Understanding Female-Identified Homicide Decedents in Maryland

Grace Douglass, MPH, Carley Graves, BS, Georgette Lavetsky, MHS, Jacqueline Shanks, MPH, Katelyn Mullins, MPH

Maryland Department of Health, Baltimore, MD

Background

Homicide is a persistent public health issue in Maryland. Maryland's homicide rate overshadows the national rate, with 12.2 deaths per 100,000 residents vs. 7.8 deaths per 100,000 nationally[1]. Maryland saw a 60% increase in homicides between 2012 and 2020 (58.2% and 61.9% among males and females, respectively), with noticeable spikes in 2015 and in 2020. Between 2019 and 2020, there was a 6.3% increase in the number of male homicide decedents, while the number of female homicide decedents increased by 55.7%[2]. In addition, 2012 National Intimate Partner and Sexual Violence Survey (NISVS) data indicated that 34.4% of women and 28.8% of men in Maryland reported experiencing sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime[3]. In 2020, COVID-related restrictions raised concerns about exacerbation of tensions in households experiencing intimate partner violence (IPV) and domestic abuse and risk for homicide.

Objectives

The objectives of this analysis are:

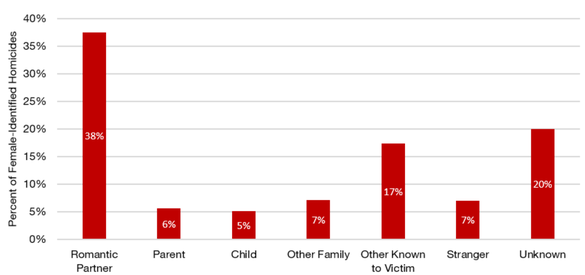
(1) Describe the circumstances of homicides of female-identified decedents, and

(2) Assess changes in circumstances of homicide coinciding with the onset of the COVID-19 pandemic and COVID-related restrictions.

Methods

The Maryland Violent Death Reporting System (MVDRS) is an enhanced surveillance system that collects a detailed body of information concerning violent death incidents occurring in Maryland by systematic review, documentation, and synthesis of data from death certificates, medical examiner reports, and law enforcement reports. The MVDRS has been administered and funded by the National Violent Death Reporting System (NVDRS), a project of the Centers for Disease Control and Prevention (CDC), since its inception in 2002. Data from the 2012-2020 MVDRS were used to analyze differences in demographics, weapons, circumstances, and victim-suspect relationship for all female-identified homicide decedents (cisgender women and male-to-female transgender women). Transgender males and legal intervention deaths were excluded. SAS 9.4 was used for all analyses.

Figure 1: Female-identified homicide victim-suspect relationships, 2012-2020



Data source: 2012-2020 Maryland Violent Death Reporting System

Table 1: Demographics of female-identified homicide decedents (N=696), 2012-2020

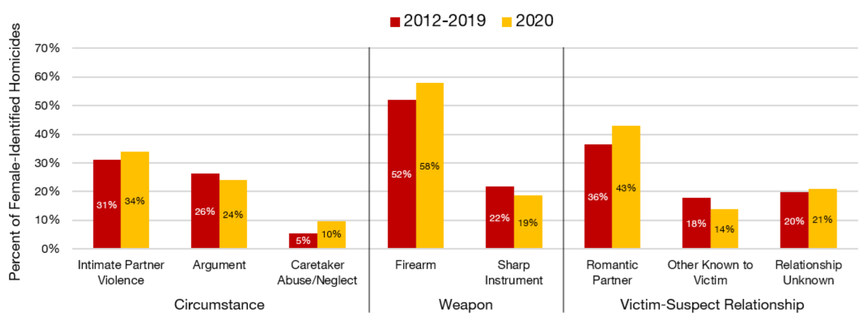
	N	Percent
Gender		
Cisgender Female	684	98%
Transgender Female	12	2%
Race/Ethnicity		
White, non-Hispanic	223	32%
Black, non-Hispanic	403	58%
Other, non-Hispanic	22	3%
Hispanic	48	7%
Age		
<18	83	12%
18-24	109	16%
25-34	167	24%
35-44	116	17%
45-54	102	15%
55-64	49	7%
65+	70	10%
Residential Area		
Large metropolitan	647	93%
Other metro/rural	47	7%

