



New Mexico Office of the Medical Investigator

Annual Report 2020



We investigate deaths to serve the living



**2020 Annual Report
Office of the Medical Investigator
State of New Mexico**

Medical Investigators

Heather Jarrell, MD
Chief Medical Investigator
Lauren Dvorscak, MD
Assistant Chief Medical Investigator
Lauren Decker, MD
Ian Paul, MD
Lori Proe, DO
Ross Zumwalt, MD

Board of Medical Investigations

Martha Cole McGrew, MD,
Interim Dean, Executive Vice Dean of the
University of New Mexico School of Medicine
David Houston, Chairman,
State of New Mexico, Board of Thanatopractice
David R. Scrase, MD, Acting Cabinet
Secretary, New Mexico Department of Health
Lynn A. Trujillo, Cabinet Secretary, New
Mexico Department of Indian Affairs
Tim Johnson, Interim Cabinet Secretary, New
Mexico Department of Public Safety

Office of the Medical Investigator
MSC07 4040
1 University of New Mexico
Albuquerque, New Mexico 87131-0001
Telephone: (505)272-3053
Fax: (505)925-0546

Website: <http://omi.unm.edu>

Office of the Medical Investigator (OMI)
2020 Annual Report

Table of Contents

Introduction 7
 Preparation of the Annual Report 7
Overview – Office of the Medical Investigator – 2020 7
 Reportable Deaths 8
 Statutory Duty 9
 Program Summary and Highlights for 2020 10
 Investigative Activity 10
 Examination Types 10
 Identification 11
 Training and Education 11
 Forensic Pathology Fellowship Program 11
 Certification Training 11
 Death Investigation Training 11
 Law Enforcement Education 11
 Public Education 12
 OMI website 12
 Center for Forensic Imaging 12
 Grief Services Program 12
 Donor Services 12
Total Cases 13
 Figure 2. Total Cases (2011-2020) 14
 Figure 3. Total Cases by Month 2020 15
 Figure 4. Total Cases by Day 2020 15
 Figure 5. Total Cases by Race / Ethnicity 2020 16
 Figure 6. Total Cases by Age and Gender 2020 16
 Table 1. Total Cases - Autopsy Status 2020 17
 Table 2. Total Cases Distribution 2020 17
 Figure 7. Total Cases by Exam Type 2020 18
Cause and Manner of Death 19
 Figure 8. Total Cases by Manner of Death 2020 19
Cause and Manner of Death - Overview 19
 Table 3. Total Cases by Gender and Manner 2020 20
 Table 4. Total Cases by Manner of Death and Race/Ethnicity 2020 20
 Table 5. Total Cases by Manner of Death (Age and Gender) 2020 21
 Figure 9. OMI Deaths by County of Pronouncement 2019 (All Manner of Death) 22
Overview – Manner of Death – Natural Deaths 23
 Figure 10. Natural Deaths (2011 - 2020) 23
Natural Deaths – Overview 23
 Figure 11. Natural Deaths by Race / Ethnicity 2020 24
 Figure 12. Natural Deaths by Age and Gender 2020 24
Overview – Manner of Death – Accidental Deaths 25
 Figure 13. Accidental Deaths (2011 - 2020) 25

Accidental Deaths – Overview.....	25
Figure 14. Accidental Deaths by Race / Ethnicity 2020	26
Figure 15. Accidental Deaths by Age and Gender 2020	26
Table 6. Accidental Deaths by Cause 2020	27
Table 7. Accidental Deaths by County of Pronouncement (2011 - 2020)	28
Overview – Manner of Death (Suicide).....	29
Figure 16. Suicide Deaths (2011 - 2020)	29
Suicide Deaths – Overview	29
Figure 17. Suicide Deaths by Race / Ethnicity 2020	30
Figure 18. Suicide Deaths by Age and Gender 2020	30
Figure 19. Suicide Deaths by Month 2020	31
Figure 20. Suicide Deaths by Day of the Week 2020	31
Table 8. Suicide Deaths by Cause 2020.....	32
Table 9. Suicide Deaths by County of Pronouncement (2011 – 2020)	33
Overview – Manner of Death – Homicide Deaths.....	34
Figure 21. Homicide Deaths (2011 - 2020).....	34
Homicide Deaths – Overview	34
Figure 22. Homicide Deaths by Race / Ethnicity 2020	35
Figure 23. Homicide Deaths by Age and Gender 2020	35
Table 10. Homicide Deaths by Cause 2020.....	36
Table 11. Homicide Deaths – County of Pronouncement (2011 - 2020).....	37
Overview – Manner of Death – Undetermined Deaths	38
Figure 24. Undetermined Deaths (2011 - 2020)	38
Undetermined Deaths – Overview.....	38
Figure 25. Undetermined Deaths by Race / Ethnicity 2020	39
Figure 26. Undetermined Deaths by Age and Gender 2020	39
Deaths of Children (19 years of age and younger).....	40
Figure 27. Children/Deaths (2011 - 2020).....	40
Figure 28. Children/Deaths by Race / Ethnicity 2020	40
Figure 29. Children / Deaths by Age and Gender 2020	41
Figure 30. Children / Deaths by Manner of Death 2020.....	41
Overview – Children by Manner of Death (Natural Deaths)	42
Figure 31. Children / Natural Manner of Deaths (2011 - 2020).....	42
Figure 32. Children/Natural Deaths by Race / Ethnicity 2020	42
Figure 33. Children / Natural Deaths by Age and Gender 2020.....	43
Overview – Children by Manner of Death (Accidental Deaths).....	43
Figure 34. Children / Accidental Deaths (2011 - 2020)	43
Figure 35. Children / Accidental Deaths by Race / Ethnicity 2020	44
Figure 36. Children / Accidental Deaths by Age and Gender 2020.....	44
Table 12. Children / Accidental Deaths – Cause 2020	45
Overview – Children by Manner of Death (Suicide).....	45
Figure 37. Children / Suicide Deaths (2011 - 2020).....	45
Figure 38. Children / Suicide Deaths by Race/Ethnicity 2020.....	46
Figure 39. Children / Suicide Deaths by Age and Gender 2020	46
Figure 40. Children / Suicide Deaths by Month 2020.....	47
Figure 41. Children / Suicide Deaths by Day of Week 2020	47
Table 13. Children / Suicide Deaths by Cause 2020	48
Overview – Children by Manner of Death (Homicide)	48

Figure 42. Children / Homicide Deaths (2011 - 2020)..... 48
Figure 43. Children / Homicide Deaths by Race/Ethnicity 2020..... 49
Figure 44. Children / Homicide Deaths by Age and Gender 2020 49
Table 14. Children / Homicide Deaths by Cause 2020 50
Overview – Children by Manner of Death (Undetermined) 50
Figure 45. Children / Undetermined Deaths (2011 - 2020) 50
Figure 46. Children / Undetermined Deaths by Race / Ethnicity 2020 51
Figure 47. Children / Undetermined Deaths by Age and Gender 2020..... 51
Table 15. Children / Undetermined Deaths by Cause 2020..... 52
Deaths of Children in New Mexico – Summary 53
Drug Caused Deaths 54
Figure 48. Drug Caused Deaths (2011 - 2020)..... 54
Drug Caused Deaths – Overview 54
Figure 49. Drug Caused Deaths by Race / Ethnicity 2020..... 55
Figure 50. Drug Caused Deaths by Age and Gender 2020 55
Table 16. Drug Caused Deaths by County of Pronouncement 2020 56
Motor Vehicle-Associated Deaths 57
Figure 51. Motor Vehicle Associated Deaths (2011 - 2020)..... 57
Motor Vehicle-Associated Deaths – Overview..... 57
Figure 52. Motor Vehicle Accident vs. Non-Motor Vehicle Accidents 2020..... 58
Figure 53. Motor Vehicle-Associated Deaths by Race / Ethnicity 2020 58
Figure 54. Motor Vehicle-Associated Deaths by Age and Gender 2020 59
Figure 55. Motor Vehicle-Associated Deaths by Month 2020 59
Figure 56. Motor Vehicle-Associated Deaths by Day of Week 2020..... 60
Table 17. Motor Vehicle-Associated Deaths by County of Pronouncement 2020..... 61
Glossary..... 62

Introduction

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 9,551 deaths in 2020. 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 represents 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 OMI. Additionally, we encourage interested researchers to contact the New Mexico Bureau of Vital Records and Health Statistics (BVRHS) for complete mortality statistics.

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

Preparation of the Annual Report

The OMI data from which this report was compiled are maintained on a web-based data management system located at the New Mexico Scientific Laboratories in Albuquerque. OMI faculty Sarah Lathrop, DVM, Ph.D., and OMI Research Scientist Garon Bodor, MS using Microsoft Office 2016 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: <http://omi.unm.edu>.

Overview – Office of the Medical Investigator – 2020

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 tasked¹ 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.

¹ NMSA Statute 24-11-1, et seq., and 7-NMAC 3.2.8

Reportable Deaths

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 a 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

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 OMI.
- Define procedures to reimburse all parties providing services to the OMI.
- 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 Investigations (FBI), Tribal Law Enforcement, military 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 the Department of Health, the Chairman of the New Mexico Board of Thanatopractice and the Cabinet Secretary of the Indian Affairs Department 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 FDMIs 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 FDMIs contact the Central Office and present the results of each investigation to Central Office Deputy Medical Investigators who work with

on-call Medical Investigators (forensic pathologists) to 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 technicians. The Scientific Laboratory Division (SLD) provides some toxicology services, with other commercial laboratories providing specialized testing. 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 preventive measures (such as 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 2020

Investigative Activity

In 2020, New Mexico had 9,551 deaths that met the criteria to become a reportable death. The OMI provided investigative services for each of these 9,551 deaths. OMI's Deputy Medical Investigators conducted 6,690 scene investigations in 2020. Following these investigations, OMI retained jurisdiction of 4,795 deaths and relinquished jurisdiction of 3,596 deaths to private physicians. An additional 1,160 deaths were investigated as consultations, resulting in a total caseload of 9,551 medicolegal investigations. OMI ordered the transportation of 4,961 decedents who died in 2020. A granular examination of the case distribution is presented in the Total Cases section beginning on the section entitled 'Total Cases'.

Examination Types

Of the 9,551 reportable deaths in 2020, OMI performed 2,090 autopsies (2,006 full + 84 partial), 1,797 pathologist externals, 721 field externals, and 4,943 decedents did not receive a physical examination of any type. As a department of the UNM Health Sciences Center, OMI performs autopsies for the hospital as a consultant; however, OMI does occasionally take jurisdiction over some of those cases. In 2020, OMI took jurisdiction over 861 cases. Of those cases, 52 received a full or partial autopsy, 3 received an external examination, and 806 cases only needed their records reviewed in order to have a proper cause and manner of death assigned. A granular examination of the examination types is presented in the 'Total Cases' section of this report.

Identification

Each year OMI receives hundreds of cases where remains are initially unidentified. Approximately 99% of these cases are successfully identified through OMI's investigative efforts. Our staff identifies these cases through fingerprint analysis, postmortem forensic dental examinations, DNA analysis, and x-ray and CT comparisons. The investigative staff dedicates many hours to reviewing "cold cases" and are able to identify many cases with the advancement of DNA technology and by resubmitting fingerprints to the FBI that were originally unmatched. In 2020, the investigative staff identified all but 26 decedents.

Training and Education

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 forensic pathologists are faculty members within 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 Pathology 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 years in advance.

Certification Training

All OMI Central Office deputy medical investigators are required to become certified by the American Board of Medicolegal Death Investigators to perform a death investigation. Additionally, the OMI provides in-house training for the deputy medical investigators throughout New Mexico and in the past year, 19 individuals successfully completed the training and received certification as new Field Investigators. 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. (i.e., Native American police officers).

Death Investigation Training

OMI provided continuing education on a variety of forensic topics to over 100 Field Investigators through weekly webinars. This training was open to several other medical examiner offices throughout the country through Project ECHO, and representatives from offices in Oklahoma, Indiana, and California also participated.

Law Enforcement Education

Death investigation training is provided at the New Mexico State Police Academy, the New Mexico Law Enforcement 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 the New Mexico Department of Health, funeral homes, hospitals, correction facilities, the EMS training site, UNM, CNM, high schools, civic organizations, state search and rescue groups, and tribal authorities.

OMI website

The OMI website at <http://omi.unm.edu> provides instant access to information concerning OMI, staff, services offered, reports, and record requests.

Center for Forensic Imaging

The Center for Forensic Imaging (CFI) is located within OMI. The CFI performs computed tomography (CT), magnetic resonance imaging (MRI), and radiography, in support of the clinical service of the OMI, as well as research and education.

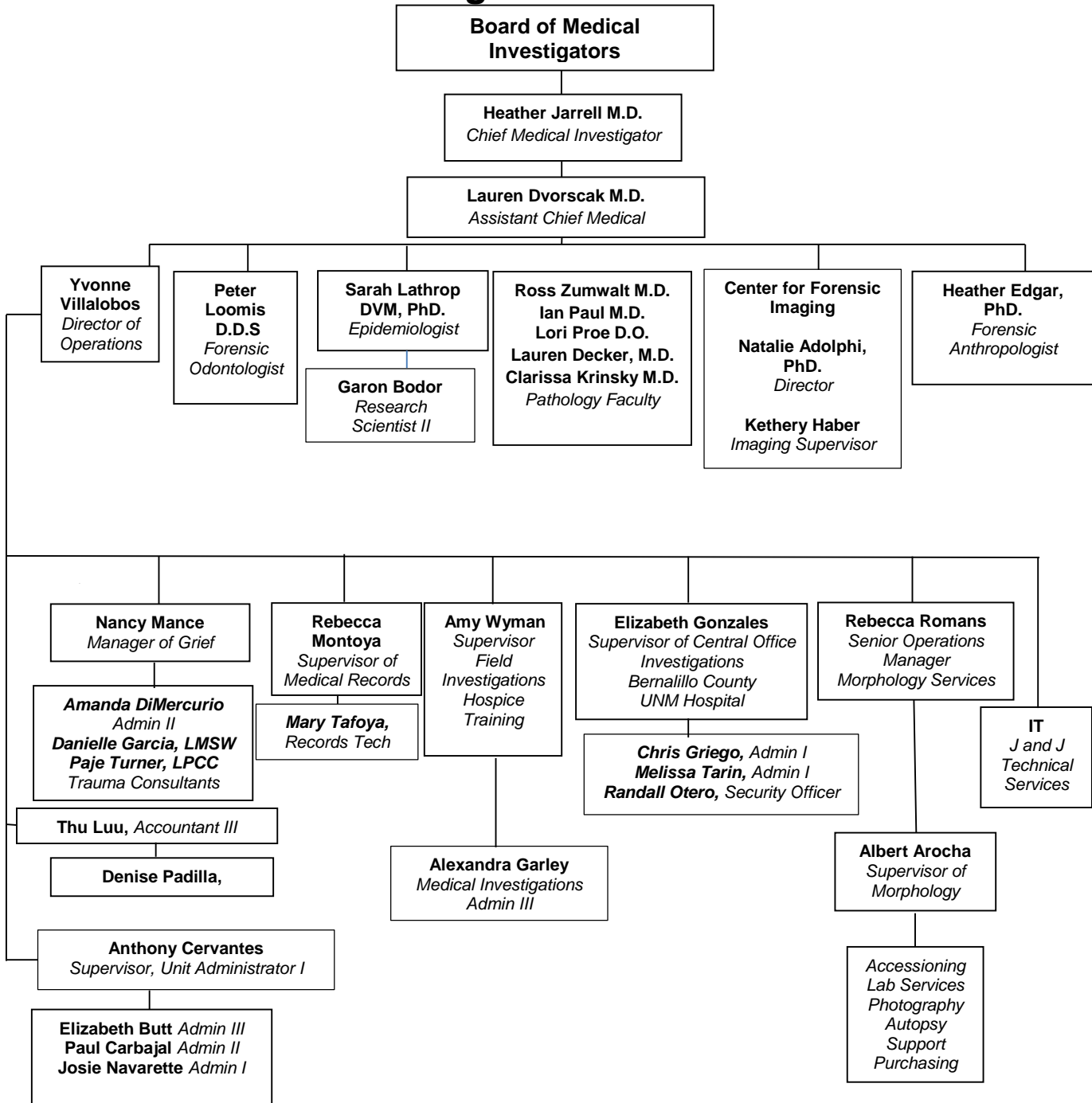
Grief Services Program

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 expanded over time and now includes support for those dealing with a family member's death arising from homicide, suicide, or accident. Currently, GSP contracts with grief counselors throughout the state and also has three counselors located on-site in Albuquerque, all who provide trauma and grief support for families dealing with this sudden and unexplained death. Services include: crisis support, trauma and grief support/counseling, advocacy, counseling groups, and information and referrals. Additionally, the GSP provides consultation, training, and public presentations focusing on trauma and complicated grief education across 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 2020, OMI ensured that 100% of potential organ donors and their families were allowed to give the gift of life. OMI works closely with New Mexico Donor Services and Lion's Eye Bank to provide life-saving organs for transplantation, in New Mexico and across the country. Our thanks go 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
2020 Organizational Chart



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 – Bureau of Vital Records and Health Statistics, New Mexico Department of Health.

Figure 2. Total Cases (2011-2020)

