide** – The *manner of death* in which death results from the intentional harm of one person by another.

**Jurisdiction** – The extent of the Office of the Medical Investigator’s authority over deaths. The OMI authority covers reportable deaths that occur in New Mexico, except for those occurring on federal reservations (American Indian and military) and in Veteran’s Administration hospitals. New Mexico Statute 24-11-5NMSA 1978 and descriptions in the OMI policy manual define reportable deaths. The OMI may be invited to consult or investigate cases over which it has no jurisdiction.

**Investigation/Field Examination** – An investigation and external examination conducted at the scene to determine cause of death.

**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*.

**Method of Death** – The *method of death* describes the physical means leading to a cause of death. For example, *the cause of death* in a case is *Asphyxia*, but an *accidental hanging* brought on the asphyxia and would be the *method of death*.

**Motor Vehicle Accident Related Deaths** – An accidental death involving a motor vehicle. Motor vehicles include automobiles, vans, motorcycles, trucks and all terrain vehicles. Excluded are bicycles, tricycles, aircraft and trains. The decedent is usually a driver of, a passenger in, or a pedestrian struck by a motor vehicle. The death of a bicyclist struck by a motor vehicle is considered to be a motor vehicle accident related death.

**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.

**Non-Motor Vehicle Accident** – An *accidental death* that does not involve a motor vehicle.

**Office of the Medical Investigator** – The state agency in New Mexico that is responsible for the investigation of sudden, violent or untimely deaths. The office of the Medical Investigator was created by legislation in 1973 to replace the county coroner system (see also, *Deputy Medical Investigator*).

**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.

**State Medical Investigator** – The head of the *Office of the Medical Investigator*. The State Medical Investigator must be a licensed physician licensed in New Mexico and may appoint Assistant Medical investigators, who must be physicians and *Deputy Medical Investigators*.

**SIDS** – Sudden Infant Death Syndrome is characterized by the death of an infant less than one year of age that is unexpected by history and remains unexplained after a thorough forensic autopsy and a detailed death scene investigation.

**Undetermined** – The *manner of death* for deaths in which there is insufficient information to assign another manner.