Table 2: Circumstances reported in homicides of female-identified victims, 2012-2020

	N	Percent
Circumstance		
Intimate Partner Violence	220	32%
Argument	181	26%
Precipitated by Other Crime	69	10%
Caretaker Abuse/Neglect	43	6%
Precipitating Crime in Progress	37	5%
Physical Fight	35	5%
Family Problems	29	4%
Substance Abuse Problem	28	4%
Drug-related	24	4%
Current Mental Health Problem	23	3%
Jealousy	21	3%
Interpersonal Violence	20	3%
History of Behavioral Health Treatment	17	2%
Walk-by Attack	17	2%
Alcohol Problem	16	2%
Drive-by Shooting	15	2%
Victim was Bystander	14	2%
History of Abuse/Neglect as Child	13	2%
Friend Problems	12	2%
Current Behavioral Health Treatment	12	2%
Prostitution	11	2%

Note: More than one circumstance can apply to homicides of female-identified victims.

Figure 2: Changes in selected circumstances, primary weapons, and primary victim-suspect relationships: Pre-pandemic (2012-2019) vs 2020



Data source: 2012-2020 Maryland Violent Death Reporting System

Results

There were 696 female-identified decedents in Maryland between 2012-2020. Demographics are provided in Table 1. Firearms were the most common weapon, (n=369, 53%), followed by sharp instruments (n=148, 21%), and strangulation, hanging, and suffocation (n=55, 8%). Romantic partners were the most common type of suspect (n=203, 38%); followed by suspects known to the victim, but not a romantic partner or family member (n=94, 17%). The relationship to the victim was unknown for 20% of primary suspects (Figure 1). Table 2 shows the prevalence of homicide circumstances among female-identified decedents. The most common circumstance reported was IPV, with violence between current or former intimate partner(s) reported in almost one-third of deaths (32%). Nearly one in twenty decedents who experienced IPV, and/or for whom the primary suspect was a romantic partner, were known to be pregnant at the time of death or in the year preceding death. Figure 2 shows that between the pre-pandemic period (2012-2019) and 2020, the prevalence of the following increased: IPV (31% to 34%), caretaker abuse/neglect (5% to 10%), firearms as the primary weapon (52% to 58%), and romantic partners as the primary suspect (36% to 43%); although these changes were not statistically significant. Between 2019 and 2020, the prevalence of IPV increased from 21% to 34% and the prevalence of romantic partners as primary suspects increased from 29% to 43%.

Discussion

While males are much more frequently homicide victims, the spike in homicide in 2020 disproportionately affected females. IPV was also more common in 2020 than in previous years. These increases highlight the need to direct injury prevention efforts towards preventing IPV as a mechanism for preventing homicide. Looking ahead, research is needed to identify systemic intervention points and effective interventions to support IPV survivors with high lethality risk during public emergencies (hospital, police, shelters, public health agencies, etc.), and to identify opportunities for prevention and informing policy. The findings additionally underscore the importance of disseminating and implementing domestic violence fatality review recommendations within sectors and systems that can intervene in high-risk IPV cases to prevent IPV homicides, such as criminal justice systems, health care, victim services, and abuser intervention programs. MVDRS identified limitations within the analysis due to limited suspect, circumstance, and weapon information in available source documents, particularly in urban areas where a large majority of homicides occured. Higher-quality data would provide greater insight into how data users can reduce IPV and prevent female-identified homicide in future stay-at-home situations.

This work was supported in part by U.S. Centers for Disease Control and Prevention Cooperative Agreements NU17CE10162 and NU17CE924950.

[1]Homicide Mortality by State. Centers for Disease Control and Prevention. March 2, 2022. Accessed May 30, 2023. https://www.cdc.gov/nchs/pressroom/sosmap/homicide_mortality/homicide.htm.

[2]WISQARS Fatal Injury Data Visualization Tool. Centers for Disease Control and Prevention. May 18, 2023. Accessed June 6, 2023. https://wisqars.cdc.gov/data/explore-data/home.

[3]Smith SG, Chen J, Basile KC, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. The National Intimate Partner and Sexual Violence Survey. April 2017. Accessed June 7, 2023. https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf.