

Child Deaths by Homicide

Maryland Child Fatality Review, 2010-2019



Introduction to Child Fatality Review

Child Fatality Review (CFR) is a systematic, multi-agency, and multi-disciplinary review of unexpected child deaths. The Maryland CFR Program was established by statute in Health General Article, § 5-702 4(b)(12) and Senate Bill 464 (Chapter 355 of the Acts of 1999) and is housed within the Maryland Department of Health (MDH). Local CFR teams operate in each Maryland jurisdiction and receive notice from the Office of the Chief Medical Examiner (OCME) of unexpected resident deaths of children under age 18. This report examines data related to 2010-2019 unexpected child deaths by homicide available as of October 2021. Only deaths which were reviewed by local teams were included in this analysis. There were 243 reviewed child deaths by homicide during this time period.

Child Deaths by Homicide

Death by homicide was the fourth leading manner of unexpected child deaths in Maryland during the ten-year period from 2010 to 2019; accounting for 15% of all reviewed unexpected child deaths. The number of child deaths by homicide reached a ten-year high in 2019, with 29 total deaths (Figure 1). This represents a 53% increase from the 2012 number of 19 deaths, the lowest recorded number of deaths during the ten-year time period. Of the 243 deaths by homicide occurring in the ten-year period from 2010-2019, more than three-quarters were among Black non-Hispanic (NH) children (77%, Figure 2) and nearly three-quarters were among male children (73%, Figure 3). Children ages 15-17 years old made up more than half of all reviewed child homicide deaths (54%, Figure 4).

Figure 1: Annual Number of Reviewed Child Fatalities by Homicide, Maryland, 2010-2019

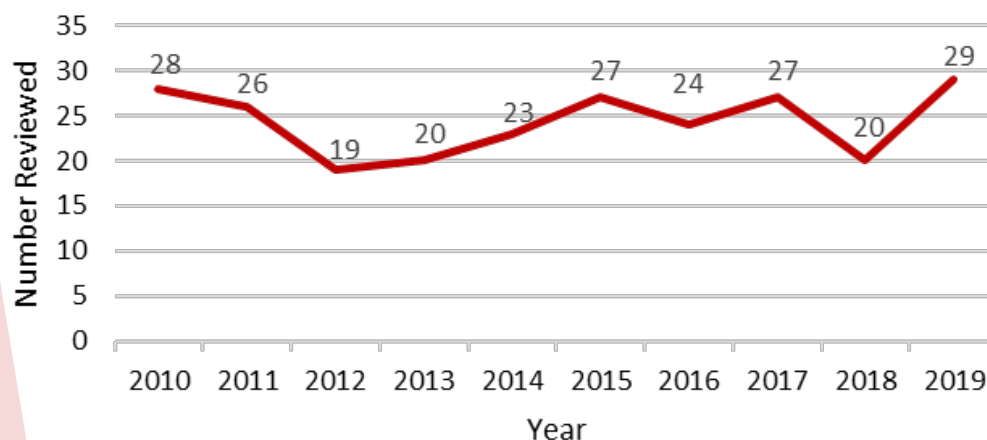


Figure 2: Homicide Child Fatalities by Race/Ethnicity

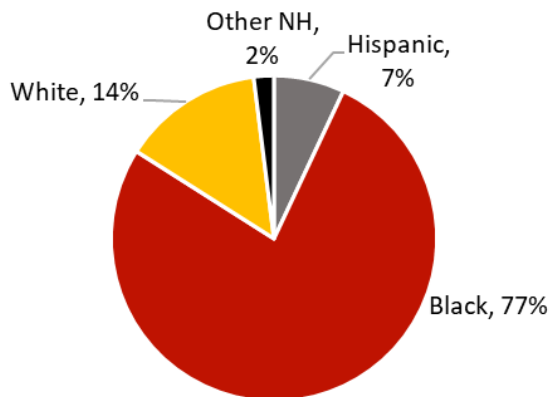


Figure 3: Homicide Child Fatalities by Sex

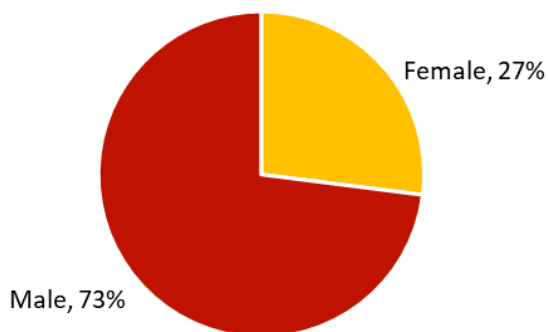


Figure 4: Homicide Child Fatalities by Age Group

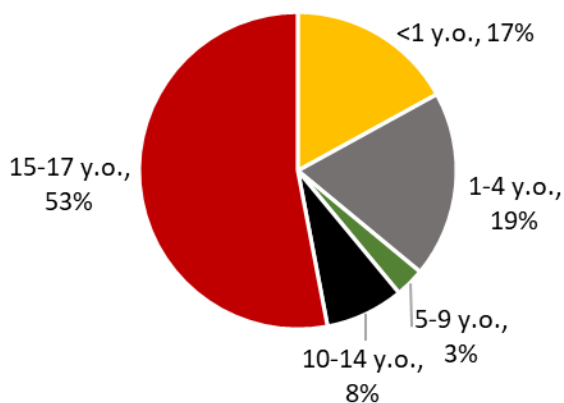


Table 1 shows the number and percent of reviewed child fatalities by homicide by jurisdiction of residence. Baltimore City had the highest number of reviewed child deaths by homicide during this time period at 129, which is more than four times the number of deaths in the next highest jurisdiction. Deaths in Baltimore City accounted for more than half of all reviewed child deaths by homicide during this time period. There were no deaths by homicide during this time period in Caroline, Dorchester, Garrett, Kent, Queen Anne’s, or Talbot Counties.