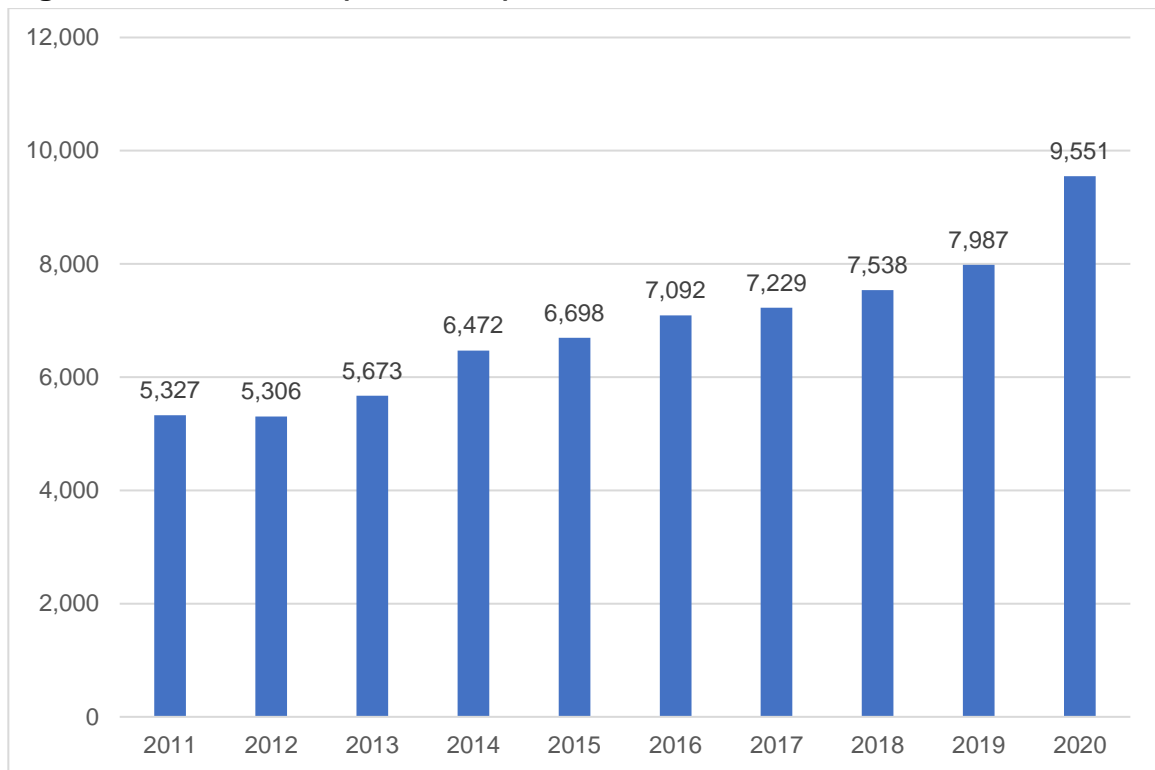


Figure 3. Total Cases by Month 2020

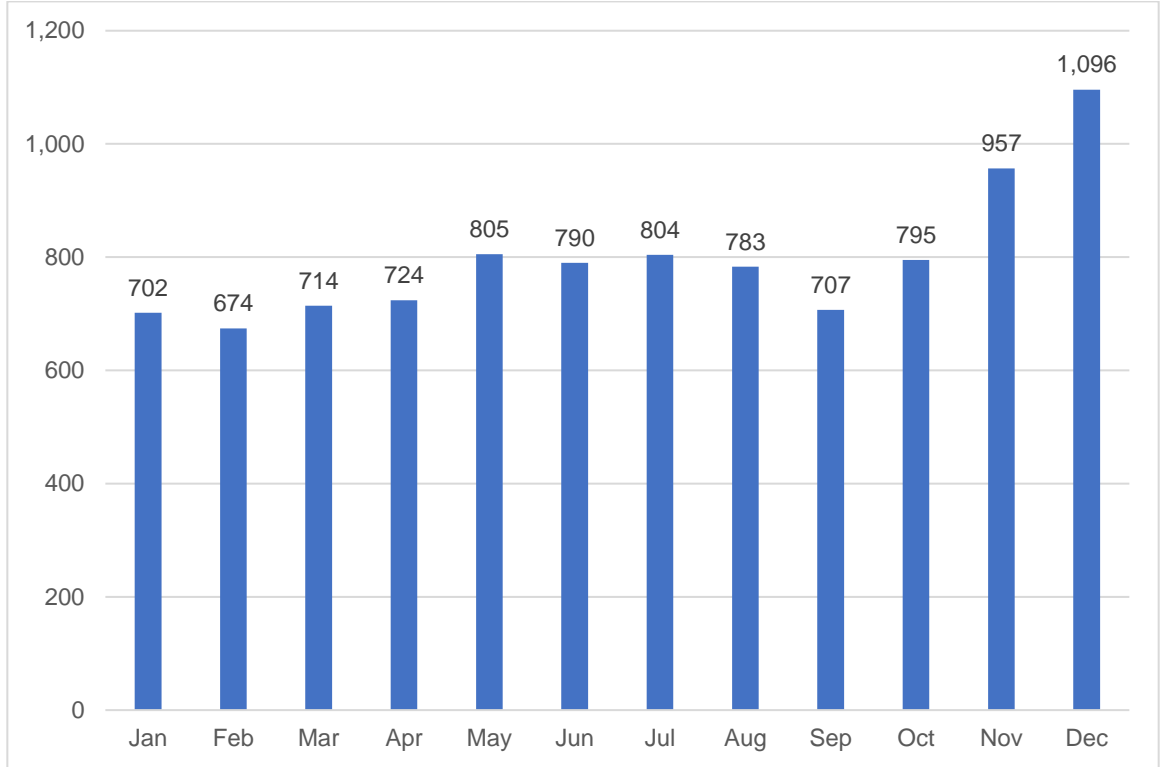


Figure 4. Total Cases by Day 2020

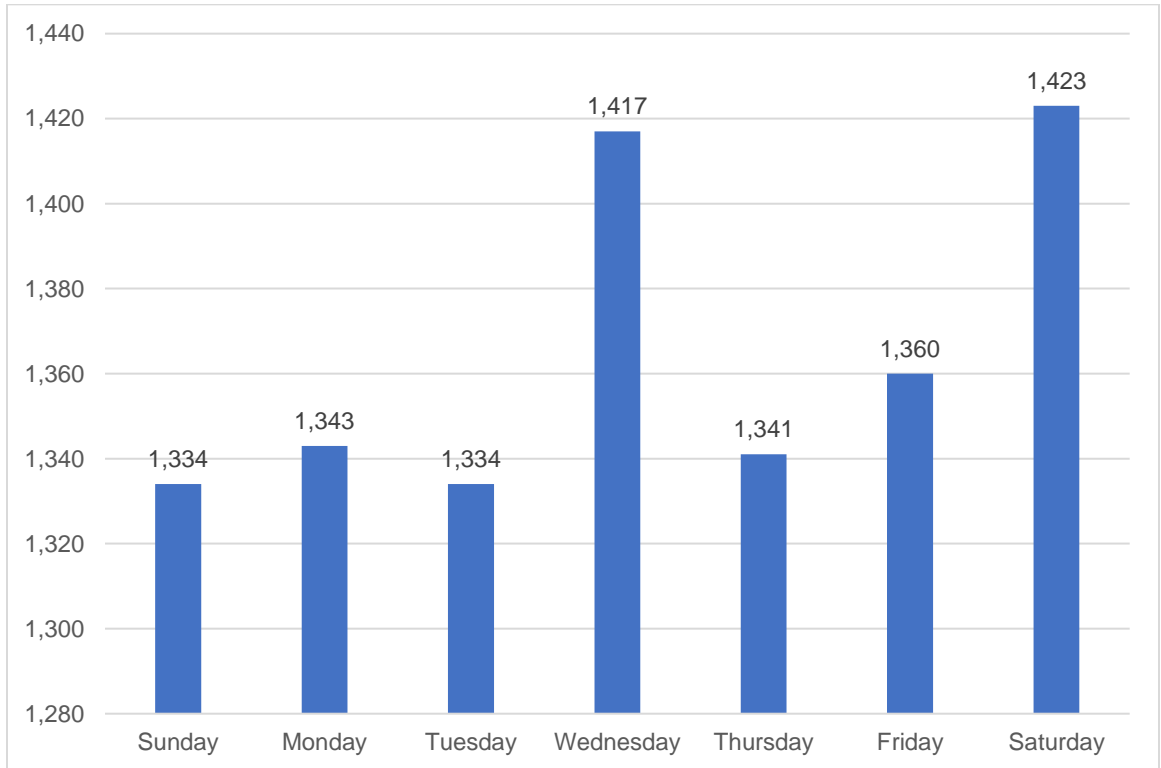


Figure 5. Total Cases by Race / Ethnicity 2020

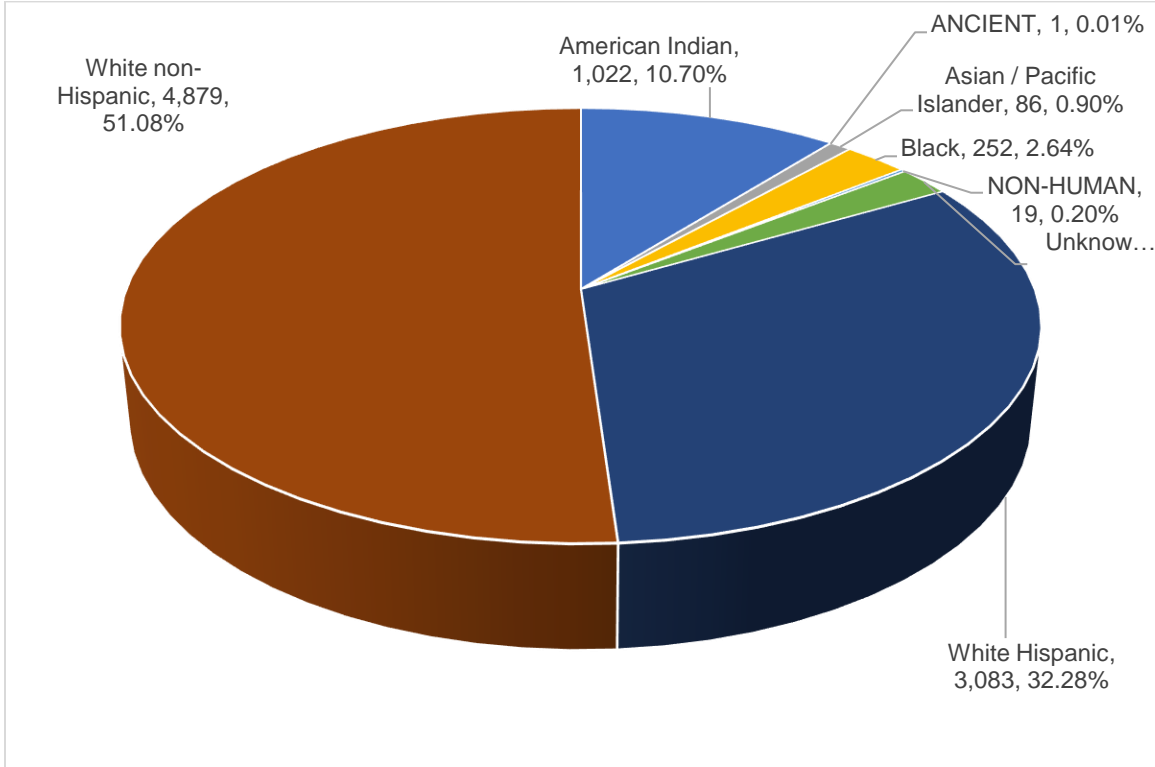


Figure 6. Total Cases by Age and Gender 2020

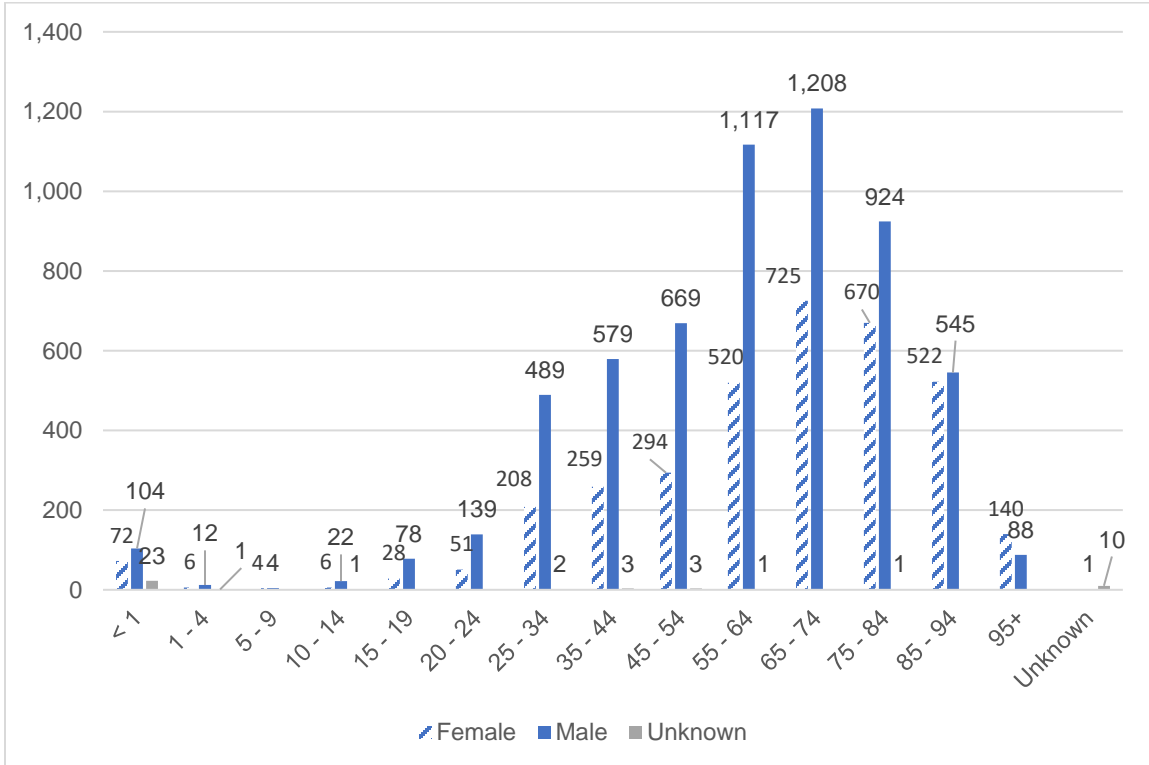


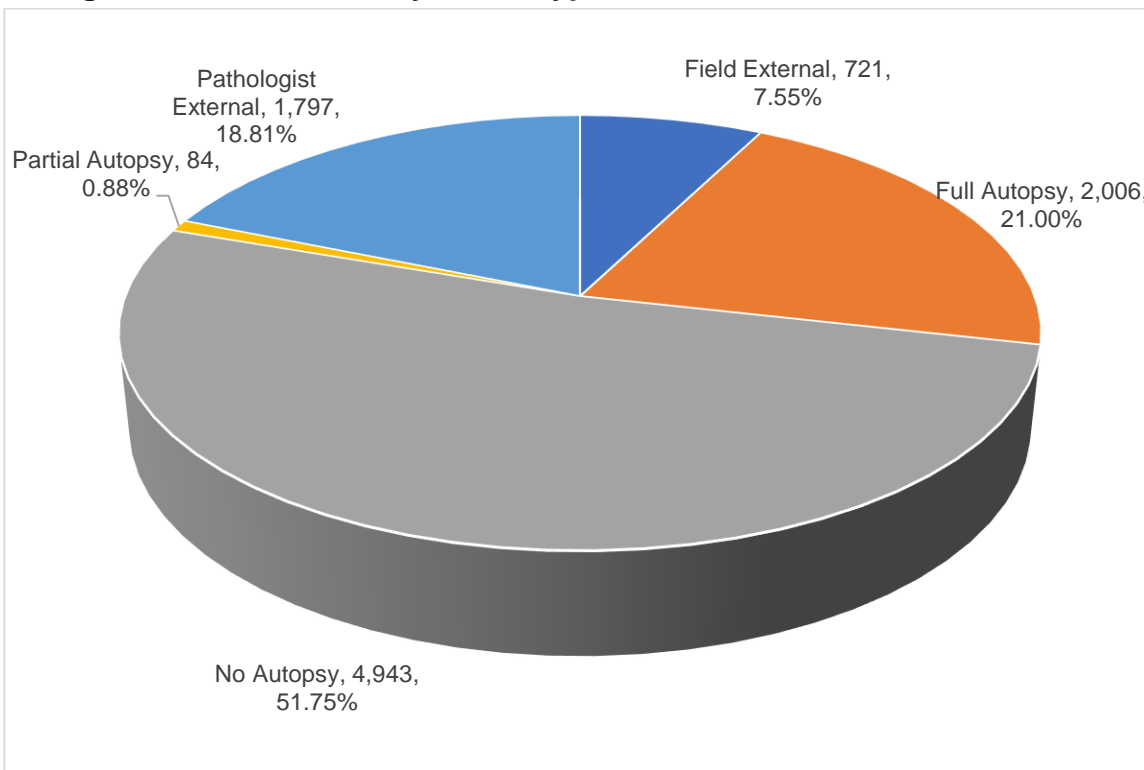
Table 1. Total Cases - Autopsy Status 2020

Autopsy	Accident	Homicide	Jurisdiction Terminated	Natural	Non-Accept	Other	Pending	Suicide	Undetermined	Grand Total
No	1,213	3	1,904	2,307	1,692	40	5	279	18	7,461
Yes	733	263	0	714	0	21	6	225	128	2,090
Grand Total	1,946	266	1,904	3,021	1,692	61	11	504	146	9,551

Table 2. Total Cases Distribution 2020

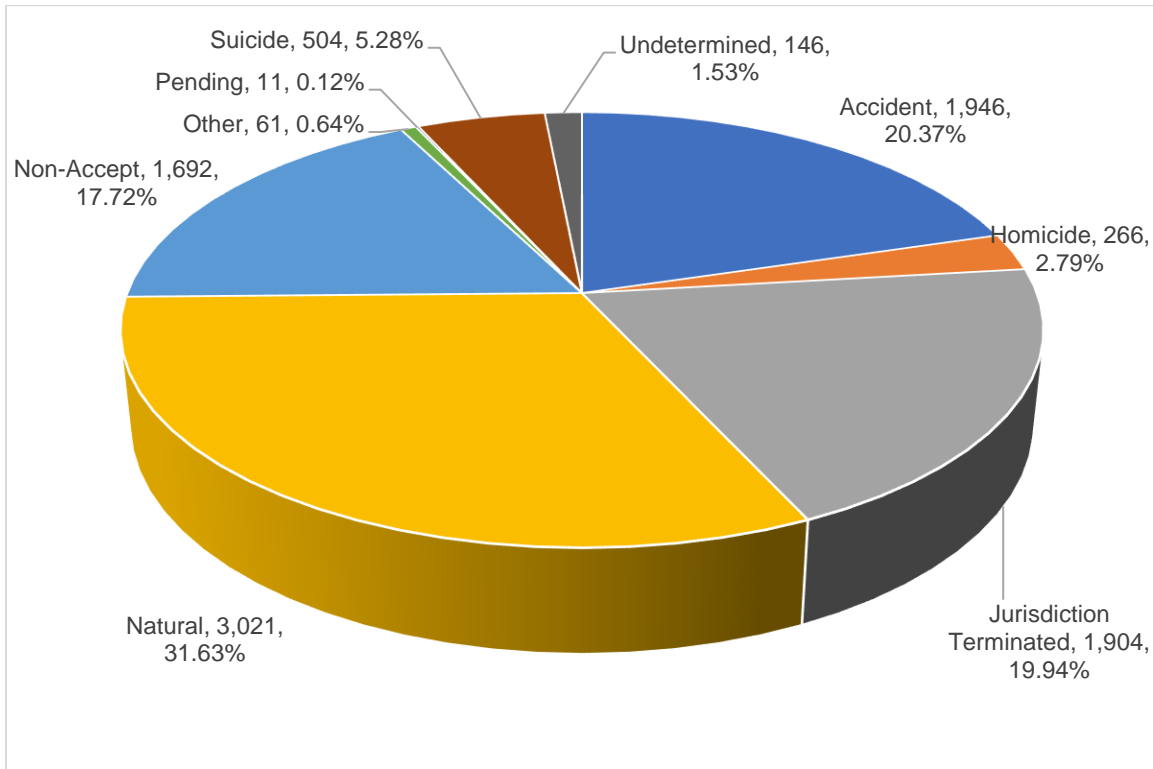
Jurisdiction	Autopsy No	Autopsy Yes	Percent Autopsied	Grand Total
OMI				
Accident	1,141	691	37.72%	1,832
Homicide	3	239	98.76%	242
Natural	1,467	592	28.75%	2,059
Other	31	5	13.89%	36
Pending	5	3	37.50%	8
Suicide	274	221	44.65%	495
Undetermined	16	107	86.99%	123
Subtotal	2,937	1,858	38.75%	4,795
Consult				
Accident	72	42	36.84%	114
Homicide	0	24	100.00%	24
Natural	840	122	12.68%	962
Other	9	16	64.00%	25
Pending	0	3	100.00%	3
Suicide	5	4	44.44%	9
Undetermined	2	21	91.30%	23
Subtotal	928	232	20.00%	1,160
Jurisdiction Terminated	1,904	0	0.00%	1,904
Non-Accept	1,692	0	0.00%	1,692
Grand Total	7,461	2,090	21.88%	9,551

Figure 7. Total Cases by Exam Type 2020



Cause and Manner of Death

Figure 8. Total Cases by Manner of Death 2020



Cause and Manner of Death - Overview

In 2020, OMI investigated 9,551 deaths, representing approximately *48.9% of the estimated total deaths in New Mexico in 2020 (*based on most recent Vital Records Report). Of the deaths investigated by OMI in 2020:

The total number of deaths investigated represents a 19.6% increase from the 2019 total, and a 79.3% increase since 2011.

The ratio of male to female deaths, when gender was clearly determined, was 1.7. Decedents classified as White non-Hispanic represented 51.1% of the total, White Hispanic 32.3%, American Indian 10.7%, Black 2.6%, and Asian/Pacific Islander 0.9%. The racial-ethnic composition of New Mexico was listed in 2019 as: 36.8% non-Hispanic white, 49.3% Hispanic, 11.0% American Indian, 2.6% African-American and 2.0% Asian/Pacific Islander. (Source: <https://www.census.gov/quickfacts/fact/table/nm/PST045217?>)

While natural deaths contributed the largest portion of OMI deaths investigated (31.6%), most natural deaths did not fall under the jurisdiction of the OMI. Multiple cases are called into OMI every year in order to verify if OMI has jurisdiction over the case. The physicians then decide if OMI is statutorily obligated to investigate the case and issue the death certificate. If they are not statutorily obligated, the case is considered as jurisdiction terminated (19.9% of 2020 cases) or non-accept (17.7% of

2020 cases). Data presented regarding natural deaths should not be interpreted as representative of all natural deaths in New Mexico.

Table 3. Total Cases by Gender and Manner 2020

Manner	Ancient	Female	Male	Non-Human	Unknown	Grand Total
Accident		663	1,277		6	1,946
Homicide		42	222		2	266
Jurisdiction Terminated		773	1,119		12	1,904
Natural		1,115	1,901		5	3,021
Non-Accept		759	930		3	1,692
Other	3	10	27	19	2	61
Pending		4	6		1	11
Suicide		106	398			504
Undetermined		33	99		14	146
Grand Total	3	3,505	5,979	19	45	9,551

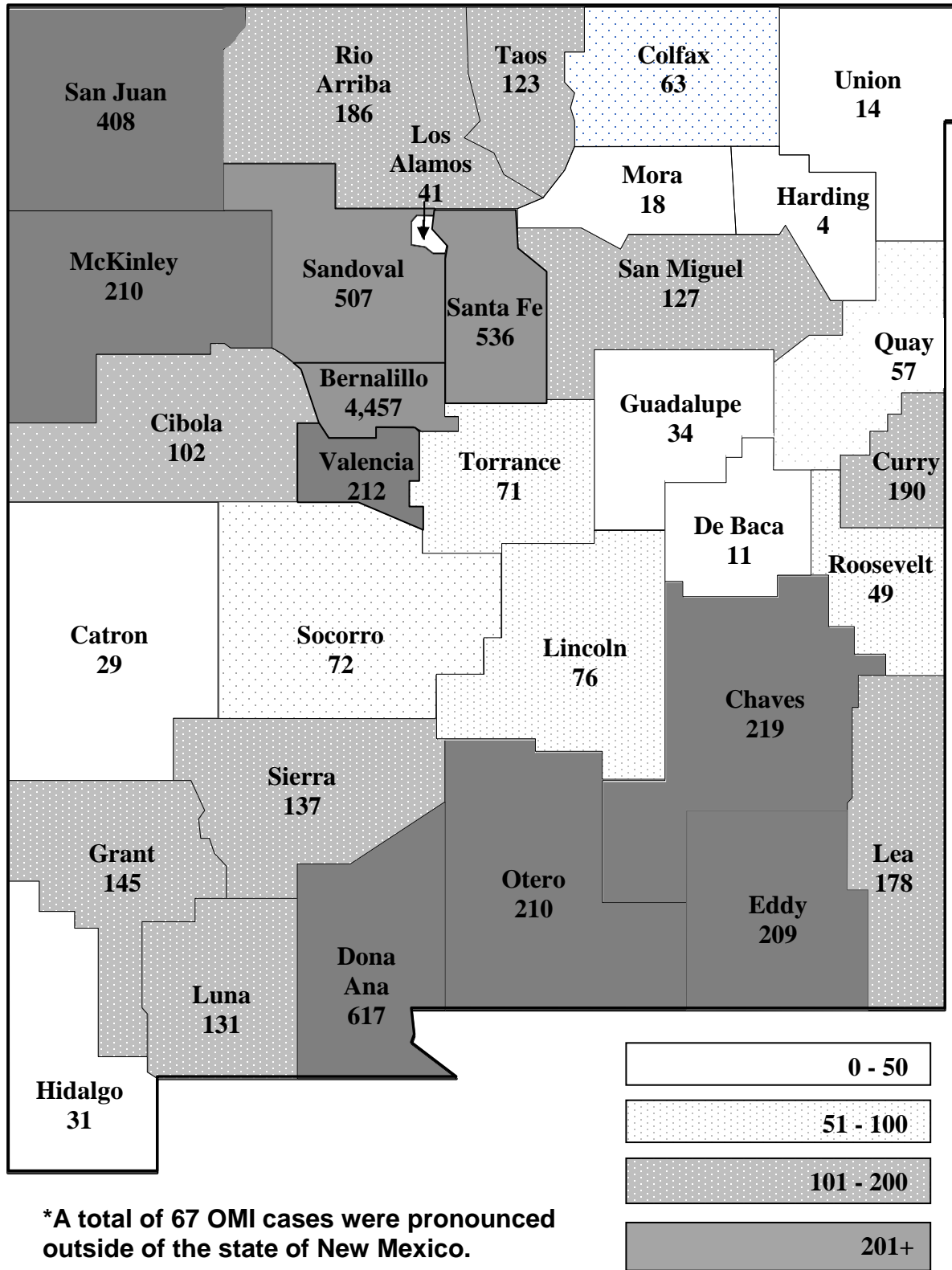
Table 4. Total Cases by Manner of Death and Race/Ethnicity 2020

Manner	American Indian	Ancient	Asian / Pacific Islander	Black	Non-Human	Unknown	White Hispanic	White non-Hispanic	Grand Total
Accident	227	0	11	62	0	36	737	873	1,946
Homicide	48	0	1	18	0	12	113	74	266
Jurisdiction Terminated	48	0	16	46	0	26	633	1,135	1,904
Natural	393	0	39	82	0	42	878	1,587	3,021
Non-Accept	211	0	12	30	0	51	523	865	1,692
Other	6	1	0	0	19	8	4	23	61
Pending	1	0	0	0	0	1	2	7	11
Suicide	50	0	6	13	0	8	153	274	504
Undetermined	38	0	1	1	0	25	40	41	146
Grand Total	1,022	1	86	252	19	209	3,083	4,879	9,551

Table 5. Total Cases by Manner of Death (Age and Gender) 2020

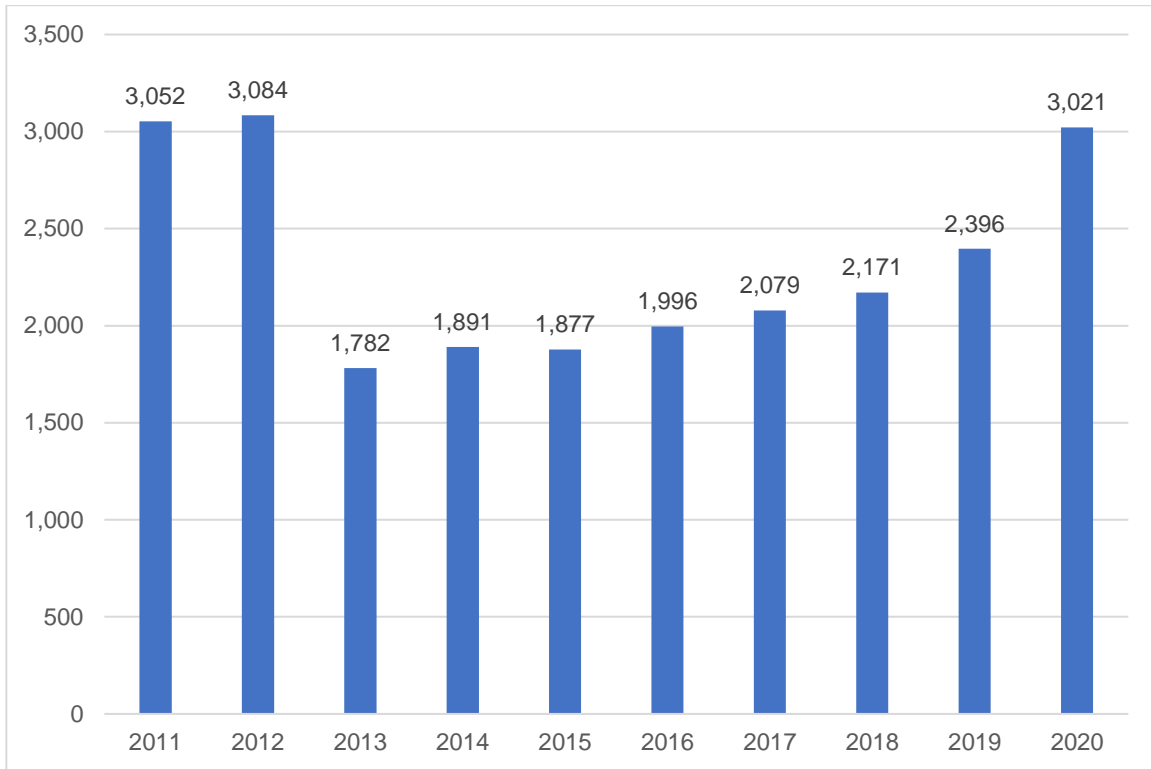
Gender/Age Group (Years)	Accident	Homicide	Jurisdiction Terminated	Natural	Non-Accept	Other	Pending	Suicide	Undetermined	Grand Total
Female										
< 1	4		5	30	28		1		4	72
1 - 4	2			4						6
5 - 9	1	1		1					1	4
10 - 14	2			2				2		6
15 - 19	15	2		4				6	1	28
20 - 24	25	2		7	2			12	3	51
25 - 34	106	7	1	52	19	1		17	5	208
35 - 44	101	14	7	88	27		1	15	6	259
45 - 54	80	7	36	104	47	1	1	15	3	294
55 - 64	83	3	89	222	100	2		15	6	520
65 - 74	47	1	186	302	165	2		21	1	725
75 - 84	69	3	199	183	211	2		2	1	670
85 - 94	99	2	196	99	120	2	1	1	2	522
95+	29		54	17	40					140
Subtotal	663	42	773	1,115	759	10	4	106	33	3,505
Male										
<1	7	3	2	32	45	3	1		11	104
1 - 4	6	1		3		1			1	12
5 - 9	2			1		1				4
10 - 14	3	1		8				10		22
15 - 19	39	16		3				20		78
20 - 24	56	24	1	11	1	1		39	6	139
25 - 34	223	65	4	78	18	2		79	20	489
35 - 44	243	50	16	137	45	4		63	21	579
45 - 54	176	27	71	259	64	1	1	57	13	669
55 - 64	222	20	185	465	160	4	1	45	15	1,117
65 - 74	122	8	295	512	224	3	1	35	8	1,208
75 - 84	76	6	308	282	211	4	1	32	4	924
85 - 94	91	1	204	94	134	3	1	17		545
95+	10		33	16	28			1		88
Unknown	1									1
Subtotal	1,277	222	1,119	1,901	930	27	6	398	99	5,979
Unknown	6	2	12	5	3	2	1		14	45
Non-Human										19
Ancient										3
Grand Total	1,940	264	1,892	3,016	1,689	37	10	504	132	9,551

Figure 9. OMI Deaths by County of Pronouncement 2019 (All Manner of Death)



