Attachment D
Kevin S. Co-Neutrals' Fatality Review for MA and JG
Summary Findings

This Executive Summary outlines findings from the *Kevin S.* Co-Neutral team's independent review of records associated with the care and deaths of two youth, MA (17 years old) and JG (16 years old) who died while in the care and custody of the New Mexico Children, Youth, and Families Department (CYFD) on May 16 and April 13, 2025, respectively. The Co-Neutral team completed a case review using the FACTS record and, in MA's case, documents provided by CYFD and Presbyterian Health Plan ("PHP" – the HCA-contracted Managed Care Organization for both youth).

At the time of their deaths, both youth were in the custody of CYFD for less than two years, though each was long known to the agency. The Co-Neutrals examined the systemic challenges and failures which appear to have prevented MA and JG from receiving certain safety, stability, and therapeutic support from CYFD – as their legal guardian – and HCA – as the state agency responsible for coordinating and ensuring access to healthcare. In many instances, the records show that MA and JG demonstrated resilience, sought help from CYFD when in crisis, and frequently showed a desire for connection to supportive adults and stability during their time in custody. MA hoped to be placed with her sister, never missed a prenatal care visit, and was open to a connection with her foster parent in her last placement. JG repeatedly asked for developmentally appropriate assistance: a job, schooling, and behavioral health care.

A significant limitation of this review is the lack of complete documentation and records available within FACTS. Due to the gaps in information available in FACTS, the Co-Neutrals repeatedly requested documents and information on April 15 and 18, May 5, and June 12 and 13 from both CYFD and HCA related to services and care for these youth, as well as information about their deaths; some but not all of this information was provided.

Key Findings

1. **At the time of their deaths, neither youth was placed in a stable family-based setting with adequate support to transition and sustain the placement while in CYFD custody. The records exemplify the inadequacy of services for children in state custody.**

2. **The placement planning processes appear from the records to have been largely untimely, uncoordinated, scattershot, and inappropriately restrictive. The records exemplify the inadequate supply of safe, family-based placements in New Mexico for children in state custody.**

3. **The youth's CYFD primary permanency coordinator (PC) case workers changed frequently, which hampered efforts to meet the youth's needs and compromised coordination with other assigned staff, including the Community Behavioral Health Clinician ("CBHC"), Independent Living ("IL") staff, and Presbyterian Health Plan ("PHP") care coordinator ("CC") and clinical staff.** The records indicate that each youth had the benefit of at least one determined and skilled staff person at some point during their time in care who advocated, mostly unsuccessfully, for their needs and wants. **The records exemplify the negative impact on children of continuous CYFD staff turnover.**

4. **Therapeutic and supportive services were not provided consistently and, in some instances, not provided at all. The records exemplify the inadequacy of behavioral health services for children in state custody.**

5. **The administrative response to MA and JG's deaths by CYFD was fully inadequate, marked by incorrect information, poor inter-agency coordination and the slow exercise of post-fatality investigation and oversight. Symptomatic of this approach, CYFD often pledged to provide key information and reports to the Co-Neutrals, which typically did not arrive as promised, if at all. In JG's case, there was inadequate follow-up with the institution where he resided to ensure the safety and well-being of the remaining residents and to correct failures related to supervision and safety.**