Table 1: Homicide Child Fatalities by Selected Demographic, Maryland, 2010-2019

	Number	Percent
Total	243	100.0
Baltimore City	129	53.1
Baltimore	28	11.5
Prince George’s	26	10.7
Anne Arundel	20	8.2
Harford	6	2.5
Frederick	5	2.1
Wicomico	5	2.1
Charles	4	1.7
Montgomery	4	1.7
Cecil	3	1.2
Howard	3	1.2
Washington	3	1.2
St. Mary’s	2	0.8
Allegany	1	0.4
Calvert	1	0.4
Carroll	1	0.4
Somerset	1	0.4
Worcester	1	0.4

Cause of Death

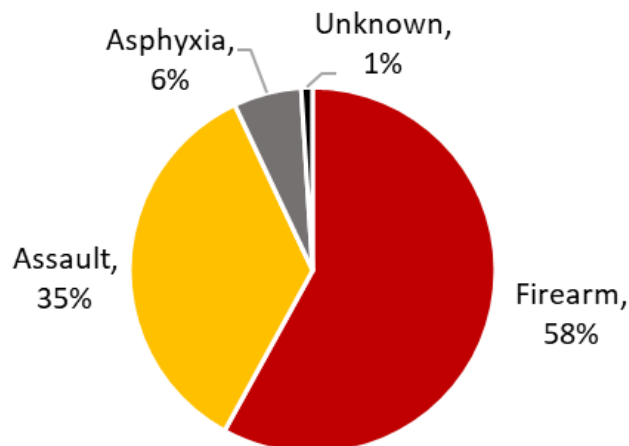
Table 2 shows the deaths by homicide by cause of death. Weapons made up approximately 92 percent of the cause of death.

Table 2: Homicide Child Fatalities by Cause of Death, Maryland, 2010-2019

	Number	Percent
Total	243	100.0
Weapon	224	92.2
Poison	7	2.9
Motor Vehicle	4	1.7
Fire, Burn, Electricity	4	1.7
Malnutrition, Dehydration, Neglect	2	0.8
Unknown	2	0.8

Figure 5 shows the deaths by homicide by weapon type. Among the 224 homicide deaths by weapon, firearms made up 58 percent of the weapons, assault (by body parts or objects) made up 35 percent, and weapons used to asphyxiate made up six percent.

Figure 5: Homicide Child Fatalities by Weapon Type



Comparison of Firearm and Assault Deaths

Table 3 compares characteristics of assault and firearm homicide deaths. Homicides caused by assault were significantly more prevalent among non-Hispanic White children. Assaults were significantly more likely to occur in the child’s home and be perpetrated by the child’s biological parent. Significantly more assault deaths were ruled by the review team to be child abuse. Firearm deaths were significantly more prevalent among males, children ages 10 or older, and non-Hispanic Black children.

Table 3: Comparison of Firearm and Assault Homicide Child Fatalities, Maryland, 2010-2019

	Assault (n=78)	Firearm (n=131)
Gender: Male*	46 (59%)	110 (84%)
Age: 10 years or older*	23 (29%)	119 (91%)
Race: Non-Hispanic White	13 (17%)	12 (9%)
Race: Non-Hispanic Black*	56 (72%)	111 (85%)
Health Insurance: Medicaid	46 (59%)	67 (51%)
Child had a history of maltreatment	22 (28%)	24 (18%)
Child had a history of drug use*	6 (8%)	45 (34%)
Child had a criminal history*	9 (12%)	71 (54%)
Child had problems in school*	13 (17%)	81 (62%)
Incident occurred in child’s home*	43 (55%)	18 (14%)
Perpetrator: Biological parent*	33 (42%)	5 (4%)
Child abuse/neglect*	50 (64%)	3 (2%)

*denotes differences that are greater than would be expected by chance alone, i.e. a statistically significant difference at $p < 0.05$.

Conclusions

Between 2010 and 2019, child death by homicide was the fourth leading manner of unexpected child deaths in Maryland. The number of child deaths by homicide reached a ten-year high in 2019, with 29 total deaths. Of the 243 deaths by homicide occurring in this ten-year period, the majority occurred among male, teen, Black non-Hispanic (NH) children in Baltimore City.

Weapons made up approximately 92 percent of the cause of death between 2010 and 2019. Among the 224 homicide deaths by weapon, firearms made up the majority of the weapons. Firearm deaths were significantly more prevalent among males, children ages 10 or older, and non-Hispanic Black children. Homicides caused by assault were significantly more prevalent among non-Hispanic White children, more likely to occur in the child's home, and be perpetrated by the child's biological parent.

Public health efforts should focus significant resources to reduce risks associated with child homicide caused by firearms, especially in jurisdictions most impacted. Outreach should be targeted to assisting, protecting, and uplifting the male, teen, Black non-Hispanic population. Research and program efforts should integrate other social determinants of health when attempting to implement positive and sustainable change.

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