Overview – Manner of Death – Natural Deaths

Figure 10. Natural Deaths (2011 - 2020)



Natural Deaths – Overview

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 (31.6% in 2020). Starting in 2013, cases reported to but not accepted by OMI were no longer assigned a manner of death, resulting in the lower numbers of natural deaths starting in 2013. 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. The 2018 Annual Report is available online at: <https://www.nmhealth.org/data/view/vital/2352/>

Figure 11. Natural Deaths by Race / Ethnicity 2020

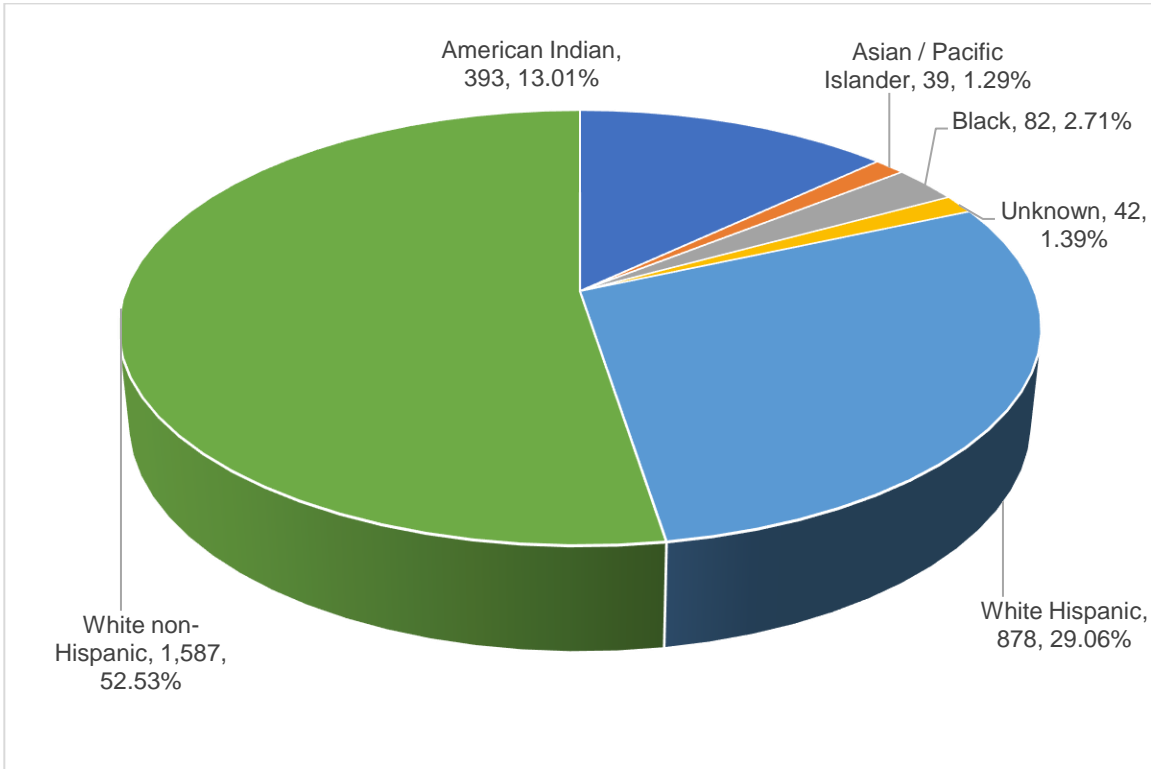
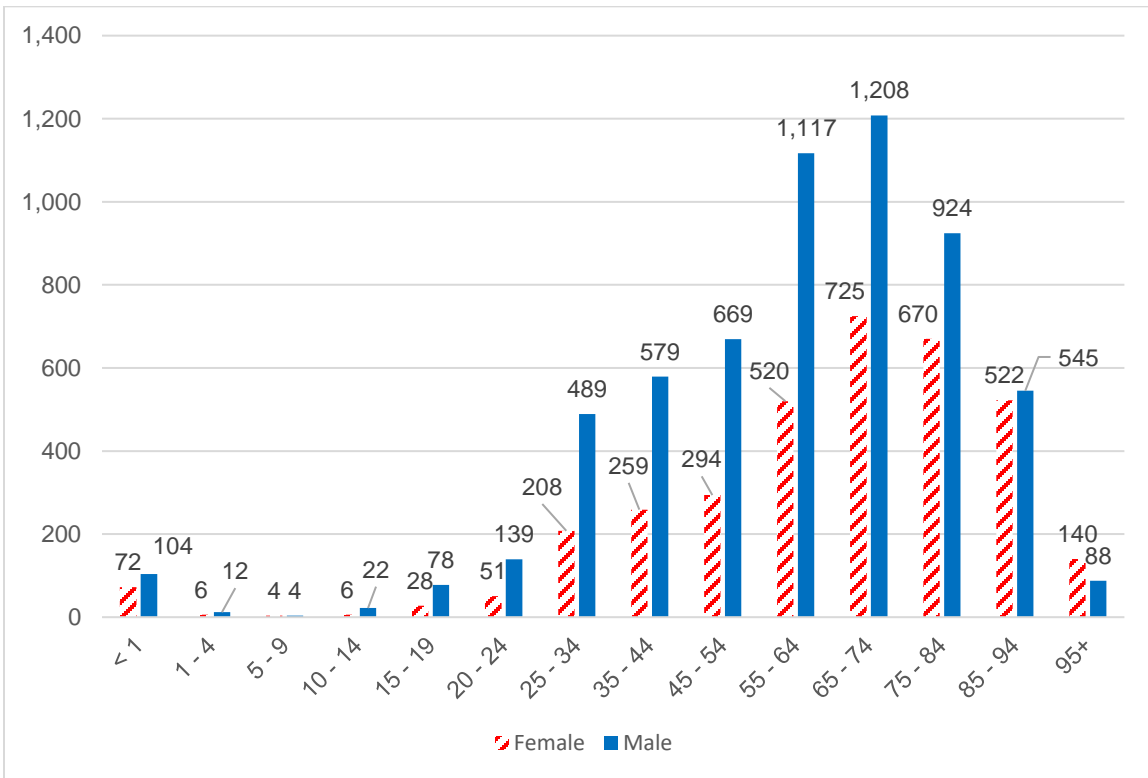
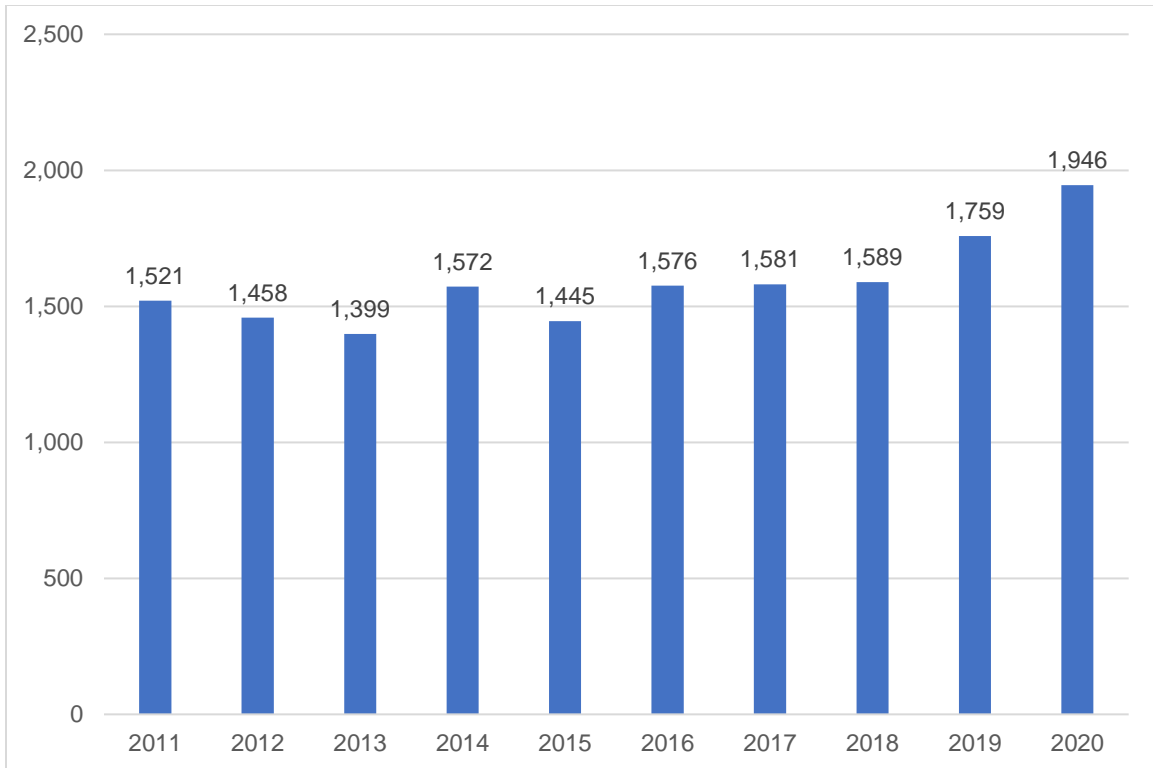


Figure 12. Natural Deaths by Age and Gender 2020



Overview – Manner of Death – Accidental Deaths

Figure 13. Accidental Deaths (2011 - 2020)



Accidental Deaths – Overview

Accidental deaths accounted for 20.4% of the deaths investigated by OMI in 2020, second only to natural deaths as a manner of death. The highest number of accidental deaths was in males 35-44 years of age.

Figure 14. Accidental Deaths by Race / Ethnicity 2020

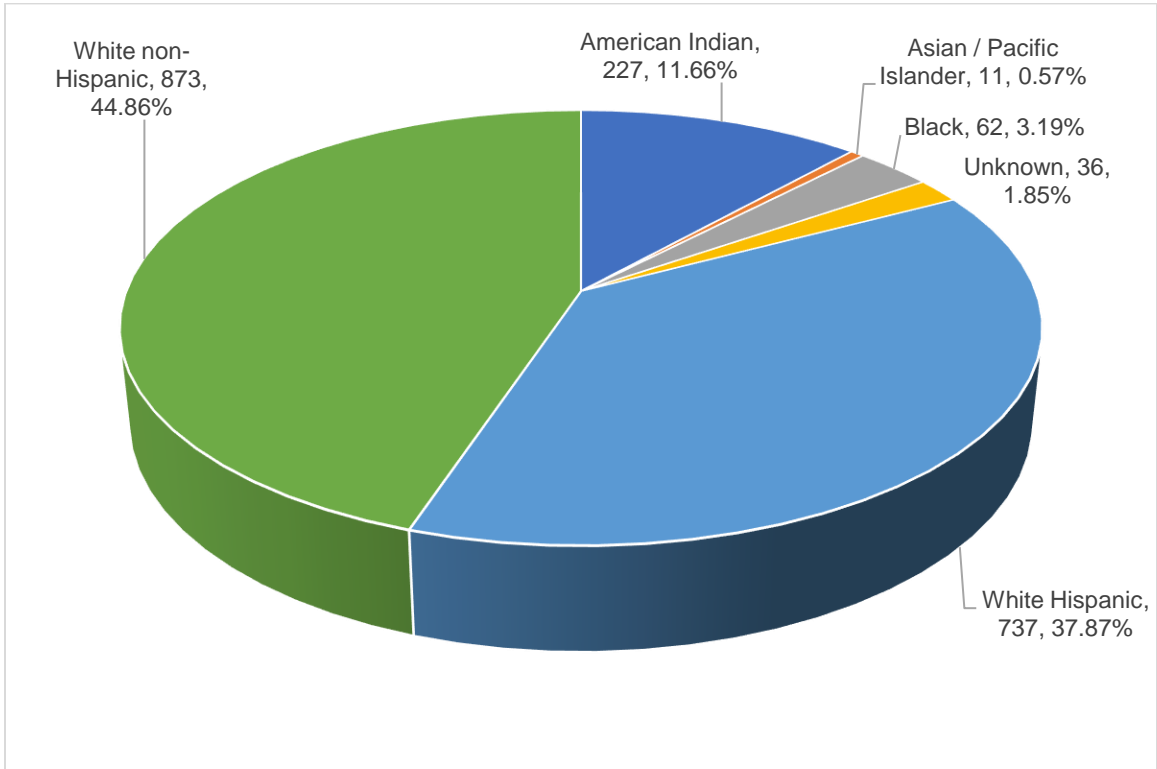


Figure 15. Accidental Deaths by Age and Gender 2020

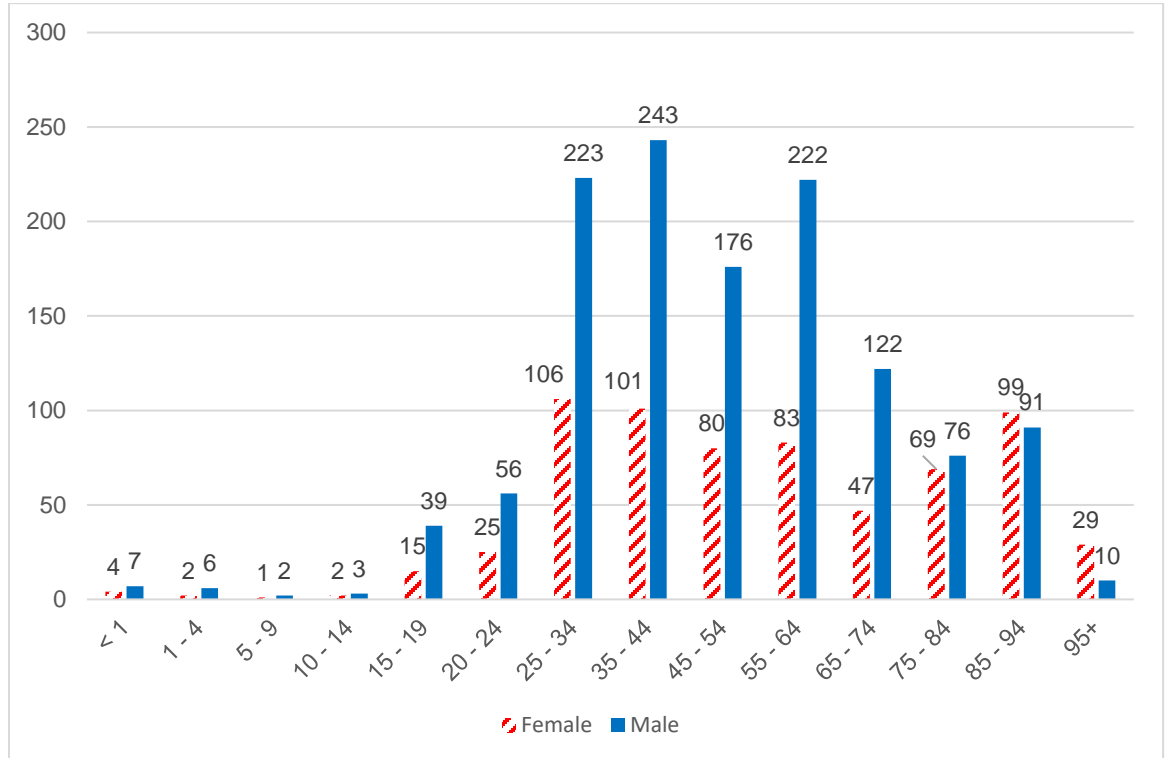


Table 6. Accidental Deaths by Cause 2020

Cause	Total
Substance intoxication	721
Multiple injuries	698
Natural	76
Cardiac arrhythmia	73
Ethanol (alcohol) intoxication	54
Pneumonia (bronchitis)	42
Exposure	38
Drowning	35
Sepsis	25
Choking	22
Thermal injuries	21
Asphyxia (suffocation, strangulation)	21
Ethanolism (chronic, alcoholism, alcoholic liver)	19
Head and neck injuries (cervical, cranio-, cerebral)	18
Diabetes	11
Inhalation of toxin	8
Cerebrovascular	8
Emboli (thrombus, phlebitis)	7
Gunshot wound(s)	5
Chronic obstructive pulmonary disease (COPD)	5
Carcinoma	5
Carbon monoxide intoxication (smoke and soot inhalation)	4
Obesity	4
Hypertension	4
Alzheimer's	4
Asthma	4
Electrocution	3
Hepatic failure	3
Chronic drug abuse	2
Renal failure	1
Respiratory Distress Syndrome	1
Aneurysm	1
Adverse allergy reaction	1
Maternal and fetal complications of birth	1
Epilepsy	1
Total	1,946

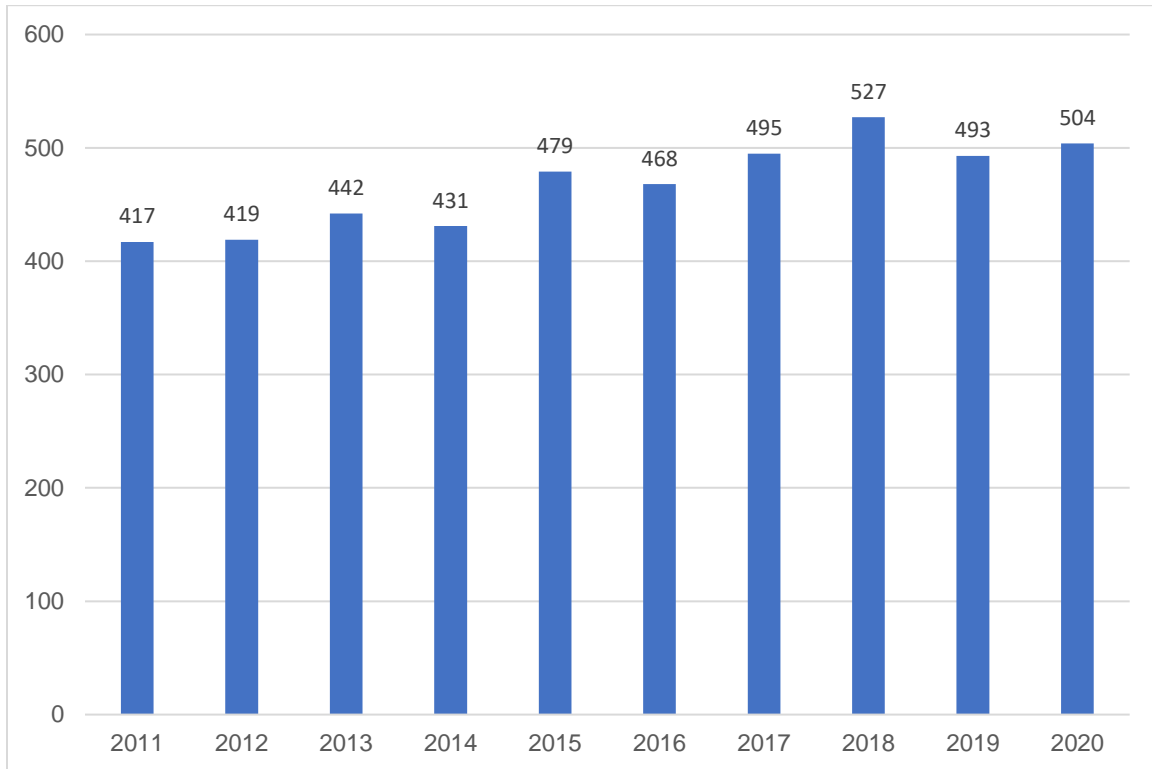
Please note that some of the causes here that are not directly apparent as accident (ie: carcinoma, dementia, etc.) are frequently due to events such as falls that lead to a fatal event but were initially precipitated by the above condition/cause noted in the table.

Table 7. Accidental Deaths by County of Pronouncement (2011 - 2020)

County	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Bernalillo	573	523	514	557	606	631	606	664	700	871
Catron	5	5	8	4	2	2	1	8	3	5
Chaves	56	35	35	37	32	33	44	45	42	33
Cibola	20	12	29	16	19	24	20	18	31	29
Colfax	10	5	17	16	12	12	6	16	13	11
Curry	30	23	22	24	22	23	24	21	29	49
De Baca	3	2	2	2	3	5	1	0	4	1
Dona Ana	96	106	80	110	110	97	114	88	113	105
Eddy	38	41	38	51	43	25	42	53	47	42
Grant	18	21	20	29	16	17	35	13	22	23
Guadalupe	8	6	10	14	12	18	12	5	14	10
Harding	2	1	1	1	0	2	0	1	0	1
Hidalgo	8	5	3	13	7	6	15	1	10	8
Lea	33	34	31	56	34	37	37	53	64	48
Lincoln	15	14	10	18	9	23	17	11	21	11
Los Alamos	8	5	5	7	2	7	6	6	6	3
Luna	12	10	15	11	12	17	7	15	18	22
McKinley	43	53	51	73	49	58	55	75	55	53
Mora	6	8	4	4	3	4	4	0	6	3
Otero	33	41	32	42	33	27	30	27	39	34
Quay	7	11	8	16	12	7	5	2	5	12
Rio Arriba	55	55	52	57	50	50	64	55	58	71
Roosevelt	10	9	5	9	9	11	14	4	9	6
San Juan	92	88	86	96	75	87	80	80	102	104
San Miguel	30	30	23	15	14	23	26	27	28	32
Sandoval	59	62	64	68	49	67	99	86	74	88
Santa Fe	122	127	109	119	110	121	102	83	121	128
Sierra	22	17	19	11	15	19	12	19	9	19
Socorro	13	9	11	18	10	22	4	8	16	22
Taos	22	28	24	23	23	23	21	28	23	29
Torrance	16	13	20	13	12	14	6	19	13	16
Union	4	4	4	3	0	1	4	2	4	2
Valencia	15	29	25	33	19	33	33	38	39	40
Out of State	37	26	22	6	21	30	35	18	21	15
Totals	1,521	1,458	1,399	1,572	1,445	1,576	1,581	1,589	1,759	1,946

Overview – Manner of Death (Suicide)

Figure 16. Suicide Deaths (2011 - 2020)



Suicide Deaths – Overview

New Mexico’s suicide rate is consistently higher than the national average, comprising 2.6% of all deaths in New Mexico, compared to 1.6% of all deaths in the U.S. The rate in 2018 (most recent data available) was 24.8 per 100,000 people, compared to a rate of 14.2 per 100,000 people in the rest of the U.S. (2018 New Mexico Selected Health Statistics, State Center for Health Statistics, Department of Health and nimh.nih.gov, respectively).

Deaths from suicide in 2020 occurred most frequently among White non-Hispanics (54.4%) and males (79.0%). More men between the ages of 25 and 34 years (15.7% of all suicides) committed suicide than any other age group by gender. More people committed suicide on Thursday (15.5%) than any other day of the week. More suicides occurred in May than any other month (10.3%). The fewest occurred in April and February (6.8%). The total number of suicides increased from 493 in 2019 to 504 in 2020 (2.2% increase).

Figure 17. Suicide Deaths by Race / Ethnicity 2020

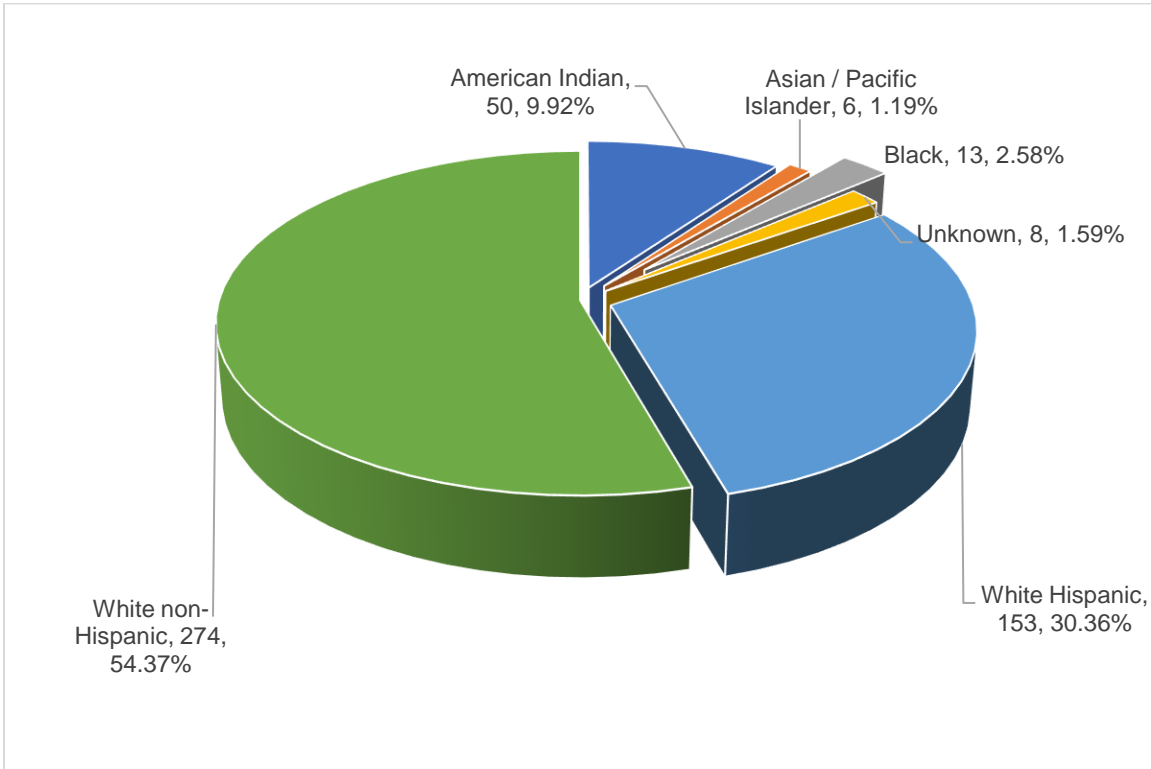


Figure 18. Suicide Deaths by Age and Gender 2020

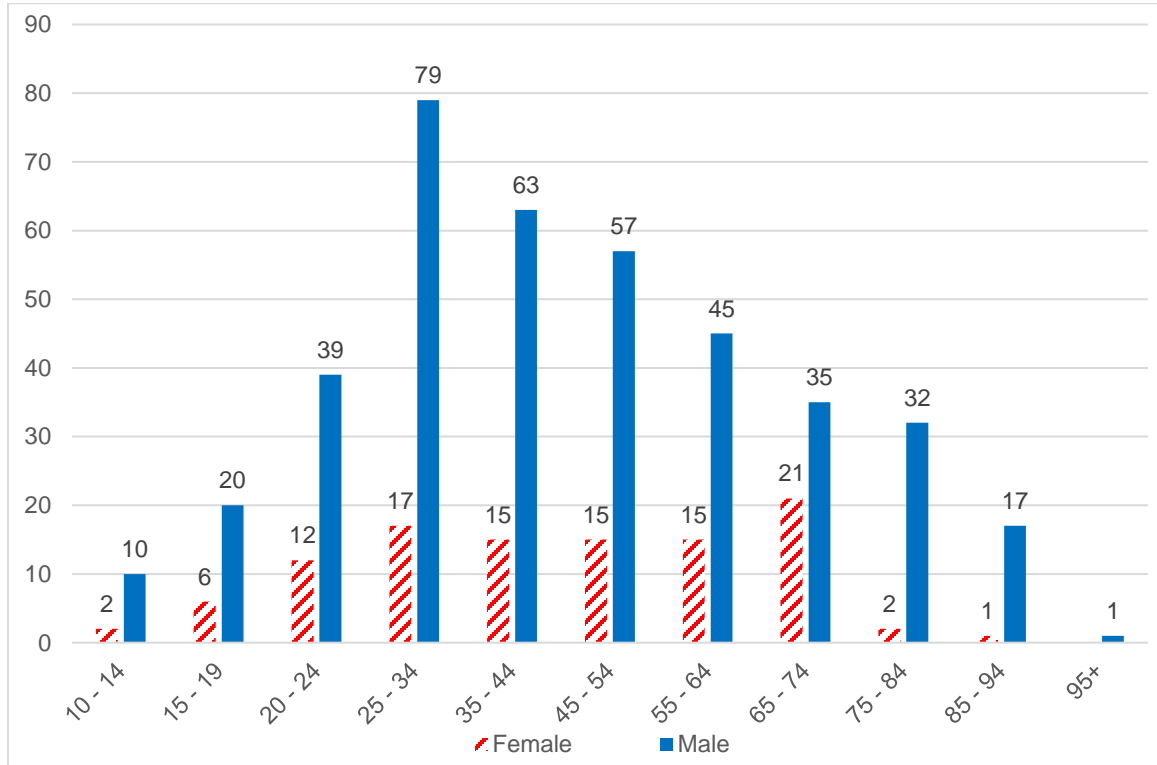


Figure 19. Suicide Deaths by Month 2020

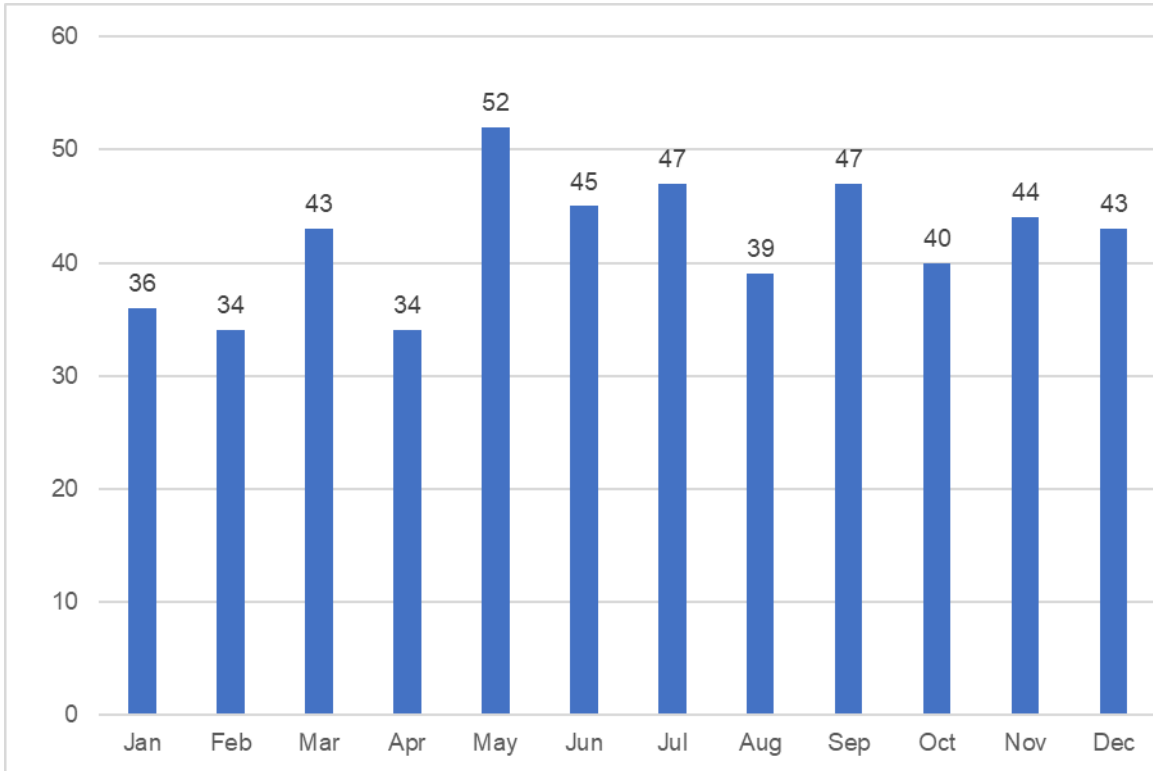


Figure 20. Suicide Deaths by Day of the Week 2020

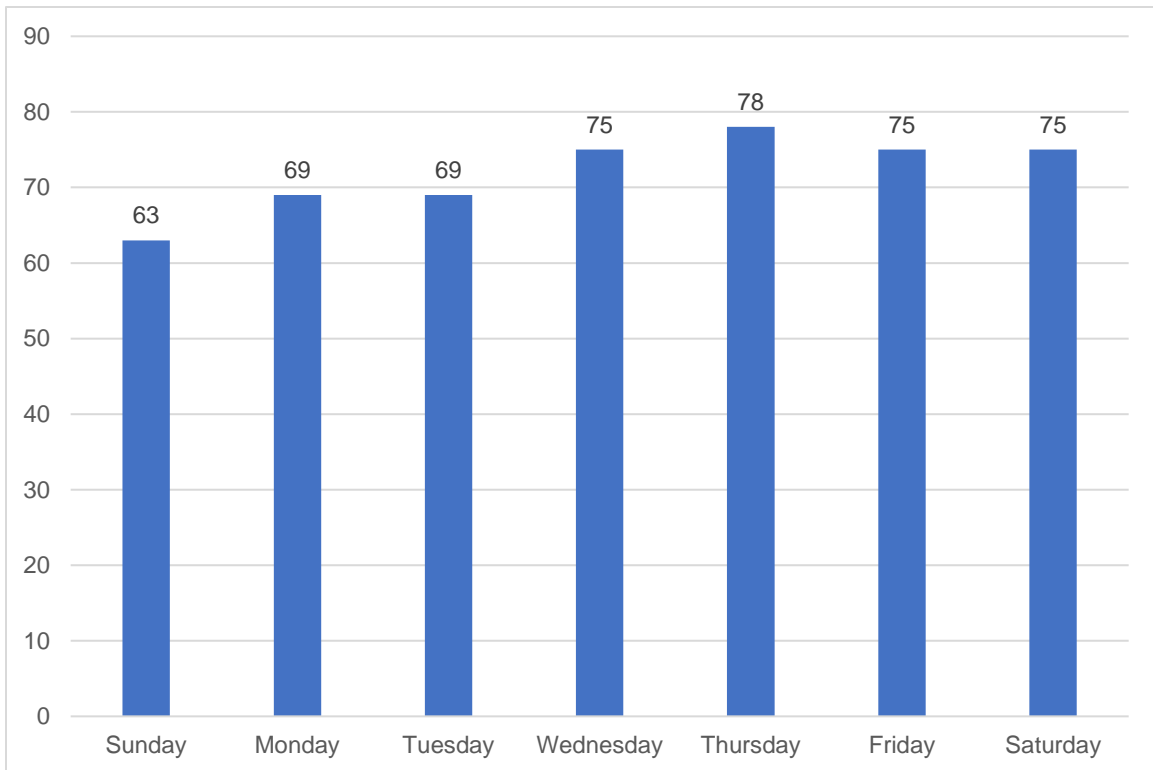


Table 8. Suicide Deaths by Cause 2020

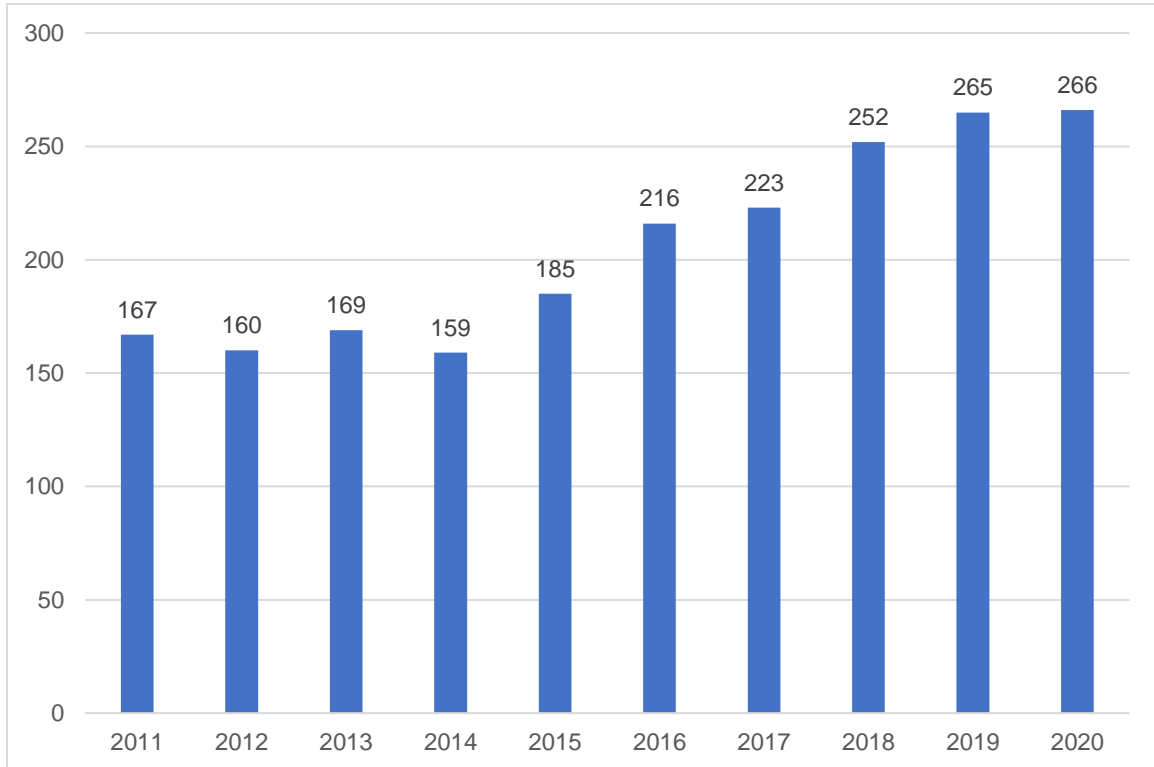
Cause of Death	Total
Gunshot wound	295
Hanging	120
Substance intoxication	45
Multiple injuries	14
Stab wound	9
Other	9
Asphyxia	4
Carbon monoxide intoxication	3
Thermal injuries	1
Ethanol intoxication	1
Drowning	1
Pneumonia	1
Sepsis	1
Total	504

Table 9. Suicide Deaths by County of Pronouncement (2011 – 2020)

County	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Bernalillo	137	146	147	147	160	149	167	175	173	178
Catron	1	8	2	1	2	2	1	4	4	2
Chaves	12	17	18	14	13	9	10	14	10	19
Cibola	5	6	9	5	10	4	4	10	9	9
Colfax	2	5	0	5	3	5	4	10	6	4
Curry	4	6	6	5	13	10	6	12	7	8
De Baca	0	1	2	0	1	0	1	0	0	0
Dona Ana	35	34	24	30	43	33	38	36	36	43
Eddy	9	14	7	13	15	14	17	17	22	13
Grant	7	9	9	11	6	12	8	13	5	6
Guadalupe	1	3	1	2	1	0	2	2	2	2
Harding	0	0	0	0	0	0	0	0	0	0
Hidalgo	2	0	1	0	5	0	3	2	4	1
Lea	8	9	10	11	14	12	12	12	11	14
Lincoln	3	6	3	11	5	6	9	10	5	7
Los Alamos	3	0	2	1	1	3	1	3	3	7
Luna	3	4	6	3	3	10	7	4	8	7
McKinley	16	10	9	7	3	12	14	13	11	13
Mora	2	1	2	1	2	3	0	2	1	1
Otero	20	11	21	10	13	16	21	19	17	9
Quay	0	2	3	1	3	5	3	5	0	7
Rio Arriba	10	12	13	7	18	12	4	12	9	3
Roosevelt	3	1	2	2	4	4	5	2	6	5
San Juan	21	22	18	27	33	27	34	31	24	36
San Miguel	6	5	7	8	7	10	10	6	4	5
Sandoval	30	21	26	26	27	21	22	26	36	34
Santa Fe	31	31	38	34	34	46	40	34	38	32
Sierra	7	2	6	6	4	4	4	4	6	4
Socorro	2	4	4	6	7	3	5	5	7	2
Taos	13	13	13	15	9	17	19	11	11	11
Torrance	3	3	6	4	7	5	5	8	5	3
Union	2	0	0	2	0	3	3	1	0	1
Valencia	14	8	20	15	13	11	12	19	11	16
Out of State	5	5	7	1	0	0	4	5	2	2
Total	417	419	442	431	479	468	495	527	493	504

Overview – Manner of Death – Homicide Deaths

Figure 21. Homicide Deaths (2011 - 2020)



Homicide Deaths – Overview

Homicides increased by 0.4% from 2019 to 2020. Homicide victims were most frequently male (83.5%) and White Hispanic (42.5%). As with suicide rates, homicide rates in New Mexico tend to be higher than the national rate, 10.8 per 100,000 in 2018 compared to a national rate of 5.0 per 100,000 (2018 New Mexico Selected Health Statistics, State Center for Health Statistics, Department of Health and ucr.fbi.gov, respectively).

Figure 22. Homicide Deaths by Race / Ethnicity 2020

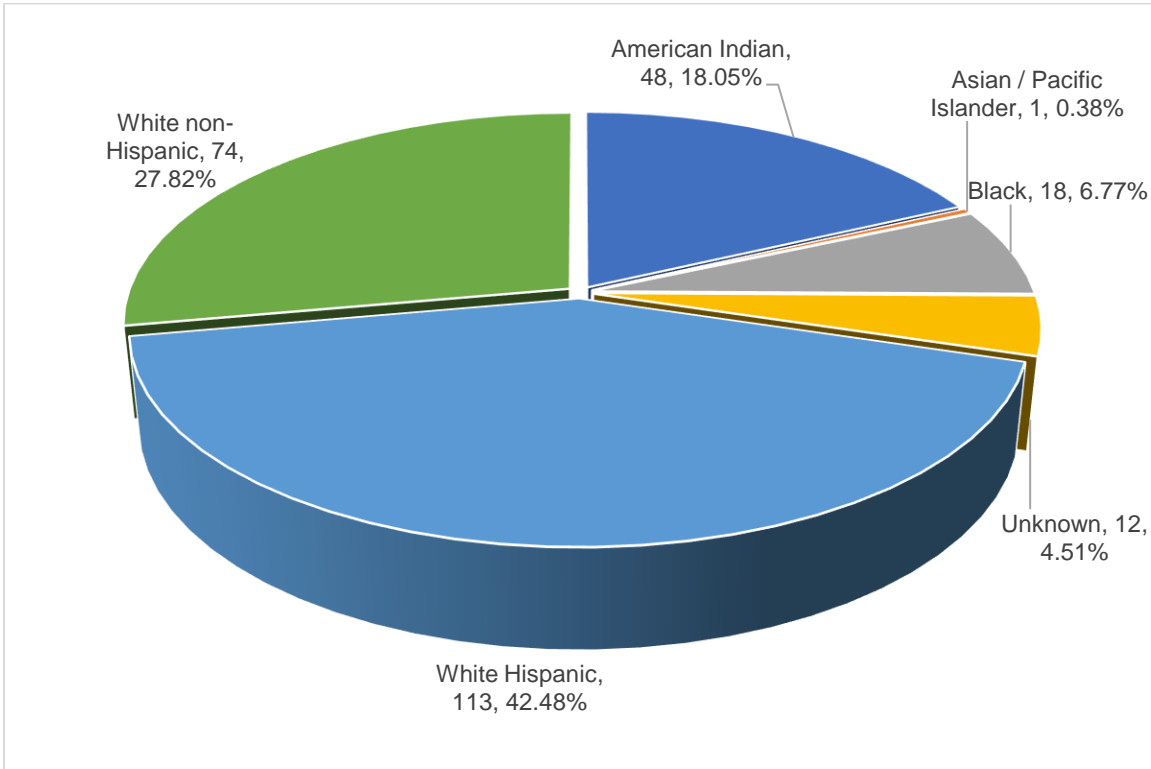


Figure 23. Homicide Deaths by Age and Gender 2020

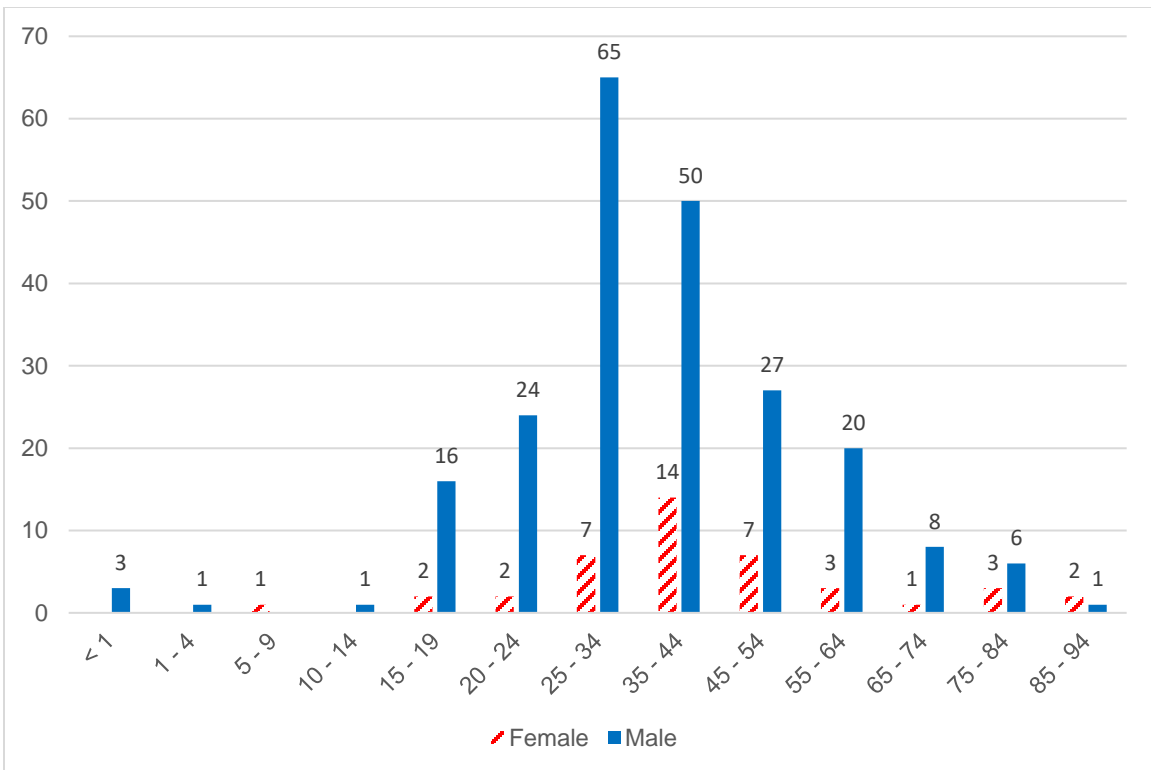


Table 10. Homicide Deaths by Cause 2020

Cause of Death	Total
Gunshot wound(s)	171
Multiple injuries	31
Stab wound(s)	26
Natural/Other	14
Asphyxia	6
Homicide/Other	4
Sepsis	4
Substance intoxication	2
Head and neck injuries	2
Pneumonia	2
Epilepsy	2
Thermal injuries	1
Aneurysm	1
Total	266

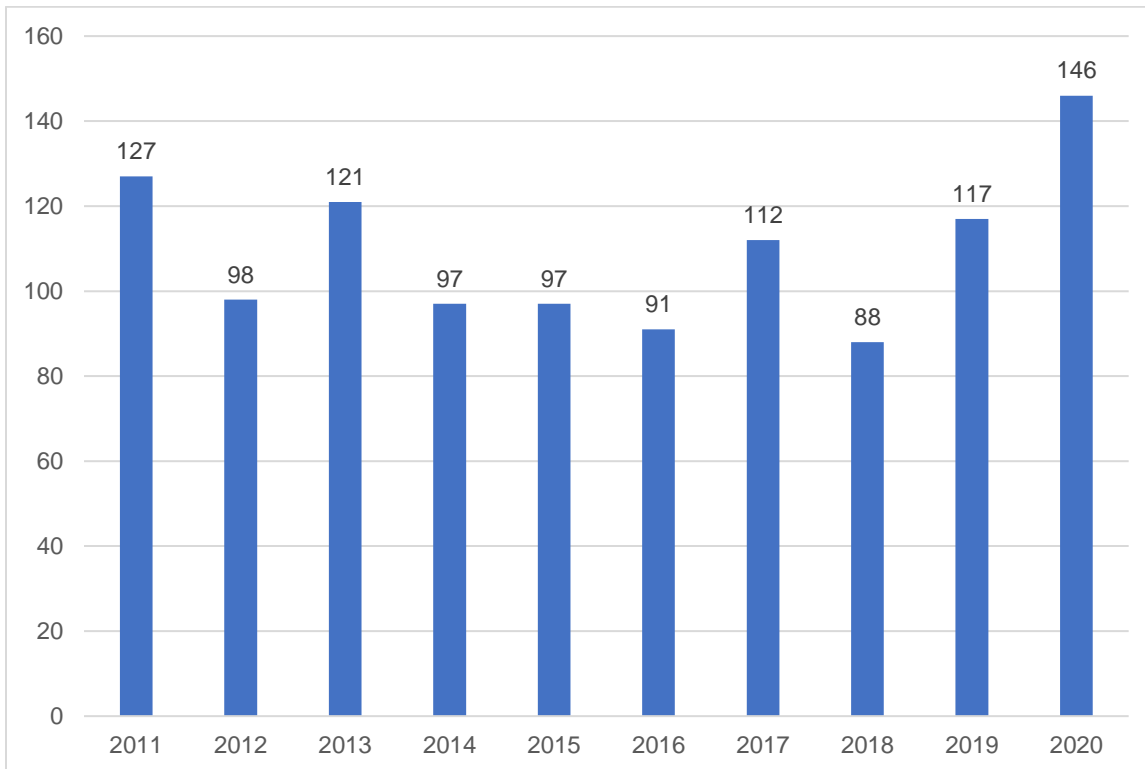
Please note that some of the causes here that are not directly apparent as homicide are frequently due to circumstances that lead to a fatal event but were initially precipitated by the above condition/cause noted in the table.

Table 11. Homicide Deaths – County of Pronouncement (2011 - 2020)

County	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Bernalillo	50	56	55	55	73	87	97	109	119	122
Catron	0	0	0	0	0	0	0	0	0	0
Chaves	6	10	13	10	11	12	7	12	11	10
Cibola	3	4	1	4	3	2	5	4	2	2
Colfax	0	1	3	1	2	3	0	0	1	1
Curry	3	3	3	2	3	4	6	2	3	2
De Baca	0	0	1	0	0	0	1	1	0	1
Dona Ana	6	7	7	10	9	10	13	10	14	16
Eddy	3	7	4	3	3	9	8	4	9	11
Grant	4	1	3	1	3	4	5	0	0	3
Guadalupe	0	0	0	0	0	0	0	1	2	0
Harding	0	0	0	0	0	0	0	0	0	0
Hidalgo	1	0	0	1	0	0	0	1	0	0
Lea	10	4	7	5	8	7	2	7	18	5
Lincoln	3	1	1	0	2	2	2	2	2	1
Los Alamos	0	0	0	0	0	0	0	0	0	0
Luna	1	0	2	0	3	0	2	4	0	6
McKinley	9	11	10	11	7	13	8	13	8	11
Mora	0	0	0	0	2	1	0	0	0	0
Otero	3	0	5	2	3	4	1	7	5	5
Quay	4	3	0	0	0	2	2	1	1	1
Rio Arriba	8	9	5	1	4	1	6	9	4	7
Roosevelt	1	0	0	1	0	2	0	3	3	1
San Juan	11	11	14	13	10	11	13	15	14	10
San Miguel	4	0	3	2	3	3	3	3	6	4
Sandoval	5	3	1	7	5	9	8	10	7	12
Santa Fe	12	11	4	6	6	5	8	7	8	8
Sierra	0	1	0	1	3	2	0	1	1	0
Socorro	0	1	1	0	2	3	2	0	1	1
Taos	2	2	3	2	2	2	4	1	5	5
Torrance	0	0	1	4	3	1	1	0	0	0
Union	0	0	0	1	0	0	0	0	1	0
Valencia	6	4	4	5	5	6	3	12	10	6
Out of State	12	10	18	11	10	11	16	13	6	15
Total	167	160	169	159	185	216	223	252	265	266

Overview – Manner of Death – Undetermined Deaths

Figure 24. Undetermined Deaths (2011 - 2020)



Undetermined Deaths – Overview

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 (less than 1% 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.

Figure 25. Undetermined Deaths by Race / Ethnicity 2020

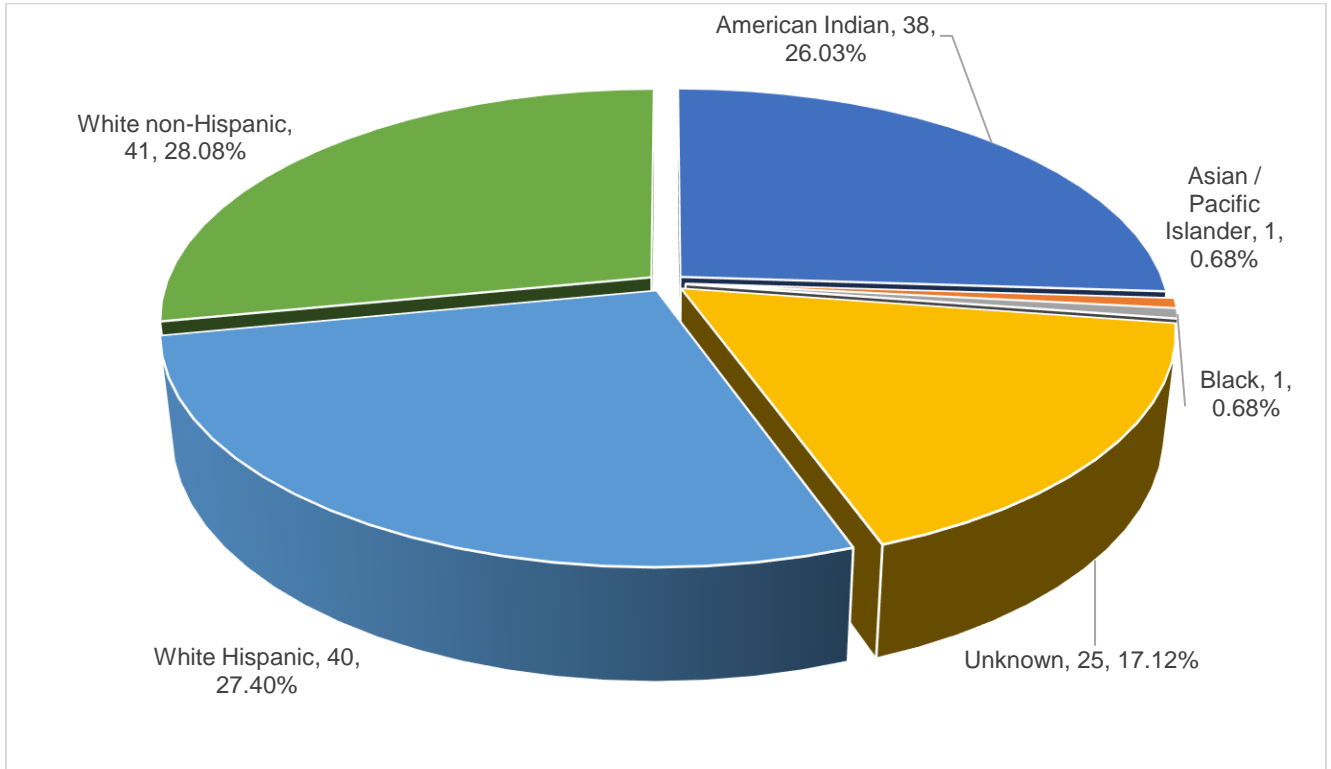
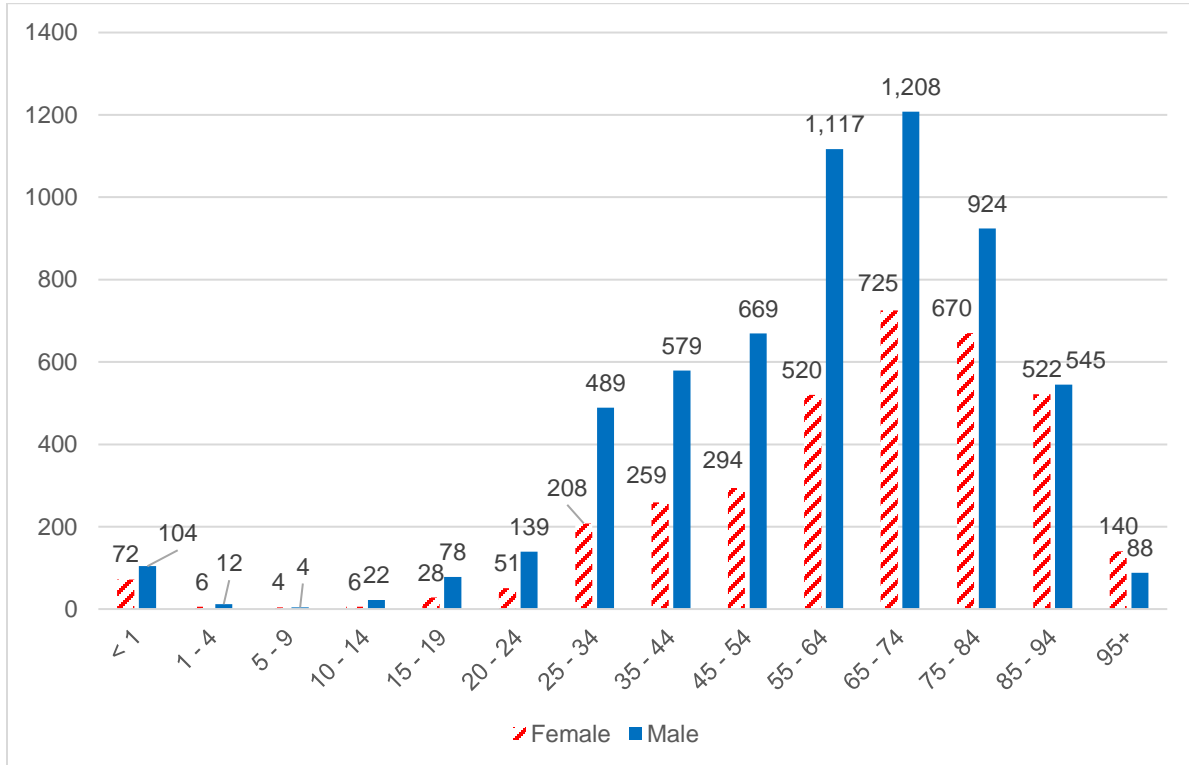


Figure 26. Undetermined Deaths by Age and Gender 2020



Deaths of Children (19 years of age and younger)

Figure 27. Children/Deaths (2011 - 2020)

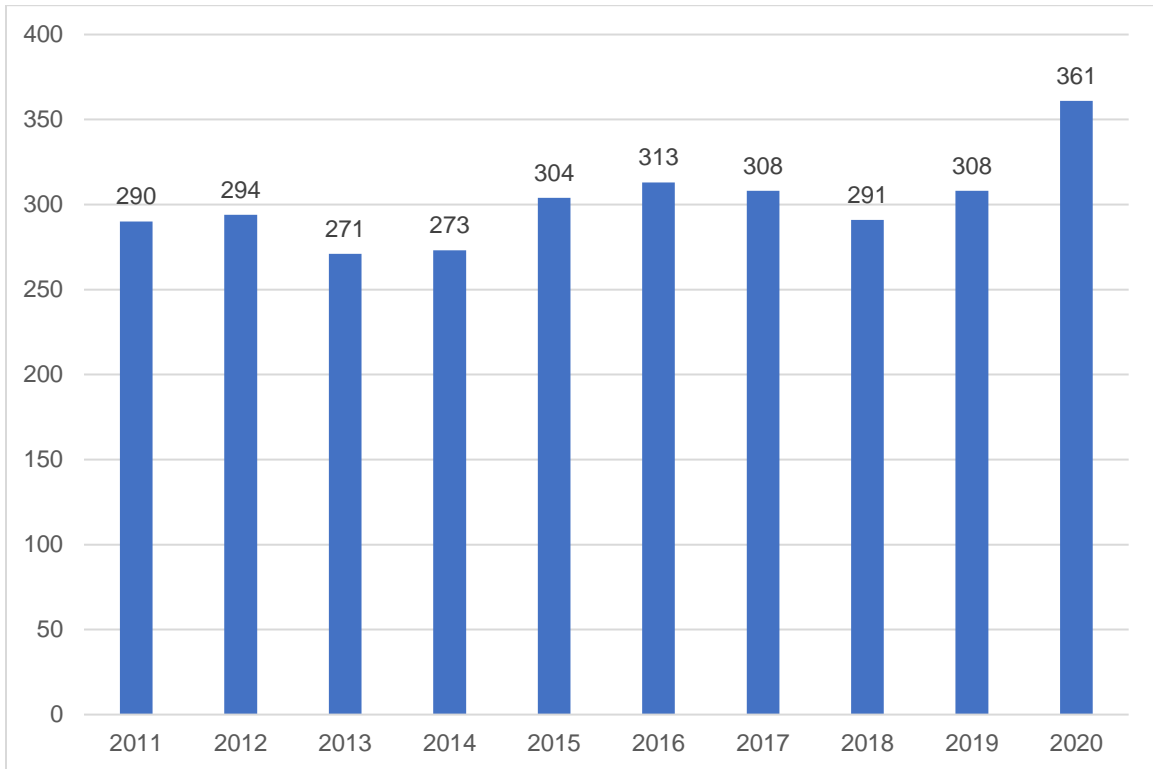


Figure 28. Children/Deaths by Race / Ethnicity 2020

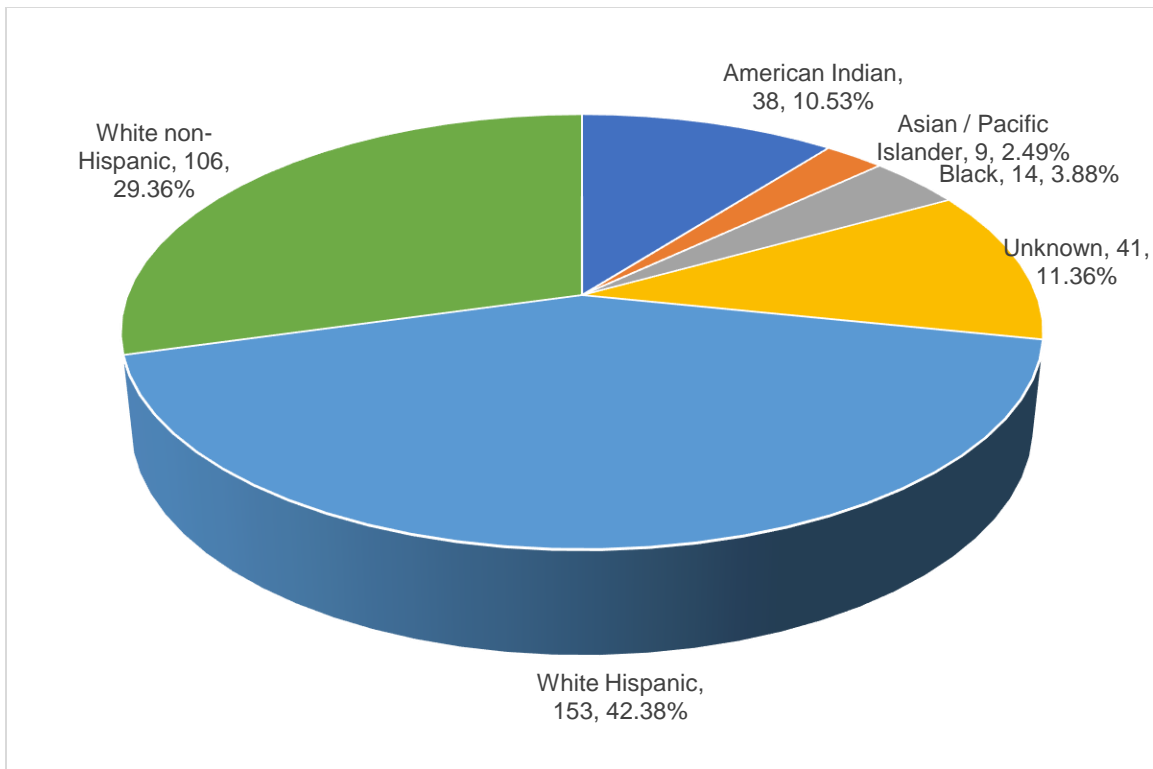


Figure 29. Children / Deaths by Age and Gender 2020

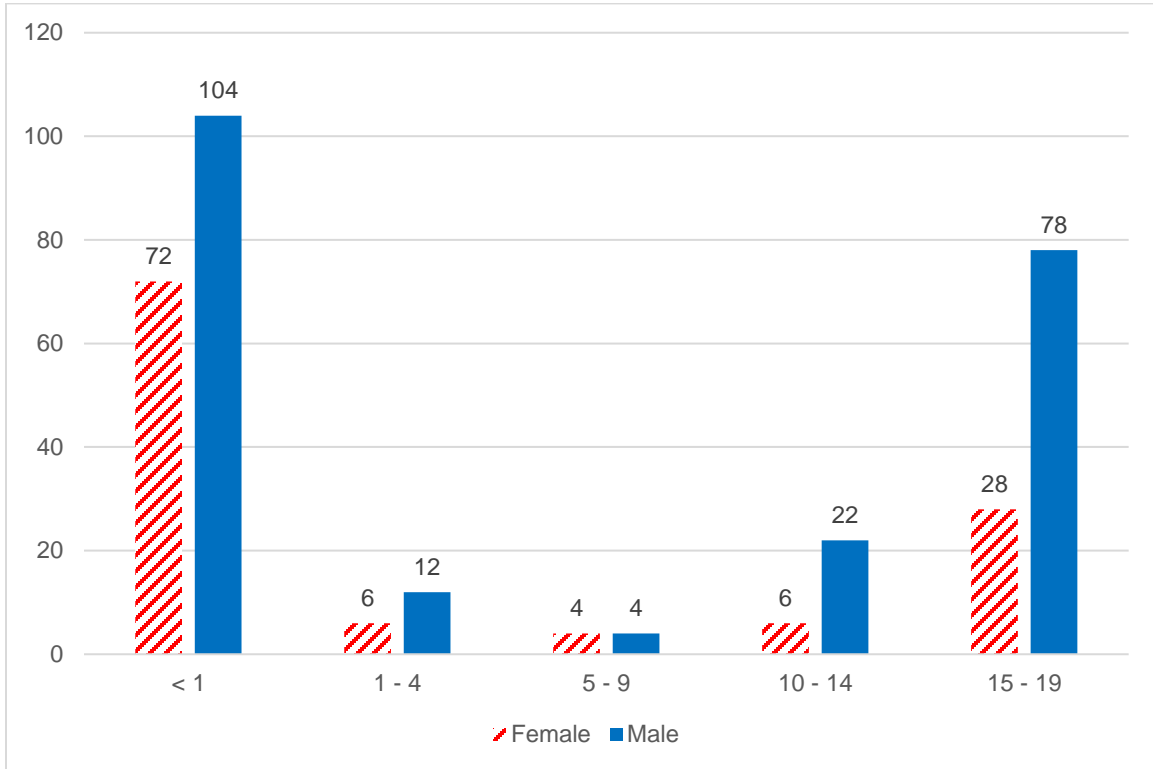
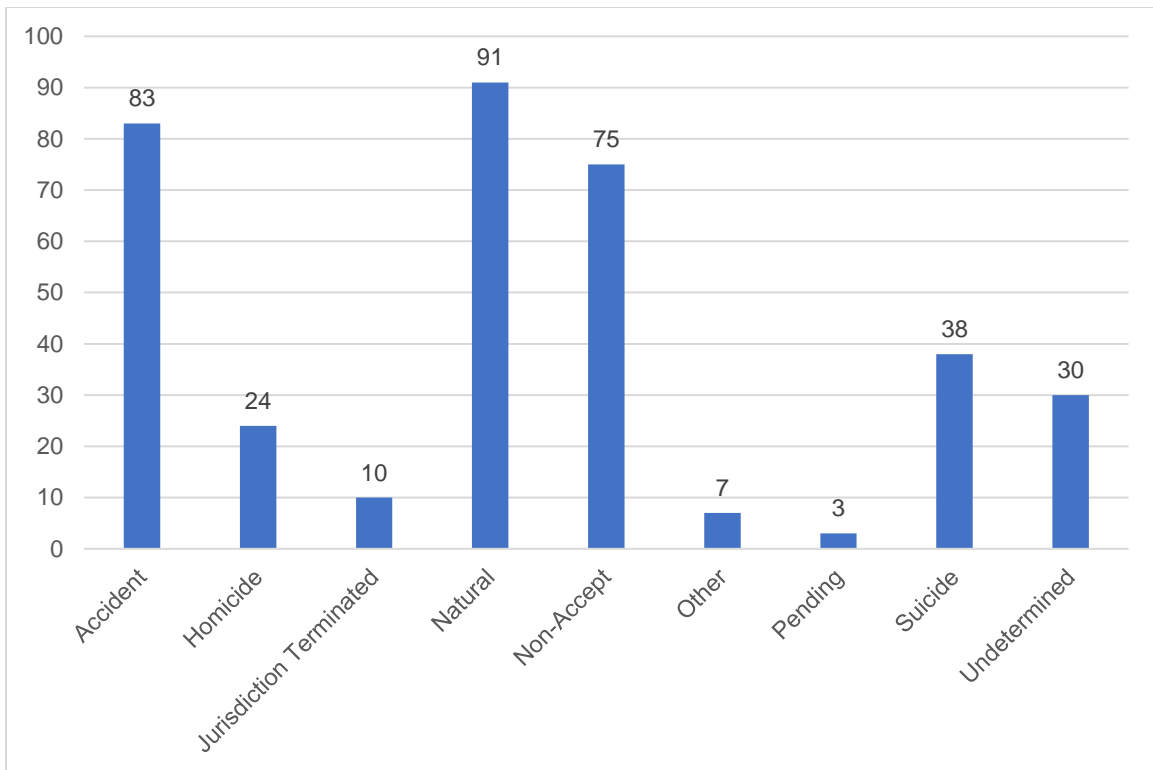


Figure 30. Children / Deaths by Manner of Death 2020



Overview – Children by Manner of Death (Natural Deaths)

Figure 31. Children / Natural Manner of Deaths (2011 - 2020)

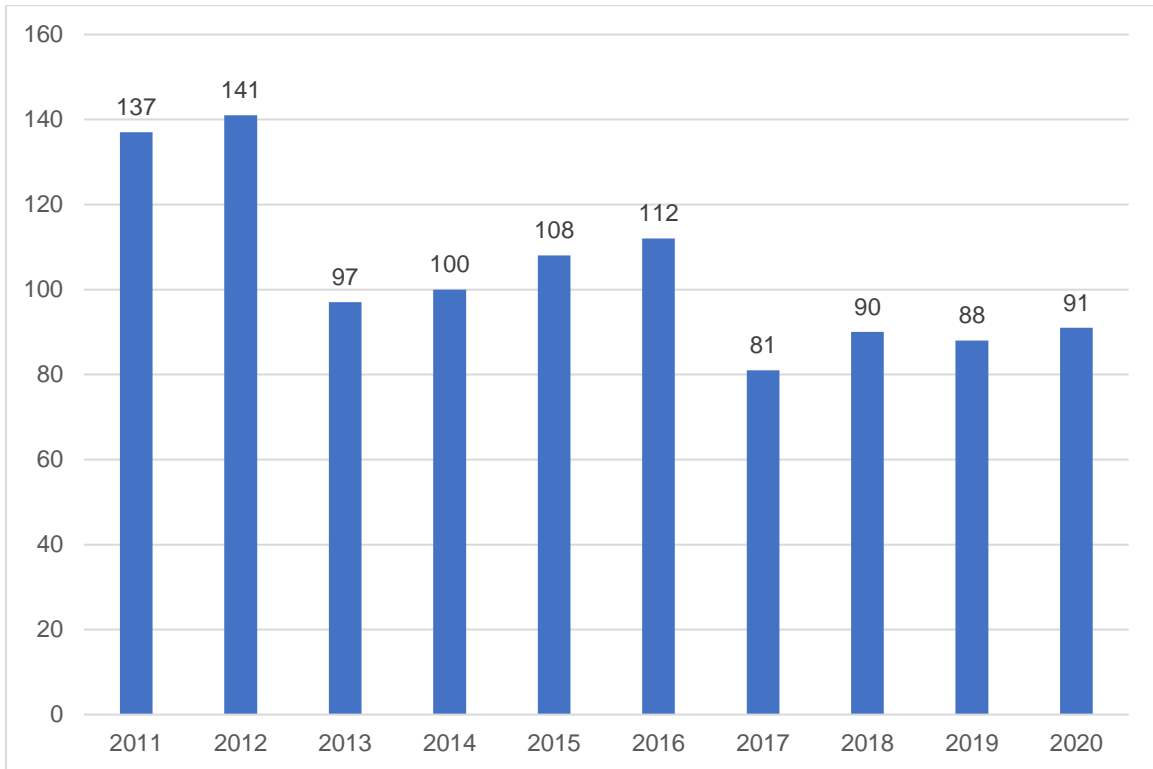


Figure 32. Children/Natural Deaths by Race / Ethnicity 2020

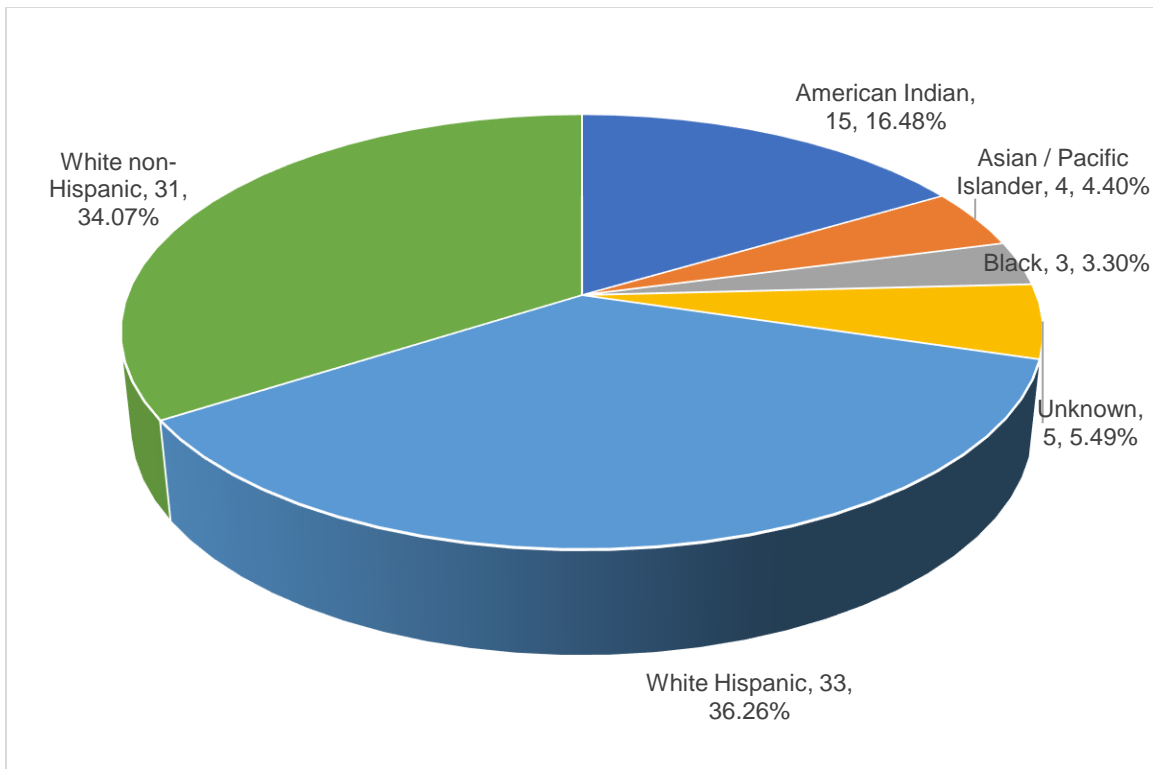
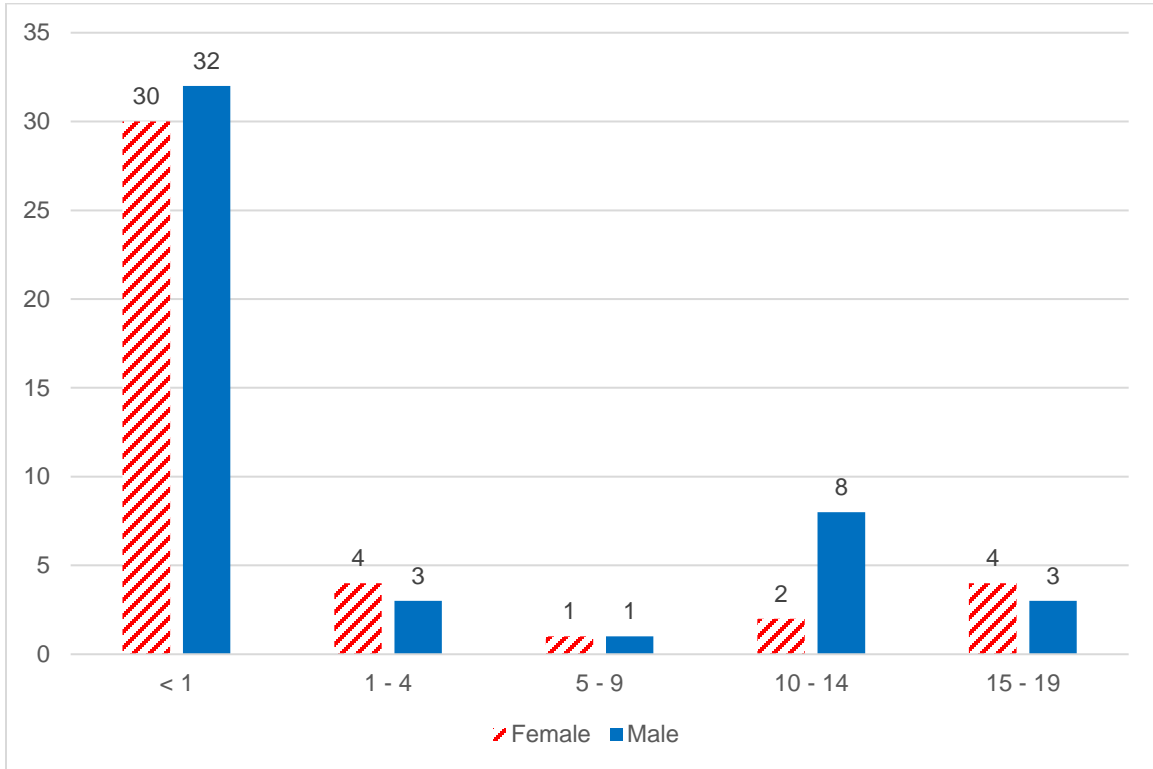


Figure 33. Children / Natural Deaths by Age and Gender 2020



Overview – Children by Manner of Death (Accidental Deaths)

Figure 34. Children / Accidental Deaths (2011 - 2020)

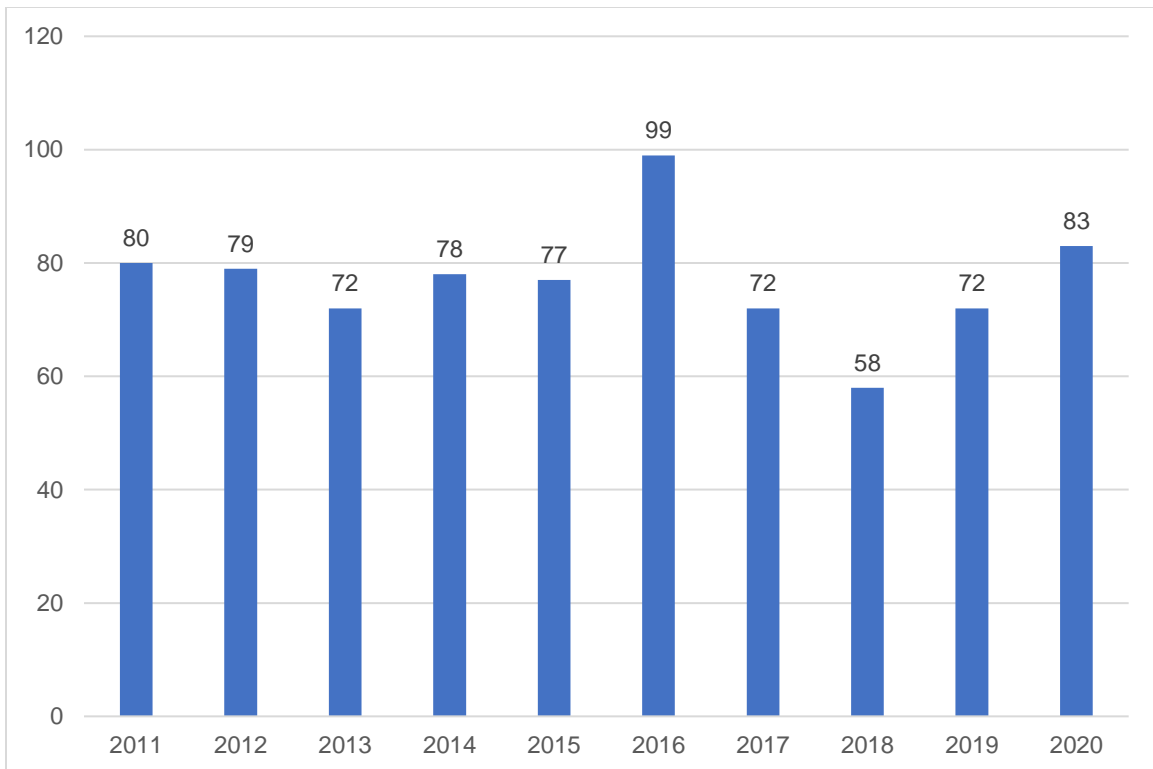


Figure 35. Children / Accidental Deaths by Race / Ethnicity 2020

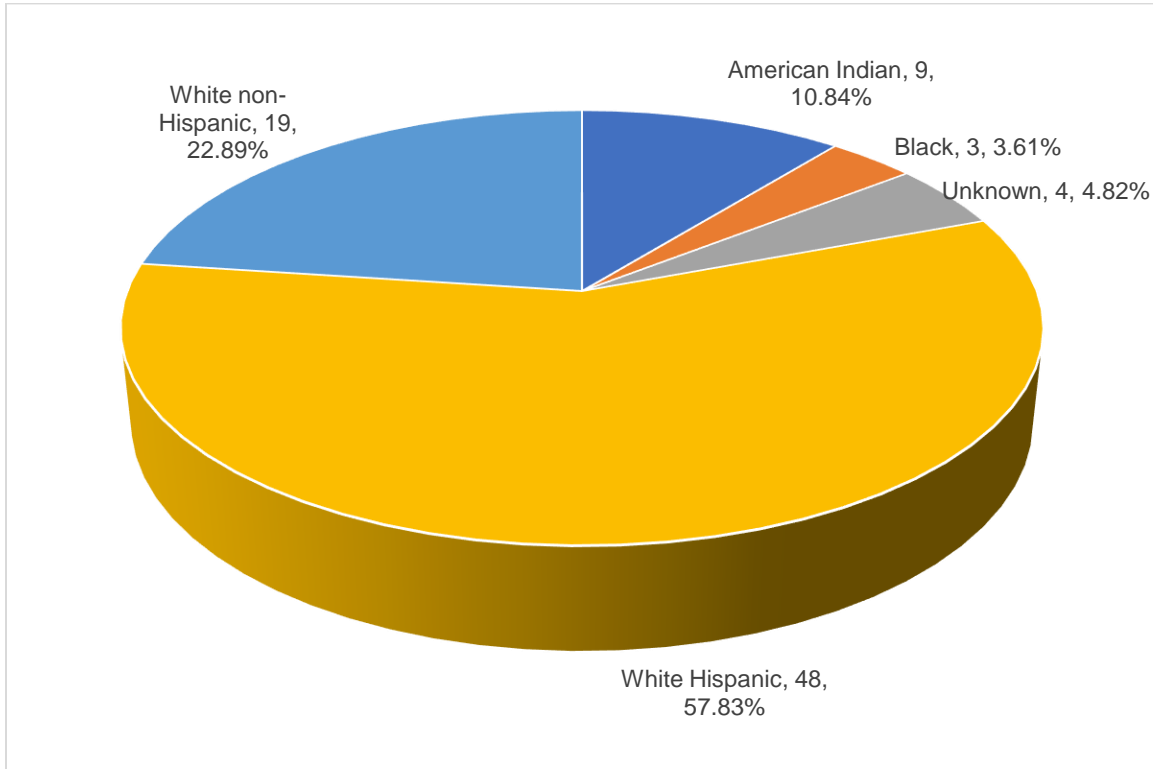


Figure 36. Children / Accidental Deaths by Age and Gender 2020

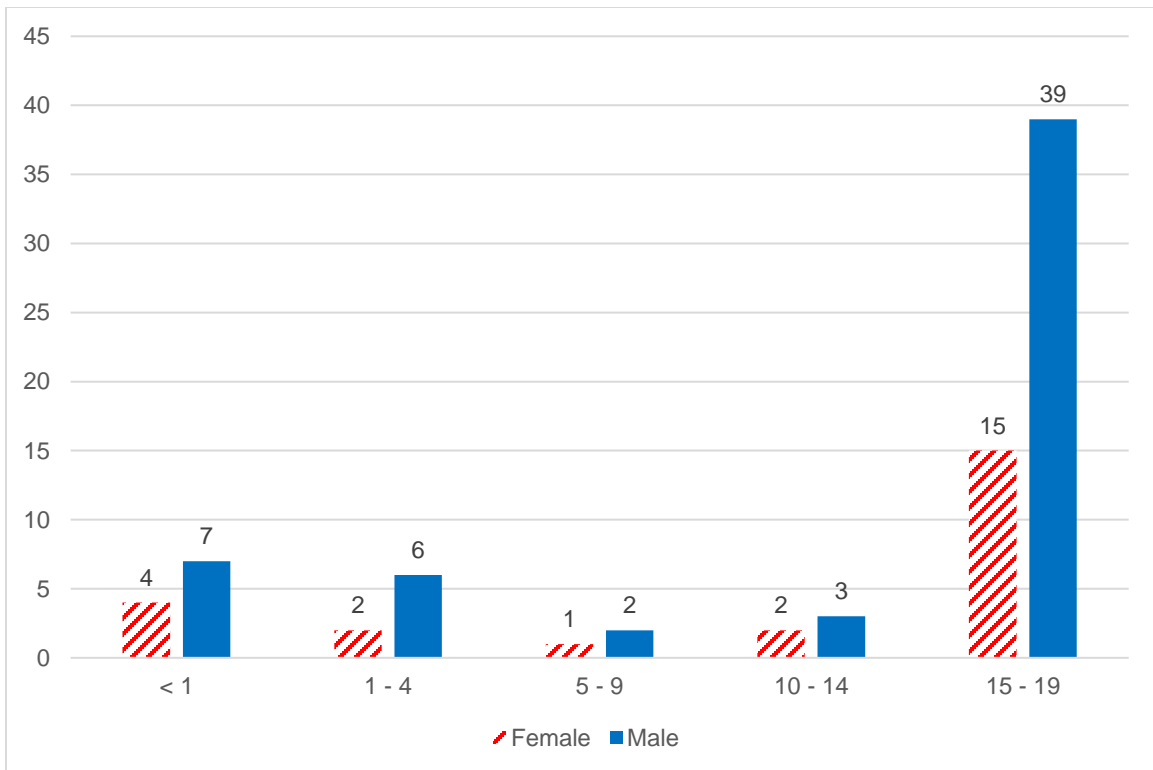


Table 12. Children / Accidental Deaths – Cause 2020

Cause of Death	Total
Multiple injuries	40
Substance intoxication	19
Asphyxia	6
Drowning	4
Natural/Other	4
Choking	2
Thermal injuries	2
Head and neck injuries	2
Toxic inhalation	1
Gunshot wound(s)	1
Ethanol intoxication	1
Exposure	1

Overview – Children by Manner of Death (Suicide)

Figure 37. Children / Suicide Deaths (2011 - 2020)

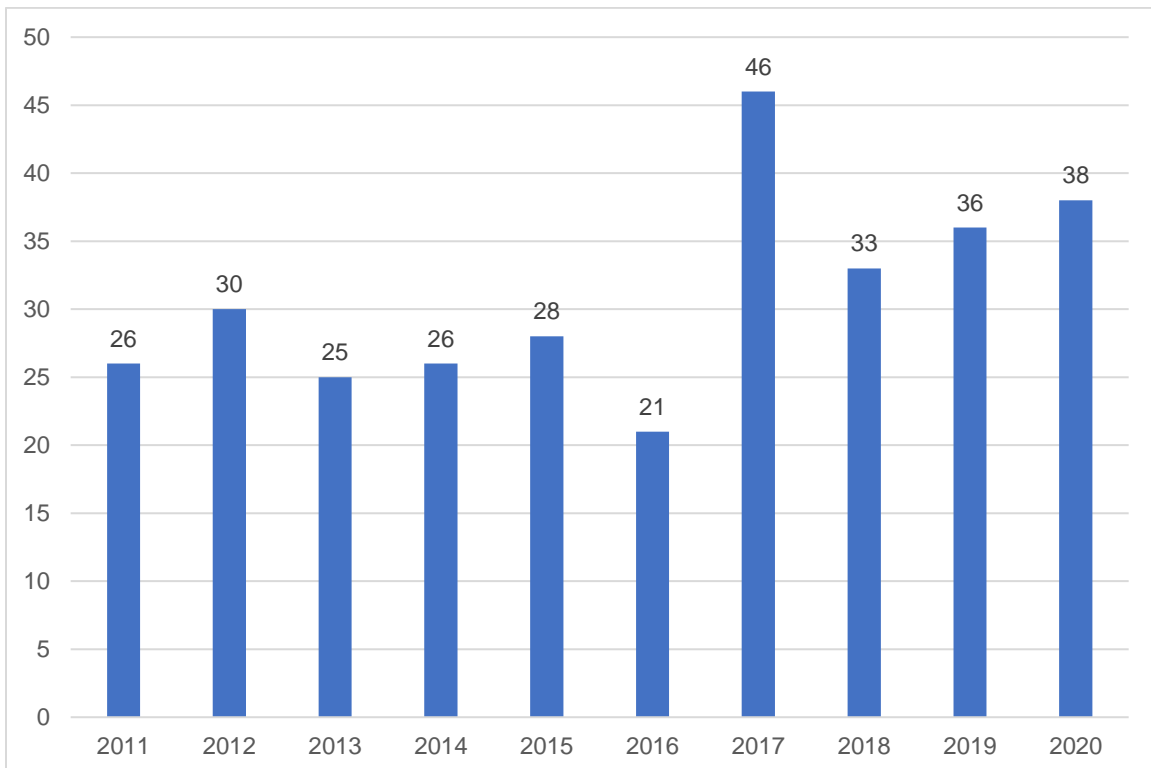


Figure 38. Children / Suicide Deaths by Race/Ethnicity 2020

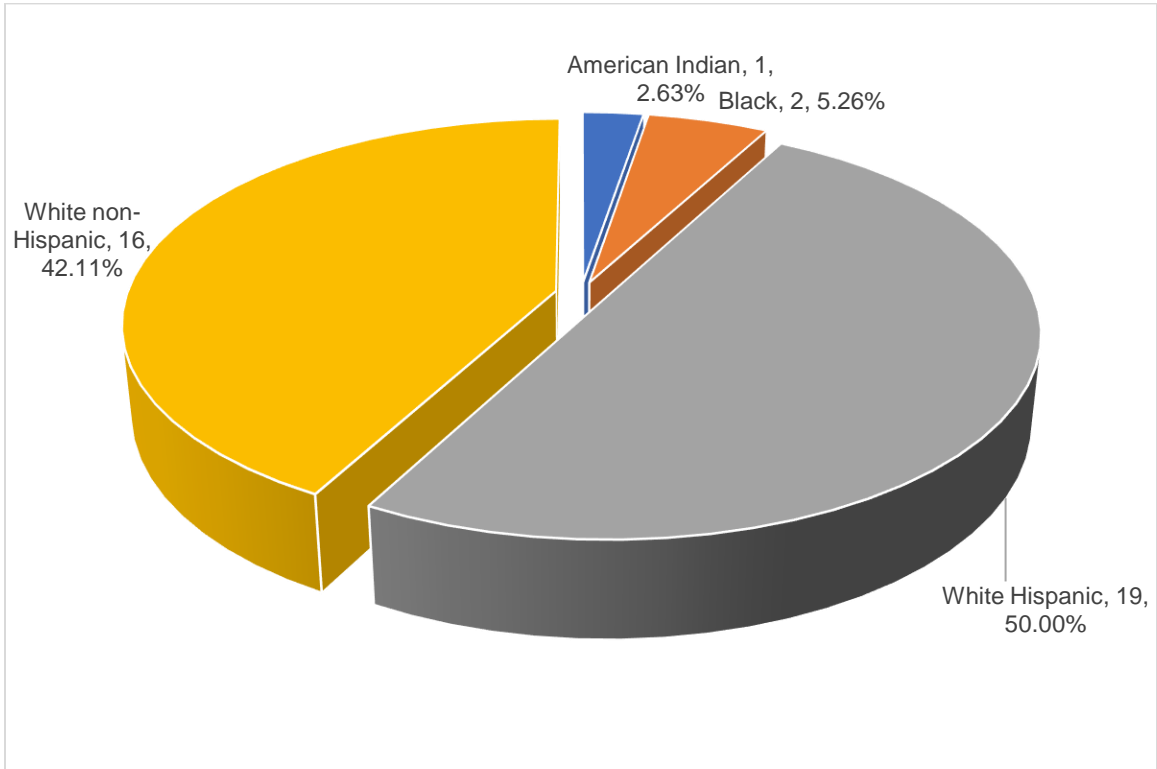


Figure 39. Children / Suicide Deaths by Age and Gender 2020

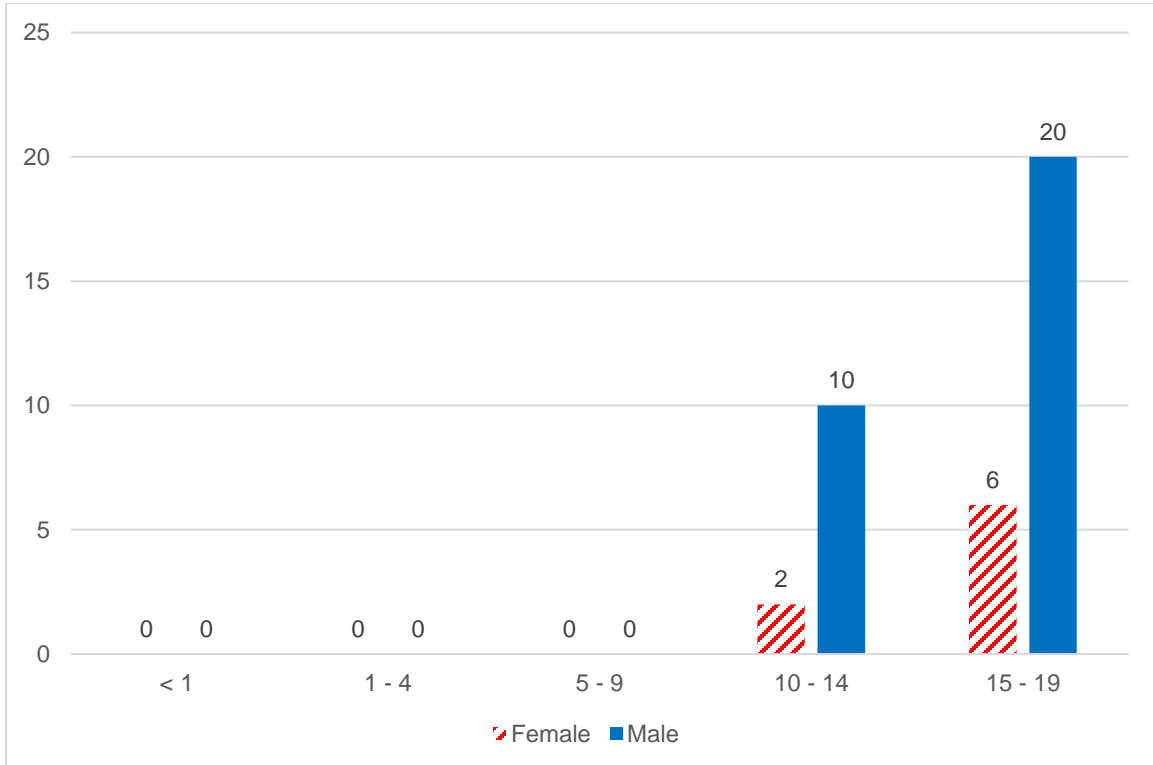


Figure 40. Children / Suicide Deaths by Month 2020

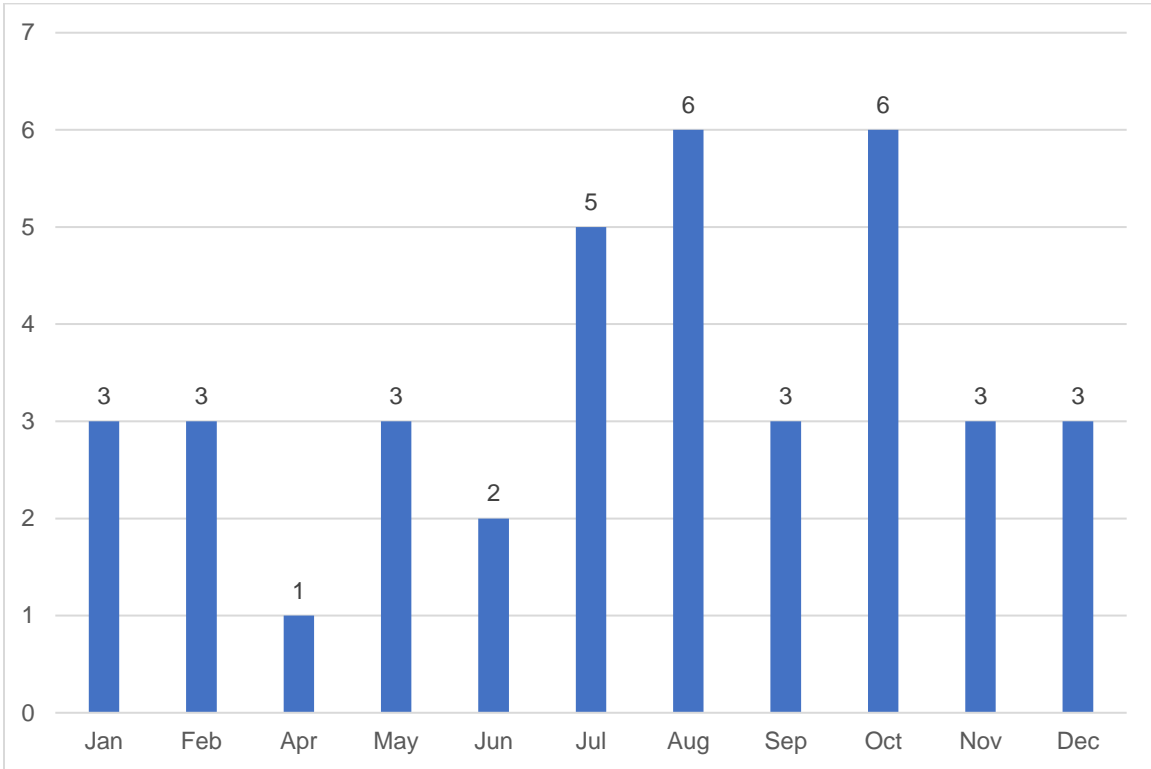


Figure 41. Children / Suicide Deaths by Day of Week 2020

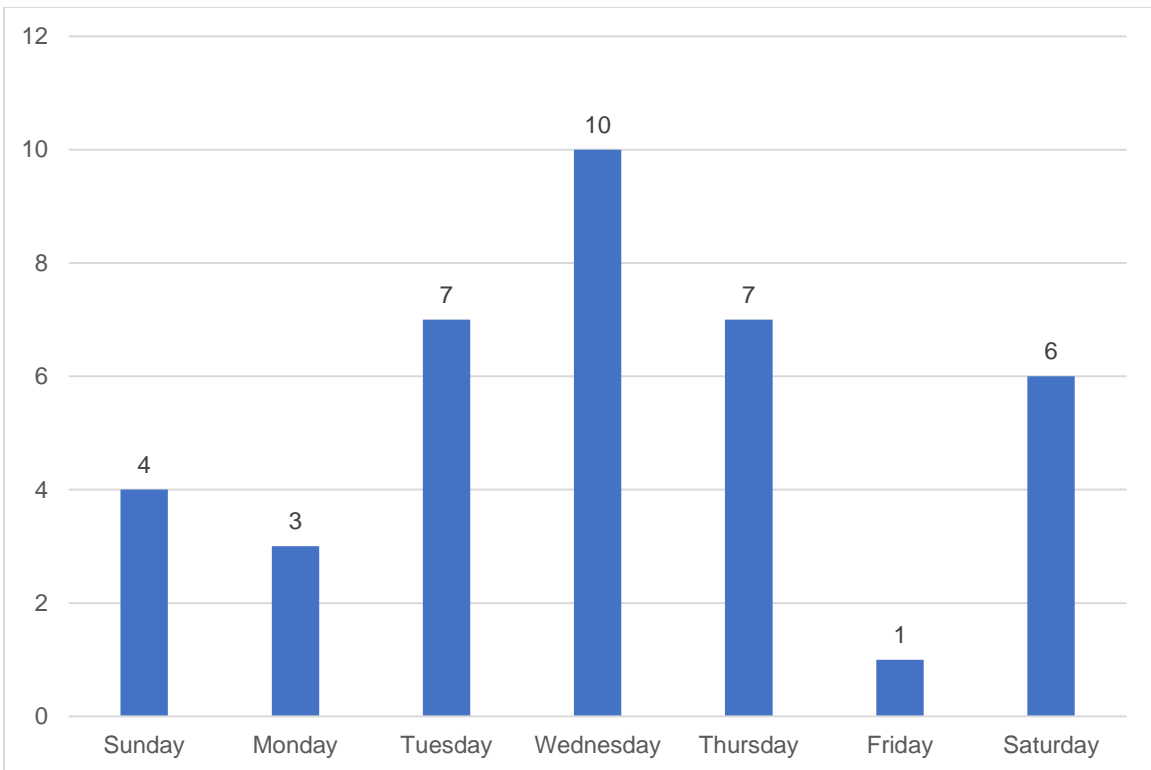


Table 13. Children / Suicide Deaths by Cause 2020

Cause of Death	Total
Gunshot wound(s)	21
Hanging	15
Multiple injuries	1
Sepsis	1
Total	38

Overview – Children by Manner of Death (Homicide)

Figure 42. Children / Homicide Deaths (2011 - 2020)

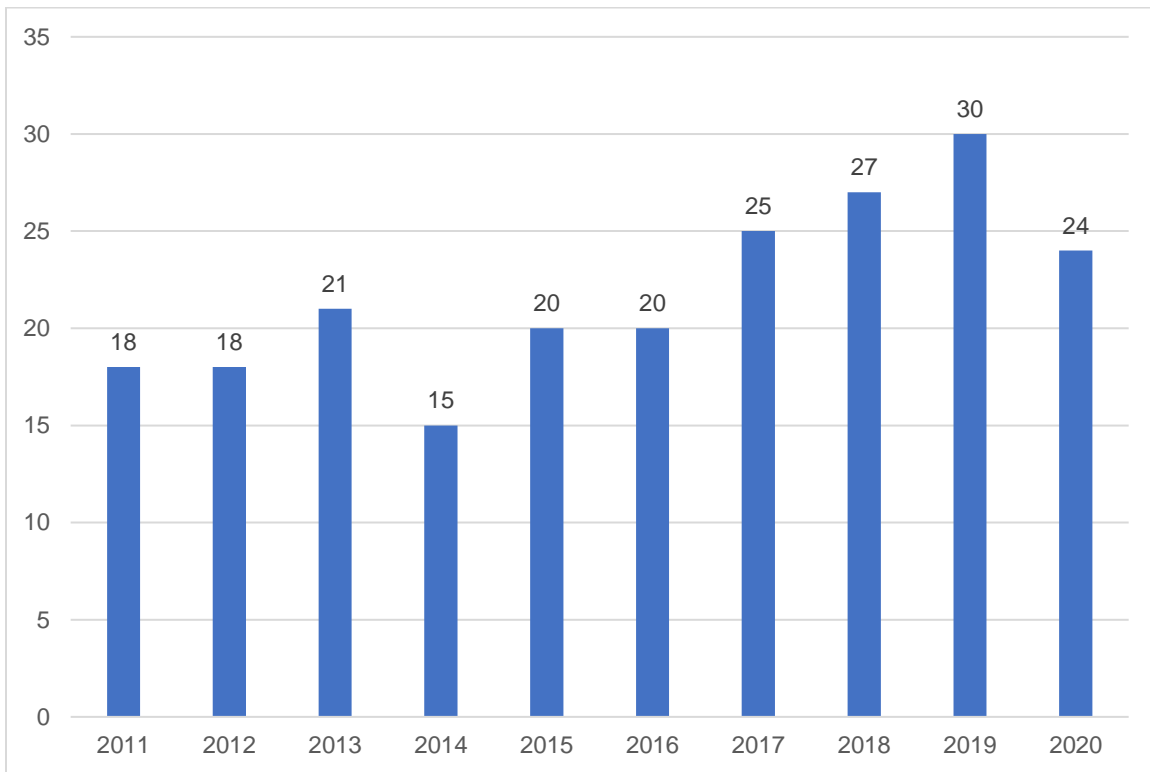


Figure 43. Children / Homicide Deaths by Race/Ethnicity 2020

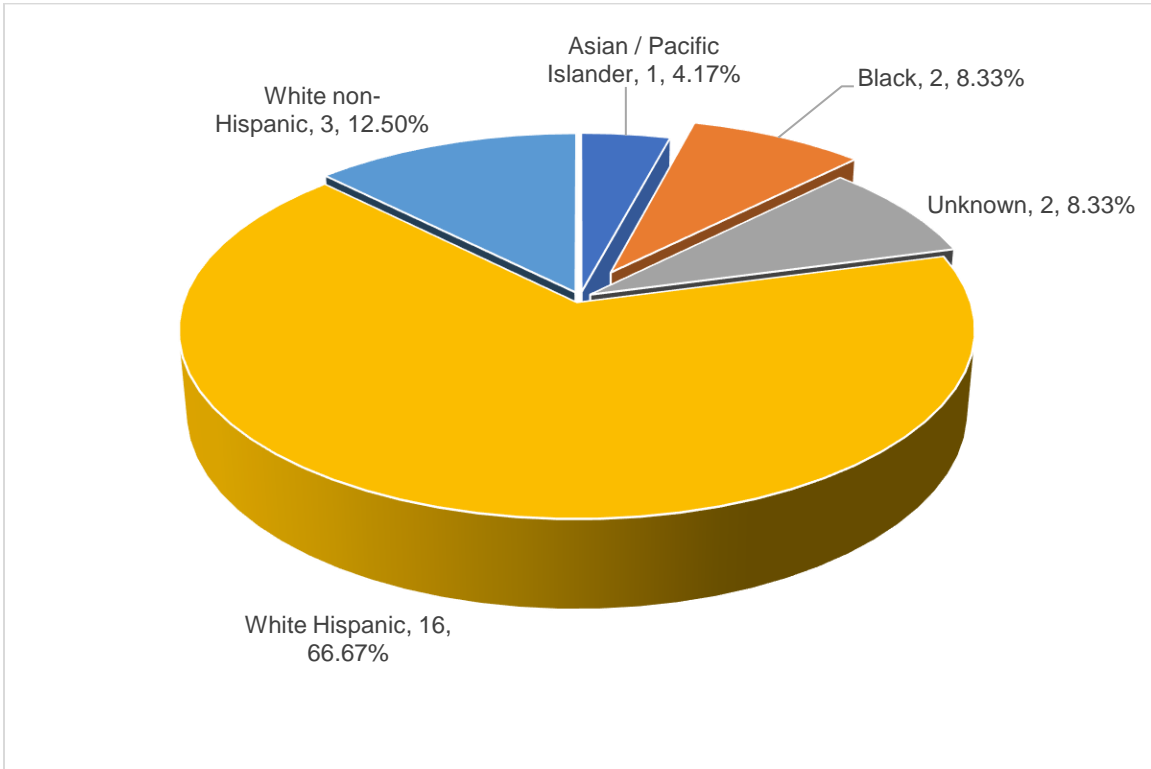


Figure 44. Children / Homicide Deaths by Age and Gender 2020

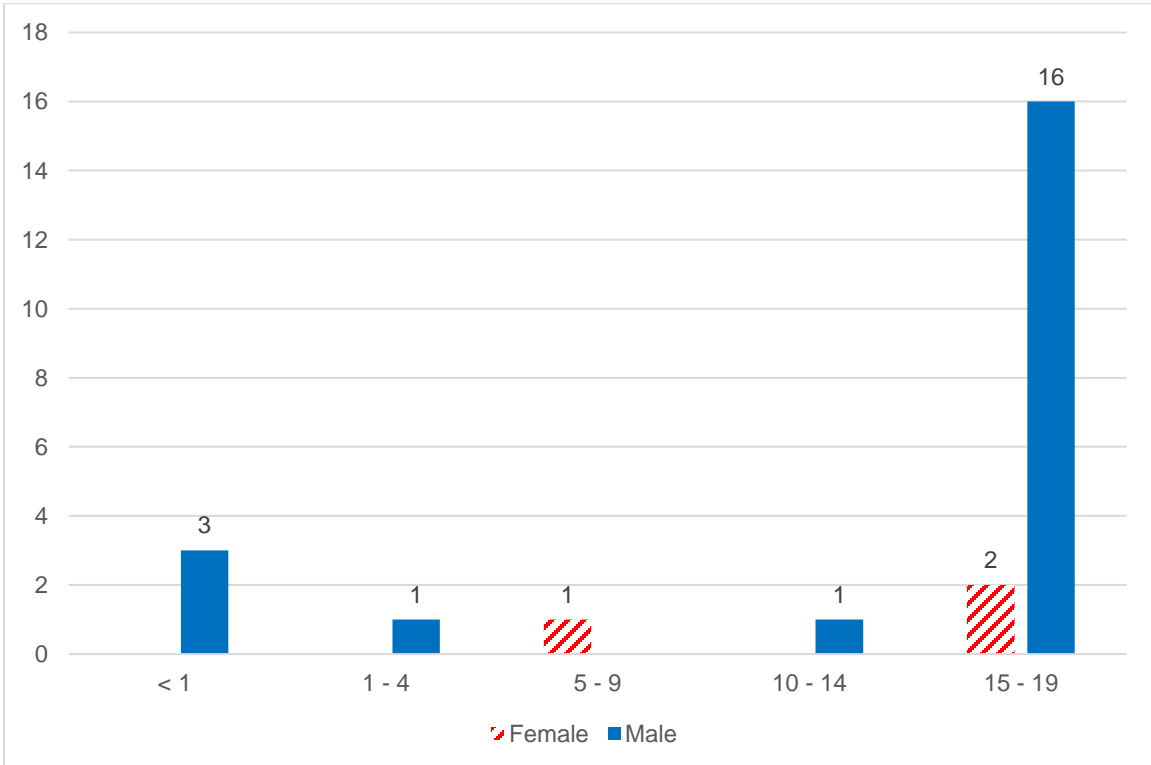


Table 14. Children / Homicide Deaths by Cause 2020

Cause of Death	Total
Gunshot wound(s)	19
Stab wound(s)	1
Multiple injuries	2
Asphyxia	1
Unspecified	1
Total	24

Overview – Children by Manner of Death (Undetermined)

Figure 45. Children / Undetermined Deaths (2011 - 2020)

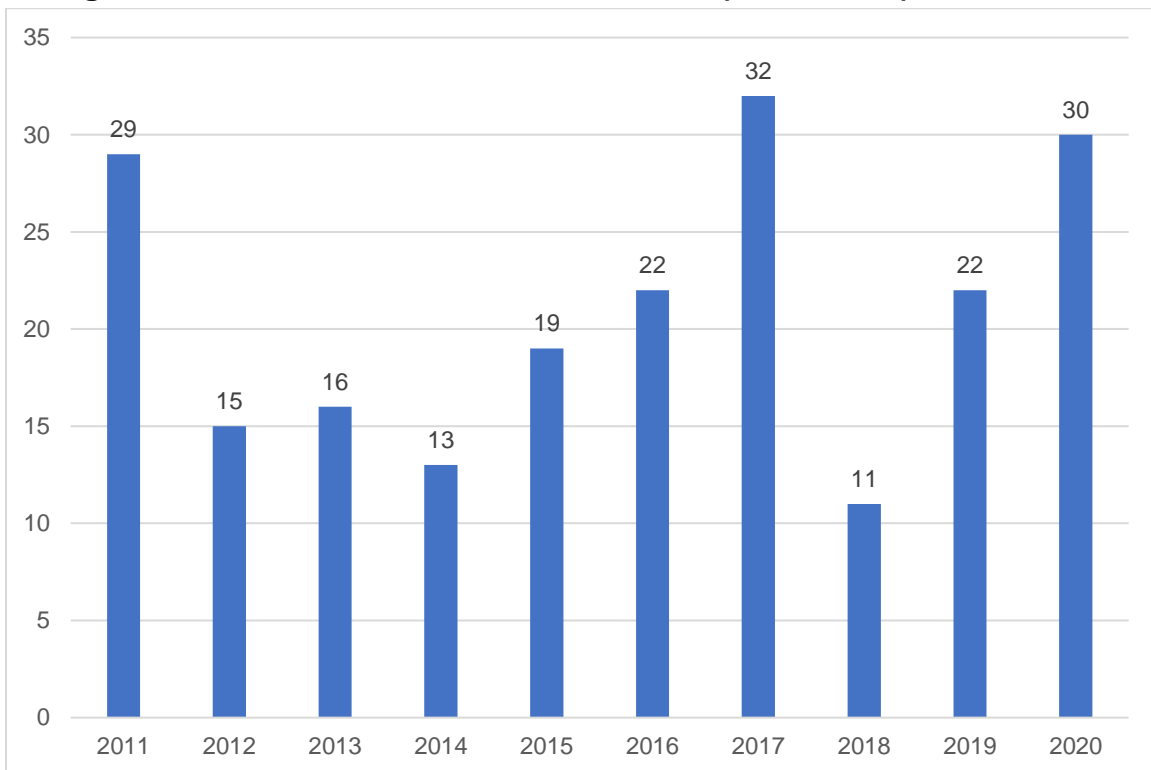


Figure 46. Children / Undetermined Deaths by Race / Ethnicity 2020

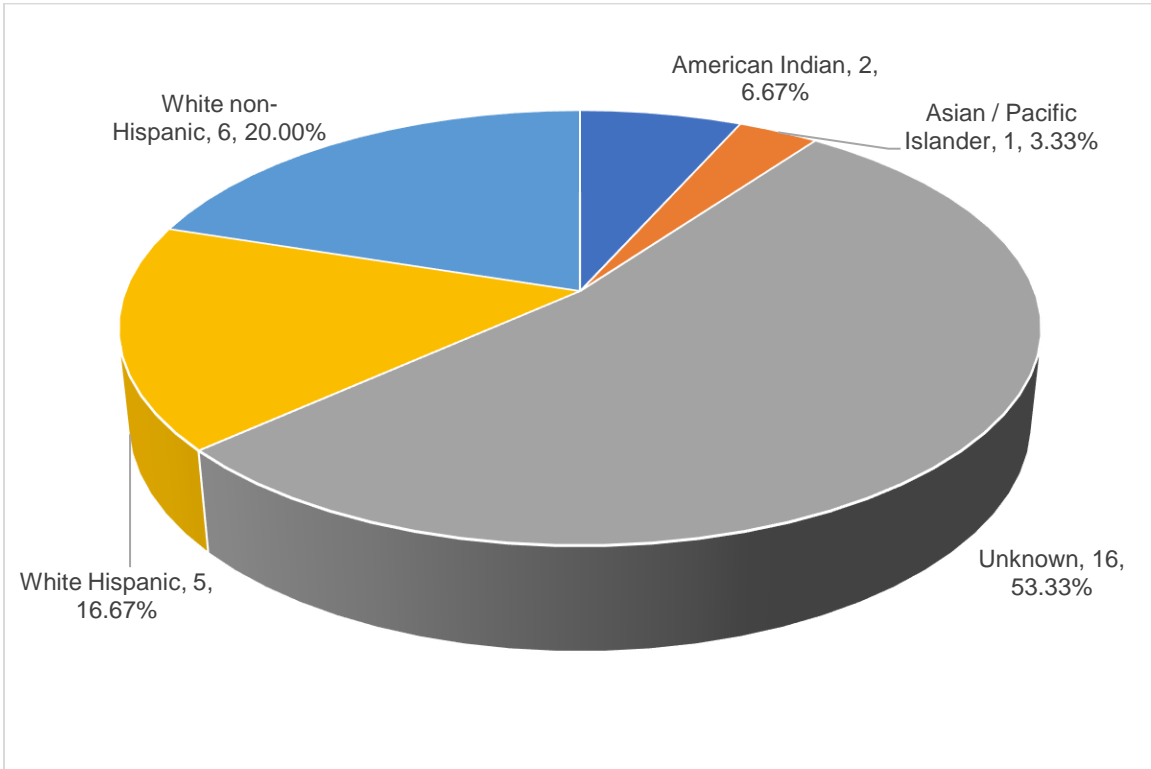


Figure 47. Children / Undetermined Deaths by Age and Gender 2020

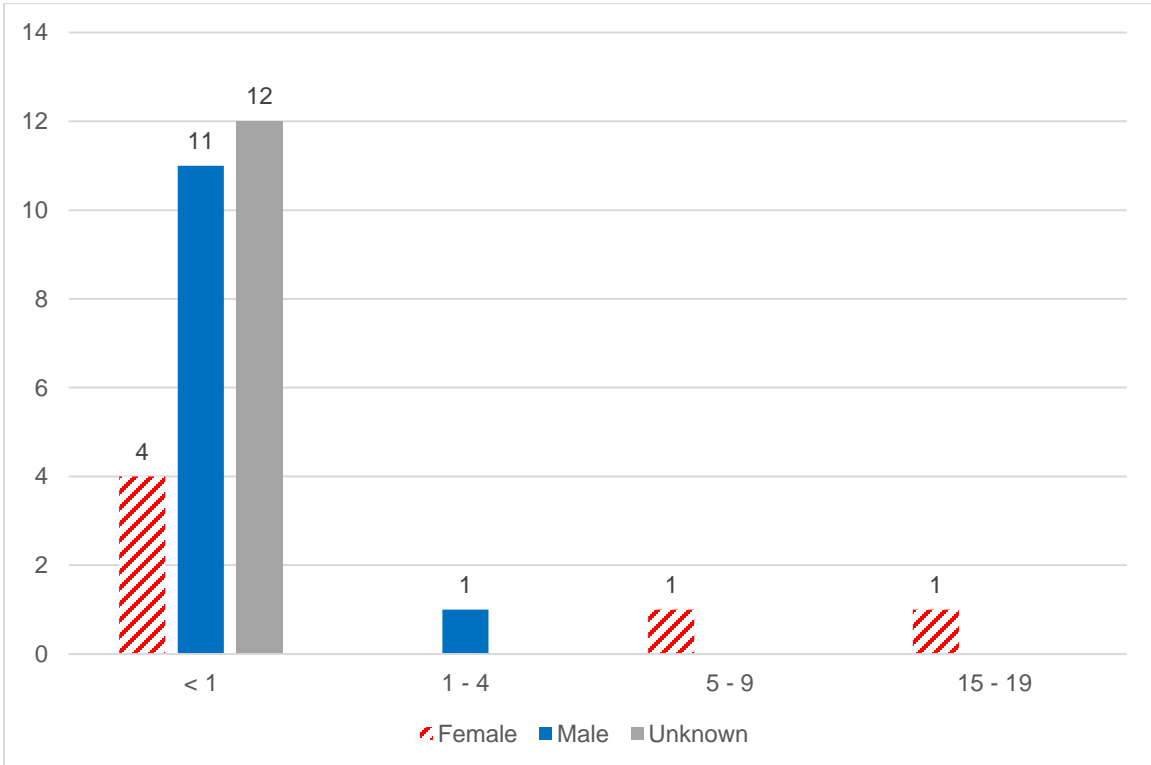


Table 15. Children / Undetermined Deaths by Cause 2020

Cause of Death	Total
Undetermined	25
Gunshot wound(s)	1
Hanging	1
Sepsis	1
Natural	1
Skeletal remains	1
Total	30

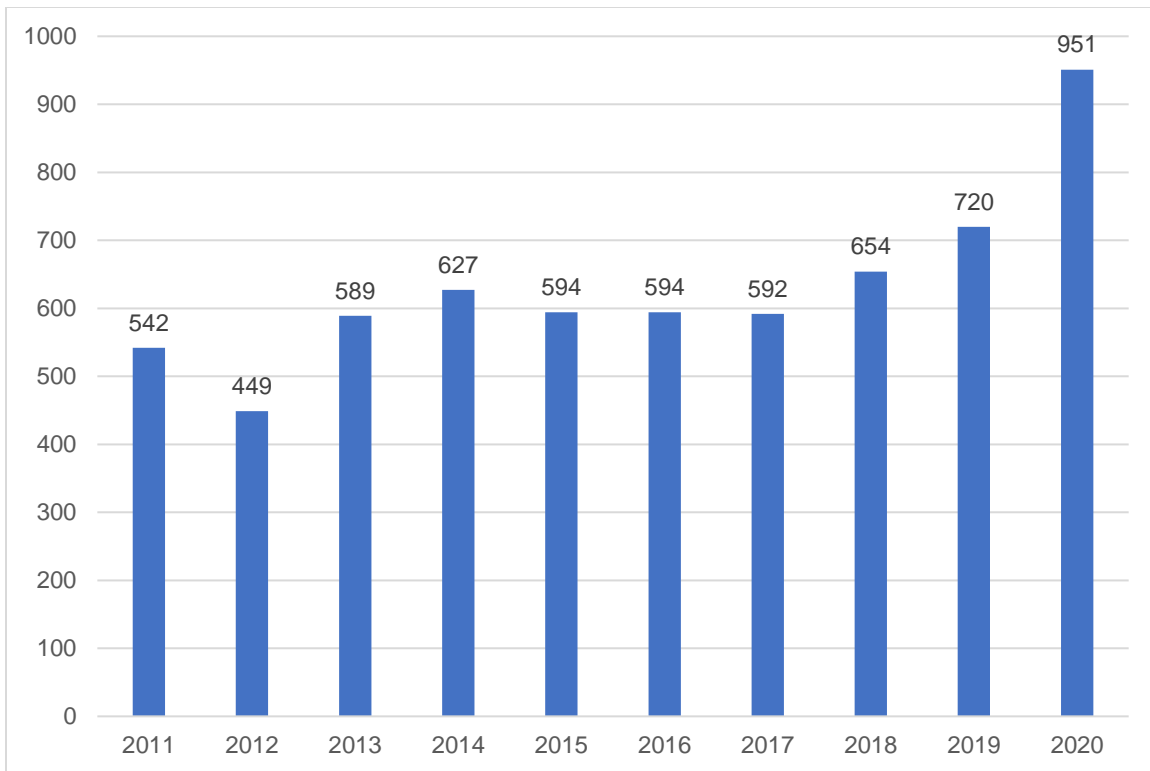
Deaths of Children in New Mexico – Summary

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%). The majority of 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.

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

Drug Caused Deaths

Figure 48. Drug Caused Deaths (2011 - 2020)



Drug Caused Deaths – Overview

Drug overdose deaths continue to be a problem in New Mexico. A wide variety of drugs, both illegal and prescription, contributed to the 951 drug-caused deaths. There was a 32.1% increase in overall drug caused deaths from 2019 to 2020. Many decedents had more than one drug present at the time of death. The most drug-caused deaths being seen in males ages 35-44 years (18.2%). 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.

Figure 49. Drug Caused Deaths by Race / Ethnicity 2020

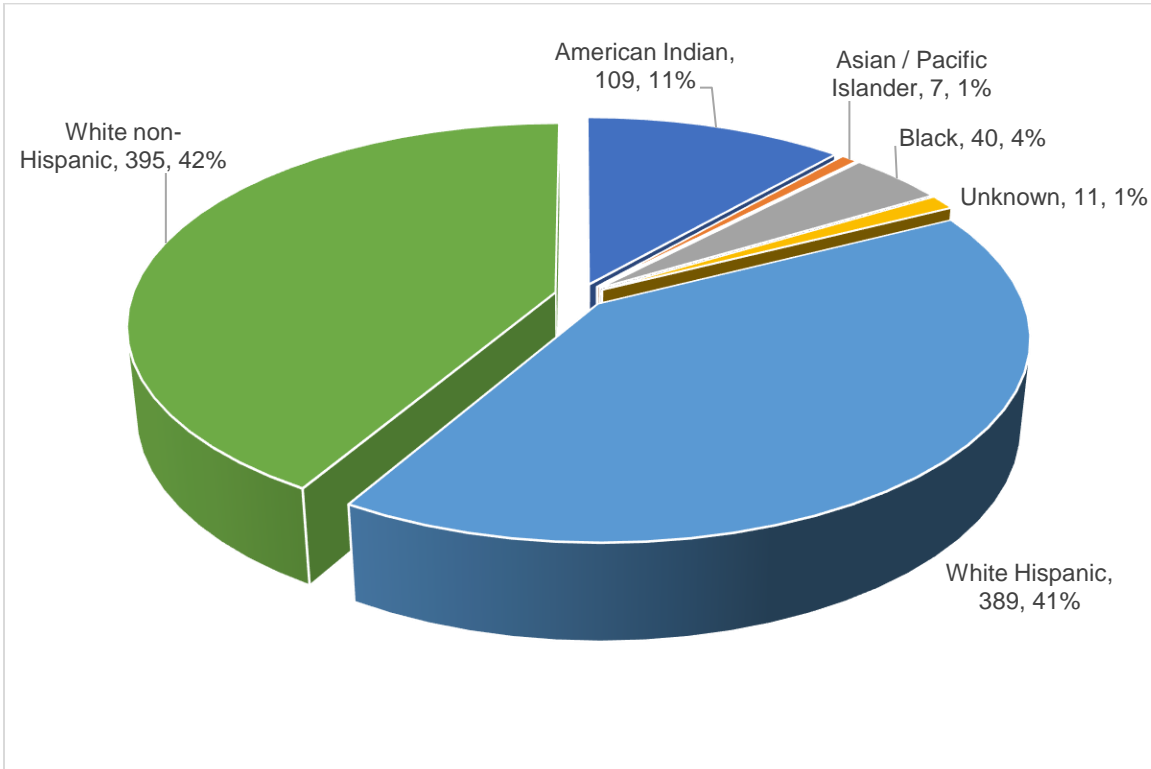


Figure 50. Drug Caused Deaths by Age and Gender 2020

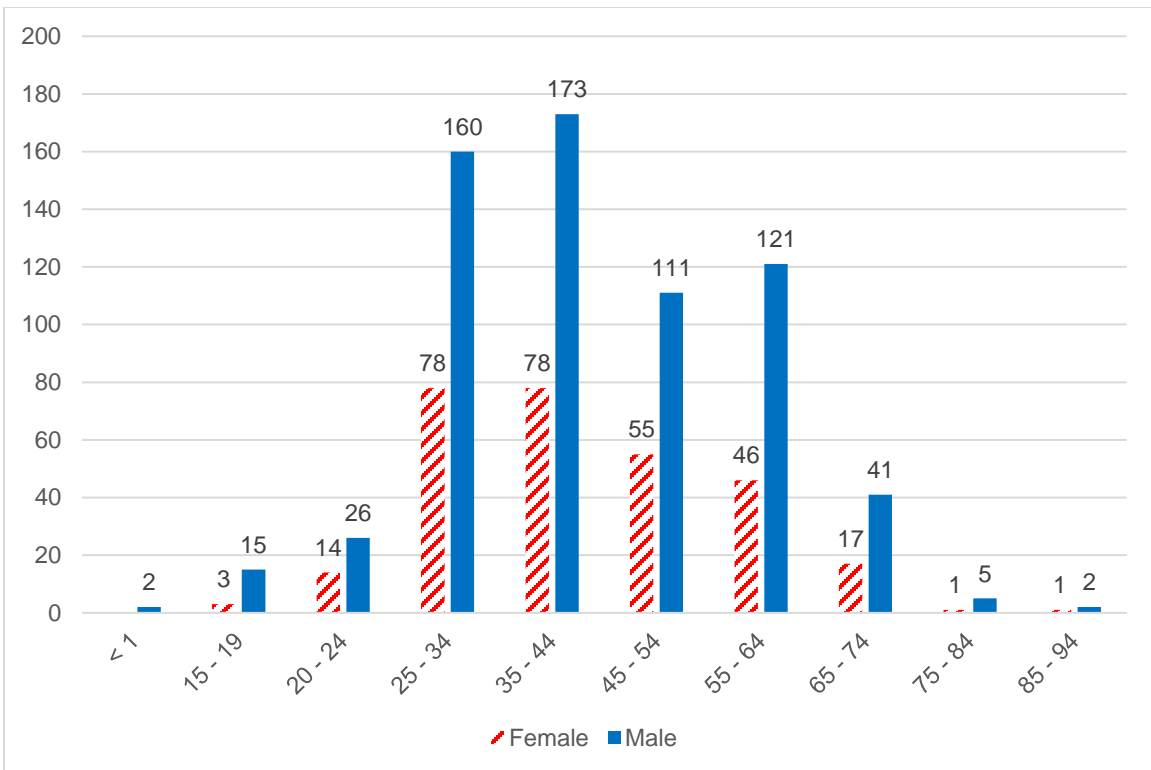
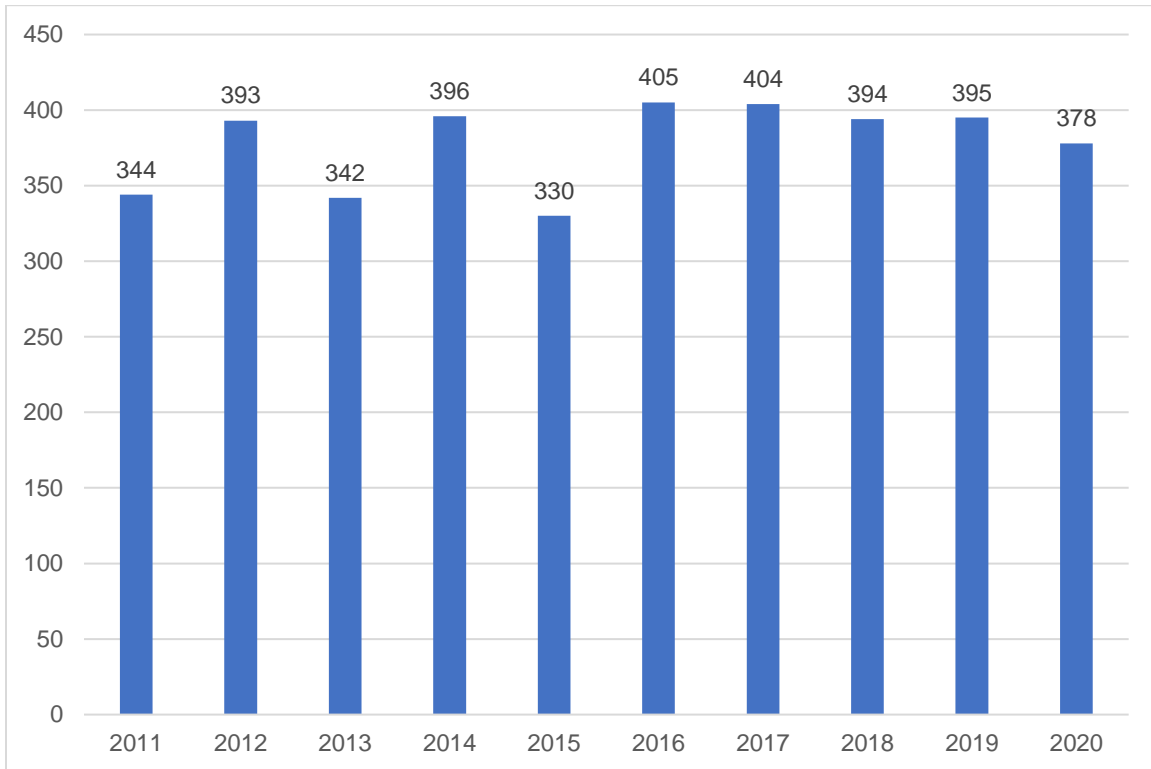


Table 16. Drug Caused Deaths by County of Pronouncement 2020

County	Total
Bernalillo	469
Santa Fe	60
San Juan	51
Rio Arriba	44
Sandoval	41
Dona Ana	39
Valencia	27
Curry	25
McKinley	23
Lea	20
Chaves	18
Eddy	17
Otero	14
San Miguel	13
Socorro	11
Grant	9
Taos	8
Torrance	8
Cibola	7
Sierra	7
Colfax	6
Catron	4
Quay	4
Roosevelt	4
Hidalgo	3
Luna	3
Mora	3
Lincoln	2
Los Alamos	2
De Baca	1
Out of State	8
Total	951

Motor Vehicle-Associated Deaths

Figure 51. Motor Vehicle Associated Deaths (2011 - 2020)



Motor Vehicle-Associated Deaths – Overview

In 2020, OMI investigated 378 motor-vehicle associated deaths, 19.4% of all accidental deaths investigated by OMI in 2020. Included in this classification are deaths of drivers and passengers of cars, trucks, and motorcycles, as well as deaths occurring when a motor vehicle struck a pedestrian or a bicyclist. American Indian decedents were over-represented, with 15.8% of motor-vehicle accidental deaths. Males ages 35 – 44 and 55 - 64 years had the highest number (13.0% each) of motor vehicle-associated accidental deaths. June saw the highest number of motor vehicle deaths (11.9%), while May had the lowest number (6.4%). More motor vehicle deaths occurred on a Tuesday (16.7%) than any other day of the week.

Figure 52. Motor Vehicle Accident vs. Non-Motor Vehicle Accidents 2020

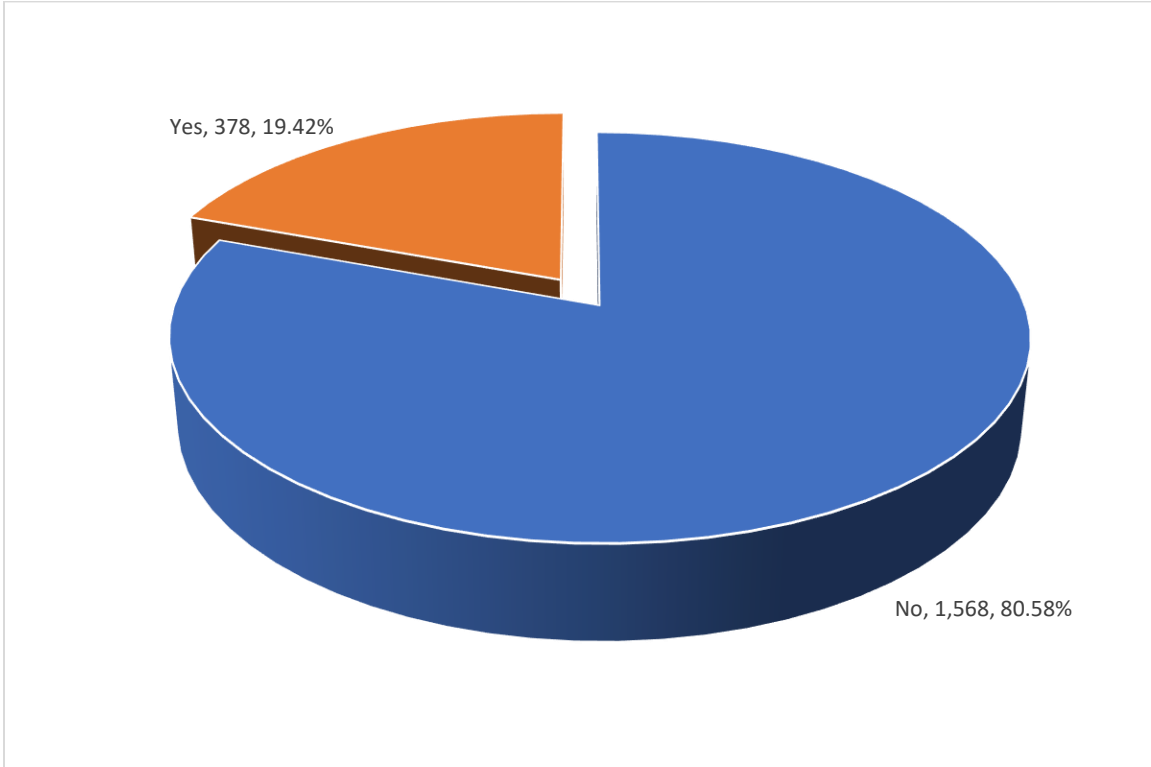


Figure 53. Motor Vehicle-Associated Deaths by Race / Ethnicity 2020

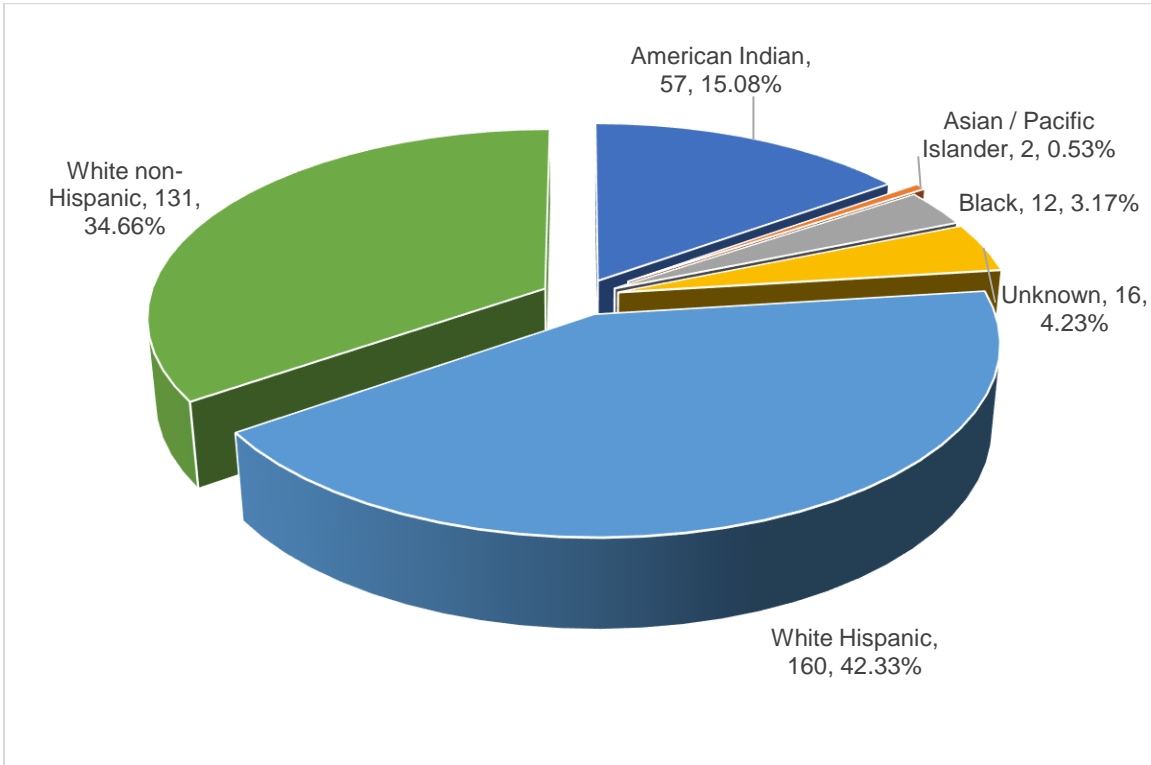


Figure 54. Motor Vehicle-Associated Deaths by Age and Gender 2020

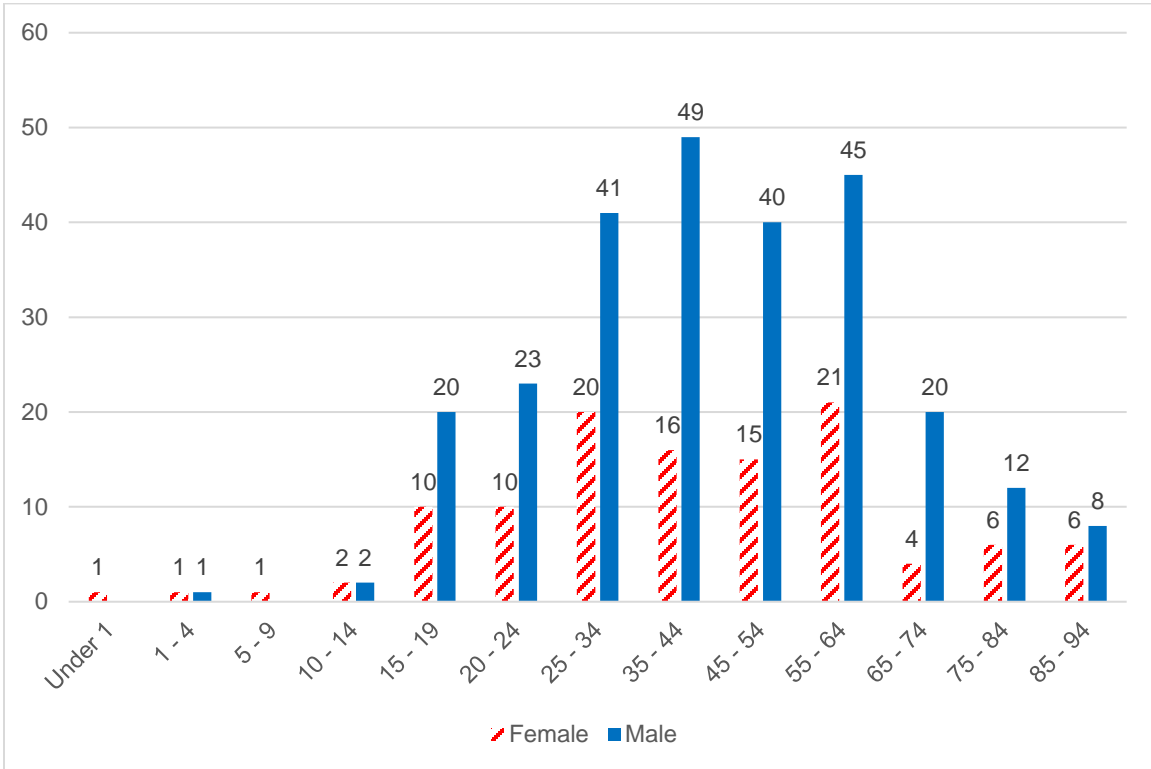


Figure 55. Motor Vehicle-Associated Deaths by Month 2020

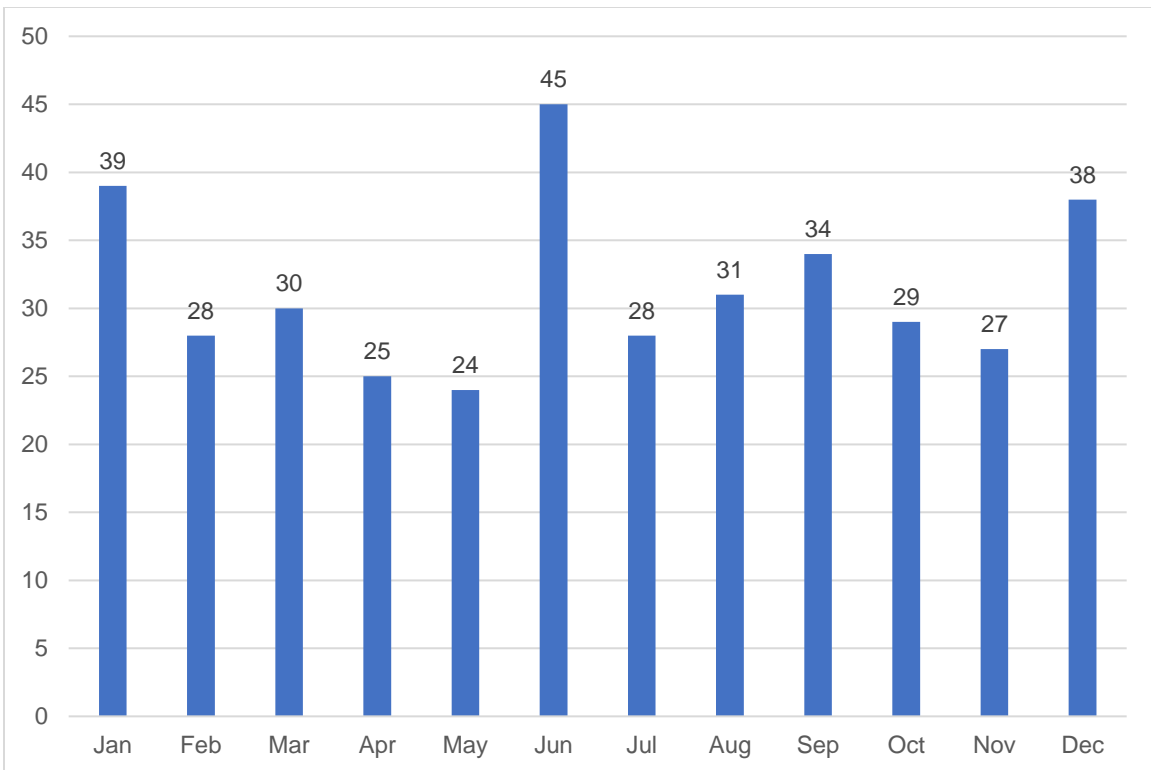


Figure 56. Motor Vehicle-Associated Deaths by Day of Week 2020

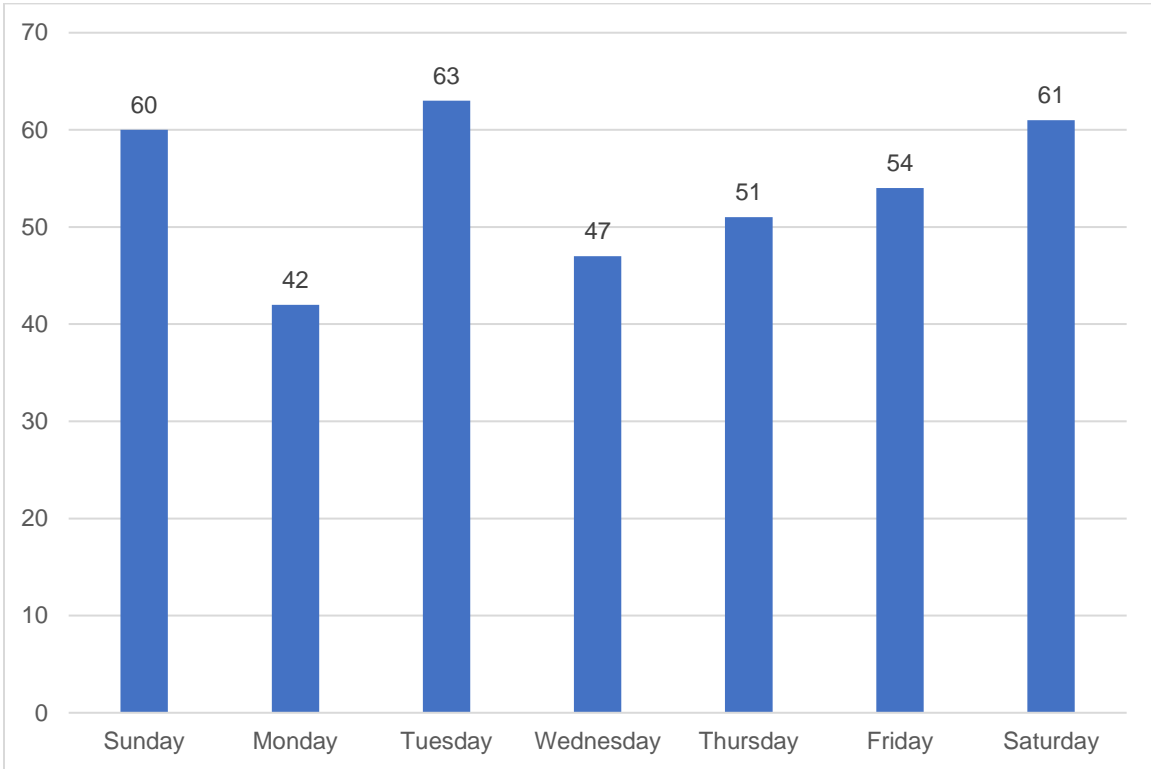


Table 17. Motor Vehicle-Associated Deaths by County of Pronouncement 2020

County	Total
Bernalillo	129
Santa Fe	27
San Juan	23
Dona Ana	17
McKinley	16
Rio Arriba	15
Cibola	14
Lea	13
Eddy	12
Sandoval	11
Chaves	10
Luna	10
Taos	10
Curry	8
San Miguel	7
Socorro	7
Guadalupe	6
Valencia	6
Grant	4
Lincoln	4
Quay	4
Torrance	4
Colfax	3
Hidalgo	3
Otero	3
Union	2
Catron	1
Harding	1
Los Alamos	1
Roosevelt	1
Sierra	1
Out of State	5
Total	378

Glossary

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*. An autopsy may be either ‘full’, with complete dissection and examination of internal structures, or ‘partial’, dissecting only a select portion of the body, such as the brain or abdomen.

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.

Consultation – Autopsies paid for by families, hospitals or investigating agencies, such as the Federal Bureau of Investigations (FBI); these autopsies are not under OMI jurisdiction and are done by request and payment.

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

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.

Exhumation – To remove a deceased body from a pre-existing grave site in order to examine the body and assign a *cause* and *manner of death* or to identify the remains using current information and/or technology.

External Examination – A detailed postmortem external examination of a body, conducted when a full or partial autopsy is determined to not be required.

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/100 milliliters (0.08 g/100mL) 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 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.

Jurisdiction Terminated – Jurisdiction terminated cases are reported to OMI, which is statutorily obligated to review the cases. However, after review proves that there was no foul play and if the decedent’s physician agrees that the death was an expected natural death, the case is then assigned a *cause* and *manner* of death by their physician. The OMI is still obligated to make sure the decedent’s remains are properly cared for.

Field External Examination – An investigation and external examination conducted at the scene to determine cause of death, with no autopsy conducted but under OMI jurisdiction.

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.

Non-accept – Non-accept cases are decedents who have died under the care of a physician, but are reported into the OMI to verify that there is no statutory obligation to investigate the case.

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*.

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